NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 28 January 2022, 9:15 AM — 12:30 PM GMT
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 28 January 2022 at 9:15am. The meeting will be held virtually via video conferencing 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".
Organiser	Karen McHugh

Agenda

AGENDA

WSFT Public Board Agenda - 28 Jan 2022.docx

1. GENERAL BUSINESS

1.1. Apologies for absence: Jude Chin
To Note - Presented by Alan Rose

1.2. Declaration of interests for items on the agenda
To Assure - Presented by Alan Rose

1.3. Minutes of the previous meeting - 17 December 2021
To Approve - Presented by Alan Rose

Item 1.3 - Open Board Minutes 2021 12 17 Dec Draft.docx

1.4. Action log and matters arising
To Review - Presented by Alan Rose

Item 1.4 - Action Log - Open.pdf

Item 1.4 - Action Log - Completed.pdf

1.5. Appointment of Interim Chair
To Note - Presented by Alan Rose

Item 1.5 - Appointment of Interim Chair - report to Board.docx

1.6. Patient story
To Note - Presented by Susan Wilkinson

1.7. Chief Executive's report
To inform - Presented by Craig Black

Item 1.7 - CEO Board report January 2022.docx

2. ASSURANCE

2.1. Insight Committee Report - January 2022 - Chair's Key Issues from the meeting
To Assure - Presented by Richard Davies

Item 2.1 - Insights Chairs key issues - January 2022 meeting.docx

Item 2.1 - Insight 4.1v2 - Dashboard update for Insight 100122.docx

Item 2.1 - Interim IQPR indicators v2.xlsx

Item 2.1 - Insight 4.2 WSFT INSIGHT COMMITTEE_IS Project Work Update_220110.doc

2.2. Finance and Workforce Report
To Assure - Presented by Nick Macdonald

Item 2.2 - Finance_Board_Report_front sheet_Dec2021.docx

Item 2.2 - Finance Report - M09 2122 FINAL.docx

2.3. IQPR - November 2021 data
To Note - Presented by Susan Wilkinson and Nicola Cottington

Item 2.3 - IQPR Trust Board Report November 2021.pdf

2.4. Improvement Committee Report - December 2021 Chair's key issues from the meetings

To Assure - Presented by Louisa Pepper

Item 2.4 - Chairs key issues - Improvement Committee report for board - December 2021.docx

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2.5. Maternity services quality & performance report

To Assure - Presented by Susan Wilkinson and Karen Newbury

Item 2.5 - January 2022 Maternity Quality Safety Perfomance Board Report.docx

Item 2.5 Annex A - Action plan following Exception report for Thematic review of 3 Intrapartum still births.docx

Item 2.5 Annex C - Roll out of Midwifery Continuity of Carer, December 2021 - Final Version.docx

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2.6. Infection prevention and control assurance framework

To Assure - Presented by Susan Wilkinson

Item 2.6 - 22-01-28 IPC.docx

2.7. Nursing staffing report

To Assure - Presented by Susan Wilkinson

Item 2.7 - Nurse Staffing NovDec FINAL.docx

2.8. Quality and Learning Report

To Assure - Presented by Susan Wilkinson

Item 2.8 - 22-01-28 Quality and Learning report.docx

2.9. Involvement Committee Report - January 2021 - None to report

To Assure - Presented by Alan Rose

2.10. People & OD highlight report

To Assure - Presented by Jeremy Over

Item 2.10 - People OD highlight report January 2022 FINAL.docx

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2.11. Charitable Funds Annual Report 2020/21

To Assure - Presented by Nick Macdonald

Item 2.11 - Charitable Funds annual report 2020 21 cover sheet.docx

Item 2.11 - Charitable Funds Annual report 20-21 V3 251021 (002) - FINAL VERSION.pdf

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2.12. Integration Report - Q3

To Assure - Presented by Kate Vaughton and Clement Mawoyo

Item 2.12 - WSFT board Jan 22_Integration Paper_FINAL.docx

10.30 am - Comfort Break - 10 minutes

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3. CULTURE

3.1. West Suffolk Review – Organisational Development plan

To Assure - Presented by Jeremy Over

Item 3.1 - West Suffolk Review - Organisational development plan Jan22.docx.docx

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3.2. Safe Staffing Guardian - Quarterly Report

To Assure - Presented by Paul Molyneux

Item 3.2 - WSFT Safe Staffing Guardian cover sheet - January 2022.docx

Item 3.2 - Safe staffing Guardian Quarterly Report October - December.docx

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4. STRATEGY

4.1. Digital strategy

To Approve - Presented by Nick Macdonald

Item 4.1 - Trust board - Digital strategy.docx

Item 4.1 - Digital strategy 2022-2026.pptx

4.2. Future system board report

To inform - Presented by Craig Black

Item 4.2 - WSFT Future System Public board report - January 2022.docx

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4.3. Digital pathology business case
To Approve - Presented by Nick Macdonald

Item 4.3 - 20220124 Digital Pathology Full Business-Case January Board FINAL.docx

Item 4.3 - Supporting Information.docx

4.4. Trust strategy
To inform - Presented by Craig Black

Item 4.4 - Cover sheet for Trust strategy launch 28012022.docx

Item 4.4 - Our vision - trust strategy.pptx

Item 4.4 - WSFT Our Strategy v3 ab small.pdf

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5. GOVERNANCE

5.1. BAF Summary and risk report
To Assure - Presented by Ann Alderton

Item 5.1 - BAF Summary and Risk Report.docx

5.2. Governance report
To Assure - Presented by Ann Alderton

Item 5.2 - January 2022 Governance Report.docx

5.3. Register of Interests Annual Report
To Assure - Presented by Ann Alderton

Item 5.3 - Register of Interests Annual Report.docx

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6. OTHER ITEMS

6.1. Questions from Governors and the Public
To Note

6.2. Any other business
To Note

6.3. Date of next meeting - 25 March 2022
To Note

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 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

Board Context

Trust Board Purpose
The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Our Vision and Strategic Objectives			
Vision Deliver the best quality and safest care for our local community			
Ambition	First for Patients	First for Staff	First for the Future
Strategic Objectives	• Collaborate to provide seamless care at the right time and in the right place • Use feedback, learning, research and innovation to improve care and outcomes	• Build a positive, inclusive culture that fosters open and honest communication • Enhance staff wellbeing • Invest in education, training and workforce development	• Make the biggest possible contribution to prevent ill-health, increase wellbeing and reduce health inequalities • Invest in infrastructure, buildings and technology

Our Trust Values	
Fair	We value fairness and treat each other appropriately and justly.
Inclusivity	We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.
Respectful	We respect and are kind to one another and patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.
Safe	We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.
Teamwork	We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

Our Risk Appetite

1. GENERAL BUSINESS

1.1. Apologies for absence: Jude Chin

To Note

Presented by Alan Rose

1.2. Declaration of interests for items on the agenda

To Assure

Presented by Alan Rose

1.3. Minutes of the previous meeting - 17 December 2021

To Approve

Presented by Alan Rose

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 17 DECEMBER 2021 AT WEST SUFFOLK HOSPITAL
Via Microsoft Teams

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Nicola Cottington	Chief Operating Officer	•	
Craig Black	Interim Chief Executive	•	
Jude Chin	Interim Non Executive Director	•	
Richard Davies	Non Executive Director	•	
Christopher Lawrence	Non Executive Director	•	
Nick Macdonald	Interim Executive Director of Finance	•	
Paul Molyneux	Interim Executive Medical Director	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	•	
Alan Rose	Non Executive Director	•	
Sue Wilkinson	Executive Chief Nurse	•	
In attendance			
Ann Alderton	Interim Trust Secretary		
Helen Davies	Head of Communications		
Georgina Holmes	Trust Office Manager *(minutes)*		
Clement Mawoyo	Director of Integrated Services		
Daniel Spooner	Deputy Chief Nurse		

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 Teams Live to enable the governors and public to observe the meeting.

Action

21/184 GENERAL BUSINESS

184.1 APOLOGIES FOR ABSENCE

There were no apologies for absence.

- The Chair welcomed everyone to the meeting; she referred to the independent review and personally, and on behalf of the board, reiterated her unreserved apology for all the hurt to staff, families and everyone involved.
- She also thanked everyone in the team for the progress that had been made during the last year to address the issues raised. There was still a long way to go and this would continue to be an ongoing process.

184.2 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

184.3 MINUTES OF MEETING HELD ON 15 OCTOBER 2021

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

Page 4, item 21/170, final bullet point – to note that this referred to the flu vaccination programme as opposed to Covid vaccinations or boosters.

184.4 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following updated provided:

Ref 1974; provide further information to the board on the ward accreditation programme. It was explained that the process for this was still being worked through.

The completed actions were reviewed and no issues were raised.

184.5 STAFF STORY – PATIENT SAFETY SPECIALISTS

- Sue Wilkinson introduced and welcomed Lucy Winstanley, head of patient safety and Megan Pontin, one of the Trust's patient safety incident investigators, who would be giving a brief summary of work undertaken to date and introduce the role of the patient safety specialist.
- In July 2019 the NHSEI produced the NHS patient safety strategy. All NHS organisations were asked to build on two foundations, a patient safety culture and a patient safety system. This included insight, involvement and improvement which the Trust had worked hard throughout the year to embed.
- The strategy also identified the need for patient safety specialists. The role of these individuals was explained together with the structure of the Trust's patient safety team, which included the requirement for a NED lead for patient safety.

Action: identify NED lead for patient safety. **S Childerhouse**

- In June 2021 the Trust had appointed two patient safety incident investigators to lead on the implementation of the patient safety incident response framework (PSIRF).
- The national strategy had a number of key deliverables which the Trust was on target to achieve and the national patient safety priorities had been embedded in a local priority plan which was being monitored through the improvement committee.
- The local priorities for the next 12-18 months were outlined together with the work being undertaken to progress these, including promoting a culture of openness and transparency which everyone was committed to.
- It was noted that it was very difficult to measure safety and quality and this was a continuous journey of improvement.
- It was important that learning was shared organisationally, not just pockets within the organisation.
- Board members were asked to support the work being undertaken on patient safety and also to complete the training module on patient safety that had been specifically designed for executives and board members.

Q How does this dovetail with learning from incidents and how did the Trust support staff who were involved in safety incidents?

A The emphasis was on undertaking different types of investigations which could be very timely, and supporting colleagues on this journey. There was now a different approach to investigations which included talking to staff and making sure they understood the process; they were involved throughout and given the opportunity to comment on draft and final reports. The aim was to keep staff, patients and relatives up to date on the whole investigation process. This approach had been very positively received by staff.

Q There were very clear asks of the executive team and board members, including identifying a NED lead and completion of the patient safety module. What was the timescale for delivery of these?

A This would be agreed with the Chair.

Action: agree date for completion of patient safety module by board members. **S Childerhouse**

Q The principle that the patient safety team were trying to adopt was in line with what was now being done with HR processes, ie understanding why something had gone wrong rather than blaming someone, as well as ensuring that staff wellbeing was embedded at the centre of this. The HR team were there to support the development of this; had Lucy Winstanley been able to link up with the HR team to ensure alignment?

A Work around restorative culture was key. Working collaboratively with the HR team would be very helpful to ensure support through the patient safety journey.

Q What part did internal communications play in terms of openness and transparency around investigations and learning from them, ie you said, we did?

How quickly were investigations taking place as individuals could be in a vacuum whilst waiting this to happen? It was not good for anyone if they were taking a long time.

A The time frames were similar to before as it was important to take time to undertake a thorough investigation. However, the difference now was that individuals were being kept in the loop to ensure that their voices were heard and they were fully involved in the process. Flexibility was required as to the time it took for an investigation to take place, depending on the complexity. Although some investigations were still taking a long time, after action reviews were undertaken very quickly.

It was reported that staff across the organisation were now feeling much more supported.

Q How would the patient safety team know in a year's time whether this had worked or not, ie was the organisation improving or not?

A This would be very difficult as it often involved measuring qualitative data. However, it would be possible to tell if things felt different; part of the PSIRF approach took away the onus for a number of investigations to be undertaken. Staff were now involved in the whole journey and it was their recommendations and actions that came out of this.

The team would welcome any suggestions for the measurement of this, eg % reduction in harm for specific areas. This was already being demonstrated through improvement plans that were being taken to the improvement committee.

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The staff survey also may provide some clues how to do this. Measures needed to be put in place which would highlight if there were pockets in the organisation where there were things that could be improved more than in other areas.

The Trust was moving to a new national system that captured data on reporting and learning; this would help to identify recurrent themes or causes for concern.

Looking back at previous RCAs had highlighted how much progress had been made and that this was moving in the right direction.

Six doctors had been trained to provide peer support for people involved in an investigation. Once this was embedded the team would get feedback from those involved in the process.

184.6 CHIEF EXECUTIVE'S REPORT

- Winter pressures had meant that the Trust was very busy across both the hospital and community. This was having a considerable impact on staff who were already exhausted.
- The organisation was now coming up to two years without a break in pressure and having experienced last winter staff had an idea of what was to come. Although a lot had been learnt from last year there was nothing that could be done to make it better or easier.
- It was not only hard for staff working in the organisation but also for patients and their families. The Trust had made the decision to suspend visiting as a safety measure; the increase in infection rates in the community demonstrated how important the decision was.
- The omicron variant was transmitting very rapidly in the community and there was a very real risk of this happening within the hospital.
- As well having to deal with the impact of the pandemic at work staff were also having to deal with the same issues as everyone else outside work. The workforce was 80% female which meant that the impact of this was being felt more, ie due to children being sent home from school etc. This was common across the whole health service.
- WSFT was partaking in the roll out of the booster campaign across the community and was being asked to deliver approximately double the number of vaccinations it had been expecting to deliver.
- The independent review was published last Thursday; the board had only received a copy of the document about 50 minutes before it was published.
- Craig Black gave his personal perspective of the content of the review. He had a mix of emotions when he read it and was very uncomfortable, angry, disappointed and embarrassed. It did not reflect the organisation that he thought he was working in or wanted to work in. He was very proud of the organisation and believed that it delivered a service way above the standard that was expected from a district general hospital.
- The review was a definitive version of events and Dr C and Dr E had been completely vindicated. Craig Black and the organisation owed them an apology and also a degree of admiration for the persistence that was highlighted in the review and was something that few people would be able to demonstrate. This was due to their absolute focus on patient safety.

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- The organisation had already started to implement actions and improvements but there was still a long way to go and this was a journey that would never be complete as the Trust should continually strive to improve culture.
- The Trust would have to produce an action plan in response to the review. A meeting had taken place with the regulators who were clear that they did not believe that there was any regulatory action that came out of the review but there was a requirement to address all of the issues through an action plan. This had to be shared with the regional office before the end of January; it would be reviewed by the board at the meeting on 28 January. It was important that people across the organisation had the opportunity to have input in this plan.
- As soon as the review was published the Trust immediately arranged staff briefings and board members had been out into the organisation and spoken to staff. Meetings had also taken place with Unison representatives, the medical staff committee and council of governors.
- This process of engagement would continue as the action plan developed to ensure that it was as comprehensive as possible and to demonstrate to staff that their suggestions had been incorporated into it. They would also have the ability to hold the board to account to deliver what they said were going to deliver.
- It was recognised that this would be a plan that was constantly evolving.

Q Re the process for the action plan; the board had not been able to meet in person to discuss this. Was it possible for this take place before the end of January to ensure that everyone agreed what they were committing to?

A As well as getting together as a board, there was also a need to think about how to engage with the organisation, which to date had been executive led, but it was important that this was done as a unitary board.

ACTION: Consider how to engage with the organisation as a unitary board, re the action plan in response to the review. — **J Over**

Q Details were provided at the end of the review on actions that had already been taken subsequent to the incident. Could assurance be provided that these actions had been embedded in the organisation and were effective, as this should help to ensure that something like this did not happen again?

A A number of people had worked hard on actions to improve things and embed these and ensure that they reached every corner of the Trust. It was important to get much better at understanding where particular teams in the organisation might need greater support, rather than just at an organisational level.

Q Some of the items listed on page 202 of the report (best practice learnings) would be reflected in the action plan. How would the board have clarity on the outcome expected from these actions? Some of these may be difficult to measure but there was a need to identify expected outcomes and targets.

A The board would need to consider how to measure this.

ACTION: Consider how to measure the outcomes and targets from actions put in place as a result of the review. — **S Childerhouse**

Q Were the freedom to speak up guardians invited to present to the board?

A The freedom to speak guardians attended board meetings on a quarterly basis to present a written report.

Q Given the pressures on the organisation and capacity available, were conversations taking place in terms of what the organisation could do and what it could not do?

A These discussions took place within the organisation almost on a daily basis. When it was under pressure it was important not to force people to do everything they would normally do. The board needed to look at what the priorities were and if there was the capacity to deliver all of these.

From an operational point of view the team was frequently assessing what needed to be prioritised. This was the same across the ICS and the local alliance. A letter had recently been received from NHSEI relating to the national incident level 4 setting out specification actions around prioritisation of work, however it did not allow organisations to reduce or stop any activities. The RAAC programme also put increased pressure on staff.

Q Re the pressure on staff and the organisation and Craig Black's comment that there was nothing that could be done to make it better or easier; previously feedback from staff was that recognition for their hard work made a big difference, ie through free car parking, free hot drinks etc. Was the Trust doing everything it could around these small gestures to make staff feel appreciated and supported?

A The Trust continued to provide free hot drinks, free leisure club subscriptions, free car parking, free food at night. However, this still felt slightly inadequate, although WSFT was doing more than some other organisations. It was also looking at the rest of the NHS to identify good practice; any ideas from board members would also be welcomed.

- When things were really bad it was very important that staff felt involved in some of the decisions and prioritisations that were being made. There was more to be done on ways to show appreciation of staff but it was also important to show that staff were being properly listened to during these times.
- Small things were important, eg survey of doctors. Honesty and autonomy were also very important and acknowledging how difficult things were, as well as ensuring that staff felt involved in decisions that were being made. The survey had shown that staff did not feel fully involved in decisions or given an explanation as to why things were happening.
- It was agreed that there was a need to look at what else could be done to show appreciation of staff and support them.

21/185 FIRST FOR PATIENTS – ASSURANCE

185.1 INSIGHT COMMITTEE REPORT – NOVEMBER AND DECEMBER 2021

- A good flow of information was being received from the sub-groups which enabled good challenge and discussion.
- Work was still required to ensure that data was accurate, complete and up to date.
- There was also a need to ensure that appropriate assurance was being fed up to the board and that this assurance was triangulated and documented to show where it had come from.
- The key issues were noted. It was suggested that there was a danger that some of issues would be on the agenda every time, although it was acknowledged that some of these were important, eg appraisals.

- There was an opportunity to give more assurance on plans for recovery and other issues, ie cancer two week wait performance and 104 week waits, both of which would be causing considerable stress to patients.
- Although comprehensive information was being received it was felt that there was still not enough scrutiny of plans in place to recover and improve performance in order achieve the trajectory. This would be looked at with the operations team to help the board gain assurance.

ACTION: look at information provided on recovery plans to provide board with greater assurance. **N Cottington**

- As the new governance structure matured it would be important to recognise the move beyond retrospective review of performance to gaining assurance and seeking evidence to demonstrate within the organisation there were effective plans so that the board could hold itself to account for the delivery of these plans, or explain why these were not being delivered. Therefore, review of evidence by these committees was really important.
- Work was currently being undertaken to ensure that community reporting was consistent with that of the hospital. It was important that this showed how the community was responding to the pressures, as well as providing assurance.

185.2 IQPR – SEPTEMBER AND OCTOBER 2021 DATA

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

185.3 IMPROVEMENT COMMITTEE REPORT

- It was noted that the Chair's key issues from two meetings were provided in this report.
- There were two sub-groups to this committee and no issues had been escalated from these groups as areas for improvement to the last four meetings of this committee. It was difficult to know what to make of this and it was a slight concern that nothing was being escalated.
- Assurance was required that nothing was being missed, however this was difficult as the committee relied on the sub-committees to carry out their work and escalate any issues. The chairs of these sub-groups also sat on the improvement committee.
- It was suggested that there was still a need to understand how the three committees were going to work together. The insight committee had a huge data driven workload, whereas the improvement committee did not have the same workload. The involvement committee had done a lot in terms of activity around the people agenda and culture agenda. A closer look was required at the terms of reference for the insight and improvement committees.
- Monthly committee meetings involved a lot of preparation and work and there was a need to reflect on this as a board as to whether time should be spent on reviewing data. The audit committee would be considering this in the new year.
- It was not obvious to the insight committee whether an item was being acted upon on through the improvement committee. It was agreed that the chairs of these two committees would discuss this further.
- The work and actions from the improvement committee were being undertaken centrally and there was a trail of this. When items were put on the improvement committee agenda there were normally detailed plans which provided a great deal of assurance in terms of how these plans were being addressed. The committee looked at whether these plans were appropriate and if they were being carried out effectively and efficiently.

Although plans may be being executed effectively, the question was whether outcome of these actions were being evidenced and the committee would be looking at this as things progressed.

- A key issue for escalation to the board from the last meeting related to learning from deaths. There was concern about the low number of preventable deaths being identified in the Trust which made it an outlier. It was proposed that there should be external input as to whether processes around this were robust.
- It was agreed that Paul Molyneux, Richard Davies and Jude Chin should discuss this.

185.4 Maternity services quality and performance report

Karen Newbury, Head of Midwifery, joined the meeting for this item.

- The board were reminded that Paul Molyneux and Richard Davies provided additional support in their role as Maternity & Neonatal Safety Champions.
- It was noted that there was a requirement for the board to have sight of the all appendices to this report prior to them going to the LMS.
- The main concern was staffing issues. The team was keen to move forward and introduce continuity of carer but they were not able to do so without additional staff.
- It was noted that the national maternity staff satisfaction survey results were appended to this report. This had been shared with all the team to assure them that they were being listened to and their concerns acted upon.
- Every Friday afternoon a 'safe space' was available for people wishing to raise concerns with the union representative.
- It was also noted that the Trust was working closely with service users, eg involvement in how the NICE guidance would be interpreted.
- The team were credited for the quantity and quality of data they were producing, despite the enormous pressure they were under.

Q The WSFT midwifery survey results included ideas from staff about what could be done to make things better and staff had come up with some very good ideas which could easily be achieved. How many of these simple things had it been possible to implement?

A A lot these had already been put in place. However, some of their other ideas would need a lot more work, ie having someone who was able to just stock rooms, as this would require funding and a job description. As more support workers were appointed this would become part of their role.

Q How could it be articulated to staff how things might look and feel different as the process progressed and what as the timescale for this?

A There was a weekly briefing to staff. There was not a definite timescale as this depended on recruitment and it was important not to give false promises that could not be achieved. The team was always informed when appointments were being made.

Q Following on from the previous discussions about the improvement committee, how was the structure of the assurance committees being used to scrutinise some of this information?

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A These papers went through internal governance and were shared with the safety champions, including Richard Davies and Paul Molyneux. They then went to the board before the LMS which meant that they were being shared widely with a good level of scrutiny.

- It was noted a lot could be learnt from this information about a very structured approach to engagement with staff. An ideal project for the improvement committee could be to look at this in greater detail before it went to the board, ie what could other parts of the organisation learn from the experiences of the maternity team.

185.5 Infection prevention control and assurance framework

- The board received and noted the monthly update on the progress to achieve compliance with the NHSE IPC COVID-19 board assurance framework.
- The team undertook the decision to provide a narrative on WSFT's journey through Covid. This was an overview of the processes through all stages of Covid, which would be used as a record/history of the Trust's management of the pandemic, including learning from outbreaks and incidents.
- It was explained that the final report would say that relatives were included in discussions, rather than 'relatives were informed'.

Q At some point there would need to be a collective NHS learning from the pandemic. Would the organisation be submitting something from a Trust wide point of view, including community?

A This piece of work would be done in collaboration with what was being done nationally, for consistency purposes.

Q One of the issues was around PPE, were there any permanent instructions about stock piling the correct PPE to prepare for the years ahead?

A No, the Trust continued to work through the normal supply chain.

- It was noted that there were a number of key lines of enquiry within the IPC board assurance framework (BAF) that the Trust was not able to evidence compliance with, eg number of side rooms, building issues. This time rather than reviewing the BAF specifically relating to Covid it was reviewed against all health care associated infections. The risk assessment remained at 20.

185/6 Nurse staffing report

Dan Spooner, deputy chief nurse, joined the meeting to present this report.

- Staffing continued to be challenging and fill rates had decreased in all areas. This was further compounded by staff isolation rates and an increase in sickness rates.
- As a result, a number of mitigating actions had had to be taken, including the rapid response pool. A review on the success of this pool would be undertaken in the future. There had been good uptake from nursing support staff but less from registered nurses.
- Funding had been received for international midwives and the Trust should be welcoming eight midwives into the organisation in the coming months.
- Everything possible was being done to mitigate for staff shortages on a daily basis and staff were being very flexible.

Q Sickness in unregistered nursing staff appeared to be an outlier compared to other groups of staff. Was there a reason for this and what was being done to address this?

A A lot of nursing assistants had been recruited to the team and it could be that healthcare was not what people thought it was, or was more challenging than they expected and a high turnover of this staff was now being seen. This was something that had been observed regionally. The Trust was looking at securing more funding for recruiting nursing assistants and also ensuring that they understood what it meant to work in a healthcare environment, as well as increasing pastoral support for these staff members.

Q What could be done to ensure that the Trust was familiar with best practice, ie something that might be working in another hospital nationally that could be copied?

A The Trust was engaging in as many national initiatives as possible to learn from best practice, including taking part in 'flex to the future workstream', improving flexible working offered and narrating what flexible working was.

It was not just about flexible working, but also about staff taking breaks and staff feeling tired. A survey was currently being undertaken in three wards who want to be engaged in a self-rostering pilot. Some interesting information had been received including comments about shift lengths.

- The Trust was working hard to support individuals and meet everyone's needs, whilst maintaining good service delivery.
- A number of staff may have already left who might have remained and welcomed flexible working processes. If there was a move to a more flexible approach the Trust needed to consider how to reach out to staff who had left the organisation and might wish to come back if they were able to work in this way.

185.7 Quality and learning report

- The team continued to review how it reported quality and learning from incidents. This report reflected what had already been presented around the patient safety framework.
- Details of complaints and how these were responded to and the learning from these were provided in this report. This highlighted the work required to be undertaken with the patient experience team, rather than identifying and focussing on individuals, ie a more holistic and supportive approach.

21/186 FIRST FOR STAFF - CULTURE

186.1 INVOLVEMENT COMMITTEE REPORT – NOVEMBER 2021

- The committee welcomed there being a governor representative as a member.
- Three items were discussed, one had clear actions and two only gave partial assurance and the committee decided to escalate these to the board. These were the annual patient experience strategy where the team had been asked to identify a number of measures that the Trust should be aspiring to, and increasing equality, diversity and inclusion (EDI).
- The committee did not feel assured about equality, diversity and inclusion (EDI). There was a challenge to governors about the NED recruitment process and to the executive team about the development of the senior leadership (bands 7/8 or 9) in the organisation.

- The committee was assured in general terms about freedom to speak up. A lot of work was being undertaken in this area, however it could only give partial assurance as not everything had yet been achieved and embedded in the organisation.
- It was noted that freedom to speak up was work in progress and it would never be possible to give complete assurance. Assurance needed to be taken in the way that people were being listened to and the work that the executive team were doing on this. There was also a need to recognise the work that was being done and would continue to be built on.
- It was acknowledged that there was still a lot to do on EDI; the EDI committee had escalated this to the board as an action. Therefore, the board needed to commit to this as a whole and come up with a set of actions as the leadership team was neither reflective or inclusive of the workforce.
- The challenge was to draw a real distinction between the work that was being done in the organisation versus visible personal commitment that each individual board member and the board as a whole should be making to this. All board members needed to think about their visible commitment to actively promote diversity and inclusion.

Action: Include in board development programme board actions and commitment to improve re equality, diversity and inclusion, particularly in relation to the leadership team. **S Childerhouse**

- A culture needed to be created that welcomed challenge; structures to address this could then be built on. This would be part of the board development programme and feature in the cultural plans.

186.2 PEOPLE & OD HIGHLIGHT REPORT

- The citation for the Putting You First Award for November was read out. Prince Rowland Gregory had produced some amazing diabetes related artwork to display within the G3 ward area, which had raised the profile that this co-morbidity could lead to undesirable symptoms.

  The board congratulated Prince Rowland Gregory on this very innovative approach and suggested that this should be widely shared with staff.
- A significant piece of work was being undertaken relating to mandatory staff vaccinations. This involved all staff working in areas where patients were cared for and was tied in with proposed legislation and the Trust's registration with the CQC.
- The amount of work that would be involved in this was causing considerable concern and was a risk re capacity in the HR team and line managers in the organisation to achieve this within the short timescale. However, the Trust fully supported the principle of vaccination and protection.
- There were still a small number staff who had not had both vaccinations, as required by proposed legislation. The Trust would be supporting these people and trying to understand what this meant for the role that they were currently in. Individuals who had not had their first vaccination had to have it by 3 February.
- This would need to be implemented in a way that was consistent with the Trust's values, ie working with staff. A multi-disciplinary team had been set up which was meeting weekly to work through the issues.

Q Would staff be given a choice if it was possible for them to be deployed in another area?

A Yes, this would be looked at.

Q Did the multi-disciplinary team include anyone who was not yet vaccinated?

A It was not known if this was the case. There was an issue around governance and the use/sharing of data showing which staff had been vaccinated.

- The board noted the appointment of the following consultants:

  Mr Thomas Athisayarai, Consultant Colorectal and General Surgeon
  Dr Anne Swift, Consultant in Public Health Medicine
  Dr William Dean, Consultant in Intensive Care Medicine and Emergency Medicine
  Dr Alexandre Costa, Consultant in Neurology

186.3 MEDICAL REVALIDATION ANNUAL REPORT

- In June 2021 it was clear that appraisal figures were not where they should be, therefore a commitment had been made to bring a further report to the board with a clearer understanding of why this was the case.
- A major piece of work had been undertaken to go through each appraisal and identify whether they were complete or not and this report provided information on this.
- New appraisers had been appointed as a result of the increase in the number of doctors requiring appraisals.

186.4 GUARDIAN OF SAFE WORKING REPORT

- This report provided data on exception reporting, locum rates and highlighted any themes.
- An area of concern was around exception reporting in Obs and Gynae. A number of F2 doctors have now been approved to cover this area out of hours.
- It was noted that this report related to the summer period and more challenges were likely to occur during the next few months. The high figures in August reflected the new doctor handover.

Q Re the ongoing issue with junior doctors in surgery out of hours, was it anticipated that the recruitment of new junior doctors in the surgical division would resolve the problem?

A This was not likely to be the answer to this, although it provided more capacity during the handover period. Work was being undertaken on improving the experience of junior surgical doctors but if this did not work there may need to be a move towards registrars doing full shifts. However, there would be major resource and funding issues with this as well as them not having as much operating time. This would continue to monitored.

Q It was not unusual to see surgical colleagues being unhappy with work patterns /support within an organisation. Was additional work required to support senior surgical colleagues to ensure that junior doctors were well supported and that there was a flexible approach to this? This was also about how to support and nurture junior staff.

A This was being looked at in a number of ways including better handover in surgical teams. Work was being undertaken with surgeons relating to job plans to include commitment to their time on ward rounds, for consistency. This would also provide additional support and a training opportunity for junior doctors both during the week and at weekends.

Junior doctors appeared to feel supported by consultants but this would continue to be looked at through surveys etc.

21/187 FIRST FOR FUTURE - STRATEGY

187.1 THE GREEN PLAN

- There was a requirement for trusts to provide a sustainability plan which would be effective from 1 April 2022.
- This report provided a response to this requirement and the organisation's green plan. However, the Trust intended to go much further than was detailed in the plan being presented today.
- The proposal was was for the project management office to focus entirely on the sustainability agenda. A lot of work would be undertaken to develop a more comprehensive plan for the organisation and further information would be presented to the board over the next few months.

Q Was there scope for mirroring the freedom to speak up network by having a network of green champions across all departments?

A This was part of the plan but had not yet been implemented.

Q This was a very interesting report which was strategically very important and would have an impact on the way the Trust worked as well as there being a cost to it. Although it was recognised that there was a tight timescale it was a concern that the board was being asked to approve this without having had the opportunity to go through it in greater detail. Would the board have a chance to consider this and the consequences more widely?

A It was intended to produce a fully costed plan, particularly around the benefits that it was intended to achieve through the sustainability programme. A more comprehensive plan would be considered for discussion by the board.

The board approved the green plan, recognising the tight timescale.

187.2 FUTURE SYSTEM BOARD REPORT

- This report had already been to the future system programme board and executive team. It provided details of the current situation, including the environmental impact assessment which was a key part of the planning application, and ongoing engagement with staff and the wider community.
- Clinical engagement was getting to a point where it would provide key information for the schedule of accommodation. This would be included in the the first stage of the design of the new facility that would inform the planning application.
- The board ratified the co-produced recommendations described within the clinical and digital workstream update.

Q Re the community workstream, historically there had been risks around revenue funding that would be required and workforce risks in terms of moving activity into the community. Was this being considered, although it was understood that it would not be possible to get a complete answer yet?

A In the development of the business case the financial part of this was from an organisational perspective. The economic case would have a much better look at the impact of this and would consider the impact on other organisations, including community services, primary care, social care etc.

21/188 GOVERNANCE

188.1 BAF SUMMARY

- It was agreed that the risk relating to the digital transformation was within the board's appetite for risk and could therefore be considered for de-escalation by the insight committee.
- It was noted that there was a requirement to discuss the national IT paper on 'what good looked like' and assess the Trust's progress against this. This could validate whether the Trust was ready to de-escalate this risk. It was agreed that the insight committee would look at this at its next meeting.
- The board noted the increase in the risk score for emergency capacity.
- To support the merging of the CIP risk and financial sustainability risk. It was noted that there was more work would be done on the financial sustainability risk.
- It was noted that the BAF was a statement of those risks that were sitting outside the risk appetite that the board was comfortable with. These risks were being actively managed and mitigated all the time.
- It was proposed that the involvement committee should consider BAF 7 as there should be a more explicit reference to raising concerns, considering that the whole of the independent review was about how the Trust managed concerns.
- The audit committee would consider topics for future 'deep dives'.

188.2 GOVERNANCE REPORT

- WSFT had been placed in segment 3 of the NHS system oversight framework and was still waiting for the mandated support that it would be given as a result of this.
- The decision had been taken to dissolve the scrutiny committee. Following the establishment of the 3i committees and senior leadership team it was felt that the responsibilities of the scrutiny committee now sat elsewhere, as indicated in this report.

  The board supported the dissolution of the scrutiny committee.

188.3 WEST SUFFOLK NHS FOUNDATION TRUST CONSTUTION

- A constitution committee had been established, consisting of governors and directors, to review areas of the constitution that required updating, including increasing the composition of the board to give it more flexibility by having more NEDs and EDs.
- The other proposed amendments were detailed in the report and were self-explanatory.
- Approval of the amended constitution was required by both the board and CoG. Last night's CoG meeting (16 December) had been postponed until 17 January, when governors would be asked to approve this.
- It was noted that item 25 (page 11) referred to 'he', ie gender specific. This would be amended.

DRAFT

- The board approved the revised constitution subject to the above amendment.

21/189 OTHER ITEMS

189.1 QUESTIONS FROM GOVERNORS AND THE PUBLIC

Q It has always been apparent from previous data that appraisals and mandatory training have been an issue within the hospital. In the papers for today there are several mentions of this. Can we be assured that the process of appraisal and mandatory training is not merely a 'tick box' activity, page 84 Convene. Issues concerning mandatory training appear once again with reference to this taking place in the staff's own time? Foetal monitoring is red once again with the Obstetricians being the biggest concern. Can we be assured that this recurring theme will not lead to safety concerns for the patient?

A Appraisals and mandatory training were very important with regard to safety and wellbeing both for staff and patients and were not a tick box exercise. This was currently a particular challenge due to the sustained pressure in the organisation. A monthly report on this continued to be produced and concerns were then raised through the insight committee.

The target levels were currently not being met.

With regard to the provision of mandatory training and assurance around safety, mandatory training was not the only training that people were receiving. Other levels of supervision and training were also provided to staff.

It was important that appraisals continued to be looked at as these were one of the first activities to be overlooked when capacity or staffing was under pressure. These were a significant and fundamental part of making people feeling valued as well as looking at their personal and professional development. It was important to try and prioritise these and allow both managers and staff to make time for this, even when things are busy.

189.2 ANY OTHER BUSINESS

- The Chair apologised to Nicola Cottington for not introducing her and welcoming her to her first board meeting.
- There had not been the opportunity to hear from the finance director and it was considered that there should be a finance report to the board.

Action: include finance report on board agenda. **A Alderton / N Macdonald**

- Key issues:
  - patient safety and module for completion by board members.
  - Identify a patient safety champion.
  - Action plan arising from rapid review – ensure involvement from staff across the whole organisation and governors and share widely with the public. This would be considered in future board meetings.
  - Work around 3i committees, particularly role of insight and improvement.
  - Escalation re partial assurance on EDI and freedom to speak up - need for board commitment and embedment.
  - Governor involvement and engagement in patient safety work; this was an important part of the membership and engagement remit.

- The Chair requested feedback as to whether board members considered that the meeting had fitting within the Trust's values.
- It was considered that there had been more challenge than in previous meetings but this could still improve.

- The importance of learning from the content of the review resonated in many items.
- There was a lot of content which made it difficult to focus on key issues that need to be debated and decisions made on. Need to consider items on the agenda and how to concentrate on fewer issues.
- The Chair thanked everyone in the organisation, including governors and volunteers and wished everyone a happy Christmas.

189.3 DATE OF NEXT MEETING

Friday 28 January 2022, 9.15am

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

DRAFT

1.4. Action log and matters arising

To Review

Presented by Alan Rose

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
1974	Open	28/05/21	Item 14.3	Provide further information to the board on the ward accreditation programme. .	Using a codesign methodology, the Ward accreditation steering group has been meeting weekly since May to scope the needs of the project, identify stakeholders and relevant workstreams. The steering group has now moved to monthly meetings and a smaller project group will take the actions identified forward in creating tools, process and pilot schedule. The project plan will be presented to the board in September. Project continues, update at October board. Verbal update provided at today's meeting (15.10.21). **Current ongoing pressures have precluded progress in this matter. However, the Trust continues to focus on combining work with the info team on quality dashboard to support the infrastructure.**	SW	~~30/07/2021~~ ~~03/09/2021~~ 15/10/2021	Amber	
1997	Open	15/10/21	Item 10.2	Board discussion/workshop required to discuss Trust's priorities and what it would not be able to do	**Board strategic workshops are being developed as part of the Board evaluation undertaken with Integrated Development Ltd.**	SC/AA	~~17/12/2021~~ 28/2/2021	Green	

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

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
1985	Open	30/7/21	Item 11	Chair-to-chair escalation of concern re pathology meetings if not taking place	Update to be provided following completion of workshops (approx 3 months). **Regular departmental meetings taking place and session to be convened with ESNEFT as part of acute collaboration work.**	~~HB~~ NC	~~17/12/2021~~ 28/01/2022	Complete	28/01/2022
2001	Open	15/10/21	Item 13	Integration Report - Q2 - consider measures to illustrate impact of change for inclusion in report to board.	Work commenced with Susan Wilkinson and Nicola Cottington to align the Community with Trust wide reporting. **Community reporting will be incorporated in the overall Trust reports, as agreed with Nicola Cottington and Sue Wilkinson.**	CM	17/12/21	Complete	28/01/2022
2002	Open	15/10/21	Item 14	Emergency Preparedness - Arrange for a deep dive following feedback from NHSE on EPRR review.	It is proposed that a summary of the core standards review be presented to the Improvement Committee. **This matter has been delegated to the Corporate Risk Committee.**	NC/AA	17/12/21	Complete	28/01/2022
2003	Open	17/12/21	Item 1.5	**Staff Story-patient safety specialists** - identify NED lead for patient safety.	**Louisa Pepper confirmed as NED Lead.**	SC	28/01/22	Complete	28/01/2022
2005	Open	17/12/21	Item 1.6	**Chief Executive Report -** consider how to engage with the organisation as a unitary board, re the action plan in response to the review.	**Today's (28.1.22) agenda item refers.**	JO	28/01/22	Complete	28/01/2022
2006	Open	17/12/21	Item 1.6	**Chief Executive Report** - consider how to measure the outcomes and targets from actions put in place as a result of the review.	**Today's (28.1.22) agenda item refers.**	JO	28/01/22	Complete	28/01/2022

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2007	Open	17/12/21	Item 2.1	**Insight Committee Report** - look at information provided on recovery plans to provide board with greater assurance.	**Recovery plan for cancer performance presented to Insight.**	NC	28/01/22	Complete	28/01/2022
2008	Open	17/12/21	Item 3.1	**Involvement Committee Report** - include in board development programme board actions and commitment to improve re equality, diversity and inclusion, particularly in relation to the leadership team.	**Included in programme for 2022.**	SC / JO	28/01/22	Complete	28/01/2022

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

1.5. Appointment of Interim Chair

To Note

Presented by Alan Rose

Board of Directors 28 January 2022

Report Title:	Item 1.5 - Appointment of Interim Chair
Report Prepared by:	Ann Alderton, Interim Trust Secretary
Previously Considered by:	Council of Governors 17 January 2022

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive Summary
Governors are responsible for the appointment of the Chair of an NHS Foundation Trust. Following the resignation of Sheila Childerhouse in December 2021, the Council of Governors approved the appointment of Jude Chin as Interim Chair on 17 January 2022. This followed a selection and appointment process led by the Council of Governors' Nominations Committee. Jude Chin will be interim Chair until a permanent Chair is appointed by the governors. The Nominations Committee of the Council of Governors has started that process.
Action Required of the Board
To note the decision of the Council of Governors

Risk and assurance:	If the Trust does not appoint a new chair in a timely manner to provide leadership to the Board of Directors ad Council of Governors, this will cause Board and Council instability, uncertainty and loss of public confidence and increase the risk of regulatory intervention and loss of autonomy
Legal and regulatory context	NHS Act 2006, Health and Social Care Act 2012, NHS Foundation Trust Code of Governance

1.6. Patient story

To Note

Presented by Susan Wilkinson

1.7. Chief Executive’s report

To inform

Presented by Craig Black

CEO Board report - January 2022

Report Title:	Item 1.7 - CEO report
Executive Lead:	Craig Black, CEO
Report Prepared by:	Helen Davies, head of communications
Previously Considered by:	None

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

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.
Action Required of the Board
For information

Pressures on the Trust

As we start a new year, we do so experiencing significant pressures on all parts of the organisation, as well as the broader health and social care system.

As such, on Wednesday 29 December 2021, we declared a critical internal incident across the Trust. The incident was driven by the high numbers of patients coming through our front doors as well as significantly reduced staffing levels due to illness or self-isolation from Covid-19.

Declaring a critical internal incident meant we stepped up our internal practices to enable us to focus on maintaining safe services for patients during this period of sustained demand and operational pressure.

While we continue to face pressures across the Trust, the last few days have seen a demonstrable improvement in our performance and across the key indicators used to take such decisions. Therefore, on Friday 14 January, we stood down from the critical internal incident.

Despite stepping the incident down, we are maintaining our 'enhanced response structure', which includes daily strategic review meetings to monitor the situation, so if there is deterioration again, we have the framework in place to take swift action.

Whilst we are in this difficult period, we are working hard to create additional bed capacity and have taken a number of actions such as converting a ward in Newmarket Community Hospital into a 33-bed inpatient unit supporting medically optimised patients.

As well as creating additional capacity, we are also focusing heavily on discharge and are working across the system to increase our discharge capacity to help ensure that patients are being looked after in the most appropriate place for their needs.

We are also asking staff to work flexibly at short notice to help fill gaps. Staff are doing an incredible job during this difficult time and I am humbled by their hard work and dedication.

We have had to take the difficult decision to postpone some elective surgery and outpatients' appointments and are working to re-book patients wherever possible and are reviewing these decisions regularly so we can reintroduce them as soon as possible.

Unfortunately, whilst cases of Covid-19 are still so high in the community, we are still having to restrict visiting to our hospitals. This is never an easy decision and it is one we are reviewing regularly. Whilst patients are apart from their loved ones, we have our award - winning clinical helpline and our 'keeping in touch' service, to keep families and friends updated and connected.

Appointment of interim chair

We are delighted to announce that Jude Chin has been appointed by the council of governors as interim chair of West Suffolk NHS Foundation Trust.

Jude, who has taken up the role with immediate effect, was a non-executive director on the board at the Trust. He has a wealth of experience at board level in a range of sectors and is a former vice-chair at Colchester Hospital University NHS Foundation Trust. We know he will provide invaluable insight and leadership.

We look forward to working with Jude on improving the health services we provide to our local communities.

The process of recruiting a permanent chair has already begun, with the nominations committee of the council of governors having held its first meeting to confirm the appointment process.

Supporting the national Covid-19 vaccination effort

Following West Suffolk Hospital's successful in-house vaccination programme for staff and clinically vulnerable patients, we were asked by the CCG to support community vaccination efforts and specifically to address vaccine inequality. The West Suffolk Covid-19 Vaccine Taskforce was formed in late November and comprises of a diverse range of healthcare professionals and non-clinical staff.

We have worked with system partners to provide equipment and staff to support their vaccination sessions, put additional drop-in capacity into Haverhill, Sudbury & Bury and our pharmacy has become a distribution hub with our team assisting to move vaccine and consumables around the healthcare system in Suffolk to allow as much capacity as possible to be offered to the public.

We are now focusing on targeted vaccination, working with various groups with very specific needs for whom mainstream vaccination provision is not suitable, to ensure that no one is left behind.

Delivering new Covid-19 treatments

The Trust has recently started delivering new Covid-19 treatments, which are being provided to non-hospitalised Covid-19 positive adults and children (aged 12 years and above) in the highest risk cohorts.

The new treatments include a neutralising monoclonal antibody (nMAB), which can significantly reduce outcomes of hospitalisation or death. In the first instance, the clinic is being run out of a bay in our G10 ward until a permanent home can be found.

We are delighted to be able to offer this service to those in our community who are at the highest risk of serious illness or death from Covid-19

Top national recruiting site on the global RECOVERY trial

At the end of last year we heard that the Trust was named as the top national recruiting site for the global RECOVERY trial for two consecutive weeks in November. The RECOVERY (Randomised Evaluation of Covid-19 Therapy) trial is one of the world's largest clinical research trials investigating treatments that may benefit people hospitalised with suspected or confirmed Covid-19. The trial has 189 active sties and over 45,000 participants worldwide.

A notable output from the trial is that it has found that repurposed drugs, such as the low-cost dexamethasone, reduces death by up to one third in hospitalised patients who have severe respiratory complications. This discovery has saved millions of lives.

To be the top recruiter for this vital research project is a testament to the hard work and dedication of the research team and everyone who supports them.

Community matron becomes 'Queen's Nurse'

One of our community matron's, Kate Foxwell, has been awarded the title of 'Queen's Nurse' from the Queen's Nursing Institute in recognition of her commitment to high standards of patient-centred care and continually improving practice.

Kate is now taking part in the Queen's Nurse programme, which brings together a network of community nurses from all over the country, enabling them to learn from one another and access high quality professional support and development. Congratulations Kate.

2. ASSURANCE

2.1. Insight Committee Report - January 2022 - Chair's Key Issues from the meeting

To Assure

Presented by Richard Davies

Board of Directors – 28 January 2022

Report Title:	Item 2.1 – Insight Committee Jan 2022 – Chair's key issues
Executive Lead:	Dr Richard Davies, NED, Insight Committee Chair
Report Prepared by:	Dr Richard Davies, NED, Insight Committee Chair
Previously Considered by:	n/a

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☐

Executive Summary
The Insight Committee met on 10 January 2022. Below is the Chair's Key Issues document which will constitute the standard template for Insight Committee reports to Board.
Action Required of the Board
To approve the report

Risk and assurance:	The development of and transition to a new structure for organisational governance may result in a failure to escalate significant risks to management, the executive team and the board of directors, caused by a disruption to the previous information and communication flows whilst new arrangements are being established.
Equality, Diversity and Inclusion:	*n/a*
Sustainability:	*n/a*
Legal and regulatory context	Well-Led Framework NHSI FT Code of Governance

Chair's Key Issues – 10 January 2022 meeting

Part A

Originating Committee	Insight Committee	Date of Meeting	10 January 2022
Chaired by	Dr Richard Davies	Lead Executive Director	Nicola Cottington

Agenda Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Trust Dashboard Development Project	Recognition that this is a Trust priority to "achieve a fully integrated performance reporting system which brings together information about the organisation in a way that is easy to interpret, easy to communicate and supports staff to make informed decisions". However, it is also acknowledged that this is a complex project which will take some time to deliver. Nick Macdonald is now responsible for this project. To: - Enable the Board to receive escalations and assurance - Provide visibility of key metrics - Understand trends and measure impact of interventions The plan looks very good but requires a considerable amount of work and support from IT – and timelines currently uncertain. Need to continue to monitor progress and all 3i committees need to be aware of progress on this project Paper needs to be disseminated to other 3i committees for information (Item 4.1 v 2)	Escalation to other 3i committees	BAF Risk 1	Item 4.1 v 2
Interim IQPR update	The importance of developing the new IQPR at pace and ensuring, in the meantime, an effective interim IQPR was discussed. The Trust needs to ensure that the appropriate data is presented, in the appropriate format (ideally in SPC format with operational narrative) to the appropriate committees and governance groups. The committee received information and assurance that work was ongoing to develop the new IQPR and that in the meantime the interim IQPR will ensure visibility of a minimum dataset covering all mandated and contractual data. Work is ongoing with task and finish groups to ensure that this is the case and to agree other relevant metrics for final IQPR. The proposed interim IQPR indicators were presented (see attached).	Assurance	BAF Risk 1	Interim IQPR indicators v2

Information strategy update	An update on the Information Services 2021/22 Project Work was presented. work on multiple projects is going well (see attached for details) but the Information Team were challenged on links between these individual projects and a clear overall strategy – it was agreed that it would be appropriate to refresh the Information Services strategy, and this will be presented at a future date	Approval	BAF Risk 8	Item 4.2
Finance and Workforce Governance Group	Continuing poor appraisal performance across the Trust – current actions are not proving effective and there may be multiple reasons for this (operational pressures, inadequate leadership guidance/training, cultural issues etc) – agreed that appraisal is even more important when operational pressures are high – there is a real need to understand why current actions are not improving the situation – it was agreed that we should refer to Improvement committee for further work to correlate data and look at this issue in more detail	Escalation to Improvement Committee (James MacFarlane and Rebecca Gibson will take this forward)	BAF Risk 9	
Patient Access Governance Group 1	Long waits (104 week) Whilst there is a planned trajectory to improve this situation and there is ongoing clinical review of patients waiting a long time for treatment, this issue remains a concern and in particular the issue of the 'risk' that this poses to individual patients and the organisation. It was agreed that this should be escalated to the Improvement Committee	Escalation to Improvement Committee (Nicola Cottington will take this forward)	BAF Risk 4	IQPR
Patient Access Governance Group 2	2ww issues discussed - breast performance is a concern (due to high demand) but there is sensible plan with a planned trajectory for improvement over the next few months. This will need to be monitored. It is good to see that the dermatology 2ww data has improved significantly with the introduction of AI (as anticipated). The committee was assured by the ongoing work to confirm the acceptability (for staff and patients) and safety of this approach (to date the feedback looks good). This will continue to be monitored	Assurance	BAF Risk 4	IQPR
Patient Access Governance Group 2	Histopathology has been reporting a significant backlog through December due to increased demand and a vacant post – but there has been a very significant improvement through January with extra sessions and a new appointment and the team should be commended on this	Approval		

Patient Quality and Safety Governance Group	Pressure Ulcers: - Long-lie pathway – current paramedic response times are leading to some patients having a long-lie following a fall, with increased risk of tissue damage. Work is ongoing within the System – but within the Trust there is work on developing a fast-track pathway through ED for these patients - There is currently no clear pathway for patients with PUs requiring MRI to exclude osteomyelitis. A multi-disciplinary panel is considering development of a consultant led service	Assurance		
Clinical Effectiveness Governance Group	Requirement to ensure that consultant job plans reflect time for audit and QI work (not necessarily currently the case). Agreed that this will be taken 'off-line' and a group will be set up to look at this in more detail – feeding back to Clinical Effectiveness group and to Insight for escalation if and when required	Approval		
Community Governance Group 1	There are ongoing issues about the way that community services feed in to Trust governance structures, and the inclusion of community services in Trust strategic discussions. Work is ongoing but this needs to be kept at the forefront of our minds in Board discussion	Escalation to Board for information and reflection	BAF Risk 2	
Community Governance Group 2	Avoidant and Restrictive Food Intake Disorder (ARFID) – concern that the System is letting children down – with ongoing uncertainty regarding funding. Much of this is out of the Trust's control although this remains a priority issue for the CCG. The Community Paediatric services can only continue to do what they can to support these children, however they will continue to push on this issue and Sheila Childerhouse will raise at the System level.	For information		
Date Completed and Forwarded to Trust Secretary		**13 January 2022**		

Part B

Receiving Committee	Board of Directors	Date of Meeting	10 January 2022
Chaired by	Sheila Childerhouse	Lead Executive Director	Craig Black

Agenda Item	Record of Consideration Given (Approved/ Response/ Action)
Date Completed and Forwarded to Chair of Originating Committee	

Insight Committee – 10th January 2022

Agenda item:	xx			
Presented by:	Nick Macdonald – Director of Resources (Interim)			
Prepared by:	Nick Macdonald – Director of Resources (Interim) and Jodie Price – Performance Manager			
Date prepared:	04/01/2022			
Subject:	Trust dashboard update			
Purpose:	x	For information		For discussion and agreement

Update summary:
To date no formal specification for this dashboard has been agreed. However, in broad terms the focus of the dashboard should be to:

- Enable the board to receive escalations and assurance
- Provide visibility of key metrics – ie the deliverables for which the Trust is responsible
- Understand trends, and measure impact where interventions have been made.

This week Executive Directors discussed this project and agreed the Executive Sponsor would be Nick Macdonald (Director of Resources). He is now responsible for this project, including identifying scope, resources, risks and timeframes. This is a significant project, which requires appropriate specification and project management. Whilst it is a priority requirement for the organisation all of the objectives will take some time to deliver.

This project requires significant support from the Information Services Team, as well as suitable infrastructure from the Digital team to ensure that all appropriate people have immediate access to relevant, good quality information. It therefore needs to align with the Information Services Strategy and Digital Strategy, as well as the Trusts strategy.

Background

We are required to provide statutory information to regulatory bodies as well as sharing across the wider health and social care systems.

However, since the new governance framework came into place during 2021 we have been unable to provide all the information required to assure the Board and the 3i committees against agreed KPIs

We have also found ourselves acting on gut feel and anecdotal evidence when making urgent and difficult decisions. We should be using accurate, timely and relevant information to ensure that objective and optimal decisions are made.

There is a shortage of strong management information that could be utilised for both performance reporting and operational prioritisation and decision making.

We currently produce a lot of information that may not be utilised, may not be in a user-friendly format, or may not be reliable enough to be effective. This should be reviewed and rationalised where appropriate. However, some of this information is exactly what we require and we need to guard against losing this too.

What do we want to achieve?

The vision is to achieve a fully integrated performance reporting system which brings together information about the organisation in a way that is easy to interpret, easy to communicate and supports staff to make informed decisions.

A good performance reporting system has several key components. It needs to be timely, clear, relevant, easily accessed and have the capability of running automated reports.

This reporting needs to be a practical way of managing services and providing assurance, as opposed to reporting just to 'feed the beast'. Managers should be able to explain issues and have an action plan to redress poor trends before these are drilled into at performance review meetings. Trend graphs should highlight improvements as action is taken.

How will this be achieved?

In order to achieve this the proposal is to use a Business Intelligence (BI) dashboard. A BI dashboard should be fully customisable and interactive. It is an information management tool that will support the analysis and visualisation of Trust data to track different aspects of performance.

A BI dashboard combines charts and graphs on a single screen, which enables those reviewing the data to see the 'bigger picture' as well as be able to 'drill' into that data to see it at a more granular level. For example: data trends over time, or a specific service.

The dashboard can be designed to include specific KPIs and metrics that the Trust is required to report against, and that users need for assurance and local decision making. Tolerances to highlight RAG performance would also be included.

The dashboard would have the ability to pull data from multiple sources and in real time. Access to real time data via the dashboard would generate calls to action and support staff with informed and timely decision making.

In order to maximise efficiency and reduce duplication we would, wherever possible, ensure individuals, and appropriate committees, have the ability to drill down (self service). We would also aim to produce reports in common formats wherever possible, particularly where used by multiple users..

The dashboard would also be viewed in the governance/divisional/service meetings rather than the current process of producing paper-based reports, which are not always useful and may require further analysis. Users will be able to drill down at various meetings where required. Ideally and queries raised should be answerable by representatives of those services as any concerns ought to be the same as those they have already investigated as part of local management.

This drill down facility would allow easier identification of trends, both positive and negative, as well as seeing the effectiveness of actions that have been taken.

We would ensure users have access to appropriate information and reports through self service (with appropriate training) and resilient IT.

Performance reporting needs to meet 3 types of needs as below.

Next steps :

Produce specification and project plan for discussion and approval at Senior Leadership Team and bring to next Insight meeting.

Ref:	**Schedule 4 - Quality requirements** **A - Operational standards**
	RTT waiting times for non-urgent consultant-led treatment
E.B.3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral
	Diagnostic test waiting times
E.B.4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test
	A&E waits
E.B.5	Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department
	Cancer waits - 2 week wait
E.B.6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment
E.B.7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment
	Cancer waits – 31 days
E.B.8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers
E.B.9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery
E.B.10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen
E.B.11	Percentage of Service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy
	Cancer waits – 62 days
E.B.12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer
E.B.13	Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers
	Mixed-sex accommodation breaches
E.B.S.1	Mixed-sex accommodation breach
	Cancelled operations
E.B.S.2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice
	B - National Quality Requirements
E.A.S.4	Zero tolerance methicillin-resistant Staphylococcus aureus
E.A.S.5	Minimise rates of Clostridium difficile
E.A.S.6	Zero tolerance RTT waits over 52 weeks for incomplete pathways
E.B.S7a	All handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 30 minutes
E.B.S.7b	All handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 60 minutes

E.B.S.5 Waits in A&E not longer than 12 hours

E.B.S.6 No urgent operation should be cancelled for a second time

VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE

Duty of candour

Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider (other than those dealing with children, teenagers and young adults) across all tumour sites

Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider dealing with children, teenagers and young adults across all tumour sites

Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis
Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis

C. Local Quality Requirements

Infection Prevention and Control
Isolation

3.1 Percentage of service users identified as requiring isolation not isolated within 2 hours and where mitigating action not taken

MRSA elective and emergency screening

3.2.1 Percentage of service users identified for screening swabbed within 24 hours of admission split by elective and non elective.

3.2.2 Percentage of service users completing decolonisation treatment where it should be completed during hospital stay

Hand Hygiene

3.3.1 Compliance with the WHO 5 moments of hand hygiene in non-urgent situations

3.3.2 Compliance with universal precautions in non-urgent situations

Pressure Ulcers Indicators

4.1 All admitted service users have a pressure ulcer risk assessment on admission within 24 hours. Definition to be consistent with latest NHS Improvement Guidance (Dec 2018).

Falls Indicators - Adult Inpatient Falls

5.1.a Trust wide falls per 1000 occupied bed days

5.1.b Trust wide falls with moderate harm, severe harm or death per 1000 occupied bed days.

5.1.c All service users identified at risk have a multifactorial falls assessment on admission

Patient Safety Indicators

6.1 A maximum two-week wait standard for rapid access chest pain clinic.

Discharge Summaries to be sent to GP's from:

6.3.a Emergency Non Elective (including ED) within 24 hours

6.3.b Elective within 24 hours

6.3.c Outpatients within 3 working days

Deteriorating patient

6.4 All inpatients (Paediatrics and Adults) receive regular observations (vital signs) and appropriate responses/escalation to signs of deterioration using recognised early warning tools.

VTE

6.7.a Percentage of patients having VTE assessment

6.7.b Percentage of service users who are assessed at risk have prophylaxsis prescribed.

Workforce

6.8 Staff Mandatory Training - specifically infection prevention and control; information governance; safeguarding levels 1 -3; PREVENT; Mental Capacity Act, Deprivation of Liberty Safeguards;

Nutrition and Hydration

8.1.a All admitted service users should have nutritional assessments, including maternity and paediatrics, completed on admission within 24 hours and be reassessed at least every 7 days.

8.1.b All service users identified at risk seen by dietician within 2 working days of referral and have a nutritional care plan formulated

Stroke

9.1 Stroke: 6 month Follow up - All stroke survivors follow up assessment to be submitted to SSNAP

9.2 Stroke: Care Planning - Percentage of applicable service users who are assessed by a nurse and at least one therapist within 24 hours, all relevant therapists within 72 hours and have rehabilitation goals agreed within 5 days of clock start.

9.3 Stroke: Early Supported Discharge - Percentage of service users treated by a stroke skilled early supported discharge team

9.4 Stroke: Scanning - Percentage of service users scanned within one hour of clock start

9.5 Stroke: Scanning - Percentage of service users scanned within 12 hours of clock start

9.6 Stroke: specialist consultant - Percentage of service users who were assessed by a stroke specialist consultant physician within 24 hours of clock start.

9.7 Stroke: Thrombolysis - Percentage of eligible service users given thrombolysis (according to the royal college of physicians guideline minimal threshold)

9.8 Stroke: Ward admission - Percentage of service users directly admitted to a stroke unit within 4 hours of clock start.

9.9 Length of stay - People treated on a Stroke Unit for >90% of their stay

9.1 Stroke Service: Provider rating to remain between A-C in each of the 9 domains covered in SSNAP where the Provider is at this level. For the one domain (SaLT) where the Provider is at level E, this will be improved to level to C by March 2017.

Maternity

10.1 Proportion of women delivered who breastfed babies within first 48 hours

10.2 Total Lower Section Caesarean Section Rate (%)

10.3 Midwife/Birth Ratio

10.4 1:1 care established labour

West Community Hospitals - Length of Stay
West Community Hospitals - Admissions & Discharges
West Community Hospitals - DToC Bed days
West Community Services - Face to face contacts Adult services
West Community Services - Face to face contacts Paediatrics services
West Community Services - Total Contacts by Service
West Community Services - Children Wheelchair Performance

Paediatric Speech and Language

KPI ref:	**High priority' KPIs in Schedule 2A (Annexe A) - Local performance requirements**
1	% of patients seen following triage within 72 hrs.
2	% of patients seen following triage within 4
3	Standard equipment delivered as emergency within 4 hours, as indicated, on receipt of order request.
3.1	Standard equipment delivered within Same working day, as indicated, on receipt of order request.
4	Standard equipment delivered within Next working day, as indicated, on receipt of order request.
4.1	Standard equipment delivered within 2 working days, as indicated, on receipt of order request.
4.2	Standard equipment delivered within 5 working days, as indicated, on receipt of order request
5	Community equipment service % of deliveries within 7 working days
6	Standard equipment delivered within 10 working days, as indicated, on receipt of order request.
7	Improving discharges and maintaining acute and community Delayed transfers of care at a minimum level - % of bed days identified as DTOC
8	Lymphoedema service (west only) % of palliative referrals seen within 2 weeks of receipt of referral
9	Lymphoedema service (west only) % of urgent referrals seen within 4 weeks of receipt of referral
10	Lymphoedema service (west only) % of routine referrals seen within 14 weeks of receipt of referral
11	Children speech and language therapy % of children who have started treatment within 12 weeks of initial assessment (Currently measured as number of children waiting less than 3 months as at the end of the month for a package of care)
12.a	Care Coordination Centre % of calls answered within 60 seconds
12.b	Care Coordination Centre Calls audits 1% calls answered to be audited for quality, accuracy and content
12.c	Care Coordination Centre Electronic referral process audit 1% of electronic referrals audited for compliancy of process and accuracy
12.d	Care Coordination Centre Accuracy rate of interaction
13	Bowel and bladder service % of patients receiving products who are re assessed annually
14	Community hospital in patients discharge summaries % of summaries sent to the GP practice within 1 working day of discharge.
15	Children in care % of initial health assessments completed within 15 working days of receiving all relevant paperwork.
16	(Mobile patients) Simple leg ulcers ABPI >0.8 <1.3; wound area less than 100cm²; duration shorter than one year) 70% healed within 12 weeks / 95% healed within 18 weeks
17	(Mobile patients) Complex leg ulcers ABPI>0.8 <1.3; duration longer than 1 year from first presentation; lymphovenous disease; current infection / history of recurrent infections; patient non concordance) 70% Healed within 18 weeks / 95% healed within 24 weeks
18	Timeliness of response to Education, Health and Care plans (% of 'information and advice responses' submitted to the Local Authority (LA) within 6 weeks of receipt of the request by the LA.
19	% of patients seen following triage emergency within 2 hrs.
20	Standard equipment collected within Next working day, as indicated, on receipt of order request
21	Community equipment service collection % of urgent collections within 3 working days
21.1	Standard equipment collected within 5 working days, as indicated, on receipt of order request.
22	Standard equipment collected within 10 working days, as indicated, on receipt of order request.

23 Number of inpatient transfers to an acute unit for the same condition as an emergency within 72 hours of admission split by community inpatient location. (Currently don't capture if the transfer is for the same condition)

KPI ref: Schedule 4 - Mandatory

KPI 1 18 week referral to treatment for non Consultant led services 10 services: Paed OT, PT, SLT, Adult SLT West, Wheelchairs, Neuro nurses, Parkinson's, SCARC, Environmental & Heart Failure West

KPI 2 Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a Child in Care

KPI 3 Percentage of Service Users (children) whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service

KPI 4 Percentage of Service Users (children) assessed to be eligible for NHS Continuing Healthcare whose review health assessment is completed annually

KPI 5 18 week RTT for Paediatric Consultant led services

KPI 6 18 week RTT for Paediatric non Consultant led services

Clinical Quality Contract Performance Indicators

Falls (Inpatient Units)

Total numbers of inpatient falls (includes rolls and slips NOT assisted)
Falls from height e.g. bed, chair
Fall from same height
Assisted falls and near misses
Falls from height e.g. gentle slide from chair
% of total falls resulting in harm
Numbers of falls resulting in moderate harm
Numbers of falls resulting in severe harm
Numbers of patients who have had repeat falls (assisted falls excluded)
% of RCA reports for repeat fallers
Numbers of falls per 1000 bed days

Pressure Ulcers, Community Number of new PU, change in reporting November

Cat 2
Cat 3
Cat 4
Unstageable

Pressure Ulcers, Inpatient Number of new PU, change in reporting November

Cat 2
Cat 3
Cat 4
Unstageable

Safeguarding People Who Use Our Services From Abuse

Number of adult safeguarding referrals made
Satisfaction of the providers obligation eliminating mixed sex accommodation

Emergency transfers from inpatient beds to acute care

Total numbers of inpatients transferred as an emergency to acute care (in any time period)

Infection Control

MRSA Bacteraemia Number of cases
MRSA RCA reports
C.Diff number of cases (trajectory only)
C.Diff associated diseases (CDAD) RCA reports
Infection control training

Total number of medication incidents in month
Level of actual patient harm resulting from medication incidents
No harm
Low harm
Moderate
Number of SCH attributable incidents involving Controlled Drugs

Incidents
NRLS (i.e. patient safety) reportable incidents
Number of Never Events in month
Number of Serious Incidents (SIs) that occurred
Number of SIs reported to CCG in month
Percentage of SI reports submitted to CCG on time
Duty of Candour Applicable Incidents (includes non SIs)

Severity of NPSA Reportable Incidents
None
Low
Moderate
Major
Catastrophic

Training Compliance
Adult Safeguarding
Children Safeguarding
WRAP
MCA / DoLs Training compliance

Service User satisfaction - Patient Experience Report

Current IQPR Board report indicators

To be grouped accordingly by division / speciality / or as agreed as not currently grouped appropriately		
Indicator title / reference	Description	Keep / Remove
Emergency department attendances	A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	Information only
RTT waiting list	A count of the patients on the waiting list for treatment.	
Acute 18 week RTT complaince %	% of patients on incomplete RTT pathways	
RTT waiting list precovid comparison	A year on year comparison of the number of patients waiting for treatment	Remove
RTT 52 week waits	A count of the number of patients who are waiting for treatment and have been waiting longer than 1 year for treatment. This is a national key performance indicator with a national expectation of 0.	
Add 104 week waits		
Elective admissions	A count of the number of patients that were admitted for an elective/planned procedure. This is a local metric used to monitor changes in activity.	
Non elective admissions	A count of the number of patients who were admitted following an unplanned or emergency episode. This is a local metric used to monitor demand.	
Staff sickness	A measure of staff sickness across the Trust. This includes community staff. This is a local metric to monitor the capacity of our workforce.	
Covid related sickness / isolation	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.	
Elective operations (excluding private and community)	This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	
Covid detected inpatients	This is a count of the number of patients admitted to the hospital who tested positive for Covid. This is a local measure to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	
Covid inpatient deaths	A count of the number of patients who have died following a positive Covid result. This is a local metric to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	
Diagnostic performance - % within 6 weeks	To measure compliance with the national standards for access to diagnostic treatment. This metric measures the percentage of patients who receive diagnostic treatment within 6 weeks of referral. The national standard is 99% to receive a diagnostic within 6 weeks.	
Cancer 2 week wait for urgent GP referrals Total	To measure compliance with the national standards for access to cancer diagnosis. This metric measures the percentage of patients who are seen within 2 weeks from referral from their GP for suspected cancer. The national standard is 93% to been seen within 2 weeks.	
Cancer 2 week wait Breast symptoms Total	This metric is a sub set of the national 2 week wait metric and measures those GP referrals specifically with breast symptoms. The target is the same as the overall 2 week wait of 93% of patients to be seen within 2 weeks.	
Cancer 62 day GP referrals Total	To measure compliance with the national standards for access to cancer treatment. This metric measures the percentage of patients receive cancer treatment within 62 days of referral by their GP. The national standard is 85% to have received treatment within 62 days.	
Cancer referrals	A count of the number of patients referred to the hospital with suspected cancer, requiring investigation. This metric shows the activity by month for cancer services, which informs the national metric which measures the number of these patients that were seen within 2 weeks (further in the performance pack).	
Add all other cancer indicators from previous IQPR		TBC
Incomplete 104 day waits	A count of the number of patients who have waited longer that 104 days for treatment for cancer from GP referral. This is a national standard and is expected to be 0.	
Duty of Candour	This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	
Within 10 days: Duty of Candour	The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.	
Acuity measures	A range of measures have been identified which are analysed to provide an overall acuity score, as displayed in this chart. This provides an overview of the acuity of admitted patients.	
Acute falls per 1000 beds	A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	
Patient Safety Incidents reported (Total, resulting in harm)	A count of the number of patient safety incidents reported in total and those resulting in harm	
Patient Safety Incidents reported (Total and per 1,000 occupied bed days)	The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	
Pressure ulcers	A count of the number of recorded new pressure ulcers across the Trust. This metric will include those recorded in the acute hospital and community settings	
Acute pressure ulcers per 1,000 beds	measure of the number of pressure ulcers in the acute hospital measured per 1000 bed days. Community inpatient pressure ulcers are excluded from this metric.	
Nutrition	% of patients with a Malnutrition Universal Screening Tool (Adults)/Paediatric Yorkhill Malnutrition Score (Children) assessment completed within 24 hours of admission	
New complaints	New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
Closed complaints	Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	

Overdue responses	Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	
Community non-consultant led 18 week max. wait	Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric Occupational Therapy, Paediatric Physio and Paediatric Speech and Language Therapy, There are no patients waiting over 52weeks for treatment from referral, so community look at number of patients waiting over 14 weeks. Historically, 14 weeks was agreed on as an internal measure because it gives an approx. number of patients who would breach the 18 week target at the end of the next month.	
Community non-consultant led 18 week compliance	Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	
Contacts for ALL community services (adults and paediatrics)	Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	
Contacts for community paediatric services	Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	
Community referrals	There should be one reason per referral, i.e. if a patient is referred in to the INTs for 2 requirements either simultaneously or over time, eg leg ulcer dressing and phlebotomy, then there are 2 referrals.	
Community INT referrals by urgency	Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	
Community INT compliance by urgency	Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	

INSIGHT COMMITTEE – 10th January 2022

Agenda item:	4.2			
Presented by:	Nickie Yates, Head of Information & Contracting			
Prepared by:	Nickie Yates, Head of Information & Contracting			
Date prepared:	5th January 2022			
Subject:	Update on the Information Services 2021/22 Project Work			
Purpose:		For information		For approval

Executive summary:

This paper is to provide the Insight Committee with an update on the position presented in July on the Information Services 2021/22 project work.

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	X	X	X

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

Recommendation:

The Insight Committee is asked to note the work completed and developments underway.

Update on the Information Services 2021/22 Project Work

(note this is known projects as at 05/01/22)

	RAG	PROJECT STATUS	UPDATE
DIGITAL PROGRAMME - PHASE 5 PROJECTS			
Maternity Reporting: Data Quality/ Fixes / Optimisation		Complete	Maternity live in e-Care, reporting and DQ checks in place. There is a dq reporting process to support the data submissions that is embedded and now part of BAU.
CERT & MOCK Domain refresh		In progress	Both domain refreshes complete. There remain ongoing issues linked to the refresh with the PIEDW attached to the testing domains.
CSP v6 upgrade		Complete	Implemented into the live e-Care domain
ECDS		Complete	Implemented into the live e-Care domain
PIEDW Admin upgrade (to support ECDS)		In progress	The ECDS upgrade identified that an PIEDW Admin upgrade was required to support ECDS reporting, therefore this work is currently underway. Testing is complete, however there are outstanding issues with Cerner to fix prior to implementation into the live domain.
Critical Care		Not yet started	Critical Care project has a delayed start of June 22.
RPAS		Not yet started	RPAS project has a delayed start of June 22.
Endoscopy: Medilogik		In progress	Awaiting go-live date for project, limited impact on reporting as dual entry across e-Care and Medilogik by operational staff will continue, so reporting in the main remains unchanged to current provision.
Change Control Process		In progress	BAU - ongoing workload
CSP v7.10 upgrade		Not yet started	Due to start in March 2022.
INFORMATION SERVICES PROJECTS			
1 - LUNA project (MBI supplier)			
LUNA phase 1 - Dashboard upgrade		On hold	To expediate the move to the LUNA tool for PTL tracking, the dashboard upgrade has been re-planned to occur after the LUNA PTL deployment.
LUNA phase 2 - RTT Deconstruction		In progress	Testing identified differences in reported position, therefore further testing required. DQ staff are currently using the tool to ensure there are no further issues and to perform UAT of the product. Once this is complete, we will pilot with three specialties for operational UAT, prior to a full rollout.
LUNA phase 3 - FU Deconstruction		In progress	FU deconstruction has been completed by MBI. Trust to review and test once RTT issues above resolved.
LUNA phase 4 - Operational deployment - RTT Tracking		Not yet started	Dependent on phase 2 above.
2 - Power BI Dashboards			
Power BI: Inpatient		Complete	Dashboard is live and available via the Power BI self service portal.
Power BI: D2OA/ Criteria to reside (C2R) Historic Dashboard		In progress	The Trust is moving over to using C2R categorisation of patients, and therefore the dashboard is being developed for this criteria. The C2R went live in e-Care in November.
Power BI: C2R Live Dashboard		Complete	Dashboard is live and available via the DISCERN reporting portal.
Power BI: ED dashboard (update)		On hold	Update put on hold due to changes in staffing in the Information team and introduction of ECDS. To be rescoped and then dashboard update to be completed.
Power BI: Pathology Dashboard		In progress	Due to the volume of data involved, the project was re-scoped and separate dashboards are being developed for each department. The are in the final review / testing stages with the operational and reporting team.
Power BI: RTT Dashboard		Complete	Dashboard is live and available via the Power BI self service portal.
Power BI: Pain Service Metrics		Complete	End product was produced in excel not Power BI.
Power BI: COVID		Complete	Dashboard is live and available via the Power BI self service portal.
3 – DataWarehouse (DW) Replacement			
ANS system review scoping work		In progress	Preparation work complete. Awaiting dates from supplier to complete the workshops to form the review.
Replacement DW		Not yet started	Pending outcome of ANS review
Reporting with new DW		Not yet started	Pending outcome of replacement DW, to enable reporting to migrate.
4 - General Reporting projects			
SQL / Power BI Dashboard: Clinical Dashboard		On hold	A specification for this is required prior to development, while the scope is being determined by clinical staff this project is put on hold.
Bed model		Complete	Weekly bed model is live. Further enhancements requested to incorporate COVID data, awaiting confirmation of requirements from Operations.
Exec Summary Dashboard		In progress	
Reporting for III Governance Structure		N/A	Agreed existing reporting meets requirements, nothing specific required for each governance board.

	RAG	PROJECT STATUS	UPDATE
4 - General Reporting projects			
ESD Dashboard		Complete	End product was produced in excel not Power BI.
SPC Executive Dashboard		Complete	Introduction of a daily SPC dashboard with a number of metrics relating to COVID pressures was implemented to support the Strategic and Executive groups.
5 - IS Efficiencies			
PIMS replacement		On hold	
Automation of routine reporting: All Divisions		On hold	Whilst this is on hold as a project, the reporting team are reviewing on an ad hoc basis when time allows.
Review of existing reporting for consolidation		On hold	Whilst this is on hold as a project, the reporting team are reviewing on an ad hoc basis when time allows.
6 - HR for IS			
Cancer Reporting Transfer		In progress	Work underway to develop a Cancer performance tracking dashboard in Power BI, and recruitment to a Band 5 support post. Transfer of reporting function planned for June.
Recruitment to RPAS DQ Staff Team: Training and deployment		Complete	5 out of 6 RPAS DQ staff recruited and in post. Work has commenced on the DQ clean-up of e-Care data ahead of the data migration for RPAS. RPAS project has a delayed start of June 22.
WSFT / SYSTEM / NATIONAL PROJECTS			
7 - Population Health		In progress	Work continues against the overall project plan. In addition, there is a system wide Population Health project being scoped to support elective recovery.
8 - Alliance System Working		On hold	Initial work completed, awaiting next steps work to be identified. Activate engagement in the alliance system working to facilitate thisagenda.
9 – Elective Recovery Fund / Accelerator Programme		In progress	Ad hoc requests for reporting to support ERF / Accelerator are being dealt with as they arise.
10 - Performance Review Process		On hold	A specification for this is required prior to development, this is being scoped by the Performance Team and is still awaited. Work has begun independently of this with the HR team, to reproduce the current reporting in Power BI to enable drill down functionality. This will then be incorporated into the final Trust wide dashboard product once specification is known. Finance are also developing a finance KPI section separately that will incorporated into the Trust wide dashboard.
11 - Quality Improvement Projects		Complete / BAU	Monthly meetings are in place to discuss project work, as new projects are identified this is dealt with through BAU.
12 – Public Health Projects		Complete / BAU	Monthly meetings are in place to discuss project work, as new projects are identified this is dealt with through BAU.
13 – Length of Stay (LOS) Project		Complete	Dashboard is live and available via the Power BI self service portal.
14 – Regional UEC Reporting and Intelligent Conveyance Workstreams / SHREWD		In progress	The SHREWD reporting is split into two sets of indicators. A test file has been submitted for the first set of indicatora and that was successful, therefore the data will commence flowing routinely for these from w/c 10th January. The team will then begin work on pulling the data for the second set of indicators.
15 – Immunisation Programme		Complete	Routine reporting in place for both COVID and FLU vaccinations (Power BI Dashboards).
16 – ICPS Review		Complete	
17 – Community Scheduling (Malinko) Project		On hold	Work was completed to resolve the reporting issues creating on implementation of Malinko, however the Malinko project was suspended prior to deployment.
19 – Booster Vaccination Programme		Complete	
19 – Mandatory Vaccination Programme		In progress	Reporting requirements currently under development, currently working with HR to identify staff who do not meet the vaccination requirement.

- Complete
- In progress - behind time
- In progress - on track
- Not yet started

2.2. Finance and Workforce Report

To Assure

Presented by Nick Macdonald

Board of Directors – 28 January 2022

Report Title:	Item 2.2 - Finance and Workforce Board Report for December 2021
Executive Lead:	Nick Macdonald, Executive Director of Resources (Interim)
Report Prepared by:	Charlie Davies, Deputy Director of Finance (Interim)
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☒	☒	☒

Executive Summary

The reported I&E for December is breakeven (YTD break-even).

We previously agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%. However, due to the funding arrangements for 21/22 the Trust has recorded a break-even position up to Month 9. It is anticipated that in H2 we will be spending more than in H1, a result of seasonal variations, winter pressures and funded developments. Despite this, with mitigations in place we are planning to achieve an overall breakeven position for the full financial year 21/22.

Whilst some draft guidance to aid planning for 22/23 was released in late December we are waiting for significant further detailed guidance to be able to plan effectively for next year. What is known is that while we anticipate a reduction in income of between £7-8m in 22/23 (linked to an anticipated reduction in overall COVID spend) there is an expectation that the Trust will break even in 22/23. While we assess the risks and available mitigations to achieving break even, a key part of financial planning for 22/23 is identifying opportunities to remove these additional costs of COVID wherever possible and developing and delivering a robust cost improvement plan.

Action Required of the Board

The Board is asked to review this report

Sustainability:	*The paper highlights a potential risk to financial performance in 22/23.*

FINANCE AND WORKFORCE REPORT
December 2021 (Month 9)

Executive Sponsor : Nick Macdonald, Director of Resources (Interim)
Author : Charlie Davies, Deputy Director of Finance (Interim)

Financial Summary

I&E Position YTD	£0m	break-even
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£11.8m	on-plan
EBITDA margin YTD	5%	on-plan
Cash at bank	£22.5m	

Executive Summary

- The reported I&E for December is break-even (YTD break-even).
- Planning for a breakeven position for the financial year 21/22.

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
- Funding arrangements for 2022-23

SUMMARY INCOME AND EXPENDITURE ACCOUNT - December 2021	December 2021 Budget £m	December 2021 Actual £m	December 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	24.4	24.5	0.1	216.9	215.8	(1.1)
Other Income	3.5	3.6	0.1	29.4	27.9	(1.6)
Total Income	**27.8**	**28.0**	**0.2**	**246.3**	**243.7**	**(2.6)**
Pay Costs	17.9	17.8	0.1	159.3	159.7	(0.3)
Non-pay Costs	8.6	8.9	(0.3)	76.4	72.2	4.2
Operating Expenditure	**26.6**	**26.7**	**(0.2)**	**235.7**	**231.8**	**3.9**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**1.2**	**1.3**	**0.1**	**10.6**	**11.8**	**1.3**
Depreciation	0.8	0.7	0.0	6.8	6.6	0.2
Finance costs	0.5	0.6	(0.1)	3.8	5.2	(1.5)
SURPLUS/(DEFICIT)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**

FINANCE AND WORKFORCE REPORT – December 2021

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- Income and Expenditure Summary Page 3
- Cost Improvement Programme Page 3
- Trends and Analysis Page 4
- Income and Expenditure by Division Page 5
- Balance Sheet Page 8
- Cash Page 8
- Debt Management Page 9
- Capital Page 9

Key:

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

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

FINANCE AND WORKFORCE REPORT – December 2021

Income and Expenditure Summary as at December 2021

The reported I&E for December is breakeven (YTD break-even).

We previously agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%. However, due to the funding arrangements for 21/22 the Trust has recorded a break-even position up to Month 9. It is anticipated that in H2 we will be spending more than in H1, a result of seasonal variations, winter pressures and funded developments. Despite this, with mitigations in place we are planning to achieve an overall breakeven position for the full financial year 21/22.

Budget Setting

Whilst some draft guidance to aid planning for 22/23 was released in late December we are waiting for significant further detailed guidance to be able to plan effectively for next year. What is known is that while we anticipate a reduction in income of between £7-8m in 22/23 (linked to an anticipated reduction in overall COVID spend) there is an expectation that the Trust will break even in 22/23. While we assess the risks and available mitigations to achieving break even, a key part of financial planning for 22/23 is identifying opportunities to remove these additional costs of COVID wherever possible and developing and delivering a robust cost improvement plan.

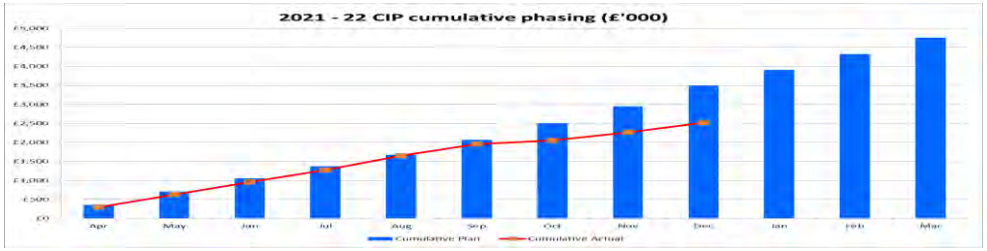
Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	0	0	0	⟺	Green
YTD surplus/ (deficit)	0	0	0	⟺	Green
EBITDA (excl top-up) YTD	0	0	0	⟺	Green
EBITDA %	0.0%	0.0%	0.0%	⟺	Green
Clinical Income YTD	(171,863)	(170,097)	(1,765)	↑	Amber
Non-Clinical Income YTD	(74,439)	(73,594)	(845)	↑	Amber
Pay YTD	159,315	159,654	(339)	↑	Amber
Non-Pay YTD	86,994	84,049	2,945	↓	Green

Cost Improvement Programme (CIP) 2021-22

The CIP programme for 2021-22 is £4.8m (100%). In the year to December we achieved £2.5m (53.1%) against a plan of £3.5m (73.5%), which is a shortfall of £972k.

Recurring/Non Recurring	2021-22 Annual Plan £'000	Plan YTD £'000	Actual YTD £'000
Recurring			
Outpatients	-	-	-
Procurement	242	157	107
Activity growth	-	-	-
Additional sessions	101	101	101
Community Equipment Service	271	203	184
Drugs	51	38	38
Estates and Facilities	63	49	5
Other	394	272	251
Other Income	147	139	219
Pay controls	28	21	14
Service Review	-	-	-
Staffing Review	269	144	144
Theatre Efficiency	20	13	-
Contract Review	319	239	98
Workforce	-	-	-
Consultant staffing	-	-	28
Agency	-	-	-
Car Park income	75	56	-
Unidentified CIP	1,587	880	90
Recurring Total	**3,567**	**2,313**	**1,280**
Non-Recurring			
Pay controls	99	93	133
Theatre Efficiency	280	280	369
Staffing Review	-	-	-
Other	810	810	743
Estates and Facilities	-	-	-
Non-Recurring Total	**1,189**	**1,183**	**1,244**
Total CIP	**4,756**	**3,496**	**2,524**



FINANCE AND WORKFORCE REPORT – December 2021

Trends and Analysis

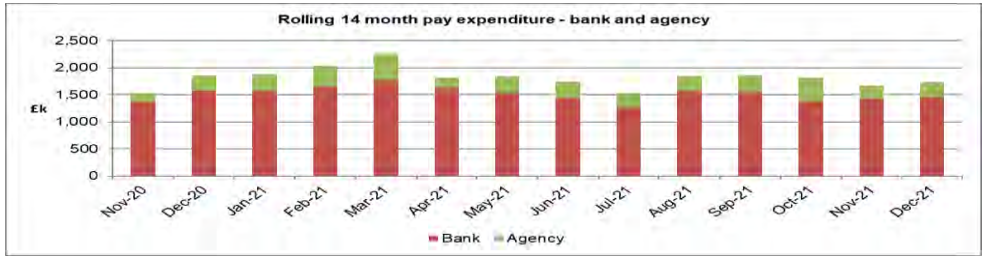
Workforce

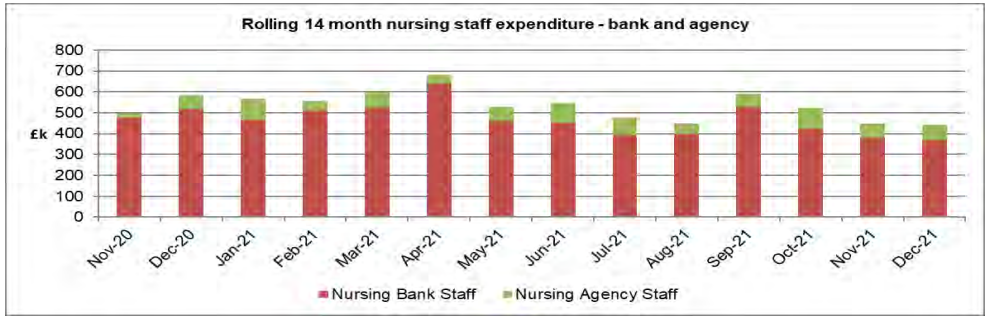
During December the Trust spent £0.1m less than budget on Pay costs (£0.4m overspent YTD).

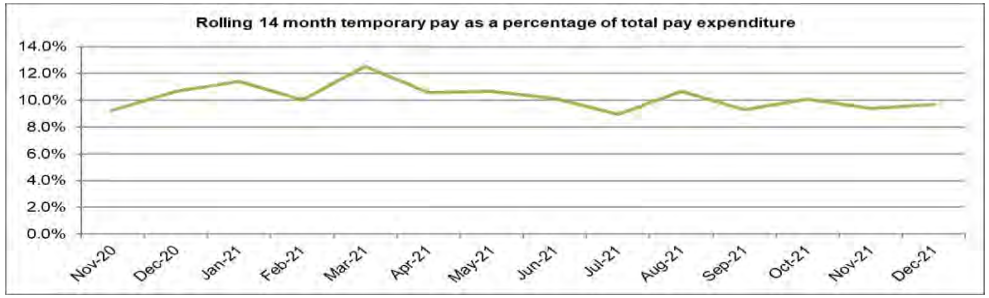
Monthly Expenditure (£)				
As at December 2021	Dec-21	Nov-21	Dec-20	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	17,938	17,941	16,577	159,315
Substantive Staff	16,092	16,091	15,565	143,791
Medical Agency Staff	113	128	153	1,168
Medical Locum Staff	341	186	351	2,511
Additional Medical Sessions	302	360	251	2,521
Nursing Agency Staff	74	71	70	646
Nursing Bank Staff	369	378	516	4,039
Other Agency Staff	88	48	62	802
Other Bank Staff	183	206	239	1,894
Overtime	139	139	130	1,097
On Call	121	153	87	1,184
Total Temporary Expenditure	1,730	1,671	1,859	15,863
Total Expenditure on Pay	17,822	17,762	17,424	159,654
Variance (F/(A))	116	179	(847)	(339)
Temp. Staff Costs as % of Total Pay	9.7%	9.4%	10.7%	9.9%
memo: Total Agency Spend in-month	275	248	285	2,616

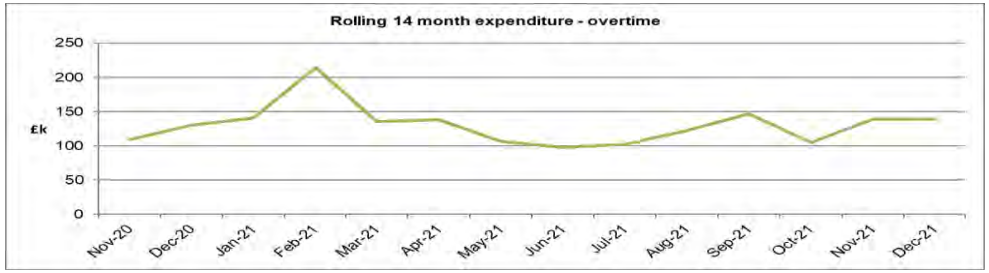
Monthly WTE				
As at December 2021	Dec-21	Nov-21	Dec-20	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,533.2	4,513.8	4,190.7	42,390.9
Substantive Staff	4,066.9	4,062.9	3,922.8	36,470.3
Medical Agency Staff	4.9	12.8	10.6	60.5
Medical Locum Staff	28.3	21.4	26.5	237.8
Additional Medical Sessions	11.7	5.2	7.5	55.1
Nursing Agency Staff	11.2	10.7	16.4	95.8
Nursing Bank Staff	112.0	113.2	153.1	1,124.9
Other Agency Staff	15.8	16.0	15.1	129.8
Other Bank Staff	68.3	71.8	89.5	721.0
Overtime	36.7	36.2	30.3	279.3
On Call	6.8	8.2	5.2	68.9
Total Temporary WTE	295.7	295.5	354.2	2,773.1
Total WTE	4,362.5	4,358.4	4,277.0	39,243.4
Variance (F/(A))	170.7	155.3	(86.3)	3,147.5
Temp. Staff WTE as % of Total WTE	6.8%	6.8%	8.3%	7.1%
memo: Total Agency WTE in-month	31.9	39.4	42.1	286.1

Pay Costs









Income and Expenditure Summary by Division

Position by Income, Pay and Non Pay	Income		Pay		Non Pay		Capital Charges and Financing Costs		Total	
Division ▲	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £	**In-Month Variance £**	**YTD Variance £**
Medicine	628K	-1,157K	-53K	-1,692K	-338K	-942K			**238K**	**-3,791K**
Surgery	-343K	-4,545K	46K	831K	-187K	130K			**-484K**	**-3,584K**
Women & Children	-194K	-41K	-49K	-77K	-61K	-1,314K			**-305K**	**-1,432K**
Clinical Support	-28K	-659K	-28K	-441K	-758K	-2,156K			**-814K**	**-3,256K**
Community Services	129K	171K	-39K	-529K	-313K	-737K	0K	1K	**-224K**	**-1,094K**
Estates and Facilities	-169K	-1,679K	-61K	-623K	-193K	-430K	1K	12K	**-423K**	**-2,720K**
Corporate	203K	5,299K	300K	2,193K	1,575K	9,668K	-67K	-1,282K	**2,011K**	**15,879K**
Trust	**226K**	**-2,610K**	**116K**	**-339K**	**-276K**	**4,219K**	**-66K**	**-1,268K**	**0K**	**1K**

Medicine (Sarah Watson)
The Medicine division is ahead of plan by £238k in month but behind plan by £3.8m YTD.

Clinical income is ahead of plan by £633k in month but behind plan by £914k YTD. Increased A&E attendances has led to non-elective activity outperforming planned levels by 4% in month. This is partly offset by ambulatory care activity level being lower than planned, meaning that non-elective activity as a whole was in line with the 19/20 average.

Outpatient attendance and procedure levels meant that outpatient activity was 12% below planned levels for December and 15% below the 19/20 average. Elective activity was 15% below planned levels for December, and 14% below the 19/20 average, primarily due to admitted patient care day case numbers.

Excluding clinical income, the division is behind plan in month by £394k and £2.9m YTD. Non-pay costs are £338k over budget in month, driven by a £315k pressure on drugs, a result of under recognition of YTD costs.

Pay costs account for £53k and £1.7m of the overall over spend (in the month and YTD respectively). Significant YTD pay costs include:

- ED Registrars (£621k) - the reduction in the use of temporary staffing to cover substantive vacancies is a continued area of focus for the division.
- Consultants (£443k) – primarily due to spend on additional sessions and agency staff.
- Unregistered Nursing (£419k) – primarily relates to spend on band 2 bank and band 3 rotation nursing staff.
- Junior Doctors (£305k) – due to a combination of spend on F2s and locums.
- Registered nursing overtime (£167k).
- The above pressures have been partly offset by a £988k under spend on substantive Registered Nursing across the Division.

Surgery (Sally Payne)
The overall financial position for the division was £484k behind plan in month (£3.6m behind plan YTD).

Clinical income was behind plan by £333k in month and £4.4m YTD. Elective activity remains low against plan (underperforming by 19%) with reduced elective bed capacity and theatre availability to support inpatient work. Additional capacity

has been secured within the Independent Sector as well as progressing with ICS mutual aid. Similarly, outpatient activity was behind plan by 13% in December.

Non-elective activity in December exceeded plan by 3.0%, with the division seeing increases within General Surgery and Orthopaedics compared to previous month. Emergency pathways were under significant pressure in month which increased the need to balance maintaining COVID capacity, non-elective capacity and trying to protect our elective capacity.

Excluding clinical income, the division is behind plan in month by £151k and ahead of plan by £842k YTD.
Pay expenditure reported an underspend of £46k in month (£831k YTD), driven by nursing vacancies but partially offset by overspends within medical staffing.
Non-pay expenditure reported an overspend of £187k in month (underspent £130k YTD) due largely to clinical supplies.

Women and Children's (Simon Taylor)
In December, the Division reported an adverse variance of £305k (£1.4m YTD).

Income was £194k behind plan in-month and £41k behind plan YTD. Activity levels have continued to increase since the start of the financial year however in month both elective and non-elective activity were behind plan. Year to date, Gynaecology and Paediatrics are behind plan (both 13%) whilst Neonatology is ahead of plan (49%). Obstetrics is on plan.

Pay is overspent by £49k in-month (£77k YTD). In-month drivers include the need for additional COVID capacity in the Paediatric Ward, staff sickness in the Neonatal Unit and the use of locums within Women's Services. Year to date, a large number of unfilled midwife posts have offset cost pressures, however a number of these posts have now been successfully appointed to.

Non-pay is overspent by £61k in-month (£1.3m YTD). In-month, paediatrics spent more than planned on drugs and consumables. Year to date, cost pressures have arisen from processing historic invoices in Maternity and consistent overspends on the paediatric drugs budget.

Clinical Support (Simon Taylor)
In December, the Division reported an adverse variance of £814k (£3.3m YTD).

Income was £28k behind plan in-month and £659k behind plan YTD. In-month, the Radiology Service was behind plan for outpatient, breast screening and direct access activity. Year to date, direct access radiology activity has increased to accommodate the increase in GP referrals. However, breast screening and outpatient radiology activity has been lower than plan. The first of two business cases to provide more radiology capacity has been approved. This should help to address the capacity issues that the department currently experiences.

Pay is overspent by £28k in-month (£441k YTD). Diagnostics has overspent on medical and non-medical pay throughout the year as the team work additional hours to address the current backlog demand for imaging, and pathology has overspent from providing the COVID SAMBA testing service. These pressures are partially offset by the vacancies in outpatient nursing and pharmacy.

Non-pay is overspent by £758k in-month (£2.2m YTD). In-month, payments for legacy invoices in pathology, mobile radiology and additional endoscopy capacity have generated the overspend. Year to date, the overspend has been driven by recovery related pressures in the radiology and outpatient budgets.

Community Services (Clement Mawoyo)
In December, the Division reported an adverse variance of £224k (YTD £1.1m).

Income reported £129k above plan in December (YTD £171k), driven by the funding in month from Aging Well covering additional pay costs already incurred by the Division.

Pay reported an adverse variance of £39k in month (YTD £529k). Agency staff were used to cover some vacant Therapy roles in Adult Physiotherapy, Occupational Therapy, Dietetics and the Early Intervention Team.

Non-pay reported an adverse variance of £313k in month (YTD £737k). This was due to:

- additional community equipment costs (£208k) incurred to enable timely hospital discharges. There has been a marked increase in faster response speeds; emergency, 4 hour and same day deliveries to support in response to acute capacity constraints.
- Unachieved CIP (£47k) from the additional H2 CIP target.
- A stepped increase in activity in Community Health Teams, notably nursing and therapy patient face to face contacts; higher than pre-Covid levels and resulting in non-pay expenditure increasing on dressings and consumables (£35k), as well as non-recurrent additional cost to support the transfer of services from Haverhill Health Centre and other smaller cost pressures (£23k)

Estates and Facilities

In December, the division recorded an adverse variance of £424k (£2.73m YTD).

Income in the area is behind plan by £169k in month and behind plan by £1.68m YTD. This is driven by car park and restaurant income being significantly affected by Covid-19, currently running at 36% of pre-pandemic levels (FY2019/20 to P9).

Non-pay costs are overspent in month by £193k (£430k YTD). Drivers include previously unaccrued air-conditioning refrigeration costs (£26k), YTD postage costs (49k) and unachieved CIP (£61k).

Pay costs for the month exceed budget by £61k (£623k YTD), a result of the higher than anticipated use of bank staff across Portering (22k), Domestic Staff (£17k) and Telephone service (£15k).

Corporate

Corporate areas have recorded an underspend in month of £2.0m against budget (£15.9m YTD). This variance is largely a result of the unanticipated (at the time of budget setting) central funding received in the year supporting the Trust to:

- deliver services through the COVID 19 pandemic
- increase our elective and outpatient activity back to pre-pandemic levels.

Pay costs recorded a positive variance of £300k, a result of a number of vacancies across Corporate departments (overall WTE's across Corporate areas are 338.8 in month against a budget of 364.43).

FINANCE AND WORKFORCE REPORT – December 2021

Statement of Financial Position at 31 December 2021

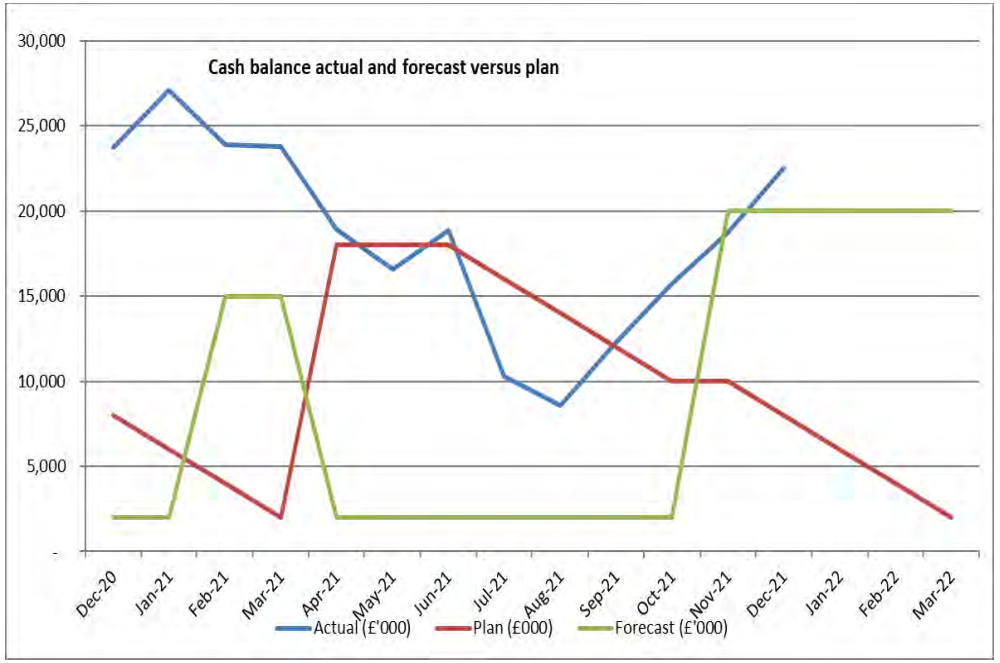
STATEMENT OF FINANCIAL POSITION

	As at 1 April 2021	Plan 31 March 2022	Plan YTD 31 December 2021	Actual at 31 December 2021	Variance YTD 31 December 2021
	£000	£000	£000	£000	£000
Intangible assets	52,198	54,398	53,798	62,637	8,839
Property, plant and equipment	137,103	168,603	159,603	155,447	(4,156)
Trade and other receivables	6,341	6,341	6,341	6,341	0
Total non-current assets	**195,642**	**229,342**	**219,742**	**224,425**	**4,683**
Inventories	3,481	3,481	3,481	3,406	(75)
Trade and other receivables	19,362	19,362	19,362	18,877	(485)
Cash and cash equivalents	23,788	2,006	8,006	22,503	14,497
Total current assets	**46,631**	**24,849**	**30,849**	**44,786**	**13,937**
Trade and other payables	(52,522)	(37,779)	(40,979)	(48,033)	(7,054)
Borrowing repayable within 1 year	(6,439)	(5,500)	(5,500)	(8,886)	(3,386)
Current Provisions	(46)	(46)	(46)	(46)	0
Other liabilities	(1,357)	(3,357)	(3,357)	(14,952)	(11,595)
Total current liabilities	**(60,364)**	**(46,682)**	**(49,882)**	**(71,917)**	**(22,035)**
Total assets less current liabilities	**181,909**	**207,509**	**200,709**	**197,294**	**(3,415)**
Borrowings	(47,719)	(43,319)	(45,519)	(44,158)	1,361
Provisions	(852)	(852)	(852)	(852)	0
Total non-current liabilities	**(48,571)**	**(44,171)**	**(46,371)**	**(45,010)**	**1,361**
Total assets employed	**133,338**	**163,338**	**154,338**	**152,284**	**(2,054)**
Financed by					
Public dividend capital	158,650	188,650	179,650	177,596	(2,054)
Revaluation reserve	8,743	8,743	8,743	8,743	0
Income and expenditure reserve	(34,055)	(34,055)	(34,055)	(34,055)	0
Total taxpayers' and others' equity	**133,338**	**163,338**	**154,338**	**152,284**	**(2,054)**

There has been little movement in the balance sheet against plan and the year-end position and the balances continue to be in line with expectations. The capital additions are slightly ahead of plan, however this is due to the profiling of the plan, with a larger amount of capital additions in relation to structure works occurring earlier in the year than anticipated in the plan. The movement in cash is noted below.

Cash Balance Forecast for the year

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



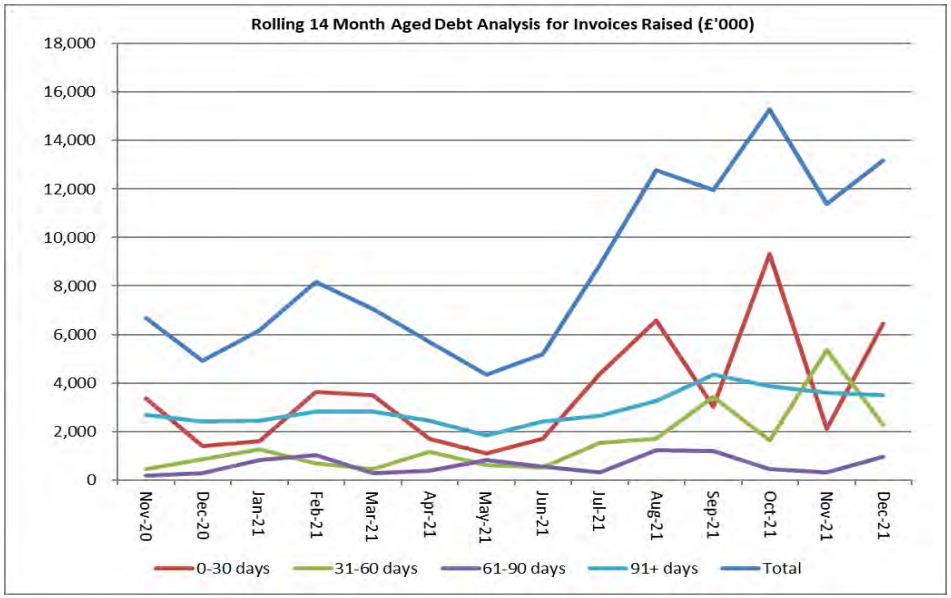
The Trust's cash position is currently being rigorously monitored during 2021/22 and we continually need to ensure that the timing of the capital payments is line with capital cash funding due to be received. The cash position is more favourable than expected and the forecast has been revisited. This is due to the fact that we have received income in advance from the CCG, which is being shown in deferred income. We are also expecting to receive additional PDC for capital funding rather than having to use cash reserves.

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 – December 2021

Debt Management

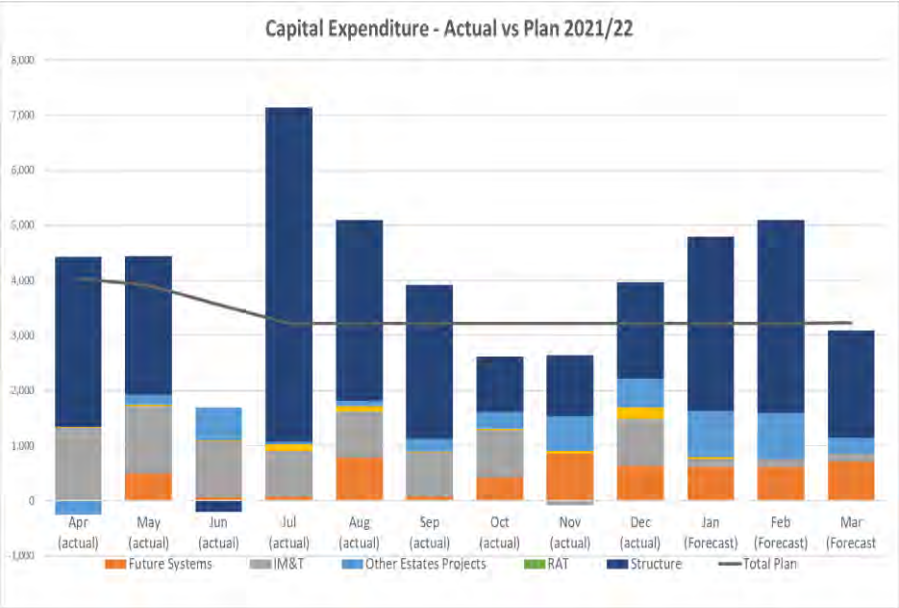
The graph below shows the level of invoiced debt based on age of debt.



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 continues to remain stable. The large majority of the debts outstanding are historic debts, although these are reducing. Over 89% of these outstanding debts relate to NHS Organisations, with 25% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances and a significant amount of work has been completed in this area to help reduce these historic balances.

Capital Progress Report



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	2021-22
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Future Systems	10	492	63	82	780	80	415	850	636	613	613	710	5,344
IM&T	1,316	1,219	1,016	825	835	796	863	-87	854	146	146	146	8,075
Medical Equipment	14	25	16	118	102	16	23	56	197	34	0	0	601
Other Estates Projects	-246	191	601	51	92	225	312	634	523	843	840	284	4,350
Structure	3,088	2,507	-201	6,062	3,281	2,802	1,003	1,102	1,758	3,159	3,491	1,949	30,001
Total / Forecast	4,182	4,434	1,495	7,138	5,090	3,919	2,616	2,555	3,968	4,795	5,090	3,089	48,371
Total Plan	4,038	3,915	3,561	3,216	3,216	3,216	3,216	3,218	3,218	3,218	3,218	3,229	40,479

The plan figures shown in the table and graph match the plan submitted to NHSI. The 2021/22 Capital Programme has been set at £40.5m with £30m of this relating to structure works. The spend to date is £35.4m.

The forecast has been revisited due to the Trust being awarded additional capital funding for other projects. The Trust is now on track to achieve the capital allocation with no overspend, and to spend the additional funding that has been awarded, by the end of March 2022.

2.3. IQPR - November 2021 data

To Note

Presented by Susan Wilkinson and Nicola Cottington

Trust Board Report

Agenda Item:	2.3			
Presented By:	Nicola Cottington & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Nov-21			
Subject:	Performance Report			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

A new approach to Board reporting is underway and this version has been developed within the revised principles. The main visual differences include the addition of a description field which provides a definition of the metric on display as well as some small amendments such as the addition of the current month's figure for easier reading. The agreed plan for the future board report was to report by exception based on the performance of the metrics, which were to be monitored using statistical process control (SPC) charts. The report will in future include SPC charts and appropriate narrative. A project is underway to produce an integrated performance dashboard which will, in future, generate this report. To allow the principle of reporting by exception to continue the exception filtering will be a manual assessment rather than an automated one for the current time. For this reason, the content of the Board report may vary as indicators perform as expected and are removed or perform exceptionally and are added to the board report. Further planned developments include the addition of recovery trajectories and a further review of community metrics; these will be incorporated in future versions. This is an iterative process and feedback is welcomed. Covid datix and Perfect ward Charts have been removed and that they will be presented within other board reports from the Chief Nurse.

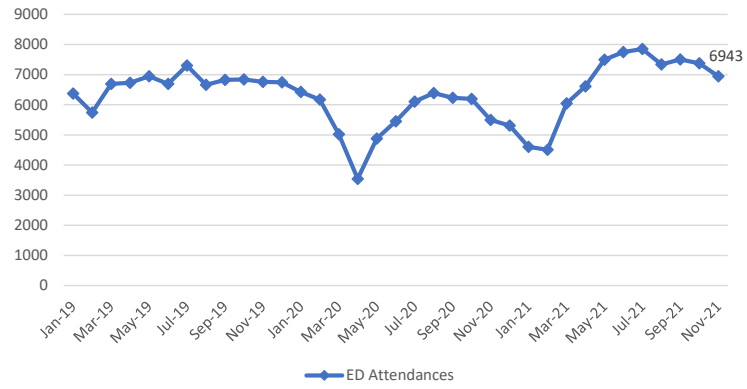
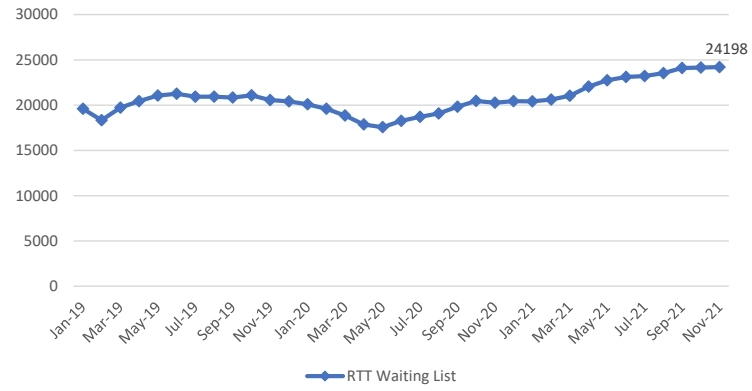
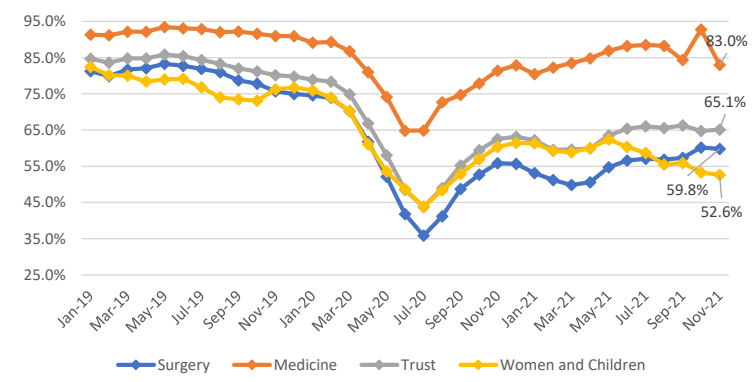
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

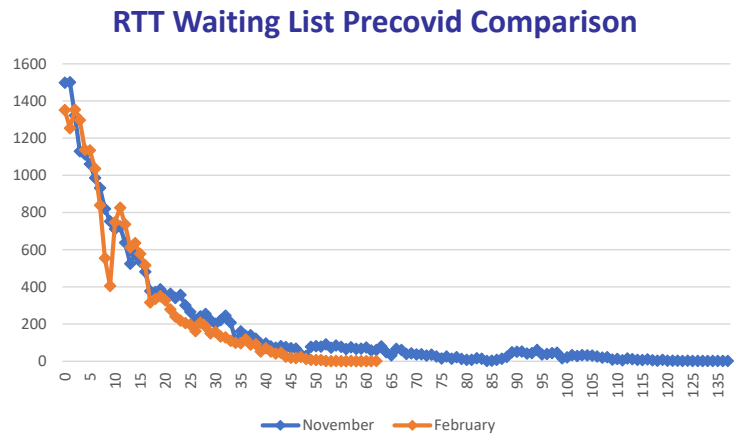
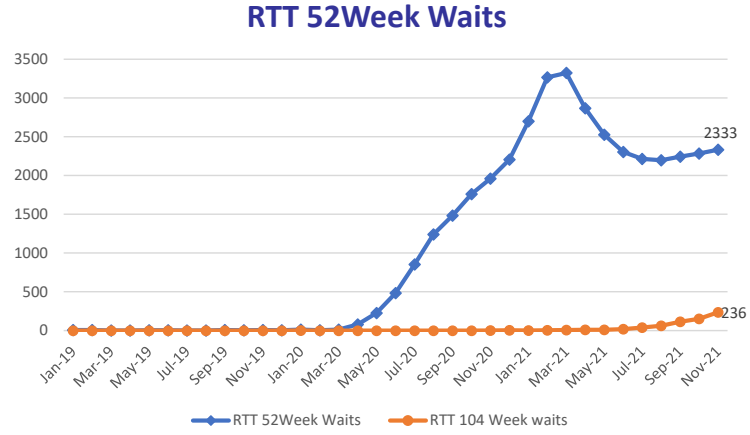
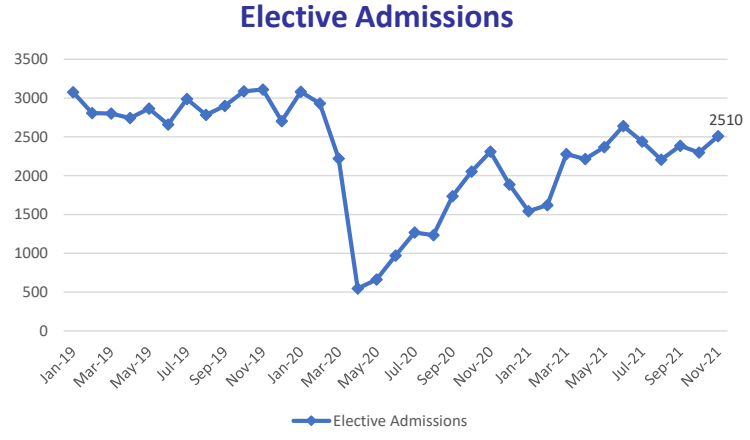
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X	**X**				**X**

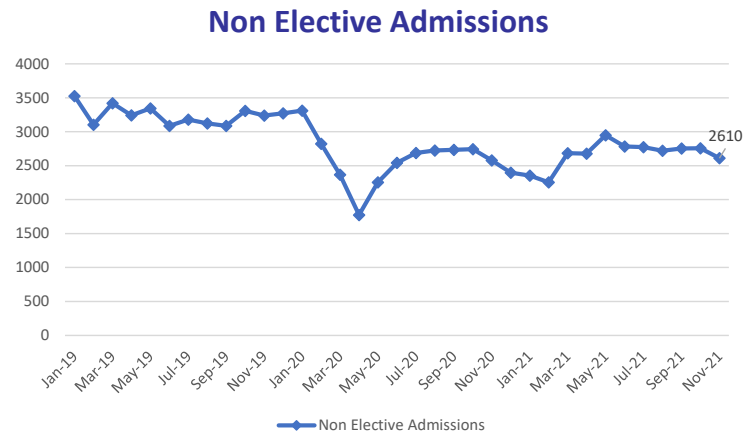
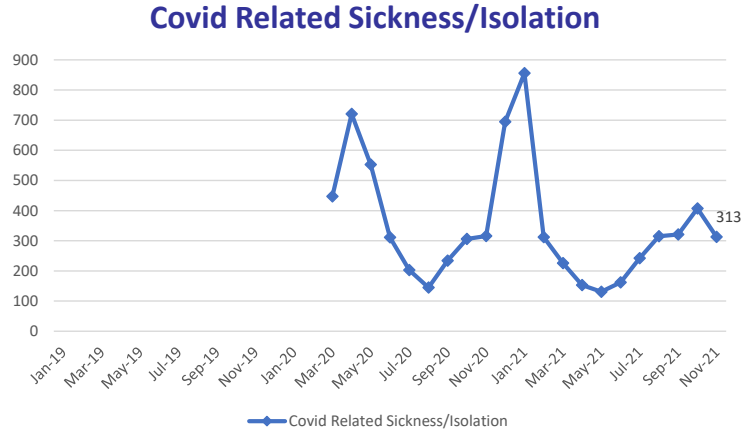
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

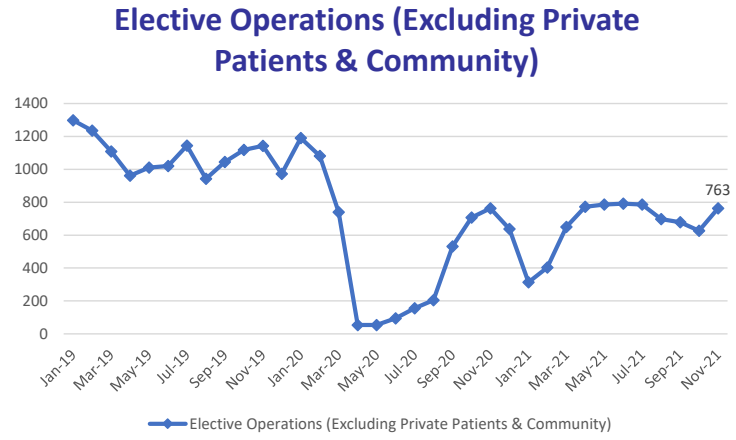
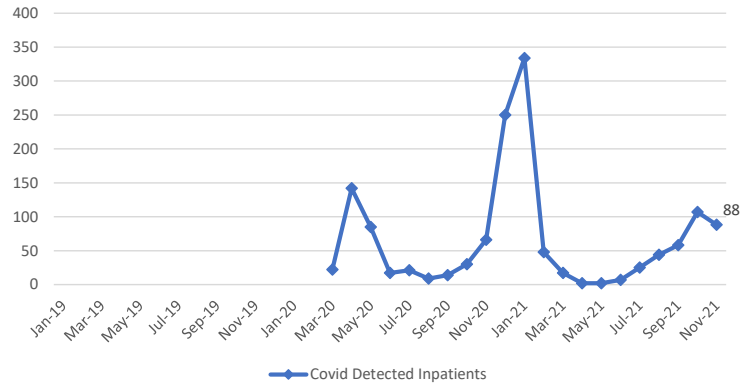
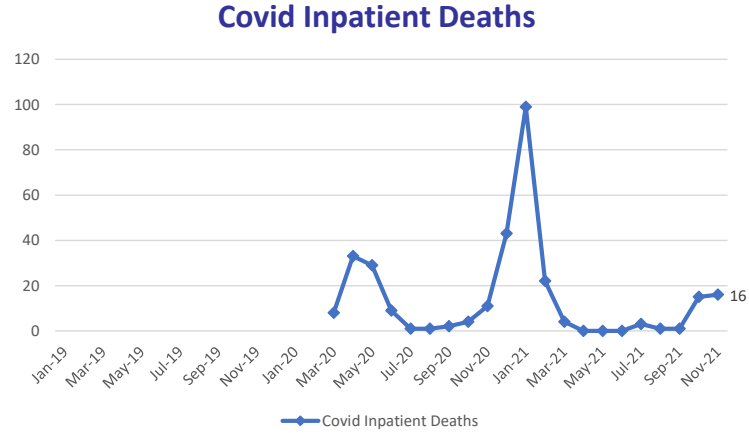
Recommendation:

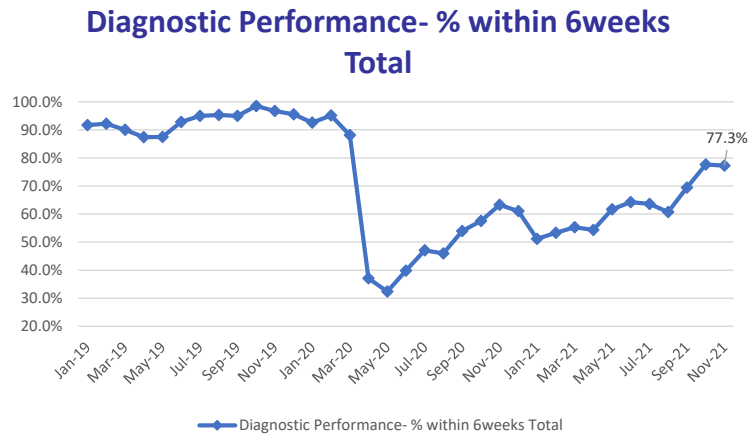
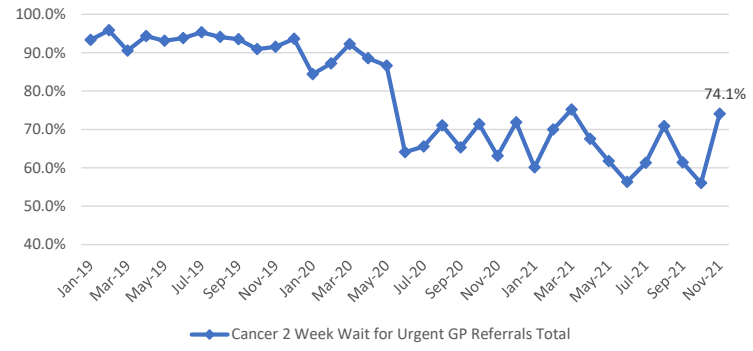
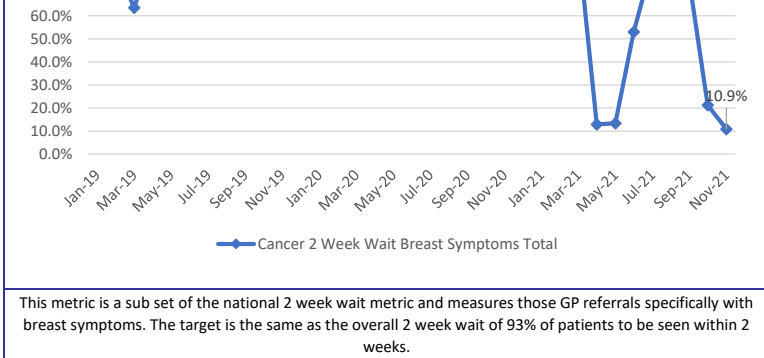
That Board note the report.

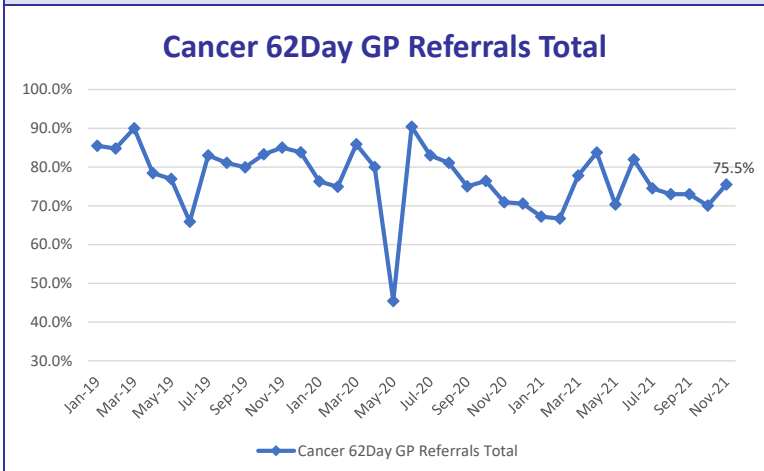
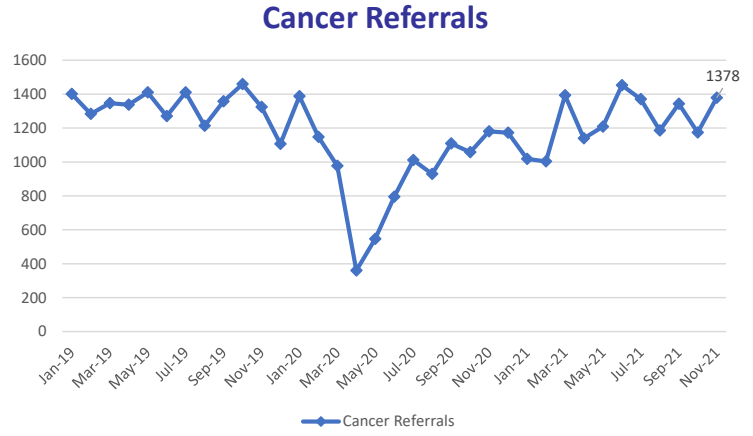
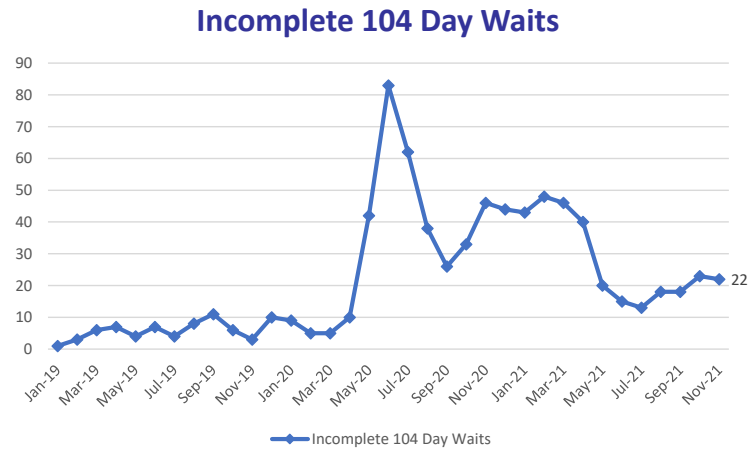
Board Report KPIs	Narratives
Emergency Department Attendances 	Attendances have continued to decrease, with reductions in both non-admitted and admitted attendances. The number of attendances remain above those for the same period the previous year, when there were Covid restrictions in place.
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
RTT Waiting List 	There has been a small increase in total waiting list size as in the previous month, as patients are waiting longer. This is due to the backlog created by the pandemic and ongoing theatre and bed capacity constraints due to a combination of the roof remedial programme and non-elective pressures.
A count of the patients on the waiting list for treatment.	
Acute 18 Week RTT Compliance % 	Overall performance has been fairly static from October to November as has been seen in the last 5 months, improvement on overall performance will remain a challenge due to the ongoing backlog, plus theatre and bed capacity constraints. General Medicine, Rheumatology, Geriatric Medicine and Cardiology were the only services to achieve over 90% compliance.
% of patients on incomplete RTT pathways	

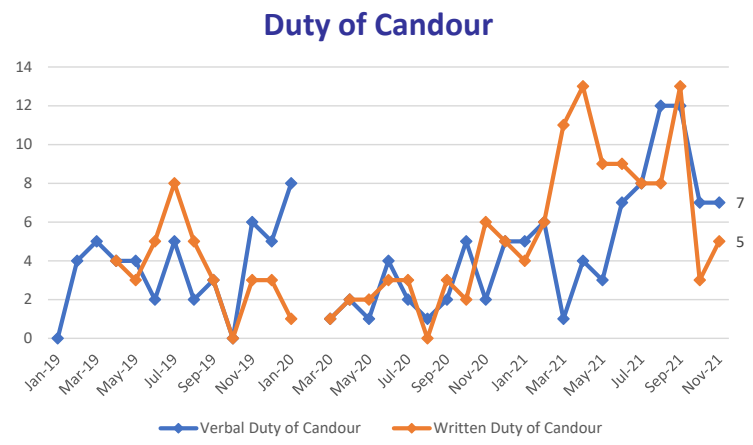
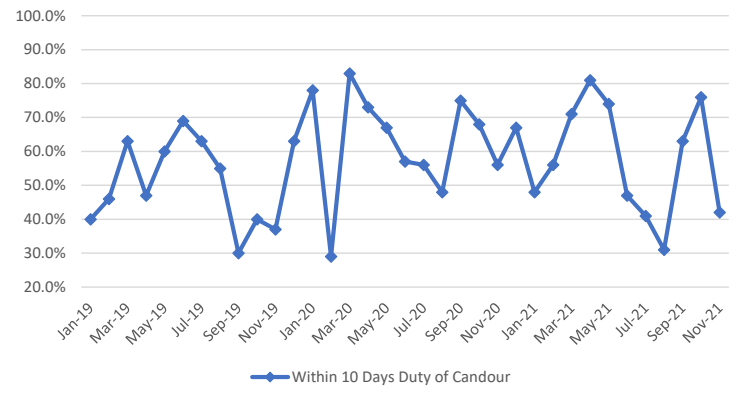
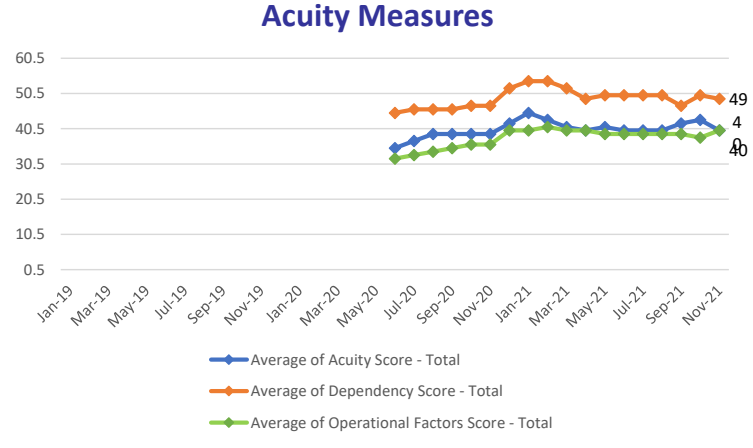
Board Report KPIs	Narratives
	Overall waiting list shape very similar to pre-pandemic however as expected tail is significantly longer, with many patients waiting over 104 weeks.
A year on year comparison of the number of patients waiting for treatment.	
	Increase in patients over 52 weeks and more significantly 104 weeks this month. 236 patients had been waiting over 104 weeks at the end of November, with the majority of these within Orthopaedics, followed by Gynaecology. Significant actions are in place to ensure WSFT achieves trajectory of 210 patients over 104 weeks by end of March 2022.
A count of the number of patients who are waiting for treatment and have been waiting longer than 1 year for treatment. This is a national key performance indicator with a national expectation of 0.	
	Increase in elective admissions in November, with the highest number since June 2021. Endoscopy and day surgery continue to run with good productivity and this number should increase from the 16th December onwards with additional elective theatre capacity back on line.
A count of the number of patients that were admitted for an elective/planned procedure. This is a local metric used to monitor changes in activity.	

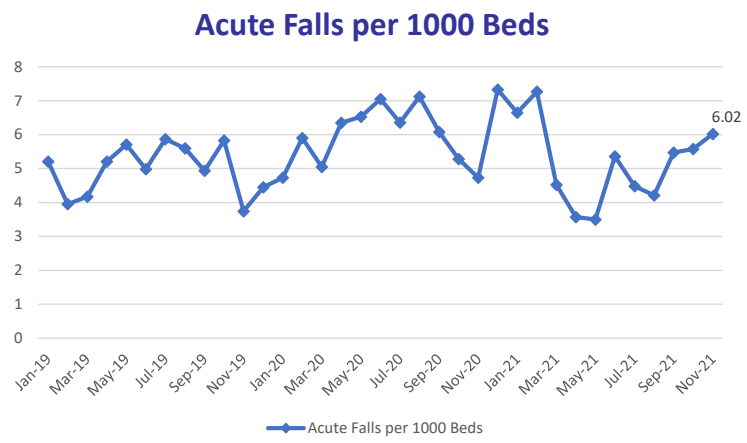
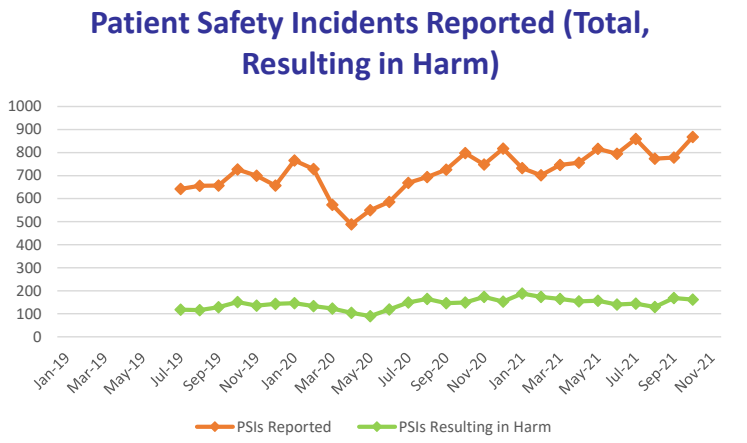
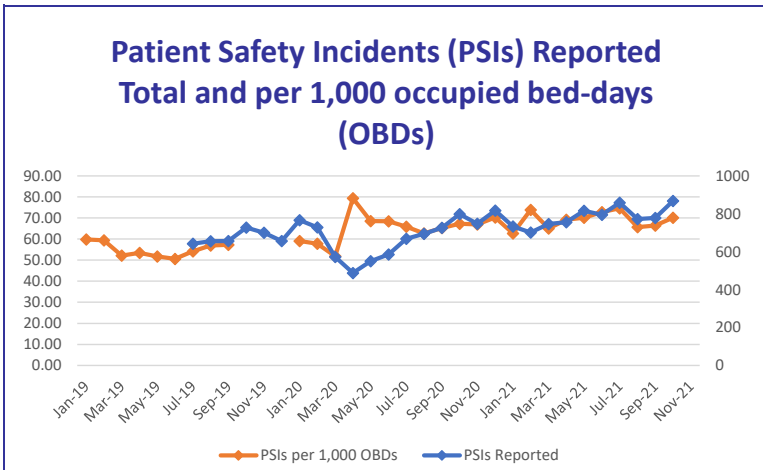
Board Report KPIs	Narratives
	For the month of November there is a reduction of 146 admissions compared with October. The data shows a reduction in admissions of all specialities apart from paediatrics who had a slight increase.
A count of the number of patients who were admitted following an unplanned or emergency episode. This is a local metric used to monitor demand.	
	The Trust's 12 month cumulative (rolling) absence figures at the end of November 2021 was 4.2%, a consistent position equal to that of September and October 2021, both recording 4.2%.
A measure of staff sickness across the Trust. This includes community staff. This is a local metric to monitor the capacity of our workforce.	
	This chart illustrates the number of sickness episodes related to COVID-19. In November 2021 there were 313 episodes recorded which is a decrease on October 2021 which recorded 407 episodes of COVID-19 related sickness.
A count of our staff who have been off sick with a Covid related symptoms or to isolate. This is a local metric to monitor the impact of Covid on our workforce.	

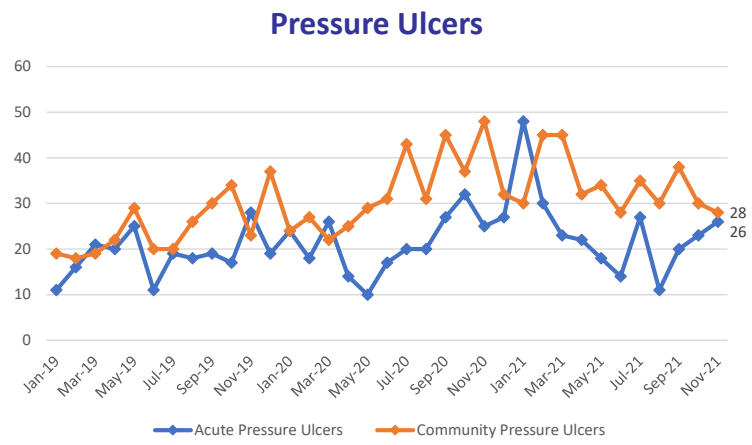
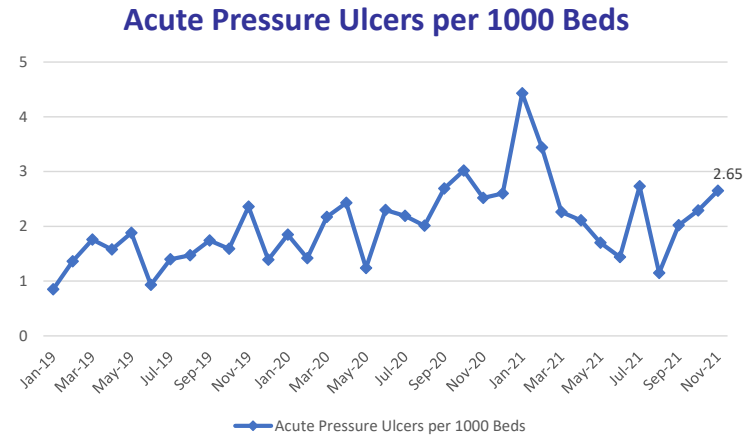
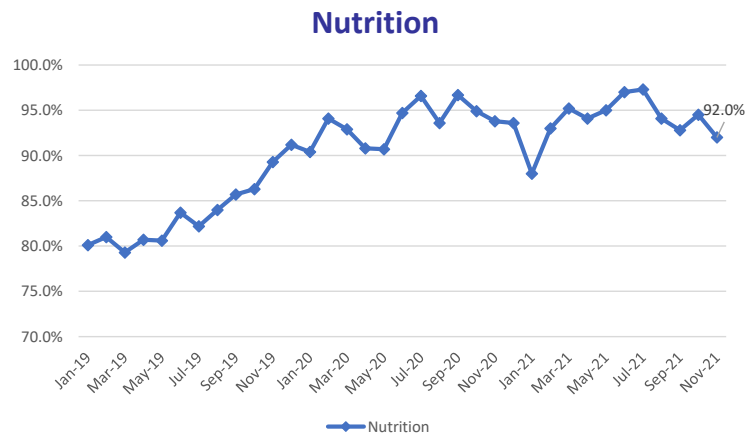
Board Report KPIs	Narratives
	Increase in numbers from October to November, however October was a particularly low month with reductions to one elective theatre for one week in Main theatres and the impact of half term.
This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	
	There were 88 individual patients admitted during November, who had their first diagnosis of Covid-19. In November the highest number of Covid positive inpatients residing in the trust on any one day was 40.
This is a count of the number of patients admitted to the hospital who tested positive for Covid. This is a local measure to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	
	There were 16 patients who died within 28 days of a positive Covid result in November. The total is now 304. These figures are as published by NHSE.
A count of the number of patients who have died following a positive Covid result. This is a local metric to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	

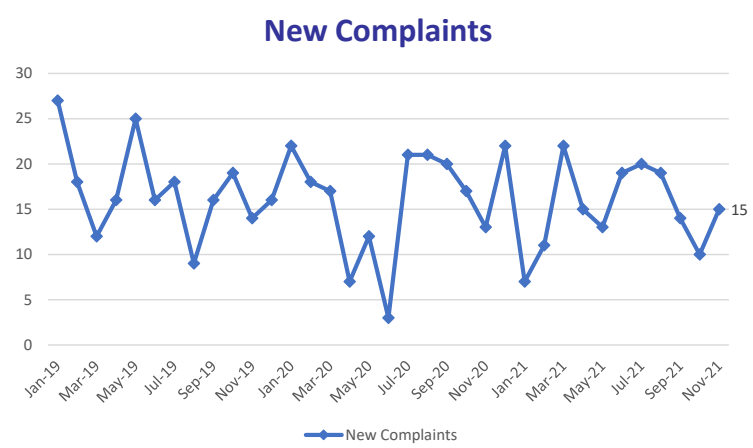
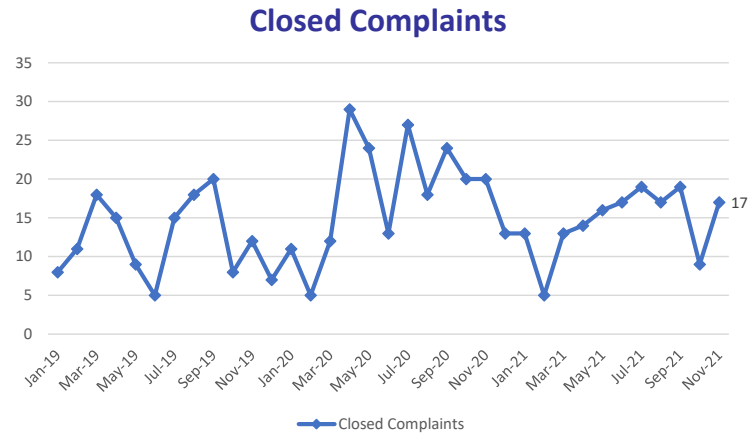
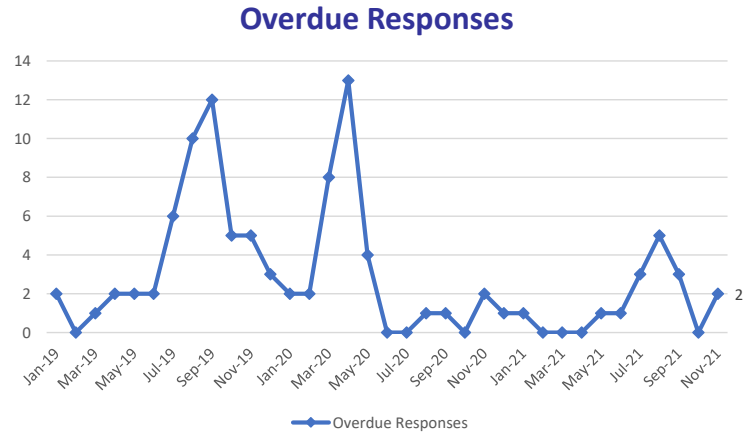
Board Report KPIs	Narratives
	Performance has stabilised since the significant improvement seen in October. Endoscopy services continue to recover well, CT continues to perform at 100%. MRI has seen a slight dip in performance due to a huge increase in demand and nearly 200 patients added to the waiting list in the last month. Ultrasound performance is a challenge, with forecasts for recovery at the end of January at risk.
To measure compliance with the national standards for access to diagnostic treatment. This metric measures the percentage of patients who receive diagnostic treatment within 6 weeks of referral. The national standard is 99% to receive a diagnostic within 6 weeks.	
	There has been a significant improvement in performance from October to November, however still well below the 93% standard. Most significant improvement is due to skin performance, which is now over 80% having fallen to around 20% for some months, this is due to a new pathway for referrals using AI technology. Breast is a significant concern with performance back down to around 20% due to large increases in referrals.
To measure compliance with the national standards for access to cancer diagnosis. This metric measures the percentage of patients who are seen within 2 weeks from referral from their GP for suspected cancer. The national standard is 93% to been seen within 2 weeks.	
	There has been a further reduction in performance for breast symptomatic patients, mostly due to the large increases in breast referrals which has continued for some months. Patients are triaged and seen in clinical priority.
This metric is a sub set of the national 2 week wait metric and measures those GP referrals specifically with breast symptoms. The target is the same as the overall 2 week wait of 93% of patients to be seen within 2 weeks.	

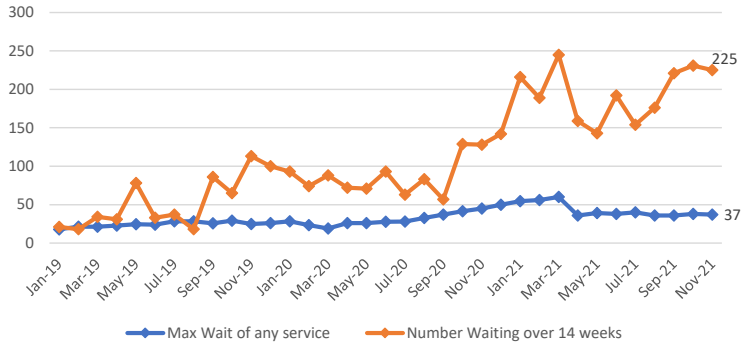
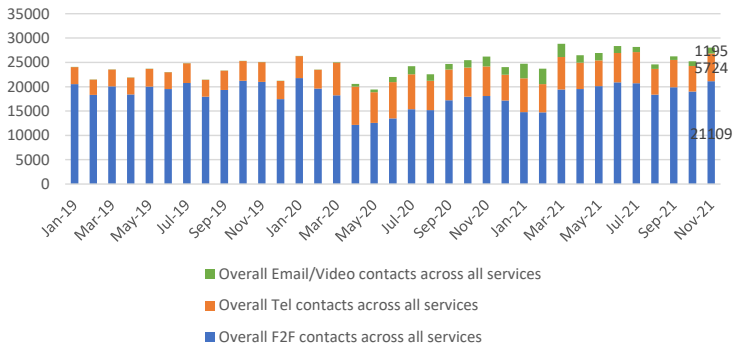
Board Report KPIs	Narratives
	Patients treated within 62 days has improved in November, taking performance higher than the last 4 months. With theatre capacity a continued challenge, the majority of patients over 62 days are within Colorectal and Urology.
To measure compliance with the national standards for access to cancer treatment. This metric measures the percentage of patients receive cancer treatment within 62 days of referral by their GP. The national standard is 85% to have received treatment within 62 days.	
	Referrals back up to the high number we last saw in June 2021. Breast, Urology and Skin all had above average numbers in November.
A count of the number of patients referred to the hospital with suspected cancer, requiring investigation. This metric shows the activity by month for cancer services, which informs the national metric which measures the number of these patients that were seen within 2 weeks (further in the performance pack).	
	Reduced by one for the month end position. On-going focus on all patients over 104 days on a cancer pathway. Mostly due to complex patient pathways.
A count of the number of patients who have waited longer that 104 days for treatment for cancer from GP referral. This is a national standard and is expected to be 0.	

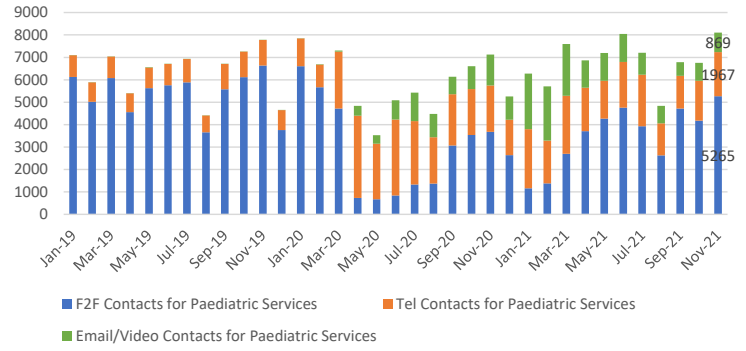
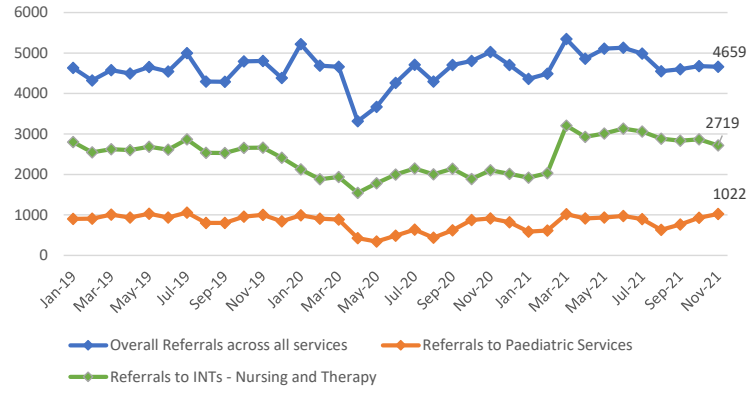
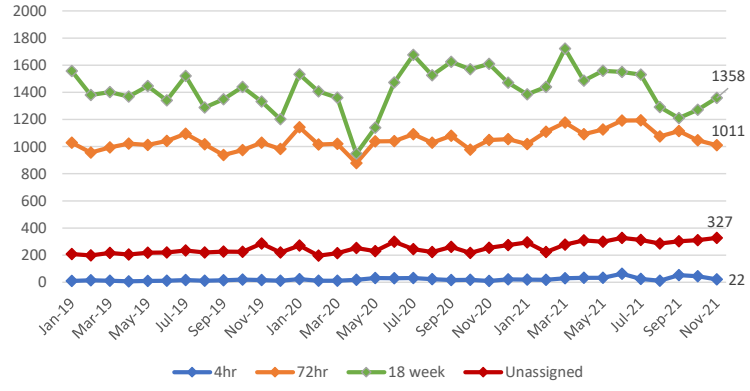
Board Report KPIs	Narratives
 This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue	An on-going system and process review to enable more timely management of Duty of Candour compliance continues in conjunction with the duty of candour improvement plan.
 The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.	
 A range of measures have been identified which are analysed to provide an overall acuity score, as displayed in this chart. This provides an overview of the acuity of admitted patients.	Overall the metrics have plateaued in the past few months, with a slight increase in the operational metric. This will be in regard to the number of admissions and discharges in November, which saw an increase. This intelligence has been acknowledged during the daily safety huddles, where senior clinical leads meet to discuss incidents and acuity pressures each day. This information assists with staffing decisions and is utilised in conjunction with safe care data which is recorded by the wards daily. Many wards are experiencing an increase in the number of complex patients with challenging behaviour, which is also placing the workforce under increasing pressure. Nurse staffing in particular, remains under pressure and focus during November due to vacancy, isolation and increasing levels of sickness, however this is not reflected in these measures.

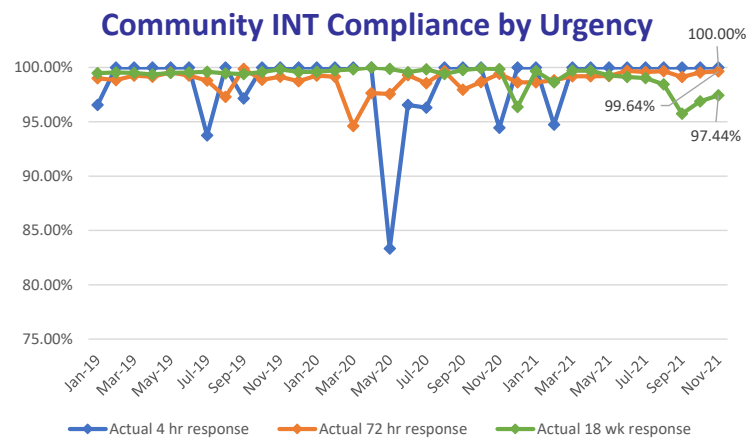
Board Report KPIs	Narratives
	This is now reported in Staffing paper.
A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	
	Numbers of PSI not supplied on this occasion as not able to draw accurate data from Datix that reflects current position. This will be rectified and submitted in the next IQPR. The process for reporting PSI and reviewing PSI with harm remains a priority process for the organisation.
A count of the number of patient safety incidents reported in total and those resulting in harm	
	Numbers of PSI not supplied on this occasion as not able to draw accurate data from Datix that reflects current position. This will be rectified and submitted in the next IQPR. The process for reporting PSI and reviewing PSI with harm remains a priority process for the organisation.
The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	

Board Report KPIs	Narratives
	This is now reported in Staffing paper.
A count of the number of recorded new pressure ulcers across the Trust. This metric will include those recorded in the acute hospital and community settings	
	
A measure of the number of pressure ulcers in the acute hospital measured per 1000 bed days. Community inpatient pressure ulcers are excluded from this metric.	
	This is now reported in Staffing paper.
% of patients with a Malnutrition Universal Screening Tool (Adults)/Paediatric Yorkhill Malnutrition Score (Children) assessment completed within 24 hours of admission	

Board Report KPIs	Narratives
	15 formal complaints received in November. The main theme that were picked up from November was the standard of communication within the emergency department and the acute assessment unit. We will be working closely with the ward/unit managers and matrons to ensure staff learn from the patients experience that had been highlighted within the complaints.
New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	
	17 complaints closed in November. A good amount of complaints closed which has subsequently led to a decrease in our overall complaints.
Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	
	2 complaints were classed as overtime. These needed a more extensive review given the complexity.
Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	

Board Report KPIs	Narratives
Community Non Consultant Led 18week Max Wait 	The number of services with patients waiting over 18 weeks has remained at 2 in November. At the end of October these services were: Paed SLT and Wheelchairs. The maximum wait for each of these services are: Paed SLT - 34 weeks (decreased from 30.) Wheelchairs - 37 weeks (increased from 38 weeks) Paed SLT and Wheelchair services were both exceeding the wait times prior to COVID, these 2 services have papers and support from the CCG both in understanding demand and increasing resources. The lack of face to face group work and restrictions in schools etc are having a continued profound effect on Paed SLT activities, as are vacancies within the service. Wheelchairs has a high number of patients who are shielding or just unwilling to have home visits at this time, access to Special Schools and Care Homes has been limited because of COVID, staff numbers have been affected because of COVID and BREXIT has affected the supply of equipment that has been stuck at ports. The number of child breaches may be increasing but the number of handovers is actually increasing significantly.
Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric Occupational Therapy, Paediatric Physio and Paediatric Speech and Language Therapy, There are no patients waiting over 52weeks for treatment from referral, so community look at number of patients waiting over 14 weeks. Historically, 14 weeks was agreed on as an internal measure because it gives an approx. number of patients who would breach the 18 week target at the end of the next month.	
Community Non Consultant Led 18week Compliance 	The aggregated % of patients treated within 18 weeks for all community services in November was 92.18% with the lowest individual service being Wheelchairs at 82.28%.
Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	
Contacts for ALL Community Services (Adults and Paediatrics) 	The total activity for community services has returned to pre-COVID levels and exceeded the values although the ratio of face to face and other means of contact (telephone, video and email) have altered.
Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	

Board Report KPIs	Narratives
Contacts for Community Paediatric Services 	The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options.
Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	
Community Referrals 	Referrals to the majority of the community services for 2021 YTD has exceeded the same periods of 2019 and 2020.
There should be one reason per referral, i.e. if a patient is referred in to the INTs for 2 requirements either simultaneously or over time, eg leg ulcer dressing and phlebotomy, then there are 2 referrals.	
Community INT Referrals by Urgency 	Referrals to the INT services have returned to pre-COVID numbers or exceeded them.
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	

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

2.4. Improvement Committee Report - December 2021 Chair's key issues from the meetings

To Assure

Presented by Louisa Pepper

Board of Directors – 28 January 2022

Agenda item:	2.4			
Presented by:	Louisa Pepper, Non-executive Director			
Prepared by:	Ann Alderton			
Date prepared:	24 January 2022			
Subject:	Improvement Committee report and Chair's Key Issues			
Purpose:	X	For information	X	For approval

Executive summary:

The Improvement Committee met on 13 December 2021. The transition to the committee operating as a board assurance committee is still in progress, further steps towards which included the approval of its terms of reference and the decommissioning of the Improvement Programme Board.

Attached is the Chair's Key Issues document which will constitute the standard template for Improvement Committee reports to Board.

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*	*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:	N/A
Risk and assurance:	The development of and transition to a new structure for organisational governance may result in a failure to escalate significant risks to management, the executive team and the board of directors, caused by a disruption to the previous information and communication flows whilst new arrangements are being established.
Legislation, regulatory, equality, diversity and dignity implications	Well-Led Framework NHSI FT Code of Governance

Recommendation: To approve the report

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Chair's Key Issues

Part A

Originating Committee	Improvement Committee	**Date of meeting**	13 December 2021
Chaired by	Jude Chin	**Lead Executive Director**	Sue Wilkinson

Agenda Item	**Details of Issue**	**For: Approval/ Escalation/Assurance**	**BAF/ Risk Register ref**	**Paper attached? ✓**
3.1	**Community pain assessments/QI approach:** James Macfarlane was assured that there was good progress with the pain assessment work and improvements being seen.	Assurance		
3.2	**Committee membership:** To be reviewed by Ann Alderton and Jude Chin outside of the meeting.	Assurance		
3.3	**Quality dashboard**: A decision was needed regarding what information should be included; Nicola Cottington to lead.	Assurance		
5.1	**PSIRP priorities – Diabetes:** The inaugural meeting of the new diabetes group had been held, led by Nicholas Levy and reporting into the Patient Quality & Safety governance group (PQSGG). Terms of reference were being developed, meetings would be bi-monthly and have a multi-disciplinary approach with representation from diabetes specialists and nurse leads, AHPs, specialist groups such as the Deteriorating Patient Group, Drugs and Therapeutics Committee etc. The focus would be on the rise in incidents relating to medication management of insulin across acute and community, training and education, deteriorating patients etc. The topic would also remain a PSIRF priority for 2022.	Assurance		
5.3	**National safety priorities: Infection Prevention (IPC BAF and 'learning from Covid'):** The BAF had been signed off by the Infection Prevention & Control Committee and added as a corporate risk on the Trust risk register. It brought together several similar infection control risks (VRE, C.*diff*, MRSA/MSSA etc) into one over-arching risk which would be going to the Trust Board. Issues highlighted included the lack of side rooms which could not be addressed, poor ventilation in ward areas as the window restrictors were a necessity, ability to socially distance patients due to lack	Assurance		

	of space etc. The learning from Covid report had been agreed by the executive directors and being checked by the Trust legal team before going to the Trust Board. The Infection Prevention & Control Committee meets monthly and reports into the PQSGG quarterly along with the IPCC annual report.			
6.1	**2022 work plan:** The data was still being worked through to see what was needed to provide assurance. It was clarified that this should be qualitative measures rather than quantitative as the role of the committee was to look at quality improvement.	Assurance		
Date completed and forwarded to Trust Secretary				

Part B

Receiving Committee	**Board of Directors**	**Date of Meeting**	**13 December 2021**
Chaired by	**Sheila Childerhouse**	**Lead Executive Director**	**Craig Black**
Agenda Item	**Record of Consideration Given (Approved/ Response/ Action)**		
Date Completed and Forwarded to Chair of Originating Committee			

2.5. Maternity services quality & performance report

To Assure

Presented by Susan Wilkinson and Karen Newbury

Trust Open Board– 28th January 2022

Agenda item:	2.5			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Paul Molyneux, Interim Medical Director & Executive MatNeo Safety Champion/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery			
Date prepared:	January 2022			
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;

- e-Care
- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- National best practice publications
- Reporting and learning from incidents and Action Plan (Annex A)
- Compliance with reporting incidents to HSIB
- Maternity Clinical and Quality dashboard (Annex B)
- Roll out of Midwifery Continuity of Carer (Annex C)

e-Care

This item will be removed from future reports unless there is a need to identify any safety or quality issues. Data correction and cleansing is still required, however there continues to be a marked improvement.

Maternity improvement plan

The Maternity 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, SBLCBv2, UKOSS). In addition, the plan has captured the actions needing completion from the 60 Supportive Steps visit from NHSE/I and continues to be reviewed by the Maternity Improvement Board every two weeks. To note; completion of actions has been hindered due to the high demand on clinicians to work clinically due to Covid absences.

Safety Champion Walkabout feedback

The Board-level champion undertakes a monthly walkabout in the maternity and neonatal unit. 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.

The Safety Champion Walkabout took place on 23/12/2021 across ward F11, Labour Suite and Maternity Day Assessment (MDAU), including discussions with Specialist Midwives. Discussions raised:

- Midwifery staffing establishment not appropriate for MDAU especially with triage element
- Gaps in registrar cover for MDAU can compromise timely treatment and decision making
- Lack of time to complete Mandatory training, resulting in staff having to complete in their own time.
- Reports that 'things are feeling better', excitement around recruitment of Maternity Care Assistants and Overseas recruitment.
- The role of the Digital Midwife is much appreciated and e-Care now seems much improved.

The Local Maternity and Neonate System (LMNS) raised a concern regarding WSFT being an outlier regarding carparking charges for parents who are visiting their children on Neonatal Unit (NNU) to our NED Safety Champion. This issue has been raised previously, however WSFT is now the only Trust in our LMNS that still charge parents. The LMNS asked that the Trust recognises; how important the parental role is to fulfil and they should not be classed as 'visitors', they are almost certainly going to be visiting daily and that stays particularly on the NNU can be prolonged.

Concerns raised are captured on the Safety Champion action plan until actions completed and moving forward issues raised and actions taken will be summarised in the monthly maternity staff paper 'Risky Business'.

Listening to Staff

The National Staff Satisfaction Survey results were published in March 2021. On the back of the results, key elements of the survey were used to form a targeted questionnaire to band 5 & 6 midwives in April 2021, however survey returns were low in number. The division was keen to develop further action points by listening to staff in more detail and have led focus groups run by a manager from a different department. The division alongside their HR Business partner and Board Safety Champion continues to develop different methods to engage with staff to ensure support and that there is every opportunity for staff to be listened to in an open, supportive and productive way. Further to the whistleblowing within the maternity services, a very short survey was sent to all midwifery staff to gain further understanding of what support is required to move forward. The results were shared with all staff and volunteers were sought to attend solution focused groups, unfortunately none came forward. This will be reviewed again once the high Covid absence rate has decreased.

In the meantime, the department actively listens to all staff via the Safety Champion Walkabout and in addition we have introduced the following;

- Freedom to Speak Up Guardians attend the maternity unit to increase their profile, accessibility and explain their role to all staff including students.
- The Staff Support team have been attending the department at shift changes to offer support to any staff member and continue to work with individuals on a one-to-one basis.
- The HR team undertake detailed exit interviews and feedback any issues or themes arising.
- The Royal College of Midwives representation undertakes a weekly 'Safe Space' to empower staff to raise concerns and to support them in reporting their concern through the appropriate channels.

Service User feedback

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.

Ward/Dept	Survey returns	Nov FFT score	Survey returns	Dec FFT Score
F11	37	97	13	100
Antenatal	13	100	31	94
Postnatal Community	37	100	25	100

Labour Suite	Nil		Nil	
Birthing Unit	Closed	N/A	Closed	N/A

0 compliments were shared with the patient experience team for women & children's division for logging in November & December 2021.

National best practice publications

The Royal college of Gynaecologists and Obstetricians (RCOG) published their latest guidance regarding Covid and pregnancy. The latest recommendations have been captured in our local guideline and communicated to all maternity staff in particular the importance of recommending the Covid vaccination and undertaking a new Venous thromboembolism (VTE) risk assessment for all Covid positive cases, due to the increased risks in pregnancy and immediately postnatal.

Reporting and learning from incidents and Action Plan (Annex A)

An external thematic review to identify any potential care issues or themes in relation to three intrapartum stillbirths that occurred during the period of 15th November 2020- 30th January 2021 was undertaken. The report was received in December 2021 and an assessment of the findings undertaken by the maternity team.

All three patients presented with reduced fetal movements. The saving babies lives care bundle (v2) states that fetal movements must be discussed and documented at each touchpoint with a patient and this did appear to happen, demonstrating good practice.

There are no other over-arching themes that connect these cases and for two out of the three cases it is unlikely that different care would have changed the outcome.

The report identified seven recommendations that have been captured in an action plan. (Annex A)
The full report will be shared with the Closed board due to the number of cases and therefore inability to ensure anonymity of the families involved. The full report and action plans will be shared with the families and Local Maternity and Neonatal System.

Compliance with reporting incidents to HSIB

There were no incidents reported to HSIB in December.

Maternity dashboards (Annex B)

Indicators of maternity safety & quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance & Governance dashboard). From this month onwards, red rated data will be represented in line with the national NHSI model of SPC charts.

Indicators	Narrative
Total number of Caesarean sections and emergency sections	Trends reviewed and expected variance in conjunction with patient choice
Induction of labour	Expected increase due to increase in antenatal surveillance. In line with region and national picture.
Post-partum haemorrhages >1500mls	In line with increase of caesarean section and induction of labour, however QI project continues.
Training compliance	Reflects staffing shortages due to Covid.
Decision to delivery times for grade 2 sections	Business case for F2 doctors approved. QI work continues- multi rationale identified and on-going work required. No adverse

	effects reported despite delay.
Smoking at time of delivery	LMNS trend and therefore local, LMNS and regional focus on providing support

Roll out of Midwifery Continuity of Carer (Annex C)

We are required to provide a trajectory report to the LMNS, Regional and National Team regarding our Midwifery Continuity of Carer (CoC) rollout, so that this is a default model of care for all eligible women by the end of March 2023. The report details our plan, in a stepped approach to meet this. Currently we require approximately 28 whole time equivalent midwives to enable us to meet this target and therefore recruitment is our biggest risk. Ongoing recruitment continues, including co-working with the LMNS and region for International and national recruitment of midwives.

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

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

Previously considered by:	
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: Receive for information	

Annex A Thematic Review Action Plan

Annex B Maternity SPC charts from Clinical and Quality & Safety Dashboards – Red Rated

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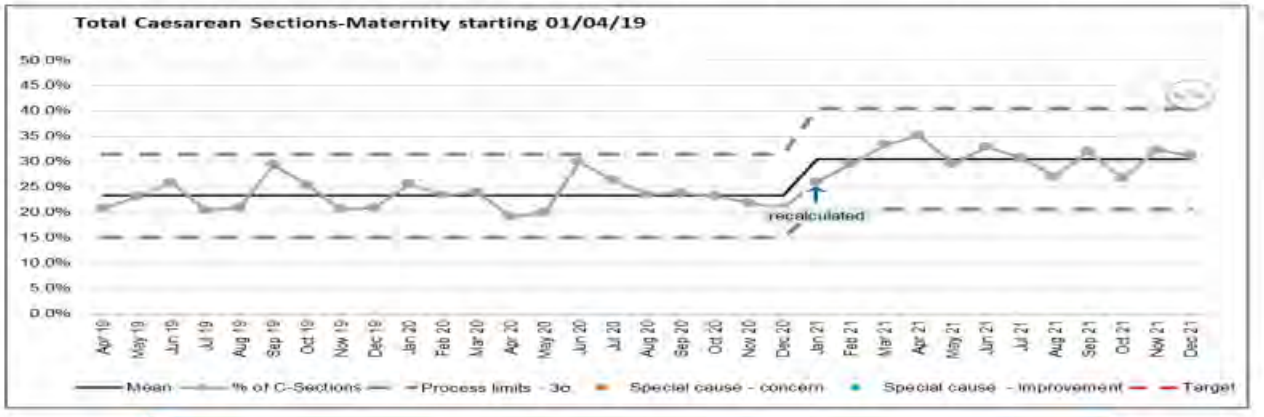
Descriptor			Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Total number of caesarean sections (expressed as % of all deliveries)	<26.%	> 26.%	55 35.2%	56 29.6%	56 32.9%	66 30.8%	54 27%	65 32%	53 26.7%	57 32.3%	49 31.2%



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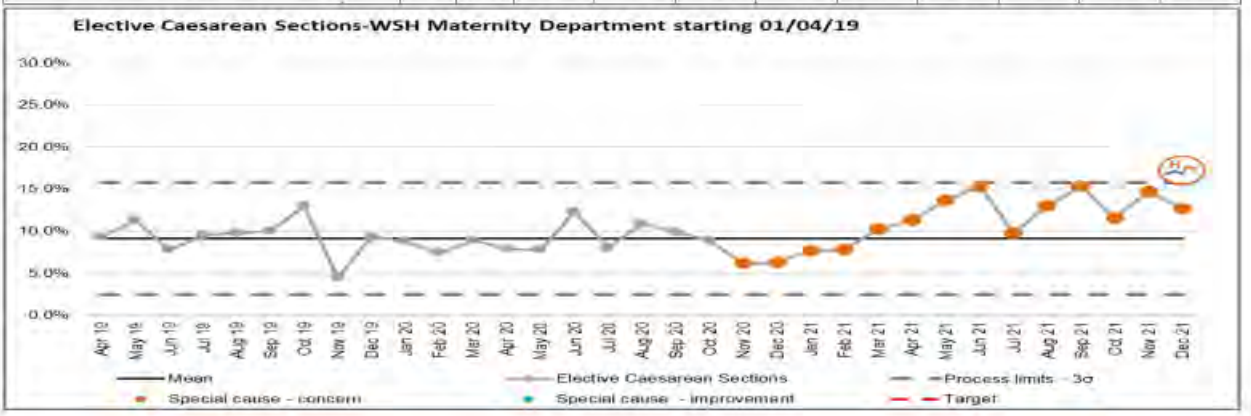
Descriptor				Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Total number of elective (Grade 4 LSCS) (expressed as a number & % of all deliveries)	11%	>11% - 13%	13% or more	18 11.3%	26 13.7%	26 15.3%	21 9.8%	26 13%	31 15.4%	23 11.6%	26 14.7%	20 12.7%



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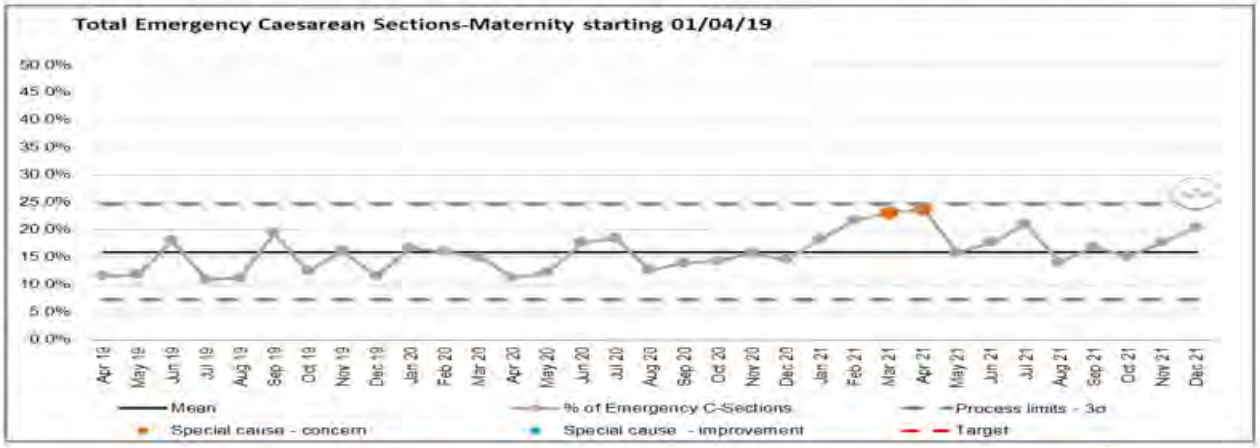
Descriptor				Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Total number of emergency (Grade 1,2 &3 LSCS) (expressed as a number & % of all deliveries)	14.3%	14.4%-14.9%	15% or more	37 23.7%	30 15.8%	30 17.6%	45 21%	28 14%	34 16.9%	30 15.1%	31 17.6%	32 20.4%



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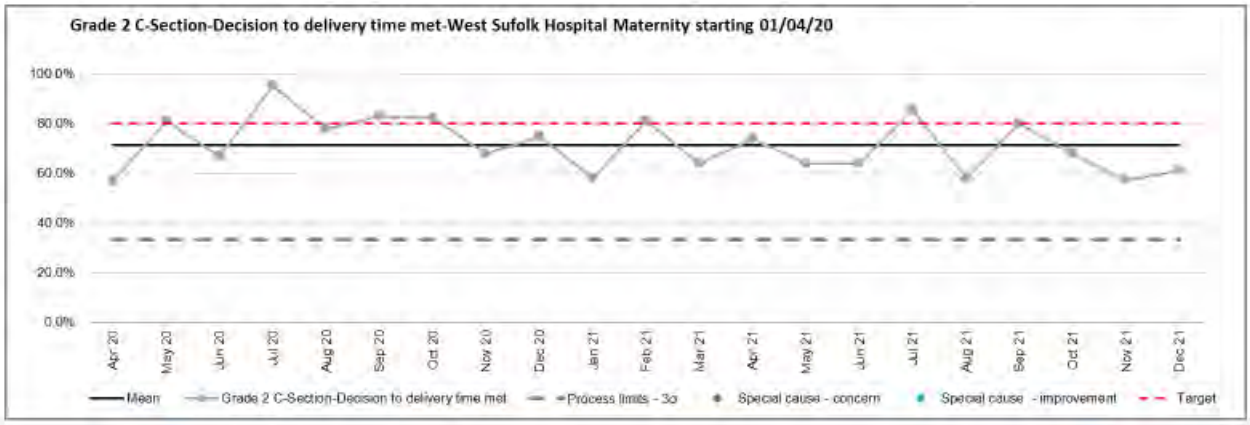
Descriptor				Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Total number of Grade 2 LSCS achieved within the 75 mins decision to del interval	80%	76 - 79%	75% or less	74%	64%	66%	57.80%	57%	80%	68%	57.10%	61%



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Descriptor				Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Total number of IOL (expressed as a number & % of all deliveries) (ref NMPA)	<31%	>31% - 32.9%	>33%	67 43.5%	76 41%	65 38.2%	78 36.4%	71 35.5%	69 34.6%	85 43.3%	72 41.3%	64 41.0%

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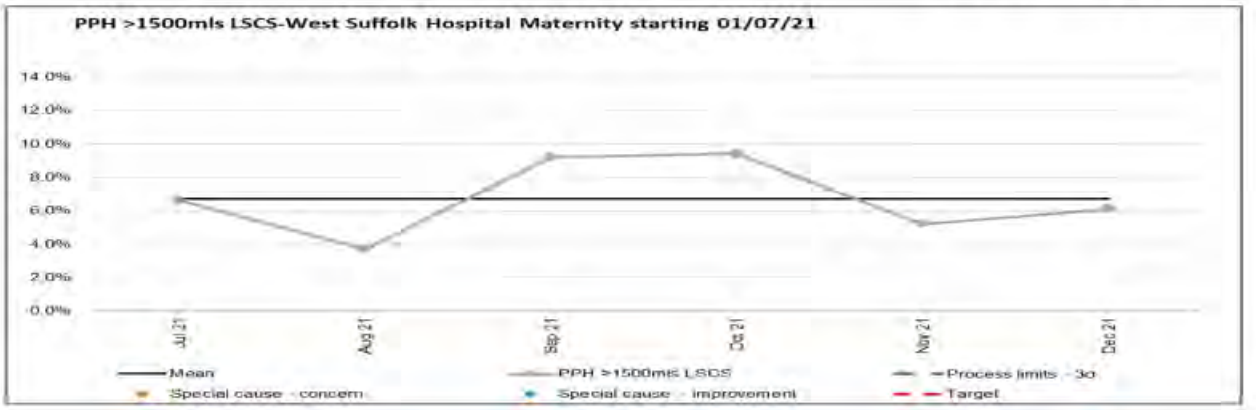
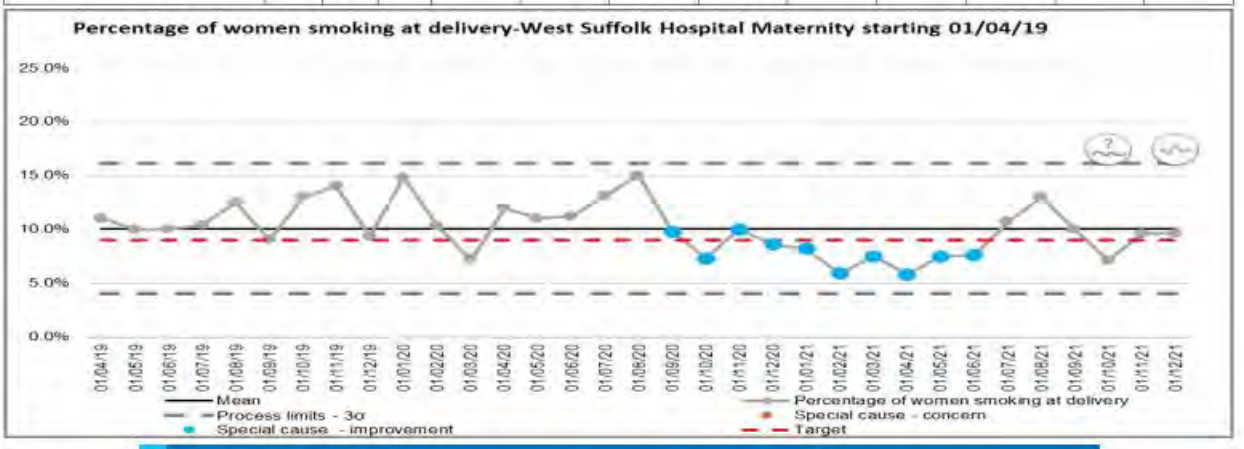
Descriptor	Green	Amber	Red	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Total of PPH over 1,500 mls as a % of all LSCS	≤ 4.3%		≥ 4.4%	3 6.6%	3.7%	9.20%	5 9.4%	3 5.2%	3 6.1%

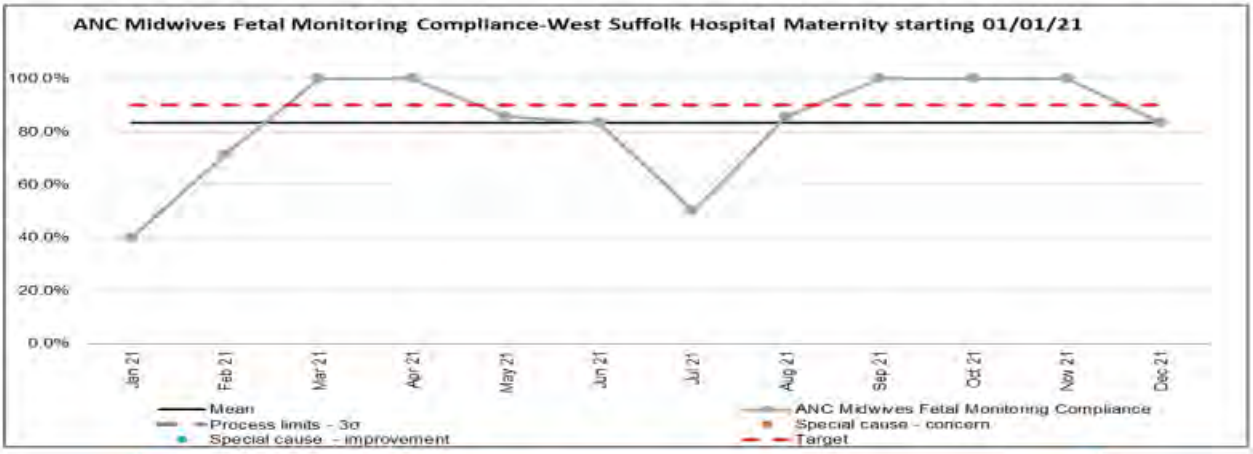


Descriptor				Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
% of women smoking at delivery	≤6%	6.1% - 7.9%	≥ 8%	5.8%	7.5%	7.6%	10.7%	13.0%	10.0%	7.1%	9.6%	9.6%

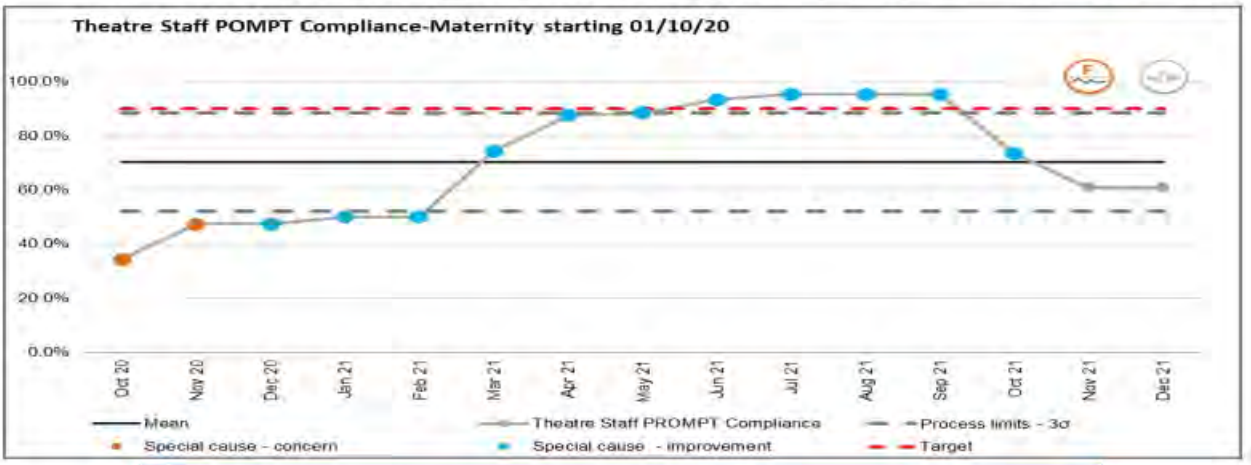


Quality& Safety Dashboard Red rated SPC charts

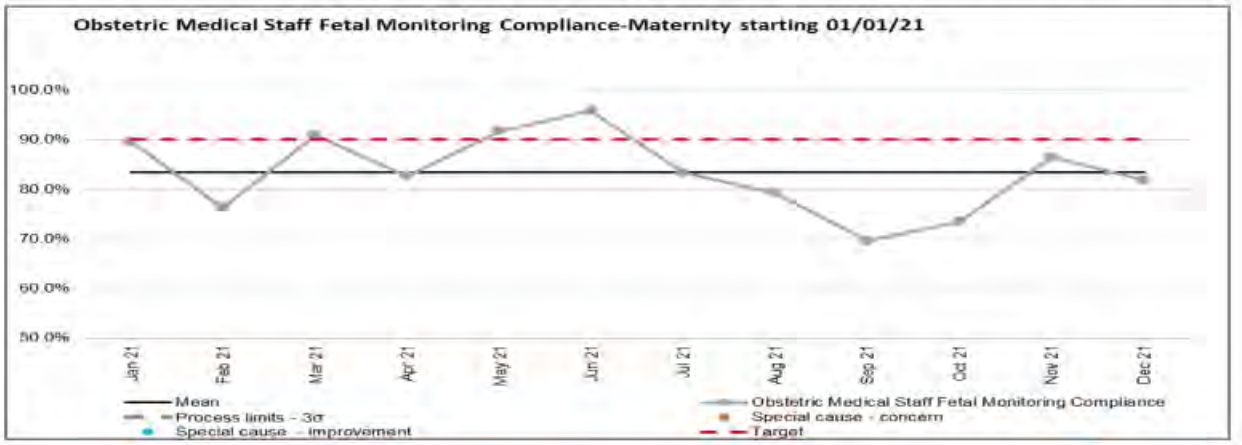
Appraisal completion	Standard	May	June	July	August	September	October	November	December
ANC Midwives: % compliance with **All Fetal Monitoring** training	90%	85.7%	83.3%	50.0%	85.7%	100.0%	100.0%	100%	83.30%



Mandatory Training Overview	Standard	Feb	March	April	May	June	July	August	September	October	November	December
Theatre staff compliance with **PROMPT** training	90%	50.0%	74.4%	87.5%	88.4%	93.3%	95.4%	95.4%	95.4%	73.3%	60.87%	60.00%



Mandatory Training Overview	Standard	March	April	May	June	July	August	September	October	November	December
Obstetric Medical Staff: % compliance with **All Fetal Monitoring** training	90%	90.9%	82.6%	91.7%	95.8%	83.3%	79.2%	69.6%	73.4%	86.4%	81.80%



Delivering high quality, safe care, together

Annex C - Roll out of Midwifery Continuity of Carer

Action plan following Exception report for Thematic review of 3 Intrapartum still births 2020-2021				
Recommendation	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Comments/action status** *(Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)*
1. The report should be shared with the Trust, commissioners, the LMS, staff members and the families involved	• Report included in next Maternity Quality and Safety paper to Closed Board • Report to be shared with LMNS at next Safety Forum • Report and action plan to be shared with maternity staff via departmental governance, e-mail. Post on staff social media page informing them of where to access the report and action plan • Families to be contacted to determine method for feedback and to then share report including this action plan	28.02.22	KN, HOM	Plan to share report with Maternity Quality and Safety (Governance) Meeting 17th January 2022 – this will be shared with all maternity staff via email. Post will then be shared on secure staff social media page, signposting them to where to find the report and action plan. Plan to share report with Safety Champions by 19th January 2022. Report to be included in next HOMS paper to Board in Jan 2022 Report to be shared with LMNS 3rd Feb 2022 at LMNS Safety Forum

2. Best practice would indicate that the Maternity Unit must have a safeguarding lead midwife and a full complement team to provide specialist and continuity of carer for vulnerable women and their families	None – already completed	N/A	N/A	Safeguarding lead midwife in post with oversight of all vulnerable women and families. Where continuity of carer is not in place, woman allocated case loading midwife to ensure continuity.
3. There is a need to raise the profile of fetal movements with women and to review the information women are given to support this. While documentation regarding fetal movements is happening we would recommend considering additional strategies to re-enforce the importance of this to women.	Communications team asked to publish weekly posts on maternity social media pages regarding fetal movements	31/12/2021	JS, Deputy HOM Communications Team	Leaflets in top 5 languages already on website and posters in maternity key areas. Communications team are sharing weekly posts via social media regarding fetal moments. 01/01/2022 Action now complete
4. The diabetic pathway should be reviewed to ensure that it is consistent with the NICE guideline in terms of CBG targets and to consider how information giving and support for vulnerable diabetic women is achieved.	None- already completed	N/A	N/A	New guideline in place, ratified December 2021. This brings the care of diabetic women using our service in line with Nice guidance. Perinatal mental health guideline was also ratified in December 2021, this addresses needle phobia and advocates therapies for this during pregnancy. A vulnerable woman's clinic has been established and is now an embedded pathway for women who may benefit. This offers continuity of consultant who specialised in the care of women who have vulnerabilities.

5. There should be a clear formal documented risk assessment undertaken when women present in labour, to assist in decision making re place of birth and the type of fetal heart rate monitoring that is appropriate. This risk assessment should also consider when a patient needs escalation for review by the obstetric team.	None- already completed			Risk assessment now in place.
6. All high-risk women should be seen in person by the obstetric registrar covering delivery suite on admission and twice daily as part of a consultant led ward round per the Ockenden report.	Admission review by obstetric registrar to be added to the following guidelines; Handover of Care CG10562-1 Clinical Risk Assessment in Labour CG10549-1	28/02/2021	V. M-S Clinical & Quality Assurance Midwife	Admission review by obstetric registrar embedded in practice.
	Audit compliance for admission review by obstetric registrar	28/02/2021	KC, Obstetric Lead Consultant	
	None	N/A	KC, Obstetric Lead Consultant	Twice daily consultant led ward rounds in place and audits demonstrate fully embedded into practice.

7. The fetal monitoring guideline and fetal monitoring training package for the department should ensure that particular attention is paid to the difficulties of fetal heart monitoring in the second stage of labour. This will include use of FSE to separate fetal from maternal pulse and the use of tools (such as SBAR) to promptly escalate concerns to the appropriate team member.	None	N/A	N/A	Robust training plan in place for all staff required to interpret CTG fetal monitoring. This online package encompasses CTG interpretation in the second stage. This training is further supported by twice weekly fetal monitoring training sessions that utilise learning from recent cases. This includes discussions regarding the quality of the trace discussed and the advocacy of FSE where required. This is led by the obstetric and midwifery lead for fetal monitoring. Both the online package and the sessions are mandatory and compliance is monitored monthly on the Quality Dashboard and reviewed at the The training package is supported by a comprehensive guideline that was updated September 2020

	Embed SBAR communication when escalating fetal monitoring concerns	31.01.22	Fetal monitoring leads	SBAR escalation, although the preferred method of communication could further be reinforced through the fetal monitoring sessions. 01/01/2022 SBAR escalation now included in fetal monitoring sessions.

Action RAG rating

Complete	
On track	
At risk	

Plan for roll out of Midwifery Continuity of Carer

Report Title	**Roll out of Midwifery Continuity of Carer**
Report for	**Information**
Report from	**Maternity Services**
Lead for Safety Action	**Karen Green**
Report Author	**Sarah Spall, Better Births Project Lead**
Date prepared	**December 2021**

1. **Report Title –** Roll out of Midwifery Continuity of Carer.

2. **Purpose of the Report**

   To provide information about how many teams and how many midwives we will need so that Continuity of Carer (CoC) becomes the default model of care for all eligible women by end March 2023. It also identifies the key building blocks we need to have in place for this model to be rolled out at scale.

3. **Background**

   Following consultation over the summer 2020 we rolled out our Wave 1 teams in November 2020:

   - Iceni covering Thetford and Brandon
   - Willow covering Bury and Woolpit
   - Bluebell covering Mildenhall, Red Lodge and Newmarket
   - Primrose covering Sudbury
   - Sapphire – for women who have had 2 or more Caesarean births or who declined a VBAC following consultant review (area wide).

   Within the first 3 weeks it was evident that safe staffing was proving a significant challenge for both Bluebell and Primrose teams so they were paused until staff levels could be increased. We continued with Iceni, Willow and Sapphire teams.

4. **Required Standard**

   - All eligible women to be booked onto the pathway by 29 weeks gestation.
   - Women to receive 70% of care from her named midwife antenatally and postnatally and to receive intrapartum care from a team midwife.
   - Target BAME women and women who live in areas of disadvantage first.
   - Teams to have a head count of 8 and a caseload size of 1:36 per WTE midwife (national standard).
   - Care will be monitored locally using the Maternity Services Data Set. This will enable us to monitor the outcomes for women and babies monthly.

5. Our Establishment

Current funded Establishment	113.92 WTE
Revised BR+ - 19 midwives short, but we have received funding for 18 midwives (12 funded by the Trust and 6 funded by Ockenden monies)	18 WTE
August 2021 – revised Establishment in which to implement full roll out	131.92 WTE
Current Vacancies 11.5 WTE (10.62 WTE Hospital + 0.88 WTE Community)	11.5 WTE

6. Our Workforce Plan

Total women requiring care	3150 women
Intend to birth elsewhere: Rosie Maternity Hospital and NNUH	550 women
Out of area referrals: Stowmarket	200 women
Attrition 10%	315
Total women not eligible	1065 women
Total women eligible for full pathway	2085 women
Midwives required to provide CoC @ 1:36 ratio	57.92 Midwives
Teams needed to achieve full CoC with a head count of 8 and 7.2 WTE Note: Based on our learning from Wave 1	8
Current budgeted Establishment	131.92
Total not cared for on CoC pathway	1065
No. of midwives required to provide care for women not on CoC pathway and care staffing @1:96 ratio (Traditional) looking after 550 women	5.73 Midwives
Workforce Establishment to care for all women in the Community (both CoC and Traditional)	63.65 Midwives
Core Midwives (Hospital Midwifery 53.95 WTE, Specialist Midwifery 13.28 WTE, Antenatal Clinic 3.64 WTE = 70.87)	70.65 Midwives
TOTAL required	134.30 WTE
Shortfall	2.38 WTE

7. Our Plan for Roll Out

The pace of roll out is dependent on the success of recruitment.

December 2021, we have 11.5 WTE vacancies across the service. We need to fill these vacancies and recruit an additional 19.5 midwives, i.e. 29.5 midwives in total, but we have a total of 18 midwives due to qualify between now and end March 2023. Providing all the students qualify and remain with us – we will have a net number of 11.5 WTE vacancies to fill, on top of an attrition rate of 4.68%.

We have found over the last year all we have managed to do is tread water with recruitment and we have not managed to recruit a sufficiency of midwives to give the critical mass required to roll out CoC at the pace needed. There is no doubt that the national shortage of midwives and Covid have impacted negatively on our ability to progress with further roll out of teams this year as originally planned.

Recruitment is the biggest risk to our ability to reach the ambition of CoC becoming the default model of care for all women by 2023.

Quarter 4 2021/2022	• Continue to embed Iceni, Willow, Sapphire teams. • Boost the headcount Willow so that they can provide Birth availability 24/7. • Start to plan the support programme for Newly Qualified Midwives based on the James Paget Hospital model. • 6 students due to qualify Feb 2022 – these newly qualified midwives will be allocated to a community team for their preceptorship to make the transition from student to develop their practice further. • Continue to recruit midwives – aiming for 2 per month. • First meeting of the CoC Steering Group – to meet monthly thereafter to monitor progress.
Quarter 1 2022/2023	• April confirm staff for Team 4 Bluebell Midwives (covering Mildenhall, Lakenheath and Red Lodge) and start to build caseload, upskilling of staff in the team, PDM (Practice Development Midwife) to provide support with team development. • **June – Team 4 Bluebell Midwives 'Go Live'** • July- confirm staff for Team 5 Primrose Midwives (covering Sudbury) and start to build caseload, upskilling of staff in the team, PDM to provide support with team development. • Continue to recruit midwives – aiming for 2 per month. • Skill mix planning – to prepare for Band 5's joining the teams. • Secure additional funding for 2.4 WTE midwives.
Quarter 2 2022/2023	• 3 students due to qualify Aug 2022 (will feed into Team 6 and 7). • Continue to recruit midwives – aiming for 2 per month. • Review overall progress to date, staffing and vacancies. • Review roll out of final 3 teams.

Quarter 3 2022/2023	• **October – Team 5 Primrose Midwives 'Go Live'** • October confirm staff for Team 6 Bury 2 and Team 7 Blackbourn Midwives and start to build caseload, upskilling of staff in the team, PMA to provide support with team development. • Continue to recruit midwives – aiming for 2 per month. • Take stock of recruitment and vacancies. • Review Sapphire team – either continue as a specialist team or 'build from' to help create 8th team. • Review SOP October 2022.
Quarter 4 2022/2023	• 9 students due to qualify Feb 2023 – will feed into Team 8. • **January – Team 6 Bury 2 Midwives 'Go Live'** • **January – Team 7 Blackbourn Midwives 'Go Live'** • **March – Team 8 Haverhill Midwives 'Go Live'**

8. Building Blocks

- **Caseload size**

  We already have our 3 Wave 1 teams that went live in November 2020. We have used the learning from the implementation of these teams to inform the roll out of further teams. We know from experience that we need to have a head count of 8 in each team and 7.2 WTE to roll out within safe staffing and for midwives to adhere to the caseload size of 1:36. This is within the national guidelines.

- **Training**

  Each midwife to have had a personal Training Needs Analysis and have the opportunity to upskill in the 3 months lead in time before the team goes 'live' so that they have the set of competencies required for the change in working pattern. We will work with the PDM's (Professional Development Midwives) and PMA's to achieve this.

- **Linked Obstetrician**

  The Consultant Obstetricians are working in small teams to provide Consultant Led Care by specialism, e.g. diabetes, cardiac, mental health etc. – as per Ockenden recommendation. The Consultants also work in small teams to provide advice/support to the Community midwifery teams for women who are identified as Midwifery Led Care.

  We already have a named Lead Obstetrician for Continuity of Care and each of the current teams has a linked Obstetrician. The midwives are able to contact the Consultant via 'message centre'. This role is evolving and we will continue to build on the learning. The new outreach clinic at Thetford has been particularly well received by both midwives and the women.

- **Standard Operating Policy (SOP)**

  The SOP M0017 (first issued Nov 2020) provides assurance around roles and responsibilities. This is currently being updated and will go to Governance in January 2022.

- **Newly Qualified Midwives**

  We are currently developing our model for supporting newly qualified Band 5 midwives in teams based on the learning from James Paget Hospital (JPH), who have successfully supported their preceptors as part of the roll out teams. We would look to have 1 per team. These midwives would have a smaller caseload (1:18) and work two shifts on Labour Suite/ Birthing Unit once a week in order to achieve their competencies required.

- **Recruitment**

  The ability to recruit midwives at pace will be a significant challenge against a known national shortage of midwives and continues to present the greatest risk to the programme. International recruitment is being progressed and there is a rolling programme of recruitment in place. The vacancy rate will be monitored monthly and progress on recruitment of midwives needed. If we are successful in recruiting midwives faster than anticipated we will review the roll out plan and look to bring forward the 'Go Live' date for individual teams if possible.

9. Manging the Operational Implementation

The role of the West Suffolk Hospital Continuity of Carer Steering Group will be to support the operational implementation of Continuity of Carer across West Suffolk, so that by March 2023 it becomes the default model of midwifery care for all women.

The group will provide support to help unblock any challenges and discuss safety and quality issues across West Suffolk to improve outcomes for women and their families and ensure that appropriate workforce development is in place to deliver safe maternity care.

Members of the group will be responsible for promoting continuity of care and help create the environment for change that will be needed to make the new model of care a success.

The group will enable the Clinical Lead and Project Manager to report to the LMNS Operational Group on progress made and highlight any risks or areas where additional support may be needed from the wider maternity transformation programme.

2.6. Infection prevention and control assurance framework

To Assure

Presented by Susan Wilkinson

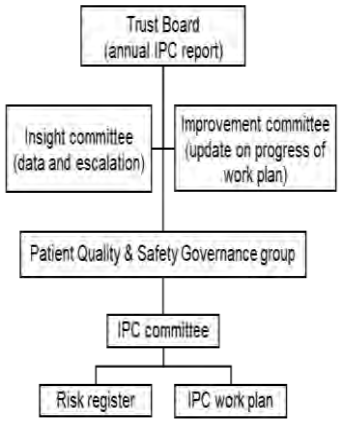
Board of Directors – 28th January 2022

Report Title:	Item 2. 6 – Infection prevention & control
Executive Lead:	Sue Wilkinson Exec Chief Nurse (DIPC)
Report Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness
Previously Considered by:	Infection prevention & control committee

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☒

Executive Summary

The trust recognises the ongoing risk of COVID-19 and other healthcare acquired infections and the role the Infection prevention & control (IPC) team and committee have in managing this risk. The trust is currently applying a hierarchy of controls* to manage the ongoing COVID-19 pandemic and the current Omicron surge.



The Infection prevention & control (IPC) committee have formally approved the risk assessment RR5204 *Prevention of Healthcare associated infection (HAI) and the risk of occupational healthcare associated infection* and this will receive quarterly review as required by its current Red (major x weekly) rating. The local 'learning from Covid-19' reviews and national guidance together form part of the ongoing IPC work plan which, alongside the infection prevention risk register entries, forms the IPC work plan.

The risk assessment addresses all HAIs as many controls are similar for multiple infections and is supported by the recent (December 21) updated *Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022.*

Annex 1 provides this month's IPC Covid-19 dashboard.

Annex 2 provides a copy of the risk assessment RR5204

**Hierarchy of controls (Hyperlink to national guidance - www.gov.uk)*

Action Required of the Board

Receive for information and assurance

Risk and assurance:	RR5204 Prevention of Healthcare associated infection and the risk of occupational healthcare associated infection
Legal and regulatory context	NHSE - 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.

Annex 1 - IPC dashboard

Measure (Dec-21 data)	Data for last three reporting months		
	Previous month	Last month	This period
Nosocomial C19 (probable + definite)	21	4	9 ↑
Incidents relating to C19 management	84	64	14 ↓
Admissions swabs within 24 hours of DTA	98%	99%	99% →
Staff sickness / absence due to C19	407	313	660 ↑

C-19 admission swabs

The total number of patients swabbed in December remained very high with compliance of 99% of patients having a swab taken within 24 hours of the DTA. 11 patients (0.7%) did not have a record of having a swab taken in this episode.

Incidents with COVID in narrative description

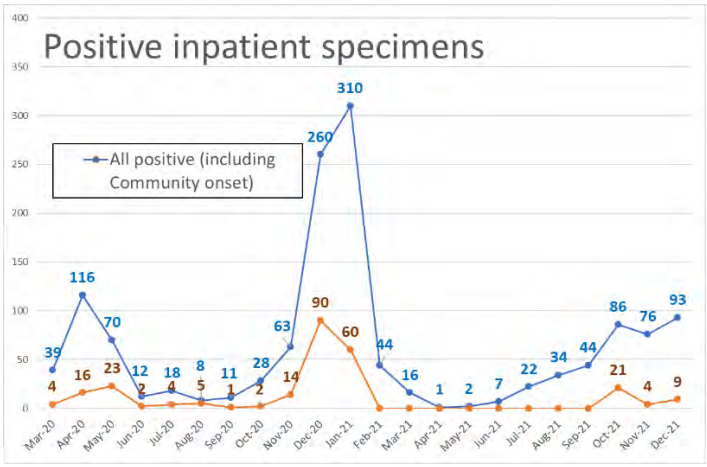
The total number of incidents relating to C-19 recorded in December fell. This is mainly due to the reduction in number of mislabelled sample incidents reported by the laboratories (principally microbiology)

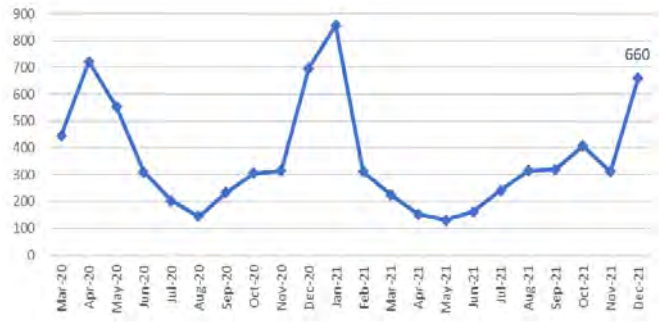
There were no red or amber incidents reported in the period and the most common (14/35 = 40%) incident type was staffing issues (all staff groups).

Nosocomial (Hospital-Onset) C-19

There were nine cases identified in December; definite (two) and probable (two). There is a clear rise in community infections in the period October-December.

The significant number of nosocomial cases in October were related to an outbreak on F7 which was, at the time, a designated ward for medically optimised for discharge patients and therefore the majority of these patients had a length of stay beyond 8 days which accounted for the high number of definite cases.





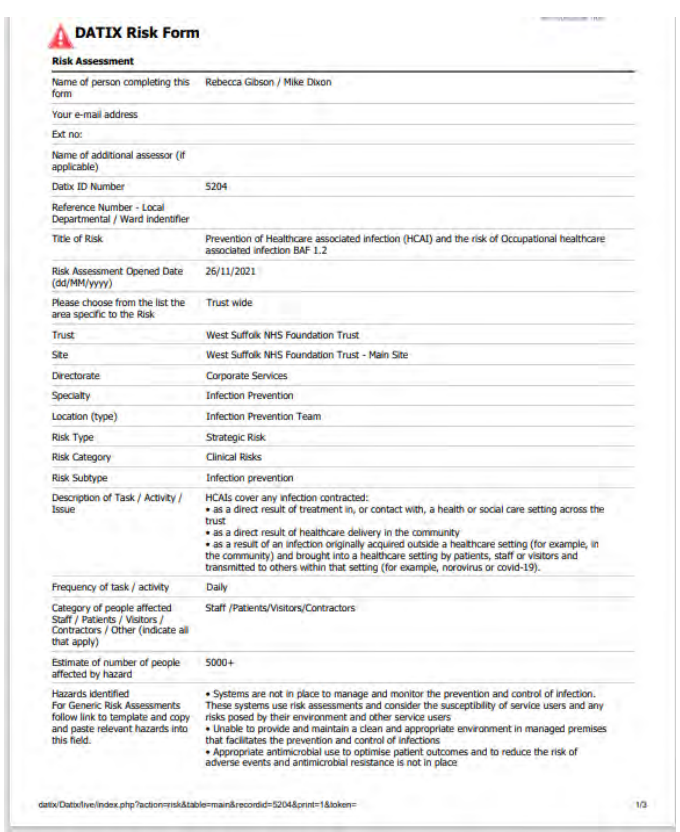
COVID-19 related sickness / isolation

This is a count of our staff who have been off sick with a Covid related symptoms or required to isolate.

In December 2021 there were 660 episodes recorded, an increase from November (313) and likely a consequence of Omicron becoming the dominant variant at that time.

We have continued to review all national guidance throughout the pandemic and assure that our local processes align to the national guidance.

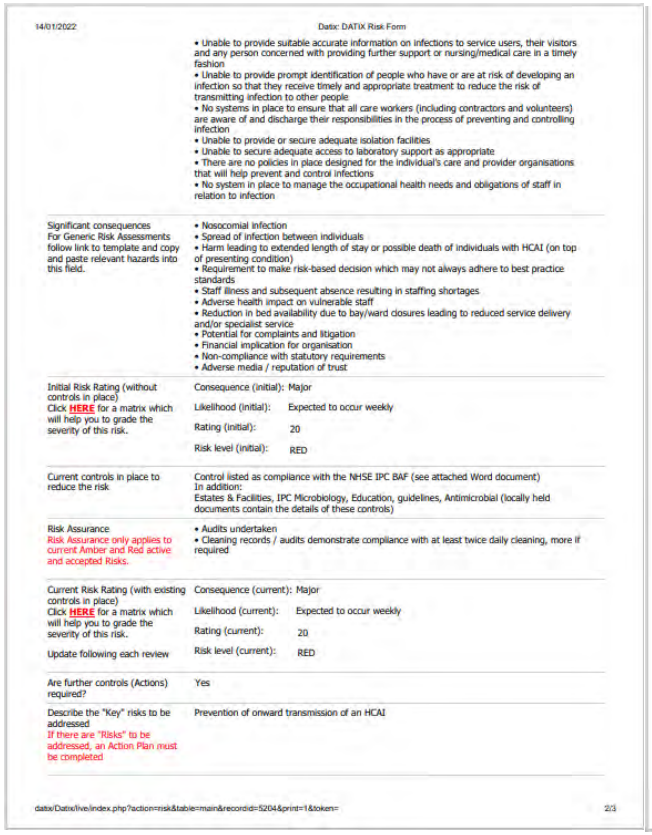
Annex 2 - Risk assessment RR5204



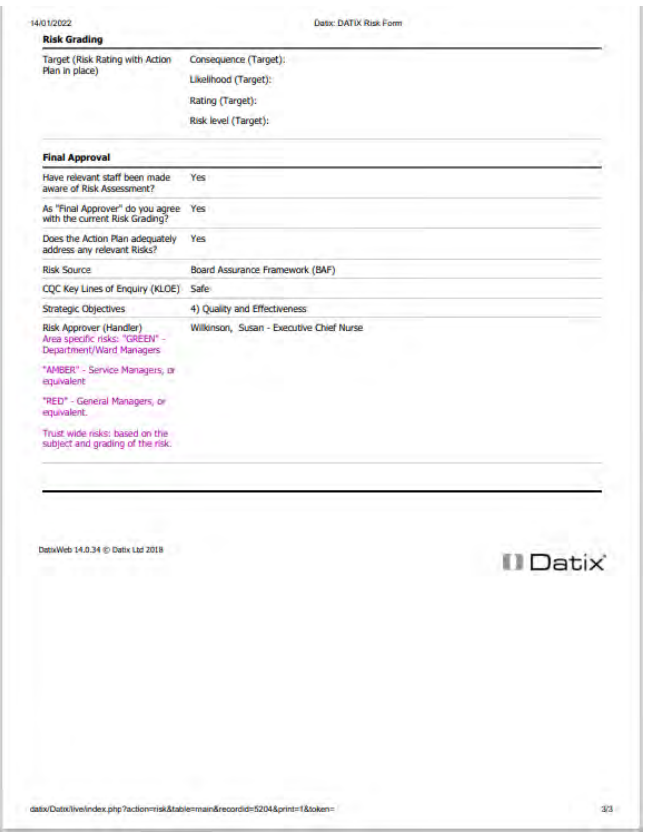
DATIX Risk Form

Risk Assessment

Name of person completing this form	Rebecca Gibson / Mike Dixon
Your e-mail address	
Ext no:	
Name of additional assessor (if applicable)	
Datix ID Number	5204
Reference Number - Local Departmental / Ward Indentifier	
Title of Risk	Prevention of Healthcare associated infection (HCAI) and the risk of Occupational healthcare associated infection BAF 1.2
Risk Assessment Opened Date (dd/MM/yyyy)	26/11/2021
Please choose from the list the area specific to the Risk	Trust wide
Trust	West Suffolk NHS Foundation Trust
Site	West Suffolk NHS Foundation Trust - Main Site
Directorate	Corporate Services
Specialty	Infection Prevention
Location (type)	Infection Prevention Team
Risk Type	Strategic Risk
Risk Category	Clinical Risks
Risk Subtype	Infection prevention
Description of Task / Activity / Issue	HCAIs cover any infection contracted: • as a direct result of treatment in, or contact with, a health or social care setting across the trust • as a direct result of healthcare delivery in the community • as a result of an infection originally acquired outside a healthcare setting (for example, in the community) and brought into a healthcare setting by patients, staff or visitors and transmitted to others within that setting (for example, norovirus or covid-19).
Frequency of task / activity	Daily
Category of people affected Staff / Patients / Visitors / Contractors / Other (indicate all that apply)	Staff /Patients/Visitors/Contractors
Estimate of number of people affected by hazard	5000+
Hazards identified For Generic Risk Assessments follow link to template and copy and paste relevant hazards into this field.	• Systems are not in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users • Unable to provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections • Appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance is not in place



	• Unable to provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion • Unable to provide prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people • No systems in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection • Unable to provide or secure adequate isolation facilities • Unable to secure adequate access to laboratory support as appropriate • There are no policies in place designed for the individual's care and provider organisations that will help prevent and control infections • No system in place to manage the occupational health needs and obligations of staff in relation to infection
Significant consequences For Generic Risk Assessments follow link to template and copy and paste relevant hazards into this field.	• Nosocomial infection • Spread of infection between individuals • Harm leading to extended length of stay or possible death of individuals with HCAI (on top of presenting condition) • Requirement to make risk-based decision which may not always adhere to best practice standards • Staff illness and subsequent absence resulting in staffing shortages • Adverse health impact on vulnerable staff • Reduction in bed availability due to bay/ward closures leading to reduced service delivery and/or specialist service • Potential for complaints and litigation • Financial implication for organisation • Non-compliance with statutory requirements • Adverse media / reputation of trust
Initial Risk Rating (without controls in place) Click HERE for a matrix which will help you to grade the severity of this risk.	Consequence (initial): Major Likelihood (initial): Expected to occur weekly Rating (initial): 20 Risk level (initial): RED
Current controls in place to reduce the risk	Control listed as compliance with the NHSE IPC BAF (see attached Word document) In addition: Estates & Facilities, IPC Microbiology, Education, guidelines, Antimicrobial (locally held documents contain the details of these controls)
Risk Assurance Risk Assurance only applies to current Amber and Red active and accepted Risks.	• Audits undertaken • Cleaning records / audits demonstrate compliance with at least twice daily cleaning, more if required
Current Risk Rating (with existing controls in place) Click HERE for a matrix which will help you to grade the severity of this risk. Update following each review	Consequence (current): Major Likelihood (current): Expected to occur weekly Rating (current): 20 Risk level (current): RED
Are further controls (Actions) required?	Yes
Describe the "Key" risks to be addressed If there are "Risks" to be addressed, an Action Plan must be completed	Prevention of onward transmission of an HCAI



Risk Grading

Target (Risk Rating with Action Plan in place)	Consequence (Target): Likelihood (Target): Rating (Target): Risk level (Target):

Final Approval

Have relevant staff been made aware of Risk Assessment?	Yes
As "Final Approver" do you agree with the current Risk Grading?	Yes
Does the Action Plan adequately address any relevant Risks?	Yes
Risk Source	Board Assurance Framework (BAF)
CQC Key Lines of Enquiry (KLOE)	Safe
Strategic Objectives	4) Quality and Effectiveness
Risk Approver (Handler) Area specific risks: "GREEN" - Department/Ward Managers "AMBER" - Service Managers, or equivalent "RED" - General Managers, or equivalent. Trust wide risks: based on the subject and grading of the risk.	Wilkinson, Susan - Executive Chief Nurse

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2.7. Nursing staffing report

To Assure

Presented by Susan Wilkinson

Trust Board – January 2022

Report Title:	Item 2.7 - Quality and Workforce Report & Dashboard – Nursing November and December 2021
Executive Lead:	Sue Wilkinson
Report Prepared by:	Daniel Spooner
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☐

Executive Summary

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

Highlights

- RN fill rates in the day under 90%
- Some reduction in staff isolation rates
- Reduction in sickness rates increased in both RN and NA groups
- Improved KPIs in Maternity
- Launch of metric driven enhanced bank rate
- Opening of additional capacity in F9, driving surge plans to support ward teams

Action Required of the Board

For assurance around the daily mitigation of nurse staff.
No action needed

Risk and assurance:	*New risk raised with opening of ward F9:*
Equality, Diversity and Inclusion:	*N/A*
Sustainability:	*N/A*
Legal and regulatory context	*Compliance with CQC regulations for provision of safe care*

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 in November and December 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 November 2021 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 June 21	94%	95%	95%	109%
Average Fill rate for July 21	93%	93%	95%	107%
Average Fill rate for August 21	89%	91%	91%	104%
Average fill rate for September 21	91%	92%	89%	107%
Average fill rate for October 21	88%	87%	87%	101%
Average fill rate for November 2021	89%	87%	88%	102%
Average fill rate for December 2021	88%	82%	86%	96%

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

Highlights

- Fill rates in November remained static with a decline in December, most noticeably in care staff
- Overfill in Paediatrics and Neonatal due to continuation of winter staffing and planning for RSV surge
- Areas of concern G8, F8, AAU

- Consistent underfill on G10 (Covid), however this was mostly mitigated due to low occupancy on the ward
- AAU challenged due to consistent need to keep escalation area open.

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).

4. Sickness

Sickness rates has increased since June 2021. Increased RN sickness for fourth consecutive month. 1% improvement on NA sickness.

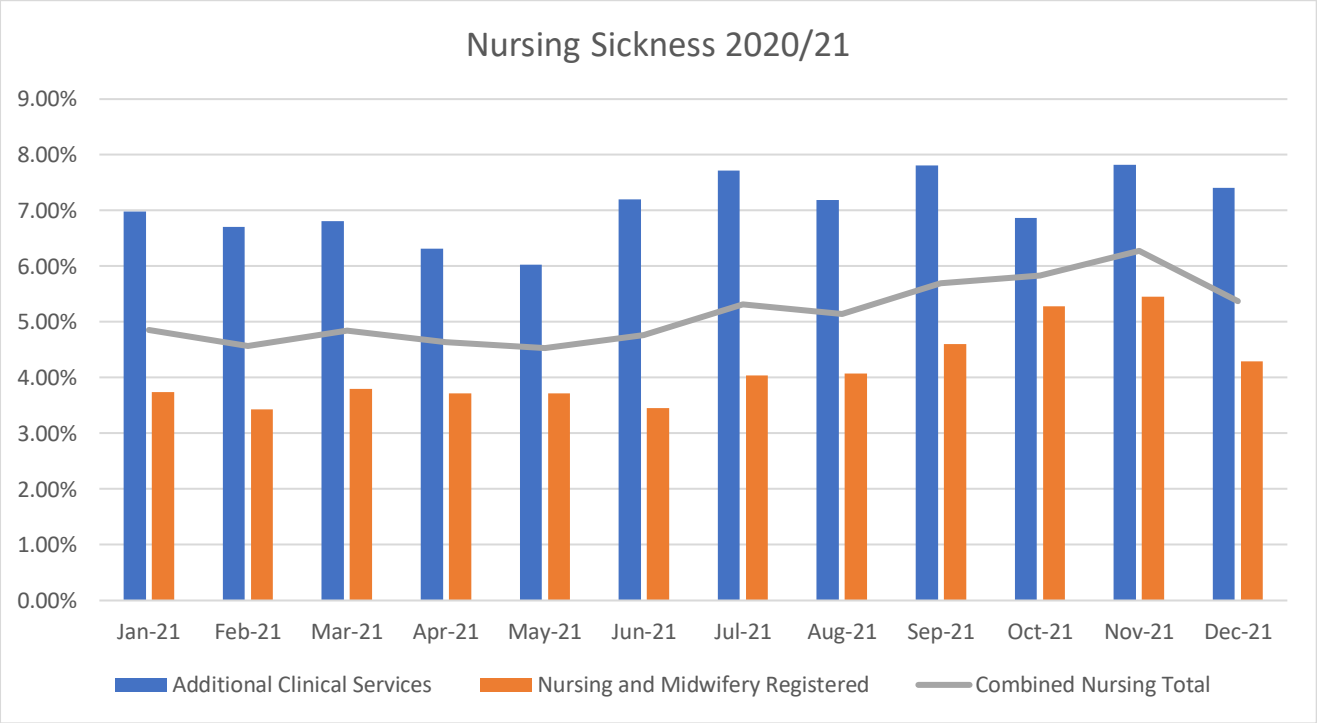

Chart 2.

	May 21	Jun-21	July-21	Aug-21	Sep-21	Oct-21	Nov 21	Dec 21
Unregistered staff (support workers)	6.32%	6.03%	7.20%	7.70%	7.31%	8.04%	6.96%	7.41%
Registered Nurse/Midwives	3.72%	3.72%	3.45%	4.04%	4.12%	4.71%	5.34%	4.29%
Combined Registered/Unregistered	**4.63%**	**4.53%**	**4.76%**	**5.31%**	**5.22%**	**5.85%**	**5.91%**	**5.38%**

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). There is a slight reduction in isolation rates in both roles. This is illustrated in chart 3. A twice daily risk assessment panel continues to review isolation requirements of individual staff that are either contacts or Covid positive. The risk assessment panel

is chair by the DIPC, and membership includes, infection control team, deputy chief nurse and public health consultants. The aims of the panel include

- Supportive conversations and risk assessment of staff returning to clinical area
- Supporting line manager to understand regular changes in isolation guidance
- Ensure staff can return at earliest opportunity in line with national guidance

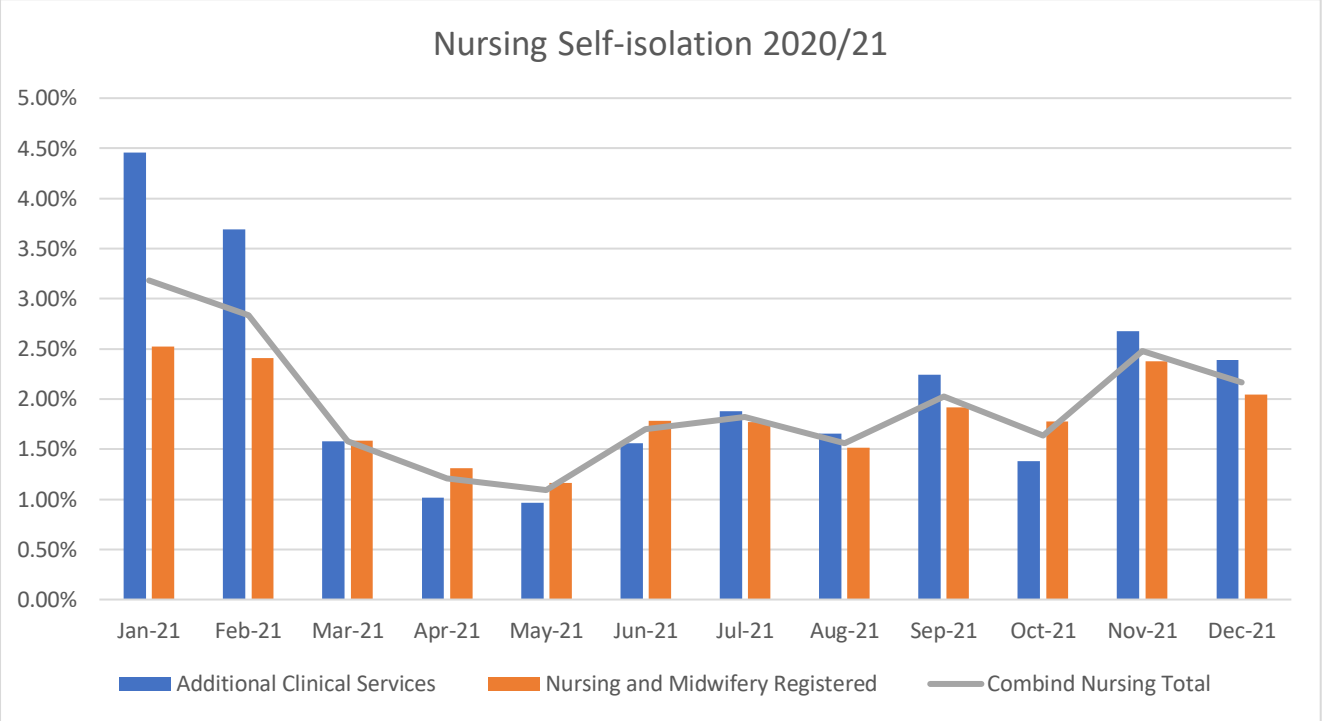

Chart 3

5. Recruitment and Retention

Vacancies: Registered nursing (RN/RM):

- Inpatient RN/RM WTE vacancies is 116.5 WTE or 16% this is a marginal increase from previous report. (Table 4)
- Total RN/RM (all areas) is 13.1% minimal change between M8 and M9 Total substantive numbers remain relatively static (Table 4b).
- Vacancies for nursing assistants and unregistered staff have seen a marginal improvement in M9

	Inpatient	Sum of Actuals Period 4 (July)	Sum of Actuals Period 5 (Aug)	Sum of Actuals Period 6 (Sept)	Sum of Actuals Period 7 (Oct)	Sum of Actuals Period 8 (Nov)	Sum of Actuals Period 9 (Dec)	WTE VACANCY at period 7
RN/RM Substantive	Ward	602.0	605.9	616.4	611.1	611.7	610.8	116.5
Nursing Unregistered Substantive	Ward	389.3	386.7	384.1	382.5	379.9	385.4	51.5

Table 4. Ward/Inpatient actual substantive staff with WTE vacancy

The chart below demonstrates the total RN establishment for the inpatient areas. While we have seen an increase in vacancy rate this financial year due to the increased establishment in many areas, the total number of substantive RNs is not a declining trend (chart 4a). This is demonstrating a sustained improvement since the starting point of April 2020 but has plateaued since May 2021 despite uplift in establishments in many areas.

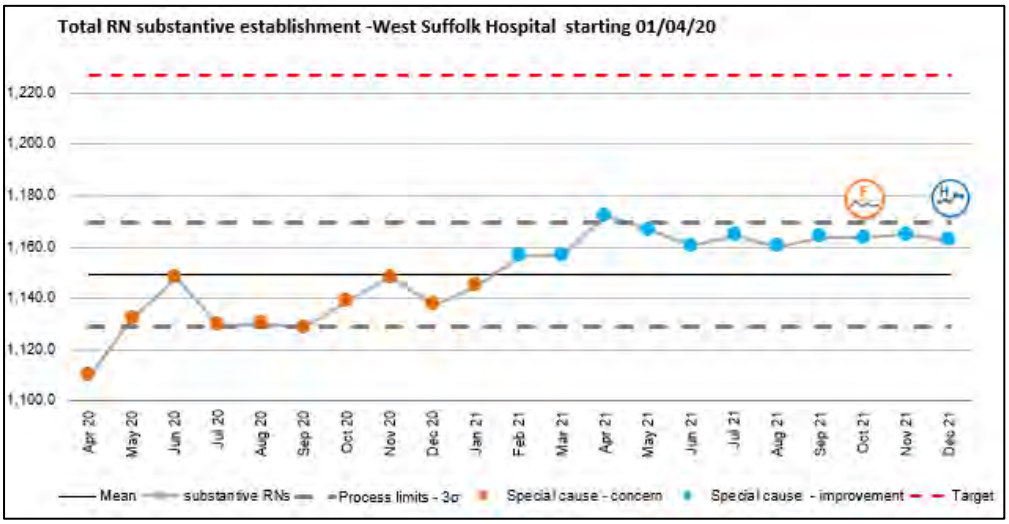

Chart 4a: SPC data adapted from finance ledger

6. New Starters and Turnover

International Nurse Recruitment:

International recruitment (IR) continues and we are on track to deliver our target number by April 2022. From November 2021 the arrival of nurses is planned to increase from five to eight. Plans to increase this further in January and February to eleven is being realised as we work to increase classroom activity. Regular interviews are being conducted with the ward teams to ensure the pipeline continues.

- Eleven IR nurses arrived in September as planned. This was over our planned eight nurses to compensate for no arrivals planned in December, as reduced pastoral support will be available over the festive period. A further eleven nurses will be planned for January

Funding has been agreed to support eight international midwives join WSH in early 2022. First round of interviews was held in December with staggered start dates potentially planned for February 2022 and spring 2022.

New starters

	July	August	September*	October	November	December
Registered Nurses	12	17	36	14	14	17
Non-Registered	16	19	12	11	11	10

Table 6: Data from HR and attendance to WSH induction program
*two inductions ran this month

- In November 2021 fourteen RNs completed induction; of these; eleven were for acute services, two for pure bank and one midwife joined this cohort
- In November 2021, eleven NAs completed induction; of these four NAs are for the acute Trust, two for midwifery services and five for the community

- In December 2021 seventeen RNs completed induction; of these; sixteen were for acute services and one for bank services
- In December 2021, ten NAs completed induction; of these, five NAs are for the acute Trust, two for bank services and three for community services

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs has increased from 8.52% to 9.22% which although remains below the trust ambition of <10% is increasing on month. NA turnover has also increased from to 13.93% to 16.79%

Turn Over 01/01/2021 - 31/12/2021								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,277	1,105	110	81.61	127	101.95	9.95%	9.22%
Additional Clinical Services	570.00	481.00	190	165.97	91	80.76	15.96%	16.79%

Table 7. (data from workforce)

7. Quality Indicators

Falls

Falls per 1000 bed days is below the national average (set in 2015) of 6.63. A full list of falls and locations can be found in appendix 3.

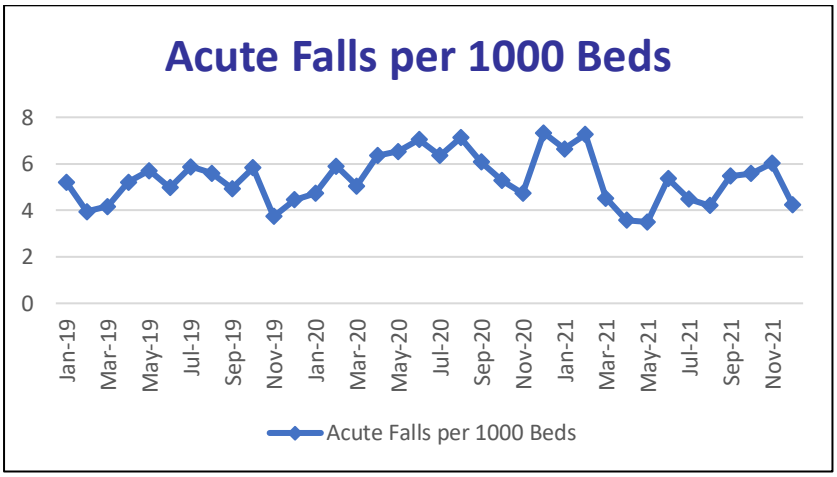

Chart 8

Pressure Ulcers

December has again seen an increased incidence of pressure ulcers, 35 (30 previous month) These incidences a have been spread evenly across both the surgical and medical divisions, with the exception of F8 and F7 which have seen spikes in the incidence of pressure ulcers. Despite the significant pressures and number of referrals to the TVN the team are providing wards with quarterly reports of incident rates and anatomical locations so teams can focus on common incidences in their area.

The TVN team proactively responded to high referral rates to publish a staff bulletin as ward-based training was reduced. we have however been able to provide a bulletin and continue to send out relevant information.

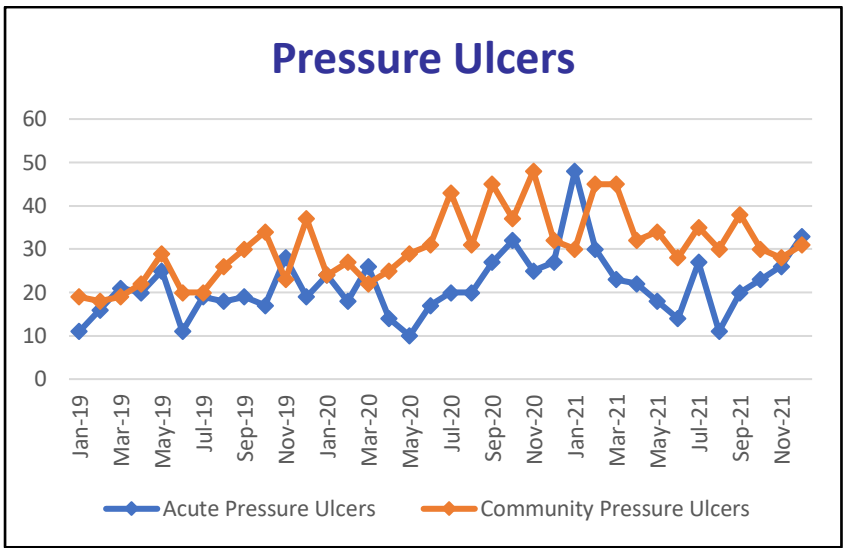

Chart 9a

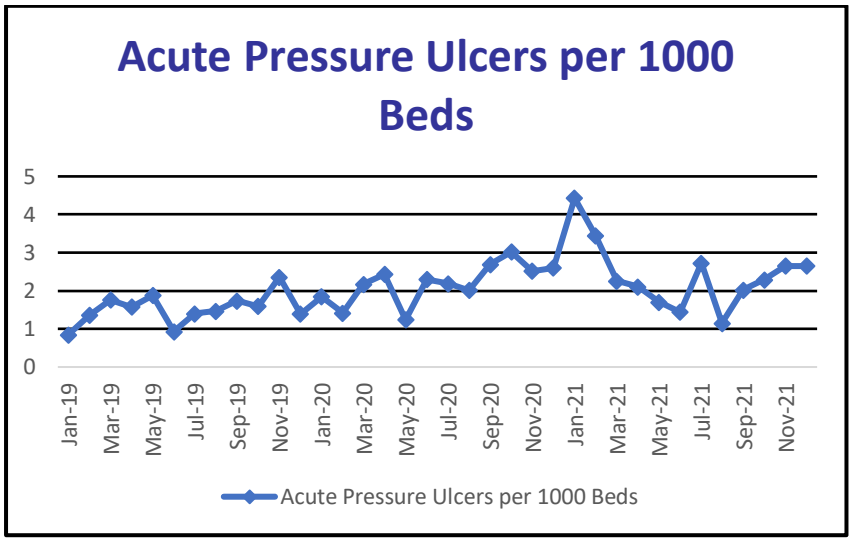

Chart 9b

8. Compliments and Complaints

Table 10. demonstrates the incidence of complaints and compliments for this period.

In November the average number of calls to the clinical helpline was 87. This increased to 104 in December likely to be driven by the implementation of restricted visiting in December following increased community prevalence and the emerging Omicron Covid variant

Complaints have reduced for three consecutive months particularly reducing from A&E and gynaecology which is positive following the observed increases in both areas. Communication is still the most common reason for patient concerns.

	Compliments	Complaints
June 2021	31	19
July 2021	23	20
August 2021	17	19
September 2021	30	14
October 2021	15	10
November 2021	18	15
December 2021	22	10

Table 10

9. Adverse Staffing Incidences

Staffing incidences are captured on Datix with recognition of any red flag events that have occurred as per National Quality Board (NQB) definition (Appendix 4). Nursing staff are encouraged to complete a Datix as required so any resulting patient harm can be identified and reviewed.

- In November there were forty Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidents

- In December there were 33 Datixs recorded for inpatient nurse staffing that resulted in a Red Flag event (see table 11). No harm is recorded for these incidents

Red Flag	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	4	23	12	22	19	20	10
>30-minute delay in providing pain relief	0	4	7	3	2	5	4
Delay or omission of intention rounding	5	12	12	7	10	12	12
<2 RNs on a shift	1	1	2	10	6	7	5
Vital signs not recorded as indicated on care plan	1	0	0	5	3	3	1
Unplanned omissions in providing patient medication	0	1	0	2	0	0	1
Total	11	49	33	49	40	40	33

Table 11

10. Maternity Services

A full maternity staffing report will be attached to the maternity paper as per CNST requirements.

The maternity service has experienced increasing challenges this month and this is reflected in the number of red flag events, Midwife to birth ratio and the supernumery status of the labour suit coordinator. This is now recognised as a national staff crisis and the maternity team will be responding to regional and national assurances around staffing mitigation.

Red Flag events

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

- There were three red flag events in November. No harm was recorded as in impact of these incidents.
- There were forty-three red flag events in December. No harm was recorded as in impact of these incidents. Thirty-four of these were related to staff absences due to Covid 19 sickness or isolation

Midwife to Birth ratio

Midwife to Birth ratio was 1:26 in November and 1:23 in December, these are the first months to achieve this since December 2020, which are below the national average of 1:28, or Birth-rate Plus recommendation of 1:27.7. This was achieved due to low numbers of women giving birth in November and December. December was the lowest number of babies born this year. Provision of 1:1 care in labour continued to be 100% for these months.

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 November 100% compliance was achieved
- December 99% compliance was achieved

11. Emerging Staffing escalations

On December 30th 2021, due to the unprecedented challenges within the organisation a decision was made to open 14 beds on the empty ward F9. At the time of writing this ward remains open and is being staffed by the current ward nursing establishment. This has created additional pressure on the nursing workforce within the context of current absences.

NHSE have requested that further 'super surge' capacity is planned to address the potential rise demand in services from 20th January for approx. 6-8 weeks. This has required additional actions and cessation of some services and roles to support the potential demand in the coming weeks. Appendix 5 contains a full explanation of mitigations and action to support this. The actions suggested will be in place for the next eight weeks with a review of effectiveness in the next four. The additional staffing plans and actions will support the current nursing shortfall and will be enable short notice flex into super surge areas if they are required.

The Executive Chief Nurse Susan Wilkinson will also be sending a personal letter to all nursing and AHP staff to acknowledge the Trust is experiencing and highlighting the message of support from the professional bodies and Chief Nursing Officer of England (Appendix 6)

Community surge plans are in place and are being reviewed in January 2022.

12. Recommendations and Further Actions:

- Not the impact of super surge capacity planning on nurse staffing and possible implications for patient care.
- 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.

Appendix 1. Fill rates for inpatient areas (November 2021): Data adapted from Unify submission

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

	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	843.5	1192	1937.5	1643.25	1023.5	995.5	1341	1252.5	141%	85%	97%	93%	452	4.8	6.4	11.2
Glastonbury Cour	690	686	977.5	1019	690	690.5	525	526	99%	104%	100%	100%	384	3.6	4.0	7.6
AAU	2070.5	1810.25	2408.25	1684.75	1713.5	1256.5	1380	1321.5	87%	70%	73%	96%	761	4.0	4.0	8.0
Cardiac Centre	2627	2231	1222	1167.5	1725	1382.5	690	664.5	85%	96%	80%	96%	632	5.7	2.9	8.6
G9	1372	1344.4167	1380	1363	1380	1174.5	1035	1292	98%	99%	85%	125%	752	3.3	3.5	6.9
F12	537.75	614.7	345	326.75	690	518	345	448.5	114%	95%	75%	130%	240	4.7	3.2	7.9
F7	1725	1393.25	1724	1530.25	1379.85	1170	1725	1509	81%	89%	85%	87%	683	3.8	4.4	8.2
F9	1725	1378.25	1718.75	1446.75	1028.5	901.5	1378	1430	80%	84%	88%	104%	744	3.1	3.9	6.9
G1	1380.5	887	347	479.5	690	692	340.5	315	64%	138%	100%	93%	485	3.3	1.6	4.9
G3	1722.25	1410.25	1725	1487.1667	1035	1018	1035	1359.5	82%	86%	98%	131%	864	2.8	3.3	6.1
G4	1450.01667	1179.75	1481	1148.6667	943	784.5	1276.5	1140	81%	78%	83%	89%	896	2.2	2.6	4.7
G8	2419.5	1687.25	1754	1674.1	1725	1355.416667	1031	1044.08333	70%	95%	79%	101%	615	4.9	4.4	9.4
F8	1380	1420	2066.48333	1682.2167	1035	752	1380	1398	103%	81%	73%	101%	723	3.0	4.3	7.3
Critical Care	2741.5	2587	330	382	2754.75	2512.666667	0	219	94%	116%	91%	N/A	388	13.1	1.5	14.7
F3	1725	1488.5	2064.5	1824.75	1035	1044	1380	1293	86%	88%	101%	94%	732	3.5	4.3	7.7
F4	747.5	623.5	582	271.5	655.5	529	488	346.5	83%	47%	81%	71%	633	1.8	1.0	2.8
F5	1736.5	1401	1375.5	1092.25	1035	911	1046.5	918.5	81%	79%	88%	88%	698	3.3	2.9	6.2
F6	1972	1613.5667	1585	1478.5	1380	999.5	690	920	82%	93%	72%	133%	942	2.8	2.5	5.3
Neonatal Unit	981.5	1120	216	189.75	972	1010	156	132	114%	88%	104%	85%	116	18.4	2.8	21.1
F1	1191.08333	1468.8333	685	614.25	1035	1276.5	0	95.5	123%	90%	123%	100%	115	23.9	6.2	30.0
F14	672	954	312	508	672	705.5	0	120.5	142%	163%	105%	100%	106	15.7	5.9	21.6
F10	1372	1108	1368.5	1063.25	1035	783.5	1380	1202	81%	78%	76%	100%	707	2.7	3.2	5.9
Total	33,082.10	29,598.52	27,604.98	24,077.15	25,632.60	22,462.58	18,622.50	18,947.58	**89%**	**87%**	**88%**	**102%**	**12668**	**4.1**	**3.4**	**7.5**

Appendix 1. Fill rates for inpatient areas (December 2021): Data 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	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	918.25	1182.25	2074	1696.5	1028	978.5	1391	1349.5	129%	82%	95%	97%	452	4.8	6.7	11.5
Glastonbury Cour	713	714.16667	1075	1062	697.5	685	542.5	576.5	100%	99%	98%	106%	384	3.6	4.3	7.9
AAU	2104	1750.75	2501.5	1533.75	1782	1150	1426	1380	83%	61%	65%	97%	761	3.8	3.8	7.6
Cardiac Centre	2660	2265.75	1244	1149.9167	1782.5	1483.5	713	625.5	85%	92%	83%	88%	632	5.9	2.8	8.7
G9	1425.5	1378.5833	1415	1361	1426	1152	1069.5	1357.5	97%	96%	81%	127%	752	3.4	3.6	7.0
F12	553.5	657	356.5	319	713	496.5	356.5	340	119%	89%	70%	95%	240	4.8	2.7	7.6
F7	1752.25	1438.9167	1754.75	1408.75	1390	1189.916667	1771	1493.25	82%	80%	86%	84%	683	3.8	4.2	8.1
F9	1782.5	1552.75	1761.75	1535	1069.5	993.5	1422.5	1331	87%	87%	93%	94%	744	3.4	3.9	7.3
G1	1432	1048.5	356.5	322.5	713	713	356.5	291.983333	73%	90%	100%	82%	485	3.6	1.3	4.9
G3	1782.5	1468.5	1770.5	1503	1069.5	1046.5	1069.5	1293	82%	85%	98%	121%	864	2.9	3.2	6.1
G4	1793	1569.5	1849	1679.5	1069.5	931.5	1426	1252	88%	91%	87%	88%	896	2.8	3.3	6.1
G8	2466.5	1757.1333	1800.5	1574.8333	1759.48333	1341.483333	1079.4	1016.75	71%	87%	76%	94%	615	5.0	4.2	9.3
F8	1426	1446	2139	1561	1063.5	800	1426	1420.5	101%	73%	75%	100%	723	3.1	4.1	7.2
Critical Care	2822.75	2611.75	341	269	2848.75	2467.666667	0	93	93%	79%	87%	N/A	388	13.1	0.9	14.0
F3	1782.5	1517.5	2139	1719.5	1069.5	1058	1426	1288	85%	80%	99%	90%	732	3.5	4.1	7.6
F4	793.5	673	586.5	402.5	575	507	506	416	85%	69%	88%	82%	633	1.9	1.3	3.2
F5	1782.5	1393	1418.5	1203.25	1069.5	896.25	1047	926.75	78%	85%	84%	89%	698	3.3	3.1	6.3
F6	2018	1668	1670.5	1348.5	1424.5	1092	713	1006.5	83%	81%	77%	141%	942	2.9	2.5	5.4
Neonatal Unit	1068	1191.5	216	200.5	996	1020	144	114	112%	93%	102%	79%	116	19.1	2.7	21.8
F1	1221.75	1405	713	644	1069.5	1276.5	0	70.25	115%	90%	119%	100%	115	23.3	6.2	29.5
F14	620	618	318	277.5	744	744	0	0	100%	87%	100%	N/A	106	12.8	2.6	15.5
F10	1412.5	1062.5	1422	1039	1069.5	828.5	1416	899	75%	73%	77%	63%	707	2.7	2.7	5.4
Total	34,330.50	30,370.05	28,922.50	23,810.50	26,429.73	22,851.32	19,301.40	18,540.98	**88%**	**82%**	**86%**	**96%**	**12668**	**4.2**	**3.3**	**7.5**

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

Ward/Department	Register Nurses/Midwives			
	Actual establishmet	Budgetted establishment	Vacancy rate (WTE)	Vacancy percentage %
AAU	21.6	30.1	8.5	28.3
Accident & Emergency	64.9	77.3	12.4	16.0
Cardiac Centre	35.0	40.7	5.7	14.1
Glastonbury Court	10.9	11.7	0.8	6.8
Critical Care Services*	40.3	50.0	9.7	19.4
Day Surgery Wards	12.6	11.0	-1.6	-14.9
Gynae Ward (On F14)	12.6	14.1	1.5	10.3
Neonatal Unit	19.2	20.6	1.4	6.7
Rosemary ward	13.8	18.6	4.8	25.8
Recovery Unit	25.0	25.4	0.4	1.6
Ward F1 Paediatrics	22.0	22.1	0.2	0.8
Ward F12	9.6	11.9	2.3	19.4
Ward F3	19.6	22.2	2.6	11.6
Ward F4	12.6	13.6	1.1	7.9
Ward F5	19.1	22.2	3.0	13.7
Ward F6	18.1	26.6	8.5	32.1
Ward F7 Short Stay	23.5	24.9	1.4	5.8
Ward F9	18.1	21.8	3.7	17.1
Ward G1 Hardwick Unit	25.4	30.6	5.2	16.8
Ward G3	20.9	22.1	1.2	5.3
Ward G4	22.1	22.1	0.0	0.0
Ward G8	22.0	32.7	10.7	32.6
Renal Ward - F8	18.5	19.5	0.9	4.8
Ward F10	14.4	19.0	4.6	24.2
Respiratory Ward - G9	20.1	23.7	3.6	15.3
Total	541.8	634.3	92.5	14.6
Hospital Midwifery	49.5	58.9	9.4	15.9
Continuity of Carer Midwifery	18.4	31.0	12.6	40.6
Community Midwifery	16.9	19.1	2.2	11.7
Total	84.8	109.0	24.2	22.2

Ward/Department	NA/MCA			
	Actual Establishment	Budgeted Establishment	Vacancy rate (WTE)	Percentage Vacancy %
AAU	22.0	28.3	6.4	22.4
Accident & Emergency	33.3	34.5	1.2	3.4
Cardiac Centre	15.5	15.7	0.2	1.5
Glastonbury Court	10.7	12.6	1.9	15.2
Critical Care Services	2.8	1.9	-0.9	-48.9
Day Surgery Wards	3.9	3.9	0.0	0.0
Gynae Ward (On F14)	2.0	2.0	0.0	0.0
Neonatal Unit	3.9	4.3	0.4	9.6
Rosemary ward	23.0	25.8	2.7	10.6
Recovery Unit	0.9	0.9	0.0	1.2
Ward F1 Paediatrics	6.8	6.7	-0.1	-1.0
Ward F12	4.5	5.9	1.3	22.7
Ward F3	22.7	25.8	3.1	12.2
Ward F4	8.7	14.6	5.9	40.6
Ward F5	16.0	18.1	2.1	11.6
Ward F6	17.4	17.4	-0.1	-0.4
Ward F7 Short Stay	19.1	25.8	6.7	26.0
Ward F9	24.0	23.2	-0.8	-3.3
Ward G1 Hardwick Unit	10.2	10.5	0.3	3.2
Ward G3	21.5	23.0	1.5	6.6
Ward G4	19.3	22.8	3.5	15.5
Ward G8	22.2	20.6	-1.5	-7.5
Renal Ward - F8	23.0	25.8	2.8	10.7
Ward F10	14.7	23.2	8.5	36.6
Respiratory Ward - G9	18.4	18.0	-0.4	-2.1
Total	366.2	411.1	44.9	10.9
Hospital Midwifery	13.6	15.6	2.0	12.7
Continuity of Carer Midwifery	0.0	0.0	0.0	0.0
Community Midwifery	3.9	3.8	-0.1	-3.2
Total	17.5	19.4	1.9	9.6

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

Ward/Department	Register Nurses/Midwives			
	Actual establishmet	Budgetted establishment	Vacancy rate (WTE)	Vacancy percentage %
AAU	22.1	30.1	8.0	26.6
Accident & Emergency	63.1	77.3	14.2	18.3
Cardiac Centre	33.9	40.7	6.8	16.6
Glastonbury Court	10.9	11.7	0.8	7.1
Critical Care Services*	39.4	50.0	10.6	21.1
Day Surgery Wards	12.2	11.0	-1.2	-10.7
Gynae Ward (On F14)	12.2	14.1	1.9	13.5
Neonatal Unit	19.4	20.6	1.2	5.7
Rosemary ward	13.7	18.6	4.9	26.2
Recovery Unit	25.2	25.4	0.2	0.8
Ward F1 Paediatrics	21.2	22.1	0.9	4.1
Ward F12	9.9	11.9	2.0	17.0
Ward F3	22.7	22.2	-0.5	-2.3
Ward F4	13.0	13.6	0.6	4.5
Ward F5	18.5	22.2	3.7	16.6
Ward F6	18.9	26.6	7.7	28.9
Ward F7 Short Stay	21.8	24.9	3.2	12.6
Ward F9	19.1	21.8	2.7	12.3
Ward G1 Hardwick Unit	26.0	30.6	4.6	14.9
Ward G3	20.8	22.1	1.3	5.8
Ward G4	21.8	22.1	0.3	1.4
Ward G8	23.2	32.7	9.4	28.9
Renal Ward - F8	18.8	19.5	0.7	3.5
Ward F10	16.4	19.0	2.6	13.7
Respiratory Ward - G9	18.6	23.7	5.1	21.5
Total	542.8	634.3	91.4	14.4
Hospital Midwifery	47.9	58.9	11.0	18.7
Continuity of Carer Midwifery	18.4	31.0	12.6	40.6
Community Midwifery	16.8	19.1	2.3	12.2
Total	83.1	109.0	25.9	23.8

Ward/Department	NA/MCA			
	Actual Establishment	Budgeted Establishment	Vacancy rate (WTE)	Percentage Vacancy %
AAU	21.9	28.3	6.4	22.7
Accident & Emergency	35.7	34.5	-1.2	-3.5
Cardiac Centre	17.1	15.7	-1.4	-8.8
Glastonbury Court	13.0	12.6	-0.4	-2.8
Critical Care Services	2.8	1.9	-0.9	-48.9
Day Surgery Wards	3.9	3.9	0.0	0.0
Gynae Ward (On F14)	3.0	2.0	-1.0	-50.0
Neonatal Unit	3.9	4.3	0.4	8.6
Rosemary ward	22.1	25.8	3.7	14.4
Recovery Unit	0.9	0.9	0.0	1.2
Ward F1 Paediatrics	7.2	6.7	-0.4	-6.2
Ward F12	5.1	5.9	0.8	13.5
Ward F3	21.8	25.8	4.1	15.8
Ward F4	8.9	14.6	5.8	39.3
Ward F5	13.5	18.1	4.6	25.4
Ward F6	19.3	17.4	-2.0	-11.3
Ward F7 Short Stay	20.0	25.8	5.8	22.4
Ward F9	23.0	23.2	0.2	0.8
Ward G1 Hardwick Unit	9.7	10.5	0.9	8.3
Ward G3	21.2	23.0	1.8	7.7
Ward G4	20.1	22.8	2.7	11.8
Ward G8	18.3	20.6	2.3	11.0
Renal Ward - F8	22.4	25.8	3.4	13.2
Ward F10	17.3	23.2	5.9	25.6
Respiratory Ward - G9	18.5	18.0	-0.4	-2.4
Total	370.2	411.1	41.0	10.0
Hospital Midwifery	15.2	15.6	0.4	2.4
Continuity of Carer Midwifery	0.0	0.0	0.0	0.0
Community Midwifery	3.9	3.8	-0.1	-3.2
Total	19.1	19.4	0.3	1.3

*areas that have received an establishment uplift this month CCS (7wte) and Continuity of Carer (12.7wte)

Appendix 3:

Ward by Ward breakdown of Falls and Pressure ulcers November and December 2021

HAPU

Nov-21	Cat 2	Cat 3	Unstageable	Total
Cardiac Centre - Ward	1	0	0	1
Critical Care Unit	3	0	0	3
F3 - ward	2	0	0	2
F5 - ward	1	0	0	1
F6 - ward	2	0	0	2
G1 - ward	2	0	0	2
G10	1	0	0	1
G3 - Endocrine and General Medicine	4	2	0	6
G4 - ward	1	0	0	1
Gastroenterology Ward	2	0	1	3
Renal Ward	2	0	0	2
Winter Escalation (Rosemary)	2	0	0	2
F7	3	0	0	3
Early Intervention Team	1	0	0	1
Total	**27**	**2**	**1**	**30**

Dec-21	Cat 2	Cat 3	Unstageable	Total
Cardiac Centre - Ward	1	0	0	1
F5 - ward	1	0	0	1
G1 - ward	1	0	0	1
G8 - ward	1	0	0	1
Recovery	1	0	0	1
Early Intervention Team	0	0	1	1
Critical Care Unit	2	0	0	2
F12 Isolation Ward	2	0	0	2
F3 - ward	2	0	0	2
G3 - Endocrine and General Medicine	1	1	0	2
Winter Escalation (Rosemary)	2	0	0	2
F6 - ward	3	0	0	3
Respiratory Ward	3	0	0	3
Renal Ward	5	0	0	5
F7	5	0	0	5
Total	**30**	**1**	**1**	**32**

Falls

Nov-21	None	Negligible	Minor	Moderate	Major	Total
Community Paediatric SLT	1	0	0	0	0	1
Critical Care Unit	1	0	0	0	0	1
F14 (Gynae - EPAU)	1	0	0	0	0	1
Macmillan Unit	1	0	0	0	0	1
Renal Ward	1	0	0	0	0	1
Early Intervention Team	1	0	0	0	0	1
F3 - ward	2	0	0	0	0	2
Glastonbury Court	2	0	0	0	0	2
Emergency Department	1	0	1	0	0	2
F6 - ward	2	0	1	0	0	3
F12 Isolation Ward	4	0	0	0	0	4
Gastroenterology Ward	1	1	2	0	0	4
Respiratory Ward	1	2	1	0	0	4
F5 - ward	3	1	1	0	0	5
G4 - ward	4	0	0	1	0	5
Cardiac Centre - Ward	5	0	1	0	0	6
G3 - Endocrine and General Medicine	5	0	1	0	0	6
G10	5	1	2	0	0	8
G8 - ward	6	2	0	0	0	8
Winter Escalation (Rosemary)	7	0	1	0	0	8
Acute Assessment unit (AAU)	8	0	0	0	0	8
G1 - ward	5	1	2	0	1	9
F7	12	1	0	0	1	14
Total	**79**	**9**	**13**	**1**	**2**	**104**

Dec-21	None	Negligible	Minor	Moderate	Major	Catastrophic	Total
CHT Mildenhall	1	0	0	0	0	0	1
Critical Care Unit	0	0	1	0	0	0	1
F1 - Ward	1	0	0	0	0	0	1
F14 (Gynae - EPAU)	1	0	0	0	0	0	1
F4 - ward	1	0	0	0	0	0	1
Respiratory Ward	0	0	0	0	1	0	1
Stroke Early Supported Discharge Servic	1	0	0	0	0	0	1
Wheelchair Services	0	1	0	0	0	0	1
Acute Assessment unit (AAU)	1	0	0	0	0	0	1
Early Intervention Team	1	0	0	0	0	0	1
Major Assessment Area (MAA)	1	0	0	0	0	0	1
F3 - ward	2	0	0	0	0	0	2
F5 - ward	2	0	0	0	0	0	2
G10	2	0	1	0	0	0	3
Gastroenterology Ward	4	0	0	0	0	0	4
Renal Ward	2	1	1	0	0	0	4
Emergency Department	2	0	1	1	0	0	4
F6 - ward	5	0	0	0	0	0	5
G3 -	1	2	2	0	0	0	5
G1 - ward	3	1	2	0	0	0	6
G8 - ward	5	1	1	0	0	0	7
Cardiac Centre - Ward	7	1	0	0	0	0	8
F7	7	0	1	0	0	0	8
G4 - ward	8	0	2	0	1	0	11
Winter Escalation (Rosemary)	8	0	3	3	0	1	15
Total	**66**	**7**	**15**	**4**	**2**	**1**	**95**

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:

Executive Directors Meeting – 19.1.22

Report Title:	Super Surge Planning Nursing Plan
Executive Lead:	Sue Wilkinson
Report Prepared by:	Daniel Spooner
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☐

Executive Summary
This paper builds on a plan that was presented and agreed at Executive Directors meeting on 5th January 2022, following the unanticipated need to open ward F9 for surge capacity on 30th December 2021. There has been a further ask from NHSI/E for SNEE system to open an additional 120 beds working on admission's modelling data. It is predicted that our daily Covid admissions will rise from 4-5 a day to 20 per day at the end of the month. Original plans to address this have already be surpassed and there is an anticipated need to open additional patient beds. This paper described formal action to take that will further mitigate the current nursing deficit and allow for staffing additional beds as identified by CRT team
Action Required of the Board
For assurance around the daily mitigation of nurse staff. To acknowledge the action of the super surge plan will possibly result in care not to a standard the trust would aspire to

Risk and assurance:	*New risk raised with opening of ward F9:*
Equality, Diversity and Inclusion:	*N/A*
Sustainability:	*N/A*
Legal and regulatory context	*Compliance with CQC regulations for provision of safe care*

WSHFT Nursing Workforce Deployment Covid 19 Super Surge staffing plan

Background

It is anticipated that the current to capacity and the CV pandemic will require the current nursing workforce to be stretched excessively over the coming 2 months. This is further compounded by the need to provide additional inpatient beds within WSHFT.

- NHSE/I have requested that we plan for 'Super Surge' with the expectation that urgent services continue
- The ask is to provide 120 super surge beds across SNEE to manage the expected increase in capacity
- There is an understanding from NHSE/I that stepping into super surge will impact on routine services
- Mutual aid for critical care is already taking place for clinical reasons and decompression
- The request is to surge into physical space that already exists which is never or has hardly ever been used for delivery
- Timeframe of super surge – implementation 20th Jan 2022 for period of 8 weeks

Super surge Plan

1. Re-commission 2 beds within F8 (no additional staff required)

2. Utilise 33 beds within F9 (increasing ward by 19 beds)
    - Staffing model will need increasing to support this increase - support from staff across organisation
    - Consideration for patient cohort and medical cover

3. Utilise 12 beds within F4 (increase in medical beds and staffing due to patient mix))
    - Staffing, resources and infrastructure in place
    - Capacity as a result of cancelling some elective surgery

The mitigation proposed in the previous paper will not be adequate given the current absences due to vacancies, sickness and Covid isolations, so further action is needed. current process for managing daily staffing review, mitigation and escalation will remain. To ensure this happens as effectively as possible the Deputy Chief Nurse will attend the daily safety huddle and support the matron team in mitigation and identification of escalations.

A reduction in Nursing ratios was already agreed to mitigate the surge staffing enacted on December 30th 2021. An update of this can be found in Appendix 1

In Critical Care areas staffing capacity is reviewed three times as day using an acuity framework consistent with the East of England critical care network.

This is only sustainable for short periods of time due to safety risks to. Elective services will need to be reduced or paused in an agreed priority order to return to level 2 staffing and Level 3 staffing will be pre-empted where possible to allow for timely and proactive staff redeploys.

If staff are redeployed it is expected that we will work to clear principles of deployment:

- Staff will not be asked to undertake duties for which they do not have the necessary knowledge, training or registration.
- Staff safety is a priority and all measures will be in place to ensure staff health and safety, including access to appropriate personal protection equipment, (PPE).
- Staff will be paid on existing grade.
- Deployment means that staff will not be expected to continue undertaking work in substantive role whilst being deployed
- Staff personal circumstances will be considered, including childcare arrangements, travel arrangements and medical conditions when considering suitability, type and length of redeployment.

WSP Flexible pool shift bookings will be increased as required and are reviewed on a daily basis as with winter planning. Enhanced pay rate for this service has been in place since December 2021 and is planned to continue until end of February 2022

Super Surge Staffing model in inpatient setting as follows

- a maximum of one registered nurse for every eight/nine patients in adults, and one for every six/ patients in Children's services, (where possible, if ratios are required to be higher justification will be given at the safe staffing meeting.
- Support from deployed registered healthcare practitioner and admin staff
- Nursing assistants

Current nurse staffing process.

A full staffing review will occur at 9.30 and 1530 which will be chaired by the Matron of the Day (MOD) or DCN
Attendance at 09.30 and 15.30 will also be:

1. Matron of the Day (MOD)
2. Matron rep from Medicine
3. Matron rep from Surgery
4. Matron/DDOM midwifery
5. MOD and Matrons (15:30)

Mitigation and deployment will be overviewed from these meetings with priority consideration given for ensuring ED/EAU, critical care, emergency surgery and that safe staffing ratios and skill mix are met in all other areas.

Rapid response allocation to be planned and agreed at these meetings
The Covid 19 super surge staffing plan will be used at the time of super surge into additional areas are open to support safety at front door

To support the provision of nursing care the task listed below will be reduced in frequency to ensure nursing time is maximised for direct patient care

- Care rounding expectation reduced from 2 hourly to 3 hourly
- Reduced frequency of weekly audits. Every two weeks.
- Bed linen change when visibly soiled instead of daily
- Supporting independent care of patients

Additional actions to support staffing

- Clinical Nurse specialist and Specialist nurses to diarise support to inpatient area
- Educational teams to schedule daily support to wards
- Facilitate international nurses to join temporary register prior to completing OSCE program
- Ward liaison officer project revisited
- Ward Managers to be 80% clinical and within nursing numbers for next 6 weeks (review in 4 weeks, to extend to 8 if required). Ward Managers can do long days where appropriate and in keeping with work life balance. 20% to maintain recruitment and staff wellbeing support
- Zonal bleep holders to be removed and return to clinical numbers
- Matrons to provide 1 day a week clinical within wards
- Heads of Nursing a DCN to hold daily staffing bleep to increase matron ability to support
- Executive Chief Nurse to formally write to nursing and AHP teams to recognise the significant challenge in the coming weeks (example letter appendix 2)

To conclude, the amended establishments reflect intentional staffing during this super surge period (appendix 1). There have been and will be occasion when staffing falls below even this. Particularly at night when there is limited resilience to RN sickness/absences. If this occurs resulting in a ratio of 1:16 only essential nursing care will be expected for example

- Timely medications administered
- Timely observations and appropriate escalation
- Admission risk assessments handed to the next shift
- Hygiene needs as required
  (this list is not exhaustive) and nursing staff should prioritise care and document any omissions, escalating any concerns via the usual routes of line managers.

NB: staffing Datixs should and will be completed if staffing levels affect patient care

Original and Super Surge Staffing Plan.

			Budgeted establishment				Super Surge establishment				Day patient: RN ratio
			Day		Night		Day		Night		
	WARD	Beds	RN	NA	RN	NA	RN	NA	RN	NA	
Medicine	AAU	30	5	5	4	4	4	4	4	4	1 t0 6
	F8	27	4	6	3	4	3	5	2	3	1 to 9.6
	G9	25	4	4	4	3	4	4	4	3	1 to 6.25
	F10	26	4	6	3	4	4	4	3	3	1 to 6.25
	F12	8	2	1	2	1	2	0	1	1	1 to 4
	F7	34	5	5	4	4	4	4	3	3	1 to 8.25
	G5	33	5	5	3	4	4	4	2	3	1 to 8.25
	G1	12	4	2	2	1	3	1	2	1	1 to 4
	G3	33	5	5	3	4	4	4	2	3	1 to 8.25
	G4	33	5	5	3	4	4	4	2	3	1 to 8.25
	G7	22	6	3	5	2	5	2	4	1	1 to 5.5
	G8	30	7	4	5	3	5	3	4	3	1 to 8.6
	NCH	33	4	6	3	4	4	5	3	3	1 to 8.25
	Medicine Total		**60**	**57**	**44**	**42**	**50**	**44**	**36**	**34**	
Surgery	F3	34	5	6	3	4	4	4	2	3	1 to 8.5
	F4	33	4	4	2	2	4	4	2	3	1 to 8.5
	F5	33	5	4	3	3	4	4	3	2	1 to 8.25
	F6	33	5	4	4	2	4	4	3	3	1 to 8.25
	Surgical Total		**19**	**18**	**12**	**11**	**16**	**16**	**10**	**11**	
W&C	F14	8	2	1	2	0	2	1	1	1	1:4
Super Surge	F9	33	-	-	-	-	4	4	2	3	1:8
	F8	2	-	-	-	-	0	0	0	0	NA
Total needed		**522**	**81**	**76**	**58**	**53**	**72**	**65**	**49**	**49**	

APPENDIX 6: Personal letter to staff

18 January 2022

Name
Address

West Suffolk NHS Foundation Trust
Hardwick Lane
Bury St Edmunds
Suffolk
IP33 2QZ

Tel: 01284 713500

Dear XXXX,

I am writing to you to express my immense gratitude for the consistent and excellent care you are providing our patients over this very challenging period. I know we are asking you to consistently go over and above the usual expectation of care delivery and for that I am hugely grateful.

I want to reassure you that the senior team is working extremely hard to mitigate risks from the pressures we're experiencing across the whole organisation. One of our primary goals is ensuring clinical areas are supported as best they can be with the resources we have available at the time. Whilst we are under these pressures, we know there will be times when you are very stretched and we understand the anxiety and distress this may cause you and your colleagues. We also recognise that when our services are at this high level of escalation it can mean that we are not always able to deliver care in the way we would like and that can challenge our professional values. Please know that we are doing everything we can to support you to be able to deliver the care we know you want to be able to give to our patients.

Please know that I and the senior nursing team are working hard to support you the best we can during this time. We are looking out for you, advocating for you and ensuring that the nursing, midwifery and AHP voice is heard loud and clear in all our discussions and decision making.

I urge you to talk regularly with your peers and teams and access the suite of support services available to you at our Trust. Please also continue to raise any issues or concerns through the usual routes of your line manager, senior team or myself. If you don't feel comfortable to raise your concerns to your team members, you can also access the freedom speak up guardians who can be contacted anonymously via email at FreedomToSpeakUp.Mailbox@wsh.nhs.uk

I would also like to reassure you that the Chief Nursing Officers for the UK and regulatory bodies, including the NMC and HCPC, have released statements of support to say that that the context of care provided will be considered if concerns are raised. Links to these statements can be found below.

https://www.nmc.org.uk/news/news-and-updates/a-joint-letter-from-the-cnos-and-nmc-to-directors-of-nursing-across-the-uk/

https://www.hcpc-uk.org/news-and-events/news/2021/joint-statement-from-chief-executives-of-statutory-regulators-of-health-and-social-care-professionals/

Once again thank you. I am humbled and inspired by your continuing dedication to our professions and the patients that are within our care. While the near future is uncertain, I know that we will face it together with pragmatism, bravery and as a united team.

Best wishes,

Susan Wilkinson
Executive Chief Nurse

2.8. Quality and Learning Report

To Assure

Presented by Susan Wilkinson

Trust Open Board – 28 January 2022

Report Title:	Item 2.8 - Quality & learning report
Executive Lead:	Sue Wilkinson – Executive Chief Nurse
Report Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive summary

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from activities in the period since the last report. It includes the following sections.

1: Learning from incidents

1.1 Q2 thematic analysis of incidents

1.2 Reports approved since last meeting

2: Quality & Safety dashboard

Update

3: National patient safety updates

(*one or more from: PSIRF, patient safety syllabus, 'learning from patient safety events' incident reporting system, patient safety specialists workplan, patient safety partners. Further information on all of these subjects can be found on NHS England's patient safety webpage https://www.england.nhs.uk/patient-safety/)*

3.1 Patient safety syllabus

3.2 Patient safety partners

4: Learning from other sources:

(one or more from: LfD, staff, external, claims, patient & public)

4.1 Learning from deaths

4.2 Patient and public feedback

5: Theme

(one or more from: HSIB and other national best practice reports, clinical audit and QI, external quality assurance visits, 'Greatix' and a focus on one (or more) subject(s) within the PSIRP).

The Maternity thematic review of stillbirths has been received and is being responded to (see Maternity paper). We continue to ensure that all external reports are reviewed and themes from these will be included in future iterations of this paper.

Action Required of the Board

Receive for information

1. Learning themes from incident investigations

1.1 Q2 thematic analysis of incidents

A detailed report providing a breakdown of the 'top six' (most commonly reported) incident categories was provided to the January Patient Quality and Safety Governance group. The findings of these quarterly thematic reviews will feed into and inform our PSIRF plan for next year and also help identify areas for further safety improvement work in the Trust.

A total of 2872 incidents were reported in Q2 July – Sept 2021 (compared to 2931 in Q1). The top six were similar to the previous quarter and remain similar in Q3 (analysis currently underway).

It is noted that 80% of incidents reported in Q2 resulted in no harm, this includes 'near miss' incidents, the reporting of which is an indicator of a good reporting culture as well as an opportunity to identify and address clinical risks before they give rise to future harm.

Pressure ulcers	645 ↑	Included in 2021/22 PSIRP
Falls	253 ↑	Included in 2021/22 PSIRP
Medication	230 ↓	Included in 2021/22 PSIRP (specifically relating to Diabetes / Insulin)
Clinical care & treatment	205 ↓	Included in 2021/22 PSIRP (specifically related to shared care and out of hours escalation)
Safeguarding	189 ↓	Not included in 2021/22 PSIRP WSFT uses Datix to record DoLS applications and safeguarding referrals to 'Customer First' which form the majority of this figure 95% (179/189) rather than concerns about safeguarding within WSFT care.
Discharge, transfer and follow-up	147 ↓	Included in 2021/22 PSIRP (specifically related to safe discharge)

↓↑ indicates number compare to Q1. Note: No specific inferences can be drawn through a comparison between just two time periods. The quarterly review process is developing an SPC model for future data review however this is not yet available for this report.

1.2 Reports approved since last meeting

Since the last Board report there have been 11 reports approved at panel (see table below). This included one Never Event report and five other PSIIs. The full PSII reports are provided as an appendix to the closed board paper *Serious Incidents, Claims, Red complaints, Inquests and other external reviews of WSFT cases*.

• WSH-IR-73072	Retained object post procedure (Never Event)
• WSH-IR-74596	Delay in treatment - resulting in sight loss
• WSH-IR-75608	Adverse drug reaction (to ferinject)
• WSH-IR-74024	Delay in recognition of deterioration
• WSH-IR-74406	Failure to escalate deteriorating patient during night shift
• WSH-IR-76717	Fall resulting in major fracture
• WSH-IR-76076	Fall resulting in major fracture
• WSH-IR 73525	Long delay for patient to be admitted from ED.
• WSH-IR 69882	Inappropriate discharge of patient on sliding scale (insulin) to residential home
• WSH-IR 77595	Fall resulting in major fracture
• WSH-IR 72348	Failure to escalate deteriorating patient

Safety recommendations from PSIIs will be aggregated with other investigations and linked with appropriate improvement work/projects. The Action Oversight Group will be responsible for overseeing the follow-up of all the safety recommendations, either as standalone or via the specialist groups reporting frameworks in the new 3i committee structure.

2. Quality & Safety dashboard

(*being developed – this will include key KPIs and quality measures in future*)

The Insight committee (who are overseeing this project) received an update in January and referred it to Improvement and Involvement for their information. Discussion took place at Improvement in January of the importance of ensuring the availability of relevant indicators to support the ward / clinical area accreditation process and the specialist committee 'insight' reporting.

3. National patient safety updates

3.1 Patient safety syllabus

Health Education England, in partnership with NHS England and NHS Improvement, The Academy of Medical Royal Colleges and eLearning for healthcare published new patient safety training materials on the 27th October which can be accessed via the elearning for healthcare hub.

The training has been devised following the publication of the NHS Patient Safety Strategy. The syllabus sets out a new approach to patient safety emphasising a proactive approach to identifying risks to safe care while also including systems thinking and human factors, all of which has been incorporated into the training. Levels three to five of the training are expected to be available by the end of March 2022.

The training has five levels, which build on each other, the first two levels '*Essentials for patient safety'* and '*Access to practice'* are now available. Level one is the starting point and all NHS staff, including those in non-patient facing roles are encouraged to complete it. It also contains an additional element *Essentials of patient safety for boards and senior leadership teams*	This leadership element includes sections on: • Human, organisational and financial costs of patient safety • Benefits of a framework for governance in patient safety • Understanding the need for proactive safety management and a focus on risk in addition to past harm • Key factors in leadership for patient safety • Harmful effects of safety incidents on staff at all levels

3.2 Patient safety partners

The Trust is collaborating with partners across the ICS to agree a system approach to patient safety partner (PSP) development. Whilst each organisation agrees that locally recruited PSPs is the best approach, we are keen to ensure there is some standardised ICS central training, resource sharing where possible/appropriate, and a network for PSPs to share good practice and learning. The ICS will ensure local policies relating to PSP activity, payment and recruitment are aligned.

Focusing more specifically on WSFT, the patient safety and experience teams are working together to develop the PSP role over 2022-23. National guidance will be followed and the PSPs will feed into safety structures and committees, whilst also acting as link members to the Trust's patient VOICE group. Plans are underway to explore how existing VOICE members and other patients/relatives can become involved with safety activities, with a view to later developing these activities into the set PSP roles in early 2023.

4. Learning from other sources

4.1 Learning from Deaths (LfD)

The LfD bulletins are available to all staff on the intranet

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

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

	Deaths	Deaths with an SJR* completed	SJRs classified as Poor / Very poor care	Deaths judged as >50% preventable**
Jan21-Mar21	346	61 (197 for SJR)	8	0
Apr21-Jun21	202	27 (69 for SJR)	5	0
Jul21-Sep21	215	18 (59 for SJR)	6	0
Oct21-Dec21	297	4 (95 for SJR)	2	0

** SJR - Structured Judgement Review **National reporting requirement*

There is ongoing discussion relating to preventable deaths and how / where this data is captured and reported with the change to PSIRF. A review of data on preventable deaths (using other trust's quality accounts) obtained some limited benchmarking data (below) which is now being considered within a wider review of the Learning from Deaths reporting programme. The information was found from a review of trust's annual reports (quality accounts) available online. It should be noted that this did not include any definition of how the judgement was made for each trust.

Trust	**2019/20**	**2020/21**
WSFT	9/1056 = 0.85%	2/1074 = 0.19%
CUH	21/1524 = 1.37%	31/1585 = 1.95%
ESNEFT	= 0.6%	= 2.9%
Kings Lynn	1/1095 = 0.09%	19/1241 1.53%
N&N	18/3675 (2410 in hospital) = 0.49%	No data available
JPH	1/1142 = 0.08%	1/1132 = 0.88%
Hinchinbrook	10/2048 = 0.48%	10/2289 = 0.38%

4.2 Patient and public feedback

30 complaints were responded to in Q2 in total. 5 were deemed to be upheld and 13 were deemed to be partially upheld at the time of producing this report. Actions from these are set out in the table overleaf.

The complaint process enables feedback to staff and/or personal reflection however these are not listed as actions in the tables provided.

The Patient Experience team work closely with the Patient safety team to ensure any incidents of concerns identified through complaints are captured and recorded and collaborate to produce timely feedback on investigations to the complainants.

Ref.	Issues identified	Actions and learning
1974	Patient complains that they were administered the wrong medication during a spinal anaesthesia for an elective caesarean section. They states that the amount of morphine given to them contained 10x the amount it should have	Improvements in communication at the time of requesting the drugs so that there is absolute clarity as to which preparation is required, for example “morphine suitable for intrathecal use” Improvements in the process for checking the drugs prior to administration as part of the spinal procedure. As well as drug name, concentration and expiry date the route should also be confirmed i.e. “morphine 1mg/ml for intrathecal use” Revisit actions as listed in initial Supply Disruption Alert published February 2020 to ensure trust is meeting these. Continue to raise awareness amongst multidisciplinary team of supply issue with diamorphine and alternatives in case of lack of availability. Ensure shortages of diamorphine on day communicated through huddles and team brief. Recirculate Clinical Guideline” Peri-operative management of patients receiving intrathecal morphine – when diamorphine is unavailable “to all relevant staff. Timely completion of risk assessments for national drug supply issues to identify and mitigate potential risks
1977	Patient complains about their treatment during labour. Particularly that they suffered seizures and that they are unable to remember the birth of their child. They also raise concerns that their pain was not managed effectively and that they have bruises on her arms due to their cannula and staff taking bloods.	Detailed discussion with Anaesthetist regarding analgesia should be offered to all women on PET Protocol. Epidural to be strongly recommended to women undergoing Induction of Labour on PET Protocol with unstable BP. Continue Labetalol Intravenous Infusion should be commenced if Blood pressure remains unstable despite Magnesium Sulphate Infusion. Depart Summary sent to GP on the day of mother’s discharge contained limited and inaccurate information. In complex clinical circumstances the GP Depart Summary should be written by Obstetric Team. The mother reported multiple concerns regarding the care she received. A follow up appointment with a Consultant Obstetrician and Consultant Anaesthetist will be arranged to discuss these further. Where possible personal valuables should be given to patient’s relatives for safe keeping, and if this is not possible Patient’s Property Guideline is available on Intranet to advise on an alternative safe storage.
2019	Patient's spouse complains that their partner did not receive anything to eat or drink until they visited on the ward. They also complain that their partner has not been reviewed by a doctor over the weekend.	Case used as a learning example of how and why maintaining intake and fluid charts is so important and the importance of ensuring relatives receive communication of treatment plan at all times
1980	Patient's spouse raises concerns about partner ‘s care and treatment over three admissions. States that spouse’s seizures were misdiagnosed and that this led to a failure in preventing and treating multiple strokes. Further complains that staff refused to carry out an MRI scan.	Ensure slings and hoists are appropriately measured and information (on ‘nil by mouth’ status) is updated on patients’ bed boards
1910	Patient's spouse raises concerns that during an ERCP procedure a foreign body was found from a previous procedure	Investigation shared widely across Trust so other specialities can explore whether checking the tip of any device prior to use should become standard practice. Endoscopy team clarify and confirm MHRA reporting practice for consumable items within the Endoscopy Unit team and ensure a guide on how to do this is easily available. Share MHRA reporting with the wider Trust via the staff briefing.
2022	Patient complains that when they attend for a blood test staff always struggle to take blood.	Guidance received from CUH on their technique to reduce pain to withdraw blood sample from patient’s specific port
1997	Patient complains about treatment during and after birth of their baby. Patient feels that they were given incorrect information about size of baby which led to induction and an emergency c-section.	Midwifery staff reminded that side rooms without working call bells should not be used, information regarding feeding support or advise is clear, and to encourage patients to raise any concerns or questions prior to discharge.. Additional training in relation to postnatal care and wound care as part of their annual mandatory training.
2009	Patient complains about gynaecological care and treatment. States they have not been given clear information about their treatment and they also raise concerns about the attitude of a staff member.	Patient information leaflet for Zoladex and its side effects is being constructed for future use.

Ref.	Issues identified	Actions and learning
2004	Patient complains that they attended day surgery unit for a procedure and was informed when they arrived that the procedure could not take place as filler was not available.	Apologies were given for lack of timely communication and future treatment plans clarified Operational review of how the Trust can obtain filler for future patients
2015	Patient's spouse raises concerns that partner did not receive appropriate treatment in the ED as they tested positive for Covid-19 and staff focused on this and not that patient had been hit by a car.	Junior and middle grade doctors have been reminded to decide whether a full body scan is required for trauma patients
1991	Complainant is concerned about the care and treatment of partner during labour specifically as wasn't examined prior to being told to start pushing when last examination was 3cm. Further concerns have been raised in regards to the delay and lack of pain relief.	All midwives have been reminded to ensure cannulas are being checked regularly.
2028	Patient raises concerns that errors were made when carrying out the pre-natal testing to check the blood type of their unborn child.	More robust system for patients attending antenatal unit for non-routine blood tests including booking email / message. Patients to be sent group + screen form to bring to appointment so staff aware why patients attending. Consultant happy to meet with patient to discuss concerns further if she feels this would be beneficial. Staff will contact patient in to arrange a further blood test and appropriate follow-up.
1998	Patient had recent procedure which resulted in a swab being left inside them. This has since been removed however patient has had a number of infections following this and has been on various antibiotics to try and clear the infections.	Undertake additional swab count for procedures involving an orifice where there is a risk of bleeding Current theatre swab count policy requires updating to reflect swab counts for gynaecology/urology and other procedures involving an orifice
1994	Patient complains about the care and treatment they received after experiencing a miscarriage. patient also complains about the professionalism of the consultant giving the bad news and how they acted when assessing them.	Acknowledgement that clear communication and understanding during a difficult time like a miscarriage is very important.
1985	Patient's relative complains about poor communications regarding their relative's telephone consultations. Also states that when family contacted the department to enquire as to why the consultations had not gone ahead as planned the member of staff that they spoke with was very rude.	Need for patients to be discharged from stroke unit rather than transferred to DWA, staff on stroke unit will aim to provide patients with a stroke passport as early as possible in their admission, not waiting until the day of discharge. Importance of communication with patients' relatives to ensure they will be home or that a key is available when patients are discharged. Capacity for therapists working in the community is currently undergoing a review.
2017	Patient's relative complains about a lack of communication during relative's admission. Experienced difficulty obtaining information about their parent's care. Also raises concerns about the care and treatment provided and believes that this has limited their parent's recovery.	District nurses have been reminded about the importance of completing care plans. District nurses to communicate more clearly the different responsibilities of carers and nurses.
2001	Patient complains about care and treatment during labour. She feels that they were not appropriately supported throughout their labour. Patient also upset that their spouse was not able to be with them during there time on F11.	Case used as a learning example during huddles and monthly team meetings
2021	Patient's relative complains about the manner of the consultant during their relative's appointment.	Reassurances given that feedback has been reflected on for learning and to improve services for future patients.

2.9. Involvement Committee Report - January 2021 - None to report

To Assure

Presented by Alan Rose

2.10. People & OD highlight report

To Assure

Presented by Jeremy Over

Board of Directors – 28 January 2022

Report Title:	Item 2.10 - People & OD Highlight Report
Executive Lead:	Jeremy Over, Executive Director of Workforce & Communications
Report Prepared by:	Members of the Workforce & Communications directorate
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive Summary

The People & OD highlight report was established during 2020-21 as a regular 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, alongside the escalation reports from Involvement Committee, to reflect 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
- Implementing mandatory vaccination (vaccination as a condition of deployment)
- Developing West Suffolk's approach as a flexible employer
- Appraisal and mandatory training quarterly report
- Consultant appointments

Action Required of the Board

For discussion and noting

Risk and assurance:	Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.
Equality, Diversity and Inclusion:	The work described around mandatory vaccination will include an assessment of the impact on minority groups and by protected characteristic.
Sustainability:	Staff retention.
Legal and regulatory context	Certain themes within the scope of this report may relate to legislation such as the Equality Act, and regulations such as freedom to speak up / protected disclosures.

Putting You First – January award

Volunteer gardeners: Trevor Webber, Sue Feather and Barbara Bradshaw
Nominated by Val Dutton, voluntary services manager

I would like to nominate our volunteer gardeners at West Suffolk for the incredible work they have done in transforming our hospital courtyards back into pleasant areas.

The courtyards had become very overgrown during the lockdown as the volunteers weren't able to come in.

Our three volunteers have worked so hard to clear them back and even plant winter bedding plants in some to make nicer areas for our staff and patients to use.

We have received lovely comments from the breast care and physio managers who are so grateful for the work the volunteers have done in sorting out their courtyard.

Vaccination as a condition of deployment (VCoD) – mandatory staff vaccination within healthcare settings in England

The Department of Health and Social Care (DHSC) has formally announced (9 November) that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care.

The government regulations will come into effect from 1 April 2022. This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April 2022 deadline.

Detailed implementation guidance has been issued which defines the scope of the requirement as follows:

"Workers who have face-to-face contact with patients and/or service users and who are deployed as part of CQC regulated activity."

A multi-disciplinary implementation group has been formed and is taking forward this work, which includes staff representation. This is supported by detailed and robust guidance at a national level, which is still forthcoming. Whilst we have a high vaccination rate at West Suffolk there will be a number of staff who have not yet taken up the vaccination. Furthermore, the scope of the guidance ("workers") means that others – agency staff, students, volunteers for example), are also in scope.

The Board will be briefed verbally on the very latest position. Priority areas of work for January have been:

- Data analysis and verification of all staff's vaccination status
- Staff briefing and Q&A sessions
- Agreement of a detailed 'scope' definition for West Suffolk
- Engagement with the wider system around potential redeployment opportunities
- Drafting of line manager guidance to support 1-1 conversations

Timescales remain challenging, and there is a significant risk that this requirement will impact on staff availability, recruitment and retention, both at West Suffolk and across the NHS in England.

"Flex for the Future" – becoming an ever more flexible employer

Supporting the commitments made in the NHS People Plan for England around moving to flexibility by default, contractual changes came into effect on 13 September 2021 and the new Section 33 of the NHS terms and conditions of service handbook (balancing work and personal life) providing the right from day one to request flexible working, no limit on the number of applications and regardless of the reasons for a request. The Trust has updated our flexible working policy to reflect these changes and is committed to promoting flexibility options at the point of recruitment and through regular staff engagement through one-to-ones, appraisals and team discussions. A mechanism for organisational oversight and review of decision making has been introduced to ensure greater consistence of access to flexible working and a revised structure at divisional level aimed at supporting managers to be more explorative in reaching mutually workable outcomes.

To support the NHS People Promise: '*we work flexibly'*, and to help us at WSFT to better embrace and embed flexible working, we have joined a new NHS programme, called **Flex for the Future (Flex).** The aim of the programme is to draw on the collective knowledge and experience of other NHS providers across the country who are successfully implementing flexible working practices. It will provide a step-by-step programme to support us to create our own local plan to deliver more flexible working opportunities in all roles. The programme which started in September 2022 runs over a six-month period up to March 2022.

The WSFT Flex project change team:

Juliette Maguire – HR business partner (project lead)
Dan Spooner – Deputy chief nurse
Sarah Turner – HR business partner
Rebecca Rutterford – wellbeing and inclusion manager
Dr Katherine Rowe – Consultant Anaesthetist (ITU)
Kirsty Hammond – Senior HR advisor
Paul Pearson – WSFT staff side chair
Laura Wilkes – knowledge and library services manager/Unison representative

Jeremy Over, Executive Director of workforce and communications and Richard Davies, Non-Executive Director (and Well-being Guardian) are project sponsors.

We know flexible working is going to be a key enabler for us to attract and retain talent to the Trust; allowing colleagues to balance commitments and interests outside work, supporting their health and wellbeing and ultimately leading to a more positive experience of work and the workplace and improved staff engagement. We also know that it can be challenging to support different requests fairly and consistently in a 24-7 service environment. However, we are committed to ensuring that we have policies and practices to support and promote a positive work/life balance and give colleagues a greater choice and control of where, when and how they work.

A key aim of the Flex team is to move WSFT from an organisation that *'accommodates flexible working requests when they are made'* to one that '*openly supports, encourages and celebrates flex*' and we support the design of working arrangements that are right for WSFT and are effective in balancing the needs of colleagues and their work life balance, with the

patient/service needs and the user experience. We recognise that the balance and solution may look and feel different services and roles within the trust depending on these factors.

Following as a guide the NHS Flex for the Future model the flex change team have:

- undertaken initial data collection and analyse for WSFT and have reviewed and strengthened mechanisms for on-going data collection
- identifying areas for focus;
- and are in the process of developing an action plan for flexible working

To inform this and in recognition of the importance of supporting managers, and the need to understand from their perspective the challenges, barriers and opportunities to shape policies and working arrangements, a series of facilitated manager discussion groups are being run through February and March, with initial indication showing a high level of interest from across the organisation. Running alongside this will be an all staff short survey to ensure we fully understand colleagues' perspectives around what is important to them and what things might make the important difference to them.

A full copy of the agreed action plan will be available to be shared with the Board through the Involvement Committee when agreed.

Appraisal and mandatory training quarterly report

Mandatory training
Our mandatory training programme brings together the essential knowledge and skills that our teams must possess, as required by law, statute and / or wider NHS policy. Fundamentally it contributes to our number one priority as an organisation - safety: for patients, individual members of staff, and their colleagues, helping to demonstrate that we are up to date.

Overall mandatory training compliance in January 2022 was 89% (see appendix).
Compliance varies between divisions with Women and Children, Community and Clinical Support services at 93% well above the Trust target of 90%. All other divisions are below 90%. HR business partners continue to work with their divisions to support mandatory training compliance.

Compliance amongst staff groups varies. Work is underway to identify any ways in which compliance can be increased amongst those groups with lowest compliance and the greatest decrease since September 2021. These are students 69% and medical staff 76%.

In addition to the ongoing impact of social distancing reducing training capacity in the Education Centre all face-to-face mandatory training was cancelled for two weeks in October 2021 and no face-to-face mandatory training is being run in January due to operational pressures: decisions taken within the remit of our Covid-19 strategic group, which will inevitably have an impact on compliance. E-learning continues to be offered when it is an appropriate alternative.

Appraisal
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.

The overall trust appraisal compliance rate was 78% at the end of December 2021; a reduction of 1% since the last report to the Board and below the target compliance rate of 90%. Divisions continue to work against their agreed action plans and trajectories to reach compliance. Appraisal compliance is below the Trust target of 90% across all divisions. Details are provided in the appendix.

HR business partners continue to work with their divisions to support completion of appraisals but report significant challenges as a result of the significant operational and staffing pressures experienced over recent months.

Managers have been encouraged to undertake appraisals focussing on the importance of a supportive conversation to identify help needed, recognise achievements and set priorities rather than completion of paperwork. This approach was promoted to all staff at a staff briefing in November 2021.

Recent Consultant Appointments

Post:	Consultant Obstetrician & Gynaecologist (benign gynaecology)
Interview:	7 January 2022
Appointee:	Dr Nada Al-Shammari
Start date:	7 January 2022

Current post: Fixed-term Consultant: West Suffolk NHS FT
September 2020 to present

Previous Position:
October 2018 – September 2019
Consultant Gynaecologist, Cambridge University Hospitals

Divisional Appraisal Summary

Reporting date: 13/01/2022
Report period: 01/01/2021 - 31/12/2021
Prepared by: Workforce Information Team

NHS
West Suffolk
NHS Foundation Trust

Division	Total Assignments	Total Applicable Staff	Total Applicable Staff Expired	Total appraisals due within 3 months	Total New Starters	Total Maternity	Divisional Compliance Rate	Movement (on last month)	Trend (Rolling 12 months)
Clinical Support Division	626	530	96	89	81	15	81.89%	4.11%	
Community Division	968	810	148	138	131	27	81.73%	0.13%	
Corporate Services Division	459	382	132	71	64	13	65.45%	1.31%	
Estates & Facilities Division	427	393	62	92	32	2	84.22%	-1.17%	
Medical Division	1109	906	212	208	176	27	76.60%	0.35%	
Surgical Division	808	688	171	128	101	19	75.15%	0.92%	
Women and Child Division	356	291	59	56	53	12	79.73%	1.68%	
Trust total	**4753**	**4000**	**880**	**782**	**638**	**115**	**78.00%**	**0.93%**	

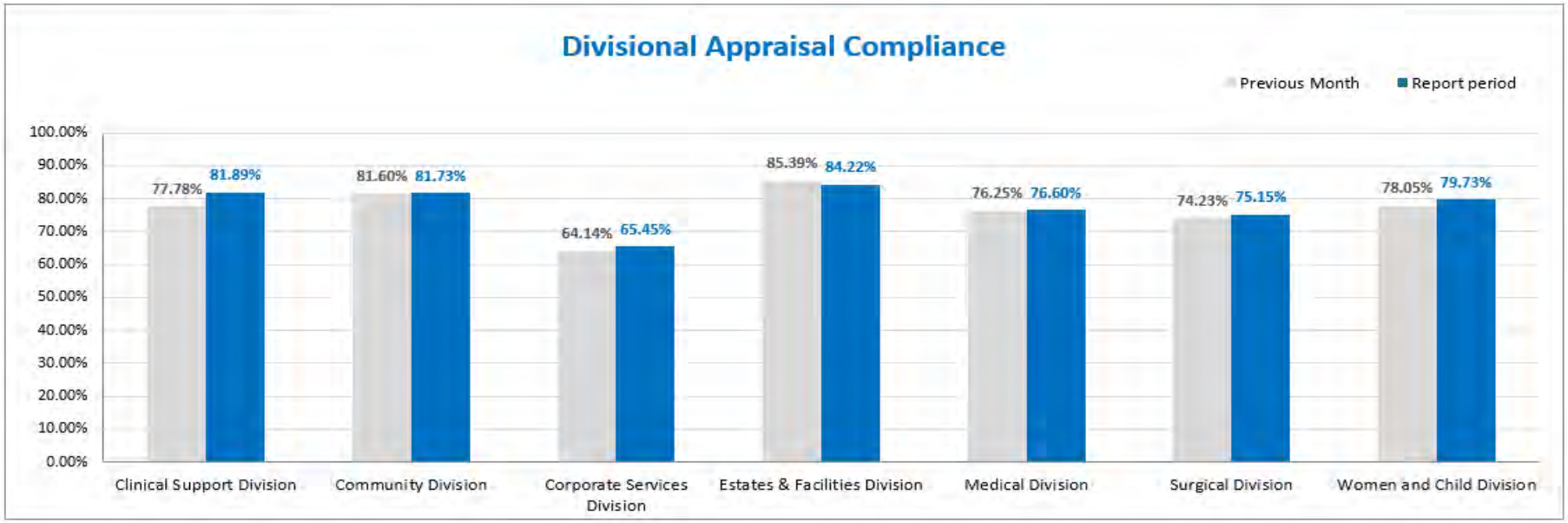

Table 2: Trust and divisional mandatory training analyses January 2022

Division	September 2021 % compliance	January 2022 % compliance	Red-rated subjects (less than 70%)	Change from September report %
Overall	90	89	Freedom to speak up (see below)	-1%
Clinical Support	94	93	MHNC (61%), Safeguarding Children Level 3 (50% n=2)	-1%
Community	93	93	BPT (54%)	No change
Corporate Services	88	89	MHC (0% n=2), CR (44%), Safeguarding Children Level 3 (0% n=2)	+1%
Estates & facilities	92	89	CR (13%)	-3%
Medicine	88	86	Safeguarding Children Level 3 (66%)	-2%
Surgery	89	87	MHC (64%)	-2%
Women and Children	91	93	None	+2%

Key: CR = conflict resolution; MHNC = manual handling non-clinical; MHC = manual handling clinical; BLS = basic life support; BPT = blood products and transfusion

Table 3: staff group mandatory training analysis

	July-21 % compliance	Jan-22 % compliance	Change from July 2021 %
Add Prof Scientific and Technic	92	89	-3%
Additional Clinical Services	94	90	-4%
Administrative and Clerical	92	92	No change
Allied Health Professionals	96	94	-2%
Estates and Ancillary	90	87	-3%
Healthcare Scientists	98	97	-1%
Medical and Dental	81	76	-5%
Nursing and Midwifery Registered	93	91	-2%
Students	81	69%	-12%

Freedom to speak up training was introduced as mandatory for all staff in December 2021 and compliance data will be excluded from totals until July 2022 as including this new topic has a distorting effect on the overall compliance percentage. New requirements for some staff for moving and handling training are also excluded for the same reason. Overall progress with compliance for both of these subjects is given below.

Subject	December 2021	January 2022
Freedom to speak up – core training for all workers	7%	24%
Moving and handling clinical – level 2	n/a	94%

2.11. Charitable Funds Annual Report 2020/21

To Assure

Presented by Nick Macdonald

Trust Board – 28 January 2022

Report Title:	Item 2.11 – Charitable Funds annual report 2020/21
Executive Lead:	Nick Macdonald (Interim Executive Director of Resources)
Report Prepared by:	Liana Nicholson
Previously Considered by:	Audit Committee and Charitable Funds Committee

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive Summary
The 2020/21 Annual Report and Accounts for MyWish can be found attached. The Annual Report and Accounts were approved by the Charitable Funds Committee, and subsequently the Audit Committee, on 5 November 2021, subject to some final clearance points from the auditors. The document was subsequently signed by the Chair on 7 December and the auditors issued their opinion on 9 December 2021. The audit opinion issued was true and fair with no exceptions to report. The 2020/21 Annual Report and Accounts have been submitted to the Charity Commission, in line with the timetable for submission of 31 January 2022.
Action Required of the Board
None.

Legal and regulatory context	*The Charity is required to produce an Annual Report and Accounts in line with the Charity Commission regulations.*

My Wish Charity (Registration Number 1049223)

Annual Report 2020/21

My Wish Charity

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Foreword by the Chair of the Trustee of My Wish Charity (formerly West Suffolk Hospital Charity)

Welcome to our annual report for 2020/21. We are a Trustee body established as a separate legal identity from the West Suffolk NHS Foundation Trust ("The Trust") but work with them in partnership for the benefit of NHS patients and their families from West Suffolk and the surrounding area.

We exist to further improve the provision of high quality patient care throughout the Trust, focusing on the use of modern technology in areas not covered or fully supported by central NHS funds.

Key highlights of our year:

- **Launching our COVID Appeal to help support staff and patients.**
- **Offer staff extra training to enhance the service they provide.**
- **Launching our 25 Appeal to support a play specialist post.**

Your donations made this work possible and your future donations are key to our continued success.

This is my fifth report as Chair and I would like to thank the volunteers who fundraise and help us, my fellow board members, and the volunteers who work alongside the professional staff of the Trust.

I hope that like me you will be inspired by our plans. If you would like to donate, details about how to do this are set out at the end of this report. Please support us, as every pound donated counts.

Sheila Childerhouse **Date: 7 December 2021**

Chair

Who We Are

My Wish Charity is an independent registered charity (registered number 1049223). We exist to raise funds and receive donations for the benefit of the patients of West Suffolk NHS Foundation Trust. By securing donations, legacies and sponsorship, My Wish Charity can provide the 'icing on the cake' to make a real difference for the patients, their families and the staff who look after them.

Providing both acute and community care, the Trust is our key partner in fulfilling our charitable aims.

We would like you to support us in our crucial work, so please read on and let us tell you more about ourselves, what we do, what we have achieved and how we go about spending the money given to us.

Our mission

By raising new money and careful management of our existing funds, My Wish Charity is able to fund expenditure to seek to support the aims and objectives of West Suffolk NHS Foundation Trust and the organisations it works with 'To serve the patients and their families receiving services from the West Suffolk NHS Foundation Trust by funding facilities, equipment, training, education and to support associated healthcare and complimentary services for patients.'

Payments are made in accordance with charity law, our constitution and the wishes and directions of donors. In making payments, we endeavour to reflect the wishes of patients and staff by directing funds towards areas they tell us are most in need. During the year 2020/21, payments of £549k were made. Our future plans are to continue to raise our level of fundraising that will help us work with our NHS partner to transform the health prospects for patients in our community.

The directors of West Suffolk NHS Foundation Trust acting on behalf of the Corporate Trustee believe they have complied with their duty to have regard to the Charity Commission's public benefit guidance when exercising any powers or duties to which the guidance is relevant. This is demonstrated by our activities throughout the year

What we have achieved: highlights from the activities undertaken in the year

Our key aim is to serve the NHS patients of West Suffolk Hospital, Newmarket Hospital and the community services that West Suffolk NHS Foundation Trust provides for the public benefit. By working with the NHS we assist patients of every walk in life, irrespective of race, creed, ethnicity or personal or family financial circumstances. We put this aim into practice by helping the patients, their families and carers, and visitors to the hospital by:

- **Enhancing the care our partner hospital can offer through new equipment and building improvements to deliver better facilities**
- **Investment in people and in creating a caring environment for the patients receiving care, their families and visitors**
- **Providing direct support to patients by way of information, networking support, better facilities and occasional payments**.

We do this through a range of programmes funded by you, our generous donors. Highlights from the main programmes undertaken in the year are detailed below to give you a wider understanding of the difference we can make together to patients today and in the future.

During that last year, sadly we were overcome with Covid 19, we knew straight away that we needed to support our very overworked staff in the best ways possible. We set up our Covid 19 appeal and very quickly realised that our amazing community wanted to support this. Below are **some** examples of what we have been able to do with this support, we are also extremely grateful to everyone that went above and beyond not just by donating money.

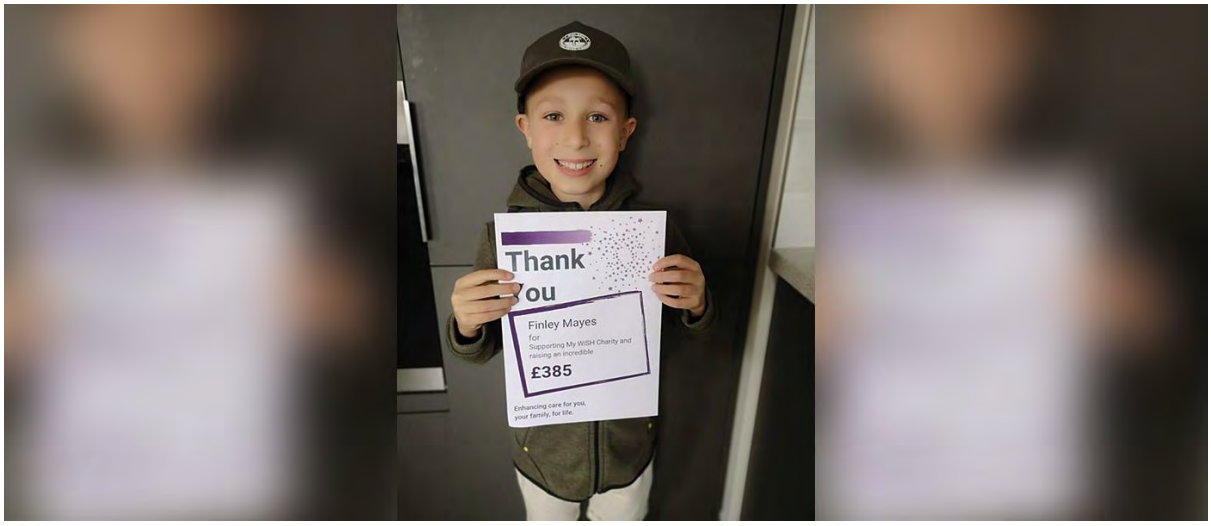
We have been able to fund the Trust to employ extra staff members;

- A psychologist for staff support
- An extra chaplain
- A play specialist
- A digital communication officer

Items for staff and patient wellbeing and support;

- Welfare packs
- Calm rooms
- Art supplies for isolated patients
- Digital devices for patients to contact their loved ones while isolating
- Marquees for staff so they can take a socially distanced rest
- Revamped counselling rooms for patients who were attending appointments alone
- Outside furniture for staff to take breaks
- Defibrillators for our community staff to carry around with them
- Exercise trackers for our cardiology patients so they could be treated remotely
- Tactile murals for our community paediatric waiting areas
- TV's for our side rooms for our isolating patients

The Charity once again has been extremely well-supported by our local community, and for this we are extremely grateful.



Young Finley Mayes made the best use of his time away from school during lockdown to raise money for charity.

The seven-year-old, who lives in Kedington, ran a mile a day in aid of the Help Your NHS Hospital Covid-19 appeal.

The appeal supports the work of the West Suffolk Hospital, and is aimed at supporting patients and also the staff at the hospital in Bury St Edmunds during the pandemic.

He said he and his mother Sophie, who works part time as a social worker at the hospital, thought it would be “a helpful job” to raise money to support the NHS after being inspired by the “Clap for Carers” campaign and because staff have been doing a “brilliant job” looking after people with Covid-19.

The Kedington Primary School pupil had an initial target of £100 but exceeded that by raising a total of £385.

Sophie said: “We ran a mile every day during May just before Finley went back to school the middle of this month.

“When we started doing the ‘Clap for Carers’ that kind of gave us the idea of raising money for the hospital.

She praised all the people who supported them and added: “It was also nice to get out and about and get some fresh air and doing something healthy during the lockdown.”

And Finley added: “The first few days were fairly easy but it got harder and harder.

“Some days I had to do it on my own (when his mother was at work) and I then had to run around the front of the house in our little garden area.

“I was running one day and I tripped over and fell and hurt my knees but I kept going and they are all better now. I just wanted to raise the money for the NHS.”

Josh Wright set himself a challenge which really tested his strength both physically and mentally.

The 26-year-old customer service manager ran a total of 13 half marathons in 13 days in a bid to raise money.

He originally set his fundraising target at £750 but smashed his target by far, his final figure was an incredible £1,779!

Raising money for the charity is nothing new for Josh as his previous escapade was running a half marathon with his dad, Leslie and holding a 24-hour gaming session with friends. These raised £1,283 for the appeal.

And he has also been involved with the Soapbox Challenge being part of the HS Direct team where he works from its site on the town’s Moreton Hall Estate, in Skyliner Way.

Josh said: “I did a half marathon last year at the Norwich Showground and I wanted to do a bit more this year so decided on the 13 in 13 days.”

“The 13 runs were all round Bury from my home and all different routes and I did them after I’d finished work as I’m now working from home,” he said.

Sally Daniels, appeal manager, said “Josh is such an inspirational fundraiser. He takes on these crazy challenges and just works so hard to raise money for us. We really are so grateful”.

Caring youngsters Ella and Cameron Fisher brought a ray of sunshine into the lives of NHS staff at the West Suffolk Hospital after making luxury goody bags.

They contained an array of items including soaps, snacks, water bottles, tea bags, notebooks, pens, chocolate treats, candles, cream tea vouchers, shower gel and hand cream.

And some of the bags even contained drawings by comedian Keith Lemon as he wanted to get involved after seeing what the pair were up to via their Instagram social networking site.

And Ella, who has just turned 13, and her 11-year-old brother, who live in King Edward VII Road, in Newmarket, have also had other celebrities and famous people backing them via their website including Davina McCall and Kym Marsh.

They initially set up the project after spotting the short supply of personal protection equipment for hospital workers.

The youngsters wanted to do more as a thank you to the amazing NHS staff and decided to make and fill shoeboxes containing surprise gifts. They contacted businesses who gave them a host of items to the children and they set up a fund to purchase items after people asked if they could donate money.

Soon the shoeboxes were filled so they turned to creating the bags and so far 350 have been given out with three hospitals benefiting from their efforts … Addenbrooke's, Newmarket and the West Suffolk, in Bury St Edmunds.

Their mother Emma said: "They said they wanted to support the NHS workers as a thank you and it just grew from there.

"The children are always looking for things to help raise money for charities and we have had a lot of dealings with the NHS and we are always grateful to them."

Friends and neighbours came out of their homes to watch five-year-old Olivia-Rose Lawrence walk past them on her way to raising over £1,300.

The five-year-old was gaily dressed in a robot costume and walked two miles round the Howard Estate, in Bury St Edmunds, during lockdown.

And the money she raised has gone to the My WiSH charity, which supports the work of the town's West Suffolk Hospital, and has been directed towards the WiSH Upon A Star appeal and the critical care unit.

Olivia-Rose, who is a pupil at the Guildhall Feoffment Community Primary School, came up with the idea for the fundraising initiative and took inspiration from Capt Sir Tom Moore who raised millions for NHS charities for walking laps of his garden.

Her father Tony, who ran three marathons in five weeks last year raising £1,000 for the hospital charity, said that his daughter came up with the idea and wanted to do something to support the West Suffolk and collected a total of £1,362.05 from her efforts.

His runs were in memory of his father Malcolm who was treated at the hospital back in 2017 and was also significant for his daughter's fundraising.

"She effectively walked round the block two times," he said. "And it was an impressive amount of money that she raised.

"She saw Capt Tom on the television and wanted to raise the money. She's a kind-hearted girl and wanted to do something similar for My WiSH. She was pleased and very excited when she finished."

The money came from family and friends plus a collection she made on the route round the estate as people came out to watch her.

Tony added: "There was a lot of people who came out and supported her and I am really proud of her and so happy that she wanted to do something."

Neil Baxter was a man on a mission during lockdown.

The photographer from Bury St Edmunds went out snapping iconic images of people and their families adjusting to the Covid-19 restriction with the clients donating money to charity.

He raised a total of £1,220 for My WiSH Charity, with the money directed towards the Help Your NHS Hospital Appeal, set up during the pandemic.

He visitied people mainly from in and around the town and including places in Stowupland, Rattlesden and Brandon and as far afield as Norwich, taking doorstep portraits and he particularly enjoyed visiting those families which got creative depicting their life during the pandemic.

Neil photographed one family where the daughter had embraced home baking, the son had barely got off his games console and the mum had enjoyed the odd tipple.

His first shoot was of a couple celebrating their seventh wedding anniversary – who he also photographed on their wedding day.

“I’ve loved taking pictures of those who want to tell their lockdown story, where they have taken a bad situation and embraced it,” said Neil. “I’ve had requests from all over for me to come and take doorstep pictures, even as far afield as Norwich.”

Neil asked for donations per shoot from clients with all proceeds going to My WiSH.

He said: “Once isolation kicked in it meant I was months staying in the house doing nothing and when people started doing the ‘Clap for Carers’ I saw a few other people raising money for the NHS and felt I wanted to do the something.

“I had seen a few other photographers taking pictures on people’s doorsteps and in years to come it could be a keepsake for them to help them tell their story of the pandemic. I thought that I could offer this doorstep scheme and people could donate whatever they think it’s worth.

“I must have done between 100 and 200 houses during that time. It’s something to say thank you to the NHS and every penny that they get helps, especially when there’s a global crisis going on. And it has got me out of the house.”

Sue Smith, head of fundraising, said “Neil has taken some amazing photos which have really captured family life during lock down. We can’t thank him, and all his models, enough for their support.”

The caring and life-saving work of staff on the Macmillan Unit at the West Suffolk Hospital, in Bury St Edmunds, is something that Tracey Feeney has much to be thankful for.

She ran an impressive 10k to raising funds for the department which potentially saved the life of her husband Gareth who had a rare blood disease called immune thrombocytopenic purpura (ITP) as her way of repaying the treatment he received.

She raised a huge £981 for the Macmillan unit at the hospital which is incredible as she had set her target at £500!

Tracey, who lives in Bury St Edmunds, said her 34-year-old husband was diagnosed with the complaint in July 2019 and has been receiving treatment since then.

ITP is a bleeding disorder in which the immune system destroys platelets, which are necessary for normal blood clotting.

People with the disease have too few platelets in the blood. The normal platelet count is between 150 and 400 thousand million platelets per litre of blood but at its worse Gareth’s count was at eight.

It meant he had a critical count at risk of internal bleeding or bleeding on the brain and when platelets get this low you must stay in hospital to be prepared for a transfusion if a bleed occurs.

Tracey said: “Gareth spent a lot of time in the West Suffolk Hospital and in particular the Macmillan Unit where he had countless appointments and tests with the haematologist doctors and nurses and countless phone calls and sudden hospital visits at all hours. They were always so friendly and helpful and just made the entire nightmare as easy and

comfortable as possible, despite the hours spent waiting for platelets to rise and test results. It kept on yo-yoing all the time.

“It is mostly due to these amazing people in an amazing unit why he is in remission and back to full(ish) health again although there has been a couple of times when he has felt unwell.

“Although in remission, it could come back at any time with a vengeance and regular appointments and tests are ongoing for the foreseeable future. The Macmillan ward at West Suffolk Hospital and the doctors and nurses working there potentially saved Gareth’s life.

“I want to give directly back to this unit and I know that no amount of money will ever be enough, but I believe the unit would greatly benefit from money raised and I’m hoping to try and raise as much as possible to show our gratitude.

“There was never a truer saying than every little penny counts, especially for a unit such as Macmillan. The pennies are potentially the difference between life and death.”

Golfers, donors, plus a series of fundraising initiatives helped to raise £10,000 to support the work of carers of dementia patients at the West Suffolk Hospital.

A Captains’ Charity Day, held at Stowmarket Golf Club, attracted 96 participants split into 24 teams of four, with each team paying £160; a total of £242 was made from a cake sale; while additional money came via a bottle on the bar at the clubhouse and an auction along with suppliers to the business of men’s captain Martin Anderson donating between £2,000 and £3,000 towards the fund.

Mr Anderson linked up with ladies’ captain Joan Hunter, and senior’s captain Ian Hay for the golf day which was held in July last year.

But the coronavirus pandemic delayed them handing over a cheque to the My WiSH Charity, which supports the work of the hospital, in Bury St Edmunds, with the money directed towards the Forget Me Not Dementia Appeal.

Mr Anderson, who was the club captain for 2019/2020, said they chose the appeal which was close to his heart as his mother suffered from the complaint and died in January 2017.

“I wanted to do something to raise money for the dementia campaign as my mother died from dementia and we all agreed to do it for the same charity,” he said. “And we only just got round to doing the presentation because of the coronavirus restrictions. Many thanks to the members and sponsors for their generosity and support throughout the year.”

The money raised will be used to buy a digital reminiscence machine (DGM) and fund music and art therapy sessions for patients.

The DGM is known as a RITA (Reminiscence Interactive Therapy Activities) and is like a television crossed with a tablet. It has a touch screen and allows patient to watch TV, play music, but also play games such as bingo. It helps calms the patient, reduces falls as they are less likely to get out of bed and wander and increase patient experience.

They cost £5,000 each and the money raised by the golf club will be used by the Keeping In Touch team who work with patients across the hospital, helping them to feel less isolated and keeping them connected with their loved ones.

Maggie Woodhouse, the dementia practitioner, said: “We have a monthly dementia audit across the hospital recording that 25% to 30% of our patients are affected by dementia, delirium or confusion so supporting these patients enables a better experience and better outcomes on discharge. This interactive equipment is aimed at patients who are anxious about the hospital environment and can be used to avoid agitated behaviour and to increase the patient experience, they can be personalised to the patient, using music pictures, films and activities.”

And Sally Daniels, My WiSH fundraising manager, added: “The amount raised by the golf club is just amazing and we can’t thank Martin, Joan and Ian enough for their support. As Maggie said, we have a large number of patients who will really benefit from using the equipment and also the therapy sessions. We are so proud to continue to support our Forget Me Not Dementia appeal to ensure that, not only is the hospital stay the best it can be, but that the experience is actually enriched.”

Jasmine Ackland has lost her long locks.

But it has all been worth it. For not only has 14ins of her hair gone to a good cause it has also helped to raise money for My WiSH Charity.

The 14-year-old got a new look and confused many of her school friends at the Mildenhall College Academy, some who struggled to recognise her.

For along with the enforced absence from the college due to Covid-19 and her short hairstyle she has taken on a totally new look.

She had it cut at the Creative Hair Salon, in Thetford, and at the same time has raised £357.50 thanks to the support of family and friends and teachers at the academy. The money has been directed to the Butterfly Appeal which is run by the charity.

Her mother Rachael, who is head of science at the college her daughter attends, said that it was difficult for her to have her hair cut as she has a “tic” but her hairdresser Stephanie Fenton was “very patient and understanding.”

Jasmine has mental health problems and has been treated at the hospital for her complaint which helped her also decide on raising money for My WiSH Charity.

Rachael said: “She did not want to do it for a big national charity but a local one.

“She has had her hair long all her life but she likes her short hair now. It was a shock when she went back to school as people could not recognise her as they had not seen her for six months. It was a major change for her and some people thought that she was transitioning into a boy.”

Jasmine also feels that cutting her hair has given her a fresh start.

Sally Daniels, fundraising manager, said “Jasmine looks great with her new cut. It’s fantastic to hear that her fundraising has not only benefited families across west Suffolk but has also been a real boost to her own self esteem.”

The generosity of members of a masonic lodge in Bury St Edmunds has helped to purchase devices to help and reassure patients having MRI scans.

They have come after Bob Rider attended the West Suffolk Hospital where he is being treated for cancer.

The charity steward of the Solea Masonic Lodge had an MRI scan and discovered that the department needed a new way to play music for patients having scans as their iPods were broken.

So Mr Rider approached his members for funds and they came forward and supplied two Amazon Fires, at a cost of £50 each, which will mean patients can choose music and also children will be able to play games while they wait.

He said: “I had an MRI scan and they asked me what music I would like. When I came out I asked one of the nurses what happened with the music as it wasn’t working. She explained that the iPods were broken and so I said I would see if I could do something. I went to the Lodge and we obtained the two devices.”

He said the 42 members of the Lodge have a charity fund and raise money which funded the Amazon Fires which were handed over the My WiSH Charity, which supports the work at the hospital, in Bury St Edmunds.

Claire Moore, the MRI superintendent at West Suffolk, said: “We are incredibly grateful for these devices. They will allow us to play music to patients, upload MRI safety apps and show children videos or cartoons designed to reassure.

“The thought of MRI is quite intimidating, we do all we can to reassure patients but offering our patients music is a focus for them. Feedback is always positive with statements such as ‘listening to ‘Mr Blue Sky’ helped take my mind off the scan.’ The patients leave feeling that the experience was not as bad as they had feared and music choice is always an ice breaker for our nervous patients.

“Thank you on behalf of staff in MRI and all patients who will benefit.”

Sally Daniels, fundraising manager, also thanked the Solea Lodge and added “As a charity, our aim is to provide the extras that the NHS cannot. Thanks to people like this we are able to do that and we can’t thank the Masons enough for their continued support.”

A couple from Cavenham cycled the equivalent of 300 miles to France in a bid to raise money for the bereavement and labour suites at the West Suffolk Hospital.

Molly and Jack Deal carried out the ride from their home on a static bike riding the distance from Bury St Edmunds to its French twin town of Compiegne.

And their bid to raise the money comes after their daughter was born prematurely at the hospital on New Year's Eve at just 16 weeks and six days.

Twenty-seven-year-old Molly, who is a sales executive at Treatt, said: "On the most difficult day of our lives, the midwives at West Suffolk Hospital gave us the most amazing support and kindness. To them they are just doing their jobs, but to us they are heroes.

"We named our daughter after one of the midwives who looked after us during our time in hospital.

"We were made to feel comfortable as possible on the labour ward and appreciated the personal space provided by the bereavement suite.

Molly and Jack, 31, who is an accountant, named their daughter Kendall and the couple want to recognise the very special care and attention they both received following their loss.

Molly added: "All the midwives were so caring as it was such an awful situation for us but they helped us to make it more bearable. They were just there for us and they were there for us until we went home.

"The support that we had we did not expect and we had a service for Kendall."

A campaign to fund the bereavement suite was set up by the My WiSH Charity which supports the work of the hospital and was opened in July 2018.

It provides a calm, comfortable space where families will be able to receive psychological and practical support following the loss of a baby.

Three rooms have been decorated and consist of the main bedroom, wet room and a kitchen/sitting room which is also used for counselling purposes.

Alex Badman, of Bury St Edmunds and who worked at RAF Mildenhall as operations flight deputy commander 100th Air Refuelling Wing for eight years, died in February this year of corona virus.

His daughter Katie described Alex as a loving father who always cared about children.

“His big white beard meant he was often asked to don a Father Christmas costume to hand out presents to local children in Bury St Edmunds, RAF Mildenhall and further afield,” she said.

A fund-raiser set up in his memory raised a staggering £9402!

Alex supported My Wish over several years before his death, including convincing a team from RAF Mildenhall to take part in one of the charity’s Soap Box Challenges.

The family’s connection to the charity meant they wanted to fund-raise for the #25 Appeal which supports the hospital with play therapist.

A play therapist is someone who is employed by the hospital to make visits for children more fun and less scary, in turn potentially preventing future hospital phobia.

Sally Daniels, fund-raising manager for My Wish, said the Badman family, including Jill, Alex’s wife, had been active in the charity in recent years.

“The Badman family have been great supporters of My WiSH Charity with both Jill and Alex supporting us over the years,” she said. “Alex was kind enough to share his extensive engineering knowledge with our soapbox teams back in 2019 and we know this was invaluable to everyone.

“The amount raised by the family just highlights what a special man Alex was so from all of us here at the charity we would like to express our sincere condolences and thank everyone for their donations.

“The difference the play specialist will make to our young patients means Alex is certainly leaving behind a legacy that will benefit our future generations.”

Six workmates from the Tesco store, in Newmarket, have helped to raise over £1,000 for one of the wards at the West Suffolk Hospital.

It came after one of their team at the store suffered a stroke back in July last year and was treated by staff on G8, the stroke ward of the hospital, in Bury St Edmunds.

George Carter, Luke Milner, Mark Masterton, Andrew Robertson, Connor Stanley and Louise Baron ran a half marathon last month.

They had initially set a target of £500 but the final result was double that amount with £1,070 being handed over to the My WiSH Charity.

The six, who all work in the backroom of the store dealing with the huge online shopping demand, decided to carry out the fundraising initiative after their colleague Mark Davy had the stroke. They wanted to raise the money for the ward as a way of thanking staff for the care they gave to the 31-year-old.

The run started from the store in Fordham Road and went via the High Street, past the stables and along Exning Road and back to the store.

George said: “We did not expect to get that much money but we were thrilled as Mark had had a tough time.

“It was out of the blue really, he had the stroke and lost the movement on his left side.

“Everyone did it in under three hours with one doing it in under two hours and two more just over the two-hour mark.

“We stayed together for the first 10k and we all had our own targets that we wanted to get to but it started chucking it down with rain towards the end of it.”

Mark was on the stroke ward for four-and-a-half weeks after losing the movement in his left arm and left leg.

He said: “I was out and about during the day and I stayed up a bit late but when I went to bed at about midnight it all started and the room started spinning. I had to bang on the wall to get attention from my dad who called the paramedics.

“All the nurses and staff at the hospital were brilliant along with the physios and I was determined to walk out of the hospital unaided.

“I am starting to walk a bit and try and walk every day between three and four miles and go to see the physios for two hours a week.”

He uses a SaeboFlex, which is a high-profile splint used to support and assist the movement of the hand and arm, and added: “My hamstring is still a bit weak but I am determined to get back to normal since day one and have had long-term goals.”

He paid thanks to his six workmates for carrying out the fundraising initiative.

How we funded our work, our achievements and performance

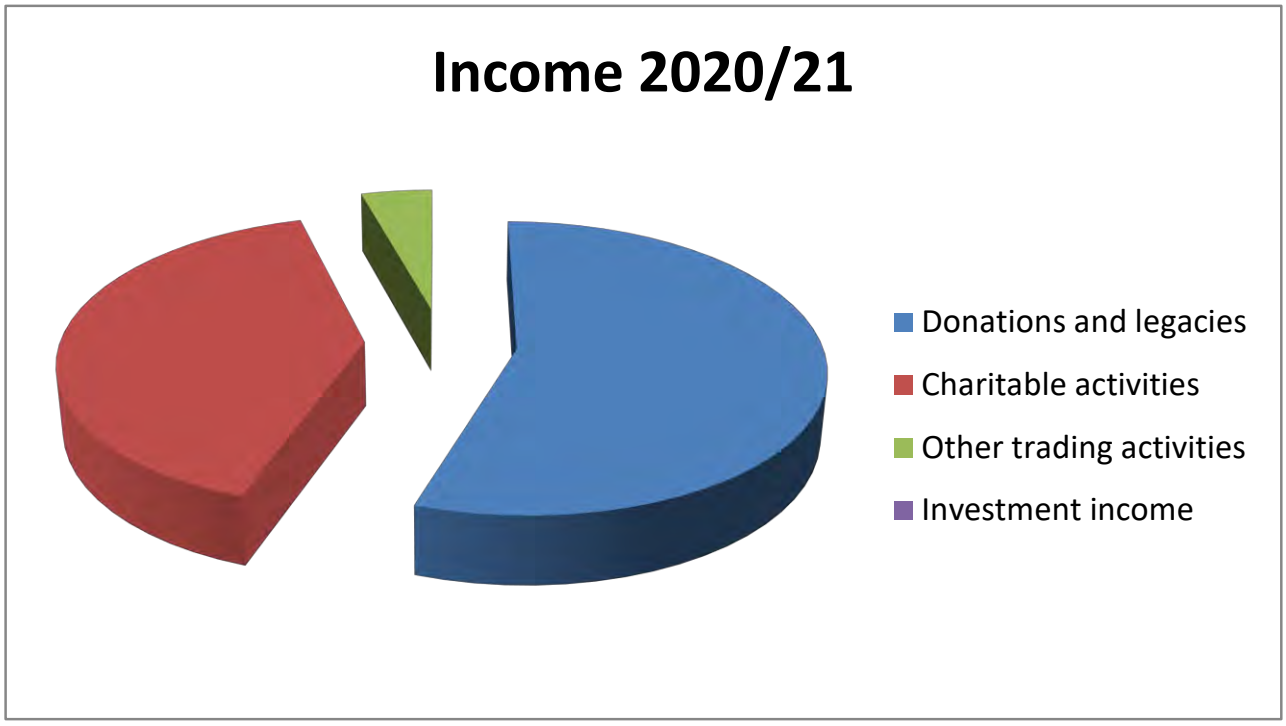
In this section we firstly explain how we raised the money and then how we spent it.

Money received: £695k ***Money spent: £549k***

My Wish Charity can only continue to support the work of the Trust for as long as we receive the money needed. Almost all of our income comes from the voluntary efforts of the general public. Overall, we ended the year with income exceeding expenditure by £107k before investment gains.

Money received: sources of funds

The pie chart shows our main sources of income. The largest is termed voluntary income and represents gifts and donations from the public.



Donations and legacies £375k – Our largest source of income is from the public and by local companies keen to support their local community:

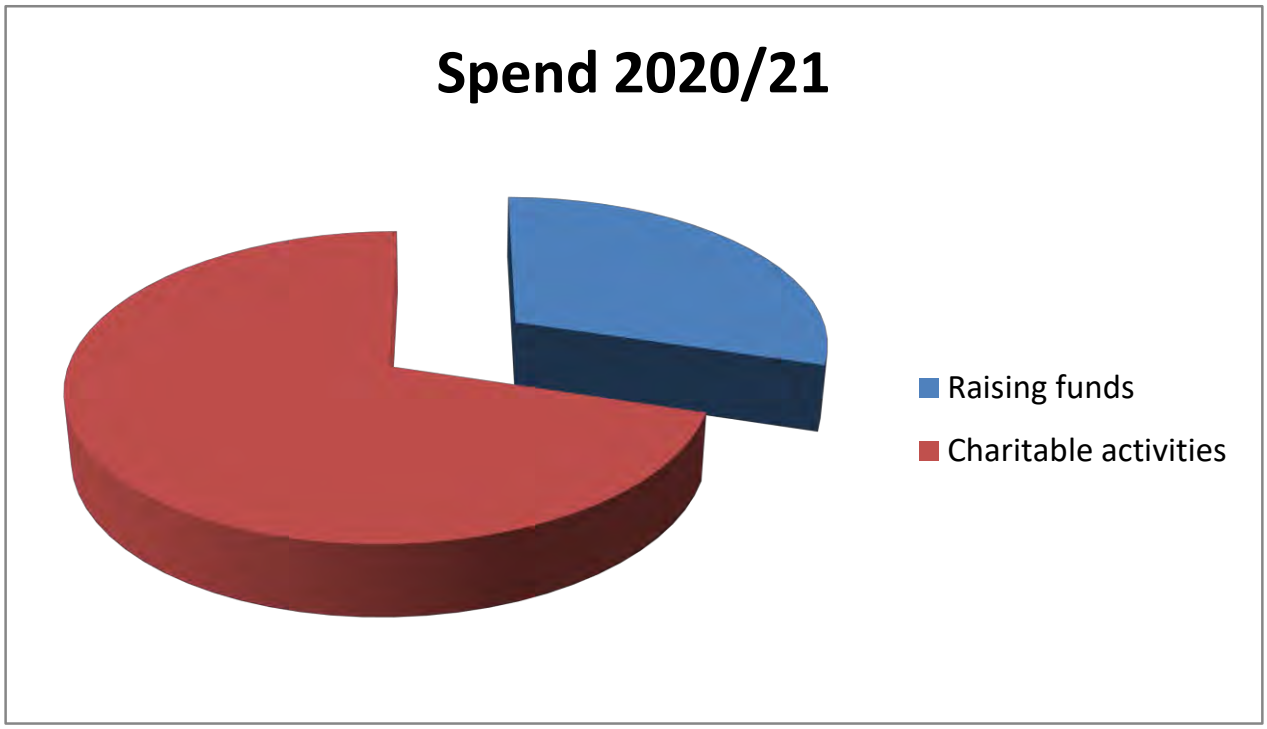
- **Gifts from the public £272k** – from a few pence in a collecting box to several hundred pounds from grateful relatives, we are fortunate to receive thousands of generous gifts each year towards our work.
- **Corporate Donations £31k** – many companies adopt charities as a way of putting something back into the community. My Wish Charity is grateful to the companies that have donated over the year and to their employees who have given their time and money to maximise the corporate support we receive.
- **Legacies £72k** – a gift in a will really is an investment in the future, and we are fortunate to be remembered by people each year.

Charitable activities £289k – the majority of this relates to grants received from the NHS Charities Together Charity

Other trading activities £31k – by supporting an existing event or organising one of their own with the knowledge and approval of the Trustee, thousands of people have had a good time whilst raising money for My Wish Charity. The Coronavirus pandemic has resulted in many fundraising events being cancelled and therefore the income is considerably down on previous years.

- **West Suffolk Hospital other organised fundraising £3k**
- **Course fee income £1k**
- **Third party fundraising £27k**

Money spent: what we spent the money on



Our charitable work was made up of five distinct areas. The costs shown below exclude attributable support costs as set out in note 9 to the accounts:

Clinical Care & Research Posts: The funds support a counsellor and a nurse within the Macmillan Unit a Clinical Psychologist in SCBU and a children's play specialist the cost of these staff was **£34k** in 2020/21.

New equipment: The NHS of course buys much of its own equipment for day to day use and has its own capital programme but NHS capital funds for large items of equipment are scarce. With advances in technology we can make a real difference in purchasing items. We spent **£159k** on new equipment. Examples of equipment purchased this year are:

- **Paxman scalp coolers**
- **Portascan 3D Scanner**
- **Sonosite Ultrasound System**
- **Surgery trolley and lift assist lithotome**

- **Lucas 3 Chest Compression System**
- **Clearway 2 cough assistor**

Adaptations to buildings: We spent **£37k** in 2020/21 on a number of minor capital projects including the refurbishment of the Lymphodema room and a drugs room.

Staff education and welfare: We spent **£78k** on a wide variety of training and educational courses for our staff.

Patient education and welfare: We spent **£43k** supporting education and the welfare of patients.

Performance against objectives

Spending the money is only part of the story because we are concerned to achieve value for money. To ensure the money is well spent applications for General Fund funding include questions about the objectives, impact and success criteria for the proposed project.

Our fundraising performance
Members of My Wish fundraising department organise fundraising events and co-ordinate the activities of our supporters both in the hospital and in the wider community on behalf of the Charity.

During the year the total donations, legacies and income from fundraising came to £695k compared to 2019/20 of £890k.

We benchmark our fundraising activity with our peers through the Association of NHS Charities and monitor the comparative success of campaigns and overall fundraising cost to income ratios. Compared to other NHS Trusts, although we have a low cost income ratio, there is the opportunity to increase the level of donations further.

Section 162a of the Charities Act 2011 requires charities to make a statement regarding fundraising activities. Although we do not undertake widespread fundraising from the general public, the legislation defines fund raising as “soliciting or otherwise procuring money or other property for charitable purposes.” Such amounts receivable are presented in our accounts as “voluntary income” and include legacies and grants.

In relation to the above we confirm that all solicitations are managed internally, without involvement of commercial participators or professional fund-raisers, or third parties. The day-to-day management of all income generation is delegated to the fundraising team, who are accountable to the Trustee.

The charity is not bound by any undertaking to be bound by any regulatory scheme; however the charity has voluntarily registered with the Fundraising Regulator and complies with the relevant codes of practice. We have received no complaints in relation to fundraising activities.

The Charity fundraises money from two main sources, the Fundraising Team at the Charity and members of the public who fundraise on behalf of the Charity. The Fundraising Team are all employed by West Suffolk NHS Foundation Trust and as such have to undergo mandatory training that includes Safeguarding Adults, Safeguarding Children, Equality and Diversity and Human Rights. The Fundraising Team is managed proactively through the management structure and their ultimate manager is the Executive Director of Workforce & Communications. It is impossible to apply the same rigour to members of public however the

Head of Fundraising works closely with members of the public to ensure that relevant guidelines and legislation is complied with.

What we plan to do with your donations: our future plans

We will achieve our mission by working with the NHS to develop the facilities to treat the community of West Suffolk. We will identify ways in which we can actively assist NHS staff to treat all patients to the best of their ability. We will also actively seek guidance from those staff members to any pieces of equipment that would enhance the care of patients, and their families. Our open invitation to the reader of our annual report and accounts is to join with us in our exciting mission of compassion for the community of West Suffolk by making a gift to secure the best care.

Our detailed plans are to:

- Complete the Butterfly Appeal
- Continue to engage with our community services and Newmarket hospital
- Continue to engage and develop relationships with the wider community
- Support the Hospital and community services in purchasing equipment and providing training in line with donor wishes

Your support makes these plans possible and to help us, please do consider making a donation.

How we manage the money

The Charity was entered on the Central Register of Charities on the 15 September 1995. The Charity is constituted of 89 individual funds (2019/20: 91) as at 31 March 2021 and the notes to the accounts distinguish the types of fund held and disclose separately all material funds.

Charitable funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service & Community Care Act 1990 and these funds are held on trust by the corporate body.

Our payment making policy

All payments are normally made from the Charity – these funds comprise two elements:

- Unrestricted funds contain funds where the donor has not expressed any specific conditions for which the donation must be used.

- Restricted funds (which contain donations where a particular part of the Hospital or activity was nominated by the donor at the time their donation was made) are managed by nominated charity fund-holders who are responsible for the day to day running of the funds. Delegated powers of authority are in place. However, the ultimate responsibility for all such funds remains with the Corporate Trustee. Reviews are undertaken by the Charitable Funds Committee of the Charity's funds and actions are taken as required.

Exceptionally, transfers may be made from the reserves to finance grant supported projects which would otherwise be delayed due to a shortage of unrestricted funds. This discretion is only exercised where there is a significant on-going benefit and the projects are considered to be a high priority.

Our reserves policy

The Trustee's reserves policy is to expend unrestricted income within a reasonable period of time in furtherance of the charitable objects. Under normal circumstances, a period of one year is considered to be reasonable; therefore the Charity would be expected to hold reserves approximately equal to average annual unrestricted income. The average is determined over a three year reference period.

As at 31 March 2021 the unrestricted reserves held was £316k. This compares to an expected average annual unrestricted income of approximately £174k. The main reason for the high level of reserves is due to a combination of a high level of investment gains and a reduced level of unrestricted income. The Trustee believes that the level of reserves is sufficient.

Our financial health: a strong balance sheet

The assets and liabilities of My Wish Charity as at 31 March 2021 are stated below, compared with the position at 31 March 2020.

	31 March 2021	31 March 2020
	£'000	£'000
Fixed Assets	2	4
Fixed Asset investments	1,592	1,143
Total Current Assets	895	919
Creditors falling due within one year	(97)	(102)
Total Net Assets	**2,392**	**1,964**
Income Funds		
Restricted	2,076	1,714
Unrestricted Income Funds:		
Our reserve: 'general fund'	316	250
Total Funds	**2,392**	**1,964**

A few helpful definitions:

Net current assets represent cash held on deposit less the value of accruals (money owed to others for expenses chargeable to the year) and outstanding liabilities.

Creditors falling due within one year represent the balance of money owed within 12 months to suppliers of goods and services.

Restricted income funds represent money which is held by the Trustee which can only be used for specified purposes.

Unrestricted income funds are funds available to be spent within the objects of the Charity which can legally be spent wholly at the discretion of the Trustee. In practice, respecting the non-binding preferences expressed by donors, the Trustee has sub categorised the unrestricted income funds under two headings.

Our general fund represents those funds available for distribution by the Trustee at their discretion which have not been restricted or earmarked.

About investments

The Trustee continues to invest in a common investment fund - COIF Ethical Investment Fund managed by CCLA Investment Management ltd. During the financial year the Charity increased its investment with a further purchase of £167,000 of units in the same fund.

How we organise our affairs: reference and administrative details

The Charity

The Charitable Funds are registered with the Charity Commission under an **umbrella registration number My Wish Charity (formerly known as West Suffolk Hospital Charity)** and Other Related Charities – Register number 1049223 in accordance with the Charities Act 2011.

Related Charities:

West Suffolk Hospitals Trust Charitable Fund	1049223-1
The West Suffolk Hospital Charity	1049223-3
Sudbury Hospital Charity	1049223-2
Joyce Marno-Edwards Fund	1049223-4
West Suffolk Hospital Education Centre	1049223-5

The Trust Board devolved responsibility for the on-going management of funds to the Charitable Funds Committee which administers the funds on behalf of the Corporate Trustee.

The Committee meets at least three times a year. The Committee members are paid for their duties for the Trustee but do not receive any additional pay, emoluments or other financial benefit from the Charity. Whilst the Committee members are not paid for their time they can claim expenses, details of which are disclosed in the accounts.

The Charity's main fund has NHS wide objectives as follows: “The Trustee shall hold the trust fund upon trust to apply the income and, at their discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service.”

Strategic aims are:

- To manage and govern the fundraising programme in line with best practice to ensure funds are raised effectively, efficiently, ethically and economically
- Fundraising should be in accordance with the Ethical Fundraising Policy of West Suffolk NHS Foundation Trust and follow the Institute of Fundraising’s Codes of Fundraising Practice
- To increase the charitable income – fundraising and donations - raised by My Wish Charity. This will be through a comprehensive fundraising programme which ensures fundraising income is sustainable and regular
- To promote legacies in a responsible way
- To ensure all areas of the Hospital are aware of the work of My Wish Charity and how fundraising can help each and every aspect of the trust
- To encourage the appropriate spending of charitable funds by fundholders to enhance the experience of patients, visitors and staff throughout the Trust
- To engage and build strong relationships with partners, patients, carers, staff and other stakeholders

How to contact us

The Charity office and principal address of My Wish Charity is:

The Trust Fund Office
West Suffolk NHS Foundation Trust
Hardwick Lane
Bury St Edmunds
IP33 2QZ
☏ 01284 713237

For fundraising queries please contact:

The Head of Fundraising
My Wish Fundraising Office
Hardwick Lane
Bury St Edmunds
IP33 2QZ
☏ 01284 712952

Our Trustee

The West Suffolk NHS Foundation Trust is the Corporate Trustee of the Charity, governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011.

The Corporate Trustee is responsible for deciding policy and ensuring that it is implemented.

During 2020/21 the Trust Board consisted of:

Non-executive Directors

Sheila Childerhouse (Chair)	Appointed 1 January 2018 until 31 December 2020 reappointed 1 January 2021 until 31 December 2023
Gary Norgate	Appointed 1 September 2013 until 31 August 2016 Reappointed 1 September 2016 until 31 August 2019 Reappointed 1 September 2019 until 31 August 2020 Stepped down as NED on 31 May 2020
Alan Rose	Appointed 1 April 2017 until 31 March 2020. Reappointed 1 April 2020 until 31 March 2023
Richard Davies	Appointed 1 March 2017 until 28 February 2020 Reappointed 1 March until 28 February 2023
Angus Eaton	Appointed 1 January 2018 until 31 December 2020 Reappointed 1 January 2021 until 31 December 2023 Standing down with effect from 31 May 2021
Louisa Pepper	Appointed 1 September 2018 until 31 August 2021 Reappointed until 31 August 2024
David Wilkes	Appointed 31 July 2020 until 11 June 2021
Rosemary Mason (Associate)	Appointed 24 August 2020 until 22 June 2021

Directors

Stephen Dunn	Chief Executive – appointed 3 November 2014
Craig Black	Executive Director of Resources – appointed April 2011
Rowan Procter	Executive Chief Nurse – appointed 2 November 2015 left 21 June 2020
Nick Jenkins	Executive Medical Director – appointed 17 November 2016 left31 May 2021
Helen Beck	Executive Chief Operating officer – appointed 1 May 2017
Jeremy Over	Executive Director of Workforce and Communications – appointed November 2019
Susan Wilkinson	Executive Chief Nurse – appointed 1 June 2020

More details about the Trustees can be found in West Suffolk Hospital NHS Foundation Trust Annual Report.

The names of those people who served as agents for the Corporate Trustee on the Charitable Funds Committee, as permitted under regulation 16 of the NHS Trusts (membership and Procedures) regulations 1990 were as follows:

			2020/21 Attendance	**2019/20 Attendance**
Sheila Childerhouse	-	Chair	4 / 5	4 / 5
Stephen Dunn	-	Chief Executive	5 / 5	5 / 5
Gary Norgate	-	Non-Executive Director	1 / 1	5 / 5
Angus Eaton	-	Non-Executive Director	3 / 3	5 / 5
David Wilkes	-	Non-Executive Director	4 / 4	
Craig Black	-	Director of Resources	4 / 5	4 / 5
Helen Beck	-	Chief Operating Officer	5 / 5	4 / 5
Richard Davies	-	Non-Executive Director	0 / 3	
Louisa Pepper	-	Non-Executive Director	0 / 3	3 / 5
Jeremy Over	-	Director of Workforce and Communications	3 / 5	2 / 2

The Trustee is also assisted in their work by a number of professional advisors, as detailed below:

External auditors:
BDO LLP
55 Baker Street
London
W1U 7EU

Internal auditors:
RSM Risk Assurance Services LLP
Marlborough House
Victoria Road South
Chelmsford
Essex
CM1 1LN

Bankers:
National Westminster Bank
7 Cornhill
Bury St Edmunds
Suffolk
IP33 1BQ

Legal advisors:
Mills & Reeve
Francis House
112 Hills Road
Cambridge
CB2 1PH

Charity governance, structure and management arrangements

The Charity was established using the Special Purposes Charity model by issuing a Declaration of Trust dated 6 March 1997. The objects clause states: "For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by the West Suffolk Hospital".

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund and by designating funds the Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers and staff. Where funds have been received which have specific restrictions set by the donor, restricted funds are established.

The charitable funds available for spending are for staff and departments within the Trust's Directorate management structure. Each fund is managed by a designated fund holder.

The Charity has adopted the Institute of Chartered Secretaries and Administrators' guidance for an induction process for newly appointed members of the Trust Board and Charitable Funds Committee. This process currently includes information about the Charity, including the governing document, the Charitable Funds Committee Terms of Reference, Trustee's Annual Report and Accounts and information about trusteeship. An induction to the hospital and a guided tour of the beneficiary Trust's facilities and any other additional training that their roles may require is also available.

Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charity. The Committee is required to:

- Control, manage and monitor the use of the fund's resources
- Provide support, guidance and encouragement for all its income raising activities whilst managing and monitoring the receipt of all income

- Ensure that “best practice” is followed in the conduct of all its affairs fulfilling all of its legal responsibilities
- Ensure that any Investment Policy approved by the Trust Board as Corporate Trustee is adhered to and that performance is continually reviewed whilst being aware of ethical considerations
- Keep the Trust Board fully informed on the activity, performance and risks of the Charity.

The accounting records and the day-to-day administration of the funds are dealt with through the Charitable Trust Fund Accountant, located in the Finance Department, West Suffolk NHS Foundation Trust, Hardwick Lane, Bury St Edmunds, Suffolk, IP33 2QZ.

Trustee recruitment, appointment and induction

Non-Executive Members of the Trust Board are appointed by the Trust’s Council of Governors and Executive members of the Board are subject to recruitment by the Trust Board. Members of the Trust Board and Charitable Funds Committee are not individual Trustees under Charity Law but act as agents on behalf of the Corporate Trustee.

Key management personnel remuneration

The Chief Executive of the Trust, under a scheme of delegated authority approved by the Corporate Trustee, has day to day responsibility for the management of the Charity. The Charity operates with agreed operating procedures. These have been reviewed and updated during the financial year. The Trust Director of Resources is employed by West Suffolk NHS Foundation Trust.

The Charity does not directly employ any management or employees. Employees associated with fundraising and in an administrative capacity have an appropriate amount of their time recharged from the Trust to the Charity depending on the amount of time undertaking charitable duties.

The board members of the Corporate Trustee are paid by West Suffolk NHS Foundation Trust and receive no direct remuneration for the work that they undertake for the Charity.

Details of expenses of board members of the Corporate Trustee incurred on behalf of the Charity are disclosed in note 11 to the accounts.

The board members of the Corporate Trustee are required to disclose all relevant interests and register them with the Charity and withdraw from decisions where a conflict of interest arises. All related party transactions are disclosed in note 2 to the accounts.

Risk analysis

As part of the business planning exercise carried out during the year, the Trustee has considered the major risks to which My Wish Charity is exposed. It has reviewed systems and identified steps to mitigate those risks. Four major risks have been identified and arrangements have been put in place to mitigate those risks set out below:

- ***Future levels of income***

  My Wish Charity is reliant on donations to allow it to make payments to its NHS partner. If income falls then the Trust would not be able to make as many payments or enter into longer term commitments with the NHS body we support.

The Trustee mitigates the risk that income will fall by engaging with the Fundraising Department. That Department comprises dedicated fundraising experts who work with My Wish Charity to provide a co-ordinated approach to raising funds. Fundraising activity is regularly benchmarked against our peers and thorough reviews are undertaken after major campaigns and events to understand what worked well and how things could be done better.

- ***Impact of COVID19***

  The COVID19 pandemic has impacted in many ways. There is the potential for loss of income and a reduction in the value of investments.
  - The level of income (excluding legacies) has risen compared to 2019/20.
  - The impact of the pandemic resulted in a reduction in the value of investments but this reduction has been reversed and there was a significant gain in the investment during the year.

- ***Unforeseen changes in the operation of the NHS***

  The NHS is, by its very nature, subject to national changes in government policy as well as local politically driven decisions. The Trustee has identified this as a risk as it may mean initiatives or healthcare activities supported by My Wish Charity are no longer delivered in the local area. The Trustee regularly liaises with other NHS partners to understand the changes that they are facing at an early stage.

- ***Maintaining the reputation of the Charity***

  The Trustee is conscious of the importance of maintaining its reputation within the community.

Income and Expenditure

Income and expenditure is monitored by individual fund, on a monthly basis as part of the monthly balancing process. The Charitable Fund Accountant looks for anomalies which may indicate exposure to risk and if any are detected will bring them to the attention of the Audit Committee via the Assistant Director of Finance.

Wider networks

My Wish Charity is one of over 250 NHS linked charities in England and Wales who are eligible to join the NHS Charities Together (formally known as Association of NHS Charities). As a member charity, we have the opportunity to discuss matters of common concern and exchange information and experiences, join together with others to lobby government departments and others, and to participate in conferences and seminars that offer support and education for our staff and board members.

The charity has organisational membership with the Institute of Fundraising.

The charity became a voluntary member of the new Fundraising Regulator.

Related parties

My Wish Charity works closely with, and provides all of its funding to, the West Suffolk NHS Foundation Trust (the Trust). Transactions with The Trust are considered to be related party transactions which are disclosed within the financial statements accordingly.

Our relationship with the wider community

The ability of the Charity to continue its vital support for the West Suffolk Hospital is dependent on its ability to maintain and increase donations from the general public. The charity also continues to forge strong relationships with members of staff of the hospital without whose co-operation the ability to make an effective contribution would be much diminished.

Volunteers

The Trustee would like to pay tribute to:

- Our volunteers for their time, support, and commitment
- The members of staff who give of their time out of hours in support of the work on the committees, in developing ideas for charitable fundraising and expenditure with us to identify how we can help them care for the patients
- Our fundraisers who do so much to encourage others to enrich the lives of others through donations and fundraising activities.
- The Charity has a handful of regular volunteers that help out at events; their roles vary from car park duties to serving food and drink. We are indebted and extremely grateful to our volunteers as without them the charity could not run as efficiently as it does.
- Our ambassador Frankie Dettori has been incredibly supportive, and we are extremely grateful to him.

Having read all about us, please consider supporting the work of My Wish Charity

The challenge facing My Wish charity in the future is to maintain and grow our support so that we can continue to make a difference to West Suffolk Hospital, Newmarket Community hospital, and all the services they provide out in the community.

What could your gift buy?

- **£2** could buy a birthday cake for a patient spending their birthday in hospital away from their home.
- **£350** can provide 10 welcome home packs containing essentials for vulnerable patients going home to empty cupboards after a hospital stay.
- **£900** could pay for a therapist to have extra training to become competent in treating dysphagia (swallowing problems)
- **£1,000** could buy recliner chairs for patients who are having treatments
- **£2,000** could purchase an Automated External Defibrillator (AED) for a community staff.
- **£5,000** can buy a vein viewer machine, which locates veins easily taking any anxiety away from our young and vulnerable patients.
- **£8,000** could buy a chest compression system which delivers continuous compressions to a cardiac patient without the need of the care giver being hands on.
- **£20,000** can purchase a 3d scanner for our maternity patients.
- **£28,000** could buy a BK3500 ultrasound machine that can help detect cardiac arrest faster.
- **£50,000** could buy an Echo cardio machine.

If you have a larger gift in mind, please talk to us. We always have a number of major projects waiting funding.

If you would like to make a donation or support any of our fundraising activities, please give us a call on **01284 712952** or send an email to **fundraising@wsh.nhs.uk**.

Signed on behalf of the trustee:

Name: Sheila Childerhouse (Chair of Trustee)
Date: 7 December 2021

Statement of Trustees' responsibilities in respect of the Trustees' annual report and accounts

Trustee responsibilities

The Trustee is responsible for preparing the Annual report and the financial statements in accordance with applicable law and regulations.

Charity law requires the Trustee to prepare financial statements for each financial year in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards and applicable law). Under charity law the Trustee must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources, including the income and expenditure, of the charity for that period.

In preparing these financial statements, the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- make judgements and accounting estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The Trustee is responsible for keeping adequate accounting records that are sufficient to show and explain the charity's transactions and disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Statement as to disclosure to our auditors

In so far as the Trustee is aware at the time of approving our Trustee's annual report:

- there is no relevant information, being information needed by the auditor in connection with preparing their report, of which the auditor is unaware; and
- the Trustee has taken all steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Signed on behalf of the Corporate Trustee:

Sheila Childerhouse
Chair of West Suffolk NHS Foundation Trust, Corporate Trustee
7 December 2021

INDEPENDENT AUDITOR'S REPORT TO THE CORPORATE TRUSTEE OF MY WISH CHARITY

Opinion on the financial statements

We have audited the financial statements of My Wish Charity for the year ended 31 March 2021 which comprise the Statement of Financial Activities, the Balance Sheet, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland* (United Kingdom Generally Accepted Accounting Practice).

In our opinion, the financial statements:

- give a true and fair view of the state of the Charity's affairs as at 31 March 2021 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remain independent of the Charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Conclusions related to going concern

In auditing the financial statements, we have concluded that the Corporate Trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Corporate Trustee with respect to going concern are described in the relevant sections of this report.

Other information

The Corporate Trustee is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon. Our responsibility is to read the other information and, in doing so, consider whether the other information is materially

inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Matters on which we are required to report by exception

In the light of the knowledge and understanding of the Charity and its environment obtained in the course of the audit, we have not identified material misstatement in the Strategic report or the Trustee's report.

We have nothing to report in respect of the following matters in relation to which the Charities Act 2011 requires us to report to you if, in our opinion;

- adequate accounting records have not been kept by the Charity, or returns adequate for our audit have not been received from branches not visited by us; or
- the Charity's financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of the Corporate Trustee

As explained more fully in the Statement of Corporate Trustee's responsibilities, the Corporate Trustee is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Corporate Trustee determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Corporate Trustee is responsible for assessing the Charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trustees either intend to liquidate the Charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

We have been appointed as auditor under Section 149 of the Charities Act 2011 and report in accordance with the Act and relevant regulations made or having effect thereunder.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Extent to which the audit was capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Our procedures included the following:

- inquiring of management and those charged with governance, including obtaining and reviewing supporting documentation in respect of the Charity's and Corporate Trustee's policies and procedures relating to:
    - o identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - o detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - o the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations;
- discussing among the engagement team, regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, we identified potential for fraud in the following areas: revenue recognition, and posting of unusual journals;
- obtaining an understanding of the Charity's and Corporate Trustee's framework of authority as well as other legal and regulatory frameworks that the Charity and Corporate Trustee operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Charity. The key laws and regulations we considered in this context included the Charities Act 2011. Other relevant laws and regulations identified include, VAT legislation and PAYE legislation.

In addition to the above, our procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Charitable Funds Committee and the Board of the Corporate Trustee;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Our audit procedures were designed to respond to risks of material misstatement in the financial statements, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery, misrepresentations or through collusion. There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's ("FRC's") website at:

https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Use of our report

This report is made solely to the Corporate Trustee, as a body, in accordance with Chapter 3 of Part 16 of the Charities Act 2011. Our audit work has been undertaken so that we might state to the Charity and Corporate Trustee those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Charity and the Corporate Trustee as a body, for our audit work, for this report, or for the opinions we have formed.

DocuSigned by:
Rachel Brittain
945F22100B63425...

Rachel Brittain
For and on behalf of BDO LLP, statutory auditor
London, UK

9 December 2021

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

My Wish Charity Statement of Financial Activities for the year ended 31 March 2021

	Note	Unrestricted Funds 2020/21 £000	Restricted Funds 2020/21 £000	Total Funds 2020/21 £000	Unrestricted Funds 2019/20 £000	Restricted Funds 2019/20 £000	Total Funds 2019/20 £000
Income and endowments from:							
Donations and legacies	3	86	289	375	202	551	753
Charitable activities	4	14	275	289	3	36	39
Other trading activities	5	4	27	31	2	96	98
Investment income	7	0	0	0	0	1	1
Total Income		**104**	**591**	**695**	**207**	**684**	**891**
Expenditure on:							
Raising funds	8	29	134	163	19	129	148
Charitable activities	9						
Clinical Care and Research Posts		0	37	37	0	54	54
Purchase of New Equipment		30	145	175	100	234	334
New Building and Refurbishment		20	21	41	0	17	17
Staff Education and Welfare		(3)	89	86	29	91	120
Patient Education and Welfare		1	46	47	18	38	56
Total Expenditure		**77**	**472**	**549**	**166**	**563**	**729**
Net gains / (losses) on investments		39	243	282	0	0	0
Net income/(expenditure)		66	362	428	41	121	162
Gross transfer between funds	20	0	0	0	0	0	0
Net movements in funds		**66**	**362**	**428**	**41**	**121**	**162**
Reconciliation of Funds:							
Total funds brought forward		250	1,714	1,964	209	1,593	1,802
Total funds carried forward		**316**	**2,076**	**2,392**	**250**	**1,714**	**1,964**

All income and expenditure are derived from continuing activities.

The notes set out on pages 38 to 46 form part of these financial statements

My Wish Charity Balance Sheet
as at 31 March 2021

	Notes	Unrestricted Funds £000 31 March 2021	Restricted Funds £000 31 March 2021	Total Funds £000 31 March 2021	Unrestricted Funds £000 31 March 2020	Restricted Funds £000 31 March 2020	Total Funds £000 31 March 2020
Fixed Assets							
Intangible	14	0	2	2	0	4	4
Investments	15	333	1,259	1,592	275	868	1,143
Total Fixed Assets		**333**	**1,261**	**1,594**	**275**	**872**	**1,147**
Current Assets:							
Debtors	16	5	205	210	95	169	264
Cash at bank	17	2	683	685	(101)	756	655
Total Current (Liabilities) / Assets		**7**	**888**	**895**	**(6)**	**925**	**919**
Liabilities:							
Creditors falling due within one year	18	(24)	(73)	(97)	(19)	(83)	(102)
Net Current (Liabilities) / Assets		**(17)**	**815**	**798**	**(25)**	**842**	**817**
Total Assets less Current Liabilities		**316**	**2,076**	**2,392**	**250**	**1,714**	**1,964**
Net Assets		**316**	**2,076**	**2,392**	**250**	**1,714**	**1,964**
Charitable Funds	24						
Restricted income funds		0	2,076	2,076	0	1,714	1,714
Unrestricted income funds		316	0	316	250	0	250
Total Charitable Funds		**316**	**2,076**	**2,392**	**250**	**1,714**	**1,964**

The financial statements were approved and authorised for issue by the Corporate Trustee and were signed on its behalf on 7 December 2021

Signed:

Name: Sheila Childerhouse
Trustee

The notes set out on pages 38 to 46 form part of these financial statements

My Wish Charity Statement of Cashflow

Year Ending 31 March 2021

	Note	Total Funds 2020/21 £000	Total Funds 2019/20 £000
Cash flows from operating activities:			
Net cash provided by / (used in) operating activities	19	197	284
Cash flows from investing activities:			
Dividends, interest and rents from investments	7	0	1
Purchase of investments	15	(167)	0
Net cash provided by / (used in) investing activities		**(167)**	**1**
Change in cash and cash equivalents in the reporting period		30	285
Cash and cash equivalents at the beginning of the reporting period		655	370
Cash and cash equivalents at the end of the reporting period	17	**685**	**655**

The notes set out on pages 38 to 46 form part of these financial statements

1 Accounting Policies

[a] Basis of Preparation

The financial statements have been prepared under the historic cost convention.

The accounts (financial statements) have been prepared in accordance with the Charities Act 2011 and the Statement of Recommended Practice (FRS 102)' - "Charities SORP (FRS 102)" second edition, issued in October 2019, and applicable United Kingdom accounting standards.

The Trustee considers that there are no material uncertainties about the My Wish Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

The Trustee has considered the following areas in its assessment of the Charity being a going concern, operational capability, market-based demand and structural finance.

Operational capability - The Charity has reviewed its structure and has increased its administration and fundraising resources to ensure that the Charity can continue to fundraise and improve its administration function. The Charity considers resourcing at the Charitable Funds Committee.

Market based demand - The Charity has considered the fundraising environment particularly in light of the coronavirus pandemic. Initially income has risen following increased support for the NHS and the NHS charities together appeal. The Committee is aware that the new post covid environment may produce challenges but feel the Charity has sufficient resources to manage any downturn in income.

Structural finance - The Charity has in place a reserves policy to ensure the continued availability to fund ongoing expenditure. The Charity does not enter into significant long term expenditure commitments that would put pressure on cash balances. The most significant creditor is West Suffolk NHS Foundation Trust and this relates to reimbursement of incurred charitable funds expenditure. This means that should income reduce significantly expenditure can be cut maintaining the financial stability of the Charity.

The main risk of failure of the Charity is if income should cease for some unspecified reason. This is felt to be extremely remote as the Charity is well supported locally and any publicity around loss of income would generate local support. However, should there be a significant drop in income then the Charity has few ongoing expenses that cannot be ceased within an appropriate time period.

In future years, one of the key risks to the My Wish Charity is a fall in income from donations or investment income but the Trustee has arrangements in place to mitigate those risks (see the Risk analysis section of the Trustee Annual Report, page 28). In addition the Charity does not have ongoing contractual commitments that would impact on the going concern assumption.

[b] Funds

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. The charity has no endowment funds.

Those funds which are neither restricted nor endowment income funds, are unrestricted income funds which are sub analysed between designated (earmarked) funds where the Trustee have set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and unrestricted funds which are at the Trustee's discretion. The major funds held in each of these categories are disclosed in note 24.

[c] Income

All income is recognised once the Charity has entitlement to the resources, it is probable that the resources will be received and the monetary value of income can be measured with sufficient reliability.

[d] Income from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable; this will be once confirmation has been received from the representatives of the deceased's estate that:

- probate has been granted to pay the legacy; and
- all conditions attached to the legacy have been fulfilled or are within the charity's control.

Material legacies which have been notified but not recognised as income in the Statement of Financial Activities are disclosed in a separate note to the accounts with an estimate of the amount receivable (note 21).

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

[e] Expenditure and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of expenditure for which it was incurred.

[f] Allocation of support costs

Support costs are those costs that do not relate to a single activity. These include some staff costs, internal and external audit costs and IT support. Support costs have been apportioned between fundraising costs and charitable activities on the proportion of total spend.

Income from investments is allocated to funds twice a year based upon the balance of the funds held at the time of allocation.

[g] Fundraising costs

The costs of generating funds are those costs attributable to generating income for the Charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the Charity's objects. The costs of generating funds represent fund raising costs together with investment management fees. Fund raising costs included expenses for fund raising activities.

[h] Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the Charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 9.

[i] Governance costs

Governance costs are classified as support costs and have therefore been apportioned between fundraising activities and charitable activities. There is no effect on the total expenditure for 2019/20 or 2020/21.

[j] Intangible fixed assets

Valuation

Intangible fixed assets are non-monetary fixed assets that do not have physical substance but are identifiable and are controlled by the Charity through custody or legal rights. Intangible fixed assets include purchased intangible assets such as software licences. Although such assets lack physical substance they provide an ongoing benefit to the Charity. FRS102 requires that intangible fixed assets must be held at their historical cost. The residual value of intangible fixed assets is nil when calculating the charge for amortisation unless evidence exists to the contrary. The carrying value of intangible assets are reviewed for impairments in periods or changes in circumstances indicate the carrying value may not be recoverable.

Amortisation

Amortisation on intangible assets are charged as an expense to the relevant Statement of Financial Activities category reflecting the use of the asset. Intangible assets are amortised at rates calculated to write them down to estimated residual value on a straight line basis. The intangible assets relate to software and this has been amortised over seven years.

[k] Realised and Unrealised Gains and Losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated quarterly based on the change in market value in the quarter. These are apportioned to the funds based on the average fund balance for the quarter. Any realised gains and losses are apportioned to funds in accordance with the fund balances at the date of sale.

[l] Debtors

Debtors are amounts owed to the Charity. They are measured based on the recoverable amount.

[m] Cash and Cash Equivalents

Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in 90 day notice interest bearing savings accounts.

[n] Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt.

[o] Pensions

My Wish Charity has no direct employees. Staff costs incurred in connection with the Charity are recharged at cost by the Corporate Trustee, West Suffolk NHS Foundation Trust and include pensions costs. Employees are able to join the NHS Pension Scheme in accordance with its rules. The Charity is not an employer that accesses the pension scheme directly therefore further disclosure is not required.

2 Related party transactions

Individuals

Members of the Charitable Funds Committee are also non-executive and executive members of West Suffolk NHS Foundation Trust. The Trust is the main beneficiary of the Charity. The Charity has provided funds to The Trust for approved expenditure made on behalf of the Charity. This funding amounted to £549k (2019/20: £729k) of which there is a net creditor of £62k (2019/20: £91k) with the Trust. The expenditure is analysed in greater detail in notes 8 and 9. The Trust also recharges the Charity for members of staff who are directly involved with the Charity, the details of which are given in note 12.

None of the members of the West Suffolk NHS Foundation Trust board or parties related to them has undertaken any transactions with the Charity or received any benefit from the Charity in payment or kind. The Trustee received no honoraria or emoluments in the year. Expenses paid to the Trustee are disclosed in note 11.

The Trust makes a number of clerical and transaction staff available to the Charity, by agreement with the Trustee. These include:
- Fundraising, office and administrative staff at a cost of £173k (£157k in 2019/20)

3 Income from donations and legacies

	Unrestricted Funds 2020/21 £'000	Restricted Funds 2020/21 £'000	Total 2020/21 £'000	Total 2019/20 £'000
Donations from Individuals	72	200	272	286
Corporate Donations	2	29	31	27
Legacies	12	60	72	440
Total	86	289	375	753

Donations from individuals are gifts from members of the public, relatives of patients and staff. Gift Aid is recovered from individual donations if a declaration is signed.

4 Charitable activities

	Unrestricted Funds 2020/21 £'000	Restricted Funds 2020/21 £'000	Total 2020/21 £'000	Total 2019/20 £'000
Grant Income	7	246	253	0
Other income	7	29	36	39
Total	14	275	289	39

Grant income mainly relates to money received from the NHS Charities Together charity and is being spent on projects that relate to the Coronavirus pandemic.

5 Other trading activities

	Unrestricted Funds 2020/21 £'000	Restricted Funds 2020/21 £'000	Total 2020/21 £'000	Total 2019/20 £'000
Course fee income	1	0	1	4
West Suffolk Hospital other organised fundraising events	0	3	3	37
Third party fundraising	3	24	27	57
Total	4	27	31	98

6 Role of Volunteers

Like all charities My Wish Charity is reliant on a team of volunteers for our smooth running. Our volunteers perform two roles:

Fund advisors:- there are 92 West Suffolk NHS Foundation Trust staff who manage how the Charity's designated funds should be spent. These funds are designated (or earmarked) by the Trustee to be spent for a particular purpose or in a particular ward or department. Each fund advisor has delegated powers to spend the designated funds that they manage in accordance with the Trustee's wishes. The Trustee determines what each fund can be spent on and the amount that can be spent in a year. Fund advisors who spend more than £5,000 are required to report to Charitable Fund Committee setting out what they spent the money on.

Fundraisers: there are about 25 local volunteers who actively fundraise for the My Wish Charity by running events and the use of collections.
In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

7 Gross investment income

	Unrestricted Funds 2020/21 £'000	Restricted Funds 2020/21 £'000	Total 2020/21 £'000	Total 2019/20 £'000
Short term investments and deposits and cash on deposit	0	0	0	1
Total	0	0	0	1

8 Analysis of expenditure on raising funds

	Unrestricted Funds 2020/21 £'000	Restricted Funds 2020/21 £'000	Total 2020/21 £'000	Total 2019/20 £'000
Fundraising support costs	29	134	163	148
Total	29	134	163	148

9 Analysis of charitable expenditure

The Charity did not undertake any direct charitable activities on its own account during the year. All of the charitable expenditure was in the form of funding approved expenditure.

Expenditure was approved principally in favour West Suffolk NHS Foundation Trust to carry out activities that will benefit patients. The Charity reimbursed expenditure incurred by West Suffolk NHS Foundation Trust or its staff.

	Funded Activity Unrestricted 2020/21 £000	Funded Activity Restricted 2020/21 £000	Funded Activity Total 2020/21 £000	Support costs 2020/21 £000	Total 2020/21 £000	Total 2019/20 £000
Clinical Care & Research Posts	0	34	34	3	37	54
Purchase of New Equipment	27	132	159	16	175	334
New Building & Refurbishment	18	19	37	4	41	17
Staff Education & Welfare	(3)	81	78	8	86	120
Patient Education & Welfare	1	42	43	4	47	56
Total	43	308	351	35	386	581

10 Allocation of support costs and overheads

All support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are support costs which relate to the strategic and day to day management of a charity. The basis of allocation is the average monthly balance of each fund.

	Raising funds £000	Charitable activities £000	2021 Total £000	2020 Total £000
External audit (2019/20 figure includes an undercharge from 2018/19)	2	5	7	7
Governance	2	5	7	7
Amortisation	1	1	2	3
Computer maintenance	1	3	4	3
Salaries and related costs	10	25	35	28
Other	1	1	2	2
	15	35	50	43

	Unrestricted funds £000	Restricted funds £000	2021 Total £000	2020 Total £000
Raising funds	3	12	15	9
Charitable activities	5	30	35	34
	8	42	50	43

11 Trustee's remuneration, benefits and expenses

The board members of the Corporate Trustee receive no direct remuneration for the work that they undertake on behalf of the Charity. However, they can claim expenses to reimburse them for costs that they incur in fulfilling their duties. No board members claimed or were entitled to claim any expenses during the year (2019/20: £nil). Board members of the Corporate Trustee receive remuneration from The Corporate Trustee, West Suffolk NHS Foundation Trust, in accordance with their contracts of employment.

12 Analysis of staff costs and remuneration of key management personnel

The Charity does not directly employ any members of staff. However, the Funds are recharged by the Trust for employees providing support services to charitable activities as well as a clinical member of staff supported directly by an individual fund. Support employees were the Charitable Fund Accountant, Technical Accountant and members of the fundraising team. No employee had emoluments in excess of £60,000 (2019/20: £nil). My Wish Charity has no key management personnel (2019/20: £nil).

12a - Staff Costs and Employee Benefits

	2020/21 £000	2019/20 £000
Salaries and wages	169	159
Social Security Costs	14	18
Employers Pension Contribution	25	30
Total	208	207

12b - Employee numbers

Average Headcount	9.4	9.6
Average Full Time Headcount	3.9	4.0
Average Part Time Head Count	5.5	5.6
Average WTE	6.7	6.1
Number of Employees earning over £60,000 (excluding employer pension contributions)	Nil	Nil

13 Auditor's remuneration

The external auditor's remuneration of £6,978 including irrecoverable VAT (2019/20: £6,978) related solely to the audit of the financial statements with no other additional work undertaken by the external auditors (2019/20: none undertaken).

14 Intangible fixed assets

Software	2020/21	2019/20
Cost	**£000**	**£000**
At 1 April	17	17
At 31 March	17	17
Accumulated amortisation		
At 1 April	13	10
Provided during the year	2	3
At 31 March	15	13
Net book value		
Net book value at 31 March	**2**	**4**

15 Fixed asset investments

Movement in fixed asset investment	31 March 2021	31 March 2020
	Total	**Total**
	£000	**£000**
Market value brought forward	1,143	1,143
Add purchase of investment	167	0
Less net gain / (loss) on revaluation	282	0
Market value as at 31 March	**1,592**	**1,143**

The Charity investments are in the COIF Ethical Investment fund managed by CCLA. The valuation of the investment is based on the bid price at the year end date.

16 Analysis of current assets

Debtors due within one year	31 March 2021 Total £000	31 March 2020 Total £000
Other debtors	210	264
Total	**210**	**264**

17 Analysis of cash and cash equivalents

	31 March 2021 Total £000	31 March 2020 Total £000
Cash in Hand	685	655
	685	**655**

18 Analysis of current liabilities

Creditors due within one year	31 March 2021 Total £000	31 March 2020 Total £000
Trade Creditors	90	95
Other Accruals	7	7
Total	**97**	**102**

Creditors represent sums owed at the year end by the Charity. Of this amount £62k (2019/20: £91k) is owed to a related party, West Suffolk NHS Foundation Trust, for costs incurred by the Trust on behalf of the Charity in the furtherance of the Charity's objects.

19 Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2021 £000	2020 £000
Net income (as per the Statement of Financial Activities)	428	162
Adjustments for:		
Amortisation	2	3
Gain on investments	(282)	0
Dividends, interest and rents from investments	0	(1)
Decrease in debtors	54	211
(Decrease) / increase in creditors	(5)	(91)
Net cash provided by / (used in) operating activities	197	284

20 Transfer between funds

There were net transfers of £NIL (2019/20: £14) from restricted funds to unrestricted funds. These resulted from the closure of dormant

21 Material Legacies

Legacy income is only included in income where receipt is reasonably certain and the amount can be estimated with reasonable accuracy, or the legacy has been received. As at 31 March 2021 there were 2 legacies totalling £202,000 that had been notified but not received (2019/20: £264,000). These legacies have been included as income and as debtors.

22 Comparative figures

The comparative figures relate to the 12 month period between 1 April 2019 and 31 March 2020.

23 Post Balance Sheet Events

The Coronavirus pandemic has not had a detrimental impact on the charity since the year end.

24 Analysis of charitable funds

Name of Fund	Source of Fund	Purpose	Fund Balance 1 April 2020 £000	Income	Expenditure	(Loss) /gain on investments in year	Fund Balance 31 March 2021 £000
Macmillan Service	Donations	Patient and Staff welfare	554	101	(187)	68	536
Every Heart Matters	Donations	Patient and Staff welfare	21	1	(3)	3	22
BD Allen Fund	Legacy	Training for Nursing Staff	23	(1)	(17)	2	7
Scanner Appeal	Donations	Purchase of equipment	15	0	(1)	1	15
Oncology Service	Donations	Patient and Staff welfare	17	0	(2)	2	17
SCBU	Donations	Patient and Staff welfare	38	10	(16)	4	36
Paediatric and Childrens Ward	Donations	Patient and Staff welfare	27	4	(7)	4	28
Breast Cancer Fund (ex Lizzie Duncan)	Donations	Patient and Staff welfare	58	2	(6)	8	62
Microbiology	Donations	Patient and Staff welfare	21	1	(2)	2	22
Bereavement Room	Donations	Patient welfare	14	6	(2)	1	19
Mercury Dementia Appeal	Donations	Patient and Staff welfare	37	11	(13)	5	40
Ophthalmic Fund	Donations	Patient and Staff welfare	89	11	(5)	12	107
Cardiology	Donations	Patient and Staff welfare	28	8	(4)	4	36
Palliative Care	Donations	Patient and Staff welfare	279	36	(29)	39	325
Haematology research fund	Donations	Patient and Staff welfare	15	0	(2)	2	15
Stroke services	Donations	Patient and Staff welfare	16	0	(2)	2	16
Newmarket Radiology	Donations	Patient and Staff welfare	15	0	(1)	1	15
Newmarket Hospital	Donations	Patient and Staff welfare	77	16	(12)	10	91
Wish upon a Star	Donations	Patient and Staff welfare	21	16	(6)	3	34
Chemical Pathology	Donations	Patient and Staff welfare	39	5	(6)	5	43
Critical Care	Donations	Patient and Staff welfare	10	7	(1)	1	17
Phamacy Social Amenities	Donations	Patient and Staff welfare	14	2	(3)	2	15
Emergency Department	Donations	Patient and Staff welfare	11	10	(2)	1	20
Rheumatology	Donations	Patient and Staff welfare	50	0	(5)	6	51
Covid 19	Donations	Patient and Staff welfare	0	315	(93)	21	243
Other Restricted Funds			225	30	(45)	34	244
Total Restricted Funds			1,714	591	(472)	243	2,076
Unrestricted funds	Donations	Patient and Staff welfare	250	104	(77)	39	316
			1,964	695	(549)	282	2,392

These are the major funds referred to in Accounting policy note 1(b) the disclosure is based on fund previously disclosed in 2019/20 and funds with brought forward incurred during the year with balances greater than £15,000 and others where there were significant items of income and expenditure incurred during the year.

2.12. Integration Report - Q3

To Assure

Presented by Kate Vaughton and Clement Mawoyo

West Suffolk NHS Foundation Trust Board Meeting – 28th January 2022

Report Title:	Item 2.12 - West Suffolk Integration Update
Executive Lead:	Kate Vaughton, Director of Integration
Report Prepared by:	Jo Cowley, Senior Alliance Development Lead, WSCCG Sandie Robinson, Associate Director of Transformation, WSCCG Rebecca Jarvis, Deputy Director of Integration, WSCCG Clement Mawoyo, Director of Integrated Adult Health and Social Care, West Suffolk
Previously Considered by:	West Suffolk CCG Governing Body

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

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
Action Required of the Board
The Board are asked to note the progress being made on individual initiatives and collaborative working across the system.

Risk and assurance:	
Equality, Diversity and Inclusion:	
Sustainability:	
Legal and regulatory context	

West Suffolk Integration Update

West Suffolk NHS Foundation Trust Board Meeting

28th January 2022

1.0 Introduction

1.1. This paper provides a regular 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. The information is shown against our three ambitions

a. Empower people to live healthy connected lives
b. Ensure joined up accessible and responsive services
c. Create environments that enable people to thrive

1.3. A section on how the Alliance partnership is engaging with the Integrated Care System (ICS) transition plans is also included. Actions we are taking across the Alliance are set out in our Alliance Action Plan which is available from Jo Cowley (jo.cowley@westsuffolkccg.nhs.uk).

2.0 Empower people to live healthy connected lives

2.1. This section of the report covers information about digital innovations that are helping people to remain living at home, and able to manage long term conditions, as well as information about the growing partnerships that are being formed across the Alliance to encourage physical activity and support wellbeing.

2.2. **Pulse Oximetry at Home** – Pulse Oximetry at Home enhanced service was introduced in December 2020 to support the remote monitoring of patients with confirmed or possible COVID-19. Patients most at risk of poor outcomes were best identified by oxygen levels. The use of oximetry to monitor and identify 'silent hypoxia' and rapid patient deterioration at home was recommended to reduce hospital admissions. The Enhanced Service contract originally ran from December 2020 until 31 March 2021 and has been extended to support practices and patients over the winter months.

2.3. **WHZAN** – During the first phase of the pandemic WHZAN Blue Boxes were provided to all Care Homes in West Suffolk. The boxes contain observation equipment to record vital stats and a tablet. Care staff can take and record the observations of residents and GPs are able to access the data. Currently the kits are only being used in a small number of homes. We are in the process of revisiting the training and information provided at the launch and speaking to care home staff and GPs to see what support /training is required going forward to encourage use. Understanding the uptake, gaps and measuring the impact of this programme of are keys parts of this next phase of the roll out.

2.4. **Current Health Kits to be used in patients' homes** – Current Health Kits are used for individuals requiring care and support in their own homes. The kit is like WHZAN but can be operated by the individual themselves or their family carers. The individual wears a monitoring disc attached to a strap that they wear on their arm. The disc measures vital statistics and updates the individuals Current Health record directly via Bluetooth. Health professionals are then able to monitor the readings via a dashboard and respond appropriately to any concerning patterns. Additional training is currently being provided for staff regarding using the kits and discussions have started across the ICS concerning the potential of setting up a central hub that would review the dashboard 24/7 and action alerts /

appropriate responses as required. Currently around 8 kits are out at one time, it is anticipated that this will increase with the additional training provided.

2.5. **Support for mental wellbeing** – A collaborative partnership has been created between Suffolk MIND, the Norfolk and Suffolk Foundation Trust and Abbeycroft Leisure to test the impact of a place-based approach to enhance mental wellbeing. The aim is to work with people who experience challenges with their mental health and are deemed to have low risk and low complexity.

2.6. The aims of the pilot are to:

- Redivert demand on primary care and pressure on secondary mental health services
- Support the PCN workforce by jointly recruiting a Community Connector with NSFT and Abbeycroft
- Further develop effective working relationships with the VCSE, Mental Health and PCN workforce
- Think differently about the community health, care and wellbeing operating model
- Promote positive mental wellbeing.
- Capture data and insight

2.7. An additional enhancement to the approach will be achieved if the partnership is successful in a Dream Fund application. A short video that is part of their bid is available on You Tube here - https://youtu.be/q5FgJ6Ooct8. The video provides a 2-minute overview of some successful approaches that the partnership has used to increase wellbeing through physical activity.

2.8. **Wellbeing in West Suffolk**: There is a growing realisation that we need a shared vision and plan for wellbeing in West Suffolk across our Alliance partners and the key lines of enquiry have been agreed to support this, with a core team established, and project leads recruited.

2.9. The key lines of enquiry are:

- Better understand and support the voluntary and community sector
- Think differently about the role of Social Prescribing and how as a system we fund it
- Promote physical and social activity in tackling inequalities and living healthy and connected lives
- Keeping a focus on wellbeing in death and bereavement
- Creating a circle of support around an individual/family with and step up/down to Health and Care

3.0. Ensure joined up accessible and responsive services

3.1. **Vaccine programme in West Suffolk**: During December there was a coordinated plan to offer booster Covid-19 vaccinations to everyone aged 18 or over. Over 39 events were stood up with around 63,000 people vaccinated – 2,000 of these jabs were first doses. Clinics were run by pharmacies, GPs and the West Suffolk Hospital, as well as at the large vaccination centres in Newmarket and Bury St Edmunds. A roving model was established for care homes and housebound patients.

3.2. The whole system came together to provide the workforce to achieve this level of delivery, supported by local communities as well as non-clinical staff, friends and families.

3.3. In Newmarket we were able, once again to take advantage of our links with the racing industry and put on clinics at The Racing Centre. The charity, Racing Welfare, and other groups used local networks and social media to publicise walk in clinics for three days in December and January. The first two clinics were supported by the Suffolk Lowland Rescue team, and the final one by the local Tesco's Community Champion and some of the Tesco's staff.

Suffolk Lowland Rescue team helping out at a pop up event at Newmarket Racing Centre

Weekend walk-in Clinics run by Bury Town Primary Care Network

3.4. As part of our focus on inequalities our hospital vaccination team are now starting to offer a personalised service, where this is the only way for someone to receive their vaccination. The service is creating targeted advertising, aiming to reach people who have not yet come forward for their vaccination.

3.5. Working out of the Macmillan Unit at West Suffolk Hospital, which is quiet and calm, the team are providing time before and at the appointment to answer questions and address any issues for the person and their family or carer.

3.6. **Transformation initiatives: ROSI (Record Once Share Information)** – A pilot will run in the Bury Town Locality in January and February to introduce a digital record that will record a person's care plan and wishes regarding their end-of-life care. The digital record is in final developments stages, this includes a patient held application. A training package for use of ROSI will be developed which will include the wider topics around death and dying. Although a simple concept this has not been achieved before and could represent a significant improvement in the join up of services provided for people and their families at a very difficult time.

3.7. **Severe Mental Illness (SMI) Physical Health Checks** – Ensuring that people with a severe mental illness get regular health checks is a key preventative health and wellbeing measure for this group. GP practices have been working with the Norfolk and Suffolk Foundation Trust to ensure that there is an up-to-date record of the people who require a check.

3.8 The NSFT Clinical Lead has cleansed all SMI registers and has reduced list sizes by around 30% on average. This has ensured that patients who do not fit the clinical criteria for a serious mental illness or have been in remission for a significant period of time are no longer on the practice register. All System One practices have given NSFT Clinical Lead access to their clinical system and 15/18 System One practices have given the NSFT Clinical Skills Practitioner direct access; this allows the patient notes to be updated in real time and ensures all of the completed elements of the health check are recorded accurately.

3.9. In West Suffolk 20 out of 24 practices have given NSFT permission to undertake health checks of those patients on the SMI register who are currently under Secondary Care, with the remaining four trying to engage these patients first with a view to referring to NSFT where necessary. NSFT continue to take referrals for those patients under Primary Care who are difficult to engage within practice, this ensures that everybody who is entitled to a physical annual health check is offered one.

3.10. Suffolk User Forum have been commissioned to support patients with follow-up interventions identified via the physical health check referred by NSFT. A further £45k of funding has been allocated to this project, which will enable this intervention to be rolled across Primary Care. The referral form has been shared with practices and an update on progress will be noted in the next performance paper.

3.11. **Integrated Neighbourhood Teams (INTs)** – The programme to integrate community health and adult social care teams within our localities continues to progress. A detailed Operational Integration Programme has now been established with workstreams, risks and milestones identified. Clement Mawoyo, the Director of Integrated Adult Health and Social Care for West Suffolk, is providing the leadership for the programme, and a wide range of front-line managers, CCG and hospital colleagues are involved in taking forward this complex piece of work.

3.12. The headlines from the project in the last couple of months have included:

- Joint communications across community teams with monthly Team Talk newsletters and quarterly joint Team Talk Webinars & Q&As sessions started in November
- Integrated Management Structure has been proposed and consultation with affected staff has completed
- Boundary Review work revisited and now working on plans to implement proposals agreed by the Alliance (pre Covid) by April 2022
- Outputs from Maturity Matrix and the One Team Programme have been brought together and locality plans are now in place with another review of the Maturity Matrix planned to take place every 6 months.
- Occupational Therapy Integration Plan developed and underway – key developments include progress with a Peer review and Shadowing programme to increase learning, knowledge and identify key integration opportunities in this area
- Joint business planning has been initiated to develop an integrated community business plan for the west – workshops have involved alliance and system stakeholders to ensure connectivity

3.13. The One Team Leadership Programme final report is out. The programme included social care and community health staff along with GPs, colleagues from the hospital and the district councils. The final report is now out with collated messages from across the three cohorts. This work is being fed into the INT programme as detailed above and is contributing to the ICS transition programme. Some of the asks that came out of the programme were:

3.14. **Covid and surge pressures –** Partners within the Alliance continue to work together to build resilience and a collaborative response to the variation in demand both in our hospitals and in the community. Through the West Suffolk System Resilience Group meetings and the tactical cell calls, we aim to maintain local oversight, unite system to call to action, and inform plans going forward.

3.15. We have operationalised a system plan of high impact interventions to build resilience into high demand areas both within the acute and community system and alongside our social care partners who are critical in respect of their role within the care market.

3.16. **Improving our Urgent Community Response** – We have built in additional capacity to support in hospital admission avoidance:

- Increased access to medical and frailty nurse specialist support
- Invested in the enhanced INT offer to provide 24/7 wrap around support at home as part of the responsive model of care
- Improving utilisation of the social prescribing offer and have a planned recruitment within the Acute Assessment Unit to bring social prescribing to people earlier on their hospital stay

3.17. **Increasing the level of discharge capacity**

- Discharge to Assess community beds – our initial plan invested in an additional 30 care home beds but in recent weeks, in response to support the challenges in the home care market has peaked at over 100 (including designated settings)
- Newmarket Hospital – converted to provide a 33 bedded escalation ward for acute beds to mitigate the roof fail safe work
- Hospice support – invested in an additional two end of life specialist support beds
- Weekend discharges – invested in community and hospital teams to support 7-day discharges
- Patient transport – invested in additional transport capacity to support discharge
- Personal health budgets will be available as one-off payments to help people on pathway 0 to move home at least a day early from hospital

3.18. **Additional community nursing support 7 days a week**

- Invested in additional peripatetic nursing and support staff capacity to support growth in nursing demand

3.19. **Improving access to primary care**

- Extension of GP streaming hours
- Improving utilisation of GP plus
- Improving access to GP availability over weekends to avoid the peak demand on Mondays

3.20. **Increasing access to specialist End of Life support**

- Enhancing the 24/7 telephone advice line
- Working with GPs to ensure proactive prescribing of Just in Case medication
- Additional consultant sessions at WSFT

3.21. Within the community there is an additional emphasis on supporting people who are at risk of escalating need or who have been discharged from hospital. We have signed up to an additional 48 frontline positions and one data post to support the Multi-Disciplinary Team management of the rising risk and supported discharge cohorts. Evidence to date is showing these service users are benefiting from shorter future length of stays and admission preventions at the point of coming onto the caseloads.

3.22. Despite the significant investment in additional capacity, the level of demand on our local services has been unprecedented and without impact on our model of care and workforce.

Despite this we have seen an overwhelmingly resilient local response and we will reflect on the lessons we have learnt to inform recovery of our workforce and services.

4.0. Create environments that enable people to thrive

4.1. In this section of the report there are two examples of collaborative working which will help people to thrive.

4.2. **Supporting ex-rough sleepers in Bury St Edmunds** – An innovative project in West Suffolk has provided support for ex-rough sleepers. 11 units of accommodation have been set up through a partnership between West Suffolk Council and Sanctuary Housing, and a grant from the Next Steps Accommodation Programme for three years until 2024. Alongside this the CCG has worked with the Marginalised Vulnerable Adults (MVA) service, hosted by Essex University Partnership Trust, to provide personalised and coordinated healthcare provision as part of the wraparound service.

4.3. The primary focus of the MVA clinicians has been to carry out a full physical and mental health screening to create a plan for each client. This screening identified some significant health issues for clients including poorly managed diabetes and cardiovascular issues. These plans have ensured that we are able to measure successful outcomes agreed from the beginning of the care provision.

4.4. The healthcare support being provided is having a range of benefits for clients and the wider Suffolk system. Several of the clients are linking in with primary healthcare services in a way that they never have before, which is leading to improved management of medication. All clients have now registered with a GP. If a GP is unavailable, the MVA clinicians can provide advice, support, and signpost to relevant services to ensure that clients receive the care they need. There is now greater opportunity for easy access to support with both clients and MVA clinicians based at the same site. All agencies involved have been attending multi-disciplinary team meetings to review the needs of clients and this has proved valuable to ensure communication and consistency in the delivery of the wraparound care being offered. This model is working very well. The clients that are engaging can see the benefit of this support and feel safe in this environment.

4.5. With input from the clinicians, the clients are accessing several other healthcare services and referrals have been made to primary and secondary health services. Seven of the nine clients are now fully vaccinated against COVID-19. The remaining two have each had one dose and have declined the second. Hepatitis C and sexual health screening has also been planned. Approximately half of the clients are accessing dentistry that is provided on a bus that targets hard to reach groups.

4.6. The impact of the joint approach to healthcare has resulted in specific, positive outcomes for a number of the clients. This includes no evidence of insulin overdose for one client since receiving support, where previously this had been an ongoing risk. Another client is now engaging with support with a range of agencies around improved health, harm reduction and risk management which also means agencies can work together more effectively and reduce duplication.

4.7. We also know that clients are linking with Turning Point our addiction treatment provider and are having conversations about rehabilitation from drug and alcohol abuse. This is a significant step for some clients and something that would not have happened without the MVA clinicians being available to guide and support

4.8. Three case studies have been provided that show the impact for the people involved, and these are attached as **Appendix 1** to this report.

4.9. **Sustain our future – partnership with West Suffolk College:** West Suffolk College have been running a “call to action” with their students to mobilise people around key themes that all contribute to how we can collectively sustain our future. The key priorities are:

- Health – What makes us happy? Engaging the voice of young people in how health and care transform mental health
- Employment – A career in Health and Care: connecting young people to their community to start to build experience and interest in a career in Health and Care.
- Climate – Reducing emissions: engaging the voice of young people in how Anchor Institutions in West Suffolk can take action to tackle climate change

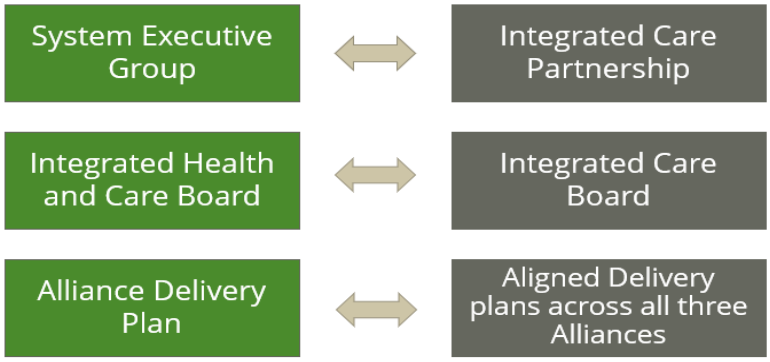
4.10. Students will be invited to a launch event to share initial ideas with a celebration event in the Summer 2022 to sign off the project and next steps.

5.0. Thriving Places – playing our part in the ICS transition

5.1. The NHS has nationally set out a road map to "*remove barriers to integrated care and create the conditions for local partnerships to thrive*". As part of this the three CCGs within The Suffolk and North East Essex ICS were due to close at the end of this financial year and the new statutory body of the ICS be created. This has however now been delayed until July 2022 to allow staff to focus on the national priorities of vaccinations and Covid response and recovery.

5.2. During November and December workshops were held at ICS level and within key Alliance meetings to explore the changes required as part of this move through the lens of place and locality. Partners have looked to promote our six localities as the buildings blocks of our system, driving the change from the ground up. The Alliance is supported in this work by two consultancies – Attain and Tricordant – with the help made available through the central ICS function. This work is ongoing.

5.3. Existing Alliance governance already aligns with the emerging ICS structure. The following diagram shows how the main collaborative forums map across to each other.



5.7. For further information about any of the initiatives described in this report please contact Jo Cowley (jo.cowley@westsuffolkccg.nhs.uk).

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 partnership working.

Appendix One – Client case studies

The following case studies relate to clients who have been accommodated through the Next Steps Accommodation Programme (NSAP) and provided with personalised healthcare through the Marginalised and Vulnerable Adults (MVA) service.

Case Study One (CS One)

Previous history: Before receiving support, CS One placed substantial demand on local services during periods of rough sleeping. In terms of healthcare, in the six months prior to entering supported accommodation at NSAP there were thirteen 111 calls, eight out of hours calls, and seven visits to accident and emergency. CS One would regularly overdose on insulin and be admitted to hospital, struggling to manage diabetes, drink very heavily and abuse prescription medication.

Current situation: CS One is now maintaining engagement with the personalised healthcare service. Since being accommodated and supported through NSAP from April 2021 there have been no insulin overdoses and a reduced demand on emergency services with three 111 calls, six out of hours calls, two visits to accident and emergency and one admission to hospital.

CS One has engaged with Turning Point to start addressing drug and alcohol abuse, has had a medical review and been supported to change their GP and start a prescription for anti-depressants. Health Outreach have maintained contact with CS One when away from the project and have incorporated regular visits to the NSAP accommodation, working alongside West Suffolk Rough Sleeper Service Navigators and Prevention Officers. MVA have provided vital support allowing informed decisions to be made promoting health and wellbeing. CS One is beginning to manage diabetes with ongoing input and is looking forward to starting a gym membership imminently.

Future plans: CS One has hopes of becoming a substance misuse support worker by utilising a wealth of lived experience. They now aspire to move on to sustainable independent living with support from MVA and West Suffolk Council's Rough Sleeper Service. They have rekindled an interest in music and opportunities are being explored for them to have a presence on YouTube.

Case Study Two (CS Two)

Previous history: CS Two has a history of rough sleeping before being accommodated through the government's everyone in initiative. They have previously been a significant user of public services including healthcare provisions, CS Two was at constant risk of misadventure as a result of chronic alcohol abuse. CS Two regularly visited accident and emergency and they suffered a broken arm falling on concrete stairs, fell in the local river twice and sustained a traumatic head injury due to another fall from height. Their vulnerability on the street resulted in regular attacks by other street drinkers.

Current situation: Since being accommodated and supported through NSAP from April 2021, support, often intensive, has been provided by Sanctuary Supported Living, MVA, and West Suffolk Council's Rough Sleeper Service including dedicated support from their Specialist Substance Misuse Worker. There has been a very substantial reduction in emergency healthcare demand to no 111 calls, no out of hours calls, and a relatively low five visits to accident and emergency, reducing from ten in the six months before receiving this support. The coordinated care now in place has reduced duplication across the system.

CS Two has re-engaged with Turning Point and the MVA service has structured a treatment programme involving Vitamin B, Thiamine and anti-seizure medication. CS Two has also engaged with Dental Outreach Services. Health Outreach maintain regular contact with CS Two when away from the accommodation as well as a structured programme in the supported accommodation setting. Although there are still major issues with alcohol misuse, CS Two is now safer and open to health care in a way not experienced for very many years. They have been reintroduced to fishing and undertakes this regularly as part of their holistic support programme.

Future plans: CS Two will continue to receive support from MVA and West Suffolk Council's Rough Sleeper Service to move on to palliative care.

Case Study Three (CS Three)

Previous history: CS Three has a long history of drug use and an extensive record of offending. They were adopted by 180 Team as a Prolific Offender but was removed due to non-engagement with services and were effectively impossible to manage. CS Three had been housed in hostels over the years but due to behaviour and habits was evicted each time. Sporadic engagement with Turning Point in respect of continued drug dependency, supplementing Methadone with street drugs. High levels of 111 calls and hospital admissions again due to drug use. Physical and mental health issues due to drug use and lack of stable housing. Also involved heavily in drug supply and County Lines activity. CS Three placed significant demand to criminal justice, health and housing services.

Current situation: CS Three has been accommodated at NSAP since April 2021 and has engaged well with support. CS three has re-engaged with Turning Point and has undergone a treatment review resulting in variations to prescribed medication, changing from Methadone to Subutex which is a very positive transition. Regular GP medication reviews relating to mental health/anxiety. There has been a reduction in 111 calls and only one admittance to accident and emergency during a period in Police custody. Health Outreach suspected DVT and have encouraged treatment. Support given around harm reduction. Offending has decreased. CS Three requested 180 support but scoring too low with a two against a threshold of 75+. This represents the scale of the reduction in demand upon services.

Future plans: CS Three has been offered a Rough Sleeper single occupancy accommodation in order to return to their local area and where family support network exists. CS three is feeling positive with the move and is excited for the future. They will continue to be supported by Health Outreach and Turning Point. Ongoing tenancy support will be provided by the Rough Sleeper Service.

10.30 am - Comfort Break - 10 minutes

3. CULTURE

3.1. West Suffolk Review – Organisational Development plan

To Assure

Presented by Jeremy Over

Board of Directors – 28 January 2022

Report Title:	Item 3.1 - West Suffolk Review – Organisational Development plan
Executive Lead:	Jeremy Over, Executive Director of Workforce & Communications
Report Prepared by:	Jeremy Over, Executive Director of Workforce & Communications Ann Alderton, Interim Trust Secretary
Previously Considered by:	Council of Governors (in part)

For Approval	For Assurance	For Discussion	For Information
☐	☐	☒	☒

Executive Summary

Background and Introduction

The West Suffolk Review, commissioned by NHS England on behalf of the Department for Health and Social Care, was published last month.

At the meeting of the Board of Directors on 17 December, the chief executive Craig Black responded on behalf of the Board: *"As a Trust we accept full responsibility for the failings and shortcomings which led to the review; we got it wrong and remain truly sorry to the staff and families affected.*

"We know the actions taken by the Board which led to the independent review have understandably caused upset and anger amongst many of our staff, patients and their families, as well as our community, and this has brought unwanted attention to the Trust. We know for the individuals most directly affected the impact on their wellbeing has been significant.

"Whilst the investigation has been taking place, we have been working hard to build an open, learning and restorative culture. Our aim is to help staff feel confident to speak up and be supported when they raise concerns, and for issues to be dealt with sensitively and appropriately".

NHSE/I have notified the Trust that they do not intend to take regulatory action as a result of the report but have asked the Board to produce an action plan for the 28 January meeting of the Board of Directors.

This paper summarises the current position in relation to the learning, reflection and response thus far, including the organisational development actions that have already been taken and require further embedding. It also highlights the engagement undertaken to date, and what more needs to happen, to ensure our plans are based on the priorities for staff, governors, patients and teams and can carry the confidence of stakeholders.

Status of this paper and current position

In the period since publication our priorities have been to engage with and provide support to a number of different groups. First and foremost, those colleagues most affected by the actions rightly criticised in the report; our staff and teams more broadly; the families involved and our wider community, through being open and engaging with media queries; and the council of governors, whose role is to hold the NEDs individually and collectively to account for the performance of the Board and represent the interests of members and the public.

We are grateful to the many individuals who have spoken up during this period, which has involved a range of views and ideas around how we move forward together. We are also conscious that, for the majority of the period since publication the Trust has faced severe operational and staffing pressures and has spent time in a state of 'internal critical incident', which will likely have affected the extent to which people may have been able to contribute, and to spend time forming our actions plan. We are

also mindful that it will take considerable time not just to work together on actions to grow our culture, but to convince and reassure people that change has happened and to restore trust where this has been lost.

We are also grateful to the review team for taking time to consider the improvements we have already been working on together at WSFT and the positive comments attributed to this in the report.

With all this in mind, it is proposed that we frame our plans around *organisational and culture development*, to try and avoid the mistake that a simple action plan, delivered in a matter of weeks or months would remedy the situation, post-publication. There is a risk that quickly producing an action plan might also give the impression that there is no further engagement work to do around our priorities, which would be a mistake.

Thus, at this point, this paper does two things:

(1) Given that the failings identified in the report lay predominantly in the domain of Board governance (and its consequent impact on culture), and that the Council of Governors has a formal role within our constitution in this regard, an update is provided on discussions with the Council of Governors to date, and what has been agreed by them to work on our way forward together

(2) Proposes nine themes of work that capture the priority areas for organisational and cultural development at WSFT in light of the learnings from the report. For some of these there are actions that we have already worked on and require further embedding, and additional actions (noting that this is not yet complete and further actions may not yet have been identified).

(1) Board Governance and the role of Council of Governors

The role of the Council of Governors is to hold the NEDs individually and collectively to account for the performance of the Board and represent the interests of members and the public. The role of governors in "holding to account" is one of assurance of the performance of the unitary Board.

Referring to the main themes of The Healthy NHS Board, the Board's responsibilities are formulating strategy, ensuring accountability and shaping culture. The Board's performance fell short on both ensuring accountability and shaping culture and that needs to be the main focus of its response. The review does acknowledge the significant and substantive changes made by the Trust in the intervening time between the events investigated in the report and its publication, but there is always room for improvement.

Appendix 1 of this paper sets out a response to feedback from Governor colleagues thus far; from discussion at a 16 December meeting; through conversations; and a request for feedback from governors following an email request. Some of the questions are clarification questions about the detail, and where applicable, the response refers back to the evidence in the report that either answers the question or provides context.

This appendix has been shared with the Governors earlier this month where it was agreed to establish a Governor-Director West Suffolk Review working group, comprising a majority of governors and chaired by a governor to provide further oversight and input, and to facilitate their role around holding to account the performance of the Board.

(2) Our Organisational Development plan – nine draft themes

As indicated above, whilst it may be tempting to quickly produce an 'action plan' in response to the report, these is a risk that this might oversimplify the task of cultural change and/or mistakenly give the impression that the previous failings can be remedied in short order. This is not the case.

Furthermore, lessons have been learnt during the two-year period since the review was commissioned, which has prompted relevant actions and improvement that needs to be sustained and embedded.

However, it remains imperative to track our engagement, commitments and progress and thus it is proposed that we form an 'organisational development plan' that brings together the wide-ranging

themes of work that all relevant to how we learn from, respond and improve in light of the report's findings.

To date, nine themes of work have been identified, and these are set out in appendix 2. It is proposed that we use this structure to continue to capture the progress made already, commit to what requires further embedding, and logging of additional, agreed actions that will enable us to sustain and build improvement. Discussion and feedback of these nine priorities is requested to ensure that all relevant areas of organisational development are included.

It is further proposed that the Involvement Committee is delegated responsibility for overseeing the further development of this plan, including the agreement of measures through which we may gain assurance that it is making the required difference.

Action Required of the Board

The Board is asked to:

- review this report and discuss it, and ensure it is reflective of the Board's collective response in relation to how we learn and improve
- support the establishment of a Governor-Director West Suffolk Review working group, comprising a majority of governors and chaired by a governor
- critically-evaluate the draft organisational development priorities and support the recommendation to delegate oversight of the plan to the Involvement Committee

Risk and assurance:	If we do not address the reflections and learning of the West Suffolk Review within an appropriate timeframe and fail to manage the governance consequences in a just and fair manner, this will cause Board instability, uncertainty and loss of public confidence and increase the risk of regulatory intervention and loss of autonomy
Legal and regulatory context	NHS Act 2006, Health and Social Care Act 2012 Your Statutory Duties: A reference guide for NHS Foundation Trust Governors – Monitor 2013 The NHS Foundation Trust Code of Governance July 2014

Our Trust Values	
Fair	We value fairness and treat each other appropriately and justly.
Inclusivity	We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.
Respectful	We respect and are kind to one another and patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.
Safe	We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.
Teamwork	We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

Appendix 1

Section 1: Board Responsibility – Culture

Governor Questions and Observations	What the Review says	Is this a Board Responsibility?	Learning Opportunity
Theme: Serious Incident Reporting			
What was the reason for the four-month delay between the self-medicating incident and it being formally reported?	From the Report "the leadership and management culture at West Suffolk was not always one which encouraged staff to raise concerns, both of which offer reason for reflection more widely in the NHS. "Rather than see [the delay in reporting the self-medicating incident] as a possible indication that the incident was not serious, there were real questions to be addressed about an apparent reluctance to raise a Datix in this instance. "…action may be needed – and I believe has since been taken at West Suffolk - to address an apparent reluctance to report patient safety incidents. The need for an open culture in which staff understand the importance of incident reporting, confident that all will be dealt with fairly, is one that applies to all NHS organisations. A culture where staff feel the need to keep their heads down has to be addressed. (p30-31)	The Board is responsible for shaping culture and raising concerns is a cultural issue. Having the right policies and procedures in place relating to the relating to the reporting of Serious Incidents and oversight of them are a Trust wide and Executive responsibility. Everybody in the Trust has a responsibility to report a serious incident they are aware of. However, if there is a blame culture in place either locally or on an organisation-wide basis, staff may be reluctant to raise concerns out of fear of retaliation or	Regular audits and benchmarking of incident reporting can help identify outliers in terms of the numbers of patient safety reports. Outliers can be areas of the Trust that under-report or where there are a high number of safety incidents for other reasons. Regular review and scrutiny of the numbers of incidents reported and the severity of those incidents is important.
Theme: Biometric Testing			
Where did the idea come from and who made the decision? Why was this course of action pursued?	"The police identified that there were fingerprints on the envelope" (p103) "the decision to use biometric data originated with the directors leading the initial investigation" (p122)	The report states that the board was not consulted about the proposal to seek biometric data from members of staff in March 2019 (p183) The review also reports that a number of people questioned the	The decision to use biometric data was a decision made by the executive directors leading the initial investigation and not a board decision.

Governor Questions and Observations	What the Review says	Is this a Board Responsibility?	Learning Opportunity
Could assurance be given that none of the NEDs was involved?	[The CEO] put it in *the context of the sheer awfulness of the letter* [to Mr W] *,…the data breach, the fact that there had been police involvement already and they had provided fingerprint samples, the ongoing coroner's proceedings…all meant that organisationally and personally we didn't give enough thought to the severity of what we were embarking on and the impact on staff…those directly involved have received a personal written apology for the stress and upset caused* "the executive directors, the Chair, and one of the non-executive directors were aware of the proposed use of biometric data"(p36)	action but the directors leading the investigation did not drop this until September 2019. At no point was it considered an issue that needed to be escalated to the Board.	Decisions of an unusual or controversial nature should be risk assessed. This might have triggered a "red flag" in the risk report to the Board. At the time of the events in the review, this would have been at the closed Board but this report is now discussed at the Board meeting in public.
Theme: Freedom to Speak Up/ Managing Performance/ Context and Culture			
Could assurance be given that practices had or would be changed so that those exercising their freedom to speak up were not victimised in future? What assurance is there that everyone understands that there is an absolute separation of the FTSU process and performance management? Are all of management aware of the FTSU processes even if the activity is not specifically called that? Is there evidence of clear feedback to the initiator of impact/response to FTSU issues they have raised?	The Review comments specifically on this (p201): "I looked specifically at the Trust's current: • attitude toward mediation in contentious HR matters. • approach toward allegations of bullying and/or undermining. • attitude toward the taking of, and compliance with, Occupational Health advice. • understanding of the importance of separation of the investigation of FTSU concerns and performance management or disciplinary proceedings. • increased focus on the wellbeing of any member of staff who is the subject of disciplinary or performance management processes. • appreciation of the importance of potential challenge from the overseeing non-executive director in MHPS proceedings. • work toward improving the staff's confidence in its *Speak Up* culture an aspect of which was surveying Trust staff on *What Matters To You* and basing their	The Board is responsible both for shaping culture and ensuring accountability. The way the FTSU process and performance management were managed in the Trust, as described in the Review, was a failure of both aspects of these duties. The Review highlights the improvements in systems of internal control, which are measurable and tangible, and provide the legal, governance and control framework that staff will operate in. This is about accountability and having robust procedures will minimise the risk of breaching law, regulations and good practice. However, these are not sufficient on their own and without having a compassionate, caring and	Embedding a healthy culture across an organisation requires sustained effort and consistency of approach, often over a number of years. It is also difficult to measure, as there are more negative indicators (eg. Incidences of external whistleblowing, trends in the number of FTSU referrals), than there are positive ones. Understanding the characteristics of a just and restorative culture, as opposed to a blame culture and the self-awareness to identify poor behaviours and challenge them when they arise is key to change. Also, by being visible, engaging across the organisation during times of stress and challenge, both to communicate appreciation and get a sense of how they are feeling is a

Governor Questions and Observations	What the Review says	Is this a Board Responsibility?	Learning Opportunity
Does the recent letter to the press from the maternity department indicate that insufficient progress has been made since the events of the review? Could assurance be given that policies are fit for purpose and complied with? (this question is repeated also below under accountability) Was the Executive Team out of touch with senior medical teams and operating in an echo chamber? Some of the interactions between the Executive Team and other parties – both in witness accounts of meetings and in the content of emails - come across as confrontational and judgemental.	staff engagement strategy on the themes that emerged from that consultation. • continuing support for the *Better Working Lives* project led by the Trust's Deputy MD. • approach toward the assembly and retention of documentation produced in the course of HR investigations. and draft policies relating to: • Managing Conduct and Expected Standards and • Expected Standards "These changes are significant and substantive. If fully embraced and adopted at all levels within the Trust they will greatly lessen – and hopefully eliminate - the errors and missteps that bedevilled the Trust's approach to the matters which are the subject of this Review".	responsive culture based on openness, transparency and candour and values that reflect that.	characteristic of effective compassionate leadership by the Board and the Council. Living the values is something that applies to everybody who is part of the organisation: every member of staff, senior leaders, the executive team, the Board of Directors and the Council of Governors.

Section 2: Board Responsibility – Accountability

Governor Questions and Observations	What the Review says	Is this a Board Responsibility?	Learning Opportunity
Theme: Governance			
Is there a robust escalation policy in place (to the Board) for when issues that are initially quite properly dealt with by the Executive as operational, but are then found to have a wider impact on the Trust's reputation or relationship with the wider community?	"Like many large organisations, NHS Foundation Trusts have within their governance structures, whether formally or more informally, a series of checks and balances that are intended to ensure that they operate fairly and effectively. These provide the opportunity for collective or individual reflection and second thought, making it less likely that a Trust departs from well-established (and mandatory) policies. "In my review of this matter it was evident that these checks and balances did not work effectively. I am conscious that I have had the opportunity to review the matters in question with the benefit of some hindsight. But it is clear that the unfortunate train of events described has led to considerable distress for many, and to the Trust's reputation being seriously damaged" (p27) "All involved in leading and managing NHS organisations frequently find themselves called upon to make decisions quickly. In the heat of the moment, the wrong call can sometimes be made. It is important that the culture of the organisation and the leadership environment and approach allows for individuals to feel comfortable with the various checks and balances operating effectively – such as challenge from their Boards - and to change direction if, on further reflection, that is appropriate". (p29)	The Board is responsible for ensuring internal control and reports and reports on its performance in the Annual Governance Statement in the Annual Report. Assurance is usually provided through the Audit Committee, whose programme of work is based on the Trust's Board Assurance Framework identifying the principal risks to the Trust's strategy. One of the challenges in all systems of internal control, is that some controls (eg. Segregation of duties in a performance management process and the need to maintain independence and put in place ethical barriers for a potential appeals process) can act as obstacles to openness. Having the emotional intelligence to understand what can be shared and discussed openly (eg.policy details, process design) and what should not (eg. Personal data relating to a complaint or performance report) is key to effective decision making in these circumstances.	Operational (and strategic) issues that appear high risk should be subject to a robust risk assessment process and reported on Datix. This is especially important if departing from well-established policies. If the likelihood of the risk materialising or the impact of it on the Trust changes during the management of a particular issue, then so too should the risk assessment. Strategic risks and operational risks that are particularly high are reported to the Board (previously closed Board: currently the Board meeting held in public) and form the basis of the work of the Audit Committee.
Could assurance be given that policies are fit for purpose and complied with?	See above under Freedom to Speak Up/Performance Management	See above under FTSU, this is part of the Board's duties for both shaping culture and ensuring accountability	See above under FTSU

Governor Questions and Observations	What the Review says	Is this a Board Responsibility?	Learning Opportunity
Theme: Role of the Governors/Member Engagement			
With the benefit of hindsight and from the governors' perspective at what point should governors have been aware of the chain of events before this appeared in the press? How could governors have challenged better? Even if the matter had been discussed with the NEDs and the board it would have been in the closed board meetings which were governors were not privy to. If governors are part of the Governance in how the trust is run, we have to at least have an overview with suitable assurances as to the running of the trust? What is the role of staff governors in these circumstances?	There is no mention of the governors in the Review. None of the events in the review fall within the role of the Council of Governors in holding the NEDs to account for the performance of the Board. This should not be viewed as a negative thing as governors as it indicates that the boundaries between the Board of Directors and Council of Governors were operating effectively. As the majority of the criticisms related to the actions of executive directors outside the boardroom, there is very little reported in the board papers that would have given rise to a "red flag" about the performance of the board in relation to either accountability or culture. In fact, most of the reports the governors would have seen would have presented a positive view on culture (eg. The Trust's staff survey results being among the best in the country). With regard to the role of staff governors, whilst they are elected by staff rather than public members, they have no more rights and privileges as regards information about the board's performance than other governors. Depending on their role, staff governors may see more of the board members, but their general experience of the Trust is limited to their own sphere of control.	All Board responsibilities – formulating strategy, ensuring accountability and shaping culture – requires effective engagement with governors and members. The Council has received appropriate training in its duties, both virtually and in person. It has also undertaken a self-assessment of its own effectiveness, which has informed a programme of work for 2021/22.	At the time, minutes of the closed board were not shared with the Council of Governors. This has now been addressed and governors will receive this information going forward. However, effective engagement needs to be much wider than this and the publication of this review has highlighted areas of development which includes the following: • The Board's understanding of the role and duties of the Council of Governors and its relationship with it. • The Council's understanding of its duties as regards to "holding to account". • The Council's understanding of Trust culture and values. • The need to re-ignite member engagement post-pandemic and to have sufficient staff governor involvement in member engagement. The board is in the process of reviewing its own development needs following an independent evaluation. It is important that the Council also gets the same opportunity.

Governor Questions and Observations	What the Review says	Is this a Board Responsibility?	Learning Opportunity
Theme: Confidentiality			
The briefings that governors received about the letter were very basic and they were told that this was due to the need to maintain confidentiality of individuals. Re communication to governors, there had been an ongoing problem/issue between identifying where confidentiality stopped and where secrecy began. Why are governors hearing about controversial issues through the media rather than directly from the Board?	As well as being an issue in communication with governors, this is also an issue that comes up in the report and may have been a barrier to effective board consideration of the matter and the decision-making process in general. "Being told to *trust the process* was a naïve and ill-judged injunction in the circumstances; whilst there was an issue of confidentiality …to Dr A to consider, it should have been possible to balance that against the need to demonstrate that patient and practitioner safety issues were being appropriately considered (p29)". Also the SID highlighted this as an issue in relation to the investigation of the self-medicating incident and asked the Board to consider "the extent to which an optimum balance between confidentiality and transparency of progress to stakeholders was maintained" (p86)	Some of these reflections are the same as those described under "Governance" above. The Board has a duty to maintain confidentiality in a number of situations – commercial confidentiality and the confidentiality of personal data (staff and patients) being the main ones. The closed session of the Board should be reserved only for discussion of papers containing confidential information and those papers should only be shared with board members, though minutes should be made available to governors (redacted if necessary). The bar should be set very high, ensuring that even difficult and contentious decisions that are not confidential, should be in the public part of the meeting wherever possible. Governors have signed a code of confidentiality, but this does not give them the "right" to view confidential papers, only the duty to maintain confidentiality when confidential papers are shared with them.	The Trust Board should not use confidentiality as a mask to hide behind but must always be maintained within legal and regulatory frameworks. Communications with governors should always be governed by the principles of openness and transparency. However, governors need to accept that there are genuine reasons why some information cannot be shared with them, if it is not essential as part of their duties as governors to hold the NEDs to account for the performance of the Board. This includes details of ongoing disciplinary cases and serious incident reports as these will contain personally identifiable information. Governors must also accept that there is always a risk that an information breach could result in the media reporting on a confidential matter that they have not been sighted on and that this is not an indicator of a lack of openness and transparency. Good communications and open and honest dialogue between the Board of Directors and Council of Governors are key, as are taking responsibility for getting things wrong

Governor Questions and Observations	What the Review says	Is this a Board Responsibility?	Learning Opportunity
			and ensuring there is learning from mistakes and misjudgements.

Section 3: Role of Council of Governors – Support and Challenge in rebuilding trust and confidence

Governor Questions and Observations	What the Guidance Says	What are the options?	Learning Opportunity
Theme: Holding to Account/Next Steps			
Most of the staff spoken to want to move on. Some of those who were mentioned in the report, even if they were not criticised, have been affected by what happened and feel hurt and judged. What can the governors do to help the Trust recover from this and to heal and achieve closure? How should governors hold the NEDs to account for their actions? Should the entire Board be replaced to help the Trust move on?	There is a divergent view among the Council as to its next steps. The next steps must be in accordance with the duties of the governors to hold the NEDs to account for the performance of the Board and represent the views of members and the public. It is clear from the wording of some of their questions that some governors do not understand that "holding to account" refers to the performance of the unitary board and not the performance of individual members of the board. However, this distinction is helpful in dealing with a case like this which refers to historical events and where the focus should be on "what can we learn from what happened?" and "what can we do to reduce the risk of it ever happen again?" The Chairman of the Trust has resigned already. All bar one of the executive board members who were in post at the time of the review have left the Trust and that executive board member was not criticised. Of the NEDs, there is only one NED member still on the board whose actions were criticised in the report. Governors need to balance the needs of the Trust for stability and	It is not practicable for the whole Council to work on next steps and it is recommended that a Review Working Group (Task and Finish) is set up to discuss this report and work with the Trust on the implementation of the West Suffolk Review Action plan. One of the tasks for this group could be to use the learning from the review to identify overarching criteria against which Board performance should be measured, which could include (but not be limited to) the following: <u>Reflection</u> • What does the Board understand to be the root causes of the events described in the review? <u>Culture</u> • What can the board do to ensure that the Trust's values are understood by everybody	Some of the language and behaviour used by some governors reflects a blame culture rather than a just and restorative culture but this has also highlighted a collective misunderstanding among some governors of what "holding to account" means. As mentioned above, commissioning an independent effectiveness review of the Council of Governors would help reflection and learning of the boundaries between the role of the Executive, the NED and the Council of Governors, as well as provide learning for both the Board of Directors and Council of Governors as regards communication and engagement.

Governor Questions and Observations	What the Guidance Says	What are the options?	Learning Opportunity
	continuity against the need for change and there is an opportunity to achieve the latter through the Chair and NED recruitment during the first few months of 2022.	and that behaviours and attitudes, even when dealing with stressful, challenging and upsetting situations, reflect those values? How will it know, and how can it provide the necessary assurance to governors, staff, members and the public • What does the Board think that it could have done differently? <u>Accountability</u> • What are the principal actions that the Board needs to take to address the deficiencies in the "checks and balances" described in the review? <u>Relationship with Governors</u> • What can the governors do to support the Board to rebuild public trust and confidence in the Foundation Trust?	

Appendix 2: DRAFT nine themes of work

Theme	Actions thus far	Next steps
Board development	• External board development programme commissioned; commenced October 2021 • 360 feedback exercise for the Board • Rebuilding the executive team • Strengthened Board assurance function with new sub-committee structure	• Content of Board development plan for 2022 to be agreed • Development session with review author to support broader learning and Board response • Recruitment of next WSFT Chair • Recruitment to NED vacancies • Recruitment of next chief executive
Governor voice / engagement	• Governor briefings and Q&A sessions • Ongoing training programme for Governors (externally-facilitated)	• Take forward the agreed Governor-director working group • Build lessons learned into person specifications for board recruitment
Staff voice / engagement	• 'What Matters to You' (WMTY) staff engagement • WMTY feedback used to generate WSFT interim People plan • Staff briefings / Q&A sessions including with medical staff committee	• Use national staff survey results (2020) to support teams and identify further actions • Plan 'What Matters to You' engagement #2 for 2022 • Continued engagement with staff representatives and relevant groups to direct action plan / response
Patient Safety	• Investment & growth in Quality Improvement function (70% increase in QI projects) • Early adopter of Patient Safety Incident Response Framework (PSIRF) (improved incident responses; investigation timelines; and involvement of staff & patients • Patient Safety specialists appointed	• Embedding and evaluation of PSIRF • Further promotion of incident reporting through Datix, reflective of speaking up principles and FIRST values
Freedom to Speak Up	• Strengthened and expanded SU Guardian function • SU Guardians have established SU staff champion network 2x Board self-assessment in 2021 • Quarterly SU Guardian reports to Board in public; opportunity for Board challenge from Guardians • Mandatory FTSU training for all staff agreed and launched	• Work with National Guardian's Office to learn from best organisational SU practice • Expand SU staff champion network, focusing on areas not yet involved
HR processes & oversight	• Pause of active HR cases at start of project to fully explore informal resolution options • New misconduct policy approved and operational, founded on just culture principles and informal resolution where possible. This policy also includes safeguards to avoid mixing of performance management with speaking up matters, and a pre-investigation toolkit	• Continue HR policy transformation in partnership with staff representatives, ensuring these frameworks reflect refreshed FIRST values and restorative approach • Develop plans to embed the priorities identified through national 'Future of NHS HR & OD' report

	• Investment in HR partner team to support & coach managers and teams • All formal HR cases reported (anonymously) to closed session of Board for oversight and assurance	
Organisational strategy	• New 5-year strategy developed for WSFT with staff and other stakeholders • Strategy overtly recognises past failings and the importance of learning lessons to develop our culture • Investment in staff well-being a strategic priority, with investment in staff psychology support services and other well-being measures	• Launch the strategy (Feb 2022) • Embed strategic priorities in our working practices • Build alignment through divisions and teams using the strategic priorities to set their own goals • Refresh staff well-being strategy and agree priorities for future investment / focus
Embedding our values	• The engagement work to develop our new strategy included refreshing our FIRST values and behaviours – now agreed	• First and foremost, the Board to champion and demonstrate the FIRST values and behaviours • Raise the profile of FIRST values across organisation and embed in our working practices
Leadership & management development	• Focus on culture change through 5 o'clock club sessions in 2021 (e.g. Megan Reitz; Michael West)	• Agree priorities for leadership & management development to embed lessons learned from the report • To include focus on skills / approach to dealing with speak up concerns and creating a speak up culture within teams • Consider people management objectives for leaders and managers within appraisal framework

3.2. Safe Staffing Guardian - Quarterly Report

To Assure

Presented by Paul Molyneux

Trust Board – 28 January 2022

Report Title:	Item 3.2 – Safe Staffing Guardian Quarterly Report – October – December 2021
Executive Lead:	Paul Molyneux, Medical Director
Report Prepared by:	Francesca Crawley, Guardian of Safe Working
Previously Considered by:	

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☐

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

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QUARTERLY REPORT ON SAFE WORKING HOURS

DOCTORS AND DENTISTS IN TRAINING

1st October 2021 – 31st December 2021 Executive Summary

Introduction

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

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

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

Summary data

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

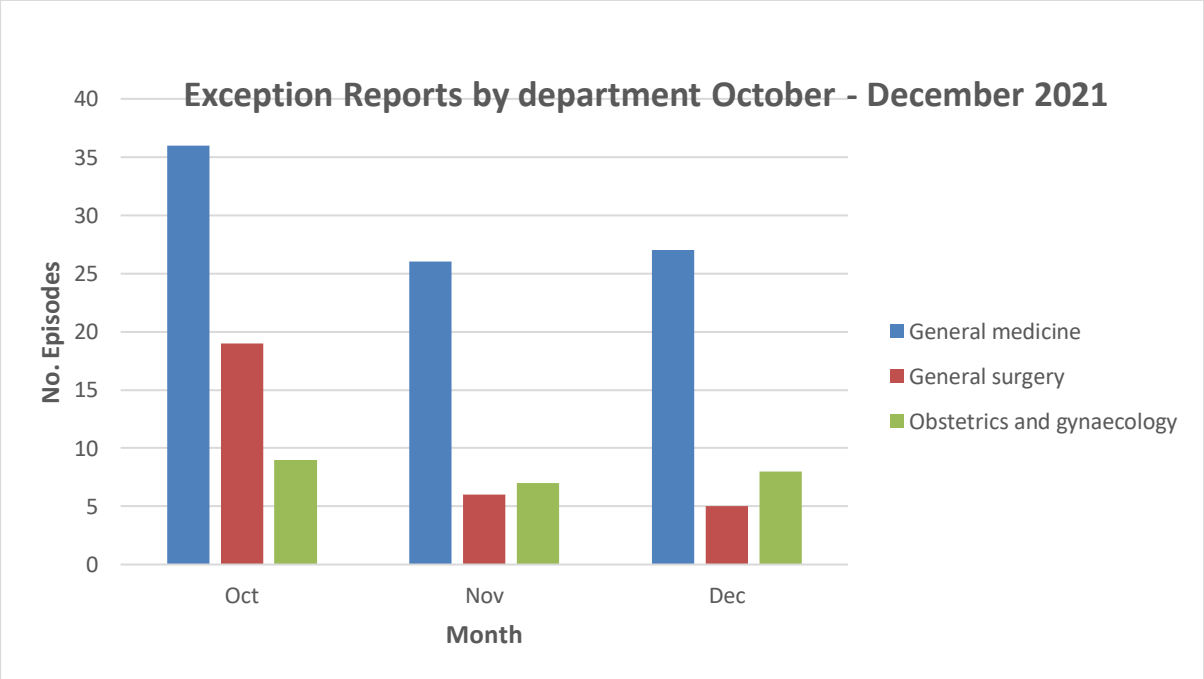
1. Exception reporting: 1st October – 31st December 2021

a) Exception reports (with regard to working hours)

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

Exception Reports by EXCEPTION TYPE						
Department	Grade	Pattern of Hours worked	Educational Opportunities or available Support	Support available during Service Commitments	Hours of Work	Total overtime hours claimed
Medicine	F1	1	7	3	45	74.5
	F2				22	27.75
	ST/CT 1-2		2		9	11
Surgery	F1		1		16	28.75
	F2		3	1	8	19.25
	CT 2				1	2.5
Women & Children	F2				3	3.5
	ST 1 - 7			1	20	16.75
Total		1	13	5	124	184

Exceptions reports by month and department



The rise in ER from O&G is recognised by the department and, recognising the increased workload over recent years, they submitted a business case to have a second doctor on call out of hours. This has been successful and they will be extending their rota to supply additional out of hours cover. Recruitment is underway and the new rota is due to start in April 2022.

b) Work schedule reviews for period 1st October 2021 – 31st December 2021

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

No work schedule review requests were received during this period.

The work schedules are annually reviewed in April by PGME, the College Tutors and Service Managers.

2) Immediate Safety Concerns: 1st October 2021 – 31st December 2021

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

There has been 1 ISCs raised in this period. This related to inadequate cover out of hours one night in medicine. This was due to sick leave and has been addressed by the service manager.

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3) Locum Bookings: 1st October 2021 – 31st December 2021

TABLE 1: Shifts requested between 1st October 2021 – 31st December 2021 by 'reason requested'

Department	Maintain Minimum Numbers, Additional Beds/Clinics, Rota Compliance, Shadow Shift and Induction Cover	Leave (Annual, Carers, Maternity, Paternity, Study, Unpaid)	Sickness and Reduced Duties	Extra	COVID-19 Additional Dependency	COVID-19 Self-Isolation	Vacancy	Grand Total
Anaesthetics		1	10	5			10	**26**
Emergency Medicine	1	87	21	17	2	1	287	**416**
ENT	2	1	3			4		**10**
General Medicine	26	38	42	33		1	20	**160**
General Surgery	43	12	61	14		2	24	**156**
Obs & Gynae	1	5	7			8	10	**31**
Ophthalmology		2	4				1	**8**
Paediatrics	3		20			3	32	**58**
T&O	2		12	3			29	**46**
Theatre/Outpatients Schedule	1		2	3			5	**11**

TABLE 2: Shifts requested between 1st October 2021 – 31st December 2021 by 'Agency / In house fill'

Filled by NHS / Agency		
Department	**NHS**	**Agency**
Anaesthetics	26	
Emergency Medicine	318	98
ENT	10	
General Medicine	160	
General Surgery	156	
Obs & Gynae	31	
Ophthalmology	8	
Paediatrics	58	
T&O	25	21
Theatre/Outpatients Schedule	11	
E- Care	5	
Total	**808**	**119**

4) Vacancies – 1st October 2021 – 31st December 2021

Department	Grade	October	November	December
Emergency Dept	ST3+	2	2	2
Emergency Dept	F2	1	0	0
Anaesthetics	Specialty Doctor	3	1	1
Anaesthetics	CT1 – 2	1	2	2
ENT	ST1 - 2	0.2	0.2	0
Medicine	ST3+	2	2	1
Paediatrics	ST1 – 3	1.1	1.1	1.1
Total		**10.3**	**8.3**	**7.1**

5) Fines – 1st October 2021 – 31st December 2021

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

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

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

Matters Arising

- The surgical division has recruited extra juniors to support the out of hours cover. These doctors started in December 2021. There is a regular survey looking at OOH support in surgery, which I continue to monitor. OOH cover in surgery remains on the risk register. Informal feedback suggests that the situation has improved, but the data is not yet available to confirm this.

- Supported Development time remains challenging as a consequence of winter pressures. The juniors have met this week to discuss this, supported by the Director of Medical Education.

- Winter pressures have resulted in staff shortages across the trust. The juniors coordinated a survey to show how they would prefer to be used during this critical period and their views will be included in any changes to their rotas. This has had the support of the Foundation TPD and the DME, along with service managers.

- Food at night is an issue again as Time Out is not providing enough hot food for all staff groups. I raised this at TNC this week and am grateful for their support to try to resolve this

4. STRATEGY

4.1. Digital strategy

To Approve

Presented by Nick Macdonald

Trust Board – 28th January 2022

Report Title:	Item 4.1 - Trust Digital strategy
Executive Lead:	Nick Macdonald
Report Prepared by:	Liam McLaughlin
Previously Considered by:	

For Approval	For Assurance	For Discussion	For Information
☒	☐	☒	☐

Executive Summary

The Digital strategy for 2022-2026 builds on the IM&T strategy that was approved by the board in May 2018 and aims to enhance further the Trust's position as a Global Digital Exemplar.

It outlines the main drivers that have informed the development of the strategy and proposes the overall ambition as **"Putting people at the heart of digital"**. It defines a set of digital principles and aligns the digital strategy with the overall Trust strategy.

The three pillars of the strategy are:

- Digital empowerment
- Digital culture
- Digital foundations

and it describes how digital technologies and solutions can underpin these priorities.

The strategy acknowledges the importance of alignment with the Future System approach and its programmes of work. It presents a high-level roadmap of some of the key milestones during the period and finally describes some of the proposed approaches to ensure successful delivery of the strategy.

The digital strategy includes three appendices for reference, drawing from the NHP Digital Blueprint work carried out by Atos in late 2020, background and case studies on some of the digital technologies and a summary of the stakeholder engagement from early 2021 which was supported by Atos.

Action Required of the Board

For discussion and approval

Equality, Diversity and Inclusion:	Putting people at the heart of digital means that issues of Equality, Diversity and Inclusion are centre stage and the principle of digital first but not digital only is recognition that digital is only one part of the way we engage with our patients, staff and local community
Sustainability:	The digital strategy aims to support sustainability by reducing carbon emissions through variety of digital technologies especially around reduction in travel as a result of remote working and virtual consultation

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Digital strategy 2022-2026

Liam McLaughlin
Chief Information Officer
January 2022

Digital drivers

West Suffolk NHS
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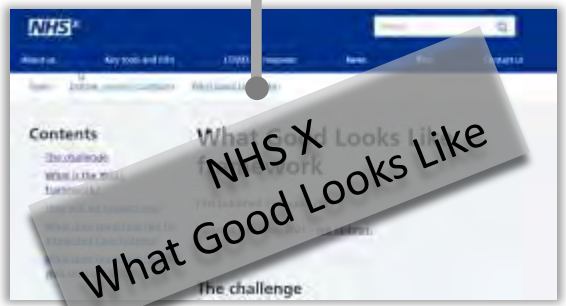
putting people at the heart of digital



Digital principles

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Digital first but not digital only
Ensuring that there is an equitable alternative offer for any patients and carers who can't or don't want to engage with technology

Digitally safe environments
Giving people the confidence to use technology for their desired purpose and with robust security in place

Building digital solutions with and for the patient
Ensuring that solutions are intuitive and empower the patient to take ownership of their care should they wish

Implement now but plan for the future
Pro-actively planning for digital advances and implementing technologies with the capacity to adapt

Digital to promote wellbeing (for patients, relatives, carers and staff)
Rather than adding complexity and uncertainty, digital should alleviate pressures and stress

Optimise what we already have
Technologies and systems must be adopted and used correctly by staff and patients to unlock their true value.

Technology as an enabler of transformation
Health and business needs should drive transformation, enabled and supported by digital technologies

Maintain balance of functionality, security and ease of use
New technologies be easy to use while providing additional secure capabilities

Trust alignment

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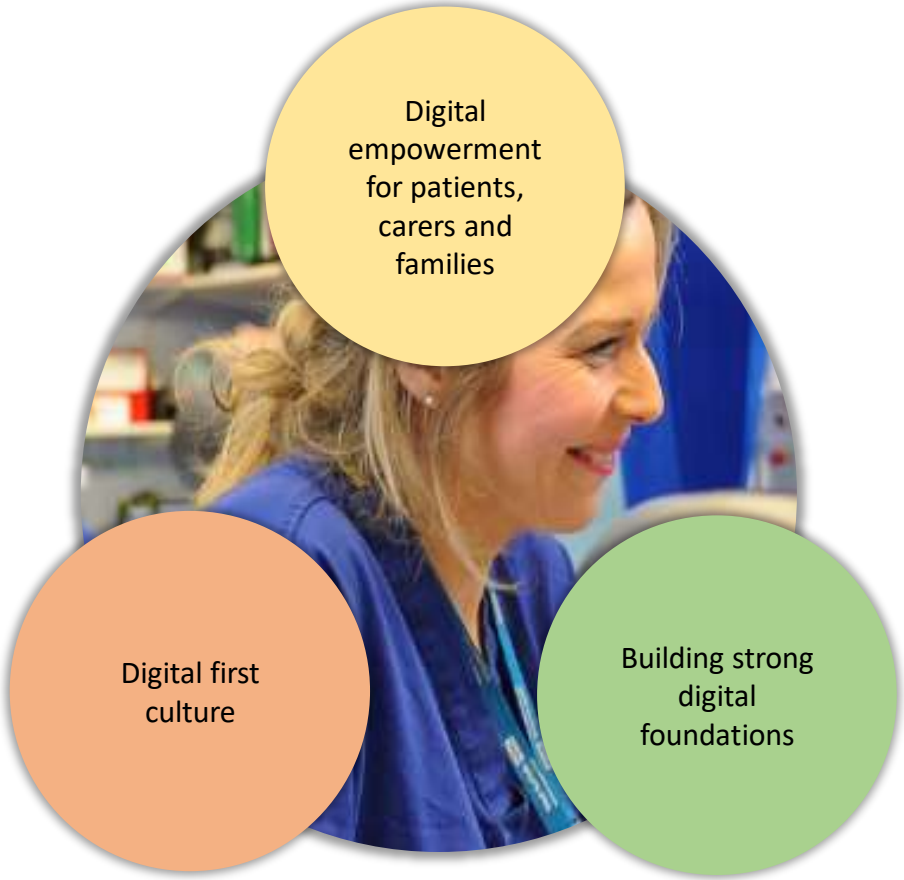
WSFT Trust Strategy		WSFT Digital Strategy	
Vision and values	Strategic objectives	Digital approach and ambitions	Digital activities

Deliver the best quality and safest care for our local community

- First for our patients
- First for our staff
- First for our future



Digital empowerment
- Improved access to information and digital alternatives
- Self care and personalisation
- Apps, wearables and home devices
- Digital front door

Digital first culture
- Digital leadership and confidence
- Access to digital irrespective of physical location
- Data protection and cyber security
- Care at home and virtual wards

Digital foundations
- Regular device refresh
- Reliable and consistent experience
- Virtualisation and single sign-on
- Move to cloud
- Interoperability and shared records
- Digital twin

Digital empowerment

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Theme	As a patient, carer or family member….	Digital solutions
Improved access to my information	✓ I have digital options that improve and simplify access to the support I need ✓ I can book and change appointments online ✓ I can access easy to read advice on-line ✓ I can have online consultations (but still choose face-to-face if preferred) ✓ I can be sign posted to other services and support in my local area	➢ Telephone and online consultation options ➢ Patient portal accessed via the NHS app
Improved experience of healthcare services	✓ My experience of healthcare is improved through digital options (takes less time, more at home) ✓ I have improved communication with healthcare staff and can give feedback on my care quality	➢ Apps, wearables, home devices ➢ Tools to capture and analyse patient experiences / journeys
Self-care and personalisation	✓ I can access online resources and home devices that allow me to manage my care ✓ I can manage and personalised care of someone I care for via digital options ✓ I will be able to access devices and data that can advise on preventing ill health allowing me to be healthy and independent for longer	➢ Patient apps including condition specific advice and guidance ➢ Patient information
Tell us once	✓ I only have to tell my story once to a healthcare professional and not have to repeat it to others ✓ I am confident that information I am happy to be shared will be available to all those involved in my care	➢ Interoperability of systems ➢ Wide adoption of Shared Care Records (HIE) ➢ Enterprise wide data architecture
Personal health record	✓ I have online access to my health record, or record of someone I care for, and can input into it if I wish ✓ I have confidence that my personal health information is safe and secure when shared across organisations supporting me	➢ Patient portal with patient's own data, measurements and feedback
Using data to improve the health of others	✓ I know and trust that only anonymised health information is used to improve care quality ✓ I know that health data will be used to predict and prevent ill health, address health needs and inform clinical decision-making	➢ Whole population health data analytics ➢ Clinical data insights ➢ Business intelligence

Digital culture

West Suffolk NHS
NHS Foundation Trust

Theme	As an employee of West Suffolk FT….		Digital solutions
Freeing up more time for care (reducing admin time, smart tools to capture)	✓ I will have better access to advice and guidance at the point of care ✓ Digital tools will reduce routine tasks giving me more time to deliver care and support my colleagues	✓ I use digital tools to communicate with the people I care for and can collaborate with colleagues ✓ I can easily capture data at the point of care (improving data quality)	➢ Clear pathways of care ➢ Efficient data capture ➢ Optimisation of processes
The tools needed to do my job	✓ I have real-time read and write access to patient records anytime, anywhere ✓ Our systems align with those of other health and social care organisations ✓ I will be fully mobile having access to relevant apps such as Microsoft 365	✓ I can update my team's information and it is linked and used across other systems ✓ I have access to responsive digital support and new equipment when needed	➢ Fully integrated patient record system ➢ Tools to enable seamless remote and mobile working ➢ Access to telephony services (unified comms)
Digital leadership and confidence	✓ My induction will give me a good understanding of trust systems ✓ I have opportunities to develop my digital skills and confidence, and the time to identify and test new digital ways of working	✓ I feel I am part of a 'digital by default' organisation where senior leaders place high value on an investing in data, digital and technology and use these to provide better healthcare and improve staff satisfaction	➢ Regular ongoing training and 'digital induction' ➢ Visible digital leadership ➢ Accurate and timely information
Data protection and security	✓ I am confident that the trust has robust cyber security arrangements and high levels of technical resilience to protect patients' and staff records	✓ I have data protection training and see it is a key part of patient safety ✓ I can access and share data via the interoperability of our systems	➢ Cyber security training ➢ Systems to protect staff and patient confidentiality
Sustainability and efficiency	✓ The Trust will be digitally efficient ✓ The trust will use digital options to reduce its CO_2 emissions (e.g. Virtual working to reduce travel)	✓ Procurement standards will include single sign-on and interoperability requirements to improve efficiencies and external collaborations	➢ Digital care pathways ➢ Virtual consultation and remote working to reduce physical journeys ➢ Cloud based data centres and services

Digital foundations

West Suffolk NHS
NHS Foundation Trust

Theme	West Suffolk FT will….		Digital solutions
Core EPR platform	✓ Ensure the core EPR systems and domains are current and fit for purpose ✓ Extend the scope of the EPR where feasible ✓ Review the EPR contract	✓ Continually optimise functionality in the EPRs to enhance and improve usability and reflect changes to clinical pathways	➢ EPRs as the integration platform ➢ Bring Critical care and medical specialties onto e-Care and revised outpatient functionality
Cloud, data centre servers and storage	✓ Implement the best of cloud technologies using a blend of private cloud, platform as a service (PaaS), infrastructure as a service (IaaS) and serverless solutions	✓ Move server solutions to the cloud in a phased way and as the opportunity allows ✓ Ensure that cyber defences are fully implemented and maintained throughout	➢ Cloud first solutions ➢ Wide range of tools to monitor cyber threats that are current and responsive ➢ Adopt a zero-trust security model
Mobile and flexible working	✓ Implement a five year rolling refresh for Trust digital devices, refreshing 20% per annum of the current estate, providing staff with equipment capable of dealing with the demands of modern applications and systems	✓ Replace desktop devices with a laptop or a mobile devices wherever possible to enable a more mobile workforce, better equipped to take full advantage of digital ways of working	➢ Device and operating system upgrades to supported releases ➢ Implement Microsoft 365 to enable new ways of collaborating and sharing ➢ Device integration with core systems
Networking	✓ Continue to invest in core, edge and Wi-Fi network capabilities across all Trust, hub and community sites	✓ Provide resilient and diversely routed connections into the public internet network	➢ Core, edge and wifi network upgrades ➢ Develop the digital anchor tenancy model for all remote sites
Interoperability – access to information, systems and applications	✓ Develop a coordinated architecture for data repositories ensuring data is accessible, interoperable and transparent ✓ Enable single sign-on across all clinical areas	✓ Support wide access to business intelligence and clinical informatics tools ✓ Explore opportunities from machine learning (ML) and artificial intelligence (AI)	➢ Implement OpenEHR to provide separation of data and application ➢ Provide tools for self service access to data ➢ Build a robust, resilient and cost effective virtual desktop capability

Future system

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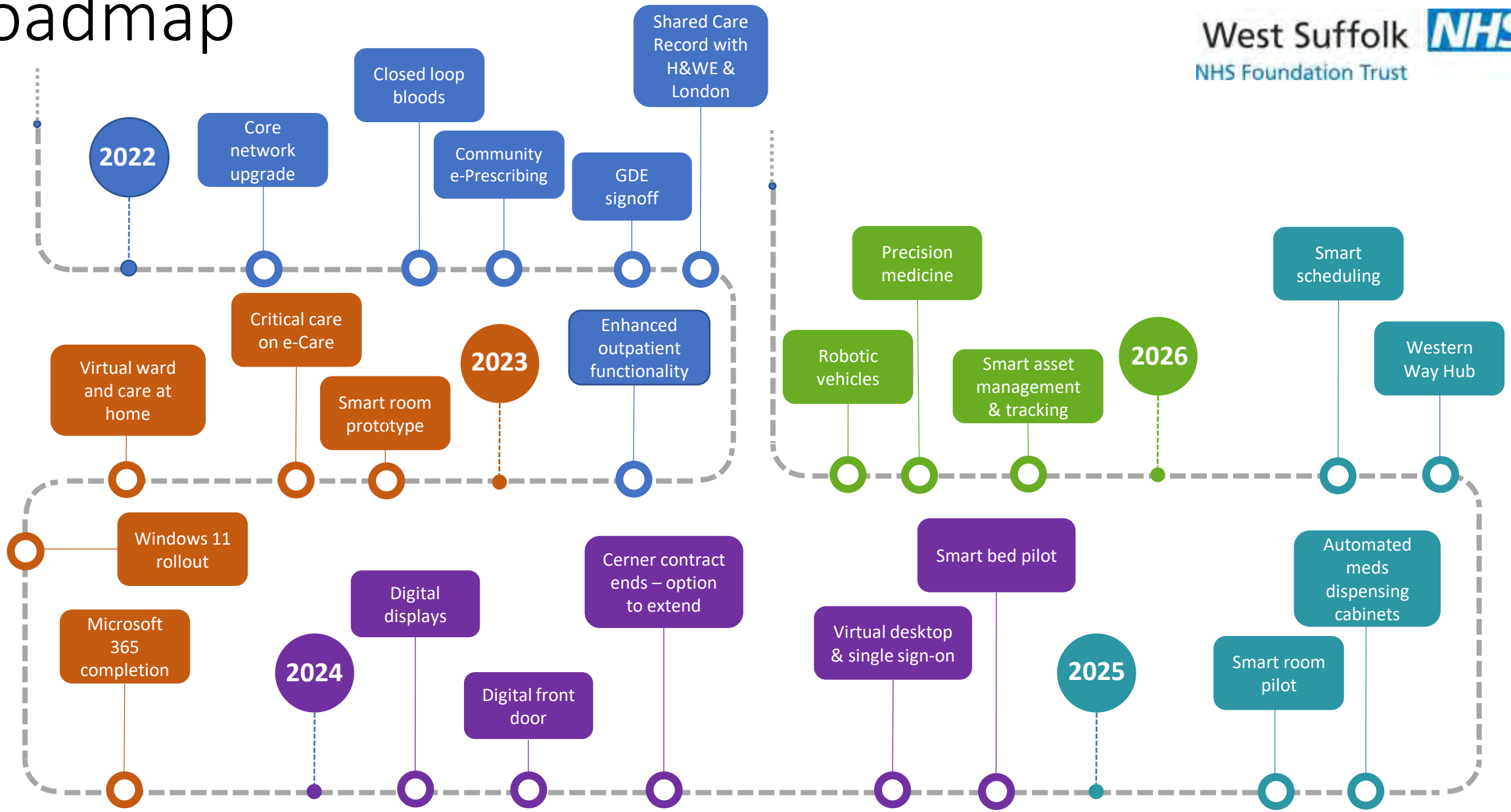
Intelligent sensors	Smart rooms	Distributed antenna system
Smart infrastructure	Real time location services	Cybersecurity
Digital twin	Building management system	Unified comms
Wayfinding	5G	
Medical grade wifi		
Digital front door	Personal health record	Digital workplace
Digital signage	Remote monitoring	Robotic process automation
Digital wayfinding	Virtual assistant/bots	
Immersive technologies	Telemedicine	
Digital pathology	Smart scheduling	Command centre
Smart beds	Automated dispensing cabinets	Single sign on
Artificial intelligence	Conversational agents	Voice recognition
Precision medicine	Analytics platform	
Robotics		

Typically implemented as part of the construction

The interaction of the new build with the wider health & social care system

Operating model of the clinical pathway and associated digital information

Roadmap


2022
Core network upgrade
Closed loop bloods
Community e-Prescribing
GDE signoff
Shared Care Record with H&WE & London
2023
Virtual ward and care at home
Critical care on e-Care
Smart room prototype
Enhanced outpatient functionality
2026
Robotic vehicles
Precision medicine
Smart asset management & tracking
Smart scheduling
Western Way Hub
2024
Windows 11 rollout
Microsoft 365 completion
Digital displays
Digital front door
Cerner contract ends – option to extend
2025
Virtual desktop & single sign-on
Smart bed pilot
Smart room pilot
Automated meds dispensing cabinets

The how…

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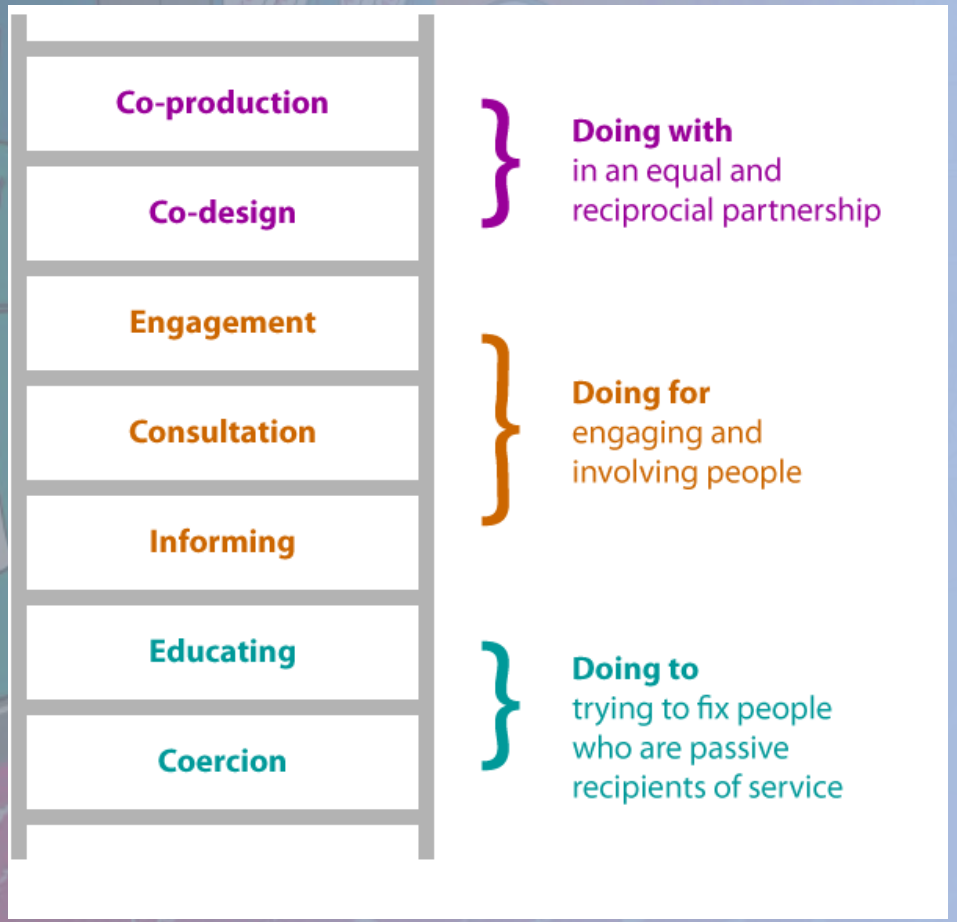
Co-production: ***'delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.'***



"EFFICIENCY IS DOING THINGS RIGHT; EFFECTIVENESS IS DOING THE RIGHT THINGS."
PETER DRUCKER

Integrity is doing the right thing when no one is watching.
C.S.Lewis

"Transparency is the currency of trust."
—Freda Lewis-Hall, MD
EVP and Chief Medical Officer, Pfizer Inc.

Appendix 1
Future profiles

Diagnostics & Pathology Future Profile

"Patients wait too long for appointments and are too long in the department"

Name: Deborah
Age: 45
Role: Nurse Endoscopist

Bio: Deborah is part of an incredible team whose ability to be flexible and support one another is invaluable. It is important for this service to be connected to other services in the hospital and across the wider community

Key goal: Make manual & administrative processes more efficient, speed up the turn around time of biopsy results

Journey Steps

Patients use their patient portal app on their smart devices to book their endoscopy appointments at times that are convenient for them – educational material in the portal prepares patients for the procedure	When Deborah arrives at work, she checks her endoscopy list for the day through the EHR where she can see all the bookings and e-referrals in one place	All patients can self check in at the endoscopy reception upon arrival and get real time stats on the running of the department to inform them of any delays to the service. After checking in, the health care assistant performs Hb checks on specific patients that are sent directly to the patient record	During one of the procedures, Deborah encounters some unusual findings and uses digital workplace tools to share a live video of the endoscopy with the Gastroenterology Consultant for advice using voice recognition software to control the interaction and take notes	Deborah sends a biopsy to the lab which is processed by the digital pathology service. The service is supported by AI for rapid interpretation and is validated by 2 consultants remotely. This significantly reduces the time taken to manually process pathology samples	The images, voice to text clinical notes and the Consultants advice are automatically curated into a procedure note, patient letter and discharge letter for Deborah to validate and send out. Once the pathology report is complete patients with benign conditions are automatically informed and those with more serious conditions are booked into a follow up clinic

Technology

Fabric
Footprint
Flow

Digital Front Door A patient portal for accessing health services and tools	**e-Referrals** Electronic referral management between care settings and specialties	**Self Check-In Kiosks** Digital check-in performed by patients **Point of Care Testing** Tests rapidly processed at the location of the patient	**Digital Workplace** A tool for collaborative communication and working **Voice Recognition** Voice to text recording	**Digital Pathology** High-resolution digital images of pathology specimens that can be enhanced with AI analysis	**AI W/ Robotic Process Automation** The intelligent automation of manual administrative tasks

Benefits

Patients	Increased autonomy and ownership over health		Knowing the running time of the department manages patient expectations	Right management plan for the patient, first time, with no delay		Rapid pathology results and follow up help to alleviate anxiety waiting for results
Staff		Time saved in logging onto multiple systems and eliminating duplicative work	More efficient processing of patients, freeing up reception staff to do other work	Reassurance and hands-on learning for the Nurse Endoscopist		The automatic curation of notes and letters is a huge time saver
Service	Reduced DNA rates optimise service efficiency and clear the waiting list more quickly			Improved risk profile and better quality care	Digital pathology significantly reduces waiting times for results and increases their accuracy. Digital images can be easily shared with specialists, without needed to physically send glass slides to different places for review	Significant time savings improving service efficiency, staff morale and patient satisfaction

Therapies & Community Services Future Profile

"would love complete service wrapped around the patient in their own home wherever possible"

Name: James
Age: 27
Role: Physiotherapist

Bio: James works in an incredibly adaptive team who work across different communities (e.g. mental health services). The team work proactively to ensure that patients receive the best quality care, whether that be in the hospital or at home.

Key goal: service to be 'home first', empowering patients to be pro-active with their healthcare

Journey Steps

James starts his day by attending the Orthopaedic MDT remotely as he is running a community rehab clinic straight after. The excellent 5G connectivity never lets him down. Using the virtual ward, James can review his patients' remotely collected data to see how everyone is doing	James can see patient's vital signs and exercise sensor data giving him insight into their compliance and the cardiovascular effort allowing him to adjust and personalise rehabilitation plans for each patient. He can also see care plans from other services to inform his decision making	James uses voice recognition technology with his first patient who doesn't speak English. The conversation is effortless, and James doesn't need to make any notes as voice recognition software is used to capture and record information directly into the patient record which patients can access via the DFD	During the clinic James uses a gamified augmented reality device to encourage some of the patients who are struggling with their exercises for motivation	One of James' patient's is recovering from major trauma and needs a lot of physical support. New robots that can perform this task have really helped reduce the physical burden on James and the need for bulky equipment like hoists	James uses the voice recognition tool on his work laptop to record the notes for his consultations which are automatically turned into clinic letters ready to be sent out

Technology

Fabric
Footprint
Flow

Digital Workplace A tool for collaborative communication and working	**Remote Monitoring** Real time patient data from connected devices	**Voice Recognition** Voice to text recording & translation	**Immersive Technology** Virtual and augmented reality to support staff and patient education	**Robotics** Physical robots that can perform manual, care related tasks	**Robotic Process Automation** The automation of manual administrative tasks
Virtual Ward Review of remote data from connected devices	**Longitudinal Care Record System** End to end patient record	**Digital Front Door** A patient portal for accessing health services and tools			

Benefits

Patients					
More effective time management and improved staff morale not needing to rush to clinic from the MDT in morning traffic	Personalised care based on data driven insights	Reassured that they are being understood and have detailed information to look back on	Different tools work to motivate different people, it's good to have variety	Improved sense of dignity not having to be supported by the hoist	
Staff					
A single view of the information needed in the virtual ward reduces preparation time	A good understanding of patient progress and areas to focus on	Fully engaged in discussion and not distracted by taking notes		Improved personal health and safety, can assess patient more easily not having to physically support them	
Service					
	The longitudinal record informs decision making across care settings	Cost savings by using technology to replace expensive translation services		Risks associated with manual handling reduced	Productivity gains by reducing administrative tasks

Education and Research Future Profile

"we need simulated experiences to replicate some teaching of content and practical skills for staff members or students"

Name: Hannah

Age: 56

Role: Clinical Research Nurse & Lead for Undergraduate Nursing at University of Suffolk

Bio: Hannah works in the research team, leading undergraduate nursing at the local university. Hannah works with a great team, getting involved in a variety of really interesting studies, ensuring that she is always close to the action, to learn as much as possible.

Key goal: Utilise both the physical and virtual world to result in the richest learning experiences.

Journey Steps

Hannah starts her day with a remote clinic aiming to recruit patients to a clinical study in oncology. She uses a digital twin model to demonstrate how different medications affect different patients and that the study hopes to find more specific and effective treatments	Hannah books a clinic room to see the recruited patients for their pre-trial tests a week later. The patients who agree to take part can fill in the necessary paperwork online to save time at the face-to-face appointment	At the face-to-face appointment Hannah provides a remote monitoring kit to the trial recruits which allows the trial team to monitor patient vital signs and symptoms in response to the trial drug. This enables them to collect more granular data for secondary use, but more importantly respond rapidly to anyone who has adverse effects to the drug	Later in the week Hannah needs to arrange for all her first-year nursing students to gain some experience in A&E. Speaking to the CCC she can identify the most appropriate times to arrange a series of student visits when there will be plenty for them to do and see but with adequate supervision	Prior to the students going to A&E they practice triaging patients in the clinical skills lab using augmented reality enhanced simulated patients. Students sign into the lab with their smartcard and are sent a digital feedback form automatically. Once complete, they receive their training certificate	Several feedback forms mention that the temperature in the clinical skills lab is uncomfortably low. Hannah speaks to the Estates team who inform her that they have already ordered a new radiator as the building sensors flagged the issue a few days before

Technology

Fabric

Footprint

Flow

Digital Twin An exact digital replica of an individual's body to model and predict the response to different treatments	**Smart Scheduling** Intelligent scheduling taking into account service needs and changes	**Remote Monitoring** The ability to collect real time patient data through connected devices	**Command Control Centre** One platform drawing together data from the hospital environment and delivering data driven insights	**Immersive Technology** Virtual and augmented reality ± simulation to support staff and patient education	**Environmental Sensors** Sensors located around the building to control the environment for maximum comfort and energy efficiency

Benefits

Patients	Precision medicine means care is specific to me and will lead to more effective treatment	Less time spent waiting in the clinic, filling in paperwork	Being able to stay at home to be monitored is more convenient		
Staff	Visual aids help to get the point of research across to patients and increases recruitment	Trials don't run on a regular schedule so it's great to be able to get a room when needed	Closer monitoring helps to identify patients who need clinical input sooner	Identifying the best time for students to visit A&E will maximise their learning and experience whilst not overwhelming the department when it is busy	Training in simulated environments improves learning and is safer for patients when students are less experienced
Service	Developing a precision medicine practice	Flexible use of rooms reduces the overall space requirement for the hospital	More data for secondary use and actionable insights		Automated feedback/ certification increases the return rate and identifies service improvements

Environmental sensors keep the hospital comfortable for patients and staff and allow analysis to identify cost savings

Emergency Care Future Profile

"High volume of patients arriving in a short time"

Name: Jack

Age: 58

Role: Emergency Care Nurse Practitioner

Bio: Jack works within WSFTs emergency department and loves being part of a service which is so connected to the wider hospital. Jack finds his job very rewarding as he gets to help so many different patients, for a variety of different reasons.

Key goal: Manage the hospital flow more effectively, resulting in shorter patient waiting times.

Journey Steps

Jack takes a call with a paramedic who is assessing a patient in a nursing home with a deep cut on their leg. Using video and images of the wound Jack gives the paramedic instructions on how to manage the patient in the community, avoiding a trip to A&E	A&E is starting to get very busy, there are only a few beds free, so Jack calls the Command Control Centre to identify the bed status around the hospital and how long it might take to transfer patients out of A&E	While CCC are working on freeing up some beds around the hospital, Jack checks the number of patients who are currently in the waiting room. He can see that 10 new patients have self-checked in in the last 25 minutes. Thermal cameras detect that 3 of these are febrile.	Most patients have completed their self-triage documentation via mobile app which gives Jack recommendations on who to see next. One patient doesn't have a mobile so the receptionist takes them through the self-triage on one of the department tablets	Some patients in the queue are walk-ins and others have been referred. Jack can see the referral details in the EHR saving him time accessing multiple systems. The e-referrals are automatically processed and analysed and incorporated into the triage documentation started by the patient	The next patient Jack sees has severe tonsilitis and is unable to swallow fluids. Jack refers to ENT using the e-referral tool in the EHR and in the meantime places a cannula, prescribes fluids, analgesia and a stat dose of steroid. The medication & fluid is checked against the patient details and retrieved from the ADC using biometrics

Technology

Fabric | Footprint | Flow

Digital Workplace A tool for collaborative communication and working	**Command Control Centre** One platform drawing together data from the hospital environment and delivering data driven insights	**Self Check-In Kiosks** Digital check-in performed by patients	**Digital Front Door** A patient portal for accessing health services and tools	**AI W/ Robotic Process Automation** The intelligent automation of manual administrative tasks	**Automated Dispensing Cabinets** Computerised drug & equipment storage devices at the point of care

Benefits

Patients	Right management plan for the patient, first time, with no delay	CCC reduces the administrative burden of bed management on clinical staff freeing them up for patient care. The CCC has oversight across all the beds and events in the hospital making them much more efficient at managing beds	Patients have greater involvement in their care journey and there is greater confidentiality & privacy compared to speaking to a receptionist across a desk	Reduction in the need to repeat information & awareness of waiting times helps manage expectations	Less repetition of information	Right treatment, right time
Staff	Reassurance and hands-on learning for the Paramedic		Receptionists are freed up for other work	As the patient has already started the documentation there is less to write and more time with the patient	The automatic curation of notes and letters is a huge time saver	Frequently used medication is always in stock
Service	Avoided unnecessary review in A&E			Intelligent prioritization of patients means that the most unwell are seen sooner, reducing the risk of deterioration	Significant time savings improving service efficiency, staff morale and patient satisfaction	Improved safety profile & audit trail

Paediatrics & Outpatient Clinic Future Profile

"Would be amazing to have quicker test results for bloods, urine MCS and flu etc."

Name: Helen
Age: 45
Role: Paediatrician

Bio: Helen loves working in paediatrics as no two days are the same. The service has rapid turnover compared to other departments, and Helen loves this fast-paced environment.

Key goal: Quicker and more accurate test results, so that turnover can be faster

Journey Steps

Helen starts the day in a Complex Care Clinic where she collaborates with colleagues across several disciplines to manage children with complex care needs. The team start with an MDT, dialing in specialists from Addenbrooke's, to agree on management plans for the patients	As patients arrive for clinic, they are seen by the nurse who performs a series of baseline tests such as observations, urine dip and finger prick blood tests that are all automatically stored in the EHR for review by Helen to inform her care plan	One of Helen's patients, Abby, is a toddler with developmental delay and low weight. The MDT agrees she should be trialed on NG tube assisted feeding and this is explained to Mum and Dad using an educational video created in house. The video is also available through DFD mobile app	Helen explains that the NG tube will be placed and checked in the hospital and after that will be managed by the Community Children's Nursing Team so that Abby can spend as much time as possible at home. Helen books the NG placement and makes the e-referral via the EHR to community services	Abby is admitted to the Paediatric Ward to have her NG tube placed and checked. Dad finds the interactive bedside terminal very helpful for distracting Abby from the unfamiliar environment and keeping her calm. Abby and Dad face-time Mum through the terminal while she is on her lunch break	Once Abby has had her NG tube placed and is being managed in the community, her care team made up of the Hospital Paediatric Team, Community Nurses, Community Dietitian and her School Nurse all have access to the care plan to inform their decision making

Technology

Fabric
Footprint
Flow

Digital Workplace A tool for collaborative communication and working	**Point of Care Testing** Investigations performed, processed and reported in real time, at the point of care	**Digital Front Door** A patient portal for accessing health services and tools	**e-Referrals** Electronic referral management between care settings and specialties	**Integrated Bedside Terminals** Devices that provide information and entertainment during inpatient stay	**Longitudinal Care Record System** End to end patient record combining all records from all providers

Benefits

Patients					
Right management plan for the patient, first time, with no delay	Minimally invasive tests are better tolerated by patients and there is no delay for results	Readily available educational tools and support services with care givers that Mum & Dad recognise		Reduces boredom and makes patients feel more at home	
Staff					
Consensus agreement on management plans provides reassurance	Results are available to immediately inform treatment plans	Visual aids help patient understanding and can be re-watched after the consultation	Time saved in logging onto multiple systems and eliminating duplicative work & inefficient paper-based referrals		Integrated care with clinical records being available across care settings increases efficiency and care quality through the transparent sharing of information
Service					
Reduces the risk of litigation through consensus agreement of specialists	Increased service efficiency and care quality				

Elective Care & Theatres Future Profile

"Important to provide patients with an overview of what to expect"

Name: Paul

Age: 30

Role: Trainee Anaesthetist

Bio: The elective care service is a great place to be as it is a very cohesive team, who have the ability to adapt, flex and work together. The service is key to a patients journey, and is well connected with the patients themselves, and their families.

Key goal: Improved patient education so that they know what to expect

Journey Steps

Paul reviews the 5 patients on the morning General Surgery list. He can see all the information he needs in the EHR and through the longitudinal care record he can also review information from previous procedures outside of the hospital	Paul visits each patient to explain the anesthetic procedure. During his conversations Paul activates the environmental controls that turn the cubicle windows opaque and activates sound isolation for privacy and confidentiality. He also shows the patients how to change the lights and temperature which they might find useful when they are recovering post-operatively	Before leaving the patients, Paul shows them where to find educational material on the bedside terminal about their anesthetic procedure so that they can review material and ask any questions when they arrive in the anaesthetic room	Whilst the automated cleaning robots work in the main theatre between cases, Paul prepare the drugs and fluids using the ADC	One of Paul's patients has a severe phobia of needles and he uses a VR experience to help relieve the patient's anxiety and distress.	After the procedure, all documentation is stored on the EHR and in the longitudinal care record for instant access by other care providers such as the GP. Patients have access to their discharge information through the DFD app which is supplemented with patient educational tools such as wound care and pain management

Technology

Fabric

Footprint

Flow

Longitudinal Care Record System End to end patient record combining all records from all providers	**Environmental Control** The ability to alter the environment to suit the needs of the space	**Integrated Bedside Terminals** Devices that provide information and entertainment during inpatient stay	**Automated Dispensing Cabinets** Computerised drug storage at the point of care **Robotics** Physical robots performing manual tasks	**Immersive Technology** Virtual and augmented reality to relieve anxiety	**Digital Front Door** A patient portal for accessing health services and tools

Benefits

Patients

Integrated care with clinical records being available across care settings increases efficiency and care quality through the transparent availability of information

No need to worry that others can overhear personal information. Environmental controls maximise comfort

The opaque windows signal to staff outside the cubicle that they shouldn't enter at this point, reducing interruptions

Predicting patient needs and optimising the environment improves patient satisfaction

Reassurance and time to review information that is unfamiliar so any additional questions can be answered

Ensures patients have all the information they need

Right treatment, right time

Calmer and more relaxed during a procedure that would usually cause great distress

Readily available educational tools and personalised discharge advice

Staff

Frequently used medication is always in stock

Theatre staff are free to do other work instead of cleaning

Theatre list runs to time

Visual aids help patient understanding and reduce patient anxiety and queries

Service

Improved safety profile & audit trail

Reduced follow up questions from patients improves time management for staff and improves patient satisfaction

Women's Services & Pharmacy

"ideal if we could streamline the process and shorten the turnaround time."

Name: Tim Age: 42 Role: Pharmacist	Bio: Tim works in the pharmacy at WSFT and his main aim is to ensure that patients and staff receive the correct medicine at the right time, improving the wider hospital flow.	Key goal: Utilise technology to speed up monotonous tasks

"we need less admin for midwives"

Name: Emma Age: 36 Role: Midwife	Bio: Emma is a Midwife at WSFT and her main priority is to spend as much time with her patients as possible during their labour	Key goal: minimise manu administrative tasks and harness technology to keep Mum and baby connected

Journey Steps

Tim receives a medication request through the EPMA system for an anti-hypertensive for a pregnant woman, Maria, admitted with pre-eclampsia who has multiple co-morbidities. He checks all the information and validates the drug ready for dispensing to the patient	Tim is notified by the ADC system that the incorrect anti-hypertensive has been taken from the ADC by Emma, tracked by her biometric login, and calls the ward. Emma realises her mistake when the barcode scanning at the bedside didn't match up. She replaces the medication in the ADC and takes the correct one	Tim informs Emma that he is sending a requested medication up to the ward for another patient that isn't routinely stocked in the ADC. It will arrive shortly by AGV	Several hours later Maria's BP is still rising, and the baby is showing signs of distress. The Consultant plans an emergency c-section and can see that theatres are currently free. Emma prepares Maria's documentation for theatre which is much quicker as it can be automatically pre-populated using the admission notes. Emma double checks the information and enters any missing parts	After the emergency c-section Emma shows Maria how to live stream to her baby in SCBU, alongside Dad who is at home, using the bedside terminal	When Maria and baby are ready to go home, Emma gives her a remote BP device to monitor her BP over the next few weeks. Emma also informs Maria that she can directly message the ward with any concerns through the DFD app which also has access to educational resources and support groups with other Mums

Technology

Fabric
Footprint
Flow

Electronic Prescribing & Medicines Administration Digital medicine management	**Single Sign On w/ Biometrics** Access multiple services with one credential	**Automated Guided Vehicles** Robots that can perform manual tasks	**Smart Scheduling** Intelligent theatre management	**Integrated Bedside Terminals** Devices that provide information and entertainment during inpatient stay	**Remote Monitoring** Real time patient data from connected devices
Automated Dispensing Cabinets Computerised drug storage	**Barcode Scanning** Barcoded wristbands map medications to patients		**AI W/ Robotic Process Automation** The intelligent automation of manual administrative tasks		**Digital Front Door** A patient portal for accessing health services and tools

Benefits

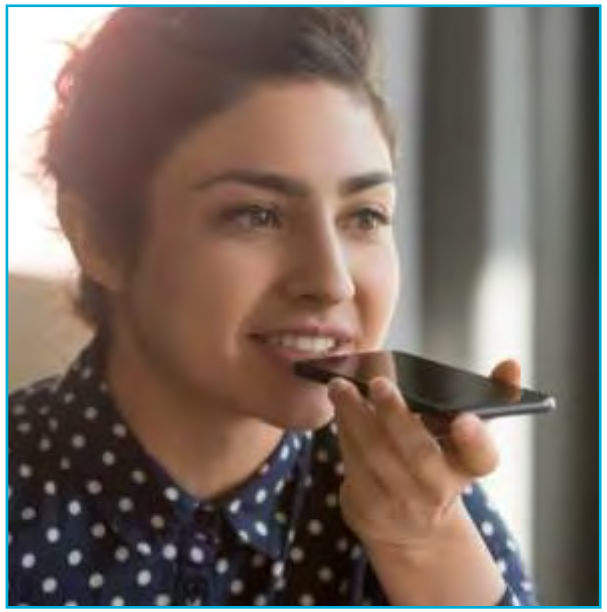
Patients	Right dose, right time	Reduced waiting time for medication delivery, freeing up staff to work on other tasks	Midwives can spend more time providing patients with reassurance at a stressful time in the delivery instead of filling in paperwork	Mum remains connected to her partner and baby even if they aren't in the same room, helping the bonding experience	Convenience of being able to stay at home with a new baby rather than coming to the hospital for check ups & support
Staff	Convenient point of care access to medications and safety measures to prevent errors				Follow up appointments are freed up, only those who aren't improving need to be seen again or managed face to face
Service	Improved drug safety		Improved documentation accuracy and detail through automation and streamlined efficiency with smart scheduling	Patients have a positive experience in the department	Freed up appointments reduce waiting list times

Appendix 2
Digital technology themes

Digitally empowered patients

Build new services that empower patients to take charge of their own health.

Digital services and technologies will not and should not replace the care provided by our dedicated team of staff. Instead, it should facilitate and enable care to be tailored around the needs and preferences of each and every patient, giving them the confidence to engage as much as they wish.



Our Desired Outcomes

- **Enhanced Patient Portal** with access to electronic patient records.
- **Easier access to health information**, supplemented by patient education and healthcare community platforms, national support groups etc.
- Self monitoring of health through wearables and other smart devices.
- **Patients managing their care before, during and after,** through appointment booking and management tool, Digital Consent Form, Virtual pre-op consultation, Digital Feedback form.
- **Patient self administration** with digital hospital systems such as Self Check In, Smart Parking, Integrated Bedside Terminals, Customised Voice Assistant.
- Patient engagement at point of care, with interactive immersive experiences and gamification of systems.

Benefits

- Reduced unnecessary admissions
- Improved patient experience
- Improved general standard of health of patients

Risks & Challenges

- Security of sensitive patient data
- Varying levels of patient digital competency, with potential to exclude those patients who are unwilling or unable to adopt a more digital way of interacting with care.

West Suffolk NHS
NHS Foundation Trust

Access anywhere quality care

Easy access to quality care, delivered physically or virtually depending on patient preferences, where possible.

The trend towards providing care across numerous channels, both physically and virtually, has been accelerated by the global Covid-19 Pandemic. There are significant benefits for patients, their families, and staff, that can be realised through establishing capability in both.

Our Desired Outcomes

- Access to healthcare **virtually** in the comfort of their own home, or at a care provider closer to home, enabled by advanced video consultations.
- **Remote monitoring** to gather patient information outside of traditional healthcare settings, and integrated to EHR.
- Access to health supplies and prescriptions through Automated Dispensing Cabinets.
- Virtual appointments allow for **specialists** to see more patients and provide patients with the **flexibility** to manage their schedule without having to travel to a care setting, opening up more care options to less mobile patients.
- **Preparation for planned admissions** can begin virtually so that patients are engaged and informed before they step foot in the hospital / care setting.

Benefits

- Enhanced Patient Experience through quicker and easier access to the right care.
- Increased patient throughput.
- Reduced unnecessary admissions.

Risks & Challenges

- Installing suitable infrastructure and technology in remote care settings.
- Patients having the requisite technology in their own home.
- Varying levels of patient digital competency.
- Virtual care to supplement and compliment F2F care but not replace it.

West Suffolk NHS
NHS Foundation Trust

Interoperable and Intelligent Systems

Digital tools and platforms that empower our workforce.

WSFT and the wider healthcare community is made up of a range of digital tools, platforms and systems. In order for them to provide efficiencies, break down silos and be willingly adopted across the board, they must connect in a seamless manner and be intuitive for users.

Our Desired Outcomes

- **Easy access to actionable data** extracted from different clinical and non-clinical systems to drive the notion of data-driven care across the trust.
- **Use of predictive analytics** (eg: Machine Learning to predict patient length of stay) for better care planning and improving patient experience.
- **Platform Architecture** that facilitates efficient usage and enables core activity, through intuitive user workflows, standardised functionality, adequate licencing and regular updates.
- **IT Support** function that is easily accessible and responds quickly to bugs and errors with systems.
- **Data** processes in place to extract, store and analyse data from multiple systems. Capability to turn data into **Management Information, Reporting** and actionable **Insights.**
- **AR/VR** based education systems to train staff and patients using immersive technology
- **Ease of access** to multiple systems, such as through Single Sign On and Biometrics, giving staff significant time savings.

Benefits

- Better-informed decision making in both clinical and non-clinical settings.
- Improved Digital wellbeing of Staff
- Staff time saving and efficiency
- Enhanced Patient Experience

Risks & Challenges

- Different systems required for different departments.
- Keeping sensitive data secure, for instance Paediatrics.

Community integration

Build integrated digital services with social care, mental health and other healthcare providers to deliver quality community care.

One of the key strengths of WSFT is its network of healthcare providers, both in an acute setting and in the community. Digital services must transcend all settings, in order to create a seamless experience for patients and staff. Community Integration also allows patients to be treated closer to or in their home, which significantly increases patient experience and relieves pressure on major centres such as West Suffolk Hospital.

Our Desired Outcomes

- Integration between care providers to enable **information transfer,** creating efficiencies for staff receiving patients from a different care provider.
- Leveraging the strengths of each healthcare provider to provide a complete **end to end patient pathway.**
- **Patient Experience** – treated in their community by clinicians who they are familiar with.
- Use of **Mobile Devices** to provide immersive patient experience in the community, through **AR and VR.**
- Collaboration within the Alliance to facilitate collective progress.

Benefits

- Patients have easier and quicker access to the specific care they need, improving patient experience and quality of health.
- Reduced unnecessary admissions.
- Reduced average length of stay.
- More informed decision making based on collective data and information.

Risks & Challenges

- Installing enabling infrastructure and technology in care settings.
- Patients having the requisite technology in their own home.
- Varying levels of patient digital competency.

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Smart and robust infrastructure

Make our infrastructure and systems modern, secure and interoperable.

The success of digital and IT projects often hinges on existing networks, infrastructure and hardware. Just as important as delivering leading technologies is ensuring that the enabling core infrastructures are fit for purpose, particularly for staff who use them every day.

Our Desired Outcomes

- **Platform Architecture** that provides essential functionality for all staff to perform tasks efficiently.
- **Network Infrastructure** that not only supports the introduction of new digital systems, but provides connectivity and functionality as BAU for all staff in all locations.
- **Digital systems to enhance patient care** such as Smart Rooms, Digital Wayfinding, and Patient RFID Tracking.
- **Digital systems to enhance staff efficiency** such as Tap and Go / Biometric Log on, Digital Pens, Smart asset management and tracking.
- Regular appraisal and horizon scanning to ensure infrastructure is in place to facilitate digital advances, and that **infrastructure is futureproof.**
- **Hardware** that is role specific to meet needs of remote working, such as dual screen.

Benefits

- Patient Experience and increased digital competency.
- Staff time saving and efficiency.
- The ability to capitalize and benefit from new digital systems as an early adopter.

Risks & Challenges

- Ensuring infrastructure is futureproof in a rapidly changing and developing market.
- Maintaining security, particularly with remote working.

Digital culture

Building a supportive culture that strengthens the way we behave, think and communicate using digital.

Simply implementing digital services and new technologies will not guarantee adoption and benefit realisation. Sufficient L&D, support and communication must be provided in order to embed change and ensure that staff, patients and all users have a positive perception of digital.

Our Desired Outcomes

- Clearly defined **Communication channels** and **collaboration tools.**
- **Digital Inclusion**, creating a 'Digital First not Digital Only' culture.
- **L&D** provided as part of new system rollouts but also available to support staff with BAU activity to support the collective development of digital competency of the work force and patients.
- Network of early adopters able to develop, test and trial digital systems and technologies.

Benefits

- Enhanced digital wellbeing of staff.
- Readiness and willingness to adopt future new digital services and technologies seamlessly.

Risks & Challenges

- Varying levels of digital competency across staff, patient and community groups.
- To build up confidence in digital systems takes time, and can be quickly undermined by any issues that staff and patients experience with the technology or systems.

Open Source

definition: **Open source** software is software with source code that anyone can inspect, modify, and enhance.
"Source code" is the part of software that most computer users don't ever see; it's the code computer programmers can manipulate to change how a piece of software—a "program" or "application"—works. Programmers who have access to a computer program's source code can improve that program by adding features to it or fixing parts that don't always work correctly.

Our approach

- We will consider open source software when available and wherever the functionality matches or approaches the best of products available
- Open source projects, products, or initiatives embrace and celebrate principles of open exchange, collaborative participation, rapid prototyping, transparency, meritocracy, and community-oriented development
- Rich functionality has been developed by dedicated resource with deep knowledge of the subject matter area frequently with close clinical engagement making solutions relevant and appropriate

Benefits

- Rich functionality typically at a much lower cost

Risks & Challenges

- The development timescales can be unpredictable due to wide variations in priorities and availability of knowledgeable development resources
- Whilst the software is sometimes considered “free” it usually required expertise in configuration and optimisation of the product carried out and charge for by commercial companies

Use case

We have implemented Open Eyes which is open source software to support the Ophthalmology department.

Likewise, the ICS wide End of Life solution (ROSI) is based on OpenEHR which is the leading open source platform as a repository for clinical data

Digital foundations

Telephony

definition: **Telephony** *within the Trust has many facets that include basic telephone services. However, there are a number of other key components that are also utilised including; Call Centre Services, Branch and Cloud hosted services, as well as integrating call features in to other clinical or administrative systems. The integration with other communication systems such as bleep and paging services, SMS or mobile technologies are also key within a modern technically advanced system.*

Our approach

- Single person, Single number through the use of soft phones and mobile Apps that enable a users Office number to be presented on any device therefore reducing the need for additional mobile phones for work
- Integration with other core systems such as e-Care and TEAMS for Patient consultation services
- Moving towards a true Branch and Cloud Hosted Solution through the Trusts investment of its current on premise solution which enables this migration through being cloud ready
- Consolidation of systems to improve end user experience and potentially reduce cost and complexity
- Transformation from BT ISDN Services to VoIP over SIP services between sites and remote clinics

Benefits

- Single platform to provide the highest level of service
- Reduced complexity by reducing the need for on premise equipment
- Cloud Hosted services that integrate into other open source or open platform solutions to deliver improved patient care

Risks & Challenges

- Balancing the need to provide a rich telephone solutions while maintaining a simple user experience.
- Costs

Use case

The IT Department has been working with Cerner and Unify to develop direct from patient record calling. This is the ability to open a patients record, and click their telephone number and dial the patient directly, thereby reducing time and dialing errors during busy periods.

Digital foundations

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Endpoint

definition: **Endpoints** *are the devices used by staff to aid in the giving of care. Endpoints can include, mobile phones, tablets, laptops, desktops, specialist devices and monitoring. Through the use of IoT, endpoints are capable of providing Realtime monitoring, analysis and diagnostic capabilities. By providing the right endpoint device or collection of devices to the right person it is possible to improve patient care and provide the tools needed to save lives.*

Our approach

- Mobility First, through high performance devices that provide real time information to care givers throughout the Trust
- Maximise device perform, minimise the number of devices required
- Reduce complexity
- Data rich through the use of IoT, providing real time data centrally collated and easily assessible through appropriate tools
- Virtualised infrastructure, further reducing the need for workstations through the use of Thin Client technologies.
- Tap and Go, Follow me Printing and following me Desktops
- Password-less user access, through the use of biometric technology

Benefits

- Access to systems where ever there is suitable connectivity.
- Capable of working from home or remote locations
- Standardised docking solutions
- Dual screen capable without the need to purchase additional monitors

Risks & Challenges

- Mobile Endpoint devices are typically more expensive than their desktop based counterparts
- Mobile endpoints are more at risk of loss or damager
- The speed to which endpoint devices are updated, leaves the Trust with a shorter life cycle than previously considered.

Use case

Due to the pandemic, we took the decision to move to a mobile first workforce, replacing existing desktop devices where appropriate and deploying standard docking stations to enable staff to work from multiple locations, including from home. Our Community staff are entirely mobile first enabling them to access systems from anywhere there is public internet connection.

Digital culture

Cyber Security

definition: **Cyber security** *is how individuals and organisations reduce the risk of cyber attack.*

It's core function is to protect the devices we all use (smartphones, laptops, tablets and computers), and the services we access both online and at work from theft or damage.

It's also about preventing unauthorised access to the vast amounts of Personal Identifiable Data we store on these devices, and online.

Our approach

- To move away from the old Maturity Based approach for Cyber Security to a Risk based model.
- The IT Department will identify key Trust assets such as Critical systems, functions, people, data and applications, once identified we will prioritise and focus on those elements that create the highest cyber risk. Focusing on the highest risks enables to the department to apply the appropriate level of control without excessive costs or technology controls to manage them

Benefits

- Reduced complexity
- Reduced cost of monitoring and managing the infrastructure to mitigate potential risks
- More streamlined focused monitoring and responsiveness to threat detection and resolution

Risks & Challenges

- Old habits die hard
- Identifying high risk elements is not just an IT Task
- User awareness and training

Use case

The Trust was the first hospital to implement Darktrace, the global leading tool for cyber security, that uses AI to detect and autonomously respond to cyber attacks in real time. It is modeled on the human immune system and learns and understands 'self' for everyone and everything in the system. It can then spot subtle signals of an advanced attack whether it come from the network, cloud or endpoint devices

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Cloud computing

definition: **Cloud computing** is the on-demand availability of computer system resources, especially data storage (cloud storage) and computing power, without direct active management by the user. The term is generally used to describe data centres available to many users over the Internet. Large clouds, predominant today, often have functions distributed over multiple locations from central servers. If the connection to the user is relatively close, it may be designated an edge server.

Our approach

- The government strategy is to follow a **Cloud First** approach using public cloud offerings wherever possible
- We will move to cloud provision by developing strategic partnerships with cloud providers that enable the Trust to deliver its objectives in technology as an enabling service.
- Consumers of cloud services should be able to unilaterally provision computing capabilities, like server time and network storage, as needed without requiring human interaction with each service provider.
- It's highly likely the Trust will utilise many cloud servers in the future, including but no limited to PaaS, SaaS, IaaS and many more. As offerings from cloud providers become ever wider the IT Department will look to harness these technologies to enable faster, more robust and scalable solutions.

Benefits

- Offers the ability to scale services to match demand
- Collaboration with other organization's become easier
- Revenue based financial modelling enables the organization to better manage costs without the impact of capital budgeting
- Reduced physical presence of a Data Centre within the Trust building

Risks & Challenges

- The costs of cloud computing need to managed carefully
- There is a proliferation of suppliers and hosting services that need careful evaluation
- Connectivity to the internet becomes critical and so demands high bandwidth and resilient connections

Use case

We developed the staff vaccination system in Microsoft Azure public cloud with links to on-premise database servers. It allowed staff to book their vaccinations from any location and allowed them to amend their appointments through links into confirmation e-mails

Digital foundations

Networking

definition: **Network,** *The hardware layer that underpins how devices connect and communicate with each other. The protocols used to provide fast, safe and secure transmission of data across a wide range of devices. Modern networks have evolved to be more than just switches in a rack delivering services to devices within a building or campus to enable integration between sites and the cloud. Through being Software defined, cloud ready and highly secure a network underpins the requirements of a modern Hospital.*

Our approach

- WIFI First, using the latest WIFI 6 technology to deliver greater performance, resilience and security throughout the Campus and beyond.
- 5G/+ Mobile Technology built-in to the Core network and vendor agnostic, delivering highspeed services to expand the Enterprise network using secure public services
- Built using the latest Fabric Technology at the network Core providing scalability to deliver services that grow as required ensuring performance is always appropriate for demand
- Cloud ready ensures integration with the latest management platforms to seamlessly expand the enterprise into the Cloud whilst still maintaining complete control and security of the Trusts information assets.
- Software Defined to enable greater flexibility, prevent vendor lock-in and provide new services as they become available

Benefits

- Flexibility to deliver services over a wide range of devices and sites
- Highspeed reliable fixed and mobile connectivity enabling care from any care giving location
- Enabling Enhanced Building intelligence Management Systems

Risks & Challenges

- Poor connectivity options available within the region
- Limited or no diverse routing into the main site
- Poor mobile signals within the area

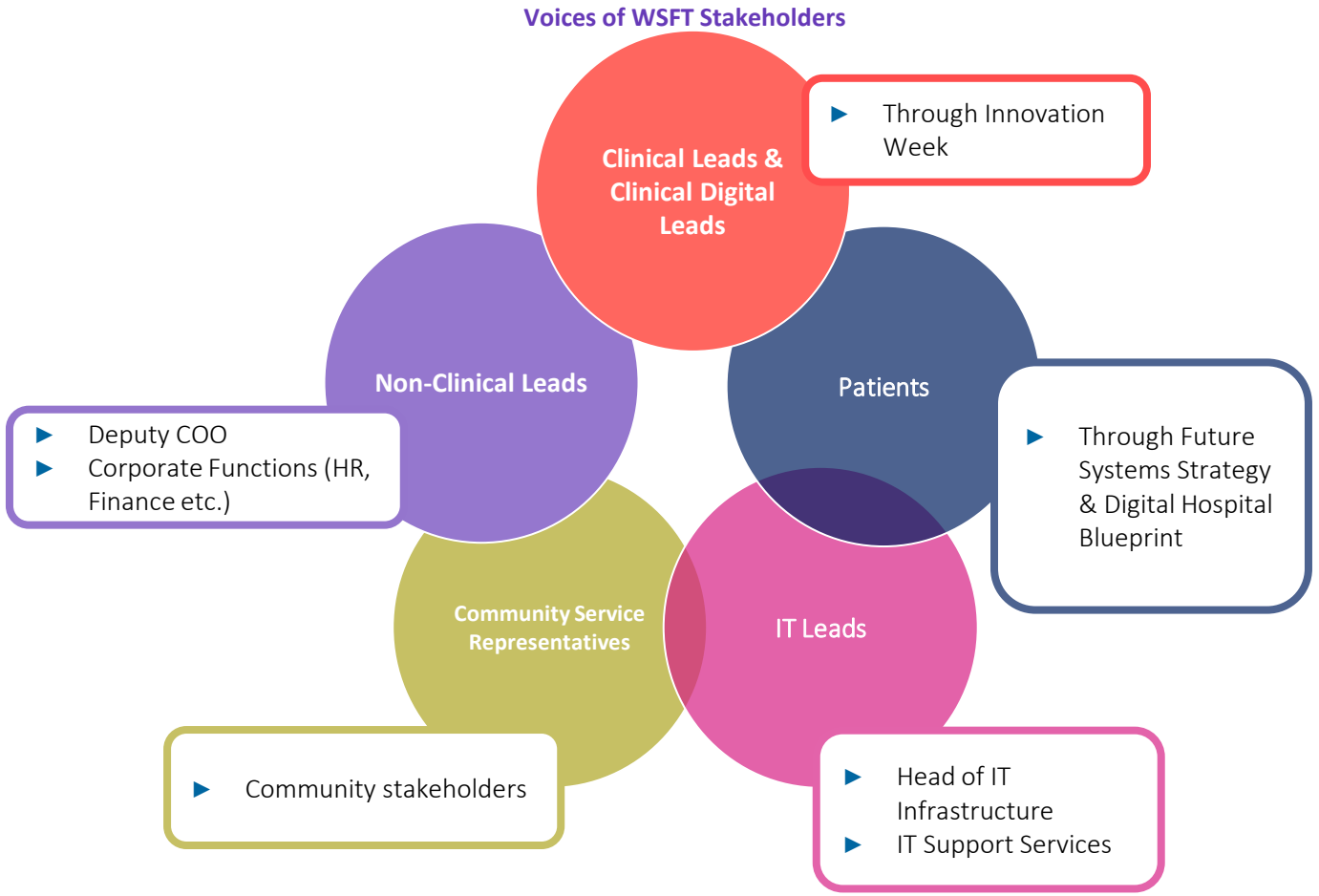
Use case

We have recently purchased the latest Fabric network Core technology from Extreme Networks to develop our network infrastructure enabling the Trust to expand out capacity and throughput and utilize the latest cloud servers whilst maintaining a secure virtual boundary

Appendix 3
Stakeholder engagement

Engagement approach

- ✓ Incorporate inputs from business priorities, IT priorities, dependencies, financial constraints, and current IT state
- ✓ Conduct current state analysis
- ✓ Identify digital demand by considering Voices of WSFT stakeholders
- ✓ Assist WSFT to balance business priority vs costs
- ✓ Create 5-year strategic roadmap



*We will adopt a **'use existing'** approach to draw inspirations from what's present and then engage with additional stakeholders (as required) to ensure **'no voice is left unheard'***

Stakeholder Engagement Sessions

Team	Name	Role
Digital / IT	Ian Coe	CNIO
	Sarah Judge	CCIO Community
	Emma Hatton	Application Support Manager
	Guy Hooper - EPR	Head of Digital Projects and Programmes
	Rob Howorth - Technical	IT Infrastructure Manager
	Seema Moss	IT Training Manager
	Andrew Smith	Technical Projects Manager
	Liam McLaughlin	CIO
	Sarah-Jane Relf	Head of Digital Transformation
Executives	Craig Black	Director of Resources and Deputy CEO (responsible for IT)
	Helen Beck	COO
	Nick Jenkins	MD
	Sue Wilkinson	Chief Nurse
	Dermot O'Riordan	CCIO and Consultant Surgeon
HR	Claire Sorenson	HR
Clinical Directors		
Medical Secretaries		

Team	Name	Role
Operations	Alex Baldwin	Deputy COO
	Simon Taylor	Associate Director of Operations - Surgery
	Michelle Glass	Associate Director of Operations - Community
	Sarah Watson	Associate Director of Operations - Medicine
	Michelle O'Donnell	Associate Director of Operations -Women & Children & Clinical Services
	Jo Raynor	Performance/Quality Improvement
Quality Improvement	James McFarlane	QI Lead
	Natasha Rivers	QI Lead
	Denise Pora	Deputy Director of Workforce (Development)
	Sue Deakin	Consultant and Human Factors
	Dan Spooner	Deputy Chief Nurse
Community	Kevin McGinness	Local Area Manager and Co-production Lead
	Sandra Webb	Local Area Manager and Co-production Lead
	Michelle Glass	Associate Director for Community and Integrated Services
	Nic Smith-Howell	Associate Director of Integrated Community Paediatric Services
	Gylda Nunn	Integrated Therapies Manager, co-production lead for Therapies Workstream
Communications	Helen Davies	Head of Communications

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Digital Fortnight

We engaged with 41 attendees across 11 clinical workstreams over the 2 weeks

Name	Role
Emma Cameron	Clinical Innovation Lead and GP trainee
Diogo Silva	Clinical Information Fellow and junior doctor
Liam McLaughlin	Chief Information Officer
Dermot O'Riordan	Chief Clinical Information Officer (CCIO) and consultant surgeon
Ian Coe	Chief Nursing Information Officer
David Ross	Consultant in O&G and deputy CCIO
Tom Houghton	Consultant in Paediatrics and deputy CCIO
Chris Barlow	Digital Business Analyst in community and therapist
Sarah Judge	CCIO for community and therapist
Maryam Jadidi	Consultant anaesthetist and deputy CCIO
Simon Whitworth	Chief Pharmacist
Guy Hooper	Head of Digital Programmes and Projects
Nicola Yates	Head of Information and Contracting
Anne Swift	Consultant in Public Health
Helena Jopling	Associate Medical Director for future system (and public health consultant)
James Butcher	Future Systems Operations Lead
Mark Manning	Head of Nursing Future Systems
Tracy Morgan	Programme Manager Future Systems Clinical workstreams
Sarah Jane Relf	Head of Digital Transformation

Name	Role
Lorraine Weaversmith	Emergency Services clinical lead
Bethany Barrett	Emergency Services clinical lead
Victoria Wilson	Women's Services clinical lead
Matthew Larkin	Women's Services clinical lead
Jon Nicolson	Theatres/Critical care clinical lead
David Higgins	Theatres/Critical care clinical lead
Trish Bivins	Theatres/Critical care clinical lead
Marcos Martinez	Planned care clinical lead
Bethany Barrett	Planned care clinical lead
James Whatling	Education and research clinical lead
Mark Hunter	GP lead
Katherine Picinelli	Paediatrics clinical lead
Clare Harrison	Paediatrics clinical lead
Kirsty Rawlings	Outpatients clinical lead
Linda Johnston	Pathology/Mortuary clinical lead
Tracey Green	Pathology/Mortuary clinical lead
Craig Vickery	Diagnostics & Endoscopy clinical lead
Annie Kelling	Diagnostics & Endoscopy clinical lead
Sandra Webb	Community and Therapies clinical lead
Liza Asti	Community and Therapies clinical lead
Rosie Finch	Community and Therapies clinical lead
Gylda Nunn	Community and Therapies clinical lead

Key challenges, demands and opportunities extracted from the stakeholder engagement sessions

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Challenges	Large number of IT & Digital Projects in the backlog, with changing and competing priorities.	Increasing number of digital services and platforms for staff and patients to use. 'Digital Pile On' preventing time savings and efficiencies.	Pressure to reduce unnecessary admissions, reduce length of stay and treat patients in the community / at home	No easy access to data or reports across systems. Lack of translation from data to information.	Effectiveness and perception of Digital and IT is dependent on Network, Infrastructure, Hardware and Devices.
Digital Demands	✓ Earlier engagement with stakeholders when developing systems and tools ✓ Smaller, incremental improvements through dynamic projects ✓ Quicker procurement ✓ Establish a formal prioritisation process	✓ Remove duplication of work with integrated and interoperable systems ✓ Benefits realization ✓ Streamline workflows to break down silos ✓ Training and support to ensure all staff know how to use systems correctly ✓ Decommission legacy platforms ✓ Network Infrastructure must be robust	✓ Empower patients to own their care ✓ Smart infrastructure and clinical systems ✓ Equip staff with secure hardware to deliver care from anywhere ✓ Consistency across care settings ✓ Easy access to information ✓ Interoperable systems to remove silos between health care settings ✓ Coordinated progression across Alliance	✓ Centralised Data Warehouse ✓ Data accessible to those who require it ✓ Interoperable systems that enable data to be collected and transferred. ✓ Data-driven decision making ✓ Data and reports translated into usable Management Information ✓ Reports, Management Information and Insights communicated.	✓ Systems must be fit for purpose for all users ✓ Licenses up to date ✓ Futureproof infrastructure and hardware to accommodate growth ✓ Suitable devices and security to enable effective and safe remote working ✓ Accessible and responsive IT Helpdesk
Opportunities	● Digital Delivery ● Communications ● Procurement ● Digital Principles to inform prioritisation ● Wider promotion of and accurate use of Change Request Process ● Change Management	● L&D ● Platform Architecture ● Digital Culture ● Benefits Realisation	● Patient Empowerment ● Community Integration ● Security ● Communications ● Platform Architecture ● Change Management	● Data Management ● Platform Architecture ● Communications	● Security ● Platform Architecture ● IT Support ● Procurement

Stakeholder Voices

Digital / IT Department

- Lack of formal process or matrix for prioritising digital projects.
- Digital ambitions and principles should inform prioritisation.
- There needs to be a long-term strategy that is flexible enough to accommodate changes in short term priorities.
- Strategy should include some specific, measurable objectives.
- Improved accuracy is needed around estimation of time and resource needed to deliver projects.
- Projects should be broken down into smaller, dynamic projects that can deliver incremental value.
- Give the patients the tools to take responsibility for their own care where possible.
- Need to improve the identification, realization and measurement of benefits.
- Technologies should be implemented to achieve specific benefits, not just 'because we can'.
- Invest sufficient time to shifting culture.

Medical Secretaries

- Helpdesk – Lack of communication, unclear escalation routes. Known issues, faults, maintenance etc should be communicated centrally. Allocated point of contact per department would be useful.
- Training – often done by respective teams. More resource allocation to training required
- Appropriate engagement with staff early in the project journey. Address concerns.
- Ownership – clarity needed around which team is responsible for which digital project / platform.
- Siloes between departments and ownership of issues.
- Programmes and Platforms must be fit for purpose and include all features that are required for each job role, including whilst WFH.

Nursing

- More effective use of the technology we already have.
- Virtual consultation / remote monitoring – learn from Covid-19.
- Digital inclusivity.
- Digital often adds layers and time for staff rather than removing it.
- Technology shouldn't replace F2F, but enable staff to better target patients who need assistance.
- Don't lose the 'art of nursing' to technology and 'ticking a box but missing the point'.
- Security required on personal devices.

Stakeholder Voices

Digital Board

- Digital and Technology often enables us to do things better but not quicker
- Digital shouldn't just replicate the processes we already have. It should innovate and improve.
- Reduced variation in care delivery should equal better care, but it's not necessarily one size fits all.
- Tackle resistance to change through education of the short and long term benefits, for staff and patients
- Key improvements: Tap 'n' Go, Patient Portal, Interoperability.
- Ensure we consider what neighbouring trusts are doing when we make decisions around platforms / providers. Don't become an 'island'.
- Don't just target specific constraints.

Clinical Directors

- Patients should be given the tools and ability to take ownership of their own care.
- Several specialist systems to provide specific functionality is often better than a one size fits all system, as long as they are interoperable.
- Workload is high as a result of Covid-19 disruption. Digital systems and technology must contribute to reducing this.
- We must guide stakeholders through the full journey of digital and tech – understand it, use it, realise benefits from it.
- Better integration of primary care notes
- Two-way communication with patients is an opportunity to empower and generate efficiencies. E.G whilst they are on a waiting list, pre-assessment forms and consultations etc.
- Last IT Survey found that digital reduces f2f engagement. We need to improve patient safety and also engagement and wellbeing.
- eConsent

Quality Improvement

- Patient Empowerment is key. Owning their own patient journey.
- Interactive tools and platforms that can help visualize pathways would be beneficial for staff and patients.
- L&D is required to ensure that staff know how to use systems effectively.
- Data Management could be improved – access to data and transfer of data between departments and systems. Better visualization of data and trends.
- Systems must integrate better, to remove boundaries between departments.
- Consistency of interaction with tools and systems across departments is crucial.
- Remote working has been adopted well and must continue to be enhanced and embedded in our culture.

Stakeholder Voices

Clinical & Human Factors

- If technology helps us to do our jobs then Patient Safety will naturally increase. Efficiencies must be gained, such as with SSO / Tap n Go.
- Hardware should have multiple functions and be intuitive for a human being to use.
- New systems are often introduced but we need to make sure we are using existing systems correctly too.
- L&D to enable correct usage. Work as Imagined vs. Work as done
- Marginal Gains – small improvements = significant impact.
- Communication is key – provide people with a channel to collaborate and influence.

HR

- Transition to remote working has been managed well and must continue to be embedded.
- Data extraction, transfer and analysis could be improved.
- Systems must integrate better to remove boundaries.
- Security measures must be reviewed. E.g emails.
- Prioritisation of Digital Projects must be more dynamic and collaborative.
- Procurement must ensure hardware is fit for purpose and essential functionality met before cost considered.
- Resistance to change exists. L&D and communications would help to better embed digital and technology into WSFT's culture.
- Efficiency would be achieved if new joiners could begin their onboarding process virtually before they start.

Projects Portfolio

- Prioritisation process should begin earlier (previous October) to ensure we are prepared and changes can be made ahead of the budget.
- Change Control Process is robust.
- Communication and engagement – giving stakeholders visibility of projects early will increase successfully deliveries.
- Increase the input from clinicians in development phase.
- Remote working must be carefully considered at a specific level, to suit individual needs.
- Community Integration and treating people in their own homes is a key element of the strategy.
- Integration of platforms and systems is advanced.

Stakeholder Voices

Community Services

- Hardware rollout has successfully enabled culture shift to remote working.
- Lack of Data Warehouse – reporting process is based on workarounds.
- Integration between systems such as eCare and Systm One needs to be improved.
- Geographical proximity between care settings must be considered.
- Hardware and technology must be futureproof.
- Rollouts of technology and services must be supported by sufficient training, which must remain accessible as BAU.
- Communication within the Alliance must be regular, with effective change management in place to ensure coordinated progress.
- Pro-active horizon scanning to ensure we anticipate digital advances.

Associate Directors of Operations

- To unlock full benefits from systems such as eCare, we must set out roadmaps and plans as to 'how' we are going to optimize their use.
- This must include how we are going to empower patients and staff in order to drive successful adoption of new systems.
- We aren't effective at turning Data into operational information. 'Data rich but information poor'.
- Network infrastructure must be improved to support adoption of systems.

Paediatrics and Community

- Shift to remote working has been managed well.
- Specific challenges around safeguarding mean that Systm One and other key platforms require tailored approach.
- The number of new features, systems and projects that are delivered is limited by Developer / IT Resource available.
- Smart technologies are applicable in both acute and community settings, particularly around 'play' based activities – e.g. toys being replaced with Tablets. Virtual/Augmented Reality and Gamification.
- Audio integration and Digital Pens to provide richness of records.
- Collaboration tools such as Sharepoint could be improved, to improve security and enable easier transfer of large files.
- Single Sign On and Biometric Log in should be implemented as standard, for security and time saving benefits.
- Virtually connect with patients before a visit – good for putting elderly or children's minds at ease and becoming familiar pre-visit.
- Remove duplication of effort. For instance, capture patient experience at point of care through ambient listening, not in a later survey.

Stakeholder Voices

Communications

- Good public website that is focussed on patient accessibility.
- System to manage website.
- Looking to update the intranet.
- Digital Newsletter via Outlook.
- How you communicate with staff in clinical roles and community roles.
- Digital solutions that can help engage with staff.
- Nothing is centralised – different digital systems.
- Time to look at 'digital' is a challenge.
- Anything the department does needs to be accessible.
- Some people don't want to engage digitally.
- Digital Signposting via digital screens etc.
- Patient portal for messaging etc.
- Digital forms.
- E-learning.

CCIO

- WSFT buy-in to the importance and value of digital.
- Resourcing the delivery of project backlog is a challenge.
- Interoperability of systems must be improved.
- Need to store, access and use data more effectively. The right data to the right staff at the right time.
- Better use of the cloud and data visualization tools in the front end.
- Machine Learning and Predictive Analytics big opportunities.
- More methodical approach to prioritisation of IT Projects Required.
- Communication channels must be clearly defined and consolidated.
- Ensure patient preferences are at the heart of ways of working.
- Empower patients and integrate wearables and data into EHR.

4.2. Future system board report

To inform

Presented by Craig Black

Public Board Meeting – 28th January 2022

Report Title:	Item 4.2 - Future System Board Report
Executive Lead:	Craig Black
Report Prepared by:	Gary Norgate
Previously Considered by:	Future System Programme Board

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☐

Executive Summary

As a general indication of health, the status of those tasks within the control of Future System Programme remain unchanged as 'Green' and significant strides having been made in several key areas:

1. Work continues on a detailed assessment of the impact that building a new hospital on Hardwick Manor would have upon the environment (known as an Environmental Impact Assessment - EIA). As we continue to work on surveys of the site's hydrology and potential archaeological value, we are also now working with the Suffolk Wildlife Trust to devise ways to maximise the net contribution our project will make to the ecological bio-diversity of our county.
2. We remain on track to formally submit our application for outline planning consent in the Spring of 2022.
3. Phase 4 of the coproduction of our hospital design is underway and will focus on translating the schedule of accommodation and 1:500 plans to the 1:200 designs required for our outline business case.
4. In parallel, we are about to start the work aimed at co-producing the strategic, system-wide solutions aimed at transforming the way parties within the integrated care system (ICS) collaborate and interact. This work will commence with an ICS workshop in January that will review and consider the implications that our demand and capacity modelling will have upon the financial and operational outlook of our system.
5. Our finance workstream is working on the formal appraisal of our shortlisted options – including the construction and analysis of respective benefits. This is a significant undertaking as the magnitude and credibility of the benefits associated with our project will be a significant determinant of our outline business case.
6. Further to the successful site visit from the National Hospital Programme and NHSI/E, we have now arranged for Julian Kelly, NHSI/E Chief Financial Officer, to visit in February.
7. The second phase of our public pre-application planning engagement has now been completed. During the course of both phases we have reached 129,000 people online via organic and paid for social media posts and adverts with significant likes and shares across Facebook, Instagram and Twitter; had 12,711 visits to both our websites; spoken to more nearly 450 people online and face to face at our events and received more than 1,600 completed feedback forms via the post, at events and online.
8. We have now received confirmation of funding for the 21/22 financial year. The requests for funding across the national hospitals programme significantly exceeded the available budget, however, our discussions were highly constructive and we have received the £3.9m that we requested.

Business Cases and Project Plan

We remain on track to submit an Outline Business Case by the close of 2022. Said case has four key areas of focus:

1) **Proving Value for Money** – economic appraisal of the five shortlisted options, benefits appraisal, risk appraisal and sensitivity analysis (the Economic Case).
2) **Preparing for a potential deal** – outline procurement strategy, risk apportionment, payment options and accountancy treatment (the Commercial Case).
3) **Affordability and Funding Requirement** – preparation of the financial model (the Financial Case).
4) **Planning for a Successful Delivery** – project, change and risk management and benefits realisation (the Management Case).

We expect the procurement and commercial strategy to be defined by the National Hospitals Programme, however, we have a huge amount of work to before submitting a credible OBC and, with this in mind, I would highlight the following activities and milestones:

- **The submission and conclusion of our application for outline planning consent**. Submission of our planning application remains on track for spring 2022 and we hope to secure a positive determination by the close of the summer. This is a hugely significant milestone and provides the bedrock upon which we can start to plan our construction. Failure to secure a positive outcome will necessitate us revisiting other potential sites which could add as much as 12 months to our schedule and could cost an additional £50m of net cost. With this risk in mind, every effort is being made to engage our public and relevant agencies to ensure our application reflects all of the concerns and risks identified.
- **The translation of our co-produced clinical model and its associated schedule of accommodation into a relatively detailed 1:200 outline design**. This level of clarity is sufficient for the project to be taken to market and will provide the first glimpse of what a new hospital will actually look like and how it will function. This 'phase 4' Co-production is underway and scheduled to complete July 2022
- **Identification of benefits associated with operating a new hospital**. The cost of operating a larger hospital with more beds will inevitably increase from its current level. Such an increase will require a greater share of the largely fixed Integrated Care System budget at the expense of other parts of the system. Consequently, identification and commitment to efficiencies enabled by the improved facility are a hugely significant part of our business case. Work on these benefits has commenced and we expect a co-produced outcome by June 2022
- **Identification of the wider strategic changes necessary to address ever increasing demand.** Similar to the point above, the ICS cannot continue to 'sweat' existing assets to meet demand. The Future System Programme provides a fresh impetus to a system-wide drive to collaborate more effectively and ensure any new facilities are sustainable. As mentioned in last month's report, a workshop has been planned for the last week of January at which the implications of our demand and capacity research will be shared and debated with our ICS colleagues.
- **Creation of the 'Management Case'.** A smooth transition to new ways of working within a new hospital is obviously hugely important and to this end we have commenced the planning and development of our management case. The eventual execution of the plan will sit with the leadership of the Trust and as such they will be engaged in its coproduction. This work is just starting and will be complete by 23rd September 2022
- **Completion and submission of an outline business case.** All of the work above will culminate in the creation and submission of a full outline business case which we expect to complete by the end of the calendar year.

Other highlights to note include a site visit from Julian Kelly and Nathalie Forrest[1] which has been scheduled for early February. This visit signifies the interest that we are generating and the impression that we have as a credible, entirely deliverable project.

Engagement from colleagues throughout the Trust and our ICS partners remains high, however, as the pandemic exacerbates winter pressures, it is expected that operational priorities could limit immediate availability and could cause delays.

The following ideas that underpin our rationalised schedule of accommodation were ratified by the West Suffolk FT Board at their meeting in December:

- Configure all services to run across 7 days a week, daytimes and evenings (15 sessions per week)
- New general adult inpatient beds limited to 60
- A large outpatient centre in the Western Way development
- Maximum use of elective hubs across the ICS
- "Abolish waiting"-no departmental waiting rooms, just central café/waiting area and departmental receptions
- Working from home becoming routine, including for some the clinical work that can be done remotely
- Education to stay in the Drummond Centre (refurbished)
- Day surgery to be housed in the Treatment Centre (refurbished /extended)
- Sharing of ultrasound rooms

Ratification does not mean that these ideas are immovable decisions, they simply provide broad principles that allow us to progress our design activities with an appropriate level of direction and detail. Many of these ideas will require significant research, discussion and planning before being implemented, however, they do describe a direction of travel to inform our activities and focus.

The application of these ideas has reduced the schedule of accommodation to c.85k sqm. From a capital perspective, building this size of hospital is considered to be on the upper edge of affordability, however, the potentially bigger issue is the implications that such a build will have upon annual operating costs and how they relate to the overall budget of the ICS. With these challenges in mind two workshops have been planned:

Workshop #1, With our ICS partners – to discuss our demand and capacity modelling, what it means for operating costs and how we might collectively address the seemingly endless growth in demand.

Workshop #2, With NHP / NHSI/E – aimed at socialising and gaining outline agreement to the scale of our proposed development and its consequent affordability.

We hope to have completed both workshops in time for the next Board meeting and expect therefore to share that the conclusions will have upon our preferred option.

Estates Workstream

The main thrust of the Estates workstream continues to be the preparation of essential documentation for our planning application which will include the completion of our Environmental Impact Analysis. The key points being progress this month include:

1) The visual impact of a new hospital is a key planning concern. In order to understand this issue, the team have worked with the local planning authority to agree 17 points around the proposed site from which to consider the summer and winter visual impact of the proposed design / massing.

[1] Julian Kelly is the Chief Financial Officer of NHSI/E and Nathalie Forrest is the Senior Responsible Officer for the National Hospitals Programme.

2) Developing an effective strategy for the protection of fungi.
3) Work to understand and mitigate the risk of flood.
4) Development of additional cycle and pedestrian walkways around the site.
5) Archaeological surveys.
6) Design and quantification of remedies to compensate for the ecological disruption caused by building on the parklands of Hardwick Manor[2].

Collectively, these areas illustrate the complexity of building on a green-field site such as Hardwick Manor, they also describe the effort being put in by the team to ensure we protect this environment as best we can. None are considered to be insurmountable and we remain confident that we can successfully secure a positive outcome from our application which remains on track for a submission on or before 31st March.

Clinical / Digital Workstream

Having successfully rationalised the schedule of accommodation (SOA), the focus of the clinical and digital workstreams is now upon a fourth round of Co-production aimed at translating said SOA into a physical design at a scale of 1:200. In parallel to these activities the aforementioned ICS workshop will be used to test the validity and affordability of the underpinning demand and capacity modelling.

A key outcome from the ICS workshop will be the commitment to identify opportunities for collaboration and strategic change that will mitigate the seemingly endless growth in demand for service.

Alongside the immediate work to develop the clinical model and its associated physical and digital infrastructures, work is now commencing on the development of the delivery plans. It may seem early to be worrying about the transition to a new building, however:

1) The OBC requires us to demonstrate that we have the commitment and resources required to deliver the project and its associated benefits
2) Many of the changes to working practices that underpin the benefits and efficiencies of the new infrastructure can and should be implemented now so that they are embedded in time for the move into the new building.

There has been some debate as to who owns the 'management case' and, alongside the Trust Executives, we have concluded that the process of researching and facilitating the development of the plans will be owned and lead by the operational lead appointed to the Future System Team (James Butcher), however, it is critical that operational ownership be established as it is only the Trust itself that can truly embed the necessary changes and realise the associated benefits.

Communications and Engagement

We have now completed our second phase of pre-application public engagement. This exercise has employed a range of methods to maximise inclusion and ensure that everyone has the opportunity to shape our plans.

To date, both phases of the pre-application planning engagement have:

- Reached 129,000 people online via organic and paid for social media posts and adverts with significant likes and shares across Facebook, Instagram and Twitter.
- 12,000 visits to our website

[2] Legislation dictates that developments such as ours must endeavour to create a net gain in biodiversity. The methods for doing so include; enhancing other parts of the same site, creating an alternative site of equal / greater biodiversity or purchasing biodiversity credits that allow other parties to develop alternative ecologically rich environments. Calculations of size and cost are subjective and the WSFT team are engaged with both Council and Environmental agencies to design the most effective solution.

- Received approx. 1,697 completed feedback forms via the post, at events and online.
- Had media coverage in the BBC (online and drive time radio), Bury Free Press and East Anglian Daily Times.
- Spoken to more than 421 people at our face to face and online events. The latest Bury St. Edmunds event received 107 visitors alone.
- Hosted personal visits to Hardwick Manor as well as fielding personal calls and meetings where requested.

Over-arching feedback is positive with most concerns raised around; building height, traffic and car parking. Many individuals would like concrete plans for these elements however they do appear to understand that we are not in a position to confirm these as yet.

Personal sessions were offered to anyone voicing significant concerns and an event held at Hardwick Manor for our immediate neighbours attracted 12 different households from a total of approximately 23. Support for our plans was universal.

Finance

I am delighted to confirm that we have secured funding for the development of our OBC. We had originally requested £6.4m of which we had already received £1.4m. Initial discussions concerning the outstanding £5m were prefaced by an explanation that the national budget was significantly over-committed. With this in mind, we explained how we could utilise our current underspend and contingency to reduce our requirement and we were subsequently awarded £3.9m (all of what we were requesting). This award means that we can continue at our current pace with no impact on our momentum or programme plan. I see the award as a significant vote of confidence.

The finance workstream is about to take front and centre stage as we prepare our economic and finance cases. The economic case focusses on the selection of the optimal value for money solution and as such we are revisiting the 4 options shortlisted within the strategic outline case and conducting a detailed appraisal of the respective benefits and risks. This exercise will culminate in a formal facilitated workshop at which stakeholders will agree the choice of the preferred option. The identification of benefits associated with the preferred option is far from simple and will require commitment from the operational teams that will be required to realise them post implementation.
The finance case determines the extent to which the proposed solution is affordable and fundable over time. The implications of the clinical service changes and agreed growth levels are being assessed and will be presented to the ICB in the summer prior to finalisation to ensure 'affordability'

Having just explained how much work is involved in the coming months, it is with significant regret that I have to announce the departure of Zoe Selmes from our team. Ever the professional, Zoe has given us plenty of notice and will play a significant part in the selection of, and handover to, an appropriate replacement (as if there could ever be such a thing!!). To this end we have advertised the post and shortlisted two extremely strong candidates for interview. I hope to announce our new team member by next Board meeting. That said, I did want to take this opportunity to say a huge thank-you to Zoe for her sterling contribution.

All in all, this has been a period in which significant progress has been made in the funding of our project, the development of our schedule of accommodation, the positive national positioning of our project, the understanding of our preferred site and our engagement with our stakeholders and community.

At the next meeting we aim to confirm the imminent submission of our planning application and a clear report on the conclusions gained from our ICS and NHP workshops.

Action Required of the Board

To note this report for assurance

Risk and assurance:	*n/a*
Equality, Diversity and Inclusion:	*n/a*
Sustainability:	*n/a*
Legal and regulatory context	*n/a*

4.3. Digital pathology business case

To Approve

Presented by Nick Macdonald

NHS
West Suffolk
NHS Foundation Trust

Open Trust Board Meeting –28 January 2022

Report Title:	Item 4.3 - Implementation of Digital Reporting Solution within the Histopathology Service
Executive Lead:	Nick Macdonald
Report Prepared by:	Sarah Rollo, Joe Burford, Linda Johnston
Previously Considered by:	October 2020 - WSFT Board for strategic approval to proceed with determining costs

For Approval	For Assurance	For Discussion	For Information
☒	☐	☐	☐

Executive Summary

A proposal for the full implementation of digital pathology in Histopathology. The mandate for this project was produced as a result of capital funding from the NHSI for digital pathology. This is funding that is accessible to **networking trusts** resulting in WSFT obtaining a potential £1m capital investment. Approval of this project will result in revenue costs of £1.3m and deliver £0.9m of anticipated savings over a five-year period.

Our plan includes working in collaboration with networking trusts (WSFT, NNUH and ESNEFT) to roll out a fully integrated digital histopathology service across the East of England. The scope of this project includes the ability to scan, view and report slides digitally, at a remote location, anywhere in the world. There will be a common reporting platform, encompassing image viewing, reporting and extra requesting as well as potential for implementation of artificial intelligence (AI). All data and viewing/reporting software is to be cloud hosted rather than physically residing onsite.

Our aim is to aid flow of patient data across sites which will have multiple benefits, including data transfer for patients receiving cancer treatments at separate hospitals, and also to facilitate second opinions between colleagues. This will result in reduced turnaround times (TAT) for outsourced work and those that need second opinions; more comprehensive MDTs; and improved quality of diagnosis.

Action Required of the Board

Approval of revenue costs associated with digital pathology to enable WSFT to access the capital funding provided by NHSI.

Risk and assurance:	Not pursuing digital pathology increases risk of recruitment and retention of diminishing pool of consultant histopathologists. Digital pathology also demonstrates that WSFT are networking with local hospitals – without such networking arrangements leaves the service vulnerable and working against NHSI Carter report recommendations and GIRFT Review 2021.
Sustainability:	Digital pathology will provide resilience within the service which has increased in urgency since the COVID-19 epidemic. It provides flexibility for consultants to manage workload and enhances remote working. Increases economic viability by removing the requirement for taxi usage for the transfer of slides. A digital service also provides opportunities to insource work from external hospitals

West Suffolk NHS Foundation Trust
Investment

BUSINESS CASE
PROFORMA

Cancer and Diagnostics – Implementation of Digital Reporting Solution within the Histopathology Service

Document Control Information	
Version Number	v2.4
Authors	Fiona Berry Sarah Rollo Joe Burford Linda Johnston Matt Larkin
Date	January 2022

SECTION A : EXECUTIVE SUMMARY	
Case Title	Implementation of Digital Reporting Solution within the Histopathology Service
Lead Organisation	West Suffolk Hospital NHS Foundation Trust
Case Lead	Linda Johnston
Service/Specialty	Pathology

A1 : Brief Summary of Case

Overview
This business case is seeking revenue investment of £1,284k over five years to implement a digital reporting solution within the histopathology service that delivers £855k of anticipated savings over the same period. Digital pathology, also known as whole slide imaging (WSI), is performed using specialised, high throughput scanners that capture a digital image of the whole slide for review. This "virtual slide" is an image created by the digitisation of the glass slide that can be viewed at a remote location, anywhere in the world. Digital pathology can provide a flexible platform for safety, quality and efficiency improvement. It will also future-proof our diagnostic capabilities, whilst allowing us to work more flexibly and creatively to meet targets and maintain standards.

The manner in which histopathology services are delivered is changing at a regional and national level. In the UK, we face increasing pressures to meet cancer turnaround time targets as well as an increasing complexity of specimens requiring a more complex assessment to meet the requirements of national datasets. It is known that healthcare systems face a global shortage of pathologists, while diagnostic workloads and complexities continue to increase. Hence, there is a pressing need to innovate and modernise the way pathology services are delivered to provide more accurate and timely diagnosis. There is a trajectory of a 4.5% increase of Cellular Pathology requests year on year with an estimated 32% of UK Cellular Pathologists expecting to retire within the next five years.

The introduction of digital technology will have a significant impact in reducing turnaround times (TAT) for outsourced work and those that need second opinions; more comprehensive MDTs; and improved quality of diagnosis. This will translate into quicker results for patients on a suspected cancer pathway. It is thought that it may lead to improved productivity amongst consultants though this is not yet certain. It will lead to greater flexibility for consultants, allowing them to work off-site, which should support the retention and recruitment of Consultant Histopathologists.

Current WSH Picture
At present, the service is complimented by a full establishment of consultants, whilst neighbouring Trusts suffer from long-term vacancies. West Suffolk Hospital's Cellular Pathology department consists of 9 Consultant Pathologists, 1 Consultant Biomedical Scientist and 1 trainee consultant, with 1 consultant due to retire. The department generates roughly 80,000 slides per annum with a 6% average yearly increase.

In Q1 2021/2022 74% of patients at WSH were told their cancer diagnosis outcome within 28 days. In the last year, Cellular pathology have failed to meet the 3 day TAT and in the last quarter, have failed to meet the national 7, 10 and 21 day TAT.

If WSH do not implement a digital reporting system, there is the risk that if advancement continues at the same speed, manual reporting will become more inefficient and outdated and we will provide a comparably poorer diagnosis for patients when compared to Trusts with digital reporting. WSH will fail to recruit staff and could lose existing staff from an already shrinking pool of trained Histopathologists.

The Benefits of Digital Pathology

The investment in a digital reporting system will deliver the following benefits (based on 2021 data);

- **Save 3,494 TAT days** on gaining a **second opinion for 250 patient cases** in 2021, equivalent to **9.57 years of time saved**
- **Improve** the **quality of 529 cases** sent for SMDT review by having all images ready for full review
- **Significant time saving** of Band 3 MDT preparation
- **Faster diagnosis** for **1043 cases** that have had stains requested from external referral sites
- **Save £1000 per year** of taxi/courier costs associated with second opinions/SMDT, sending slides to consultant homes
- **Save £1000 per year** on retrieving slides from storage
- **Improve** the quality of cancer **diagnosis by 10%,** through more accurate counting and measurement of samples. This will **benefit ALL cancer diagnosis**
- Repurposing staff time to establish more efficient workflows
- Improved case management could reduce backlog – current spend **81 sessions of consultant overtime** which equates to £40k and **reduced TAT** for **1,620 patient cases**

For a full list of benefits of digital pathology please see **Supporting information 1**

This business case requests WSFT to approve revenue funding associated with the capital expenditure from the regional digital capital funding from the NHSEI and support future commitments to digital pathology. This will enable WSFT to implement 100% digital pathology as a network of NHS Trusts, as per guidance from ICS Digital Programme Director - Suffolk & North East Essex ICS and Liam McLaughlin WSFT CIO.

This funding would be used to procure:

- **Programme Management resource** to manage the project
- **Scanners** to scan the glass slides
- **Image Management Software** (IMS) that can be integrated into local IT infrastructure
- **IMS Viewer** providing tools for viewing and management of case loads
- **IT System integration**

To date funding of £100K has been secured from the East of England Cancer Alliance. A bid for capital funding has been submitted to NHSE/I in conjunction with NNUH and ESNEFT. Procurement planning has commenced, including tender documentation and supplier visit demonstrations.

Due to the scale of the transformation required to move to Digital Pathology, revenue investment from WSFT will be required for:

- **Data storage**

- **Licensing and Maintenance costs**

Financial benefit to Trust or wider health economy (incl. cost avoidance)	Yes
Necessary to mitigate patient safety risk (quality)	Yes
Necessary to meet legal or regulatory requirement (mandatory)	Yes

A2 : Financial Impact Assessment			
Income and Expenditure	**Recurrent (first full year)**	**Non-Recurrent**	
	Annual Revenue	**Revenue**	**Capital**
Expenditure (-) : Additional incremental costs	(£213k)	£0	(£280k)
Savings (+) : Cost reductions	£28k	£	£
Income (+) : Additional to be delivered by investment	£0	£	£
Surplus / (Deficit) of proposal	(£185k)	£	(£280k)

A3 : Other Impacts	
Activity : Additional to be delivered by investment	Yes
Workforce : Increase / (decrease) in wte	Yes
Other capacity constraints (e.g. beds / theatres / clinics)	Yes
Availability of capital	Yes

SECTION B : STRATEGIC CONTEXT

B1 : Current Service Provision

Current Service
Developing and maintaining a fast, efficient and fully staffed Histopathology laboratory is crucial in supporting the wider cancer pathway, meeting and exceeding national targets and giving patients the best start to their treatment.

The Current Workflow
The Histopathology Services at WSH use traditional manual methods to report on cases. Tissue and samples coming into the lab are prepared and placed onto slides. The slides are manually

transported around the lab to the individual Histopathologists. Each Histopathologist uses a microscope to make their diagnosis. All case notes and consultant commentary are kept separate to the slides. There is no electronic record of the tissue sample itself, only the physical slides.

The slide stays with the histopathologist and remains on their workbench. If it is felt a second opinion is required, the slides are packaged and posted / transported to the required destination, this can be outside of WSH. The average wait for a second opinion is 2 weeks. On top of the time it has taken to get the initial diagnosis.

A medical secretary matches the consultant's case notes with the slides and types up the case report. Slides are taken and archived. If the slides are required for an MDT, they need to be physically found and retrieved. Slides are not always routinely archived, causing delays in MDTs and wasting staff time.

When a report from an outsourced case is received, the Medical Secretaries must manually match the result to the patient and input the findings. This can further delay case reporting by days. **For a full list of limitations of current process please see supporting information 2.**

Patient Benefit
Patients are not benefiting from an efficient service at present. A digital reporting system would mean all case notes and slides are kept together and accessible to staff immediately. Removing any delays to MDTs and enabling consultants across the cancer pathway to compare previous and current images of a patient sample, which is not currently possible. It would remove the physical movement of slides around the lab, transportation outside of the trust for a second opinion, and ensure copies of all slides are available whenever they are required.

Digital Use	Description
Use of digital pathology for primary diagnosis of pathological specimens	To complement and enhance light microscopy examination of glass slides. Use of digital and AI improve efficiency.
Assessment of Immunohistochemistry (IHC)	To complement and enhance light microscopy examination of glass slides. Use of digital and AI improve efficiency.
Multi-disciplinary team (MDT)	The selection, collection, review and presentation of whole slide images or annotated regions of interest of cases for discussion at multidisciplinary meetings. If this use is taken in isolation, slides can be scanned after initial conventional glass slide diagnosis, then reviewed and presented digitally. Removes requirement for manual MDT preparation (currently 1x Band 3 WTE).
Frozen section diagnosis	The use of whole slide images to provide rapid, intraoperative histopathological opinion. To provide frozen section support to partnered institutions or to utilise specialised pathologists working off site or out of hours.
Receiving and requesting second opinions/review cases	The use of a DP system to render or request a second opinion on a previously examined case, e.g. a difficult skin case from a general pathologist to a dermatopathologist. Removes requirement for taxi/courier costs. Improves TAT.

Remote diagnosis	The use of DP to allow pathologists to view and report slides from off-site locations, including other networked hospitals and their home office. Removes requirement for taxi/courier costs. Improves TAT.
Insourcing/outsourcing of diagnostic work	The use of DP to allow the movement and exchange of units of diagnostic work among different pathology service providers. Improved inhouse efficiency will reduce backlogs/TAT and need for overtime/locum requirements. (Currently spent 81 OT sessions Aug-Oct 21)
Manual, Paper-based laboratory work processes	Barcoding cassettes/slides will reduce the potential for slide transcription errors and potential for mis-diagnosis.
Use of Voice Recognition embedded within digital reporting systems	Improves turnaround times by not having to wait for administrative staff to type up reports.

The key objectives for the implementation of digital pathology would be as follows:

Objective 1: Increase Histopathologist Productivity
Information access and sharing
A fully integrated single application 'PACS-like' reporting platform is required to encompass the digitised image of the slide sample, the reporting software used to generate the pathologist's report and the function to request extra testing on a case. This will make the analysis of specimens more efficient and will enable flexible working. It will also significantly reduce the administrative burden of reviewing previous samples relating to a current patient request (virtual slide archive instead of physical retrieval from a slide archive). Often, radiology images and reports are referred to when generating a histopathology report and therefore the aim is for this data to be integrated. For wider information, the potential for a region wide IMS will also help with information sharing and access to patient records that might previously have been inaccessible if stored at an alternate hospital in the region. Overall, the aim is to enable access to all information pertaining to a patient sample anywhere, anytime within the region which will inevitably lead to more accurate reporting.

The histopathology reporting application also enables the potential for insourcing and outsourcing of work. The adoption of digital pathology may allow WSFT to generate additional income by providing a consultant service to other trusts nationally and internationally and increasing our support to private and research projects. E.g., radiology often reports on cases in other countries such as New Zealand. A consultation can generate up to £500 per session.

Through realising the reporting benefits associated with Digital Pathology and Artificial Intelligence, we will aim to deliver a 12% improvement in productivity for 80% of the Histopathologist workforce when fully digitised (based on discussions with NHS Trusts who have already implemented Digital Pathology and current literature.)
Improvements in histopathology productivity will be partly due to:

- Efficient method and case management through good integration between the digital pathology system and the Laboratory Information Management System (LIMS)
- Presence of useful tools in software such as measurements, annotations; and
- Presence of auto-alignment of sections allowing sections to be easily aligned side by side and after each other.

This improved productivity will facilitate faster diagnosis and improve TAT. The latest quarterly national statistics on waiting times for suspected and diagnosed cancer patients accessing WSH services were released on 12th August 2021 by NHS England and NHS Improvement. Currently, more than a quarter of patients are not being told their diagnosis within the expected TAT.

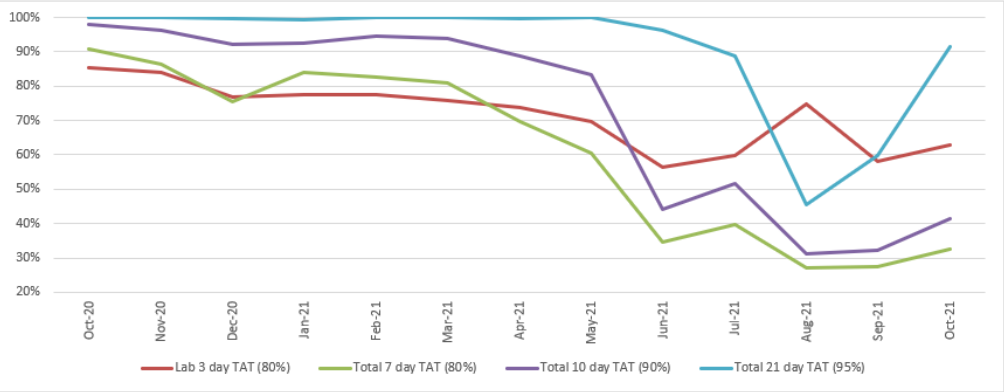
Number of people at WSH told cancer diagnosis outcome in Q1 2021/22

Clinical Commissioning group	Total	Within 28 days	After 28 days	% told within 28 days
NHS West Suffolk CCG	3199	2354	845	74

In the last year, Cellular pathology have failed to meet the 3 day TAT and in the last quarter, have failed to meet the national 7, 10 and 21 day TAT.

Histopathology - From Receipt 95% pass

Metric	Target	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Lab 3 day TAT (80%)	80%	85.21%	84.14%	76.82%	77.40%	77.39%	75.97%	73.65%	69.79%	56.39%	59.98%	74.93%	58.08%	62.75%
Total 7 day TAT (80%)	80%	90.66%	86.24%	75.63%	83.85%	82.66%	80.93%	69.74%	60.65%	34.75%	39.86%	27.18%	27.39%	32.68%
Total 10 day TAT (90%)	90%	97.81%	96.19%	92.09%	92.50%	94.64%	93.81%	88.90%	83.42%	44.05%	51.79%	31.15%	32.08%	41.53%
Total 21 day TAT (95%)	95%	99.93%	100.00%	99.79%	99.17%	99.91%	99.94%	99.77%	99.85%	96.14%	88.70%	45.37%	59.70%	91.50%



Objective 2: Improve slide management
Safe faster standardised reports and increased MDT integration
Histopathology services are unusual in that the service users are the patient facing clinical team not the patients directly. A successful project therefore means accurate, up to date, standardised, safe, faster histopathology reports and more integrated participation at MDT meetings. The latter is clearly enhanced with digital projection of images. Collaborative working will inevitably lead to standardised synoptic reports. This allows clinicians to have simplified access to the relevant information required to treat the patient. As part of the wider pathology digitisation project, enhanced clinical information sharing for patient data to all relevant clinical users will provide faster and better clinical care, including GP access to the full patient record and patients transferring between hospital sites for care. Inevitably this will lead to efficiencies and eliminate unnecessary repeated tests.

A key objective will be to reduce time and staff resource for sorting, packing, unpacking and transporting slides for review, MDTs and specialist review (second opinion).
Measurable outcomes will consist of:

- 100% of reported / authorised cases available on time for MDTs (not all cases will be available, due to their complexities)

- Efficiency savings through reduced staffing for MDT preparation and Administrative support. This is currently done by Band 3 staff.
- Very limited storage space currently – often storage is outside of lab e.g. the MRI store. This issue will not be resolved until new facility is built or we store off-site like we currently do (added transport costs) for retrieval and storage costs. With the adoption of digital pathology, fewer slides (of a younger age) would need to be stored on-site

Objective 3: Enable longer term AI efficiencies
Digitisation of histopathology provides immediate and long-term benefits for patients when considering the enhanced diagnostic capabilities. Digitisation alone allows faster accurate measurements. This has important implications in cancer care (including margin assessment, tumour measurements and mitotic figure counts). The rapid development of Artificial Intelligence and deep learning will lead to optimised outcomes for patient care leading to faster, more accurate and unified reporting.

The greatest savings of implementing Digital Pathology are likely to be made when Artificial Intelligence (AI) tools can take on some of the assessments currently being made by pathologists. PathLAKE and others are currently developing tools which will reduce the time spent on colon biopsy reporting, prostate cancer identification and grading, breast cancer Ki67 scoring, bronchial lavage cell counts, as well as tools which improve patient selection for prostate, breast and colon cancer post-surgical treatments. The aim is to have these tools at proof-of-concept stage by the end of 2023.
Examples of some of the AI tools in development and how they would transform Histopathology are shown below. These significant future savings would be in addition to those already included in this Business Case.

Speciality	PathLAKE AI tools	Consultant time saved (%)
Colon	Colon biopsy screening tool	20
Prostate	Prostate cancer tool	38
Breast	Breast LN Met	20
Skin	Dermpath	24

Objective 4: Use of barcoding and digital macroscopic dictation for improved patient safety and streamlining of laboratory processes
Patient safety is paramount in any healthcare process. Digitisation of histopathology involves a complex change in laboratory processes and cannot be considered as simply plugging in a camera to scan slides. To recognise the patient safety benefits of digitisation and to allow for integration of the scanners, LIMS and lab processes, barcoding of blocks and slides is a pre-requisite.

Thermal printing onto cassettes or slide labels will provide a unique, scannable 2D barcode containing selective patient and tissue information which will reduce the requirement for manual transcription processes, reduce the potential for transposed reports and facilitate slide scanning. Barcoding will also result in improved integration of laboratory equipment with the LIMS. This will improve the flow of cases through a department, and potentials for human error during the laboratory processes and reporting are reduced. The assurance that the case contains the correct patient sample and contains all the information necessary by the time it appears on a screen for the consultant to report ensures a safe, correct report for the patient.

Incorporating barcoding into laboratory processes will bring several advantages in addition to those associated with digital pathology.

- Reduces the likelihood of samples getting mislabelled
- It is a significant step towards creating a LEAN workflow. The productivity benefits this would bring includes reducing time spent finding blocks/slides, permits single person dissections, Integration with scanners, printers and tracking systems, reducing the risk of missed tests and improves productivity.
- Save significant time during slide preparation and quality control which will improve the laboratory preparation time

B2 : Desired Future Position for WSFT

Improving patient journeys
WSFT objective: ***"Continuously improve and transform services for patients so that they see the right person as soon as possible, with minimal waits for treatment and able to leave hospital at the right time"***
Aligned outcomes of Digital Pathology:

- Improved patient safety due to a reduction in manual transcription processes
- Improved patient safety through reduction of mislabelling errors/missing cases
- Management of workflow with ability to produce detailed process reports
- Reporting system will support prioritisation of urgent cases
- Faster case transfer times between lab and assigned pathologist
- Rapid access to digital slides for second opinions, retrieval of previous cases and diagnostic information at MDTs
- Estimated 12% improvement in Histopathologist productivity when compared to analogue (microscope) workflows

Working with our communities
WSFT objective: ***"Develop the beneficial behaviours of an 'integrated Care System' by acting as one system, jointly accountable for improving our population's health and wellbeing, outcomes, and experience, within a defined financial envelope"***
Aligned outcomes of Digital Pathology:

- Improved information sharing and collaboration opportunities e.g. case reviews for MDTs and second/specialist opinions
- Opportunities of insourcing/outsourcing diagnostic work across ICS and wider pathology networks

Strengthening the organisation
WSFT objective: ***"Continue to develop a skilled and sustainable workforce for now and the future, inspired to be the best for patients and proud to work for WSFT"***
Aligned outcomes of Digital Pathology:

- Ability to attract future workforce (Histopathologists working/training at hospitals with Digital Pathology would not wish to take the step back to microscopes)
- Future flexible working opportunities e.g. remote working
- Improved education and training (future Histopathologists unlikely to train in a hospital without Digital Pathology)
- Enables WSFT Pathology department to work as part of a network with other Trusts (ME6 and ME7) without having to join a formal partnership that manages the entire service.
- Platform for secure data transfer reducing risk of IG breach
- Performance reports and spot trends for service improvement

- Improved digital audit trail required for ISO15189

Contributing nationally and internationally
WSFT objective(s):

- Develop a world-class digital technology infrastructure
- Continue to develop and foster world-class biomedical research
- Play our part in the UK Life sciences strategy

Aligned outcomes of Digital Pathology:

- UK Industrial Life Sciences strategy highlights the need for modern tools to replace manual based approaches using microscopy to facilitate developments in Artificial Intelligence and improved diagnostics
- Importance of Digital Pathology to the development of the WSFT as a GDE and biomedical research across the research sector
- Closer networking with other organisations and pathology partnerships as per WSFT Pathology strategy

Other local trusts who have committed to Digital Pathology:

CUH – business case approval gained in September 2020. Member of PathLAKE + and have secured £1.8m capital funding. CUH are our tertiary referral centre with whom we network closely with in Histopathology.

Eastern Pathology Alliance (EPA) (NNUH, QEH and JPH) Phase 1 (Completed) - Implement specimen tracking and digitalise 4 specialities equating to 30% of current reporting caseload converted to digital due to complete December 2020. For information, the Cancer Alliance are fully supportive of a networked approach and have part funded (sponsored) Phase 1 for EPA.

ESNEFT – WSFT share an ICS with ESNEFT

NNUH – Implemented specimen tracking and are scanning roughly 30% of workload.

Our ambition is to create a holistic and common shared reporting platform between WSFT, NNUH and ESNEFT. This will enable us to create a pool of digital reporting capacity and specialisms in the region, share AI products and to help attract histologists to our region.

B3 : Regional Strategic Fit

For WSFT Pathology service to be sustainable and be able to compete with alternative providers and networks, we must embrace new ways of working to maximise efficiencies and deliver the highest quality of patient care. WSFT are neighboured by EPA (NNUH, QEH and JPH), CUH and ESNEFT, all of which present challenges to the sustainability and viability of WSFT Pathology. The desired future position is to strengthen WSFT pathology service and to improve interoperability of ME6 and ME7, creating a functioning sub-regional network. This will ensure that a patient's diagnosis is delivered as quickly as possible, getting it right first time.

In light of the recent COVID pandemic and with the significant pressures in terms of recovery facing WSFT, digital pathology provides an excellent opportunity to work in a different way which will increase productivity and help clear the backlog of patients.

B4 : National/International Drivers

The **Carter review** recommends the formation of **networked pathology services** and the development of 'hub and spoke' collaborations. Digital pathology will assist institutions in the flexible use of clinical expertise in relation to laboratory locations, pathologist offices and multidisciplinary team meeting (MDT) inputs. The NHSI will be focused on how WSFT Pathology delivers the outcomes of the Carter review, on which Pathology networks were designed upon.

In order to secure our position as a viable provider we have to maximise efficiencies – which digital pathology will provide. At a time where skilled resource is lower than the demand, WSFT needs to attract candidates and retain by investing in technology. This also supports our position as a GDE.

The East of England Cancer Alliance are implementing a new diagnostic standard for cancer (**Faster Diagnosis Standard**) that emphasises the importance of receiving results within 28 days of an urgent suspected cancer referral from primary care. This will support the drive to ensure that patients who are diagnosed with cancer can be offered earlier treatment, which will improve outcomes. Cancer services will be required to submit data on how many patients have been given a confirmed cancer diagnosis or informed they do not have cancer by day 28.

The **GIRFT REPORT** published September 2021
Recommendation: Embracing new technologies in pathology
GIRFT looks at the use of digital pathology, decision support systems and artificial intelligence (AI) in pathology, focusing on some key examples of where these innovations are adding value, easing resource issues, and enabling better quality interpretation. Actions following the report include for labs, trusts and networks to plan for implementing digital pathology, as a means to address workforce challenges and improve patient experience. With an expected implementation date of 12 months following publication.

Investing in digital technology will contribute to the Trust's cancer reporting and ability to meet cancer targets. The key ambitions within the NHS Long Term Plan for Cancer are:

- by 2028, 55,000 more people each year will survive their cancer for five years or more; and
- by 2028, 75% of people with cancer will be diagnosed at an early stage (stage one or two).

This is a challenging standard to meet therefore it will be crucial to ensure that laboratory processes are working as efficiently as possible. Digital pathology will facilitate accurate diagnosis and timely MDT review.

- The National Cancer Taskforce Strategy's paper 'Achieving World-Class outcomes; a strategy for England 2015–2020 highlights a drive towards achieving earlier diagnosis, the need to make investment to deliver a modern, high-quality cancer service, the need to identify and address workforce capacity gaps, the need to increase diagnostic capacity, and the need to support and streamline regional multidisciplinary team meetings and cancer networks.
- Cancer Research UK highlighted the national pressures on clinical pathology services in their paper Testing times to come? An evaluation of Pathology capacity across the UK, identifying the need for institutions to invest into infrastructures to support digital pathology and the role that it can play in allowing clinical pathologists to work more flexibly, reducing the impact of workforce shortages, facilitating the operation of clinical networks and reducing subjectivity.
- A digital pathology system would meet key elements of the National Information Board's Framework for Action 'Personalised Health and Care 2020 especially those relating to improved access, personalised medicine, supporting innovation and getting best use

from technology. The paper emphasises the importance of links to molecular and genomic medicine (1000 Genomes Project). It would also support other information management and technology targets such as moving towards paperless reporting and maximising the usage of the NHS number.

- The National Advisory Group on Health Information Technology's paper Making IT work: harnessing the power of health information technology to improve care in England (states clearly that the advisory group believes that trying to achieve the aims of the five-year forward view without giving highest priority to digitisation would be a costly and painful mistake. The paper acknowledges that while it is natural to seek a short-term financial return on investment (ROI) from health information technology (IT), experience has shown that short-term ROI is more likely to come in the form of improvements in safety and quality than raw financial terms. Cost savings may take 10 years or more to emerge, since the keys to these gains are reconfiguration of the workforce, local adaptation of digital technologies, and a re-imagining of work processes. The paper concludes that 'to those who wonder whether the NHS can afford the ambitions to digitise in today's environment of austerity and a myriad of ongoing challenges, we believe the answer is clear: the one thing the NHS cannot afford to do is to remain a largely non-digital system'.
- The national Chief Clinical Information Officer's 'Newcastle Declaration' states that complete, accurate and timely information fundamentally underpins safe and effective health and social care.

SECTION C – OPTIONS APPRAISAL

C1 : Non-financial

Option 1: Do Nothing

- Do not invest in Digital Pathology at WSFT
- Do not access capital funding
- Do not enter Digital Network with NNUH and ESNEFT

Category	Description	Likelihood	Impact	Risk
Recruitment	Less able to attract a skilled workforce from a reducing national supply	4	4	16
Life Sciences & Industrial Strategy	Reliance on manual systems impacting ability to establish links with industry, research and industrial strategy with EPA and CUH as neighbouring trusts	3	3	9
Pathology Network	Increased barriers to establishing Carter Review's pathology network deliverables	4	4	16
Capital Award Funding	Delaying Digital Pathology would miss the opportunity of receiving financial support from the ICS Digital funding streams.	5	4	20
MDT delays	Risk of continued delays to patient care due to missing glass slides required for MDTs	3	4	12
Reputation	WSFT ability to compete with neighbouring trusts in the design of the new pathology service	4	4	16

Option 2: Full Digital Implementation (Scanners and Digital Reporting Platform) Preferred option

- Invest in Digital Pathology at WSFT
- WSFT Board to approve strategic business case to proceed with securing capital funding and to approve revenue funding associated with digital pathology
- The transformation to Digital Pathology is a large scale and complex project which will need to be driven by a cross functional team.
- The digital ICS lead has confirmed that project resource could be secured with capital funding.
- WSFT consultants are engaged and committed to the digital agenda.
- In light of the need for a large- scale asset replacement scheme at WSFT, the investment in digital pathology would future-proof any asset investment.
- A strategic approval for Digital Pathology would allow WSFT to draft required resource needed for the project, estates requirements (in light of the future facility) and IT requirements.

Staff	Lab Manager for Project/Change Management Consultant for Programme Leadership/Management IT Lead for building and testing interfaces Scanner operators for testing and operating scanning equipment during implementation phases Laboratory support for sorting slides for scanning validation during implementation phases
Estates	Installation costs (power points, network points, benching)
Data Storage	Data storage will be incorporated into the digital Pathology provider contract.
Maintenance	Maintenance costs will be incorporated into the tender and supplier contract

Option 2 - Advantages	Description
Overcome current limitations/challenges of current manual processes	See Supplementary information 2
Cost saving	See **The Benefits of Digital Pathology** on page 3
Financial support	Not delaying strategic approval to Digital Pathology will allow WSFT to access capital funding streams for 20/21 and 20/22 onwards
Shared learning	Being aligned with the other NHS trusts implementing digital (CUH, OUH, NUH, UHCW)

Option 2 – Non-financial risks					
Risks/Barriers	Description	Likelihood	Impact	Risk	Mitigation
Estates	Future System – any digital pathology system must be considered within the future position of pathology estate	5	3	15	Need to ascertain future pathology estate strategy. DP requirements will be considered in future systems workshops Data storage hosted off site so won't need to

					worry about moving it to the new hospital
IT Support	Other large IT projects (e.g. LIMS replacement/upgrade)	4	4	16	Need to engage with IT as to workplan for 21/22
Project Management Resource	Leadership and resource to drive project forwards	4	3	12	Possible funding available. David – capital fund WSH Project manager available until October 2022
Digital Pathology Experience	Understanding and ability to implement Digital Pathology	3	2	6	Using links with CUH, NNUH, PathLAKE trusts
Transitional disruption	Transitional disruption to service e.g. double reporting and interoperability delays	4	3	12	Histopathologist backfill during verification Work closely with clinicians to minimise any impact of increased TATs on patient care
Training	Barriers to user acceptance and training	3	2	6	Training and validation steering group Good communication throughout process
Reputation	WSFT must be able to share data safely and effectively with neighbouring trusts in the design of the new pathology service	2	4	8	Ensure chosen digital pathology solution is compatible with neighbouring Trusts
IG		2	5	10	Work with IG teams to ensure data sharing agreements are correct

Option 2 – Financial risks – unknown at this time but predicted					
Risks/Barriers	Description	Likelihood	Impact	Risk	Mitigation
Insufficient capital funding	Insufficient capital funding/ to fully implement Digital Pathology at WSFT (scanners, workstations, software, maintenance and data storage)	2	4	8	A range of financial options are available to suit budget. Timeline monitored closely by programme and project.
Inability to spend funding in current financial year	NHSEI capital funds need to be spent by the end of 2021/22	4	4	16	Suppliers, procurement and finance aware of timeline limitations
Estates	All works required must be built into current pathology laboratory.	2	3	6	Laboratory reorganisation near complete with use of C.A funding

Option 3: Partial Digital Implementation (Scanner and viewing platform for MDT and referrals)

- A strategic approval for option 3 would allow WSFT to begin to use digital pathology without the revenue burden of full implementation. It will enable more efficient MDT preparation and improve TAT for referred cases.
- Invest in Digital Pathology at WSFT
- WSFT Board to approve strategic business case to proceed with securing capital funding
- The transformation to Digital Pathology is a large scale and complex project which will need to be driven by a cross functional team. To gain full benefits from Digital Pathology, Option 2 is required.
- The digital ICS lead has confirmed that project resource could be secured with capital funding.
- WSFT consultants are engaged and committed to the digital agenda.
- Invest in Digital Pathology at WSFT
- WSFT Board to approve strategic business case to proceed with securing capital funding
- The transformation to Digital Pathology is a large scale and complex project which will need to be driven by a cross functional team. To gain full benefits from Digital Pathology, Option 2 is required.
- The digital ICS lead has confirmed that project resource could be secured with capital funding.
- WSFT consultants are engaged and committed to the digital agenda.
- In light of the need for a large- scale asset replacement scheme at WSFT, the investment in digital pathology would future-proof any asset investment.
- A strategic approval for Digital Pathology would allow WSFT to draft required resource needed for the project, estates requirements (in light of the future facility) and IT requirements.

C2: Financial

The table below appraises the cost of each of the options:

Option	Initial Capital Cost	Total Annual Revenue Cost					Total Cost Over Contract Term	Net Present Value to Health System	Net Present Value to Trust
		Year 1	Year 2	Year 3	Year 4	Year 5			
	£000	£000	£000	£000	£000	£000	£000	£000	£000
1 - Do Nothing									
2 - Full Digital Implementation	(£280)	(£185)	(£206)	(£101)	£27	£35	(£709)	(£695)	(£415)
3 - Partial Digital Implementation	(£280)	(£185)	(£183)	(£181)	(£179)	(£177)	(£1,184)	(£1,103)	(£823)

The table shows the total cost of each option in each financial year in the cashflow section. Any figure with brackets around it is a net cost and conversely, any figure without brackets is a net income.

Option 2, has the smallest total cash outflow because it has the lowest running costs of all the options. This is because the 12% productivity gains from implementing digital reporting reduce the need for additional consultant recruitment. As the option also includes slide scanning, the staff and transport savings also offset the annual costs. Whilst the investment results in a negative Net Present Value (NPV), the NPV appraisal from the Trust's perspective is lower because the capital costs are funded by NHS England. The net cost to the Trust, including the productivity gains, is circa £142k per annum. If external funding, like Cancer Alliance funding, can be secured for two years this option has the potential to be cost neutral.

Option 3, has the largest total cash outflow because it has the highest running costs of all of the options. This is because only the savings from slide scanning are possible. Whilst the investment results in a negative Net Present Value (NPV), the NPV appraisal from the Trust's perspective is lower because the capital costs are funded by NHS England. The net cost to the Trust, including the slide scanning savings, is circa £237k per annum.

Whilst options 2 and 3 are net costs to the Trust with negative NPVs, the investment in the service is likely to facilitate significant savings from the introduction of Artificial Intelligence in the future.

SECTION D : THE PREFERRED OPTION

D1 : Preferred Option

Option 2 – to commit to full digital implementation with a phased implementation over a number of years which will dovetail with plans for the new hospital facility.

D2 : Risk Assessment

As per above (pg 13)

D3 : Consultation

Digital Pathology is a key task within the WSFT Pathology strategy. Ryan Butel (Clinical Lead for Cellular Pathology WSFT) is fully engaged. WSFT is actively seeking lessons learnt from other NHS trusts who have implemented Digital Pathology (aforementioned).
Digital Pathology is part of the strategy and WSFT Pathology Transformation Manager has engaged IT, Estates, CDs, all Cellular Pathology staff

D4 : Commissioning Support

N/A

D5 : Accommodation Requirements

N/A

D6 : Implementation
To be confirmed subject to strategic approval.

D7 : Workforce
See Table 6 page 12

SECTION E : NEW OR REPLACEMENT EQUIPMENT

E1 : Consultation	
For clinical equipment new to the organisation, has it already been approved by the Clinical Equipment Panel (or equivalent)?	No (subject to procurement)
Have EBME and Decontamination Services been consulted?	No (subject to procurement)

E2 : New or Replacement Equipment Details	
Equipment Description	Will be as a result of tender
Expected Life of Equipment (Years)	N/A
Existing equipment	N/A
Location (Ward/Department)	Cellular Pathology
Year purchased/Age of equipment	N/A
Asset Register Number/Book value ***(check with Finance)***	N/A
Disposal Options	N/A

E3 : Other Considerations
Have the following been considered? If so, please state outcome.

Staff workload implications or additional resource required?	Yes please see previous content
Service Parts and Maintenance requirements – budget implications; and costings?	Yes please see previous content
Transport implications – costs and staff resource?	N/A
Service Contract required – manufacturer's costs and frequency?	Yes please see previous content
Training – costs; resource implications and frequency?	Yes please see previous content
Item tracking requirement – costs and feasibility?	Yes please see previous content
Additional Test equipment; and calibration required?	Yes please see previous content
IT/Software implications?	Yes please see previous content
Disposal – special needs required and costs?	Disposal of current hardware to be included in next BC
Impact on staff resource re contract management?	Yes please see previous content

SECTION F : DECLARATION *(to be completed in all cases by the Lead Organisation FD)*

Please read and tick the below declaration. Cases will not be processed unless all information is given. Departments refer to those of the lead organisation and any other organisation in the STP directly affected (including local authorities).	
Internal Governance Processes have been completed including seeking support of all relevant Corporate departments and seeking NED approval if relevant	☐
I confirm that users have been fully involved with the formulation of this business case and have accepted the proposals.	☐
By submitting this form, I confirm that the information provided is true, complete and accurate.	☐

Signature:		FD, Lead organisation
Date:		

SECTION G : APPROVAL (as per Standing Financial Instructions)	
Is this business case approved?	Yes / No
Comments: Delete as appropriate The business case is approved up to a financial limit of £---,---. OR The business case has been recommended for "Approval in Principle" to move to the next stage in the process. Additional Comments:	
Signature FD:	

Date:	

APPENDIX 1 : COSTS

COSTINGS WILL BE PROVIDED BY FINANCE. AS A MINIMUM THEY SHOULD INCLUDE THE BELOW. VAT MUST BE INCLUDED IF IT IS PAYABLE/ NOT RECLAIMABLE FROM HMRC.

Provide Annualised Income and Expenditure. Add lines as required. **Note**: Income and Savings (+), Costs (-).			
Description	**Option 1**	**Option 2**	**Option 3**
Income			
All types of income			
Pay			
Including support staff		(£48,000)	
Savings		£169,070	£26,164
Non Pay			
Variable and non-variable		(£204,956)	(£204,956)
Savings		£2,000	£2,000
PDC		(£3,924)	(£3,924)
Set-up Costs (non- recurrent)			
Net Revenue Cashflow		**(£85,809)**	**(£180,716)**
Depreciation		(£56,058)	(£56,058)
Surplus/(Deficit)		**(£141,867)**	**(£236,773)**

Annualised Income and Expenditure. Option 2. **Note**: Income and Savings (+), Costs (-).						
Description	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Income						
All types of income						
Pay						
Including support staff	£0	(£120,000)	(£120,000)	£0	£0	(£240,000)
Savings	£26,164	£123,152	£225,959	£231,952	£238,126	£845,352
Non Pay						
Variable and non-variable	(£204,956)	(£204,956)	(£204,956)	(£204,956)	(£204,956)	(£1,024,778)
Savings	£2,000	£2,000	£2,000	£2,000	£2,000	£10,000
PDC	(£7,848)	(£5,886)	(£3,924)	(£1,962)	£0	(£19,620)
Set-up Costs (non-recurrent)						
Net Revenue Cashflow	**(£184,640)**	**(£205,690)**	**(£100,921)**	**£27,035**	**£35,170**	**(£429,045)**
Depreciation	(£56,058)	(£56,058)	(£56,058)	(£56,058)	(£56,058)	(£280,288)
Surplus/(Deficit)	**(£240,697)**	**(£261,748)**	**(£156,979)**	**(£29,023)**	**(£20,887)**	**(£709,333)**

Annualised Income and Expenditure. Option 3. **Note**: Income and Savings (+), Costs (-).						
Description	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Income						
All types of income						
Pay						
Including support staff	£0	£0	£0	£0	£0	£0
Savings	£26,164	£26,164	£26,164	£26,164	£26,164	£130,820
Non Pay						
Variable and non-variable	(£204,956)	(£204,956)	(£204,956)	(£204,956)	(£204,956)	(£1,024,778)
Savings	£2,000	£2,000	£2,000	£2,000	£2,000	£10,000
PDC	(£7,848)	(£5,886)	(£3,924)	(£1,962)	£0	(£19,620)
Set-up Costs (non-recurrent)						
Net Revenue Cashflow	**(£184,640)**	**(£182,678)**	**(£180,716)**	**(£178,754)**	**(£176,792)**	**(£903,578)**
Depreciation	(£56,058)	(£56,058)	(£56,058)	(£56,058)	(£56,058)	(£280,288)
Surplus/(Deficit)	**(£240,697)**	**(£238,735)**	**(£236,773)**	**(£234,811)**	**(£232,849)**	**(£1,183,866)**

Capital Costs

Description	**Option 1**	**Option 2**	**Option 3**
Construction Cost (inclusive of fees and planning costs)			
Medical Equipment			
Other Equipment		£216,538	£216,538
ICT and Telecoms		£63,750	£63,750
Total Capital Cost		**£280,288**	**£280,288**

Financial Appraisal

Description	**Option 1**	**Option 2**	**Option 3**
Capital Costs		(£280,288)	(£280,288)
Net Revenue Cashflow		(£85,809)	(£180,716)
External Funding		£1,000,000	£1,000,000
Net Present Value (NPV) of costs at 8%		(£677,580)	(£1,016,713)
IRR		0%	0%
Payback (Years)		-	-

APPENDIX 2 : OPTIONS BENEFITS APPRAISAL

1) Score the criteria identified in Appendix 3
2) Apply the weighting to each criteria
3) Obtain weighted scores for each option (Weighted score = Raw Score * Weight)
4) Apply the cost of each option to determine a cost per benefits point

Criteria	Weight	Option1		Option 2		Option 3		Option 4	
		Raw Score (0-5)	Weighted Score	Raw Score (0-5)	Weighted Score	Raw Score (0-5)	Weighted Score	Raw Score (0-5)	Weighted Score
Clinical Priorities (5 or 0)	**20**								
Change Programme (5 or 0)	**20**								
Patient Experience	**30**								
Risk	**30**								
Total Benefits Weighted Score	**100**								
Recurring Revenue Cost (£000)	**n/a**								
Cost per Benefit Point (£/Pts)	**n/a**								

APPENDIX 3 : CAPITAL INVESTMENT CRITERIA

Score	Trust Clinical Priorities	Trust Change Programme	Patient Experience	Current Risk with no Investment
5	Business Case Supports the Trust clinical priorities of: [to be completed]	Business Case Supports the Trust change programmes of of: [to be completed]	Clear Evidence that the case delivers a specifica and tangible improvement to patient experience	Very high risk score as per Trust's risk assessment matrix
4			Clear evidence that the case drives a specific and tangible improvement to patient experience	High risk score as per Trust's risk assessment matrix
3			Clear evidence that the case drives the strategy on improving patient experience	Medium risk score as per Trust's risk assessment matrix
2			Evidence that the case influences a specific part of the strategy on improving patient experience	Moderate risk score as per Trust's risk assessment matrix
1			Evidence that the case influences improvements in patient care	Low risk score as per Trust's risk assessment matrix
0	Business Case does not support the Trust clinical priorities	Business Case does not support the Trust Change Programme	No impact on patient experience	No risk
Weighting	x20	x20	x30	x30

Supporting Information 1: Benefits of Implementing Digital Pathology

Improving patient safety

Reduced risk of patient/slide misidentification errors
The use of an integrated digital pathology system, with paperless transmission of digital slides directly to the pathologist significantly reduces the possibility of a misidentification or transposition error (eg, mixing up slides from two patients). These are potentially the most serious errors that can originate in the diagnostic laboratory, with an incidence estimated at 1%.[20] Digitisation of prescription practices, with the introduction of e-prescribing lead to a significant reduction in the relative risk of medication error of 13%–99%.[21]

Reduced risk of tissue/slide loss or damage
Potential loss and damage of valuable patient tissue on glass slides is a risk faced by laboratories on a daily basis as they transport glass from the laboratory to the diagnostician, from the feeder hospital to the regional cancer centre for review, or from the general pathologist to the recognised expert. Digital slides provide a portable, instantaneously transmissible diagnostic image which does not fade or degrade, and is not subject to the transport risks faced by glass slides.
Improving the diagnostic workflow

Workload allocation
A digital pathology system offers the flexibility and agility for streamlined 'pushing' and 'pulling' of cases to and by pathologists to respond to fluctuations in workload or case mix in a department. Digital slide management software can allow the entirety of a pathology workforce access to outstanding or backlogged work, enabling pathologists with extra capacity to 'pull' pooled cases.
Conversely, a digital pathology system also allows for expedited 'pushing' of cases from a pool, or between pathologists, to ensure cases are promptly transferred to the most appropriate diagnostician within a network, or across a region.
Enabling flexible workload distribution, both within an institution and across a network allow for closer capacity-demand matching and a more lean approach to achieving the requisite diagnostic output for a population.

Rapid case tracking, archival and retrieval
In the conventional laboratory with glass slide diagnostics, trays of slides and request forms are delivered to and transferred between a variety of locations within the laboratory and the diagnostic department. There are ample opportunities for slides to get mislaid, and urgent sourcing of a glass slide can be time consuming for clerical and diagnostic staff. A digital system ensures that a crucial or time-sensitive case can be accessed instantly, by any registered user, should the need arise.
Review of previous specimens can be vital in cases such as the assessment of progressive disease or evaluation of a new tumour in a patient with cancer, and is likely to improve the quality of the pathologists' assessment of a live case. The storage of digital slides allows for instant retrieval and review of cases, a process which is time consuming and inefficient using conventional glass slide archives.

Increased diagnostic efficiency
One time and motion study identified potential for a 13% time saving in pathologist diagnostic efficiency with digital slide reporting, with efficiency gains in the organisation of, querying, matching and searching of cases.[22] In addition, a limited number of diagnostic centres and individual diagnosticians have reported increased diagnostic efficiency using digital microscopes versus conventional light microscope.[23] These improvements relate to a

number of specific areas, including rapid availability of images, faster on-screen measurements and annotations of slides and ability to multitask while using a computer screen for diagnosis, instead of switching between the microscope and the PC. In addition, pathologists do not have to physically load and unload microscope slides, compare glass slide labels with paper request forms or refocus their microscopes for tissue of different thicknesses. While the existing literature shows promise, more work is needed in terms of large-scale clinical deployments before we have evidence of improved diagnostic efficiency.

Reduced case transfer times between the laboratory and the diagnostic pathologist
Current glass slide dependent processes rely on delivery or collection of assembled cases of glass slides from the laboratory, an inefficient process requiring time and manpower, which risks loss or damage of slides. With a digital pathology system, slides are instantaneously accessible to diagnosticians without the need for physical case assembly and delivery.

Faster diagnosis of urgent cases
Prioritisation of urgent cases can be difficult to manage using conventional glass slide processes, and is often reliant on manual tagging or labelling of specimens as urgent. This can be difficult to do when slides are in transit, in pools or on pathologists' desks. Recategorisation or escalation of case urgency is difficult and time consuming. Digital pathology allows easy flagging and escalation of priority of cases, and enables the laboratory administrator to 'push' the most urgent cases to the top of pathologist's worklists, without the need for explicit communication.

Faster access to external second opinion
Substantial numbers of slides are transferred between hospitals, either as submissions for MDT discussion at regional cancer centres, or for second opinion of difficult or rare entities from recognised specialists. Faster turnaround times of cancer specimens are likely to lead to improved quality of cancer diagnosis and care. The Royal College of Pathologists, through Good Pathology Practice,[24] recommends that all pathologists should actively participate in referral practice as this is in the best interests of patients, good continuing professional development and good practice, and that financial considerations should not be a deterrent to referral.

Faster access to molecular/ancillary testing
Digital pathology provides a platform for parallel specimen workflows between histopathology and molecular medicine. When the pathological assessment of a case is liberated from stained tissue on glass, the glass and tissue can be expedited to molecular medicine where appropriate, converting a sequential histopathology—molecular workflow to a more efficient parallel process. Digital pathology allows rapid tumour annotation and cellularity assessment for downstream microdissection.
Improving workforce factors

Platform for flexible working
Digital pathology offers the potential for more flexible patterns of work for pathologists, freeing the diagnostician from geographical and temporal restraints on where and when they can work. In this respect, it can help to optimise the working hours of the workforce, helping those working less than full time to maximise the hours they can offer and providing an incentive for those considering retirement to continue to offer their services on more flexible terms.

Platform for remote working
The ability of digital pathology to support working from remote locations has the potential to optimise the existing workforce by allowing the pathologist to make efficient use of their time, regardless of the location at which they are based, for example, allowing them to review their MDT cases from University locations, allowing regional 'spokes' to take on extra work from

'hub' institutions when there are backlogs, etc. This mode of working can also help cover temporary staffing issues, for example, allowing local colleagues to cover specialist reporting during periods of illness/annual leave.

Improved teaching, training and mentoring

Improved access to, and sharing of instructive and unusual cases is likely to prove of great benefit to undergraduate and postgraduate education, histopathology training and continuing professional development. Access to quality teaching cases can vary within and between departments. Digitisation and subsequent anonymisation of pathology images for a local teaching/training archive would provide an excellent resource for a department. In addition, the ability to view digital cases simultaneously allows a trainer and any number of trainees to share cases in real time, so the trainee and trainer can receive instantaneous feedback on a case.

Recruitment and retention

The inherent flexibility of a digital pathology diagnostic system should help to future-proof histopathology, allowing the workforce to offer their skills in a variety of ways. As well as aiding retention of staff periretirement, the perceived 'revolution' from light microscopy to digital microscopy could help to rebrand histopathology as a modern, innovative and exciting field for junior doctors to work in. The ability to work from remote locations may be particularly helpful in recruiting to traditionally hard-to-staff geographical regions or subspecialties.

Ergonomic advantages

One of the largest implementations of digital pathology to date was initiated to improve workplace ergonomics, because a member of staff was unable to perform conventional microscopy due to neck pain (reference [14] and Thorstensen S, personal communication). Conventional microscopy is linked to a range of workplace-based morbidities including neck and back problems.[25] Digital pathology allows greater diversity in working positions for pathologists, as neck position does not have to be fixed, and a range of ergonomic input devices can be used, tailored to pathologist preference and any existing musculoskeletal problems.

Improving service quality

Improved information sharing and collaboration

As already discussed, digital pathology allows for streamlined sharing of images, both within and between departments, allowing rapid access to second opinion, or double reporting of difficult cases. In a study by Manion *et al*, in which over 5000 referral cases were reviewed and reported by a second pathologist, 11.3% of reviews had minor or major differences in diagnosis with the original diagnosis and 1.2% of all reviews would have resulted in a change in patient management.[26] A survey of laboratories in the USA noted that 6.6% of all histopathology cases were reviewed before sign out, suggesting second opinions are often obtained in clinical practice, especially in challenging areas such as breast disease.[27] Digital pathology renders second opinion and double reporting of specimens faster and more efficient, which may help lower the threshold for seeking a second opinion, improving the quality of diagnosis and patient care.

The Royal College of Pathologists tissue pathways for gastrointestinal disease state that double reporting of slides is advisable in cases of dysplasia in inflammatory bowel disease, dysplasia in Barrett's oesophagus and cancers from bowel cancer screening patients.[17] Digital slides are easily marked and annotated, further speeding up the process of obtaining an answer to a specific question, for example, are these cells in a blood vessel? If the process of sharing cases is made simpler, it is likely that pathologists will reduce their threshold for sharing cases, which may lead to better quality diagnosis for the patient.

The introduction of biomedical scientist prereporting and screening also requires double reporting during training, and pathologist review of certain cases, which could be expedited with digital pathology.[28]

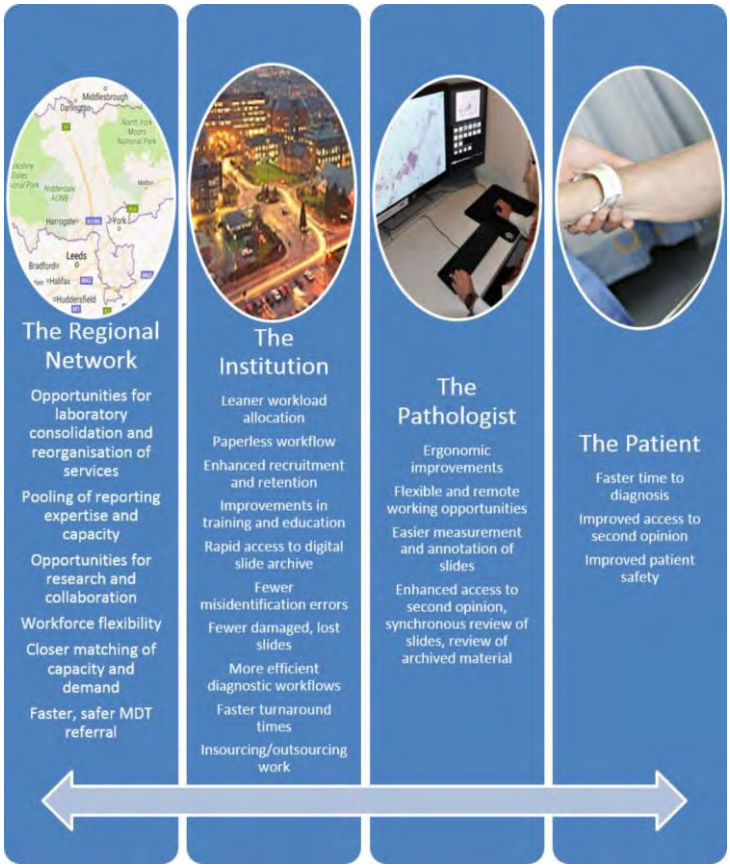
Improved access to archived slides
As discussed previously, streamlining access to a patient's previous histology is likely to lower the threshold for pathologists to review previous specimens, with the potential to improve the quality of the diagnosis for that particular patient. Direct comparison of a current tumour biopsy with a previously resected tumour from the same patient may allow the pathologist to avoid costly further immunohistochemical investigation of the new tumour.

Ability to perform synchronous analysis of slides
Multiple digital slides can be viewed simultaneously on one screen, allowing synchronised assessment of conventional H and E histology with multiple immunohistochemical stains or special stains. The images can be aligned and locked in the same position, making assessment of complex stains and their distribution in tissue far more accurate and simple to perform. The time to physically load and unload multiple glass slides for a relatively rapid assessment (of gross tumour positivity or negativity) is a significant part of the task of immunostain scoring process, suggesting that this task could be more rapid with a digital platform.

More convenient cancer staging
Minimum datasets for cancer cases required careful measurement of tumour volume and surgical margins. These measurements often form the basis of tumour staging, and can dictate further treatment decisions for the patient. Making measurements on the light microscope is time consuming, and there can be considerable interobserver variability in measurements taken by different pathologists. Digital slide viewers can use on-screen measurement tools which enable multiple measurements to be made and recorded in a few keystrokes or mouse clicks. More accurate and reproducible measurement of tumour size and margin status will allow more accurate staging of tumours, and the selection of more effective treatment options for patients.

Clearer diagnostic audit trails
Digital pathology software allows for automatic and comprehensive diagnostic audit trails including data on who has viewed slides, when, where and for how long. It also facilitates annotation of regions of interest, which have formed the basis of a diagnosis. Some systems also incorporate these images of these regions of interest into the pathology report.

Research and development opportunities
A digital pathology image archive represents a valuable resource, with diagnostic images made readily available for research purposes. Rapid transfer and availability of diagnostic slides will encourage collaboration and pooling of resources between diagnostic departments and higher education facilities, facilitating participation in national and international studies and clinical trials.
In addition to providing rapid access to slides for academic purposes and clinical trial review, large volume databases of digital slides can be used in the development of new computerised algorithms for the rapid detection of new quantitative diagnostic and prognostic markers in tumours.
The benefits of digital pathology can also be considered from the viewpoint of the patient, the pathologist, the institution and the regional network (figure 3)



Supporting Information 2: Limitations of Current Processes

The limitations of the current system include:

- The storage and retrieval of slides is a manual process, therefore identifying cases relies on; slides being filed correctly and personnel to finding/retrieving slides
- Transportation of slides for second opinion or for specialist MDT review at tertiary care centre involves Taxi/Courier. This can lead to breach of Turnaround times (TAT) and there is the potential for of loss of slides
- The current system does not provide full traceability of samples therefore cannot provide the complete audit trail required for UKAS
- The team cannot easily monitor workflow at individual process points within the laboratory therefore utilisation of staffing resource is not optimised
- MDT meetings are currently paper based; admin support is required to print reports and involves the physical pulling and retrieval of slides (cost of 2WTE administrative colleagues at B3)
- Consultants awaiting manual MDT prep which is not ideal in time restrained scenario
- No resilience for allocation of urgent cases for reporting (e.g., COVID, snow, overtime etc)
- The technical processes in the lab are reliant on paper-based systems which are time consuming and open to human error
- There are currently no slide/label printers resulting in manual transcription of information - open to human transcription errors
- Current Histology equipment is not fully integrated which impedes workflow and the repetition of tasks reduces productivity.

4.4. Trust strategy

To inform

Presented by Craig Black

WSFT Open Board - 28 January 2022

Report Title:	Item 4.4. - Launch of West Suffolk NHS Foundation Trust's strategy
Executive Lead:	Craig Black
Report Prepared by:	Helen Davies and Anna Hollis
Previously Considered by:	

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive Summary

Today we are launching the new five-year strategy for West Suffolk NHS Foundation Trust, called "First for our patients, staff and the future" (2021- 2026).

To launch the strategy in this pack you will find:

- the full strategy report;
- a one-page overview of the vision, ambitions and the new First Trust values

We also have a short animation explaining our strategy, which will be played during the meeting.

The aim of the strategy is to provide a clear set of ambitions and objectives to guide the direction and work of the organisation.

Teams across the Trust are already beginning to map their local strategies to this overarching plan.

Action Required of the Board

For information and launch

Risk and assurance:	n/a
Equality, Diversity and Inclusion:	n/a
Sustainability:	n/a
Legal and regulatory context	n/a

VISION:

TO DELIVER THE BEST QUALITY AND SAFEST CARE FOR OUR LOCAL COMMUNITY

POWERED BY OUR FIRST TRUST VALUES

FAIRNESS * INCLUSIVITY * RESPECT * SAFETY * TEAMWORK

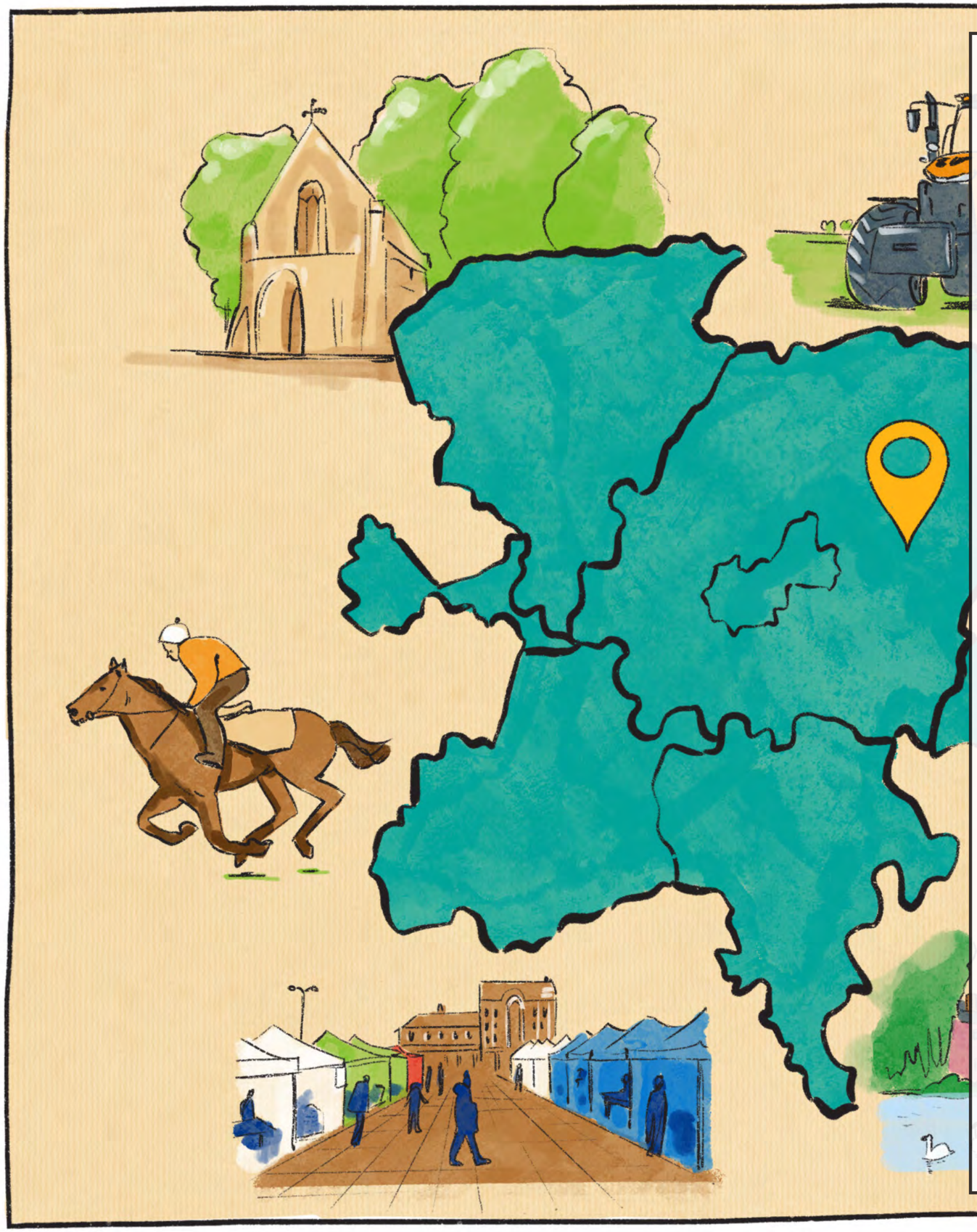
NHS
West Suffolk
NHS Foundation Trust

First for our patients, staff and the future

West Suffolk NHS Foundation Trust

Our strategy 2021-2026

Putting you first



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Foreword from chief executive and chair

In many cases, people have the right to choose where they receive NHS treatment. In addition, NHS staff can choose where and what NHS trust to work for. Our ambition is to be the first choice NHS provider for our patients, our people and our community and to prepare for the future health and care needs of our local population.

Since we published our last strategy in 2015, Our patients, Our Hospital, Our Future, together, West Suffolk NHS Foundation Trust (WSFT) has changed a lot. We are no longer just a hospital; we now work across two hospitals, a wide range of community locations, in people's own homes, in a GP surgery and in a reablement unit in a care home, where we offer temporary care after you are discharged from hospital. Over the past five years, there have been many highs and lows and there are both challenges and opportunities on the road ahead.

First and foremost, we are an organisation rooted in, and faithful to, our community. We are staffed by people living and involved locally, looking after local people, doing our best for each other. It is your families and ours who we have the privilege and pleasure of caring for.

The last 18 months has been an unprecedented time for all of us. COVID-19 has turned our lives upside down and has had a huge impact on the NHS. COVID-19 is by far the worst of many events that WSFT has experienced over the past five years. For many people it has been the worst time of their lives. Yet it has shown us that we can succeed, and that as long as we work together and look after each other, we can get through the tough times. We are proud to be part of the West Suffolk team.

As we look forward to better times, we know there is a lot of work ahead. We need to recover and repair, acknowledging our high emergency department and inpatient demand alongside dealing with our elective surgery waiting lists and working through our planned estates maintenance programme.

We will listen, and keep improving. We will celebrate success, and strive to learn from the things that go wrong.

The next five years will see more change, more uncertainty, yet we have real opportunities to transform how we provide care across our hospital and community services. We are delighted that the Trust has been named as one of 40 to benefit from the Government's New Hospital Programme. With the West Suffolk Hospital coming to the end of its life, a new healthcare facility is much needed and will help us to continue to deliver high quality, safe care for our patients and our community well into the future.

As we embark upon the next five years, we set out clearly in this strategy our future ambitions and how we are going to achieve them. We are grateful to the broad range of people who helped shape this strategy, both in the Trust and more widely.

Putting our patients, our people and our community first, is what drives us. Together, we hope we will look back in 2026 and feel proud of our efforts and successes.

Craig Black, interim chief executive and Jude Chin, interim chair

Future direction

Vision:
To deliver the best quality and safest care for our local community

Ambition:
First for patients

- Collaborate to provide seamless care at the right time and in the right place
- Use feedback, learning, research and innovation to improve care and outcomes.

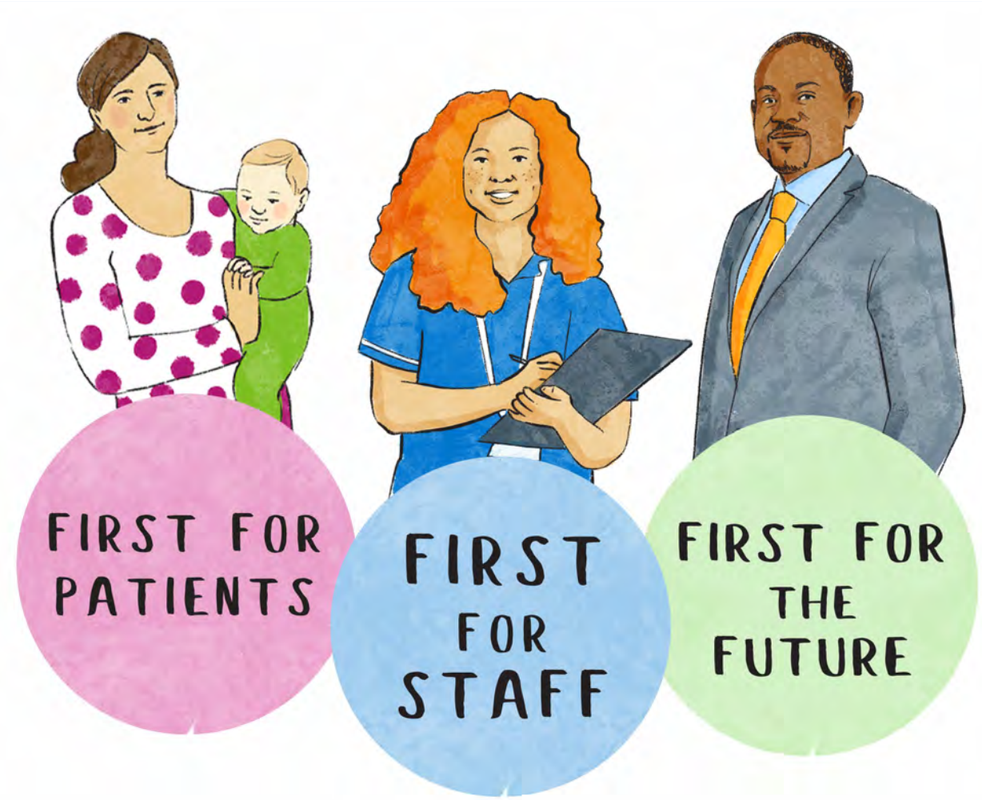
Ambition:
First for staff

- Build a positive, inclusive culture that fosters open and honest communication
- Enhance staff wellbeing
- Invest in education, training and workforce development.

Ambition:
First for the future

- Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities
- Invest in infrastructure, buildings and technology.

Powered by our First Trust Values
Fairness • Inclusivity • Respect • Safety • Teamwork



The West Suffolk NHS Foundation Trust

The Trust in numbers

A typical year pre-Covid-19: April 2019 – March 2020	
280,000 catchment population	78,892 attendances at the emergency department
4,353 staff	15,594 operations per year
6,296 public and 5,196 staff foundation trust members	264 people looked after at the end of their lives
2,367 babies born	341,965 visits to outpatients
225,166 contacts with patients through community services (including face to face, telephone and email)	

Who we are and what we do

The West Suffolk NHS Foundation Trust (WSFT) provides hospital and community services to a population of around 280,000 people. Services are delivered over a largely rural geographical area of roughly 600 square miles.

The catchment area extends beyond Thetford in the north and Sudbury in the south, to Newmarket to the west and Stowmarket to the east. It serves the population of the west of Suffolk and parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

The West Suffolk Hospital is the location from which the Trust provides a full range of acute and secondary care services. This includes an emergency department, maternity and neonatal services, a day surgery unit, eye treatment centre, Macmillan Unit and children's ward. It has approximately 500 beds in total and is a partner teaching hospital of the University of Cambridge.

Outpatient clinics and some diagnostic services (x-ray and ultrasound) are provided from a number of outreach sites including Newmarket, Botesdale, Thetford, Stowmarket, Haverhill and Sudbury.

The Trust provides community services for the residents of west Suffolk through the West Suffolk Alliance with Suffolk County Council, Suffolk GP Federation and Norfolk and Suffolk NHS Foundation Trust. A range of nursing and therapy services and specialist services are provided in patients' own homes, health centres and community buildings. The community paediatric service operates across Suffolk.

Ongoing temporary care and rehabilitation services are provided with 20 inpatient beds at Newmarket Hospital, alongside facilities for other services. A further 20 reablement beds are commissioned from Care UK at Glastonbury Court, a care home in Bury St Edmunds, and staffed by WSFT nursing and therapy teams. In addition, we can share the use of 10-14 temporary care beds at Hazell Court in Sudbury.

The Trust is one of the largest employers in the area, employing nearly 5,000 staff.

Since April 2020, the Trust has also provided primary care services at Glemsford Surgery via a sub-contracting arrangement with the existing GP partners.

The last five years

2016

- **May:** e-Care, our electronic patient record, goes live
- **Aug:** Care Quality Commission rates our quality of care as Good
- **Sept:** West Suffolk Alliance forms between Suffolk County Council, WSFT, Suffolk GP Federation and Norfolk and Suffolk NHS Foundation Trust
- **Sept:** Trust announced as one of first 12 Global Digital Exemplars
- **Nov:** Suffolk and North East Essex sustainability and transformation plan is published

2017

- **Feb:** King Suite at Glastonbury Court opens to provide a dedicated rehabilitation facility
- **Oct:** Community services formally join WSFT

2018

- **Jan:** CQC rating rises to Outstanding
- **April:** The first UK link between two hospital electronic patient records is turned on between e-Care at WSFT and eHospital at Cambridge University Hospitals NHS Foundation Trust
- **May:** Sustainability and transformation partnership is formalised into Suffolk and North East Essex Integrated Care System
- **Dec:** Phase 1 of new acute assessment unit opens
- **Dec:** New cardiac centre opens

2019

- **May:** Safety alert issued about reinforced aerated autoclaved concrete (RAAC) planks used in construction of main hospital building and former front residences – thorough maintenance programmes developed in response
- **June:** We learnt about the State of Suffolk, including that by 2037, Suffolk will need nearly two more West Suffolk Hospitals if current patterns of illness continue
- **Oct:** Final phase of acute assessment unit is completed
- **Oct:** West Suffolk Hospital named as a site for investment in the national New Hospitals Programme

2020

- **Jan:** CQC rating drops to Requires Improvement
- **Mar:** Glemsford Surgery joins WSFT, creating WSFT Primary Care Services
- **Mar:** COVID-19 hits
- **April:** The West Suffolk Alliance starts working with the Institute of Healthcare Improvement to continue improving quality
- **Sept:** My WiSH Charity celebrates 25th birthday
- **Sept:** WSFT's health information exchange now connects health records between GP surgeries, community care and hospitals throughout Suffolk and Essex

2021

- **May:** WSFT announced as part of Suffolk and North East Essex Integrated Care System £10m 'elective accelerator' to speed up the recovery of routine services following the Covid-19 pandemic

What our community thinks of us

In 2020:

- 94% of patients recommended WSFT as a place to receive care
- 83% of staff recommended WSFT as a place to receive care
- 74% of staff recommended WSFT as a place to work.

Clinical achievements

- The endoscopy, radiology, housekeeping, catering, IT department and the Macmillan Unit all hold national accreditations for excellence
- We regularly receive top A grade in overall assessment by the Sentinel Stroke National Audit Programme
- Best for hip fracture care 2017, 2018, 2020 (England, Wales and Northern Ireland) according to the National Hip Fracture Database.

The impact of the COVID-19 pandemic

Across the country, the COVID-19 pandemic brought the tireless work of the NHS into sharp focus.

Our staff worked in uncertain, unpredictable circumstances, going above and beyond every day. We strained every part of our systems, processes and resources to serve the sickest in our community.

What has become more apparent through this unparalleled time is our resilience and determination to look after our patients and community in the best way we can. Day-in, day-out, our staff strive to deliver the best possible care for our patients.

There is no doubt that the pandemic has taken its toll on our staff and services. For many this period has been the worst of their lives. However, despite this they have stepped up to care for the sickest and most vulnerable in our community in extremely difficult circumstances.

As we cautiously move into a period of recovery, we are working hard to restore services affected by the pandemic. Our waiting lists grew longer as we had to pause services to focus our efforts on Covid-19. We know this is upsetting for patients – as well as our staff who want to do their best for people in their care.

As part of the Suffolk and North East Essex Integrated Care System we have been awarded funding and extra support to implement innovative ways to increase the number of elective operations.

This work is not just about doing more of the same, but also thinking about how we diagnose, treat, and monitor our patients in ways that maximise our efficiency. For example, rather than bringing every patient in for routine review at set periods, we may offer individual support plans with a mix of in-person appointments, online consultations, and patient-led recovery techniques and support. This is better for patients, and means our staff can focus time on the patients who need it the most.

We will continue to do all we can to work our way through these waiting lists and provide the care our community needs.

April 2020/March 2021

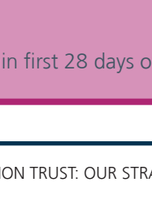
1,016
Covid-19 + inpatients

759
Covid-19 + patients discharged

257
Covid-19 + patients died*

16,594
telephone clinics

102,609
telephone consultations



40,859
calls made via our clinical helpline service

1,041
video clinics

2,889
video consultations

1,313
laptops provided to staff to support home working

16,000
local health and care staff vaccinated

48
live virtual cardiac rehab groups delivered (17 April–10 July); continue to offer six virtual cardiac rehab groups per week

*Death was within first 28 days of Covid-19 + swab

Case study: Helping staff wellbeing through the pandemic

Looking after our staff has never been more important. At the start of the pandemic, a staff support psychology team was put in place to provide extra emotional and mental wellbeing support for colleagues across the Trust.

Led by consultant clinical psychologist Emily Baker, the team is made up of highly trained mental health workers, offering sessions for individuals and teams throughout the week.

Through the pandemic, the team have seen over 625 members of staff in a range of roles and have run over 150 group sessions and online sessions for all staff on issues such as managing anxiety and sleeplessness.

Emily explains: "Our main message is that it's ok not to be ok. We are here to help staff across the organisation with their well-being. We offer support with issues such as sleeping or coping with negative thoughts.

"We've found that a lot of the concerns staff have are from a mixture of challenges outside of work combined with the increased demands of working in the NHS during the pandemic. I'd like everyone to know that we're only a message away and as a Trust we're one team and in this together."

Case study: Connecting patients with families and friends

The West Suffolk Hospital's keeping in touch service was launched in April 2020. The aim was to help family and friends to contact loved ones who were in hospital during the pandemic.

With lockdowns and tighter visiting restrictions, the Trust's **keeping in touch** service used technology to bring people closer together even though they, physically, had to be kept apart.

Not only were benefits felt by patients and family members but ward staff could also see the difference the calls made to their patients.

Having fallen whilst at home, Jackaleen, 91, came into our care at West Suffolk Hospital. 3,000 miles away in the USA, her daughter, Lisa, and grandchildren, Emily and Katie, were very worried.

Lisa and the family were able to have video calls with Jackaleen during her stay through our keeping in touch service.

Having had several video calls during her mum's stay Lisa said: "The keeping in touch team is a gift from heaven. Everyone in the team, including Dawn, Livvy, Chloe, Lauren and Natalie, went above and beyond loving and caring for us all. They all loved my mum during her stay, they were all so wonderful."

Case study: Keeping families updated on loved ones in hospital

Our clinical helpline, launched in April 2020 following the national suspension of visiting in hospitals, took more than 40,000 calls in its first year.

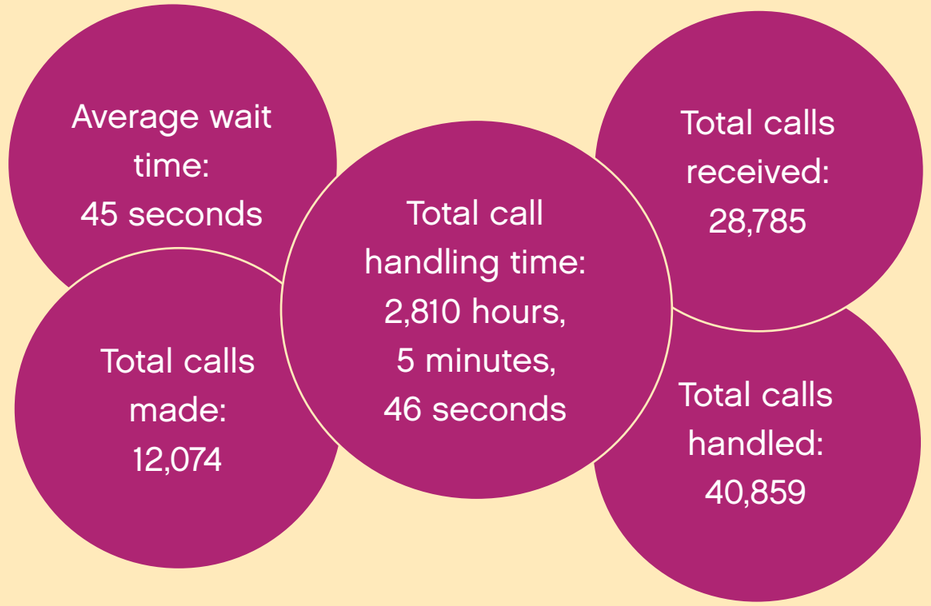
Just one week into the first UK lockdown, the patient experience team saw the difficulty visitor restrictions were having on patients and relatives. They came up with the idea of helping loved ones stay up to date with hospital care and helped set up a team, each member with a clinical background, to run a virtual helpline.

Having a separate helpline for families to get updates on loved ones in our care meant ward staff were able to spend more time caring for patients. The team could access e-Care, our electronic patient record, to keep up to date with the latest diagnoses and care being provided, giving families regular updates.

Trust head of patient experience Cassia Nice said: "Our clinical helpline was a true team effort and we couldn't have done it without our amazing helpline clinicians. Helpline staff have offered support during a time of uncertainty, assisting relatives and carers to make sense of what they are being told."

A family member of one patient said of the service: "After my father was admitted with a fractured hip I was able to get daily updates on his condition and care from the fantastic helpline team. It has been extremely reassuring. The benefits are immense as it takes the pressure off the ward staff. I, the caller, get someone knowledgeable at the other end of the phone very quickly. It has taken away a lot of stress."

The success of the helpline means the Trust will continue with the service even after visiting restrictions have been fully relaxed.



What's changed?

The national picture

Nationally, the NHS is being asked to focus on various ways to improve the care we provide and make sure that everyone gets the best possible experience of the NHS.

The **NHS Long Term Plan** says we need to:

1. Modernise the way we work and rely less on hospitals and giving people more control over their own health and where they receive their care.
2. Do more to prevent illness and reduce inequalities in health experienced by different groups of people.
3. **Improve the quality of our care and the outcomes** for the people we look after. We should especially focus on children and young people, those with cardiovascular disease, stroke, diabetes, respiratory disease, mental health problems, or cancer, and people waiting for an operation. We should use more research and innovation to get there.
4. **Recruit more staff** into a wider variety of jobs, and everyone needs to feel **happy and valued** in their work.
5. We should make the most of everything the **digital world** can offer us.
6. We need to keep **living within our means**, both in terms of money and **how green we are**.

We also need to adapt to the threat of new and untreatable infectious diseases ever present in the background.

To achieve all these things and more, the public, private and voluntary sector organisations which help to look after people's health, care and wellbeing, have started working more closely together. The Trust is a member of two groups in particular – the West Suffolk Alliance and the Suffolk and North East Essex Integrated Care System. Both groups have published their own strategies in the past five years.

This new strategy of our own reflects the ways in which we are working with them towards two common aims: improving the health of our community and reducing inequalities.

New local partnerships – what are they?

The West Suffolk Alliance and the Suffolk and North East Essex Integrated Care System (SNEE ICS / Can Do Health and Care) are agreements between local organisations to work more closely together to make sure people get the best possible care. There is a long history of health and care organisations working together to make sure people get the best possible care. For example, by being a member of the East of England Cancer Alliance, we make sure our cancer treatment stays at the cutting edge.

As members of the West Suffolk Alliance and SNEE ICS, we have signed up to working more closely with local organisations such as councils, volunteer groups, leisure centres and GPs. We call this 'integration' and refer to working as a 'whole system' to improve health and care. Together we consider the wider determinants of health – be that social issues, deprivation, inequalities or mental health.

The SNEE ICS covers a broader geography (Suffolk and North East Essex) and the West Suffolk Alliance focuses on a more local footprint to ensure we drive meaningful integrated services to our local population.

We know what our local people need because the Suffolk County Council Health and Wellbeing Board finds out through local health data research and engagement with local people.

What does this mean for our patients?

At the points in your life that you need the care of our specialists:

- We'll look after you in the way that you need, when you need it, in the place that is best for you
- We'll be as joined up as we can with everyone else who looks after you.

What does this mean for our staff?

In many of our services we are working more collaboratively with staff from our partner organisations to provide the right service in the right place at the right time for our patients and members of our community.

We are changing the way we are working and joining up our care in ways that better meet the individual needs of the people we serve.

Our vision, ambitions and values

Our vision

To deliver the best quality and safest care for our community.

By putting our patients at the heart of our services, and working as part of the West Suffolk Alliance and the Suffolk and North East Essex Integrated Care System, we can make the greatest possible contribution to prevent ill health, increase well-being and reduce health inequalities.

This is our vision because:

- that is what our community needs and expects from us
- our staff want to deliver the highest quality care
- if we focus on quality and safety, then everything else will follow.

Our ambitions

To achieve our vision, our strategy is focused on three key ambitions.

- First for patients
- First for staff
- First for the future.

You can read more about these in the following pages.

Our values

Our First Trust Values are powering our vision and ambitions.

Our First Trust Values are the guiding principles and behaviours which run through our organisation and will help us deliver our vision and ambitions in the right way.

We will use them to always strive to improve the services we provide to our community and the way that we work as a team and with our partners.

To reflect the changes the Trust has been through in recent years, we have updated these values to reflect the evolution of the organisation, the journey it is on and the culture we are striving to create across the Trust.

Powered by our First Trust Values

Fairness • Inclusivity • Respect • Safety • Teamwork

Fairness – We value fairness and treat each other appropriately and justly.

Inclusivity – We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.

Respect – We respect and are kind to one another and to patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.

Safety – We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.

Teamwork – We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

Ambition: First for patients

Executive leads – chief nurse and director of integrated community health and adult social care

Our patients are at the centre of everything we do. The quality of care that we provide to them is our driving force. We strive to deliver the best patient outcomes and patient experience in the most appropriate setting available. We are committed to joining up services locally, collaborating with our partners and supporting our staff to make continuous improvements – no matter how big or small – that challenge us all to raise our standards.

Collaborate to provide seamless care at the right time and in the right place

- We will strive to provide a seamless experience, with good communication from beginning to end
- We will treat everyone with dignity and respect, and as quickly as possible
- We will continue to adapt to the presence of COVID so we can provide services without putting anyone at unnecessary risk of infection
- We will join up more care with our neighbouring organisations, following the West Suffolk Alliance strategy
- We will provide more care in people's own homes and in their local areas.

Use feedback, learning, research and innovation to improve our care and outcomes

- We will ensure patients and families can share their experiences, positive and negative, to help us improve through our **experience of care strategy**
- We will give everyone the tools and support they need to put quality and safety first, by:
- making sure everyone has the confidence to raise concerns and to make changes when things go wrong
- applying our safety and learning strategy to drive forward continuous improvement
- training more staff in quality improvement methods, human factors and ergonomics
- sharing learning internally and looking outwards to learn from others
- taking care with how we use our money, staff, equipment and buildings, so we can continue to afford to invest in better care
- We will keep the good things that have come out of the Covid-19 pandemic, like the keeping in touch service
- We will do more clinical and non-clinical research, involving patients and members of the public
- We will support and celebrate new ideas and innovations in all parts of the Trust and across all teams.

Case study: Helping patients recover at home

An innovative pathway joining up health and care services supports people to be cared for at home.

Pathway One is an integrated way of working that helps with the safe and timely transfer of patients from the West Suffolk Hospital to their own home.

From May 2019 to March 2021, almost 1,425 patients went home with a Pathway One referral, with their care transferred to our community therapists. Recently the service reached its target of achieving 100 discharges in a month. Overall, the pathway has saved almost 3,000 bed days at the hospital, and ensured people can achieve as much independence as possible at home whilst getting the care they need.

Responsive services team lead Jenny McCaughan said: "The patient benefits under this way of working because pathway one helps remove steps and delays in getting patients back to their homes and reduces risks associated with remaining in hospital. It gives the power back to the patient, and gives them a voice so that their individual needs can be met."

Once at home the patient is fully assessed and is seen by their local community health team from day one, who regularly evaluate the best care for the patient going forward.

The service is a West Suffolk Alliance example of hospital and community teams working with our social care colleagues from Suffolk County Council and its Home First team for the benefit of patients.

Case study: Improving care and outcomes for patients

The Trust is on a journey to develop its culture. As part of this we are continuing our work to embed quality improvement (QI) throughout the organisation to improve quality of care and outcomes for patients.

We are creating a quality and safety framework that supports staff at all levels to build their QI skills, and explore and identify QI opportunities where they identify problems, test ideas to improve outcomes and learn from the results. Quality improvement can be used for almost any project, big or small, clinical or non-clinical and is an ongoing process.

In addition, we are taking part in the national **Patient Safety Incident Response Framework** pilot, which is designed to help us further improve the quality and safety of the care we give to patients. As part of this work, we are using Trust data to help us understand and learn from the risks more common to the organisation.

We have taken on more staff to help develop our work on safety and quality improvement. With their focus, and a more joined-up approach across staff groups, we will build on work already undertaken. Involving our staff and patients in the design, management and delivery of QI, and giving them the tools and methods to do this in a more meaningful way will help us achieve improved care, better measurable outcomes and positive patient experiences.

Ambition: First for staff

Executive leads – director of workforce and communications and medical director

We must all take good care of each other, so together we can take good care of our patients. We will strive together to build a culture of fairness, openness and learning, that is inclusive and supports all staff to be the best they can be. We want to be recognised as a great place to work.

Build a positive, inclusive culture that fosters open and honest communication

- We want everyone – no matter what role they play in the Trust – to embed a culture where everyone feels valued and listened to; where the interests of patients and staff are not at odds with one another; and where kindness, good communication and compassion towards one another are standard behaviours
- We will deliver our first People Plan informed amongst other things by the findings of the 'What Matters To You' exercise we did with staff in the summer of 2020
- We will keep using this method of large-scale conversations with staff as an ongoing approach to hear how leadership in the organisation is working and how it could be better
- We will communicate and co-produce better within the Trust, with patients and families, and with the organisations we work with.

Case study: Listening to staff

In 2020, the Trust launched What Matters To You (WMTY), a staff engagement programme to identify how Covid-19 had impacted on our staff and ways of working.

Using feedback from the 2,000 responses we received, we are now working on our first **West Suffolk People Plan** and will deliver this over the course of this strategy.

It will focus on the five key themes which emerged from the WMTY staff engagement, which are:

- The importance of great line managers
- Creating an empowered culture
- Building relationships and belonging
- Appreciating all our staff
- The future and recovery.

A central focus of the People Plan is our commitment to build an open, learning and restorative culture. The Trust is on a journey to improve and we are using the feedback from the WMTY survey and our Care Quality Commission report to guide this.

We are taking steps to introduce and embed cultural change through the way that we manage employee relations and are determined to build an approach that is supportive, kind and compassionate.

Our vision is an open and transparent culture which supports staff to contribute freely and play a full part in our improvement.

We want our colleagues to be confident to speak up and raise concerns about the care we provide, and confident that they will be treated fairly and given the time to learn from and heal when involved in patient safety incidents. We know there is much more we need to do.

Over the coming years we will be working closely with staff to bring about change, for example through initiatives with our Freedom to Speak Up Guardians, the national Patient Safety Incident Response Framework, and bringing in new and improved HR policies and incident review processes. We will use findings from both the annual and quarterly NHS Staff Surveys to monitor progress and make further changes for the better.

Enhance staff well-being

We knew it before – but Covid-19 has made it clearer than ever – looking after our staff is essential. Research shows that line managers play a really important role in how staff feel.

- We will do everything we can to protect and improve the health, wellbeing and safety of our staff
- We will promote the value of great line management and support and develop all our current and future line managers.

Case study: Looking after staff

The mental and physical wellbeing of staff is a priority for the Trust.

We have boosted our staff support psychology service, helping them to be there for anyone in need. We have run well-being initiatives including our **Love Yourself** campaign and introduced **Wellbeing Wednesdays** to encourage staff to take time for themselves.

The Trust has worked hard to vaccinate staff against COVID-19, offering the first and second vaccinations to our staff and other health and social care workers from January 2020 and more recently booster doses. To date more than 32,000 vaccines have been delivered.

The Trust has partnered with a local leisure company, Abbeycroft Leisure, to offer all staff free access to exercise classes and facilities. We have a staff physiotherapist for those needing consultation and treatment; and our education and training team ensure colleagues have access to learning about best practice to stay safe at work. We support the NHS cycle to work scheme, and encourage staff to walk or cycle to work where possible.

As well as our human resources team, there are peer support services available such as the speaking up champions. Staff networks for black and minority ethnic; lesbian, gay, bisexual and trans people; people with disabilities; and those going through the menopause have been established.

My WiSH charity has provided a range of benefits to staff, including welfare packs. Calm rooms and two marquees were furnished by the charity so that staff had somewhere to go to relax during the pandemic. Lastly, the Chaplaincy team offers friendship and support to our whole community, regardless of whether they identify as having a faith.

Invest in education, training and workforce development

As a learning organisation, we keep our staff up to date with best practice and train the next generation of NHS professionals. We want to help every member of staff reach their full potential in their role.

- We will maintain and build on our existing relationships with the University of Cambridge, University of Suffolk, University of East Anglia and West Suffolk College, training staff in a wide range of clinical and corporate roles
- We will provide career progression for all our staff to help them reach their potential
- We will continue to embrace new theories and platforms, such as virtual learning environments and blended learning
- We will create more new roles and use novel approaches to recruitment to reduce vacancies.

Case study: Investing in staff

For Archie Libero, an endoscopy staff nurse, being a nurse was a family affair. She proudly followed in her mother's footsteps – but that doesn't mean it was an easy path.

Moving between the Philippines and the UK meant that although Archie completed her university nursing degree she wasn't able to get the post-registration experience she needed to finalise her qualifications.

"Despite this," she says, "I continued to work in healthcare. I worked in a dementia care home as a carer, then a team leader for three years until I got a job in the West Suffolk Hospital endoscopy unit as a senior endoscopy assistant.

"The education team in the Trust and my manager have been very helpful and supported me to become a UK registered nurse. Eventually, I was able to qualify for a two-year nursing degree apprenticeship programme.

"The nursing profession is extremely rewarding, knowing that we are making a difference to people's lives. I like how every day is different and love how I can help a patient get through their day. However, it can also be tough mentally, physically and emotionally.

"Working through my dissertation and assignments while working full time during the pandemic was stressful. Becoming a registered nurse has opened up a lot of opportunities for me in the nursing field. I one day hope to become a specialist nurse or a clinical nurse endoscopist."

Ambition: First for the future

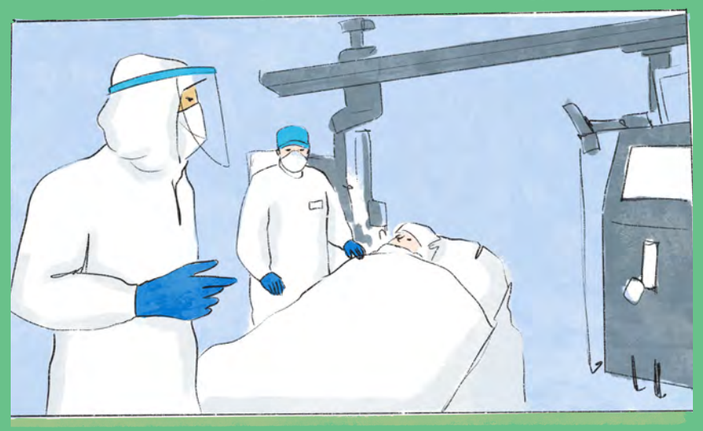
FIRST FOR THE FUTURE

Executive lead – director of resources and chief operating officer

Advancing our digital and technological capabilities to better support the health and wellbeing of our communities is vital. We want to be at the forefront of these changes and have an opportunity to progress this through the planning of a new healthcare facility. Together with patients, public and staff, we will shape health and care services that are fit for current and future needs, helping people to stay well and get well.

Invest in infrastructure, buildings and technology

With the expansion of our services over the last five years, we now operate from just under 100 premises across Suffolk. Our main hospital building on our Hardwick Lane site is nearing the end of its life and the facilities we can offer vary considerably across our total estate. We need safe, modern, accessible buildings and the best technology to help us work well.



- We will maintain all our buildings, facilities and equipment to the best possible standard and make sure everyone has a comfortable environment to be cared for and work in
- We will finalise planning permission and detailed designs to progress the replacement of West Suffolk Hospital under the national **New Hospital Programme**
- We will make optimum use of the digital and medical technologies we already have available, and continue to be at the forefront of digital healthcare in the UK
- We will always have a non-digital offer for those that can't or don't want to use digital solutions
- We will sensitively, securely and responsibly use the wealth of data and information we have at our fingertips to understand quality and outcomes and tailor our care to people's needs.

Case study: Planning for a new hospital

In September 2019, the Government announced its New Hospital Programme, which aims to deliver a long-term programme of investment in health infrastructure, including funding for 40 new hospitals.

The West Suffolk NHS Foundation Trust (WSFT) was named as one of 40 new hospitals and has started work on planning for a new healthcare facility.

This is an exciting opportunity to change the way healthcare is delivered in west Suffolk. We want to create a state-of-the-art healthcare facility that provides modern care that is fit for future generations; makes the best use of digital technology throughout the building and in delivering better clinical care; and reduces our impact on the environment. This will be better for our patients, community, staff and partners.

The Trust and its partners within the local integrated care system (ICS) and West Suffolk Alliance are at the beginning of this project. We want to involve as many people as possible in the design and planning of the new healthcare facility – so it is a hospital designed by the people for the people.

At the end of 2020, we confirmed that the recently purchased Hardwick Manor had, following an extensive appraisal process, been selected as our preferred site for the new facility.

We are now starting to look at how we will provide our services in the new healthcare facility and how a new hospital at the Hardwick Manor site would affect our local environment. This work will inform our outline hospital designs and an application for planning consent.

Please visit https://www.wsh.nhs.uk/New-healthcare-facility/New-healthcare-facility.aspx for further information.

Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities

By well-being we mean looking after the community's physical, mental, emotional, social, and economic needs. We're here to help make you better when you are ill, and to support you to help keep yourself well in the first place.

- We will adapt our services to do more to increase everyone's well-being and prevent ill health
- We will recognise and value the role you play in managing your own health and wellbeing, involving you in conversations and decisions about your health and care, moving from 'what's the matter with you?' to 'what matters to you?'
- We will maximise our social impact as an **anchor institution** rooted in our local community – providing training and employment opportunities for local people, buying from local businesses, supporting local charities and community groups
- We will minimise our environmental impact with our Green Plan.

Case study: Looking after the environment

As part of the NHS and a major organisation in our local community, we have a responsibility to work in a way that has a positive effect on the communities we serve – reducing our impact on the environment and creating healthy, resilient communities.

The Trust is currently developing its Green Plan, which will replace our Sustainable Development Management Plan.

We will be following the NHS Green Plan guidance and addressing important issues such as reducing our carbon emissions and working towards net zero; lowering air pollution; looking at the direct impacts of our actions and the potential to improve our environmental sustainability across many areas; as well as our influence on local supply chains and our communities.

Our recent work in this area includes installing LED lighting across the main hospital – saving electricity, reducing our bills and improving lighting across the Trust.

How will we know when we've got there?

One of the principles of continuous improvement is using measurement to know how we're getting on.

We will measure the progress we make against this strategy. We will need a wide range of measures to understand what is going well and what needs to change. We already use a lot of markers to show ourselves, our community and our regulators how we are doing, but they don't always all feel meaningful.

To bring this strategy to life and to show how it relates to the people who are most important to us, we are going to focus on three key measures, one for each ambition, as well as our combined quality rating for our Care Quality Commission (CQC) assessment. This is in addition to the usual Board key performance indicators that the Trust works to.

In 2020, we were rated as requires improvement by the CQC.

We will aim for a combined CQC rating of good by 2026.

First for patients

The Friends and Family Test is one of the ways that we ask for anonymous feedback from our patients or their carers. The test has one question: "Overall, how was your experience of our service?" Patients can rank their answers from very good to very poor. In our most recent score, 94% of people said their care was good or very good. That means 6% didn't.

We will aim for 95% of patients to recommend us as a place to receive care by 2026.

In the annual NHS staff survey, our staff are asked to rate our care against the question: "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation." In 2020, 83% of staff said they would recommend us as a place to receive care. That means 17% wouldn't.

We will aim for 90% of staff to recommend us as a place to receive care by 2026.

First for staff

In the annual staff survey, our staff are also asked to rate the Trust against the question: "I would recommend my organisation as a place to work". In 2020, 74% of staff said they would recommend us as a place to work. That means 26% wouldn't.

We will aim for 81% of staff to recommend the Trust as a place to work by 2026.

First for the future

This ambition is harder to measure. We haven't got a good measure at the moment to rate our progress against all the different things we want to achieve. Many of the plans we have for the future rely on our relationships with our partner organisations, especially the members of the West Suffolk Alliance. The plans under this ambition also mean a lot to local people and communities. To measure progress against this ambition, we will ask our Alliance partners and our community to help.

We will ask a panel of local representatives to score us once a year on how we are doing. We will work out a scoring system with their help and as soon as we have done that, we'll set ourselves an aim for what we want to achieve by 2026.

While we will always do our best to strive for 100% in scores, we have worked with our staff and Board to identify what we think are realistic targets to drive improvements, that consider previous trends and acknowledge the pressures we are facing as we emerge from the pandemic.

WEST SUFFOLK ALLIANCE
about people & places
CAN DO HEALTH & CARE
NHS West Suffolk NHS Foundation Trust
FIRST FOR PATIENTS
CLINICAL HELPLINE
Waiting lists
Waiting lists
FIRST FOR STAFF
STAFF PSYCHOLOGY TEAM
ADDITIONAL WELLBEING SUPPORT
WEST SUFFOLK PEOPLE PLAN
FIRST FOR THE FUTURE
POSITIVE & INCLUSIVE
MAKE MEANINGFUL CHANGES
National Guardian
Freedom to Speak Up
VOLUNTARY SECTOR
WIDER PARTNERS
PRIMARY CARE
COMMUNITY SECTOR
EDUCATION PROVIDERS
COUNCILS
TELEPHONE CALLS
POSITIVE PATIENT EXPERIENCE
ENVIRONMENT
MENTAL HEALTH
ISOLATION
DISCRIMINATION
DEPRIVATION
PHYSICAL ACTIVITY
HOUSING
BETTER HEALTHCARE OUTCOMES
PATIENT SAFETY
QUALITY IMPROVEMENT
WEST SUFFOLK
"I LOVED IT SO MUCH AS A STUDENT I DECIDED TO STAY"
FAIRNESS
PROVIDING EXCELLENT CARE
SAFETY
EVERY DAY IS DIFFERENT
TEAM WORK
THERE'S ALWAYS SOMETHING TO LEARN
ENJOYED!
"I REALLY FEEL VALUED BY THE PEOPLE I WORK WITH AND THE PEOPLE I SEE AND TREAT"
SUPPORTED
APPROACHABLE
INCLUSIVITY
A WHOLE BIG TEAM ETHOS
RESPECT
EVERYONE IS SO FRIENDLY
HOLISTIC

West Suffolk NHS Foundation Trust
Hardwick Lane
Bury St Edmunds
Suffolk
IP33 2QZ

NHS
West Suffolk
NHS Foundation Trust

5. GOVERNANCE

5.1. BAF Summary and risk report

To Assure

Presented by Ann Alderton

Board of Directors – 28 January 2022

Report Title:	Item 5.1 - Board Assurance Framework
Executive Lead:	Ann Alderton, Interim Trust Secretary
Report Prepared by:	Ann Alderton, Interim Trust Secretary
Previously Considered by:	Board of Directors December 2021

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☒

Executive Summary

The Board assurance framework is a tool used by the Board to manage its principal strategic risks.

Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

The Board approved its risk appetite statement at the October meeting of the Board, following which the BAF risks were reviewed individually with the executive team during November 2021.

Action Required of the Board

a) To note the updated BAF and the consolidation of the CIP risk and financial sustainability risks into a single updated BAF entry.
b) Based on the BAF risks, controls and assurances consider topics for future Audit Committee 'deep dive' review or Board development

Risk and assurance:	Failure to effectively manage risks to the Trust's strategic objectives. Agreed structure for Board Assurance Framework (BAF) review with oversight by the Audit Committee. Internal Audit review and testing of the BAF.
Legal and regulatory context	The BAF underpins the Board's Annual Governance Statement within the annual report and is a critical part of the Head of Internal Audit's annual opinion.

Background

The Board assurance framework is a tool used by the Board to manage its principal strategic risks.

Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

Appendix 1 shows the allocation of the BAF risks to each of the Board's assurance committees.

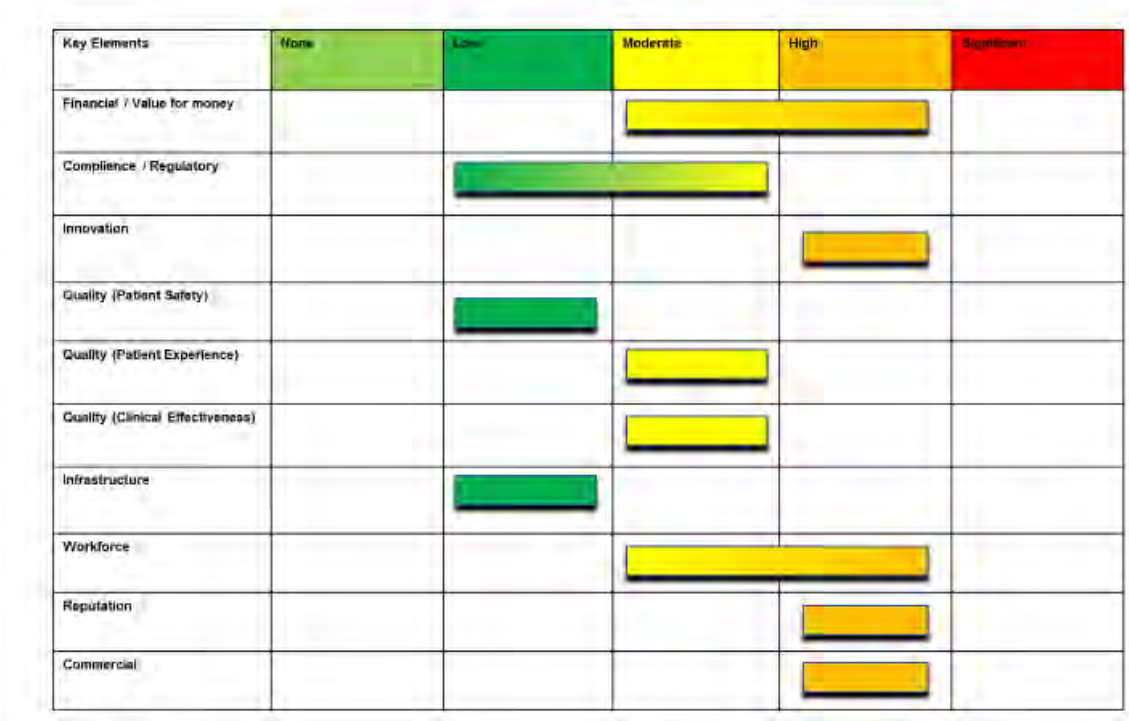
Appendix 2 provides supporting detail of current mitigating actions and the most recent assurances relating to those actions.

The Role of the Assurance Committees

Board assurance committees are responsible for considering all relevant risks within the BAF and the corporate risk register as they related to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the audit committee or the board as appropriate. The committees will be responsible for recommending changes to the BAF relating to emerging risks and existing entries within their remit for the executive to consider. When the target risk in the BAF is met, a full report will be made to the committee recommending its removal from the BAF, which will the committee will consider and make an appropriate recommendation to the Board.

Risk Appetite Statement

The Trust's risk appetite statement has been reviewed and is being used as a tool to determine which risks should be prioritised by the board for controls assurance purposes. Where the Trust has a cautious view of risk (green to yellow), and the current risk is higher than this, this risk will be reviewed more frequently and in greater depth by the board and its committees. When a target risk is achieved and this is lower than the Trust's risk appetite, the Board will consider the removal of a risk from the Board Assurance Framework, though it will remain on the Trust's risk register for ongoing executive management.



Current Risk Profile

All but one of the BAF risks are red. All of the red risks are outside the Trust Board's agreed risk appetite.

The amber risk relates to digital transformation. Assessed at Annual x Major = Amber, this has achieved its target risk and is within the Trust Board's agreed risk appetite. We are awaiting confirmation that this has been formally de-escalated from the BAF.

Financial Risk Assessment

During the review of Risk 5 (CIPs) and Risk 6 (Financial Resource allocation), the Director of Resources considered that the identification and delivery of CIPs is a control to address the financial sustainability risk and not a separate risk in its own right. This has now been completed.

Red Risk Report

This report now also includes an update on the corporate and operational **red risks** previously reported separately.

Risk No.	Title	BAF Y/N	Risk level (current)	Risk Subcategory
24	Potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow)	N	Red	Corporate Risk
4168	Impact of Managing COVID-19 (Coronavirus) on Trust business as usual activity	N	Red	Corporate Risk
4499	Provision of thrombectomy service for stroke patients in our region	N	Red	Corporate Risk
4724	Staffing shortfalls	N	Red	Corporate Risk
4800	Lack of Emergency call Bell System	N	Red	Operational Risk
4890	Evacuation of the West Suffolk Hospital primarily due to RAAC issue	N	Red	Operational Risk
4917	Missing samples causing a delay to getting results to the right patient at the right time.	N	Red	Operational Risk
5092	Capacity and demand of the e-Care Meds Team	N	Red	Operational Risk
5107	Post the collapse of RAAC planks, it is assessed that there will be the release of large amounts of dust into the air	N	Red	Operational Risk
5136	Saving Not Signing Documents on e-Care	N	Red	Corporate Risk
5151	No availability of a second obstetric team outside the hours of 8am and 8pm Mon-Fri	N	Red	Operational Risk
5181	Fukuda Spirometry tubing is currently not available	N	Red	Operational Risk
5190	RAAC plank concerns within Antenatal	N	Red	Operational Risk
5199	Extreme weather and concerns how it affects the RAAC roof and walls	N	Red	Operational Risk

The corporate risks are currently being managed through management committees (RAAC Red Risk, Senior Leadership Team, Executive Directors). Operational risks are reviewed quarterly with the relevant risk owner.

Future Reporting Arrangements

The Board Assurance Committees will update the board at every meeting when they receive updates on any of the BAF strategic risks.

The BAF will be updated following each update and reported to the public board at every other meeting.

Appendix 1

Allocation of BAF Risks to Board Sub-Committees

Board Assurance Committee	Well-Led Key Lines of Enquiry	BAF Risks Assigned	Current Risk
Improvement	• **Is there a culture of high quality, sustainable care?** • **Are there robust systems for learning, continuous improvement and innovation**	1. If we do not establish effective governance structures, systems and procedures over safety and quality, this will lead to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action	Quarterly x Major = Red [No change}
Insight	• **Are there clear and effective processes for managing risks, issues and performance** • **Is appropriate and accurate information being effectively processed, challenged and acted upon**	2. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	Weekly x Major = Red [Increased]
		3. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will affect our ability to deliver safe, effective and efficient services and care to patients	Weekly x Major = Red [No change]
		4. If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience [Risk is being considered for de-escalation by Insight Committee]	Annual x Major = Amber [No change]
		5. Risk relating to CIP has been deleted and incorporated into Risk 6	Quarterly x Major = Red [No change]
		6. External financial constraints (Revenue and Capital) impact on Trust and system sustainability and model of service provision in the west Suffolk system *(even when services delivered in the most efficient way possible).* This includes failure	Quarterly x Major = Red [No change]

Board Assurance Committee	Well-Led Key Lines of Enquiry	BAF Risks Assigned	Current Risk
		to identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services while delivering the agreed control total	
Involvement	**Are the people who use the services, the public, staff and external partners engaged and involved to support high quality sustainable services?**	7. If we do not value our workforce and look after their well-being, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale, and staff choosing to leave WSFT	Quarterly x Major = Red [No change]
Core Resilience Team Red Risk Oversight Committee		8. If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices	Quarterly x Major = Red [No change]
Future Systems Programme Board		9. If we do not manage the programme to build and deliver a new healthcare facility and model of service delivery to time and budget, this may result in cost pressures, potential harm incidences, capacity pressures and improvement notices	Quarterly x Major = Red [No change]

Appendix 2

Summary mitigating actions and gaps in assurance

	Residual Risk	Target Risk
1. Failure to maintain and further strengthen effective governance structures, systems and procedures over safety and quality, leading to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Safe staffing - see separate BAF risk	-	-
Build assurance dashboard and framework for quality indicators to support development of ward accreditation programme	SW	Apr 22
Development programme for ward managers and matrons to support ward accreditation	SW	Apr 22
Align accreditation framework and KPIs with Nursing, midwifery and AHP strategy	SW	Apr 22
Co-produce nursing, midwifery and AHP strategy to meet current and future system needs (reflecting the updated Trust strategy - pending)	SW	Jan 22
Develop patient safety and learning strategy	LW	Apr 22
Quarterly review of the CQC Insight publication with actions to address outlying indicators overseen by Insight Committee	RG	Dec 21
IQPR refresh project (this will enable reinstatement of the previously listed control "IQPR including key quality indicators (including community) – reported to open board and also reported to Insight Committee. This supports timely identification, escalation and action to address issues of concern".	NC	Mar 22
Review 2021/22 Quality Priorities and develop 2022/23 quality priorities through the Improvement Committee with Board sign-off as part of the Annual Report/Quality Accounts	RG	Mar 22

Assurances

- Organisational Framework for Governance approved by Board September 2021
- Serious incidents, complaints, claims and inquests report to board (every meeting)
- Maternity reporting to Board and attendance of head of midwifery (every meeting)
- Quality reporting to Board on key performance indicators e.g. infection prevention and control, maternity (every meeting)
- Learning from Deaths report to board
- Monthly breakdown of nurse staffing levels reported to board
- Programme of IPB external reviews
- External review of maternity services (CCG, region and CQC) – supportive (June '21)
- Maternity external support – reported as part of maternity plans to IPB
- Regulatory PSIRF sign-off of WSFT framework
- Internal audit reporting:
    - Responsive internal audit programme linked to IPB assurance requirements (draft programme for 2021/22)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - CQC Improvement Plan – Stage 1 Substantial Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - Fit and Proper Persons - Partial Assurance (Jan 2021)

	Residual Risk	Target Risk
2. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	Weekly x Major = Red	Quarterly x Moderate = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Operational and staffing plans to safely deliver winter escalation and surge capacity (see separate BAF risk)	COO	Feb 22
Implementation of: length of stay and discharge programme supported by ECIST to include system out of hospital capacity programme, frailty programme, the application of right to reside	COO	Feb 22
Addition decant ward (G10)	COO	Completed Oct 21
Transformation initiatives: - review of home IV therapy to inform business case (Apr 21) - expansion of the virtual ward concept	COO	Feb 22
Review E-Zec contract performance when we return to more normal levels of outpatient activity	COO	Completed Nov 21
Review of space allocated to paediatrics and frailty within the ED footprint	COO	Completed Aug 21
Implement final versions of new ED access standard in line with national roll out	COO	Apr 22
System to approve community bed requirement and funding for additional community bed base	COO	Completed Sep 21
Submitted a range of bids for funding to support admission avoidance and improved hospital flow – funding schemes to be implemented	COO	Dec 21

Assurances

- Access and performance reporting arrangements to Board e.g. IQPR, operational report and transformation report (qrtly)
- External monitoring of stranded and super stranded and medically optimised for discharge
- Monitoring of bed utilisation
- Attain report – informs and validates the decant plans to support RAAC remediation
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - Civil Contingencies Act - Advisory (July 2020)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

	Residual Risk	Target Risk
3. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will our ability to deliver safe, effective and efficient services and care to patients ***(emergency standard is considered separate BAF entry)***	Weekly x Major = Red	Quarterly x Moderate = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Theatre 1 recommissioned (delayed due to RAAC remediation and Covid)	COO / DoR	Feb 22
Shadow monitor against new 28-day standard – identify areas for improvement	COO	Completed Sep 21
Outpatient transformation programme with focus on digital and embedding of Covid learning – delivering benefits to key milestones. Advice and guidance virtual consultation PIFU	COO	Mar 22
Development of longer term contract for additional Orthopaedic capacity with the BMI	COO	Dec 21
Continue to progress opportunities to fund an elective hub at Newmarket	COO	Feb 22
Development of Ophthalmic injection suite	COO	Jan 22
Development of an additional clinical area within the JFDU	COO	Mar 22
Improve operational efficiency in line with the GIRFT HVLC	COO	Feb 22
Develop business case for community diagnostic hub at Newmarket	COO	Feb22
Assurances		

- Board reports and monitoring (every meeting)
- Weekly SNEE activity level review
- Cancer and diagnostics activity progress against trajectory (monthly)
- Internal audit reporting:
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

Awaiting confirmation of de-escalation

	Residual Risk	Target Risk
4. If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience	Annual x Major = Amber	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Preparation 2022/23 digital programme plan with funding envelope to Digital Programme Board review	Craig Black	Mar 22
Agreed plan for the delivery of HIMSS 6 and 7 (with key external organisational dependencies) with NHSD/NHSX. To include closed loop blood and medication	Sarah Judge Liam McLaughlin	Mar 22
Implementation of full Infection Control solution integrated with e-Care to support mandated measures for Covid19 monitoring	Guy Hooper	Completed Dec 21
Delivery of Closed Loop blood request and administration	Guy Hooper	Apr 22
Deliver programme for population health management in the west of Suffolk, working with local partners and Cerner to develop the solution	Helena Jopling	Mar 22
Deployment of new Antivirus solution to support further strengthening of Cyber Security defences	Rob Howorth	Dec 21
Review of digital governance structure/framework	Sarah-Jane Relf	Dec 21
Key deliverable to support Future System programme: - Support for the Future systems engagement fortnight - Commission first services from an offsite data centre - Engagement with architects and surveyors on development of a digital twin for the new buildings		Ongoing Complete Dec 21 Ongoing
Regular updates from Pillar Groups to Digital Board and onto Trust Board: - Pillar Group 1 Acute Developments - Pillar Group 2 (Wider Health Community [SNEE]) - Pillar Group 3 Community Developments - Pillar Group 4 Infrastructure	Craig Black Sue Wilkinson Craig Black Helen Beck Nick Jenkins	On-going
Assurances		
• Digital Programme Board reporting to Board, including NED membership (quarterly) • Cyber Essential Plus audit report • Cyber security penetration test report • Data Security and Protection Toolkit assessment		

Incorporated into Risk 6

	Residual Risk	Target Risk
5. If we do not identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services then we will not meet our control total, face potential regulatory action and intervention and fail to deliver high quality and safe services	Quarterly x Major = Red	Quarterly x Major = Red

Now includes Risk 5

	Residual Risk	Target Risk
6. External financial constraints may impact on Trust's sustainability through tariff, contract and pattern of service provision in the west Suffolk system resulting in inequitable allocation of resources to meet the care and service need of the local community	Quarterly x Major = Red	Quarterly x Major = Red
Description of additional controls required (actions being taken)	Lead	Due date
Delivery of year end position (Board reporting) with escalation as required	DoR	Mar 22
Agree financial position with (including anticipated funding for 22-23) with the system and regional team	DoR	Mar 22
Agree budget position internally	DoR	Mar 22
Finalise CIPs to deliver financial plan for 2022/23 (dependent on response to system/ regulatory framework)	COO/DoR	Mar 22
Review divisional business plans (underpinned by sustainable clinical models) to reflect the requirements to deliver additional backlog activity)	COO	Dec 22
Develop a system-wide information strategy with underpinning tools to improve performance monitoring	DoR	Jun 22
Respond to national guidance for operational planning cycle for 2022/23	RJ	Apr 22

Assurances

Internal – level 2

- Monthly reporting to Board through finance and performance reports (monthly)
- Operational plan approved by Board
- Controls and assurance for internal efficiency set out in CIPs

External - level 3

- Control total agreed with NHSE/I
- Delivery of year end position
- Alliance partnership working for services in west Suffolk – Alliance strategy

	Residual Risk	Target Risk
7. If we do not value our workforce and look after their wellbeing and development, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale and staff choosing to leave WSFT	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Development of next iteration of People Plan in support of the new WSFT strategy and reflecting national priorities	JO	Mar 22
Evaluation of additional staff support measures during pandemic and agreement of next steps	JO	Jan 22
Implementation of lessons learned from external review of whistleblowing matters	JO	Mar 22
Establish Mandatory staff vaccination implementation group and deliver action plan	JO	Apr 22
Assurances		
• Safer staffing - trust-wide establishment review approved by Board (Jan '21) • Approved WSFT people plan, with monthly reporting to Board • Vacancy levels – reported monthly • National staff survey – reported to board • Friends and family and staff recommender scores		

	Residual Risk	Target Risk
8. If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices *[Linked to structural risk assessment (ref. 24) rated as Red]*	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Implementation of controls associated with red risk re RAAC planks (Datix 24) potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow): - Emergency planning - Assessment and repair - Remediation (failsafe installation) - Communication - Research and development - Site and system risk (including continued occupation of WSH site)	C Black	Mar 23
Deliver approved capital programme for 2021/22, including key capacity developments	C Black	March 22
Sudbury asset disposal as part of agreed plan	C Black	March 23
Secure capacity as part of one public estate (OPE) development at six hubs across West Suffolk	C Black	March 24
Communication strategy for structural risk based on agreed remediation plan with clinical model to support capacity requirements (linked to Attain work)	C Black	ongoing
Assurances		
• Reporting to Board (monthly) • Monthly risk review meeting – monitors progress and escalates issues/concerns • Legal opinions on activity undertaken (latest Jan 2021) • Regional office Charles Hanford (pending) - Charles undertakes a quarterly review of performance in completing the surveys etc. to report to the national oversight group • Engagement in 'best buy' hospital forums ongoing (ongoing) • EPRR feedback from exercise Hodges (Oct 20) • Internal audit reporting: o Civil Contingencies Act - Advisory (July 2020) o Risk Management - Reasonable Assurance (Nov 2020)		

	Residual Risk	Target Risk
9. If we do not manage the programme to build and deliver a new healthcare facility and model of service delivery to time and budget, this may result in cost pressures, potential harm incidences, capacity pressures and improvement notices	Quarterly x Major = Red	Annual x Major Amber
Description of additional controls required (actions being taken)	Lead	Due date
Implementation of the agreed programme of work to support key workstreams for: 1. Finance Workstream 2. Clinical Workstream 3. Estates Workstream 4. IM&T Workstream 5 Communications and Engagement Workstream 6. Workforce Workstream	Zoe Selmes Helena Jopling Jacqui Grimwood Liam Mclaughlin Emma Jones Sarah Shaw	Ongoing
Develop a change log to identify the gaps in the “out of scope” work to inform proposals to strengthen governance and accountability with system partners	Tracy Morgan	Ongoing
Outline Business Case submission	Craig Black	Oct 22
Assurances		
• FS Programme Board with NED membership meets monthly and reports to the Board of Directors • Monthly update to the board on progress with the project, providing detailed updates on all key stages of the programme		

5.2. Governance report

To Assure

Presented by Ann Alderton

Board of Directors – 28 January 2022

Report Title:	Item 5.2 - Governance Report
Executive Lead:	Ann Alderton, Interim Trust Secretary
Report Prepared by:	Ann Alderton, Interim Trust Secretary
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive Summary
This report summarises the main governance headlines for December 2021, as follows: • Interim Chair Appointment • Council of Governors • Senior Leadership Team report • Agenda Items for the March Board meeting
Action Required of the Board
To note the report

Legal and regulatory context	NHS Act 2006, Health and Social Care Act 2013

Governance Report

1. Interim Chair Appointment

Following the resignation of Sheila Childerhouse as Chair, the Council of Governors appointed Jude Chin as Interim Chair at their meeting of 17 January 2022. The selection and appointment process was managed by the Governors' Nomination Committee, who have also started the process for the appointment of a permanent Chair and up to three new non-executive directors.

2. Council of Governors' Meeting 17 January 2022

The Council of Governors approved the revised Trust Constitution, which included the option to increase the number of non-executive directors on the Board. As the Board of Directors had also approved it at its meeting of 17 December 2022, this revised Constitution has now come into effect.

During the process of updating the Constitution, governors noted that the procedure for managing investigations into governors alleged to have breached the Code of Conduct was not fit for purpose and needed further work. The Council agreed to establish a Standards Task and Finish group to take this forward.

Governors also discussed the next steps relating to the West Suffolk Review by Christine Outram, which was published in December 2021. The governors are keen to support the Board and the Trust in implementing the learning from that report and to ensure that they fulfil their duty to those who elected and appointed them to hold the NEDs to account for the performance of the Board and to represent the interests of members and the public. To move things forward at pace, the Council agreed to the establishment of a Governor/Director working group to take this forward, reporting to the Council of Governors.

3. Senior Leadership Team Report

The Senior Leadership Team is a decision-making forum which provides strategic leadership for the organisation and is responsible for the implementation and delivery of the Trust's strategic direction, business plan and associated objectives, ensuring that a cohesive decision-making process and co-operative approach is applied to issues which have an impact across the organisation. The Team is still in a developmental stage but has considered a number of strategic issues in its recent meetings, which has included discussion of the People plan, the Green Plan, Nursing Workforce Surge Staffing arrangements and consideration of business cases. There are no issues escalated for the Board's attention.

4. Agenda Items for the Next Meeting (Annex A)

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.

5. Use of Trust Seal

To note use of the Trust Seal, pursuant to Standing Order section 8. The Trust Seal was used on the following occasions:

Seal No. 151 – Lease relating to property at West Suffolk Hospital between West Suffolk Hospitals NHS Foundation Trust and WHSmith Hospitals Ltd - Sealed by Nick Macdonald, witnessed by Ruth Williamson (12 January 2022).

Seal No. 152 – Licence for alterations relating to property at West Suffolk Hospital between West Suffolk Hospitals NHS Foundation Trust and WHSmith Hospitals Ltd - Sealed by Nick Macdonald, witnessed by Ruth Williamson (12 January 2022).

Annex A: Scheduled draft agenda items for next meeting – 25 March 2022

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
General Business					
Patient/staff story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	CB
Report from 3i Committees: Insight, Improvement & Involvement	✓		Written	Matrix	RD / AR / JC
First for Patients/Staff – Assurance and Culture					
Insight Committee Report - Finance and workforce report - Operational report - IQPR	✓		Written	Matrix	NM/NC/RD
Involvement Committee Report - People and OD Highlight Report o Appraisal and mandatory training report o Putting you First award - The People Plan - Staff Survey 2021	✓		Written	Matrix	JMO/AR
Improvement Committee Report - Infection prevention and control assurance framework - Maternity services quality and performance report (inc. Ockenden) - Nurse staffing report - Quality and Learning report – quality priorities - Learning from Deaths	✓		Written	Matrix	SW / PM
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
First for the Future					
Budget 2022/23	✓		Written		NM
Capital Programme	✓		Written		NM
Future system board report	✓	✓	Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System	✓		Written	Matrix	CB
Governance					

Governance report, including - Agenda items for next meeting - Use of Trust's seal - Senior Leadership Team report - Board well led developmental review	✓		Written	Matrix	AA/RJ
Board assurance framework and risk report	✓		Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)	✓	✓	Verbal	Matrix	JC

Annex B: NHS Systems Oversight Framework Segmentation Letter

NHS England and NHS Improvement East of England
2 – 4 Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Dear Craig,

The West Suffolk NHS Foundation Trust: NHS system oversight framework segmentation

As you will be aware, NHS England and NHS Improvement (NHSEI) recently consulted on the new NHS System Oversight Framework (SOF) 2021/22, which introduced a new approach to provide focused assistance to organisations and systems.

Following feedback from local leaders and others, this new SOF is now being implemented. The final SOF can be found here.

Following consideration by the NHSEI regional support group, it has been agreed that West Suffolk NHS FT should be placed into SOF segment 3 and mandated support.

What this means in practice is that the regional team will work collaboratively with you to undertake a diagnostic stocktake to identify the key drivers of the concerns that need to be resolved. Through this, we aim to better understand your support needs, reach agreement on clear and timely exit criteria.

We recognise and thank you for the efforts of you and your teams to provide the best quality care to our patients, including meeting and recovering from the additional challenges COVID-19 has posed. This decision is not a reflection of all those staff who have worked so tirelessly for patients this year in particular, but an opportunity for us all to work together to build better and more sustainable services for those patients for the future.

If you wish to discuss the above or any related issues in more detail, please contact Catherine Morgan in the first instance.

Yours sincerely

Catherine Morgan OBE
Regional Chief Nurse: East of England

Annex C: Reassignment of Scrutiny Committee Delegated Responsibilities

Delegated Responsibilities	Assigned to:
1. To recommend to the Board of Directors projects and developments to be considered for inclusion in the Committee's work programme. The Committee's work programme will be determined through an annual review, taking into account the annual review of the operational and strategic plans, and supported by ongoing review of the meeting agendas of the Committee and the Board of Directors.	This is an administrative duty which applies to the Board and its committees collectively. It is the Board's responsibility to establish appropriate governance for its major projects and developments.
2. To report to the Board any new projects or developments proposed for inclusion in the work programme during the year.	Major projects have their own governance arrangements, reporting to the Board of Directors directly
3. To ensure project management structures and processes are in place to ensure effective scrutiny of the projects within the Committee's work programme.	This is primarily an executive responsibility (Senior Leadership Team). Independent assurance over the project management arrangements for the Trust's major projects will fall within the Audit Committee's remit.
4. To review committee's work programme as a standing agenda item at each meeting and report this to the Board.	This is an administrative duty which ceases with the committee
5. To receive, review and recommend business cases when appropriate to the Board of Directors. All business cases of a level to require a Strategic Outline Cases (SOCs) will be considered by the Committee prior to presentation to the Board.	This is managed on a case by case basis, through the Senior Leadership Team and then the Board. Task and finish groups will be established for complex projects.
6. To secure the necessary Executive support to ensure the work programme is delivered and to: (a) Approve the scope of the projects and oversee their implementation (b) Approve the managers who will manage the project on its behalf and define their roles and responsibilities (c) Approve the project documentation (d) Approve the reporting arrangements, structure and frequency (e) Approve the sequence and timescale of the work (f) Identify resource implications to the Board of Directors (g) Agree any changes to a project's scope	These are executive responsibilities and are decided upon and approved by the responsible manager, the Executive Directors and/or the Senior Leadership Team.

Delegated Responsibilities	Assigned to:
(h) Initiate action to address any matters which are beyond the authority of other managers to resolve (i) Agree any arrangements for evaluation (j) Officially close the projects from the work programme	
7. For all significant projects, and in line with its own Financial Instructions, Department of Health and Social Care and NHS Improvement guidance as appropriate, the Committee will ensure that, if required, a third party is engaged to undertake a process of due diligence prior to any agreement on the transfer of services. This includes having an independent: (a) Assessment of the underlying financial position of services that WSFT may look to develop and/or take on; (b) Analysis and comment upon the assets and liabilities to be assumed; (c) Identification of internal control weaknesses including observations on systems and personnel; (d) Identification of transitional issues and potential assistance with post-transaction integration issues; (e) Identification of areas of risk (and opportunity) that may require specific protection (through warranties and indemnities) in any necessary agreements with other organisations.	This is undertaken by the board on a case-by-case basis, with separate task and finish groups set up for large major projects
Approval of Business Cases and investments up to a value of £250,000	Senior Leadership Team has authority to approve business cases and investments up to a value of £250,000

5.3. Register of Interests Annual Report

To Assure

Presented by Ann Alderton

Board of Directors – 28 January 2022

Report Title:	Item 5.3 - Register of Interests Annual Report
Executive Lead:	Ann Alderton, Interim Trust Secretary
Report Prepared by:	Georgina Holmes, FT Office Manager
Previously Considered by:	

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive Summary
It is a Constitutional requirement that appointed board Directors have a duty to avoid conflicts of interest with the Trust. To ensure full openness and transparency, the register of directors' interests is formally reviewed and updated on an annual basis. At each Board meeting declarations are also received for items to be considered.
Action Required of the Board
To note the summary of the register of directors' interests.

Legal and regulatory context	NHS Act 2006, Health and Social Care Act 2013

REGISTER OF DIRECTORS' INTERESTS

The Codes of Conduct and Accountability for NHS Trusts requires all Trusts to draw up and maintain a register of director's interests. This register consequently lists all interests, defined by the Codes as relevant and material for all its Board and non-Board directors.

The definition of interests is as follows:

- Directorships held in private companies or plcs.
- Ownership or part ownership of private companies, businesses or consultancies, likely or possibly seeking to do business with the NHS.
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or a voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for NHS services.

	Declared Interest	Date Reviewed / Amended
Trust Chairman		
Sheila Childerhouse	Partner in T&D Childerhouse farming company Trustee of the East Anglia's Children's Hospices Director of Charles Burrell & Sons (dormant company) Associate Oliver & Co Sole Trader as Childerhouse Consulting	28 January 2022
Non Executive Directors		
Jude Chin (interim) *(appointed 01/09/21)*	Director of SSAT (The Schools Network) Ltd Shareholder of SSAT (The Schools Network) Ltd Trustee The Seckford Foundation Trustee The Seckford Education Trust Trustee The Academies Enterprise Trust	28 January 2022
Richard Davies	I am currently working part-time for the University of Cambridge, assisting with the COVID operations Helpdesk. The Cambridge University Clinical School has a contract with the WSFT to provide clinical student teaching.	28 January 2022
Angus Eaton *(resigned 31/05/21)*	Group Chief Risk Officer for Hastings Group. As an insurer there is the potential that Hastings or its subsidiaries could have financial, commercial or litigation business with the NHS. Non-Executive Director of The Motor Insurance Bureau	28 January 2022

	Declared Interest	Date Reviewed / Amended
Christopher Lawrence *(appointed 01/06/21)*	Lambeth conference company – Director. Appointed by Archbishop of Canterbury. University of East Anglia Staff Superannuation Scheme, Trust Director, Chair Chair of Trustees, The Horstead Centre, Horstead, Norfolk – charity providing residential activities for young people. Appointed by Bishop of Norwich	28 January 2022
Rosemary Mason *(resigned 22/06/21)*	Director Quay House (Portsmouth) Ltd *(2021 declaration)*	28 January 2022
Louisa Pepper	Trustee for Daval Charitable Trust	28 January 2022
Alan Rose	Chairman, Howard House Patient Participation Group, Felixstowe Governor on Board of Anglia Ruskin University Wife is a public governor of ESNEFT (Colchester and Ipswich Hospitals)	28 January 2022
David Wilkes *(resigned 11/06/21)*	Non-Executive Director Pauls Malt Ltd *(2021 declaration)*	28 January 2022
Chief Executive		
Stephen Dunn *(resigned 3 August 2021)*	Trustee of "Brightstars" charity Director of Helpforce Community Honorary Commander, USAF Lakenheath *(2021 declaration)*	28 January 2022
Executive Directors		
Helen Beck *(retired 30 November 2021)*	Director of S L Beck non-clinical Consultant Ltd	28 January 2022
Craig Black	Nil	28 January 2022
Nicola Cottington *(appointed 1 November 2021)*	Nil	28 January 2022
Nick Jenkins *(resigned 31/05/21)*	Nil	28 January 2022
Nick Macdonald (interim) *(appointed 01/08/21)*	Nil	28 January 2022

	Declared Interest	Date Reviewed / Amended
Clement Mawoyo *(appointed 5 July 2021)*	Nil	28 January 2022
Paul Molyneux (interim) *(appointed 01/06/21)*	I am Director of a private company, PD Molyneux Neurology Consultancy Ltd. This company offers private neurology consultancy work at the BMI Bury St Edmunds. I provide support and advice for both the MS Society and MS Trust on a voluntary basis. I do occasional Advisory Boards with Pharma, offering expertise in my subspecialty area (Multiple Sclerosis). I recently did an Advisory Board for Biogen. I have been sponsored in the past to attend international conferences, in relation to my role as Consultant Neurologist, by Pharma, most recently in April 2021. This has included registration fees, travel and accommodation.	28 January 2022
Jeremy Over	Nil	28 January 2022
Kate Vaughton	Being proposed to Abbeycroft Leisure to take up a Trustee post at their board meeting on 27 January 2022.	28 January 2022
Susan Wilkinson	Nil	28 January 2022
Trust Secretary		
Richard Jones	Director of Friars 699 Limited (which changed its name to "The Pathology Partnership Limited"), dissolved via voluntary strike-off on 20/4/2021. Councillor of Brockley Parish Council	28 January 2022
Ann Alderton (interim) *(appointed 14 June 21)*	Tredaran Consulting Ltd – Director and Owner Councillor Beyton Parish Council	28 January 2022

6. OTHER ITEMS

6.1. Questions from Governors and the Public

To Note

6.2. Any other business

To Note

6.3. Date of next meeting - 25 March 2022

To Note

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 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