Board of Directors (In Public)

Schedule	Friday 27 March 2020, 10:00 AM — 11:15 AM GMT
Venue	Northgate room, Quince House, West Suffolk Hospital, Bury St Edmunds IP33 2QZ
Description	A meeting of the Board of Directors will take place on Friday, 27 March 2020 at 10:00 in Northgate room, Quince House, West Suffolk Hospital, Bury St Edmunds, Governors / NEDs will attend via conference call facility
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

10:00 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

   Please note the following agenda reports have been postponed; matters arising, nurse staffing, appraisal, consultant appointment, 7-day services, education, culture and engagement, NED responsibilities, agenda items for next meeting.
   For Reference - Presented by Sheila Childerhouse

NHS
West Suffolk
NHS Foundation Trust

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 31 January 2020
   For Approval - Presented by Sheila Childerhouse

   Item 5 - New format Open Board Minutes 2020 02 28 Feb Draft.docx

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

10:10 DELIVER FOR TODAY

7. COVID-19 report (verbal)
   To RECEIVE a briefing
   For Report - Presented by Helen Beck

8. Integrated Quality and Performance report
   To ACCEPT the report
   Presented by Helen Beck and Rowan Procter

   Item 8 - February 2020 IQPR SPC - JH.pdf

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

   Item 9 - Board report Cover sheet - M11.docx

   Item 9 - Finance Report Final - Feb 20.docx

10:40 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

10. Quality and learning report
    To APPROVE the quarterly report
    For Report - Presented by Rowan Procter and Nick Jenkins

    Item 10 - 20-03-27 Quality and Learning report - Mar 2020.docx

11. Putting you first award
    To NOTE a verbal report of this months winner
    For Reference - Presented by Jeremy Over

10:50 BUILD A JOINED-UP FUTURE

12. Trust improvement plan
    To APPROVE the report recommendations and the plan which addresses the CQC findings
    For Report - Presented by Rowan Procter

    Item 12 - Trust improvement plan.docx

11:00 GOVERNANCE

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

    Item 13 - TEG report.doc

14. Charitable Funds
    To ACCEPT the report
    For Report - Presented by Gary Norgate

    Item 14 - Charitable Funds Board Report.docx

11:10 ITEMS FOR INFORMATION

15. 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

16. Date of next meeting
    To note that the next meeting will be held on Friday, 24th April 2020 at 9:15 am in West Suffolk Hospital
    For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

17. The Trust Board is invited to adopt the following resolution:
"That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act 1960
For Reference - Presented by Sheila Childerhouse

AGENDA

Presented by Sheila Childerhouse

10:00 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

Please note the following agenda reports have been postponed; matters arising, nurse staffing, appraisal, consultant appointment, 7-day services, education, culture and engagement, NED responsibilities, agenda items for next meeting.

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 31 January 2020

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 28 FEBRUARY 2020 AT WEST SUFFOLK HOSPITAL

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	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
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 Vaughton	Director of Integration and Partnerships		
Lucy Hampton	Executive Coach		
Governors in attendance (observation only)			
Florence Bevan, Peta Cook, Justine Corney, Amanda Keighley, Joe Pajak, Jane Skinner, Liz Steele			

Action

GENERAL BUSINESS

20/27 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

There were no apologies from board members. It was noted that Tara Rose had sent her apologies for this meeting.

The Chair welcomed everyone to the meeting.

20/28 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Question: What was the preparedness of the organisation for coronavirus and what steps had been taken to ensure that staff were aware of what they should be doing? Should WSFT issue a statement to the public about its preparedness?

Answer: The organisation was as prepared as it could be but the national guidance changed rapidly. All communication was being managed nationally therefore it was not possible for WSFT to issue any communication to the public. The advice to people was to look at the government website or call 111.

Action: A briefing could be circulated to governors and NEDs as soon as possible. **H Beck**

Question: Would the Trust wold receive funding from the government to support the additional costs related to coronavirus?

Answer: There was a firm commitment that the cost of any reasonable additional resource requirement would be reimbursed.

Question: It was not considered that non-emergency patient transport should be showing as complete and should remain as an ongoing action?

Answer: The action to provide more data had been completed but it was agreed that this was an ongoing issue.

Action: This was on the risk register but would continue to be followed up. **H Beck**

Question: As a result of the continuing numbers of discharge summaries that were not produced in a timely way could assurance be provided that more vulnerable patients were not missing out on the care they needed in the community?

Answer: There was now a better real time report to help improve performance of availability of discharge summaries to GPs. These were part of complex discharge planning processes for complex and elderly patients; therefore this should not be an issue for these patients. Community staff and GPs could access e-Care and view these.

It was noted that the proposed improvements for quality walkabouts would be a very useful tool.

20/29 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

20/30 DECLARATION OF INTERESTS

There were no declarations of interests.

20/31 MINUTES OF THE MEETING HELD ON 31 JANUARY 2020

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

Page 2, item 20/02, second paragraph, reference to carbon dioxide monitoring should read carbon monoxide monitoring.

20/32 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following updates given:

Item 1752: Need a clear plan, including timescales, to deliver improvement in nutrition performance (including feedback from the F9 pilot). It was noted that the target date was now 24/4/20. An update would be provided under agenda item 8.

Item 1802: Detailed report on mitigation and timescale for improvement on pressure ulcer performance. The target date was 27/03/20; an update would be provided under agenda item 8.

The completed actions were reviewed and there were no issues.

20/33 CHIEF EXECUTIVE'S REPORT

- The board was formerly receiving the CQC report today and this was included in the board pack. It was determined to learn, change and make improvements and this would be discussed in today's meeting. All immediate safety concerns had already been addressed and a detailed action plan would be going to the quality summit next week and would then come back to the board and would be monitored and reported openly and transparently.

- The organisation remained very busy during the winter period and he thanked all staff in the hospital and community for their hard work in managing this. He also thanked those staff and teams involved in the preparation around coronavirus.

- The staff survey had been received and would be discussed later in the meeting. This was the first time that all staff had been asked to complete the survey. It provided a lot of valuable feedback which would help with learning and changing in response to the CQC report.

Question: What would the Trust be doing differently and what had it learned as a consequence of the report, "How will we know if Integrated Care Systems (ICS) reduce demand for urgent care?"

Answer: This report was particularly focussed on the payment mechanism and how this was used in order to drive certain behaviour; therefore blended demand had been introduced. This had moved towards a block contract which disincentivised organisations from admitting patients unnecessarily. This was something that the organisation was trying to put into practice and working in a different way with the community and primary care.

If the Trust had not implemented actions and worked with the community to manage demand it was likely that attendances and admissions could have been higher. The system was working in a more integrated way and was a lot further on than most of the country.

DELIVER FOR TODAY

20/34 INTEGRATED QUALITY AND PERFORMANCE REPORT

Question: Some 'when' dates had now been included but the actions were still not very specific. What steps were being taken to ensure that 'when' represented a real objective and real plan by a set date?

Answer: There had been issues with getting information and reports collated in a timely manner to enable the executive team to check and challenge.

The Trust was in the process of recruiting a falls lead. Once this individual was in place and had undertaken an assessment and produced a clear plan it would be possible to start to understand a 'when' date for improvement.
Action: A date for when there would be an improvement plan would be provided at the board next meeting but this needed to be meaningful. **R Procter**

A quality improvement lead was now in post who would be meeting with the Trust's pressure ulcer lead to ensure that appropriate actions were being taken. A deep dive was also being undertaken to understand the improvements required.
Action: A more detailed plan would then be produced so that a 'when' date could be provided; this should be available for the next board meeting. **R Procter**

- There was now a safety dashboard for falls, pressure ulcers, nutrition etc which would be viewed by staff. Over the next few weeks meetings would take place with senior matrons and ward managers to ensure that assessments were being undertaken to the right standard and in a timely fashion and appropriate care plans were in place. This was about providing assurance and empowering the team.

- Acknowledgement of complaints within three days had improved and it was expected that this should continue over the next few months as additional staff

were recruited to the team.

- A quality improvement project was required for duty of candour as this was not achieving the target and the Trust was currently a significant outlier.

Question: It was acknowledged that duty of candour could be complex but what should the acceptable level be and how could this be tested?

Answer: The acceptable standard was no outstanding duty of candours and these should be completed within the time frame. This had been discussed with the clinical directors, and if the consultant in charge wished to personally undertake duty of candour they would have a set number of days to do this, otherwise it would be done as a standard.

Action: A date for this to be implemented was requested for the next meeting. **N Jenkins**

Question: There was no narrative in the report on sepsis; what would be done to sustainability meet the target?

Answer: The target was met in January. The standard was still 100% and the SPC chart showed a sustained improvement in performance although it was below the standard. 74% equated to four patients breaching the one hour target.

A rapid assessment and triage area was being implemented which would be staffed with clinicians and nurses to enable early intervention. Nurses were also being trained so that they could administer antibiotics if doctors were not available.

Question: When was it expected that controls would be in place to bring the Trust back up to the required standard?

Answer: The rapid assessment and triage area would be operational for the next reporting period but it was not possible to determine the timeline for improvement as this was dependent on patient numbers to enable the sign off of staff as competent, but these staff should increase each month. Once this was achieved the floor co-ordinators would be aware which staff were competent so that these individuals could undertake assessments and administer antibiotics

Action: An assessment of the impact of the establishment of the rapid assessment and triage area would be provided for a future meeting. **H Beck**

- There were a lot of metrics for the emergency department in the IQPR that the Trust was no longer monitoring against, including the four hour target. Last week comparable information on emergency performance against the other 14 pilot sites had been received. This was the first time this data had been seen and would provide an opportunity look at and address any issues. WSFT had performed exceptionally well across the range of metrics and was usually second or third out of 14.

Question: When could WSFT could start reporting openly on emergency department performance? It was very important that the Trust could report this information to the public as soon as possible.

Answer: Trusts has been told that there would be a summary report from the national team in March and they should get an indication of which metrics would be measured, what the role out would be and how this would be managed.

- The major issue with RTT was capacity within the organisation, ie consultants, junior doctors, theatre capacity. This was not going to improve unless significant investment was achieved as a result of the quality summit.

- There had been significant increase this week with RTT 52 week waits. Six patients in ophthalmology were due to administration issues; this had been addressed and staff training was being undertaken. There was a more major issue with a vascular patient who had been lost for three years. This patient had now been seen and duty of candour had been undertaken. This patient had not been transferred over to e-Care and this was being thoroughly investigated but to date it appeared that this was the only occurrence.

Question: Was there a general learning point about transferring specialties to e-Care.

Answer: It was explained that a lot of work had been undertaken to ensure that this did not happen. This was being looked into in case there were other incidents in other specialties; however it was not believed that this was a general problem.
Action: The outcome of the review of this would be reported back to a future meeting. **H Beck**

- Capacity issues continued to affect cancer waiting times, including two week waits and diagnostics within six weeks, particularly in endoscopy. The change to 'straight to test' was starting to have an impact on two week waits as well as significant activity issues in cystoscopy performance. Additional resource was being brought in to assist with cystoscopies and the Trust was working with the Cancer Alliance and ESNEFT to look at specific pathways and where immediate improvements could be made.

- It was expected that the six week target would be removed under the new regime next year. WSFT was working towards this and focussing on the two week wait and 28 days. The 62 day GP referral should ultimately result in improved performance. The original plan was to achieve the target in March but this was now likely to be April and the CCG had been informed of this.

Question: Re two week cancer referrals, what were the proposed actions particularly in relation to issues around dermatology and clinic capacity?

Answer: The actions were about ensuring referrals coming in on the two week pathway were appropriate. However, demand for this meant that more and more people would be referred on the two week referral pathway.

Question: What other options were being looked at as a system for different ways of managing this.

Answer: Part of the long term plan was a complete overhaul in the way that outpatients were managed as not all these patients needed to come into the hospital. Telederm services had been put in place by the CCG which delivered a three day turnaround but there was currently poor uptake of this from Suffolk GPs. Video conferencing and 'straight to test' were also being implemented to help to address this.
Action: More information should to come back to a future meeting. **H Beck**

20/35 FINANCE AND WORKFORCE REPORT

- Financial performance continued to be consistent with previous months and the pressure that the organisation was under. This was reflected in expenditure, mainly on staffing but also in pay and equipment in the community. The Trust was still forecasting to hit its control total on the basis that it had secured funding to cover the extra activity that had been delivered this year.

- The cash position remained a concern and discussions were taking place with the CCG and regional office about when the additional funding would be received.

- The main focus of the financial department was the financial position and budget for next year. The organisation now employed significantly more nurses than at the start of the year and is it moved into next year this would create a pressure financially.

Question: Would the additional CIP of £1.8m be achieved and how much would be carried over into next year that had not been achieved?

Answer: The additional £1.8m CIP would be achieved and approximately £2m was likely to be carried over into next year.

Question: How could the Trust stress test the unknowns that could impact on next year, eg coronavirus?

Answer: There was a contingency to manage issues that were not known about. Where there were national pressures there tended to be a national approach to funding for these.

Question: The cost of additional sessions was very low for the third month in a row; was good or bad and what impact it was having on patients?

Answer: There was a balance between additional capacity and achieving the financial target. The role of the board was to judge whether decisions made within the organisation were appropriate or not. Where specialties were exceeding the target the Trust would look at controlling the number of additional sessions with a view to managing the financial position. However, where specialities were failing the target there would not be the same cap on expenditure.

These were conscious decisions or due to the availability of staff to undertake additional sessions or the reluctance of some consultants to do additional work due to the pension issue. Until this was resolved it would not be possible to have the level of additional sessions required in some areas.

Question: What was being had been done to alleviate the pension situation?

Answer: A few consultants had benefitted from local measures to address this. There had been some attempt at assurance from the government that doctors should not worry about pension implications this year but they were not all convinced by this.

Question: To what extent had the impact of the responses to the CQC report started to be costed.

Answer: Discussions would take place with the CQC, CCG and regional office next week at the quality summit but there was no guarantee that additional funding would be received to address all the concerns.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

20/36 CQC INSPECTION REPORT

- The Trust continued to implement improvements, including the development of the Perfect Ward app and the quality walkabouts were being restructured to

provide additional assurance. Subject to the outcome of the quality summit the action plan would be going to the next board meeting.

Question: The sequence of this was queried, ie the Trust would be engaging with the regulator about the plan as an organisation, but the full detail had not yet been to the board and even if the regulator was in agreement with the plan the board might not be.

Answer: The detailed action plan would not be taken to the quality summit but this would be a discussion about proposed improvements and what had already taken place and agreeing a timescale for production of the final action plan. Some of the improvements would require more detailed discussion and additional investment. The final plan would need to be signed off by the board.

Question: With reference to the three recommendations, including annex 1, Perfect Ward, how could there be wider input into these, eg soft intelligence?

Answer: There was a section for free flow and this would also be fed into the improvement plan.

Action: The new quality walkabout process would be implemented, including the capture of soft intelligence. **R Procter**

20/37 NURSE STAFFING REPORT

- WSFT had the best vacancy factor in the region and subject to objective structured clinical examination (OSCE) approval in the next three months the vacancy rate would be at nearly zero.

Question: What action was being taken to address the fact that theatres had a 140-150% fill rate and were red rated on sickness and absence?

Answer: There were regular meetings about sickness and also regular meetings between theatre teams. Sickness absence in theatre teams and actions being taken was being to address was being looked into. Overtime was paid in theatres as it was not possible to get theatre agency staff.

Action: Assurance on actions being taken to address sickness absence in theatres would be provided to a future meeting. **H Beck**

Question: What assurance could be provided around changes that could be implemented following the departure of Paul Morris, deputy chief nurse?

Answer: The Trust was going through a process around the patient safety role. The position of deputy chief nurse had been offered to an individual who was currently a deputy director of nursing at an acute Trust.

Question: What impact would the CQC report have on recruitment of staff.

Answer: It was not considered that this was likely to have an impact on nurses but it appeared that it this and the media reports could be more of an issue with recruitment of consultants.

The first concern was to retain people and address any issues with the environment within teams. The results of the staff survey and CQC report provided a fairly good idea where the pockets of lower morale were and these areas needed to be supported.

20/38 NURSE STRATEGY UPDATE REPORT

Question: There did not appear to be anything that represented a response to the freedom to speak issues up and culture of reporting and handling of these.

Answer: This report provided an update on this strategy that was produced and approved two years ago. It was considered that nurses felt free to speak up and but it would be helpful to understand this from the bottom up. The medicines division had set up a series of drop in sessions and these had been so popular that the senior leadership team arranged monthly drop in sessions so that staff could discuss any issues.

It was stressed that the board was not complacent about people being able to speak up and was aware that this was an issue for some staff. The CQC report had mainly been around what doctors had said; feedback from nursing staff tended to be about staffing and staff movements. The executive team had agreed that they needed to get a lot better about feeding back on what they were doing about concerns raised through datix or suggestions that were made.

20/39 CONSULTANT APPOINTMENT REPORT

None to report.

20/40 PUTTING YOU FIRST AWARD

Jeremy Over read out the citations for the following members of staff who received Putting You First Awards for February: Adey Thompson, Paul Sackett and Jaz Rackham, estates; Russell Williams, IT; Sarah Thirlby, neonatal nurse

The board congratulated and thanked these members of staff for going the extra mile.

20/41 STAFF SURVEY AND IMPROVING OUR CULTURE

- The staff survey and CQC report had been received by the Trust in the last six weeks. These did not appear to give mixed messages and it was important to look at these side by side. Even the best scores in the country in the staff survey were not perfect scores; they were averages and there could be a massive variation in different areas of the organisation. This was a tool to assist in understanding where things were working well and identify areas that required help and support. The action plan from this would form part of the CQC action plan, ie there would be one action plan for the Trust.

- WSFT's results were positive compared to other hospitals in the country, of the eleven themes, eight had improved and three remained unchanged. The key message was what staff said about support that had been provided to them by their immediate managers.

- The areas that provided cause for concern and how these results could be used to make a difference for staff were highlighted. The leadership team were starting to talk about what should be different and staff had been asked for feedback on three themes which related to recommendations in the CQC report, ie

  1. More and better listening to staff feedback to inform how we lead and improve
  2. Focused and better support for specific issues and teams identified in the CQC report

3. Greater focus on leadership development and continuous learning across WSFT to ensure we have the best culture

- Whilst it was important to think carefully about pace there could be risks around this, ie too much change too fast or when making changes from the top down. The board needed to be very mindful of this and ensure that people were fully engaged in any changes made.

Question: What could be done to address the views of the 48% of staff who had not responded to the staff survey?

Answer: A very detailed overview of these results was sent out to staff seven days ago inviting feedback; this would gave the 48% the opportunity to have a voice. Staff conversations about the results of the staff survey and CQC report would also be arranged which would provide everyone with the opportunity to take part and have their say.

Question: Women & Children had been highlighted by the CQC and in the staff survey as an area that might have an issue. What was being done to address this beyond the musts dos and should dos of the CQC.

Answer: Members of the internal leadership team would take up some of the challenges; there was a new head of midwifery and work was being undertaken around culture and supporting the senior management team in this area. and trying facilitate better working relationships between consultants as a group with the midwives and operational team.

20/42 NON-EMERGENCY PATIENT TRANSPORT

- Management changes that had been made had worked relatively well but this remained a concern, particularly in outpatients and further improvement was still required. The Trust would continue to challenge the contract provider and the CCG about this.

Question: What would the plan would be if things had not improved by May?

Answer: In May the Trust would look at whether there had been a sustained improvement, if not further discussions would be required with the provider and the CCG. The were no alternative providers as the previous provider had made it very clear that they were not interested in providing this service and the other provider in Norfolk were no better than the current provider.

Question: Were clinics flexible enough to accommodate the 25% of patients using this service who missed their appointment.

Answer: It was confirmed that wherever possible these patients were seen.

Action: A report would come back to the board in May and a verbal update provided prior to this. **H Beck**

BUILD A JOINED-UP FUTURE

20/43 NEW HOSPITAL DEVELOPMENT

- This report provided an overview of the process and the resource requirement for the development of a case for the new hospital which would provide a healthcare facility for the next 40-50 years..

- A strategic outline case (SOC) would be presented to the board in April. The next step would be to produce an outline business case (OBC). This would be a two year process requiring significant internal and external engagement. and would involve a lot of work from a number of people at a time when there were other major areas of focus for the organisation.

Question: How would the organisation mitigate against this becoming a distraction from other issues requiring focus.

Answer: This was being externally funded and the plan was to backfill the time of staff involved in this project but this would be a considerable challenge. A key appointment would be a programme director. It was very important to have appropriate engagement from both internal staff and external partners/stakeholders etc.

Question: Would there be a role for Addenbrooke's, Norfolk and Norwich and ESNEFT as part of the regional process for this.

Answer: This had to be within the ICS; there would be input from ESNEFT and discussions with the other two organisations where appropriate.

Action: Address the oversight of a lack of operational representation in the development programme. — **C Black**

GOVERNANCE

20/44 TRUST EXECUTIVE GROUP REPORT

The board received and noted the content of this report.

20/45 AUDIT COMMITTEE REPORT

The board received and noted the content of this report.

20/46 COUNCIL OF GOVERNORS MEETING REPORT

The board received and noted the content of this report.

20/47 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted. There would be a verbal update on patient transport.

ITEMS FOR INFORMATION

20/48 ANY OTHER BUSINESS

The Chair asked the board to reflect and feedback on whether some of the board sub-committees were appropriate and also the way that the board worked. — **S Childerhouse / R Jones**

20/49 DATE OF NEXT MEETING

Friday 27 March at 9.15am in the Northgate Room, Quince House, WSFT.

RESOLUTION TO MOVE TO CLOSED SESSION

20/50 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. Chief Executive’s report

To ACCEPT a verbal report on current issues from the Chief Executive

For Report

Presented by Stephen Dunn

10:10 DELIVER FOR TODAY

7. COVID-19 report (verbal)

To RECEIVE a briefing

For Report

Presented by Helen Beck

8. Integrated Quality and Performance report

To ACCEPT the report

Presented by Helen Beck and Rowan Procter

Trust Board – March 2020

Agenda item: **Presented by:** **Prepared by:** **Date prepared:** **Subject:**	Integrated Quality & Performance Report Craig Black Joanna Rayner, Head of Performance and Efficiency March 2020 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.							

NHS
West Suffolk
NHS Foundation Trust

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

Putting you first

NHS
West Suffolk
NHS Foundation Trust

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.

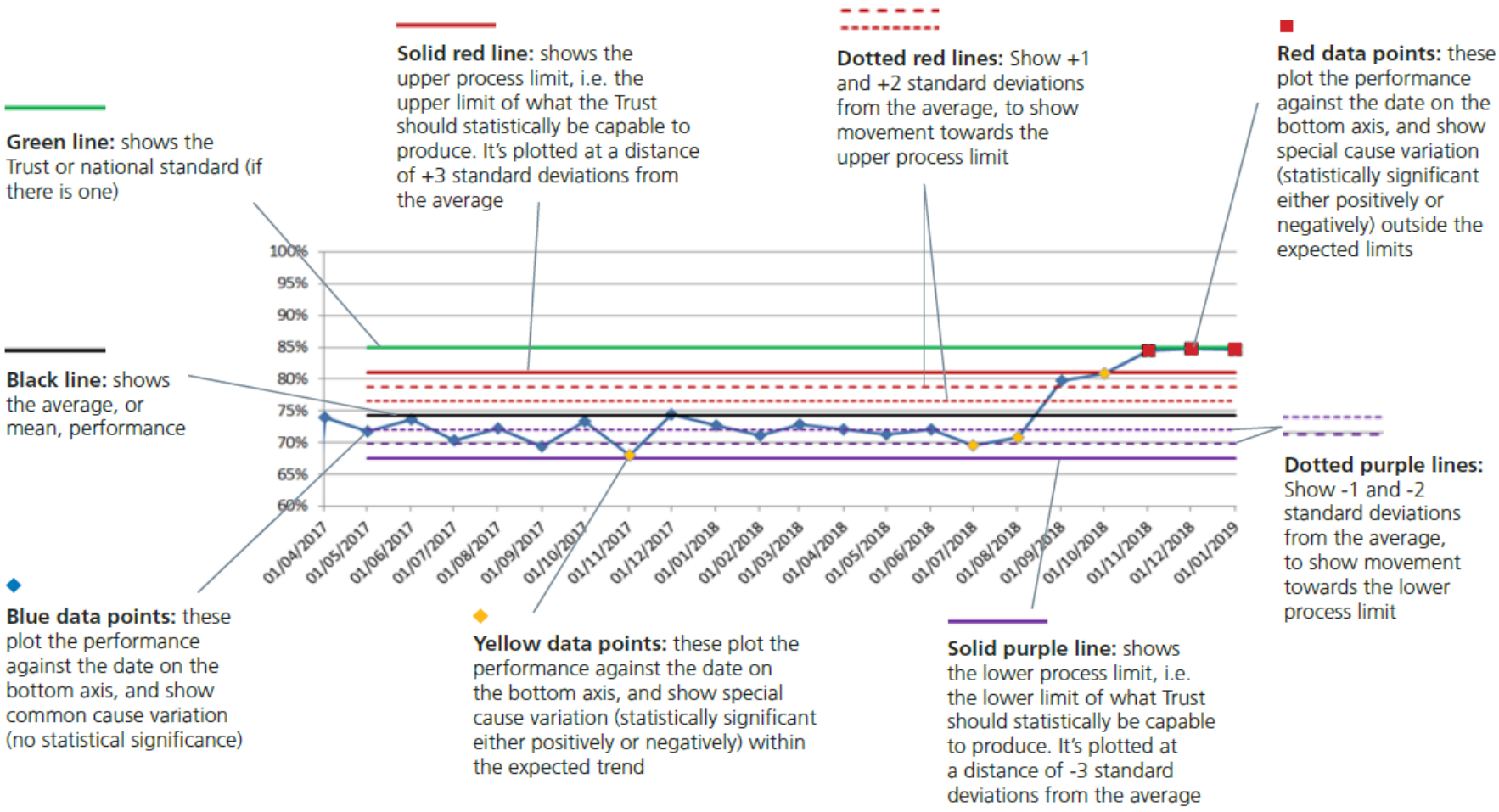
A control chart always has:

- 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



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	Feb-20

Safe domain	Standard	Actual	Trend	Assurance	Notes
New Pressure Ulcers - Trust	0	45	Special Cause Variation - High	Consistently above target	

Effective domain	Standard	Actual	Trend	Assurance	Notes
Discharge Summaries: A&E	95%	82%	Common Cause Variation	Consistently below target	
Discharge Summaries: Non Elective Admissions	95%	86%	Special Cause Note/Investigation - High	Consistently below target	
Discharge Summaries: Elective Admissions	85%	90%	Special Cause Note/Investigation - High	Hit and miss against target	

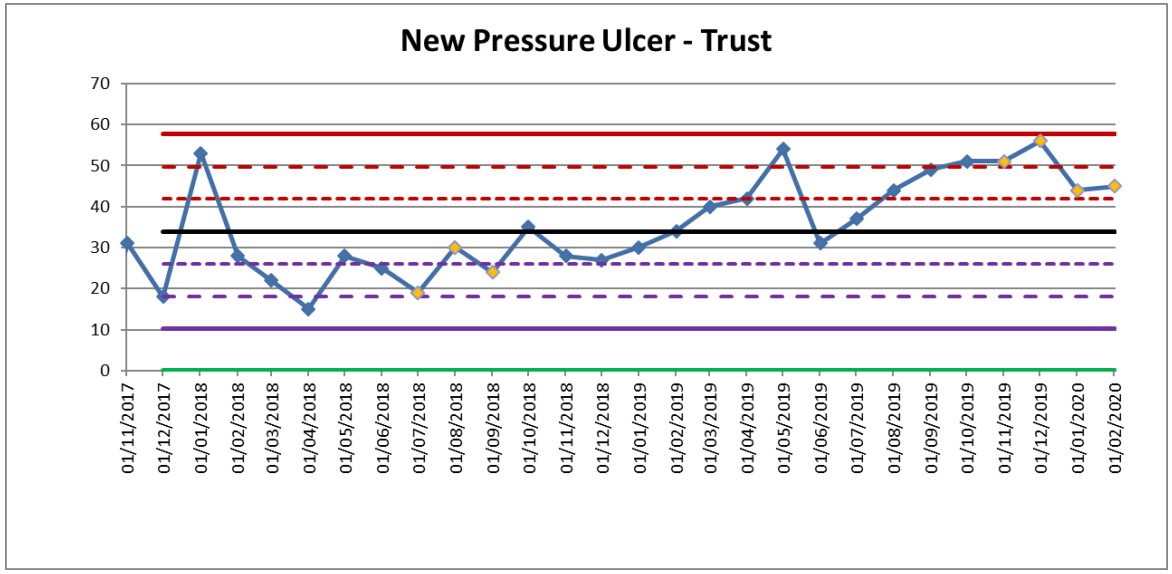
Caring domain	Standard	Actual	Trend	Assurance	Notes
Compliments	No target	10	Common Cause Variation	No target	
Complaints	20	20	Common Cause Variation	Hit and miss against target	
Complaints responded to within agreed timeframe	90%	40%	Common Cause Variation	Hit and miss against target	

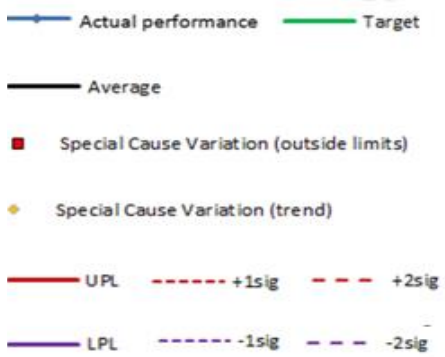
Responsive domain	Standard	Actual	Trend	Assurance	Notes
Referral to Treatment 18 week standard	92%	78%	Special Cause Variation - Low	Consistently below target	
Diagnostics 6 week standard	99%	95%	Special Cause Variation - Low	Hit and miss against target	
Sepsis	100%	100%	Common Cause Variation	Hit and miss against target	
Cancer 2 week GP referral to assessment standard	93%	87%	Special Cause Variation - Low	Hit and miss against target	
Cancer 2 week breast referral to assessment standard	93%	96%	Common Cause Variation	Hit and miss against target	
Cancer 62 day referral to treatment standard	85%	76%	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%	100%	Common Cause Variation	Hit and miss against target	

Well-led domain	Standard	Actual	Trend	Assurance	Notes
Sickness Absence	3.5%	4%	Common Cause Variation	Hit and miss against target	
Proportion of Temporary Staff	12%	9%	Common Cause Variation	Hit and miss against target	

Maternity	Standard	Actual	Trend	Assurance	Notes
Number of deliveries (births)	210	175	Special Cause Variation - High	Hit and miss against target	
Caesarean Section rate	22.6%	23%	Special Cause Variation - High	Hit and miss against target	
Breast Feeding Initiation	80%	76%	Common Cause Variation	Hit and miss against target	

Pressure Ulcers - Trust



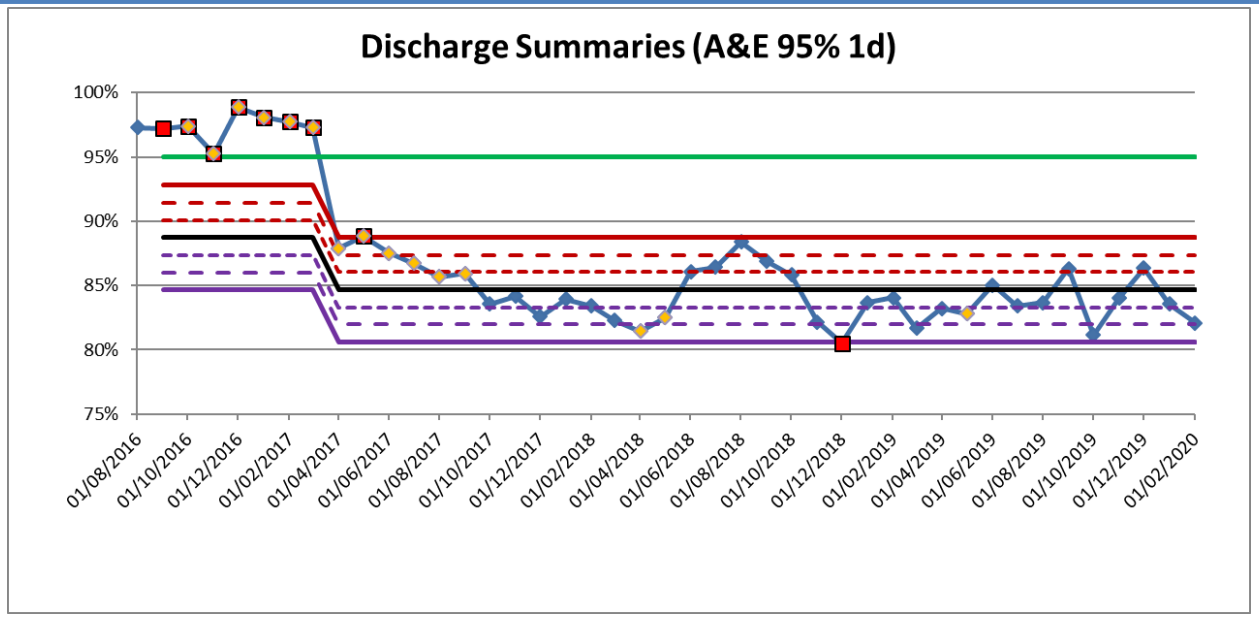


Narrative

Owner	Rowan Procter
What	Special Cause Variation - High
Why	After January's decrease in new pressure ulcers, February saw an overall increase of one new pressure ulcer, as an organisation. Again, incidence in the Community was higher than in the acute setting (28, compared to 21 during January), but this is still an improvement on December, which is positive and a reflection of the focused training provided by the Tissue Viability Service. Moisture associated skin damage reporting has increased, data is now available for a complete year and a plan will be developed to understand conversion rates to pressure ulcers.
How	Design and roll out change in Community investigation pathway. This will be reviewed after 3 months to see if it provides a suitable model that could be applied in our acute and the community hospitals as well
When	June 2020

Safe

Discharge Summaries ED

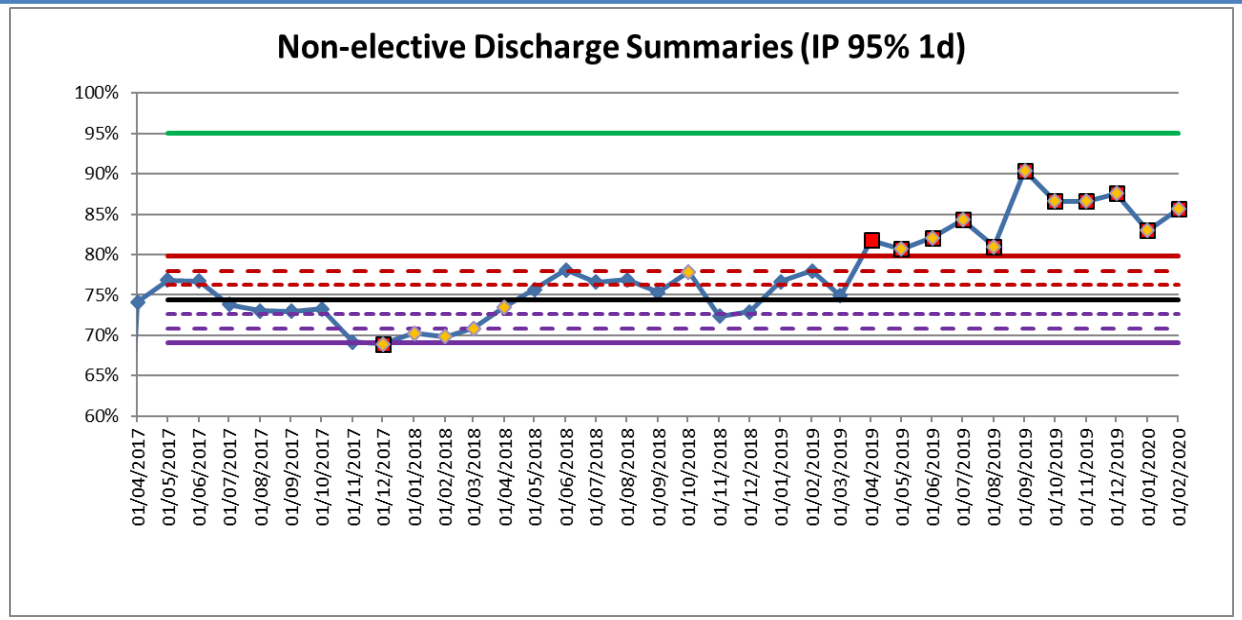


Narrative

Owner	Helen Beck
What	Common Cause Variation
Why	The performance has evidenced that the current actions are not having the desired impact. A new approach is being investigated to ensure that relevant data is received on the wards in a timely manner to enable improvements in this area.
How	Identify and deliver relevant data at ward level to enable timely completion of discharge summaries.
When	March 2020

Effective

Discharge Summaries Non elective admissions

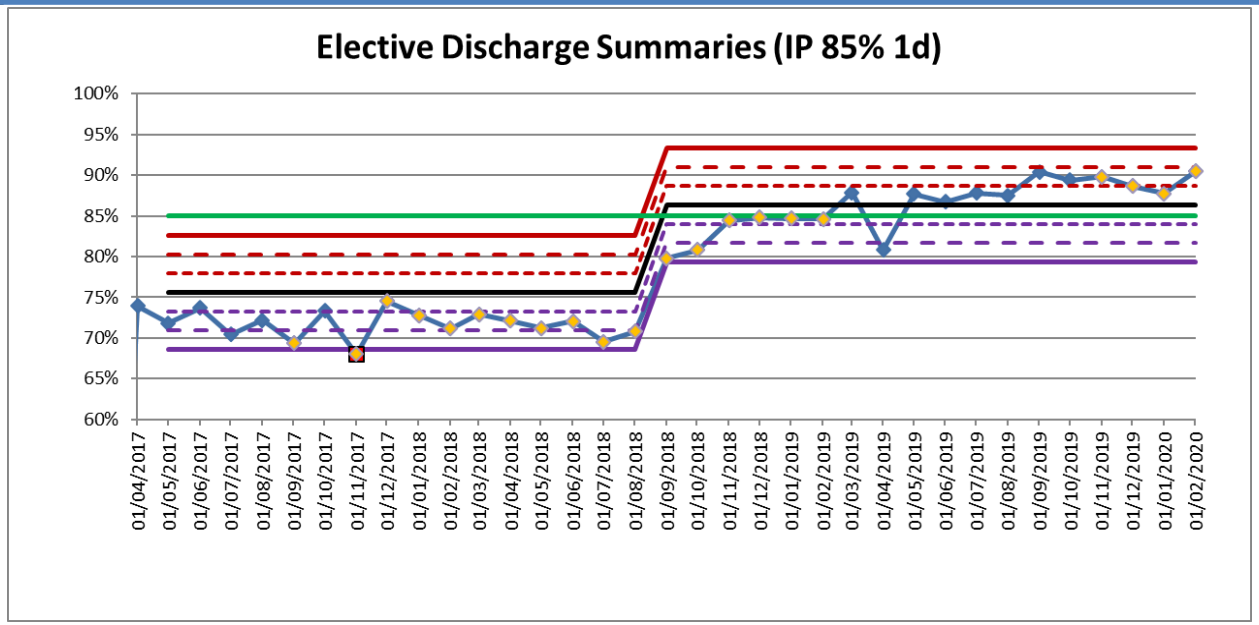


Narrative

Owner	Helen Beck
What	Special Cause Note/Investigation - High
Why	The performance has evidenced that the current actions are not having the desired impact. A new approach is being investigated to ensure that relevant data is received on the wards in a timely manner to enable improvements in this area.
How	Identify and deliver relevant data at ward level to enable timely completion of discharge summaries.
When	March 2020

Effective

Discharge Summaries Elective admissions

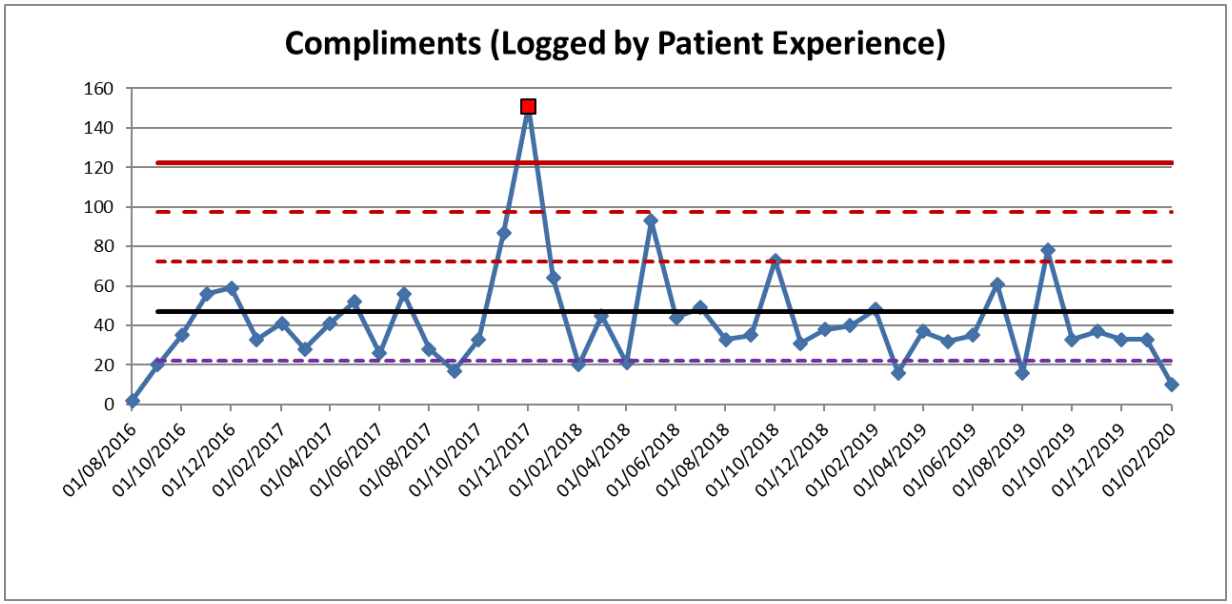


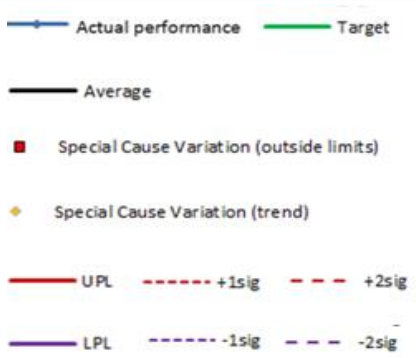
Narrative

Owner	Helen Beck
What	Special Cause Note/Investigation - High
Why	The performance has evidenced that the current actions are not having the desired impact. A new approach is being investigated to ensure that relevant data is received on the wards in a timely manner to enable improvements in this area.
How	Identify and deliver relevant data at ward level to enable timely completion of discharge summaries.
When	March 2020

Effective

Compliments



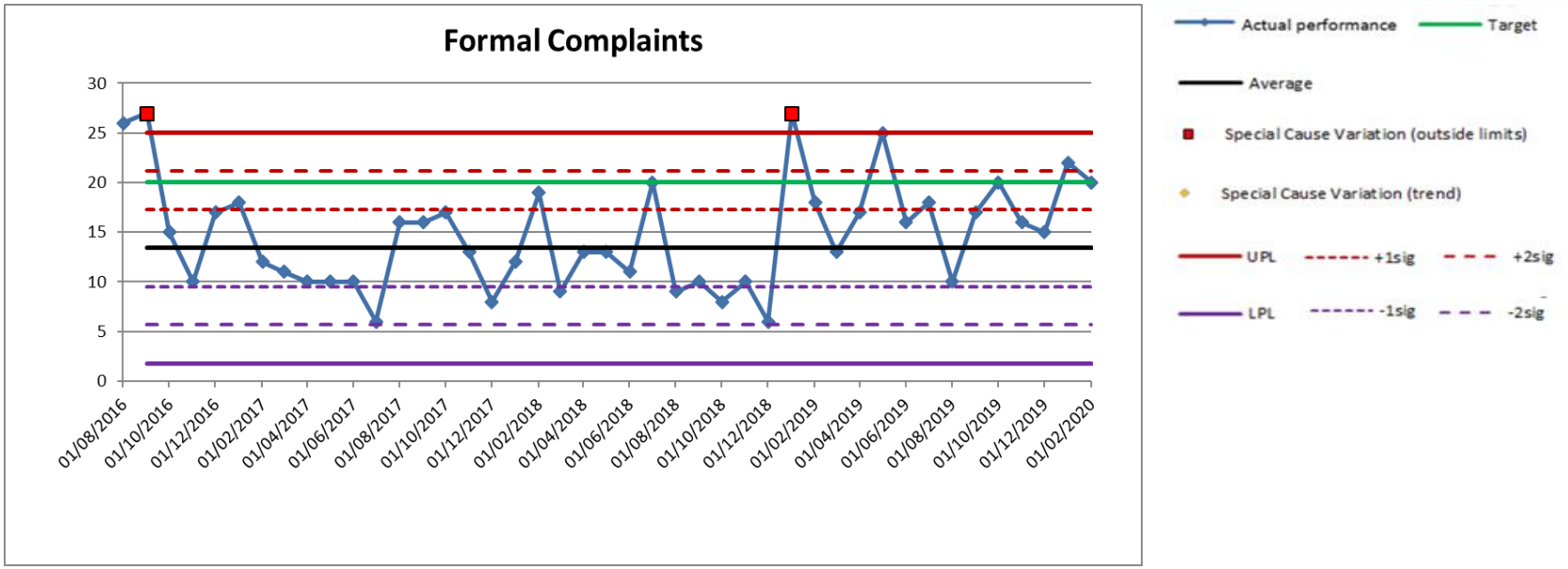


Narrative

Owner	Rowan Procter
What	Common Cause Variation
Why	Wards and departments provided less compliments to the patient experience team for central logging.
How	Our aim is for all compliments to be shared with the patient experience team.
When	Ongoing

Caring

Complaints

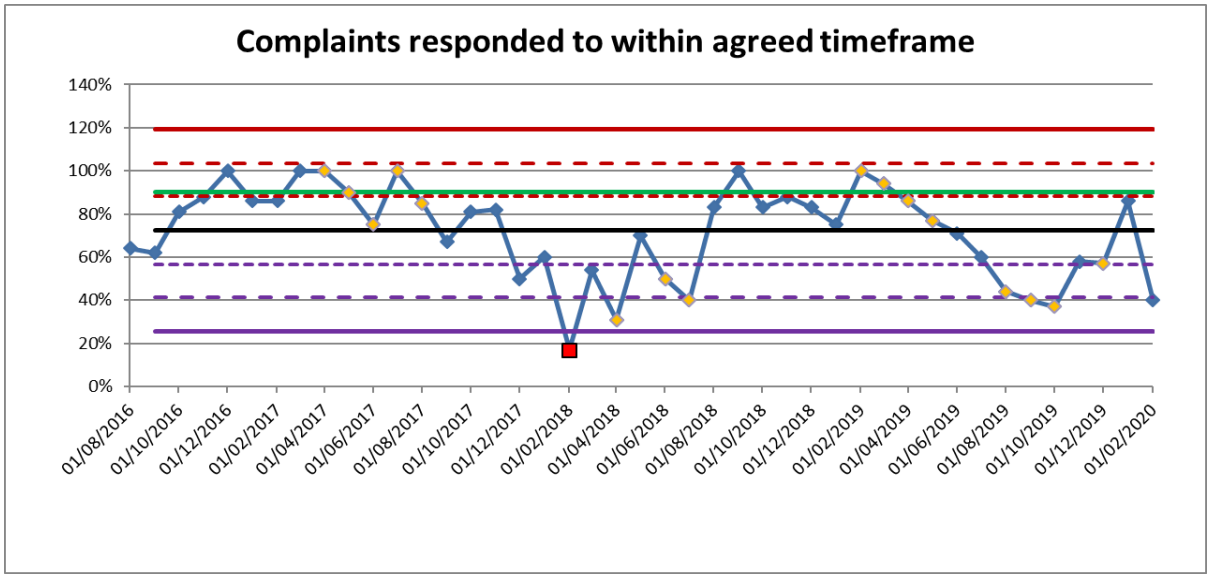


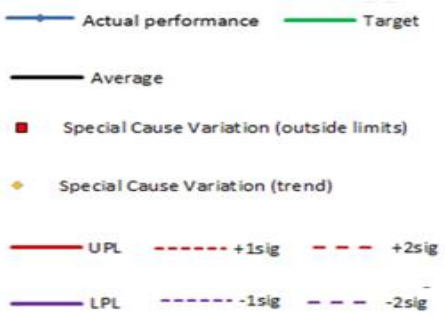
Narrative

Owner	Rowan Procter
What	Common Cause Variation
Why	Close analysis of themes and trends arising in complaints continues to be monitored across the Trust. Complaints continue to be of a complex nature with a higher proportion of 'red' and 'amber' complaints to previous years.
How	Restructure of patient experience team will allow much closer analysis and overview of all feedback being received to enable targeted work with areas across the Trust. This will combine all feedback channels, not just formal complaints and will help to address issues prior to escalation and encourage learning.
When	May 2020

Caring

Complaints responded to within agreed timeframe



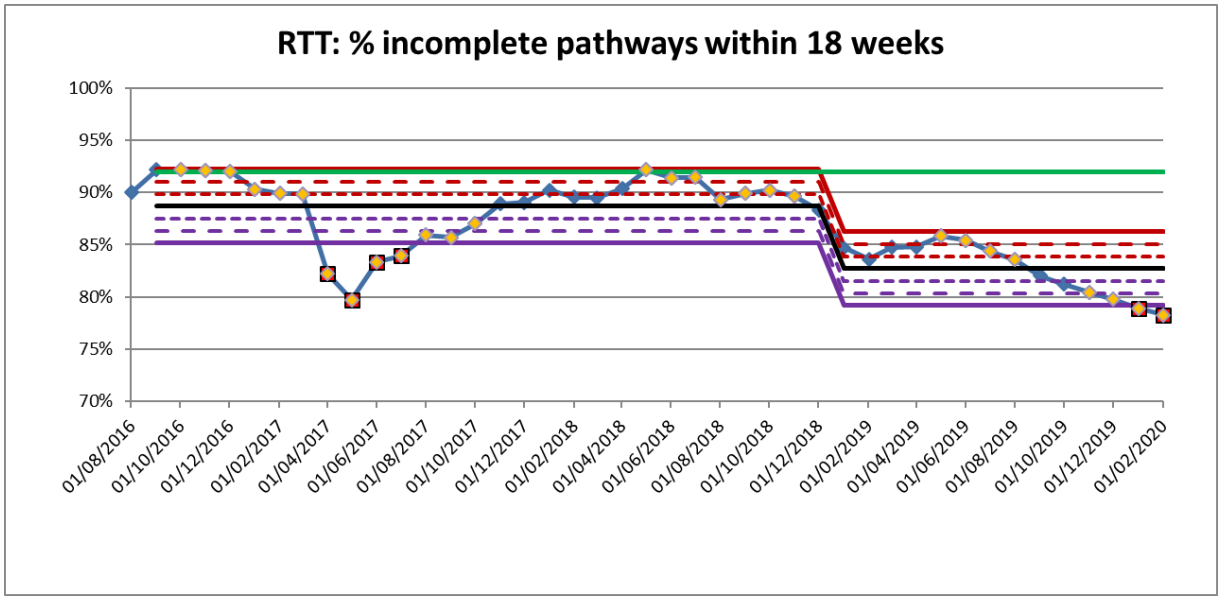


Narrative

Owner	Rowan Procter
What	Common Cause Variation
Why	The patient experience team remains in a difficult situation with regard to staffing which is continuing to impact on response timeframes.
How	Appointment of Patient Advice and Liaison Service Manager who can assist with complaint responses until appointment of Complaints Manager
When	April 2020

Caring

RTT

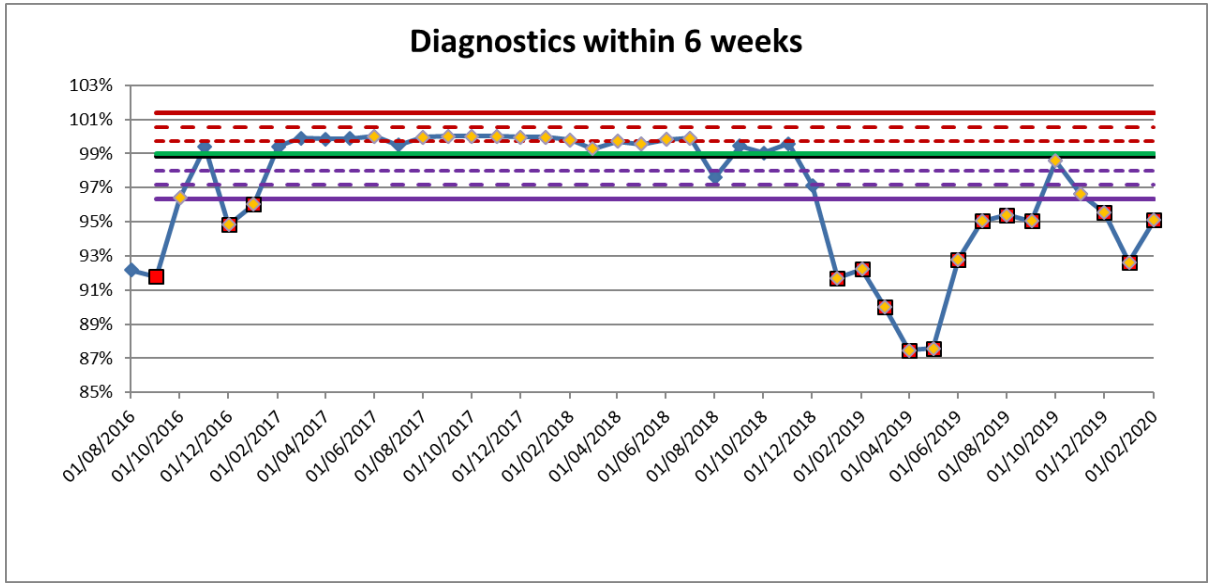


Narrative

Owner	Helen Beck
What	Special Cause Variation - Low
Why	Performance has remained around 78% for February, with significant underperformance in General Surgery, Trauma and Orthopaedics, Ophthalmology, Gastroenterology and Gynaecology, which are all performing well below the national average.
How	Business cases to be completed for General Surgery, Orthopaedics, Ophthalmology and Gynaecology, which will entail what is required and how it can be delivered to recover performance to 92%.
When	March 2020

Responsive

Diagnostics within 6 weeks

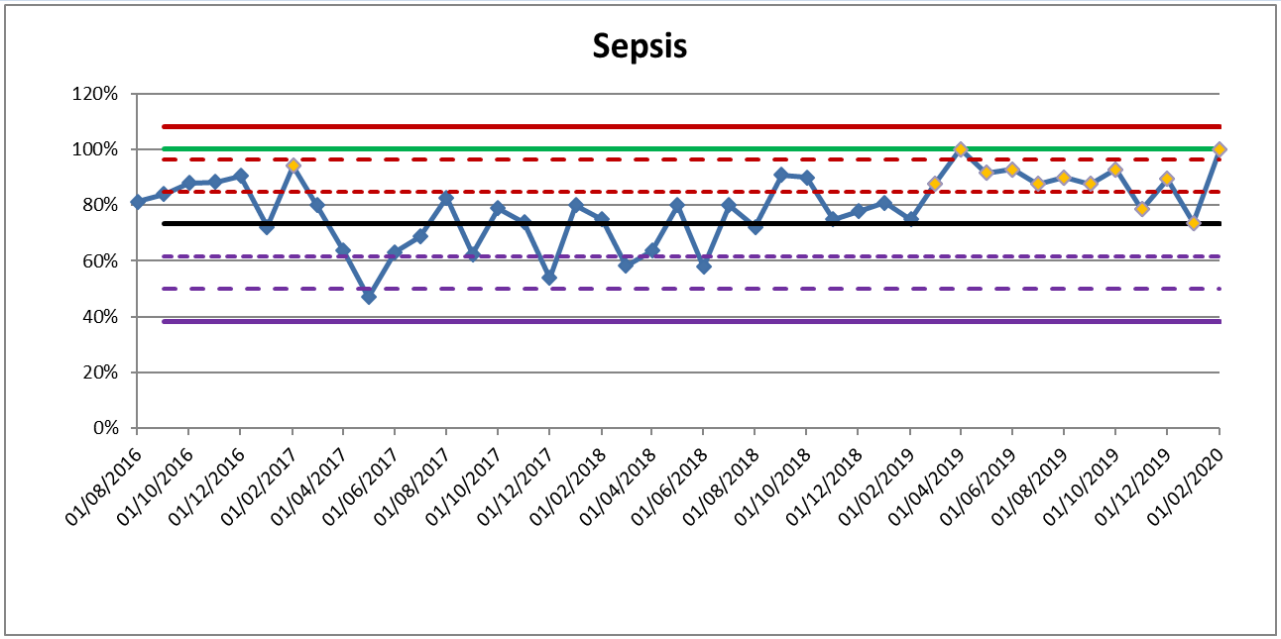


Narrative

Owner	Helen Beck
What	Special Cause Variation - Low
Why	The challenges within Endoscopy continue to be related to availability of scopers to undertake endoscopies. Alongside this, there are also challenges with nursing staff to be able to resource the lists due to vacancies, sickness and staffing of winter escalation.
How	The first meeting of the Endoscopy Oversight Group has taken place. The group explored options for increasing endoscopy capacity are being explored including releasing consultants from other activity (if able) and insourcing. A draft action plan is being reviewed and added to ensure that all areas for improvement identified by the Improvement Support Team are being addressed.
When	Ongoing

Responsive

Sepsis

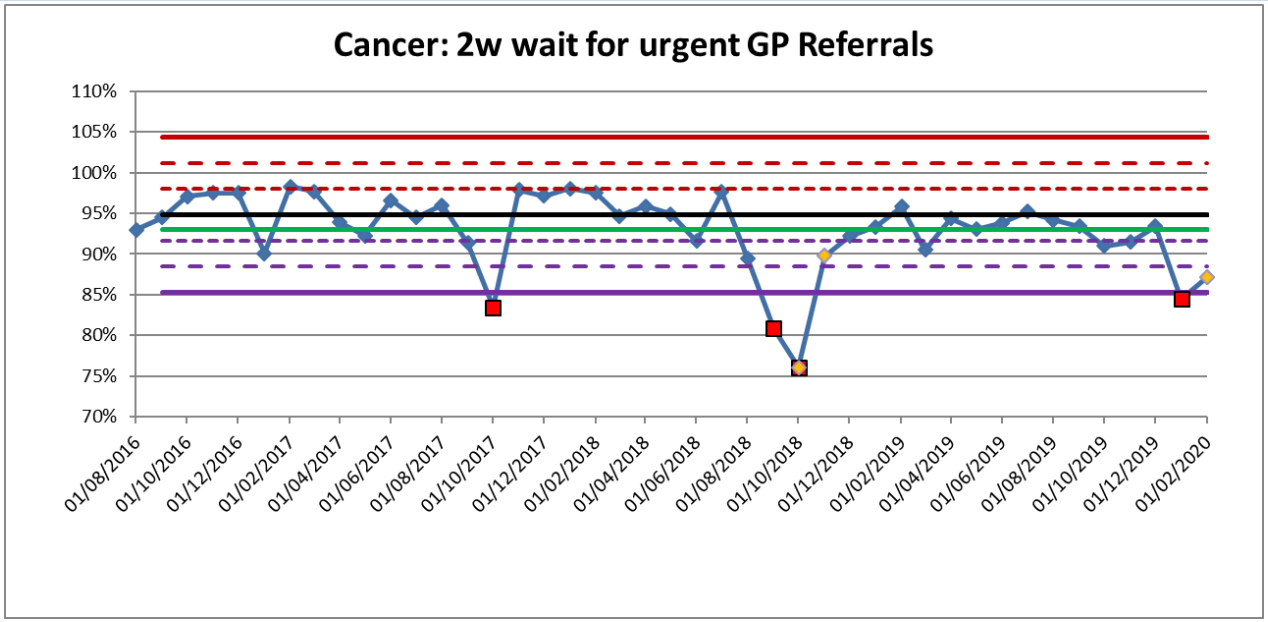


Narrative

Owner	Rowan Procter
What	Common Cause Variation
Why	Verbal update to be provided
How	Verbal update to be provided
When	Verbal update to be provided

Responsive

Cancer 2 week referral

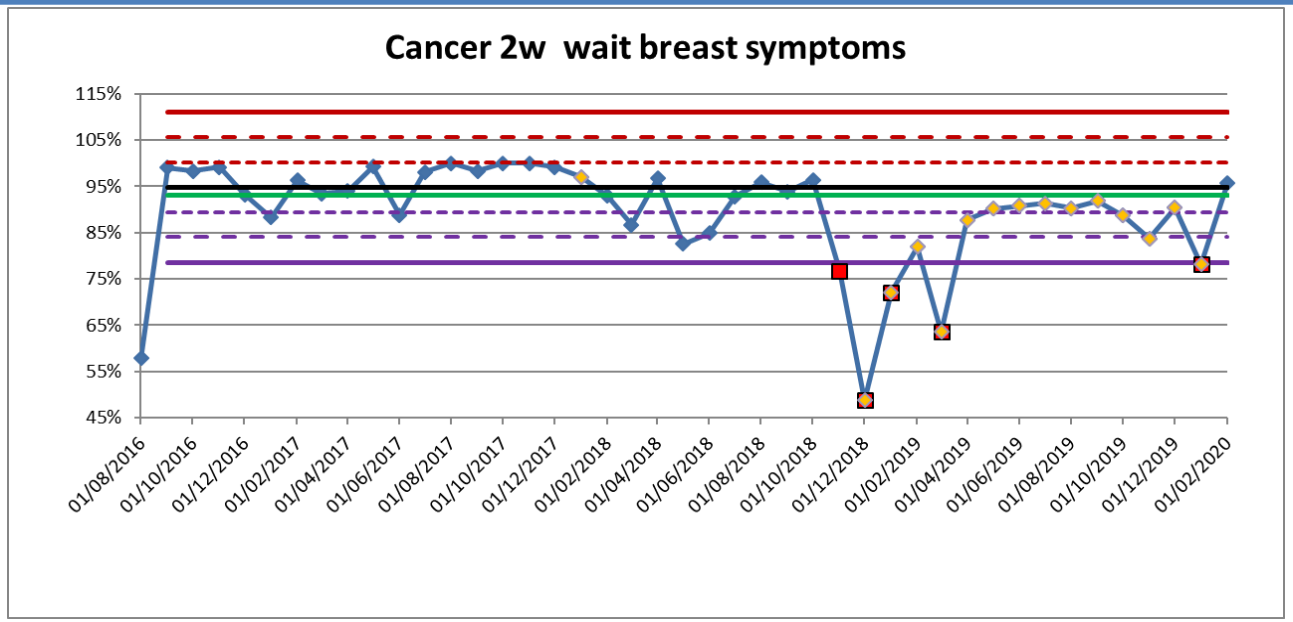


Narrative

Owner	Helen Beck
What	Special Cause Variation - Low
Why	There has been a slight improvement since January performance, which is mostly due to the recovery of Skin 2 week wait performance. However due to implementation of the straight to test service in Colorectal, this has, as predicted seen a decrease in the Colorectal 2 week wait performance as these patients are going straight to Endoscopy and thus improving on the 28 day performance, but not quite being seen within 2 weeks.
How	To improve on quality and the appropriateness of 2-week wait referrals, a revision to the first page of the 2-week wait referral form with appropriate changes in the clinical criteria across the specialty were agreed by the SNEE Cancer Locality meeting. This change is currently in the process of final approval by the Clinical Commissioning group for introduction across the Integrate Care system. These changes are aimed to help improve patient awareness and availability within 14 days for referral and support demand management in the Trust.
When	March 2020

Responsive

Cancer 2 week referral Breast

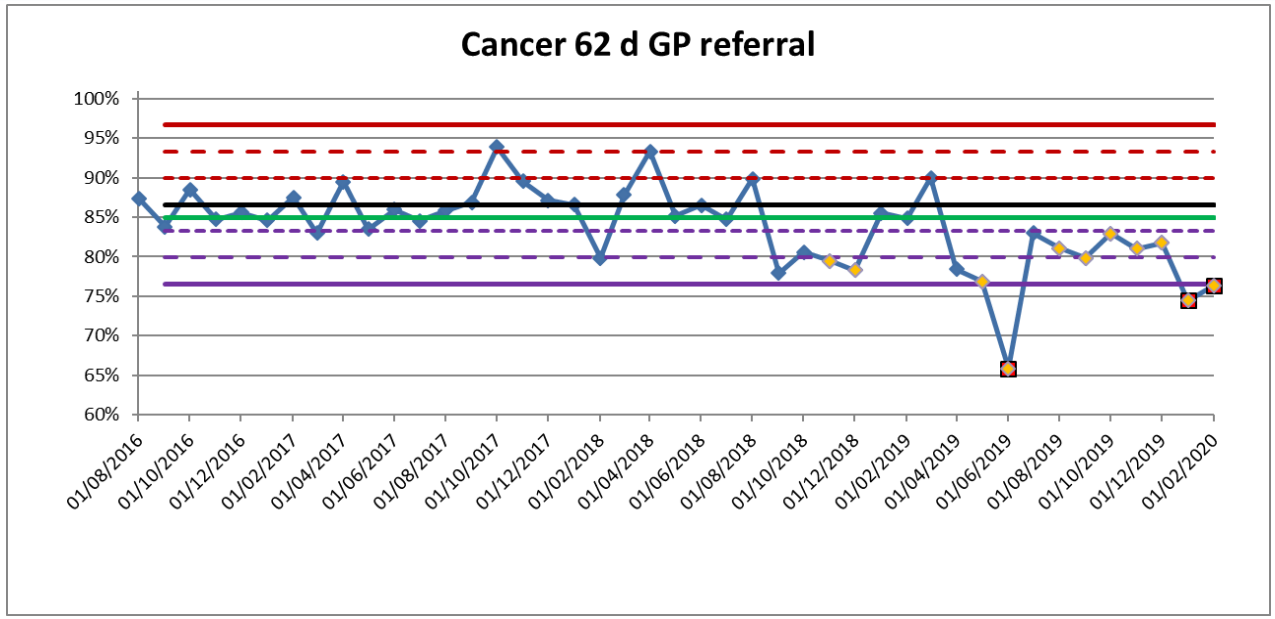


Narrative

Owner	Helen Beck
What	Common Cause Variation
Why	Verbal Update to be provided
How	Verbal Update to be provided
When	Verbal Update to be provided

Responsive

Cancer 62 Day

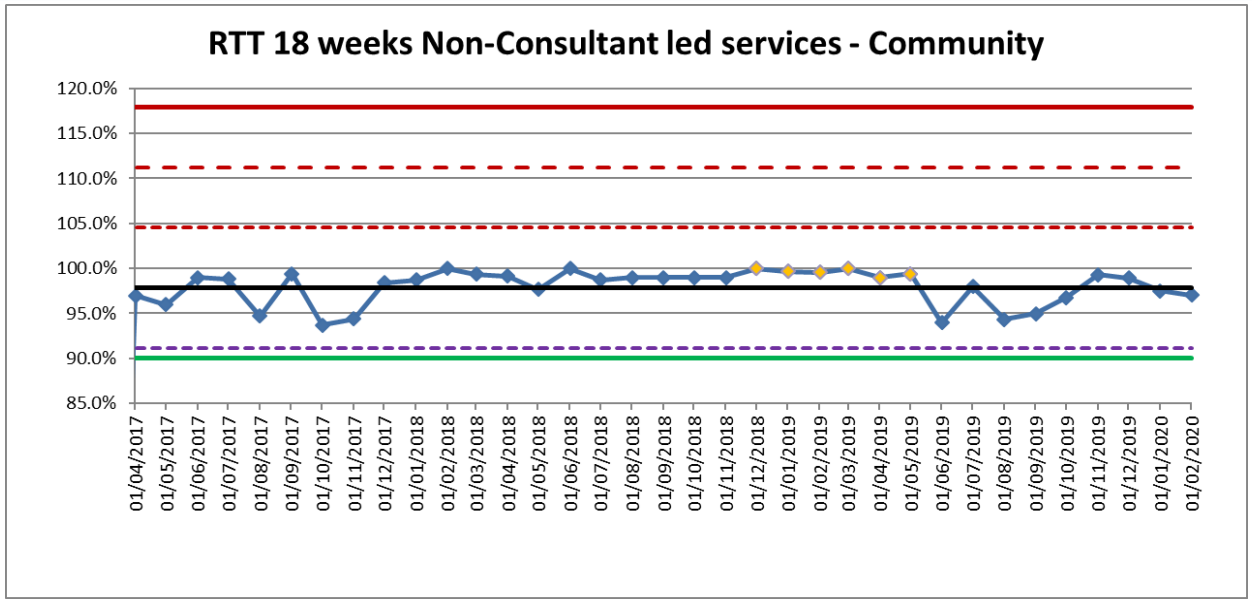


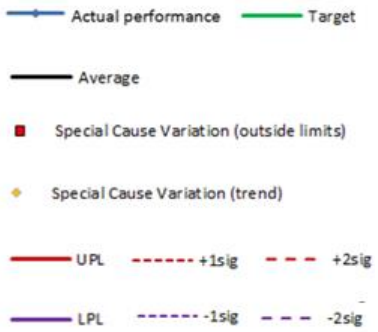
Narrative

Owner	Helen Beck
What	Special Cause Variation - Low
Why	Current performance is 76% owing to 19.5 treatments over 62 days. This is broken down as follows - 5 x Colorectal, 9 x Urology, 2 x Skin, 1 x Head and Neck, 1 x Haematology, 1 x Breast and 0.5 Gynaecology.
How	Prostate biopsies to move from Day Surgery to Johanna Finn diagnostic unit.
When	March 2020

Responsive

RTT non consultant led



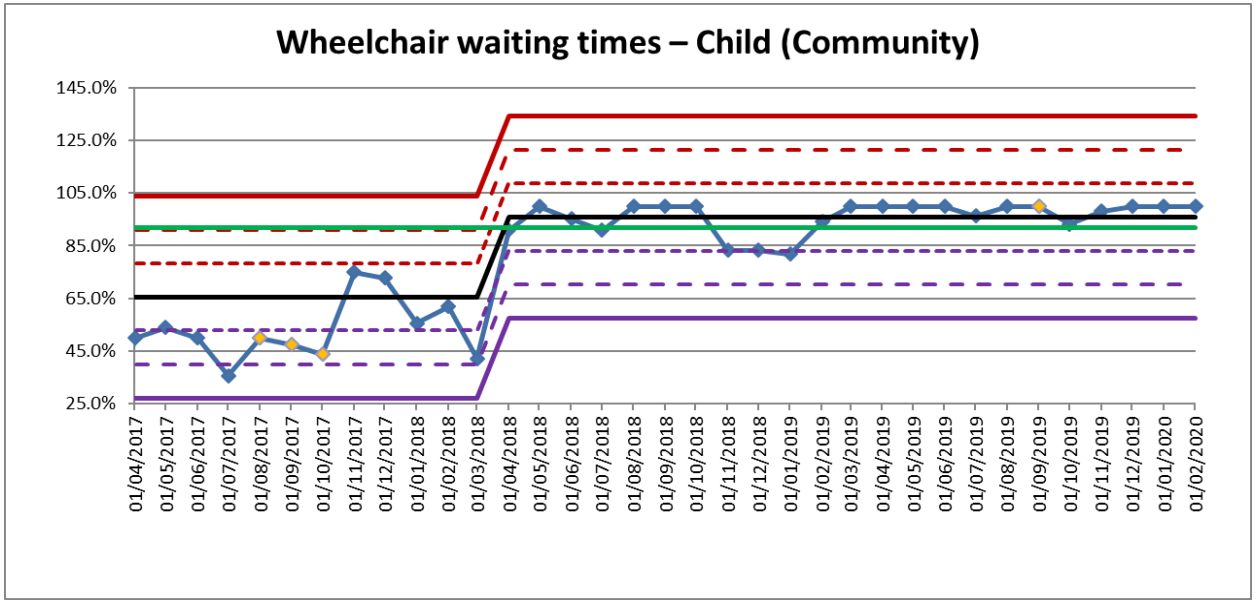


Narrative

Owner	Helen Beck
What	Common Cause Variation
Why	Verbal update to be provided
How	Verbal update to be provided
When	Verbal update to be provided

Community

Wheelchair waiting times – Child (Community)

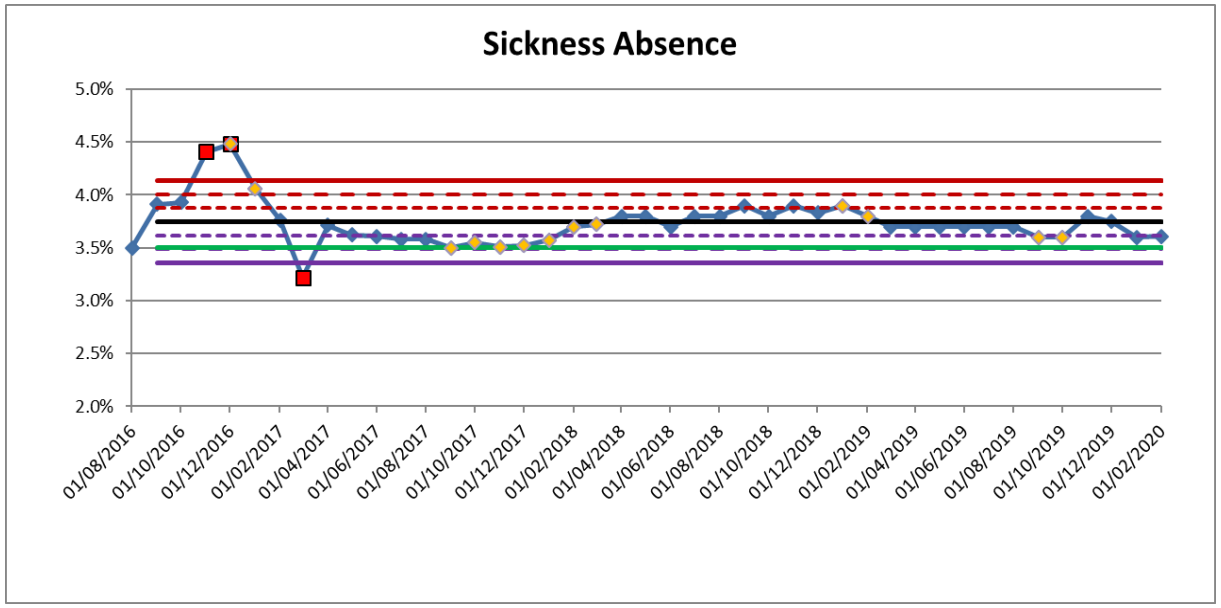


Narrative

Owner	**Helen Beck**
What	**Common Cause Variation**
Why	Verbal update to be provided
How	Verbal update to be provided
When	Verbal update to be provided

Community

Sickness absence

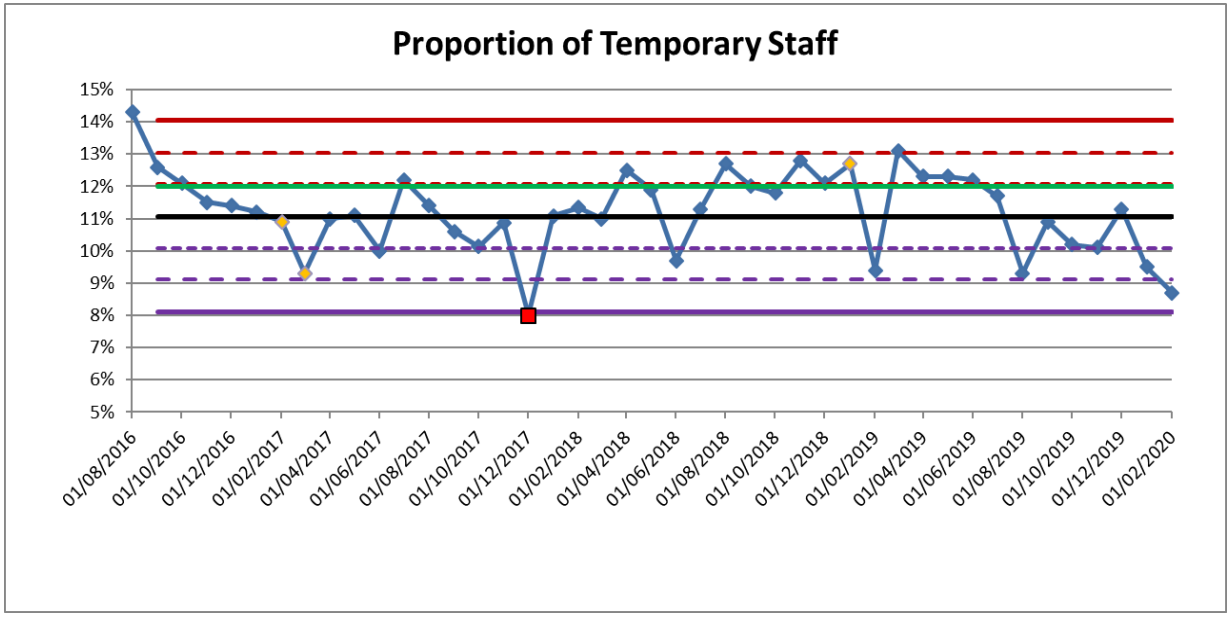


Narrative

Owner	Jeremy Over
What	Common Cause Variation
Why	Current sickness absence levels are 0.2% lower than in February 2019. When compared to other NHS organisations we are below other comparable organisations. NHS in England is 4.21%. East of England trusts 4.01%. Acute trusts in England 4.04% and Community providers 4.59% (figures NHS Data September 2019)
How	With regard to musculoskeletal problems, we will review the trusts' staff physiotherapy service, as the levels of referral continue to rise.
When	September 2020

Well Led

Proportion of temporary staff

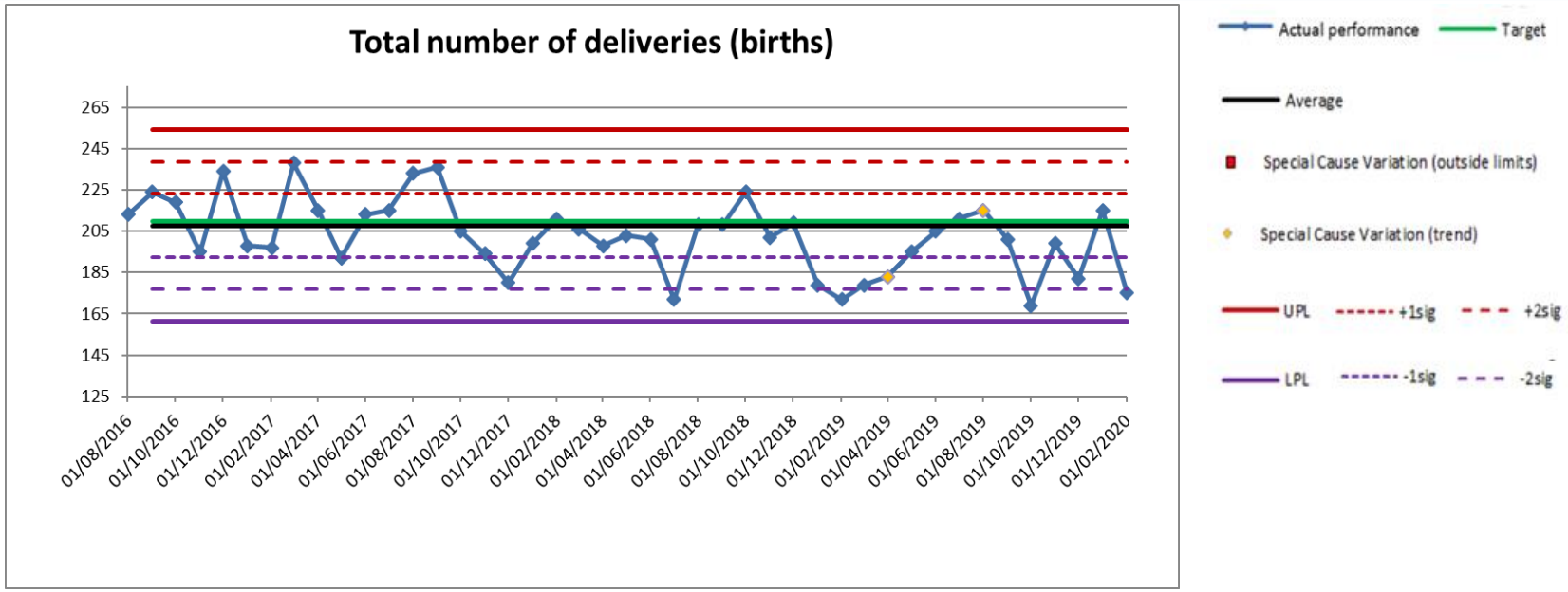


Narrative

Owner	-
What	Common Cause Variation
Why	Verbal update to be provided
How	Verbal update to be provided
When	Verbal update to be provided

Well Led

Total number of deliveries

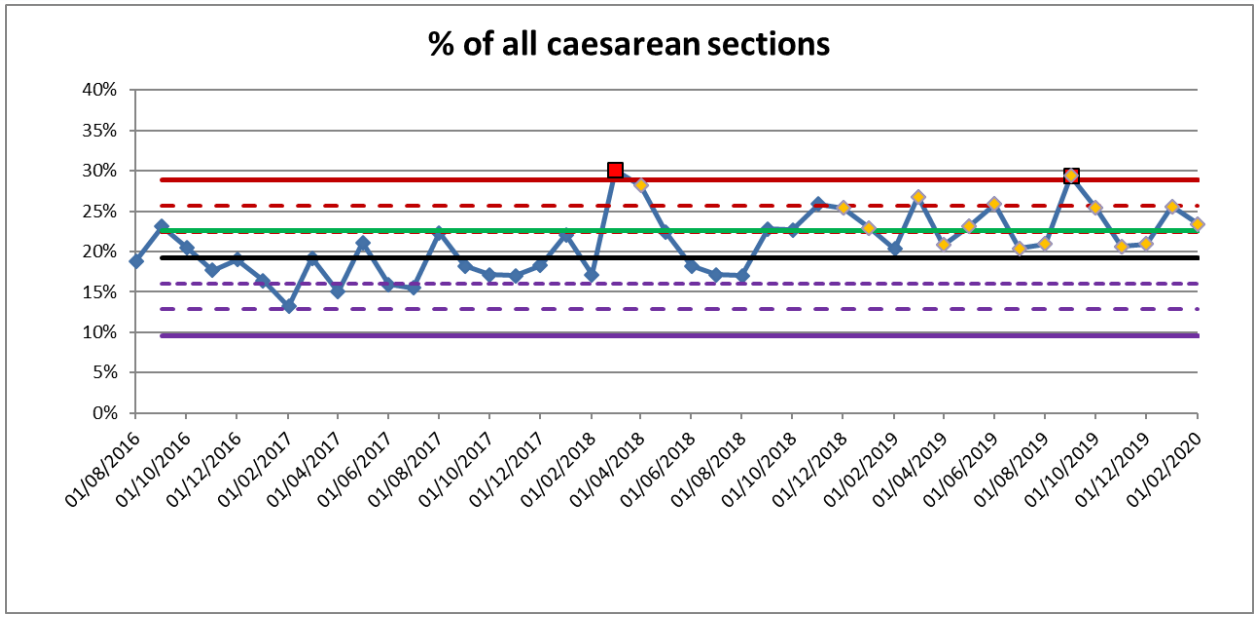


Narrative

Owner	Rowan Procter
What	Special Cause Variation - High
Why	The number of deliveries naturally fluctuates from month to month. The overall trend does appear to fall below the expected number on average and this is reflected in trends nationwide (Office of National Statistics).
How	Continue to monitor birth rates monthly and discuss at the next Women Health Governance meeting on 16/03/2020.
When	16/03/2020

Maternity

Caesarean section rate

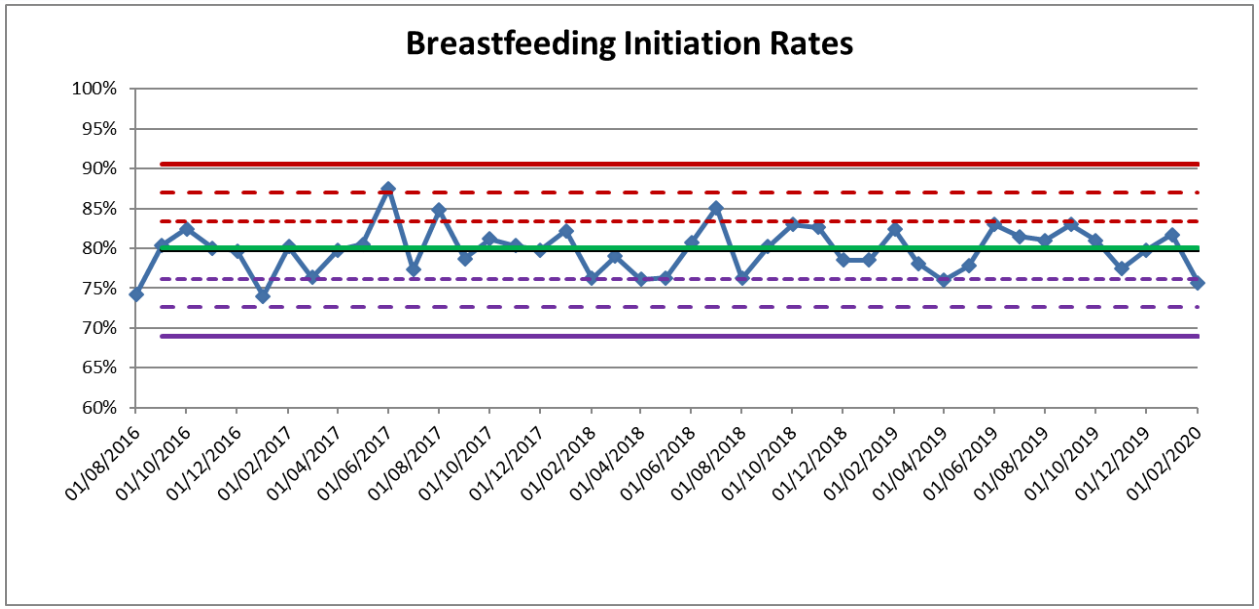


Narrative

Owner	Rowan Procter
What	Special Cause Variation - High
Why	Verbal update to be provided
How	Verbal update to be provided
When	Verbal update to be provided

Maternity

Breast feeding initiation



Narrative

Owner	Rowan Procter
What	Common Cause Variation
Why	The initiation of breastfeeding rate for February was 75.7%, down from the 81.7% in January. There were fewer births in February and this adversely affected the rate. 48 of the 173 mothers gave an initial formula feed. A breakdown of the formula feeding percentage by midwifery team geographical areas shows Castle Hill (15) 31.3%, Lark (12) 25%, Gainsborough (10) 20.8%, Forest Heath (7) 14.6% and Out of area (4) 8.3%. The information will be forwarded to the Midwifery Team Leads to enable them to consider the prevalence of formula feeding in their localities.
How	Midwifery team leads asked to examine the data for their particular team and report to the Infant Feeding Co-ordinator. This is data that has not previously been collected, and it may help to enable targeted action in areas where formula feeding is more prevalent. This is turn, could help to improve the breastfeeding initiation rates.
When	May 2020

9. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – February 2020

Agenda item:	Item 9			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	20th March 2020			
Subject:	Finance and Workforce Board Report – February 2020			
Purpose:		For information	x	For approval

Executive summary:
The reported I&E for February is a deficit of £1.1m, against a planned deficit of £1.6m. This results in a favourable variance of £0.5m in February (£3.1m YTD).

The Trust is forecasting to meet its control total for 2019-20 which is to break even. As a result the Trust anticipates receiving all PSF/FRF associated with meeting its control total.

Costs relating to COVID 19 are being captured and we expect these to be fully funded. Therefore the forecast is unaffected.

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
FEBRUARY 2020 (Month 11)

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

Financial Summary

I&E Position YTD	-£0.8m	loss
Variance against plan YTD	-£3.0m	adverse
Movement in month against plan	£0.5m	favourable
EBITDA position YTD	-£0.4m	adverse
EBITDA margin YTD	-0.2%	adverse
Total PSF Received	£9.355m	accrued
Cash at bank	£1.3m	

Executive Summary

- The planned surplus for the year to date was £2.3m but the actual deficit was £0.8m, an adverse variance of £3.1m.
- This position includes funding associated with a significant increase in activity during 2019-20. As a result the Trust anticipates receiving all PSF/FRF associated with meeting its control total.
- The Trust is forecasting to meet its control total for 2019-20 which is to break even.
- This forecast assumes all costs relating to COVID 19 are fully funded

Key Risks

- Delivery of £8.9m CIP programme
- Capturing all COVID 19 related costs and being fully reimbursed for these

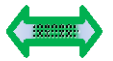
SUMMARY INCOME AND EXPENDITURE ACCOUNT - February 2020	Feb-20			Year to date			Year end forecast		
	Budget £m	Actual £m	Variance F/(A) £m	Budget £m	Actual £m	Variance F/(A) £m	Budget £m	Actual £m	Variance F/(A) £m
NHS Contract Income	16.6	15.0	(1.6)	205.9	207.6	1.7	224.9	226.4	1.5
Other Income	2.5	6.5	4.0	26.5	29.9	3.4	29.0	32.2	3.2
Total Income	**19.1**	**21.5**	**2.4**	**232.4**	**237.5**	**5.1**	**253.8**	**258.6**	**4.8**
Pay Costs	14.6	15.1	(0.6)	157.9	160.9	(3.0)	172.4	176.3	(3.9)
Non-pay Costs	6.2	7.9	(1.6)	73.3	77.0	(3.7)	80.5	82.0	(1.5)
Operating Expenditure	**20.8**	**23.0**	**(2.3)**	**231.2**	**237.9**	**(6.7)**	**252.8**	**258.3**	**(5.4)**
Contingency and Reserves	0.0	0.0	0.0	(2.9)	0.0	(2.9)	(0.9)	0.0	(0.9)
EBITDA excl STF	**(1.7)**	**(1.5)**	**0.1**	**4.1**	**(0.4)**	**(4.5)**	**1.9**	**0.3**	**(1.6)**
Depreciation	0.7	0.5	0.1	7.4	6.7	0.7	8.1	7.4	0.7
Finance costs	0.3	0.1	0.2	3.6	3.0	0.5	3.9	3.3	0.6
SURPLUS/(DEFICIT)	**(2.7)**	**(2.1)**	**0.5**	**(6.8)**	**(10.1)**	**(3.3)**	**(10.1)**	**(10.4)**	**(0.3)**
Provider Sustainability Funding (PSF)									
MRET, FRF/PSF - Financial Performance	1.0	1.0	0.0	9.1	9.4	0.3	10.1	10.4	0.3
SURPLUS/(DEFICIT) incl PSF	**(1.6)**	**(1.1)**	**0.5**	**2.3**	**(0.8)**	**(3.0)**	**0.0**	**(0.0)**	**0.0**

FINANCE AND WORKFORCE REPORT – FEBRUARY 2020

Contents:

Key:

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

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

FINANCE AND WORKFORCE REPORT – FEBRUARY 2020

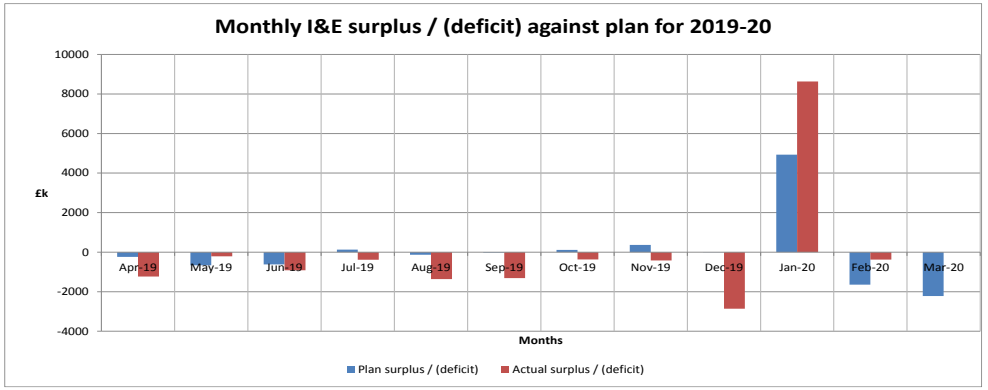
Income and Expenditure Summary as at February 2020

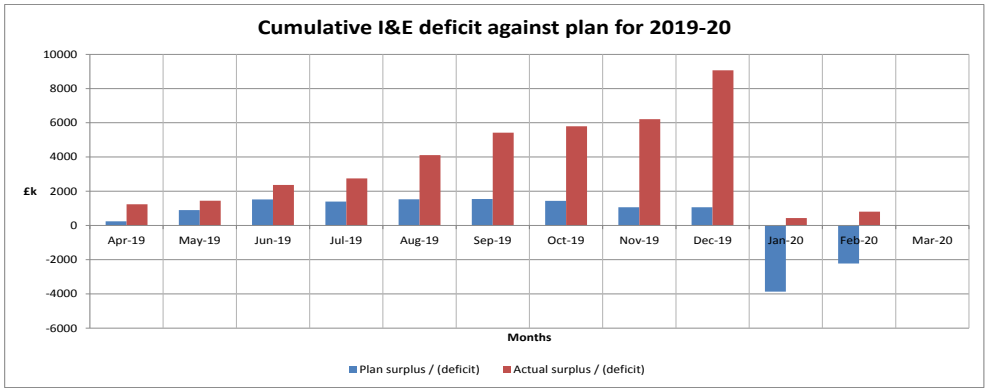
The reported I&E for February is a deficit of £1.1m, against a planned deficit of £1.6m. This results in a favourable variance of £0.5m in February (£3.1m YTD).

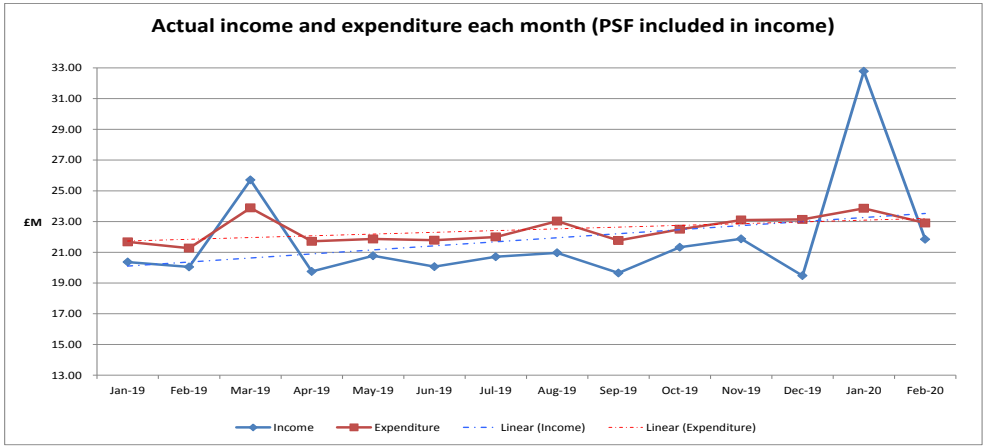
The Trust is forecasting to meet its control total for 2019-20 which is to break even. As a result the Trust anticipates receiving all PSF/FRF associated with meeting its control total.

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)	(1,642)	(1,093)	550	↓	Red
YTD surplus / (deficit)	2,228	(807)	(3,035)	↓	Amber
Forecast surplus / (deficit)	9	9	(0)	↔	Amber
EBITDA (excl STF) YTD	4,109	(428)	(4,537)	↓	Red
EBITDA (%)	1.7%	(0.2%)	(1.9%)	↓	Red
Clinical Income YTD	(198,678)	(200,340)	1,662	↑	Green
Non-Clinical Income YTD	(42,809)	(46,499)	3,690	↑	Green
Pay YTD	157,871	160,913	(3,042)	↑	Red
Non-Pay YTD	81,388	86,733	(5,345)	↑	Red
CIP target YTD	8,267	8,347	80	↑	Amber





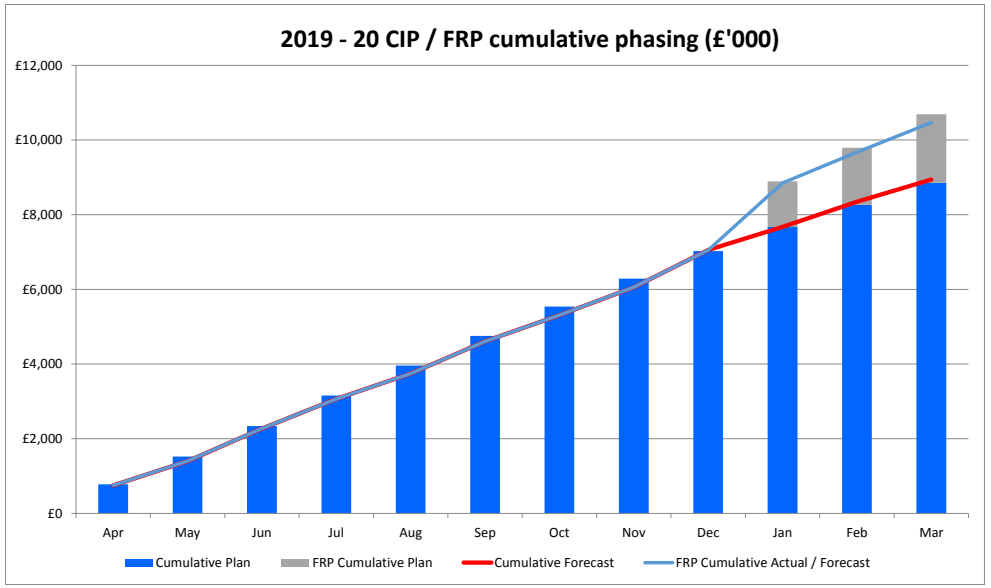


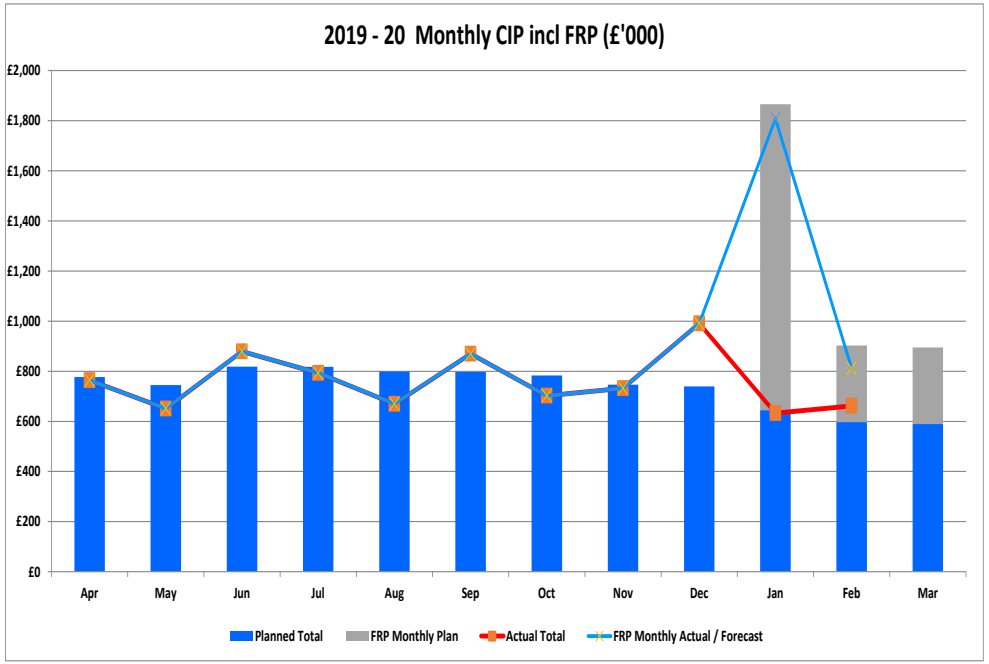
Cost Improvement Programme (CIP) 2019-20

In order to deliver the Trust's control target in 2019-20 we needed to deliver a CIP of £8.9m (4%). By February we planned to achieve £8,267k (93.3% of the annual plan) but achieved £8,347k (94.3%), £80k ahead of plan.

We have also developed a Financial Recovery Plan (FRP) to deliver £1.8m of savings this year. By February we planned to achieve £1,526k (83.3% of the FRP) but achieved £1,325k (72.4%), 201k behind plan.

Recurring/Non Recurring	2019-20 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	100	92	84
Procurement	696	637	978
Activity growth	-	-	-
Additional sessions	15	14	3
Community Equipment Service	575	564	483
Drugs	1,740	1,715	1,855
Estates and Facilities	60	55	75
Other	1,344	1,175	1,427
Other Income	1,740	1,633	1,707
Pay controls	361	331	276
Service Review	20	18	13
Staffing Review	1,076	997	866
Theatre Efficiency	178	160	71
Recurring Total	**7,905**	**7,390**	**7,838**
Non-Recurring			
Estates and Facilities	87	81	-
Other	489	449	122
Pay controls	376	347	387
Non-Recurring Total	**951**	**877**	**509**
Total CIP	**8,856**	**8,267**	**8,347**
Financial Recovery Plan			
Pay Controls	443	369	242
Additional Sessions	294	245	124
Non Pay	143	119	90
Drugs	252	210	252
Medical	58	48	46
Nursing	138	115	113
Income	131	109	129
Other Income	72	60	72
Agency	45	38	50
Other	256	213	207
Total FRP	**1,832**	**1,526**	**1,325**
Grand Total	**10,688**	**9,793**	**9,673**

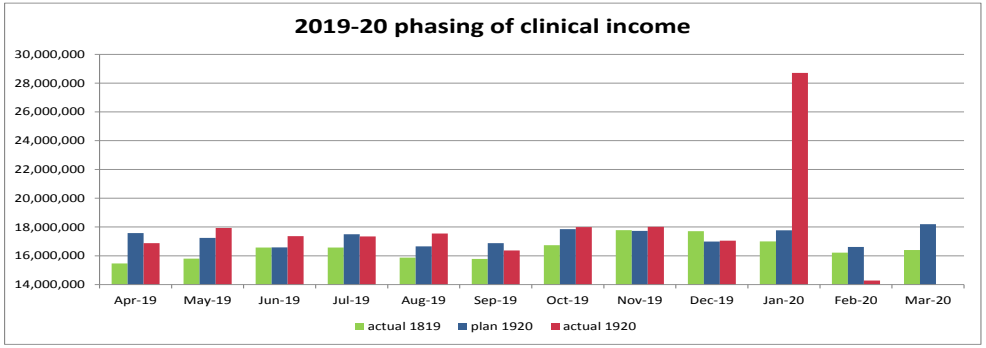




FINANCE AND WORKFORCE REPORT – FEBRUARY 2020

Income Analysis

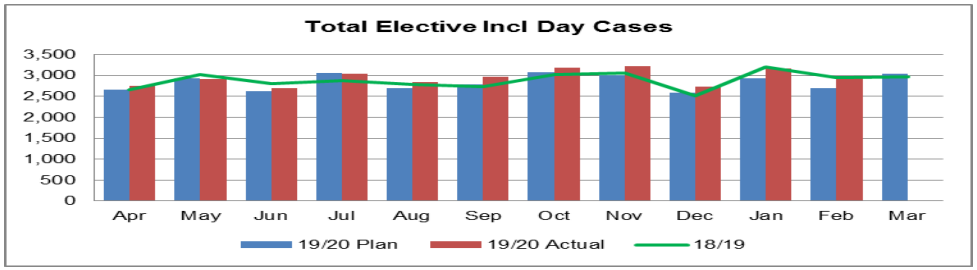
The chart below demonstrates the phasing of all clinical income plan for 2019-20, including Community Services. This phasing is in line with phasing of activity.

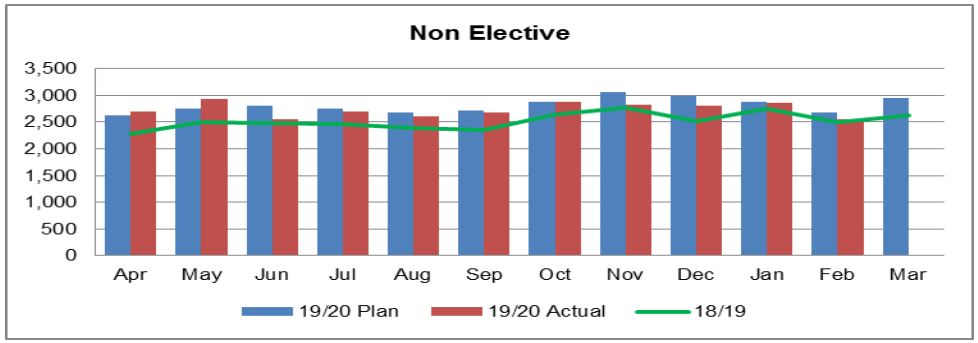


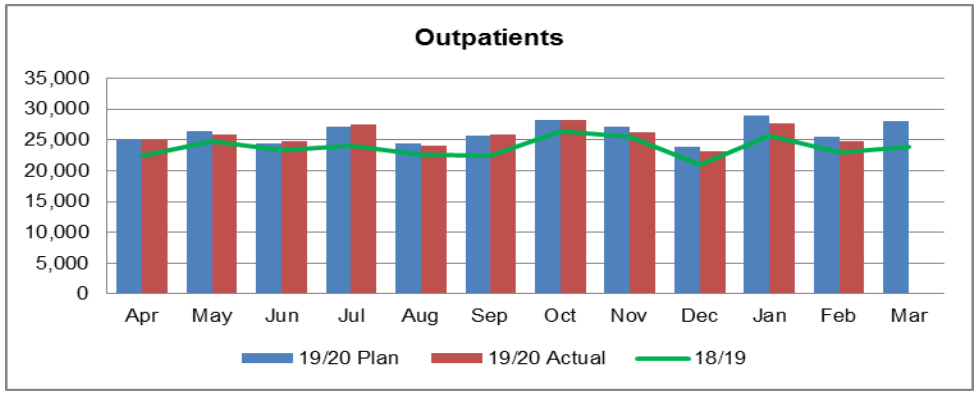
The income position was under plan for February. The main area of underperformance were within Other Services.

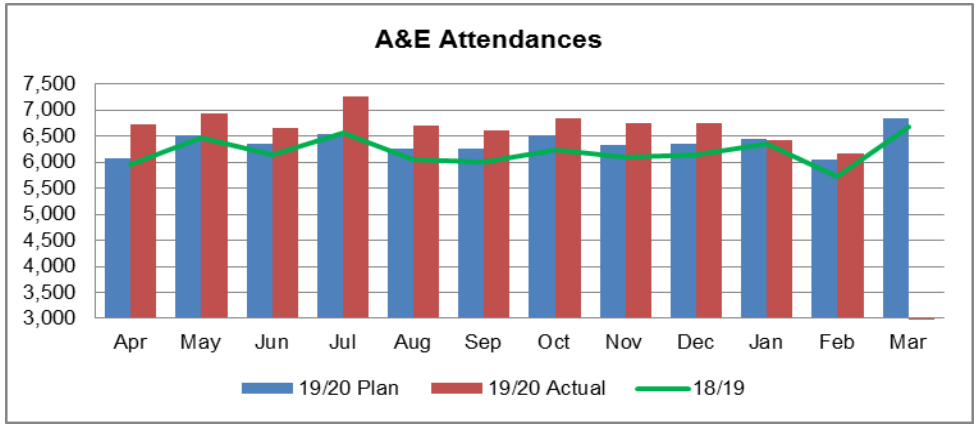
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	860	905	44	9,917	10,675	758
Other Services	1,174	(827)	(2,001)	36,801	37,310	509
CQUIN	166	172	5	1,893	1,898	5
Elective	2,555	2,984	429	30,283	30,721	438
Non Elective	6,138	6,079	(59)	68,583	68,336	(247)
Emergency Threshold Adjustment	(335)	(335)	0	(3,801)	(3,801)	0
Outpatients	3,058	3,057	(2)	34,480	34,274	(206)
Community	2,988	2,988	0	27,787	28,192	405
Total	**16,605**	**15,022**	**(1,583)**	**205,943**	**207,605**	**1,662**

Activity, by point of delivery



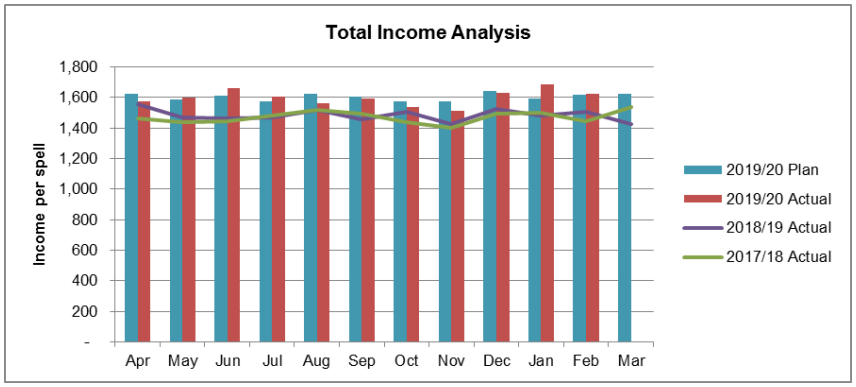


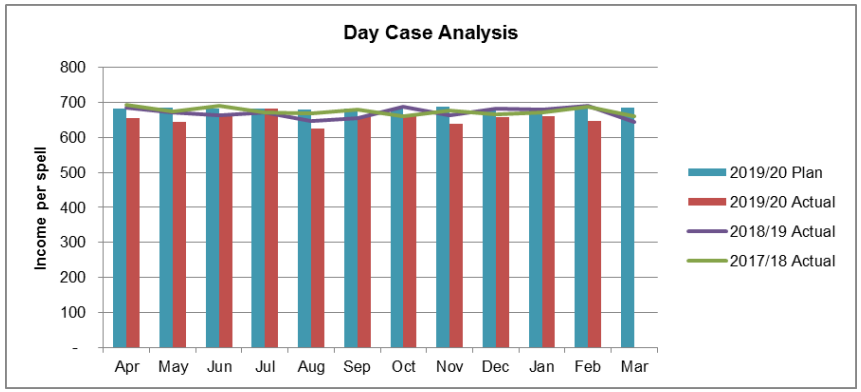


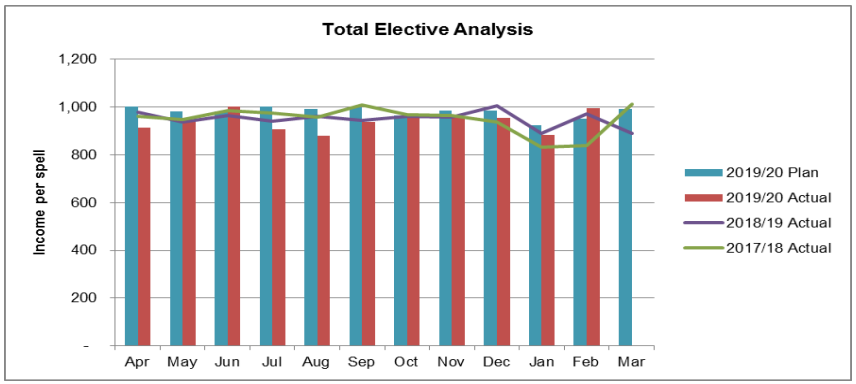


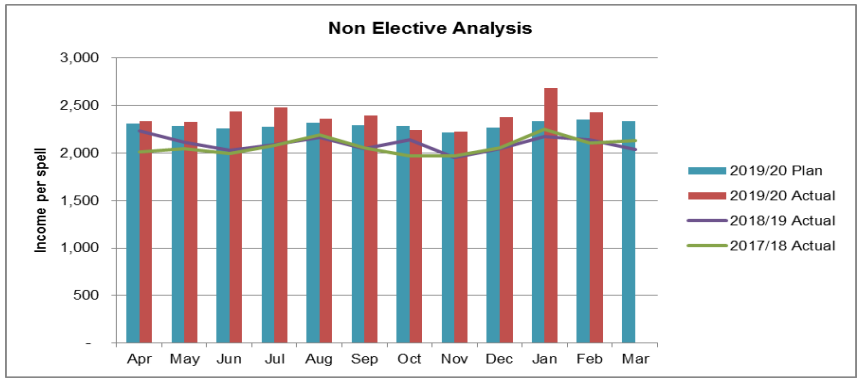
FINANCE AND WORKFORCE REPORT – FEBRUARY 2020

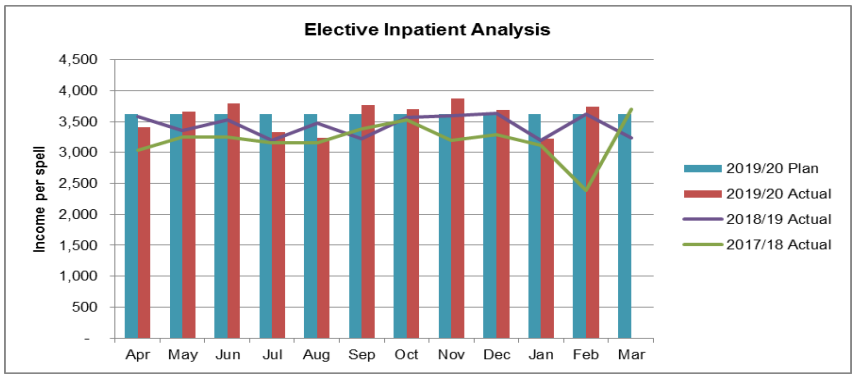
Trends and Analysis

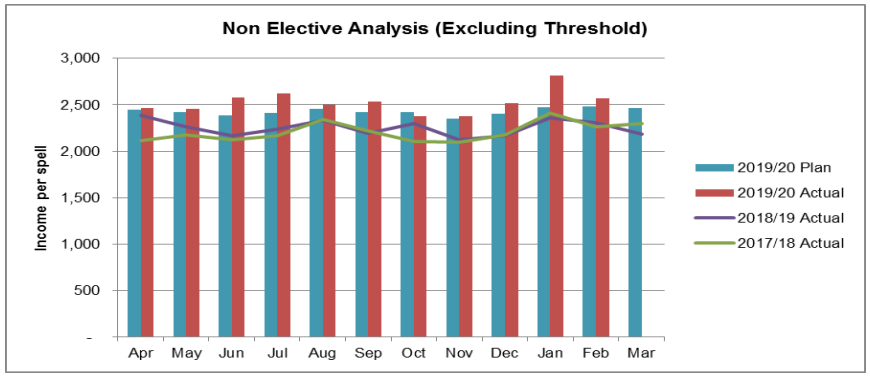












FINANCE AND WORKFORCE REPORT – FEBRUARY 2020

Workforce

Monthly Expenditure (£) Acute services only				
As at February 2020	Feb-20	Jan-20	Feb-19	YTD 2019/20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**12,816**	**12,802**	**11,905**	**138,837**
Substantive Staff	11,806	11,915	10,670	125,531
Medical Agency Staff (includes 'contracted in' staff)	183	43	131	1,637
Medical Locum Staff	234	344	246	3,014
Additional Medical sessions	214	161	272	2,729
Nursing Agency Staff	127	87	95	1,487
Nursing Bank Staff	365	290	244	3,175
Other Agency Staff	135	57	18	829
Other Bank Staff	161	155	122	1,594
Overtime	59	50	180	1,247
On Call	70	68	73	752
Total temporary expenditure	1,550	1,255	1,380	16,462
Total expenditure on pay	**13,356**	**13,169**	**12,050**	**141,993**
Variance (F/(A))	(540)	(367)	(145)	(3,157)
Temp Staff costs % of Total Pay	11.6%	9.5%	11.5%	11.6%
Memo : Total agency spend in month	445	188	244	3,952

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at February 2020	Feb-20	Jan-20	Feb-19
	WTE	WTE	WTE
Budgeted WTE in month	**3,348.2**	**3,352.4**	**3,238.3**
Employed substantive WTE in month	3161.39	3150.34	2959.31
Medical Agency Staff (includes 'contracted in' staff)	11.67	4.24	14.56
Medical Locum	27.46	29.38	5.28
Additional Sessions	17.34	13.55	16.04
Nursing Agency	27.54	12.41	24.09
Nursing Bank	105.55	87.95	73.99
Other Agency	21.62	11.29	5.35
Other Bank	67.7	61.72	53.59
Overtime	14.6	10.32	51.79
On call Worked	6.04	6.27	6.86
Total equivalent temporary WTE	**299.5**	**237.1**	**251.6**
Total equivalent employed WTE	**3,460.9**	**3,387.5**	**3,210.9**
Variance (F/(A))	(112.7)	(35.1)	27.4
Temp Staff WTE % of Total Pay	8.7%	7.0%	7.8%
Memo : Total agency WTE in month	60.8	27.9	44.0
Sickness Rates (January/December)	4.05%	4.05%	4.24%
Mat Leave	1.91%	2.12%	2.79%

Monthly Expenditure (£) Community Service Only				
As at February 2020	Feb-20	Jan-20	Feb-19	YTD 2019-20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,753**	**1,753**	**1,561**	**19,035**
Substantive Staff	1,726	1,683	1,506	18,084
Medical Agency Staff (includes 'contracted in' staff)	(6)	12	8	104
Medical Locum Staff	3	7	3	47
Additional Medical sessions	1	2	1	12
Nursing Agency Staff	11	1	17	157
Nursing Bank Staff	27	25	24	288
Other Agency Staff	(1)	8	4	47
Other Bank Staff	9	6	7	82
Overtime	4	4	4	61
On Call	3	3	2	38
Total temporary expenditure	52	68	71	836
Total expenditure on pay	**1,778**	**1,751**	**1,577**	**18,920**
Variance (F/(A))	(25)	1	(16)	114
Temp Staff costs % of Total Pay	2.9%	3.9%	4.5%	4.4%
Memo : Total agency spend in month	5	21	29	308

Monthly Whole Time Equivalents (WTE) Community Services Only			
As at February 2020	Feb-20	Jan-20	Feb-19
	WTE	WTE	WTE
Budgeted WTE in month	**542.12**	**542.07**	**486.25**
Employed substantive WTE in month	513.72	507.73	472.61
Medical Agency Staff (includes 'contracted in' staff)	0.00	0.74	0.51
Medical Locum	0.35	0.35	0.35
Additional Sessions	0.00	0.00	0.00
Nursing Agency	1.58	0.20	2.36
Nursing Bank	7.66	7.74	6.95
Other Agency	4.48	3.39	1.92
Other Bank	2.69	1.81	2.15
Overtime	1.30	1.19	1.37
On call Worked	0.00	0.04	0.00
Total equivalent temporary WTE	**18.1**	**15.5**	**15.6**
Total equivalent employed WTE	**531.8**	**523.2**	**488.2**
Variance (F/(A))	10.34	18.88	(1.97)
Temp Staff WTE % of Total Pay	3.4%	3.0%	3.2%
Memo : Total agency WTE in month	6.1	4.3	4.8
Sickness Rates (January/December)	4.68%	4.13%	4.73%
Mat Leave	3.37%	3.44%	3.35%

FINANCE AND WORKFORCE REPORT – FEBRUARY 2020

Pay Trends and Analysis

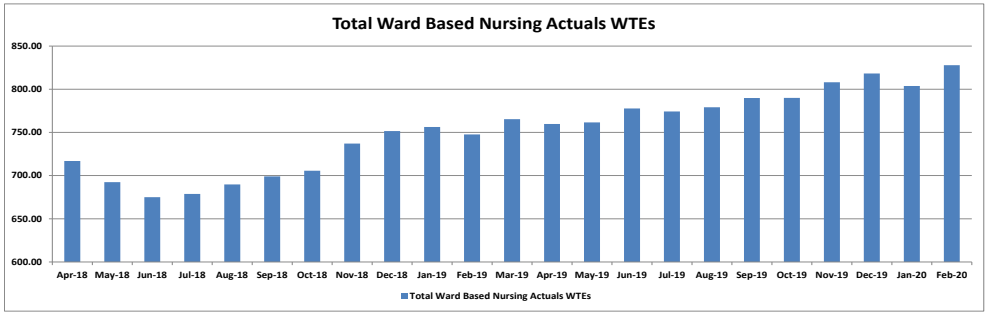
Nursing – Staffing levels

The tables below compare actual registered and unregistered nursing within ward based and non-ward based services between April 18 and February 2020.

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 12 months there has been a total increase in nursing of 80.1 WTEs (10.7 %) in ward based areas, and 110.8 WTEs since April 2018 (15.5%).

	Jan 19 to Jan 20			Feb 19 to Feb 20			April 18 to February 20		
Nursing WTE Actual Increase / (Decrease)	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total
Registered	3.77	33.12	**36.89**	37.52	24.73	**62.25**	36.56	53.59	**90.15**
Unregistered	43.67	(3.69)	**39.98**	42.57	(4.42)	**38.15**	74.26	2.44	**76.70**
Total	47.44	29.43	**76.87**	80.09	20.31	**100.40**	110.82	56.03	**166.85**

	Dec 18 to Dec 19			Jan 19 to Jan 20			Feb 19 to Feb 20		
Nursing WTE % Increase / (Decrease)	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total
Registered	5.6%	4.5%	**4.9%**	0.9%	4.9%	**3.4%**	9.3%	3.6%	**5.7%**
Unregistered	12.5%	6.7%	**10.6%**	12.6%	(2.08%)	**7.6%**	12.4%	(2.40%)	**7.2%**
Total	8.9%	4.9%	**6.8%**	6.3%	3.4%	**4.8%**	10.7%	2.3%	**6.2%**

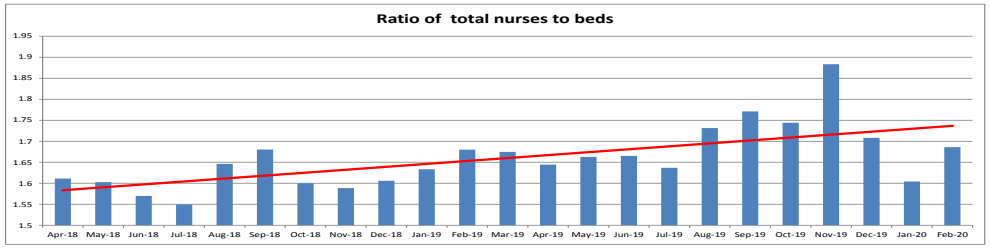


Due to increasing bed capacity the next table compares ward based nursing WTEs with average beds open in each month to demonstrate whether the increase in staffing is in line with growth in capacity. Looking at the total increase in nursing negates changes associated with the implementation of bay based nursing. It can be seen that the ratio of total nurses to beds in February 2020 is slightly higher than April 2018 but similar to February 2019.

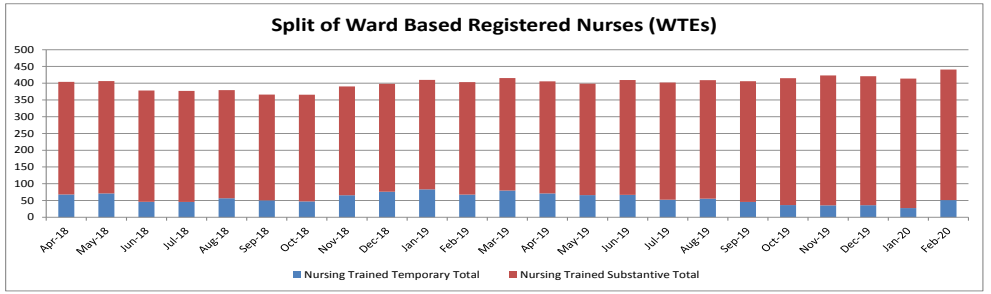
WTEs incl A&E	Apr-18	Apr-19	Dec-18	Dec-19	Jan-19	Jan-20	Feb-19	Feb-20	
Average Beds (midnight count)	445	462	468	479	463	501	445	491	
Registered WTEs	404	406	398	421	410	414	403	441	
Unregistered WTEs	313	354	353	397	346	390	344	387	
Total	717	760	752	818	756	804	748	828	115.5%

All wards incl A&E	Apr-18	Apr-19	Dec-18	Dec-19	Jan-19	Jan-20	Feb-19	Feb-20	yr on yr
Registered per bed (incl Agency)	0.91	0.88	0.85	0.88	0.89	0.83	0.91	0.90	101.4%
Unregistered per bed	0.70	0.77	0.75	0.83	0.75	0.78	0.77	0.79	105.4%
Total Nursing per bed	1.61	1.64	1.61	1.71	1.63	1.60	1.68	1.69	103.2%

Excluding A&E	Apr-18	Apr-19	Dec-18	Dec-19	Jan-19	Jan-20	Feb-19	Feb-20	yr on yr
Registered per bed (incl Agency)	0.76	0.73	0.73	0.74	0.75	0.69	0.75	0.77	102.6%
Unregistered per bed	0.65	0.72	0.71	0.77	0.70	0.73	0.72	0.74	105.7%
Total Nursing per bed	1.42	1.45	1.44	1.51	1.46	1.42	1.48	1.51	104.1%

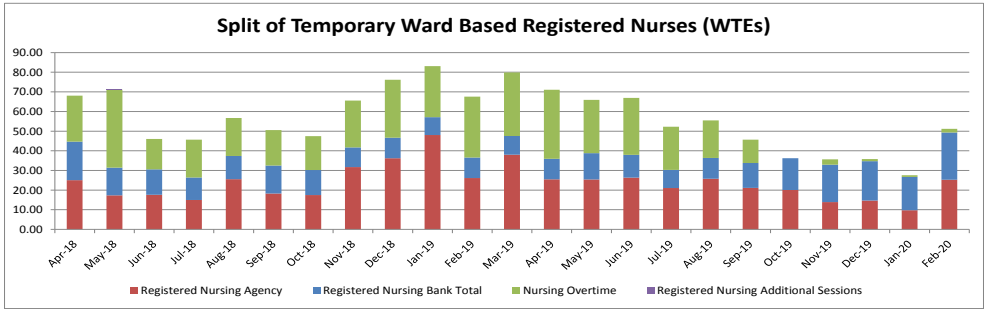


Excluding escalation areas there were 53.5 WTE vacancies at the end of February 2020 (55.5 WTE last month). The tables below demonstrate the split between substantive and non-substantive nurses in ward based areas and how these were filled, as well as a table demonstrating the net vacancies after filling vacancies with temporary staff.

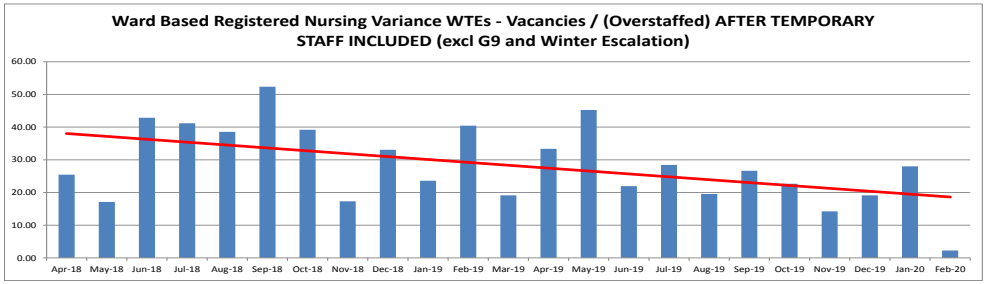


We used 51.2 temporary WTEs to fill almost all vacant posts during February (27.5 WTE last month). Ward based nursing overtime has almost ceased.

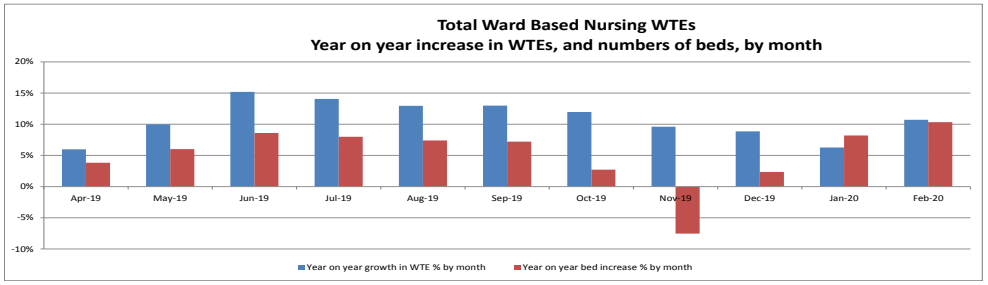
FINANCE AND WORKFORCE REPORT – FEBRUARY 2020



After using temporary nursing staff there remained 2.3 WTE uncovered Ward Based Registered Nursing Vacancies during February (28.0 WTE last month)



The following graph shows the % growth in WTEs comparing the same month in 2019 to 2018. This is charted against the % growth in bed numbers in the same month. In total there has been a 15.5% increase in staffing since April 2018, and whilst the bed base has fluctuated it has usually increased by around 10%.



Note that November 2019 bed numbers appear to be very low. This is due to F10 being closed (and only 11 beds in October) and Bays 4 and 5 being closed on F7.

Division	Ward Area	Sum of plan january 20	Sum of Actual january 20	NET vacancies (over / (under)) January 20	Sum of plan february 20	Sum of Actual february 20	NET vacancies (over / (under)) February 20
Medical Services	A&E Medical Staff	6.12	7.00	0.8800	6.12	7.18	1.0600
	Accident & Emergency	64.46	59.54	(4.92)	64.46	71.63	7.1700
	C.C.U.	0.00	0.00	0.0000	0.00	0.00	0.0000
	Ward F9	20.85	18.41	(2.44)	20.85	18.33	(2.52)
	Ward F12	11.27	9.22	(2.05)	11.27	9.77	(1.50)
	Ward G1 Hardwick Unit	23.74	22.91	(0.83)	23.74	21.60	(2.14)
	Cardiac Ward	22.60	19.34	(3.26)	22.60	19.84	(2.76)
	Ward G4	19.78	19.10	(0.68)	19.78	20.40	0.6200
	Ward G5	18.93	16.42	(2.51)	18.93	18.50	(0.43)
	Ward G8	24.62	24.79	0.1700	24.62	27.92	3.3000
	Medical Treatment Unit	7.04	7.20	0.1600	7.04	7.27	0.2300
	Respiratory Ward	20.69	19.52	(1.17)	20.69	19.77	(0.92)
	Cardiac Centre	40.14	36.84	(3.30)	40.14	37.40	(2.74)
	AAU	27.30	24.07	(3.23)	27.30	27.59	0.2900
	Ward F7 Short Stay	22.66	23.49	0.8300	22.66	23.20	0.5400
Medical Services Total		330.20	307.85	(22.35)	330.20	330.40	0.2000
Surgical Services	Ward F3	19.57	19.78	0.2100	19.57	18.78	(0.79)
	Ward F4	13.78	13.44	(0.34)	13.78	12.49	(1.29)
	Ward F5	19.59	18.12	(1.47)	19.59	19.15	(0.44)
	Ward F6	21.41	19.14	(2.27)	21.41	19.30	(2.11)
Surgical Services Total		74.35	70.48	(3.87)	74.35	69.72	(4.63)
Woman & Children S	Gynae Ward (On F14)	10.78	10.53	(0.25)	10.78	12.57	1.7900
Woman & Children Services Total		10.78	10.53	(0.25)	10.78	12.57	1.7900
Community	Newmarket Hosp-Rosemary ward	12.43	11.02	(1.41)	12.43	12.77	0.3400
	Community - Glastonbury Court	11.69	11.57	(0.12)	11.69	11.72	0.0300
Community Total		24.12	22.59	(1.53)	24.12	24.49	0.3700
Grand Total		**439.45**	**411.45**	**(28.00)**	**439.45**	**437.18**	**(2.27)**

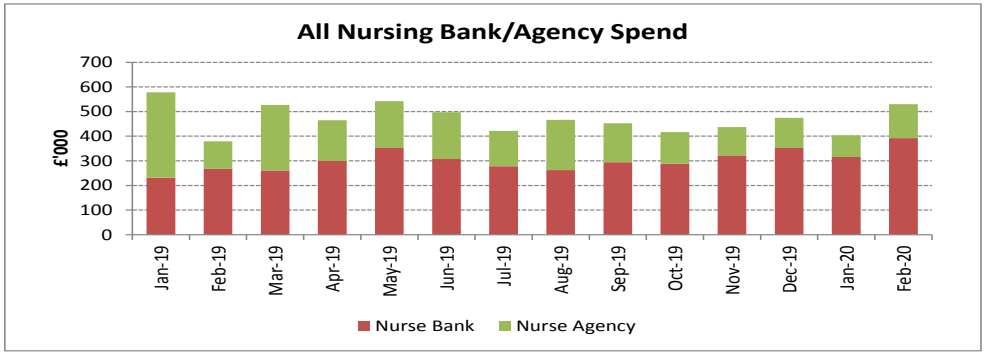
Ward Based Unregistered Nurses were over established by 34.41 WTE during February after utilising temporary unregistered nurses, broken down as below :

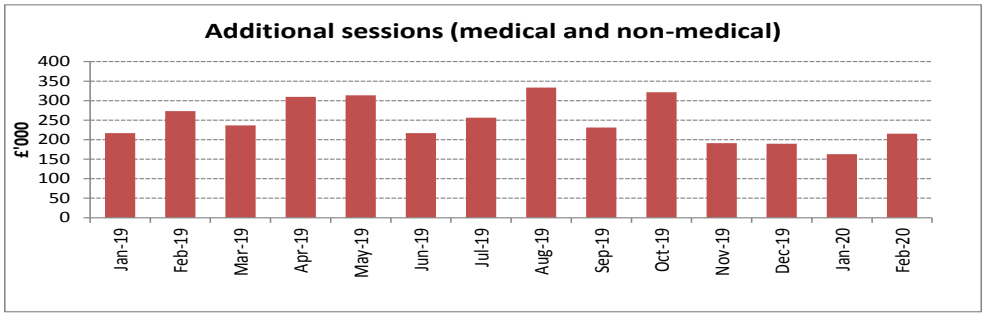
Division	Ward Area	Sum of plan january 20	Sum of Actual january 20	NET Vacancies (over / (under)) January 20	Sum of plan february 20	Sum of Actual february 20	NET vacancies (over / (under)) February 20
Medical Services	Accident & Emergency	26.51	25.8	-0.71	26.51	25.33	(1.18)
	C.C.U.	0	0	0	0	0	0.00
	Ward F9	23.18	26.78	3.6	23.18	28.1	4.92
	Ward F12	5.15	7.76	2.61	5.15	6.63	1.48
	Ward G1 Hardwick Unit	9.01	10.37	1.36	9.01	13.86	4.85
	Cardiac Ward	25.8	26.08	0.28	25.8	28.08	2.28
	Ward G4	25.03	28.85	3.82	25.03	27.1	2.07
	Ward G5	23.18	31.65	8.47	23.18	33.01	9.83
	Ward G8	25.13	23.71	-1.42	25.13	23.97	(1.16)
	Ward G9 Escalation Ward	0	3.7	3.7	0	5.41	5.41
	Respiratory Ward	21.13	22.21	1.08	21.13	19.92	(1.21)
	Cardiac Centre	15.2	21.11	5.91	15.2	20.5	5.30
	AAU	29.8	30.57	0.77	29.8	28.41	(1.39)
	Ward F7 Short Stay	31.94	28.97	-2.97	31.94	28.82	(3.12)
Medical Services Total		261.06	287.56	26.5	261.06	289.14	28.08
Surgical Services	Ward F3	23.11	26.62	3.51	23.11	26.24	3.13
	Ward F4	9.61	10.04	0.43	9.61	9.53	(0.08)
	Ward F5	15.36	17.28	1.92	14.51	16.55	2.04
	Ward F6	18.04	19.66	1.62	17.2	19.49	2.29
Surgical Services Total		66.12	73.6	7.48	64.43	71.81	7.38
Woman & Children Serv	Gynae Ward (On F14)	1	3	2	1	2.07	1.07
Woman & Children Services Total		1	3	2	1	2.07	1.07
Community	Newmarket Hosp-Rosemary ward	13.47	12.76	-0.71	13.47	12.53	(0.94)
	Community - Glastonbury Court	12.64	13.06	0.42	12.64	11.46	(1.18)
Community Total		26.11	25.82	-0.29	26.11	23.99	(2.12)
Grand Total		**354.29**	**389.98**	**35.69**	**352.6**	**387.01**	**34.41**

FINANCE AND WORKFORCE REPORT – FEBRUARY 2020

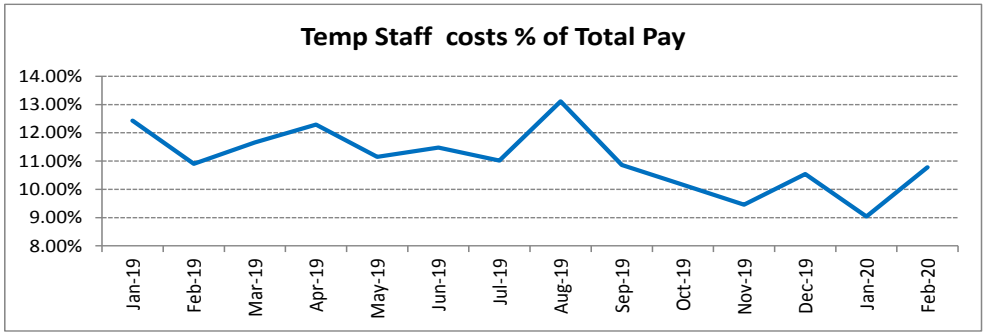
Pay Costs and Analysis

During February the Trust overspent by £565k on pay (£3.0m YTD).

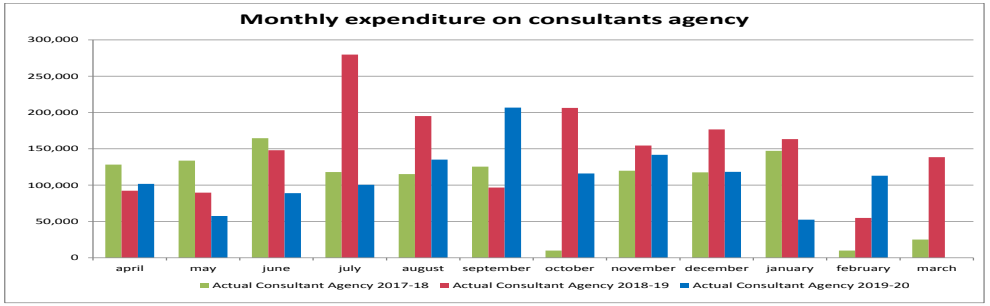




Expenditure on Additional Sessions was £215k in February (£163k in January)

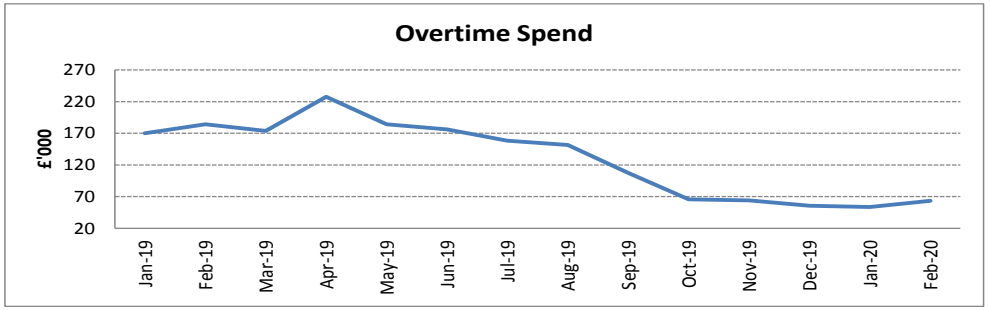


The Trusts proportion of temporary pay expenditure fell to 9.0% in January 2020 which has been our target, but increased to 10.8% in February.



Temporary Expenditure on Medical Staff 2019-20	Average M1-7	Actual Nov 19	Actual Dec 19	Actual Jan 20	Actual Feb 20	Forecast March 20	Forecast Total Year End	Forecast Year End Adverse Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
A&E Medical Staff	140	95	186	108	154	133	1,659	1,168
Gastroenterology	59	-6	6	32	52	38	337	109
Diabetes	34	67	19	23	15	49	409	349
Cardiology	37	31	32	22	28	27	396	209
Junior Doctors - On Take Teams	20	54	18	19	26	28	483	323
General Surgery	31	20	27	37	22	56	380	235
Stroke	23	18	72	-9	2	24	269	232
Anaesthetics	30	-6	15	7	9	9	241	143
Care of the Elderly	21	7	22	38	20	18	255	133
Urology	15	33	18	19	11	11	195	125
Dermatology	20	18	17	-3	12	9	192	102
Clinical Haematology	10	25	21	16	35	4	171	161
Plastic Surgery	22	14	5	8	27	16	225	170
Community Paeds Medical Servs	15	13	15	17	-2	16	165	124
Microbiology	1	6	29	24	21	71	161	161
Grand Total (for those cost centres forecasting > £100k adverse variance)	**478**	**390**	**502**	**359**	**435**	**509**	**5,539**	**3,745**

Overtime costs are falling as a result of an initiative to replace planned overtime with bank shifts (that do not attract the overtime premium). However, these are likely to increase substantially in relation to sickness levels associated with COVID 19.



FINANCE AND WORKFORCE REPORT – FEBRUARY 2020

Summary by Division

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS (NET CONTRIBUTION) - February 2020

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	(6,936)	(7,240)	304	(78,895)	(80,581)	1,686
Pay Costs	4,224	4,424	(200)	44,933	45,792	(859)
Non-pay Costs	1,444	1,381	63	17,564	17,229	335
Operating Expenditure	**5,669**	**5,806**	**(137)**	**62,497**	**63,021**	**(524)**
SURPLUS / (DEFICIT)	**1,267**	**1,435**	**167**	**16,397**	**17,560**	**1,163**
SURGERY						
Total Income	(5,156)	(5,122)	(33)	(58,639)	(57,797)	(842)
Pay Costs	3,117	3,204	(87)	34,171	34,788	(617)
Non-pay Costs	1,136	1,099	37	12,858	12,603	255
Operating Expenditure	**4,253**	**4,303**	**(50)**	**47,030**	**47,392**	**(362)**
SURPLUS / (DEFICIT)	**903**	**820**	**(84)**	**11,609**	**10,405**	**(1,205)**
WOMENS and CHILDRENS						
Total Income	(1,811)	(2,125)	315	(21,333)	(21,154)	(179)
Pay Costs	1,224	1,314	(90)	13,462	13,949	(487)
Non-pay Costs	150	180	(30)	1,707	1,747	(40)
Operating Expenditure	**1,374**	**1,494**	**(120)**	**15,169**	**15,696**	**(527)**
SURPLUS / (DEFICIT)	**437**	**631**	**194**	**6,164**	**5,459**	**(706)**
CLINICAL SUPPORT						
Total Income	(833)	(815)	(18)	(9,274)	(9,346)	72
Pay Costs	1,521	1,522	(2)	16,751	16,667	83
Non-pay Costs	969	1,067	(98)	11,529	12,644	(1,116)
Operating Expenditure	**2,490**	**2,590**	**(99)**	**28,279**	**29,311**	**(1,032)**
SURPLUS / (DEFICIT)	**(1,657)**	**(1,774)**	**(117)**	**(19,005)**	**(19,965)**	**(960)**
COMMUNITY SERVICES						
Total Income	(3,193)	(3,398)	205	(35,486)	(36,021)	535
Pay Costs	2,344	2,423	(80)	25,511	25,622	(110)
Non-pay Costs	849	1,038	(190)	10,837	11,694	(857)
Operating Expenditure	**3,193**	**3,462**	**(269)**	**36,349**	**37,316**	**(967)**
SURPLUS / (DEFICIT)	**0**	**(64)**	**(64)**	**(863)**	**(1,295)**	**(432)**
ESTATES and FACILITIES						
Total Income	(445)	(454)	9	(4,651)	(4,610)	(41)
Pay Costs	874	849	25	9,614	9,555	59
Non-pay Costs	620	720	(100)	6,648	7,239	(590)
Operating Expenditure	**1,494**	**1,569**	**(75)**	**16,262**	**16,794**	**(532)**
SURPLUS / (DEFICIT)	**(1,049)**	**(1,115)**	**(67)**	**(11,611)**	**(12,184)**	**(572)**
CORPORATE (excl Reserves)						
Total Income	(1,791)	(3,379)	1,588	(33,359)	(37,329)	3,970
Pay Costs	1,265	1,397	(131)	13,429	14,540	(1,112)
Non-pay Costs (net of Contingency and Reserves)	1,055	2,376	(1,321)	9,438	13,841	(4,404)
Finance & Capital	1,015	630	384	10,956	9,734	1,222
Operating Expenditure	**3,335**	**4,404**	**(1,068)**	**33,823**	**38,116**	**(4,293)**
SURPLUS / (DEFICIT)	**(1,545)**	**(1,024)**	**520**	**(464)**	**(787)**	**(323)**
TOTAL						
Total Income	(20,165)	(22,535)	2,370	(241,637)	(246,839)	5,202
Pay Costs	14,569	15,134	(565)	157,871	160,913	(3,042)
Non-pay Costs	6,224	7,863	(1,639)	70,582	76,998	(6,417)
Finance & Capital	1,015	630	384	10,956	9,734	1,222
Operating Expenditure	**21,808**	**23,627**	**(1,820)**	**239,409**	**247,646**	**(8,237)**
SURPLUS / (DEFICIT)	**(1,642)**	**(1,093)**	**550**	**2,228**	**(807)**	**(3,035)**

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 (Sarah Watson)

The division reported a favourable variance of £167k, in month (£1.2m YTD).

Clinical income exceeds plan by £304k in the month. This is driven by the sustained increase above plan in both A & E activity and admitted patient care (non-elective and elective). This increased income offsets overspends arising from these seasonal activity increases.

In the middle of January, the Trust opened the second of the designated winter escalation wards, G9 (winter "surge" ward). This is in addition to the winter "escalation" ward (F10) being opened at the beginning of December. Whilst some budget is available, this was only intended to cover the costs for one ward for a period of 10 weeks. As both wards have been open in month, and are predicted to remain open for at least the remainder of the financial year, we are anticipating significant overspends against budget to occur.

In month, the winter wards recorded a £145k overspend against budget, split £134k pay costs and £11k non-pay costs, accounting for the majority of the overspends noted for the division in pay (£200k). The YTD position (£411k and £65k overspent respectively) takes into account the overspend noted in M2 & M3 earlier in the year, a consequence of keeping the previous winter escalation ward open longer than planned. Whilst no budget exists, the impact of having two wards open has been included within the forecast position for a number of months and the forecast overspend recorded in M11 (£728k) reflects a £22k improvement in month.

The remaining overspend on pay (£66k) is offset by a large underspend on non-pay, driven by reduced spend on Drugs in month (a trend that has been noted throughout the year, albeit at a lower rate than witnessed in M11). Excluding the winter wards and clinical income, the Medicine Division is now forecasting a £42k overspend for this financial year

Surgery (Simon Taylor)

The division reported an adverse variance of £84k in month (£1.2m adverse variance YTD).

Income is behind plan by £33k in month and £842k behind plan year to date. Elective inpatient activity is ahead of plan, partly caused by the planned catch up of orthopaedics, as a result of cancelations in January. Non elective activity continues to be low across surgery.

Pay overspent by £87k in the month and has a £617k overspend year to date. Nursing underspent slightly, but is overspent year to date. There was two significant overspends in pay - administration staffing continues to have a cost improvement plan that did not achieve due to delays in implementation. The second is due to medical staffing pressures.

Non pay underspent by £37k in month and has a £255k year to date underspend. Drugs continue to be overspent, however there has been significant underspends in ophthalmology theatres due to resolution of credit notes and also lower dispensing of hearing aids.

Women and Children's (Darin Geary)
In February, the Division reported an favourable variance of £194k (£706k adverse variance YTD).

The phasing of contract income has improved the income position to £179k behind plan YTD though neonatal and non-elective activity remain lower than expected.

Pay reported a £90k overspend in-month and is £487k overspent YTD. The YTD overspend continues to be driven by medical staffing gaps in Paediatrics and RTT pressures in Gynaecology. The recruitment process for an acute consultant in Paediatrics is continuing.

Non-pay reported a £30k overspend in-month and is £40k overspent YTD. Spend on drugs remains high as are other costs associated with increased Paediatric activity.

Clinical Support (Darin Geary)
In February, the Division reported an adverse variance of £117k (£960k YTD).

Income for Clinical Support reported £18k behind plan in-month but remains £72k ahead of plan YTD due to high levels of outpatient and breast screening activity.

Pay continues to be broadly in line with budget and is £83k underspent YTD. 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 and Pathology where a locum microbiologist is in post.

Non-pay reported a £98k overspend in-month and is £1,116k overspent YTD. The overspend is driven largely by activity pressures in Diagnostics. Demand related pressures in both Pathology and Radiology continue to put constant pressure on the Division's non-pay budget.

Community Services and Integrated Therapies (Michelle Glass)
The division reported an adverse variance of £64k in month, (£432k YTD)

Income reported a £205k over recovery in month, (£535k YTD) following an agreement to recover some costs incurred by the Division.

There was an in-month over spend on pay of £80k, (£110k YTD). Whilst the Division continue to use agency staff to cover some vacant roles, agency has now reduced in some services following recruitment to vacancies, for example in Newmarket Hospital's Rosemary Ward. However, the Division continue to use agency staff to cover some vacancies across Occupational Therapy, Speech Therapy, Dietetics and Paediatric consultancy in order to provide capacity to support winter escalation wards. Agency staff were also used to ensure service resilience, support patient flow and manage service demand across the services.

Non-pay reported an adverse variance of £190k in February, (£857k YTD). The in-month position reflects a backdated and prior year charge for both a property lease and externally commissioned beds. Increased expenditure on Community Equipment and associated activity costs were also incurred, to support both the facilitation of hospital discharge and to enable patients to remain independent at home. We have also put in place a number of initiatives, such as providing clinical advisor capacity to ensure utilisation of recycled special equipment and frequent core stock product reviews to ensure the most effective products are prescribed, to manage the impact of additional demand. The community equipment budget is profiled to anticipate higher spend in month twelve, so we do not anticipate significant further escalation of cost pressures, based on current levels of demand.

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.

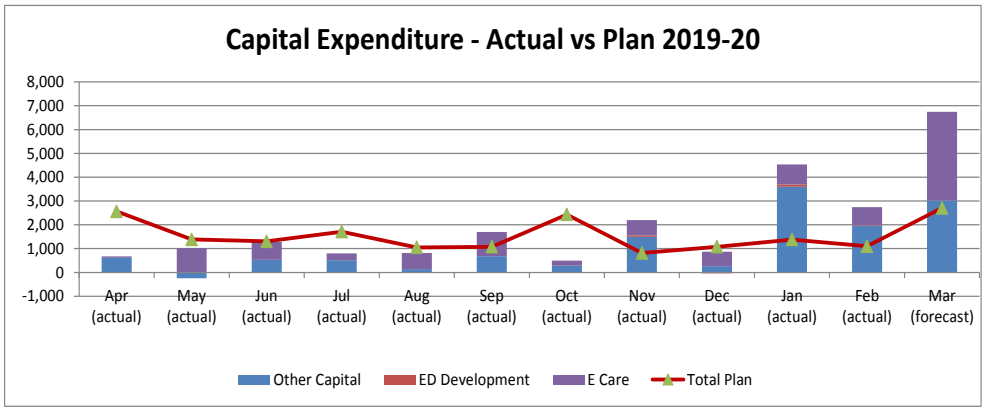
Metric	Value	Score	Plan	Forecast
Capital Service Capacity rating	1.0	4	4	4
Liquidity rating	-43.5	4	4	4
I&E Margin rating	-0.4%	3	2	2
I&E Margin Variance rating	-0.1%	2	1	1
Agency	-15.0%	1	1	1
Use of Resources Rating after Overrides		3	3	3

The Trust is scoring an overall UoR of 3 this month, which is consistent with previous months. The forecast rating has improved based on our current forecast position.

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 Actual £'000	Dec Actual £'000	Jan Actual £'000	Feb Actual £'000	Mar Forecast £'000	Total 2019-20 £'000
E Care	34	1,019	743	290	679	1,018	214	640	608	839	771	3,713	10,568
ED Development	0	0	0	0	0	0	0	60	-40	99	20	10	149
Other Schemes	636	-242	534	512	138	683	278	1,494	260	3,598	1,952	3,024	12,867
Total / Forecast	670	777	1,277	802	817	1,700	492	2,194	829	4,536	2,743	6,746	23,584
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 eight months the Trust was waiting final confirmation of a capital loan to support the capital programme. This meant that 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. This loan partly supports the capital expenditure and therefore is not additional capital resource. As a result of this released funding the capital schemes commenced during December. A number of these schemes will not complete prior to the year end. Project managers have reviewed their schemes in light of the funding and the forecast represents the current view on how far the schemes will progress given the tight timescales.

The Trust also received notification of additional capital funds mainly for IT schemes, these funds total c£3m. These additional funds are included within the forecast and are due to spend within the financial year. However, the impact of Coronavirus on the suppliers ability to meet the timescales means that there is risk to completion of the capital programme asset out in the forecast.

The forecast also takes account of the purchase of Glemsford Surgery on 31 March 2020. This is funded through a sale and leaseback arrangement.

Statement of Financial Position at 29th February 2020

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2019	Plan 31 March 2020	Plan YTD 29 February 2020	Actual at 29 February 2020	Variance YTD 29 February 2020
	£000	£000	£000	£000	£000
Intangible assets	33,970	35,940	35,867	36,316	449
Property, plant and equipment	103,223	115,395	115,049	119,464	4,415
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**	**155,341**	**160,834**	**5,493**
Inventories	2,698	2,700	2,700	3,001	301
Trade and other receivables	22,119	20,000	20,000	31,473	11,473
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	1,050	1,255	205
Total current assets	**29,324**	**23,750**	**23,750**	**35,729**	**11,979**
Trade and other payables	(28,341)	(32,042)	(32,172)	(30,818)	1,354
Borrowing repayable within 1 year	(12,153)	(3,134)	(3,134)	(30,984)	(27,850)
Current Provisions	(47)	(20)	(20)	(47)	(27)
Other liabilities	(1,207)	(992)	(1,646)	(1,792)	(146)
Total current liabilities	**(41,748)**	**(36,188)**	**(36,972)**	**(63,641)**	**(26,669)**
Total assets less current liabilities	**129,823**	**143,322**	**142,119**	**132,922**	**(9,197)**
Borrowings	(84,956)	(99,186)	(98,887)	(79,838)	19,049
Provisions	(111)	(150)	(150)	(111)	39
Total non-current liabilities	**(85,067)**	**(99,336)**	**(99,037)**	**(79,949)**	**19,088**
Total assets employed	**44,756**	**43,986**	**43,082**	**52,974**	**9,892**
Financed by					
Public dividend capital	69,113	70,430	70,061	70,088	27
Revaluation reserve	6,931	9,832	8,021	6,451	(1,570)
Income and expenditure reserve	(31,288)	(36,276)	(35,000)	(23,565)	11,435
Total taxpayers' and others' equity	**44,756**	**43,986**	**43,082**	**52,974**	**9,892**

Non-Current Assets

The net capital investment in intangible assets and property, plant and equipment (PPE) is higher than originally planned. The Capital Programme for 2019/20 has increased since it was set at the start of the year and therefore the asset base is increasing. The acquisition of Newmarket Hospital on 30 September is also reflected within property, plant and equipment.

Trade and Other Receivables

Receivables are higher than plan. This is due to the Trust recognising £10m expected from the CCG for over activity. This has been settled in March and the cash has been received.

Cash

The cash position continues to be rigorously monitored on a daily basis to ensure that the minimum level requirement of £1m is maintained. The cash balance has remained stable and we are managing our working capital position with the funds and borrowing available.

Trade and Other Payables

These have decreased by £1.9m since January and are slightly below plan. The Trust has been able to pay more suppliers as more funding has been received towards the year end, particularly around capital spend.

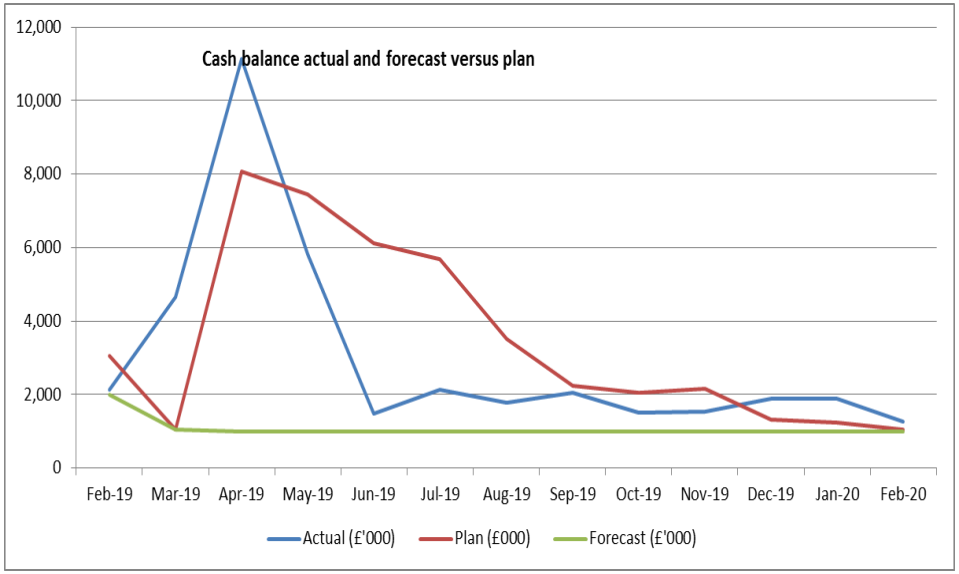
Borrowing

No further borrowing will be required for 2019/20. To date the Trust has borrowed £10.8m against the reported in year deficit. As the Trust is forecasting to break even, no further revenue support is available. The Trust has received £7.4m of capital loans. We will receive an additional £0.8m in March.

FINANCE AND WORKFORCE REPORT – FEBRUARY 2020

Cash Balance Forecast for the year

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

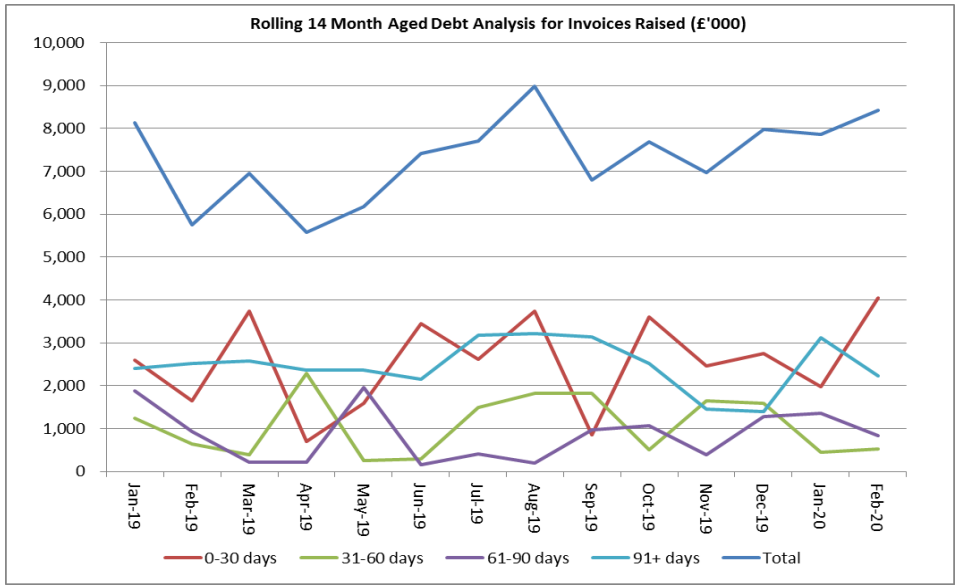


The cash position is being rigorously monitored on a daily basis to ensure that the minimum level requirement of £1m is maintained. The February 2020 cash position is in line with the plan.

We are forecasting to achieve a £1m balance at the end of the year. No further borrowing will be required for 2019/20. The CCG settled the large debtor balance in March, which was owed to us for additional activity performed during the year. This means that the Trust will be able to settle a large number of historic creditor balances before the year end.

Debt Management

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



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

The overall level of sales invoices raised but not paid has increased by £0.5m since January, however the aged debts over 31 days has decreased. Over 84% of these outstanding debts relate to NHS Organisations, with 34% 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.

10:40 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

10. Quality and learning report

To APPROVE the quarterly report

For Report

Presented by Rowan Procter and Nick Jenkins

Trust Open Board – 27th March 2020

Agenda item:	10			
Presented by:	Rowan Procter – Executive Chief Nurse			
Prepared by:	Governance Department			
Date prepared:	March 2020			
Subject:	Quality and Learning report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 31/12/19.

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 Q3 report
- Theme report on dementia
- '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 Q3

There were 13 SI reports submitted in Q3. There were two reports which were collaborations with another organisation in the quarter All cases which included a patient's death had the final report reviewed by the 'learning from death' group to determine preventability (see section 2).

In Q3 no cases were reported to the HSIB (Healthcare Safety Investigation branch) for external investigation. In 2020 the two first HSIB reports which relate to the care of a WSFT patient have been issued and future reports will contain a summary of the learning, local review of content and any actions arising from these reports.

Incident details	Learning
WSH-IR-49026 Baby transfer to tertiary centre after suffering seizures on the day of birth	**Root causes** The root cause is considered to be sepsis which developed during the intrapartum period and was not recognised or treated in a timely manner. Following robust investigation this appears to be because the current systems in place for recognising sepsis do not take account of the whole clinical picture, but focus mainly on maternal pyrexia. **Lessons learned** • Current system for frequency of observations to monitor maternal and fetal well-being is not well utilised on the antenatal ward currently, and could benefit from being reviewed. • Given that the indication for spinal anaesthetic and emergency caesarean section was an abnormal fetal heart rate trace; application of a fetal scalp electrode prior to transfer to theatre should have been considered. • The East of England ODN Neonatal Antibiotic Policy (published on the intranet) used by the Trust was due for review in July 2018 and should therefore be replaced with a more up to date version if available.

Incident details	Learning

	Actions
	• Escalate maternity 'red flag' incidents which are incidences related to reduced midwifery staffing
	• Review current system for determining correct frequency of antenatal observations, as described in MAT0086 Guidance for performing maternal and fetal observations during antenatal admissions.
	• Review the following policies:
	  ○ MAT0113 Systemic inflammatory response syndrome (SIRS) and Sepsis.
	  ○ MAT0091 Identification of the seriously ill woman and for those requiring critical care.
	  ○ Neonatal Antibiotic Policy
	• Neonatal observations must be recorded on a chart and any abnormal findings should be escalated appropriately.
	Shared learning pathways
	Share all learning from this investigation with the wider team via Risky Business. Note: The Consultant Paediatrician who was involved in reviewing this case requested that Risky Business should also be emailed to all junior doctors as well as the Consultants. This will happen every month moving forward.
	Present this case at the monthly perinatal mortality meeting, which is a shared learning forum between obstetricians and paediatricians

WSH-IR-50108
Patient suffered cardiac arrest following ingestion of large overdose of mixed types of medications
 	
**Joint investigation with NSFT and the Ambulance trust*
 	
Lessons learned and actions listed relate to the WSFT elements of care only
	Root causes
	The review of the care and service delivery provision from mental health services did not identify a single root cause to the incident. From the perspective of WSFT; X took a catastrophic overdose of a combination of complex medication some hours before admission. These medications will interact with each other, especially when taken in volume. Toxbase advice focuses on individual drugs taken and the risk involved making overall management of the cocktail taken difficult to predict.
	Lessons learned (WSFT only)
	• Possibility of late complications should have been considered due to the potential of delayed side effects of the medications by all the teams involved with X's care.
	• Serial ECGs should have continued to be recorded following the abnormal findings in order to closely monitor any further cardiac changes.
	• All patients who are requiring a higher level of intervention should be escalated to and reviewed by the most senior clinician within the specialist team and recorded in the electronic notes system.
	• A larger volume of intravenous fluid and administration of sodium bicarbonate could have been considered due to the many medications ingested and suggested consideration via Toxbase.
	• Further blood tests were not completed in order to closely monitor X's salicylate levels as suggested by Toxbase.
	• Consideration for a voice to voice conversation/live advice from the national poisons unit should be given and decisions recorded in the event of a cardiac arrest directly relating to an overdose.
	Actions
	• Review and update of '*The patient referral to critical care process map for ward doctors*'. To include below;
	  ○ Critical care staff need to consider a lower threshold for ICU admissions for complex patients with the potential for deterioration
	  ○ CCS team should consider senior review/ conversation with complex cases for further discussion and consideration for ICU admission
	  ○ Implementation of a robust process to ensure that requests for further review of deteriorating patients is prioritized and communicated so as to provide optimal and safe patient care
	• Electronic advice from Toxbase should be utilized and advice sort by phone to the national poisons unit to ensure appropriate management of complicated overdose patients www.toxbase.org

Incident details	Learning
	Shared learning pathways For discussion at appropriate M&M meetings, Medical Divisional Board, Surgical Divisional Board, ED, AAU and ICU Clinical Governance Meetings, Audit Meetings and Shared Learning Event Clinical doctor induction and individual specialty clinical teaching Reminder to all ED and AAU and ICU staff and to include teaching within clinical skills training
WSH-IR-50350 Patient with acutely deranged liver function test. Delay in full virology screen may have led to X passing Hep A to family	**Root causes** Missed investigation, delay in diagnosis- thus impacting on passing the infection to other members of the family. **Lessons learned** • Missed opportunity when assessing the patient on initial admission to request appropriate investigation, thus creating a delay in diagnosis. • The medical team could have discussed with microbiology team or laboratory team if not sure what investigation should have been requested. • If a referral is sent it is the responsibility of the team asking for the request to chase and make sure patient is seen and correct advice is sought. Medical team failed to do so. • Gastroenterology bed was not available, if X was managed on the Gastro ward the patient would have likely had all of the screening completed in a timelier manner. **Actions** • To initiate new order set/alert to ensure consistency when requesting Hepatitis blood tests currently there is no provision to complete all types of hepatitis from one request. Laboratory IT lead working on splitting the Liver Database up in to its component parts and making it an order set. This will allow the inclusion of Hepatitis testing in addition to those performed by Biochemistry. • Nurse coordinators to raise the request in every bed meeting, to provide assurance from the patient flow team those requests are considered. **Shared learning pathways** Case briefing for AAU physicians and the medical team Share incident with patient flow team and nurse coordinators Present report to Medical and Surgical Divisional Board
WSH-IR-51210 Patient suffered cardiac arrest following diagnosis of aortic dissection (at second admission). Died prior to transfer to tertiary unit	**Root causes** Undiagnosed aortic aneurysm (subsequent tear and dissection) in first presentation to ED resulting in discharge home with a diagnosis of musculoskeletal chest pain, with analgesia and safety netting. Symptoms were not typical of dissecting aortic aneurysm with first admission, therefore, a differential diagnosis was not considered **Lessons learned** • Delay in recording ECG in first admission. This ECG did not show any acute changes. Whilst an earlier or repeat ECG would not have necessarily have changed treatment at the time, or outcome, it is considered good practice to follow guidelines regarding patients presenting with chest pain. • Bi-lateral blood pressures were not recorded during the first admission (although bi-lateral blood pressures were recorded second admission with no obvious disparity). • There was an issue around transfer of a level two patient to the specialist hospital, and identifying the most appropriate member of staff to act as escort **Actions** • 'Guidance on: the transfer of the critically ill adult, (The Faculty of intensive Care Medicine, Intensive Care society, Published May 2019)', needs to be reviewed, adapted where necessary and implemented within the organisation as a whole; inclusive of the intensive care unit, emergency department and other areas where an urgent clinical transfer of an unwell patient to a specialist centre is required. • Guidance once created, should be signed off at clinical effectiveness committee level, and available for all staff in appropriate areas when required. • Review of chest pain presentation and investigations required should be carried out, with focus around timeliness of tests and investigations needed inclusive of clear guidelines relating to potential 'aortic pain' as a discriminator for chest pain.

Incident details	Learning
	Shared learning pathways Disseminate this report to appropriate governance meetings. Include this patient story within the shared learning events.
WSH-IR-51213 Failure to diagnose Guillian–Barre Syndrome	**Root causes** Failure to identify patient was suffering from Guillian Barre Syndrome in a timely manner; resulting in discharge with subsequent readmission 5 days later, very unwell requiring intubation and ventilation with admission to intensive care and prolonged stay in hospital. **Lessons learned** The referral pathway of medical patients between the emergency department and the acute assessment unit needs to be reviewed Nursing and medical documentation needs improvement in the emergency department, the possibility of a discharge proforma regarding the patients mobility needs to be looked at with the help of the e-care leads, with the possibility of this being used for discharge to identify any issues. **Actions** • Review of the AAU clinical model policy, with focus on the referral process between the emergency department and the acute assessment unit. • Discussion with e-care about the development of a nursing discharge proforma to be used to identify patients who may have mobility issues. • Embedding of the existing professional standards for the emergency department and the acute assessment unit **Shared learning pathways** Share report with all clinical and nursing staff in the emergency department, discuss at emergency department clinical governance meeting and Medical Divisional Board.
WSH-IR-51584 Failure to transfer a mental health patient to mental health service, placing other patients and staff at significant risk. **Joint investigation with NSFT* *Actions listed relate to the WSFT elements of care only*	**Root causes** There was sudden change of plan to accept the patient to Southgate Ward on 11th September which caused distress and made the management of the patient on a surgical ward more difficult, placing patients and staff at risk **Lessons learned (WSFT and NSFT)** Need to ensure there are clear communication pathways with the On-call management team for Norfolk and Suffolk Foundation Team to improve the process of managing mental health patients, ensuring care is provided in the most appropriate setting for the individual Missed communication regarding the section status of the patient on arrival at WSFT. **Actions (WSFT only)** • Clear communication process to ensure appropriate transfer information of patient's needs is relayed to accepting ward team. **Shared learning pathways** To share at Governance meetings and team meetings in both Trusts
WSH-IR-50251 Failure to isolate a patient with Measles leading to extensive patient and staff exposure to highly infectious pathogen	**Root causes** Failure to isolate a patient with fever, rash and recent history of foreign travel until transfer to the short stay Medical admissions ward 11 hours later. **Lessons learned** Random access technology within the Laboratory would expedite results rather than Batch testing, The Emergency Department requires more than one single room, Staff who are non-immune and not permitted to work during the incubation period should be given written information and the manager should also receive a copy, Timely staff Occupational Health screening should be ensured through line management **Actions** • The Emergency Department requires more than one single room for adult patients; this should be a priority in the proposed new developments for the department. • A Standard Operating Procedure (SOP) for a Measles incident should be devised to clarify the timeline of actions as there is an extremely small window of opportunity in which to protect vulnerable contacts.

Incident details	Learning
	• Staff immunity records should be accessible and held centrally, and a backup available, should the third party 'host' fail. • Measles tests (serological and PCR) should be identified as urgent to the Laboratory by the teams (patient's clinical team/ Infection Prevention team and Consultant Microbiologist). Once the specimens are obtained they must be transported to the Laboratory immediately to ensure timely processing. **Shared learning pathways** Report and its findings shared at Trust wide at the shared learning event. SI report shared with all staff involved in investigation, department team and Consultants. Investigation to be discussed at ED Governance meeting, divisional Governance steering group and Infection Prevention & Control Committee.
WSH-IR-51180 Category 4 pressure ulcer whilst in the care of the Community health teams	**Root causes** Too much emphasis placed on shared care with the wife and a lack of continuity of follow up to ensure care was carried out as prescribed. **Lessons learned** Community Tissue Viability Service now in place to enable referral for advice about pressure issues at an early stage Noted that the potential for improvement was 'limited' due to a history of recurrent category 4 pressure ulcers and a 'static' category 3 **Actions** • Liaison with Wheelchair Service to ensure consistency with provision of the correct grade of pressure relief in bed and seating. • Non-Concordance flowchart to be reviewed to ensure up to date and all Community Nurses reminded to use this within their documentation • Community Clinicians to be reminded to document: o Mental capacity for patients, including when patient has capacity to understand advice given and the capacity to make decisions and understand the consequences of these decisions o If potential safeguarding issues have been raised and the reason for any decision not to make a safeguarding referral **Shared learning pathways** Investigation to be discussed at team meetings to ensure all clinicians are aware of actions that can be taken to avoid such incidents in the future. Learning from this investigation to be shared more widely via CREWS (the Community newsletter) Discussion with Wheelchair Service Manager to ensure consistency with provision of pressure relief equipment
WSH-IR-51123 Category 4 pressure ulcer whilst in the care of the Community health teams	**Root causes** Deterioration in overall condition of health as the patient was nearing the end of life **Lessons learned** The importance of: • Comprehensive initial pressure ulcer assessment performed by a qualified nurse. • Correct pressure ulcer classification and documentation. • Regular wound assessment and supporting images. • Regular and accurate risk assessments **Actions** • Focused education for all clinical staff on the classification of pressure ulcers including Waterlow and MUST risk assessment • Audit of staff attendance at teaching session provided by TVN • Band 7 / 6 to work together to coordinate a monthly report and meetings to discuss current pressure ulcer patients • Senior matron undertake random audit to ensure appropriate compliance with SOP to ensure all new referrals are being assessed by an appropriate qualified member of staff following initial referral. • Develop a SOP to escalate clinical concerns to Senior Matron, communicate SOP to clinical teams and monitor compliance.

Incident details	Learning
	Shared learning pathways Communication to all Community teams via CREWS
WSH-IR-51533 Patient fall possibly resulting in head injury. Some treatment delay due to multiple ward moves. Patient subsequently died.	**Root causes** A frail patient who moved to multiple wards in a short period of time, which could contributed to the increasing disorientation, and hinder continuity of care when diagnosing and making a plan of care. **Lessons learned** Missed opportunity to order CT head following the second fall , requested once transferred to the next medical ward Delay in commencement of the blood transfusion, (a low HB can cause postural hypotension and low platelets increase the risk of spontaneous bleeding.) **Actions** • Patient flow to ensure the decisions made when transferring patients within the WSHFT are robust and appropriate. • Trust wide focus with Matrons and ward managers to focus the continuing drive of the importance of documentation, to provide assurance of safe / appropriate care. **Shared learning pathways** Trust wide 'Matrons message', Medical Consultants to remind junior medical teams
WSH-IR-51690 Patient fall resulting in neck of femur fracture	**Root causes** This incident has been deemed as unavoidable as all opportunities to provide falls prevention strategies were utilised. The patient was confused due to his clinical condition and attempted to mobilise unaided. **Lessons learned** The patient's state of mind was mentioned in several places. However a formal mental capacity was not completed on this admission. Need for more timely assessment from early intervention team (EIT) Anticipatory use of wander guard to alert when patient who is requiring assistance coming out of bed unaided. **Actions** • Ward to hold own supply of wander guards and, if not available on the ward, request it via medical equipment library. • Regular audits to check MCA is completed in a timely manner as stated in the MCA act. • Create a standard operating policy for falls with new focus on completing one lying and standing BP on admission. This will be highlighted in the falls awareness week. Currently there is no face to face falls training; Electronic learning is available for falls. **Shared learning pathways** Feedback at monthly ward meeting, Bring this case to the attention of EIT team.
WSH-IR-51007 Patient fall resulting in neck of femur fracture	**Root causes** This incident has been deemed as avoidable as nursing staff did not follow the bay based nursing directive and handover took place outside of the bay. It is thought that had staff been handing over in the bay this fall may have been avoided. **Lessons learned** Consider the impact moving patients with cognitive impairment has when patients are moved to different clinical areas **Actions** Design and implement a falls board for staff and relatives • Fully embed bay based handover • Encourage staff to consider the impact moving patients with cognitive impairment has when patients are moved to different clinical areas; be mindful when receiving handover to check the patient's cognitive status. **Shared learning pathways** Communication from Ward Manager to the team will be disseminated through a monthly newsletter; this will share details of the incidences and learning. Findings and learnings will be shared at divisional level through ward governance

Incident details	Learning
WSH-IR-49690 Patient fall resulting in neck of femur fracture	**Root causes** Considered to be an unavoidable fall. The Staff member was waiting for assistance from another member of staff as she had assessed the patient to be unsteady. The patient may have not understood or heard this request to wait but continued to try and walk and regrettably fell. **Lessons learned** Post fall assessment not completed fully – important to be accurate with documentation as it would have scored a low risk. No Doctor's falls order set initiated on E Care **Actions** No specific actions apart from the shared learning **Shared learning pathways** In Matrons Message to the ward. Also in the next Clinical Governance meeting.

2. Learning from Deaths

'Learning into action' in Q3

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 Q3 identified the following themes in addition to those reported as an SI (of which there were xxx in Q3).

Themes from poor care:

There were further examples highlighting the previously noted theme of **failed / delayed recognition of end of life**. The recently issued NICE guidance NG142 https://www.nice.org.uk/guidance/ng142 includes the following recommendation (ref 1.1.1)

"*People managing and delivering services should develop systems to identify adults who are likely to be approaching the end of their life (for example, using tools such as the Gold Standards Framework, the Amber Care Bundle or the Supportive and Palliative Care Indicators Tool [SPICT]). This will enable health and social care practitioners to start discussions about advance care planning, provide the care needed, and to support people's preferences for where they would like to be cared for and die*."

The implementation of this NICE guidance is expected to provide opportunities for an improvement project to address some of the aspects of these themes and therefore the progress from baseline assessment through improvement project to implementation will be followed by the LfD group.

Three cases were highlighted for review as a serious incident in Q3. Two were downgraded at an initial Day two review meeting and one was reported as an SI (a patient who had a delay in diagnosis of sepsis). In addition two SIs were reported for patient's deaths which were not highlighted as poor care through an SJR review (one fall and one category 4 pressure ulcer).

Investigation outcomes of the three 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-51210	Patient fall possibly resulting in head injury. Some treatment delay due to multiple ward moves. Patient subsequently died.	LfD group agreed >50% preventable*
WSH-IR-51533	Patient suffered cardiac arrest following diagnosis of aortic dissection (at second admission). Died prior to transfer to tertiary unit	LfD group agreed >50% preventable*
WSH-IR-50108	Patient suffered cardiac arrest following ingestion of large overdose of mixed types of medications	LfD group not yet reviewed

* >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.

The first example of this was chosen following feedback from the chair of the VOICE group (who is also the patient representative on the LfD group) who had been in conversation with the wife of the patient (who died following an anaphylaxis which was reported as an SI and a LfD case) who was considering joining VOICE but who reported that she "*doesn't feel that what the Trust agreed to do has been done".* It was agreed therefore to trial the process in 2019 with a review of the action related to 'Plan D' (difficult airway) front of neck access pack training.

The review noted that there are currently two governance half days conducted each year, which include difficult airway situations. A front of neck access video will be shown to all junior doctors when they start twice a year. Three times a year there will be front of neck access scenarios in ICU where the team on duty at the time will not be aware of what scenario they will be getting. Plan D Kits are also on all the crash trolleys in the education centre and are talked about and shown to the staff during their training. An 'airway coffee table' has been discussed, this is the idea of taking the Plan D kit and a mannequin to various locations/environments in the trust especially those where this scenario is least expected. The coffee table element refers to the setup of the trolley, which provides refreshments to encourage staff to participate and learn.

This review found considerable evidence of implementation which was very positive. The lead for deteriorating patients has taken the responsibility for communicating this back to the patient's wife to ensure she is given suitable reassurance of the details with the supporting evidence.

The opportunity to undertake such a review also provides a benefit for cases subject to inquest where it enables the organisation to demonstration learning and action following a death to provide assurance to the Coroner that a Regulation 28 (prevention of future deaths) is not required.

Learning into action (L*into*A)

The 2020/21 LfD 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 use GREATix to formalise the feedback and reporting upon this activity.

Table 1: GREATix submitted following reviews in Q3.

Team	Narrative excerpt
ED / Stroke Team / CT staff / ITU	Although outcome poor, excellent multidisciplinary approach and excellent care from ED to the ITU.
Ward G8 nursing staff	Husband of stroke patient reported care his wife received was fantastic and they couldn't have been more caring or more kind. He couldn't believe how well he was being looked after as her husband - always being offered cups of tea.
Ward Manager on G5	Patient died. Husband said that the ward manager was wonderful and caring. When he went back to give the ward some chocolates, X took the time to speak to him, despite being on the way to another meeting, and gave him a hug which was really appreciated
FY2 Ward G4	Great documentation in the notes about a difficult discussion with the family of a patient who was deteriorating and needed end of life care - showed empathy and kindness.
Named consultant	Wonderful discussion with the family of X who deteriorated after an operation for a hip fracture and was possibly facing withdrawal of treatment

Team	Narrative excerpt
Named FY1	Several lovely discussions with the family of a dying patient clearly documented with empathy and kindness
Palliative Care Team	The family of a dying patient told me it was wonderful to go to see their mum and find that she had been given a blanket and a teddy bear, and that the hospital had volunteers who would sit with their mum when they couldn't.
Named FY1	very good discussion with the family of X about her deterioration and the decision to start end of life care, with consideration for the patient and her family. This is not easy for an FY1 to do unaccompanied but A did it very well
Nurse in ED	Excellent care- early recognition of sepsis and good clear documentation
Named ST7	Good documentation of discussion with family re their dying husband/ father

In addition the following GREATix was reported by a member of staff (unrelated to the LfD review process) "*This is a personal issue but my father is on G4 and probably terminal. All the staff have been exceptional in their caring and willingness to help. My Dad is being looked after excellently but so are we - his relatives. Nothing seems too much trouble. The whole ethos of the ward is just right! I am so impressed*."

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	161	22	41
Q1 19/20	257	115	12	32
Q2 19/20	222	128	22	38
Q3 19/20	275	71	6	17

* SJR = Structured judgement review

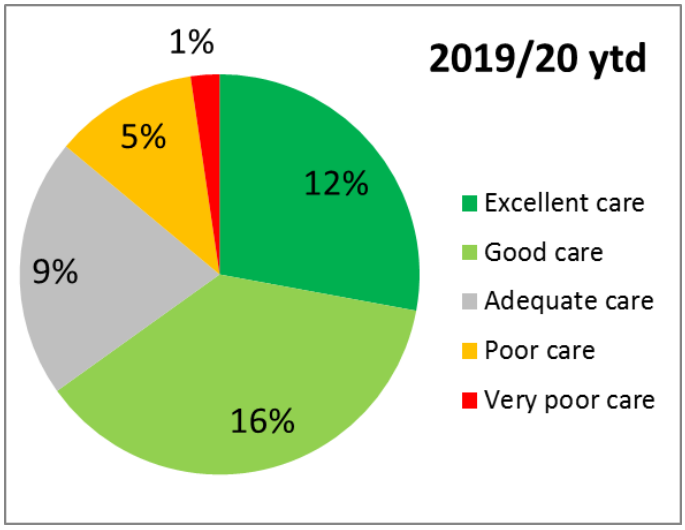


Chart 1: SJR outcome classifications

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 440 cases reviewed in 2019/20 to date only 37 (6%) were classified as Poor or Very poor. 204 (28%) were classified as Good or Excellent.

(data prepared as at 20th March 2020)

Table 3: Poor Care / Very Poor care 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
Q4 18/19	22	0	12	2	3	1 0 confirmed as SI
Q1 19/20	11	0	5	2	1	4 2 already an SI 2 pending SI decision
Q2 19/20	20	0	9	2	1	8 1 confirmed as SI 2 already an SI 3 not an SI 2 pending SI decision
Q3 19/20	6	6				pending pending

Of the six cases of Poor / Very poor care in Q3; none have yet had an executive review to highlight investigation or action requirements therefore no cases have been classified as a requiring Serious incident (SI) decision making.

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	1	3
Q2 19/20	4 (2 still pending)	pending	2
Q3 19/20	2	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 ten deaths in 2019/20 to date which were the subject of an SI investigation, five were found to be "*More likely than not to have been due to problems in the care provided to the patient*", one was found to be "*Unlikely to have been due to problems in the care provided to the patient*" and four are still pending presentation to LFD group. All four cases are scheduled to be discussed in the meetings in Q1 20/21 now they have completed the investigation pathway.

3. Quality Walk About from Q3

During Q3 there were a total of **10 executive-led quality walkabout visits** in the following areas:

- Medical wards: G1, G3, G4, G8, AAU and the frailty unit
- Surgical ward F4
- Paediatric ward F1
- Specialty areas – main outpatients and the urology suite

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 are being added to the future schedule.

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

Opportunities for charitable fund refurbishment of non-clinical areas, storage solutions and a specific point about review of informatics on G1 was also noted (identified two systems which don't 'talk to each other')

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**.

New actions identified during the quarter 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. 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**.

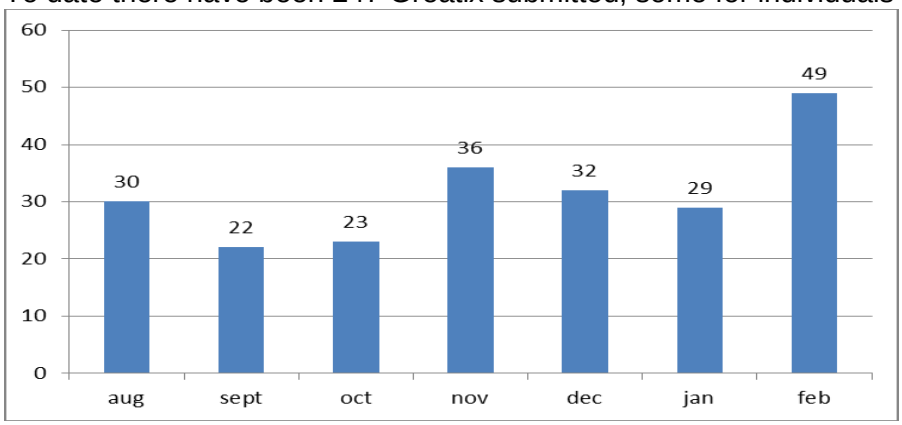
In Q3, an extraordinary walkabout was undertaken to enable **action follow up**. Visits to wards by the Deputy Head of Patient Safety enabled update of closure status as well as evidencing actions in situ. A number of actions were able to be closed using this method which will now be repeated on a quarterly basis. Separate to this, regular email updates via the Datix record are now being undertaken to enable closure of the more simple actions.

The opportunity to incorporate the walkabout schedule into the future plans for **ward accreditation** will be considered as part of the planning for 2020/21.

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 247 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. In 2020 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 and thanking teams

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 four examples from Q3 shared below.

- Three Junior doctors in O&G *They were all singled out for praise by the undergraduate medical students who have been doing an attachment in Women and Child health. All three went above and beyond in providing teaching, support and inspiration to our student doctors. They provided this despite a busy workload, and their efforts were very much appreciated both by the medical students and the consultant body.*

- The Housekeeping team *Responded swiftly and efficiently to a request to clean F10 ready for winter escalation. Not sure if it was anticipated, I don't think there was any pre-warning but within a few hours I received a message to say the clean had started. Outstanding work!*

- ENT doctor on call and the Band 4 on F4. *Doctor due off shift at 5pm but stayed until 7pm to see patients directly referred from ED to relieve pressure at the front door. The Band 4 on F4 assisted with venepuncture and cannulation to allow full assessment and treatment of these patients working hand in hand with the doctor*

Team Support worker (Wheelchair Services) *Visited a patient to complete an outstanding wheelchair issue. Patient advised that they had received an unsuitable showerchair from medequip which meant that they had been unable to have a shower as the chair was too wide to fit through the doorway. X took it upon himself to get the issue resolved which meant numerous calls to organisations. The service is under a huge amount of pressure with capacity but it's encouraging that X still recognised that in the patient's hour of need he was able to influence the situation even though it's not something he would normally deal with.*

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	Dementia
Source	NICE / National Audit Dementia / WSFT Dementia Prevalence Survey
Risk register entry	N/A
Trust owner	Lead Nurse Dementia & Frailty

Summary of learning and areas for improvement in this topic

Dementia Prevalence
- 850,000 people with dementia in the UK - will increase to over one million by 2025 and over two million by 2050
- 1 in 3 people born in the UK this year will develop dementia in their lifetime
- 1 in 6 people over the age of 80 have dementia
- 70 per cent of people in care homes have dementia or severe memory problems (Alzheimer's Research UK / Alzheimer's Society)

West Suffolk Hospital prevalence:
On the last Tuesday of every month we run a dementia prevalence survey, reviewing every adult inpatient to see if they have a known dementia, delirium or cognitive impairment / undiagnosed dementia. Ward breakdowns are shared with the ward teams and Matrons, trust breakdown is indicated below. This shows that on average 25% of our patients have a cognitive impairment.

Month	Beds occupied	Known dementia	Suspected dementia/CI	Delirium	Total	Percentage
30 Apr 2019	443	36	39	34	109	25%
28 May 2019	432	39	28	26	93	22%
25 June 2019	415	46	33	21	100	24%
30 July 2019	423	25	46	35	106	25%
27 Aug 2019	401	34	36	28	98	24%
24 Sep 2019	412	35	36	31	102	25%
28 Oct 2019	395	34	47	18	99	25%
26 Nov 2019	398	36	39	32	107	27%
31 Dec 2019	428	35	44	39	118	28%
28 Jan 2020	453	38	57	44	139	31%

NICE Guidance

The trust has self-assessed against these clinical guidelines / quality statements; in areas where there is not full compliance actions have been identified.

- *NICE Dementia Guideline NG97 - Dementia: assessment, management and support for people living with dementia and their carers (2018)*
- NICE Quality Standard 184 - Dementia (2010 – updated 2019)
- NICE Delirium Clinical Guideline 103 - Delirium prevention, diagnosis and management (2010)
- Delirium Guideline: Quality Standard 63 - Delirium in Adults (2014)

National Audit of Dementia (NAD)

NAD: Round 4 local report received August 2019

- data reviewed and presented to October Dementia & Frailty Steering Group
- highlights and recommendations to December Patient Experience Committee
- highlights and recommendations to December Elderly Medicine meeting

Highlights:

- 100% of staff had dementia training compared to 90% nationally
- 74% face to face training - work shop or study day compared to 55% nationally
- 95% staff indicated that they felt better prepared following training, 92% nationally

4 key recommendations:

- 4AT delirium screen within 24 hours of admission
- use of ‘This is me’ / personal profile
- improve eCare completion of baseline assessment on admission
- information to the Board to identify proportion of patients with dementia for: in hospital falls; delayed discharge; readmitted within 30 days; night time bed moves

Actions:

Improve compliance with screening

- easy access to 4AT tool now available for Doctors via Alert or Tasks
- promote use of 4AT rather than AMTS
- education re need for assessment and how to complete included in Drs training sessions on dementia and delirium
- attending ward governance meetings to show how to access 4AT via alert or tasks
- NICE delirium guidance CG103 – delirium care plan in development

To increase use of patient profile

- share findings at dementia champions meeting & encourage as part of champion role
- use 1 form across the trust – personal profile
- where to record on eCare that this has been completed

To improve baseline assessment recording

- share findings
- ensure everyone auditing knows where information should be recorded in eCare

Current systems in place

- Lead Nurse Dementia, Frailty & Carers (0.8 WTE)
- Dementia Practitioner / Trainer post (1.0 WTE)
- Monthly dementia prevalence survey
- Daily report from eCare
- Monthly dementia report – summary by ward
- Datix reporting set up to enable patients with dementia to be identified
- Quarterly Dementia & Frailty Steering Group
- Dementia & frailty action plan focussed on four key areas: environment / dementia friendly hospital; dementia pathway; patient & carer experience; training & development
- Quarterly dementia & carer champions meetings

Challenges we face

Screening not completed, or completed but not recorded in the correct place (therefore unable to pull this data from eCare)

What we are doing:

- changes to eCare to simplify recording
- focus on 4AT delirium screening (incorporates AMTS dementia screen)
- education – attending ward clinical governance meetings to demonstrate process

Dementia diagnosis not always recorded

What we are doing:

- highlighting at ward clinical governance meetings
- information team collating data from monthly snap shot surveys to enable comparison with daily reports, to demonstrate more clearly the discrepancies
- use this data to highlight the need to record diagnosis in PowerChart
- continue monthly snap shot audit until improvement in recording of diagnosis seen
- 'current confusion', 'cognitive impairment' and 'memory loss' added to terms pulled for daily report

Environment and space

What we are doing:

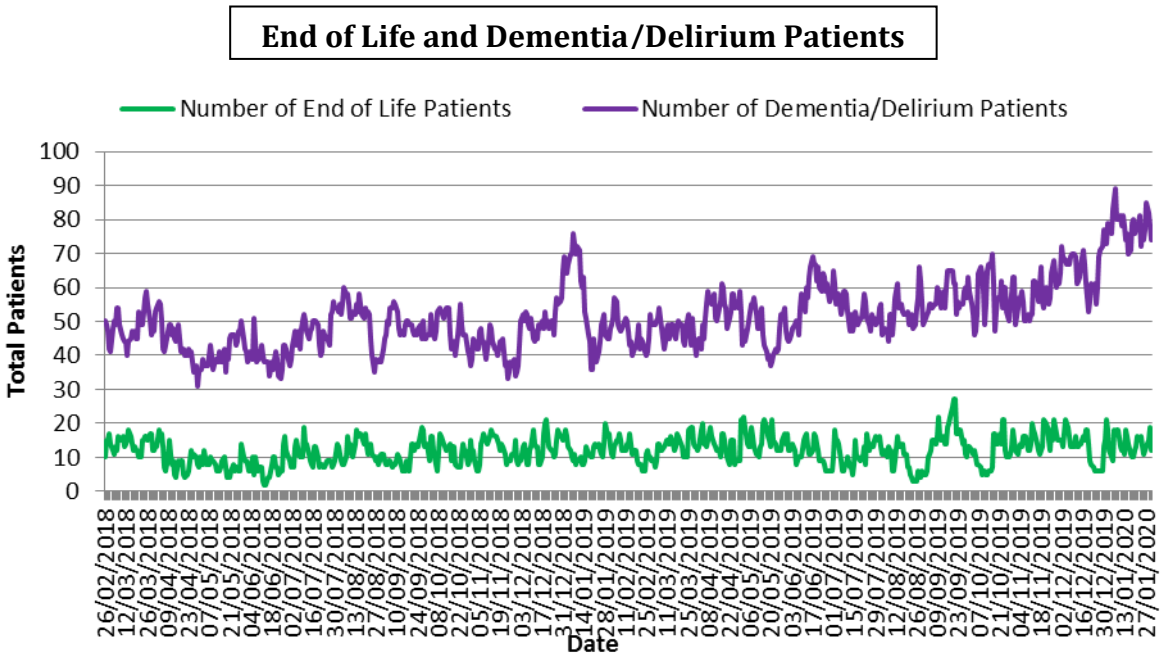
- forget-me-not memory walk on ground floor – some pictures replicated on 1st floor
- using memory walk images for ward pictures – F12, F5, G7
- coloured bays & signage to support way finding – in wards G4, G5, G7, F3, F10
- theatres – pictures for entrance doors and recovery cubicle
- radiology department pictures
- working with facilities to agree interiors strategy for dementia, including signage

Unfamiliar environment / lack of stimulation

What we are doing:

- purchased RITA systems for 6 wards - G4, G5, G8, F3, F7, F9
- activities boxes on wards
- twiddle muffs
- Suffolk Art Link forget-me-not visitors programme
- encourage family to visit
- carers badges to enable more open visiting for family carers

With the numbers of patients with dementia across the trust increasing we are unable to see all the ward referrals. The following chart is taken from the daily acuity report and highlights the number of patients with dementia / delirium in comparison to the number of patients at end of life:



As well as numbers of referrals the complexity of patients is also increasing and there is a growing demand for additional dementia support for the wards. To help manage this demand a proposal was outlined to develop dementia support worker roles

- role function was agreed June 2018
- business case submitted for a team of four band 3 dementia support workers – proposal turned down January 2019
- currently collating further data to evidence the need for additional staff
- looking to pilot one band 3 support worker role

7. Mitigated red risks

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

1) EU exit risk assessment (DATIX ID 3534)
The risk assessment has been downgraded to Amber (Annually x Moderate=Amber)
The current mitigation includes:

- 'deep dive' audit of arrangements and reported governance structure to the Audit Committee
- Business continuity plans reviewed
- Procurement and staffing reviews completed

2) Issues around contacting both paediatric and obstetric staff using medic bleep (DATIX ID 3798)
The risk assessment has been downgraded to Amber (Annually x Major= Amber)
The current mitigation includes:

- If a paediatrician or obstetrician is required in an urgent situation (not emergency)staff to dial 2222 on their baton bleep number. Request switchboard to tell the person required to ring or come to ward area.

3) Ability to deal with contaminated self-presenters (DATIX ID 3805)
the risk assessment has been downgraded to Amber (5 Yearly x Catastrophic= Amber)
The current mitigation includes:

- Decontamination unit handed over to ED
- Portering staff trained in putting up the decon tent

4) Hydroxychloroquine Screening service does not have capacity to meet demand
(DATIX ID 4053)
The risk assessment has been downgraded to Amber (%-yearly x Catastrophic=Amber)
The current mitigation includes:

- Follow-up patients will still be reviewed by existing clinics within the service provision.
- SOP in place
- Patient leaflet provided to patients

8. Learning from RIDDOR incidents

During Q3 the number of incidents reported to the HSE under RIDDOR reduced by one from the previous quarter (five incidents). Learning and mitigation included:

- Improvements to carpark
- Additional moving and handling training
- Maintenance undertaken

9. Learning from patient and public feedback:

Ten complaints received in Q3 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-1581	Five-minute delay in telephone pick up in main switchboard.	• Influx of calls at that time resulted in delays however team have been reminded of the importance of timely pick up.
WSH-COM-1611	Did not do enough to assist patient with personal hygiene.	• Although patient did not tolerate washing by staff, due to aggression aggravated by his dementia, attempts should have been made to inform wife to assist with his care. Highlighted at ward governance meeting.
WSH-COM-1599	Attitude of nursing staff was poor.	• Reflective discussion with the member of staff and senior matron.
WSH-COM-1555	Missed opportunities in reviewing patient's condition and the opportunity for fast track discharge. Due to patient's frailty this should have been reviewed sooner and an application for CHC fast track funding made.	• Information update around services, fast track discharge and hospice care has taken place with the oncology team to ensure lessons are learned from this case. Discharge planning have offered support in ensuring staff understand criteria.
WSH-COM-1602	Community midwife had long nails which is against uniform policy for clinical staff. She conducted a sweep which is an infection risk with these nails.	• All midwives reminded of policy regarding wearing of false nails and Trust uniform policy and professionalism/standards, including discussion with the staff member in question.
WSH-COM-1604	NHS wheelchair provided to patient however there were significant delays in his driving assessment being scheduled, resulting in him being unable to use the wheelchair for several months.	• A new appointment service for wheelchair services has been implemented which will ensure these types of issues are minimised and an appointment was expedited for this patient.
WSH-COM-1619	Appointment scheduled with a consultant patient had requested not to see.	• Review of gynaecology department administration processes. Able to identify how this occurred and booking procedures have been changed to minimise this happening again.
WSH-COM-1592	Delays in initiating palliative care	• Reminder sent to ward staff to reiterate contact with palliative care team and contact details; also included in junior doctor teaching. • End of life training to be delivered to ward staff. • Palliative care ward champions to liaise with palliative care team daily to identify patient who would benefit from extra support. • Consider palliative training and link roles to disseminate better knowledge/skills within team regarding out of hours palliative medical support, improving ward-based situations.
WSH-COM-1580	Delay in prophylactic management of VTE	• Ward has changed their ward round process so that daily check regarding the status of patients and their Heparin injections are carried out. This is being reviewed to be shared Trust-wide.
WSH-COM-1563	Delay in approval of Sativex. Lengthy avoidable delays in submitting IFR to the CCG and patient not kept informed	• Complaint shared with the Drugs and Therapeutics Committee for reflection on processes and issues raised in this case. Pain service has recruited to vacancies to ensure patients receive regular communication updates.

There were no area observations undertaken across the Trust In quarter three

11. Putting you first award

To NOTE a verbal report of this months winner

For Reference

Presented by Jeremy Over

10:50 BUILD A JOINED-UP FUTURE

12. Trust improvement plan

To APPROVE the report recommendations and the plan which addresses the CQC findings

For Report

Presented by Rowan Procter

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 27 March 2020

Agenda item:	12			
Presented by:	Richard Jones, Trust Secretary			
Prepared by:	Richard Jones, Trust Secretary			
Date prepared:	23 March 2020			
Subject:	Trust improvement plan			
Purpose:		For information	x	For approval

Executive summary

Revised introduction in the context of COVID-19

This report provides an overview of the work undertaken in response to the CQC report findings. The original expectations of how and when the Trust would respond is now being reviewed in the context of the national emergency response to COVID-19.

The basis of this report is the plan that we develop a Trust improvement plan which addresses the CQC findings and also incorporates wider organisation improvements in order to ensure a sustainable approach to improvement which is underpinned by robust Trust processes and governance.

Critical to our improvement plans is engaging with senior leaders and clinical groups on areas such as culture, leadership and accountability. With the current essential focus on COVID-19 this activity has effectively paused. While there will be some tactical improvements which will still be delivered at this point our response can only be limited so as not to detract from the appropriate focus of the strategic, clinical and operational capacity on our COVID-19 response.

The Board is asked to note and approve this position. Future reports will provide updates on the appropriate tactical actions and as we progress with our response to COVID-19 we will consider how and when capacity will be available to reengage with the strategic improvements within the plan.

The CQC report contains a total of 74 findings - **32 MUSTs and 42 SHOULDs**. Each of the findings has an Executive lead agreed.

The Executive lead is responsible for the delivery and assurance to the CEO for their allocated findings. Detailed **improvement plans** have been developed for each finding (or group of findings). These are owned and maintained by the executive lead with updates submitted centrally to the CQC-updates inbox.

Exec owner	Must	Should	Total
Craig Black	2	1	3
Helen Beck	7	9	16
Jeremy Over	7	8	15
Nick Jenkins	2	3	5
Rowan Procter	16	21	37
Grand Total	**34**	**42**	**76**

Annex A provides a summary of the improvement plans for the MUST CQC findings. An assurance assessment of the plans has been undertaken by Richard Cracknell, WSCCG. Each exec is meeting with Richard Cracknell to review this assessment and develop their response accordingly.

The February **Quality Summit** highlighted the need for assurance that the improvement plans to address the CQC findings do not only address the specific service issues flagged in the report but ensure that the corporate system within which the activity takes place is robust. For example, the CQC report highlighted the need to ensure that local clinical guidelines within maternity services are in date (CQC finding 27). Action to address this within maternity has been identified. However, there is clearly a need to put in place a corporate approach to ensure the effective access to and management of corporate and service level policies and clinical guidelines.

A summary of key organisational improvements is detailed on Table 2. These are structured as:

- Maternity
- Getting the basics right
- Organisational effectiveness and responsiveness
- Culture and governance

Table 2: Organisational improvements based on reflections, including Quality Summit

Maternity
Review the service's **governance arrangements** to ensure: - Clear executive leadership - Clear accountability and responsibilities from service to Board (linked through corporate teams)
Strengthen governance for **clinical learning** by ensuring that processes for governance, oversight of risk and quality improvement are consistent across the service *(links with Trust-wide improvement)*
Embedded culture across all services and staff groups to: - empower staff to address the basics and escalate their concerns - support changes and improvement (links with Trust-wide *improvement*)
Review how monitoring and assurance of maternity services is **reported to Board** and subcommittees
Map **sources of assurance** for quality and performance in maternity services, including: - use of peer review - User experience is embedded (including Maternity voices). Consider role of NEDs and governors in gaining and reviewing assurance.
Getting the basics right
Develops and empower clinical and management leadership to lead their service's quality improvement, through a framework underpinned by autonomy and clear accountability
Engage in the '***Shared Governance: Collective Leadership programme***' run by NHS England to: - address disconnect between quality and 'getting the basics right' *e.g. what can go wrong is resus trolleys not check or that checking fridges ensures medicines are effective or compliance with mandatory training* - empower staff to be the 'eyes' for the Trust and address concerns locally, but ensure clear escalation when required - support timely adoption of national best practice
Review key systems and process to ensure that they **support staff to do the right thing**, minimising complexity and frustration e.g. incident reporting triggers
Ensure that **improvements made can be** sustained, ensuring clear arrangements to monitor and escalate issues
Review and **strengthen assurance** on the effectiveness of the systems in place, including peer review and service/ward accreditation
Integrate the Trust's quality improvement programme with that of the **Alliance and integrated care system (ICS)**
Embed **active learning** into the Trust's processes to ensure actions are effective in delivering planned benefits. This includes incidents, complaints and clinical audit.

Strengthen **incident reporting** to support reporting, duty of candour and learning from all incidents. Learning the lessons from the national patient safety investigation response framework (PSIRF) pilot
Organisational effectiveness and responsiveness
Improve the access to corporate and service-level **policies, procedures and clinical guidelines**
Demonstrate safe and effective systems are in place to manage **patient surveillance and follow-up** *Links with strategic CQC finding 6*
*Working as part of the integrated care system (ICS) programme delivery performance improvements for **access challenges**, including patient referral to treatment (RTT) time* *Links with strategic CQC finding 9*
Culture and governance
Review the corporate **leadership and accountability for functions that support quality**, including patient safety, clinical effectiveness, risk and quality improvement.
Review the arrangements in place for **freedom to speak up** including the Trust's guardian role *Links with strategic CQC finding 45*
With partners develop tools and metrics which provide confidence that the Trust's improvement plan moves the **organisational culture** as well as the Board, individuals and teams into a place that can deliver the required improvements e.g.360 feedback
Effectively engage with staff and partners to **review the Trust's strategy**, ambition and objectives, reflecting the cultural emphasis to empower staff, ensure openness and embed improvement
Ensure that access to and reporting of **information supports best practice** in supporting the delivery of high-quality care as well as meeting business needs *Links with strategic CQC finding 7*
Review the Board and subcommittee structures and commission an **independent well-led review** based on the NHSE/I developmental review guidance

These key organisational improvements are combined with the 'strategic' CQC findings (Table 3). This combination allows a **comprehensive Trust improvement plan** to be developed for 2020/21 which incorporates CQC findings and can be monitored by the Board ensure we effectively learn the lessons and embed improvements across the whole Trust. The 'tactical' CQC findings will be mapped to the Trust improvement plan and monitored.

Table 3: CQC strategic findings

Ref.	CQC finding
1	The trust must take definitive steps to **improve the culture, openness and transparency** throughout the organisation and reduce inconsistencies in culture and leadership. To include working relationships and engagement of consultant staff across all services.
3	The trust must ensure that processes for **incident reporting, investigation, actions and learning** improve are embedded across all services and that risks are swiftly identified, mitigated and managed. The trust must ensure that incident investigations and root cause analysis are robust and that there are processes for review, analysis and identification of themes and shared learning.
4.1	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - **clinical audit is monitored and reviewed to drive service improvement.**
4.2	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - **mortality reviews are monitored and reviewed to drive service improvement.**
4.4	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - **complaints are monitored and reviewed to drive service improvement.**
6	The trust must ensure that robust processes are embedded for **patient follow up appointments and those on surveillance pathways**. To include systems and process for regular oversight and assurance that patients are not being lost to follow up across all specialties within the organisation.

7	The trust must take definitive steps to ensure that the **information used to monitor, manage and report on quality and performance** is accurate, valid, reliable, timely and relevant.
9	The trust must continue to take action to improve **performance against national standards such as the 18 week referral to treatment (RTT)** standard, six week diagnostic standard ad access standards related to suspected and confirmed cancer management
33	The trust should ensure that consultant and team communication is improved in relation to the North East Essex and Suffolk Pathology Services (**NEESPS**). The trust should ensure that a review of the current working environment, equipment and processes within Pathology services is undertaken to identify and address any immediate ongoing concerns.
34	The trust should ensure that effective processes are in place to promote and protect the **health and wellbeing of all staff**.
45	The trust should continue to promote the **freedom to speak up guardian** so that all staff understand what the role is and know who their guardian is.
65	The trust should ensure that governance and oversight are strengthened to ensure performance and **local audit** are monitored and measured to improve practice.
66	The trust should ensure that processes are in place and effective to monitor compliance with **best practice and national guidance** relevant to the service.

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:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							

Recommendation:

The Board is asked to note and approve this position. Future reports will provide updates on the appropriate tactical actions and as we progress with our response to COVID-19 we will consider how and when capacity will be available to reengage with the strategic improvements within the plan.

The original expectation was that the Board approve the following:

1. To review and comment on the organisational improvement themes (Table 2)
2. To note the identified strategic CQC findings (Table 3)
3. To note the summary of improvement plans (Annex A)
4. To approve the approach of combining the organisational and strategic CQC findings to provide a comprehensive Trust improvement plan. Noting that tactical CQC findings will be mapped to this plan and monitored.

Annex A: Summary CQC improvement plan (for MUST findings)
Note some CQC findings have been grouped and are being addressed through a single action plan e.g. mandatory training

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
1	The trust must take definitive steps to improve the culture, openness and transparency throughout the organisation and reduce inconsistencies in culture and leadership. To include working relationships and engagement of consultant staff across all services.	Jeremy Over	We know that hospitals where staff feel more engaged and supported have better outcomes, lower mortality, reduced infections, fewer mistakes and are more efficient, (M West, 2012: King's Fund). This is why supporting and staff and growing the best culture is crucial for our future. An overarching cultural improvement plan, informed by what staff think and feel, will be developed. It will involve the following approaches: 1. More and better listening to staff feedback to inform how we lead and improve 2. Focused and better support for specific issues and teams identified in the CQC report 3. Greater focus on leadership development and continuous learning across WSFT to ensure we have the best culture The attached action plan details the approaches that will be taken to do this, in support of and in partnership with our staff.	31/03/2021	Staff Survey and Medical Engagement Scale scores Collated feedback and ideas from staff Evidence of staff suggestions put into practice	Reporting to Trust Executive Committee Reporting to Trust Board of Directors Consultation with and feedback from staff representatives - staff governors and union representatives

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
3	The trust must ensure that processes for incident reporting, investigation, actions and learning improve are embedded across all services and that risks are swiftly identified, mitigated and managed. The trust must ensure that incident investigations and root cause analysis are robust and that there are processes for review, analysis and identification of themes and shared learning.	Rowan Procter	Implementation of the WSFT local Patient Safety & Learning (PS&L) strategy with specific reference to key principle 4. 4. 'Continually learning and improving' and local implementation of the NHSI's Patient safety incident response framework (PSIRF)	31/03/2020	1. reports to meetings listed below 2. minutes of meetings below 3. completion of NHSI's PSIRF 'readiness assessment' template 4. updated Incident reporting policy 5. copies of shared learning documents (bulletins, agendas, committee reports, etc.)	PS&L strategy implementation plan will be reported to the Quality group in a monthly basis. There is a standalone implementation plan that sets out PSIRF progress will be reported to Trust Board via the Quality & Risk committee. PSIRF is also subject to external monitoring as it is a system wide project led by Lisa Nobes (Director of Nursing and Quality Suffolk (East and West) and North East Essex CCGs)
4.1	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - **clinical audit is monitored and reviewed to drive service improvement.**	Nick Jenkins	There is a lack of evidence that learning from clinical audit is translated into clinical practice.	01/07/2020	There will need to be structured evidence collected centrally demonstrating implementation into clinical practice of trustwide learning from clinical audit.	This will be monitored and reported by the quality/patient safety/clinical learning team.
4.2	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - **mortality reviews are monitored and reviewed to drive service improvement.**	Nick Jenkins	There is a lack of evidence that learning from mortality reviews is translated into clinical practice.	01/07/2020	There will need to be structured evidence collected centrally demonstrating implementation into clinical practice of trustwide learning from mortality reviews.	This will be monitored and reported by the quality/patient safety/clinical learning team.
4.4	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - **complaints are monitored and reviewed to drive service improvement.**	Rowan Procter	Weekly monitoring by Executive and monthly by the Board	31/05/2020	1. tracking spreadsheet 2. monthly Board report	Weekly review of compliance

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
5	The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are maintained in line with trust policy. To include responding to concerns raised in an appropriate and timely manner and ensuring support mechanisms in place for those involved.	Jeremy Over	1. To undertake a review of HR policies to ensure that they are kinder and more compassionate 2. To use the HR Case Review meetings to include, policy compliance, staff support and learning points. 3. To implement the “Just Culture” approach to HR processes in accordance with the national guidelines “Improving People Practices”.	31/12/2020	1. Policy reviews will be developed in partnership with union representatives and presented at “Trust Council” for ratification. 2. Learning Points and agreed actions will be shared with Trust Council and the Trust Negotiating Committee (Medical & Dental) 3. Implementation programme for embedding the Just Culture approach to be in place with recorded milestones and process for evaluation of impact.	Reporting to Trust Board; consultation and feedback from staff; union representatives and from Staff Governors; and the Health and Wellbeing Steering Committee.

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
6	The trust must ensure that robust processes are embedded for patient follow up appointments and those on surveillance pathways. To include systems and process for regular oversight and assurance that patients are not being lost to follow up across all specialties within the organisation.	Helen Beck	Review, Identify and design process for follow up and surveillance bookings. Revision of SOPs to include new processes and escalation in the event of capacity gaps. Consideration of feasibility to produce a report of all unbooked patients with follow up appointment as the clinic outcome code. To implement and facilitate training to all specialities on the new processes for Follow Ups and Surveillance patients.	28/02/2020	recruitment of 2 members of staff in TAC for ward follow up booking - Completed use of message centre consult template to replace paper clinic outcome slips - change request submitted use of specialty worklists on e-Care for PA/Service managers to track patients they are unable to book - change request submitted SOPS generated - for each specialty on Booking processes, use of message centre, use of worklists Virtual Clinics to be set up for each specialty by Service manager Audit of e-Care follow up list Training to be given on Booking of Follow Ups & Surveillance patients and using Worklists/Message Centre	Relevant service manager to oversee worklists to monitor capacity this will then be reported into individual division weekly RTT meetings, and escalated to weekly Access meeting if required.
7	The trust must take definitive steps to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.	Craig Black				

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
8	The trust must continue to develop information technology systems and integration across the community services	Craig Black	There is a proposal which will shortly go to Trust Board to invest £2.26M to provide Community Health Staff Information Technology and uplift IT Revenue by close to £600K to sustain this. On the authority of the CFO this project has already been initiated with the appointment of a Project Sponsor (Exec Director), Technical Lead and Project Manager. Starting in Jan 2020 Community Sites will be subject to technical survey (planning for change) ahead of infrastructure Implementation and Service Migration that will start in Q1 FY20/21. The Trust expects that by the end of FY20/21 all Community Staff will have up to date technology, access via modern networks and will see a notable reduction in downtime and service interruptions. Once this modern technical platform is in place then the ability to commence far wider service integration and leverage many of the advanced technologies use at the West Suffolk Hospital become possible. At this time a Project Board and a Project Team have been formed and dates for these to meet are now in the diary. The new PM is preparing a Project Initiation Document and draft Project Plan for sign off at the Project Board. Weekly RAG reports will be generated once the project start alongside monthly highlight reports and exceptions reports/plan where necessary.	31/10/2020	Project Initiation Document will set scope and timeline Weekly Project RAG Reports will document progress, record issue and confirm milestones Monthly Project Highlight Reports will confirm progress, manage risks and issues and report on finances Project Exception Reports/Plans will document any variation away form critical path	Project Board is chaired by Chief Operating Officer (COO) and reports via Pillar 3 Programme Board to Trust Digital Board Project Team meets fortnightly is heavily engaged with users and will deliver workstreams Project Manager will generate Weekly RAG reports and monthly Highlight reports

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
9	The trust must continue to take action to improve performance against national standards such as the 18 week referral to treatment (RTT) standard, six week diagnostic standard ad access standards related to suspected and confirmed cancer management	Helen Beck	Business cases to be developed for Orthopaedics, Ophthalmology, General Surgery and Gynaecology which will include up to date demand and capacity models, which will shape the direction of the business cases. The business cases are expected to outline plans and costs to reduce the current backlog and balance the demand to enable the services to meet the national standard. Action plans for all other specialities will continue to be updated on a monthly basis and will be discussed at the new RTT steering group meeting with the ADO's. A comprehensive action plan is under development for Endoscopy now not that demand and capacity has been completed and this will be discussed and reviewed at the new bi-weekly Endoscopy oversight meeting.	31/03/2020	A reduction in the overall RTT waiting list size. Increase in compliance to national standard to that of the national average. Reduction in 52 week breaches. Compliance with national diagnostic standard. Reduction in cancer PTL size and compliance with national standard back to 85% by July.	Monthly RTT steering group meeting, weekly access meeting, Cancer PTL meeting, Cancer steering group meeting with the CCG.

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	Rowan Procter	Implementation of the WSFT local Patient Safety & Learning (PS&L) strategy with specific reference to key principle 2. 'Being open and honest'. which describes four key actions: 1. Carry out duty of candour for patients promptly, sensitively and sympathetically. 2. Report via the IQPR and CDs meetings. 3. Continue to support 'freedom to speak up' by promoting staff guardians 4. Give opportunity for patients, families and carers to participate in SI investigations. Ensure open comms channels throughout process. NB: This has an overlap (but is not directly the same as) CQC ref 3+4.3 with regard to the implementation of the NHSI's Patient safety incident response framework (PSIRF) The DoC project will include looking at WHY we do not have timely DoC completion (which is likely to be multifactorial) not just HOW.	30/05/2020	1. IQPR DoC indicators (timeliness, verbal overdue, written overdue) 2. minutes of meetings below 3. updated Being Open policy	PS&L strategy implementation plan will be reported to the Quality group on a monthly basis. There is a standalone implementation plan that sets out the details
11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	Jeremy Over	Non-adherence to F&PP (excluding those due to length of service of board member) will be formulated into an action plan to enable both ED and NED F&PP pathways and record keeping are appropriate and robust. Initial focus will be on the non executive directors pathway and a local review will be undertaken.	31/07/2020	A fully completed F&PP file for every appointee	HR will undertake a review of the F&PP files on an annual basis. Executive and NED appraisal compliance will be monitored in line with standard trust process. Annual compliance report to the Audit Committee

12	The trust must ensure that mandatory training attendance, including training on safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level	Jeremy Over	Mandatory training • Overall trust compliance levels have risen from 87% in August 2019 to 90% in December 2020. • Review of mandatory training subjects, renewal period and delivery methods was undertaken on 16th September 2019. The expected outcome is an increase in compliance of between 2-4% overall. All actions will be completed in April 2020. • A mandatory training report, including all trust wide mandatory training subjects is reported • Specific streamlining of the junior doctors induction process in place, to include, working with other trusts to transfer existing compliance and supported e-learning on site. • Review of community training data following concerns raised as to accuracy of the data – • Reports are provided on a monthly basis to all managers, detailing compliance for staff. • Community training data – An issue has come to light when the data load was taking place activity was still taking place which has resulted in this information being overridden by the upload which has taken place (this has resulted in end dates being incorrect) Work is now taking place to rectify this. • Education & Training Team are currently inputting the amendments made following the full mandatory training review (see item above). • Following the Mandatory Training Steering group held on the 14th January 2020. Safeguarding Children Level 3 will be reported on yearly, not three yearly. This will be a change for Community Staff, as acute staff are already recorded on a yearly basis. PROMPT training compliance. The education team	31/08/2020	A monthly mandatory report is taken from the trusts HR system (electronic staff record - ESR). This is reported in a number of ways; line managers receive a compliance report outlining all staff, using a RAG system, subject compliance is also reported to the subject matter experts , and the trust board receive monthly reports though the IPQR reporting process.	Monthly directorate meetings review compliance levels. In addition a quarterly appraisal and mandatory board report, including progress with the recovery plan, is reported and discussed at board level.

			will be working closer with the midwifery team to improve their compliance and to review their overall mandatory training programmes. There is a meeting scheduled, between the Education & Training team and Trina Harvey (Midwifery PDN), to discuss midwifery training in further detail. (For information – Rowan Proctor is writing a response on this.) • The implementation of ESR Manager Self Service in April 2020 will also enhance local availability of MT reports and individual compliance Current actions/ processes • Specific induction Days - which are role related and cover mandatory training. These are held on a monthly basis and must be completed on an employee's first day with the Trust. Departmental induction is undertaken by each area, as per the trusts policy. • Mandatory Training refresher days held weekly and are separated by job roles and requirements. • Reports are provided on a monthly basis to all managers, detailing compliance for staff. • Staff have access to Self Service which is available 24 hours a day and shows compliance rates. E17 • Subject leads receive the subject analysis report on a monthly basis. • Data cleansing of OLM career management in relation to the mandatory training review • Meetings are taking place with community leads to ensure the mandatory training requirements are correct • The applicant Portal which allows applicants to access their ESR (Electronic Staff Record) has been launched. The portal allows applicants to access and complete their mandatory			

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
			e-learning training prior to their start date and confirm and track their recruitment status. Any training which has been completed at a neighbouring Trust which is part of the Streamlining project will show on the applicant's portal as already compliant. • A full review of Induction programmes to ensure they are appropriate for both acute and community colleagues. This has meant some significant changes to both the content of training and to the delivery. Changes have been made throughout the year based on feedback from staff. There is a significant change to the layout, which is hoped will balance between staff being trained appropriately and safety without sacrificing unnecessary delays in starting in the workplace. The new programme started in January 2020.			

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
13	The trust must ensure staff complete patient risk assessment to identify patients at risk of deterioration and risk assessments for day to day care activities.	Rowan Procter	e-Care change requests put in place to amend: 1) Changes to triage form, mandate safeguarding concerns yes/no box 2) Changes to triage form, mandate falls history/risk of yes/no box, to then generate ED falls assessment if yes ticked 3) Changes to ED safety checklist, to mandate all fields, to add n/a column, to move pressure area assessment from 2nd hr to 1st hr, to add drop down box on pressure area assessment to choose from skin intact, DTI, category 1-4 (to be able to choose more than one) 4) To mandate observation, pain score fields on triage form for both adult & paediatrics 5) To communicate changes to staff 6) To complete weekly audits to monitor compliance 7) To request compliance data from the information team 8) To have 1-1 with staff which are non-compliant 9) Add to perfect ward	30/04/2020	New e-Care changes to triage form and patient safety checklist completed and live on system 14/01/20 Staff compliance data for new safety checklist requested from information team on 15/01/19 – aw data To complete staff 1-1 when compliance data received from information team. To review perfect ward questions and change accordingly. Changes communicated to ED team via email on 03/01/20 and added to weekly hot topics to ensure ED team had efficient time to review the planned changes 10 days before the live changes were made on e-Care	To complete weekly audits of 10 patients to monitor compliance. To communicate with staff regularly for feedback regarding the changes made +/- continually monitoring any requirements for further amendments

14	The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy.	Rowan Procter	1) Pharmacy to audit all fridge temperatures with in Emergency Department. The maximum temperatures reached are as expected for drug fridges. Some temperatures were almost certainly due to the door being open whilst trying to find stock. Action to address issue resulting from temperature audit: - Introduction of trays into the fridge to keep stock together to minimise time looking for drugs - Pharmacy Assistant responsible for stock replenishment to return all excess fridge stock to pharmacy to improve airflow within the unit - Assess requirement of rigid cold blocks in fridge and remove if unnecessary - Installation of more accurate external fridge thermometers on advice of pharmacy - Request monthly audits from pharmacy to ensure continued compliance 2) Ambient temperature monitoring Ensure appropriate systems and processes are in place to monitor ambient room temperatures in areas where drugs are store and appropriate escalation processes where required. Actions to address issue: - Installation of thermometers in all rooms used for storage of drugs. - Introduction of ambient room temperature checking on to existing fridge temperature checks - Compliance to be audited within monthly perfect ward assessments 3) Escalation of increased temperatures Ensure appropriate escalation of increased temperatures to Unit Manager to ensure appropriate action taken Actions to address issues:	28/02/2020	Outcome and recommendations from pharmacy temperature audit (email from James Curtis dated 22nd January 2020) Communications to staff via email and hot topics. Examples of escalations from staff to unit manager (email examples available) Examples of escalations from unit manager to pharmacy (email examples available)	Daily checks of fridge and ambient room temperatures. Monthly perfect ward audits. Outcomes of pharmacy audits.

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
			- Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) - Issue included in weekly hot topics discussed at all handovers. - Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4) Long term strategy: Trust wide consideration of centralised temperature monitoring			
15	The trust must ensure that staff records in relation to equipment and medication checks are completed.	Rowan Procter	1) Review of documentation for equipment and medication checks Departmental review of existing documentation with a view to simplifying checklists and improve compliance. Actions: - Conducted a review of documentation in January - Removed unnecessary extra checklist for daily paediatric checks - Simplification of resus checks including reduction of date checking from weekly to monthly. - Inclusion of back stacks checking into resus one checklists 2) Review of online checking Duplication of paper and online checking was causing confusion and impact on compliance. Decision taken to remove requirement for online checking while improved paper checks were embedded within the normal practices of the department. Long term strategy to replicate improved paper checklist on to the online system. - All changes communicated to staff via email and hot topics	31/03/2020	Improved checklists Emails and hot topics communication to staff	Completed checklists Perfect ward provides assurance for compliance with completion of checklists Monthly audit for quality of checks

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
16	The trust must improve medicines management, particular in respect of management of controlled drugs, storage of patients' own medications and monitoring ambient room temperatures in drugs rooms.	Rowan Procter	See item 20. for ambient temperature monitoring. Other items will feed into item 15. details tbc. Item 20 - Trustwide action plan in progress with D&T oversight	31/03/2020	Outline the metrics/information that measure performance against this CQC finding	How and where is/will performance against the identified metrics/information be reported
18	The trust must ensure that all bank and agency staff have documented local inductions.	Jeremy Over	West Suffolk Professionals • A generic trust induction checklist is to be enhanced and re-implemented for all new agency and bank workers. • This will be followed up with a local area induction to be completed during first worked shift. Agency and Bank workers will complete local area induction on the commencement of their first shift. If additional shifts are undertaken in different areas, it is the expectation of the trust that a local induction will be conducted for each new area worked. • All bank staff training is to be reviewed and recorded on OLM. Medical Staffing • All Agency staff are given induction booklets before their first day, which they are required to sign and return a statement confirming they have read and understood this on their first day. • Bank medical staff are formed by current training and trust doctors, therefore are covered by local induction process.	30/09/2020	West Suffolk Professionals - Local inductions will be recorded using a standard template issued to the worker on appointment which will be signed by both the individual and the area manager once local induction has been completed. Medical Staffing - Signed confirmations are filed on their personal files.	Ad hoc audit checks will be undertaken by both the West Suffolk Professionals and Medical Staffing teams to ensure compliance. This will be reported to the HR Director on a quarterly basis. The first report will be produced in quarter 2.
19	The trust must ensure that medicines are stored securely within the main and day surgery theatre department.	Helen Beck	Implement Drug Security plan as provided by Simon Taylor	31/03/2020		
20	The trust must improve monitoring ambient room temperatures in drugs rooms.	Rowan Procter	Trustwide action plan in progress with D&T oversight	28/02/2020		

21	The trust must improve monitoring of women’s records and ensure that a greater number of records are audited monthly.	Rowan Procter	Audits to be undertaken weekly until 31/01/2020 and outcomes/learning shared with staff via 'Take 5' and sharing events on a weekly basis. Ongoing auditing of records to be undertaken via perfect ward on a monthly basis. Findings to be fed back via Staff to be reminded to complete via 'Take 5', e-mails. Competency folder present in each area. Every member of staff completed knowledge and competency self assessment. Audit of notes on monthly basis to ensure ongoing compliance and feedback to staff via Women's Health Clinical Governance. Actions to be documented and reviewed on a monthly basis at that meeting. Staff to be reminded to complete via 'Take 5', e-mails. Competency folder present in each area. Every member of staff completed knowledge and competency self assessment. Audit of notes on monthly basis to ensure ongoing compliance and feedback to staff via Women's Health Clinical Governance. Actions to be documented and reviewed on a monthly basis at that meeting. Staff to be reminded to complete via 'Take 5', e-mails. Competency folder present in each area. Every member of staff completed knowledge and competency self assessment. Audit of notes on monthly basis to ensure ongoing compliance and feedback to staff via Women's Health Clinical Governance. Actions to be documented and reviewed on a monthly basis at that meeting. Staff to be reminded to complete via 'Take 5', e-mails. Competency folder present in each area. Every member of staff completed knowledge and competency self assessment. Audit of	01/02/2020	• Details of how information has been disseminated throughout the department: o Copies of Take 5 o Documented evidence of staff attending updating sessions and what has been discussed. o HAS ANYTHING BEEN ADDED TO THE MANDATORY TRAINING?? o Has anything like a competency tool been developed. Particularly for any support staff undertaking MEOWS. How does the service assure themselves that they are trained and competent? • Copy of audit tool • Copy of results of weekly audit compliance. • Actions taken on improving learning from SIs: current processes and examples of information sharing? • Evidence of any Datix completion when MEOWS not been completed?	• Future audit of MEOWS will demonstrate improved compliance. • Completion of appropriate observations will not be a future theme in Datix or

Ref.	CQC finding	Exec owner	Overview of planned improvement	Delivery date	Evidence for delivery	Monitoring and assurance
			notes on monthly basis to ensure ongoing compliance and feedback to staff via Women's Health Clinical Governance. Actions to be documented and reviewed on a monthly basis at that meeting. All staff informed via 'Take 5', CQC 'Back to Basics' folders in each clinical area. Notes audited weekly until 31/01/202 to ensure compliance			
26	The trust must ensure they carry out daily checks of resuscitation equipment.	Rowan Procter	Ward Manager on F11 to check daily. Labour Suite co-ordinators to check daily. Service manager to check weekly compliance in all areas.	31/01/2020		
27	The trust must ensure clinical guidelines are up to date.	Rowan Procter	Business Case for Clinical effectiveness midwife/ safety/audit midwife to be completed. Bank Band 7 midwife to undertake role in the meantime. Survey all guidelines to produce spreadsheet of out of date guidelines/ due to expire soon. Chase up/allocate guidelines. Collate feedback. Approve via clinical governance.	08/02/2020		
29	The trust must ensure diagnostic test results are available in a timely manner.	Helen Beck				
31	The trust must ensure staff complete and record patient pain assessments in patient records.	Helen Beck	Provide updated written guidance on completion of core assessment template where the Pain tool sits. Follow up with training for SystmOne Superusers to role out to teams. Audit process to be agreed and rolled out via Governance Steering Group.	Mar-20	Completion of pain assessments	Via Perfect ward app, Include in CREWS updates, Divisional PRM and CQC improvement plan governance

11:00 GOVERNANCE

13. Trust Executive Group report

To ACCEPT the report

For Report

Presented by Stephen Dunn

Board of Directors – 27 March 2020

Agenda item:	13			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	20 March 2020			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

2 March 2020

Steve Dunn provided an **introduction** to the meeting recognising the impact of recent media coverage on our local population and staff. The operational pressures and plans for Coronavirus were reviewed.

Quality, operational and financial performance was reviewed from the recent reports. A number of areas of challenge were considered in more detail, including consistently capturing patient assessments and referral to treatment (RTT). Plans to maintain and improve performance were discussed, including bringing online additional theatre capacity. Cancer capacity remained a challenge. It was noted that additional capacity within the complaints team is now starting and will support improvements for patients and staff. It was recognised that the receipt of funding, to reflect the addition activity undertaken, will allow us to meet the control target. Although work is still required to ensure that we maintain control of costs and deliver cost improvement plans. The plans for 2020/21 were reviewed, including CIPs and additional pressures e.g. CQC improvement plans.

It was confirmed that a **quality summit** would be held on 4 March with regulators and stakeholders. The draft [presentation as reviewed which centred on four themes: maternity, basics, organisational responsiveness and culture.

A report from the **Quality Group** was received. changes to the quality walkabout process were noted along which action in relation to serious incidents. Plans to develop quality improvement (QI) with our new head of QI were discussed.

A report on **research and development** (R&D) was received. It was recognised that while the level of R&D activity had reduced this remained above plan. The work undertaken was welcomed by TEG.

Two **radiology business cases** were approved to support additional MRI capacity and the move to the use of nasendocopy. The later will reduce diagnostic timeframes and ENT theatre capacity requirements.

The operational preparedness for **COVID-19** was reviewed, including the clinical and operational forms that are being established to support the Trust's preparations and response.

16 March 2020

This meeting was dedicated to reviewing the Trust's emergency response to **COVID-19.**

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

14. Charitable Funds

To ACCEPT the report

For Report

Presented by Gary Norgate

Trust Open Board Meeting – 27th March 2020

Agenda item:	14			
Presented by:	Gary Norgate, Non-Executive Director			
Prepared by:	David Swales, Technical Accountant			
Date prepared:	19 March 2020			
Subject:	Charitable Funds Board Report			
Purpose:	X	For information		For approval

Executive summary:

The Charitable Funds Committee met on 28th February 2020. The key issues and actions discussed were:-

- The Committee noted that the Butterfly Appeal was nearing its target and that this had been a successful appeal.
- The Committee was updated on current and future fundraising events and all were progressing well and providing great exposure for the charity and the Trust
- It was noted that the JN estate had been finalised with total amount of £242k being received. The HS property had been sold and this estate was nearing finalisation and once this is done the funds will be distributed.
- The Committee discussed the RS property this had not sold as the access to the flat was difficult and that this was deterring potential buyers. The executors are to be asked to consider if there were any options in terms of improving the access.
- The Committee noted the successful application for funds towards the changing places bathroom.
- The Committee noted the increase in the role of the Charitable Funds Administrator, this together with the upgrade to the finance system will enable a more flexible approach to administration and will result in amongst other things an increase in gift aid.
- The Committee was advised of the latest position regarding the investment gain. Since the year end this had grown to £150k. The Committee discussed the emerging Coronavirus issue and agreed that to look again at this should the gain reduce to NIL (ie original investment value).
- There was one overdrawn fund caused by VAT not being able to be recovered. The fundholder had been contacted and arrangements were in place to resolve the overdrawn balance.
- The Committee received a presentation for the funding of a play specialist for the ED department. Funding was approved for a 2 year fixed term post.

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							

11:10 ITEMS FOR INFORMATION

15. 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

16. Date of next meeting

To note that the next meeting will be held on Friday, 24th April 2020 at 9:15 am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

17. The Trust Board is invited to adopt the following resolution:

“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

For Reference

Presented by Sheila Childerhouse