Board of Directors (In Public)

Schedule	Friday 29 November 2019, 9:15 AM — 11:30 AM GMT
Venue	ABC Room, Newmarket Hospital, Exning Road, Newmarket CB8 7JG
Description	A meeting of the Board of Directors will take place on Friday, 29 November 2019 at 9.15 in the ABC Room, Newmarket Hospital, Exning Road, Newmarket CB8 7JG
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

Agenda Open Board 29 Nov 2019.docx

9:15 GENERAL BUSINESS
Presented by Sheila Childerhouse

1. Introductions and apologies for absence
   To NOTE any apologies for the meeting and request that mobile phones are set to silent
   For Reference - Presented by Sheila Childerhouse

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

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

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

5. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 1 November 2019
   For Approval - Presented by Sheila Childerhouse

   Item 5 - Open Board Minutes 2019 11 01 November Draft.docx

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

   Item 6 - Action sheet report.doc

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7. Chief Executive's report
   To ACCEPT a report on current issues from the Chief Executive
   For Report - Presented by Stephen Dunn

   Item 7 - Chief Exec Report Nov '19.doc

9:40 DELIVER FOR TODAY

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8. Integrated quality and performance report
   To ACCEPT the report
   For Report - Presented by Rowan Procter and Helen Beck

   Item 8 - Integrated Quality & Performance Report_October19_Draft_v2 AP UPDATE V3.docx

   Item 8 - Master IQPR SPC October19 v2.docx

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

   Item 9 - Board report Cover sheet - M07.docx

   Item 9 - Finance Report October 2019 FINAL.docx

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10. Winter planning - tracking report
    To ACCEPT the report
    For Report - Presented by Helen Beck

    Item 10 - WSFT Trust Board winter plan tracking report 211119.doc

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10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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11. Nurse staffing report
To ACCEPT a report on monthly nurse staffing levels
For Report - Presented by Rowan Procter

Item 11 - Board Report - Staffing Dashboard - October 2019 sc further edit.docx

Item 11 - WSFT Dashboard - October 2019.xls

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12. Quality and learning report
To receive the report
For Report - Presented by Rowan Procter

Item 12 - Quality and Learning report - Nov 2019.docx

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13. Antenatal and newborn screening report
To approve the annual report
For Approval - Presented by Nick Jenkins

Item 13 - AN Screening annual report cover sheet - Nov 2019.doc

Item 13 - WSFT ANNB 2018-2019 FINAL VERSION Annual Report.pdf

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14. Consultant appointment
Nothing to report this month
For Report - Presented by Jeremy Over

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15. Putting you first award
To NOTE a verbal report of this month's winner
For Report - Presented by Jeremy Over

11:10 BUILD A JOINED-UP FUTURE

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16. 7 day services report
To approve the report
For Approval - Presented by Nick Jenkins

Item 16 - Trust Board 7 day services report 221119.doc

Item 16 - Appendix one_WSFT 7DS_self-assessment_assurance_framework_autumn 2019.pdf

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17. Staff health and wellbeing programme
To approve the report
For Approval - Presented by Jeremy Over

Item 17 - Staff health and wellbeing programme - Trust Board Nov 19.doc

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11:20 GOVERNANCE

18. Trust Executive Group report
To ACCEPT the report
For Report - Presented by Stephen Dunn

Item 18 - TEG report.doc

19. Audit Committee report
To approve the report recommendations
For Approval - Presented by Angus Eaton

Item 19 - Audit Committee Report November 19.doc

Item 19 Appendix 1 - MyWish Final report and accounts.pdf

20. Charitable funds report
To APPROVE the report
For Approval - Presented by Gary Norgate

Item 20 - Charitable Funds Board Report 29th November 2019.doc

21. Council of Governors meeting report
To NOTE the report
For Report - Presented by Sheila Childerhouse

Item 21 - CoG Report to Board Nov 2019.doc

22. Annual governance review
To approve the report recommendations
For Approval - Presented by Richard Jones

Item 22 - Annual governance review 2019-20.doc

Item 22 - Annex A Annual Governance Review questionnaire 2019-20.doc

Item 22 - Annex B KLOE prompts and characteristics.docx

23. Agenda items for next meeting
To APPROVE the scheduled items for the next meeting
For Approval - Presented by Richard Jones

Item 23 - Items for next meeting.doc

11:30 ITEMS FOR INFORMATION

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

24.1. To NOTE that the next meeting will be held on Friday, 31 January 2020 at 9:15 am in West Suffolk Hospital
For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

25. 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
Presented by Sheila Childerhouse

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For Approval

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DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 1 NOVEMBER 2019

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Helen Beck	Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
Richard Davies	Non Executive Director	•	
Steve Dunn	Chief Executive	•	
Angus Eaton	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Gary Norgate	Non Executive Director	•	
Louisa Pepper	Non Executive Director	•	
Rowan Procter	Executive Chief Nurse	•	
Alan Rose	Non Executive Director	•	
In attendance			
Georgina Holmes	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Kate Read	Interim Deputy Director of Workforce		
Tara Rose	Head of Communications		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only)			
Peter Alder, Florence Bevan, Peta Cook, Justine Corney, Jo Pajak, Jane Skinner, Liz Steele			

Action

GENERAL BUSINESS

19/201 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

There were no apologies for absence.

The Chair apologised to attendees for the issue with Wi-Fi which meant that some people were having problems accessing the papers.

She welcomed everyone to the meeting and thanked everyone who had been part of meetings with the CQC this week which had been very challenging. She was very grateful to everyone for their support and for supporting to one another.

'How Power Silences Truth'

The Chief Executive explained that this video of a TED talk linked with the freedom to speak up guidance.

Chair considered that this had been very thought provoking; particularly in a Trust where the board and senior a management thought they did listen to people. She proposed that it should be used as part of the Trust's training programme. Kate Read explained that this video was being used in a training package which was being piloted by HR to help encourage people to speak out.

The Chief Executive noted that the biggest risk was complacency and suggested that this video should be shared with the whole leadership of the organisation. He also referred to open door culture and the importance of the board members continuing to be very visible in the organisation and also being aware of how they spoke and behaved. **R Jones**

19/202 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Liz Steele commended everyone who had met with the CQC. She explained that there had recently been an informal governors meeting to discuss and agree questions to be addressed at the Council of Governors meeting on 13 November. However, she felt that one of the questions raised needed to be taken to the board which related to transport and discharges. Sometimes when patients were told they were going to be discharged they were given mixed messages. They were moved into the discharge area to wait but then their transport was not arranged until later in the day and by the time they arrived home their care package had gone and they returned home to no one to meet them. She considered that this was part of the ongoing patient transport issue.

Helen Beck acknowledged that this was an issue and confirmed that the Trust was very aware of this. She confirmed that a patient going home too late for their care package sometimes resulted in a failed discharge. A meeting was taking place this morning to discuss WSFT being given more control over the discharge of patients and this would be implemented from 1 December. Further information would be provided under agenda item 11.

The Chair asked if volunteers going into a patients' homes could be co-ordinated as part of discharge arrangements. Helen Beck said that this was not possible as it was too ad hoc.

Joe Pajak thanked Tara Rose for her communication to the governors on Brexit. He asked for assurance that the Trust was listening to staff, particularly those in the community, about their concerns around Brexit, given local media reports and what was happening in terms of ESNEFT and the effect of staff shortages and losing valuable staff who were going home and would not return. It was not considered that this was such an issue for WSFT but this would be followed up under agenda item 10.

19/203 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

19/204 DECLARATION OF INTERESTS

None to report.

19/205 MINUTES OF THE MEETING HELD ON 27 SEPTEMBER 2019

The minutes of the above meeting were agreed as a true and accurate record.

19/206 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following update given:

Item 1751; continue to improve the narrative in the IQPR to ensure consistency and clarity in terms of the 'when' field for timing of improvements. Angus Eaton considered that the progress update for this action did not provide enough detail, ie when and how issues were being addressed.

Craig Black explained that the requirement for this information had been stressed and was enforced at performance review meetings and would continue to be. However this was something that people found challenging which was why this was not always done immediately. It was recognised that was an ongoing challenge but dates needed to be meaningful and achievable. He acknowledged that this was a long way from being where it should be and work would continue on this with the divisions, but in a supportive and constructive way

Angus Eaton understood this and asked if there was the capability in the organisation so that people who owned this were able to do this. Helen Beck said that they had been asked to say if they were unable to provide a trajectory and the reasons for this. The Chair asked for more detailed information to be included in this report.

Alan Rose referred to the minutes of the last meeting, item 19/177, and asked if the board would receive feedback on the Intensive Support Team's review of the Trust's cancer performance. Helen Beck explained that they had not provided feedback on the Trust's cancer performance but on the process for managing patients through pathways and this would be discussed by the scrutiny committee.

The completed actions were reviewed and there were no issues.

19/207 CHIEF EXECUTIVE'S REPORT

The Chief Executive also thanked staff and governors who had met with the CQC and for the commitment and passion they had shown. The CQC had fed back that there were areas of notable good practice but also areas where progress had been a little slow for a number of reasons. Further detail of the feedback would be received in due course, either before or after Christmas.

The announcement of funding for a new hospital in Bury St Edmunds and the green light on the formal development plan was excellent news. It was hoped that this would go ahead regardless of the forthcoming election. He explained that it would be a challenge to plan a new hospital taking into account partnership working and integration. Governance arrangements would need to be developed to ensure that that this was a system based development. However, this would take five to ten years therefore the capital programme at WSFT needed to continue. **S Dunn**

He thanked Kate Read for attending board meetings following Jan Bloomfield's retirement and the arrival of Jeremy Over, who would be joining the Trust this month.

The financial position had been a key focus of the executive team and organisation as a whole.

Gary Norgate asked about Buurtzorg and if this would be taken any further than the pilot in Barrow. Kate Vaughton explained that a lot of work had been undertaken with the Kings Fund to look at the model. Learning from this had been taken to produce a suite of different ways of working and this was being piloted in the Bury Town locality and would be a west Suffolk version of Buurtzorg. The Chair asked for an update of this pilot at a future meeting. **R Jones / K Vaughton**

DELIVER FOR TODAY

19/208 INTEGRATED QUALITY AND PERFORMANCE REPORT

Rowan Procter reported that there had been two cases of c.difficile which were being investigated to establish whether they were attributable to WSFT.

There were three outstanding duties of candour and the reason for these being outstanding was being looked into. A significant piece of work was being undertaken on overdue root cause analyses (RCAs) and it was hoped to see an improvement in November.

Month on month improvements were being seen in nutrition assessments, which was very positive.

There had been a significant reduction (75%) in staff in the complaints team due to resignations, maternity leave and sickness. As a result the CCG had agreed to provide some support to the team. It was noted that complaints were becoming more complex which meant that it took longer to provide an appropriate response.

One baby had required cooling due to sepsis but had now recovered.

The Chair referred to the complaints team and asked if there was the right skill mix in this team due to the complexity of the complaints. Rowan Procter explained that senior matrons and other appropriate staff got involved and on some occasions met with family members to enable a more detailed response to be provided face to face.

Alan Rose explained that two whole time equivalents were being allocated to the complaints team as this was so important. This was unlikely to be before the end of the year therefore a delay in response times was likely to be seen again next month.

Gary Norgate asked about the issue of outstanding duties of candour and RCAs and if this was indicative of an increase or undue pressure on staff which was creating these delays. Rowan Procter said she did not think it was that simple and a workshop had been held yesterday on duty of candour. Even though there appeared to be a delay in duty of candour the Trust had got better at this and what was meant by it.

Gary Norgate said that he was pleased to see the work being undertaken on nutrition and that it was moving towards an improvement by the end of November. He referred to complaints and asked if it would take to the end of the year for there to be two additional people in place. Rowan Procter said that this had been looked into and staff had been reassigned in the short term. However she explained that there was a level of skill in responding to complaints.

He also noted the improvement in elective discharge summaries and asked if anything could be learned from this that could be applied to non-elective discharge summaries. Helen Beck explained that a lot of non-elective discharges were related to the volumes coming into the hospital, particularly through the emergency department. The same principles were being applied but it was more of difficult on wards with multiple different teams and challenges. Further training had been undertaken with Christopher Browning and Dermot O'Riordan to educate people on the value and the importance of the quality of these.

Richard Davies asked about pressure ulcers and the target for a 5% reduction by the end of the financial year. He noted that pressure ulcers were increasing and that in the Acute Assessment Unit (AAU) this appeared to be due to patients coming in from the community. He asked if the overall increase was due to patients from the community of if pressure ulcers were being acquired within the hospital. Rowan Procter said that that she would bring this information to the next meeting. **R Procter**

He referred to the target of a 5% reduction; he understood that this was difficult in the community as the Trust had less control. However, as this would be easier in the hospital and he asked if the target was as challenging as it should be.

Rowan Procter explained that this was a moment in time target and then it would need to be maintained as this was the best practice level. She explained that 5% was taken from the outturn from last year.

The Chair requested more detail and insight on pressure ulcers in the next report. **R Procter**

Angus Eaton queried the sickness absence in the community figure of 8.8%. Kate Read explained that this was a typo and should be 3.8%.

Louisa Pepper acknowledged the improvement in nutrition assessments. However, she asked if the board should be concerned about paediatrics and if this was a recording issue. Rowan Procter explained that a focussed piece of work was being undertaken on recording nutrition in this area but it was not easy to record what a child had actually eaten as parents often brought in food. This would remain a focus and would continue to be reported to the board. **R Procter**

Helen Beck reported that referral to treatment times (RTT) had deteriorated further. This was not completely unexpected as the team was continuing to validate and address the number of patients within 18 weeks and at the beginning of pathways which meant that a reduction in the overall waiting list size was being achieved. However the challenge was capacity and demand. The Trust had considered outsourcing to other providers but to date had not been able to secure clinically safe capacity with other providers. In addition a general surgeon and orthopaedic surgeon had unexpectedly gone on long term sick leave which had also reduced capacity. However, orthopaedic capacity had now improved significantly and the Trust was also in the process of recruiting additional general surgery consultants, but ophthalmology remained a concern.

Diagnostics was at 95% for September and had been at 97% for the last two weeks and it was hoped to achieve the 99% target by the end of November. This performance helped to drive cancer performance. The Trust was not achieving the cancer two week wait with breast symptom target due to patient choice; currently there were no capacity issues.

The cancer 62 day GP referral position had now improved and was currently at 80% versus a target of 85%, which was only due to one patient (ie 77-80%). It was expected that this would continue to improve.

The intensive support team (IST) had been invited to WSFT to review its processes on monitoring and tracking, understanding capacity and demand and if it had appropriately trained people. A detailed report was available and there had been no surprises. Training and education and understanding capacity continued to be focussed on. The detail of this report would go to the scrutiny committee and an action plan would be presented to the regional cancer summit on Monday. There were also tools which would be deployed to help analyse pathways.

The IST was currently in the Trust to look at capacity and demand in the endoscopy department.

Gary Norgate asked about RTT and the issues in the past with the data set and data warehouse. He asked for assurance that this was no longer a problem and this was now due to capacity and operational demand. Helen Beck believed that this was now the case, however the Trust was using Cerner's data warehouse and since this report there had been another issue with a fix that needed to be applied. Therefore this data recording could sometimes cause an intermittent issue but processes were in place to identify these very quickly so they could be fixed within a short space of time.

Angus Eaton referred to the stroke early supported discharge team (SESDC) and the missed target due to 12 deaths and the comment that these were unavoidable. He asked for assurance that this had been appropriately investigated. Helen Beck explained this was not about patient care and that patients who died could not be supported by the early discharge team. These patients had met the criteria for supported discharge but had died before they were able to go home.

The Chief Executive queried why these patients who had died were included in the figures. Helen Beck explained that this monitored all the patients who were suitable and referred to the team and if they used the service. It was agreed to review these figures. **H Beck**

Richard Davies asked about the deep dive on RTT and specialties that were not going to be outsourced. He asked if this would improve in those specialities that now had enough capacity. Helen Beck explained that in a lot of specialties there was a backlog therefore outsourcing was needed. However, because of sickness in orthopaedics and general surgery the backlog increased.

He also asked about the two week wait for breast cancer and patient choice and if the Trust was being appropriately flexible and offered appointments that patients could attend and if there was the capacity to do this. Helen Beck confirmed that most patients were offered at least two appointments, although there was not a large amount of capacity. The Trust was engaging with GP colleagues about the message given to patients when they were referred. Tara Rose explained that she had recently been working with the CCG's communications team to produce information on the importance of attending these appointments.

The Chair asked if there was the internal capacity for insourcing. Helen Beck explained that the Trust had insourced day case endoscopy but it could not insource major surgery.

19/209 FINANCE AND WORKFORCE REPORT

Craig Black reported that the financial position was similar to that reported in previous months, ie an overspend against plan. This was mainly due to additional activity beyond what was originally planned. Activity was significantly above what was predicted for the year and the Trust was now forecasting that the acute activity would be £7m-8m over the original assumption and in the community approximately £1m over the original assumption. It was expected that the re-forecast would be £10m above the original plan. However, there was a correlation between the additional activity delivered and the additional money spent which provided some assurance that there was not a loss of control in the organisation. The forecast on current expenditure would mean the Trust would miss its plan by approximately £11.8m.

Corrective actions to the value of £1.8m were detailed on page 5 of this report. A number of these had already been implemented or were going through the quality assessment process.

An analysis of nurse staffing levels was given on page 9, including a comparison of the number of nurses employed by WSFT in September 2018 and September 2019. There were 40 more registered nurses and 50 more unregistered nurses this year compared to last year; however there were also additional beds open. The analysis of the number of nurses per bed showed that there was additional capacity open but more nurses per bed within the organisation.

Analysis indicated that the acuity of patients has increased this year, which suggested that the Trust was achieving its aim of having the sickest patients in its beds. However, this placed more pressure on nurses and it was not apparent on the wards that they were benefitting from having additional nurses per bed.

Work continued to reduce the number of temporary nurses that the Trust employed.

WSFT was mandated to achieve a cash balance of £1m at the end of each month. This had been achieved but as the organisation lost money it needed to borrow money in order to continue to achieve this figure.

Alan Rose referred to page 1 and asked about the reforecast loss of £10m; he noted that this was a variance and that the loss would actually be £20m. He felt that this wording should be made clear throughout the board papers. **C Black**

He said that he was encouraged by the trend in reduction in temporary staff over the last six months and it was a tribute to the work of all the teams that this had been achieved. He asked if this could be reduced to below 8% and if there was a metric that the Trust should aim for, eg 5%. Craig Black said that a reduction below 8% could be possible but explained that not all temporary staffing spend was bad and that some temporary staff were required if the organisation was trying to achieve an incremental increase in activity. He would look at what he believed would be the correct lowest level for temporary staff **C Black**

Angus Eaton asked for assurance that when suggesting there would be a £10m variance winter pressures and more general pressures on the Trust had been taken into account. Craig Black explained that the table on page 5 gave details of the derivation of the forecast and additional costs that were anticipated and these were included in this. Angus Eaton asked if demand was more than predicted a further conversation would need to be had. Craig Black confirmed that this would be the case but that the organisation would not have the capacity for further demand.

Angus Eaton asked if everything was being done to ensure that the Trust ended up in the best position it could at the end of the year, including pay and non pay costs. Craig Black confirmed that everything was being looked at; some non-pay costs were for equipment relating to discharges or consumables used in theatres etc. He agreed that the organisation needed to focus on achieving the lowest numbers possible. Longer term the work within the alliance and ICS was around demand management. Currently in both east and west Suffolk there was more activity than there was capacity for, therefore there was a need to reduce demand.

Gary Norgate thanked Craig Black for the work that had been done on efficiency. He asked about the table on page 154 which gave details of monthly expenditure on agency consultants and noted that this had increased over the last few months, particularly in September. Nick Jenkins explained that this related to temporary staff and the majority was due to pension issues and substantive staff not wanting to work as much as normal due to tax implications on their pensions. Therefore they had reduced their overtime or in some cases no longer wanted to work full time. As a result temporary staff had to be employed to cover the gap in resources.

Gary Norgate asked about quality assessments for initiatives to reduce costs. It was explained that some of these had already taken place and more would be undertaken this week.

19/210 EU EXIT REPORT

Helen Beck explained that there was no written report, as the situation had not been known at the time papers were submitted and circulated.
Detailed reporting had previously increased but this had now stopped. The Trust was as prepared as it could be and this information had been shared with the board and governors. There was no evidence in the organisation that Portuguese nurses would be returning home due to Brexit. Originally they had come over to the UK as the economy was favourable, however this had now improved in Portugal therefore a number had returned home. A number had come over for two years and were now returning; some had been promoted and gone elsewhere to more specialist units which was a reflection on the experience and training they had received at WSFT. Nick Jenkins reported that he had worked with a Portuguese nurse who had recently joined the Trust.

Louisa Pepper asked about pharmacies reporting that some medicines were in short supply and asked for assurance that this was not due to Brexit. Helen Beck explained that this should not be due to Brexit and that shortages in pharmaceuticals regularly occurred for all sorts of reasons and there were contingencies in place to look for alternative supplies or alternative medicines. Nick Jenkins agreed and said that this continued to be an ongoing issue. Kate Vaughton explained that this was also the case in community pharmacies and was an annual cycle and a business issue rather than a Brexit issue.

Angus Eaton asked what the trigger would be to increase activity again. Helen Beck explained that this would come from the 'top' and a detailed report had to be completed every day and was not able to be copied and pasted.

19/211 NON-URGENT PATIENT TRANSPORT UPDATE

Helen Beck reported that there had been a significant shift in the relationship; the executive of E-Zec had approached the CCG to say that they recognised that his was not working and suggested an alternative to address the problem. They had put forward proposals which worked in some of their other contracts. They had offered to increase resources on the road in terms of increasing vehicles by 30% and a 25% increase in staff at no additional cost to the system. They had also suggested that they continued to manage the outpatient activity, which was a significant volume of patients, but handed over to WSFT more local control of discharge vehicles.

A meeting to agree the details of how this would work was taking place this morning. WSFT should have total control of three vehicles and the people co-ordinating these vehicles. However, at times three vehicles would not be enough therefore the escalation process for when more vehicles were required needed to be understood. The plan was to go live with this from 1 December, therefore an improvement was unlikely to be seen until the end of January but she should be able to provide assurance around the plan at the next board meeting. **H Beck**

Kate Vaughton said this would also improve the ability to work with the voluntary sector and other partners when patients were discharged.

It was confirmed that patient transport was on the agenda for the Council of Governor meeting.

19/212 WINTER PLANNING – TRACKING REPORT

Helen Beck explained that the actual against the bed model was being tracked.

To date this was slightly under, which was very positive and going against the trend in both Suffolk and Norfolk and on some occasions WSFT was helping other organisations out. The Trust was trying not to open winter escalation areas until they were planned to open, whereas other organisations already had their escalation areas open and full. This was a reflection on the work that had been undertaken in the community to reduce the level of admissions.

She explained that this report did not include a model for different increases in demand as this would only be applied if the level of demand went above 4%. Alan Rose said that this was more about planning ahead and the organisation being prepared if demand increased, eg to 6%.

This report also included details of finance and recruitment and paediatric plans in terms of an increase in nurses and accounting for an increase in acuity with more sustainable medical cover during the winter period. Work was also being undertaken on operational plans for day to day management in the organisation over the Christmas and new year bank holiday period which was also more difficult.

The Chair asked about paediatrics and if additional medical capacity would be in place in time for winter. Helen Beck said that on a locum basis some of this should be but work had also been undertaken with consultants to split on-call with back up on-call to increase emergency resources. Nick Jenkins explained that they were also looking at whether it was possible re-phase some of the electivity activity and move to non-elective inpatient work in the winter.

Gary Norgate referred to the very positive statistics on the use of the admissions avoidance vehicle and asked if the system had considered putting in another one. Helen Beck explained that it had been agreed to put another vehicle into the system and there was a need to work with GP practices so that they used it appropriately.

Richard Davies considered this to be a very good report and was very impressed with the proposal for a multi-disciplinary team (MDT) review of stranded patients. However he queried whether five minutes per patient was enough. Helen Beck explained that this was not about a detailed MDT review but to ask challenging questions around the details and if something could be done more quickly and if the patient still needed to be in hospital.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

19/213 NURSE STAFFING REPORT

Rowan Procter explained that some of the numbers in this report varied from the workforce report as it was produced at a different time. She explained that there was an over establishment of unregistered nurses of 2.5 wte as approximately 50 overseas nurse were included in these figures who were waiting for their OSCE and would then appear in the registered nurse figures.

She highlighted the positive number of compliments received, both in F5 and F6. The board congratulated these wards taking into account the challenges they faced.

19/214 NATIONAL PATIENT SURVEY REPORT

Kate Read reported that since June there had been a focussed action to deliver a sustained improvement in mandatory training compliance and an overall increase of 4% had been seen. Work continued towards achieving 90% in all aspects.

The mandatory training portal had recently been rolled out which meant that staff were now able to complete their mandatory training before they joined the Trust. WSFT was also engaging with neighbouring Trusts so that staff did not have to complete training that they did not need to. In future staff on agenda for change contracts would not be able to progress to the next pay point without completing their mandatory training and having an appraisal.

Staff governors had reported that induction sessions and mandatory training for community staff had been well received. Work continued to update this and ensure that community staff received the relevant training.

It was noted that mandatory training requirements for Non-Executive Directors were being clarified.

19/215 SAFE STAFFING REPORT

Nick Jenkins referred to the matters arising section of this report which demonstrated changes that the Guardian of Safe Working had been able to effect both at an individual level and within the organisation

There had been challenges with the rapid implementation of the change to the contract for junior doctors to reduce weekend working by December 2019. The Trust had achieved this as far as possible by negotiating with the incumbent doctors.

One medical ward appeared to be busier than before. This area was one doctor short, therefore it has been decided to recruit a locum until the vacancy was filled. In the meantime the medical management team was trying to mitigate this as far possible by moving junior doctors around to cover this area.

He explained that foundation doctors were still employed by WSFT even if they were placed in primary care or mental health. In one case the Trust had intervened where a junior doctor had been asked to work additional hours in mental health.

Alan Rose considered the matters arising to be very helpful as this provided assurance on what was being undertaken to protect doctors. The board agreed that this report was very informative and provided assurance; it was requested that this was fed back to Francesca Crawley, Guardian of Safe Working and the HR team. **N Jenkins**

19/216 FREEDOM TO SPEAK UP

216.1 Freedom to Speak Up Guardian

Nick Finch updated the board on the work he had undertaken in his role as Freedom to Speak Up Guardian during the last five months. This included attending Trust inductions and working with Gary Norgate, Senior Independent Director. He also outlined future plans, including improving community staff awareness.

Louisa Pepper thanked Nick Finch for a very good report and asked if there were any barriers to his day to day work in this role or if there was anything that the NEDs could do to encourage staff to report concerns. He said that he did not think there were currently any barriers.

Nick Jenkins asked him what happened when a member of staff went to him rather than to their line manager and did not want to talk to their line manager. Nick Finch explained that if this was the case he would discuss this with HR.

Gary Norgate said that people should continue to reflect on the video at the beginning of this meeting and that Nick Finch was very easy to approach. He felt that there had been some good cases which showed that people were willing to speak up but there had also been some instances where people would not speak up. He considered that there was a robust process for managing cases and that there were realistic outcomes.

216.2 Response to national FTSU guidance

Kate Read explained that this report set out WSFT's response to the FTSU guidance. She highlighted the Trust's response to each of the expectations.

The board approved the response from the Trust. It was confirmed that the board would be updated on a regular basis, in response to the national FTSU guidance. **J Over**

19/217 CONSULTANT APPOINTMENT REPORT

The board noted the appointment of the following:

Dr Katerina Achilleos, Consultant in Rheumatology
Dr Hsu Pheen Chong, Consultant in Nephrology and AMU

It was noted that both of these individuals had previously worked at WSFT.

19/218 PUTTING YOU FIRST AWARD

Kate Read reported that Putting You First Awards had been received by Lois Light (EIT nurse), Mitchell Laws (EIT bank nursing assistant) Sonia Denny (EIT charge nurse) and Iain Ferguson (reablement support worker)

Lois Light and Mitchell Laws were driving to Newmarket to treat a patient when they saw an accident ahead on the A14. They pulled over, blocked the traffic and went to check on the person whose car had rolled over.

The person was crawling out of the car and was struggling to walk. There was lots of smoke and Lois and Mitch supported the person to a place of safety assisted by a member of the public. They sat with the person until the paramedics arrived. During this time, Lois phoned the EIT office to let them know they were on their way to a patient who was at end of life and in a lot of pain. Sonia Denny and Iain Ferguson were due to finish their shifts but offered to stay on to go out to the patient. Driving via back roads they attended the patient and stayed for several hours to support the patient.

The board congratulated Lois, Mitchell, Sonia and Iain for their actions and compassion. This was considered it be a very good story with everyone involved doing the right thing.

BUILD A JOINED-UP FUTURE

19/219 INTEGRATION REPORT

Kate Vaughton explained that this report also incorporated the transformation update as they had previously overlapped.

There had been some excellent and innovative bids for the Realising Ambitions funding. The bids had all been through a process with a panel that was represented

across the majority of the system and experts for the three priority areas for funding, ie obesity, loneliness and mental health. Funding of £437k was agreed for 24 organisations within the alliance area. She explained that the Suffolk Community Foundation also had access to other money for supporting these bids.

Louisa Pepper agreed that the bids had all been very worthy. She explained that there would be a review at the end of the month where some of the organisations would be showcasing their initiatives.

Kate Vaughton referred to appendix 1, Mildenhall and Brandon locality plan. The Chair considered this to be very good as these plans were now fitting in under the ICS plan.

Gary Norgate noted that Helen Beck would be leading a locality and asked if she had the capacity. Helen Beck explained that locality lead roles were not intended to be a job in their own right but a senior person who could make contacts and unlock things for the various localities. She felt that this was something that needed to be considered and she had people to assist her; however how it should be resourced in the future would need to be reviewed. Kate Vaughton agreed and explained that relatively senior support had also been put into the other localities.

The Chief Executive said that this was a significant shift in the move towards system working and integration. Alan Rose said that it was disappointing that the CQC had shown no interest in this at all.

Gary Norgate asked about mental health. Kate Vaughton explained that detailed modelling around the workforce, finances etc was currently being looked at. This would be taken to a clinical senate in December to validate the models. A further update would be available in January.

Richard Jones asked when there would be an update on the paediatric system review. Helen Beck explained that the output from the first piece of work would be going to the steering group in the next two weeks and then to the Children and Young People's board for ratification and next steps. Further details would come back to the board. **H Beck / K Vaughton**

Helen Beck referred to the frailty collaborative and said that this was a good example of how the teams were working together. The learning points from this were detailed in appendix 2 of this report. As from Monday the new approach to frailty had been incorporated into business as usual and two bays on F7 were now managed as the frailty assessment unit. The role of the transformation team would be to ensure there were the correct KPIs so that the impact of this could be measured. It was proposed that there should be a quality walkabout in this area.

Helen Beck and Kate Vaughton asked for feedback on whether this report met the board's requirements for the future and also the frequency of reporting, eg bi-monthly. The reporting schedule would then be amended appropriately. **R Jones**

GOVERNANCE

19/220 TRUST EXECUTIVE GROUP REPORT

The Chief Executive highlighted the organisational development work to be undertaken by NHS Elect to clarify responsibilities at business until level. Angus Eaton commented on Annex A, leadership development and talent management programme which he considered to be very reassuring.

He referred to the patient safety and learning strategy and explained that there was a desire to cascade this across the organisation rather just in relation to serious incidents etc.

The board approved the patient safety and learning strategy.

Angus Eaton asked how progress against this could be measured. Rowan Procter proposed that the board should receive an annual update on progress and this would be included in the reporting schedule. **R Jones**

19/221 QUALITY & RISK COMMITTEE REPORT

The board received and noted the content of this report.

19/222 CHARITABLE FUNDS REPORT

Gary Norgate referred to the work that this very small but committed team was doing, eg £19k from one event, an increase in legacies and also ethical investments. It was agreed that this was a very good and dynamic team who were very committed.

The Chief Executive explained that he would be running in the London marathon and would welcome support for this through Virgin Just Giving.

19/223 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted and approved.

ITEMS FOR INFORMATION

19/224 ANY OTHER BUSINESS

There was no further business.

19/225 DATE OF NEXT MEETING

Friday 29 November at 9.15am at Newmarket Hospital.

RESOLUTION TO MOVE TO CLOSED SESSION

19/226 RESOLUTION

The Trust board agreed to adopt the following resolution:-
"That members 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.

6. Matters arising action sheet

To ACCEPT updates on actions not covered elsewhere on the agenda

For Report

Presented by Sheila Childerhouse

Board of Directors – 29 November 2019

Agenda item:	6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	25 November 2019			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

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

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

Actions are RAG rating as follows:

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

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

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

Previously considered by:	The Board received a monthly report of new, ongoing and closed actions.
Risk and assurance:	Failure effectively implement action agreed by the Board
Legislation, regulatory, equality, diversity and dignity implications	None

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1736	Open	26/7/19	Item 8	Provide quarterly reporting on locality baseline reviews	Scheduled to complete first round of reviews in October/November. Will be included in the next NEW FORMAT integration report scheduled in Jan '20	KV	31/1/20 ~~(29/11/2019)~~	Amber
1749	Open	27/9/19	Item 2	In respond to national patient survey finding relating to discharge issues and communication it was confirmed that a repeat training session will be scheduled for the trainees (including primary care perspective)	This has been scheduled for 11 December 2019 - pending final confirmation for primary care lead.	NJ	29/11/19	Green
1751	Open	27/9/19	Item 8	Continue to improve the narrative in the IQPR to ensure consistency and clarity in terms of 'When' field for timing of improvements e.g. pressure ulcers. Also agreed as art of next phase of IQPR development to review the SPC metrics which are indicators as future performance	1/11/19 - agreed to provide more granular responses, if unable to state a timescale for improvement then indicate the blockers to doing this.	CB	31/01/20	Green
1752	Open	27/9/19	Item 8	Noted overview of nutrition performance in the IQPR and quarterly learning reports. However agreed that need a clear plan, including timescales, to deliver improvement (including feedback from the F9 pilot).	**Included in IQPR but action ongoing. Plans and progress to be reported to the Quality Group in December with IQPR update to January '20 Board**	RP	29/11/19	Amber

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1754	Open	27/9/19	Item 8	Provide an update on action to improve access/use of care plans in e-Care	**The transformation team are spending time with district nurse team to look at a number of issues. One being the e-Care access that they have and how this is used. There will be an update later in December**	RP	29/11/19	Amber
1759	Open	27/9/19	Item 15	Following co-production process the Patient Experience Committee to receive plan in response to the national patient survey results	**Report schedule for Patient Experience Committee on 6/12/19**	RP	31/01/20	Green
1768	Open	1/11/19	Item 7	Develop the governance arrangements in response to the national funding announcement for new development. Needs to be approached as a system-based development.	Framework being developed for submission to DH. Will be included on Scrutiny agenda for December	SD	31/01/20	Green
1775	Open	1/11/19	Item 11	Review delivery of the new model for non-emergency patient transport	Verbal update 29/11/19 on final model proposal in Jan '20.	HB	31/01/20	Green
1777	Open	1/11/19	Item 16	Prepare updates for Board based on agreed schedule in response to the national FTSU guidance	The Board reporting scheduled have been updated to reflect the following timeline: Dec '19 – staff invited to speak-up at board Jan '20 – updated FTSU strategy Aug '20 – update FTSU guardian report format Oct '20 – annual report	JO	31/01/20	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1778	Open	1/11/19	Item 19	Include update on the paediatric Suffolk-system review in next quarterly integration report	Board forward plan updated to reflect this requirement - to be included in next report Jan '20	HB/KV	31/01/20	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1748	Open	27/9/19	Item 2	Provide local perspective in response to national report regarding unrelieved pain in palliative care in England	**The results of the national palliative care audit were presented at the last Patient Experience Committee. Our results showed that we outperform the national position on a number of metrics including 'Was given sufficient pain relief' (80% of WSFT [patients indicated highest ratings, compared to 72% nationally)**	RP	29/11/19	Complete
1753	Open	27/9/19	Item 8	Continue to monitor effectiveness of action to improve appointment access and uptake for children in care initial assessments	Expect improvement from October - reported to Board at the end of November 2019. **Included in IQPR**	HB	29/11/19	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1755	Open	27/9/19	Item 8	Report the conclusion of the duty of candour (DoC) review	As reported to Board on 1 November in the IQPR options to improve all three DoC indicators have been reviewed. This is multi-faceted with separate issues relating to different professions, different divisions and even record-keeping and it has been suggested that it might benefit from a QI-style improvement plan. The new patient safety incident response framework (PSIRF) pilot will also impact on our DoC arrangements. A presentation on PSIRF is scheduled for Q&RC meeting on 13/12/19. This will lead to a project implementation plan for PSIRF, including DoC.	NJ	29/11/19	Complete
1767	Open	1/11/19	Item 1	Share the TED talk with leadership roles within the Trust ('How your power silences truth', Megan Reitz)	Included on TEG meeting 19/11/19, including discussion re cascade within divisions	RJ	29/11/19	Complete
1769	Open	1/11/19	Item 7	Schedule update on the Buurtzorg pilot in Bury Town and future plans	Scheduled for Quality & Risk Committee meeting on 27 March 2020	RJ	29/11/19	Complete
1770	Open	1/11/19	Item 8	Pressure ulcers – bring back more detailed analysis of the data to understand the drivers for performance and likelihood of delivering the target	**Included in Quality & Learning report**	RP	29/11/19	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1771	Open	1/11/19	Item 8	Nutritional assessment – focus on improvement in paediatrics for recording nutrition	**Included in IQPR**	RP	29/11/19	Complete
1772	Open	1/11/19	Item 8	Review reporting of stroke performance in relation to supported discharge, which currently includes patients who die within the hospital	**Included in Quality & Learning report**	HB	29/11/19	Complete
1773	Open	1/11/19	Item 9	Ensure clear language to be a variance of £10m against control total (total £20m loss)	**Reflected in finance report**	CB	29/11/19	Complete
1774	Open	1/11/19	Item 9	Recommend an appropriate de minimis limit for temporary staff	**Reflected in finance report**	CB	29/11/19	Complete
1776	Open	1/11/19	Item 15	Pass on the thanks of the Board to Francesca Crawley and HR team for the report, including the very informative 'matters arising' section	Thanks and recognition of the Board communicated to team	NJ	29/11/19	Complete
1779	Open	1/11/19	Item 19	Amend reporting schedule to reflect change to quarterly integration report (replacing previous Alliance and Transformation reports)	Reporting matrix updated	RJ	29/11/19	Complete
1780	Open	1/11/19	Item 20	Include in Board's reporting schedule review of progress against the safety and learning strategy	Reporting matrix updated	RJ	29/11/19	Complete

7. Chief Executive’s report

To ACCEPT a report on current issues from the Chief Executive

For Report

Presented by Stephen Dunn

Board of Directors – 29 November 2019

Agenda item:	7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	20 November 2019			
Subject:	Chief Executive's Report			
Purpose:	X	For information		For approval

Executive summary:

This report provides an overview of some of the key national and local developments, achievements and challenges that the West Suffolk NHS Foundation Trust (WSFT) is addressing. More detail is also available in the other board reports.

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

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

Previously considered by:	Monthly report to Board summarising local and national performance and developments
Risk and assurance:	Failure to effectively promote the Trust's position or reflect the national context.
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

To receive the report for information

Chief Executive's Report

All the leaves are brown and the sky is grey…! It might have finally started to turn cold, but we've been **preparing for the coming winter** since the summer months to make sure we're as ready as we can be. As well as all of the practical, operational plans that look at things like our bed modelling and escalation areas over the winter period, there are some really important messages that we're sharing with staff and patients. As part of the Trust's business as usual Red2Green approach, we are once again focusing on assisting our patients to keep moving this winter. Getting our patients sitting up, getting dressed and keeping moving helps encourage mobility, which can in turn reduce harm, enhance dignity and promote speedier recovery. This winter we want to keep our patients as active as possible rather than staying in bed. It is particularly important for older people to keep mobile, as it can:

- improve mental and physical wellbeing
- allow patients to feel more involved with their treatment and care
- prevent further health complications - immobility has a higher risk of thrombosis or delirium, pressure sores, infection, contractures, loss of confidence, and greater dependence.

Supporting our patients to get up, dressed and moving so we can get them home to their loved ones sooner is a priority.

But with the winter season comes our usual plea for staff and members of the community to have their **flu jab**. Along with 66% of my colleagues, I've had mine! I'm pleased that so many of our staff have opted for this additional level of protection; flu is highly contagious and it can have a devastating impact on healthy people, let alone those who are already vulnerable. If you have the opportunity, please do have your vaccination – contact your GP or pop into a pharmacy to get yours.

We've celebrated four years of having our **wonderful bleep volunteers** this month. Wearing a bright red uniform, our 29 hospital 'bleep' volunteers are available to run errands across the West Suffolk Hospital site – each volunteer carries a phone on their shift, so staff can contact them when necessary. On an average month, these wonderful volunteers save staff more than 54 hours and make 450 trips to and from the hospital pharmacy. And we mustn't forget that our bleep volunteers are just one group of the many, many we are lucky enough to have here at the Trust. They are so valued and appreciated.

The **West Suffolk Hospital** has been standing proudly on its current site for 45 years. It's been very good to us, our patients, and our community over that time, but (like us!), as it ages it's important that we pay it more attention and take good care of it. Naturally with a building that's getting older, creaks and strains start to show. You may have seen our estates development team out and about across the site, doing normal and planned structural checks to make sure everything is still working as it should be. With a site of this size, it's a continual, rolling programme of work.

This month we've shared communications with our staff, the public, and proactively with our local media teams about the work we're doing around reinforced autoclaved aerated concrete (RAAC) planks, which were used in the original build of West Suffolk Hospital and the front residences in the 1970s. We've had a robust estates programme for many years, but since receiving a report specifically about RAAC planks, we've increased our assessments. These investigations are ongoing with the support of experienced, structural engineers, and as of yet no unexpected signs of stress tension have been identified. However, our plan is to continually check all of the RAAC planks in a rolling programme - staff, patient and visitor safety matters to us above all else. We have documented our estate challenges for many years, and the West Suffolk Hospital has been given a maximum life-expectancy of 2035. That's why it's so positive that our need for a new hospital has now been acknowledged at a national level.

Now that the **Care Quality Commission (CQC)** has concluded its planned visit of our Trust, I have sent a huge thank you to staff for all their focus and effort during the inspection period. I know it's been a full-on few months. We won't know our final results until the New Year, but we have had some high-level feedback that I wanted to share with you all.

The main thing they commented on was how accommodating and engaging staff all were – which is just our 'west Suffolk way' through and through. They have also picked out a few specific examples of excellent practice, care and innovation that they saw while they were here:

- The oncology team undertaking a 'Disney party' for a patient
- Using video consultations in outpatients
- The implementation of a staff idea in cardiology, that uses coloured dots to show when medications are due to expire
- An improved children's environment in the emergency department
- The introduction of a bereavement midwife and perinatal mental health midwife
- Excellent pre-assessment and ongoing care plans for particularly vulnerable patients after they'd had surgery
- The early-bird group within community children's services.

In general terms, they commented on the great strides we're making with integration, that we have an excellent approach to safeguarding, and most pleasingly, that they saw a real focus on quality with everyone they spoke to.

But there were also a number of things that could have been improved, and that we need to listen to and take on board. The inspectors found some issues with some of our basic practices - inconsistent hand washing standards, some resus trolleys that weren't checked, and medicines and substances that weren't secured or locked away properly. Our mandatory training completion, particularly in the community, wasn't as high as it should have been, and some e-Care checklists weren't being completed properly. Separately to this, we are also working to ensure that consistent pathways are in place for patients that require follow-up.

We are also taking action to further improve our maternity services following concerns raised by the CQC. Concerns have been raised about how we record patient observations after we have taken them, which are currently not in line with national guidance. The CQC also identified that we should make changes to the way we monitor women in our care, again to bring us in line with national guidance. We are making the necessary changes and the CQC is satisfied with the plans we have in place to make the improvements required. We have taken this feedback seriously, and are acting accordingly to improve the care we provide, and continue to ensure the mothers and babies at our hospital are safe and well cared for.

So we do have some challenges around the big picture. We're doing lots of things really well, but we need to keep working on improving some of our 'big ticket' items at a quicker pace, like our referral to treatment times. We've done a lot of work to improve our staffing levels, which was acknowledged by the CQC, but I also know that lots of staff are tired and that, although we have more nursing staff than we've ever had before and have very few vacancies, it doesn't always feel that way. I know that several people voiced specific concerns to the inspectors, and that these were heard by the CQC. I think that passion we all hold also came across to the inspectors during their visit, and I really thank you for that. We now need to make sure that we address any CQC concerns quickly.

Overall in terms of October's **quality and performance** we continue to be challenged against a range of metrics. There were 68 falls, 51 Trust acquired pressure ulcers and three C. difficile infections. The challenge of demand and capacity continues with four standards failing the target for October 2019. These areas were cancer two-week wait for urgent GP referrals with performance at 91.0%, cancer two-week wait breast symptoms with performance at 88.7%, cancer

62 day GP referral with performance at 81.6%, and incomplete 104 day wait with two breaches reported in October 2019. Referral to treatment performance for October was 81.2%, with four patients waiting longer than 52 weeks. The Trust is part of a pilot scheme trialling a number of new metrics for emergency department (ED) performance. These new metrics have replaced the longstanding 4-hour wait performance metric, so this has been removed from the report. When the new metrics have been agreed nationally they will be included in this integrated quality and performance report.

Our **financial position** remains extremely concerning with the deterioration in our financial performance with the month seven position reporting a deficit of £5.7m YTD which is £4.4m worse than plan. We agreed a control total to breakeven which means we need to deliver a cost improvement programme of £8.9m. We continue to forecast to meet our plan to break even in 2019-20. However, this requires a recovery plan to reduce the current rate of expenditure by around £10m. We do have recovery plans in place but it's clearly going to take a huge effort from all colleagues to get us to where we were aiming to be, which was to break even at the end of this financial year.

As we are all very well aware **EU Exit** did not happen on 31 October. I can assure you that we remain actively engaged in the national preparations for EU exit, with the expectation that these arrangements will ramp-up once again in the New Year under a new Parliament.

Chief Executive blog - A look back at my summer reading
https://www.wsh.nhs.uk/News-room/news-posts/A-look-back-at-my-summer-reading.aspx

Deliver for today

Frailty assessment unit opens
As you may remember, back in early August, the Trust carried out a successful, two week 'test and learn' of our frailty at the front door service. This enabled us to produce a clinical model that will see the Trust fulfilling its commitment to provide a better service for frail patients. This is in line with national targets to provide at least 70 hours per week of acute frailty care. Our new frailty assessment unit (FAU), opened permanently on the 28 October, meaning that patients who are assessed as frail will be transferred to the FAU for a comprehensive geriatric assessment, with a more prompt decision about a discharge home or admittance to a ward. This will improve patient experience, and also facilitate better patient flow through the hospital.

Top scores for our emergency department team in CQC emergency care survey
Congratulations to our fantastic emergency department team, who have matched some of the highest scores in England in the Care Quality Commission's latest urgent and emergency care survey! The Trust matched the highest scores for the availability of help from members of staff while patients were waiting in the emergency department, and also the overall score for waiting times in the emergency department.

Invest in quality, staff and clinical leadership

Staff recommend us as a top Trust to receive care
Staff have once again rated our hospital and community services as one of the best places to receive treatment and best places to work. In the most recent NHS Staff Friends and Family Test (FFT), 92% of staff surveyed said you would recommend the Trust as a place to receive treatment, the seventh highest percentage recorded in England. In addition, 79% of staff said you would recommend it as a place to work, which is the tenth highest percentage recorded in England. These are both well above the national averages of 81% and 66% respectively.

Occupational Therapy Week
Occupational Therapy Week (4-10 November) was a national awareness week run by the Royal College of Occupational Therapists (RCOT) to promote the value of occupational therapists and the fantastic work they do across the UK.

Here, our occupational therapists have the opportunity to rotate in post and work in a wide range of areas around the Trust including medicine, orthopaedics, mental health and neurology, allowing them to network and develop their knowledge, skills and understanding of other roles. They take a holistic and person-centred approach to the care they provide, which facilitates successful multi-disciplinary team working and enables patients to achieve the best possible quality of recovery and optimum independence. They'll often liaise with external organisations such as social and mental health services, charities and other specialist teams to support their patients once they leave hospital. The Trust has recently introduced a new rotation working with adult and community services. The occupational therapist takes the role of social services OT and works closely with social workers and independence and wellbeing practitioners, reviewing care packages, identifying those who might benefit from financial and carers assessments and supporting both informal carers and care agencies.

Newmarket hosts regional learning event
The Community Hospitals Association (CHA) held a sharing and learning day at the Trust in November, with the theme 'Achievements and challenges in community hospitals – sharing experiences'. Newmarket Community Hospital was chosen to host the event, which saw people who work in community hospitals across the region coming together for information, discussion and creative sessions.

Build a joined-up future

Restart a Heart Day
As a Trust we have taken on Restart a Heart Day. The purpose of the day is to encourage people to learn cardiopulmonary resuscitation (CPR). In a recent survey, it was discovered that 47% of people would not intervene to give a bystander CPR due to a fear of making the situation worse. Our very own resuscitation team had a stand at the main hospital entrance providing CPR training, and our community cardiac rehabilitation team prepared an information display at Sudbury Health Centre. Be sure to check out our short video of our resuscitation team demonstrating the three easy steps on the Trust's Facebook and Twitter accounts.

Global AF awareness week (18-24 November)
Atrial Fibrillation (AF) is the most common sustained cardiac arrhythmia increasing the risk of a stroke by five times. In fact, one in five of all strokes is attributed to this arrhythmia. Patients with AF who have a stroke also have increased levels of mortality, morbidity and disability, with longer hospital admissions compared with other stroke patients. Since 2017, through a transformation project led by the West Suffolk Clinical Commissioning Group (WSCCG), it has been recognised that locally there needs to be an increase in the identification and treatment of AF patients in west Suffolk. The CCG is actively encouraging and promoting awareness raising regimes to reduce the incidence of AF-related strokes and improve the healthcare experience of patients with AF across the region. The highest priority is in detecting AF as prevalence data advises that over 1,700 people in west Suffolk have undiagnosed AF.

A network of community volunteers has been established who are trained and equipped with AF mobile detection devices - detecting to an accuracy of more than 97%. Within 30 seconds, a *Kardia AliveCor* device can establish if a patient has 'possible atrial fibrillation', which would be indicative for the patient's GP to undertake further investigation through an ECG or heart-trace to establish the best form of direct oral anticoagulation (DOAC) therapy.

National news

Deliver for today

People share what a good A&E experience looks like
This Healthwatch Report provides data from a poll of 1,700 people surveyed in July and October 2019. It concerns proposed changes to the current performance targets for A&E. It shows that awareness of currents targets is low, people aren't clear when the clock starts ticking, average waiting times are easier to understand and waiting times are less important to people than other aspects of their experience.

Ear, nose and throat surgery: GIRFT programme national specialty report
The GIRFT review of ear, nose and throat (ENT) surgery services visited 126 units across the country and found that thousands more people could be treated on a day-case basis rather than having an overnight stay in hospital. Through a series of recommendations and by sharing the good practice of units with higher than average day-case rates, GIRFT aims to: ensure more patients are treated without the worry or inconvenience of a stay in hospital; make ENT departments more resilient to pressures on beds; and allow trusts to free up beds for use by other specialties.

Invest in quality, staff and clinical leadership

Putting Always Events at the Center of Patient-Centered Care
The Institute for Healthcare Improvement conducted an interview with two leading proponents of Always Events which is an improvement methodology based on the Model for Improvement. The difference from a traditional QI approach lies in the starting point - rather than health care organizations determining what we think will make the biggest difference for patients, you start with a blank piece of paper and ask people who use your services, their families, and care providers what matters to them.

Sexual orientation monitoring is 'an important commitment' for the NHS
This report by the Women and Equalities Committee identifies issues with healthcare for members of the LGBT community. Research by has shown that LGBT people are at higher risk for certain issues, such as smoking and associated health problems, high BMI, and some mental illnesses. However, according to the report, 'very few front-line services are collecting information about the sexual orientation and gender identity of their patients as part of registration' and this impacts the care that LGBT people receive. Currently, the government's LGBT Action Plan advocates voluntary sexual orientation monitoring. The report recommends that this monitoring should be made compulsory, and that any service providers that do not comply should 'face fines at a level equivalent to those imposed for not monitoring ethnicity'. It also recommends the creation of a five-year plan of LGBT campaigns and the inclusion of LGBT content in healthcare education curricula.

Build a joined-up future

Performance tracker 2019: a data-driven analysis of the performance of public services
Jointly published with the Chartered Institute of Public Finance and Accountancy (CIPFA), this report projects the demand and spending on nine public services for the next five years: GPs, hospitals, adult social care, children's social care, neighbourhood services, police, prisons, courts, and schools. The report estimates that the government and local authorities will spend £191.1 billion on these nine services by 2023/24. While this may be enough to meet demand (except in adult social care), this will not be enough for the government to make improvements, such as better care for cancer patients and reduced violence and self-harm in prisons. In adult social care, any government would have to spend nearly £1 billion more just to keep pace with demand.

English local government funding: trends and challenges in 2019 and beyond
This report looks at councils' revenues and spending, focusing on the trends and choices taken over the past decade. It also looks at the outlook for local government funding, both in the short and longer term. It finds that cuts to funding from central government have led to a 17 per cent fall in councils' spending on local public services since 2009–10. It also finds that councils' spending is increasingly focused on social care services – now 57 per cent of all service budgets.

No age limit: the hidden face of domestic abuse
In this report, Age UK advocates legislation to change what is understood as domestic abuse and make it easier for people to recognise or report it, as well as to improve the resources available to help victims and survivors. This includes training for health care practitioners and better links between the NHS and police.

9:40 DELIVER FOR TODAY

8. Integrated quality and performance report

To ACCEPT the report

For Report

Presented by Rowan Procter and Helen Beck

Trust Board – November 2019

Agenda item:	8			
Presented by:	Rowan Procter, Executive Chief Nurse Helen Beck, Chief Operating Officer			
Prepared by:	Rowan Procter, Executive Chief Nurse Helen Beck, Chief Operating Officer Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	November 2019			
Subject:	Trust Integrated Quality & Performance Report			
Purpose:	x	For information		For approval
Executive summary:	The attached report provides an overview of the key performance measures for the Trust. A detailed section is included from page 15 onwards.			

<table>
<tr><td rowspan="2">Trust priorities</td><td colspan="3">Deliver for today</td><td colspan="2">Invest in quality, staff and clinical leadership</td><td colspan="2">Build a joined-up future</td></tr>
<tr><td colspan="3">X</td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td rowspan="2">Trust ambitions</td><td>Deliver personal care</td><td>Deliver safe care</td><td>Deliver joined-up care</td><td>Support a healthy start</td><td>Support a healthy life</td><td>Support ageing well</td><td>Support all our staff</td></tr>
<tr><td></td><td>x</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Previously considered by:</td><td colspan="7">Monthly at Trust Board</td></tr>
<tr><td>Risk and assurance:</td><td colspan="7">To provide oversight and assurance to the Board of the Trusts performance.</td></tr>
<tr><td>Legislation, regulatory, equality, diversity and dignity implications:</td><td colspan="7">Performance against national standards is reported.</td></tr>
<tr><td colspan="8">Recommendation:

The Trust Board notes the monthly performance report.</td></tr>
</table>

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Integrated quality and performance report



Month Seven: October 2019

Putting you first

CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

ARE WE SAFE?

Healthcare associated infections (HCAIs) – There were no MRSA Bacteraemia - hospital attributable cases and there were 3 hospital attributable clostridium difficile cases within the month. (Exception report at page 19). The trust compliance with decolonisation decreased in October to 90.0%. (Exception report at page 26).

CAS (Central Alerting System) Open (PSAs) – 5 Patient Safety Alerts have been received in October 2019. All of the alerts have been implemented within timescale this year to date.

Patient Falls (All patients) – 68 patient falls occurred in October 2019, which is an increase from 55 in September 2019. (Exception report at page 21).

Pressure Ulcers – 51 cases occurred in October 2019, which is an increase from 49 in September 2019. (Exception report at page 22).

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons – The rate of cancelled operations for non-clinical reasons was recorded at 1.4% in October 2019. (Exception report at page 31).

Cancelled Operations Patients offered date within 28 Days - The rate of cancelled operations where patients were offered a date within 28 days was recorded at 100% in October 2019 compared to 82.9% in September 2019.

Discharge Summaries - A&E has achieved a rate of 81.2% in October 2019, whereas inpatient services have achieved a rate of 86.6% (Non-elective) and 89.4% (Elective). (Exception report at page 32).

ARE WE CARING?

Mixed Sex Accommodation breaches (MSA) – No Mixed Sex Accommodation breaches occurred in October 2019.

Friends and Family (FFT) Results – The Trust continues to receive positive rating for all services, both in the overall experience and in the "Extremely likely or Likely to recommend" question. WSH is in the top 10% of all Trusts and receives higher average rating than its peer group, particularly for A&E services.

Complaints responded to in time – October 2019 reported performance at 37.0% compared to 40.0% in September 2019. (Exception report at pages 36).

ARE WE RESPONSIVE?

Cancer – The challenge of demand and capacity continues with four areas failing the target for October 2019. These areas were Cancer 2 week wait for urgent GP Referrals with performance at 91.0%, Cancer 2 week wait breast symptoms with performance at 88.7%, Cancer 62 d GP referral with performance at 81.6%, and Incomplete 104 day wait with 2 breaches reported in October 2019. (Exception reports at pages 44-47).

Referral to Treatment (RTT) – The percentage of patients on an incomplete pathway within 18 weeks for October 2019 was 81.2%. The total waiting list was 21073 as at the end of October 2019, with 4 patients who breached the 52-week standard. (Exception reports at pages 40-42).

ARE WE WELL LED?

Appraisal - The appraisal rate for October 2019 is 83.0%. (Exception report at pages 59).

Sickness Absence – The Sickness Absence rate for October 2019 is 3.6%. (Exception reports at page 58.)

2. INTEGRATED QUALITY & PERFORMANCE REPORT DASHBOARD

This dashboard provides an overview of performance against key targets that form the key lines of enquiry and KPIs of NHS Improvement and the CQC. These are reviewed in further detail in the individual sections of the report, which are aligned to the CQC. Exception reports are included in the detailed section of this report.

INTEGRATED QUALITY & PERFORMANCE REPORT																
Are we..	Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Av/YTD
1. Safe	1.01	CAS (Central Alerting System) Open	NT	4	7	8	8	13	11	10	6	6	1	1	4	5	33
	1.02	CAS (Central Alerting System) Overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	96.0%	96.1%	94.4%	94.6%	95.2%	95.4%	95.0%	95.4%	95.1%	95.2%	96.2%	95.6%	94.3%	95.3%
	1.05	Clostridium Difficile infection - Hospital Attributable	`	1	2	0	0	4	1	1	2	1	1	2	3	3	13
	1.06	MRSA Bacteraemias - Hospital Attributable	0	0	0	0	0	0	0	0	1	0	0	1	0	0	2
	1.07	Patient Safety Incidents Reported	NT	511	478	546	766	625	646	670	651	587	617	622	632	715	4494
	1.08	Never Events	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0
2.Effective	2.02	Canc. Ops - Cancellations for non-clinical reasons	1%	1.5%	1.3%	0.5%	1.0%	1.0%	0.6%	1.9%	1.2%	1.9%	0.8%	1.6%	1.3%	1.4%	1.4%
3. Caring	3.01	Compliments (Logged by Patient Experience)	NT	73	31	38	40	48	16	37	32	35	61	16	78	33	292
	3.02	Formal Complaints	20	8	10	6	27	18	13	17	25	16	18	10	17	20	123
	3.03	Mixed Sex Accommodation Breaches	0	0	0	0	28	0	0	0	0	4	2	0	0	0	6
	3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	96.0%	98.0%	98.0%	98.0%	97.0%	97.0%	95.0%	95.0%	98.0%	97.0%	97.0%	96.0%	97.0%	96.4%
	3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	96.0%	96.0%	97.0%	97.0%	97.0%	97.0%	97.0%	96.0%	97.0%	96.0%	96.0%	96.0%	96.0%	96.3%
	3.06	A&E - Extremely likely or Likely to recommend (FFT)	90%	96.0%	96.0%	97.0%	96.0%	97.0%	99.0%	94.0%	88.0%	95.0%	87.0%	89.0%	92.0%	93.0%	91.1%
	3.08	Community - Extremely likely or likely to recommend	80%	100%	100%	97.0%	98.0%	95.0%	100%	95.0%	97.0%	95.0%	94.3%	95.2%	97.0%	97.2%	95.8%
4. Responsive	4.02	RTT: % incomplete pathways within 18 weeks	92%	90.2%	89.7%	88.3%	84.7%	83.6%	84.8%	84.8%	85.8%	85.4%	84.4%	83.3%	82.0%	81.2%	83.9%
	4.03	52 week waiters	0	7	6	10	7	7	2	1	4	4	2	2	6	4	23
	4.04	Diagnostics within 6 weeks	99%	99.0%	99.6%	97.1%	91.7%	92.2%	90.0%	87.5%	87.6%	92.8%	95.0%	95.4%	95.1%	98.6%	93.1%
	4.05	Cancer: 2w wait for urgent GP Referrals	93%	76.1%	89.8%	92.2%	93.4%	95.8%	90.5%	94.3%	93.1%	93.8%	95.3%	94.2%	93.5%	91.0%	93.6%
	4.06	Cancer 2w wait breast symptoms	93%	96.4%	76.7%	48.8%	72.1%	82.0%	63.5%	87.8%	90.6%	90.8%	91.3%	90.3%	91.8%	88.7%	90.2%
	4.07	Cancer 31 d First Treatment	96%	99.3%	100%	100%	99.2%	100%	100%	100%	98.0%	99.0%	99.0%	100%	100%	100%	99.4%
	4.08	Cancer 31 d Drug Treatment	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.09	Cancer 31 d Surgery	94%	100%	100%	100%	94.4%	100%	100%	100%	95.0%	100%	100%	100%	100%	100%	99.3%
	4.10	Cancer 62 d GP referral	85%	80.6%	79.5%	78.3%	85.5%	84.8%	90.0%	78.4%	76.9%	65.9%	83.0%	81.1%	79.9%	81.6%	78.1%
	4.11	Cancer 62 d Screening	90%	80.0%	93.8%	87.9%	100%	100%	95.2%	92.9%	90.5%	86.7%	100%	100%	82.8%	95.7%	92.6%
	4.12	Incomplete 104 day waits	0	0	3.0	0	0	1.0	1.0	2.0	4.0	5.0	6.0	3.0	3.0	2.0	25.0

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INTEGRATED QUALITY & PERFORMANCE REPORT																
Are we..	Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Av/YTD
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)	NT	NA	NA	NA	NA	7.4%	NA	NA	NA	NA	NA	NA	NA	NA	NA
	5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	93.0%	NA	NA	NA	91.0%	NA	NA	NA	92.0%	NA	NA	93.0%	NA	92.5%
	5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	82.0%	NA	NA	NA	78.0%	NA	NA	NA	79.0%	NA	NA	75.0%	NA	77.0%
	5.04	Turnover (Rolling 12 mths)	<10%	8.0%	8.0%	8.0%	8.0%	7.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	5.0%	7.6%
	5.05	Sickness Absence	<3.5%	3.8%	3.9%	3.8%	3.9%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.6%	3.7%
	5.06	Executive Team Turnover (Trust Management)	<20%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.4%
	5.07	Agency Spend	550	381	620	500	637	330	524	426	366	482	364	530	452	399	431
	5.08	Monitor Use of Resources Rating	NT	3	3	3	3	3	3	3	3	3	3	3	3	3	3
6. Productive	6.01	I&E Margin	Var	-6.40%	-6.00%	ND	-6.10%	-5.80%	-5.50%	-5.80%	-6.70%	-7.60%	-6.90%	-7.60%	-8.00%	-5.90%	-6.93%
	6.03	Capital service cover	Var	-0.63	-0.50	ND	-0.42	-0.25	-0.27	0.34	0.23	0.12	0.17	-0.22	-0.35	-0.37	-0.08
	6.04	Liquidity (days)	NT	17.56	21.57	ND	15.86	15.18	26.80	24.13	24.98	22.90	32.70	37.91	41.60	41.00	32.2
	6.05	Long Term Borrowing (£m)	4	75.5	76.5	ND	85.5	64.1	65.4	95.7	85.0	88.2	82.2	83.4	81.7	83.0	85.6
	6.06	CIP (Variance YTD £'000s)	1.9	-28	-46	-53	-45	-48	0	-32	-75	-46	-70	-199	-127	-208	-108.1
7.Maternity	7.01	Total number of deliveries (births)	210	224	202	209	179	172	179	183	195	205	211	215	201	169	1379
	7.02	% of all caesarean sections	26%	22.7%	25.9%	25.4%	22.9%	20.3%	26.8%	20.8%	23.1%	25.9%	20.4%	20.9%	29.4%	25.4%	23.7%
	7.03	Midwife to birth ratio	1.32	1.31	1.29	1.30	1.28	1.26	1.27	1.27	1.28	1.29	1.30	1.31	1.29	1.26	1.29
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	95%	93.0%	94.4%	95.0%	96.0%	95.0%	93.0%	94.0%	93.0%	97.0%	97.0%	93.0%	95.0%	95.0%	94.9%
	7.06	Maternity SIs	NT	1	0	0	0	1	0	1	1	2	0	0	1	1	6
	7.07	Maternity Never Events	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates	80%	83.0%	82.6%	78.5%	78.5%	82.4%	78.1%	76.0%	77.8%	83.0%	81.5%	81.0%	83.0%	81.0%	80.5%
8. Community	1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	4.27	RTT 18 weeks Non-Consultant led services - Community	90%	99.0%	99.0%	100%	99.7%	99.6%	100%	99.0%	99.4%	94.0%	98.0%	94.4%	95.0%	96.7%	96.6%
	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	100%	100%	100%	NA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	100%	99.9%	100%	96.6%	100%	100%	100%	100%	100%	93.8%	97.3%	97.1%	100%	98.3%
	4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.0%	99.2%	98.4%	99.0%	98.8%	99.3%	100%	99.5%	99.3%	98.8%	99.5%	99.9%	98.9%	99.4%

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Putting you first

3. IN THIS MONTH – OCTOBER 2019, MONTH 7

This table highlights incoming activity to the Trust, compared to the number of treatments and discharges from the Trust to provide a summary overview of overall capacity and demand. It provides a comparison to last year for the monthly and year-to-date activity.

From Month Year	Oct-2019

To Month Year	Oct-2018

WEST SUFFOLK HOSPITAL INTEGRATED QUALITY & PERFORMANCE REPORT - Summary of New Referrals & Completed treatment

In this month.... Oct-2019

Mth We Received.....	Oct-19	Oct-18	Variance	Var. %	Traffic
GP Referrals	5,283	7,678	-2,395	-31.2%	↓
Other Referrals	4,732	6,150	-1,418	-23.1%	↓
Ambulance Arrivals	2,069	1,815	254	14.0%	↑
Cancer Referrals*	1,187	1,090	97	8.9%	↑
Urgent Referrals*	2,488	3,053	-565	-18.5%	↓

YTD We Received.....	2019	2018	Variance	Var. %	Traffic
GP Referrals	41,795	47,108	-5,313	-11.3%	↓
Other Referrals	35,700	38,569	-2,869	-7.4%	↓
Ambulance Arrivals	13,446	12,375	1,071	8.7%	↑
Cancer Referrals*	7,624	7,419	205	2.8%	↑
Urgent Referrals*	18,586	19,347	-761	-3.9%	↓

Mth We Delivered.....	Oct-19	Oct-18	Variance	Var. %	Traffic
ED Attendances (excluding GP Expected/Streamed)	6,249	5,247	1,002	19.1%	↑
**ED Attendances(Adjusted)	7,597	6,693	904	13.5%	↑
GP Expected via ED	592	574	18	3.1%	↑
GP Streamed	367	435	-68	-15.6%	↓
GP Expected direct to AAU/AEC	389	437	-48	-11.0%	↓

YTD We Delivered.....	2019	2018	Variance	Var. %	Traffic
ED Attendances (excluding GP Expected/Streamed)	41,882	36,621	5,261	14.4%	↑
**ED Attendances(Adjusted)	50,999	46,018	4,981	10.8%	↑
GP Expected via ED	4,054	3,867	187	4.8%	↑
GP Streamed	2,459	3,075	-616	-20.0%	↓
GP Expected direct to AAU/AEC	2,604	2,455	149	6.1%	↑

A&E - To IP Admission Ratio	28.5%	28.6%	-0.1%	-0.1%	↓
Outpatient Attendances	28,242	28,232	10	0.0%	↑
Inpatient Admissions	6,391	6,362	29	0.5%	↑
Elective Admissions	3,104	2,971	133	4.5%	↑
Non Elective Admission	3,287	3,391	-104	-3.1%	↓
Inpatient Discharges	6,407	6,341	66	1.0%	↑
Elective Discharges	3,112	2,947	165	5.6%	↑
Non Elective Discharges	3,295	3,394	-99	-2.9%	↓
New Births	196	224	-28	-13%	↓

A&E - To IP Admission Ratio	27.4%	26.5%	1.0%	3.7%	↑
Outpatient Attendances	184,834	179,001	5,833	3.3%	↑
Inpatient Admissions	42,449	41,359	1,090	2.6%	↑
Elective Admissions	20,306	19,242	1,064	5.5%	↑
Non Elective Admission	22,284	22,117	167	0.8%	↑
Inpatient Discharges	42,456	41,358	1,098	2.7%	↑
Elective Discharges	20,562	19,226	1,336	6.9%	↑
Non Elective Discharges	21,931	22,132	-201	-0.9%	↓
New Births	1,406	1,414	-8	-1%	↓

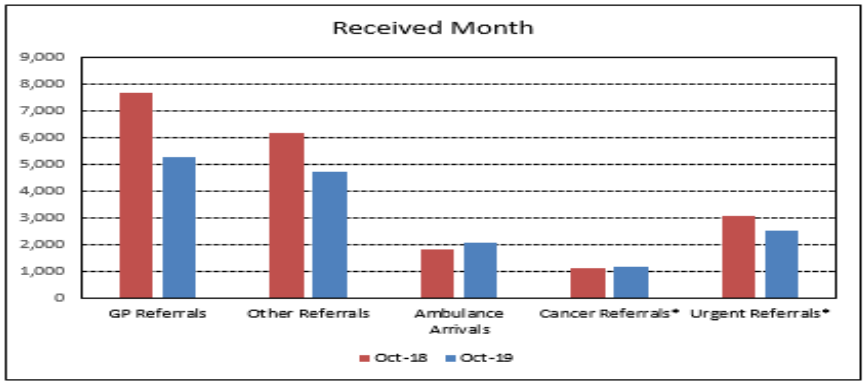
* - Included in Referrals Above

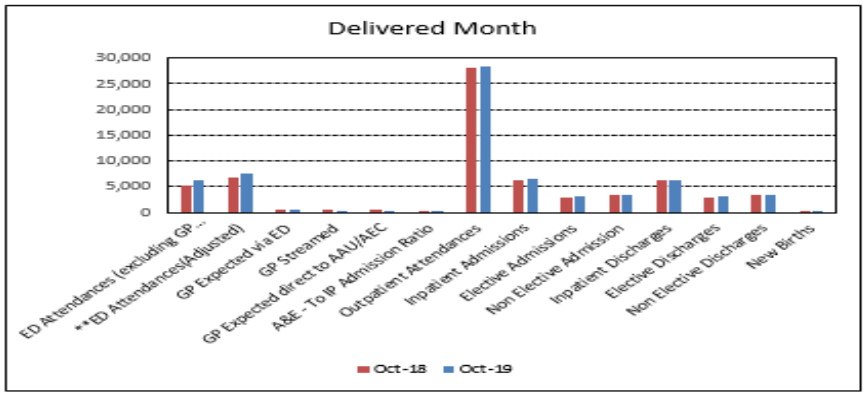
** - The ED adjusted figure adds ED attendances, GP Streamed and all GP expected (Including direct to AAU/AEC) together to reflect the position in 2017 when these were reported together.

A&E Attendances Year chart (Adjusted)

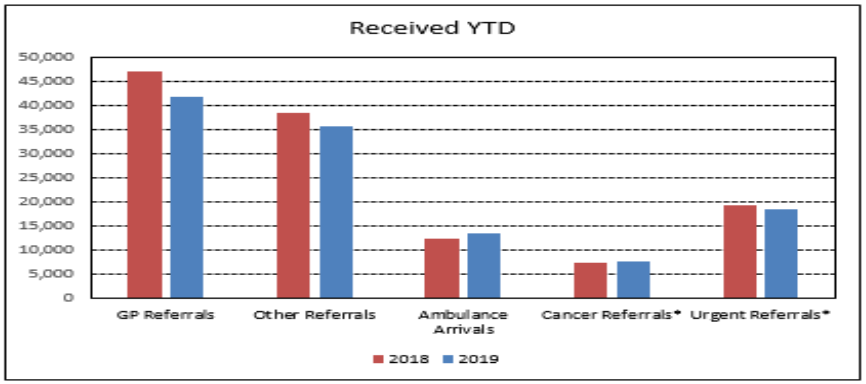
GP, cancer referrals and other referrals demonstrate a reduction year on year. A&E attendances continue to show an increase and incomplete RTT pathways are higher than last year.

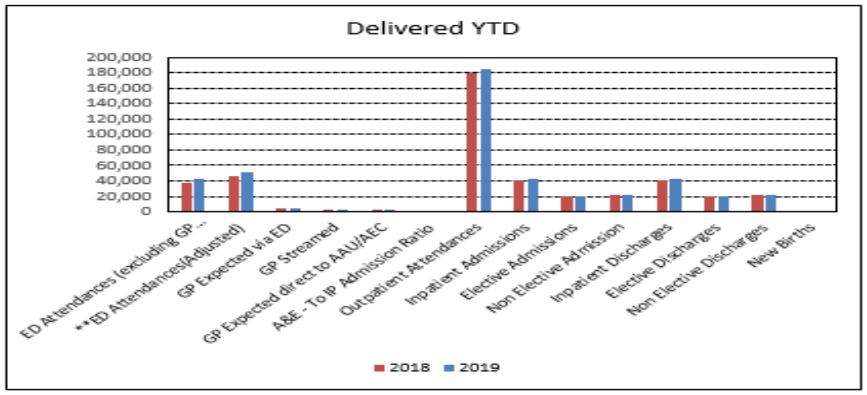
Monthly





Yearly





Putting you first

DETAILED REPORTS

4. DETAILED SECTIONS – SAFE

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD(Apr19 Oct19)
1.Safe	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	100%	94.4%	100%	100%	100%	100%	100%	83.0%	88.9%	100%	96.0%
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	100%	96.0%	100%	96.2%	96.4%	87.1%	89.0%	100%	100%	100%	100%	100%	100%	98.4%
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	96.0%	96.0%	100%	97.9%	100%	96.4%	100%	98.0%	100%	100%	91.0%	90.0%	97.6%	96.7%
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	100%	100%	100%	97.0%	99.3%	99.2%	100%	99.4%	100%	99.2%	100%	100%	98.8%	99.6%
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	100%	100%	95.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.14	HII Compliance 4b: Preventing surgical site infection perioperative	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	100%	100%	100%	90.0%	ND	90.0%	100%	100%	100%	100%	100%	98.3%
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	100%	90.9%	100%	100%	ND	100%	100%	100%	100%	100%	100%	100%
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	94.0%	97.0%	98.0%	92.2%	88.8%	95.2%	96.0%	94.2%	96.1%	100%	100%	98.8%	95.0%	97.2%
	Incidents	1.18	Safety Thermometer: % of patients experiencing new harm-free care-Trust	100%	98.7%	98.7%	96.2%	98.3%	97.0%	97.9%	96.6%	97.8%	97.0%	99.1%	98.3%	97.1%	98.3%	97.7%
		1.19	Safety Thermometer: % of patients experiencing new harm-free care - Community	100%	98.9%	99.0%	96.4%	98.4%	97.0%	99.0%	96.1%	99.7%	98.6%	99.7%	99.3%	99.0%	99.3%	98.8%
		1.20	No of SIRIs	NT	4	3	5	6	2	2	5	6	1	3	2	6	4	27
		1.21	RIDDOR Reportable Incidents	NT	3	2	3	1	3	3	2	2	2	0	1	2	1	10
		1.22	Total No of E. Coli (Trust level only)	NT	0	0	1	2	0	1	1	3	2	4	3	1	0	14
		1.23	No of Inpatient falls - Trust	NT	61	48	61	81	54	56	74	75	61	73	62	55	68	468
		1.24	No of Inpatient falls - WSH	<48	47	35	53	61	42	47	60	66	53	65	58	50	61	413
		1.25	No of Inpatient falls - Community Hospitals	NT	14	13	8	20	12	9	14	11	8	8	4	5	7	57
		1.26	Falls per 1,000 bed days	NT	4.29	3.35	4.82	5.21	3.95	4.17	5.21	5.71	4.98	5.87	5.60	4.94	ND	5.39
		1.27	No of Inpatient falls resulting in harm - Trust	NT	12	17	15	25	14	15	21	15	18	22	15	17	23	131
		1.28	No of Inpatient falls resulting in harm - WSH	NT	11	13	12	22	10	13	16	14	14	20	14	17	20	115
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	NT	1	4	3	3	4	2	5	1	4	2	1	0	3	16
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	0	0	0	2	1	0	0	4	2	1	2	1	1	0	11
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	0	0	0	2	1	0	0	4	2	1	2	1	1	0	11
		1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.69	PU present on admission to service - Trust	NT	77	71	78	99	69	87	89	90	88	62	89	80	51	549
		1.70	PU present on admission to service – Inpatients	NT	60	57	61	77	49	58	60	62	64	35	72	69	17	379
		1.71	PU present on admission to service – Community teams	NT	17	14	17	22	20	29	29	28	31	27	17	11	34	177
		1.33	Number of medication errors	NT	71	54	61	79	78	72	89	76	65	89	56	83	73	531
		1.72	New PU - Trust	0	35	28	27	30	34	40	42	54	31	37	44	43	51	308
		1.67	New PU – Inpatients	0	13	19	17	11	16	21	20	25	11	17	18	19	17	127
		1.68	New PU – Community teams	0	22	9	10	19	18	19	22	29	20	20	26	30	34	181
		1.73	Moisture associated skin damage	0	NA	NA	NA	17	18	22	18	14	14	26	21	29	42	164
		1.74	Device related (% of total)	NT	NA	NA	NA	2.0%	6.0%	5.0%	4.0%	5.0%	3.0%	2.0%	4.0%	0.0%	2.0%	2.9%
		1.60	% of patients at risk of falls (with a Falls assessment)	NT	73.3%	72.7%	71.6%	73.0%	71.9%	73.9%	73.2%	73.7%	73.1%	73.2%	74.7%	72.3%	74.3%	73.5%

Putting you first

Are we..		Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD(Apr19 Oct19)
1. Safe	Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	90%	NA	NA	89.0%	NA	NA	88.0%	NA	NA	87.0%	NA	NA	91.0%	NA	89.0%
		1.39	MRSA Bacteraemias - Community Attributable	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		1.40	Clostridium Difficile infection - Community Attributable	NT	3	2	2	4	1	6	3	4	3	5	1	2	3	21
		1.41	MRSA - Decolonisation	95%	95.0%	97.0%	94.0%	94.0%	100%	92.0%	100%	100%	94.0%	100%	95.0%	100%	90.0%	97.0%
		1.42	MRSA - RCA Reports	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.43	MSSA (Hospital)	NT	1	1	0	0	0	2	0	0	1	1	2	0	0	4
		1.44	SIRI final reports due in month submitted beyond 60 working days	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
		1.45	SIRIs reported > 2 working days from identification as red	0	0	0	0	0	0	1	0	0	0	1	0	1	0	2
		1.46	Green, Amber & Red Active / Accepted risk assessments not in date	0	4	2	3	79	55	55	55	53	56	53	19	0	1	237
		1.47	Datix Risk Register Red / Amber actions overdue	0	1	4	1	65	65	65	65	64	65	41	30	1	3	269
		1.48	Rapid access chest pain clinic access within 2 wks.	95%	99.2%	99.2%	100%	100%	100%	100%	100%	100%	100%	100%	97.5%	99.0%	100%	99.5%
		1.75	Verbal DoC undertaken within 10 working days of incident report	NT	NA	NA	NA	NA	NA	NA	47.0%	60.0%	69.0%	63.0%	55.0%	30.0%	40.0%	52.0%
		1.76	Total written (initial notification letter) Duty of Candour still outstanding at month-end NB: Only includes cases where verbal has already been completed	3	NA	NA	NA	NA	NA	NA	4	3	5	8	5	3	0	28
		1.49	Verbal Duty of Candour outstanding at month-end	0	0	0	6	0	4	5	4	4	2	5	2	3	0	20
		1.50	Hand Hygiene Audits	100%	100%	99.6%	98.8%	100%	100%	99.7%	100%	100%	99.5%	100%	97.0%	99.0%	100%	99.4%
		1.51	Quarterly antibiotic audit	98%	NA	NA	90.0%	NA	NA	87.0%	NA	NA	89.0%	NA	NA	90.0%	NA	89.5%
		1.52	Serious Incident RCA actions beyond deadline for completion	0	5	11	5	14	8	13	25	21	26	19	14	16	8	129
		1.53	% of Green Patient Safety incidents investigated	NT	64.0%	60.0%	59.0%	71.0%	72.0%	71.0%	63.0%	74.0%	63.0%	68.0%	67.0%	68.0%	76.0%	68.4%
		1.54	Quarterly Environment/Isolation	90%	NA	NA	93.0%	NA	NA	92.0%	NA	NA	92.0%	NA	NA	93.0%	NA	92.5%
		1.55	Quarterly Visual Infusion Phlebitis score documentation	90%	NA	NA	84.0%	NA	NA	85.0%	NA	NA	86.0%	NA	NA	87.0%	NA	86.5%
		1.56	Isolation data (Trust Level only)	90%	91.0%	91.0%	90.0%	80.0%	75.0%	85.0%	85.0%	85.0%	89.0%	85.0%	87.0%	87.0%	87.0%	86.4%
		1.57	Pain Mgt. internal report	80%	85.5%	NA	NA	84.5%	NA	NA	85.2%	84.1%	84.3%	83.2%	84.3%	83.5%	80.3%	83.6%
		1.58	Nutrition % of patients with a MUST/PYMS assessment completed for within 24hrs	95%	83.0%	83.0%	84.0%	83.0%	81.0%	79.0%	81.0%	81.0%	82.0%	83.0%	84.0%	85.7%	86.2%	83.3%
		1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)	41	75	84	98	78	82	38	57	70	84	112	63	42	ND	71
		1.61	E coli - Hospital Attributable	NT	2	0	1	2	0	1	1	3	2	4	3	1	0	14
		1.62	E coli - Community Attributable	NT	14	13	11	8	9	16	12	18	17	24	24	15	13	123
		1.63	Klebsiella spp. - Hospital Attributable	NT	0	0	1	0	1	0	1	0	0	1	1	0	0	3
		1.64	Klebsiella spp. - Community Attributable	NT	1	3	2	1	1	1	2	3	4	6	1	6	3	25
		1.65	Pseudomonas - Hospital Attributable	NT	0	0	0	0	1	0	2	0	0	0	0	0	0	2
		1.66	Pseudomonas - Community Attributable	NT	1	0	1	1	2	0	0	1	3	4	1	1	2	12

NHS West Suffolk NHS Foundation Trust

SAFE – DIVISIONAL LEVEL ANALYSIS

Indicator	August			September			October		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
HII compliance 1a: Central venous catheter insertion	78	100		85.7	100		100	100	
HII compliance 1b: Central venous catheter ongoing care	100	100		100	100		100	100	
HII compliance 2a: Peripheral cannula insertion	90	85	100	100	78.6	100	100	95.2	100
HII compliance 2b: Peripheral cannula ongoing	100	100	100	100	100	100	100	98	100
HII compliance 4a: Preventing surgical site infection preoperative	100			100			100		
HII compliance 4b: Preventing surgical site infection perioperative	100			100			100		
HII compliance 5: Ventilator associated pneumonia	100			100			100		
HII compliance 6a: Urinary catheter insertion	100	100			100		100	100	
HII compliance 6b: Urinary catheter on-going care	100	100		100	98.2		100	91.5	
HII compliance: Antibiotic Prescribing – All care setting	100	76		90.0	96.0	100	89	96	
HII compliance: Antibiotic Prescribing – Secondary Care	63	83		65.0	74.0	100	33	74	
HII compliance: Chronic Wounds									
Total no of MRSA bacteraemias: Hospital	1	1	0	0	0	0	0	0	0
Quarterly MRSA (including admission and length of stay screens)				98	81	94			
Hand hygiene compliance	91	98	100	98.5	100	80	100	100	100
Total no of MSSA bacteraemias: Hospital	1	1	0	0	0	0	0	0	0
Quarterly Environment & Standard Principles Compliance				93	91	94			
Total no of C. diff infections: Hospital	0	2	0	1	2	0	0	3	0
Quarterly Antibiotic Audit				90	89	94			

Putting you first

Indicator	August			September			October		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Quarterly VIP score documentation				89	87	84			
No of patient falls	9	47	2	6	44	0	8	55	0
No of patient falls resulting in harm	2	12	0	2	15	0	0	20	0
No of avoidable serious injuries or deaths resulting from falls	0	0	0	0	0	0	0	0	0
No of ward acquired pressure ulcers	9	7	0	5	14	0	3	14	0
No of avoidable ward acquired pressure ulcers									
Nutrition: Assessment and monitoring	78	91	51	85	91	57	89	88	46
No of SIRIs	1	0	0	1	4	1	0	1	2
No of medication errors	11	30	6	23	39	7	17	36	7
Cardiac arrests	0	5	0	1	2	0	0	3	0
Cardiac arrests identified as a SIRI	0	0	0	0	0	0	0	0	0
Pain Management	86.3	86.2	54	84.9	86.7	48.1	80.7	83.7	46.5
VTE: Completed risk assessment (monthly Unify audit)	97.1	95.1	64.8	96.2	95.2	96.1	95.3	93.5	96.7
Quarterly VTE: Prophylaxis compliance									
Safety Thermometer: % of patients experiencing new harm-free care	93.9	97.2	90.0	97.6	96.9	100	100	97.3	100

Indicator	August			September			October		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Patient Satisfaction: In-patient overall result	95.0	85.0	83.0	93.0	86.0	85.0	93.0	86.0	86.0
How likely are you to recommend our services to friends and family if they need similar care or treatment	99.0	95.0	100.0	99.0	94.0	100	99.0	95.0	100.0
In your opinion, how clean was the hospital room or ward you were in?	97.0	96.0	97.0	96.0	97.0	98.0	98.0	96.0	99.0
How was the food choice during your hospital stay?	92.0	86.0	81.0	86.0	87.0	79.0	88.0	87.0	87.0
How was the food taste and quality during your hospital stay?	93.0	86.0	81.0	86.0	86.0	82.0	87.0	83.0	87.0
Did you feel you were treated with respect and dignity by staff?	99.0	97.0	97.0	100	97.0	96.0	99.0	98.0	99.0
Were staff caring and compassionate in their approach?	99.0	97.0	100.0	100	96.0	96.0	99.0	97.0	99.0
Did you find a member of staff to talk to about your worries and fears?	99.0	92.0	92.0	98.0	96.0	100	99.0	91.0	98.0
Were you involved as much as you wanted to be in decisions about your care and treatment?	97.0	88.0	92.0	97.0	90.0	89.0	97.0	89.0	91.0
Did you experience any noise in the night time?	91.0	82.0	95.0	84.0	75.0	78.0	83.0	77.0	92.0
Did you get enough help from staff to eat your meals?	98.0	98.0	100	99.0	94.0	100	99.0	93.0	75.0
Minutes after you used the call button did it take to get help?	86.0	71.0	85.0	80.0	71.0	79.0	86.0	74.0	90.0
Did someone from pharmacy discuss your medications with you at any time during your hospital stay?	88.0	63.0	17.0	86.0	67.0	38.0	90.0	69.0	31.0
Were you given clear written or printed information about your take-home medications?	97.0	75.0	53.0	98.0	84.0	83.0	96.0	82.0	66.0
Were the purposes of your take-home medications explained to you in a way you could understand?	96.0	71.0	68.0	96.0	82.0	89.0	94.0	78.0	80.0
Number of Inpatient surveys completed	233	177	39	237	162	56	203	199	48
Same sex accommodation: total patients	0	0	0	0	0	0	0	0	0
Complaints	1	5	2	5	9	2	2	10	6
Environment and Cleanliness	94.6	92.3	94.8	94.1	92.5	92.8	94.7	93.3	95.3

5. Exception reports – Safe

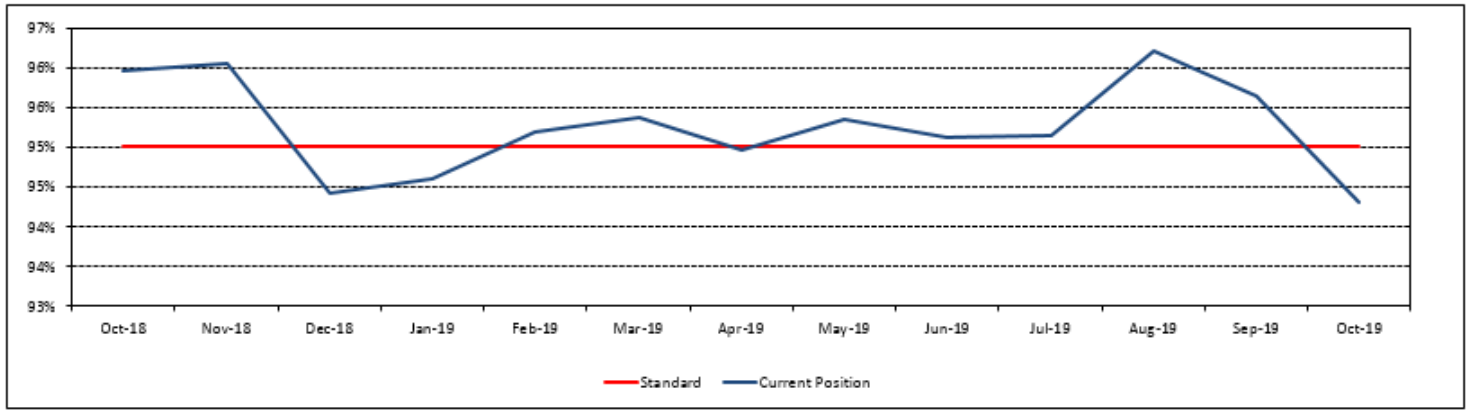
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	All relevant inpatients undergoing a VTE Risk assessment
Standard	95%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

The performance for VTE baseline assessment has reduced to 94.3% in October. Most areas are performing well but there are 3 high volume areas, DSU, CDU and G8 where performance is weaker or has fallen. The Clinical directors , lead clinicians ADOs and service managers have been written to about this. They have been asked to find out the reasons and support staff in improving performance.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	96.0%	96.1%	94.4%	94.6%	95.2%	95.4%	95.0%	95.4%	95.1%	95.2%	96.2%	95.6%	94.3%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

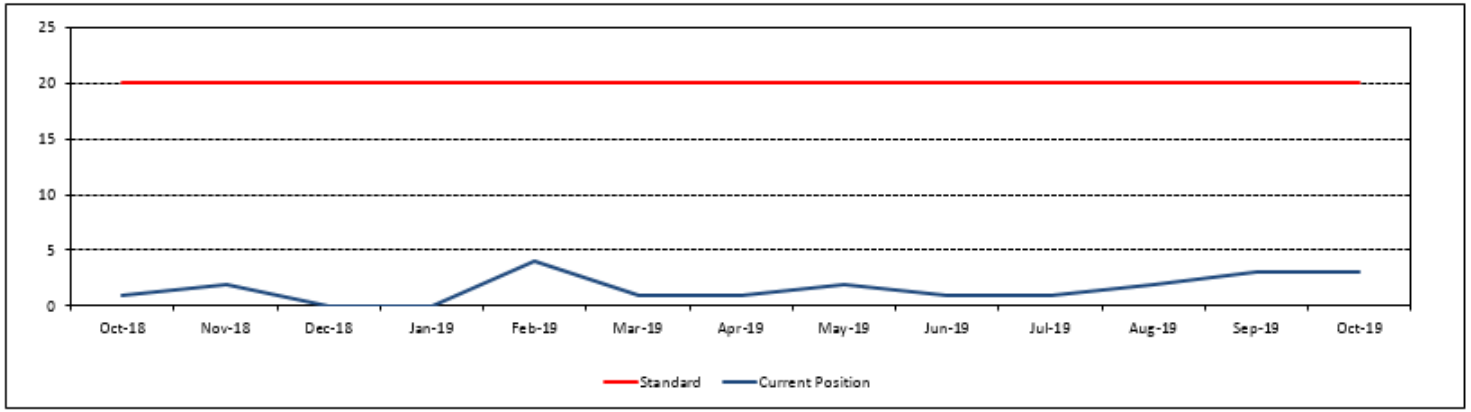
Indicator	Clostridium Difficile infection - Hospital Attributable
Standard	20
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

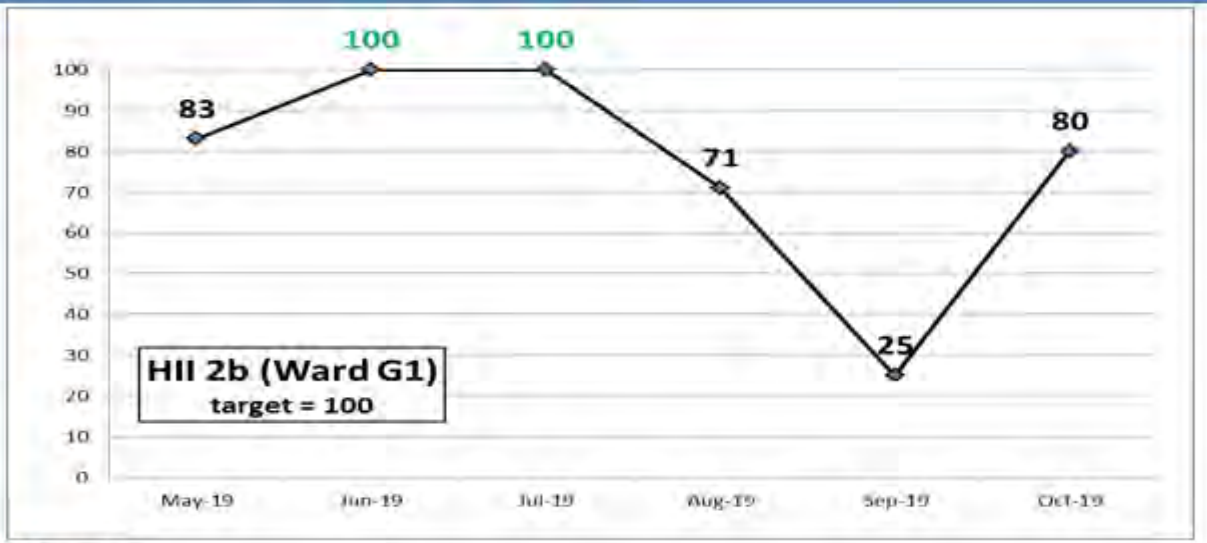
There have been 3 Hospital Onset cases recorded in October 2019. However 1 is a case which is attributed to the Trust as the specimen was sent at 72h (until 2019 this would have been a community case) this has been discussed with CCG colleagues and agreed as Non trajectory. Of the other 2 cases one is also Non trajectory and 1 is awaited. There was 1 Community Onset healthcare associated case. There are no links to the cases and ribotyping is distinct. However a possible theme is the use of Tazocin. Accordingly the risk register has been updated to reflect this.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	20	20	20	20	20	20	20	20	20	20	20	20	20
Current Position	1	2	0	0	4	1	1	2	1	1	2	3	3

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



High Impact Interventions (HIIs)

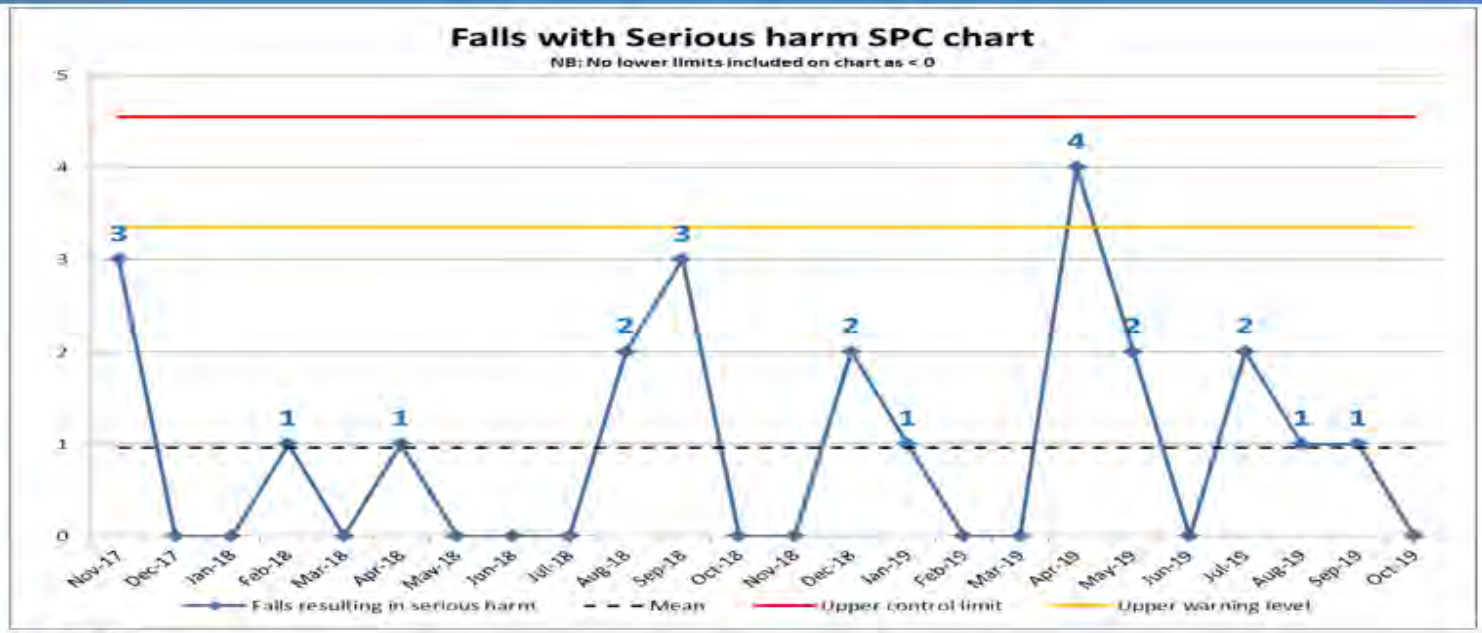


Narrative

What	Performance is measured against a target of 100% for each High impact intervention (HII). In October all of the HIIs achieved 100% except HII 2a: Peripheral cannula insertion, 2b: Peripheral cannula ongoing and 6b - Urinary catheter on-going care. Critical Care have achieved 100% in 1a this month following two months of non-compliance.
Why	Failure in 2a (on Ward G1), 2b (on Wards G3 and G8) and 6b (on Wards G1 and G3) brought performance down.
How	On the wards the Matrons work closely with the teams to ensure performance is maintained and (where necessary) improves. Ward G1 has a trend of not achieving 100% for 2a and the area is being asked to highlight themes and how to address these with Matron and HoN oversight.
When	An HII annual review was due to take place in September looking at reporting pathways with particular focus on 6b as the element most likely to fail the 100% target (although it did achieve 100% in July and August). This review has been rescheduled to November and will form part of the wider IQPR review being led by the Head of Performance.

Safe

Falls

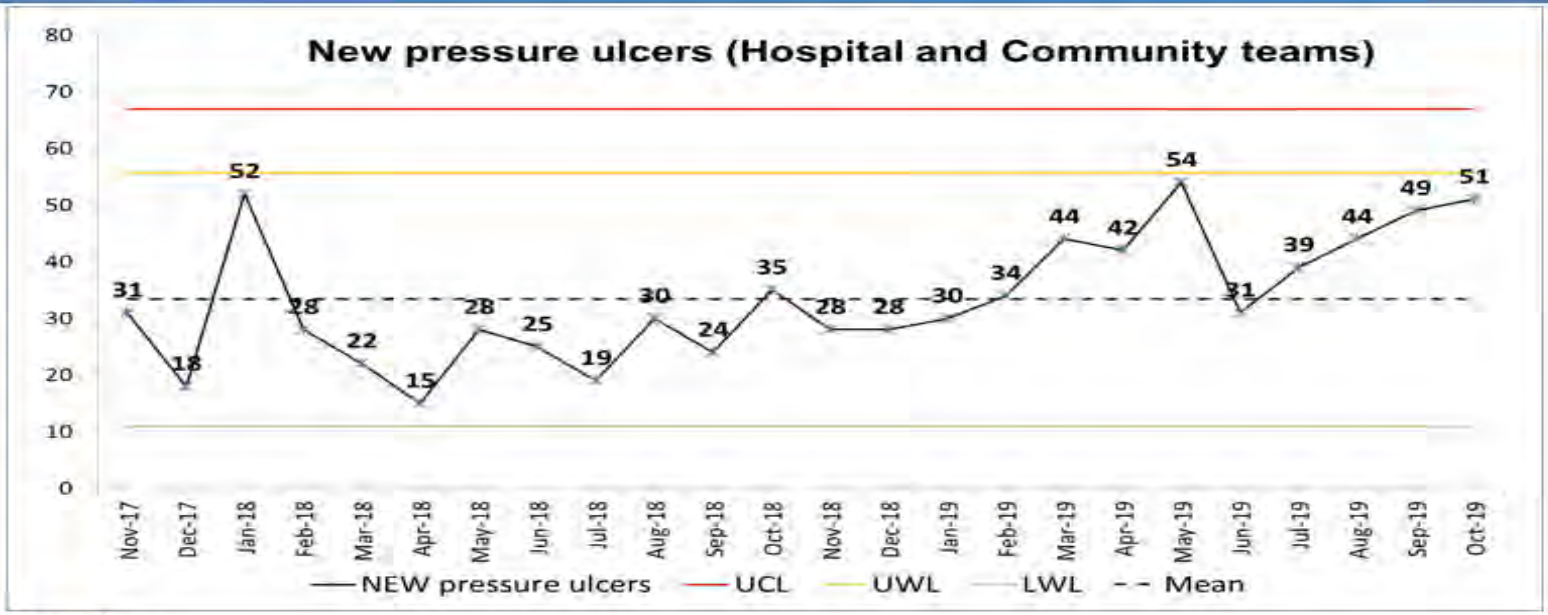


Narrative

What	The total number of Trust inpatient falls rose in October to a total of 70 (63 in WSH & 7 in Community beds), none of which resulted in serious harm.
Why	We have experienced an increase in frequent fallers, including having 2 patients each falling 4 times, and 1 patient falling 3 times. G3 has been an increase in falls to 13, however 2 patients account for 7 of these falls. In October we have seen an increase in harm, which we will monitor, but have not experienced any serious harm. YTD we have had 10 falls with serious harm.
How	We have commenced trialling new falls prevention technology on F3, G8 and currently in Glastonbury Court. Our training package is being reviewed and updated by the falls Matron. We are also looking at additional falls symbols to highlight those patients experiencing frequent falls.
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Falls Group including ongoing liaison with the contacts gained through the previous work in the regional NHSI collaborative. We now have some dedicated Matron hours focused on falls training and quality improvements within the Trust.

Safe

Pressure ulcers

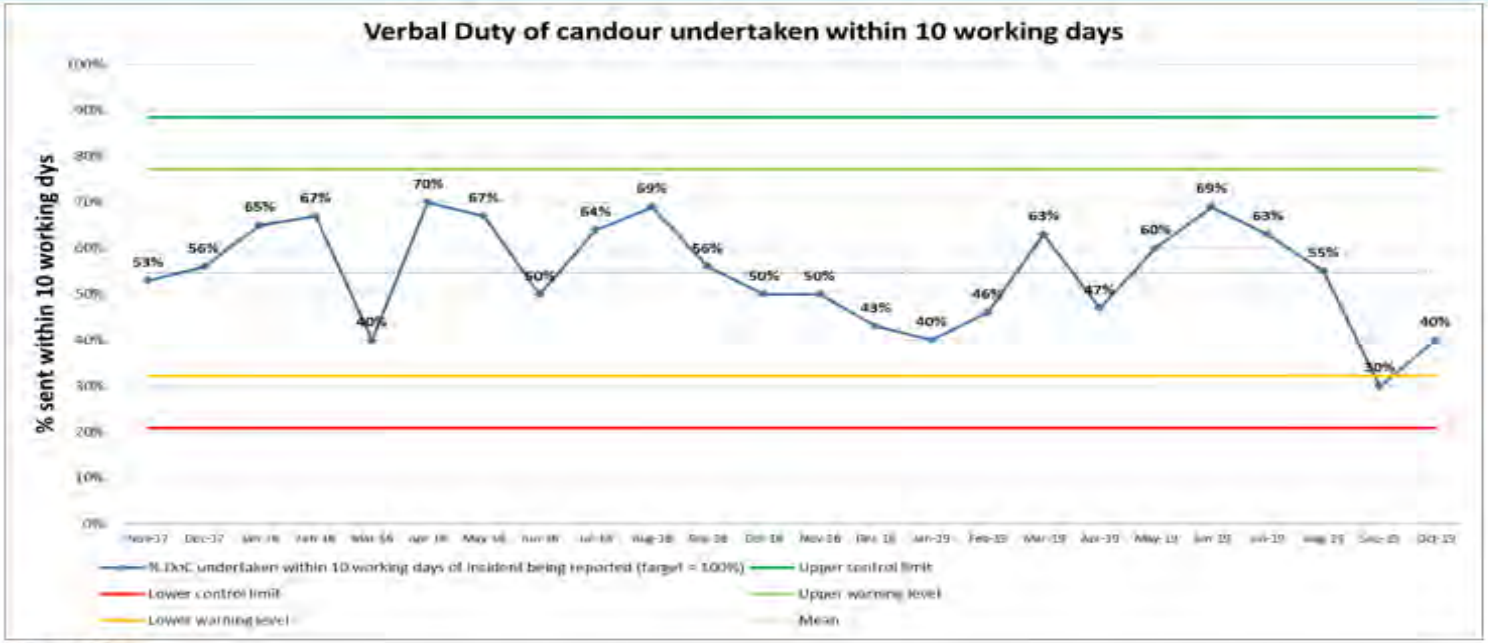


Narrative

What	An overall increase of 2 new pressure ulcers this month; the majority of this increase has been observed in the community setting, with acute new pressure ulcers reducing slightly overall.
Why	We continue to work towards adopting a demand/capacity tool within the community nursing teams, in order to ensure that as a Division we are able to ensure that the correct number/skill mix of staff are available to care for patients. Colleagues have been reminded via the internal CREWS Quality Report/Newsletter (community), of the need to ensure prompt referral to the Tissue Viability Service to ensure that these patients receive specialist clinical support before wound deterioration occurs.
How	Our Integrated Tissue Viability Team take every opportunity to enhance the skills and awareness of clinicians caring for patients and all those who may have contact with patients, either in the form of bite-size ward/department sessions which have been ongoing, or by educating WSFT volunteers during their Mandatory Training, to ensure understanding of the causes of pressure damage and strategies to reduce these. In the community setting, an additional programme of support is being provided to a large residential care home in Bury St Edmunds with the intention of sharing knowledge and skills with carers who support patients through the 24-hour period.
When	Our aspiration continues to be to reduce the incidence of new pressure ulcers by 5% by the end of the financial year; however, we recognise that this is an increasingly ambitious challenge. There is a concern that given the increasing complexity of our patients that this reduction in occurence is becoming unlikely; however, we continue to strive towards this.

Safe

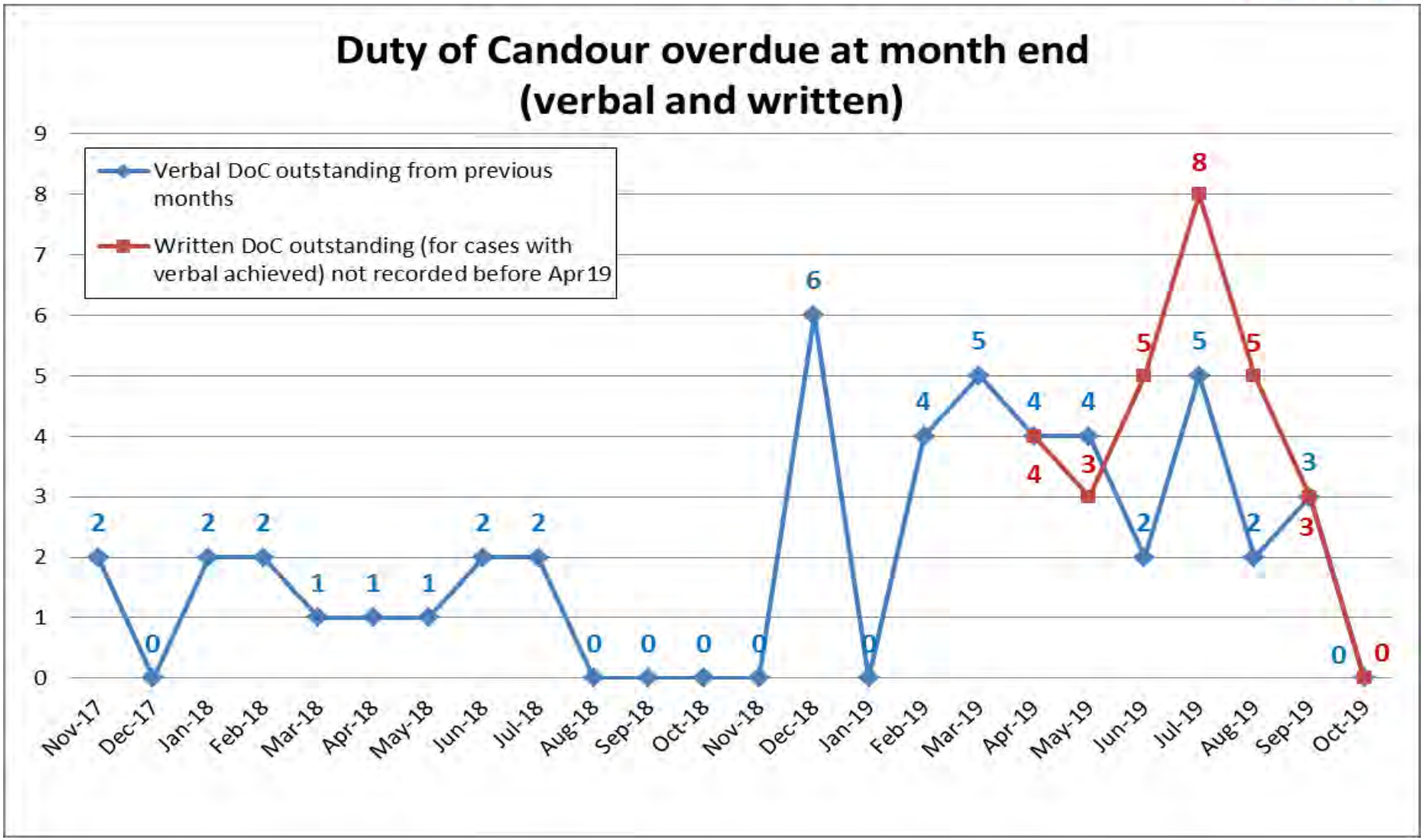
Duty of Candour



Narrative

What	Compliance with the 10 day target improved in October but is still considerably lower than target.
Why	The performance varies month on month however it not usually adversely affected by total number of cases. Executive oversight of Duty of Candour cases still pending at beginning of the month has led to an improvement this month with no cases due in October (verbal or written) still outstanding at the time of report submission.
How	In September, options to improve all three Duty of Candour indicators were discussed. This is a multi-faceted issue with separate issues relating to different professions, different divisions and even record keeping and it has been suggested that it might benefit from a QI-style improvement plan.
When	The new Patient Safety Incident Response Framework pilot will also impact on Duty of Candour and so the Duty of Candour improvement plan needs to run side-by-side with that. To that end, a timeframe of Q4 19/20 has been set.

Safe



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

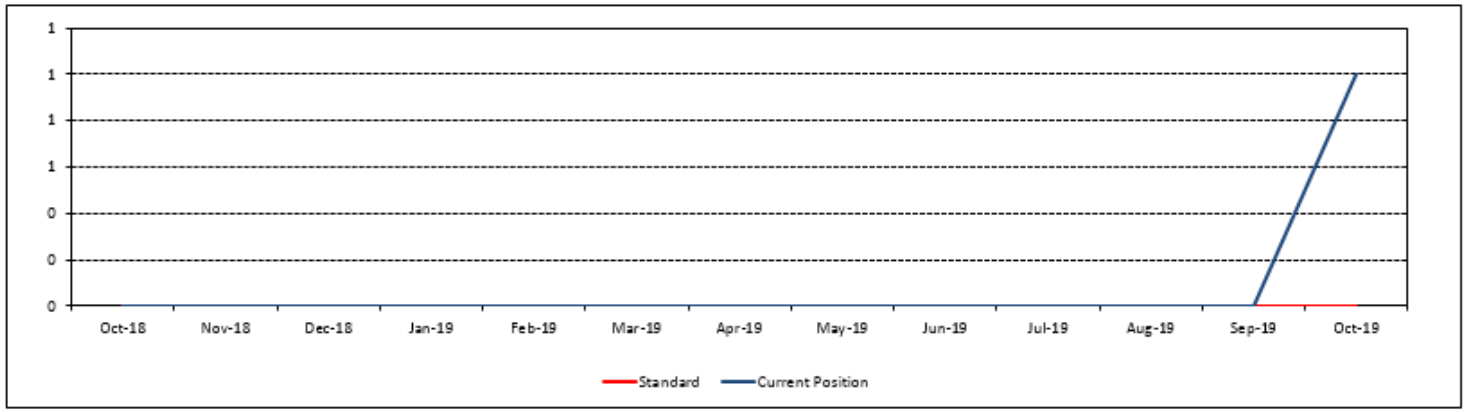
Indicator	MRSA Bacteraemias - Community Attributable
Standard	0
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

The MRSA bacteraemia is not Community as in Community services it is attributable to the CCG.CCG colleagues have investigated this and it is not within our remit to comment, the data is for information only.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	0	0	0	0	0	0	0	0	0	0	0	0	1

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

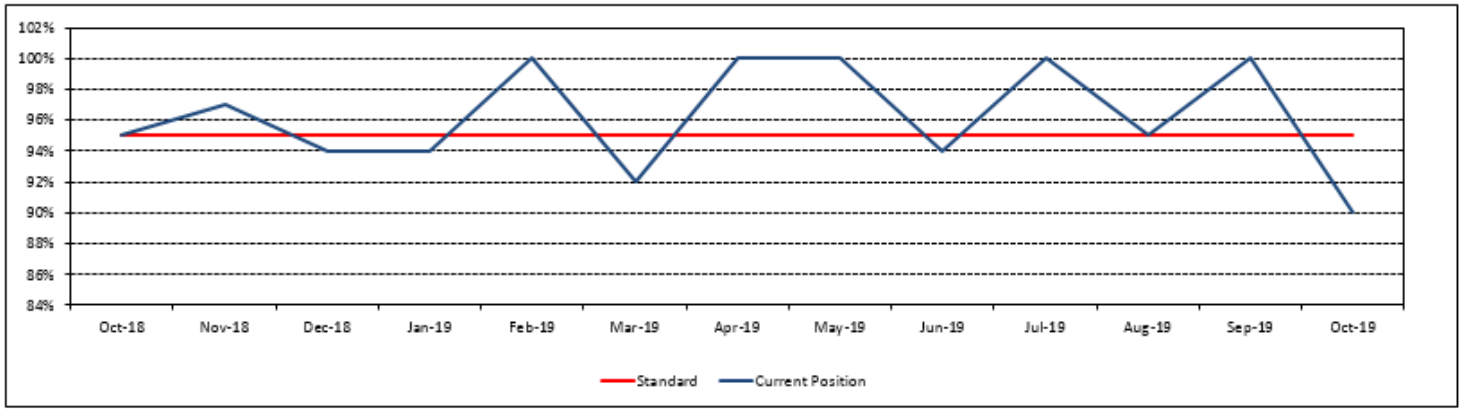
Indicator	MRSA - Decolonisation
Standard	95%
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Of the 7 patients who met the criteria for MRSA decolonization, 6 commenced in the required timeframe. 1 patient was delayed by 48 h but has completed the decolonization. This has been discussed with the ward team. The Infection Prevention team have also reviewed the process for ensuring decolonization has commenced to ensure this is more stringently captured.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	95.0%	97.0%	94.0%	94.0%	100%	92.0%	100%	100%	94.0%	100%	95.0%	100%	90.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



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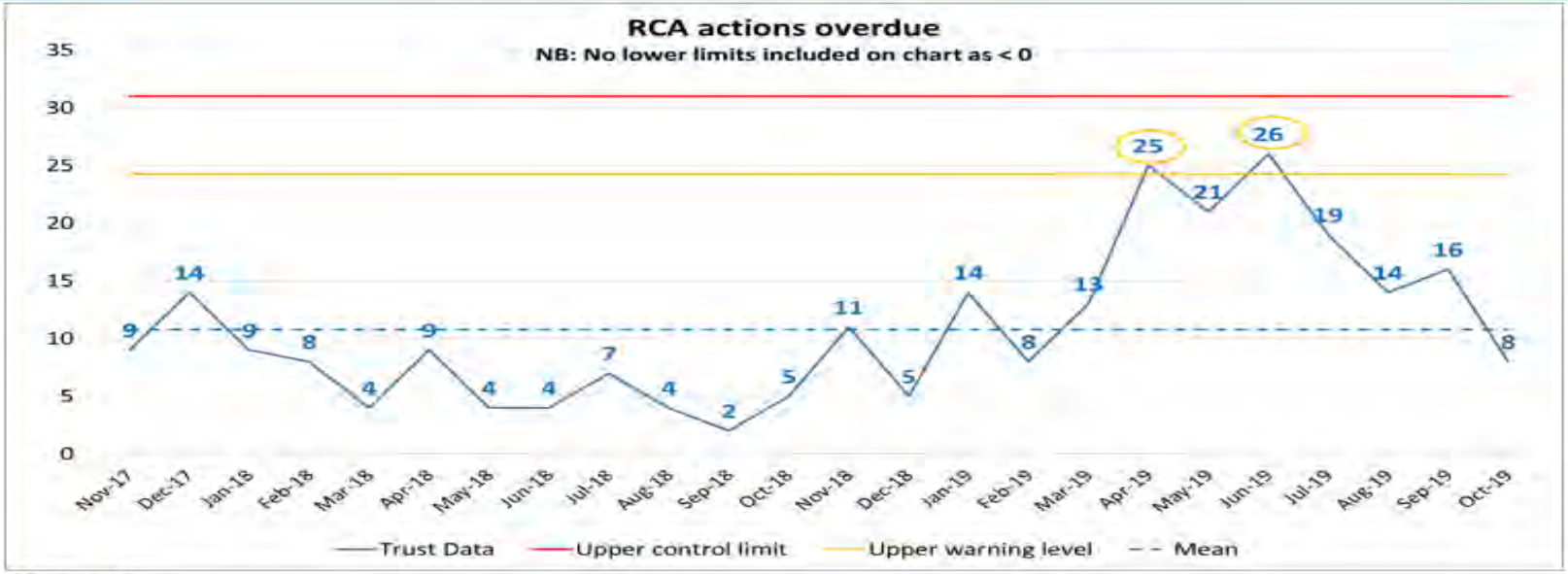
RCA actions



Narrative

What	Improving position although there are a still a small number of actions, which relate to incidents that are over 18 months old.
Why	The target of <5 overdue has not been achieved since September 2018 despite targeted follow up of the Action owners by the Patient Safety team with escalation to the Divisional steering groups and Clinical Directors meeting.
How	Monthly 'RCA actions review meeting' in the Patient Safety team, Clinical Directors report on overdue actions for which a Consultant is owner and 3-month post-report follow up ('wash-up meeting') for key SIs (such as those which are also the subject of an Inquest or have a complex action plan). More structured 'actions due' reports will be provided to the divisions to enable pro-active completion rather than waiting until they are overdue. The Trust is also participating in the national pilot of the new Patient safety incident response framework (PSIRF) which is likely to impact on this indicator in the future although this will be in the longer term.
When	The wash-up meetings are now taking place initially just for SIs which relate to inquests as this has the additional benefit of providing reassurance to the Coroner that the trust is acting upon its findings. The 'actions due' reports will be provided to the divisions from end November and the trend will be monitored to see is this has a measurable impact.

Safe

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

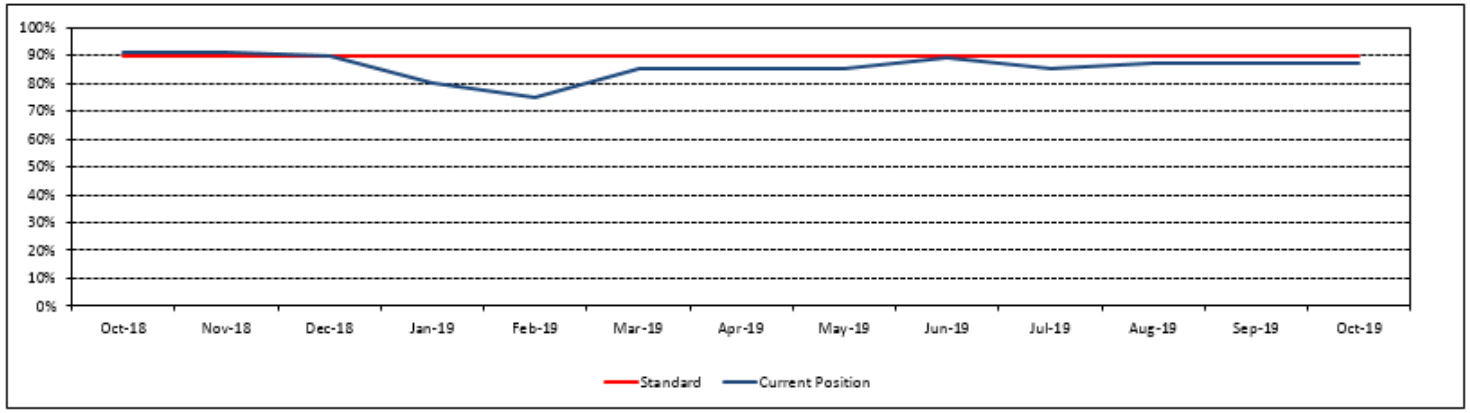
Indicator	Isolation data (Trust Level only)
Standard	90%
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

There were 3 patients identified in bays who required isolation for two of these cases it took 24h to achieve the required single room isolation.
The sideroom capacity is monitored daily (Mon to Fri) by the Infection Prevention Nurses(IPN) and occupancy is risk assessed throughout the day, including a daily review of patients on the Infection Prevention Nurses(ward visits and this information is provided to the site capacity/bed flow meetings. Wards were advised on the measures required to mitigate onward transmission. F12 Adult isolation ward has been utilized for optimum use to ensure that patients with the highest infection risk are managed there if at all possible. In October there has been 1 case of Influenza A diagnosed in Oncology outpatients (and I case in Q2 this is earlier than in previous years).

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	91.0%	91.0%	90.0%	80.0%	75.0%	85.0%	85.0%	85.0%	89.0%	85.0%	87.0%	87.0%	87.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



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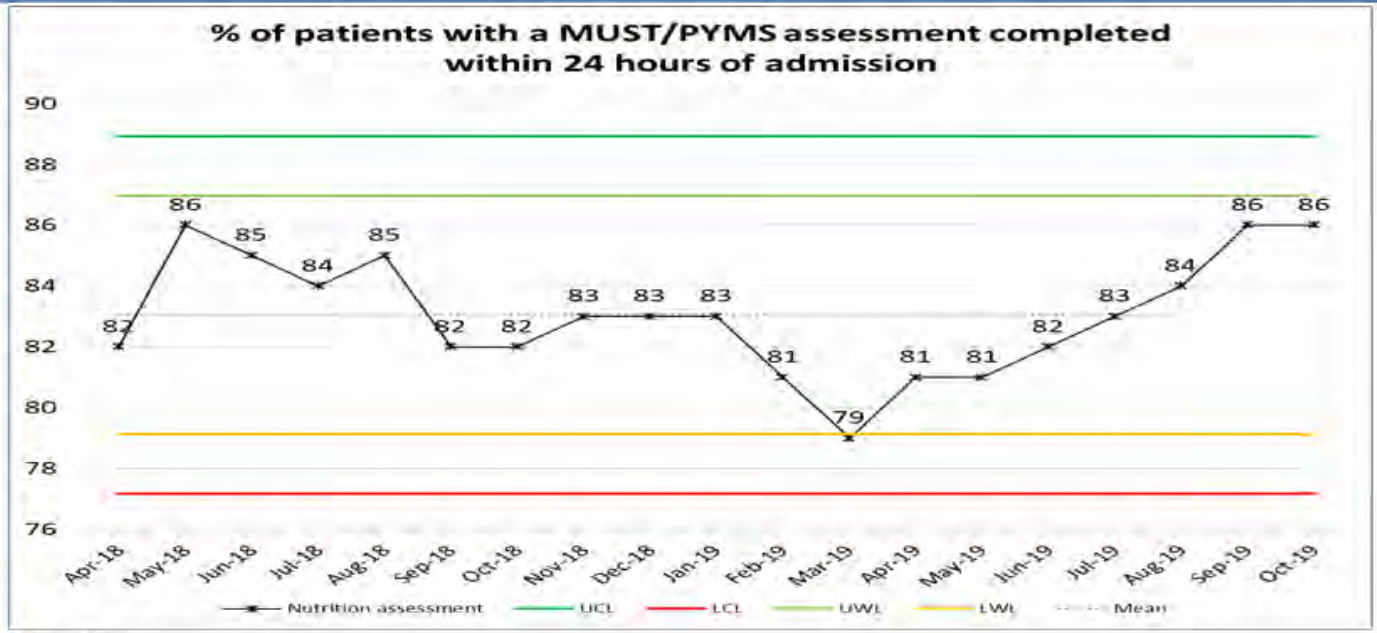
Nutrition



Narrative

What	The chart continues to show an upward trend but still within the SPC parameters.
Why	It has been identified that some areas have deteriorated in their performance and this is being actioned by the Senior Matrons aligned to the areas. Overall, the improvements are consistent and, in most cases, being maintained. It is envisaged that the recent changes in recording the assessments and monitoring via the patient safety dashboard will improve compliance overall. Paediatrics continue to struggle with compliance in recording risk assessments in a timely manner and this is being reviewed and action taken by the Clinical Service.
How	Following the completion of the NHS Improvement nutrition collaborative the work continues on progressing activity to improve nutritional assessments, referrals and care planning in addition, reviewing and enhancing the implementation of protected meal times. We have been working with the communication team to have a reduced process of 3 measures to feedback to teams. Nutritional care is also monitored via the Perfect Ward App.
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Nutrition Group and by the Matrons / Ward Managers through the use of the Nutrition dashboard and Perfect Ward audit data. There is also now a Nutrition Quality improvement sub-group set up with a structured action plan which was updated for the last Nutrition group meeting and included in the report to CSEC and the Trust Board learning reports in September.

Safe

5. DETAILED REPORTS - EFFECTIVE

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

we.		Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD(Apr19-Oct19)
2.Effective	Incidents/Reports	2.05	Cardiac arrests	NT	9	ND	3	5	5	3	4	5	0	7	5	3	3	27
		2.06	Cardiac arrests identified as a SIRI	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		2.07	CAS (central alerts system) alerts overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		2.09	NICE guidance baseline and risk assessments not completed within 6 months of publication	10	48	43	42	35	33	28	19	15	17	16	16	16	19	118
		2.10	WHO Checklist (Qrtly)	100%	NA	NA	99.0%	NA	NA	99.0%	NA	NA	99.0%	NA	NA	98.0%	NA	98.5%
		2.11	National clinical audit report baseline & risk assessments not completed within 6 months of publication	5	18	19	21	26	28	29	19	16	13	13	14	14	14	103
		2.12	Av. Elective LOS (excl. 0 days)	NT	3.25	3.50	3.35	2.81	3.92	2.91	3.17	2.89	2.76	3.16	2.41	3.15	2.82	2.91
		2.13	Av NEL LOS (excl 0 days)	NT	7.66	7.61	7.56	7.43	8.69	8.05	8.46	8.70	8.93	8.17	7.89	8.16	7.31	8.23
		2.14	% of NEL 0 day LOS	NT	14.4%	15.9%	15.4%	14.6%	13.8%	14.9%	14.2%	13.7%	13.3%	11.6%	13.3%	13.8%	17.2%	13.9%
		2.15	NHS number coding	99%	99.8%	99.8%	99.8%	99.7%	99.7%	99.8%	99.8%	99.8%	99.7%	99.5%	99.8%	99.8%	99.9%	99.8%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	85%	96.9%	100%	100%	97.0%	100%	92.8%	96.2%	92.9%	96.9%	100%	96.0%	100%	93.9%	96.5%
		2.18	Discharge Summaries (A&E 95% 1d)	95%	85.8%	82.2%	80.5%	83.7%	84.0%	81.7%	83.2%	82.8%	85.0%	83.4%	83.7%	84.9%	81.2%	83.5%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	95%	77.9%	72.4%	72.9%	76.6%	78.0%	74.9%	81.8%	80.7%	82.1%	84.3%	81.0%	86.3%	86.6%	83.3%
		2.20	Elective Discharge Summaries (IP 85% 1d)	85%	80.8%	84.5%	84.8%	84.7%	84.6%	87.9%	80.8%	87.7%	86.7%	87.8%	87.5%	90.4%	89.4%	87.2%
		2.21	All Cancer 2ww services available on C&B	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		2.22	Canc. Ops - Patients offered date within 28 days	100%	77.5%	100%	91.7%	82.8%	100%	73.3%	79.2%	93.3%	100%	90.0%	94.9%	82.9%	100%	91.5%
		2.23	Canc. Ops. - No. Cancelled for a 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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EXCEPTION REPORTS – EFFECTIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

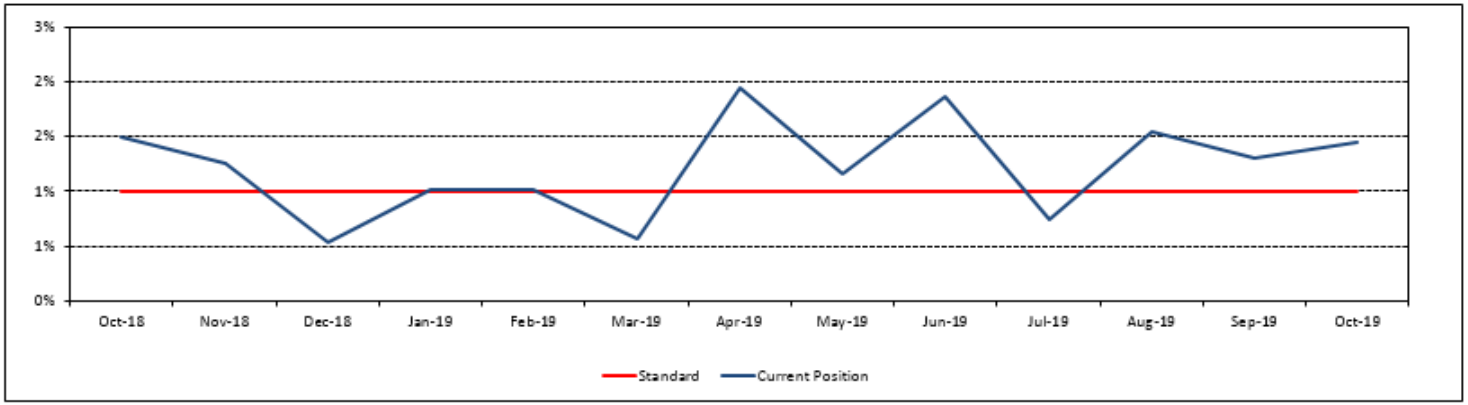
Indicator	Canc. Ops - Cancellations for non-clinical reasons
Standard	1%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

Slight increase in cancelled admissions from the previous month impacted by staffing issues in anaesthetics and equipment issues in urology Day Surgery Unit theatre.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Current Position	1.5%	1.3%	0.5%	1.0%	1.0%	0.6%	1.9%	1.2%	1.9%	0.8%	1.6%	1.3%	1.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to ensure that escalation process for elective cases is followed.	AP	Sep-18	TBC



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

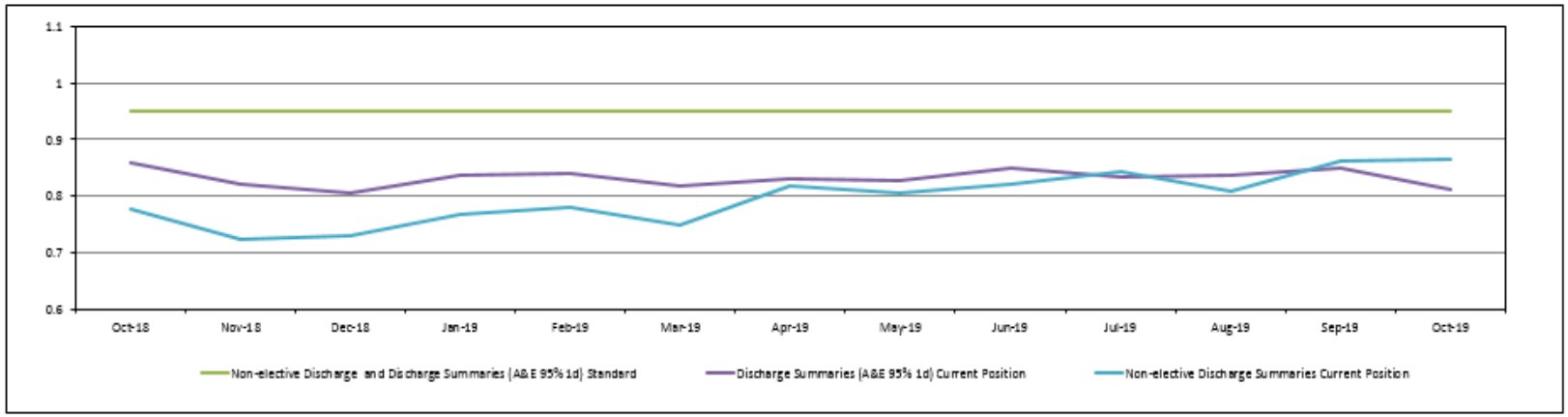
Indicator	Discharge Summaries
Standard	85%, 95%
Executive Lead	Nick Jenkins
Month	Oct-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

The position has decreased from September for both areas. We continue to work with departments to try and improve timeliness of discharge summaries. Reports identify which specific areas may need support and this is targeted through the operational divisions. We will be repeating the training that we delivered to juniors in September. This showed a demonstrable improvement for the last intake when completed.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Non-elective Discharge and Discharge Summaries (A&E 95% 1d) Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Discharge Summaries (A&E 95% 1d) Current Position	85.8%	82.2%	80.5%	83.7%	84.0%	81.7%	83.2%	82.8%	85.0%	83.4%	83.7%	84.9%	81.2%
Non-elective Discharge Summaries Current Position	77.9%	72.4%	72.9%	76.6%	78.0%	74.9%	81.8%	80.7%	82.1%	84.3%	81.0%	86.3%	86.6%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Targeted work with departments that do not comply with standard.	SJ	ongoing	



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6. DETAILED REPORTS - CARING

Are we safe? | Are we effective? | **Are we caring?** | Are we responsive? | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD(Apr19-Oct19)
3. Caring	Other Friends and Family Test Scores	3.09	IP overall experience result	90%	95.0%	95.0%	98.0%	95.0%	94.0%	95.0%	94.0%	90.0%	92.0%	91.0%	90.0%	90.0%	90.0%	91.0%
		3.10	OP overall experience result	90%	97.0%	97.0%	97.0%	97.0%	98.0%	98.0%	98.0%	97.0%	98.0%	96.0%	96.0%	98.0%	97.0%	97.1%
		3.11	A&E overall experience result	90%	95.0%	95.0%	95.0%	95.0%	95.0%	96.0%	93.0%	85.0%	93.0%	86.0%	87.0%	91.0%	90.0%	89.3%
		3.12	Short-stay overall experience result	90%	99.0%	96.0%	98.0%	98.0%	99.0%	98.0%	98.0%	99.0%	99.0%	98.0%	99.0%	98.0%	99.0%	98.6%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	90%	100%	99.0%	99.0%	97.0%	97.0%	97.0%	99.0%	99.0%	99.0%	98.0%	99.0%	99.0%	99.0%	98.9%
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	90%	98.0%	100%	100%	100%	100%	100%	100%	100%	96.0%	100%	98.0%	98.0%	100%	98.9%
		3.18	Children's services overall result	90%	85.0%	95.0%	93.0%	100%	100%	98.0%	96.0%	98.0%	98.0%	100%	100%	95.0%	100%	98.1%
		3.19	F1 Parent - overall experience result	90%	95.0%	98.0%	94.0%	97.0%	97.0%	95.0%	99.0%	98.0%	99.0%	98.0%	99.0%	97.0%	96.0%	98.0%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	90%	100%	96.0%	87.0%	100%	100%	100%	96.0%	98.0%	100%	100%	100%	100%	92.0%	98.0%
		3.21	F1 Children - Overall experience result	90%	93.0%	95.0%	93.0%	100%	100%	98.0%	86.0%	89.0%	98.0%	100%	100%	95.0%	100%	95.4%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	100%	80.0%	100%	80.0%	95.0%	100%	86.0%	100%	100%	86.0%	92.4%
		3.23	King suite - extremely likely or likely to recommend	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95.0%	100%	ND	99.2%
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	100%	96.0%	100%	100%	100%	94.0%	97.0%	98.0%	96.0%	100%	97.9%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	93.0%	93.0%	100%	100%	97.0%	90.0%	95.0%	92.0%	98.0%	100%	96.0%
		3.27	Stroke Care - Overall Experience Result	90%	100%	93.0%	ND	ND	89.0%	97.0%	96.0%	95.0%	97.0%	98.0%	89.0%	94.0%	97.0%	95.1%
		3.28	Stroke Care - extremely likely or likely to recommend	90%	100%	100%	100%	ND	93.0%	89.0%	100%	100%	100%	100%	100%	100%	100%	100%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	90%	100%	100%	100%	100%	88.0%	84.0%	94.0%	83.0%	81.0%	94.0%	80.0%	94.0%	85.0%	87.3%
		3.30	Complaints responded to within agreed timeframe	90%	83.0%	88.0%	83.0%	75.0%	100%	94.0%	86.0%	77.0%	71.0%	60.0%	44.0%	40.0%	37.0%	59.3%
		3.31	Number of second letters received	1	2	1	1	3	2	0	2	2	4	1	1	3	2	15
		3.32	Ombudsman referrals accepted for investigation	1	0	0	0	0	0	0	0	0	0	1	1	0	0	2
		3.33	No. of complaints to Ombudsman upheld	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		3.34	No. of PALS contacts	NT	224	219	143	231	211	228	184	190	191	252	207	223	229	1476
		3.35	No. of PALS contacts becoming formal complaints	<=5	1	3	0	2	5	4	2	5	6	4	2	0	5	24

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EXCEPTION REPORTS –CARING

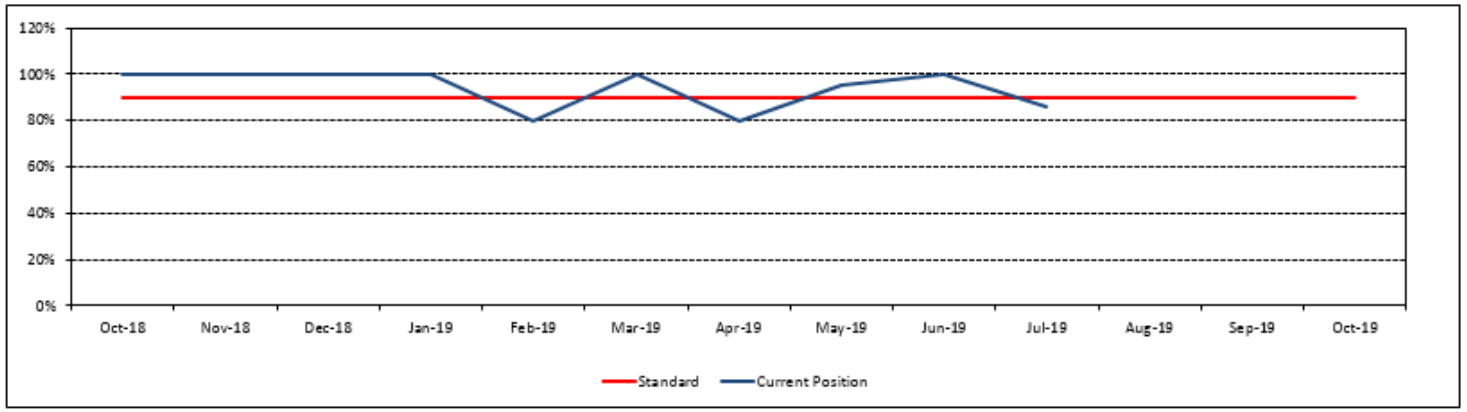
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Rosemary ward - extremely likely or likely to recommend (FFT)
Standard	90%
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Due to several amber indicators throughout the year the Head of Patient Experience will work with Rosemary Ward and the responsible managers to identify the issues with experience. A local survey will be undertaken.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	100%	100%	100%	100%	80.0%	100%	80.0%	95.0%	100%	86.0%	100%	100%	86.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

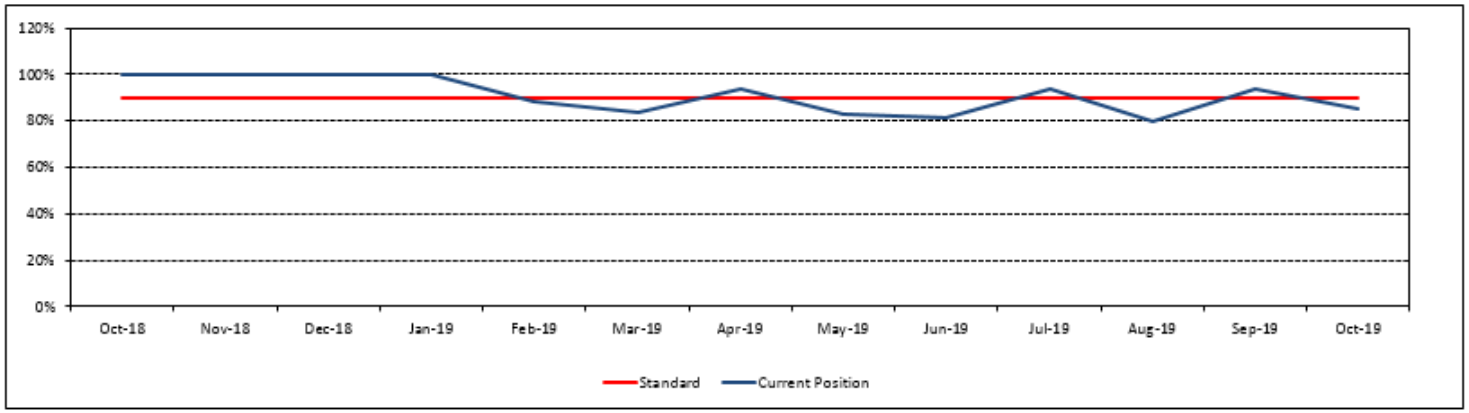
Indicator	Complaints acknowledged within 3 working days
Standard	90%
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Due to short staffing in the team since February this has impacted on performance. Increased resources have been agreed and are due to undergo vacancy approval and recruitment.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	100%	100%	100%	100%	88.0%	84.0%	94.0%	83.0%	81.0%	94.0%	80.0%	94.0%	85.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Recruit to vacancies within the team	CN	Oct-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

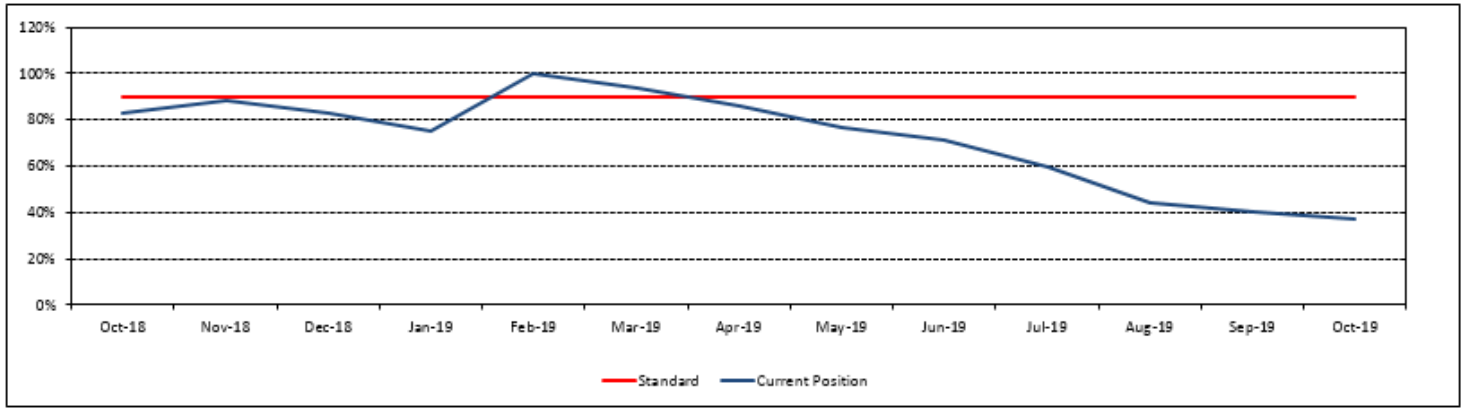
Indicator	Complaints responded to within agreed timeframe
Standard	90%
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Increased demand from previous months has continued to impact response timeframes. We are continuing to receive bank assistance to improve overall performance and increased resources have been approved by HR. Vacancy approval and recruitment are due to take place in the coming weeks.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	83.0%	88.0%	83.0%	75.0%	100%	94.0%	86.0%	77.0%	71.0%	60.0%	44.0%	40.0%	37.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Recruit to vacancies within the team	CN	Oct-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

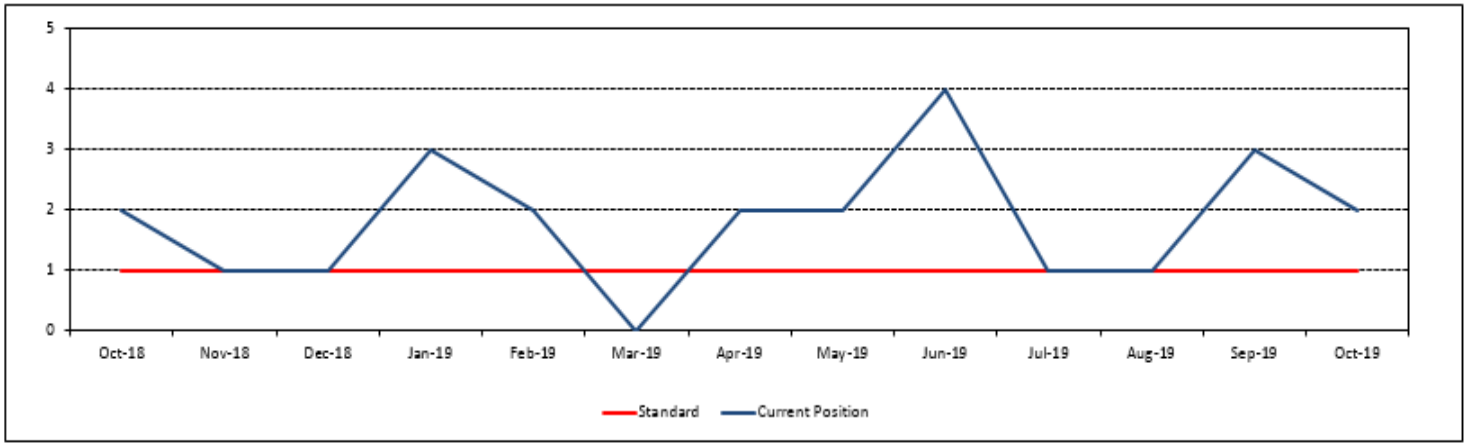
Indicator	Number of second letters received
Standard	1
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Two complainants were dissatisfied with the investigation response throughout October. Consideration should be given to increasing the benchmark for this indicator, in line with a higher mean total received complaints throughout the year.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	1	1	1	1	1	1	1	1	1	1	1	1	1
Current Position	2	1	1	3	2	0	2	2	4	1	1	3	2

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Reconsider the benchmark in line with increased complaints	CN	Oct-19	



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7. DETAILED REPORTS - RESPONSIVE

Are we safe? | Are we effective? | Are we caring? | **Are we responsive?** | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD(Apr19-Oct19)
4. Responsive	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	NT	270	268	320	287	389	460	447	404	425	432	406	488	295	414
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	120	46	45	46	47	43	43	46	46	43	55	33	26	25	39
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	16.17	13.05	15.35	20.32	14.35	13.55	14.35	13.23	20.01	17.18	20.35	11.48	14.30	15.84
		4.16	A&E -Waits over 12 hours from DTA to Admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		4.17	A&E - Admission waiting 4-12 hours from dec. to admit	4	31	24	54	125	113	65	155	105	119	133	33	80	63	688
		4.18	A&E - To inpatient Admission Ratio	32%	28.6%	30.3%	31.2%	31.3%	31.6%	29.7%	29.0%	28.8%	27.2%	25.5%	26.1%	27.1%	28.5%	27.4%
		4.19	A&E Service User Impact (re-attendance in 7 days <5% & time to treat)	1 met	1	1	1	1	1	1	1	1	1	1	1	1	1	1
		4.20	A&E/AMU - Amb. Submit button complete	80%	93.1%	94.7%	95.0%	94.9%	96.5%	95.4%	95.3%	95.6%	96.4%	94.7%	96.0%	95.8%	ND	95.6%
		4.21	A&E - Amb. Handover above 30m	0	21	15	40	61	33	41	46	41	41	129	31	57	ND	345
		4.22	A&E - Amb. Handover above 60m	0	30	8	14	59	10	15	13	36	28	74	3	18	ND	172
	RTT	4.25	RTT waiting List	18500	18071	17915	18426	19601	18341	19730	20427	21061	21253	20937	20942	20831	21073	20932
		4.26	RTT waiting list over 18 weeks	NT	1766	1855	2149	2999	3005	3006	3111	2985	3101	3270	3495	3746	3954	3380
		4.27	RTT 18 weeks Non-Consultant led services - Community	90%	99.0%	99.0%	100%	99.7%	99.6%	100%	99.0%	99.4%	94.0%	98.0%	94.4%	95.0%	96.7%	96.6%
		4.28	RTT 52 weeks Non-Consultant led services - Community	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Stroke	4.29	Stroke - % Patients scanned within 1 hr.	77%	64.0%	84.0%	80.0%	83.0%	75.5%	84.4%	75.8%	75.0%	80.0%	69.6%	70.6%	63.0%	72.5%	72.4%
		4.30	Stroke - % patients scanned within 12 hrs.	96%	100%	100%	97.5%	94.3%	98.1%	95.6%	97.0%	97.2%	95.0%	95.7%	94.1%	93.5%	96.1%	95.5%
		4.31	Stroke - % Patients admitted directly to stroke unit within 4h	75%	73.3%	83.7%	78.4%	78.4%	61.5%	78.6%	75.0%	71.4%	81.6%	77.5%	63.6%	74.4%	75.5%	74.1%
		4.32	Stroke - Greater than 80% of treatment on stroke unit	90%	88.9%	93.9%	91.9%	94.1%	84.3%	81.0%	96.9%	88.6%	86.8%	90.0%	97.0%	88.4%	91.8%	91.4%
		4.33	Stroke - % of patients treated by the SESDC	48%	52.4%	63.6%	48.0%	63.2%	49.1%	66.7%	54.2%	73.3%	55.0%	40.0%	71.4%	39.4%	40.0%	53.3%
		4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	94.0%	88.0%	90.0%	96.2%	86.8%	91.1%	90.6%	88.9%	90.0%	84.8%	85.3%	82.6%	92.2%	87.8%
		4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	73.5%	89.6%	78.4%	87.5%	89.6%	80.0%	76.2%	75.0%	77.1%	92.9%	80.0%	83.3%	77.5%	80.3%
		4.36	Stroke -% of eligible patients given thrombolysis	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		4.37	Stroke -% of stroke survivors who have 6mth f/up	50%	NA	NA	56.0%	NA	NA	57.0%	NA	NA	68.0%	NA	NA	ND	NA	68.0%
		4.38	Stroke -Provider rating to remain within A-C	C	NA	NA	C	NA	NA	C	NA	NA	C	NA	NA	ND	NA	C

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Are we..		Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD(Apr19-Oct19)
4. Responsive	Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	100%	100%	100%	ND	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	100%	100%	100%	96.6%	100%	100%	100%	100%	100%	93.8%	100%	97.1%	100%	98.7%
		4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.0%	99.9%	100%	99.0%	98.8%	99.3%	99.2%	99.5%	99.3%	98.8%	97.3%	99.9%	98.9%	99.0%
		4.42	Nursing & therapy Green referrals seen within 18 wks -Community	95%	99.7%	99.2%	98.0%	99.5%	99.5%	99.5%	99.4%	99.5%	100%	99.6%	99.5%	99.4%	99.6%	99.5%
		4.43	Wheelchair waiting times – Child (Community)	92%	100%	83.3%	83.3%	81.8%	94.1%	100%	100%	100%	100%	96.3%	100%	100%	93.2%	98.5%
		4.45	Sepsis - 1 hr neutropenic sepsis	100%	90.0%	75.0%	77.8%	81.0%	75.0%	87.5%	100%	91.7%	92.9%	87.5%	90.0%	87.5%	92.8%	91.8%
		4.48	% of initial health assessments completed within 15 working days of receiving all relevant paperwork.	95%	NA	NA	NA	NA	NA	NA	93.3%	40.0%	46.2%	50.0%	20.0%	21.1%	54.2%	46.4%
		4.46	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care	100%	33.3%	21.4%	15.4%	0.0%	20.0%	14.3%	33.3%	40.0%	38.5%	50.0%	20.0%	6.7%	45.8%	33.5%
		4.47	Percentage of Service Users (children) assessed to be eligible for NHS Continuing Healthcare whose review health assessment is completed annually	80%	86.2%	90.0%	97.0%	100%	100%	ND	99.0%	96.2%	100%	100%	100%	100%	96.0%	98.7%

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EXCEPTION REPORTS – RESPONSIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

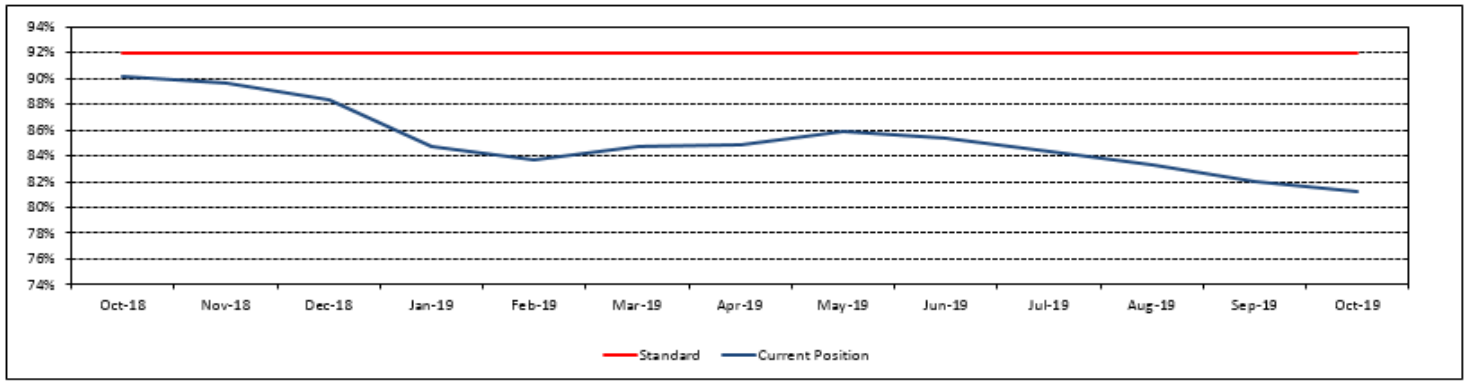
Indicator	RTT: % incomplete pathways within 18 weeks
Standard	92%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

The overall position is much the same from September to October in this standard. There is underachievement of the standard within General Surgery, Urology, Trauma and Orthopaedics, ENT, Ophthalmology, Plastics, Gastroenterology, Cardiology, Thoracic medicine and Gynaecology. Whilst some of these areas have shown minor improvement from September to October, Ophthalmology, ENT and Gastroenterology have seen a drop in performance. The possibility of any additional capacity is still being explored, which makes providing a recovery trajectory challenging.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Current Position	90.2%	89.7%	88.3%	84.7%	83.6%	84.8%	84.8%	85.8%	85.4%	84.4%	83.3%	82.0%	81.2%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Action plan for recovery in place for all specialities not meeting performance	HK	Dec-18	
Continue to monitor long waits at weekly access meeting	HK	Aug-18	
Validation of the PTL continues with internal and external validation teams and roll out of RTT training for staff	HK	Jun-19	
Options for additional activity and outsourcing still being explored	AB	Jun-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

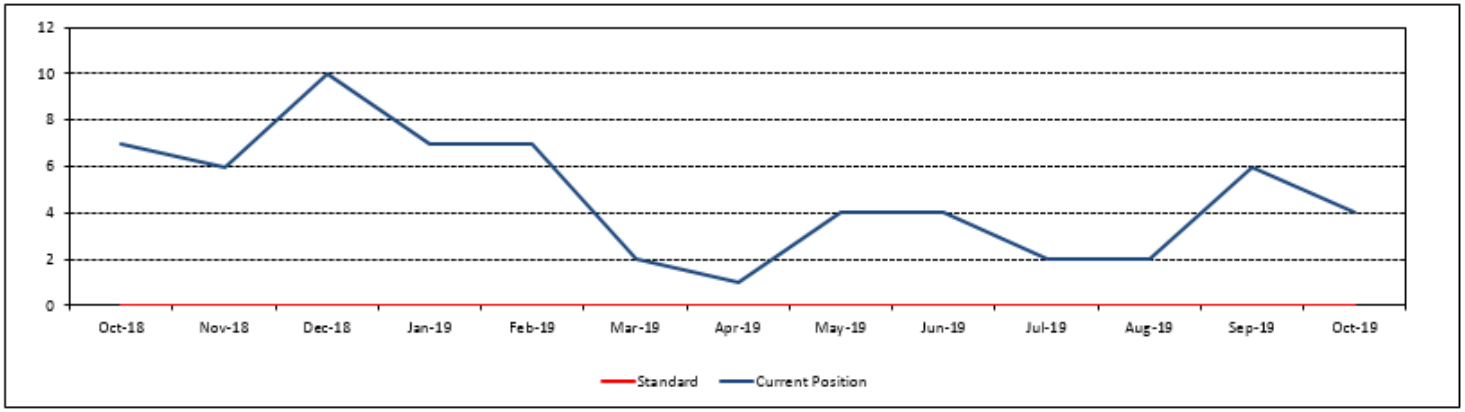
Indicator	52 week waiters
Standard	0
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

4 patients waiting over 52 weeks at the end of October. Breakdown of patients as follows; 1 x Cardiology patients - this patient has now been discharged. This was a new patient to the PTL following the e-Care reporting issues. 1 x Vascular patient - TCI date for the 18/11/19, original date for the 23/10/19 cancelled due to an issue in theatre after the patient had been anaesthetised. 1 x Orthopaedics patient, unfortunately this patient was re-validated as a 52 week breach on the 11/11/19 following an incorrect clock stop, a date is being arranged. 1 x Ophthalmology patient, unfortunately this patient was re-validated as a 52 week breach on the 11/11/19 following an incorrect RTT start date, patient was admitted and had the procedure on the 13/11/19.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	7	6	10	7	7	2	1	4	4	2	2	6	4

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Monitor of long waiting patients at weekly access meeting	HB		
RCA's completed for all patients who breach 52 weeks, with clinical harm review	HK	Jun-18	TBC



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

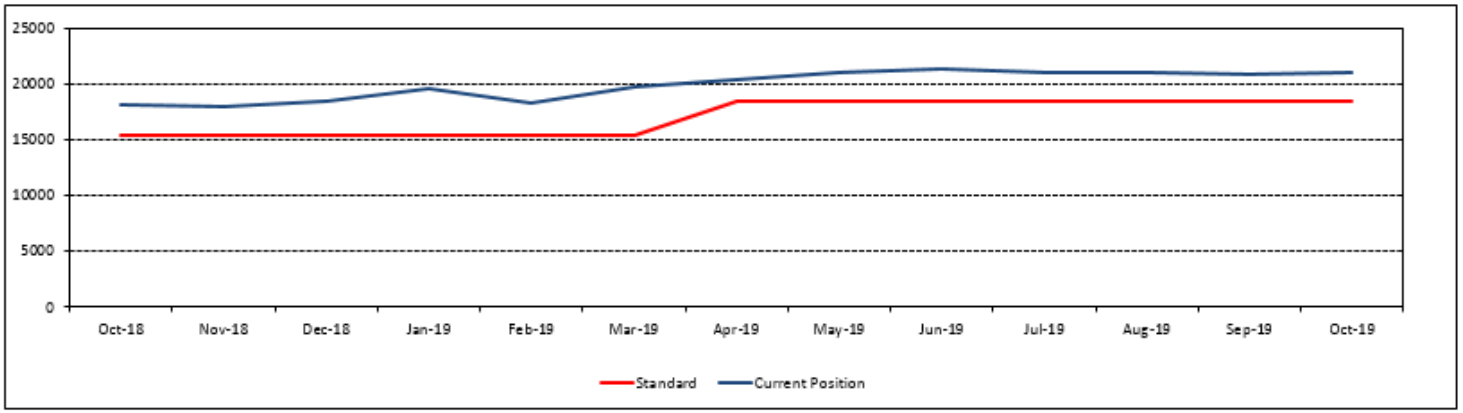
Indicator	RTT waiting List
Standard	18500
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Waiting list size much the same in October as September. Cardiology and General Surgery have seen a drop in their overall waiting list size, whilst Urology, Orthopaedics and Gynaecology remain about the same size, Ophthalmology and ENT have seen an increase in their overall waiting list size.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	15396	15396	15396	15396	15396	15396	18500	18500	18500	18500	18500	18500	18500
Current Position	18071	17915	18426	19601	18341	19730	20427	21061	21253	20937	20942	20831	21073

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Action plan for recovery in place for all specialities not meeting performance	HK	Dec-18	
Continue to monitor long waits at weekly access meeting	HK	Aug-18	
Options for in/out sourcing being explored using CCG funding - Ophthalmology has been out to interest for Cataracts, Locum consultants in place for Respiratory and Trauma and Orthopaedics, with options being explored in ENT and Gastro.	AB	Jul-19	Apr-20



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

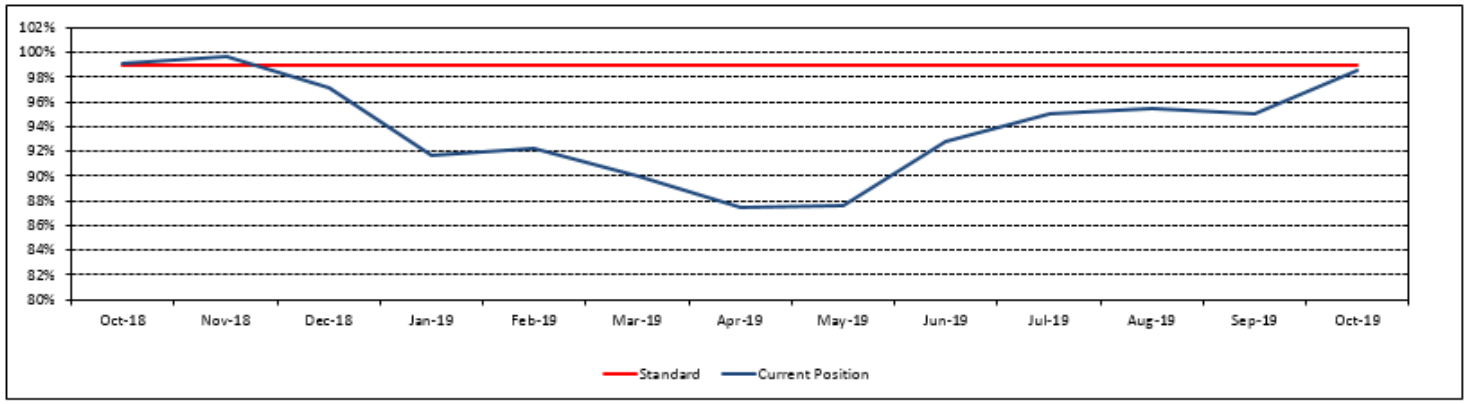
Indicator	Diagnostics within 6 weeks
Standard	99%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Diagnostic performance has improved significantly this month with improved performance across all diagnostic activities. Work continues on the colorectal and urology (cystoscopy & urodynamic) pathways in particular to provide long term sustainability.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Current Position	99.0%	99.6%	97.1%	91.7%	92.2%	90.0%	87.5%	87.6%	92.8%	95.0%	95.4%	95.1%	98.6%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Review of cystoscopy capacity and clinician timetables to establish sustainable cystoscopy capacity	S Taylor	Oct-19	Dec-19
Review of CNS Clinics to establish sustainable capacity for urodynamic's	S Taylor	Oct-19	Dec-19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

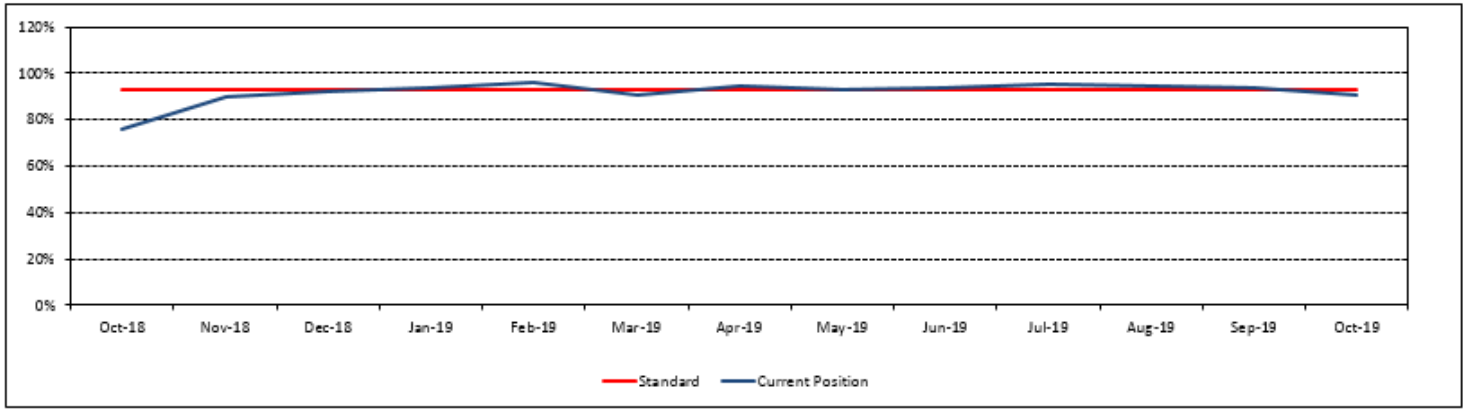
Indicator	Cancer: 2w wait for urgent GP Referrals
Standard	93%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Following sustained performance since April this year, the trust experienced a high surge of incoming referrals in October. The drop in performance is due to patient controlled factors across the specialities with only a very small number of breaches (5 out of 110) due to capacity issues.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	76.1%	89.8%	92.2%	93.4%	95.8%	90.5%	94.3%	93.1%	93.8%	95.3%	94.2%	93.5%	91.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
CCG recently carried out an audit on quality of the colorectal referral form and there is a plan to share the findings of this audit with appropriate communication going out to all referring GPs to help improve patient availability and the quality of all referral.	CCG	Oct'19	Dec '19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer 2w wait breast symptoms
Standard	93%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

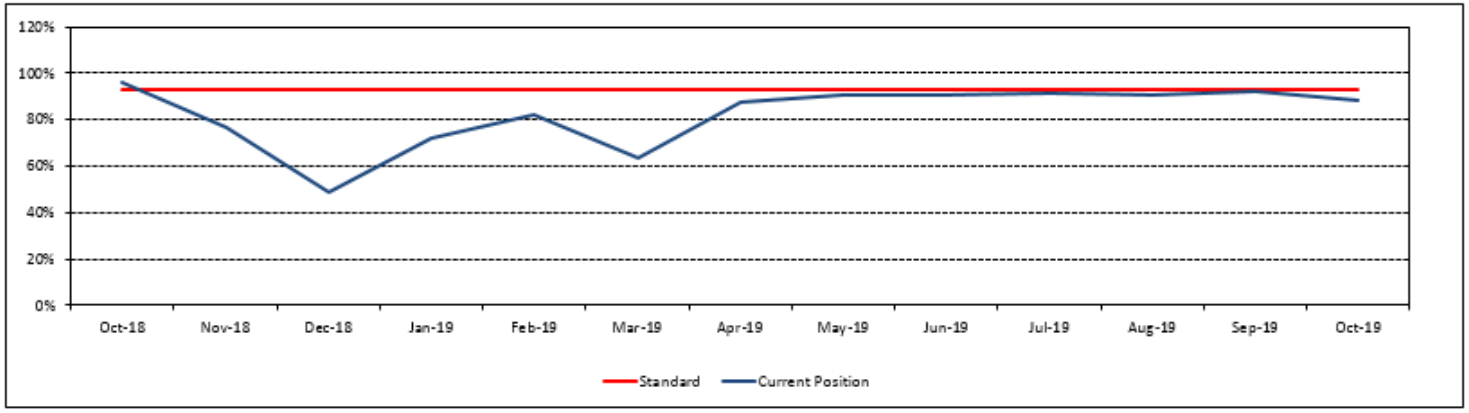
Summary of Current performance & Reasons for under performance

This is primarily due to patient controlled factors including 6 of the patients away on holidays in the 14 days window.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	96.4%	76.7%	48.8%	72.1%	82.0%	63.5%	87.8%	90.6%	90.8%	91.3%	90.3%	91.8%	88.7%

Actions in place to recover the performance — **Expected timeframes for improvements**

Description	Owner	Start	End
Capacity has been increased by an additional clinic on Friday PM for breast pain symptom patients. Patient if required further radiological investigation are booked in to the earliest available next slot week	AP	Jul-19	
New referral forms are with the CCG in the final stage of publication - these should separate the breast pain referrals, for which there is a dedicated clinic	CCG	Apr-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

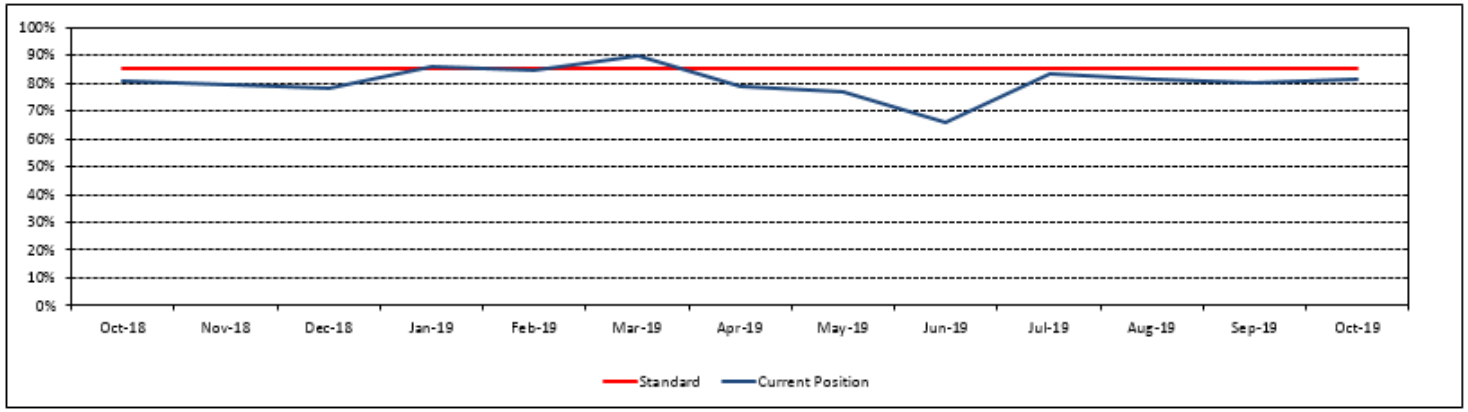
Indicator	Cancer 62 d GP referral
Standard	85%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

This is a provisional position and final performance is anticipated to be around 80%.
For October Trust breaches there were 3 Colorectal breaches and 1 breach in each of the following; Breast, Haem, Head and Neck, Lung, Skin, Upper GI and Urology.
For shared pathways there were 2 breaches in Urology and 1 each in Breast, Gynaecology, Haem, Head and Neck. Some involved cases of late referrals and once submitted by the treating hospital these will be fully reallocated back to the Trust. Once all breaches are re-allocated we expect the final performance to drop from the current 81.5% to around 80%.
Several work streams are currently in progress to tie in with the recovery action plan in place with service leads for specific pathways, regular meetings are held to ensure this is on track.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Current Position	80.6%	79.5%	78.3%	85.5%	84.8%	90.0%	78.4%	76.9%	65.9%	83.0%	81.1%	79.9%	81.6%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
All patients over 62 days are discussed in detail at the weekly Cancer PTL Meeting.	HK	Dec-18	
Colorectal, Prostate and Lung teams are currently involved in implementation of the best practice pathways with a view to improve on early diagnostics and timely treatment	HK	Jan-19	Mar-20



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

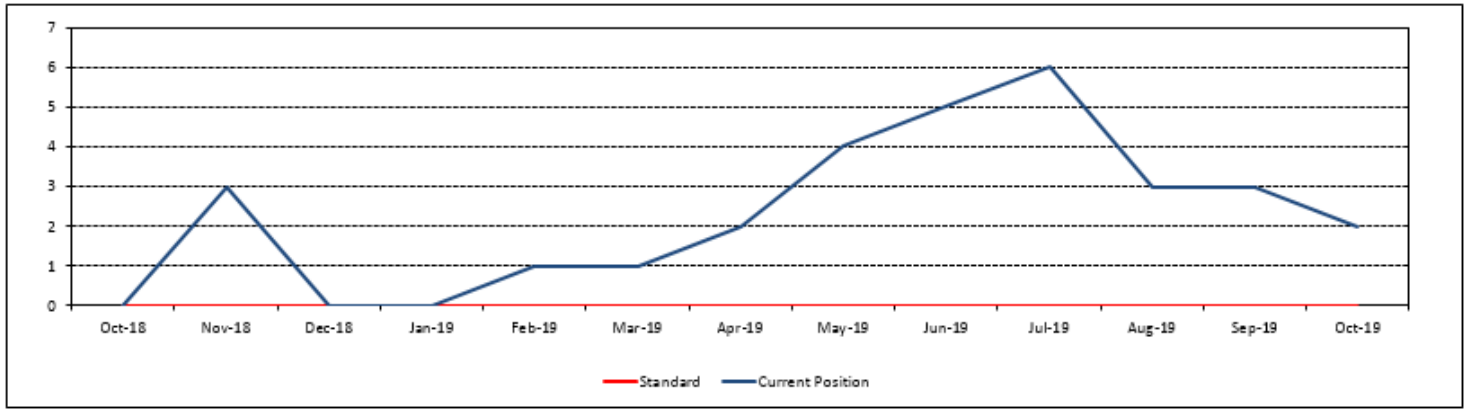
Indicator	Incomplete 104 day waits
Standard	0
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

1 Breast pathway breach owing to complex diagnostic pathway, as per patient wishes treatment plan changed requiring further invasive tests before surgery.
1 Haematology pathway breach due to an incidental finding; an initial referral to different speciality and a cross referral specialist multidisciplinary team review. This patient is suitable for Wait and Watch.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	0	3.0	0	0	1.0	1.0	2.0	4.0	5.0	6.0	3.0	3.0	2.0

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
All patients over 62 days discussed in detail at weekly cancer PTL meeting for escalation	HK	Mar-19	
104 day breaches to be submitted via DATIX and full investigation to be carried out with clinical engagement and opportunities for learning	SD	Dec-18	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

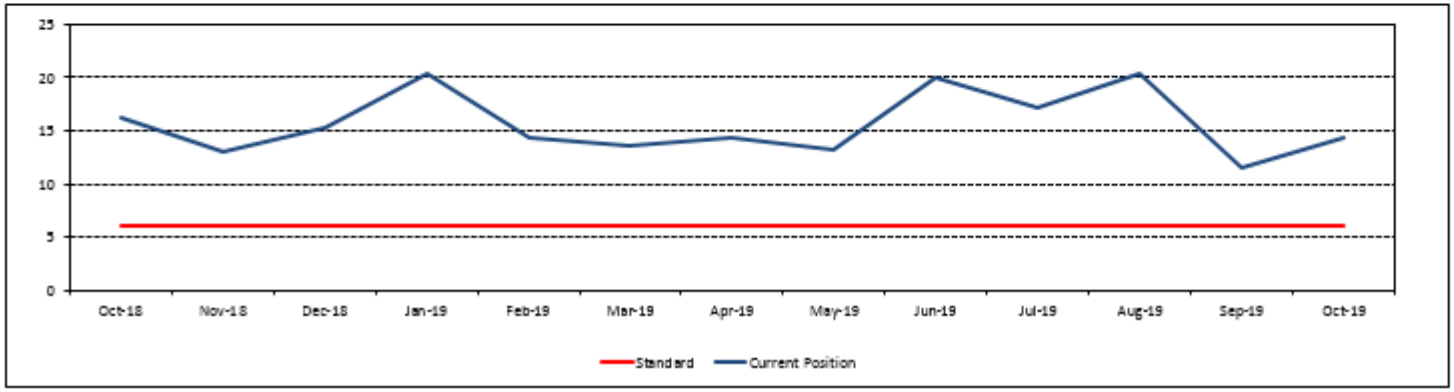
Indicator	A&E - Single longest Wait (Admitted & Non-Admitted)
Standard	6
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

The single longest waiter in October was a complex mental health patient. Once assessed by the Crisis Team, a plan was put in place for assessment under the Mental Health Act following which the decision was made for psychiatric admission. There was a delay to transfer due to bed pressures in mental health.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	6	6	6	6	6	6	6	6	6	6	6	6	6
Current Position	16.17	13.05	15.35	20.32	14.35	13.55	14.35	13.23	20.01	17.18	20.35	11.48	14.30

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Implementation of escalation process for long stay to avoid 12 Length of Stay Breaches - ensure patients are escalated to ED Management team and Site Management at 8 hours to ensure a clear plan is in place to transfer or discharge patient, eradicating 12 hour length of stays. Significant reduction in number of 12 hour length of stays (4 in October)	Ian Pridding	Jul-19	Ongoing
Focused work on Mental Health Pathways - improved working with mental health colleagues to ensure appropriate escalations of mental health patients with long stays in the department.	Ian Pridding	Oct-19	Jan-20



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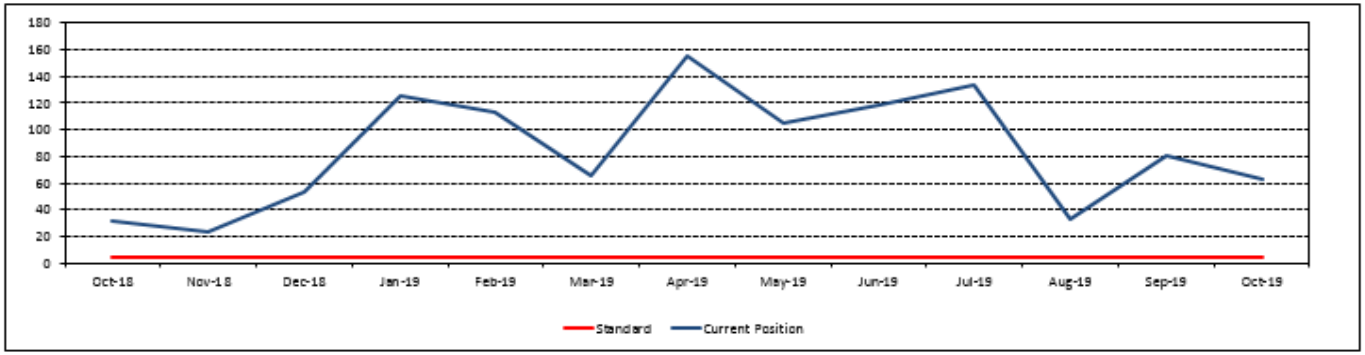
Indicator	A&E - Admission waiting 4-12 hours from dec. to admit
Standard	4
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

63 patients waited between 4-12 for a bed following a decision to admit in October. This has decreased since September.
There is a comprehensive improvement plan of ED, hospital and system wide actions to address the delays in getting patients to the appropriate ward once the decision to admit has been made.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	4	4	4	4	4	4	4	4	4	4	4	4	4
Current Position	31	24	54	125	113	65	155	105	119	133	33	80	63

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
ED Senior Ops Manager to take on managerial responsibility of Acute Assessment Unit, Ambulatory Emergency Care, F7 (Short Stay Emergency) and G3 to support more joint up working between emergency village (including establishment of Surgical Ambulatory Care Unit.) Aim to improve utilisation of UEC to improve Same Day Emergency Care metrics and avoid admissions.	Ian Pridding	Oct-19	Ongoing
Increased focus on Getting it Right First Time metrics in support of the next phase urgent care standards trial to focus on improvements to flow to department and reduction of exit block. Dedicated support funded by NHS England to drive improvements	Nicola Cottington/ Ian Pridding	Dec-19	Ongoing
Introduction of new areas within patient journey to improve patient flow: - Frailty Assessment Unit - November 2019 - Rapid Assessment and Treatment Area - December 2019 - Surgical Ambulatory Care area - December 2019	Ian Pridding	Oct-19	Jan-20
Implementation of escalation process for long stay to avoid 12 Length of Stay Breaches - ensure patients are escalated to ED Management team and Site Management at 8 hours to ensure a clear plan is in place to transfer or discharge patient, eradicating 12 hour length of stays. Successful in September (0 12 hour waits in month) Focused work on Mental Health Pathways.	Ian Pridding	Oct-19	Jan-20



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E - Ambulance Handovers
Standard	0
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

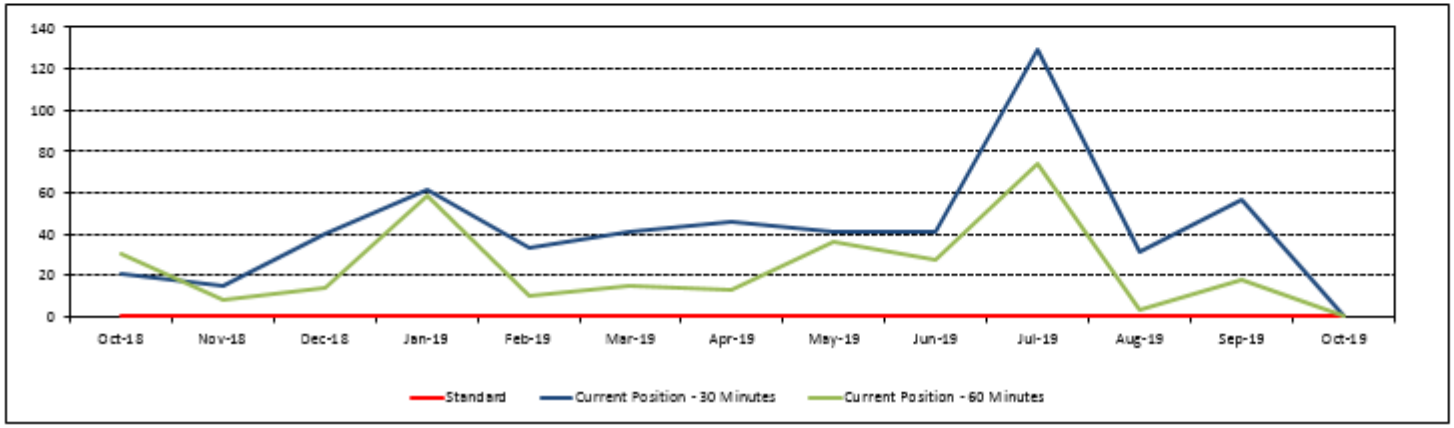
Summary of Current performance & Reasons for under performance

There is no data yet available for ambulance handover for October.
September saw an increase in patients waiting for over an hour on ambulance from 3 in August to 18 in September. There was also an increase in the number of patients waiting over 30 minutes from 31 in August to 57 in September.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position - 30 Minutes	21	15	40	61	33	41	46	41	41	129	31	57	ND
Current Position - 60 Minutes	30	8	14	59	10	15	13	36	28	74	3	18	ND

Actions in place to recover the performance — **Expected timeframes for improvements**

Description	Owner	Start	End
Establishment of a dedicated Rapid Assessment and Treatment area to facilitate time ambulance hand over, rapid review and decision making and allow space for escalation of ambulance	ED Team	Oct-19	Dec-19
Development of escalation action cards for HALO, ED Floor Coordinator and Bed and Site teams for required actions at 15 minutes, 30 minutes and 45 minutes offload delays to ensure consistent cross hospital focus and improved understanding of required action to offload ambulances.	Ian Pridding	Oct-19	Nov-19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

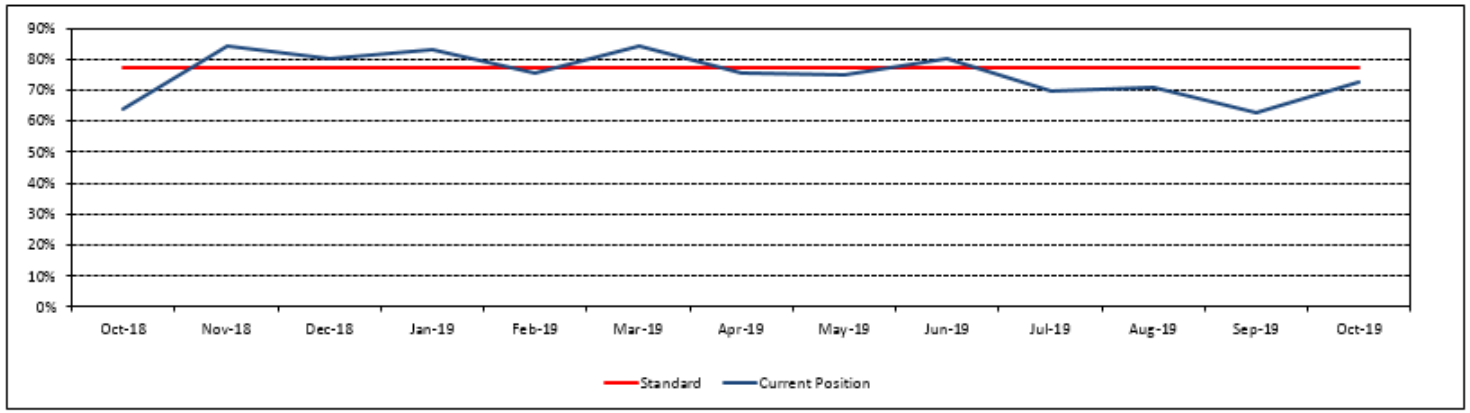
Indicator	Stroke - % Patients scanned within 1 hr.
Standard	77%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Unfortunately again this month we had a high number of atypical strokes, initially thought to be something other than stroke. Having reviewed these cases it is felt by the stroke team that as these were not typical stroke presentations, it would have been difficult for them to have been recognised as strokes. Issues persist in ED triage and delays in Med registrar seeing the patients.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%
Current Position	64.0%	84.0%	80.0%	83.0%	75.5%	84.4%	75.8%	75.0%	80.0%	69.6%	70.6%	63.0%	72.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Work is underway to produce a tick sheet for the triage nurse which will enable a CT scan to be ordered by any doctor in ED and not just be reliant on the med reg. New posters have been designed for triage rooms in ED on stroke recognition.	JA	Nov-19	Nov-19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

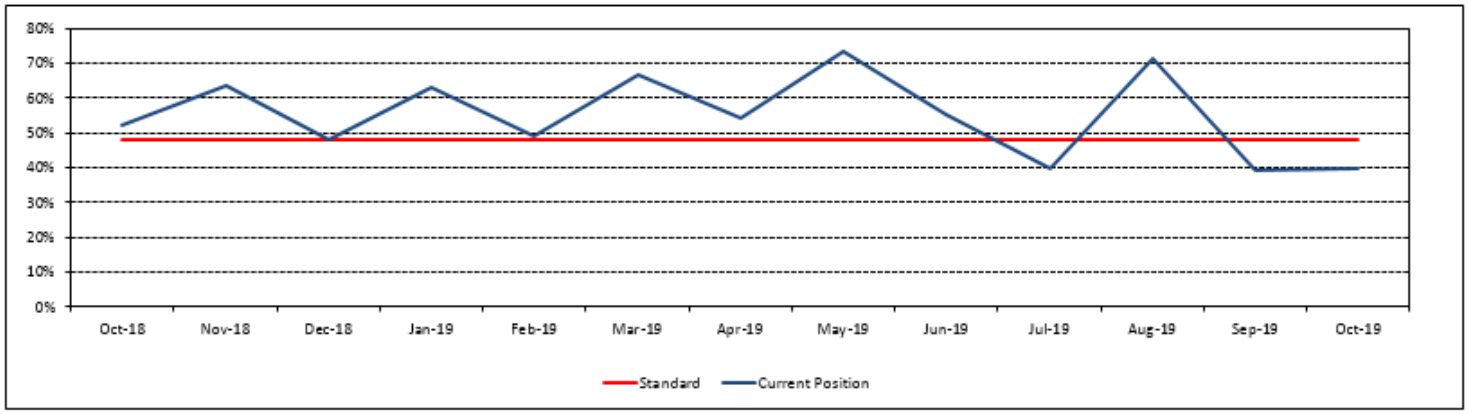
Indicator	Stroke - % of patients treated by the SESDC
Standard	48%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

All patients requiring Early Stroke Discharge team were referred to the service. This month there were higher numbers of patients not meeting the referral criteria.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%
Current Position	52.4%	63.6%	48.0%	63.2%	49.1%	66.7%	54.2%	73.3%	55.0%	40.0%	71.4%	39.4%	40.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
None as no issues identified			



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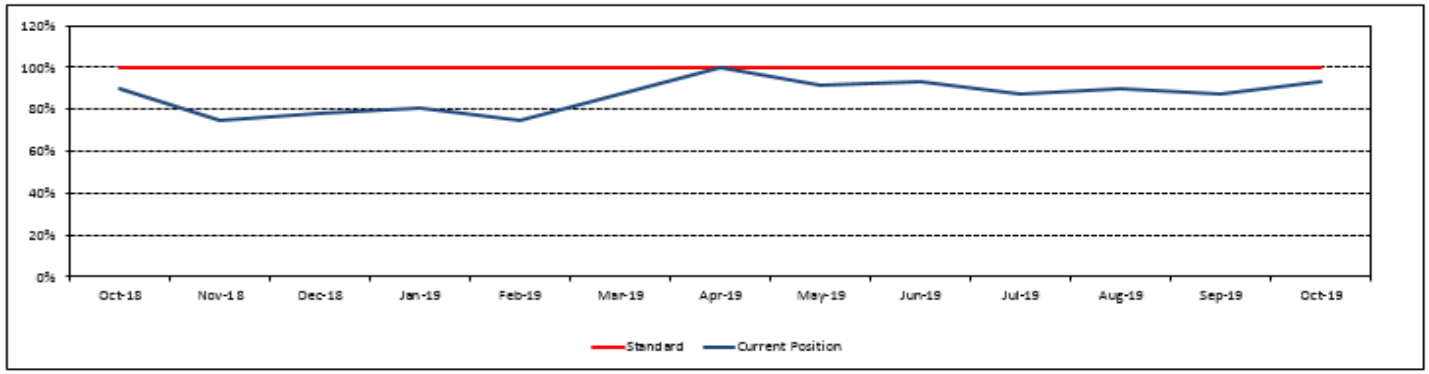
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Sepsis - 1 hr neutropenic sepsis
Standard	100%
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Performance against national standards for Door to Needle time for Neutropenic was 92.8% for the month of October. Of the 4 patient's who were admitted to G1, all 4 patient's received the required treatment within the 1 hour time scale. Of the 10 patients who were admitted through ED, 9 patient's were treated within the hour and 1 patient breached the national standard. Please see below action plan to address the issues and improve performance against this standard.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	90.0%	75.0%	77.8%	81.0%	75.0%	87.5%	100%	91.7%	92.9%	87.5%	90.0%	87.5%	92.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Introduction of the Emergency Department Neutropenic Sepsis FastTrack Pathway NSFP (Red Folder) copy displayed on info board in ED staff room	DB/AO	Dec-18	Ongoing
Separate teaching and sign-off for neutropenic sepsis anti-biotic PGD by ED PDN	GB	Dec-18	Ongoing
High level of new starters in ED, ED PDN currently working through teaching and sign-off	GB	Dec-18	Ongoing
Detailed learning and sign-off within the newly introduced Emergency Department Adult and Paediatric Competency Workbooks.	DB/AO	Dec-18	Ongoing
NSFP communicated to the ED Team through 'hot topics' at the start of the shift	IP/DB	Dec-18	Ongoing
Monthly Neutropenic Sepsis Targets to be displayed on info board in ED staff room for continued shared learning	AO/IP	Dec-18	Ongoing
Electronic register of neutropenic sepsis anti-biotic PGD sign-off (will be within the new ED training database which is currently being developed)	AO/IP	Dec-18	Ongoing
Addition to the Band 7 Floor Coordinator individual competencies, responsible for allocating the NSFP to a ED Nurse(with anti-biotic PGD sign-off) within 15 minutes of registration	IP/DB	Dec-18	Ongoing
Neutropenic Sepsis Criteria (used in RCA template) now added to NSFP (red folder) checklist, for clearer guidance	AO	Dec-18	Ongoing
To involve Floor Coordinator with answering neutropenic RCA document around explanation for individual shifts	AO	Dec-18	Ongoing
Regular ED agency nurses to complete competencies and PGD's for neutropenic sepsis antibiotics	GB	Jan-19	Ongoing
ED Administration staff to print Oncology triage from evolve at point of registration and to be included within the NSFP folder	DR/AO	Jan-19	Ongoing
Intense focus on Neutropenic Sepsis/Sepsis by Sepsis Nurse teaching sessions and utilising the ED 'topic of the week' board to share learning	BF/AO	May-19	Ongoing



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

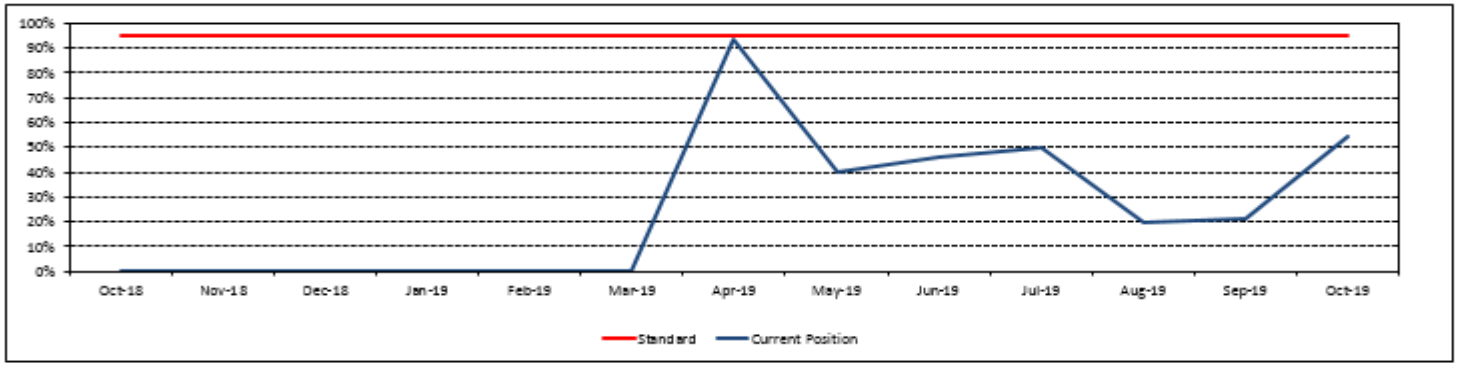
Indicator	% of initial health assessments completed within 15 working days of receiving all relevant
Standard	95%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

There were 24 Initial Health Assessments in October, 13 of which were completed within 15 working days of the service being made aware and receiving all the relevant paperwork.
Of the 11 initial health assessments that breached the 15 working days target:
9 of the 1st offered initial health appointments were outside the 15 working days

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	NA	NA	NA	NA	NA	NA	93.3%	40.0%	46.2%	50.0%	20.0%	21.1%	54.2%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Capacity challenges: • 1 Consultant Paediatrician on Sick leave post surgery • 1 Consultant Paediatrician on compassionate leave, family crisis – cancellation of some booked appointments. The above impacted on the east locality – unable to replace capacity from within team as needing to cover general paediatric clinical activity and maintain adoption activity in the absence of the Adoption Medical Advisor, above. One of the General Practitioner with Special Interest's in the west offering additional appointment slots with the view to catch up capacity lost due to holidays in August Plan for improving capacity moving forward: • Paediatricians reviewing job plan/clinic schedules to make appointments available each week (within current allocated IHA slots) rather than spread unevenly in the month • An outline business case, which is to increase a General Practitioner with Special Interest capacity, has been shared with the CCG and is being discussed • Notice given by one General Practitioner with Special Interest in the west that Initial Health Assessment work will end with effect from October. Contact to be made with another GP who has expressed an interest in this work (also mitigate by proposal above).			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care
Standard	100%
Executive Lead	Helen Beck
Month	Oct-19
Data Frequency	Monthly
CQC Area	Responsive

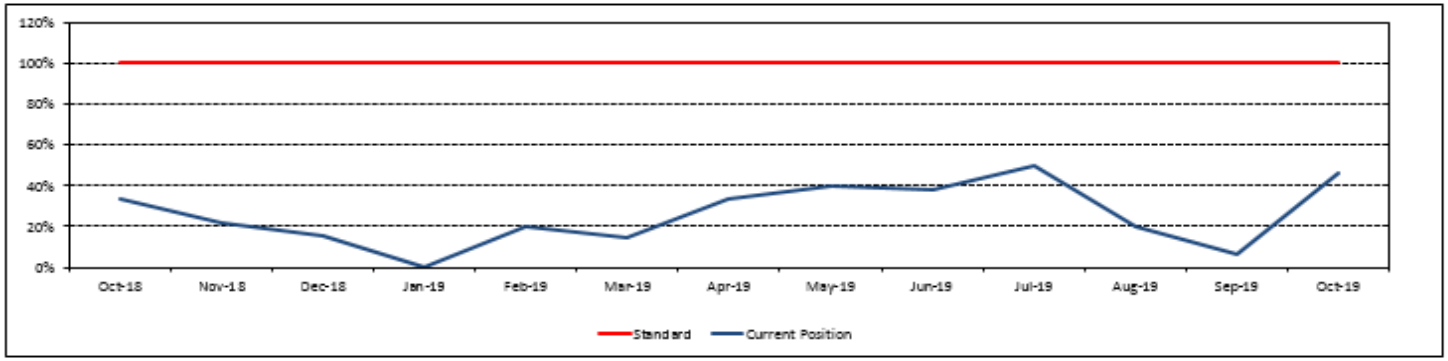
Summary of Current performance & Reasons for under performance

11 out of 24 Initial Health Assessments in September were completed within 28 days of the child being placed in care.

Of the remaining 13 Initial Health Assessments, 3 had a delay of over a week and 7 had a delay between 1-7 days from the child being placed in care and the service receiving all the relevant information.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	33.3%	21.4%	15.4%	0.0%	20.0%	14.3%	33.3%	40.0%	38.5%	50.0%	20.0%	6.7%	45.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Capacity challenges: • 1 Consultant Paediatrician on Sick leave post surgery • 1 Consultant Paediatrician on compassionate leave, family crisis – cancellation of some booked appointments. The above impacted on the east locality – unable to replace capacity from within team as needing to cover general paediatric clinical activity and maintain adoption activity in the absence of the Adoption Medical Advisor, above. One of the General Practitioner with Special Interest's in the west offering additional appointment slots with the view to catch up capacity lost due to holidays in August Plan for improving capacity moving forward: • Paediatricians reviewing job plan/clinic schedules to make appointments available each week (within current allocated IHA slots) rather than spread unevenly in the month • An outline business case, which is to increase a General Practitioner with Special Interest capacity, has been shared with the CCG and is being discussed • Notice given by one General Practitioner with Special Interest in the west that Initial Health Assessment work will end with effect from October. Contact to be made with another GP who has expressed an interest in this work (also mitigate by proposal above).			



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8. DETAILED REPORTS – WELL-LED

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we.		Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD(Apr19 Oct19)
5. Well Led	Agency, WTE & vacancies	5.09	Agency Spend Cap	486	381	620	500	486	486	486	461	461	461	461	461	461	511	468
		5.10	Bank Spend		1222	1140	1167	1114	971	1277	992	777	1000	868	1222	1031	ND	982
		5.12	Proportion of Temporary Staff	12%	11.8%	12.8%	12.1%	12.7%	9.4%	13.1%	12.3%	12.3%	12.2%	11.7%	9.3%	10.9%	10.2%	11.3%
		5.13	Locum and Medical agency spend	NT	524	570	555	522	389	448	487	238	408	389	615	487	468	442
		5.57	Additional sessions	NT	338	288	266	216	274	283	272	272	273	221	286	175	279	254
		5.16	% Staff on Maternity/Paternity Leave	NT	2.65%	2.73%	2.83%	2.80%	2.64%	2.58%	2.82%	2.67%	2.49%	2.40%	2.23%	2.01%	1.96%	2.37%
	Other	5.58	New grievance or employment tribunals in the month	NT	1	4	0	2	0	1	1	0	0	1	0	0	3	5
		5.18	Recruitment Timescales - Av no. of weeks to recruit	7	6.4	6.4	6.4	5.3	4.8	5.2	6.0	6.1	5.0	8.0	5.4	5.4	5.4	5.9
		5.19	DBS checks	95%	98.5%	97.5%	97.5%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	97.0%	97.9%
		5.20	Staff appraisal Rates	90%	76.0%	79.0%	76.4%	77.0%	76.0%	79.0%	77.0%	80.0%	81.0%	81.0%	81.0%	82.3%	83.0%	80.8%

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Are we.		Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD(Apr19 Oct19)
5. Well Led	Training	5.22	Infection Control Training (classroom)	90%	94.0%	95.0%	94.0%	96.0%	96.0%	93.0%	94.0%	95.0%	95.0%	95.0%	96.0%	96.0%	96.0%	95.3%
		5.23	Infection Control Training (eLearning)	90%	89.0%	90.0%	91.0%	91.0%	91.0%	81.0%	82.0%	82.0%	89.0%	90.0%	91.0%	91.0%	90.0%	87.9%
		5.24	Manual Handling Training (Patient)	90%	77.0%	76.0%	76.0%	80.0%	77.0%	78.0%	69.0%	80.0%	78.0%	80.0%	81.0%	83.0%	84.0%	79.3%
		5.25	Manual Handling Training (Non Patient)	90%	82.0%	86.0%	84.0%	87.0%	88.0%	67.0%	56.0%	76.0%	62.0%	67.0%	70.0%	73.0%	91.0%	70.7%
		5.26	Staff Adult Safeguarding Training	90%	91.0%	90.0%	90.0%	91.0%	91.0%	85.0%	85.0%	87.0%	89.0%	88.0%	89.0%	90.0%	89.0%	88.1%
		5.27	Safeguarding Children Level 1	90%	89.0%	90.0%	91.0%	91.0%	90.0%	91.0%	91.0%	92.0%	92.0%	92.0%	93.0%	93.0%	93.0%	92.3%
		5.28	Safeguarding Children Level 2	90%	90.0%	90.0%	91.0%	91.0%	91.0%	86.0%	86.0%	90.0%	90.0%	89.0%	92.0%	92.0%	92.0%	90.1%
		5.29	Safeguarding Children Level 3	90%	91.0%	90.0%	90.0%	91.0%	91.0%	57.0%	51.0%	71.0%	61.0%	58.0%	84.0%	83.0%	84.0%	70.3%
		5.30	Health & Safety Training	90%	89.0%	89.0%	90.0%	89.0%	89.0%	87.0%	87.0%	88.0%	90.0%	90.0%	92.0%	91.0%	91.0%	89.9%
		5.31	Security Awareness Training	90%	88.0%	89.0%	89.0%	89.0%	88.0%	81.0%	83.0%	87.0%	88.0%	88.0%	91.0%	92.0%	96.0%	89.3%
		5.32	Conflict Resolution Training (eLearning)	90%	83.0%	85.0%	86.0%	86.0%	86.0%	68.0%	70.0%	74.0%	81.0%	82.0%	85.0%	88.0%	88.0%	81.1%
		5.33	Conflict Resolution Training	90%	69.0%	74.0%	75.0%	72.0%	72.0%	77.0%	74.0%	78.0%	76.0%	76.0%	75.0%	76.0%	78.0%	76.1%
		5.34	Fire Training (eLearning)	90%	83.0%	85.0%	88.0%	85.0%	83.0%	83.0%	78.0%	83.0%	83.0%	83.0%	87.0%	87.0%	87.0%	84.0%
		5.35	Fire Training (classroom)	90%	89.0%	88.0%	86.0%	89.0%	87.0%	89.0%	88.0%	89.0%	89.0%	89.0%	91.0%	90.0%	89.0%	89.3%
		5.36	IG Training	95%	80.0%	83.0%	82.0%	81.0%	83.0%	78.0%	79.0%	81.0%	94.0%	86.0%	91.0%	90.0%	91.0%	87.4%
		5.37	Equality and Diversity	90%	81.0%	82.0%	84.0%	85.0%	85.0%	87.0%	86.0%	88.0%	90.0%	90.0%	93.0%	92.0%	93.0%	90.3%
		5.38	Majax Training	90%	89.0%	89.0%	90.0%	90.0%	89.0%	78.0%	80.0%	82.0%	84.0%	84.0%	88.0%	87.0%	92.0%	85.3%
		5.39	Medicines Management Training	90%	87.0%	87.0%	87.0%	87.0%	86.0%	80.0%	81.0%	83.0%	86.0%	86.0%	86.0%	86.0%	87.0%	85.0%
		5.40	Slips, trips and falls Training	90%	86.0%	85.0%	87.0%	86.0%	86.0%	74.0%	76.0%	79.0%	82.0%	81.0%	85.0%	86.0%	86.0%	82.1%
		5.41	Blood-borne Viruses/Inoculation Incidents	90%	87.0%	88.0%	89.0%	89.0%	87.0%	78.0%	80.0%	83.0%	85.0%	85.0%	89.0%	88.0%	89.0%	85.6%
		5.42	Basic life support training (adult)	90%	79.0%	80.0%	80.0%	81.0%	80.0%	79.0%	73.0%	81.0%	81.0%	81.0%	81.0%	82.0%	83.0%	80.3%
		5.43	Blood Products & Transfusion Processes (Refresher)	90%	74.0%	75.0%	76.0%	77.0%	76.0%	65.0%	62.0%	68.0%	77.0%	75.0%	77.0%	75.0%	78.0%	73.1%
		5.44	Mandatory Training Compliance	90%	85.0%	86.0%	86.0%	85.0%	86.0%	82.0%	82.0%	85.0%	86.0%	86.0%	87.0%	88.0%	88.0%	86.0%

EXCEPTION REPORTS – WELL LED

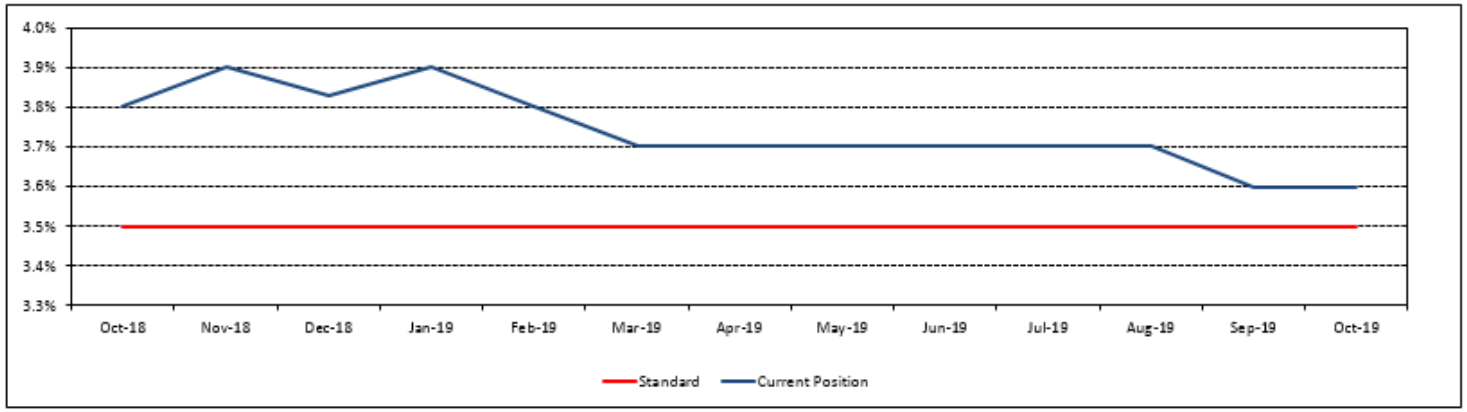
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Sickness Absence
Standard	3.5%
Executive Lead	Jeremy Over
Month	Oct-19
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Sickness absence remains at 3.6%, which is below the NHS average. Workforce teams continue to work closely with managers to support sickness absence management and to support staff to return to work.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
Current Position	3.8%	3.9%	3.8%	3.9%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.6%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
HR continue to support managers to manage both short term and long term absences			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

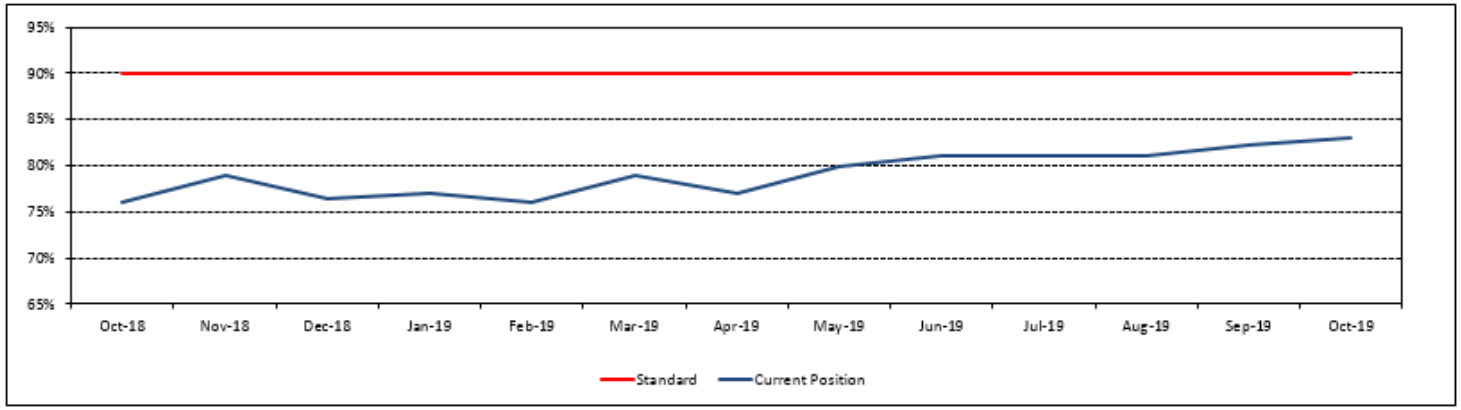
Indicator	Staff appraisal Rates
Standard	90%
Executive Lead	Jeremy Over
Month	Oct-19
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Focussed work is underway with each Division to improve appraisal compliance. As a result of this targeted activity, appraisal compliance has risen to 83%. Work continues in order to achieve 90% compliance.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	76.0%	79.0%	76.4%	77.0%	76.0%	79.0%	77.0%	80.0%	81.0%	81.0%	81.0%	82.3%	83.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The following actions have been put in place to improve compliance: 1:1 meetings with line managers to support them to undertake appraisals; targeted work to review data and update records where necessary, improvements to data sharing so that managers are able to easily identify those who require an appraisal imminently. Longer term, agenda for change pay progression policy will require all staff to have an annual appraisal recorded, the Trust is introducing ESR Self Service in order to faciliate this.	DN	Nov-19	Apr-20



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Mandatory Training Compliance
Standard	90%
Executive Lead	Jeremy Over
Month	Oct-19
Data Frequency	Monthly
CQC Area	Well Led

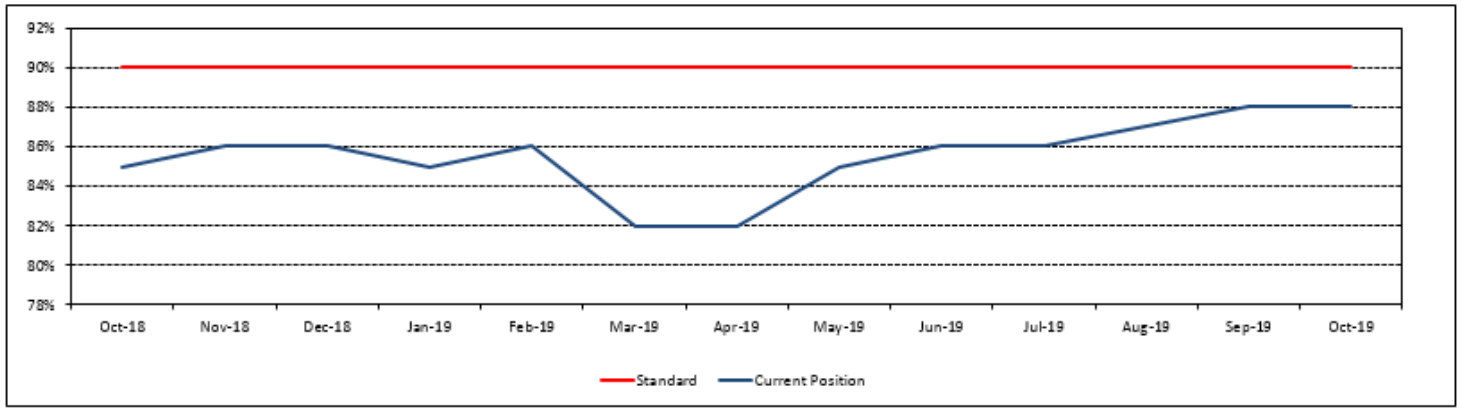
Summary of Current performance & Reasons for under performance

Following a series of focussed interventions in mandatory training, an improvement of 4% compliance has been achieved since June 2019. The Trust has been able to maintain overall compliance at 88%, 2% away from its target of 90%.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	85.0%	86.0%	86.0%	85.0%	86.0%	82.0%	82.0%	85.0%	86.0%	86.0%	87.0%	88.0%	88.0%

Actions in place to recover the performance — **Expected timeframes for improvements**

Description	Owner	Start	End
Following a review of all mandatory training at the end of September 2019, we are hopeful that an increase in compliance will take place, if all mandatory training can continue to be undertaken over the winter period. Work is continuing to be undertaken to further improve compliance, including the roll out of the applicant portal (new staff members can complete e-learning modules prior to commencing in post, therefore increasing safety and making best use of induction sessions to focus on practical face to face training. The appointment of an in-house conflict resolution trainer in the new year will increase the availability of courses. A new induction programme will be delivered from January for community teams. ESR Self Service will enable managers and staff to quickly and accurately identify if any mandatory training becomes out of date through a series of personal notifications and alerts.	DN	Nov-19	Mar-20



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9. DETAILED REPORTS – PRODUCTIVE

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD(Apr19-Oct19)
6. Productive	Activity	6.07	A&E Activity	NT	6256	6114	6155	6371	5741	6695	6729	6946	6692	7300	6661	6829	6841	47998
		6.08	NEL Activity	NT	2638	2770	2520	2750	2467	2604	2464	2695	2379	2496	2465	3476	2626	18601
		6.09	OP - New Appointments	NT	7381	7255	5995	7059	6419	7086	8369	8947	8536	9365	7660	9115	9635	61627
		6.10	OP- Follow-Up Appointments	NT	12773	12289	9834	12610	11107	11536	22314	19866	19733	21458	19079	19960	21665	144075
		6.11	Electives (Incl Daycase)	NT	3033	3047	2519	3202	2957	2971	2806	2974	2755	3095	2892	3037	3257	20816
	Finance	6.12	Financial Position (YTD)	Var	-7122	-7494	-6534	-8691	-7955	-287	529	-481	-1681	-2106	-4239	-5712	-7282	-20972
		6.13	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	21
		6.14	Cash Position (YTD £000s)	Var	1338	5162	3518	4924	6870	3600	11140	5825	1467	2119	1787	2061	1498	25897
	Ratios	6.15	% Consultant to Consultant Referrals	NT	14.0%	15.0%	17.0%	16.0%	17.0%	15.0%	17.0%	16.0%	16.0%	16.0%	15.0%	15.0%	16.0%	15.9%
		6.16	New to FU Ratios	NT	2.27	2.16	2.16	2.31	2.37	2.20	2.66	2.22	2.31	2.29	2.48	2.18	2.25	2.34

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EXCEPTION REPORTS – PRODUCTIVE

The finance report contains full details.

10. DETAILED REPORTS- MATERNITY

Are we..		Ref.	KPI	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD(Apr19-Oct19)
7.Maternity	Safe	7.09	Elective Caesarean Sections	12%	8.6%	10.4%	9.1%	6.7%	9.3%	11.2%	9.3%	11.3%	7.8%	9.5%	9.8%	10.0%	13.0%	10.1%
		7.10	Emergency Caesarean Sections	14%	14.1%	15.4%	16.3%	16.2%	11.0%	15.6%	11.5%	11.8%	18.0%	10.9%	11.2%	19.4%	12.4%	13.6%
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	40.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	71.0%	57.0%	79.0%	76.1%	92.3%	87.0%	100%	85.0%	81.0%	82.0%	64.0%	82.0%	91.0%	83.6%
		7.13	Homebirths	2%	1.8%	2.0%	1.0%	2.2%	2.9%	2.8%	3.8%	3.1%	1.5%	2.4%	2.3%	3.0%	4.1%	2.9%
		7.14	Midwifery led birthing unit (MLBU) births	20%	14.4%	NA	NA	NA	NA	NA	24.0%	14.4%	16.1%	19.4%	12.9%	14.4%	18.9%	17.2%
		7.15	Labour Suite births	77.5%	82.7%	82.6%	83.0%	78.8%	77.9%	82.1%	71.0%	82.1%	82.0%	77.3%	85.1%	82.1%	76.9%	79.5%
		7.16	Induction of Labour	29.3%	35.5%	38.3%	42.1%	40.8%	39.0%	42.2%	35.0%	39.5%	39.0%	38.9%	35.8%	38.8%	34.3%	37.3%
		7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	>14%	11.8%	13.9%	8.1%	8.9%	12.2%	11.7%	8.2%	8.2%	12.2%	8.5%	10.7%	11.5%	9.5%	9.8%
		7.18	Critical Care Obstetric Admissions	0	0	0	3	1	0	0	0	0	0	0	0	0	0	0
		7.19	Eclampsia	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
	Effective	7.20	Shoulder Dystocia	2	9	4	4	6	4	4	9	2	7	5	0	3	3	29
		7.21	Post-partum Hysterectomies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.22	Women requiring a blood transfusion of 4 units or more	0	1	0	1	1	0	1	1	0	0	0	0	0	0	1
		7.23	3rd and 4th degree tears (all deliveries)	12	3	8	2	6	2	0	7	2	4	6	4	3	4	30
	Caring	7.24	Maternal death	0	1	0	0	0	0	0	0	1	0	0	0	0	0	1
		7.25	Stillbirths	NT	0	0	0	0	0	0	1	1	2	0	0	0	1	5
		7.26	Complaints	NT	1	1	0	3	3	1	0	3	0	0	0	0	3	6
		7.27	No. of babies admitted to Neonatal Unit (>36+6)	NT	9	10	15	7	7	9	8	8	16	4	12	12	3	63
	Responsive	7.28	No. of babies transferred for therapeutic cooling	0	0	0	0	0	1	0	0	0	0	0	0	1	0	1
		7.29	One to one care in established labour	100%	100%	100%	99.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.30	Reported Clinical Incidents	50	34	42	38	50	40	59	56	47	43	61	78	44	42	371
		7.31	Hours of dedicated consultant cover per week	60	87	99	93	105	87	98	96	105	90	102	90	96	86	665
		7.32	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	70
		7.34	No. of women identified as smoking at booking	NT	22	20	34	20	18	28	23	25	22	23	27	22	30	172
		7.35	No. of women identified as smoking at delivery	NT	22	18	31	18	16	27	20	20	21	22	28	19	26	156
		7.36	UNICEF Baby friendly audits	10	NA	NA	NA	NA	NA	NA	NA	24	NA	NA	NA	NA	NA	24
		7.37	Proportion of parents receiving Safer Sleeping Suffolk advice	80%	97.0%	95.0%	97.5%	96.1%	97.0%	94.5%	95.0%	85.6%	80.0%	93.0%	81.0%	89.0%	97.0%	88.7%
	Other	7.38	No. of bookings (First visit)	NT	234	222	206	278	226	242	231	251	241	257	232	230	235	1677
		7.39	Women booked before 12+6 weeks	95%	92.0%	98.0%	95.1%	96.0%	96.4%	92.0%	95.0%	95.0%	94.0%	98.0%	97.0%	93.0%	97.0%	95.6%
		7.40	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – MATERNITY

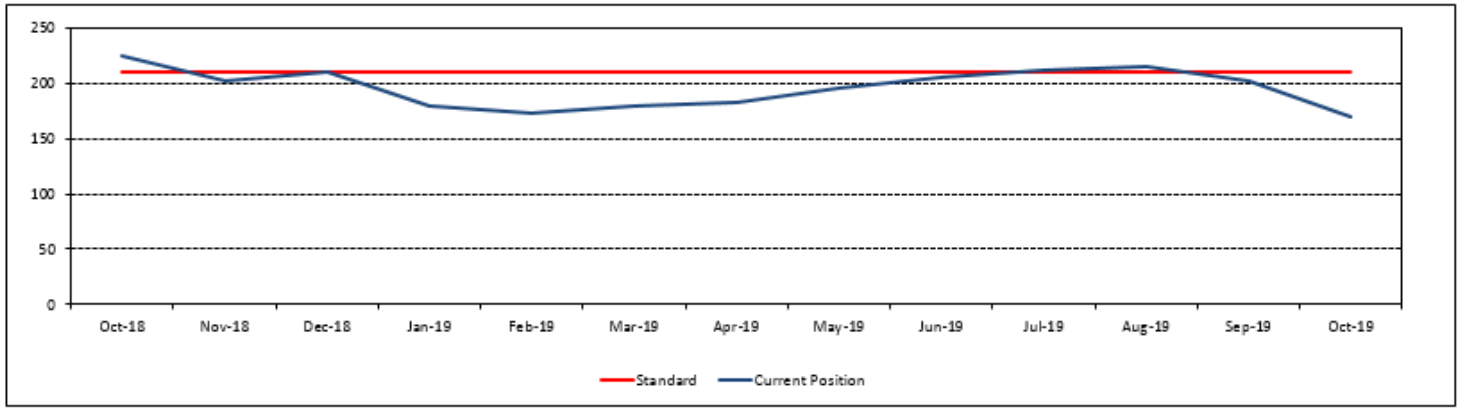
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Total number of deliveries (births)
Standard	210
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Since the Labour Suite refurbishment there appeared to be a steady rise in the numbers of births, however this month has seen a reduction. Work is ongoing to promote the West Suffolk maternity service particular on the geographical borders. When we have a formal promotion of the new labour Suite, it is hoped that we will see an increase in births.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	210	210	210	210	210	210	210	210	210	210	210	210	210
Current Position	224	202	209	179	172	179	183	195	205	211	215	201	169

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Formal opening of the Labour Suite.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Elective Caesarean Sections
Standard	12%
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Maternity

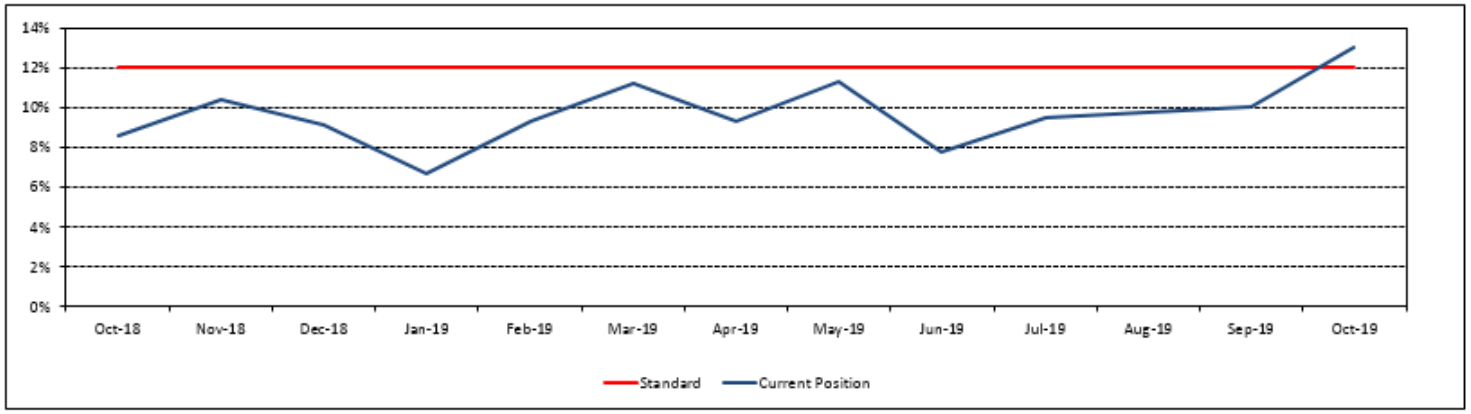
Summary of Current performance & Reasons for under performance

This month the rate of Elective caesarean sections increased to 13%. There appears to be no obvious reason for this. Further data over the next few months will establish if this is a trend. Continue to monitor. For discussion at next months Women's Health Governance.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%
Current Position	8.6%	10.4%	9.1%	6.7%	9.3%	11.2%	9.3%	11.3%	7.8%	9.5%	9.8%	10.0%	13.0%

Actions in place to recover the performance — **Expected timeframes for improvements**

Description	Owner	Start	End
To be discussed at the Women's Health Governance meeting and agree any actions if necessary.	JL	Nov-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

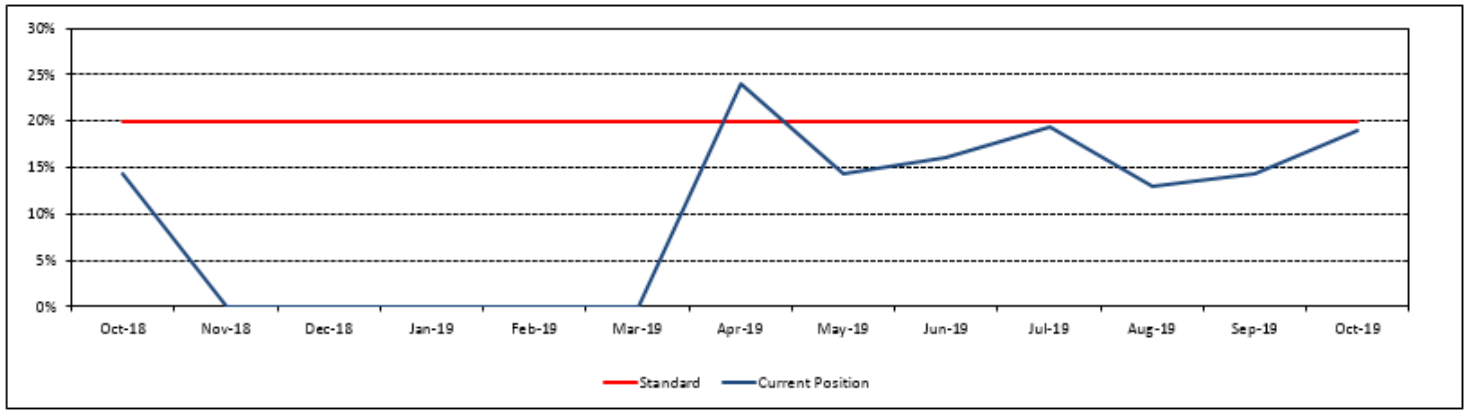
Indicator	Midwifery led birthing unit (MLBU) births
Standard	20%
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Although the rate of Midwifery led birthing unit birth is still below our standard of 20% it appears to be rising steadily. The 2019 National maternity and perinatal audit puts birth in an along side Midwifery unit at 10.1%. Our aim is to achieve a much higher rate. We continue to encourage low risk women to give birth in the Midwifery led birthing unit.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Current Position	14.4%	NA	NA	NA	NA	NA	24.0%	14.4%	16.1%	19.4%	12.9%	14.4%	18.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To be discussed at the Women's Health Governance meeting and agree any actions if necessary.	JL	Nov-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

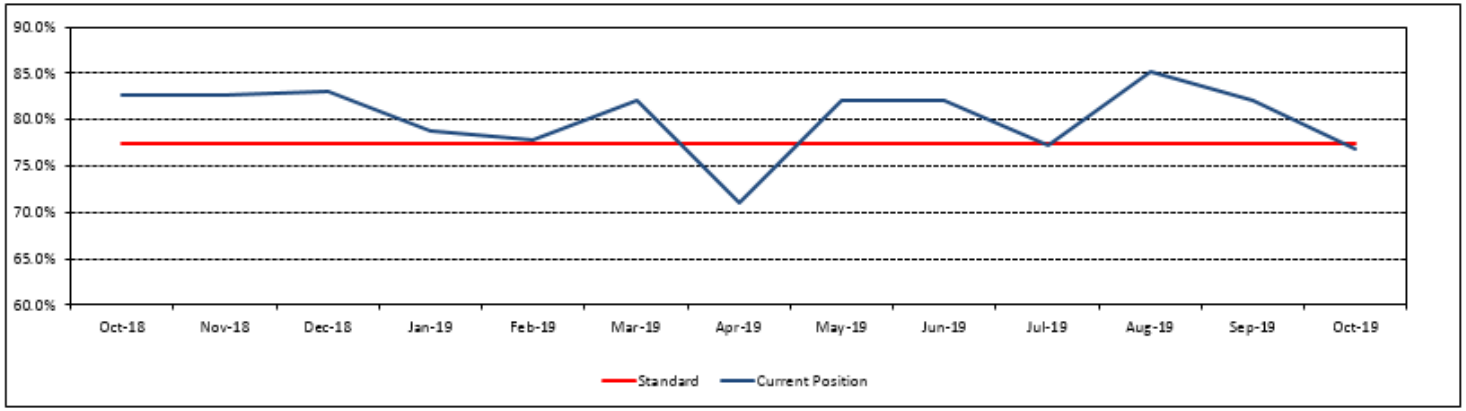
Indicator	Labour Suite births
Standard	77.5%
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There was a slight decrease in the number of births on the Labour Suite. This was mainly due to a low number of births overall and an increase in births on the Birthing unit and at home. We continue to encourage both home and Midwifery led birthing unit births for low risk women.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%
Current Position	82.7%	82.6%	83.0%	78.8%	77.9%	82.1%	71.0%	82.1%	82.0%	77.3%	85.1%	82.1%	76.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To be discussed at the Women's Health Governance meeting and agree any actions if necessary.	JL	Nov-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

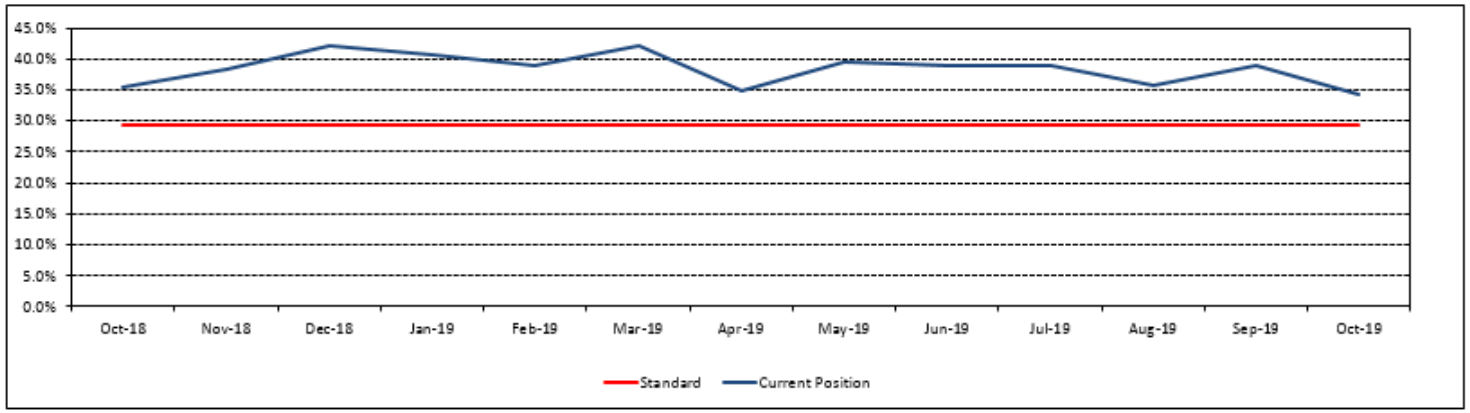
Indicator	Induction of Labour
Standard	29.3%
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There has been a slight fall in the Induction of Labour rate this month to 34.3%. However the rate remains higher than current national data National Maternity and Perinatal Audit 2019 which is 29.2%. However it is recognised in this report that this figure relates to data collected in 2017-18 and that the implementation of Savings Babies lives in particular elements relating to 'fetal movement and identification of fetal growth restriction' has seen an increase in the percentage nationally .

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%
Current Position	35.5%	38.3%	42.1%	40.8%	39.0%	42.2%	35.0%	39.5%	39.0%	38.9%	35.8%	38.8%	34.3%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To be discussed at the Women's Health Governance meeting and agree any actions if necessary.	JL	Nov-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

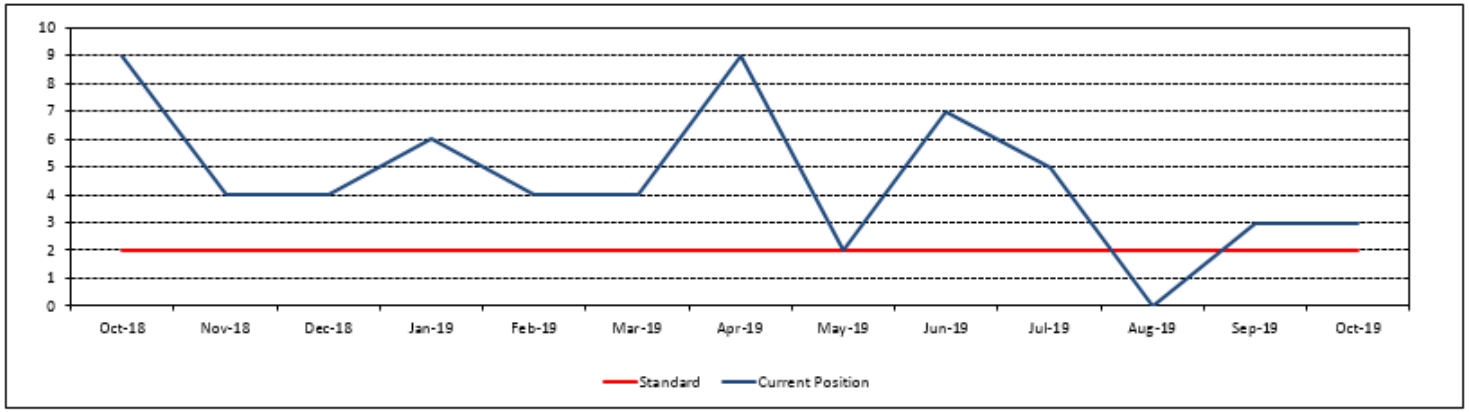
Indicator	Shoulder Dystocia
Standard	2
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Overall it appears that reporting of shoulder dystocia is decreasing. This is possibly due to the work which has been done on PROMPT training around recognition of true shoulder dytocia. Shoulder dystocia is usually an unpredicatable emergency and staff are trained regularly for the management of Shoulder dystocia. Of the Shoulder dystocia's reported this month there have been no reports of injury to either mother or baby. Audit due for presentation at clinical governance in January 2020.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	2	2	2	2	2	2	2	2	2	2	2	2	2
Current Position	9	4	4	6	4	4	9	2	7	5	0	3	3

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To be discussed at the Women's Health Governance meeting and agree any actions if necessary.	JL	Nov-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

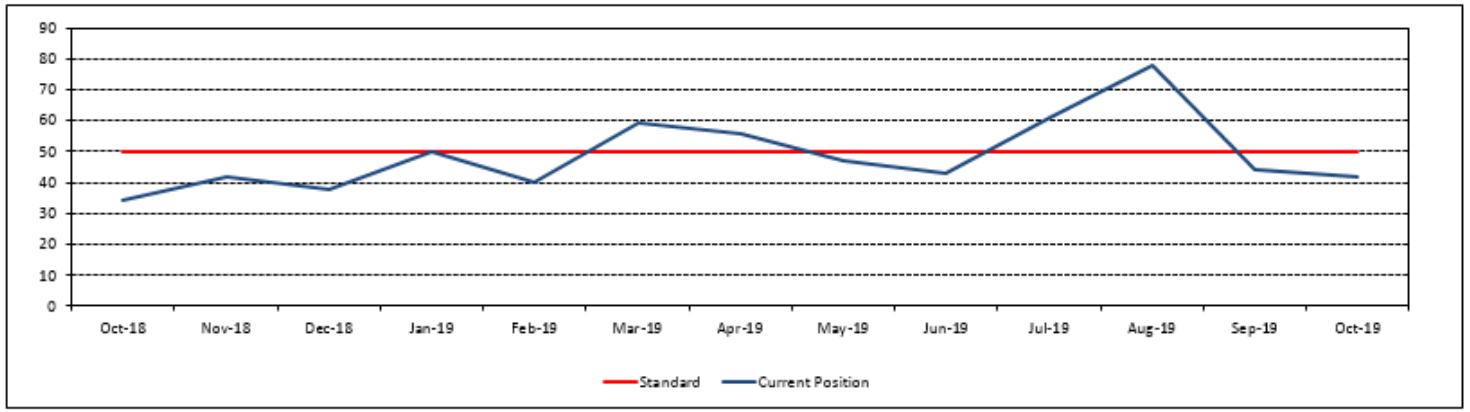
Indicator	Reported Clinical Incidents
Standard	50
Executive Lead	Rowan Procter
Month	Oct-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There has been a lower number of Datix reported this month. Although there has been a reduced number of births it is apparent staff are not always following the trigger list for reporting. This is highlighted on Risky Business monthly. Further awareness of the Trigger list and expectation of Datix completion to be included on Take 5.

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Standard	50	50	50	50	50	50	50	50	50	50	50	50	50
Current Position	34	42	38	50	40	59	56	47	43	61	78	44	42

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Highlight on Take 5	JL	Nov-19	



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Trust Board – 29 November 2019

Agenda item:	8			
Presented by:	Craig Black			
Prepared by:	Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	22nd November 2019			
Subject:	SPC Integrated Quality & Performance Report			
Purpose:	x	For information		For approval
Executive summary:	The attached report contains a new style of performance reporting using statistical process control charts.			

Trust priorities	Deliver for today			Invest in quality, staff and clinical leadership		Build a joined-up future	
	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					
Previously considered by:	Monthly at Trust Board						
Risk and assurance:	To provide oversight and assurance to the Board of the Trusts performance.						
Legislation, regulatory, equality, diversity and dignity implications:	Performance against national standards is reported.						
Recommendation: That the report is noted.							

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Understanding how performance data are presented in our Board papers

The charts in our Board report can tell you a lot about how our Trust is performing over time, but if you're not used to seeing data in this way it can take a little time to get used to. This short guide will help you to understand the charts and interpret the data we're showing you.

What is it?

The main type of chart is known as a statistical process control (SPC) chart. This plots data like a run chart, and allows you to see:

- if something is improving, deteriorating or staying the same over time
- if changes are expected, or very unusual
- whether it's likely the Trust will be able to meet the standard that's been set.

The SPC chart is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation; this then guides us on what the most statistically significant changes are, and therefore what we need to focus our attention on. It's widely used across the NHS and is considered best practice for presenting data.

What will it show me?

The beauty of SPC charts is that they allow you to identify the most significant performance changes. That means each month you might see a slightly different suite of indicators shown in this report - depending on which have flagged as having seen significant changes or trends that need discussion by the Board.

That can look like there are more negative than positive trends, but rest assured that doesn't mean everything is bad! If indicators are ticking along or doing well they may not be presented in the report every month, as the Board needs to focus on those areas where we can do better. This helps to make sure we're focusing on, and fixing, the most important things first.

What does it look like?

When we use SPC charts, we largely use the same terminology and colours as the rest of the NHS.

Generally speaking:

- Things written in grey show no significant change or trend
- Things written in blue show a positive change or trend
- Things written in orange show a negative change or trend

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You might see these terms and colours used, particularly in the summary table that gives an overview of what indicators are included in that month's report.

Assurance (how we're doing)

No target:

This means that for this particular indicator, there's no national or local standard/target to benchmark ourselves against. It's usually written in grey.

Hit and miss against target:

This means that the standard likely won't be either achieved or missed consistently – that it will vary, but not significantly so. It's usually written in grey.

Consistently below target:

This means that we're not meeting the standard, and are unlikely to under the current conditions. It's usually written in orange.

Consistently above target:

This means that we're meeting the standard, and are likely to continue doing so under the current conditions. It's usually written in blue.

Variations (the trends)

Common cause variation:

Common cause variation means there has been no statistically significant change to the trend. It's usually written in grey.

Special cause variation (blue or orange):

This will either be written in blue, to show a statistically significant positive change or trend, or in orange to show a statistically significant negative change or trend. It usually happens because we've started to do something differently.

These are points to look out for, because if there's special cause variation it means something has changed over a period of time (six data points). It's useful because it makes sure we don't react to 'one-off' changes or blips, but focus on trends that show a long term, consistent shift (either positively or negatively).

We might already know what caused the change, but if we don't it allows us to investigate and find out. Eventually if the change is sustained (positive or negative), it will become common cause variation as it'll be classed as our new norm.

Charts

For each of the indicators we show in the report, you'll be able to find a corresponding statistical process control (SPC) chart.

The chart is a graph used to study how something changes over time, and data is plotted in time order.

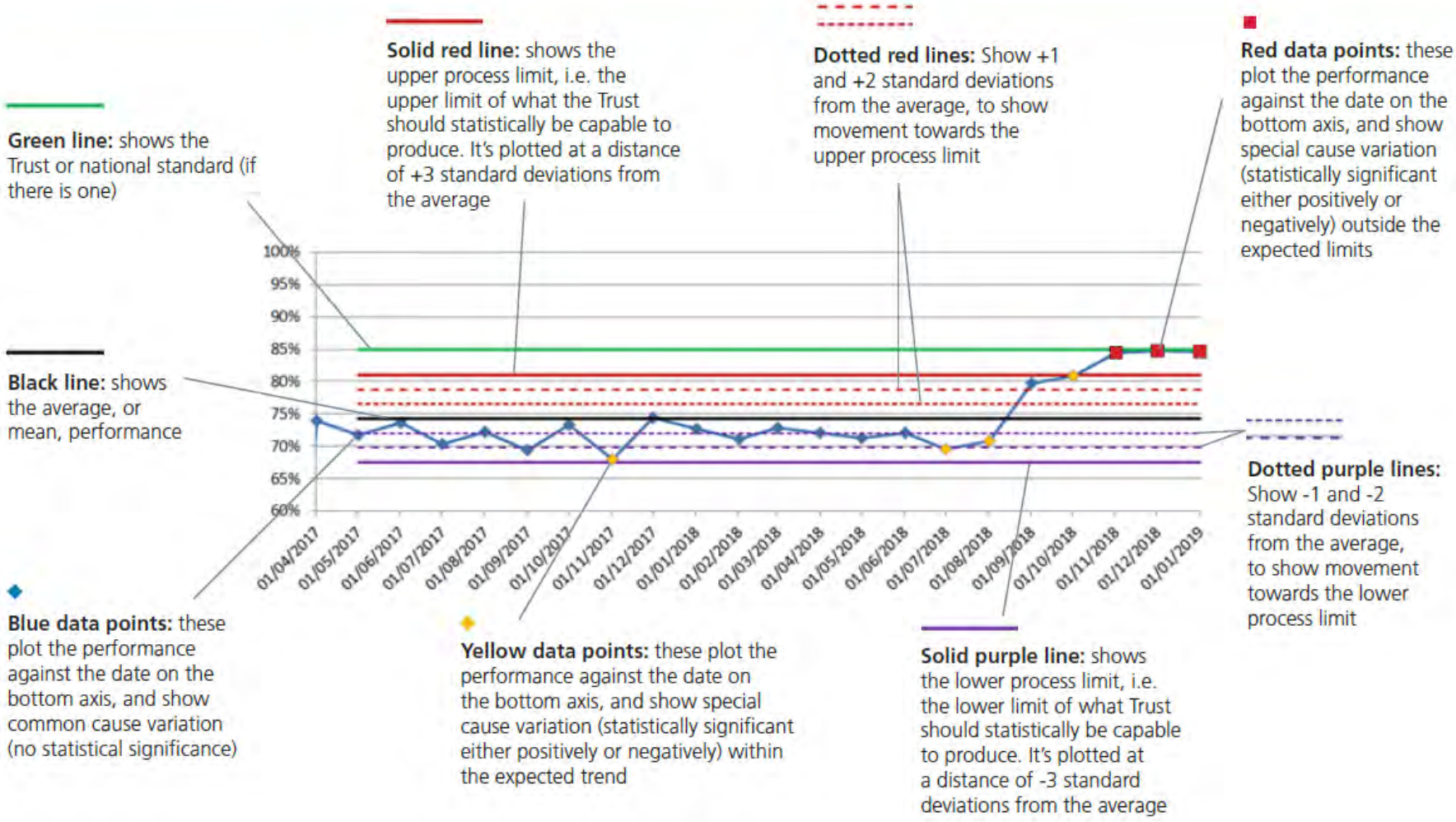
A control chart always has:

- a central line for the average or mean (shown in black on our graphs)
- an upper line for the upper process limit (shown in red on our graphs)
- a lower line for the lower process limit (shown in purple on our graphs).

These lines are determined from historical data.

On the next page you can see an example graph to help you.

SPC chart: example graph



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Summary Table

The tables below provide a summary of the indicators that are contained within the report. It is intended to provide an 'at a glance' view of the metrics to act as a guide on which KPIs to focus attention on.

Date	Oct-19

Safe domain	Standard	Actual	Trend	Assurance	Notes
New Pressure Ulcers - Trust	0	51	Common Cause Variation	Consistently above target	

Effective domain	Standard	Actual	Trend	Assurance	Notes
Discharge Summaries: Outpatients	85%	ND	ND	#VALUE!	No data since August 2018
Discharge Summaries: A&E	95%	81%	Special Cause Variation - Low	Consistently below target	
Discharge Summaries: Non Elective Admissions	95%	87%	Special Cause Note/Investigation - High	Consistently below target	
Discharge Summaries: Elective Admissions	85%	89%	Special Cause Note/Investigation - High	Consistently below target	

Caring domain	Standard	Actual	Trend	Assurance	Notes
Compliments	No target	33	Common Cause Variation	No target	
Complaints	20	20	Common Cause Variation	Hit and miss against target	

Responsive domain	Standard	Actual	Trend	Assurance	Notes
Referral to Treatment 18 week standard	92%	81%	Special Cause Variation - Low	Hit and miss against target	
Diagnostics 6 week standard	99%	99%	Special Cause Variation - Low	Hit and miss against target	
Sepsis	100%	93%	Special Cause Note/Investigation - High	Hit and miss against target	
Cancer 2 week GP referral to assessment standard	93%	91%	Common Cause Variation	Hit and miss against target	
Cancer 2 week breast referral to assessment standard	93%	89%	Special Cause Variation - Low	Hit and miss against target	
Cancer 62 day referral to treatment standard	85%	82%	Special Cause Variation - Low	Hit and miss against target	
Community referral to treatment within 18 weeks	90%	97%	Common Cause Variation	Hit and miss against target	
Wheelchair waiting times – Child (Community)	92%	93%	Special Cause Note/Investigation - High	Hit and miss against target	

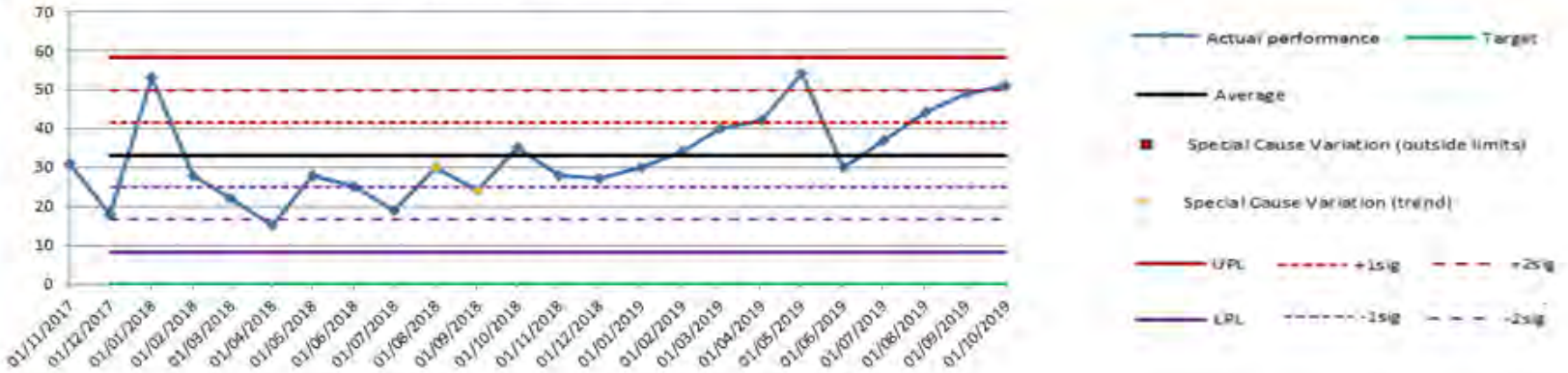
Well-led domain	Standard	Actual	Trend	Assurance	Notes
Sickness Absence	3.5%	4%	Special Cause Note/Investigation - Low	Hit and miss against target	
Proportion of Temporary Staff	12%	10%	Common Cause Variation	Hit and miss against target	

Maternity	Standard	Actual	Trend	Assurance	Notes
Number of deliveries (births)	210	196	Common Cause Variation	Hit and miss against target	
Caesarean Section rate	22.6%	25%	Special Cause Variation - High	Hit and miss against target	
Breast Feeding Initiation	80%	81%	Common Cause Variation	Hit and miss against target	

Pressure Ulcers - Trust

Safe

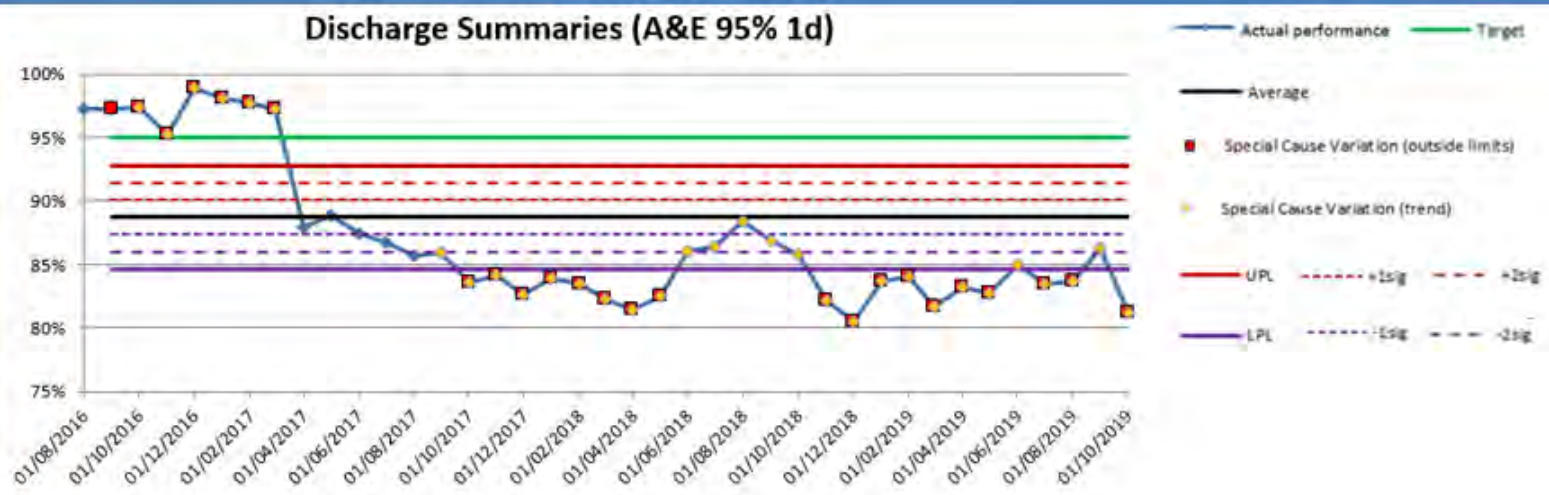
New Pressure Ulcer - Trust



Narrative

What	An overall increase of 2 new pressure ulcers this month; the majority of this increase has been observed in the community setting, with acute new pressure ulcers reducing slightly overall.
Why	We continue to work towards adopting a demand/capacity tool within the community nursing teams, in order to ensure that as a Division we are able to ensure that the correct number/skill mix of staff are available to care for patients. Colleagues have been reminded via the internal CREWS Quality Report/Newsletter (community), of the need to ensure prompt referral to the Tissue Viability Service to ensure that these patients receive specialist clinical support before wound deterioration occurs.
How	Our Integrated Tissue Viability Team take every opportunity to enhance the skills and awareness of clinicians caring for patients and all those who may have contact with patients, either in the form of bite-size ward/department sessions which have been ongoing, or by educating WSFT volunteers during their Mandatory Training, to ensure understanding of the causes of pressure damage and strategies to reduce these. In the community setting, an additional programme of support is being provided to a large residential care home in Bury St Edmunds with the intention of sharing knowledge and skills with carers who support patients through the 24-hour period.
When	Our aspiration continues to be to reduce the incidence of new pressure ulcers by 5% by the end of the financial year; however, we recognise that this is an increasingly ambitious challenge. There is a concern that given the increasing complexity of our patients that this reduction in occurrence is becoming unlikely; however, we continue to strive towards this.

Discharge Summaries ED

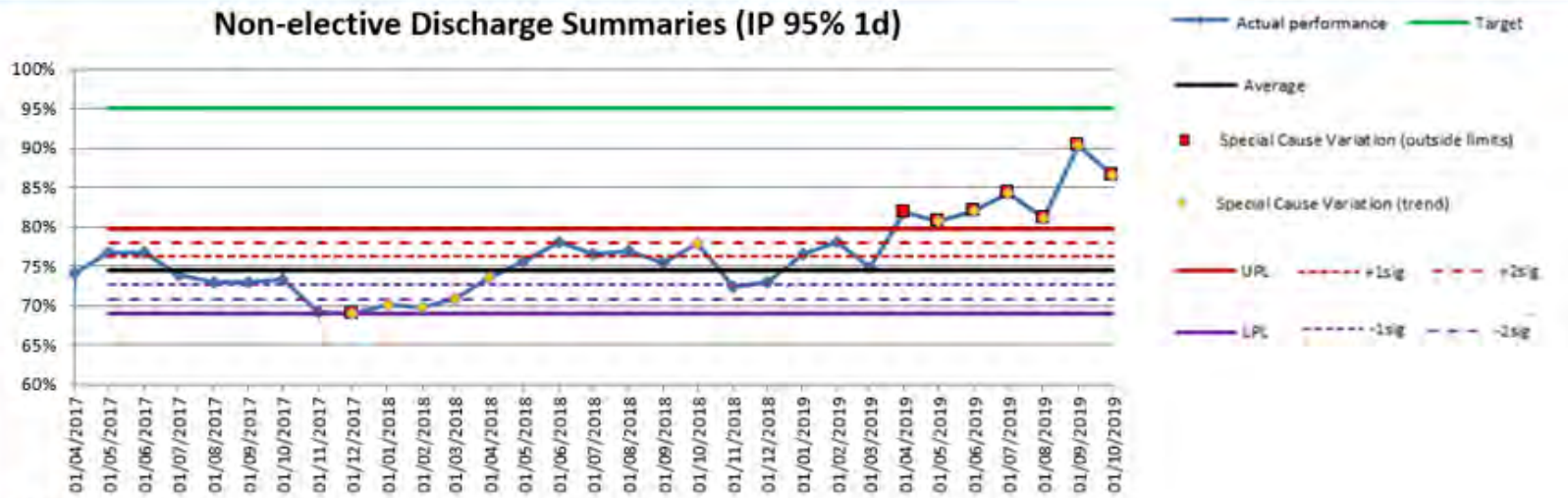


Narrative

What	Special Cause Variation – Low.
Why	We continue to work with departments to try and improve timeliness of discharge summaries.
How	Reports identify which specific areas may need support and this is targeted through the operation divisions. We will be repeating the training that we delivered to Juniors.
When	-

Effective

Discharge Summaries Non elective admissions



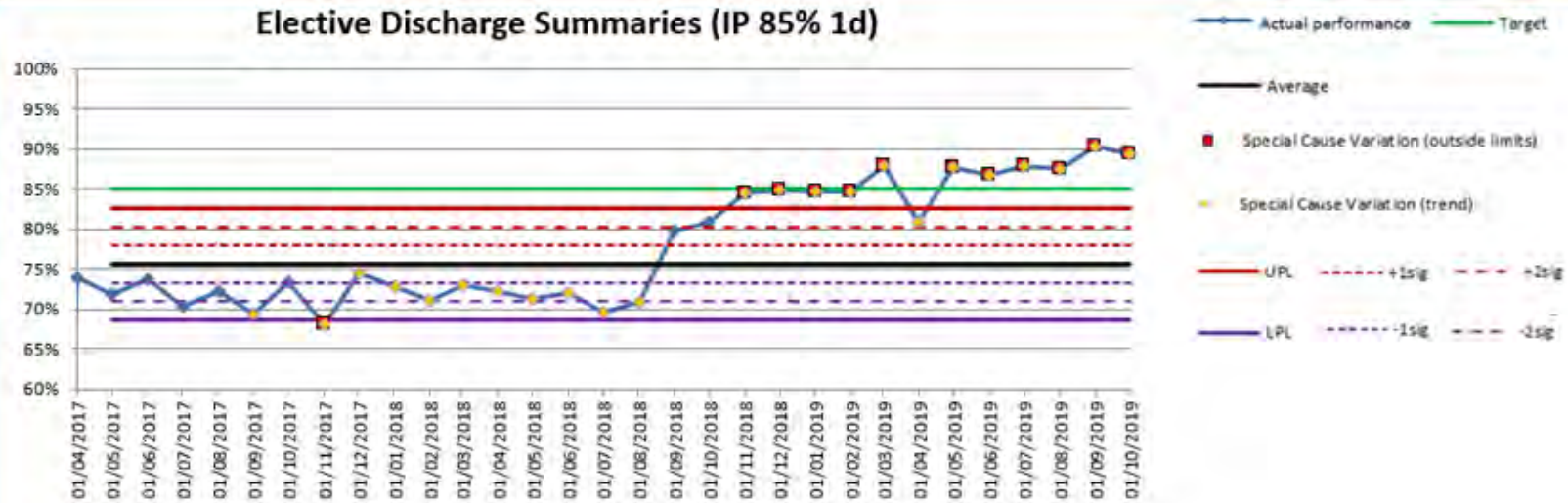
Narrative

What	Special Cause Note/Investigation – High
Why	We continue to work with departments to try and improve timeliness of discharge summaries.
How	Reports identify which specific areas may need support and this is targeted through the operation divisions.
When	-

Effective

9

Discharge Summaries Elective admissions

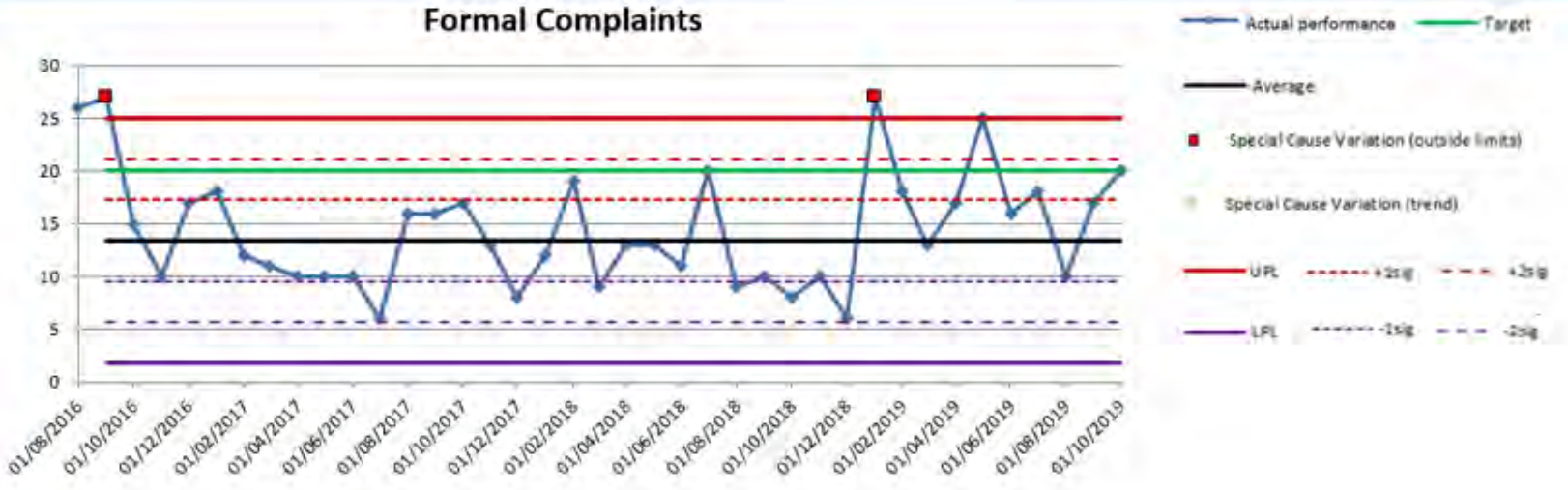


Narrative

What	Special Cause Note/Investigation - High
Why	We continue to work with departments to try and improve timeliness of discharge summaries.
How	Reports identify which specific areas may need support and this is targeted through the operational divisions
When	-

Effective

Complaints

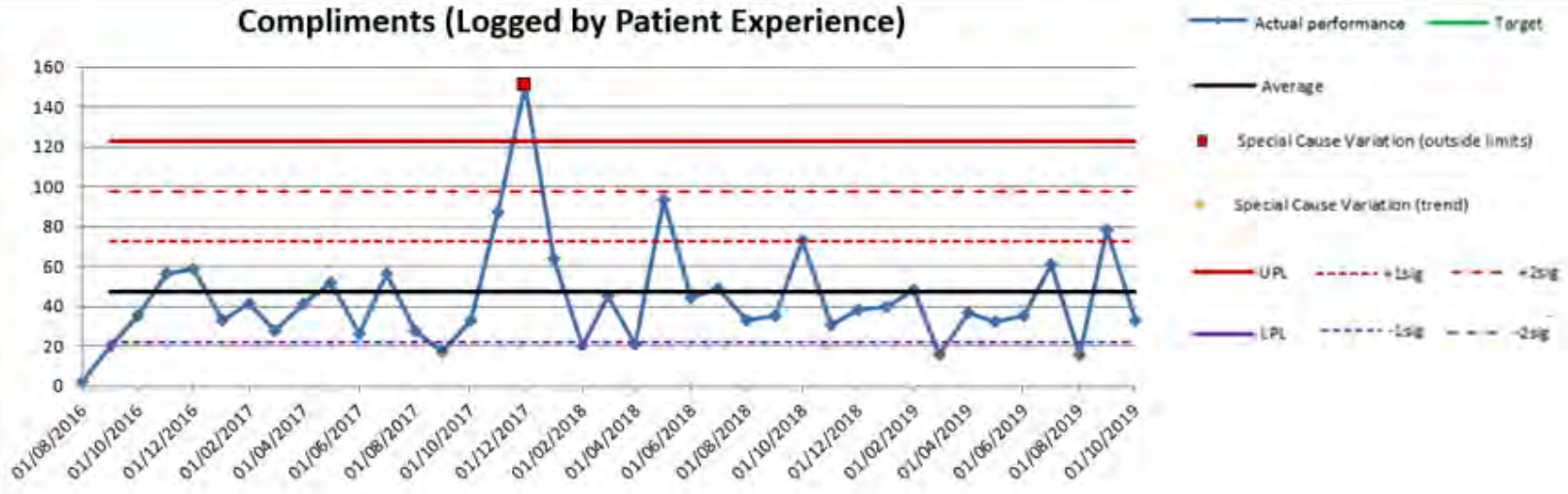


Narrative

What	Common Cause Variance
Why	Formal complaints have increased over the past calendar year and continue to remain at a higher level than previous years.
How	The PALS team continue to deal with concerns and enquiries proactively to offer support to patients and relatives and try and offer quick resolutions. Resources within the patient experience team are being reviewed to manage increasing demands.
When	The total number of complaints is expected to remain at this higher level despite the utilisation of PALS. To ensure we are delivering a good service to patients and relatives, resources within the team are being reviewed.

Caring

Compliments

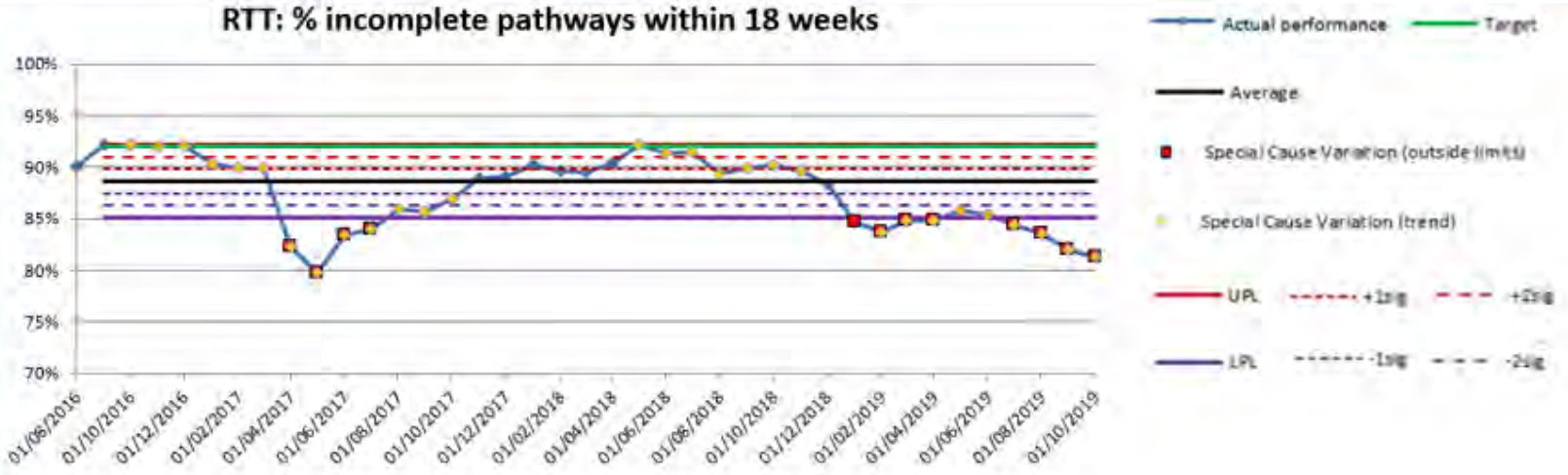


Narrative

What	Common Cause Variance
Why	Wards & Departments provided less compliments with the patient experience team for central logging.
How	Our aim is for all compliments to be shared with the patient experience team.
When	On-going message across Trust highlighting this.

Caring

RTT



Narrative

What	Special cause variation - low
Why	There is underachievement of the standard within General Surgery, Urology, Trauma and Orthopaedics, ENT, Ophthalmology, Plastics, Gastroenterology, Cardiology, Thoracic medicine and Gynaecology. Whilst some of these areas have shown minor improvement from September to October, Ophthalmology, ENT and Gastroenterology have seen a drop in performance. The possibility of any additional capacity is still being explored, which makes providing a recovery trajectory challenging.
How	Action plan for recovery in place for all specialities not meeting performance, Continue to monitor long waits at weekly access meeting.
When	Ongoing

Responsive

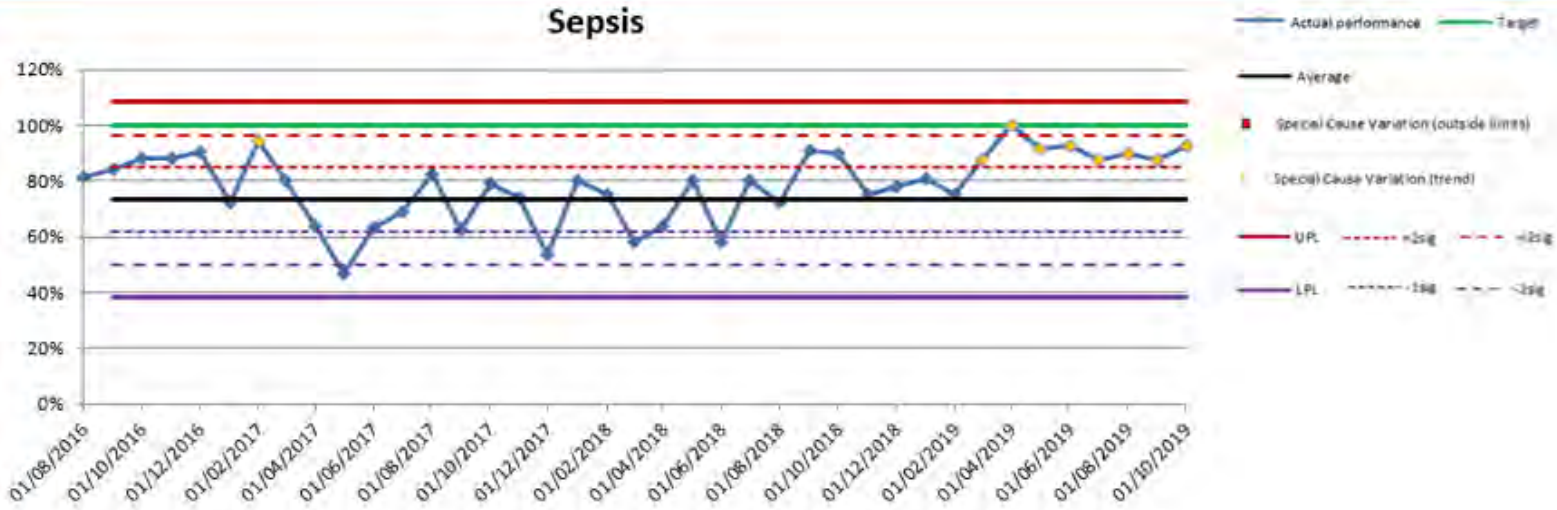
iagnostics within 6 weeks

Narrative

What	Special cause variation - low
Why	Diagnostic performance has improved significantly this month with improved performance across all diagnostic activities.
How	Work continues on the colorectal and urology (cystoscopy & urodynamic) pathways in particular to provide long term sustainability.
When	Ongoing

Responsive

Sepsis

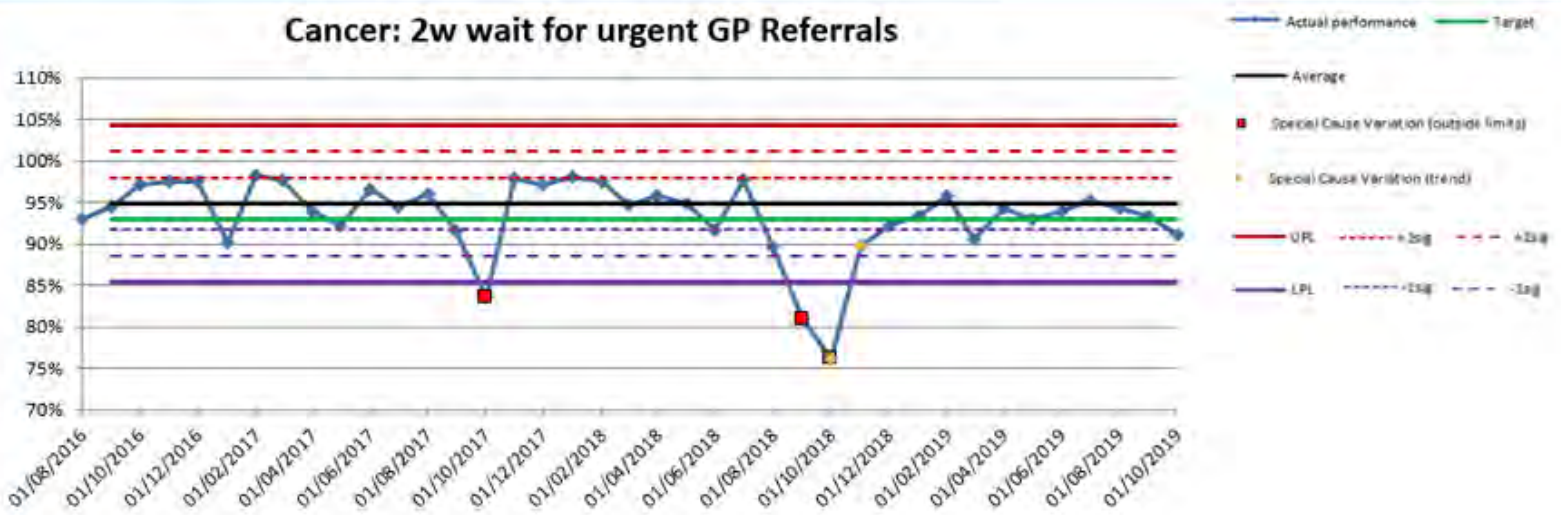


Responsive

Narrative

What	Special cause variation –high
Why	Performance against national standards for Door to Needle time for Neutropenic was 92.8% for the month of October. Of the 4 patient's who were admitted to G1, all 4 patient's received the required treatment within the 1 hour time scale. Of the 10 patients who were admitted through ED, 9 patient's were treated within the hour and 1 patient breached the national standard. Please see below action plan to address the issues and improve performance against this standard.
How	Introduction of the Emergency Department Neutropenic Sepsis FastTrack Pathway NSFP (Red Folder) copy displayed on info board in ED staff room.
When	Ongoing

Cancer 2 week referral



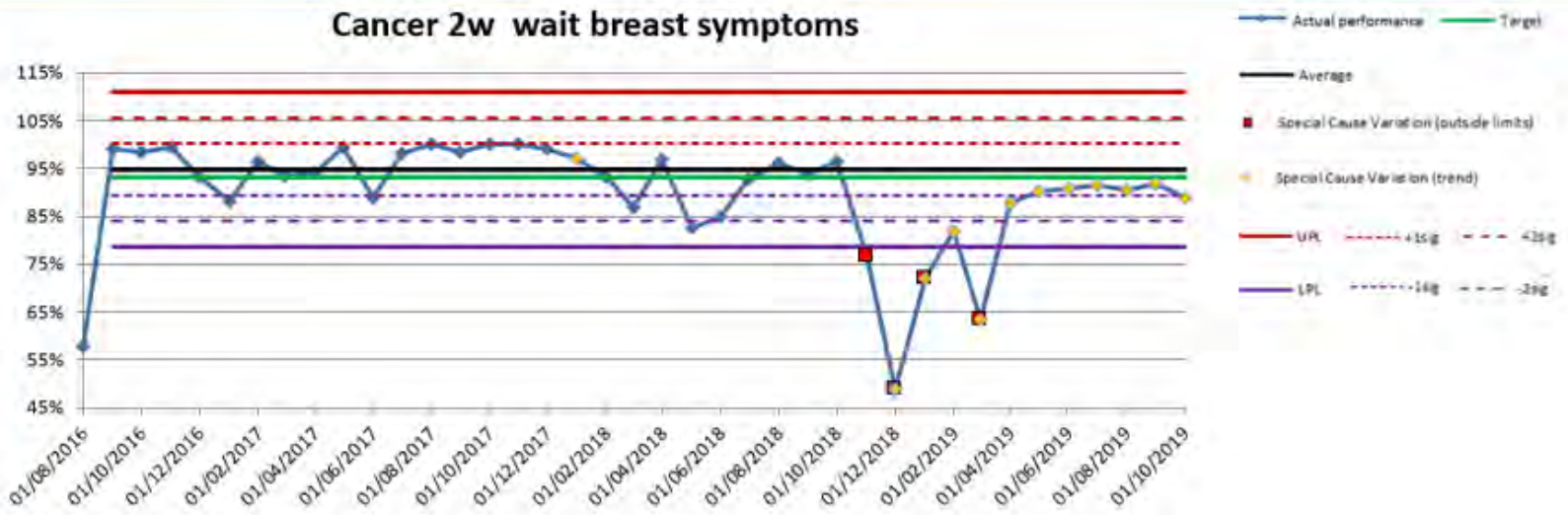
Narrative

What	Common Cause Variance
Why	Following sustained performance since April this year, the trust experienced a high surge of incoming referrals in October. The drop in performance is due to patient controlled factors across the specialities with only a very small number of breaches (5 out of 110) due to capacity issues.
How	CCG recently carried out an audit on quality of the colorectal referral form and there is a plan to share the findings of this audit with appropriate communication going out to all referring GPs to help improve patient availability and the quality of all referral.
When	Ongoing

Responsive

16

Cancer 2 week referral Breast



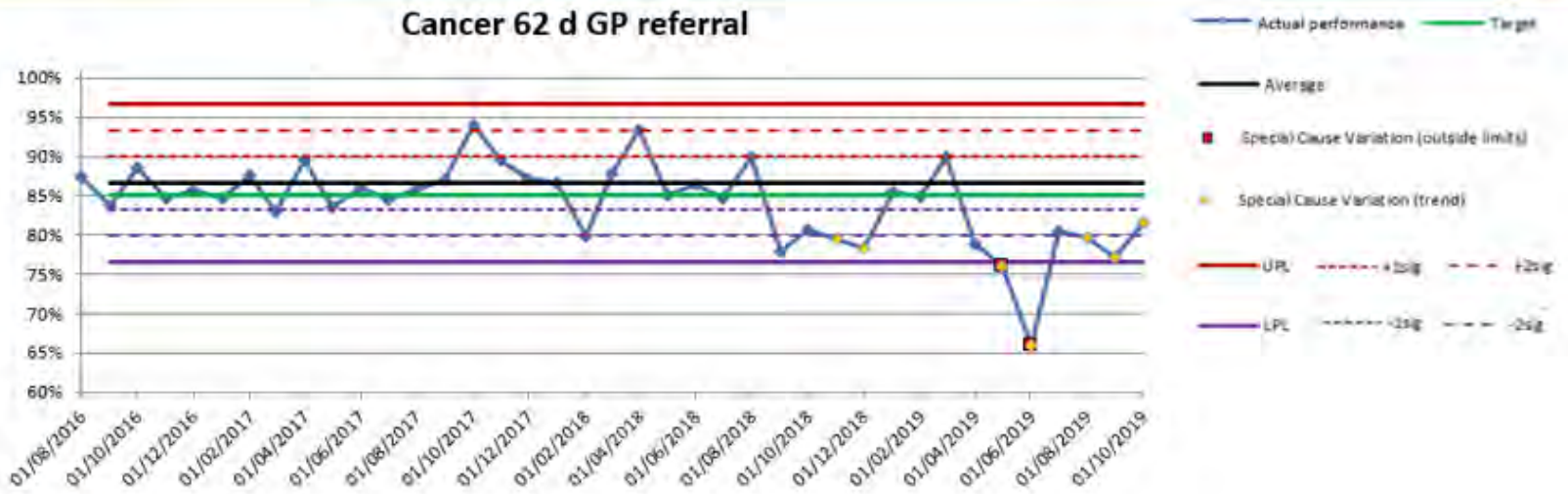
Narrative

What	Special cause variation - low
Why	This is primarily due to patient controlled factors including 6 of the patients away on holidays in the 14 days window.
How	Capacity has been increased by an additional clinic on Friday PM for breast pain symptom patients. Patient if required further radiological investigation are booked in to the earliest available next slot week
When	Ongoing

Responsive

Cancer 62 Day

Responsive

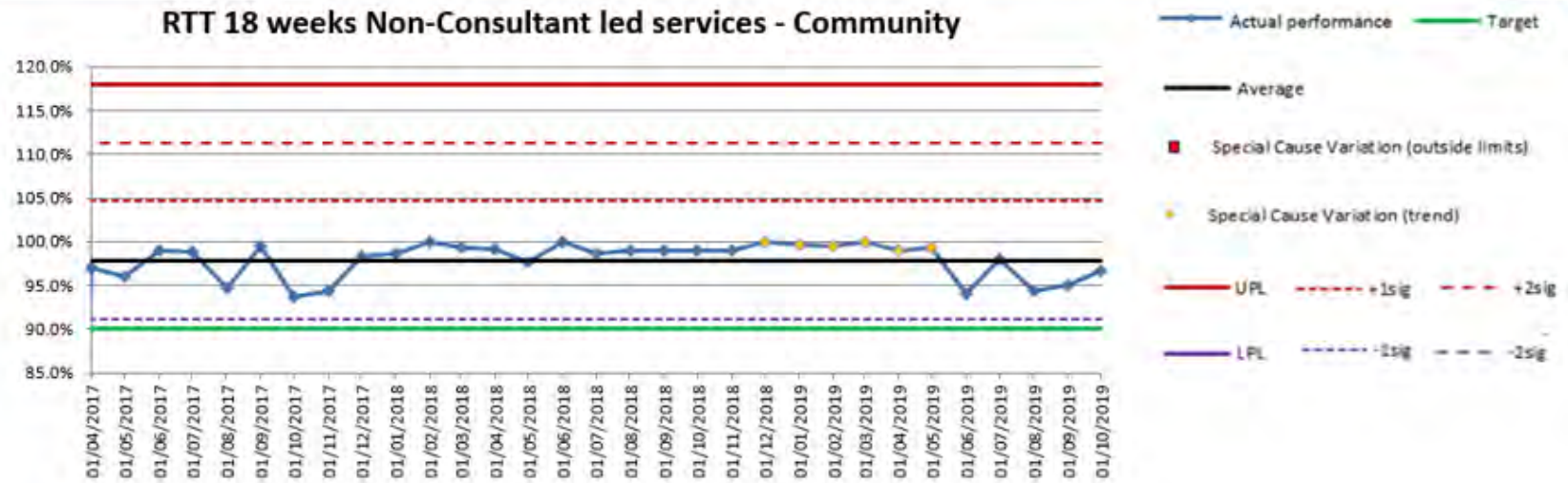


Narrative

What	Special cause variation - low
Why	For October Trust breaches there were 3 Colorectal breaches and 1 breach in each of the following; Breast, Haem, Head and Neck, Lung, Skin, Upper GI and Urology. For shared pathways there were 2 breaches in Urology and 1 each in Breast, Gynaecology, Haem, Head and Neck. Some involved cases of late referrals and once submitted by the treating hospital these will be fully reallocated back to the Trust. Once all breaches are re-allocated we expect the final performance to drop from the current 81.5% to around 80%.
How	Several work streams are currently in progress to tie in with the recovery action plan in place with service leads for specific pathways, regular meetings are held to ensure this is on track.
When	Ongoing

RTT non consultant led

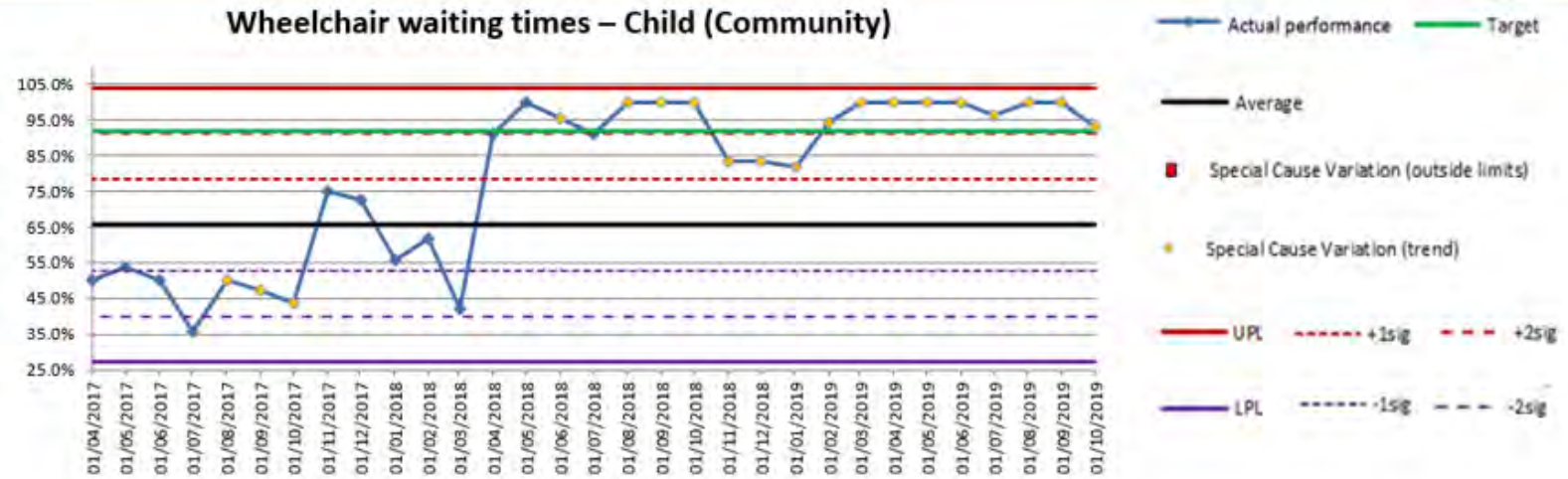
Community



Narrative

What	Common cause variation
Why	-
How	-
When	-

Wheelchair waiting times – Child (Community)

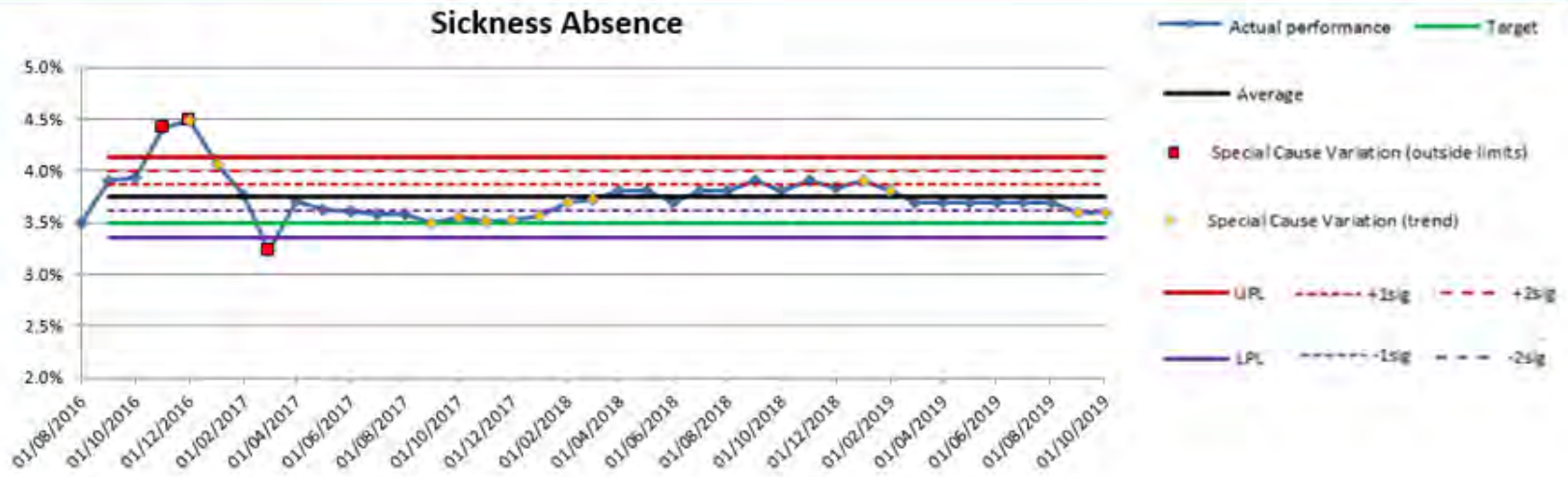


Narrative

What	Special cause variation – high
Why	-
How	-
When	-

Community

Sickness absence

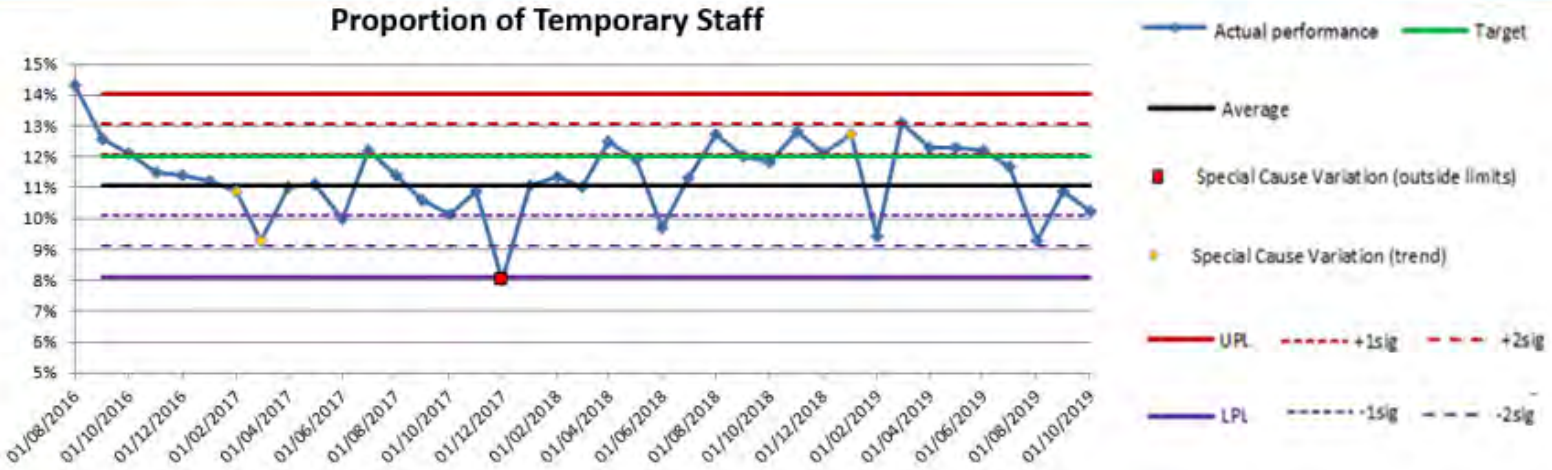


Narrative

What	Special cause variation - low
Why	Sickness absence remains at 3.6%, which is below the NHS average. Workforce teams continue to work closely with managers to support sickness absence management and to support staff to return to work.
How	HR continue to support managers to manage both short term and long term absences
When	Ongoing

Well Led

Proportion of temporary staff



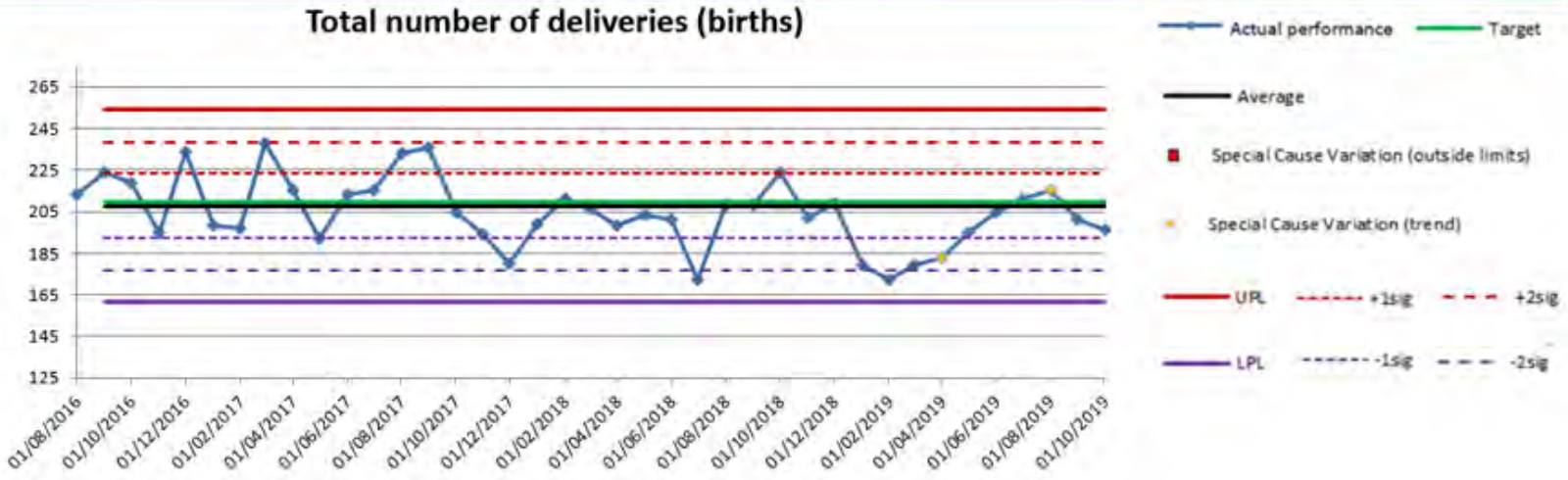
Narrative

What	Common Cause Variation
Why	-
How	-
When	-

Well Led

Total number of deliveries

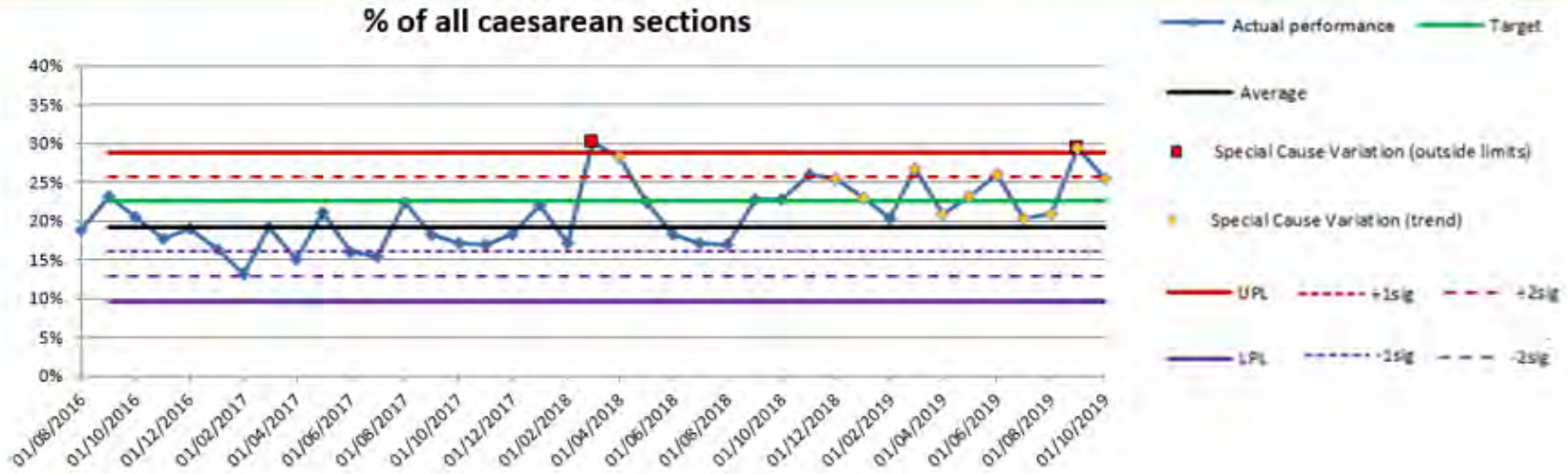
Maternity



Narrative

What	Common cause variation
Why	-
How	-
When	-

Caesarean section rate

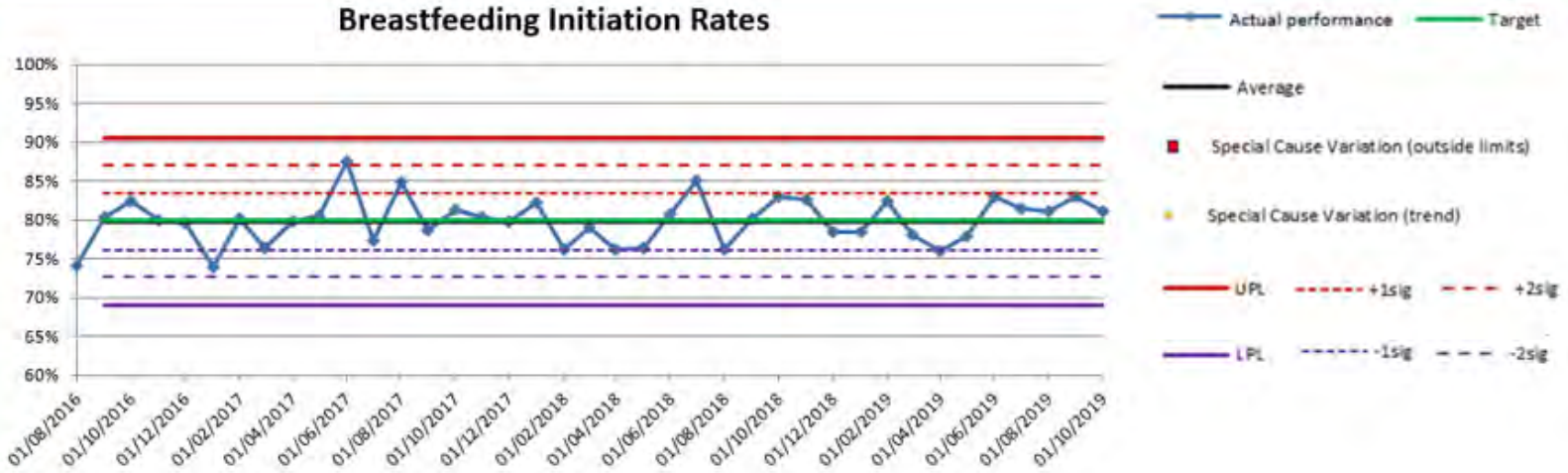


Narrative

What	Special cause variation - high
Why	This is heading back towards target.
How	The service continues to monitor via the Women's Health Governance monthly and weekly at the case management meeting.
When	Ongoing

Maternity

Breast feeding initiation



Narrative

What	Common cause variation.
Why	-
How	-
When	-

Maternity

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9. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 29 November 2019

Agenda item:	9			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	22nd November 2019			
Subject:	Finance and Workforce Board Report – November 2019			
Purpose:		For information	x	For approval

Executive summary:

The reported I&E for October 2019 is a deficit of £0.4m, against a planned surplus of £0.1m. This results in an adverse variance of £0.5m in October (£4.4m YTD). The YTD loss is now £5.4m.

The Trust plans to deliver further savings of £1.8m which will mitigate additional cost pressures in the second part of the year. We have therefore re-forecast to a loss of £10.0m (before PSF/FRF). This would mean losing PSF/FRF and our total loss would therefore be £15.7m.

We are also working with colleagues within the local health system to identify any further funding that could improve this position.

In order to formally revise our forecast outturn through the national reporting process, the Trust must provide a board assurance statement (BAS) signed by the commissioner / provider chair, accountable officer / chief executive, chief financial officer / director of finance, and audit committee chair in respect of the Trust's adherence to the revised forecast protocol and the Trust's commitment to the delivery of the recovery plan. Therefore, the Board is asked to provide delegated authority for these individuals to approve the BAS.

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

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

Previously considered by:	*This report is produced for the monthly trust board meeting only*
Risk and assurance:	*These are highlighted within the report*

Legislation, regulatory, equality, diversity and dignity implications	*None*
Recommendation: *The Board is asked to review this report and to provide the delegated authority for the Board Assurance Statement to be signed off as required in relation to the formal re-forecast.*	

FINANCE AND WORKFORCE REPORT
OCTOBER 2019 (Month 7)

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

Financial Summary

I&E Position YTD	£5.8m	loss
Variance against plan YTD	-£4.4m	adverse
Movement in month against plan	-£0.5m	adverse
EBITDA position YTD	-£4.8m	adverse
EBITDA margin YTD	-3.2%	adverse
Total PSF Received	£5.386m	accrued
Cash at bank	£1.5m	

Executive Summary

- The planned deficit for the year to date was £1.4m but the actual deficit was £5.7m, an adverse variance of £4.4m.
- The reported position includes accruing for all FRF/PSF.
- We have re-forecast to a loss of £10.0m (before PSF/FRF). This would mean losing PSF/FRF and our total loss would therefore be £15.7m.
- This forecast requires delivering a recovery plan of £1.8m.
- We are working with colleagues within the local system to identify any further funding that could improve this position

Key Risks

- Delivery of £8.9m CIP programme
- Delivery of £1.8m recovery plan
- Containing demand within budgeted capacity

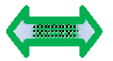
SUMMARY INCOME AND EXPENDITURE ACCOUNT - October 2019	Oct-19 Budget £m	Oct-19 Actual £m	Oct-19 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance F/(A) £m
NHS Contract Income	18.3	18.8	0.5	126.6	127.3	0.7	217.8	218.6	0.9
Other Income	2.4	2.4	(0.1)	17.0	16.3	(0.7)	29.1	27.1	(2.0)
Total Income	**20.7**	**21.2**	**0.4**	**143.6**	**143.5**	**(0.0)**	**246.9**	**245.7**	**(1.2)**
Pay Costs	14.2	14.8	(0.6)	98.6	101.3	(2.7)	170.0	173.6	(3.6)
Non-pay Costs	6.4	6.8	(0.5)	44.6	46.9	(2.3)	75.1	81.1	(6.1)
Operating Expenditure	**20.6**	**21.7**	**(1.1)**	**143.2**	**148.2**	**(5.1)**	**245.1**	**254.7**	**(9.6)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**0.2**	**(0.5)**	**(0.7)**	**0.4**	**(4.8)**	**(5.1)**	**1.8**	**(9.0)**	**(10.8)**
Depreciation	0.7	0.6	0.1	4.6	4.2	0.4	8.1	7.4	0.7
Finance costs	0.3	0.2	0.1	2.3	2.2	0.0	3.9	3.8	0.1
SURPLUS/(DEFICIT)	**(0.8)**	**(1.3)**	**(0.5)**	**(6.5)**	**(11.1)**	**(4.7)**	**(10.2)**	**(20.1)**	**(10.0)**
Provider Sustainability Funding (PSF)									
MRET, FRF/PSF - Financial Performance	0.9	0.9	0.0	5.1	5.4	0.3	10.1	4.4	(5.7)
SURPLUS/(DEFICIT) incl PSF	**0.1**	**(0.4)**	**(0.5)**	**(1.4)**	**(5.7)**	**(4.4)**	**(0.1)**	**(15.7)**	**(15.7)**

FINANCE AND WORKFORCE REPORT - OCTOBER 2019

Contents:

Key:

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

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

FINANCE AND WORKFORCE REPORT - OCTOBER 2019

Income and Expenditure Summary as at October 2019

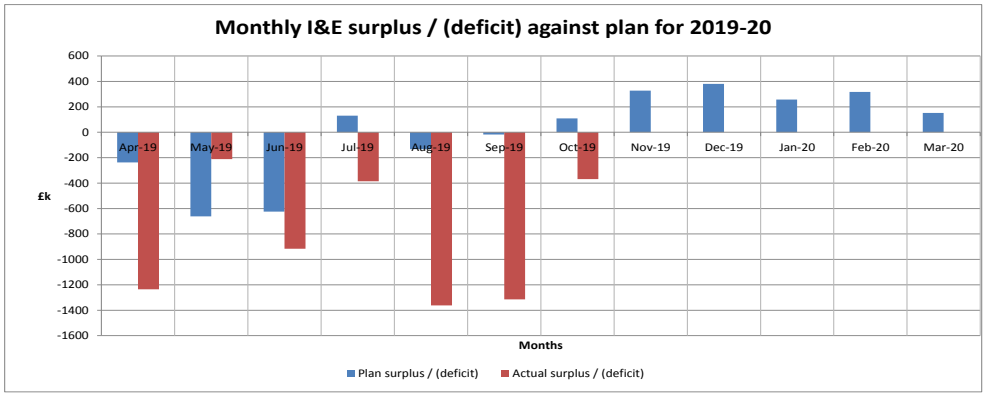
The reported I&E for October 2019 is a deficit of £0.4m, against a planned surplus of £0.1m. This results in an adverse variance of £0.5m in October (£4.4m YTD).

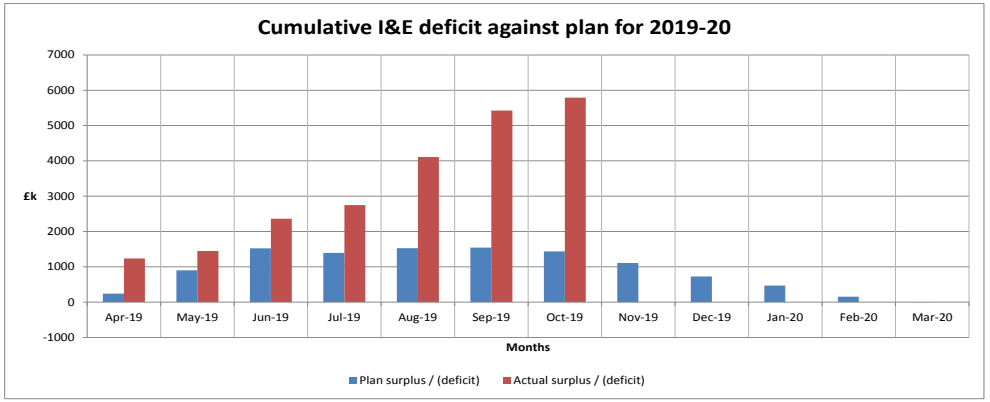
The YTD variance of £4.4m includes activity of £3.6m that is not chargeable under the GIC. Therefore the adverse position can be seen to be almost entirely driven by demand.

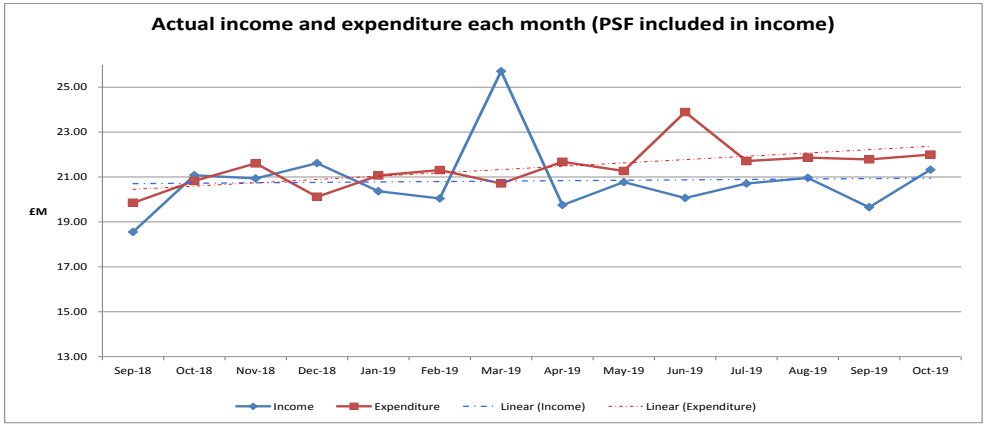
Our control total and plan is to break even in 2019-20, but the current position indicates a deficit of £10.0m after delivering a recovery plan of £1.8m. Since missing our control total will result in £6.0m PSF/FRF for 2019-20 being withheld, our actual loss is forecast to be £15.7m (after receiving £0.3m relating to 2018-19 PSF). We are therefore preparing a formal re-forecast in line with this deficit which will be submitted to NHSI/E and will form the basis for the M9 – M12 monitoring

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)	109	(369)	(478)	↓	Red
YTD surplus / (deficit)	(1,433)	(5,792)	(4,359)	↑	Red
Forecast surplus / (deficit)	1	(15,700)	(15,701)	↑	Red
EBITDA (excl STF) YTD	358	(4,759)	(5,116)	↑	Red
EBITDA (%)	0.2%	(3.2%)	(3.4%)	↓	Red
Clinical Income YTD	(121,219)	(121,882)	664	↑	Green
Non-Clinical Income YTD	(27,438)	(26,970)	(468)	↑	Amber
Pay YTD	98,623	101,325	(2,702)	↑	Red
Non-Pay YTD	51,468	53,320	(1,852)	↑	Red
CIP target YTD	5,538	5,330	(208)	↓	Amber



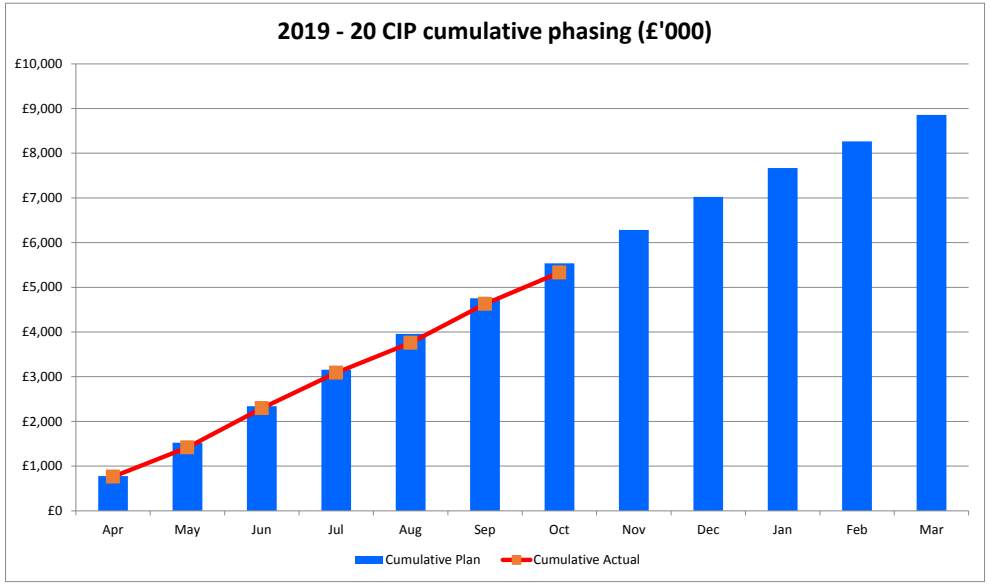


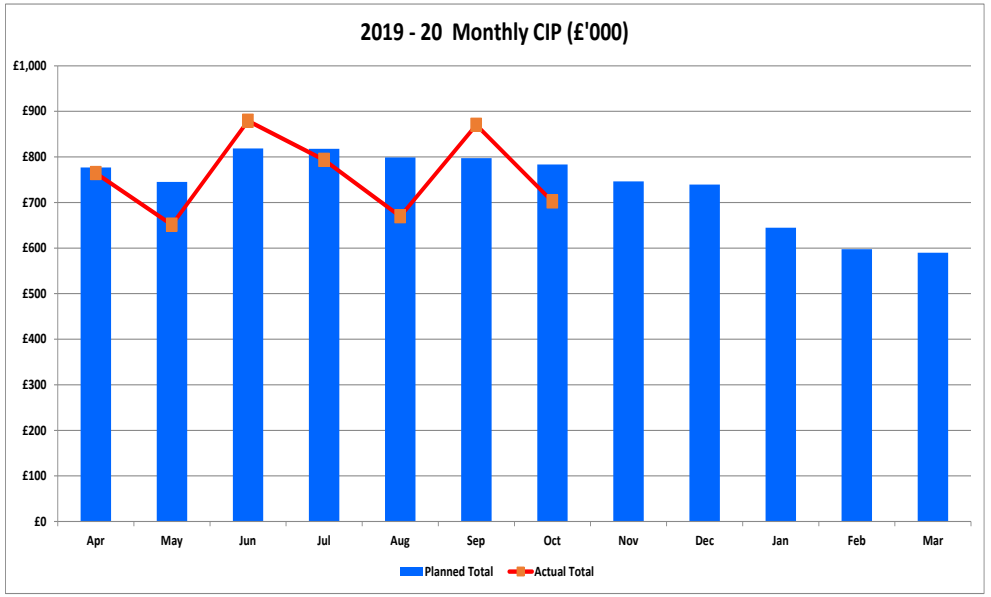


Cost Improvement Programme (CIP) 2019-20

In order to deliver the Trust's control target in 2019-20 we needed to deliver a CIP of £8.9m (4%). By October we planned to achieve £5,538k (62.5% of the annual plan) but achieved £5,330k (£208k behind plan, being 60.2%).

Recurring/Non Recurring Summary	2019-20 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	100	58	52
Procurement	731	422	573
Activity growth	-	-	-
Additional sessions	15	9	2
Community Equipment Service	575	518	448
Drugs	1,840	1,314	1,228
Estates and Facilities	60	34	34
Other	1,344	546	615
Other Income	1,743	1,173	1,158
Pay controls	361	208	166
Service Review	20	9	3
Staffing Review	1,076	662	533
Theatre Efficiency	178	90	66
Recurring Total	**8,044**	**5,042**	**4,876**
Non-Recurring			
Estates and Facilities	87	57	-
Other	350	206	36
Pay controls	376	234	418
Non-Recurring Total	**812**	**496**	**454**
Grand Total	**8,856**	**5,538**	**5,330**

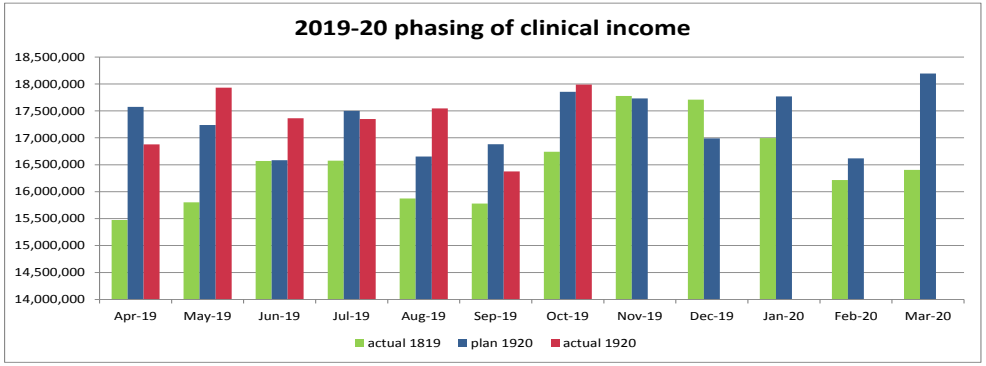




FINANCE AND WORKFORCE REPORT - OCTOBER 2019

Income Analysis

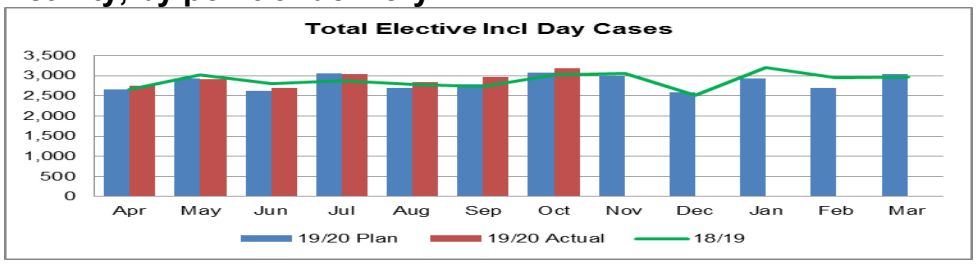
The chart below demonstrates the phasing of all clinical income plan for 2019-20, including Community Services. This phasing is in line with phasing of activity.

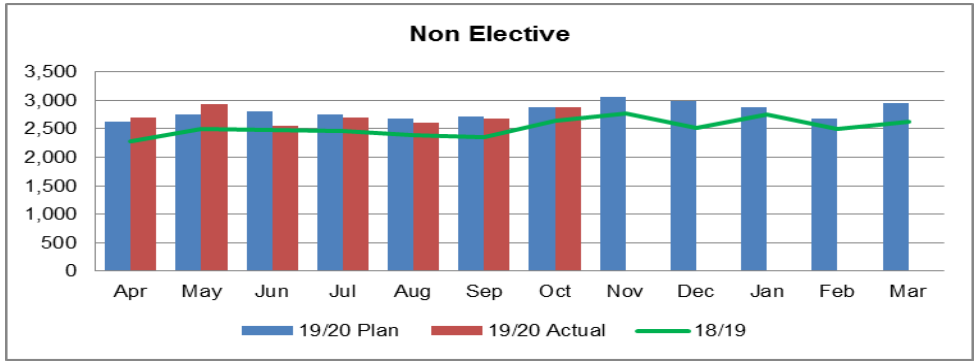


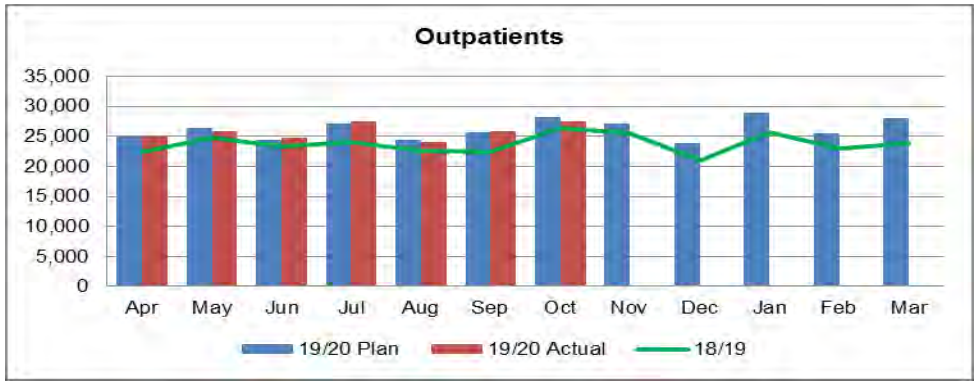
The income position was ahead of plan for October. The main areas of underperformance were within Other Service and Elective.

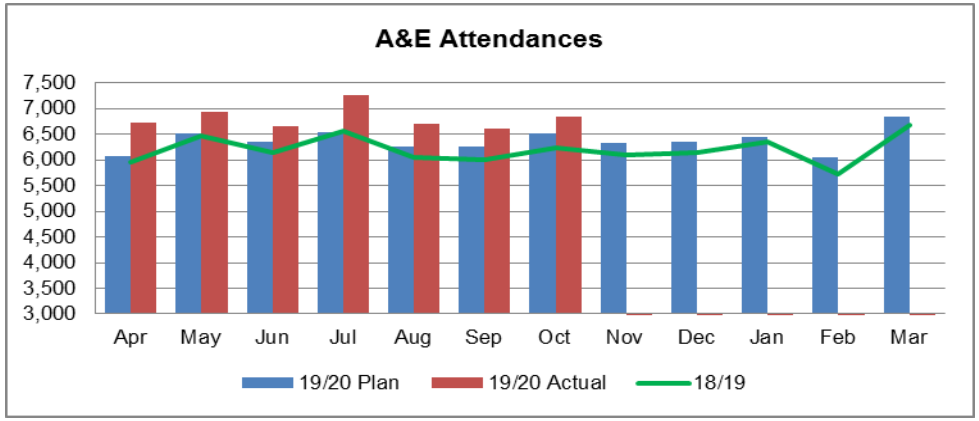
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	927	985	58	6,331	6,868	536
Other Services	797	1,469	672	12,655	13,384	729
CQUIN	181	179	(2)	1,196	1,194	(3)
Elective	2,961	3,081	120	19,535	19,201	(334)
Non Elective	6,407	6,089	(318)	42,763	42,499	(264)
Emergency Threshold Adjustment	(358)	(358)	0	(2,372)	(2,372)	0
Outpatients	3,402	3,394	(8)	21,784	21,819	34
Community	3,221	3,215	(6)	19,326	19,290	(36)
Total	**17,539**	**18,054**	**516**	**121,219**	**121,882**	**663**

Activity, by point of delivery

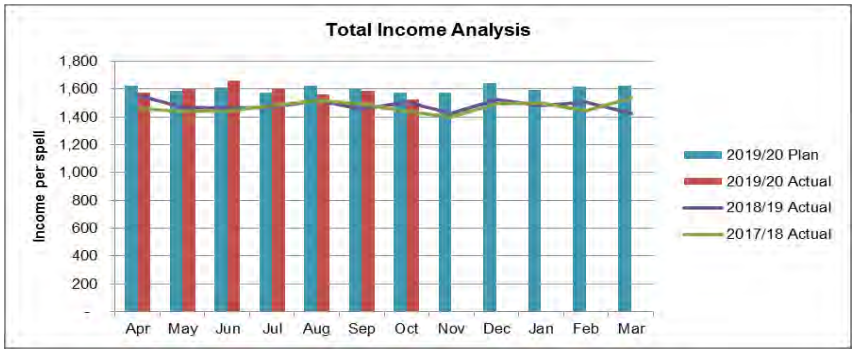


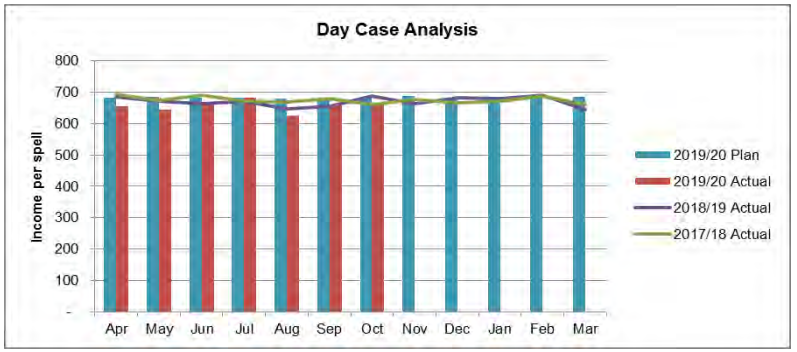


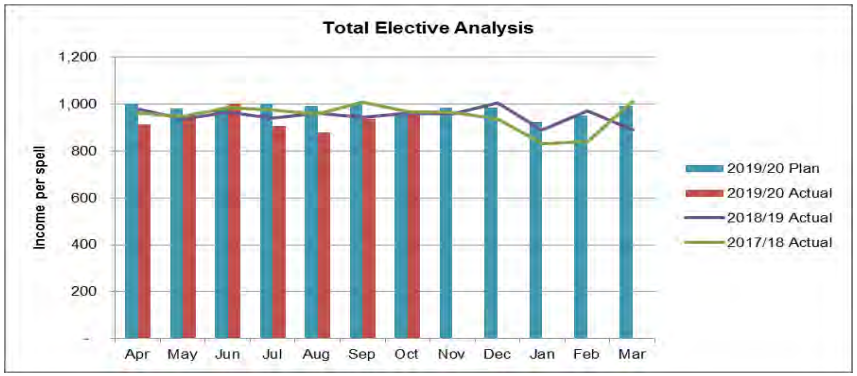


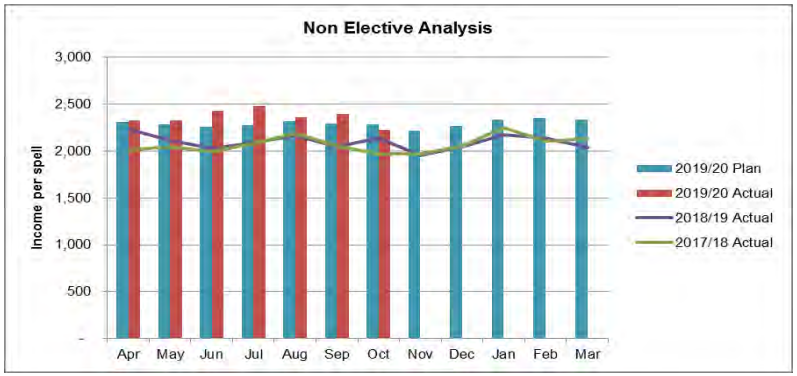


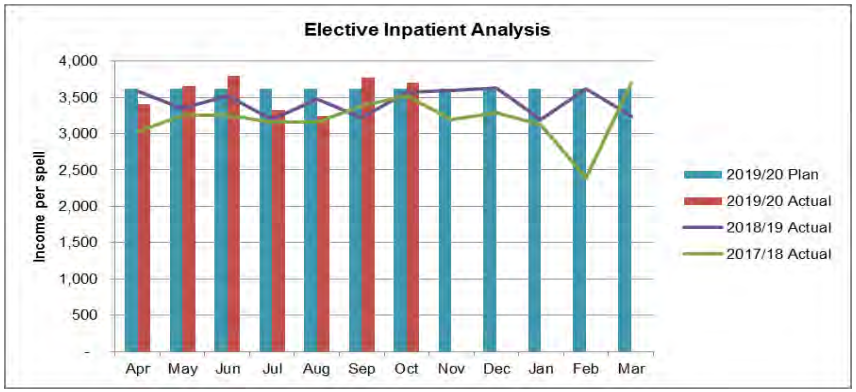
Trends and Analysis

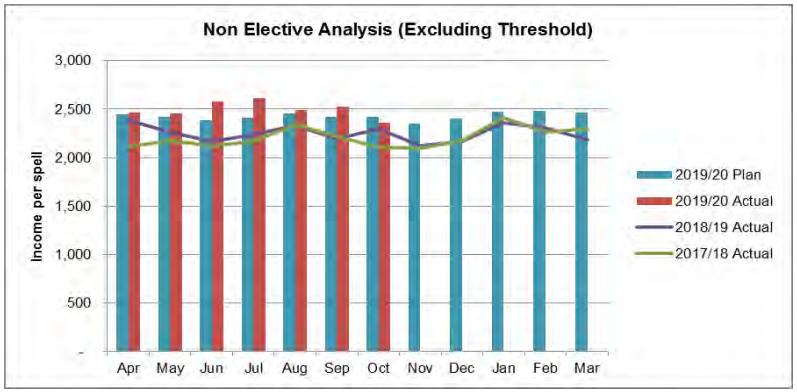












FINANCE AND WORKFORCE REPORT - OCTOBER 2019

Workforce

Monthly Expenditure (£) Acute services only				
As at October 2019	Oct-19	Sep-19	Oct-18	YTD 2019/20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**12,452**	**12,459**	**11,843**	**86,655**
Substantive Staff	11,642	11,497	10,513	78,550
Medical Agency Staff (includes 'contracted in' staff)	158	187	247	1,059
Medical Locum Staff	291	288	260	1,922
Additional Medical sessions	322	231	338	1,975
Nursing Agency Staff	114	147	78	1,059
Nursing Bank Staff	263	269	265	1,888
Other Agency Staff	53	70	13	486
Other Bank Staff	127	134	144	990
Overtime	61	103	110	1,027
On Call	49	77	60	469
Total temporary expenditure	1,438	1,505	1,514	10,874
Total expenditure on pay	**13,080**	**13,002**	**12,027**	**89,425**
Variance (F/(A))	(628)	(543)	(185)	(2,769)
Temp Staff costs % of Total Pay	11.0%	11.6%	12.6%	12.2%
Memo : Total agency spend in month	326	404	338	2,604

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at October 2019	Oct-19	Sep-19	Oct-18
	WTE	WTE	WTE
Budgeted WTE in month	**3,345.9**	**3,342.4**	**3,160.9**
Employed substantive WTE in month	3084.94	3053.57	2865.44
Medical Agency Staff (includes 'contracted in' staff)	9.72	11.32	18.42
Medical Locum	24.42	28.91	19.36
Additional Sessions	21.64	20.86	25.06
Nursing Agency	18.11	86.48	16.21
Nursing Bank	81.85	15.01	77.73
Other Agency	8.98	60.99	3.57
Other Bank	54.78	16.71	64.19
Overtime	6.82	29.89	32.5
On call Worked	6.23	7.35	6.96
Total equivalent temporary WTE	**232.6**	**277.5**	**264.0**
Total equivalent employed WTE	**3,317.5**	**3,331.1**	**3,129.4**
Variance (F/(A))	28.4	11.3	31.5
Temp Staff WTE % of Total Pay	7.0%	8.3%	8.4%
Memo : Total agency WTE in month	36.8	158.8	38.2
Sickness Rates (September/August)	3.64%	3.37%	3.86%
Mat Leave	2.06%	2.17%	2.58%

Monthly Expenditure (£) Community Service Only				
As at October 2019	Oct-19	Sep-19	Oct-18	YTD 2019-20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,752**	**1,703**	**1,557**	**11,968**
Substantive Staff	1,667	1,677	1,463	11,315
Medical Agency Staff (includes 'contracted in' staff)	14	8	14	78
Medical Locum Staff	4	3	3	31
Additional Medical sessions	0	0	0	7
Nursing Agency Staff	15	11	7	122
Nursing Bank Staff	25	25	19	194
Other Agency Staff	7	9	(12)	35
Other Bank Staff	9	9	7	49
Overtime	5	5	8	44
On Call	3	5	3	26
Total temporary expenditure	82	76	51	585
Total expenditure on pay	**1,750**	**1,754**	**1,514**	**11,900**
Variance (F/(A))	2	(51)	43	68
Temp Staff costs % of Total Pay	4.7%	4.4%	3.3%	4.9%
Memo : Total agency spend in month	36	29	9	234

Monthly Whole Time Equivalents (WTE) Community Services Only			
As at October 2019	Oct-19	Sep-19	Oct-18
	WTE	WTE	WTE
Budgeted WTE in month	**541.97**	**528.75**	**485.78**
Employed substantive WTE in month	498.59	497.31	462.94
Medical Agency Staff (includes 'contracted in' staff)	0.92	0.54	0.92
Medical Locum	0.35	0.35	0.35
Additional Sessions	0.00	0.00	0.00
Nursing Agency	3.56	1.55	1.23
Nursing Bank	8.06	7.83	6.80
Other Agency	2.70	3.85	1.27
Other Bank	2.09	2.09	2.70
Overtime	0.44	1.40	2.54
On call Worked	0.05	0.06	0.00
Total equivalent temporary WTE	**18.2**	**17.7**	**15.8**
Total equivalent employed WTE	**516.8**	**515.0**	**478.8**
Variance (F/(A))	25.21	13.77	7.03
Temp Staff WTE % of Total Pay	3.5%	3.4%	3.3%
Memo : Total agency WTE in month	7.2	5.9	3.4
Sickness Rates (September/August)	3.07%	3.22%	3.85%
Mat Leave	2.64%	2.46%	3.36%

Pay Trends and Analysis

Nursing – Staffing levels

The tables below compare actual registered and unregistered nursing within ward based and non-ward based services between April 2018 and October 2019.

It should be noted that during 2018 bay based nursing was introduced which created around 45 unregistered posts and reduced the establishment for registered nursing. Whilst the mix of staff will have changed the total numbers should remain much the same (if there has been no increase in beds). However, over the last 19 months there has been a total increase in nursing of 73.06 WTEs in ward based areas.

	Oct 18 to Oct 19			April 18 to October 19		
Nursing WTE Actual Increase / (Decrease)	**Ward Based**	**Non Ward Based**	**Total**	**Ward Based**	**Non Ward Based**	**Total**
Registered	49.10	19.85	**68.95**	10.72	30.77	**41.49**
Unregistered	35.31	11.86	**47.17**	62.34	15.59	**77.93**
Total	84.41	31.71	**116.12**	73.06	46.36	**119.42**

	Oct 18 to Oct 19		
Nursing WTE % Increase / (Decrease)	**Ward Based**	**Non Ward Based**	**Total**
Registered	13.4%	3.0%	**6.7%**
Unregistered	10.4%	6.6%	**9.1%**
Total	12.0%	3.7%	**7.5%**

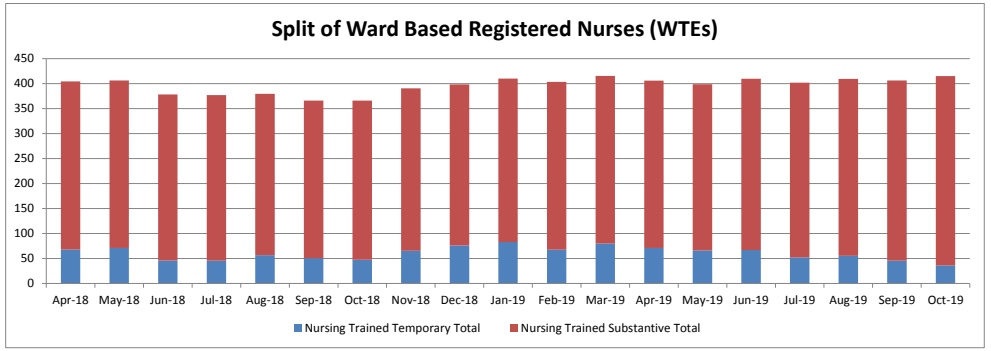
Due to increasing bed capacity the next table compares ward based nursing WTEs with average beds open in each month to demonstrate whether the increase in staffing is in line with growth in capacity. Looking at the total increase in nursing negates changes associated with the implementation of bay based nursing. It can be seen that the ratio of total nurses to beds has increased from 1.61 WTE per bed to 1.73 WTE, an increase of 7.5%.

WTEs incl A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	Sep-18	Sep-19	Oct-18	Oct-19	
Average Beds (midnight count)	445	462	432	458	430	467	438	473	419	450	416	446	441	453	incl GC
Registered WTEs	404	406	406	399	378	410	377	402	380	409	366	406	366	409	
Unregistered WTEs	313	354	286	363	297	368	302	372	310	370	333	384	340	375	
Total	717	760	692	762	675	778	679	774	690	779	699	790	706	784	

All wards incl A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	Sep-18	Sep-19	Oct-18	Oct-19	yr on yr
Registered per bed (incl Agency)	0.91	0.88	0.94	0.87	0.88	0.88	0.86	0.85	0.91	0.91	0.88	0.91	0.83	0.90	108.9%
Unregistered per bed	0.70	0.77	0.66	0.79	0.69	0.79	0.69	0.79	0.74	0.82	0.80	0.86	0.77	0.83	107.5%
Total Nursing per bed	1.61	1.64	1.60	1.66	1.57	1.67	1.55	1.64	1.65	1.73	1.68	1.77	1.60	1.73	108.2%

Excluding A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	Sep-18	Sep-19	Oct-18	Oct-19	yr on yr
Registered per bed (incl Agency)	0.76	0.73	0.79	0.74	0.75	0.73	0.72	0.71	0.76	0.76	0.74	0.76	0.67	0.90	135.0%
Unregistered per bed	0.65	0.72	0.61	0.74	0.64	0.73	0.64	0.73	0.69	0.77	0.75	0.81	0.73	0.83	114.2%
Total Nursing per bed	1.42	1.46	1.43	1.49	1.37	1.49	1.35	1.45	1.46	1.53	1.48	1.57	1.40	1.55	110.6%

Excluding escalation areas there were 58.9 WTE vacancies at the end of October 2019. The tables below demonstrate the split between substantive and non-substantive nurses in ward based areas and how these were filled, as well as a table demonstrating the net vacancies after filling vacancies with temporary staff.



We used 36.2 temporary WTEs to fill the majority of vacant posts during October (45.6 in September). All ward based nursing overtime has now ceased, although this has resulted in a small increase in bank usage.

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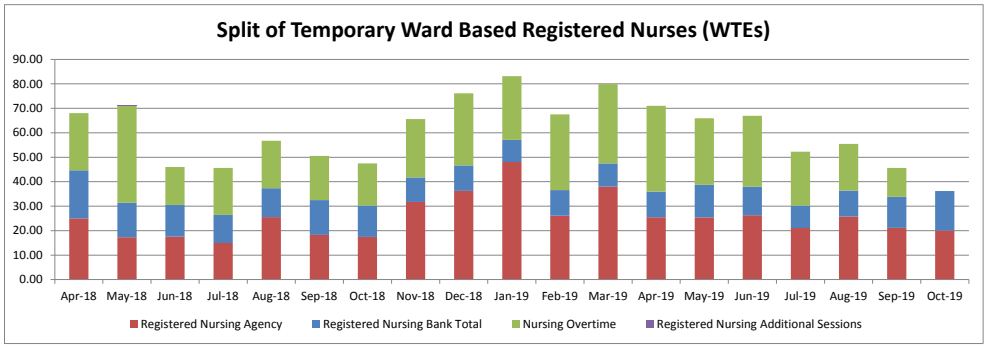
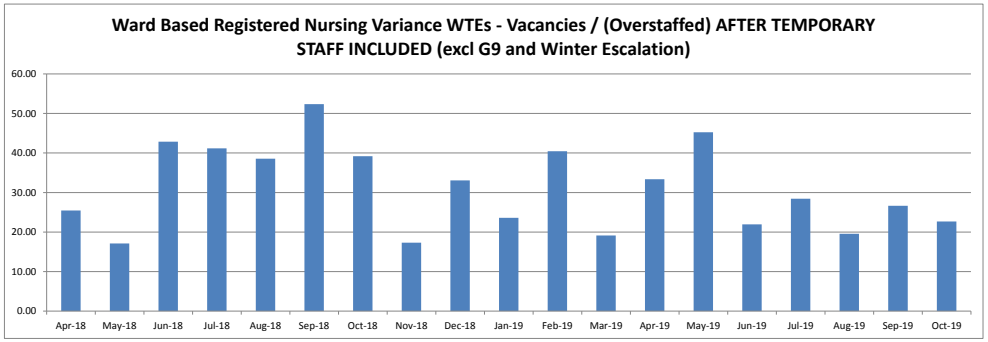


However, after using temporary nursing staff there remained 22.7 WTE uncovered Ward Based Registered Nursing Vacancies during October 2019 (26.6 WTE as at September 2019)



Ward Based Registered Nurses were under established by 22.7 WTE during October after utilising temporary registered nurses, broken down as below :

Division	Ward Area	Sum of plan september 19	Sum of Actual september 19	NET vacancies (over / (under)) September 19	Sum of plan october 19	Sum of Actual october 19	NET Vacancies (over / (under)) October 19
Medical Services	A&E Medical Staff	6.12	7.27	1.15	6.12	7	0.88
	Accident & Emergency	64.46	60.44	(4.02)	64.46	64.94	0.48
	C.C.U.	0	0	0.00	0	0	0.00
	Ward F9	20.85	18.38	(2.47)	20.85	19.94	(0.91)
	Ward F12	11.27	9.88	(1.39)	11.27	10.23	(1.04)
	Ward G1 Hardwick Unit	23.74	21.02	(2.72)	23.74	19.41	(4.33)
	Cardiac Ward	16.9	21.32	4.42	22.6	19.71	(2.89)
	Ward G4	19.78	17.28	(2.50)	19.78	17.35	(2.43)
	Ward G5	18.93	17.86	(1.07)	18.93	18.09	(0.84)
	Ward G8	24.62	20.33	(4.29)	24.62	24.6	(0.02)
	Medical Treatment Unit	7.04	7.62	0.58	7.04	7.34	0.30
	Respiratory Ward	20.69	20.19	(0.50)	20.69	20.51	(0.18)
	Cardiac Centre	40.14	35.33	(4.81)	40.14	36.97	(3.17)
	AAU	27.3	21.36	(5.94)	27.3	21.25	(6.05)
	Ward F7 Short Stay	22.66	24.23	1.57	22.66	22.95	0.29
Medical Services Total		324.5	302.51	(21.99)	330.2	310.29	(19.91)
Surgical Services	Ward F3	19.57	17.41	(2.16)	19.57	19.48	(0.09)
	Ward F4	13.78	11.88	(1.90)	13.78	11.48	(2.30)
	Ward F5	19.59	20.28	0.69	19.59	19.01	(0.58)
	Ward F6	19.57	21.53	1.96	19.57	18.97	(0.60)
Surgical Services Total		72.51	71.1	(1.41)	72.51	68.94	(3.57)
Woman & Children S	Gynae Ward (On F14)	11.18	10	(1.18)	10.78	11.14	0.36
Woman & Children Services Total		11.18	10	(1.18)	10.78	11.14	0.36
Community	Newmarket Hosp-Rosemary ward	12.43	11.19	(1.24)	12.43	12.93	0.50
	Community - Glastonbury Court	11.69	10.88	(0.81)	11.69	11.62	(0.07)
Community Total		24.12	22.07	(2.05)	24.12	24.55	0.43
Grand Total		**432.31**	**405.68**	**(26.63)**	**437.61**	**414.92**	**(22.69)**

Ward Based Unregistered Nurses were over established by 26.03 WTE during October after utilising temporary unregistered nurses, broken down as below :

Division	Ward Area	Sum of plan september 19	Sum of Actual september 19	NET vacancies (over / (under)) September 19	Sum of plan october 19	Sum of Actual october 19	NET Vacancies (over / (under)) October 19
Medical Services	Accident & Emergency	26.51	24.47	(2.04)	26.51	24.65	(1.86)
	C.C.U.	0	0	0.00	0	0	0.00
	Ward F9	23.18	26.2	3.02	23.18	25.17	1.99
	Ward F12	5.15	6.6	1.45	5.15	6.28	1.13
	Ward G1 Hardwick Unit	9.01	12.41	3.40	9.01	12.62	3.61
	Cardiac Ward	18.6	21.85	3.25	25.8	22.93	(2.87)
	Ward G4	25.03	29.38	4.35	25.03	28	2.97
	Ward G5	23.18	27.4	4.22	23.18	24.46	1.28
	Ward G8	25.13	29.77	4.64	25.13	25.87	0.74
	Ward G9 Escalation Ward	0	4.75	4.75	0	3.54	3.54
	Respiratory Ward	21.13	22.86	1.73	21.13	22.62	1.49
	Cardiac Centre	15.2	19.14	3.94	15.2	16.97	1.77
	AAU	29.8	29.91	0.11	29.8	30.02	0.22
	Ward F7 Short Stay	31.94	29.27	(2.67)	31.94	28.43	(3.51)
Medical Services Total		253.86	284.01	30.15	261.06	271.56	10.50
Surgical Services	Ward F3	22.26	25.97	3.71	22.26	26.81	4.55
	Ward F4	9.61	9.09	(0.52)	9.61	11.6	1.99
	Ward F5	14.51	14.71	0.20	14.51	15.09	0.58
	Ward F6	14.51	16.73	2.22	14.51	16.83	2.32
Surgical Services Total		60.89	66.5	5.61	60.89	70.33	9.44
Woman & Children Ser	Gynae Ward (On F14)	1	4.78	3.78	1	4.25	3.25
Woman & Children Services Total		1	4.78	3.78	1	4.25	3.25
Community	Newmarket Hosp-Rosemary ward	13.47	15.11	1.64	13.47	15.43	1.96
	Community - Glastonbury Court	12.64	13.29	0.65	12.64	13.52	0.88
Community Total		26.11	28.4	2.29	26.11	28.95	2.84
Grand Total		**341.86**	**383.69**	**41.83**	**349.06**	**375.09**	**26.03**

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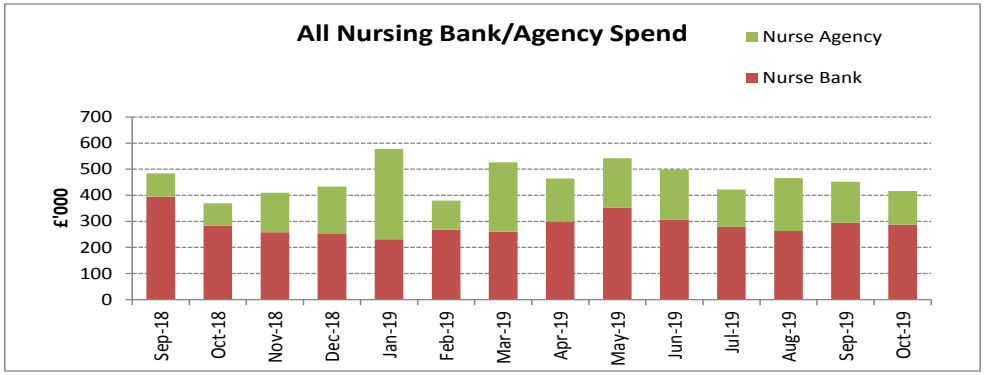
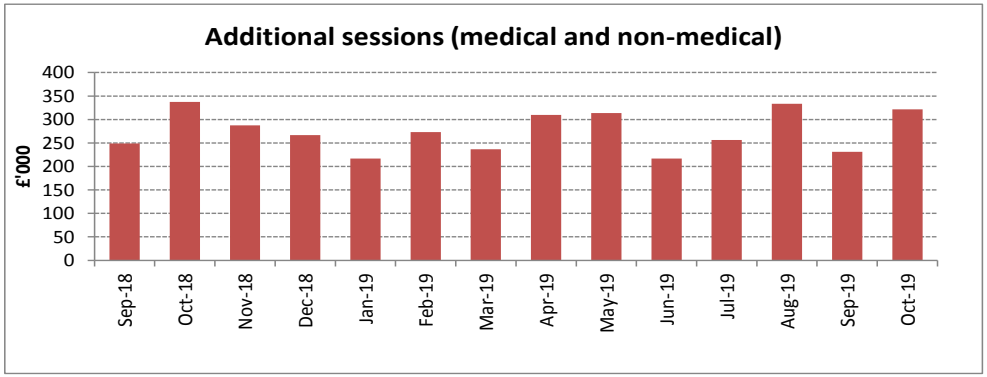
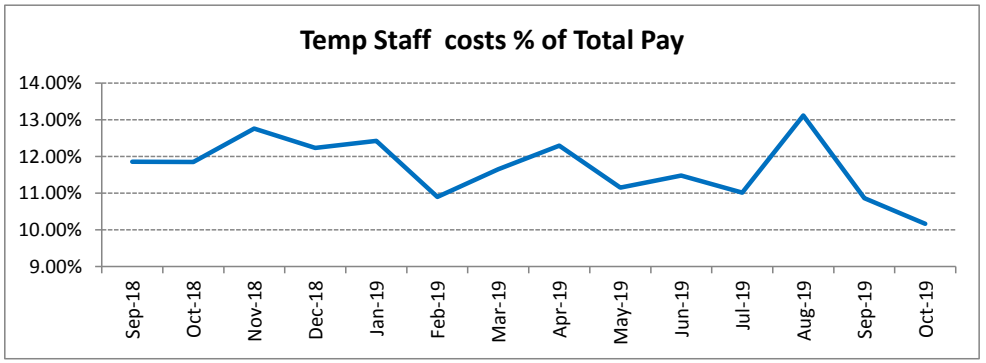
Pay Costs and Analysis

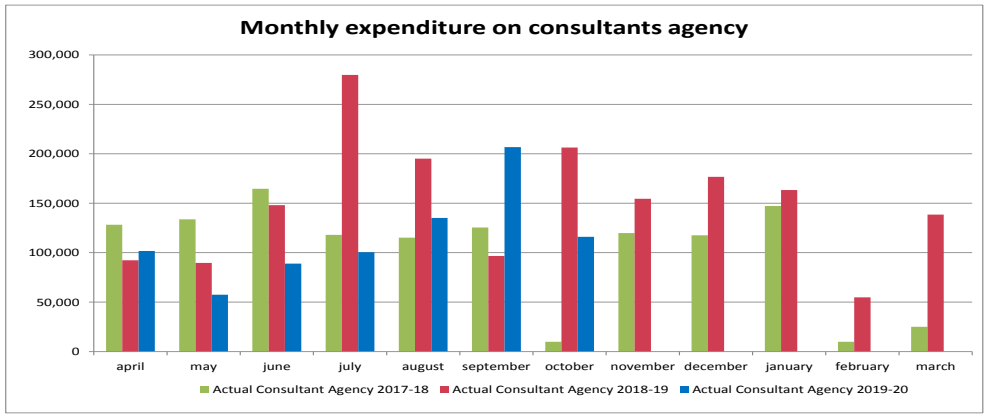
The Trust has overspent £626k on pay during October (£2.7m YTD).



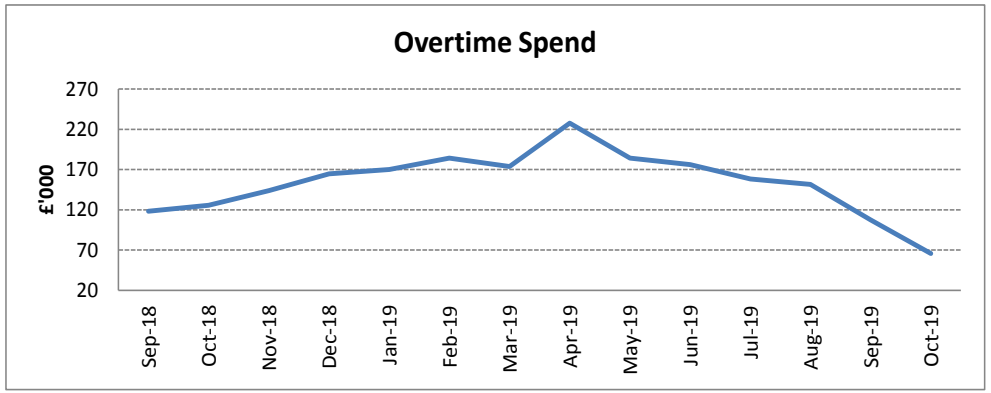




Whilst the Trusts proportion of temporary pay expenditure has fallen to 10.2% in October, if we had eradicated the premium paid for agency staff, locums and additional sessions this would have been 8.5%. We are therefore aiming to improve the proportion of temporary pay spend to less than 9%.



Overtime costs are falling as a result of an initiative to replace planned overtime with bank shifts (that do not attract the overtime premium).



Staff Recommender Scores

Our staff recommended scores for the period July to September 2019 are as below

- % of staff recommending WSH as a place to work – 75%
- % of staff recommending WSH as a place to receive treatment – 93%

FINANCE AND WORKFORCE REPORT - OCTOBER 2019

Summary by Division

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS (NET CONTRIBUTION) - October 2019

DIVISIONAL INCOME AND EXPENDITURE ACCOUNTS	Current Month Budget £k	Current Month Actual £k	Current Month Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(7,264)	(7,409)	144	(49,858)	(50,452)	594
Pay Costs	4,007	4,159	(151)	27,660	28,731	(1,071)
Non-pay Costs	1,441	1,453	(11)	10,754	10,693	61
Operating Expenditure	**5,449**	**5,611**	**(162)**	**38,415**	**39,424**	**(1,010)**
SURPLUS / (DEFICIT)	**1,816**	**1,798**	**(18)**	**11,444**	**11,028**	**(415)**
SURGERY						
Total Income	(6,423)	(6,504)	81	(37,046)	(37,004)	(42)
Pay Costs	3,035	3,259	(224)	21,339	22,026	(687)
Non-pay Costs	1,129	1,150	(21)	8,075	7,852	222
Operating Expenditure	**4,164**	**4,409**	**(245)**	**29,414**	**29,878**	**(464)**
SURPLUS / (DEFICIT)	**2,259**	**2,095**	**(164)**	**7,632**	**7,126**	**(506)**
WOMENS and CHILDRENS						
Total Income	(2,033)	(1,807)	(226)	(13,755)	(13,534)	(220)
Pay Costs	1,197	1,222	(25)	8,378	8,791	(413)
Non-pay Costs	145	157	(12)	1,052	991	61
Operating Expenditure	**1,342**	**1,378**	**(37)**	**9,430**	**9,781**	**(352)**
SURPLUS / (DEFICIT)	**692**	**429**	**(263)**	**4,325**	**3,753**	**(572)**
CLINICAL SUPPORT						
Total Income	(885)	(882)	(3)	(5,892)	(5,921)	28
Pay Costs	1,512	1,544	(32)	10,586	10,543	44
Non-pay Costs	978	1,130	(152)	7,082	7,865	(784)
Operating Expenditure	**2,490**	**2,674**	**(184)**	**17,668**	**18,408**	**(740)**
SURPLUS / (DEFICIT)	**(1,605)**	**(1,792)**	**(187)**	**(11,776)**	**(12,487)**	**(712)**
COMMUNITY SERVICES						
Total Income	(2,550)	(2,566)	16	(18,952)	(19,000)	48
Pay Costs	2,345	2,369	(25)	16,080	16,091	(11)
Non-pay Costs	1,054	871	183	6,922	7,475	(552)
Operating Expenditure	**3,399**	**3,241**	**158**	**23,002**	**23,566**	**(563)**
SURPLUS / (DEFICIT)	**(849)**	**(675)**	**174**	**(4,051)**	**(4,566)**	**(515)**
ESTATES and FACILITIES						
Total Income	(428)	(455)	28	(2,851)	(2,759)	(92)
Pay Costs	874	877	(3)	6,118	6,113	5
Non-pay Costs	635	664	(29)	4,147	4,325	(179)
Operating Expenditure	**1,509**	**1,541**	**(32)**	**10,264**	**10,438**	**(174)**
SURPLUS / (DEFICIT)	**(1,081)**	**(1,085)**	**(5)**	**(7,413)**	**(7,680)**	**(266)**
CORPORATE (excl Reserves)						
Total Income	(2,106)	(2,506)	401	(20,453)	(20,183)	(271)
Pay Costs	1,234	1,401	(167)	8,461	9,030	(569)
Non-pay Costs (net of Contingency and Reserves)	980	1,405	(425)	6,690	7,700	(1,010)
Finance & Capital	1,015	839	176	6,897	6,419	478
Operating Expenditure	**3,229**	**3,645**	**(416)**	**22,048**	**23,149**	**(1,101)**
SURPLUS / (DEFICIT)	**(1,123)**	**(1,138)**	**(16)**	**(1,595)**	**(2,967)**	**(1,372)**
TOTAL						
Total Income	(21,689)	(22,129)	441	(148,807)	(148,852)	45
Pay Costs	14,204	14,830	(626)	98,623	101,325	(2,702)
Non-pay Costs	6,361	6,830	(469)	44,721	46,901	(2,180)
Finance & Capital	1,015	839	176	6,897	6,419	478
Operating Expenditure	**21,580**	**22,498**	**(919)**	**150,240**	**154,645**	**(4,404)**
SURPLUS / (DEFICIT)	**109**	**(369)**	**(478)**	**(1,433)**	**(5,792)**	**(4,359)**

Note the clinical income figures are as earned within each Division as opposed to the contractual value (the adjustment to the block value is posted to Corporate, alongside other non-division specific income such as CQUIN and Excluded Drugs).

Medicine (Nicola Cottington)

The division reported an adverse variance of £18k in October (£415k YTD).

Pay expenditure exceeded plan by £151k in month, driven by the continued overspend against Medical Staffing (£177k in month) as well as the unplanned supernumerary costs of overseas nurses (£32k in month).

ED recorded £92k adverse variance in month, an increase of £14k compared to September. However, this continues to represent a significant reduction in temporary medical staffing spend of 25% when compared to the peak of activity in July, whilst still coping with increased activity against both prior year and plan (19% and 14% respectively). In particular the inability to substantively fill middle grade posts and cover for twilight and night shifts continue to drive this spend.

The use of temporary recruitment to cover substantive consultant vacancies and sick leave across Diabetes, Stroke, Gastroenterology and Clinical Haematology contributes £139k to the Medical staffing overspend. There are active recruitment plans across all specialities and a divisional review of all temporary medical spend across the division as part of the financial recovery plan. It is therefore anticipated that spend on locums will reduce in the coming months.

The non-pay budget is £11k overspent in month. Positive variances in transport (£17k, caused by costs being taken centrally) and Plant & Machinery leases (20k, reduction against PY) are offset by Cardiology consumables overspend (£54k) which is linked to the over-performance against income plan across Cardiology.

Medicine Division is forecasting a £1,244k overspend (excluding clinical income) for this financial year. The division is focusing on delivering its financial recovery plan and is working through schemes with reference to non-financial risks to ensure that patient safety and quality is not compromised.

Surgery (Simon Taylor)

The division reported an adverse variance of £164k in October (£506k YTD).

Income has over achieved by £81k (underachieved £42k YTD). Elective Inpatients has over achieved plan in month due to Orthopaedics and Urology activity whilst non-elective activity was below plan in Orthopaedics and General Surgery. Private patient income underachieved in month and continues to be significantly below last year's performance.

Pay reported a £224k overspend in the month and £687k YTD. Medical staffing is overspent by £185k of which £131k relates to additional sessions. Surgery has been affected by historic claims being paid in month. Action has been taken to reduce the risk of this happening in the future. Nursing continues to overspend but has improved compared to September, this is in part due to significant improvements in F6 and Critical Care. However, F6 will deteriorate in December due to supporting the SAU Model, which is not funded this year.

Non pay reported a £21k overspend in month (£222k underspent YTD). The overspend relates to one off issues and is not expected to recur.

Surgery's forecast has worsened to £1,497k, of which £587k relates to agreed unfunded cost pressures. A significant proportion of the forecasted overspend relates to additional sessions to support RTT and cover gaps due to consultant availability. Most of the remaining forecasted overspend on pay is Nursing of which £272k relates to ward based.

Women and Children's (Rose Smith)
The division reports an adverse variance of £263k in October (£572k YTD).

Income reported £226k behind plan in-month and is £220k behind plan YTD.

Pay reported a £25k overspend in-month and is £413k overspent YTD. In-month, the overspend resulted from RTT pressures in Obstetrics and Gynaecology and staffing pressures in Midwifery. Year to date, the Division has experienced cost pressures from covering gaps on the tier two medical staffing rota in Paediatrics, RTT medical staffing spends in Gynaecology and additional costs from opening beds on F10. The paediatric department have successfully recruited a tier two doctor which has helped to reduce the gaps requiring cover on the rota.

Non-pay reported a £12k overspend in-month and is £61k underspent YTD. This underspend reflects the low non-elective activity.

Clinical Support (Rose Smith)
The division reported an adverse variance of £187k in October (£712k YTD).

Income for Clinical Support reported £3k (£28k ahead of plan YTD).

Pay reported a £32k overspend in-month and is £44k underspent YTD. In month, the overspend was generated by activity pressures in Diagnostics and a locum microbiologist covering gaps in the consultant rota. Year to date, the vacancy gaps in Outpatients and Pharmacy staffing have more than offset the pay pressures experienced from the high levels of demand experienced by Radiology. The Outpatient service is holding some vacancies as part of the Division's financial recovery plan.

Non-pay reported a £152k overspend in-month (£784k YTD). In month, Diagnostics experienced cost pressures from Sunday endoscopy sessions, out of hours reporting and consumables. Pathology experienced in month cost pressures from the 2019/20 NEESPS contract, Point of Care Testing and blood products. Year to date, the demand related pressures in Radiology and the 2019/20 pathology contract have put constant pressure on the Division's non-pay budget. The Division is holding a CIP workshop to help mitigate some of the cost pressures seen in year.

Community Services and Integrated Therapies (Michelle Glass)
The division reported a favourable variance of £174k in October (£515k adverse YTD).

Income reported £16k above plan in month (£48k YTD).

In-month over spend on pay of £25k, (£11k YTD) due to the use of agency staff to support Newmarket Hospital's Rosemary Ward and locum usage to cover key practitioner vacancies in Adult Occupational Therapy and Dietetics. The Division continue to use agency staff to cover some vacancies across Integrated Therapy Services in order to meet demand, ensure service resilience and to support patient flow.

Non-pay reported a favourable variance of £183k in October, (YTD adverse variance of £552k). In month, the Division's budget recovery programme delivered, including receipt of an activity linked rebate for dressings/wound care. The YTD position reflects the increased cost of providing wheelchair equipment due to additional activity, including an investment in refurbishing recycled equipment, as well as funding improvements in IT infrastructure to support mobile working for clinicians. The year to date position also reflects increased expenditure on Community Equipment (CES) required to support patients at home, in the community. For example, to support the facilitation of hospital discharge through Pathway One, equipment is allocated early on, and there has been a marked increase in the number of requests for same day delivery to support this. The budget is profiled to anticipate higher spend on CES in the second half of the financial year, so we do not anticipate significant further escalation of cost pressures due to additional demand through the winter.

Use of resources Use of Resources (UoR) Rating

The Single Oversight Framework (SOF) assesses providers' financial performance via five "Use of Resources (UoR) Metrics.

The key features of the UOR ratings are as follows:

- 1 is the highest score and 4 is the lowest
- The I&E margin ratio is based on a control total basis rather than normalised surplus (deficit).
- The Agency rating measures expenditure on agency staff as a proportion of the ceiling set for agency staff. A positive value indicates an adverse variance above the ceiling.
- The overall metric is calculated by attaching a 20% weighting to each category. The score may then be limited if any of the individual scores are 4, if the control total was not accepted, or is planned / forecast to be overspent or if the trust is in special measures.

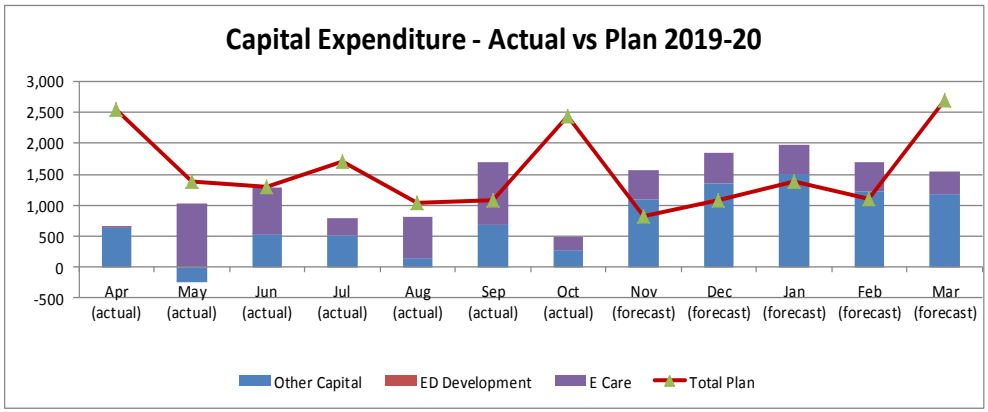
Metric	Value	Score	Plan
Capital Service Capacity rating	0.4	4	4
Liquidity rating	-41.0	4	4
I&E Margin rating	-5.9%	4	2
I&E Margin Variance rating	-5.0%	4	1
Agency	-8.0%	1	1
Use of Resources Rating after Overrides		3	3

The Trust is scoring an overall UoR of 3 this month, which is consistent with previous months.

The I & E margin rating and the Capital Service Capacity rating are closely linked and reflect the Trust is not generating a surplus in revenue to fund capital expenditure.

The Trust's revenue position for 2019/20 will need to improve to a significant surplus in order to be able to repay borrowing due and fund the planned capital programme without further borrowing.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2019-20 £'000
E Care	34	1,019	743	290	679	1,018	212	481	493	472	470	353	6,261
ED Development	0	0	0	0	0	0	0	0	0	0	0	0	1
Other Schemes	636	-242	534	512	138	683	278	1,087	1,354	1,503	1,226	1,186	8,894
Total / Forecast	670	777	1,277	802	817	1,700	489	1,567	1,847	1,975	1,696	1,539	15,156
Total Plan	2,560	1,385	1,305	1,710	1,050	1,075	2,434	815	1,075	1,380	1,101	2,702	18,592

The initial capital budget for the year was approved at the Trust Board Meeting on 26 April as part of the operational plan approval.

The capital programme for the year is shown in the graph above. The ED transformation scheme has now been approved subject to Full Business Case approval for £14.9m less £1.5m for an anticipated asset sale. This scheme is shown separately in the table above. It is now due to commence in 2020/21.

During the first seven months the Trust has been awaiting final confirmation of a capital loan to support the capital programme. For this reason many of the estates projects were held awaiting this approval. The loan was approved during the early part of November with a total of £8.2m to be received during 2019/20. The forecast assumes the position without the loan. This is to ensure the Board report reflect the NHSI return that was submitted prior to the approval of the loan. This loan partly supports the capital expenditure incurred to date. The balance will be used to commence some of the schemes previously delayed. The November capital figures will reflect this loan and the capital expenditure that can now be supported.

As the larger estate schemes have not started there are no material variances on the schemes. E-care expenditure continues to be spent. This is still within forecast but this position is getting tighter.

FINANCE AND WORKFORCE REPORT - OCTOBER 2019

Statement of Financial Position at 31st October 2019

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2019	Plan 31 March 2020	Plan YTD 31 October 2019	Actual at 31 October 2019	Variance YTD 31 October 2019
	£000	£000	£000	£000	£000
Intangible assets	33,970	35,940	35,547	35,022	(525)
Property, plant and equipment	103,223	115,395	113,720	113,007	(713)
Trade and other receivables	5,054	4,425	4,425	5,054	629
Other financial assets	0	0	0	0	0
Total non-current assets	**142,247**	**155,760**	**153,692**	**153,083**	**(609)**
Inventories	2,698	2,700	2,700	2,837	137
Trade and other receivables	22,119	20,000	20,000	20,738	738
Other financial assets	0	0	0	0	0
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	4,507	1,050	2,042	1,498	(544)
Total current assets	**29,324**	**23,750**	**24,742**	**25,073**	**331**
Trade and other payables	(28,341)	(32,042)	(30,082)	(30,718)	(636)
Borrowing repayable within 1 year	(12,153)	(3,134)	(3,134)	(13,400)	(10,266)
Current Provisions	(47)	(20)	(20)	(47)	(27)
Other liabilities	(1,207)	(992)	(5,064)	(6,469)	(1,405)
Total current liabilities	**(41,748)**	**(36,188)**	**(38,300)**	**(50,634)**	**(12,334)**
Total assets less current liabilities	**129,823**	**143,322**	**140,134**	**127,522**	**(12,612)**
Borrowings	(84,956)	(99,186)	(98,281)	(83,009)	15,272
Provisions	(111)	(150)	(150)	(111)	39
Total non-current liabilities	**(85,067)**	**(99,336)**	**(98,431)**	**(83,120)**	**15,311**
Total assets employed	**44,756**	**43,986**	**41,703**	**44,402**	**2,699**
Financed by					
Public dividend capital	69,113	70,430	69,239	69,112	(127)
Revaluation reserve	6,931	9,832	8,021	9,855	1,834
Income and expenditure reserve	(31,288)	(36,276)	(35,557)	(34,565)	992
Total taxpayers' and others' equity	**44,756**	**43,986**	**41,703**	**44,402**	**2,699**

Non-Current Assets

The net capital investment in intangible assets and property, plant and equipment (PPE) is lower than originally planned due to the phasing of the capital programme starting later than planned during 2019/20. In addition, we acquired Newmarket Hospital on 30 September for £8.5m, which is now reflected within property, plant and equipment. This was not included in the plan.

Cash

The cash position is being rigorously monitored on a daily basis to ensure that the minimum level requirement of £1m is maintained. The cash position is not significantly out of line with the plan. Revenue borrowing continues to be obtained to ensure that we can manage our expenditure payments.

Trade and Other Payables

These continue to increase and have increased by £1.7m since September. This is due to the Trust continuing to hold back payments at the end of the month to manage the cash position. The trade payables balance is in line with the plan.

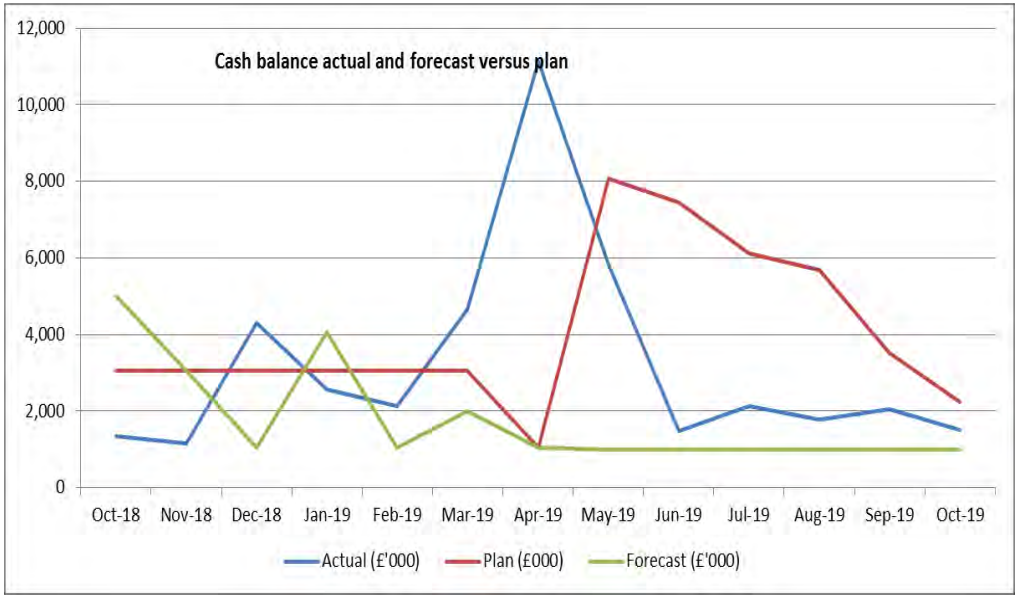
Borrowing

Our borrowing requirements continue to be kept under close review. A further loan of £2.9m has been received in November. The Capital Loan of £8.2m has now been agreed and the Trust is profiled to receive £5.7m of this in December. This will assist to recoup the cash reserves already used to pay for capital items. Further revenue borrowing is expected to be required in December, although at a lower level than in previous months. The Trust is required to repay £2m of loans by 31 March 2020.

FINANCE AND WORKFORCE REPORT - OCTOBER 2019

Cash Balance Forecast for the year

The graph illustrates the cash trajectory since October 2018. The Trust is required to keep a minimum balance of £1m.

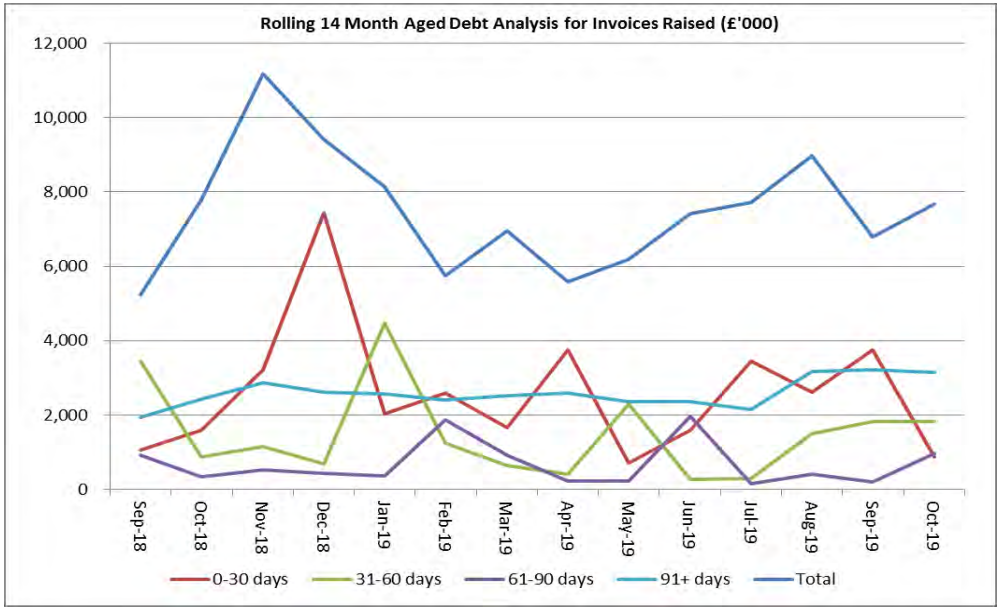


The October 2019 cash position is slightly lower than planned and is linked to the current financial position. We continue to use our cash reserves on capital spend, which we can recover once we receive our capital funding.

The cash position is being rigorously monitored on a daily basis to ensure that the minimum level requirement of £1m is maintained. As noted above, a further loan of £2.9m has been received in November. The Capital Loan of £8.2m has been agreed and the receipt of this will assist to recoup the cash reserves already used to pay for capital items. Further revenue borrowing is expected to be required in December, although at a lower level than in previous months.

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 invoices raised but not paid has increased by £0.8m since September. Over 83% of these outstanding debts relate to NHS Organisations, with over 28% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the corresponding NHS Organisations for these debtor balances.

10. Winter planning - tracking report

To ACCEPT the report

For Report

Presented by Helen Beck

Trust Board – 29 November 2019

Agenda item:	10			
Presented by:	Helen Beck, chief operating officer			
Prepared by:	Alex Baldwin, deputy chief operating officer Sarah Watson, head of nursing – medicine division			
Date prepared:	21 November 2019			
Subject:	Winter Plan			
Purpose:	x	For information		For approval

Executive summary:

This paper provides a further update on preparation for the winter season alongside the most up-to-date staffing picture.

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

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

Previously considered by:	N/A
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	*To be assured that the Trust has robust plans in place to deal with increased demand during the winter season.*

Recommendation:
The Board is asked to note the contents of this report.

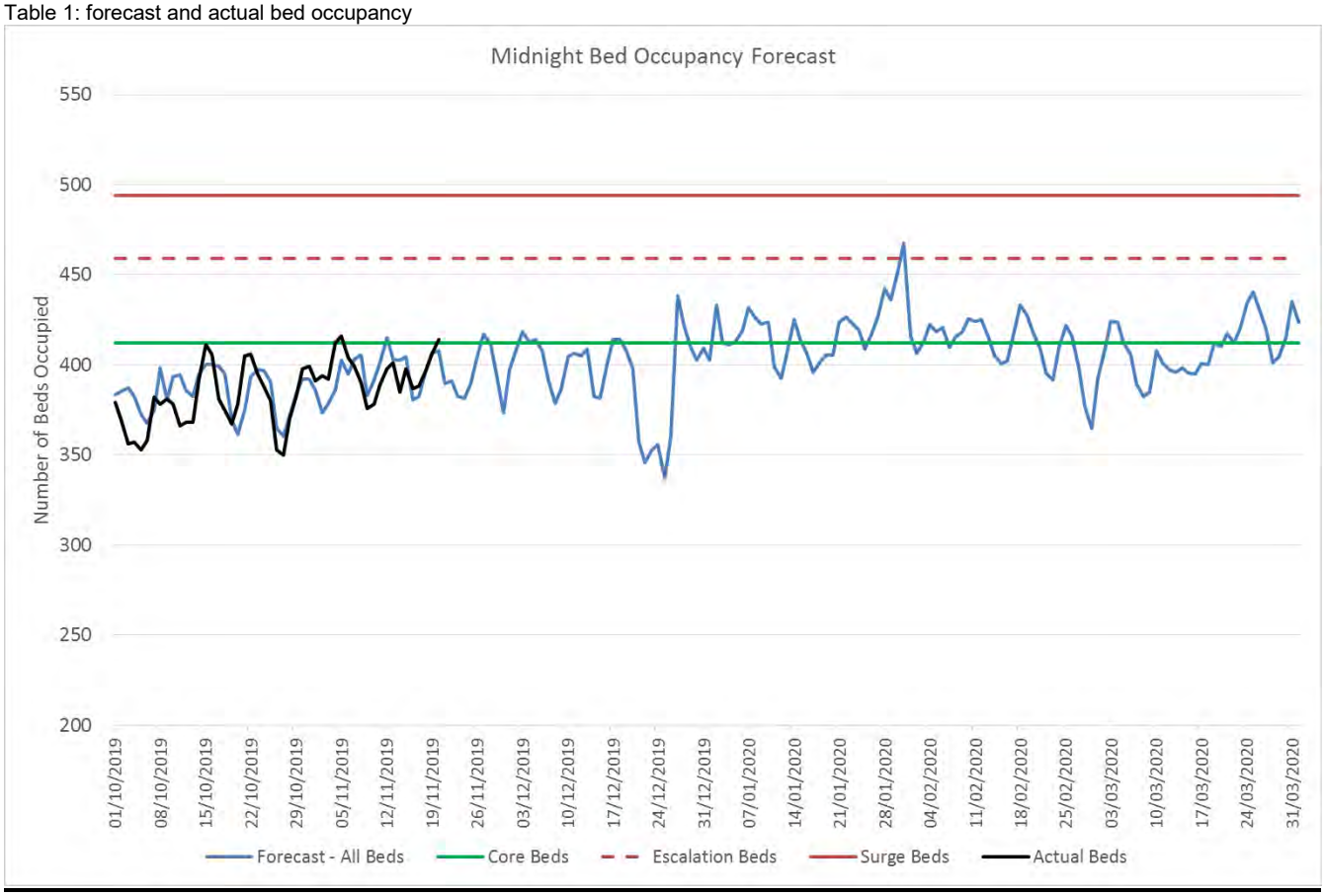
Introduction

The board has previously received a summary of proposed plans to manage anticipated increase in demand during the winter season. It is expected that the Trust will increase its acute bed base by a total of 54 additional beds (a mixture of escalation and surge capacity) with an additional 10 beds available in the community for admission avoidance and reablement support.

Current bed occupancy

Table 1 demonstrates that current bed occupancy is broadly in line with expected demand. Two minor peaks are expected in the next two weeks but we anticipate these will be manged through normal flex in capacity. Thereafter the significant peak in demand commences at the end of January and continues until the end of March. Our plans to increase capacity match these demand peaks and will be delivered as required.

Table 1: forecast and actual bed occupancy



Capacity increase

The medicine division has a robust plan to open 25 escalation beds on F10 from 16th December. It is anticipated that the majority of staff will be in place from 1st December to allow for a period of acclimatisation.

At the time of writing there remain **3.46** WTE RN vacancies to be filled. The nursing assistant establishment has **zero** vacancies and a matron and ward manager have been appointed. There remain **1.0** WTE care coordinator and **0.2** WTE ward clerk vacancies.

The medical team has been identified and will be in place for 16th December.

It is expected that an additional 29 surge beds will be opened on G9 effective from 27 January. At present there at **10.68** WTE RN and **18.42** WTE NA vacancies. In addition, **1.0** WTE care coordinator and **0.4** WTE ward clerk posts need to be filled.

Whilst there remain a number of vacancies the level of staffing is significantly better than last year and to some respect gaps will be mitigated by an incremental approach to opening surge capacity (in practice this means that bays will be opened and closed as required subject to demand and staffing levels).

Work to fill the gaps remains ongoing and a cross-divisional approach has been adopted supported by corporate colleagues. Whilst G9 staffing remains a risk further in-depth analysis of establishments has commenced to identify any additional areas which might be able to support. This includes a review of recent recruitment to identify unsuccessful candidate suitable for winter posts.

All equipment and IT requirements have been reviewed and there are appropriate plans in place.

System preparation

At a system level there are robust plans as we head into the winter season, this includes initiatives board has been briefed on previously and covers service resilience in areas such as 111, emergency, elective and cancer services, same day emergency care and community capacity and workforce. There remains an action to embed social care plans within the wider system plan which is being addressed as a matter of urgency.

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

11. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

For Report

Presented by Rowan Procter

Trust Board – 29 November 2019

Agenda item:	11			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Rowan Procter, Executive Chief Nurse, and Sinead Collins, Clinical Business Manager			
Date prepared:	18th November 2019			
Subject:	Quality and Workforce Report & Dashboard – Nursing			
Purpose:	X	For information		For approval

Executive summary:
The aim of the Quality and Workforce Report and Dashboard is to enhance the understanding ward and theatre staff have on the service they deliver, identify variation in practice, investigate and correct unwarranted variation and lead change to demonstrate value. It also complies with national expectation to show staffing levels within Open Trust Board Papers both inpatient and non-inpatient areas.

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

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

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

Recommendation:
This paper is to provide overview of October's position about nursing staff and actions taken to mitigate, future plans and update on national requirements.

The dashboard provides summary of nursing staffing levels and effect on nurse sensitive indicators
Provides an update on implementation of NHSI Document 'Developing workforce safeguards – October 2018'

NHSI Document 'Developing workforce safeguards – October 2018' update

Assistant Directors of Workforce met on 30th October 2019 to discuss how to implement the recommendations in the NHSI Document 'Developing workforce safeguards' further and determine if extra resource was required. Actions from this were to:

- Have Governance Workforce Strategy be adjusted to include required information.
- Recruitment strategy to be reviewed.
- Quality Impact Assessments to be added into organisation change policy document.
- Initiate a workforce establishment meeting

All done except Quality Impact Assessments.

A workforce establishment meeting focussing on Recommendation numbers 2, 8, 9 and 10 was held between HR and Finance on 19th November 2019.

This was to cover:
2) Trusts must ensure the three components (see Figure 1 below) are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes.

We will check this in our yearly assessment.

Figure 1: Principles of safe staffing

8) They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.

9) An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.

10) There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.

It was agreed that a paper needed to be brought to TEG, to get agreement whether to use evidence-based tools when calculating establishments OR develop a risk assessment as to why the Trust uses professional judgment and occasionally outcomes over evidence-based tools. An SOP is also to be developed when creating and maintaining establishments, this is to be done

be Charles Davies and Len Rowland. Sinead Collins is to work with Performance to get Model Hospital into Board reports.

Nursing vacancy accuracy position – There is an identified lead in assuring the Board of an accurate position.

Healthroster implementation into community – Michelle Glass, ADO Integrated Services, working with Allocate to visit neighbouring areas to see programme in real-time

Overview of October' nurse staffing position

Are we safe?
Matrons continue to have daily safety huddles and now on 7 day shift pattern to help provide safe staffing assurance. A pilot is also running around additional WSP work on Saturdays to support weekend work around sourcing bank staff outside of hours

Assurance for community staffing has interim measures of daily calls with area leads and the local area managers and nursing leads, however for a more visual and accurate measure they will have to wait till later in year before HealthRoster can start to be implemented. Senior team members are actively working with team leads to implement safer staffing measures, as identified in WSFT rostering policy, and all rosters are now visible with the development of a cloud-based IT system

Steps are well underway to ensure the wards are appropriately staffed for winter escalation wards with the correct skill mix, as well has having appropriate oversight and governance.

Are we efficient?
The sickness has got worse this month

The Heads of Nursing for Medicine, Surgery and Community meet with senior operational managers, West Suffolk Professionals Manager and the HealthRoster Lead on a weekly basis, to review forthcoming rosters with the aim to identify staffing deficits in a timely way. This ensures early identification of vacant shifts to WSP staff and provides an opportunity for proactive planning and mitigation of risk.

CHPPD figures similar to comparable wards in other hospitals.

Future planning – Nursing staff

Overseas Nurses/Nursing Assistants

Month	Number of arrivals
Jul-18	3
Aug-18	4
Sep-18	6
Oct-18	9
Nov-18	5
Dec-18	0
Jan-19	4
Feb-19	7
Mar-19	6
Apr-19	0
May-19	16
Jun-19	14
Jul-19	13
Aug-19	0
Sep-19	12
Oct-19	12
Total	110

Information as at 12 November 2019:

84 overseas nurses have passed their OSCE and are now working as Band 5 Nurses

2 OSCE Resits to be booked for November 2019

12 OSCES booked for December 2019

12 Nurses currently going through OSCE preparation and will undertake their OSCE exam in January 2020

Future Arrivals:

13 Nurses due to arrive on 29 November 2019

13 Nurses due to arrive on 2 January 2020

20 Nurses being processed and due to arrive between February - April 2020

WSH Existing Staff:

2 Internal WSH NA's have now passed their OSCE and working as Band 5 Nurses

Welcome Payments:

43 Welcome Payments have been made to Band 5 nurses joining the Trust.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Oct-19		Establishment for the Financial Year 2019/20		Data for October 2019																	
					Workforce													Nursing Sensitive Indicators					
Trust	Ward/Area Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Fill rate Registered %		Fill rate Unregistered %		Bank Use %	Agency use %	Overall Care Hours Per Patient Day	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)	Red Incidents	Complaints	Compliments
			Registered	Unregistered	Day	Night	Day	Night				Registered	Unregistered									
WSFT	ED	Emergency Department	54.91	23.43	89.0%	103.0%	87.0%	163.0%	8.2%	14.6%	N/A	-12.10	-2.30	4.70%	12.70%	1.20%	N/A	4	0	0	3	6
WSFT	AAU	Acute Admission Unit	27.30	29.59	93.0%	79.0%	70.0%	119.0%	6.5%	5.3%	17.0	-7.10	1.20	3.30%	14.10%	4.90%	0	6	1	0	0	0
WSFT	F7	Short Stay Ward	22.84	30.94	107.0%	96.0%	81.0%	93.0%	11.8%	3.8%	7.1	-0.90	-4.60	9.00%	12.80%	4.70%	2	5	1	0	0	0
WSFT	CCS	Critical Care Services	41.07	1.88	93.0%	90.0%	N/A	N/A	1.8%	3.6%	27.2	-0.40	1.00	6.00%	12.60%	4.10%	0	4	0	0	0	8
WSFT	Theatres	Theatres	61.68	22.27	100.0%	100.0%	N/A	N/A	1.7%	0.0%	N/A	-1.40	-2.80	4.70%	13.50%	1.30%	N/A	2	0	0	0	0
WSFT	Recovery	Theatres	21.23	0.96	150.0%	89.0%	79.0%	N/A	2.2%	0.0%	N/A	0.10	1.00	1.00%	14.60%	4.30%	0	1	N/A	0	0	0
WSFT	Day Surgery Unit	Theatres	28.43	8.59	69.9%	N/A	193.9%	N/A	0.9%	0.0%	N/A	-4.90	4.50	7.20%	10.40%	0.00%	0	0	0	0	0	2
	Day Surgery Wards		11.76	1.79					9.3%	0.0%		-0.60	0.10	8.50%	9.60%	4.50%						
WSFT	ETC	Opthalmology	TBC	TBC	71.0%	N/A	155.0%	N/A	1.4%	0.0%	N/A	2.20	2.80	3.60%	8.50%	4.70%	N/A	0	0	0	0	0
WSFT	PAU	Pre-assessment	TBC	TBC	73.8%	N/A	86.8%	N/A	0.9%	0.0%	N/A	0.00	1.30	7.20%	8.50%	2.90%	N/A	1	0	0	0	0
WSFT	Endoscopy	Endoscopy	TBC	TBC	155.0%	N/A	161.0%	N/A	0.0%	0.0%	N/A	-2.00	1.00	4.20%	14.50%	1.90%	N/A	2	0	0	0	2
WSFT	Cardiac Centre	Cardiology	38.14	15.20	89.0%	86.0%	96.0%	106.0%	4.0%	0.1%	10.2	-2.30	2.30	4.30%	15.10%	2.30%	0	1	1	0	0	1
WSFT	G1	Palliative Care	23.96	8.31	81.0%	103.0%	104.0%	N/A	13.0%	2.8%	11.8	-4.30	3.50	11.90%	8.70%	3.20%	1	6	1	0	0	0
WSFT	G3	Endocrine & Medicine	TBC	TBC	115.0%	163.0%	151.0%	157.0%	13.2%	4.4%	6.4	-0.30	5.80	6.60%	9.90%	0.00%	5	3	5	0	0	0
WSFT	G4	Elderly Medicine	19.16	24.36	89.0%	88.0%	97.0%	109.0%	18.3%	3.3%	5.9	-3.90	0.30	5.90%	8.70%	3.20%	2	3	1	0	1	0
WSFT	G5	Elderly Medicine	18.41	22.66	99.0%	101.0%	93.0%	133.0%	21.8%	1.9%	5.8	-2.00	-3.40	4.50%	10.70%	2.60%	0	0	4	0	0	1
WSFT	G8	Stroke	23.15	28.87	93.0%	96.0%	101.0%	120.0%	16.6%	2.3%	7.5	-0.90	0.70	4.10%	14.60%	6.50%	1	1	3	0	0	0
WSFT	F1	Paediatrics	18.13	7.16	114.0%	100.0%	101.0%	N/A	20.0%	0.0%	18.7	-1.50	2.30	7.60%	14.80%	3.60%	N/A	3	N/A	0	1	0
WSFT	F3	Trauma and Orthopaedics	19.58	22.27	86.0%	102.0%	99.0%	120.0%	20.3%	3.9%	6.5	-4.0	0.00	8.00%	12.00%	0.00%	1	4	0	0	0	0
WSFT	F4	Trauma and Orthopaedics	12.78	10.59	80.0%	93.0%	65.0%	110.0%	16.6%	0.8%	6.5	-0.8	-1.90	1.60%	11.60%	0.20%	0	3	0	0	0	1
WSFT	F5	General Surgery & ENT	19.58	14.51	103.0%	97.0%	92.0%	107.0%	8.6%	0.0%	5.8	-0.4	-0.50	3.80%	14.60%	0.00%	0	0	0	0	1	0
WSFT	F6	General Surgery	19.57	14.51	93.0%	95.0%	99.0%	106.0%	13.0%	1.5%	5.2	-0.8	1.80	8.20%	14.60%	1.90%	2	2	0	0	0	0
WSFT	F8	Respiratory	19.90	20.13	107.0%	96.0%	98.0%	101.0%	4.2%	6.7%	7.0	-1.20	0.20	4.00%	14.80%	0.00%	2	2	0	0	0	0
WSFT	F9	Gastroenterology	20.32	22.56	101.0%	99.0%	80.0%	146.0%	21.9%	0.4%	5.8	-1.50	-1.00	7.80%	12.70%	3.80%	1	3	3	0	1	0
WSFT	F11	Maternity	49.58	13.89	95.7%	96.0%	93.0%	84.0%	8.8%	0.0%	N/A	3.90	0.80	1.80%	12.10%	3.30%	0	2	0	0	2	0
WSFT	MLBU	Midwifery Led Birthing Unit															0	0	0	0	1	0
WSFT	Labour Suite	Maternity															0	0	0	1	0	0
WSFT	Antenatal/Gynae Clinic	Maternity	TBC	TBC	89.0%	N/A	74.0%	N/A	3.3%	0.0%	N/A	1.50	-0.40	3.20%	11.00%	0.00%	N/A	0	0	0	1	0
Community	Community Midwifery	Maternity	TBC	TBC	52.0%	N/A	49.0%	N/A	4.6%	0.0%	N/A	-3.50	0.00	3.60%	13.30%	7.00%	0	0	0	0	0	0
WSFT	F12	Infection Control	11.02	5.00	83.0%	82.0%	91.0%	119.0%	8.5%	1.2%	9.5	-2.90	0.90	9.50%	12.30%	0.00%	0	1	0	0	0	2
WSFT	F14	Gynaecology	11.18	1.00	120.0%	109.0%	N/A	N/A	24.3%	1.1%	12.6	-1.90	0.00	3.50%	13.30%	0.00%	0	1	0	0	1	0
WSFT	MTU	Medical Treatment Unit	7.04	1.80	89.0%	N/A	95.0%	N/A	7.6%	0.0%	N/A	1.80	-0.20	2.00%	11.90%	5.90%	0	0	0	0	0	0
WSFT	NNU	Neonatal	20.85	3.64	94.0%	80.0%	45.0%	65.0%	2.3%	0.0%	30.3	-3.10	-1.00	1.80%	19.50%	3.20%	N/A	0	N/A	1	0	8
WSFT	Outpatients	Outpatients	TBC	TBC	91.0%	N/A	162.0%	N/A	3.6%	0.0%	N/A	-0.30	-2.40	10.60%	12.10%	3.30%	N/A	0	0	0	0	0
WSFT	Radiology Nursing	Radiology	TBC	TBC	88.0%	N/A	147.0%	N/A	7.1%	0.0%	N/A	-0.40	-1.40	2.90%	3.40%	3.40%	N/A	0	0	0	0	0
WSFT	DWA	Discharge Waiting area	TBC	TBC	8.0%	N/A	33.0%	N/A	26.7%	19.8%	N/A	-1.20	-1.00	0.00%	5.00%	0.00%	0	0	0	0	0	0
Newmarket	Rosemary Ward	Step - down	12.34	13.47	130.0%	99.0%	107.0%	97.0%	3.5%	9.3%	5.6	-1.20	-0.60	6.00%	15.10%	0.00%	0	1	1	0	1	0
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64	115.0%	96.0%	100.0%	100.0%	7.1%	2.2%	4.8	-2.20	0.20	10.30%	13.50%	0.00%	0	0	2	0	1	0
					94.47% AVG	97.52% AVG	103.21% AVG	114.93% AVG				-60.50 TOTAL	8.20 TOTAL	5.36% AVG	12.14% AVG	2.44% AVG	17 TOTAL	61 TOTAL	23 TOTAL	2 TOTAL	14 TOTAL	31 TOTAL

Trust	Team Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Patient facing contact (hrs)	Unplanned requests	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (New)	Nursing/Midwifery Administrative Medication Errors	Red Incidents	Missed Visits	Complaints	Compliments
			Registered	Unregistered			Registered	Unregistered									
Community	Bury Town	Community Heath Team	17.59	5.60	1597.17	82	-2.97	-0.20	5.11%	Not available comprehensively till Healthroster implemented	Not available this month	12	0	1	0	0	0
Community	Bury Rural	Community Heath Team	10.00	1.20	814.90	35	-2.00	-1.20	6.40%			6	0	0	0	0	0
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91	901.82	47	-1.60	0.00	7.75%			1	0	0	1	0	0
Community	Newmarket	Community Heath Team	8.10	2.75	571.53	28	-2.60	0.00	1.49%			4	1	0	0	0	0
Community	Sudbury	Community Heath Team	18.03	8.36	1376.98	87	-3.48	-1.20	5.92%			8	3	0	3	0	0
Community	Haverhill	Community Heath Team	8.97	4.23	916.63	42	-2.60	0.00	10.93%			3	0	0	1	0	0
Community	Admission Prevention Service	Specialist Services	11.28	3.45	102.35	5	0.00	0.00	8.69%			0	0	0	0	0	0
Community	Specialist Services	Cardiac Rehab and Heart Failure	TBC	TBC	477.95	4	0.00	0.00	0.00%			0	0	0	0	0	0
Community	Children	Community Paediatrics	16.37	15.01	1550.45	0	0.00	-0.24	2.06%			N/A	0	0	0	0	0
					8309.78 TOTAL	330.00 TOTAL	-15.25 TOTAL	-2.84 TOTAL	5.37% AVG	#DIV/0! AVG	#DIV/0! AVG	34 TOTAL	4 TOTAL	1 TOTAL	5 TOTAL	0 TOTAL	0 TOTAL

Explanations	
	Fill Rate: an indication of patient safety - national target 80% (less than = red), Trust internal target 85% (equal and greater than = green)
	In vacancy column: - means vacancy and + means over established. Excludes maternity leave as separate column
	Sickness Trust target: <3.5%
	Annual Leave target: (12% - 16%)
	Maternity Leave: no target
	Medication errors are not always down to nursing and can be pharmacist or medical staff as well
	DSU has been split into ward and unit only by HR, that is why only a section has been split in this dashboard
	F10 (F14) gynae inpatients ward no of beds 16 and 2 SR - and have a ward attender section

Key	
N/A	Not applicable
ETC	Eye Treatment Centre
I/D	Inappropriate data
TBC	To be confirmed

12. Quality and learning report

To receive the report

For Report

Presented by Rowan Procter

Trust Open Board – 27th November 2019

Agenda item:	12			
Presented by:	Rowan Procter – Executive Chief Nurse			
Prepared by:	Governance Department			
Date prepared:	November 2019			
Subject:	Quality and Learning report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 30/09/19.

Information has been obtained from the following data sources:

- Investigation of serious incidents and resultant action plans
- Thematic analysis of incidents at all grades for the quarter
- 'Learning from deaths'
- Review of complaints received and responded to within the quarter
- Review of claims received and settled within the quarter
- Themes arising from the PALS service
- Risk assessments created or updated within the quarter
- Other soft intelligence gathered within the quarter

Key highlights in this report are as follows:

- Learning from Deaths Q2 report
- Theme reports on claims and pressure ulcers
- Learning events and bulletin
- 'Greatix' / learning from Excellence

Please note:

- Key performance indicators (KPIs) relating to the subjects listed above are reported separately in the Open Board Integrated Quality & Performance report (IQPR).
- Assurance reporting including Executive-led walkabouts and table top exercises and 'Deep dive' audits are provided to the Board sub-committees CSEC, PEC and CRC.
- Escalation (including serious new incidents, Red complaints, claims and dated inquests of concern) are reported separately to the Closed Board.

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

Trust ambitions	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
		X	X				X
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: The Board to note this report							

Activity within the quarter

This will include some or all of the following sources: completed SI investigations, aggregated incident investigations, complaints responses, themes from PALS enquiries, settled claims, learning from deaths, Executive walkabouts and table-top exercises and concluded inquests.

1. Learning themes from investigations in the quarter

SI RCA reports submitted in Q2

There were 16 SI reports submitted in Q2. There were no reports submitted on behalf of other organisations in the quarter and two cases were reported to the HSIB (Healthcare Safety Investigation branch) for external investigation.

This is the highest number of reports submitted since this report was first issued (for Q3 17/18) and is mainly a consequence of the eight falls with serious harm and three Intrauterine deaths (IUD) in the period.

Incident details	Learning
WSH-IR-47531 Delay in escalation of a deteriorating patient to senior clinicians and ITU. Patient suffered a cardiac arrest shortly after admission to ITU and despite resuscitative efforts sadly died	**Root causes** Multiple ward moves and clinical teams involved in treatment, Extremely busy weekend in hospital, Challenging IV access, resulting in delays administering blood transfusions and collecting urgent blood samples and gaps in reviews overnight by clinical staff **Lessons learned** Whilst the post take review noted possible haemolytic anaemia, correct treatment was not included within the management plan at this stage (I.e. steroids, blood transfusion) Blood coloured urine was not due to haematuria, rather excretion of blood cells; therefore irrigation was not required Severe haemolysis poses a high risk of VTE, and therefore, pharmacological thromboprophylaxis should have been discussed with the haematology team earlier for consideration Whilst the central line request was entered onto the patient electronic notes, and the on call anaesthetist had been contacted; the emergency theatres' team were not made aware of this request until later in the day (the theatres team / co-coordinator would not have been routinely accessing patient notes). Requested bloods were not collected immediately following central line insertion by the anaesthetic team despite the request from the referring junior doctor, resulting in delays obtaining blood tests, and receiving further blood transfusion

Incident details	Learning
	Actions • Review of fluid balance guideline • Development of IV fluid prescription and administration combined guideline • Nursing handover being reviewed; to consider use of SBAR tool which includes patient assessments and measurements • Discuss case with e-Care team to explore if there is a solution that can be embedded to prevent excessive 'overriding' of important tasks • Development of guideline for treatment of haemolytic anaemia for clinicians to refer to out of hours (inclusion of treatment flow chart within the WSH emergency black book) • The most appropriate place for patients should be considered prior to ward moves despite intervention required • If complex patients require intervention that ward staff are not familiar with, assistance from suitable practitioners should be sought for support on base wards (according to patient safety) • Consultant to consultant communication should be accepted practice for complex patients to ensure that the most appropriate treatment plan is managed in a timely fashion • Inclusion of agreed referral and escalation of central line requests within the theatre team with induction of new medical staff in anaesthetics / ICU / theatres CD for anaesthetics • Visual reminder in the theatres department regarding referral and escalation process (I.e. laminated sign by the telephone) • Earlier consideration for patients with complex needs and poor IV access, especially when urgent transfusion is required with regard to more IV definite access (Ie. PICC lines, central lines) • Discuss issues with IV access for complex patients requiring urgent treatment at the ICU M&M meeting for clarity over referral process between ICU and theatres **Shared learning pathways** Direct feedback to ward staff regarding importance of fluid balance Direct feedback to ward, medical and outreach staff / share report and actions at 'mop up' meeting Present case at nursing and midwifery meeting Inclusion of VTE and importance of completion / seeking guidance for complex patients for junior doctor teaching (within PfPP week) Present case at medical governance meeting to ensure that importance of referral to specific specially teams is paramount for patients with complex diagnosis
WSH-IR-49297 Unexpected death post chemotherapy	**Root cause** Different staff groups use different locations on Aria and E-Care to record patient care and planned care **Lesson learned** Communication within and between teams is key when understanding previous care, treatment and results when providing current treatment. All notes to be consistently recorded in an agreed place in order to reduce risk of information being missed Review of all relevant documentation, from all disciplines to be completed before decisions made in regard to current /future care. **Actions** • Explore alternative prescribing system for chemotherapy within E-Care • To introduce a robust documentation/checking process which is used by all clinicians and record in a Standard Operating Procedure (SOP) • Training for all staff on SOP once finalised **Shared learning pathways** Medical divisional board. Macmillan unit clinical governance meeting Copy of report sent to all Macmillan unit team

Incident details	Learning
WSH-IR-47873 IUD associated with placental abruption at 32+3 weeks	**Root cause** Placental abruption (There is a recognised increased risk of placental abruption and intra uterine death due to smoking in pregnancy) **Lessons learned with associated actions** It is important to ensure that women who smoke in pregnancy are given information about the specific risks of smoking in pregnancy, as well as being referred to smoking cessation services. At antenatal appointments it is important to record if women are taking Aspirin as advised, or if they have declined to take it (as well as repeating the advice to take it). Full MEOWS (maternal early obstetric warning system) observations are extremely important in the identification and management of a deteriorating patient. Baseline observations should be taken as soon as possible after admission. The MEOWS score should be calculated at every set of observations. If the MEOWS score 'triggers' (i.e. is three or more) observations should be repeated every 15 minutes. Remifentanyl was not available on Labour Suite when the anaesthetist requested it. This used to be ward stock but had not been re-ordered for 6 months. This meant that the doctor had to return to the main theatre to check this drug out. It was agreed that it should always be available on the Labour Suite. The anaesthetist reflected that there was a slight delay in administering Tranexamic Acid because it was locked away with the controlled drugs and not stored with the other PPH drugs. It was agreed that some should always be stored in the emergency PPH 'grab box'. It was identified at the RCA that earlier involvement of the haematology doctors after the clotting results were found to be critically abnormal would have been ideal practice (although this is unlikely to have affected the outcome). **Shared learning pathways** All staff involved in the RCA investigation will receive feedback. All staff within the maternity service will receive anonymised feedback via the monthly publication 'Risky Business'. Copies of the report will be shared with ESNEFT (Ipswich), the Local Learning Set (LLS) and with the patient's GP. Learning will be shared with the multidisciplinary team at the Women's Health Governance Meeting and at the Trust Learning from Deaths group (which receives a quarterly report)
WSH-IR-48032 IUD at 38 weeks	**Root cause** After a thorough investigation it was agreed that there appeared to be no care service delivery problems identified which had contributed to the sad outcome in this case. A postmortem was declined but histology of the placenta showed patchy mild acute chorioamnionitis, however all other maternal and fetal infection screening reported no evidence of any bacterial growth present. Unfortunately the investigation could not say with any certainly why this baby died. **Lessons learned** There should be a system in place for the clinic room at the community team base to be re-checked at the end of clinic to ensure that the room is ready and has all necessary equipment. Staff should follow Trust guidelines for referring women to: • The anaesthetic department. • Consultant led care during pregnancy. Midwives who book women for antenatal care should be made aware of the criteria for anaesthetic referral and criteria for consultant led care for women with congenital heart conditions. CO readings above 4ppm at any time during pregnancy should prompt a discussion around smoking and this should be documented in the records. Guidelines require updating: • Smoking in Pregnancy • Booking Framework Antenatal Risk assessment and Antenatal Care • Management of Small for Gestational Age Babies

Incident details	Learning
	Shared learning pathways 'Risky Business'. Women's Health Governance Meeting Trust Learning from Deaths group
WSH-IR-49426, IUD at 35+5 weeks following attendance with reduced fetal movements.	**Root cause** After a thorough investigation it was agreed that there appeared to be no care service delivery problems identified which had contributed to the sad outcome in this case. All of the results and findings indicate that undiagnosed gestational diabetes was the cause of intra uterine death. **Lessons learned** Discrepancy between symphysis fundal height measurements – need to ensure that midwives are up to date with training and guidance by the Perinatal Institute so that the correct technique is always used. **Actions** • Midwives should complete Growth Assessment Protocol e-learning package produced by the Perinatal Institute annually. This ensures compliance with the Saving Babies Lives care bundle. • The Training Needs Strategy to be updated at the earliest opportunity to reflect this. **Shared learning pathways** 'Risky Business'. Women's Health Governance Meeting Trust Learning from Deaths group
WSH-IR-46215 Baby transferred to tertiary centre for therapeutic cooling This is a standard reportable event within Maternity services at WSFT. In this case an external opinion of the case was sought in addition to the multi-professional review.	**Care delivery problems identified** CTG monitoring of the fetal heart and maternal pulse was not of a good quality to reliably assess baby's condition during the second stage of labour leading to misinterpretation of an abnormal trace and because of this the birth had not been expedited earlier. No consideration to attaching a fetal scalp electrode which may have giving a more reliable and direct reading of baby's heartbeat.There was no continuous monitoring of the maternal pulse during the second stage of labour. Had this been achieved adequately it may have enabled a clearer differentiation between the fetal heart and the maternal pulse rate. CTG interpretation - It appeared that around full dilatation an event had occurred which seriously compromised baby but which staff did not recognise in their interpretation of the CTG trace and act promptly to expedite the delivery. Human factor elements - CTG interpretation does not occur in isolation alone, but should be part of whole assessment of what happening at the time. In this case baby was premature at 36 weeks gestation, mother had made rapid progress and there was an expectation she would give birth sooner than she did. In this case it was felt there may have been some loss of situational awareness in the passage of time which may have impacted on decision making. **Actions** • Reminder to midwives co-ordinating the Labour Suite to consider requesting a member of staff to scribe in circumstances when they are unable to do this. The labour Suite to review the current system for checking levels of stock items so that is equipment available at all times in case they are required urgently Enquire to other units to evaluate the scope of the problem regarding gel nails and maternal pulse oximeter monitoring. Contact the manufacturers to enquire as to the length of the attachment life • Remind staff to consider advice on passive smoking in the household or possible exposure to environmental sources where CO readings are high and women have stopped smoking. **Shared learning pathways** Dialogue on Risky Business around the importance of effective monitoring. Discuss with the Labour Suite coordinators at their team meeting. Medical / Maternity staff to meet with the clinical director / inpatient services manager, to review and reflect, learns lessons and improve future patient care.

Incident details	Learning
WSH-IR-48226 Failure to act on abnormal investigation results	**Root cause** The X-ray report was not coded CACXR. This code is added to the report of any imaging suspicious of cancer in the chest with the results sent to the respiratory MDT for further follow up. **Lessons learned** Language used on reports must be explicit about what action is required. CACXR codes are not consistently being used. Multiple ward and consultant moves, breaks continuity of care **Actions** • Radiology to audit the robust process of using CACXR on x-ray reports when suspicion of cancer is raised to determine assurance that the risk is minimal. • e-Care team to review the process of the retrieval process of endorsed results on e-Care and share Trust wide with medical staff. **Shared learning pathways** Radiology governance Medical divisional board Teams involved in the care of the patient
WSH-IR-47946 Same ribotype of multiple cases of Clostridium difficile	**Root cause / casual factors** The potential for further onward transmission of Clostridium difficile is increased if a patient known to be colonised remains on the ward. One patient known to be colonised had multiple admissions with crossover between all three known positives Frequently touched surfaces require decontamination between each use, many of the patients on G5 require mobility aids and re enablement equipment which are handled and shared between patients. These are detergent cleaned which was insufficient in the presence of C difficile. G5 has highest rate of IV therapy within Trust and all the patients identified with C difficile were on complex regimens. The current drug preparation area is insufficient (too small) for the demand and may have contributed to cross infection in this outbreak. **Lessons learned** Need to prescribe probiotics appropriately for patients on broad spectrum antibiotic therapy Decant facility essential to undertake deep clean inclusive of entire ward HPV fogging. **Actions** • Create drug room which is fit for purpose. • Declutter ward environment and ensure stock levels are correct and reduce overstocking. • Deep clean of unoccupied ward. • Remove large linen/multipurpose trolley and order smaller closed linen trolley. • Ward medical consultants to update all of the junior doctors to check probiotic prescriptions have been commenced as part of the daily ward round. • All patients to be wheeled or walk to the bathroom to use the toilet facilities, only bedbound patients to be toileted at the bed space to reduce infection risk and preserve dignity. **Shared learning pathways** Ward management team to circulate C Difficile specific newsletter's for staff weekly for a month Clinical Governance ward meeting / divisional Governance Infection Prevention Committee Matrons' meeting
Patient fall resulting in serious harm (#NoF or head	There were eight reports submitted in Q2 for patient falls resulting in serious harm. A review of the cases found the following themes: Side rooms, Radiology, Falls care plans, LSBP, Frequent fallers, MCA/DOLS, Family involvement, Footwear, Clinical condition, Ward moves and Patient non-compliance with safety advice.

Incident details	Learning
injury)	**Actions** from these reports included: • Appropriate assessments for side-room suitability • Explore opportunities for ways to escalate when multiple radiological examinations are required / competing priorities / ways to get timely responses • Bite size training on Deprivation of Liberty, Mental capacity and LSBP • Raise awareness that hospital slippers available if patient does not have their own • Introduction of Trust policy on use of nicotine replacement therapy for patients **Shared learning pathways** Feedback to 4-ways (out of hours radiology) Dissemination of falls policy to nursing staff on relevant wards Include in ward newsletters Falls link nurses attending study days with feedback to ward staff

2. Learning from Deaths

'Learning into action' in Q2

The Learning from deaths group, meets monthly to oversee the process associated with all learning aligned to Learning from Deaths. The learning from deaths (LfD) reviews in Q2 identified the following themes in addition to those reported as an SI (of which there were four in Q2).

Themes from poor care:

No new themes were identified in Q2. There were further examples highlighting the previously noted themes of:

- Failed / delayed recognition of end of life
- Continued active treatment after palliation started.
- Inappropriate resuscitation

Two cases were highlighted for review as a serious incident in Q2. One was downgraded at an initial Day two review meeting and one was already the subject of an SI prior to the LfD review (a patient who suffered cardiac arrest following a diagnosis of aortic dissection).

Investigation outcomes of the four SIs reported in last qtr. are reported in section 1 earlier in this report. The table below provides the outcome of the LFD group review of preventability.

Ref.	Incident details	Preventability status
WSH-IR-47531	Delay in escalation of a deteriorating patient to senior clinicians and ITU	LfD group agreed >50% preventable*
WSH-IR-47442	Fall with head injury, died 5 days post-fall	LfD group not yet reviewed
WSH-IR-47711	Fall with #NoF, died 13 days post-fall	LfD group agreed >50% preventable
WSH-IR-49297	Unexpected death of a chemotherapy patient with neutropenic sepsis	LfD group agreed >50% preventable

* >50% preventable = Considered more likely than not to have been due to problems in the care provided to the patient.

In November the LfD group discussed a proposal to undertake an assurance process for a small sample of actions from the cases agreed as >50% preventable to look in depth at completion, effectiveness and communication to families about the action. More detail to be provided in the next quarterly learning report.

Learning into action (L*into*A)

The new LfD draft strategy sets out a re-structure of the way that LfD is undertaken which will enable greater resource to be allocated to implementation of learning through a series of projects. These will include focus on identified themes from reviews, learning from excellence and how to 'spread the message' to staff of all disciplines and to families.

Where a review identifies a standalone action (example from 2019 '*report a specific adverse drug interaction via the MHRA yellow card notification*'), these will continue to be captured in the LfD group's L*into*A report.

Future assurance reports to CSEC will include status reports on the LfD project plan.

Examples of excellence:

Within the SJR review process care is often recognised as Excellent / Outstanding. This can be at the levels of: Whole care episode, Team / Ward or Named individual.

The LfD team have begun to use GREATix to formalise the feedback and reporting upon this activity.

Table 1: Narrative from reviews in Q2.

Ward G3	*Family of a dying patient said that the nursing staff went above and beyond. They were a large family, and the ward allowed them all to visit, and allowed 2-3 relatives to stay with the patient - day and night*
Dr (ST1)	*Wonderful discussion with a dying patient's relatives on two separate occasions with clear, concise and empathetic records in the notes*
Ward G7	*The family of a lady who died on G7 said that all the nurses were amazing. They couldn't have wished for anything better. They said that the nurses were always checking in on the family to see if there was anything else they could do to help.*
Ward G5	*They looked after a dying man in the beginning of September and this man's wife said that the nursing staff were excellent. She could not fault them, and it was lovely that her and her family were given coffee and sandwiches when they were visiting.*

Further plans to ensuring learning from excellent care is identified and shared include:

- Cases to be invited as case presentation at a shared learning event or a case study in the shared learning bulletin.
- Exploring options for family members to provide video feedback on their experiences.
- Consideration how the LfD group family representative (could act as an ambassador to invite and support families to share their experiences - both positive and negative.

Table 2: LfD Reviews completed

Qtr.	Deaths		SJR* identified	
	Total	With SJR* completed	Poor / very poor care	Excellent care
Q3 18/19	227	227	16	52
Q4 18/19	274	147	18	41
Q1 19/20	257	113	11	32
Q2 19/20	316	116	17	34

* SJR = Structured judgement review

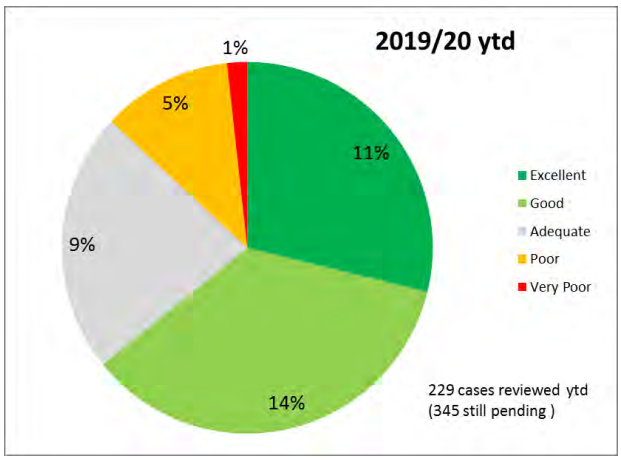


Chart 1: SJR outcome classifications

NB: this excludes IUDs and Neonatal deaths which are reported separately.

Some cases are reported which are subsequently classified as not Inpatient deaths (e.g. ED deaths) however they are included in the chart if a review has been undertaken.

Of the 229 cases reviewed in 2019/20 to date only 30 (6%) were classified as Poor or Very poor. 147 (25%) were classified as Good or Excellent.

(data prepared as at 6th November 2019)

Table 3: Outcome of SJR rating

Qtr.	Total	Poor care / Very poor care case outcome following Exec review				
		Awaiting classification	Straightforward (includes theme)	Complex case	NFA required	SI consideration required
Q3 18/19	16	0	4	0	9	3 2 confirmed as SI
Q4 18/19	18	0	12	2	3	1 0 confirmed as SI
Q1 19/20	11	3	4	2	1	2 1 confirmed as SI
Q2 19/20	17	7	6	1	1	2 1 confirmed as SI

Of the 17 cases of Poor / Very poor care in Q2; eight have had an executive review to highlight investigation or action requirements resulting in two cases being classified as a requiring Serious incident (SI) decision making (one confirmed as an SI and the other rejected as not meeting the SI definition at Exec-led 'Day two' meetings) with the remainder requiring either local M&M review, green incident investigation or falling into the previously highlighted themes. There are another seven still awaiting classification.

Table 4: Outcome of SJR rating

Qtr	SIs reported in Qtr* (for inpatient deaths in that period)	SI report presented to LfD led to judgement that death was:	
		Unlikely to have been due to problems in the care provided to the patient'	More likely than not to have been due to problems in the care provided to the patient
Q2 18/19	3	3	1
Q3 18/19	1	0	1
Q4 18/19	4	0	3
Q1 19/20	4 (one still pending)	0	3
Q2 19/20	3 (all still pending)	pending	pending

* NB: a case may be reported as an SI even if there has not been a SJR poor care outcome (e.g. most often a death following a fall which is an automatic SI) and so these numbers include additional cases not included in the previous table.

Of the eight deaths in 2018/19 which were the subject of an SI investigation, four were found to be "*More likely than not to have been due to problems in the care provided to the patient*" and four were not.

Of the seven deaths in 2019/20 to date which were the subject of an SI investigation, three were found to be "*More likely than not to have been due to problems in the care provided to the patient*" and four are still pending presentation to LFD group. One is scheduled to be discussed in the November meeting and the three other have not completed the investigation pathway.

3. Quality Walk About from Q2

During Q2 there were a total of **nine executive-led quality walkabout visits** in the following areas:

- medical wards - G4, G8 and F8
- surgical ward - F5
- specialty areas - endoscopy, maternity birthing unit, critical care and clinical skills based in the Education Centre.

The areas are chosen by the patient safety and quality team to cover a variety of settings across the hospital and community. Community visits continue to be difficult to undertake due to the logistics and practicalities of visiting teams covering a wide geography. Plans are in place to visit the inpatient community areas and quality assurance visits are taking place for community services. The ADO for community and integrated services is collating a list of suitable venues for quality walkabouts which will be shared with the patient safety team and added to the future schedule.

Some **key points** from the quarter have included:

- the innovative use of a model called ‘Clarence’ on G8 to represent elements of care patients might receive. This has been replicated in other wards in the Trust
- the consideration of utilising a different entrance method for transient ischemic attack (TIA) patients to enter the clinic as opposed to walking through the ward
- on F6 there was visible leadership with good interactions between the matron, unit manager, service manager, heads of nursing and associate directors of Ops, staff felt informed and aware of recent issues and empowered to make changes
- there were some issues raised on the maternity unit regarding safe staffing and high sickness rates. This required a second visit and the leadership team were able to address some of these concerns.

The actions from walkabouts cover simple ward based changes, such as addressing storage issues and inconsistent checking of resus trolleys and fridge temperatures. But also include wider issues such as completing service reviews and making environmental changes. The purpose of walkabouts has evolved from its starting point of scrutinising an area for patient safety and quality purposes. It now allows us to gain a sense of the area and provide an opportunity for the staff to link with the executive team, NEDs and governors. The visits also provide an opportunity for those attending to gain an understanding what is working well and what could be improved in the area and across the organisation. To reflect these changes we continue to develop the action planning process to ensure effective capture of local and corporate issues and robust follow-up to ensure learning.

There were a total of **28 new actions** identified during Q2. These are captured centrally using Datix. The use of Datix to monitor and share these actions with the ward and divisional leaders is seen as positive progress and provides the opportunity for divisional thematic review. It also enables actions to be reviewed and escalated if necessary on a monthly basis to the Trust’s Quality Group. The actions from previous walkabouts have been uploaded to Datix and the patient safety team are reviewing these to obtain an updated status for each action. This will allow us to close those that have been addressed and put in place a structure for ongoing follow up. There are **nine previous actions** due for closure which will be followed up and escalated if appropriate action is not taken, these cover:

- Improved access/use of facilities within area
- Equipment/IT
- Staffing issues
- Training and service development

5. Learning from Excellence ('Greatix')

In August 2019 the Trust launched 'Greatix; set up to capture excellent practice, positive incidences and ideas, and share them across the Trust. This is based on the national concept of learning from excellence which explains that *'Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. Excellence in healthcare is highly prevalent, but there is no formal system to capture it. We tend to regard excellence as something to gratefully accept, rather than something to study and understand.'* https://learningfromexcellence.com

To date there have been 80 Greatix submitted, some for individuals and others for whole teams. Each nomination is fed back to the name individual(s), copying in senior management with personal thanks from the Deputy Chief Nurse.

The Learning from deaths team are already using Greatix to capture and report and the system is being updated to enable capture and reporting by divisions. Most Greatix fall in the following categories

- Staff going above and beyond in their daily work
- Positive patient, family and carer experience
- Prevention of clinical incidents
- Thanking teams

Many highlight opportunities to share practice wider through forums such as the WSFT Nursing & Midwifery clinical council, Maternity Risk business newsletter, governance meetings and learning bulletins.

It is encouraging to see that staff in all areas of the trust are using Greatix and nominating colleagues who are clinical (of all disciplines), non-clinical as well as students and volunteers. There has been very positive feedback also from recipients and senior management cc'd in with three examples shared below.

"Thank you for recognising the hard work of the nurses on MTU. I work alongside a great team that often go the extra mile for our patients. They are all a great example of what a good nurse should be, and I'm truly proud to be part of MTU. Thank you once more for taking the time to send this email."

"Many thanks, I have shared this with the team. I am proud of the way we go the extra mile and support our patients' individual needs and experience in DSU"

"This is fantastic news for all involved in this project who deserve the 'pat on the back' for all their hard work put in to the huge task of transferring from the old to the new helpdesk system, while maintaining our service levels to the Trust. The fact that this has been recognised by our fellow colleagues and they have made an effort to write in and nominate the Estates Team for this award makes all the effort put into planning, procuring, installing and training of the many users of the system all worthwhile. Thank you for this acknowledgement and I will gladly share this with all those involved in this project"

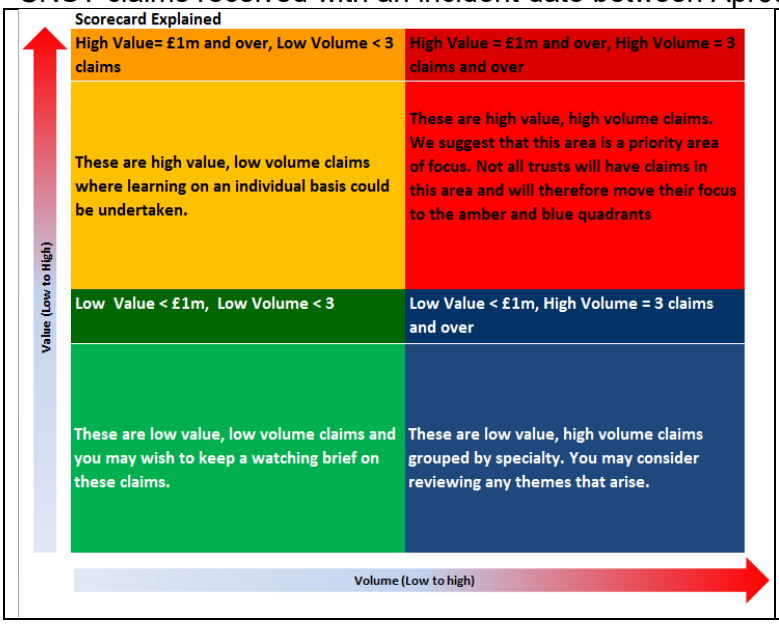
Greatix is only in its infancy at WSFT but it is hoped that through wider feedback, thanking the named individuals (and those who reported the events) and seeking ways to share the learning we can make learning from excellence as wide an opportunity for improvement as learning from incidents.

6. Other learning themes / Updates from reports in previous quarters

Subject / Theme Claims
Source Datix, GIRFT, NHS Resolution
Risk register entry N/A
Trust owner Information Governance & Legal Services Manager

Summary of learning and areas for improvement in this topic

The 2019 Claims scorecard has been issued by NHS Resolution for WSFT which includes all CNST claims received with an incident date between Apr09 and Mar19.



General Surgery 1 Haematology 1 Radiology 1	Obstetrics 3
Anaesthesia 2 Public Health 1 Dentistry 2 Dermatology 2 Endocrinology 1 Infectious Diseases 1 Neurology 1 Non-Clinical Staff 1 Not Specified 1 Plastic Surgery 1 Psychiatry/ M. Health 1 Renal Medicine 2 Respiratory / Thoracic 1 Rheumatology 2 Vascular Surgery 2	Cardiology 4 A&E 34 Gastroenterology 3 General Medicine 13 General Surgery 13 Geriatric Medicine 3 Gynaecology 13 Intensive Care 4 Obstetrics 25 Oncology 7 Ophthalmology 3 Orthopaedic Surgery 35 ENT 8 Paediatrics 3 Radiology 3 Surgical Other 4 Urology 32

NHS Resolution advise that Trusts should:

- Share headline data with the Board, on the value and volume of all claims by specialty and cause to facilitate discussion. An integrated report which triangulates complaints, (serious) incidents and claims is a recommended approach.
- Interrogate claims and the costs of these within each division, and engage all staff on your trust's claims profile.
- Utilise the scorecards to consider areas for a targeted quality improvement focus for the reduction of clinical and non-clinical claims.

The GIRFT programme provides an opportunity to undertake such a review through the GIRFT Litigation data pack which has led to the following action plan (being overseen by the Corporate Risk committee.

GIRFT Action	Trust Action	Person Responsible	Status
Assess benchmarked position compared to the national average and the top quartile when reviewing the estimated litigation cost per activity	Distribute GIRFT Data pack	Medical Director	Complete
	Divisions to review and discuss at appropriate divisional forum		
Review with the legal or claims department in your trust the claims submitted to NHR R included in the data set to confirm correct coding to that specialty. Inform NHSR of any claims not coded correctly to the appropriate specialty	Review all claims, identifying Datix numbers and claim details.	Head of IG & Legal Services	Complete
	Contact NHSR for claims that can't be identified / have been miscoded		Complete

GIRFT Action	Trust Action	Person Responsible	Status
Review claims in detail including expert witness statements, panel reports and counsel advice as well as medical records to determine if patient care could be improved	Identify claims in bottom 2 quartiles of performance	Head of IG & Legal Services	Complete
	Review identified claims with panel solicitor to confirm outcome/expert reports		Complete
	Summarise legal position on each identified claim for process carried out – SUI / expert reports / prelim analysis / repudiated / settled / closed.		Complete
	Legal services team to record learning of identified claims and report on progress	Legal Services team	Complete
Claims should be triangulated with learning from complaints, inquests and SIs and where a claim has not already been reviewed as an SI we would recommend that this is carried out to ensure no opportunity for learning is missed	Governance department to commence SIRI process for identified claims. To triangulate with complaints and inquests.	Deputy Head of Patient Safety	Complete
Reporting	Report progress to CDs	Medical Director	By end 2019
	Final GIRFT meeting		

The highlighted sections produced a 'lessons learned' document which listed 14 cases over the time period, all but one of which were either the subject of an SI at the time (six cases) or did not meet the definition of an SI but were investigated through other local pathways (including complaints and incidents) (seven cases) and only one case, raised in 2012/13 had not been considered as an SI at the time despite meeting the criteria.

This provided reassurance that the integrated approach to triangulation with incidents, complaints, inquests etc. is working well. The one case that had not been picked up (delay in identification of a pulmonary embolism) was taken to a 'day-2' SI decision making meeting where it was decided not to continue due to the age of the incident and the fact that more recent cases had explored the same subject so there was not a risk of missing opportunities for improvement in this subject area.

There were no obvious themes in the cases, the details of which were reported to the Corporate Risk committee as part of the regular Legal services report in November 2019. The 14 cases did include four alleged diagnosis delays but these were in different specialities and for different conditions.

Subject / Theme Pressure ulcers (PUs)
Source Incidents
Risk register entry RR888
Trust owner Pressure Ulcer Prevention group (PUPG)

Summary of learning and areas for improvement in this topic

Since January 2019 the trust has recorded PUs on Datix using the NHSI categorisation of:

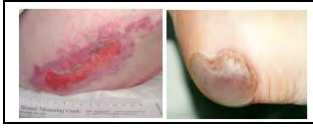
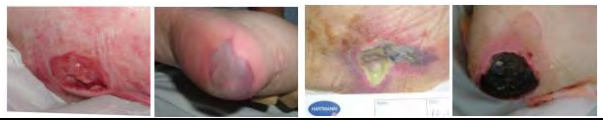
- New (developed whilst in hospital or during a Community care episode
- Present on Admission (this includes present at start of Community care episode)

The Datix incident reporting form is also designed to capture:

- Location of PU (heel, sacrum, etc.)
- Whether a medical device was contributory (hoist, nasal cannula etc.)
- Moisture damage
- Nursing / residential home (for those PU present on admission)

The reporting of moisture associated skin damage is a new (national) data requirement and the team are collating and analysis the data with a view to developing a targeted strategy for roll out in the New year to address areas of need. More details on this will be provided to CSEC and in future learning report updates.

PUs are sub-divided by categories according to depth of wound and are recorded as an incident on Datix. '*Present on admission'* are recorded and closed for record-keeping only and '*New'* are reported with a concise RCA undertaken. For Category 4 only, a serious incident (SI) report is completed and reported to the CCG as well.

Superficial	**Deep**	
Category 2*	Category 3 / Unstageable	Category 4
Green incident	Amber incident	Red incident
		

*Category 1 are not reportable

The concise RCA was designed by the Hospital and Community TVN leads (now operating as one combined team) to act as an audit tool to identify where in the patient pathway the problems occurred. By completing this for every case, regardless of severity, it provides a large dataset which can enable lessons learned and targeted action in a more structured way than just relying on a smaller number of comprehensive RCA reports.

The initial take-up of the concise RCA was gradual with some wards / community teams completing the audit more frequently than others. As it is a requirement of the investigation pathway, strategies to improve this have included TVN communication with low completing areas and the Datix team returning finally approved (that are without the RCA) incidents to the teams cc'ing in the Head of Nursing. This has seen a significant improvement in September.

The audit questions sub-divide into four focus areas:

Risk assessment and skin inspection	**Nutrition**	**Equipment and positioning**	**Patient information and capacity**
• Waterlow completed within 6hrs/at first visit? • Waterlow completed weekly or if condition changed? • Skin inspected daily(hospital) / at each visit(community)? • PU assessment template completed?	• Nutrition assessment complete / documented within 24hrs? • MUST risk assessment completed weekly / if condition changed? • Was nutrition and hydration adequate for patient's needs?	• Pressure relieving equipment in place prior to PU? • Was there any delay in equipment delivery? • Was the patient compliant with equipment use? • Was the patient compliant with position changes?	• Mental capacity assessed if patient refused care or advice? • Documented explained consequences of refusing care/advice? • PU prevention advice or leaflet given at initial contact?

The audit data is reviewed on a bi-monthly basis at the Pressure Ulcers and Complex Wounds group using the most recent three months rolling data-set to track the impact of improvement strategies. There has been a real drive to improve the nutrition awareness as a result of this RCA data as this was the biggest concern flagged through this data.

Actions taken include:

- TVNs reviewing MUST assessment completion for each patient on caseload and feedback omissions to RN caring for same.
- TVS to report trends in terms of clinical areas failing to complete MUST, to Senior Matrons.
- Focus on rising the profile of links between poor nutrition and skin breakdown at every opportunity, to include: Time Out displays, newsletters, Link Days, induction training.
- Member of TVS to join Nutrition Group.
- To enlist community Dietician support to work alongside EP within group.
- To enlist the support of Dietetic Assistant to work alongside EP to support wards with accurate and timely completion of MUST assessments.
- To review/develop patient information leaflet, particularly for patients living in their own homes, to identify first-line strategies to support improved nutritional status.

Q2 data is as follows (RAG rating GREEN >80, Amber 60-80, RED <60)

Waterlow completed within 6hrs/at first visit?	82%
Waterlow completed weekly or if condition changed?	71%
Skin inspected daily(hospital)/at each visit(community)?	92%
Has PU assessment template been completed?	59%
Nutrition assessment complete/documented within 24hrs?	87%
MUST risk assessment completed weekly/if condition changed?	79%
Was nutrition and hydration adequate for patient's needs?	74%
Pressure relieving equipment in place prior to PU?	82%
Was there any delay in equipment delivery? (LOW% is positive)	11%
Was the patient compliant with equipment use?	76%
Was the patient compliant with position changes?	71%
Mental capacity assessed if patient refused care or advice?	82%
Documented explained consequences of refusing care/advice?	73%
PU prevention advice or leaflet given at initial contact?	54%

Areas for future focus based on the above includes documentation and information provision.

7. Mitigated red risks

Due to mitigation the below 5 red risks have been downgraded to amber or closed:

- **The Management of Children in ED** (Datix 1702)
  The risk assessment has been downgraded to Amber (Annually x Major=Amber
  The current mitigation includes:
  1) Gap analysis undertaken within Paediatric task and finish group against RCPCH guidelines for care of children in emergency settings, with action plan in place.
  2) New paediatric lead nurse, band 7 in post.
  3) New paediatric ACP in post

- **Methotrexate Prescribing** (Datix 3429)
  The risk assessment has been downgraded to Amber (5-yearly x Catastrophic=Amber)
  The current mitigation includes:
  1) Rheumatology team are monitoring the bloods – so contact the patient if needed to check them, can they find out who is prescribing for oral Methotrexate
  2) Information event was held with the CCG to inform and explain the process to GP
  3) All surgeries in the area have agreed to the new process part from one. Katie Vaughton from the CCG is continuing dialogue with Angel Hill regarding the prescribing of Oral/Sub-cut methotrexate by their surgery.

- **Medical Air plant failure** (Datix 3728)
  The risk assessment has been downgraded to Amber (Weekly x Moderate=Amber)
  The current mitigation includes:
  1) Back up bottled Med Air system is in place , but this is designed for a short term solution (Hour-days) , loss of all 3 compressors on the medical air plant is not a short term fix (days-weeks). Emergency delivery process in place and agreed by BOC
  2) Secondary air plant to be installed

- **Collection and labelling of Pathology samples** (Datix 2844)
  The risk assessment has been downgraded to Amber (Annually x Major=Amber)
  The current mitigation includes:
  1) New sample collection workflow which uses a double bar code scanning
  2) Change requested from e-Care team

- **Potential failure to meet legal requirements of MHRA in blood transfusion laboratory/breach of Blood Safety and Quality Regs** (Datix 2285)
  The risk assessment has been downgraded to Amber (Annually x Major=Amber)
  The current mitigation includes:
  1) Recruited a training officer
  2) Implemented a robust Quality Management System
  3) Approval of NEESPS workforce plan

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8. Learning from RIDDOR incidents

During Q2 the number of incidents reported to the HSE under RIDDOR stayed the same as the previous quarter (six incidents). Learning and mitigation included:

- Improvements to carpark
- Moving and handling training

9. Learning from patient and public feedback:

14 complaints received in Q2 were deemed to be upheld at the time of producing this report. Actions from these were as follows:

Ref.	Issues identified	Actions and learning
WSH-COM-1548	Bad news broken inappropriately regarding stillbirth of baby.	• Staff have deeply reflected upon this complaint and will take learning forwards to future interactions and practice. They were aware that the conversation had gone badly at the time. • Discussion at staff appraisal and governance meeting.
WSH-COM-1572	CSF sample from lumbar puncture lost therefore required to undergo a second lumbar puncture.	• Dr is conducting a clinical audit on the current pathway regarding CSF collection and processing for subarachnoid haemorrhage to understand the issues and implement improvements where required. • Staff have reflected on the feedback provided for personal development. • The Trust is exploring the possibility of testing CSF samples for xanthochromia on site following an upgrade of biochemistry analysers later in the year.
WSH-COM-1513	Patient provided with incorrect calipers resulting in developing further complications.	• Appointment made for patient to attend and have calipers re-assessed. Patient has received appliances from several organisations resulting in this issue.
WSH-COM-1537	Lack of assistance with patient's personal hygiene and poor packaged food with minimal assistance to open or feed. Patient's personal belongings were also misplaced Patient has a diagnosis of dementia.	• Discussed at ward governance meeting with emphasis on assisting patients with washing including their hands • Remind staff to check if patients need help with opening packaging • Catering replacing the current orange cartons with something more user friendly • Discharge Planning Team to review re-ablement and activities available for patients on unresolved delirium pathway • Discharge Planning to develop patient information leaflets for patients and relatives to explain the process in place to support patients with unresolved delirium who are ready to be discharge from the hospital • Reimbursement for personal belongings through losses and compensation policy.
WSH-COM-1570	Patient listed with incorrect consultant resulting in consultant being unwilling to proceed with procedure. Poor attitude was displayed and the situation should have been handled differently without impact on patient.	• Consultant has offered personal apologies and acknowledges the situation was not dealt with appropriately. Has reflected on this. • Discussion within team about listing issues. • Discussion at appraisal.
WSH-COM-1533	Surgery postponed several times requiring patient to be kept nil by mouth and adequate IV fluids were not given, resulting in breastfeeding mother being unable to express. Ward staff unfamiliar with procedures to support breastfeeding mothers who are inpatients.	• Ward governance meeting reviewed this case and raised awareness about provisions for breastfeeding mothers within the hospital and specifically on the ward. • Importance of maintaining IV fluids highlighted to staff and consideration of impact of this for breastfeeding mothers.

Ref.	Issues identified	Actions and learning
WSH-COM-1549	Airway management during patient's surgery. Complication occurred resulting in tracheostomy and family query anaesthetic assessment.	• Reported as an incident (green). • Anaesthetic assessment recorded incorrectly. Mouth opening was not as wide as indicated in the assessment. There is a possibility that different approach may have been considered had assessment been carried out correctly. • Anaesthetics department to review trainee doctors training in recognising potential for airway problems. • Discussion at divisional meeting. • CD discussion with trainee doctor involved for reflection and PGME notified.
WSH-COM-1542	Elderly patients receiving evening meals later than some other wards. Concerns about care raised with PALS who requested information from consultant; consultant went to see patient on ward and 'told her off' for contacting PALS. This resulted in great upset and elderly patient self-discharging.	• Ward evening meals have changed order with G wards now receiving meals earlier in the distribution as opposed to the last wards as was the case previously. • Complaint shared with Medical Director for information. • To be discussed at consultant appraisal. • Discussion with consultant.
WSH-COM-1569	Issues with patient's personal hygiene and nursing care. Was also informed to expect contact from learning from deaths medical reviewer but did not hear anything nor receive review report.	• Discussed at ward governance meeting with emphasis on assisting patients with washing including their hands. • Staff to encourage patients to partake in bathing if they are reluctant. • Explanation regarding delays in LFD reports and apologies given. Report provided with complaint response.
WSH-COM-1559	Attitude of sonographer dismissive and rude. Patient did not feel explanations of interventions were given fully.	• Regrettably patient was booked too soon after previous scan so abdominal USS would not have been as effective, therefore requirement for transvaginal scan. • Sonographer had already reflected on this appointment as was aware it had not gone well. Has passed on personal apologies and discussed with manager.
WSH-COM-1577	Patient was physically moved by member of security team inappropriately.	• Security should not have touched patient under these circumstances. Apologies given, member of staff being re-trained and has been given written warning.
WSH-COM-1553	Patient's personal belongings lost whilst an inpatient.	• Compensated for value of items.
WSH-COM-1551	Endometrial biopsy undertaken during examination without prior consent or preparation for patient.	• Explicit consent for procedure required with explanation. • Reflection in consultant appraisal. • Information leaflet to be given as routine following biopsy.
WSH-COM-1554	Lack of monitoring and poor documentation of patient's final day. Resuscitation attempts despite DNACPR in place. Also found bereavement support team to be abrupt.	• Further work around nursing documentation within the ED department and specifically within the CDU. • CDU staff to ensure they are aware of their patients' resuscitation wishes. • Discussion at ED governance meeting. • Reflection on intervention from the Bereavement Support Team. • Provision of information relating to dealing with complaints for the Bereavement Team.

In quarter two, eight area observations were undertaken across the Trust:

- Phlebotomy
- Pharmacy (x2)
- Doppler clinic (Newmarket Hospital)
- Falls clinic (Sudbury Health Centre)
- Radiology
- Cardiology diagnostics
- Gynaecology/antenatal outpatients

These generated 11 actions, of which seven have been completed at the time of this report. 23 points for feedback were also generated, the majority of which was positive e.g. staff very friendly and polite.

Examples of quick-win actions generated:

- Paintings displayed to make cardiology diagnostics waiting area less ‘clinical’
- Coffee machine being ordered for cardiology diagnostics waiting area
- Pharmacy outpatient waiting area information to be updated
- Feedback station in pharmacy being ordered
- Movement of check-in screen in phlebotomy
- Signage tired and ‘tatty’ in x-ray waiting area
- Update stock of magazines on a regular basis in Radiology and Phlebotomy.

13. Antenatal and newborn screening report

To approve the annual report

For Approval

Presented by Nick Jenkins

Trust Board Meeting - 29 November 2019

Agenda item:	13			
Presented by:	Nick Jenkins, Medical Director			
Prepared by:	Antenatal Screening Midwives: S Bennett Day and S Augusta			
Date prepared:	13/11/19			
Subject:	Antenatal and Newborn Screening Annual Report			
Purpose:		For information	√	For approval

Executive summary:

This annual report covers the period from 1st September 2018 - 31st August 2019 and provides an overview of the quality and performance of the antenatal and newborn (ANNB) screening services delivered by West Suffolk NHS Foundation Trust (WSFT). As a Trust we deliver six antenatal and newborn screening programmes commissioned by NHS England, with quality assurance provided by Public Health England (PHE).

This report provides an overview of the annual screening Key Performance Indicators and the meeting of screening programme standards. We have highlighted numerous examples of where the Trust excels regionally and nationally. These include a commitment to obtaining blood samples by 10+0 of pregnancy, ensuring early access not only to onward treatment and intervention for individuals who screen positive to a haemaglobinopathy or infection, but also early access to obstetric care consultations and pathways for all. Also identified is our continued improvement in ensuring that the newborn blood spot is undertaken correctly on the first occasion, and we are now leading the region in having a low number of repeated screens. In line with Getting It Right First Time improvement programmes we have shared best practice both within and between trusts to help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

We are pleased to confirm that the Quality Assurance Action plan which was instigated following the planned PHE Quality Assurance visit in April 2018 has recently been closed. This is a significant undertaking and we have received positive feedback from PHE regarding the excellent progress made in meeting the actions.

For the first time we have included a summary of the NCARDRS report for WSFT. This provides detail of outcomes reported to the national congenital anomaly and rare disease reporting service and clearly identifies that the Trust are reporting fully to NCARDRS, and are providing excellent rates of detection which either meet, or are significantly above the FASP target for detection of serious anomalies.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	√						
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		√		√			
Previously considered by:	*Womens Health Governance (Local governance meeting)* *Trust executive Group*						
Risk and assurance:	*External assurance PHE QA process*						
Legislation, regulatory, equality, diversity and dignity implications	*None*						
Recommendation: To approve and receive the report							

ANTENATAL AND NEWBORN SCREENING

ANNUAL REPORT

1ST September 2018- 31ST August 2019.

Written by screening coordinators:

Sarah Bennett-Day and Sue Augusta

PRESENTED TO:

Women's Health Governance – 18TH November 2019
Trust Executive Group – 18TH November 2019
Trust Board – 29TH November 2019
ANNB Screening Steering Group – 11th December 2019
NHS England Programme Board – 22nd January 2020

NHS
West Suffolk
NHS Foundation Trust

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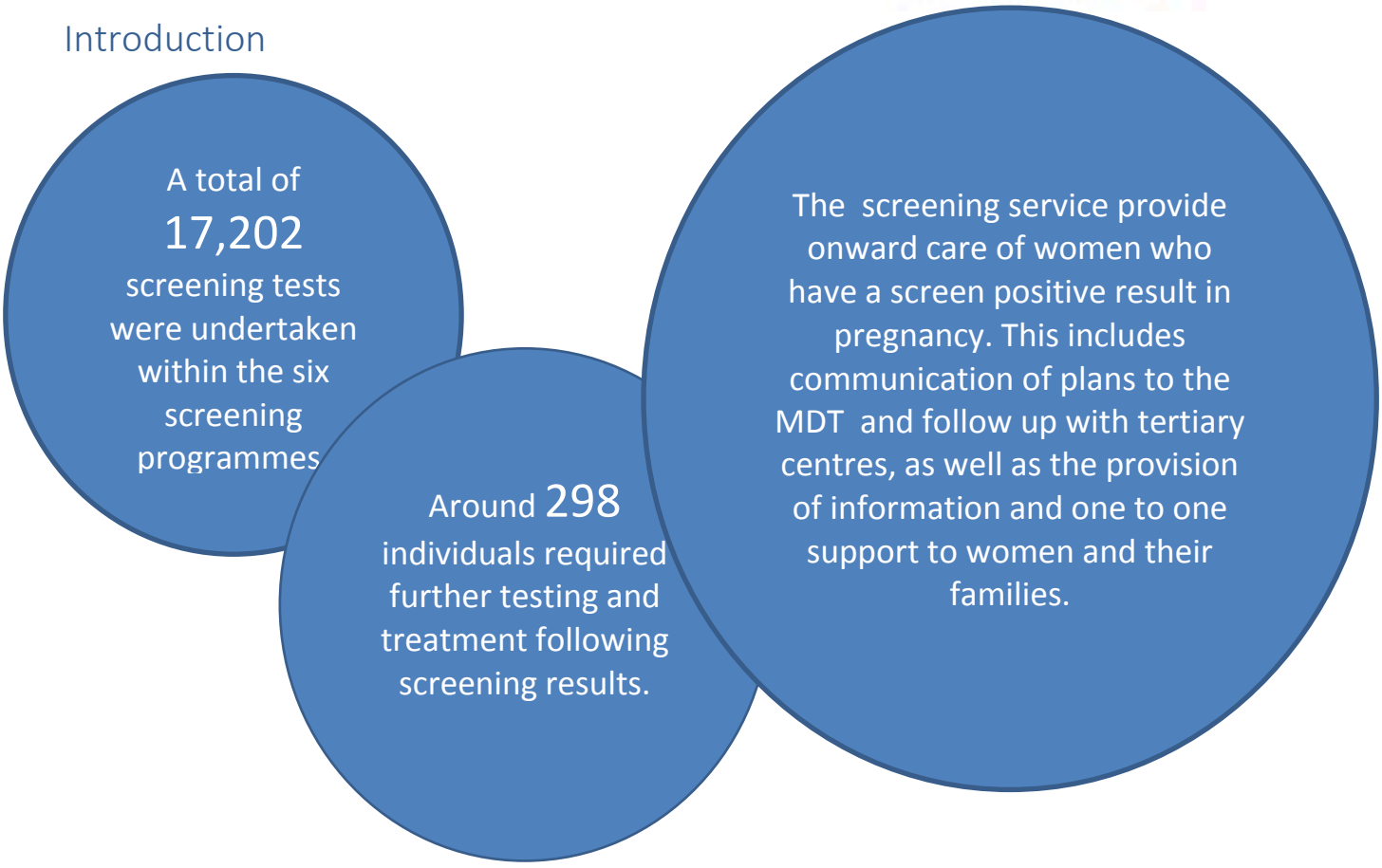


This annual reports covers the period from 1st September 2018 - 31st August 2019 and provides an overview of the quality and performance of the antenatal and newborn (ANNB) screening services delivered by West Suffolk NHS Foundation Trust (WSFT).

During this period we screened around 9465 pregnant women for a fetal anomaly, Hepatitis B, HIV and Syphilis, Sickle Cell and Thalassaemia. 7555 babies were screened for 15 conditions (14 for baby girls). As a result, we identified in excess of 298 women and babies who needed further investigations or treatment.

The vast majority of the women and babies who were identified as needing further treatment or investigations had no prior knowledge or symptoms prior to screening. We would like to express our thanks to all the maternity and screening departments and clinical colleagues, who support screening services at WSFT to ensure the identification of conditions early, offering prompt referral for onward treatment or disease prevention. We would also like to thank our commissioning colleagues at NHS England and quality assurance oversight provided by Public Health England for their role in continuing to drive up standards. Particular thanks to Lynne Saunders, head of midwifery / nursing at WSFT who has provided consistent leadership, effective challenge and advocated for high standards across the ANNB screening programmes at WSFT.

As a Trust we deliver six antenatal and newborn screening programmes commissioned by NHS England, with quality assurance provided by Public Health England (PHE).

What do we screen for?

- Sickle Cell and Thalassaemia (SCT) – uses a questionnaire about family origin and offers blood tests to screen pregnant women for conditions of sickle cell and thalassaemia. Mothers identified at potential risk are offered further testing (including partner testing). The programme is linked to the newborn blood spot programme to identify babies at risk of sickle cell anaemia to be given the best support and treatment at the earliest opportunity.

- Infectious Diseases (ID) - Programme recommends screening for all pregnant women for Hepatitis B, HIV and Syphilis so appropriate follow on tests and treatments can be offered to reduce risk of passing on infections to babies.

- Fetal Anomaly Screening Programme (FASP) – Offers the choice of screening for Down's syndrome, Edwards' syndrome and Patau's syndrome and a number of structural anomalies.

- Newborn and Infant Physical examination (NIPE) – uses a detailed physical examination to screen newborn babies and infants for anomalies with their eyes, heart, testes and hips to help early detection and diagnosis of several conditions.

- Newborn Hearing (NHSP) – Offers a hearing screening test in the first few weeks of life to find those who are born with hearing loss.

- Newborn Blood Spot (NBS) – screens newborn babies for nine rare but serious genetics or metabolic conditions. Babies who test positive are then offered early treatment and intervention to reduce the chance of long term disability.

To meet the requirements of the screening programmes different professionals and departments work together:

- The maternity services

- Obstetric ultrasound department
- Newborn hearing screening department
- Pathology services are provided in- house for haematology and microbiology requirements.
- Trisomy screening is provided by The Department of Prenatal Screening at Addenbrookes Cambridge.

Throughout this report attention will be given to the annual summary of screening Key Performance Indicators (KPI's) (appendix one) with exception reporting only.

In July 2019 NHS England extended their reporting requirements of the antenatal and newborn screening programmes. In addition to KPI reporting, RAG rating for every screening standard for each programme is now required. Please see appendix two for a report of all screening standards since the introduction of this reporting format at WSFT between July – September 2019.

Progress on the Quality Assurance action plan which was instigated in July 2018 following a planned quality visit by PHE will also be provided.

Screening Programmes Update

Sickle Cell and Thalassemia Screening (SCT)

Sickle Cell and Thalassemia Screening WSFT 1st September 2018 – 31st August 2019	
Antenatal Screening	
Number of Eligible Women	2670
Number of women screened	2669
Women declining %	0.04%
Number of Partner Testing offered	24
Number of Partner testing accepted	18
Prenatal Diagnostic (PND) testing	
Parents counselled for PND	1
PND's performed	0
Newborn Screening	
Screen positive babies	1

In line with NHS England programme standards our maternity service is committed to obtaining blood samples by 10+0 weeks of pregnancy and we are proud this was achieved consistently at >68-75% across the year. National data highlights this is above the national average of 55.9% (PHE, 2019) and is testament to the change in

local provision to online self-booking referrals for newly pregnant women and a designated community hub which aims to book pregnant women at 8 weeks gestation. This change has ensured pregnant women have early access to obstetric care pathways and has driven up Trust performance in achieving timely screening for SCT.

Infectious Diseases in Pregnancy (IDPS)

Infection Diseases WSFT 1st September 2018 – 31st August 2019	
HIV	
Eligible Women	2670
Eligible Women Tested	2667
Women declining %	0.1%
Number of positive results	0
Screen positive results attending specialist assessment within 10 working days	N/A
Hepatitis B	
Eligible Women	2670
Eligible Women Tested	2667
Women declining %	0.1%
Number of positive results	5
Screen positive results attending specialist assessment within 10 working days	100%
Receipt of Hepatitis B vaccine at birth of babies who are born to screen positive mothers	100%
Syphilis	
Eligible Women	2670
Eligible Women Tested	2667
Women Declining	0.1%
Number of positive results	4
Screen positive results attending specialist assessment within 10 working days	100%

The updating of Trust guidelines regarding Hepatitis B screening in pregnancy have been delayed as an enhanced Hepatitis B screening and immunisation pathway is anticipated from NHS England. There has been a delay in the rollout of this national pathway. NHS England are aware and are in support of our delay in updating local guidelines.

Fetal Anomaly Screening Programme (FASP)

FASP Trisomy WSFT 1st September 2018 – 31st August 2019	
Number of tests performed	1903
Opt in for trisomy screening	91%
Number of women at higher chance for trisomy	61

We are proud that our radiology imaging department have gained approval from the Quality Standards for Imaging (QSI). This means they have met an external standard that exceeds the baseline requirements of regulators, and therefore embeds a culture of quality improvement among the team. DQASS is the Down's syndrome Screening Quality Assurance Support Service which assigns flags to a dataset of nuchal translucency and crown rump length measurements required down syndrome screening purposes. Throughout the year the trust has consistently ensured that all trisomy screening is completed by sonographers who are green or amber flagged, ensuring we are meeting national screening standards for imaging within pregnancy.

The ultrasound department continues to have significant capacity pressures as a result of the maternity GROW programme. There has been no impact on the delivery of the screening programme however staff are under constant pressure. This pressure is reported quarterly at screening steering group meetings, NHS England programme board and within Women and Children's departmental meetings.

FASP Anomaly WSFT 1st September 2018 – 31st August 2019	
Number of tests performed	2226
Number of anomaly USS completed within correct timeframe 18+0 – 20+6 gestation.	99.9%
Number of referrals to tertiary centre for suspected structural anomaly at either dating or anomaly USS.	86 (3.9% of anomalies performed in time period)

FASP Standard 8: Time to intervention for women who screen positive at anomaly USS at 18+0-20+6 weeks gestation (Seen at referral tertiary centre within 5 days when an anomaly is suspected):

We are aware that we are not consistently meeting screening programme standards regarding timely intervention of women being seen within 5 days at tertiary centres when anomalies are suspected (see appendix two, FASP, standard 8). This has been due to capacity issues related to consultant availability at the local tertiary centre. When this standard is unlikely to be met, women are provided with the option

of referral to an alternative tertiary centre and all cases are discussed with a consultant obstetrician at WSFT. We are actively monitoring the situation via Trust screening steering group, with reporting and escalation if required to internal Women and Children's Business Governance meetings and via NHS England quarterly Programme Board.

Newborn Infant Physical Examination (NIPE)

NIPE WSFT 1st September 2018 – 31st August 2019	
Number of eligible babies tested	2365
Number of babies who received timely examination <72 hours of age	2346
Referrals (hips) with abnormalities suspected < 2 week pathway	14
Timely assessment of babies with hips abnormality <2 weeks.	8

This year has seen the implementation of Screening for NIPE (S4N) replacing the existing NIPE system (NIPE SMaRT). After a few initial "teething problems", the system has shown itself to be as easy to negotiate and has additional features, for example: enabling us to search historic data. Training has been disseminated to all NIPE trained midwives and paediatricans.

NIPE Standard 3 and 4: Timeliness of intervention of Developmental Dysplasia of the Hips (assessment by 2 weeks and 6 weeks of age):

National Screening Standards have not been met for babies requiring a hip USS for detection of Developmental Dysplasia of the hips, both on the two-week (see Appendix one, NP2) and six-week pathway (see appendix two NIPE, standard 4). Internal investigation and reporting to NHS England and PHE via a Screening Incident Assessment Form (SIAF) has been undertaken. Investigation has identified that an issue with the booking process in the administration department of radiology resulted in this standard not being met. Changes have been implemented with regard to training and booking systems with resultant significant improvement in the two-week pathway which is now consistently green RAG rated. Improvement is however still required to ensure babies who require a hip USS by 6 weeks of age achieve a timely appointment. This will continue to be monitored and an audit is scheduled for early 2020 to ensure positive progress has been made in achieving programme standards.

Newborn Blood Spot (NBS)

Newborn Blood Spot WSFT 1st September 2018 – 31st August 2019	
Number of eligible babies tested	2507
Total Screened positive	
Cystic Fibrosis	0
Congenital Hypothyroid Disease	2
Phenylketonuria	1
Sickle Cell Anaemia	1
SCT carrier	8
Medium-Chain Acyl-Coa dehydrogenase deficiency	0
Maple Syrup Urine Disease	1
Isovaleria acidaemia	0
Glutaric aciduria Type 1	0
Homocystinuria	0

This year has seen a much improved rate in the "avoidable repeat rate" where the first NBS sample sent to laboratories are rejected for reasons such as insufficient blood or in-complete / inaccurate data. We now have the lowest avoidable repeat rate in the region, 0.2% in our latest KPI report, with an average of 0.4% over the past year. NHS England have asked for sharing of our good practice and we have performed in-service training within key departments where issues had been identified and compiled and distributed resource packs for all users.

Newborn Hearing Screening Programme (NHSP)

Newborn Hearing Screening WSFT 1st September 2018 – 31st August 2019	
Number of eligible babies	2688
Number screened	2683
Number targeted follow ups	47
Number of audiology referrals	31

The achievable threshold on KPI's set by NHS England for newborn hearing screening coverage have been consistently maintained throughout the year at either amber or green RAG rated performance.
As identified in Standard 5, time from screening outcome to attendance at an audiological assessment, a red RAG rating was achieved (see appendix two, page 27). This was as a result of one individual who was a persistent "did not attend" to appointment offers. Achievement of this standard will continue to be monitored at the local steering group meeting and regional NHS England Programme Board.

Progress on PHE Quality Assurance Action Plan

In April 2018 a planned Quality Assurance visit by PHE to WSFT ANNB screening department resulted in a sixteen point action plan. Notification has just been received from PHE that evidence to demonstrate assurance has been submitted and signed off and the action plan is now closed. This has been disseminated to Women's Health Governance and the Trust Board. Whilst four actions from the plan remain incomplete (see appendix 3) PHE recognise that three of these actions cannot be completed until trust screening guidelines are re-written to reflect the latest screening pathways from NHS England. This is a lengthy process and a timetable for guideline and SOP re-writing has been approved with PHE and the local ANNB screening steering group. This has been added as a standard agenda item to the ANNB steering group for monitoring.

Multi-Disciplinary Team (MDT) meetings

Monthly MDT meetings are held involving representatives from the obstetric and paediatric teams, the neonatal Unit and labour ward in regard to women where screen positive conditions have been identified. This ensures effective communication throughout the department keeping all parties informed and involved in identified high risk cases. We also have a monthly video link with regional tertiary centres where women who have been referred to these centres can be discussed and plan of care confirmed.

National Congenital Anomaly and Rare Diseases Reporting Service (NCARDRS).

The sonography department report antenatally to NCARDRS at PHE regarding findings within the FASP programme.

Antenatal reporting to NCARDRS between 1st April 2018-31st March 2019 (based on any anomaly suspected at USS).

Trimester	Number of cases reported to NCARDRS	Number of false positives not confirmed at tertiary referral centre
First	18	2
Second	63	18
Third	18	0

Total	**99**	**20**

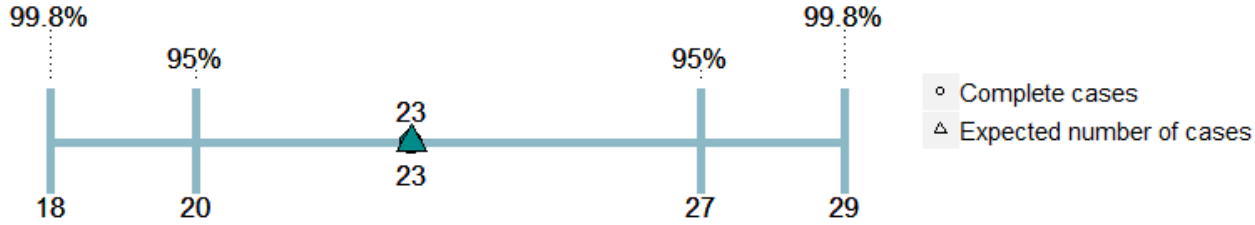
Antenatal reporting to NCARDRS between 1st September 2018-31st August 2019 of the FASP programme 11 auditable conditions

Serious Cardiac Anomaly	2
Anencephaly	1
Open Spina Bifida	2
Cleft Lip +/- palate	2
Exompaholos	1
Bilateral Renal Agenesis	1
Edwards' syndrome diagnosed on structural anomalies	3
Pataus syndrome diagnosed on structural anomalies	0
Gastroschisis	0
Congenital diaphragmatic hernia	0
Lethal skeletal dysplasia	0

In August 2019 NCARDRS requested full antenatal and postnatal data and evidence of clinical outcomes for all women and neonates identified with screen positive results via the FASP programme at WSFT for the 2017-2018 period. This was a considerable undertaking within a tight timeframe provided by PHE. Concern regarding the lack of a structured launch of the NCARDRS requirements has been fed back to the regional NHS England Programme Board for escalation to NCARDRS. New systems will be actioned within the screening team to ensure future systematic provision of data and outcomes to NCARDRS.

Data was provided to NCARDRS for 23 notifications of FASP auditable anomalies for WSFT for the period 1st April 2017-31st March 2018. In October 2019 we received confirmation that 100% of the data quality provided was complete enough to determine the result of screening, or the reason screening was not undertaken or completed. As such we have received a full NCARDRS report for WSFT which has been shared across the screening department. Based on 2713 bookings for 2017-2018, 23 complete cases were identified as within the range anticipated based on booking data, and within the minimum threshold for inclusion in this year's NCARDRS reports.

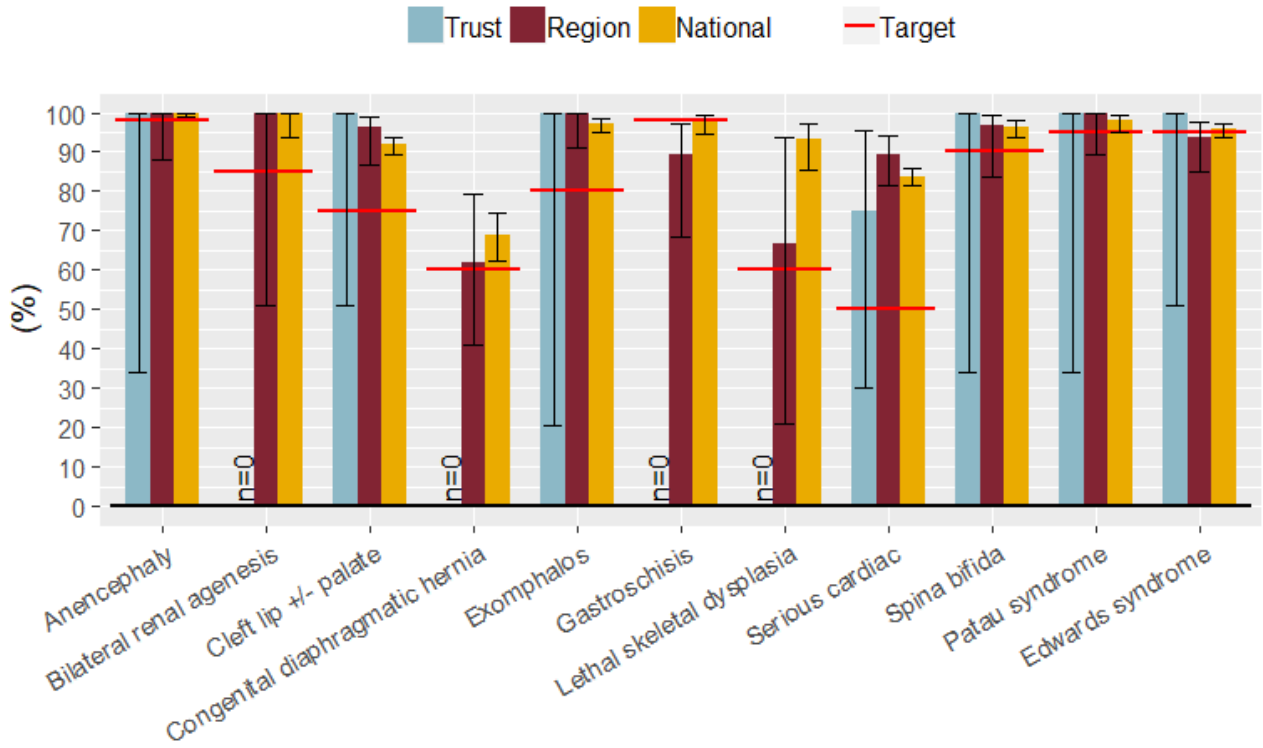
NCARDRS: Identification of where the number of complete cases sits within the expected range: Complete cases, notified versus expected, 2017-18



West Suffolk NHS Foundation Trust, source: NCARDRS, 2019

NCARDRS data regarding the FASP auditable conditions identifies excellent rates of detection from antenatal sonography at WSFT:

FASP auditable conditions, Programme detection rates including early detection (up to 23+0) (%) by condition: Trust, East of England NCARDRS region, England, 2017-2018.



West Suffolk NHS Foundation Trust, source: NCARDRS, 2018

The local detection rates are consistent with the FASP target for 7 of the 11 conditions (no cases for the other 4 conditions). The local detection rates for cleft lip +/- palate, exomphalos and serious cardiac anomalies were significantly above the FASP target.

Trisomy Data NCARDRS 2019

Laboratory screening, raw numbers – EDD 2017-18

		Down's syndrome	Edwards' syndrome	Patau 's syndrome
Detected	Combined test	2	2	2
	Quadruple test	0	-	-
Undetected	Combined test	0	0	0
	Quadruple test	0	-	-
	Incomplete	0	1	0
	Missed	0	0	0
Ineligible	Declined	1	1	0
	Early diagnosis	0	0	0
	Early fetal loss	0	0	0
	Late/no booking	0	0	0

NCARDRS, 2019

Audits

An annual screening audit timetable is in place and completion is monitored at the ANNB steering group. This timetable feeds directly into the Division of Women and Children's programme of audits.

Screening audits are reported to ANNB steering group meetings with resulting actions added to the quarterly action log.

All audits from the ANNB screening departments are reported externally to the quarterly NHS England Programme Board. Additionally, maternity screening audits are presented to Clinical Governance in the Division of Women's Health. NHSP audits are reported to the Community and Integrated Services Division Governance Group.

Patient Experience

Maternity / Sonography: We have just commenced a process of emailing anonymous patient experience questionnaires to women who are seen by the screening team following detection of a screen positive response for the FASP

programme. A delay has been encountered in this process whilst we worked with PALS to resolve issues around timely and controlled questionnaire dissemination in a sensitive manner. Patient Experience is a standard agenda item on the local steering group meeting to ensure regular monitoring and improvement.

Newborn Hearing Screening Programme: Patient Experience has been evaluated over the course of the year and resulted in favourable feedback. As a result of a recent outpatient clinic audit there has been a change in location of outpatient clinics. Service feedback regarding this will be monitored and will be fed back to both local hearing screening team meetings, community and integrated services division governance group and quarterly NHS Programme Board meetings.

Screening Inequalities

There has been a national delay in the roll out of the Non Invasive Pre-Natal (NIPT) Screening programme by NHS England, originally anticipated for rollout in 2017. NIPT provides a more sensitive and specific result regarding trisomy screening with no associated risk of miscarriage from undertaking the screen itself. This is available currently through private provision only.

Continued inequality exists therefore to women who screen positive on NHS screening trisomy results. Whilst the screening team provide brief information to ensure women and their families have informed decision making and consent about the full choices available to them following a screen positive result, there remains no clarity or direction from NHS England regarding how to address this gap.

A Did Not Attend (DNA) audit with emphasis on inequalities has been commenced to identify and provide opportunity to analyse local inequalities. Results will be fed back through clinical governance, Programme Board and local ANNB steering grp meetings.

Issues for Escalation

Failsafe

As identified in last year's annual report the screening failsafe patient tracking system is reliant completely on manual data input. Considerable work has been undertaken with the Trusts provider of electronic records Cerner to incorporate an antenatal reporting system. The aim was for a system which can largely self-populate and provide an alert system to identify women who fall outside of normal parameters. This has recently been put on hold for the foreseeable future by Cerner

and as such the continued manual input of significant data extrapolated from numerous computer systems is at risk to human error and inadvertent omissions. This has been added to the risk register of the local NHS England Programme Board.

Incidents

Screening incidents are reported through local datix systems as well as considered for reporting via the serious incident assessment form (SIAF) by NHS England (PHE, 2017). Across screening departments there has been a rise in the last twelve months of reporting SIAF's to NHS England, reflecting the open and honest reporting of all screening incidents. Close liaison exists between WSFT screening and Quality Assurance (QA) advisor at PHE regarding the submission of SIAF's in addition to local datix.

Programme	Total	Incident
Infectious Disease	2	1 x missed Hep C screen 1 x incorrectly labelled sample of suspected high risk patient, discussed with PHE QA, SIAF not required.
Sickle Cell and Thalassemia	10	3 x Incorrectly labelled. 7 x sample delay in transport to labs for processing (resulted in SIAF)
Fetal Anomaly Screening Programme	1	Missed Quad Offer (Resulted in SIAF to NHS England)
Neonatal Infant Physical Examination	2	Missed timely r/f for multiple number of 2/52 and 6/52 pathways for DDH USS assessment (SIAF to NHS England)
Newborn Blood Spot	26	25 x avoidable repeats 1 x missed offer of timely NBS sample –discussed with QA PHE, SIAF not required
Newborn Hearing Screening	4	2 x screening same ear twice 1 x screening to wrong NHS number

		1 x screened a patient twice

Learning from these incidents

In relation to antenatal incidents

Local laboratory guidelines require SCT samples to reach the labs within 24 hours of the sample being taken for the purpose of ensuring accuracy in Full Blood Count testing. This can present a problem where samples have been obtained in the community setting and are reliant on hospital transport to get them to the hospital within this timeframe. We are in discussion with both community teams and the laboratory to continue to try and improve transport links. This has resulted in a noticeable improvement in the amount of discounted/discarded samples.

The screening team has reiterated to all healthcare professionals who are involved in the taking of blood samples the importance of completing forms accurately and highlighting all pertinent information.

The pathway for “late bookers”- women who book over fourteen weeks gestation has been amended. Community midwives who identify a “late booker “will contact the screening office to ensure the woman is entered onto our failsafe system promptly, enabling timely ultrasound and offer and documentation of acceptance or decline of trisomy screening.

In relation to our newborn incidents

Regarding timing of Assessment for Development Dysplasia of the Hip – see above under NIPE Page 7.

The necessity for repeating the Newborn Bloodspot has improved greatly over the last year. We instigated learning sessions and further training, together with compiling a resource pack of information which has been disseminated to all areas. We have also ensured that all bloodspot cards are double checked before being sent to the laboratory. This has resulted in the West Suffolk Hospital as having the lowest “avoidable repeat rate” in the region at 0.2% at last KPI.

NHSP team have been reminded of protocols on checking patient details. The human errors which occurred with paper proforma’s led to the team acquiring a lap top to allow access to the Smart4Hearing system at the bedside or in clinic, screening results that have already be uploaded will be visible.

Staffing within ANNB Screening Department

Maternity: A change of lead in the screening team occurred in November 2018, with two part-time coordinators being employed to the role on 1.0 FTE basis. At the time of writing there are tentative plans to extend the hours to 1.2FTE from early 2020 to meet capacity issues due to the expansion of the screening role by NHS England. Re-benching of the office space and extra IT resources are required.

Two deputy screening midwives have been identified to provide cover in the absence of the screening coordinator, both of these members have received training to provide clinical cover.

Failsafe processes are an essential element of screening and there is one failsafe member employed on 0.8FTE. We are currently looking to ensure there is a designated deputy failsafe member to provide cover in the absence of the failsafe officer and will provide appropriate training to ensure continued failsafe quality and performance.

Ultrasonography: We have one screening support sonographer (SSS) and she in turn has an official deputy.

Newborn Hearing Screening Programme: Due to retirement there was a change in local NHSP manager at WSFT in January 2019, recruited internally. A new screener commenced in role in August, replacing the screener who was awarded the local manager role.

Education and Training

Delivery of Training to Midwifery Colleagues

The screening team provide eight mandatory training sessions per year to midwives. Provision of information is based on PHE screening material and reflects updates to NHS Screening programmes. Additionally, screening forms part of induction sessions for new midwives. Visiting lectures are provided to the University of Suffolk to student midwives.

Training is also provided on an individual or departmental basis based on needs identified through themes arising from incidents, or updates to the NHS screening programmes.

Training within the Screening team

Maternity: The screening team attend bi-annual regional forums delivered by PHE as well as ensuring compliance with training requirements related to programme standards and changes to NHS Screening Programmes.

Successful completion of a level 7 Genetics Counselling course at King's College London has been achieved, ensuring compliance with NHS England SCT programme requirements. Case reports completed for this training have been accepted for publication in a national professional midwifery journal. Specialist training regarding Down's Syndrome screening and a PHE Screening masterclass have been completed as part of the coordinators induction.

Ultrasound

Ultrasonographers complete the Fetal Anomaly Screening Programme (FASP) e-learning on a yearly basis. Each sonographer completes a training log yearly and at present this is in the process of being amended to aid easier facilitation for completion. In house audit is carried out on a regular basis.

Hearing

The local hearing screening manager is registered to undertake Certificate of assessing vocational achievement (CAVA) training as part of her induction to the role. The new screener will commence the mandatory screening diploma. Funding was secured for this individual as well as an additional long standing member of the screening team to undertake the diploma from November 2019.

The new screener will take the OSCE, practical assessment of knowledge skills required to perform hearing screening, in November 2019. On passing the screener will be deemed fully competent to screen without supervision.

Planned reconfiguration of services

Maternity Electronic Records

Maternity electronic records will be introduced to the department over the forthcoming months. We have contributed to the development of the system regarding screening and will actively be involved in trialing the system.

Potential for relocation of antenatal screening for haemoglobinopathy.

Ongoing conversations are being held between WSFT, North East Essex Pathology Services (NEESPS), PHE and NHS England regarding a potential relocation of the provision of antenatal screening for haemoglobinopathy from WSFT to laboratories at East Suffolk and Essex Foundation Trust Hospital. It is paramount that the ANNB team contribute to the identification of potential risks, any changes in the care pathway and communication links between laboratories, the ANNB team and

consultant haematologist and assess any risk that may result in relation to the correct and timely identification of at risk couples. The overall risk will be added to the Women and Children's risk register for monitoring. Meetings are ongoing with representatives from screening, obstetrics, senior operational leads, IT, pathology and haematology consultants as well as NEESPS, NHS England and PHE.

Priorities for next 12 months

The re-writing of all screening guideline to reflect latest NHS Screening programme standards and changes to local pathways is a key priority and a timetable is in place to guide and monitor this work.

Counselling room

Multiple patient feedback has been verbally received regarding the counselling room environment which has been reported to be cold and clinical and not sympathetic to a families' distress when being counselled following a screen positive result. As a result, new flooring has recently been installed alongside redecoration in a neutral wall colour. Softer decoration with sympathetic lighting, furniture, window coverings and room artefacts are urgently required to enhance this room into a more warm setting. Patient feedback questionnaires now incorporate questions regarding room environment in the aim that written feedback will contribute to a business case to enhance the room.

Trisomy screening reporting

We have escalated our concern with NHS England programme board regarding the reporting of trisomy results from the local prenatal testing laboratory. Maximum reporting of high chance results is 1:5, however local data reflects that this is not consistent with a 20% chance of having an affected fetus, but rather more consistent with a 50% of an affected fetus. This has implications of how we counsel women who receive a 1:5 result following trisomy screening and subsequent decisions women may make. Reporting of overall screening results from prenatal laboratories differs across the UK and we are currently awaiting feedback from national networks.

Reporting and Governance Structure

Internal reporting

Internal governance and risk processes have been strengthened to ensure regular monitoring of the quality and integrity of the ANNB programmes and ensure board

level oversight. Updated Terms of Reference (TOR) for the quarterly ANNB steering group meetings have been approved and a standard agenda now ensures all quality, performance and operational issues are addressed. Membership attendance from all screening departments has improved over the course of the year. Minutes and associated action plan are promptly circulated to the membership and clear lines of escalation are embedded to Women's Health Governance.

The TOR have also been updated within sonography and hearing screening departments to ensure monitoring by Clinical Support Governance and Community and Integrated Services Division Governance Group.

Screening Key Performance Issues are reported on a quarterly basis to clinical Governance in the Division of Women and Children's. Screening audits are also presented to this meeting.

A quarterly screening support newsletter is distributed to both inpatient and outpatient teams of pertinent issues within screening.

External Reporting

Data returns of the SCT, FASP and IDPS screening programmes are submitted on an annual basis to PHE, alongside quarterly reporting of HIV specifically.

KPI's are submitted to Public Health England Quarterly as well as new RAG rating of all screening programme standards. Alongside screening operational issues, KPI's are reviewed and discussed at a quarterly NHE England joint programme board, which has membership with Ipswich Hospital Trust and quality oversight provided by PHE.

Annual data regarding outcomes of congenital anomalies are reported to Public Health England on an annual basis (see NCARRDS above).

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Public Health England (2019) NHS Screening Programmes: Annual report. Available online https://www.gov.uk/government/publications/nhs-screening-programmes-annual-report (Accessed 29/10/19)

Public Health England / NHS England (2018) Managing Saftey incidents in NHS Screening Programmes. Available online https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/672737/Managing_safety_incidents_in_National_screening_programmes.pdf Accessed 4/11/19)

Appendix one – KPI summary table 1st July 2018 – 30th June 2019

* Currently KPI performance template is rounded up to 1 decimal point, e.g, 99.5%, however colour performance is based on absolute threshold to 2 decimal points, so 99.49% is amber not green. The colour displayed in the performance box is based on absolute cut offs of the threshold values, therefore may appear differently due to rounding *

KPI	Description	Threshold	Q2 1st July – 30th Sep 2018	Q3 1st Oct– 31st Dec 2018	Q4 1st Jan – 30th March 2019	Q1 1st April 2019 – 30th June 2019
ID1	Antenatal infectious disease screening - HIV coverage	Acceptable ≥ 95.0% Achievable ≥ 99.0%	98.8	98.8	99.7	99.9
ID2	Antenatal infectious disease screening - timely assessment of women with hepatitis B (high levels of infectivity)	Acceptable ≥ 70.0% Achievable ≥ 90.0%	N/A	N/A	N/A	100
ID3	Hepatitis B coverage	Acceptable ≥ 95.0% Achievable ≥ 99.0%	100	100	99.7	100
ID4	Syphilis coverage	Acceptable ≥ 95.0% Achievable ≥ 99.0%	100	100	99.7	99.9
FA1	Fetal trisomy screening - completion of laboratory request forms	Acceptable ≥ 97.0% Achievable = 100%	98.5	99.2	97.9	98.2
FA2	Fetal anomaly screening (18+0 to 20+6 fetal anomaly ultrasound) – coverage	Acceptable ≥ 90.0% Achievable ≥ 95.0%	100	100	100	99.7
ST1	Antenatal sickle cell and thalassaemia screening – coverage	Acceptable ≥ 95.0% Achievable ≥ 99.0%	100	100	100	99.8
ST2	Antenatal sickle cell and thalassaemia screening - timeliness of test	Acceptable ≥ 50.0% Achievable ≥ 75.0%	70	76	71.2	68.7
ST3	Antenatal sickle cell and thalassaemia screening - completion of FOQ	Acceptable ≥ 95.0% Achievable ≥ 99.0%	99.3	96.5	98.6	97.4
ST4a	ST4a - timely offer of PND to women at risk of having an affected infant To be set	To be set	0	0	0	0
ST4b	ST4b - timely offer of PND to couples at risk of having an affected infant To be set	To be set	0	0	0	0
NP1	Newborn and infant physical examination - coverage (newborn)	Acceptable ≥ 95.0% Achievable ≥ 99.5%	99.5 *	98.9	99.3	99.3
NP2	Newborn and infant physical examination – timely assessment of developmental dysplasia of the hip (DDH)	Acceptable ≥ 95.0% Achievable = 100.0%	50	25	100	100
NB2	Newborn blood spot screening - avoidable repeat tests	Acceptable ≤ 2.0% Achievable ≤ 1.0%	1.0	0.7	1.2	0.2

Appendix Two – Reporting on Screening Programme Standards

(new requirement as of July 2019)

Infectious Diseases

KPI performance **ID1** HIV Coverage	Acceptable standard ≥ 95% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
		99.9			
ID2 Timely referral of newly diagnosed or high risk HBV+ women to Hepatology (by 6 weeks)	Acceptable Standard ≥ 70 Achievable Standards ≥90%	Q1	Q2	Q3	Q4
		100			
ID3: Hepatitis B coverage	Acceptable standard ≥ 95% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
		99.9			
ID4: Syphilis coverage	Acceptable standard ≥ 95% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
		99.9			
Programme standards					
Standard 5a HIV Timely intervention - new and already known positive women seen by MDT ≤10 working days	Acceptable standard ≥ 97% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
		No cases			
5b: **Hepatitis B** Timely intervention - new and already known positive women seen by MDT ≤10 working days	Acceptable standard: ≥ 97% Achievable standard: ≥ 99%	Q1	Q2	Q3	Q4
		100			

5c: Syphilis
Timely intervention - new and already known positive women seen by MDT ≤10 working days

Acceptable standard ≥ 97% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
	100%			

Q1	3 x cases, 1 x serial DNA previously treated and declined further assessment

Standard 7
Hepatitis B Neonatal vaccination and Immunoglobulin administered within 24 hours of birth

Acceptable standard ≥ 97% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
	No cases			

service specifications and programme handbook

Update from National Screening Programmes

QA action plan

Update to Hep B guideline delayed as awaiting roll out of enhanced Hep B pathway

FASP

KPI performance
Standard 1 FA3 Fetal anomaly screening coverage

No Thresholds set	Q1	Q2	Q3	Q4
	90			

Standard 2 FA2 Coverage and identifying population (18=0 to 20+6 fetal anomaly USS) coverage

Acceptable Standard ≥ 90% Achievable Standards ≥95%	Q1	Q2	Q3	Q4
	99.7			

Standard 3 a Test performance screen positive rate (T21 / T18 / T13)

Screening strategy	Trisomy	Acceptable SPR	Achievable SPR
Combined	T21	1.8-2.5%	1.9-2.4%
Combined	T18/T13	0.1-0.2%	9.13-0.17%
Combined	T21/T18/T21	1.8-2.5%	19.-2.4%
Combined	T21	2.5-3.5%	2.7-3.3%

Q1	Q2	Q3	Q4
0.10 2.3 2.6			

Based on Suffolk PB joint figures

Standard 3 b Test Performance detection Rate T21 /

Screening Strategy	Thresholds	Q1	Q2	Q3	Q4

T18 / T13

T21 (combined)	DR 85%	81			
T18/T13 Combined	DR 80%	90			
T21/T18/T13 (Combined)	DR 80%	100			
T21 (Quadruple)	DR 80%				
Based on Suffolk PB joint figures					

Standard 4 Test Performance 18+0 to 20+6

DR > 50% for each serious cardiac anomaly listed	Q1	Q2	Q3	Q4
	No cases			

Standard 5 Test turnabout Time (T21/T18/T13)

Acceptable standard ≥ 97% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
	99			

	Based on Suffolk PB joint figures

Standard 6 Completion of lab request forms FA1

Acceptable standard ≥ 97% Achievable standard ≥ 100%	Q1	Q2	Q3	Q4
	98.2			

Standard 7 Time to Intervention (T21 /T18 / t13) Timely communication of higher chance results

Acceptable standard ≥ 97% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
	100			

Standard 8 Time to intervention (18+0 to 20+6) Timely referral to tertiary centre when an anomaly is suspected (seen within 5 days)

Acceptable standard ≥ 97%	Q1	Q2	Q3	Q4
	67%			

Q1	18 women referred, 6 women seen > 5 days. Capacity issues at local tertiary centre. All women offered apts at alternative centres but 6 women chose to wait to be seen by local tertiary centre. All cases discussed and agreed by Obstetric consultant. Currently examining referral pathways / contracts when referral to multiple tertiary centres is required.

Standard 9 Diagnose (T21 /T18 / T13) and 18+0 to 20+6 Test turn around times (QFPCR) (Karyotype)	Acceptable standard ≥ 90%	Q1	Q2	Q3	Q4
		N/A			
	Tests not undertaken at WSFT				
service specifications and programme handbook					
Update from National Screening Programmes	NIPT-working on procurement. New training will be required. Potential for FA1 completion of lab forms to be replaced with new KPI to measure samples received in lab that were inadequate for testing within reporting timeframe. FASP lab handbook updates				
QA action plan	FASP guideline – re-writing of guideline required. Timetabled to complete xxxx				
Local priorities	Low Papp a care pathway and provision of information to women Consideration of documentation of trisomy decline.				

Sickle Cell and Thalassemia

KPI performance **SCT –SO1 Coverage antenatal screening**	Acceptable standard ≥ 95% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
		99.9			
SCT – SO2 Timeliness of antenatal screening	Acceptable Standard ≥ 50 Achievable Standards ≥75%	Q1	Q2	Q3	Q4
		68.7			
SCT – SO3: Completion of FOQ	Acceptable standard ≥ 95% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
		97.4			
SCT – SO4 Test turnaround	Acceptable standard ≥ 90% Achievable standard ≥ 95%	Q1	Q2	Q3	Q4
		94.3			
SCT 5 – SO5 Referral. Timely offer of PND ≤12+0	To Be Set	Q1	Q2	Q3	Q4
		No cases			

	Q1 | 1 x couple with haemaglobinopathy but criteria for PND offer not met
SCT 5 a – Women at risk of infant with SCT offered PND ≤12+0	To Be Set: Q1 — No cases; Q2; Q3; Q4
SCT 5b – Couples at risk of infant with SCT offered PND ≤12+0	To Be Set: Q1 — No cases; Q2; Q3; Q4
Standard 6 SCT – SO6 Diagnosis. Timeliness of PND ≤12+6	Acceptable standard ≥ 50% Achievable standard ≥ 75%: Q1 — No cases; Q2; Q3; Q4
Standard 7 SCT- SO7 Test Timely reporting of PND performed ≤5 working days	Acceptable standard ≥ 70% Achievable standard ≥ 90%: Q1 — No cases; Q2; Q3; Q4
Standard 8 SCT – SO8 Test Reporting Newborn screen positive reports to parents receiving NBS screen positive results ≤28 days	Acceptable standard ≥ 90% Achievable standard ≥ 95%: Q1 — Reported at PB by Health Visitors; Q2; Q3; Q4
Standard 9 SCT – SO9 Referral. Timely Follow up, diagnosis and treatment of newborn infants with screen positive result ≤90 days of age	Acceptable standard ≥ 90% Achievable standard ≥ 95%: Q1 — Reported by Haem centre; Q2; Q3; Q4
service specifications and programme handbook	

Update from National Screening Programmes	
QA action plan	SCT guideline needs re-writing, timetable agreed and monitoring of compliance at local steering grp.
Local Priorities	Potential change of screening services to ESNESFT. Identification of risks / allocation of overall plan and timescale. Consideration of adding to Women and Children's risk register.

Hearing

KPI performance **Standard 1 - Identify population and Coverage NH1**	Acceptable threshold ≥ 98% Achievable threshold ≥ 99.5% Q1: 99.4 | Q2: | Q3: | Q4:
Standard 2 – Test performance hospital automated otoacoustic emission 1 (OAE1) no clear response (well babies)	Acceptable threshold ≤27% Achievable threshold ≥22% Q1: 23.8 | Q2: | Q3: | Q4:
Standard 3: Test performance hospital referral rate to diagnostic audiological assessment	Acceptable threshold ≤ 3.0% Achievable threshold ≤ 2.0% Q1: 1.3 | Q2: | Q3: | Q4:
Standard 4 – Intervention – time from screening outcome to offered appointment for diagnostic audiological assessment	Acceptable threshold ≥ 97% Achievable threshold ≥ 99% Q1: 100 | Q2: | Q3: | Q4:
Standard 5 Intervention – Time from screening outcome to attendance at an audiological assessment appointment KPI NH2	Acceptable threshold ≥ 90% Achievable threshold ≥ 95% Q1: 85.7 | Q2: | Q3: | Q4: Q1: 1 x patient with persistent DNA
service specifications and programme handbook	

Newborn Bloodspot Screening

KPI performance and Programme Standards					
Standard 6 and KPI NB2: bloodspot quality	Acceptable standard ≤2% Achievable standard ≤1%	Q1	Q2	Q3	Q4
		0.2			
standard 3 use of barcode label	Acceptable standard ≥ 90% Achievable standard ≥ 95%	Q1	Q2	Q3	Q4
		95.1			
Standard 4 sample collected on day 5	Acceptable standard ≥ 90% Achievable standard ≥ 95%	Q1	Q2	Q3	Q4
		95.9			
Standard 5 sample received at lab within 3 working days	Acceptable standard ≥ 95% Achievable standard ≥ 99%	Q1	Q2	Q3	Q4
		96.3			
Service Specifications					
Update from national meetings					

NIPE

KPI performance **Standard 1 NP1. Identify the population and coverage. Test within 72 hours of birth**	Acceptable standard ≥ 95% Achievable standard ≥ 99.5%	Q1	Q2	Q3	Q4
		99.3			
Standard 2 Timeliness of intervention (abnormality of the eye) Assessment by specialist within 2 weeks of age	Acceptable Standard ≥ 95 Achievable Standards ≥100%	Q1	Q2	Q3	Q4
		No cases			

Q1	Update on Q1 following internal investigation – 1 baby initially referred but reviewed by senior paed prior to discharge and no referral required. Therefore Q1 changed to no cases
Q2	

<table>
<tr><td>Standard 3
NP2 Timeliness of intervention of DDH Assessment by USS within 2 weeks of age</td><td>
<table>
<tr><td>Acceptable standard ≥ 95%
Achievable standard ≥ 100%</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td></td><td>100</td><td></td><td></td><td></td></tr>
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<tr><td>Standard 4
Timeliness of Intervention (DDH risk factors) Assessment of USS within 6 weeks of age</td><td>
<table>
<tr><td>Acceptable standard ≥ 90%
Achievable standard ≥ 95%</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td></td><td>58.8%</td><td></td><td></td><td></td></tr>
</table>
<table>
<tr><td>Q1</td><td>51 referrals, 30 of which were seen by week 6. The remaining 21 were seen by end of 6. All outcomes NAD. DDH clinics held twice weekly</td></tr>
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</td></tr>
<tr><td>Standard 5
Timeliness of Intervention (bilateral undescended testes) Assessment within 24 hours</td><td>
<table>
<tr><td>Acceptable standard ≥ 100%</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td></td><td>No cases</td><td></td><td></td><td></td></tr>
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<tr><td>service specifications and programme handbook</td><td>Update to handbook – New info re breech presentation between 28-40 wks.
Amended list of national hip risk factors on S4N</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Update from National Screening Programmes</td><td></td></tr>
<tr><td>QA action plan</td><td>Re-writing of NIPE guidelines.
NIPE midwives into TNA – Complete.
Updated TOR required for NIPE meeting</td></tr>
<tr><td>Local Priorities</td><td>HEE training programme
Allocation of replacement NIPE lead
NIPE meeting</td></tr>
</table>

Appendix Three – QA Action plan

Division of Women and Children's.

Antenatal and Newborn Screening Quality Assurance Action Plan (PHE screening Quality Assurance Visit, July 2018)

Aim: PHE timeframe for completion – 31.7.19

Reporting and monitoring:

- Quarterly at Antenatal and Newborn Screening operational steering group
- 6 monthly review visits by PHE QA Adviser
- Informed action plan is closed by PHE QA October 2019 via informal email following 12 mth review meeting. Awaiting formal notification as of 30/10/19.
-

Overarching Governance Arrangements	
Department	**Reporting/Monitoring/Escalation**
Maternity	Women and Children's Division (reported monthly)
Radiology	Clinical Support Services Division
Newborn Hearing	Community Division

	On Target
	Behind Target
	Completed

No	Recommendation	Evidence required	Due	Responsibility	Status	Progress

1.	Strengthen internal risk and governance processes to make sure there is regular monitoring of the quality and integrity of antenatal and newborn screening programmes	Terms of reference for the operational screening group with reporting arrangements demonstrating board level oversight. (Maternity department, obstetric radiology department and newborn hearing screening service) Improved governance process demonstrating appropriate level sign off of the quarterly key performance indicators, annual data returns and annual report Include the screening champion role in governance processes	Decembe r 2018	S Augusta / S Bennett-Day J Marling J Phillpot	Compl eted	**Closed September 19 following 12 mth QA review mtg.**
2.	Update the risk management strategy and local screening guidelines to reference "Managing Safety Incidents in NHS Screening Programmes" This needs to be included in all screening guidelines	Evidence that screening guidelines and local maternity risk management strategy contain the PHE screening incident guidance and have been and ratified through the trust framework.	June 2019	Jane Lovedale	In Progre ss	**September 2018** To be updated when strategy is updated. Waiting for Risk Management strategy to be updated and this needs to include that –any actions that are included are by exception reporting **December 2018** – Jane has commenced work on this action. **January 2019 –** Risk management strategy updated and circulated prior to ratification **Feb 19 –** ratification of risk management strategy at Jan women's health governance. Screening guidelines in process of being updated (see no 5 and will include reference to "managing safety incidents in NHS screening programmes". **April 19**- PHE screening incident guidance to be included in all guidelines – see no 5. To include Sonography and Hearing Guidelines **August 19** – Guidelines in process of being re-written / updated and collated from audiology and sonography. **September 19 –** Local strategy document required to identify guidelines that require updating (maternity/sonography/hearing),

						timeframe and responsibility for completion, escalation process if overdue, monitoring and ratification process, with reference to frequency of guideline review. Review of guidelines to be linked to annual GAP analysis. Regular monitoring and review of this screening guideline strategy document to be included in local steering group agenda and action log. This action relates to QA numbers 2,5,13. Once this is in place actions 2,5 and 13 will be closed. Draft copy sent to QA for comments. **October 2019** – Timetable written and approved for updating all Screening guidelines and SOP's. To be monitored through steering grp.
3.	To provide assurance that there are safe arrangements for newborn hearing screening staff to carry out home visits	Lone worker risk assessment completed in line with the Suffolk Community Healthcare lone worker policy	September 2018	J Phillpot	Completed	**Sep 19 –** Evidence folder reviewed by QA adviser and action confirmed as closed.
4.	To develop a newborn hearing screening guideline for the deceased baby pathway	Local guideline that is ratified through the organisation's governance framework Evidence of dissemination to staff	September 2018	J Phillpot	Completed	**Sep 19 –** Evidence folder reviewed by QA adviser and action confirmed as closed.

5.	Update screening guidelines, operational policies and standard operating procedures (SOP) to reflect programme standards for: □ infectious diseases screening □ sickle cell and thalassemia screening □ fetal anomaly screening □ newborn hearing screening □ newborn blood spot screening □ newborn and infant physical examination	Updated and published documents to: □ include the information women / parents should receive to give informed consent □ include screening pathways □ detail the support for non-English speaking people including interpreting services □ include failsafe processes in SOPs □ be recorded in the programme board minutes as published □ governance framework that includes annual update of guidelines in line with screening service specifications Evidence of approval through local governance structure	June 2019	S Augusta / S Bennett-Day J Phillpot	In progress	September 2018: Not yet commenced. **Dec 18** – New GAP analysis reflecting full 18-19 service specs requested by PHE therefore guidelines currently being cross referenced with service specs. Work has commenced on updating NIPE guideline and updating standard operating procedures for screen positive outcomes. A target for one updated guideline per month has been set at steering group. **Jan 19 –** Format for guidelines d/w QA adviser **Feb 19** – update to SCT guideline in progress. Update to NIPE guideline d/w NIPE lead **March 19** – Infectious diseases guidelines on hold due to delays in new enhanced Hep B pathway at PHE. SCT draft almost complete – see 13. **April 19** – Draft SCT guideline sent to QA adviser for r/v, awaiting comments. Concern discussed with QA adviser that may run over suggested timeframe. Advised format and content of guideline should take precedence over timeframe for completion. Discussed certain guidelines e.g, FASP and ID awaiting delayed pathways from PHE (NIPT and enhanced Hep B) therefore not pertinent to update guidelines currently. PB draft minutes April 24th- documnent: SQAS support delay in ID guideline until enhanced Hep B pathway roll out. To contact Sonography lead to request updated guidelines and obtain from hearing. **August 19 –** SCT still in draft format. NIPE guideline commenced. Hep B to be amalgamated in one infectious diseases guideline, awaiting enhanced Hep B pathway from PHE. Hearing policy is have been updated and will brought to local steering group mtg in Oct. **September 19 –** Local strategy document required to identify

						guidelines that require updating (maternity/sonography/hearing), timeframe and responsibility for completion, escalation process if overdue, monitoring and ratification process, with reference to frequency of guideline review. Review of guidelines to be linked to annual GAP analysis. Regular monitoring and review of this screening guideline strategy document to be included in local steering group agenda and action log. This action relates to QA numbers 2,5,13. Once this is in place actions 2,5 and 13 will be closed. Draft copy sent to QA for comments. **October 2019** – Timetable written and approved for updating all Screening guidelines and SOP's. To be monitored through steering grp.
6.	Include antenatal and newborn screening in the programme of audits and develop a process for feeding back findings and actions.	Audit report and related action plan Copies of minutes of local operational meetings to evidence monitoring Programme board minutes demonstrating escalation	June 2019	S Augusta / S Bennett-Day & J Lovedale	Compl eted	**Sep 19 –** Evidence log sent to QA adviser and confirmation at QA 12 mth review ation closed.
7.	To improve processes to make sure audiology and national newborn hearing screening data reports are: □ followed up in line with the screening programme operational guidance □ used to improve the newborn hearing screening service	Standard operating procedure describing the required actions in response to audiology and NHSP data reports with evidence of monitoring through local governance structure Audit reports to evidence quality of screening service and improvements plans Evidence of monitoring through local governance structure Actions recorded in: □ minutes of local hearing screening	Decembe r 2018	J Phillpot	Compl eted	**Sep 19 –** Evidence log sent to QA adviser and confirmationat QA 12 mth review action closed.

8.	Formalise the deputy screening coordinator role	Deputy screening midwife job description Documented in minutes of local governance meetings and programme board	September 2018	S Augusta / S Bennett-Day	Completed	**Sep 19 –** Evidence folder reviewed by QA adviser and action confirmed as closed.
9.	Strengthen the functions of the Screening Support Sonographer (SSS)	Revised job description that is consistent with national guidance Evidence of approval through local governance structure	December 2018	J Marling	Completed	**Sep 19 –** Evidence folder reviewed by QA adviser and action confirmed as closed.
10.	To update the job description for the hearing screening manager to reflect current processes	Revised job description that is consistent with national guidance. Evidence of approval through local governance structure	June 2019	J Phillpot	Completed	**Sep 19 –** Evidence folder reviewed by QA adviser and action confirmed as closed.
11.	1. Improve the quality of screening updates and training by: □ using resources provided by the screening programmes 2. making sure midwives who perform NIPE screening receive updates and training to give assurance of competency	Training slides and resources NIPE midwives included in the training needs analysis Evidence of approval through local governance structure	September 2018	S Augusta / S Bennett-Day	In progress	**September 2018**: Had NIPE meeting 08/08/18. Minutes requested from H. McBride 19/09/18. Request to J.S re what exact training material is recommended, no specific material but presentation being updated in line with new service specification. NIPE meeting completed and plan for ongoing updating made. To be added to TNA when updated in Feb 2019. **Dec 18** – PHE Screening masterclass attended. Relevant resources used at this added to mandatory training update. **Jan 19 –** NIPE screening updates and training D/W NIPE lead for further consideration **Feb 19** – No update **March 19** – no update **April 19** –

						1. Need to embed PHE hyperlinks used within mandatory training within action plan. 2. No action noted for last 3 months. NIPE lead to be emailed and screening steering lead cc'd in for request for update. Added to screening steering action log. D/W HOM – HOM to contact NIPE lead. August 19 – 1. PHE links not as yet added. 2. NIIPE lead has commenced re-writing of NIPE guideline. NIPE mtg organised for Oct 19 where TOR and training updates / TNA will be confirmed. **Sep 19 –** Mandatory training discussed quarterly at women's health gov. Copy of agenda to be added to Evidence folder and sent to QA. Copy of TNA document which includes NIPE practitioners within this to be added to Evidence folder and sent to QA. TOR for NIPE requires updating and to include TNA for NIPE practitioners. Aim for consideration at Oct NIPE mtg. NIPE TNA to be included as standard agenda item for NIPE mtgs. **Oct 19 –** NIPE lead to be reallocated by HOM. NIPE has been added to TNA. NIPE mtg to be scheduled asap and new TOR sent for consideration.
12.	To strengthen the newborn hearing screening service to make sure training for new hearing screeners is facilitated.	Evidence that the local manager or deputy is completing the Certificate in Assessing Vocational Achievement (CAVA) course or evidence of formalised arrangements for assessment support Information recorded in minutes from local screening steering group and programme board	June 2019	J Phillpot	Compl eted	**Sep 19 –** Evidence folder reviewed by QA adviser and action confirmed as closed.

13.	Improve the screen positive pathway to make sure women are offered pre-natal diagnosis by 12+6 weeks	Updated and ratified Haemaglobinopathy screening guidelines Evidence of approval through local governance structure	December 2018	S Augusta and S Bennett-Day	In progress.	September 2018: Partner testing now offered to all known carriers at booking. Guideline to be updated which we need to be explicit and added to antenatal booking framework. We are discussing this in Mandatory Training. The guideline re haemoglobinopathy needs to be updated as a priority and an agenda item on next local screening meeting. In our evidence for this to submit we can include the memo and mail that was sent about partner testing at booking. **Dec 18** – R Clarke removed from action. Failsafe database enhanced to ensure all pregnancies using donor egg are captured. Local Community teams and OOA notified of need to offer partner testing to unscreened donor egg pregnancies. Reinforced at Screening champion meeting. Haemaglobinopathy guideline to be updated as a priority **Feb 19 –** Haemaglobinopathy guideline in process of being updated. **April 19** – draft SCT guideline sent to QA adviser for comments. New guideline rather than updated. Keen to ensure format and content. Awaiting comments. Requirement to have clear process for fast tracking of women known to have a haemaglobinopathy. **August 19** – SCT still in draft format. Delay due to capacity issues in screening team resulting from sickness / Annual leave, discussed at July PB. Clinical workload has been priority. Service stretched due to additional pressures from NCARDS outcomes data. **September 19 –** Local strategy document required to identify guidelines that require updating (maternity/sonography/hearing), timeframe and responsibility for completion, escalation process if overdue, monitoring and ratification process, with reference to frequency of guideline review. Review of guidelines to be linked to annual

						GAP analysis. Regular monitoring and review of this screening guideline strategy document to be included in local steering group agenda and action log. This action relates to QA numbers 2,5,13. Once this is in place actions 2,5 and 13 will be closed. Draft copy sent to QA for comments. **October 2019** – SCT guideline updated and sent out for consultation. For discussion / approval at Nov W&C business mtg. Once approved can be closed.
14.	Make sure women who miscarry or terminate their pregnancy following antenatal screening are informed of the outcome of their screening tests	Updated and published infectious diseases screening guidelines. Evidence of approval through local governance structure	December 2018	S Augusta and S Bennett-Day	Completed	**Sep 19 –** Evidence folder reviewed by QA adviser and action confirmed as closed.
15.	Implement a process to record outcomes for all screened conditions. This should be is recorded electronically on the NIPE Smart IT system	Updated standard operating procedure Evidence of change via local governance structure	December 2018	S Augusta / S Bennett-Day	Completed	**Sep 19 –** Evidence folder reviewed by QA adviser and action confirmed as closed.
16.	Produce and implement an action plan to meet programme standards 3, 5 and 6	Action plan and minutes from screening steering group meeting. Quarterly newborn bloodspot laboratory report monitoring: standard 3: use of NHS number standard 5: timely sample receipt standard 6: bloodspot quality; avoidable repeat rate Evidence of monitoring through local governance structure	December 2018	R Clarke	Completed.	**Sep 19 –** Evidence folder reviewed by QA adviser and action confirmed as closed.

14. Consultant appointment

Nothing to report this month

For Report

Presented by Jeremy Over

15. Putting you first award

To NOTE a verbal report of this month’s winner

For Report

Presented by Jeremy Over

11:10 BUILD A JOINED-UP FUTURE

16. 7 day services report

To approve the report

For Approval

Presented by Nick Jenkins

Trust Board – 29 November 2019

Agenda item:	16			
Presented by:	Nick Jenkins, Medical Director			
Prepared by:	Alex Baldwin, Deputy Chief Operating Officer			
Date prepared:	22 November 2019			
Subject:	7 Day Services			
Purpose:		For information	√	For approval

Executive summary:

This paper provides a summary of the autumn 2019 7 Day Services (7DS) audit results.

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

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

Previously considered by:	*n/a*
Risk and assurance:	*n/a*
Legislation, regulatory, equality, diversity and dignity implications	*n/a*

Recommendation:
The Board is asked to note the results of the autumn 2019 audit.

1.0 Background

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services ('providers') to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

To achieve each standard, a provider must be able to meet this level of care for at least 90% of its patients.

It is expected that all Trusts are compliant with the four priority standards by April 2020.

2.0 Autumn 2019 audit results

The spring 2019 audit covered the four priority standards.

2.1 Clinical standard 2

The autumn 2019 survey reported that the overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission was **80%.**

Table 1: Time from admission to 1st consultant review by day of the week (based on day of admission)

	Day of admission									
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Weekday	Weekend	Total
Number of patients reviews by a consultant within 14 hours	16	19	24	17	15	14	10	91	24	115
Number of patients reviews by a consultant outside 14 hours	5	9	2	4	2	3	3	22	6	28
Total	21	28	26	21	17	17	13	113	30	143
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	76%	67%	92%	80%	88%	82%	76%	81%	80%	80%

Table 2: Proportion of patients reviewed by a consultant within 14 hours of admission at hospital - survey comparison

	Survey					
	September 2016	March 2017	September 2017	April 2018	May 2019	November 2019
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	72%	72%	77%	79%	78%	80%

Compliance for standard 2 has improved since May 2019. This is consistent with increased same day emergency services delivered through AAU and the front door frailty model.

It is noteworthy that 90% of patients receive a consultant review within 17 hours of admission to the hospital. This level of performance remains comparable with the May 19 survey.

Table 3: Time to 1st consultant review within 14 hours of admission by admitted specialty

	Within 14 hours	Outside 14 hours	Total	Proportion reviewed within 14 hours
Acute Internal Medicine	49	8	57	86%
Cardiology	4	0	4	100%
Diabetes and Endocrinology	1	0	1	100%
Emergency Medicine	4	0	4	100%
ENT	1	1	2	50%
Gastroenterology	2	0	2	100%
General Surgery	13	8	21	62%
Geriatric Medicine	18	3	21	86%
Haematology	0	1	1	0%
Obstetrics and Gynaecology	0	2	2	0%
Oncology	2	0	2	100%
Paediatric Medicine	3	1	4	75%
Renal Medicine	2	0	2	100%
Respiratory Medicine	1	0	1	100%
Stroke Medicine	3	0	3	100%
Trauma and Orthopaedics	10	4	14	83%
Urology	2	0	2	100%

The Trust's focus should be on consistently meeting the standard across all specialties and there is a requirement for consultant directed review to be clearly documented in e-care.

2.2 Clinical standard 8

There were no patients identified as requiring twice daily audit in the autumn 2019 survey.

The proportion of patients who required and received a once daily consultant directed review was **84%.**

Table 4: Patients who required once daily consultant reviews and were reviewed

	Day of review									
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Weekday	Weekend	Total
Once daily review required and received	52	53	49	58	53	32	36	265	68	333
Once daily review required and not received	3	4	6	2	11	20	20	26	40	62
Excluded from the analysis	1	0	4	5	1	2	7	11	9	18
Percentage - receiving required once daily reviews	94%	92%	89%	96%	88%	61%	64%	91%	63%	84%

2.3 Summary

In summary the Trust has improved performance for standard two, and maintained performance for standards five and six. Standard 8 has deteriorated since May 19 and there is a clear focus on standards of documentation to evidence once daily consultant review.

Table 5: Survey Comparison Autumn 2016- Autumn 2019

West Suffolk NHS Foundation Trust	CS2: Time to first consultant review within 14hrs	CS5:Access to diagnostics	CS6: Access to consultant directed interventions	CS8: Ongoing review
Autumn 2019	80%	100%	100%	84%
Spring 2019	78%	100%	100%	89%
Spring 2018	79%	100%	100%	95%
Autumn 2017*	77%	N/A	N/A	N/A
Spring 2017	72%	100%	100%	91%
Autumn 2016	72%	N/A**	9 out of 9	Once daily 87% Twice daily: 5%

*Autumn 2017 survey only measured clinical standard 2.
** Autumn 2016 survey measured CS2: Access to diagnostics via a survey of consultants

Focus remains on consistent delivery across the seven-day period and increasing first consultant review within 14 hours.

3.0 7 Day Services Board Assurance

The 7DS self-assessment process has changed. The online self-assessment survey has been replaced with a 7DS board assurance framework template (appendix one).

The framework template is intended to provide a single, consistent way of recording provider self-assessments of 7DS delivery. The template requires providers to complete all yellow cells either:

- with a free text commentary of performance, covering any gaps to be addressed or
- by selecting a response to questions of compliance from a drop-down list.

The template is used to summarise the headline issues relating to delivery of the 7DS clinical standards as well as providing self-assessment information. It is not a comprehensive picture of the Trust's work on 7DS nor captures the full details of the audit data gathered to support any self-assessments.

In order to provide full assurance all future audits will replicate the national audit methodology as used for the spring 2019 audit. This allows for accurate comparison with previous audit results. It is expected that the audit will run bi-annually with both the framework template and detailed analysis presented to the board for assurance.

The Trust is required to submit the assurance framework template on 29 November 2019.

7 Day Hospital Services Self-Assessment

Organisation	**West Suffolk NHS FT**
Year	**2019**
Period	**Spring/Summer**

West Suffolk NHS FT: 7 Day Hospital Services Self-Assessment - Spring/Summer 2019

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	80% of patients admitted as an emergency had a clinical assessment by a suitbale consultant within 14 hours of admission. 81% of patients admitted during week days were assessed within 14 hours. 80% of patients admitted during the weekend were assessed within 14 hours. 90% of patients admitted as an emergency were assessed within 17 hours. Overall the Trust has improved perfromance from the Spring 19 audit when 78% of patients were assessed within 14 hours. The percentage of patients who recieve assessment within 17 hours is comparable with the spring 19 survey.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Access to all modalities is avaliable 7 days per week.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Emergency Surgery	Yes available on site	Yes available on site	
	Access to all modalities is avaliable 7 days per week.	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Stroke thrombolysis	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	The proportion of patients who required and received a once daily consultant directed review was 84%. The proportion of patients who required and received a once daily consultant directed review during the week was 91%. The proportion of patients who required and received a once daily consultant directed reveiw at the weekend was 63%. There were no patients identified as requiring twice daily reveiw in the autumn 2019 survey The Trust continues to perfrom well on once daily reveiws during the week but has an opportunity to improve the frequency of consultant led reveiw at the weekend.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Performance against the remaining clinical standards as follows: 1. Patient experience - the Trust has robust mechanisms for review of patient experience measures which are reported to and reveiwed at board on a monthly basis. 3. MDT review - the Trust has robust written policies for MDT processes in all specialties which covers appropriate assessment of ongoing or complex needs and integrated management planning (including discharge planning and medicines reconciliation). 4. Shift handovers - the Trust has assurance of robust handover as evidenced by comprehensive board and ward rounds and red 2 green reviews. These are reflected by appropriate hospital policy which is standardised accross seven days. 7. Mental health - The Trust is working hard with the local mental health provider to ensure appropriate availability and response of service 24/7. 9. Transfer to community, primary and social care - the Trust has robust mechanisms for ensuring the next steps in the patient's care pathway is enabled. Evidence includes board and ward rounds, red 2 green reveiws, stranded patient reviews and an engaged and effective discharge planning team. 10. Quality improvement - the Trust has an effective board assured quality improvement strategy which includes mortality reveiws, learning from death panels, length of stay and readmission reveiws etc.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
The Trust is compliant with the standards for services it provides.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

17. Staff health and wellbeing programme

To approve the report

For Approval

Presented by Jeremy Over

Trust Board Meeting – 29 November 2019

Agenda item:	17			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Denise Pora, Deputy Director of Workforce (Organisation Development), Caroline Porter, Wellbeing Co-ordinator, *Oh: Occupational Health at Work*			
Date prepared:	31 October 2019			
Subject:	Staff health and wellbeing programme			
Purpose:	X	For information		For approval

Executive summary:

Promoting the health and wellbeing of all our staff is important to support them in delivering excellent care for our community as well as being a marker of a good employer. This report provides Trust Board members with an update on how this support is being provided and indicators of its impact.

We have continued to work with our partner *oh: Occupational Health and Wellbeing* to deliver our agreed priorities for health and wellbeing and the programme is led and overseen by the trust Health and Wellbeing Steering Group. The West Suffolk Wellbeing Plan 2019 – 2012 (**Appendix A**) sets out the range of support already available to all staff and the action being taken to build on and consolidate this.

Notable achievements since the last Board report in November 2018 include:

Supporting staff mental and emotional health wellbeing e.g. by the end of 2019 over 100 trust managers will have attended the two-day workshop provided by Suffolk MIND that follow on from a successful pilot in 2018. Additionally, by the end of the year over 100 staff will have attended a one-day mental health awareness and emotional first aid workshop. A further 25 medical staff have attended a two-day 'wellbeing' workshop for medical staff.

Understanding and addressing the needs of medical staff. The 'Better Working Lives Group' chaired by Dr Paul Molyneux, Deputy Medical Director, was set up in October 2018 and is a sub-group of the Trust Health and Wellbeing Steering Group. This group takes a particular interest in the wellbeing of medical staff and has already achieved a significant amount, including:

- Mindfulness workshops run at the Grand Round in April and May 2019 that were attended by over 50 medical staff.
- Two-day Wellbeing Workshop for medical staff in September 2019 that was attended by 25 doctors. Following excellent feedback, a further workshop is to be run in January 2020.
- Surveys were conducted to assess the levels of burnout amongst consultant medical staff and junior doctors. Learning from these is being used to identify and design appropriate support.

Staff led initiatives. We have significant, positive evidence this year of the success of engendering an enabling culture where staff can and want to lead initiatives themselves. For example:

- Addressing period poverty: Ellie Stewart, Clinical Nurse Specialist, Urogynaecology and Laura Wilkes, Trust Librarian set up period boxes in toilets around the trust giving free access to sanitary products.
- Supporting women experiencing menopause: Debs Crelly, Senior Operations Manager, is setting up an informal support network with regular meetings in Time Out amongst women in the trust who want to share information and experience about the menopause.
- Running an evening art workshop for staff: Anita Mills, who works in Diagnostic Cardiology organised two sessions with the help of a local company providing staff with an opportunity to get in touch with their creativity. A further event is planned.

Supporting staff to speak up. Making it as easy as possible for staff to speak up when they have a concern is an important element in supporting staff wellbeing. We have bought together all sources of support and branded them 'staff supporters' and provided a single point of access for contact details through the trust intranets. These have been publicised widely in the Greensheet and through posters across the Trust. Two new routes for anonymous reporting of concerns (via a telephone hotline or the Trust website) were introduced in September 2019.

An **evaluation framework** for our wellbeing programme was devised in 2018 with a mix of structural, process and outcome indicators to assess impact. This has been updated for 2019 and is attached at **Appendix B**. Overall indicators of **impact** are provided by the National NHS Staff survey which has robust, comparable data on health and wellbeing. In the 2018 survey WSFT scored 6.4, well above the average of 5.9, for the *staff health and wellbeing theme*. This covers all questions relating to health and wellbeing including work-related stress, MSK problems and line managers taking a positive interest in their staff health and wellbeing. We also scored above average for the *morale theme* scoring 6.4 (average 6.1).

The rate of flu vaccination amongst frontline staff has steadily risen in the past three years and reached 75.1% in 2018/19. Good progress has already been made towards the 2019/20 target of 80% despite issues with vaccine supply. Whilst total sickness absence rates are consistently below the East of England NHS average absences due to anxiety, stress, depression etc. are increasing and this is the top reason for staff sickness absence. This reinforces the continuing importance of efforts to support the emotional and mental wellbeing of staff.

We have also recognised the close links between wellbeing and our **inclusion** and **leadership** agendas and the impact a proactive approach to these can have on wellbeing. This is being demonstrated through the very positive responses to establishing a LGB&T+ network in October 2018 and a disabled staff network set up in July 2019. Additionally, the 'improving everyone's experience' plan developed at the Summer Leadership Summit in June 2019 is tackling poor behaviour including bullying and harassment, which will also contribute to the wellbeing of staff.

In addition to the support we receive through our partnership with *oh: Occupational Health and Wellbeing* a proposal is currently being developed by Dr Helena Jopling, Consultant in Healthcare Public Health for a four month rotation for a GP trainee to support WSFT health and wellbeing projects. Additionally, we expect a public health trainee to join the Trust in July 2020 to take up the role of Public Health Registrar, previously filled by Dr Molly Meyer-Thomas who left in April 2019.

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

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

Previously considered by:	WSFT Health and Wellbeing Steering Group (West Suffolk Wellbeing plan 2019 – 21)
Risk and assurance:	Financial risk if investment in staff health and wellbeing do not produce a financial return in reduced sickness absence or reduced staff turnover. This risk is mitigated by mobilising existing resources as far as possible.
Legislation, regulatory, equality, diversity and dignity implications	The trust is required to take action to reduce staff sickness. National guidance (e.g. NICE, the Health & Safety Executive) recommends organisations have robust and holistic policies for supporting staff health and wellbeing.

Recommendation:
Board members are invited to note progress made and the actions planned for the period 2019 to 2021.

Introduction

Promoting the health and wellbeing of all our staff is important to support them in delivering excellent care for our community as well as it being as a marker of a good employer. This report provides Trust Board members with an update on how this support is being provided and our assessment of its impact.

Development of the staff health and wellbeing programme since November 2018

We have continued to work with our partner *oh: Occupational Health and Wellbeing* to deliver our agreed priorities for health and wellbeing. Our health and wellbeing programme is led and overseen by the Health and Wellbeing Steering Group.
Our executive lead for health and wellbeing, Jan Bloomfield, Executive Director of Workforce and Communications (EDWC), retired at the end of March 2019 and this this role has been taken by Denise Pora, Deputy Director of Workforce (Organisation Development) in the interim pending the new EDWC, Jeremy Over, taking up post in November 2019. Our Public Health Registrar, Dr Molly Meyer-Thomas, who led a significant element of the work programme, left in April 2019. We currently expect new Public Health Registrar to join us in July 2020.

The 2018 action framework has been developed and updated; it is attached as **Appendix A:** West Suffolk Wellbeing Plan 2019 – 2021. This is a 'live' document which provides focus and direction for our work as well as capturing the detail of the wealth of health and wellbeing support already available to staff. The plan is regularly reviewed by the Health and Wellbeing Steering Group.

Notable developments to highlight from the last 12 months include:

Supporting staff mental and emotional health and wellbeing

- *Mental health for managers training* to help managers identify staff with mental health difficulties and provide support. The first day of the training is 'Your Needs Met'. Two-day workshop attended by 103 participants (22 consultants) March to November 2019. Medical Director has asked all Clinical Directors and Clinical Leads to participate using two days study leave. 35 staff attended this workshop in 2018.

- *Mental Health Awareness and Emotional First Aid* one day workshops for all staff (108 participants in 2019)

- *Health and wellbeing focus group* – open to all staff. The 20th September 2019 session focussed on emotional and mental wellbeing and led by Suffolk MIND and Dr Emily Baker, WSFT clinical psychologist.

Understanding and addressing the needs of medical staff
The Better Working Lives group is chaired by Dr Paul Molyneux, Deputy Medical Director and membership comprises senior medical staff and senior managers. It is a sub-group of the Trust's Health and Wellbeing Steering Group and focuses specifically on the wellbeing of medical staff. The group was established in October 2018 the group and has organised the following support activities:

- *Burnout Workshop* led by Dr Dike Drummond on burnout of medical staff and how to avoid it in October 2018. Dr Drummond is an internationally recognised expert in the arena of medical staff burnout.

- *Surveys* to assess levels of burnout amongst consultant medical staff and junior medical staff. Information from these surveys being used to identify and design appropriate support.

- 2-day *Wellbeing Workshop for medical staff* 9/10 September 2019. Attended by 25 doctors (21 consultants). The workshop included a sessions on emotional and mental health wellbeing and stress management led by Suffolk MIND and sessions on burnout and resilience and mindfulness. Feedback was excellent. Further workshop to be run in January 2020. The group aims to run three sessions annually.

- *Mindfulness workshops* run at Grand Round 24th April 2019 (How Mindfulness Can Help) and 8th May (Putting Mindfulness into Practice). Attended by total of 53 medical staff (35 consultants)

Staff led initiatives

We have excellent examples this year of the success of engendering an enabling culture where staff can and want to lead initiatives themselves. Recent developments include:

- *Addressing period poverty* Ellie Stewart, Clinical Nurse Specialist, Urogynaecology and Laura Wilkes, Trust Librarian set up period boxes in toilets around the trust giving free access to sanitary products.

- *Supporting women experiencing menopause* Debs Crelly, Senior Operations Manager, is setting up an informal support network with regular meetings in Time Out amongst women in the trust who want to share information and experience about the menopause.

- *Running an evening art workshop for staff* Anita Mills, who works in Diagnostic Cardiology organised two sessions with the help of a local company providing staff with an opportunity to get involved in a creative project. A third, Christmas themed, event is planned.

CQUIN

The CQUIN supporting the provision of healthy food and drink has ended but the Trust and W H Smith continue to abide by the rules including a ban on price promotions, advertising and placing items at checkout for items high in fat, sugar and salt, plus the provision of healthy options, including at night.

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Supporting staff to speak up

Making it as easy as possible for staff to speak up when they have a concern is an important element in supporting staff wellbeing. We have bought together all sources of support and branded them 'staff supporters' and provided a single point of access for contact details through the trust intranets. This has been publicised widely in the Greensheet and through posters across the trust.

One element of 'staff supporters' is raising concerns and in addition to their own line manager and our Freedom to Speak Up Guardian, we have promoted other routes to staff through which staff can speak up. These are:

- Trusted Partners – volunteer members of staff who provide confidential, independent advice and a listening ear
- Trust Executive Open Door – executive directors in Time Out from 8 am to 9 am every Wednesday for staff to talk to informally
- Trade Union representatives
- The Trust Human Resources Team
- The Trust Chaplaincy Service

If a member of staff feels the only way they can report their concern is to do so anonymously they now have two routes – launched in September 2019. These are a telephone hotline and in writing via the trust website.

Links to the inclusion and leadership development agendas

We have also recognised the close links between the wellbeing and inclusion agendas and the impact a proactive approach to inclusion can have on wellbeing. This is being demonstrated by staff through the very positive responses to establishing a LGB&T+ network in October 2018 and a disabled staff network set up in July 2019. Additionally, the 'improving everyone's experience' developed at the Summer Leadership Summit in June 2019 is tackling poor behaviour including bullying and harassment, which will also contribute to the wellbeing of staff.

Support to the WSFT health and wellbeing programme

A proposal is currently being developed by Dr Helena Jopling, Consultant in Healthcare Public Health for a four month rotation for a GP trainee to support WSFT health and wellbeing projects. Additionally, we expect a public health trainee to join the Trust in July 2020 to take up the role of Public Health Registrar, previously filled by Dr Molly Meyer-Thomas who left in April 2019.

Evidence of impact

An evaluation framework was devised in 2018 with a mix of structural, process and outcome indicators. This has been updated for 2019 and is attached at **Appendix B**.

Headlines

- All training workshops provided to well over 200 staff and managers to support positive emotional and mental health have been highly rated. Staff attending the workshops were clear about how they were going to use what they had learnt, for example:

  "I will use this in all 1:1 discussions with staff and in ward meetings"
  …"*mainly in my 1:1s as a line manager but also to understand the value of my own mental health*"
  …"*in my day-to-day communications with staff and patients, as well as in my personal life"*
  "Recognise and take time if I see someone struggling"
  "Open mindedness towards those who are having issues"

- WSFT scores well above the average for comparable trusts in the National NHS Staff Survey in the Health and Wellbeing theme (WSFT = 6.4, average = 5.9).

- WSFT scores well above average in the Morale theme (WSFT = 6.4, average 6.1)

- Take up rate of the flu vaccination by frontline staff has steadily increased in the past three years reaching 75.1% in 2018/19.

- Sickness absence. Trust total sickness absence rate has been below the East of England average of 4.37% for the whole period September 2018 to August 2019. However, it is concerning to note the generally upward trajectory of absence due to stress, anxiety and depression in the same period. It is impossible to measure what impact activities designed to support positive emotional and mental health have had on this figure – they may have had no positive impact or have resulted in the increase in absences being less than it would have been. The clear message we can take is the need to continue to proactively take action to support the health and wellbeing of staff and reduce the workplace factors that can result in stress, anxiety and depression.

Recommendation

Trust Board members are invited to note this report.

APPENDIX A

West Suffolk Wellbeing 2019 – 2021

Leadership

Trust Ambition 7 *Support all our staff*

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

Current services and support

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

Action 2019 to 21

- Promote personal stories of self-improvement to encourage staff engagement through Better for me, better for you campaign to be developed by the Communications team. Initially 5 staff stories to be publicised in West Suffolk and Newmarket Hospitals.
- Identify and address particular issues facing community staff in accessing wellbeing support.

Mental Health

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

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

Current services and support

- Care First Employee Assistance Programme provides access to information, advice and counselling
- Trust library provide resources for mental wellbeing, including mood boosting books for their uplifting qualities, Books on Prescription providing self-help techniques, colouring materials for mindfulness.
- Mental Health for Managers training (103 participants in 2019) and mental health awareness and emotional first aid workshops for staff (108 participants in 2019)

- Wellbeing Workshop for medical staff (25 participants - 9 and 10 September 2019)
- Mindfulness training at Grand Round 50 medical staff attended April/May 2019
- Freedom to Speak up Guardian in place since 2017 and range of other options via 'staff supporters'
- Tea and Empathy – giving staff on-the-day access to 1:1 support from a colleague if they have had a bad day and want to talk
- Trusted partners – provide a listening ear and independent advice to staff with concerns including bullying and harassment and inclusion
- Chaplaincy provides pastoral and spiritual support in times of need

Action 2019 to 21

- Action plan to tackle bullying and harassment built on learning from 2019 Summer Leadership Summit and internal survey to be implemented, including anonymous reporting, mediation support and unconscious bias training
- Trust inclusion strategy objectives 2019 – 21 and supporting action plan include taking action to support the mental health wellbeing of staff
- Doctors 'burnout' surveys – action to be taken by Better Working Lives Group
- Survey of medical staff to explore the impact of IT systems on working lives and opportunities to improve experiences – action to be taken by Better Working Lives Group
- Development of a business case for in-house clinical psychology to support staff mental health, including debriefing of individuals and teams – led by Better Working Lives Group

Life Style

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

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

Current services and support

- Engagement with Suffolk County Council Health Promotion Campaign Planning
- WSFT Smoke Free Environment
- One Life run Stop Smoking Clinics on site weekly
- NHS Health Checks. One Life Suffolk on site monthly to provide free health checks for staff aged between 40-74
- Health Walks One Life Suffolk
- One Life Suffolk weight management course for staff who meet BMI criteria
- Physical activity- WSFT Staff currently run Circuit Exercise and Tae Kwando classes on site aiming for ease of access to staff members and encourage physical activity.

- Active travel. One element is the national Cycle-to-Work scheme, purchasing cycling goods tax-free.
- Healthy Eating. Time Out staff restaurant provides healthy choices and has won Eat Out, Eat Well award.
- Preceptorship Days and other Training/workshops include the Wellbeing Market Place which provides information regarding WSH staff benefits and available support services also road showing I.T systems and programmes.

Action 2019 to 21

- Physical activity - Explore opportunities to provide further exercise options on site for staff e.g. Tai Chi
- Supporting staff to stop smoking – WSFT will be actively promoting Stoptober in October 2019
- Seek agreement for One Life presence on site once a fortnight to help promote services and provide support and information to staff and patients as required
- Healthy eating – catering team exploring vegan options in Time Out

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

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

Current services and support

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

Action 2019 to 21

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

Focus on: Preventing Flu **Trust Ambition 5** *Support a healthy life* Throughout the flu season we offer and provide our staff with the Flu vaccination
Current services and support • Flu Strategy • Follow NHS checklist for beat practice management checklist for public assurance via trust Boards.
Action 2019 to 21 • 2019/20 flu season – target of 80% vaccination of frontline/patient facing staff
Life Experiences and Ill Health **Trust Ambition 5** *Support a healthy life* **Trust Ambition 7** *Support* all *our staff* Life experiences and ill health will have a completely different meaning to each individual employee. We aim to holistically support staff through generalised life events (e.g. menopause, caring responsibilities) as well as specific health conditions
Current services and support • The Trust has a range of policies and guidance to support staff and enhance a healthy workplace culture • Health and Wellbeing Focus Group quarterly.
Action 2019 to 21 • Improving the working lives of disabled staff – Workforce Disability Equality Standard action plan developed, including establishing a disabled staff network, reviewing policies and supporting reasonable adjustments • Menopause workshop – additional workshop in 31 October 2019, explore setting up a menopause support network • Family Carer Workshops for those caring for elderly friends or relatives • Handling stress and anxiety workshop 20 September 2019 • Mental health awareness and emotional first aid workshops for staff and managers – build on 2019 activities.

- Supporting parents of children facing mental health difficulties in support of the Director of Public Health for Suffolk's Annual Report 2019 "Suffolk through a child's eyes"

Financial Wellbeing

Trust Ambition 7 *Support all our staff*

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

Current services and support

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

Action 2019 to 21

- Preceptorship marketplace 18th December 2019

Absence Management

Trust Ambition 7 *Support all our staff*

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

Current services and support

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

Action 2019 to 21

- OH contract review – ensure staff have timely access to occupational health services to support remaining at and returning to work
- Promotion of occupational health services – self referral by staff and raising line manager awareness of the support available to them
- Workforce Disability Equality Standard action plan – supporting staff with disabilities, explore potential for a disability leave policy
- The Improving Employee Health, Wellbeing and Attendance Policy is currently being reviewed, with phased returns being an element of focus

Safe Environments

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

We aim to provide all staff with a safe working environment

- Health and Safety training provided to all staff relevant to their role at induction and on-going mandatory training
- Restrictive Physical Intervention (RPI) Team. A specialist team undertakes Restrictive Physical Intervention (RPI) to provide support to staff when they are nursing clinically confused patients who become violent and aggressive.
- Management of Violence and Aggression Policy covers a wide range of issues around the creation of a safe working environment for staff through the prevention and management of physical and non-physical violence and aggression.
- All areas/departments of the hospital are required to have a Health & Safety Link person.

APPENDIX B

Staff health and wellbeing evaluation framework and dashboard 2019

Structures and Processes	Outputs	Outcomes
Physical wellbeing		
NHS health checks delivered	Staff set quit dates with on-site stop smoking service Flu vaccine coverage	NHS Staff survey - % experiencing work-related MSK problems
Emotional and mental wellbeing		
Tea & Empathy rota Trusted Partner role Staff Supporters promoted	Uptake of Care First Staff attend training supporting health and wellbeing	NHS staff survey - % experiencing work-related stress
Overall		
Quarterly staff focus groups Greensheet articles Staff led initiatives enabled Resources for staff in intranets Better Working lives group	NHS Staff survey – health and wellbeing and morale themes – overall Trust performance in comparison with other similar organisations (possible from 2019 survey) NHS staff survey - % of staff believing the Trust takes positive action on health and wellbeing	Sickness absence rate • Total • 0-3 days • % declared stress, anxiety, depression Turnover (as an indicator of staff satisfaction) NHS staff survey - % coming to work despite not feeling well enough NHS staff survey - % agree or strongly agree immediate manager takes interest in health and wellbeing

1. Structures and processes

NHS Health Checks Delivered

Target: 10 clinics available with 80 checks carried out per annum
Progress: October 2018 to September 2019: 12 clinics available, 9 clinics ran and 45 checks carried out

Tea and Empathy rota: In place and now business as usual

Trusted Partner role: Additional Trusted Partners recruited from October 2018 to broaden range of lived experience of staff available to provide support to others through this role. Trusted Partners have reported a total of 15 concerns raised October 2018 to September 2019.

Analysis of concerns raised with Trusted Partners October 2018 to September 2019:
Training and support available (1)
Workload (1)
Lack of confidence in being open about sexuality at work (2)
Listening ear to individual who had raised a formal complaint (1)
Disability issues (4)
Low morale (1)
Bullying and harassment in the workplace (3)
Issues with line manager (1)
Work processes not being followed (1)

Staff Supporters: 'Staff Supporters' branding developed and promoted throughout the trust via intranets and posters to provide staff with a single point for accessing support.

Quarterly staff focus groups: October 2018 to September 2019 31/10/18 Menopause workshop 04/04/19 Wellbeing showcase 04/06/19 Keeping a healthy weight (cancelled as only 4 staff expressed an interest, they were directed to One Life Suffolk or their GP) 20/09/19 Stress and anxiety workshop
Greensheet articles: Regular items covering all aspects of health and wellbeing in the branded 'Your Health and Wellbeing' section
Enabling staff led initiatives: Staff feel able and encouraged to initiate activities to support other staff LGB&T+ network set up October 2018 Period boxes in trust toilets to support 'end period poverty' Art workshops for staff Menopause support network Disabled staff network set up July 2019
Resources for staff on intranets: New sections on 'anti-burnout' resources and menopause resources added since October 2018
Better Working Lives Group: Better working lives group set up in October 2018 as a sub-committee of the Health and Wellbeing Steering group focusing on the health and wellbeing of medical staff

2. Output indicators

Staff set quit dates with on-site stop smoking service: data currently unavailable

Flu vaccination coverage (frontline staff) CQUIN – Improve update of 'flu vaccination. Measure is uptake by frontline clinical staff *Cut-off date for calculation of total was end December in 2016/17 but end February in following years	**2016/17***	**2017/18**	**2018/19**
	Target = 75%	Target = 70%	Target = 75%
	64.6%	74.67%	75.1%

Care First: new clients accessing care first services - data unavailable * data awaited	**Nov 2017**	**Dec 2017**	**Jan 2018**	**Feb 2018**	**Mar 2018**	**Apr 2018**	**May 2018**	**Jun 2018**	**Jul 2018**	**Aug 2018**	**Sep 2018**	**Oct 2018**
	18			31			15			7		
	Nov 2018	**Dec 2018**	**Jan 2019**	**Feb 2019**	**Mar 2019**	**Apr 2019**	**May 2019**	**Jun 2019**	**Jul 2019**	**Aug 2019**	**Sep 2019**	**Oct 2019**
	-	-	-	5	3	7	8	6	6	*	*	*

Staff attend training supporting health and wellbeing:
Suffolk MIND supporting staff mental health: 6 x 2-day workshops attended by 108 line managers March to November 2019

Evaluation:
% staff agreeing that following the session the now feel more knowledgeable about:

- The language of emotional distress **100%**
- Using reflective listening **98%**
- Using reflective reframing **100%**

% staff agreeing that due to the session they can:

- Recognise and unpack abstract language people use when distressed **100%**
- Review and agree strategies to support staff to achieve their goals **100%**
- Better recognise and support staff that may be experiencing mental ill health **100%**
- Gather concrete information that will help improve the given situation **100%**

% staff agreeing due to the session they will practice effective reflective listening that builds rapport **100%**
Comments from participants about using their learning from the workshops:
"*I will use this in all 1:1 discussions with staff and in ward meetings*" "*think more about my team's emotions*"
"*mainly in my 1:1s as a line manager. But also to understand the value of my own mental health*"
"*in my day-to-day communications with staff and patients, as well as in my personal life"*

Comments: This initial evaluation of levels of satisfaction with and reaction to the training provided will be followed up in January 2020 with a survey of all participants to evaluate how they have applied what they learnt on the workshops and the impact it has had in the workplace.

Mental health Awareness and Emotional First Aid Workshop: 9 x 1-day workshops attended by 108 staff in 2019

Evaluation:
How well did the day cover its objectives: **Excellent = 89% Good = 11%**
Rating of overall quality of the training **Excellent = 89% Good = 11%**
My knowledge on this topic has been enhanced due to the training **Yes = 100%**
Comments from participants using their learning from the workshops:
"Keeping an eye on my colleagues and watching for signs they may be stressed or anxious and helping, before it escalates"
"Being more confident when dealing with patients I encounter with psychosis"
"Recognise and take time if I see someone struggling"
"Open mindedness towards those who are having issues"
Comments: This workshop was funded by the STP and it may be funded again in 2020/21

National NHS Staff Survey	**Best**	**WSFT**	**Average**	**Worst**
Morale theme	6.7	**6.4**	6.1	5.4

National NHS Staff Survey	**Best**	**WSFT**	**Average**	**Worst**
Health and wellbeing theme	6.7	**6.4**	5.9	5.2

Comments: Presenting National NHS staff survey results in 10 themes was introduced in 2018 so comparison is not yet possible to identify trends.

National NHS Staff Survey Does your organisation take positive action on health and wellbeing?		2015	2016	2017	2018
	Best	52.1%	52.2%	51.5%	46.7%
	WSFT	37.9%	40.1%	42.0%	39.3%
	Average	30.7%	32.0%	31.7%	27.8%
	Worst	14.8%	18.2%	19.1%	15.3%
Comments: Whilst it is disappointing to see that the % of staff believing the Trust is taking positive action on health and wellbeing fell by 2.7% in 2018, it is also worth noting this appears to be a national trend with the best (-4.8%), worst (-3.8%) and average (-3.9%) % also decreasing – all by a greater amount than the WSFT % reduction.					

OUTCOME INDICATORS

3. Outcome indicators

Sickness absence: In the period September 2018 to August 2019 the total absence % FTE ranged between 2.43% and 4.33%. Trust stretch target is 3% total absence FTE. East of England average for total absence FTE is 4.37% (NHS Digital January – March 2018).

Uncertificated 0 – 3 day absences ranged between 0.24% FTE and 0.91% FTE September 2018 to August 2019.

WSFT number of days lost due to sickness absence – top five reasons*:

1. Anxiety, stress, depression, other psychiatric illness – in the period September 2018 to August 2019 the trajectory has been upward reaching 0.85% FTE in August 2019
2. Cold, cough, flu/influenza
3. Gastro-intestinal problems
4. Other known causes, not classified elsewhere
5. Other musculoskeletal problems

Staff turnover rate: 7.65%
Trust target: 10.00%

National NHS Staff Survey In the past 12 months have you experienced musculoskeletal problems as a result of work activities?		**2015**	**2016**	**2017**	**2018**
	Worst	33.5%	34.4%	34.6%	37.8%
	WSFT	**21.2%**	**22.8%**	**21.3%**	**24.7%**
	Average	25.1%	25.6%	25.8%	28.7%
	Best	19.2%	18.6%	19.7%	20.2%

Comments: WSFT figures remain consistently below the national average for comparable organisations which is positive, but there was an increase of 2.9% in 2018 over 2017 results. This is consistent with the overall increase in MSK problems reported nationally 2015 to 2018.

National NHS Staff Survey In the last 12 months have you felt unwell as a result of work related stress?		**2015**	**2016**	**2017**	**2018**
	Worst	44.9%	44.2%	45.9%	46.7%
	WSFT	**33.3%**	**34.4%**	**32.9%**	**34.9%**
	Average	36.0%	35.3%	36.7%	38.9%
	Best	24.7%	25.3%	27.9%	28.9%

Comments: WSFT figures remain consistently below the national average for comparable organisations which is positive.

National NHS Staff Survey In the last three months have you ever come to work despite not feeling well enough to perform your duties?		**2015**	**2016**	**2017**	**2018**
	Worst	65.2%	62.9%	63.0%	64.3%
	WSFT	**53.2%**	**54.0%**	**51.4%**	**51.0%**
	Average	56.8%	55.2%	56.4%	56.9%
	Best	44.6%	47.6%	47.6%	47.6%

Comments: WSFT figures remain consistently below the national average for comparable organisations which is positive.

National NHS Staff Survey My immediate manager takes a positive interest in my health and wellbeing		2015	2016	2017	2018
	Best	75.1%	73.2%	72.3%	74.0%
	WSFT	**65.6%**	**66.8%**	**67.6%**	**68.4%**
	Average	64.2%	65.7%	66.9%	67.0%
	Worst	58.4%	57.3%	58.9%	57.6%

Comments:
WSFT figures remain consistently just above national average for comparable organisations and the general trajectory for the past four years has been upward which is positive.

11:20 GOVERNANCE

18. Trust Executive Group report

To ACCEPT the report

For Report

Presented by Stephen Dunn

Board of Directors – 29 November 2019

Agenda item:	18			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	25 November 2019			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

4 November 2019

Craig Black provided an **introduction** to the meeting and welcomed Jeremy Over to the Trust. A discussion took place on the CQC inspection, including next steps and further information requests. Noted that we continue to engage in external and internal planning for EU exit.

Quality, operational and financial performance was reviewed from the recent Board papers. Discussion took place on action being taken to support the complaints team to improve performance and the need to improve compliance with duty of candour. Improvements in nutritional assessment were noted. The significant challenge of delivering the access standards was discussed in detail, including cancer performance.

Detailed discussion took place on the current **financial position and forecast** for 2019-20. It was noted that compared to a year ago we now have 145 more registered nurses, 90 of whom are ward based. Despite the increased bed capacity we are achieving higher nurses to occupied patient bed ratios. The divisional performance was reviewed and the challenge and tension between operational and financial performance noted.

Following discussion the investment was approved for point of care testing for **influenza A/B and respiratory syncytial virus (RSV)** testing. It was recognised that this would support admission avoidance and patient flow during winter. A wider discussion of winter planning took place in terms of capacity and demand and planning.

Approval was given to recruit a **replacement microbiologist**. This included a review of work pressure within the team.

The **losses and compensation** report was reviewed and key areas of expenditure noted.

18 November 2019

At the start of the meeting the membership watched the '**power that silences'** TED talk by Megan Reitz. After the video the group reflected on the key messages and recognised the importance of understanding the influence on others. As part of the discussion an update was received on the work by NHS Elect to review the leadership structures within the divisions. The output of this work will be considered by TEG.

Steve Dunn provided an **introduction** to the meeting and it was recognised that we need to maintain the focus of learning from the CQC inspection feedback as part of future meeting agendas.

Discussion took place on the **West Suffolk Hospital** communications with our staff, the public, and proactively with our local media teams about the work we're doing around reinforced autoclaved aerated concrete (RAAC) planks. It was recognised that as part of our response to the new national funding for the hospital we also need to consider the investment requirements for Newmarket Hospital.

The **red risk report** was received. There was one new red risk relating to ability to deal with contaminated self-presenters at hospital. Mitigating actions to control the risks were reviewed. No red risks were downgraded. The corporate and operation risks were also reviewed which are subject to executive review and discussion at divisional performance review meetings. As part of the agenda the meeting also received an update on the work to assess and mitigate the estates risk for the WSH site. The key strategic risks identified were:

- **System financial and operational sustainability** will impact of the quality of patient services (linked to operational performance and CIP planning and transformation).
- **Winter planning** to ensure safe staffing and capacity for winter.
- **Pathology services** – delivery of pathology services, including MHRA inspection and NEESPS accountability and control. These all have an impact on service delivery and patient services directly impacting on quality and sustainability of services.

The **Quality Group report** was received. It was noted that the group would include a focus on the improvement work as a result of the CQC feedback.

A report from the Better Working Lives Group which set out the findings of the **junior doctors' burnout survey** results was received. The report was welcomed as it puts us on the front foot of planning and working to address causes of burnout, not just addressing the symptoms. It was also recognised that the issues highlighted apply to other staff groups, not only medics.

The **capital group report** was received and it was noted that capital loan for 2019/20 has been approved by the Department of Health. The detail of the loan and value for the year is being confirmed. The reported included the consideration of Newmarket Hospital ensuring that infrastructure is maintained at Newmarket in the same way as the West Suffolk Hospital site.

The **antenatal and new-born screening report** was received prior to the Board. This outlined the screen activities undertaken between Sept '18 and Aug 19, including performance against agreed key indicators for the screening programmes.

The annual **car parking review** was considered. The principle of an inflationary uplift was supported but changes were proposed to the concession changes e.g. including the families of end of life patients in the daily concession rate.

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

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	The Board receives a monthly report from TEG						

Risk and assurance:	Failure to effectively communicate or escalate operational concerns.
Legislation, regulatory, equality, diversity and dignity implications	None
Recommendation: 1. The Board note the report	

19. Audit Committee report

To approve the report recommendations

For Approval

Presented by Angus Eaton

Trust Board Meeting – 29 November 2019

Agenda item:	19			
Presented by:	Angus Eaton, NED and Chair of the Audit Committee			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	20 November 2019			
Subject:	Audit Committee report - meeting held on 1 November 2019			
Purpose:		For information	X	For approval

Executive summary:

The Audit Committee was held on 1 November 2019. The key issues and actions discussed were:-

- **Board Assurance Framework 'deep dive' – '*Suffolk and North East Essex ICS Draft Five Year System Strategic Plan*' -** The Committee received a presentation from Susannah Howard (ICS Programme Director) on the draft five year Plan that has been developed. Susannah noted that the Plan had been written from an outcome perspective and that it had been developed with joint working and input from key stakeholders, including members of the public. The Committee discussed the presentation at length and commended Susannah on the hard work that had gone in to developing the Plan.

- **Internal Audit and Counter Fraud** - The Internal Audit Progress Report confirmed that one Audit Report had been issued since the last Audit Committee on 'Deep dive into Workforce' from the 2019/20 Audit Plan. The Report received a reasonable assurance opinion.

  Internal Audit talked the Committee through the outstanding Internal Audit recommendations raised and highlighted one high priority recommendation from 2016/17 that had not been closed. Since the Committee meeting, evidence has been provided to Internal Audit and this high priority recommendation has now been cleared. There now remains 25 un-cleared recommendations, 11 of which are overdue.

  LCFS noted that November was 'Fraud Awareness Month' and that LCFS would be in Timeout and visiting Community Sites throughout November.

- **Debt write offs** – The Committee approved the write off of debts amounting to £39,664. This predominately related to Overseas Visitor Patients that had subsequently deceased and the Trust was no longer able to actively pursue the debt.

- **Charitable Funds Annual Report and Accounts 2018/19** – External Audit presented their Audit Completion Report with the results of the audit. External Audit issued an unmodified audit opinion on the Charitable Funds Annual Report and Accounts. The Charitable Funds Committee had already approved the Annual Report and Accounts and the Audit Committee recommended approval to the Trust Board.

- **Anti-Fraud, Financial Irregularities and Anti-Bribery Policy** – The Policy was updated to ensure that it complied with the requirements of the NHS Counter Fraud Authority. The Committee approved the updates to the Policy.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		**X**		**X**		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X				X
Previously considered by:	*This report has been produced for the monthly Trust Board meeting only*						
Risk and assurance:	*None*						
Legislation, regulatory, equality, diversity and dignity implications	*None*						

Recommendation:
The Board is asked to:

- Receive and note the Audit Committee report for meeting held on 1 November 2019.
- Approve the Charitable Fund Annual Report and Accounts for 2018/19 (Appendix 1).

My Wish Charity (Registration Number 1049223)

Annual Report 2018/19

My Wish Charity

Index

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

Welcome to our annual report for 2018/19. 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:

- **Reaching the target of our Every Heart Matters Appeal**
- **Opening of our Cardiac Diagnostic unit**
- **Purchasing new equipment**

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

This is my third 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: 5 November 2019**

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 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 Foundation Trust and the organisations it works with 'To serve the patients and their families receiving services from the West Suffolk 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 2018/19, payments of £1,350k 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 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.

The Charity once again has been extremely well-supported by our local community

Recovering breast cancer patient Sylvie Smith, best known by regulars at the Moreton Hall pub, in Bury St Edmunds, has raised an amazing £1,222 for the breast unit at the West Suffolk Hospital.

She raised the money braving the shave losing all the hair on her head.

It took place at the pub on the Moreton Hall Estate and was carried out by local hairdresser Claire Butcher with a crowd of people on hand to watch and at the same time donate as Sylvie lost her locks.

She decided to raise the money for the My WiSH Charity, which supports the hospital, after being treated at the hospital for her cancer.

Bingo sessions held in Great Cornard have helped to raise thousands of pounds for the My WiSH Charity.

They have been spearheaded by Tracy Tatum, who along with family and friends, have raised an amazing £5,000 in just three years with £2,000 being raised in the past four months for the Every Heart Matters appeal.

The rest of the money has gone to the Hospitals Macmillan unit, and the charity's Love your Nodes Appeal.

Bennet Arms firework displays helps to raise £1,000 for the Macmillan Unit. Pub customers have helped to raise the money for the Macmillan Unit, at the West Suffolk Hospital, following a bonfire night and firework display.

It took place at the Bennet Arms, in Rougham, and was organised by Debbie Palmer and her husband Michael, who is currently being treated for lung cancer.

The money came following donations from those attending the event along with cash which had been set up in a tin on the bar.

The evening included a best guy competition, entertainment, a barbecue along with the fireworks with entry by donation.

Kirsty Bishop and her husband Richard wanted to repay the kindness, dedication and care they received at the neonatal unit at West Suffolk Hospital after their daughter Sophie was born 11 weeks prematurely.

So as keen caravaners they organised a rally near King's Lynn while friends organised two similar events near Wisbech and Norwich.

And the culmination of their efforts resulted in £300 being raised for the unit.

An 80s themed disco helps to raise funds for the maternity unit. People came along dressed as their idols from Freddie Mercury to Madonna and Adam Ant to Abba at a special 1980s themed fundraising event at Pakenham Village Hall.

It was organised by friends Victoria Dale and Clare Speare with a total of £840 being raised for the My WiSH Charity with the money directed towards the maternity unit at the West Suffolk Hospital, in Bury St Edmunds, and will be used to purchase dopplers to listen to babies' heart beat during labour. Both Victoria, who is a midwife, and Clare, a maternity ward clerk, work at the hospital, and decided to arrange the event after staging a similar project to raise money for village funds and now want to make it an annual event.

A former staff nurse at the West Suffolk Hospital, in Bury St Edmunds, has donated a specialist chair for F7.

The £1,000 piece of equipment can also be used as a bed for patients and was given to the My WiSH Charity by Peter Brown.

He used to be a staff nurse on F7 but is now a lecturer in adult nursing at the University of Suffolk, in Ipswich.

His father John, who lived in Great Dunmow, Essex, died in 2016, and Peter said staff and the team on F7 were "very kind" to him following his father's death and wanted to repay them for their kindness towards him.

Opening of the new cardiology suite

Launched in July 2017 our Every Heart Matters appeal was the biggest appeal the charity had undertaken but we knew just how important it was and just what a difference it would make.

The aim was to raise £500,000 to create a cardiac diagnostic unit at West Suffolk Hospital NHS Foundation Trust. The Trust were investing £5.2 million to create a cardiac unit which would include a cardiac ward, coronary care unit and an imagining suite but were unable to include the cardiac diagnostic unit in their plans.

The cardiac diagnostic staff performs around 14,500 tests a year on patients, including around 500 on children. The knowledge the staff have is just incredible and so we felt it was vital to be able to bring the unit down to join the new cardiac unit, so creating an amazing, state of the art cardiac centre for the community of west Suffolk.

Heart disease is the single biggest killer in the UK, and worldwide. On average one person dies every three minutes from the disease and activity in the hospital's cardiology department had been increasing year on year, with a significant increase in patient demand in the last five years.

A proportion of patients with heart conditions in west Suffolk had to be treated elsewhere for a range of cardiac services that were not available at West Suffolk Hospital. The new cardiac centre has changed all that. The new imaging suite means our cardiologists are able to fit pacemakers meaning patients no longer need to travel to other Trusts, their treatment is quicker which means faster recovery time. Patients can now come in as a day patient, be fitted with a pacemaker and return home the same day. This new service also means some patients aren't waiting in West Suffolk Hospital for a bed at another Trust, therefore requiring an inpatient stay of, sometimes, up to three weeks.

We did it!

October 2018 saw us welcome all fundraisers and supporters along to see the new cardiac centre before it was open to patients. It was just wonderful to be able to show people how we had spent their money and they were all overwhelmed with what they saw.

We also held a special day where press and tv came along to see our appeal ambassador, Frankie Dettori MBE unveil a plaque thanking everyone for their support. Frankie was also

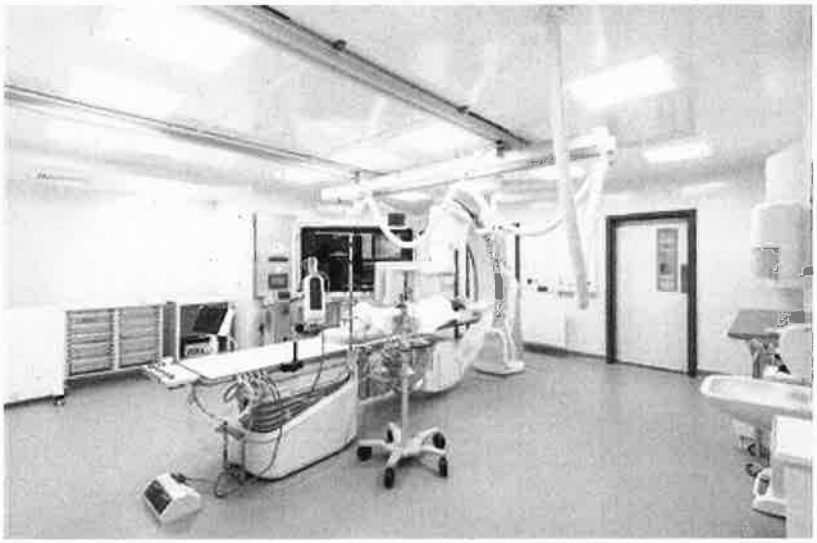
amazed with the new unit and thanked everyone who donated and made the appeal a success.

As well as pacemakers the centre is now able to perform angiograms. Previously this was performed once a week on a mobile unit with up to twelve patients only being able to be treated. The patient also needed to be 'well enough' to walk outside for the procedure. Not any more, the new centre can perform around twelve angiograms daily in its new imaging suite. It really is making such a difference.

Added to this is the new cardiac ward with its modern design. All aspects of care have been thought of. The windows are covered with a special contra vision film meaning you can see out but people can't see in. From the outside all the windows have a wonderful vision of trees. The lighting has been carefully chosen, the side rooms are all large and spacious. Each bay includes its own ensuite bathroom meaning patients have the facilities close to hand and, if needed, the bay can be closed to avoid the spread of infection.

The signage throughout the centre has been built with strong and clear graphics. This will aid our dementia patients, something that is always thought of when updating areas of the Trust.

The new cardiac diagnostic unit



Our favourite room is the ECG room. This has been created with our young patients in mind. As well as child friendly curtains and a wonderful projector which throws patterns around the room, the ceiling houses special lighting with graphics of hot air balloons. This has proved popular with patients of all ages.

The cardiac diagnostic team complete a variety of tests including electrocardiograms (ECGs), echocardiograms, and stress tests. These are now performed in a range of new, light and airy rooms with every eventuality thought of. Each room has in built oxygen and,

again, the lighting and signage has been cleverly chosen. There is plenty of room to house treadmills, desks and several members of staff if needed.

There is now a purpose built TOE (transoesophageal echocardiogram) room. This procedure was previously performed in another part of the hospital which sometimes, during busy periods, had to be used for other patients, so cancelling the TOE appointments. Now, with its own space this is no longer the case.
It's been a long journey but one we are very proud of. This huge appeal has led to an outstanding space allowing our fantastic cardiac staff to give truly amazing care.

Thank you to everyone for your support. Together we really have made a difference.

Here are just snippets of some of the amazing fundraisers that have helped us to reach our target a huge thank you to all involved, you are trues charity heroes.

Cycling mad colleagues from Delphi, in Sudbury, took to their bikes for a charity ride across Germany. They rode from Dusseldorf to the company's site in Luxembourg, a total of 250 miles, raising £1,636.10.

A glittering black tie Guineas Ball which raised a staggering £15,000, was held at Newmarket Racecourse, organised Julie Thompson, Emma Kaye and their committee.

Club captains Hannah Clark and Ray Coleman, of Bury Golf Club presented the charity with an incredible £10,355, after their year of fundraising initiatives.

A total of 89 clay pigeon shooters gathered at Eriswell Lodge, on the Brandon Road, in Eriswell, for a charity shoot which was hailed as a "fantastic" occasion.

A total of £1,131.85 was raised for the appeal.

A series of tea dances held at the British Sugar Social Club, in Bury St Edmunds, boosted the funds by £1,000.

Generous £150,000 legacy propelled the appeal forward.

NHS70 party held at the Victory Ground, in Bury St Edmunds, raised £647.

Collection at the funeral of a well-known farm labourer from Feltwell raised £1,000.

Dance night and bingo session at Brandon Leisure Centre raised £1,510.

Cycle ride from Caernarfon to Chepstow carried out by Brian Alldis, who has spina bifida and hydrocephalus, raised £660.

Mulleys coaches helped the charity advertise the appeal on their fleet of buses.

Cardiac Diagnostic staff worked tirelessly to support fundraisers events and even held their own Bake Off.

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: £928k ***Money spent: £1,350k***

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 expenditure exceeding income by £429k.

Money received: sources of funds

Donations and legacies £665k – Our largest source of income is from the public and by local companies keen to support their local community:

- **Gifts from the public £269k** – 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 £42k** – 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 £354k** – 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 £116k

Other trading activities £145k – 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.

- **West Suffolk Hospital other organised fundraising £50k**
- **Course fee income £1k**
- **Third party fundraising £94k**

Investment income £2k income from interest on bank balances.

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 as well as a Clinical Psychologist in SCBU the cost of these staff was **£75k** in 2018/19.

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 **£381k** on new equipment. Examples of equipment purchased this year are:

- **Specialist monitors for the Emergency Department**
- **Video training equipment and software**
- **ENT Equipment**
- **Rapid Infusion equipment**
- **Microscopes**
- **Dermatoscopes**

Adaptations to buildings: We spent **£532k** in 2018/19 the bulk of which was the cardiology unit. There were a number of minor capital projects including the conversion of a bathroom to a shower room and the creation of additional clinical storage space.

Staff education and welfare: We spent **£105k** on a wide variety of training and educational courses for our staff.

Patient education and welfare: We spent **£90k** supporting education and the welfare of patients this included baby cribs, bedside cabinets, seating in a number of areas, waiting room toys and gym equipment for the physiotherapy gym.

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 £928k compared to 2017/18 of £1,065k. The reduction was mainly as a result of a reduced level of legacies which tend to be ad hoc in nature.

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.

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:

- **Launch our Butterfly Appeal, enhancing care for end of life patients**
- **Provide extra training for staff members in line with donor wishes**
- **Create more patient friendly environments**
- **Support the Hospital and community services in purchasing equipment that enhances the care of patients**

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 93 individual funds (2017/18: 93) as at 31 March 2019 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 Trustees' reserves policy is to expend unrestricted incoming resources 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 2019 the unrestricted reserves held was £209k. This compares to an expected average cash reserve balance of approximately £324k. The main reason for the reduced level of reserves relates to the unrestricted funds support to the Cardiology suite.

Our financial health: a strong balance sheet

The assets and liabilities of My Wish Charity as at 31 March 2019 are stated below, compared with the position at 31 March 2018.

	31 March 2019	31 March 2018
	£'000	£'000
Fixed Assets - Intangible	7	9
Fixed Assets – Investments	1,143	-
Total Current Assets	845	2,371
Creditors falling due within one year	(193)	(149)
Total Net Assets	**1,802**	**2,231**
Income Funds		
Restricted	1,593	1,636
Unrestricted Income Funds:		
Our reserve: 'general fund'	209	595
Total Funds	**1,802**	**2,231**

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

After a number of years where the Charity held its reserves primarily in cash, the Trustee agreed to reinvest in a common investment fund. In August 2018, the Charity invested in COIF Ethical Investment Fund managed by CCLA Investment Management ltd.

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	1049223-2
Sudbury Hospital Charity	1049223-3
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 713805

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 2018/19 the Trust Board consisted of:

Non-executive Directors

Sheila Childerhouse (Chair)	Appointed 1 January 2018 until 31 December 2020
Steve Turpie	Resigned 31 May 2018
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
Alan Rose	Appointed 1 April 2017 until 31 March 2020
Louisa Pepper	Appointed 1 September 2018 until 31 August 2021
Richard Davies	Appointed 1 March 2017 until 28 February 2020
Angus Eaton	Appointed 1 January 2018 until 31 March 2020

Directors

Stephen Dunn	Chief Executive – appointed 3 November 2014
Craig Black	Executive Director of Resources – appointed April 2011
Jan Bloomfield	Executive Director of Workforce and Communications – appointed February 1991
Rowan Procter	Executive Chief Nurse – appointed 2 November 2015.
Nick Jenkins	Executive Medical Director – appointed 17 November 2016
Helen Beck	Executive Chief Operating officer – appointed 1 May 2017

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:-

			2018/19 Attendance	2017/18 Attendance
Roger Quince	-	Chair		2 / 3
Sheila Childerhouse	-	Chair	3 / 4	1 / 1
Stephen Dunn	-	Chief Executive	3 / 4	1 / 1
Gary Norgate	-	Non-Executive Director	3 / 4	4 / 4
Angus Eaton	-	Non-Executive Director	3 / 4	2 / 4
Craig Black	-	Director of Resources	3 / 4	4 / 4
Helen Beck	-	Chief Operating Officer	3 / 4	2 / 4
Jan Bloomfield	-	Director of Workforce and Communications	4 / 4	4 / 4
Louisa Pepper	-	Non-Executive Director	1 / 2	

The Trustee is also assisted in their work by a number of professional advisors, as detailed below:

External auditors:
BDO LLP
16 The Havens
Ransomes Europark
Ipswich
IP3 9SJ

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. Three 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.

- ***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. To mitigate this risk the Charity's Ethical Fundraising Policy has been reviewed and updated.

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 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.
- My Wish Charity is currently supported by a very proactive events committee. The committee consists of 7 volunteers. They meet usually on a quarterly basis unless it is just before a planned event where the meetings will be increased. Currently they are in the middle of organising the second Soapbox challenge. The charity is overwhelmed by the support of the events committee and holds them in high regard.
- The Charity also 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 in his duties for our Every Heart Matters appeal, 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?

£200 could buy a vial of magnetic beads to be used with our Sentimag machine, to treat our breast cancer patients
£300 can provide extra training for our speech and language therapists to offer Lidcome treatment for our younger patients who stammer
£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
£3,000 could purchase a twin baby bed so our tiny twins can be nursed together

£5,000 can buy a Bili-therapy Pad, which would enable phototherapy to be administered to a baby whilst being held or breastfed by mum
£20,000 could buy a Sentimag machine which would help our breast cancer patients.
£20,000 can help transform a ward to assist our patients with dementia.
£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: 5 November 2019

Statement of Trustees' responsibilities in respect of the Trustees' annual report and accounts

Under charity law, the Trustee is responsible for preparing the Trustee's annual report and accounts for each financial year which show a true and fair view of the state of affairs of the Charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice requires that the Trustee:

- Select suitable accounting policies and then apply them consistently
- Make judgements and estimates that are reasonable and prudent
- State whether the recommendations of the SORP have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, 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 its activities.

The Trustee is required to act in accordance with the trust deed and the rules of the Charity, within the framework of trust law. The Trustee is responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the Charity at that time, and to enable the Trustee to ensure that, where any statements of accounts are prepared by the Trustee under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The Trustee has general responsibility for taking such steps as are reasonably open to the Trustee to safeguard the assets of the Charity and to prevent and detect fraud and other irregularities.

Signed on behalf of the Corporate Trustee:

Sheila Childerhouse
Chair of West Suffolk NHS Foundation Trust, Corporate Trustee
5th November 2019

INDEPENDENT AUDITOR'S REPORT TO TRUSTEES OF MY WISH CHARITY

Opinion

We have audited the financial statements of My Wish Charity for the year ended 31 March 2019 which comprise the statement of financial activities, the balance sheet, the cash flow statement 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 2019 and of 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 are independent of the Charity in accordance with the ethical requirements 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. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions related to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Corporate Trustee use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Corporate Trustee have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Charity's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Trustee is responsible for the other information.

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.

In connection with our audit of the financial statements, 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 audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. 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

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;

- the information contained in the financial statements is inconsistent in any material respect with the Corporate Trustee Annual Report; or
- adequate accounting records have not been kept by the charity; or
- the My Wish 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 Corporate Trustee

As explained more fully in the Corporate Trustee's responsibilities statement, the 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 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 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 Trustee 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 144 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.

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 Charity's Trustee, as a body, in accordance with the Charities Act 2011. Our audit work has been undertaken so that we might state to the Charity's 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 Charity's Corporate Trustee as a body, for our audit work, for this report, or for the opinions we have formed.

BDO LLP

David Eagles (Senior Statutory Auditor)
For and on behalf of BDO LLP, statutory auditor
16 The Havens, Ipswich, IP3 9SJ
7 November 2019

BDO LLP is eligible for appointment as auditor of the charity by virtue of its eligibility for appointment as auditor of a company under section 1212 of the Companies Act 2006.

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 2019

	Note	Unrestricted Funds 2018/19 £000	Restricted Funds 2018/19 £000	Total Funds 2018/19 £000	Unrestricted Funds 2017/18 £000	Restricted Funds 2017/18 £000	Total Funds 2017/18 £000
Income and endowments from:							
Donations and legacies	3	160	505	665	574	351	925
Charitable activities	4	52	64	116	28	56	84
Other trading activities	5	3	142	145	5	50	55
Investment income	7	0	2	2	0	1	1
Total Income		**215**	**713**	**928**	**607**	**458**	**1,065**
Expenditure on:							
Raising funds	8	39	93	132	15	108	123
Charitable activities	9						
Clinical Care and Research Posts		0	80	80	0	60	60
Purchase of New Equipment		268	124	392	261	229	490
New Building and Refurbishment		532	7	539	34	10	44
Staff Education and Welfare		28	83	111	30	71	101
Patient Education and Welfare		9	87	96	2	5	7
Total Expenditure		**876**	**474**	**1,350**	**342**	**483**	**825**
Net losses on investments		(2)	(5)	(7)	0	0	0
Net income/(expenditure)		**(663)**	**234**	**(429)**	**265**	**(25)**	**240**
Gross transfer between funds	20	277	(277)	0	(118)	118	0
Net movements in funds		**(386)**	**(43)**	**(429)**	**147**	**93**	**240**
Reconciliation of Funds:							
Total funds brought forward		595	1,636	**2,231**	448	1,543	**1,991**
Total funds carried forward		**209**	**1,593**	**1,802**	**595**	**1,636**	**2,231**

All incoming resources and resources expended are derived from continuing activities

The notes set out on pages 28 to 36 form part of these financial statements

My Wish Charity Balance Sheet
as at 31 March 2019

	Notes	Unrestricted Funds £000 31 March 2019	Restricted Funds £000 31 March 2019	Total Funds £000 31 March 2019	Unrestricted Funds £000 31 March 2018	Restricted Funds £000 31 March 2018	Total Funds £000 31 March 2018
Fixed Assets							
Intangible	14	1	6	7	1	8	9
Investments	15	275	868	1,143	0	0	0
Total Fixed Assets		**276**	**874**	**1,150**	**1**	**8**	**9**
Current Assets:							
Debtors	16	475	0	475	498	20	518
Cash at bank	17	(468)	838	370	206	1,647	1,853
Total Current Assets		**7**	**838**	**845**	**704**	**1,667**	**2,371**
Liabilities:							
Creditors falling due within one year	18	74	119	193	110	39	149
Net Current Assets		**(67)**	**719**	**652**	**594**	**1,628**	**2,222**
Total Assets less Current Liabilities		**209**	**1,593**	**1,802**	**595**	**1,636**	**2,231**
Net Assets		**209**	**1,593**	**1,802**	**595**	**1,636**	**2,231**
Charitable Funds	24						
Restricted income funds		0	1,593	1,593	0	1,636	1,636
Unrestricted income funds		209	0	209	595	0	595
Total Charitable Funds		**209**	**1,593**	**1,802**	**595**	**1,636**	**2,231**

The financial statements were approved and authorised for issue by the Corporate Trustee and were signed on its behalf on 5th November 2019

Signed:

Name: Sheila Childerhouse
Trustee

The notes set out on pages 28 to 36 form part of these financial statements

My Wish Charity Statement of Cashflow

Year Ending 31 March 2019

	Note	Total Funds 2018/19 £000	Total Funds 2017/18 £000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	19	(335)	(211)
Cash flows from investing activities:			
Dividends, interest and rents from investments	7	2	1
Purchase of investments	15	(1,150)	0
Net cash provided by investing activities		(1,148)	1
Change in cash and cash equivalents in the reporting period		(1,483)	(210)
Cash and cash equivalents at the beginning of the reporting period		1,853	2,063
Cash and cash equivalents at the end of the reporting period	17	370	1,853

The notes set out on pages 28 to 36 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 Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) effective 1 January 2015 and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

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.

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 19). 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 incoming resources can be measured with sufficient reliability.

[d] Incoming resources 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 incoming resources 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] Resources expended 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 resources expended 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 10.

[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 2017/18 or 2018/19.

[k] 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.

[l] 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.

[m] Debtors

Debtors are amounts owed to the Charity. They are measured based on the recoverable amount.

[n] 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.

[o] 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.

[p] 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 £1,350k (2017/18: £825k) of which there is a net creditor of £169k (2017/18: £108k) 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 £146k (£141k in 2017/18)

3 Income from donations and legacies

	Unrestricted Funds 2018/19 £'000	Restricted Funds 2018/19 £'000	Total 2018/19 £'000	Total 2017/18 £'000
Donations from Individuals	25	244	269	270
Corporate Donations	8	34	42	60
Legacies	127	227	354	595
Total	160	505	665	925

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 2018/19 £'000	Restricted Funds 2018/19 £'000	Total 2018/19 £'000	Total 2017/18 £'000
Other income	52	64	116	84
Total	52	64	116	84

5 Other trading activities

	Unrestricted Funds 2018/19 £'000	Restricted Funds 2018/19 £'000	Total 2018/19 £'000	Total 2017/18 £'000
Course fee income	0	1	1	4
West Suffolk Hospital other organised fundraising events	1	49	50	11
Third party fundraising	2	92	94	40
Total	3	142	145	55

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 72 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 2018/19 £'000	Restricted Funds 2018/19 £'000	Total 2018/19 £'000	Total 2017/18 £'000
Short term investments and deposits and cash on deposit	0	2	2	1
Total	0	2	2	1

8 Analysis of expenditure on raising funds

	Unrestricted Funds 2018/19 £'000	Restricted Funds 2018/19 £'000	Total 2018/19 £'000	Total 2017/18 £'000
Fundraising events other	1	0	1	9
Fundraising support costs	38	93	131	114
Total	39	93	132	123

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 2018/19 £000	Funded Activity Restricted 2018/19 £000	Funded Activity Total 2018/19 £000	Support costs 2018/19 £000	Total 2018/19 £000	Total 2017/18 £000
Clinical Care & Research Posts	0	75	75	5	80	60
Purchase of New Equipment	265	116	381	11	392	490
New Building & Refurbishment	526	6	532	7	539	45
Staff Education & Welfare	27	78	105	6	111	101
Patient Education & Welfare	9	81	90	6	96	7
Total	827	356	1,183	35	1,218	703

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	2019 Total £000	2018 Total £000
External audit (2018/19 figure includes an undercharge from 2017/18)	1	7	8	6
Governance	1	7	8	6
Amortisation	0	2	2	2
Computer maintenance	1	2	3	3
Salaries and related costs	4	22	26	43
Other	0	2	2	4
	6	35	41	58

	Unrestricted funds £000	Restricted funds £000	2019 Total £000	2018 Total £000
Raising funds	0	6	6	12
Charitable activities	10	25	35	46
	10	31	41	58

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 (2017/18: £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 (2017/18: £nil). My Wish Charity has no key management personnel (2017/18: £nil).

12a - Staff Costs and Employee Benefits

	2018/19 £000	2017/18 £000
Salaries and wages	180	160
Social Security Costs	15	13
Employers Pension Contribution	26	22
Total	221	195

12b - Employee numbers

Average Headcount	**10.4**	**9.4**
Average Full Time Headcount	3.9	3.8
Average Part Time Head Count	6.5	5.6
Average WTE	6.4	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 (2017/18: £6,000) related solely to the audit of the financial statements with no other additional work undertaken by the external auditors (2017/18: none undertaken).

14 Intangible fixed assets

Software	2018/19	2017/18
Cost	**£000**	**£000**
At 1 April	17	17
At 31 March	17	17
Accumulated amortisation		
At 1 April	8	6
Provided during the year	2	2
At 31 March	10	8
Net book value		
Net book value at 31 March	7	9

15 Fixed asset investments

Movement in fixed asset investment	31 March 2019 Total £000	31 March 2018 Total £000
Market value brought forward	0	0
Add purchase of investment	1,150	0
Less net loss on revaluation	(7)	0
Market value as at 31 March	**1,143**	**0**

During the year the Corporate Trustee agreed to reinvest £1,150,000 in COIF Ethical Investment Fund. This was in accordance with the Charity's investment policy.

16 Analysis of current assets

Debtors due within one year	31 March 2019 Total £000	31 March 2018 Total £000
Other debtors	475	518
Total	**475**	**518**

17 Analysis of cash and cash equivalents

	31 March 2019 Total £000	31 March 2018 Total £000
Cash in Hand	370	1,853
	370	**1,853**

18 Analysis of current liabilities

Creditors due within one year	31 March 2019 Total £000	31 March 2018 Total £000
Trade Creditors	185	143
Other Accruals	8	6
Total	**193**	**149**

Creditors represent sums owed at the year end by the Charity. Of this amount £169k (2017/18: £108k) 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

	2019 £000	2018 £000
Net income (as per the Statement of Financial Activities)	(429)	240
Adjustments for:		
Amortisation	2	2
Loss/(gain) on investments	7	0
Dividends, interest and rents from investments	(2)	(1)
(Increase)/ decrease in debtors	43	(516)
Increase/ (decrease) in creditors	44	64
Net cash provided by (used in) operating activities	(335)	(211)

20 Transfer between funds

There were net transfers of £276,746 from restricted funds to unrestricted funds. £280,000 related to the transfer of funds from Every Heart Matters campaign to the general fund. The general fund bore the balance of cost of the Catheterisation Laboratory. The remainder of the transfers of £3,254 related to an item that was agreed to be funded by general funds rather than by a restricted fund (2017/18: £118,399).

21 Material Legacies

Legacy income is only included in incoming resources where receipt is reasonably certain and the amount can be estimated with reasonable accuracy, or the legacy has been received. As at 31 March 2019 there were two legacies totalling £475,200 that had been notified but not received (2017/18: £516,338). These legacies have been included as income and as debtors.
One of these legacies relates to an estate that incudes property. In accordance with our accounting policy an assessment of its value was included in these accounts as well as in the prior year. The prior year figure for this legacy was based on an agreed sale price of £301,000 for the property. The sale of this property eventually fell through and has proved difficult to sell. As a result of this the property has been included in the 2018/19 accounts at a value of £181,000.

22 Comparative figures

The comparative figures relate to the 12 month period between 1 April 2017 and 31 March 2018.

23 Post Balance Sheet Events

There were no post balance sheet events.

My Wish Charity

24 Analysis of charitable funds

Name of Fund	Source of Fund	Purpose	Fund Balance 1 April 2018 £000	Income	Expenditure	Transfers	(Loss) /gain on investments in year	Fund Balance 31 March 2019 £000
Macmillan Service	Donations	Patient and Staff welfare	350	86	(133)	0	(1)	302
Every Heart Matters	Donations	Patient and Staff welfare	150	177	(35)	(280)	(1)	11
BD Allen Fund	Legacy	Training for Nursing Staff	38	0	(11)	1	0	28
Scanner Appeal	Donations	Purchase of equipment	20	0	(1)	0	0	19
Oncology Service	Donations	Patient and Staff welfare	20	0	(1)	0	0	19
SCBU	Donations	Patient and Staff welfare	171	7	(54)	0	(1)	123
Paediatric and Childrens Ward	Donations	Patient and Staff welfare	40	8	(16)	0	0	32
Breast Cancer Fund (ex Lizzie Duncan)	Donations	Patient and Staff welfare	52	13	(4)	0	0	61
Microbiology	Donations	Patient and Staff welfare	21	1	(1)	0	0	21
Bereavement Room	Donations	Patient welfare	23	1	(2)	0	0	22
Hannah Seeley Fund	Donations	Patient and Staff welfare	15	0	(2)	0	0	13
Mercury Dementia Appeal	Donations	Patient and Staff welfare	33	3	(3)	0	0	33
Ward G8	Donations	Patient and Staff welfare	17	10	(9)	0	0	18
Ophthalmic Fund	Donations	Patient and Staff welfare	61	67	(17)	0	0	111
Cardiology	Donations	Patient and Staff welfare	23	4	(4)	0	0	23
Pharmacy social amenities	Donations	Staff welfare	16	2	(4)	0	0	14
Palliative Care	Donations	Patient and Staff welfare	26	192	(9)	0	0	209
Haematology research fund	Donations	Patient and Staff welfare	18	1	(2)	0	0	17
Stroke services	Donations	Patient and Staff welfare	19	0	(1)	0	0	18
Newmarket Radiology	Donations	Patient and Staff welfare	18	0	(1)	0	0	17
Newmarket Hospital	Donations	Patient and Staff welfare	151	1	(34)	0	0	118
Wish upon a Star	Donations	Patient and Staff welfare	16	19	(17)	0	0	18
Chemical Pathology	Donations	Patient and Staff welfare	27	7	(1)	0	0	33
Critical Care	Donations	Patient and Staff welfare	9	10	(3)	0	0	16
Rheumatology	Donations	Patient and Staff welfare	8	46	(1)	0	0	53
Other Restricted Funds			294	58	(108)	2	(2)	244
Total Restricted Funds			1,636	713	(474)	(277)	(5)	1,593
Unrestricted funds	Donations	Patient and Staff welfare	595	215	(876)	277	(2)	209
			2,231	928	(1,350)	0	(7)	1,802

These are the major funds referred to in Accounting policy note 1(b) the disclosure is based on fund previously disclosed in 2017/18 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.

20. Charitable funds report

To APPROVE the report

For Approval

Presented by Gary Norgate

Trust Open Board Meeting – 28 November 2019

Agenda item:	20			
Presented by:	Gary Norgate, Non-Executive Director			
Prepared by:	David Swales, Technical Accountant			
Date prepared:	13 November 2019			
Subject:	Charitable Funds Board Report			
Purpose:	X	For information		For approval

Executive summary:

The Charitable Funds Committee met on 20th September 2019 and 1 November 2019. The key issues and actions discussed were:-

- It was reported that the Soapbox Derby had raised c£19k and it provided some great community and corporate engagement.
- A piece of land left to the Trust was proving difficult to sell. A new approach of offering it to neighbours was agreed.
- The Committee was updated on progress with senior members of the Newmarket community on the potential for raising significant sums focussed around Newmarket Hospital
- The Committee noted the good performance of the Investment which had increased in value by £114k since the start of the financial year. The Committee also noted that the investment should be considered over the long term. Short term volatility caused by Brexit was considered and the decision to continue to hold the investment was agreed.
- The Committee was updated on a property included within a legacy that was proving difficult to sell.
- The unaudited annual accounts and report were discussed at the September meeting and were subsequently approved at the special meeting arranged for the approval (1st November). The auditors did not raise any matters of significant concern and issued a clean audit report.
- The Committee approved the setting up of a Mortuary Charitable Fund.
- The Committee approved the updated Charitable policy. There were minor changes in the update primarily concerning clarification of processes.

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

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

	X	**X**	**X**	**X**	**X**	**X**	**X**
Previously considered by:	Charitable Funds Committee						
Risk and assurance:	None						
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Trust Board is asked to consider the report of the Charitable Funds Committee							

21. Council of Governors meeting report

To NOTE the report

For Report

Presented by Sheila Childerhouse

Board of Directors – 29 November 2019

Agenda item:	XXX			
Presented by:	Sheila Childerhouse			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	19 November 2019			
Subject:	Report from Council of Governors, 13 November 2019			
Purpose:		For information	X	For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 13 November 2019. The report is presented to the board of directors for information to provide insight into these activities. Key points from the meeting were:

- The Chair thanked the governors who had met with the CQC and also those who had taken part in the various governor engagement activities during the past year.
- It was reported Vinod Shenoy had agreed to join the Council of Governors as a staff governor.
- A written report was received from the Chair which provided a summary of the focus of the meetings and activities that she had been involved in over the last three months.
- The Chief Executive's report provided an update on the challenges facing the Trust and recent achievements. He highlighted the financial position as being a key challenge and the announcement of funding for a new hospital which was very good news
- Responses to governors' issues raised were received and the recommendations noted.
- The finance and quality and performance reports were reviewed and questions asked on areas of challenge.
- A report on winter planning was received and the improvements as a result of lessons learned from last year were explained.
- An update was received on the Alliance and ICS.
- A paper on meeting etiquette and behaviour was received and noted.
- A report was received from the nominations committee and the reappointment of Richard Davies and Alan Rose for a further three year term was noted.
- A report from the engagement committee was received, including the outcome of actions in response to feedback from the Courtyard Café.
- Reports were received from the lead governor and staff governors.
- Future dates for Council of Governors meetings and the annual members meeting for 2020 were noted.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**			**Invest in quality, staff and clinical leadership**		**Build a joined-up future**	
	X			X		X	
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.						
Risk and assurance:	Failure of directors and governors to work together effectively. Attendance by non executive directors at Council of Governor meetings and vice versa. Joint workshop and development sessions.						
Legislation, regulatory, equality, diversity and dignity implications	Health & Social Care Act 2012. Monitor's Code of Governance.						

Recommendation:

- The Board is asked to note the summary report from the Council of Governors.

22. Annual governance review

To approve the report recommendations

For Approval

Presented by Richard Jones

Board of Directors – 29 November 2019

Agenda item:	22			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	18 November 2019			
Subject:	Annual governance and developmental review 2019-20			
Purpose:		For information	X	For approval

Executive summary:

The Board undertakes an annual review of its governance structure in order to ensure that it is adequately discharging its responsibilities. The questions within the self-assessment are based on the CQC and NHSI **well-led assessment framework**.

By well-led, the CQC mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture. The well-led assessment is structured around eight key lines of enquiry (**KLOE**) – see figure 1.

Figure 1: Structure of new well-led assessment framework

A summary of the characteristics for each of these KLOE is provided (**Annex B**). Each KLOE is underpinned by a set of **prompts** which are used by the CQC during their inspections.

Similar to previously it is these prompts that will be used as the basis for the Board members self-assessment of the Trust's well-led rating (**Annex A**). This will allow themes to be identified and ratings to be compared with the previous year.

In-depth, regular and externally facilitated **developmental reviews** of leadership and governance are good practice across all industries. Rather than assessing current performance, these reviews should identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance. The questionnaire results along with the forthcoming CQC inspection report will be used to inform the scope of a planned developmental review in 2020. The scope and methodology of the planned development review to be approved by the 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 care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X				X

Previously considered by:	Previously undertaken self-assessment as part of annual governance review.
Risk and assurance:	Failure to comply with NHSI single assessment framework or code of governance and quality governance framework
Legislation, regulatory, equality, diversity and dignity implications	NHSI's code of governance, risk assessment framework and quality governance framework

Recommendation:

1. The Board is asked to approve the proposal for the annual governance self-assessment approach to be administered through a questionnaire to directors (Annex A)
2. Approve that the results of the questionnaire as well as the forthcoming CQC inspection report will be used to inform the scope of a planned developmental review in 2020

Annual Governance Review 2019-20

The questions within the self-assessment are based on the CQC and NHSI well-led assessment framework.

By well-led, the CQC mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

Outstanding	Good	Requires improvement	Inadequate
The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.	The leadership, governance and culture promote the delivery of high-quality person-centred care.	The leadership, governance and culture do not always support the delivery of high-quality person-centred care. Regulations may or may not be met.	The delivery of high-quality care is not assured by the leadership, governance or culture. Normally some regulations are not met.

The assessment is structured around eight key lines of enquiry (KLOE) for leadership and governance:

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
3. Is there a culture of high quality, sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is appropriate and accurate information being effectively processed, challenged and acted on?
7. Are the people who services, the public, staff and external partners engaged and involved to support high quality sustainable services?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

A summary of the characteristics for each of these KLOE is provided separately and **should be read prior to answering these questions.** Please return the completed questionnaire (preferably electronically) by **20 December 2019** to georgina.holmes@wsh.nhs.uk

Please respond to each of the questions based on the ratings set out below:

Risk rating	Definition
Outstanding ☆	The service is performing exceptionally well.
Good ●	The service is performing well and meeting our expectations.
Requires improvement ●	The service isn't performing as well as it should and we have told the service how it must improve.
Inadequate ●	The service is performing badly and we've taken action against the person or organisation that runs it.

Well-led framework governance review

Completed by:

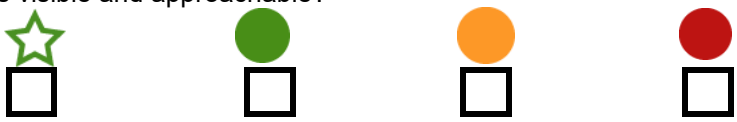
NED ☐ Exec. ☐

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

Q1.1 Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?

Q1.2 Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?

Q1.3 Are leaders visible and approachable?



Q1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?

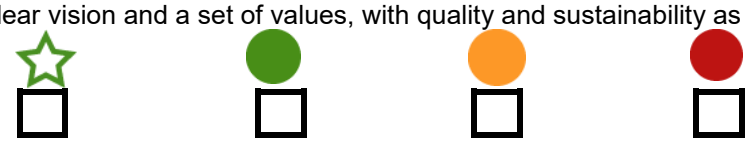
How are you assured on this KLOE? Evidence for assessment

Areas that work well

Areas for improvement

KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people who use services, and robust plans to deliver?

Q2.1 Is there a clear vision and a set of values, with quality and sustainability as the top priorities?



Q2.2 Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?

Q2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?

Q2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them?

Q2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?

Q2.6 Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?

How are you assured on this KLOE? Evidence for assessment

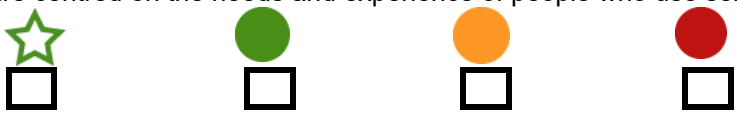
Areas that work well

Areas for improvement

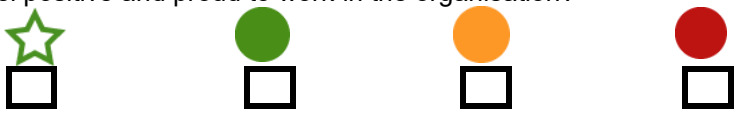
KLOE 3: Is there a culture of high quality, sustainable care?

Q3.1 Do staff feel supported, respected and valued?

Q3.2 Is the culture centred on the needs and experience of people who use services?



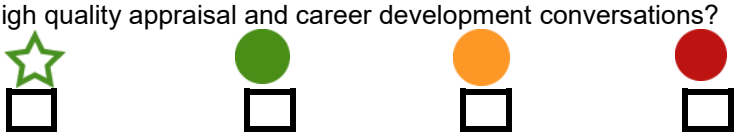
Q3.3 Do staff feel positive and proud to work in the organisation?



Q3.4 Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?

Q3.5 Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?

Q3.6 Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?



Q3.7 Is there a strong emphasis on safety and well-being of staff?

Q3.8 Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?

Q3.9 Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?

How are you assured on this KLOE? Evidence for assessment

Areas that work well

Areas for improvement

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Q4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?

Q4.2 Do all levels of governance and management function effectively and interact with each other appropriately?

Q4.3 Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?

Q4.4 Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?

How are you assured on this KLOE? Evidence for assessment

Areas that work well

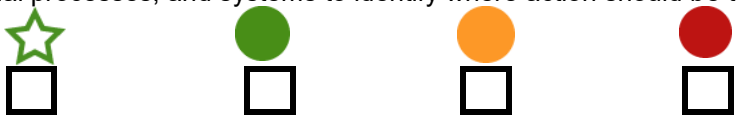
Areas for improvement

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

Q5.1 Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?

Q5.2 Are there processes to manage current and future performance? Are these regularly reviewed and improved?

Q5.3 Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?



Q5.4 Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?

Q5.5 Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?

Q5.6 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?

How are you assured on this KLOE? Evidence for assessment

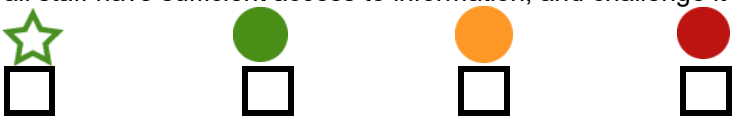
Areas that work well

Areas for improvement

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Q6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?

Q6.2 Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?



Q6.3 Are there clear and robust service performance measures, which are reported and monitored?

Q6.4 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?

☐ ☐ ☐ ☐

Q6.5 Are information technology systems used effectively to monitor and improve the quality of care?

Q6.6 Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?

Q6.7 Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?

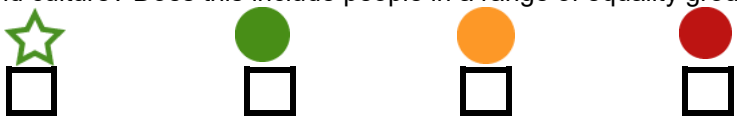
How are you assured on this KLOE? Evidence for assessment

Areas that work well

Areas for improvement

KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

Q7.1 Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?



Q7.2 Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?

Q7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?

Q7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?

Q7.5 Is there transparency and openness with all stakeholders about performance?

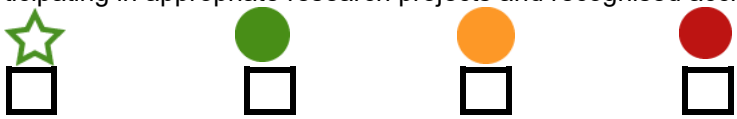
How are you assured on this KLOE? Evidence for assessment

Areas that work well

Areas for improvement

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

Q8.1 Do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?



Q8.2 Are there standardised improvement tools and methods, and do staff have the skills to use them?

Q8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?

Q8.4 Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?

Q8.5 Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?

How are you assured on this KLOE? Evidence for assessment

Areas that work well

Areas for improvement

Please return the completed questionnaire (preferably electronically) by **20 December 2019** to georgina.holmes@wsh.nhs.uk

Annex B CQC rating characteristics

Well-led			
By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.	The leadership, governance and culture promote the delivery of high-quality person-centred care.	The leadership, governance and culture do not always support the delivery of high-quality person-centred care. Regulations may or may not be met.	The delivery of high-quality care is not assured by the leadership, governance or culture. Normally some regulations are not met.
W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
There is compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There is a deeply embedded system of leadership development and succession planning, which aims to ensure that the leadership represents the diversity of the workforce. Comprehensive and successful leadership strategies are in place to ensure and sustain delivery and to develop the desired culture. Leaders have a deep understanding of issues, challenges and priorities in their service, and beyond.	Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed. Leaders at every level are visible and approachable. Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning. The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and acts to address them.	Not all leaders have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. Staff do not consistently know who their leaders are or how to gain access to them. The need to develop leaders is not always identified or action is not always taken. Leaders are not always aware of the risks, issues and challenges in the service. Leaders are not always clear about their roles and their accountability for quality.	Leaders do not have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. There is no stable leadership team, with high unplanned turnover and/or vacancies. Leaders are out of touch with what is happening on the front line, and they cannot identify or do not understand the risks and issues described by staff. There is little or no attention to succession planning and development of leaders. Staff do not know who their leaders are or what they do, or are unable to access them. There are few examples of leaders making a demonstrable impact on the quality or sustainability of services.

W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
The strategy and supporting objectives and plans are stretching, challenging and innovative, while remaining achievable. Strategies and plans are fully aligned with plans in the wider health economy, and there is a demonstrated commitment to system-wide collaboration and leadership. There is a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans are consistently implemented, and have a positive impact on quality and sustainability of services.	There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant. The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and, external partners. The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population. Progress against delivery of the strategy and local plans is monitored and reviewed and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place. Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.	The strategy and plans have some significant gaps or weaknesses that undermine their credibility, and do not fully reflect the health economy in which the service works. They may not have been recently created or reviewed. Staff do not always understand how their role contributes to achieving the strategy. The statement of vision and guiding values is incomplete, out of date, or not fully credible. Results of stakeholder consultation are not always taken into account in strategies or plans. Staff are not always aware of, support, or do not understand the vision and values, or have not been fully involved in developing them. Progress against delivery of the strategy and plans is not consistently or effectively monitored or reviewed and there is no evidence of progress. Leaders at all levels are not always held to account for the delivery of the strategy.	There is no current strategy, or the strategy is not underpinned by detailed, realistic objectives and plans for high-quality and sustainable delivery, and it does not reflect the health economy in which the service works. Staff do not understand how their role contributes to achieving the strategy. There is no credible statement of vision and guiding values. Key stakeholders have not been engaged in the creation of the strategy. Staff are not aware of or supportive of, or do not understand, the vision and values, or they were developed without staff and wider engagement. There is no effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans. The strategy has not been translated into meaningful and measurable plans at all levels of the service.

W3: Is there a culture of high-quality, sustainable care?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
Leaders have an inspiring shared purpose, and strive to deliver and motivate staff to succeed. There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. There is a strong organisational commitment and effective action towards ensuring that there is equality and inclusion across the workforce. Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process. There is strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.	Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing. Leaders at every level live the vision and embody shared values, prioritise high-quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening	Staff satisfaction is mixed. Improving the culture or staff satisfaction is not seen as a high priority. Staff do not always feel actively engaged or empowered. There are teams working in silos or management and clinicians do not always work cohesively. Staff do not always raise concerns or they are not always taken seriously, appropriately supported, or treated with respect when they do. People do not always receive a timely apology when something goes wrong and are not consistently told about any actions taken to improve processes to prevent the same happening again. Staff development is not always given sufficient priority. Appraisals take place inconsistently or are not of high quality. Equality and diversity are not consistently promoted and the causes of workforce inequality are not always identified or adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, do not always feel they are treated equitably.	There is no understanding of the importance of culture. There are low levels of staff satisfaction, high levels of stress and work overload. Staff do not feel respected, valued, supported or appreciated. There is poor collaboration or cooperation between teams and there are high levels of conflict. The culture is top-down and directive. It is not one of fairness, openness, transparency, honesty, challenge and candour. When something goes wrong, people are not always told and do not receive an apology. Staff are defensive and are not compassionate. There are high levels of bullying, harassment, discrimination or violence, and the organisation is not taking adequate action to reduce this. When staff raise concerns they are not treated with respect, or the culture, policies and procedures do not provide adequate support for them to do so. The culture is defensive. There is little attention to staff development and there are low appraisal rates.

	again. Behaviour and performance inconsistent with the vision and values is identified and dealt with swiftly and effectively, regardless of seniority. There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared. There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations. Equality and diversity are actively promoted and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.		

W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
Governance arrangements are proactively reviewed and reflect best practice. A systematic approach is taken to working with other organisations to improve care outcomes.	The board and other levels of governance in the organisation function effectively and interact with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective. Staff are clear about their roles and accountabilities.	The arrangements for governance and performance management are not fully clear or do not always operate effectively. There has been no recent review of the governance arrangements, the strategy, or plans. Staff are not always clear about their roles, what they are accountable for, and to whom.	The governance arrangements and their purpose are unclear, and there is a lack of clarity about authority to make decisions and how individuals are held to account. There is no process to review key items such as the strategy, values, objectives, plans or the governance framework. Staff and their managers are not clear on their roles or accountabilities. There is a lack of systematic performance management of individual staff, or appropriate use of incentives or sanctions.

W5: Are there clear and effective processes for managing risks, issues and performance?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
There is a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviews how they function and ensures that staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems are identified and addressed quickly and openly.	The organisation has the processes to manage current and future performance. There is an effective and comprehensive process to identify, understand, monitor and address current and future risks. Performance issues are escalated to the appropriate committees and the board through clear structures and processes. Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns. Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.	Risks, issues and poor performance are not always dealt with appropriately or quickly enough. The risk management approach is applied inconsistently or is not linked effectively into planning processes. The approach to service delivery and improvement is reactive and focused on short-term issues. Clinical and internal audit processes are inconsistent in their implementation and impact. The sustainable delivery of quality care is put at risk by the financial challenge.	There is little understanding or management of risks and issues, and there are significant failures in performance management and audit systems and processes. Risk or issue registers and action plans, if they exist at all, are rarely reviewed or updated. Meeting financial targets is seen as a priority at the expense of quality.

W6: Is appropriate and accurate information being effectively processed, challenged and acted on?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
The service invests in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care is consistently found to be accurate, valid, reliable, timely and relevant. There is a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.	Integrated reporting supports effective decision making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people with quality, operational and financial information. Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary. Performance information is used to hold management and staff to account. The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses. Data or notifications are consistently submitted to external organisations as required. There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Information technology systems are used effectively to monitor and improve the quality of care.	The information used in reporting, performance management and delivering quality care is not always accurate, valid, reliable, timely or relevant. Leaders and staff do not always receive information to enable them to challenge and improve performance. Information is used mainly for assurance and rarely for improvement. Required data or notifications are inconsistently submitted to external organisations. Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems are not always robust	The information that is used to monitor performance or to make decisions is inaccurate, invalid, unreliable, out of date or not relevant. Finance and quality management are not integrated to support decision making. There is inadequate access to and challenge of performance by leaders and staff. There are significant failings in systems and processes for the management or sharing of data.

W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
There are consistently high levels of constructive engagement with staff and people who use services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account. Services are developed with the full participation of those who use them, staff and external partners as equal partners. Innovative approaches are used to gather feedback from people who use services and the public, including people in different equality groups, and there is a demonstrated commitment to acting on feedback. The service takes a leadership role in its health system to identify and proactively address challenges and meet the needs of the population.	A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture. The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture. The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.	There is a limited approach to sharing information with and obtaining the views of staff, people who use services, external partners and other stakeholders, or insufficient attention to appropriately engaging those with particular protected equality characteristics. Feedback is not always reported or acted on in a timely way.	There is minimal engagement with people who use services, staff, the public or external partners. The service does not respond to what people who use services or the public say. Staff are unaware or are dismissive of what people who use the service think of their care and treatment. Staff or patient feedback is inappropriately filtered or sanitised before being passed on.

W8: Are there robust systems and processes for learning, continuous improvement and innovation?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
There is a fully embedded and systematic approach to improvement, which makes consistent use of a recognised improvement methodology. Improvement is seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills are available and used across the organisation, and staff are empowered to lead and deliver change. Safe innovation is celebrated. There is a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There is a strong record of sharing work locally, nationally and internationally.	There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research. There is knowledge of improvement methods and the skills to use them at all levels of the organisation. There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems, and ways of sharing improvement work. The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements. Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.	There is weak or inconsistent investment in improvement skills and systems among staff and leaders. Improvements are not always identified or action is not always taken. The organisation does not react sufficiently to risks identified through internal processes, but often relies on external parties to identify key risks before they start to be addressed. Where changes are made, the impact on the quality and sustainability of care is not fully understood in advance or it is not monitored.	There is little innovation or service development, no knowledge or appreciation of improvement methodologies, and improvement is not a priority among staff and leaders. There is minimal evidence of learning and reflective practice. The impact of service changes on the quality and sustainability of care is not understood.

23. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 29 November 2019

Agenda item:	23			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 November 2019			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

The attached 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.

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

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

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

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 31 January 2020

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Integrated quality & performance report	✓		Written	Matrix	HB/RP
Update on delivery of the new model for non-emergency patient transport	✓	✓	Written	Action point	HB
Finance & workforce performance report	✓		Written	Matrix	CB
Mandatory training and appraisal performance reports (Q3)	✓		Written	Matrix	JO
Q3 financial return, including consideration of reforecast position	✓	✓	Written	Action point	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Safe staffing guardian report – Q3	✓		Written	Matrix	NJ
"Putting you first award"	✓		Verbal	Matrix	JO
Consultant appointment report	✓		Written	Matrix – by exception	JO
Annual review of car parking	✓		Verbal	Matrix	CB
CQC inspection update	✓	✓	Written	Action point	RP
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
Integration report (including update on the paediatric Suffolk-system review and locality baseline reviews)	✓		Written	Matrix	HB/KV
Digital board report, including community IT update	✓		Written	Matrix	CB
Primary care vertical integration – decision point		✓	Written	Action point	KV
Emergency department business case		✓	Written	Action point	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS), including governance arrangements in response to the national funding announcement for new development		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Charitable Funds Committee annual report	✓		Written	Matrix	GN
Remuneration committee report - including Clinical Excellence Awards Scheme annual report	✓		Written	Matrix	AE
Register of interests	✓		Written	Matrix	RJ
Review of NED responsibilities	✓		Written	Matrix	SC

Board assurance framework review		✓	Written	Matrix	RJ
Scrutiny Committee report		✓	Written	Matrix	GN
Confidential staffing matters		✓	Written	Matrix – by exception	JO
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:30 ITEMS FOR INFORMATION

24. Any other business

To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency

For Reference

Presented by Sheila Childerhouse

24.1. To NOTE that the next meeting will be held on Friday, 31 January 2020 at 9:15 am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

25. 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

Presented by Sheila Childerhouse