Board of Directors (In Public)

Schedule	Friday 28 February 2020, 9:15 AM — 11:30 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, 28 February 2020 at 9.15 in Northgate room, Quince House, West Suffolk Hospital, Bury St Edmunds
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

Agenda Open Board 28 Feb 2020.docx

9:15 GENERAL BUSINESS
Presented by Sheila Childerhouse

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

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

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

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

NHS
West Suffolk
NHS Foundation Trust

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 - Open Board Minutes 2020 01 31 Jan Draft.docx

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

   Item 6 - Action sheet report.doc

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

   Item 7 - Chief Exec Report Feb '20.doc

9:40 DELIVER FOR TODAY

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

   Item 8 - January 2020 IQPR SPC2.pdf

   Item 8 -Integrated Quality & Performance Report_January2020 v4.pdf

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

   Item 9 - Board report Cover sheet - M10.docx

   Item 9 - Finance Report Final - January 20.docx

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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10. CQC inspection report
    To RECEIVE the CQC report and approve the recommendations
    For Report - Presented by Rowan Procter

    Item 10 - CQC report coversheet.doc

    Item 10 Annex B - CQC inspection report.pdf

NHS
West Suffolk
NHS Foundation Trust

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

    Item 11 - Board Report - Staffing Dashboard - January 2020 - Draft.docx

    Item 11 - WSFT Dashboard - January 2020 Final.xls

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12. Nurse strategy update report
    To ACCEPT the report
    For Report - Presented by Rowan Procter

    Item 12 - Nursing & Midwifery Strategy 2016-2021 Update 2020 -20200224 - Final.doc

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13. Consultant appointment
    None to report this month
    For Report - Presented by Jeremy Over

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

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15. Staff Survey and improving our culture
    To ACCEPT the report
    For Report - Presented by Jeremy Over

    Item 15 - Staff survey and improving our culture cover sheet.doc

    Item 15 - Presentation.pptx

    Item 15 - NHS_staff_survey_2019_RGR_full.pdf

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16. Non-emergency patient transport
    To NOTE the report
    For Reference - Presented by Helen Beck

    Item 16 - Non-emergency patient transport.doc

11:10 BUILD A JOINED-UP FUTURE

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17. New hospital development
    To accept the update and timeline for development
    For Report - Presented by Craig Black

    Item 17 - New hospital development update - Board Feb 2020.doc

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11:20 GOVERNANCE

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

    Item 18 - TEG report.doc

19. Audit Committee report
    To accept the report
    For Report - Presented by Angus Eaton

    Item 19 - Audit Committee Report Jan 20.doc

20. Council of Governors meeting report
    To accept the report
    For Approval - Presented by Sheila Childerhouse

    Item 20 - CoG Report to Board Feb 2020.doc

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

    Item 21 - Items for next Board meeting.doc

11:30 ITEMS FOR INFORMATION

22. 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

23. Date of next meeting
    To note that the next meeting will be held on Friday, 27 March 2020 at 9:15 am in West Suffolk Hospital
    For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

24. 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

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For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 31 JANUARY 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		
Tara Rose	Head of Communications		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only)			
Peter Alder, Florence Bevan, June Carpenter, Judy Cory Jayne Gilbert, Robin Howe, Amanda Keighley, Barry Moult, Liz Steele			

Action

GENERAL BUSINESS

20/01 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Angus Eaton.

The Chair welcomed everyone to the meeting. She said that she understood that the CQC report would be on most people's minds and apologised that this was not on the agenda and explained that this was due to timing. However, she assured everyone that work was being done to address the issues in the report and this would be as transparent as possible. The action plan would be on the Trust's website and progress tracked openly so that the organisation could be held to account.

A series of staff briefing meetings had taken place and the board were very disappointed and recognised that there were a number of things that needed to be addressed. A number of issues had already been addressed and there were many others that were being addressed and embedded to ensure these were maintained in the future. The test for the board and organisation was how it responded to this report.

She commended the staff who cared for the hundreds of patients who came through the door and thanked them for all their hard work and compassion. She said that in the past the Trust prided itself on being a learning organisation and this was particularly important now and the board needed to lead and learn. There was a strong compassionate leadership and they needed to fully support staff throughout the organisation to be their best.

20/02 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Liz Steele referred to maternity services and noted that the board papers indicated a drop in the number of births at the hospital. She asked if this was attributable to the issue of safety and also what had and was being done to rectify the failures identified and for assurance that safety had been completely restored.

Rowan Procter explained that within the CQC report and warning notice there were a number of improvements that were required. These had been rapidly implemented and reported to the CQC. These included the Modified Obstetric Early Warning System (MEOWS) which was now in place in both the maternity day assessment unit and the birthing unit and the implementation of Newborn Early Warning Tracking Tool (NEWTT) which would highlight any deterioration in a new born baby. Work had also been undertaken around compliance with asking women if they were victims of domestic abuse. Best practice was that they should be asked twice without their partner present and this had been strengthened and was being audited on a weekly basis. Carbon dioxide monitoring should be offered to every woman at every visit, even if they did not smoke. This was now embedded and was being audited on a regular basis.

It was explained that there did not appear to be a correlation with lower birth rates.

The Chief Executive said that the CQC were receiving weekly information/updates on the actions taken and would be returning in the near future to check these had been fully implemented.

Barry Moult referred to pathology services strategy and noted that there was no plan or costings in it, he asked when there would be more detail behind this. He suggested that not getting accreditation would make it harder to recruit staff. He also asked when cost savings would be seen.

Nick Jenkins explained that a pathology strategic board meeting had taken place on Monday where this had been discussed and they were asked when a work plan and any costs associated with it would be seen. It was expected that this would be within the next three months. It was not yet clear who from North East Essex and Suffolk Pathology Strategy (NEESPS) and ESNEFT would do this work.

Discussions were taking place with staff about whether they should be employed by ESNEFT or WSFT if they were working on this site. These discussions were continuing with the medical director from ESNEFT. The Chair said that she understood that these staff would like to be employed by WSFT and she had had discussions about this with the Chair of ESNEFT and a meeting was being arranged to discuss this further. Nick Jenkins agreed that staff would like to be employed by WSFT.

The Chief Executive said that this had been a source of ongoing frustration with both WSFT's board and pathology staff. The CQC report also raised this as a concern. He said that those responsible needed to redouble their efforts on this.

Gary Norgate explained that there was now a separate sessions as part of the scrutiny committee agenda where the pathology team were invited to discuss the four basic areas including accreditation and workforce. If these were addressed the relationship between the two sites would improve as well as the quality of service.

Jayne Gilbert referred to the CQC report and asked the NEDs for assurance that the Trust's policy for freedom to speak up was fit for purpose because from anecdotal evidence she did not think it was. Gary Norgate explained that the CQC had real concerns about freedom to speak up, but as senior independent director he had had several cases passed to him which showed that people were speaking up and had

the opportunity to be heard and their concerns acted upon. However, taking into account feedback that had been received an internal audit was being undertaken to look at this which would help to gain additional assurance. Discussions were also taking place with the national guardian to assist with this.

The Chair said that serious reflection was needed as the CQC report showed that not everyone in the Trust felt that this was the case. Even if the staff survey showed that people felt they had the freedom to speak up, if anyone felt that this was not the case this needed to be addressed. Alan Rose agreed and said that one data point did not give the answer and the Trust was trying to open up a series of channels so that there were many different ways that people could speak up and be heard. He said that the Trust should not be obsessed about policies but should let people raise issues through whatever route they wished. The Chair said that there would be a lot of worked focussed around this particular issue.

20/03 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

20/04 DECLARATION OF INTERESTS

None to report.

20/05 MINUTES OF THE MEETING HELD ON 29 NOVEMBER 2019

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

20/06 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following update given:

Item 1751: It was noted that 'ongoing' was still showing in various reports and this was not acceptable and it should be highlighted if the timescale was slipping. Craig Black agreed and said that there were a lot of 'ongoings' in the IQPR which was why this action was showing as amber. He had gone back to the individuals responsible for completing their sections of the IQPR about this, therefore an improvement and reduction in the number of 'ongoings' should be seen. There would be more detailed reports next month with timescales and actions. Louisa Pepper said that it was more important for people to be honest and provide an explanation as to why a timescale was slipping and the challenges that they were facing. Helen Beck reported that drop-in sessions had been set up to support people providing this information.

Item 1752: Need a clear plan, including timescales, to deliver improvement in nutrition performance (including feedback from the F9 pilot). Rowan Procter reported that nutrition assessments had improved and were on an upward trend. The outcome of the pilot had not yet been reviewed as to whether this had been positive or not.

Item 1754: Provide an update on action to improve access/use of care plans in e-Care. Rowan Procter explained that she was waiting for one more email from one of the community teams to confirm they had had training in e-care.

Item 177: Review delivery of the new model for non-emergency patient transport. Gary Norgate congratulated Helen Beck on the actions taken around this and the improvements that had been seen. She explained areas that WSFT had taken over had seen significant improvements which had also resulted in a saving on taxis etc. Further information would be available next month. The Chair said that the most important thing was that this was good news for patients.

Item 1791: Provide an update on the plan for development of the new hospital, including financial implications of the loan. The development must be underpinned by engagement with stakeholders. Craig Black explained that the strategic outline case (SOC) was being put together and meetings would be taking place with internal and external stakeholders. The Chair thanked Gary Norgate for his insight into this work.

The completed actions were reviewed and there were no issues.

20/07 CHIEF EXECUTIVE'S REPORT

The Chief Executive said that he would like to apologise for the shortcomings identified by the CQC in their report and he was sorry to have let down the public, patients and staff. He was determined to deliver the required improvements that were set out in the CQC's report. He explained that immediate action had been taken following the warning notices and there had been a number of conversations with the CQC on areas where they had safety concerns. The board and governors had also been briefed on the actions taken around the follow up issues that had been identified. Work would continue to be undertaken and shared with the CQC and board and would be a component of the improvement plan.

The report raised issues about staff not feeling able to speak up and concerns were raised by the CQC that the Trust did not have an open and empowered culture. It also highlighted a disconnect between the executive team and some consultants. As a result the Chair and Chief Executive had met with medical staff to listen to their concerns and there was now a need to move forward and fully understand and respond to some of the concerns and issues raised. It was important to ensure that there was the right culture in the organisation and that a variety of mechanisms were available for people to raise concerns and safety issues and that the executive team were hearing and listening. There was also a need to ensure that services were as safe as they could be and that safety remained the Trust's number one priority. If one person felt that they were not being listened to and were fearful about raising a concern that was one person too many.

The board was taking the report very seriously, although it was difficult to read. It was important that they listened, responded and learned quickly and put things right. The board wished to drive the improvements and see a more open and empowering culture and build on this feedback.

There had been a difficult internal investigation which related to failings in care and this had been openly and honestly communicated to the family. There had also been a significant data breach which had underpinned some of the internal investigations. However, it was clear that mistakes had been made around this investigation and that this could have been handled differently and more considerately. It was known that staff were upset about how this had been handled and the board would continue to reflect on this and an apology had been made to staff. An independent review had been commissioned and the outcome of this would be shared and the recommendations acted on.

He said that while there was a lot in the CQC report that required action and a response to, it also praised staff for the kindness, compassion and respect that they showed patients in both the hospital and the community. This was very important and must be acknowledged as staff continued to go the extra mile. Their team work was also highlighted and this was critical in delivering safe and effective care, whatever role they played across the organisation.

The hard work of staff had been evident during the past few weeks and they had been extremely busy but the organisation had been coping better and appeared to have learned lessons from previous winters. He paid tribute to staff for this and the way in which they had been recognised in the CQC report.

Alan Rose asked the executive team what they could do differently to address the issues in the report relating to the disconnect between themselves and consultants. The Chief Executive said that they needed to get out into the organisation and not be perceived as sitting within Quince House. A cultural and openness review would be undertaken specifically looking at medical engagement and a medical engagement survey would be undertaken together with a comparison with other NHS Trusts about how they supported staff and delivered an open and empowering culture. Certain specialities had been identified in the CQC report, ie pathology, paediatrics, anaesthetics. Discussions needed to be had with these groups of staff in particular and they needed to be listened to. Discussions would also be had with senior clinicians in these areas.

An action was also being considered about putting in place regular sessions for the Chief Executive and Nick Jenkins to meet with the whole consultant body and link this into internal audit and training days. Once the review had been completed and recommendations made a discussion would also take place with Henrietta Hughes, the national freedom to speak up guardian, about whether she could assist in reviewing the Trust's freedom to speak up arrangements and bring in best practice from elsewhere and consider whether there should be a freedom to speak up guardian from the consultant body. Discussions had also been had with the Trust Executive Group (TEG) about the feedback from this report and what needed to change, particularly around leadership structures to ensure more co-production of the some of the Trust's policies and approaches.

Jeremy Over said that there had been a lot of reflection; however it was important that ideas for improving support processes were shared with staff and that they were asked for feedback on these proposals. NEDs were also getting involved in this, particularly through a closer insight into the working lives of consultants. Gary Norgate said that he had recently done a back to the floor with Nick Jenkins and had had a good conversation with a consultant. He also referred to the rapid intervention vehicle (RIV) and discussions at the previous board meeting about whether it would be possible to have two of these. This was not possible but the hours for the existing vehicle had already been extended and it was helping more people.

The Chief Executive said that this Spring would be the five year anniversary of the Trust's strategy which would need to be updated. Therefore conversations needed to be had with all staff about the culture and organisation that WSFT wanted to be. He proposed considering supporting staff as the number one ambition and to make the organisation even kinder and more compassionate than it already was. He also referred to community services delivering a very strong and good outcome from the CQC report which was a very good achievement and thanked staff for this.

The Chair acknowledged this and said that she was very proud of community services which were key to the independence and wellbeing of patients.

Jeremy Over reported that the Trust had reached the 80% target set by NHS England for all hospitals for flu vaccinations.

DELIVER FOR TODAY

20/08 INTEGRATED QUALITY AND PERFORMANCE REPORT

Rowan Procter reported that there had been a month on month increase in pressure ulcers but this was mainly in the community; there had been a reduction in the number in the acute hospital site. A deep dive was being undertaken along with benchmarking with other organisations to assist in coming up with an action plan with trajectory time lines with specific numbers and it was hoped to have this for next month. The tissue viability team had been increased both in the acute hospital and community and staff in the community were being trained on this. **R Procter**

Interviews had taken place yesterday for additional staff for the patient experience team. There had been some very strong candidates and once their start dates were known it would be possible to give clearer timelines for responses to complaints. The Trust's policy for complaints stated a turnaround time of 25 days but this was currently at 35 days, which was still in line with national guidance. Some support had been provided from HR and the CCG to assist with responses but this was still a challenge.

Alan Rose suggested the response rate for complaints should be monitored on an SPC chart as the ability to respond in a timely fashion was very important as well as the number of complaints received. Rowan Procter explained that complaints response and action plan was part of the CQC action plan. They had commended the depth of responses to complaints and the learning from them. **R Procter**

Two patients who came into the emergency department (ED) breached the national standard of treatment within one hour for sepsis. Further training was taking place for ED staff on this.

There was an action plan for duty of candour as part of the improvement plan for the CQC and further clarification around this would be issued. The Trust also had a policy on duty of candour which was in line with national guidance, however clear guidance was needed on when duty of candour should be applied, ie at what point it should be undertaken. Nick Jenkins said that it was not always obvious when duty of candour should take place, particularly if an issue did not directly relate to a specific patient.

Gary Norgate said that this was a good transparent report. He referred to the CQC report and some of the statistics in this paper and noted that there appeared to be an ongoing problem in Women and Children in a number of areas. He asked Rowan Procter if she was confident that she had an understanding of all the problems within Women and Children. She said that she could not identify evidence of particular problems but recognised the need to look into this further. There was a new head of midwifery and external support was also being provided and a significant improvement plan was being pulled together but actions from these would need to be embedded to ensure that they were sustained. She explained that some of these were nuances, ie not recording that a women had been asked if she was in pain while she was in labour.

Gary Norgate asked if the board should expect to see an improvement in the statistics and, if so, when. Nick Jenkins said that the work that Rowan Procter was undertaking needed to continue, ie the relevance of measuring nutritional assessment of women who come into the Trust to have a baby. It was proposed to bring back one of the reports on the work being undertaken to enable the board to have an understanding of this. **R Procter**

Craig Black said that there was something about a balance between complete transparency and important indicators that came to the board. It was an incumbent of the whole board to understand the relative importance of the metrics within each area, eg nutrition assessments in maternity versus in medicine, pharmacists discussing medication within Women and Children verses a medical ward. Each area needed to focus its efforts on things that were important to patient groups and the board needed to ensure that the focus was on things that could make a real difference to patients.

The Chief Executive referred to the external assistance and support in midwifery and that clarity was required on what they should be doing and tracking in maternity. He agreed that the focus needed to be on the areas that were most important.

The Chair said that the integrated quality and performance report (IQPR) was very detailed and there would be also be an action plan as a result of the CQC report. There was a need to work out how this could be reported effectively and clearly. It was explained that Craig Black was working on this with Richard Jones. **C Black**

Richard Davies referred to a number of items in the IQPR that appeared to be basic and were things that people should be doing. He asked if there was a worrying culture of complacency as a result of the Trust having previously being rated as outstanding. Rowan Procter said that this needed to be reflected on with the leadership team but at grass roots level it had not made things as easy as it could have done. However, there was now an assessment tool that had to be completed when a patient was admitted. She did not consider that there was complacency amongst nurses etc. The Chief Executive agreed that doing some of the tasks was part of the day to day fundamentals about delivering safe and effective services and there was a need to look at how to motivate and gain assurance that this was being delivered, ie motivate people and maintain the pride and passion of staff.

Helen Beck referred to discharge summaries in A&E where there had been a slight improvement but this was still not at the level it should be. She explained that this was very difficult in A&E compared to inpatients and the Trust was working on how this could be done differently. Currently this was a holding position and she expected to be able to deliver further information by March. Non-elective discharge summaries had improved but further work was still required. Elective discharges summaries were achieving but this was easier for elective patients.

Referral to treatment times (RTT) had been identified as an issue in the CQC report and had been discussed regularly at board meetings. The CQC had said that the action plans were not necessarily robust. However there was a real issue around capacity within the organisation and the Trust had not been able to outsource activity locally as it had planned for. The capacity and demand analysis by speciality was currently being updated to inform a series of business cases for additional substantive capacity. Theatre one was being recommissioned as part of this year's capital programme but the revenue costs would be significant and would require system support.

There had been open and transparent conversations at the contract meeting with the CCG in order to meet the required target. The current national average performance was just over 84% and it was suggested that the Trust should work toward getting back to the national average during 202/21 subject to agreement of additional funding from the CCG It was proposed to bring the results of the work being undertaken to the scrutiny committee for a more in depth review and it was hoped that there would be a detailed plan in March. Alan Rose said that it would be helpful to know the specific constraint for each area, ie capacity, staffing etc. **H Beck**

Helen Beck referred to diagnostics within six weeks and two week wait performance and alerted the board that this would be moving towards a new standard which was 28 days to either getting a cancer diagnosis or being clear that there was no cancer. This national standard would be implemented from April onwards and was expected to be 75%; the Trust was currently at approximately 72%. This meant a lot of work would need to be undertaken to change pathways etc. Colorectal and endoscopy were moving towards 'straight to test' which would reduce waiting times by several weeks and result in a more sustainable achievement of 62 day performance. However, this would be very challenging and there would be a variation in standards while moving to this. A lot of work was also being undertaken in urology around outpatient prostate procedures.

The Chair said that she was very pleased that this should result in a more sustainable performance. It was important to remember that patients were waiting to be treated and the Trust should do everything possible to do things as fast as possible for patient experience.

It was noted that there had been a 19% increase in cancer referrals this month which highlighted the need to change pathways. Nick Jenkins referred to 'straight to test' and explained that although this would speed things up it could increase the number of tests that patients had. Also from a patient experience point of view the test would not necessarily be framed in context by a consultant. There was a need to be aware that this would not necessarily be the best use of resources or provide the best patient experience. Helen Beck acknowledged this but explained that this was a national and strategic direction of travel with a view to developing and creating diagnostic test centres.

Richard Davies agreed that there could be an issue but it was also about communicating with primary care and what was expected from GPs about having conversations with patients.

Louisa Pepper referred to RTT having been discussed by the board for a long time. She asked if the Trust was making the most efficient use of theatres and consultant resources due to the tax issue. The Chair said that the chairs' network was doing a great deal of lobbying to resolve this. The Chief Executive said that this was nationally recognised as an issue and he had spoken to Simon Stevens about this. Helen Beck said that theatre utilisation for inpatients was above the national benchmark but there was still the opportunity to improve day cases. The Trust was also looking at moving inpatient to outpatient procedures where possible.

Gary Norgate asked for assurance that patient experience had not worsened as a result of the new metrics in A&E. Helen Beck said that WSFT was the first of the pilot sites to involve Healthwatch who had assessed patient experience through the process and the evidence was that this had not had a negative impact on patient experience.

20/09 FINANCE AND WORKFORCE REPORT

Craig Black reported that the issues this month were the same as in previous months and were also highlighted in the Chief Executive's report. There was a continued overspend on pay which related to the additional activity being undertaken. The metrics report showed a position where expenditure was broadly in line with activity. This should provide assurance to the board and external organisations that expenditure was well controlled and the bottom line generally reflected the additional work.

Discussions had been had in the wider health economy about reasons for over expenditure and trying to find a solution. In previous months the board had been discussing reforecasting the final position and they had not wanted to rely on anything coming out of these discussions. The opportunity to reforecast the final position was at the end of January, however the Trust was now forecasting that it would achieve the control total which would result in achieving sustainability and transformation funding (STF), which was important for capital expenditure.

Discussions had taken place with the CCG and region who had agreed the original forecast which would be underpinned by receipt of additional income to cover the additional patients that had been treated. This reflected the strength of relationships within the local health economy and with the regulator.

The board had previously discussed the guaranteed income contract and the risks around it, but had consistently said that relationships within the health economy and how it responded to pressure was more important than the balance sheets of organisations.

WSFT was one of the few organisations which had not yet spent most of its capital plan; however it was planning to do so by the end of the financial year. It had submitted a forecast of its capital expenditure position to the regulator including an assessment of its ability to spend additional capital if it became available, this would be around supporting IT work within the community. This endorsed the board's approach to the capital position.

Controls around cash still remained strong.

Alan Rose commented on the very good relationships within the health system and also acknowledged the analytical efforts of the finance department. He suggested that demand projections needed to go forward into next year. Craig Black agreed that this was very important as additional funding was non-recurring, therefore it did not change the financial challenges for next year. He stressed that the system remained under pressure operationally, clinically and financially.

The Chair said that the board needed to be aware that some of the things that had been talked about relating to the improvements required in the CQC report were likely to require some investment and it needed to be cognisant of this.

Gary Norgate congratulated the finance team on their credibility but said that this could easily be lost. He asked about the need to still achieve the additional £1.8m CIP. Craig Black explained that while the Trust would still endeavour to achieve the £1.8m CIP it should not rely in it and the additional funding had offset this. However, the message in the organisation was that it still needed to achieve this saving. This was particularly important for next year and future performance.

Gary Norgate noted the very good job that had been done in recruiting nurses. He asked for assurance that the organisation would not become more inefficient as it recruited more people and that there would be savings on temporary staff. Craig Black confirmed that there were controls in place on the use of temporary nurses and medical staff in order to maintain its position. Nick Jenkins said that this would need to be monitored carefully as the Trust engaged with the CQC's action plan. He said that some of the costs could be due to the challenging financial situation the Trust was in and the board needed to be seen to listen and respond to anxieties about always trying to make things more efficient. Helen Beck agreed and said that a need to maintain financial controls could be result in inefficiencies operationally.

Gary Norgate noted a reduction in surgery and asked if this would continue. Craig Black said that this was mainly due to a reduction in inpatient elective activity as emergency activity increased. This should reverse once winter pressures reduced.

20/10 WINTER PLANNING – TRACKING REPORT

Helen Beck reported that the Trust had seen a 5.4% increase in demand on bed capacity. The RIV was having a very positive effect and over 300 patients had also been discharged through pathway one which was helping to keep demand down.

The charts in this report showed that the position was also much tighter at lunch time which was a reflection of the lack of capacity and pressure being seen. This was mitigated as far as possible through use of the discharge waiting area but there were still times when patients being admitted and patients being discharged did not quite balance.

The suspended elective programme had been re-planned and non-urgent orthopaedic activity re-booked.

She explained that beds referred to staffed beds and when they could not be properly staffed a decision had to be made. Both nursing teams for the escalation areas had been able to have a day for human factors training which had also helped to build them together as teams.

The winter escalation area F9 would be open all the time and G9 wold be flexed as and when required.

Helen Beck said that winter planning was now business as usual until the escalation wards closed. A lessons learned paper would be brought to the board in April/May; she asked if the board still wished to see this report for the next couple of months. It was proposed that highlights should still be brought to the board and lessons learned would always be very important. **H Beck**

Helen Beck noted that this year everything appeared to be calmer and staff were happier as they had been brought together as a team. She said that human factors were also very important.

Alan Rose said that the charts were very useful. He asked about the midday chart which showed that the organisation was breaching bed capacity a lot of the time and asked about the timescale of this and how it affected patient experience. Helen Beck said that for operational teams it could be more than an hour or two, but for individual patients it was an hour or two and the discharge waiting area was also used which was very effective in improving patient experience. The key indicator which would be shown in the closed board meeting was the length of stay for admitted and non-admitted patients.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

20/11 NURSE STAFFING REPORT

Rowan Procter explained that the staffing required for escalation areas had been included in this report but had resulted in agency and bank spend in order to mitigate risks. A number of newly recruited nurses from overseas would be joining the Trust in the next couple of months.

There were significant issues with the lack of objective structured clinical examination (OSCE) training centres and being able to book staff onto these. A letter had been sent to OSCE sites to ask them to increase capacity for WSFT.

Richard Davies noted there were a number of vacancies on F8 and in Bury Town and asked if there were any issues around these. Rowan Procter explained that this was a secure ward and there were vacancies and also vacancies in Bury Town. The Chair asked if Rowan Procter was confident that people were being appointed as quickly and efficiently as possible. Jeremy Over confirmed that this was the case but there were some areas for improvement and this was being followed up.

20/12 MANDATORY TRAINING AND APPRAISAL PERFORMANCE REPORTS

Jeremy Over explained that this report provided more in depth information than the IQPR including appraisal rates and trend lines. The CQC report had six recommendations relating to mandatory training and two which related to appraisals.

Since the CQC visit in October the Trust was now on target for mandatory training, ie 90%, but this was an average across the organisation. Further information was provided in the appendix to this report. Mandatory training and appraisal action plans were in place and were constantly being worked on and divisions supported to help them get to target levels. Appraisal compliance levels still needed to improve but this was at its highest level for a year. Performance meetings with divisions focussed on areas that needed to improve for both mandatory training and appraisals.

Gary Norgate said that the next question must be quality of appraisals, while maintaining the quantity. There needed to be a measure that the board could track.

It was explained that results of the staff survey should come back to the next board meeting.

20/13 SAFE STAFFING GUARDIAN REPORT

Nick Jenkins referred to the breakfast meeting club that had been set up to enable staff to escalate clinical or non-clinical concerns. He also highlighted the 'too tired to drive' facilities. It was noted that the better working lives group (BWLG) did not only focus on consultants but also on junior doctors.

Alan Rose referred to the question, "is there anything you want to escalate" and suggested that this should also be asked to nurses or a broader range of staff. The Chair agreed that this would be worth considering. **R Procter**

Richard Davies was very pleased that a doctors' mess was being set up in the emergency department which was so important.

20/14 CONSULTANT APPOINTMENT REPORT

The board noted the appointment of the following consultants:

Dr Anita Lazarevska, Consultant Radiologist
Dr Flora Daley, Consultant Radiologist
Dr Sarahn Smith, Consultant Radiologist

20/15 PUTTING YOU FIRST AWARD

Jeremy Over reported that Putting You First Awards had been received by a team of secretaries who had been supporting the MMODAL project for over a year.

The nomination from Sarah-Jane Relf read:

"They have worked closely with the project team to provide their input through the design stages so that we could develop something that would be great for their colleagues. They have also been piloting the new way of working and helping to address the any issues that arise.

This has been a 'bumpy' project with lots of ups and downs – one step forward and six steps back! However, the secretaries have remained positive throughout and often keep the project team going by offering encouragement and reminding them that the final prize will be worth it.

After many months of work, the new secretarial workflow is looking really good. There is a much faster workflow and, with the automated sending of letters, there are also some important safety gains.

The secretaries have been amazing and I can't speak highly enough of how important they have been to this project."

Craig Black said that these individuals had been truly excellent. He explained that this solution could have been perceived as a threat to medical secretaries but they had been completely engaged with the project and contributed to the improvements. The Chair said that this showed that change could be managed in a way that could be supportive not threatening. Kate Vaughton agreed and said that this was a testament to personnel across the organisation.

BUILD A JOINED-UP FUTURE

20/16 INTEGRATION REPORT

Kate Vaughton referred to the consultation on national guidance for primary care networks. The system had fed back on the individual specifications but colleagues' views were that it could result in a considerable amount of additional work which they did not have the resources for. It was important to keep focussing on and embedding the localities and that from a national point of view they were listened to.

There had been some very good work in the integrated neighbourhood teams (INT) which had identified a piece of work within the localities and were working with consultants in the hospital as well as GPs. They were also holding engagement events with the public in the localities and education events on various topics which had been very positive. It was requested that governors were kept informed of dates and details of engagement events with the public. **K Vaughton**

She highlighted the work being undertaken on mental health transformation and the new models that were being developed.

Details of the Realising Ambitions were given in Appendix 1 of this report. A total of £437k had been awarded to 24 organisations in the voluntary sector. Case studies for some of these would come back to the board. The Chief Executive thanked Louisa Pepper for her support in this as part of the grants panel.

Alan Rose asked if there were opportunities across the alliances for members of the workforce to move and rotate more seamlessly. Kate Vaughton confirmed that this was the case but there was also a challenge around seamless movement and joint recruitment. The Chair said that work was also being undertaken at ICS level to look at the issues at a more strategic level.

Helen Beck reported that real progress had also been made at locality level and management arrangements between health and social care. They were working to get better alignment across the areas.

Richard Davies asked about the health and social care contract and the risks around this. Kate Vaughton said she had had a long discussion with the chair of the local medical committee (LMC) about this. She did not think this would materially change what was being done around engagement at locality level. Nick Jenkins agreed and said he hoped that progress would continue and things would not change as a result of this.

20/17 DIGITAL BOARD REPORT

Craig Black highlighted the rollout of Mmodal and productivity gains; in some instances there had been a 100% improvement in productivity around medical secretaries' letter production.

The digital programme board had received a demonstration of both the atrial fibrillation and risk stratification dashboards, which were part of pillar two. Both of these were ground breaking and using information which was making a difference to patients' lives.

Pillar three was working towards exiting the current community IT contract and WSFT taking responsibility for the provision of IT services in the community. A lot of work was being undertaken in order to facilitate this at the same time as trying to invest in technology in the community.

Louisa Pepper referred to a quality walkabout she had undertaken on Tuesday and issues around some of the workstations on wheels (WoWs) in the Acute Assessment Unit. She asked for assurance that there was a fully costed programme for equipment that was required within the hospital and the community. It was proposed that she discussed this with Craig Black outside the board meeting. **C Black**

Gary Norgate commented on the go-live of e-Care across maternity services which were currently at the centre of a lot of attention. As a NED he was fully assured about the plans for this to be rolled out safely and staff were being supported as part of the solution. He said that this was a great step forward that was being well managed.

GOVERNANCE

20/18 TRUST EXECUTIVE GROUP REPORT

Helen Beck reported that on 6 January it was confirmed that national reporting on exit would stop, which meant that the Trust had reduced its risk rating to amber. This would be reviewed again in July when any impact would be assessed.

20/19 QUALITY & RISK COMMITTEE REPORT

The board received and noted the content of this report.

20/20 CHARITABLE FUNDS REPORT

The board received and noted the content of this report.

20/21 REMUNERATION COMMITTEE REPORT

The board received and noted the content of this report. The Chief Executive proposed that all the requirements of the fit and proper persons test (FIP) should be reviewed by this committee. Richard Jones explained that this was being addressed would be built into the audit programme for next year.

20/22 REGISTER OF INTERESTS

The board received and noted the content of this report.

20/23 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted but it was acknowledged that there would be additions.

ITEMS FOR INFORMATION

20/24 ANY OTHER BUSINESS

Nick Jenkins reported that there had now been two confirmed cases of coronavirus in the UK (Newcastle) in people who had returned from China. He said that this was not unexpected and none of the advice to the public and healthcare organisations had changed. Daily updates were received from Public Health England and within the organisation discussions had been had taken place with the microbiologists, AAU, ED, maternity and paediatrics who all understood the process to follow should patients arrive with symptoms.

Kate Vaughton said that communications had gone out to primary care and they were briefed and ready to react.

Richard Davies asked if there was any indication that people were over reacting and turning up at ED. Nick Jenkins said that that there had not been any indication that this was happening so far.

The Chair asked if he was confident that community services had been briefed on this. Tara Rose said that they had received the same briefing and national guidance on the actions that they were required to take.

20/25 DATE OF NEXT MEETING

Friday 28 February at 9.15am in the Northgate Room, Quince House, West Suffolk NHS Foundation Trust.

RESOLUTION TO MOVE TO CLOSED SESSION

20/26 RESOLUTION

The Trust board agreed to adopt the following resolution:-
"That members of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960.

6. Matters arising action sheet

To ACCEPT updates on actions not covered elsewhere on the agenda

For Report

Presented by Sheila Childerhouse

Board of Directors – 28 February 2020

Agenda item:	6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	20 February 2020			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

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

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

Actions are RAG rating as follows:

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

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

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

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

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1751	Open	27/9/19	Item 8	Continue to improve the narrative in the IQPR to ensure consistency and clarity in terms of 'When' field for timing of improvements e.g. pressure ulcers. Also agreed as art of next phase of IQPR development to review the SPC metrics which are indicators as future performance	1/11/19 - agreed to provide more granular responses, if unable to state a timescale for improvement then indicate the blockers to doing this. An individual response has been sent to highlight the areas which require stronger narrative. There is a need to review the IQPR and its scope - this will be followed up at future Scrutiny Committee **31/1/20 agreed to bring back plan on how IQPR will provide clarity on timescale for delivery**	CB	~~31/01/2020~~ 24/4/20	Red

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1752	Open	27/9/19	Item 8	Noted overview of nutrition performance in the IQPR and quarterly learning reports. However agreed that need a clear plan, including timescales, to deliver improvement (including feedback from the F9 pilot).	**Nutrition compliance is improving and continues on an upward trajectory due to continued focus at Ward level. There continues to be specific areas of concern and this mainly centres around paediatrics. There are plans to split the data from adults and paeds to present the trajectory in this format with an aim to achieve 95% by April 2020 in adult compliance. We are meeting with the information team to ensure the criteria is correct for this and we are capturing all the data. There has been increased focus in paediatrics and an action plan has been requested. With regard to the pilot on F9, this has been placed on hold due to being unable to recruit into the position for the trial. There has also been a change in the Service Manager, and the vacancy has also lead to the pilot being put on hold. This will be discussed at the Nutrition Steering Group this month.**	RP	~~29/11/2019~~ 24/4/20	Red

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1777	Open	1/11/19	Item 16	Prepare updates for Board based on agreed schedule in response to the national FTSU guidance	An updated FTSU strategy will be developed in light of planned work with the National Guardian's Office, and the recommendations of an imminent internal audit report following a review undertaken in January. Board to receive updates on progress	JO	27/3/2020 ~~31/01/2020~~	Green
1791	Open	29/11/19	Item 2	Provide an update on the plan for development of the new hospital, including financial implications of the loan. The development must be underpinned by engagement with stakeholders	Governance structure for new development was submitted to the Scrutiny Committee and will be reported to the Board in April as part of the strategic outline case (SOC)	CB	24/04/20	Green
1796	Open	29/11/19	Item 16	Undertake clinical risk assessment for the areas of non-compliance with the 7-day services standards	This has been discussed at Clinical Director's meeting and an update will be given at March Board as part of the next scheduled update on 7-day working.	NJ	27/03/20	Green
1797	Open	29/11/19	Item 22	Use the results of the annual governance review to inform the scope of the developmental review planned for 2020	Responses from the annual governance being collated and will be analysed alongside the CQC report and improvement plan	RJ	27/03/20	Green
1802	Open	31/1/20	Item 8	Detailed report on mitigation and timescale for improvement on pressure ulcer performance		RP	27/03/20	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1804	Open	31/1/20	Item 8	W&C performance across a range of metrics is poor – based on review of individual indicators e.g. pharmacy discussion re meds, pain and nutrition draw together a list of key indicators that will provide assurance to the Board on safety performance within the service		NJ	27/03/20	Green
1805	Open	31/1/20	Item 8	Provide a detailed report to Scrutiny committee on 18 weeks improvement plans, including detailed service-level plans with proposed target date for improvement		HB	27/03/20	Green
1807	Open	31/1/20	Item 10	Consider how the positive approach of asking 'anything you'd like to escalate' question for doctors could be applied to other groups		RP	27/03/20	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1754	Open	27/9/19	Item 8	Provide an update on action to improve access/use of care plans in e-Care	The transformation team are spending time with district nurse team to look at a number of issues. One being the e-Care access that they have and how this is used. There will be an update later in December. All access is given and staff are using it when needed – confirmation email has been issued to staff to provide assurance this is correct. **Confirmed that all community areas have now had training and are using e-Care when needed.**	RP	29/11/19	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1775	Open	1/11/19	Item 11	Review delivery of the new model for non-emergency patient transport	The new proposed model outlined at the previous Board was implemented at the beginning of December. We have seen significant improvements in the quality and timeliness of the inpatient discharge service which we are now managing internally. In relation to the outpatient service we do not yet have the December performance data (to be discussed at the contract meeting on Wednesday, 29th January), however whilst there are still some issues with this part of the service anecdotally we believe there has been an improvement. Performance data to provide assurance on this will be presented to the next meeting. **AGENDA ITEM – Non-emergency patient transport**	HB	~~31/01/2020~~ 28/2/20	Complete
1803	Open	31/1/20	Item 8	Develop the complaint section of the SPC summary to monitor response rates as an SPC chart as well as number of complaints	**AGENDA ITEM - Summary SPC**	RP	28/02/20	Complete
1806	Open	31/1/20	Item 10	Bring highlights as required rather for the winter plan rather than a standard report – include in CEO report if appropriate	Summary update provided in CEO report	HB	28/02/20	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1808	Open	31/1/20	Item 17	Provide clarity on the maintenance programme for workstations on wheels (WoWs) and planned replacement programme	During 2019/20 40 new mark 3 WoWs have been deployed. The Mk3 units have greater memory, a faster processor and the latest batch run Windows 10 and have a better configuration with improved performance. The IT engineering team are building a next generation Thin Client WoW. These use the same basic cart we have across the hospital but have an iGEL Thin Client computer, coupled to a 24 inch HD monitor, a wired scanner and a Tap & Go pad plus a new infection control keyboard and mouse. It also has a better battery, which should see charging reduce to twice a week, it is lighter and will deliver improved performance. A review meeting with suppliers in March will agree the final action progress this specification, allowing hardware to be purchased and building units to commence.	CB	28/02/20	Complete

7. Chief Executive’s report

To ACCEPT a report on current issues from the Chief Executive

For Report

Presented by Stephen Dunn

Board of Directors – 28 February 2020

Agenda item:	7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	20 February 2020			
Subject:	Chief Executive's Report			
Purpose:	X	For information		For approval

Executive summary:

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

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

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

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

Recommendation:

To receive the report for information

Chief Executive's Report

I think it important to start this report with **my reflection on the Care Quality Commission (CQC)** report and our new rating. First of all, I would like to say sorry. I am sure you were disappointed, as I was too, to read our new CQC report and find out our Trust is now rated as requires improvement. This is not the standard that our patients and community deserve. We must continue to quickly and effectively fix the issues raised in this report. We've addressed the immediate safety concerns and the Trust has taken action - including the introduction of nationally recognised monitoring for women and their babies. We've listened to what the CQC has said and getting things right for our patients is our top priority.

The CQC rated the Trust overall as 'good' for being effective and caring, and 'requires improvement' for being responsive, well-led, and safe. Of the Trust's individual service ratings, 42 are rated 'good' or 'outstanding', 11 are rated as 'requires improvement', and one is rated as 'inadequate'. The report signals areas where improvement is needed, including some areas not fully managing infection risks, medicines management or record keeping well enough, and staff not always feeling able to raise concerns. The CQC inspectors found that Trust staff across the board: 'treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions', and that they 'gave patients and those close to them help, emotional support and advice when they needed it to minimise their distress'. I am so pleased that our hardworking staff have been recognised.

Although inspectors reflected that we 'promoted an open culture' and had 'visible and approachable' leaders, it is clear that in some areas our staff are not feeling as supported as they should be. We appreciate and value our staff and know their knowledge and expertise will be at the heart of addressing some of the problems the CQC has identified. We will be reviewing our culture and openness to make sure there is an environment where everyone – including our patients, our staff and our commissioners – has an opportunity to contribute and play a full part in our improvement. We will have an opportunity to hear more about this at the Board meeting when we talk about the work we are doing and discuss the most recent staff survey results.

I am still immensely proud of the work our staff do, every day, to care for people in their time of need. We will make the improvements required. It's important to highlight our community teams, who were inspected for the first time as part of our Trust, and did themselves proud. They were rated as good overall, with inspectors highlighting areas of 'outstanding practice' in health services for children and young people. I'm delighted to have our community teams on board, and by continuing to work closely together we can absolutely learn from each other's best practice.

The CQC report also highlights that staff treat our patients with compassion and kindness, and as our staff surveys highlight the majority of our staff are proud to work here. We will build on this foundation in driving the improvements that are needed. Our staff make a profound difference to people's lives on a daily basis. We are here to care for people and their health in their times of need. We must not lose sight of this. And together as a leadership team and as a board, with the support of our Council of Governors, we will fix the things that need fixing. We are developing a robust improvement plan with an executive lead for each of the actions we've been given, and progress on this will be formally monitored at Trust Board and reported back to the CQC. We will also share our progress on this regularly.

One thing all our staff can help with is about getting the basics right. We will have a renewed focus on ensuring the correct processes are being followed across the board – from infection prevention to mandatory training. We need to make sure our staff are ensuring risk assessments, data, documentation and record keeping are all up to date – it will help us minimise the chance of patient safety incidents. This is something we will be focusing on in our regular quality walkabouts. We will also be making improvements to our electronic systems and clinical governance to ensure that, if something doesn't go to plan, we will learn and improve. We need to identify risks quicker and

share lessons wider, across our organisation. As well as ensuring an open culture, we need to be safety focused, taking human factors into account. I think these come hand-in-hand, and if we get the basics right the improvements will naturally follow.

As well as the CQC report's findings, there has continued to be some **high-profile media coverage** about our Trust, including coverage about a data breach investigation. A review of this investigation process is being commissioned, which I welcome. The review is being commissioned by NHS Improvement, and overseen by Ed Argar MP, Minister of State at the Department of Health and Social Care. An independent review with maximum transparency is the right way forward, and we are in support of this approach and again, hope to learn from the results.

I would like to **thank our staff** who have responded so well as we have experienced sustained activity and operation pressures over the New Year and January. Our plans for the winter supported our response but early January we took the decision to suspend our routine elective activity for two weeks. This allowed us to better manage activity during the period of very high demand until we were able to safely staff and open our planned surge capacity on G9. This capacity was opened in line with our plans on mid-January using 16 beds, the ward can flex up to 29 beds if required. The main impact of the decision to suspend routine elective activity was on orthopaedic joint replacements, I am pleased to say that due to the flexibility of the clinical teams and hard work of the operational teams all of the affected patients have been rebooked. We continue to track activity against our **winter model** and since the forecast spike in late January we have seen sustained pressure above the forecast levels. As a result of this we are now rebasing the prediction taking in to account the most recent data. An update on progress will be provided at the meeting.

Overall in terms of January's **quality and performance** we continue to be challenged against a range of metrics. There were 63 falls, 48 Trust acquired pressure ulcers and four C. difficile infections. The challenge of demand and capacity continues with three areas failing the cancer targets in January - cancer: 2 week wait for urgent GP Referrals with performance at 84.5%; cancer 2 week wait breast symptoms with performance at 78.1%; and cancer 62 day GP referral with performance at 74.0%. Referral to treatment performance for January was 78.9% with twelve patients waiting longer than 52 weeks. The Trust is part of a pilot scheme trialling a number of new metrics for emergency department (ED) performance. When the new metrics have been agreed nationally they will be included in this integrated quality and performance report.

Our **financial position** remains a concern. However, in January we have been able to account for the additional income associated with our increased activity which has improved our position. As a result the month ten position reports a surplus of £285k YTD which is £3.6m worse than plan YTD. Due to the additional funding we are able to forecast to meet our plan which is to break even in 2019-20 and this is in line with our control total. In order to achieve this we need to deliver a cost improvement programme of £8.9m.

The NHS and Public Health England (PHE) are extremely well prepared for **coronavirus**. Following national guidance all hospitals are putting in place NHS 111 pods at their emergency departments, so that anyone attending hospital with symptoms of the virus can be kept isolated from other patients and avoid causing unnecessary pressure in A&E. Over the coming weeks many more of us may need to self-isolate at home for a period to reduce this virus's spread. Everyone can continue to play their part by taking simple steps such as washing hands to prevent the spread of infection and calling NHS 111 first before going to the doctors or A&E if they have any concerns about or show symptoms of coronavirus. You can find the latest information and advice from Public Health England at www.gov.uk/coronavirus.

NHS England has published **operational planning and contracting guidance** for 2020/21. We are responding to these requirements from a Trust and system perspective including operational, workforce, transformation and financial settlement requirements.

Deliver for today

Bleep volunteers: now available on Sundays too!
Our fantastic bleep volunteers are now available seven days a week. Our volunteers can: deliver and collect drugs from pharmacy; deliver and collect meals from the kitchen; deliver patient notes to clinics; take patients in wheelchairs to a clinic or ward; and run ad-hoc errands for patients (for instance, buying a newspaper).

Invest in quality, staff and clinical leadership

Funding boost for Changing Places toilets
Patients with complex disabilities are set to benefit from improved, state of the art, toilet facilities in our hospital. The Trust has received £60,000 in new funding from the government to build a new Changing Places facility, one of several areas across the country to do so. The hospital's My WiSH Charity have match-funded the project to make it possible. Changing Places are toilets with additional equipment for people who are not able to use the toilet independently, including adult-sized changing benches and hoists. Disabled patients visiting the West Suffolk Hospital will now have access to these new, state of the art facilities.

Build a joined-up future

College nominates Trust for national award
A longstanding partnership between our Trust and West Suffolk College has seen us shortlisted for a national apprenticeship award. The annual apprenticeship conference awards 2020 is a 'celebration of excellence in apprenticeship delivery' where organisations and providers are awarded, and gain the recognition they deserve for their commitment to driving apprenticeships. We have been shortlisted in the Health and Science Apprenticeship provider of the year category after being nominated by the college – who currently support 20 senior healthcare support worker apprentices working at the hospital. The two organisations have been working in partnership for over 10 years and have supported over 200 apprentices as part of a working collaboration. The college nominated the hospital for the award and explained: "*Our partnership has ensured quality teaching has been delivered, professional assessments completed, and the achievement of apprentices has been exceptional giving them the opportunity to follow their dreams and aspirations*."

National news

Deliver for today

Emergency Care Improvement Programme – End of life care project
This report is part of a 12 month programme of partnership working between Hospice UK, NHS Improvement and four acute trusts exploring the patient, family and carers' experiences by walking through a potential journey - from the hospital car park, through the Emergency Department (ED), an acute assessment ward, a general ward, mortuary and bereavement services. The report includes four case studies, the walk through report and a Rapid Improvement Guide.

Health matters: physical activity - prevention and management of long-term conditions
(Public health England)
One in three adults in England live with a long-term health condition and they are twice as likely to be among the least physically active. This edition of Health Matters focuses on the benefit of physical activity for the prevention and management of long-term conditions in adults.

Invest in quality, staff and clinical leadership

Rebuilding our NHS: why it's time to invest (NHS Providers)
The long-term plan for the NHS set out a vision for an NHS built around preventive and technologically enabled models of care. This report argues that there needs to be an appropriate capital settlement to support the ambitious vision of the plan. Delivery will require the transformation and upgrade of existing facilities, as well as enhanced digital capabilities and investment in diagnostic equipment. In recent years there has been a prolonged under-investment in facilities across the English NHS as a whole, which has left too many providers with inadequate buildings, failing equipment and an inability to adopt new technologies to improve care.

An organisation losing its memory? Patient safety alerts: implementation, monitoring and regulation in England (Action Against Medical Accidents AvMA)
This report reveals serious delays in NHS trusts implementing patient safety alerts which are one of the main ways in which the NHS seeks to prevent known patient safety risks harming or killing patients. The report also identifies serious problems with the system of issuing patient safety alerts and monitoring compliance with them.

Productive Ward programme – what has been the impact? (NIHR)
The Productive Ward quality improvement programme has shown some procedural changes on hospital wards in England in the 10 years since it was introduced, but evidence to show any sustained changes to the experiences of staff or patients is hard to find. This study used quantitative and qualitative methods to evaluate the programme in six acute hospitals in England. It found some evidence of a lasting impact, such as wards continuing to display metrics and using equipment storage systems, but most hospitals that adopted the programme had stopped using it after three years (often due to a change in their approach to quality improvement).

Guarding the Guardians: what can trusts do? (NHS Providers)
Blog post describing the experiences of Freedom to Speak Up Guardians (FTSU) from a supervision group funded by the East London Foundation Trust. The post details the difficulties faced by FTSU and the role of the Executive Lead and CEO in supporting and empowering the FTSU.

Build a joined-up future

QualityWatch: Quality and inequality (Nuffield Trust)
This analysis finds people living in the most deprived areas of England experience a worse quality of NHS care and poorer health outcomes than people living in the least deprived areas. These include spending longer in A&E and having a worse experience of making a GP appointment.

What people want from the next ten years of the NHS (Healthwatch)
Following the publication of the NHS Long Term Plan, Healthwatch was asked by NHS England to talk to people across the country about how they wanted the priorities to be implemented locally. Key findings show that people affected by cancer, heart and lung conditions had a much better experience of care than those with dementia, mental ill health or learning difficulties - who report that support often wasn't in place for them and professionals did not give enough consideration to their full range of needs.

Growing our own future: A manifesto for defining the role of integrated care systems in workforce, people and skills (NHS Confederation)
This document outlines the workforce powers, freedoms and responsibilities ICSs and STPs increasingly seek and the local commitments and relationships necessary to deliver change. The manifesto sets out six key points, covering increased autonomy, deployment of the local health

and social care workforce, accountability, local initiatives, such as ‘Grow Your Own’, clarity around the future role of arms-length bodies and a wider perspective of the NHS as a major influencer in local skills development and employment.

How will we know if Integrated Care Systems (ICS) reduce demand for urgent care? (Strategy Unit)
This report describes the adoption of ‘blended payment’ schemes as a payment model to encourage the provider to moderate growth in activity by assigning them a share of the annual savings or the cost over-runs. This risk-reward sharing model is currently seen as the most appropriate way to distribute resources in the healthcare system. The National Tariff Payment System has recently adopted blended payments for emergency activity.

9:40 DELIVER FOR TODAY

8. Integrated quality and performance report

To ACCEPT the report

For Report

Presented by Rowan Procter and Helen Beck

Trust Board – February 2020

Agenda item:	Integrated Quality & Performance Report			
Presented by:	Craig Black			
Prepared by:	Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	February 2020			
Subject:	SPC Integrated Quality & Performance Report			
Purpose:	x	For information		For approval
Executive summary:	The attached report contains a new style of performance reporting using statistical process control charts.			

Trust priorities	Deliver for today			Invest in quality, staff and clinical leadership		Build a joined-up future	
	X						
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		x					
Previously considered by:	Monthly at Trust Board						
Risk and assurance:	To provide oversight and assurance to the Board of the Trusts performance.						
Legislation, regulatory, equality, diversity and dignity implications:	Performance against national standards is reported.						
Recommendation: That the report is noted.							

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Understanding how performance data are presented in our Board papers

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

What is it?

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

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

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

What will it show me?

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

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

What does it look like?

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

Generally speaking:

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

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

Assurance (how we're doing)

No target:

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

Hit and miss against target:

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

Consistently below target:

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

Consistently above target:

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

Variations (the trends)

Common cause variation:

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

Special cause variation (blue or orange):

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

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

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

Charts

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

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

A control chart always has:

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

These lines are determined from historical data.

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

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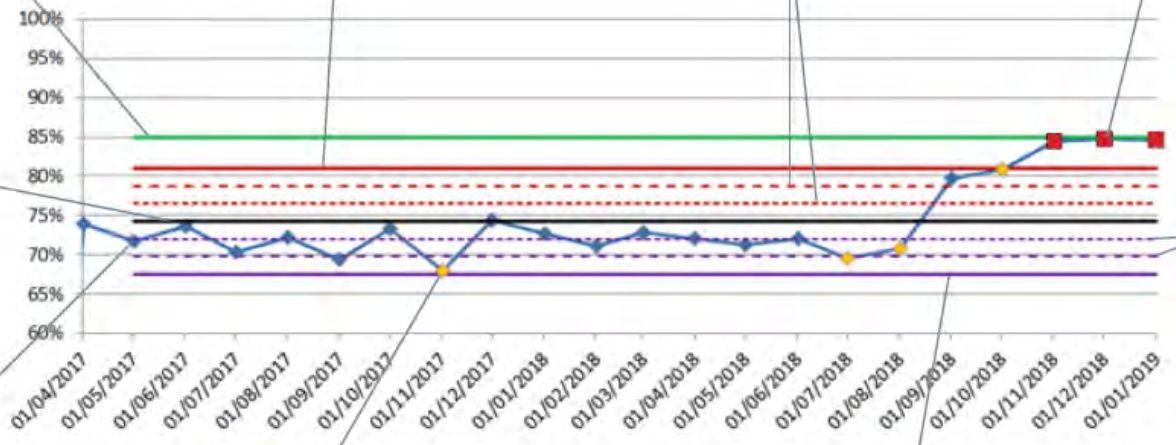
SPC chart: example graph

Green line: shows the Trust or national standard (if there is one)

Solid red line: shows the upper process limit, i.e. the upper limit of what the Trust should statistically be capable to produce. It's plotted at a distance of +3 standard deviations from the average

Dotted red lines: Show +1 and +2 standard deviations from the average, to show movement towards the upper process limit

Red data points: these plot the performance against the date on the bottom axis, and show special cause variation (statistically significant either positively or negatively) outside the expected limits



Black line: shows the average, or mean, performance

Dotted purple lines: Show -1 and -2 standard deviations from the average, to show movement towards the lower process limit

Blue data points: these plot the performance against the date on the bottom axis, and show common cause variation (no statistical significance)

Yellow data points: these plot the performance against the date on the bottom axis, and show special cause variation (statistically significant either positively or negatively) within the expected trend

Solid purple line: shows the lower process limit, i.e. the lower limit of what Trust should statistically be capable to produce. It's plotted at a distance of -3 standard deviations from the average

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Summary Table

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

Date	Jan-20

Safe domain	Standard	Actual	Trend	Assurance	Notes
New Pressure Ulcers - Trust	0	48	Special Cause Variation - High	Consistently above target	

Effective domain	Standard	Actual	Trend	Assurance	Notes
Discharge Summaries: Outpatients	85%	ND	ND	#VALUE!	No data since August 2018
Discharge Summaries: A&E	95%	84%	Common Cause Variation	Consistently below target	
Discharge Summaries: Non Elective Admissions	95%	83%	Special Cause Note/Investigation - High	Consistently below target	
Discharge Summaries: Elective Admissions	85%	88%	Special Cause Note/Investigation - High	Hit and miss against target	

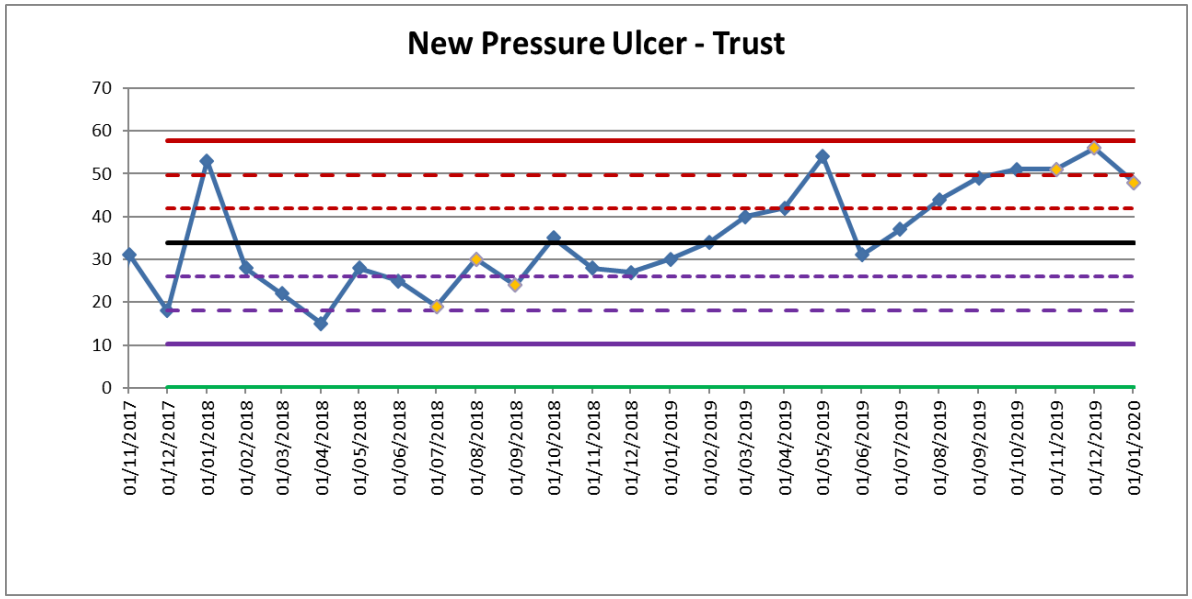
Caring domain	Standard	Actual	Trend	Assurance	Notes
Compliments	No target	33	Common Cause Variation	No target	
Complaints	20	22	Common Cause Variation	Hit and miss against target	

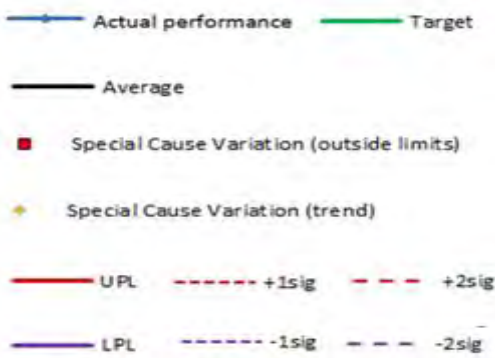
Responsive domain	Standard	Actual	Trend	Assurance	Notes
Referral to Treatment 18 week standard	92%	79%	Special Cause Variation - Low	Consistently below target	
Diagnostics 6 week standard	99%	93%	Special Cause Variation - Low	Hit and miss against target	
Sepsis	100%	74%	Special Cause Note/Investigation - High	Hit and miss against target	
Cancer 2 week GP referral to assessment standard	93%	85%	Special Cause Variation - Low	Hit and miss against target	
Cancer 2 week breast referral to assessment standard	93%	78%	Special Cause Variation - Low	Hit and miss against target	
Cancer 62 day referral to treatment standard	85%	74%	Special Cause Variation - Low	Hit and miss against target	
Community referral to treatment within 18 weeks	90%	98%	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%	10%	Common Cause Variation	Hit and miss against target	

Maternity	Standard	Actual	Trend	Assurance	Notes
Number of deliveries (births)	210	215	Common Cause Variation	Hit and miss against target	
Caesarean Section rate	22.6%	26%	Special Cause Variation - High	Hit and miss against target	
Breast Feeding Initiation	80%	82%	Common Cause Variation	Hit and miss against target	

Pressure Ulcers - Trust





Narrative

Owner	Rowan Procter
What	Special Cause Variation - High
Why	After a month on month increase in new pressure ulcer's since Jun 19, a reduction has been observed for Jan 20. The highest incidence is within the community teams. We have also noted an increase in pressure ulcer present on admission to our services suggesting increasing complexity to the needs of our patients, which is reflected during daily escalation calls between team leads.
How	Trust Pressure Ulcer Lead to meet with Quality Improvement Lead on 20.02.20 to discuss statistical basis for potential change in process of investigation of new pressure ulcers, to ensure that process is valid and themes identified for learning to be actioned.
When	February 2020

Safe

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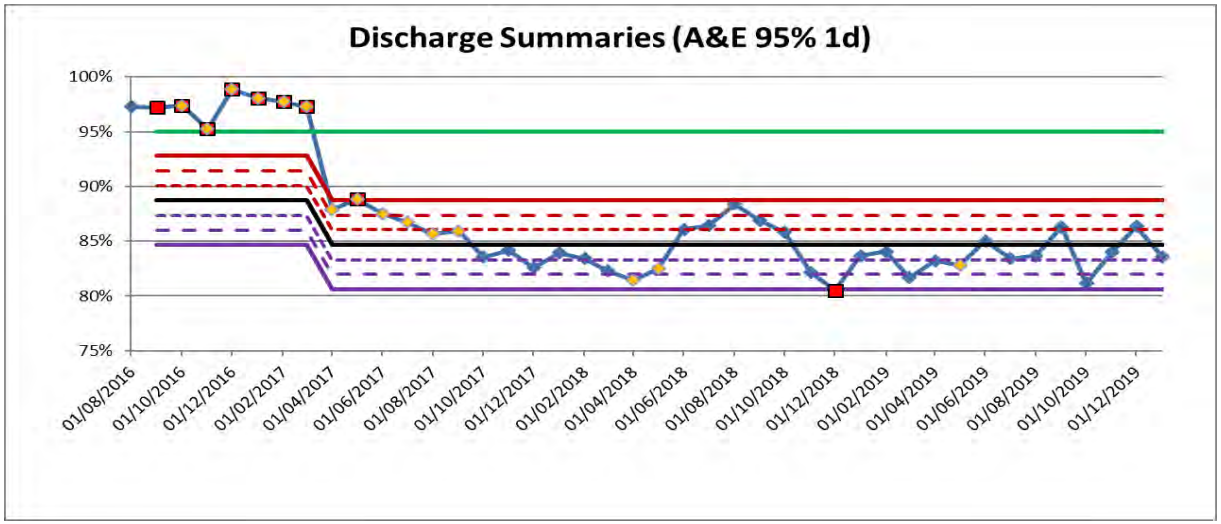
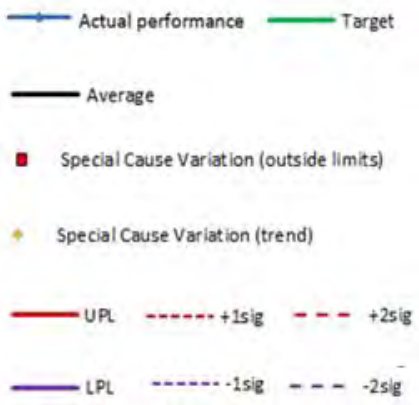
Discharge Summaries ED





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

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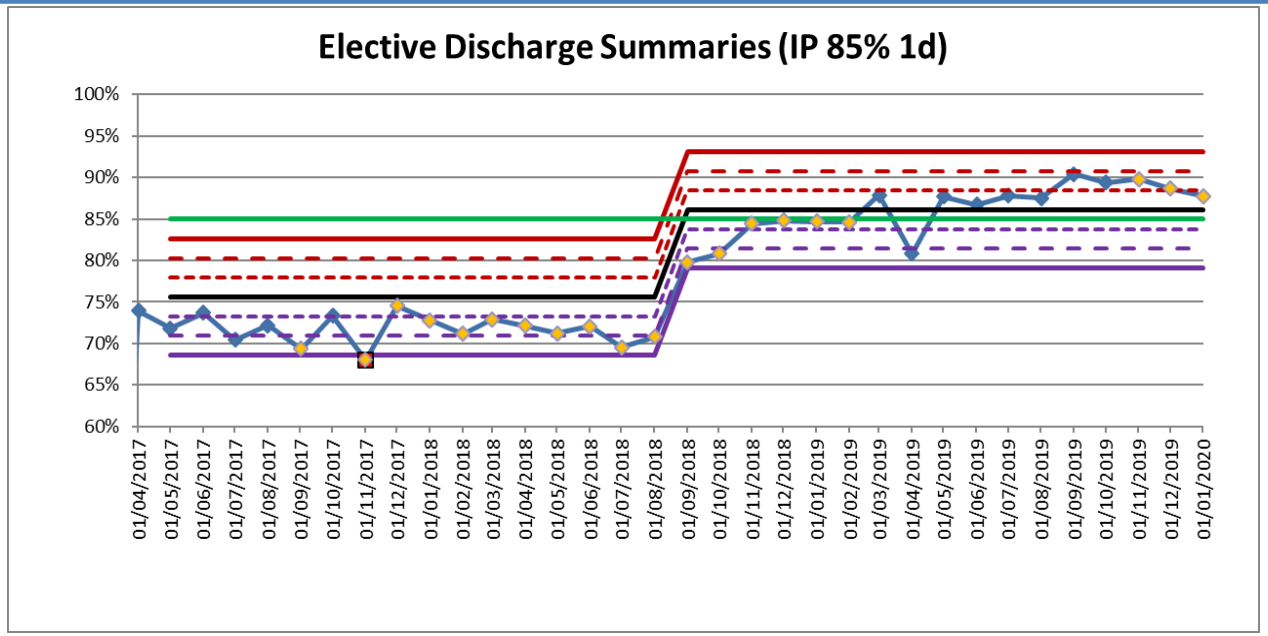
Discharge Summaries Elective admissions



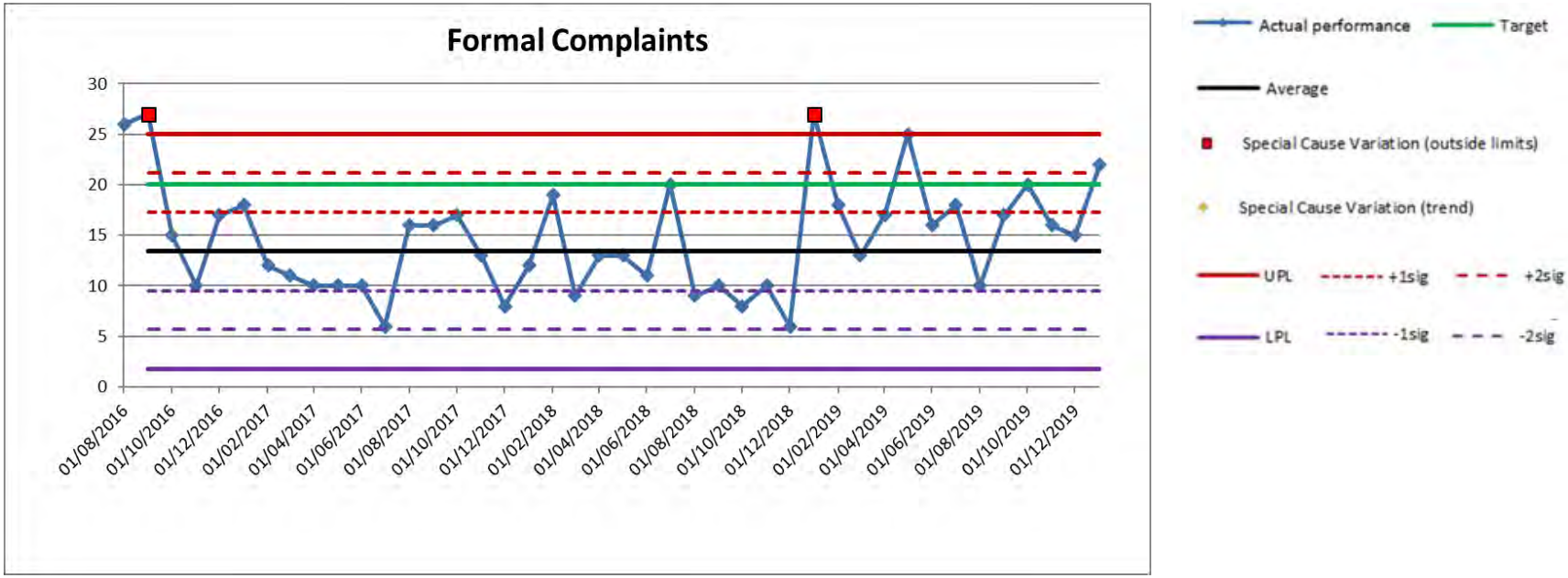
Narrative

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

Putting you first

Complaints



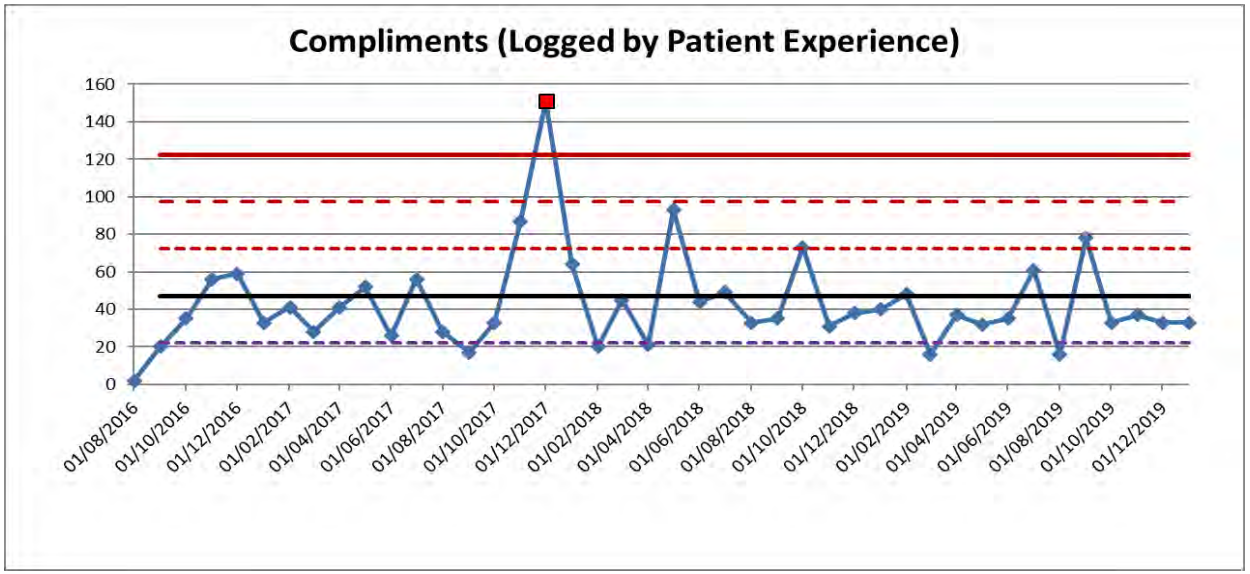
Narrative

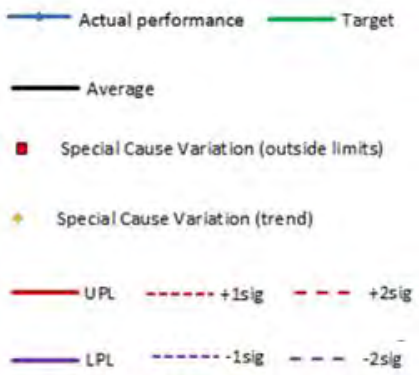
Owner	Rowan Procter
What	Common Cause Variation
Why	Close analysis of themes and trends arising in complaints continues to be monitored across the Trust. Complaints continue to be of a complex nature with a higher proportion of 'red' and 'amber' complaints to previous years.
How	Restructure of patient 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 and not just formal complaints and will help to address issues prior to escalation and encourage learning.
When	May 2020

Caring

Putting you first

Compliments





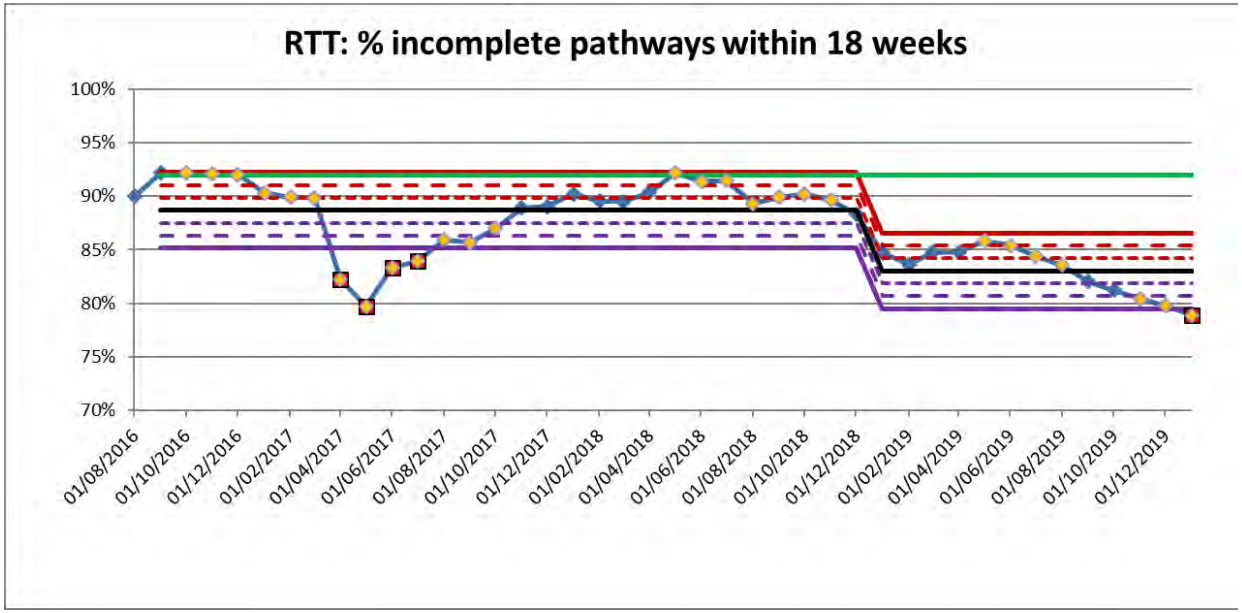
Narrative

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

Caring

Putting you first

RTT



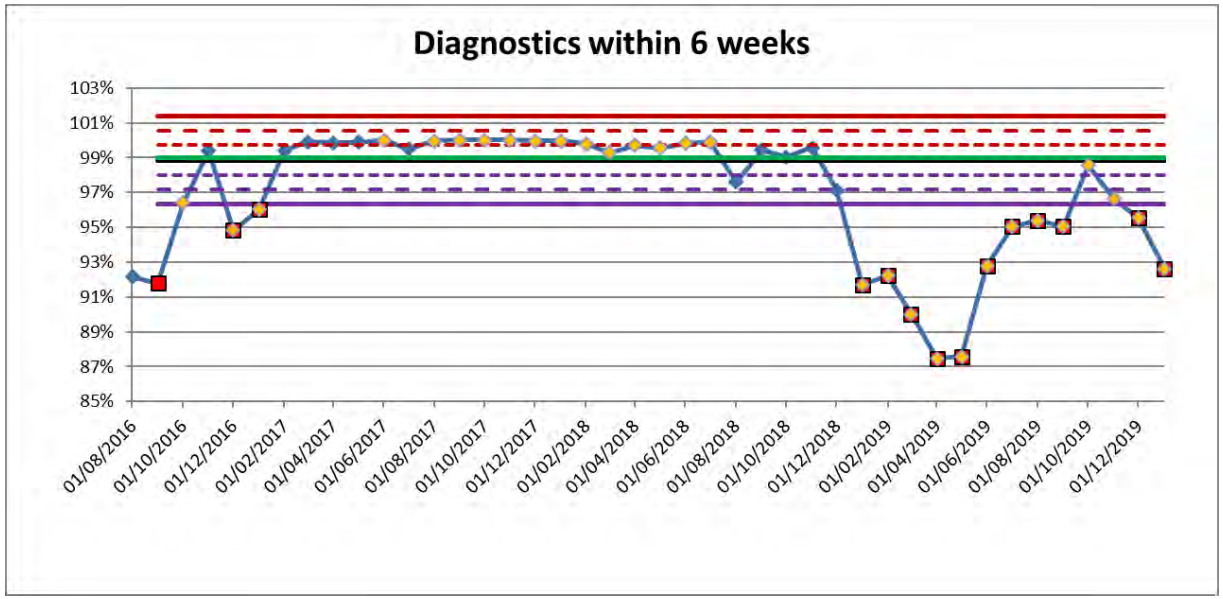
Narrative

Owner	Helen Beck
What	Special Cause Variation - Low
Why	Performance has remained around 79% for January, with significant underperformance in General Surgery, Trauma and Orthopaedics, Ophthalmology 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

Putting you first

Diagnostics within 6 weeks



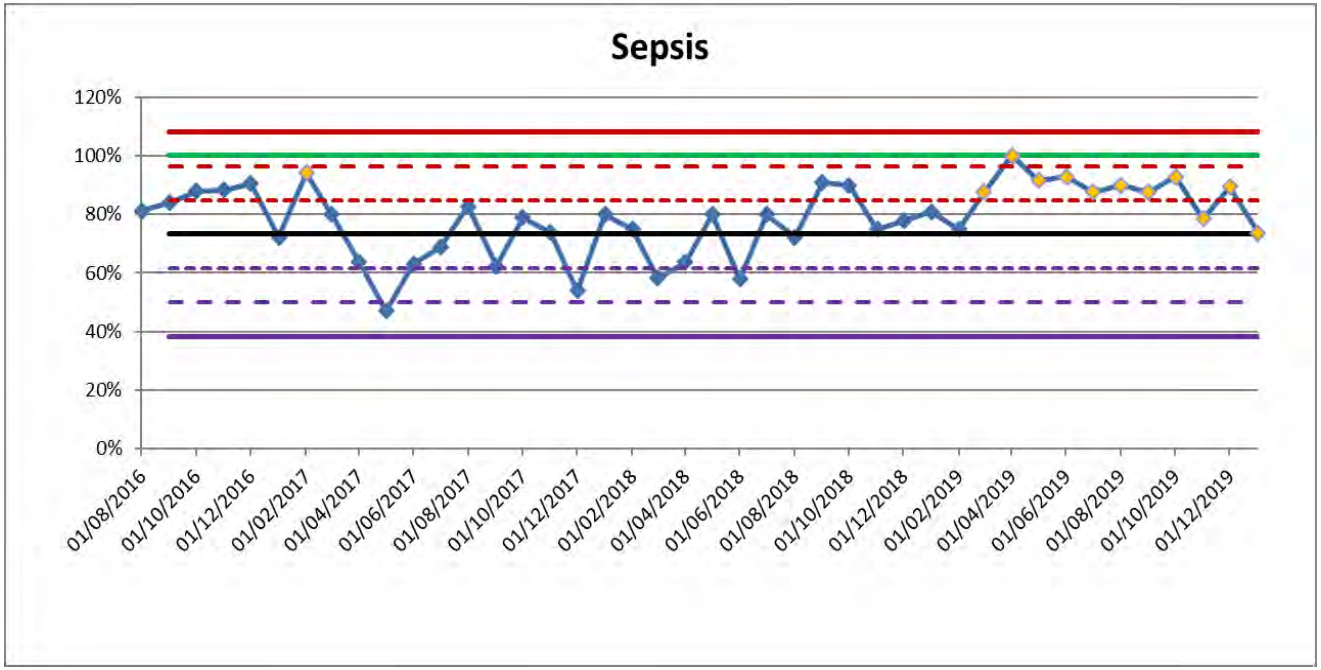
Narrative

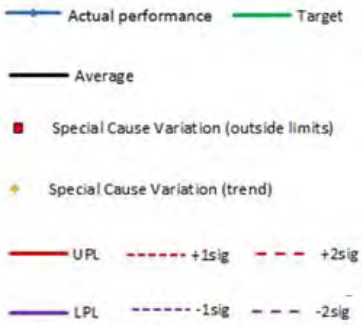
Owner	Helen Beck
What	Special Cause Variation - Low
Why	Urology cystoscopy diagnostics remains a challenge. This performance is exacerbated by shortages in workforce, however these are being positively sourced for long term solution.
How	Cystoscopy remains a challenge however the team have identified a locum resource that will increase capacity delivering additional weekly clinics.
When	April 2020

Responsive

Putting you first

Sepsis





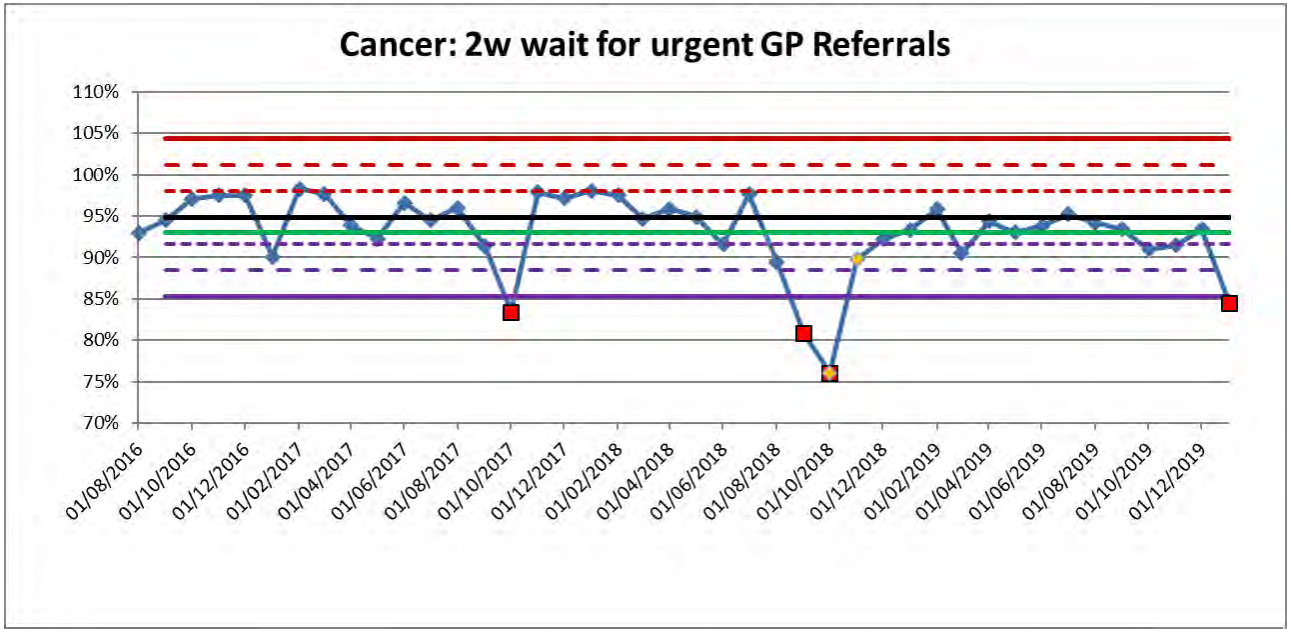
Narrative

Owner	-
What	Special Cause Note/Investigation - High
Why	-
How	-
When	-

Responsive

Putting you first

Cancer 2 week referral



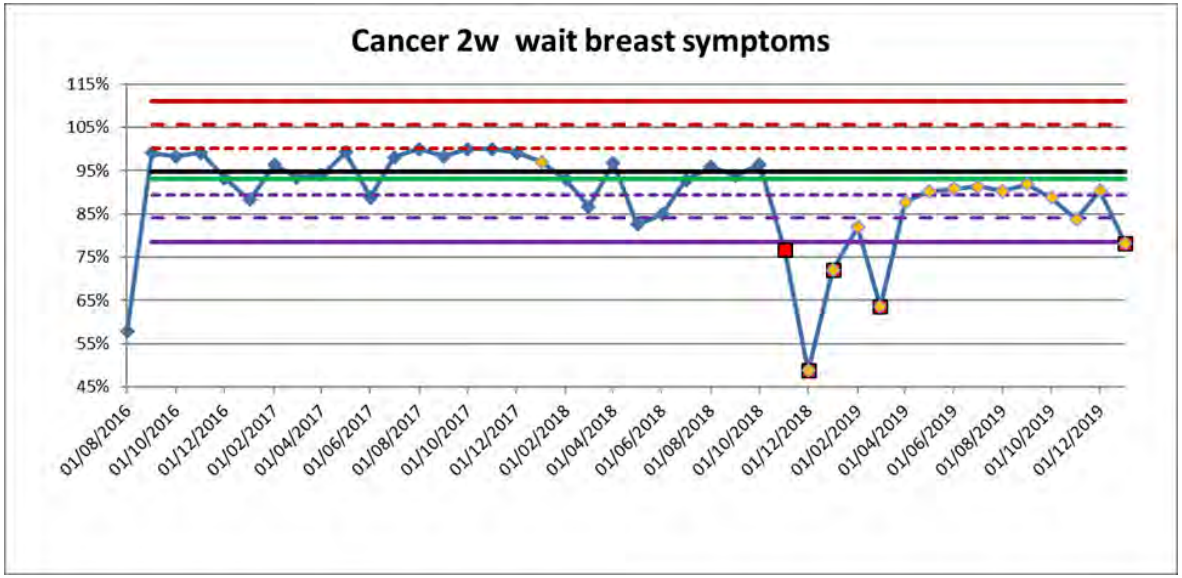
Narrative

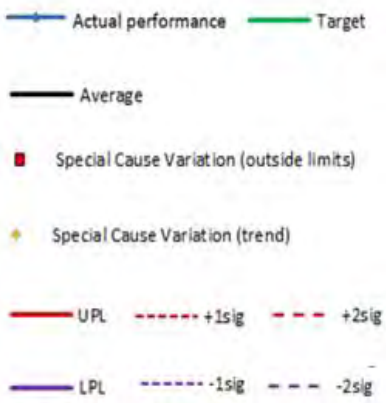
Owner	Helen Beck
What	Common Cause Variation
Why	January performance reflects patient cancellations around Christmas/New Year time with limited capacity in the New year. This was more pronounced in Dermatology than other specialties, with Dermatology accounting for 57% of 147 breaches in the month. There have also been a number of breaches due to patient choice of appointment.
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 also support demand management in the Trust
When	March 2020

Responsive

Putting you first

Cancer 2 week Wait Referral Breast





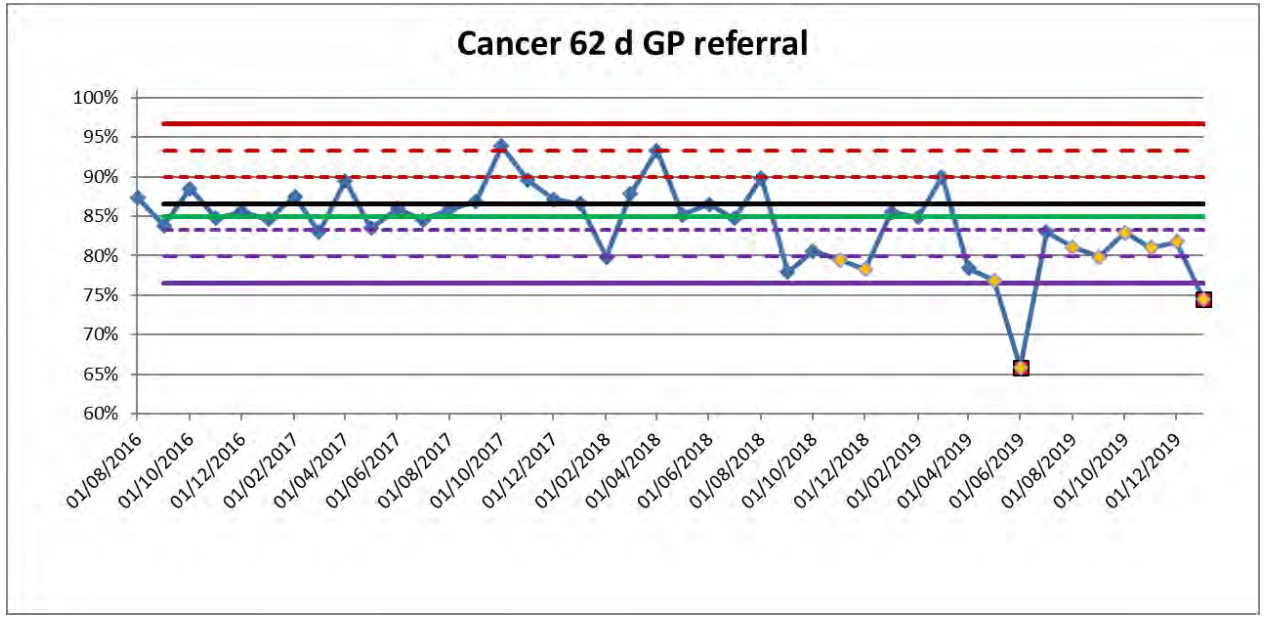
Narrative

Owner	Helen Beck
What	Special Cause Variation - Low
Why	Current Performance- 78.1%. 23 patients breached the 2WW standard for Breast symptomatic. 9 of these patients refused appointments prior to their breach date and the remaining 14 were unable to be offered a date before their breach, due to clinic capacity shortages.
How	New 2 week wait referral forms are in the process of final approval by the Clinical Commissioning Group for introduction across the Integrated Care System. This will help improve the quality and the appropriateness of referral and help manage the demand.
When	March 2020

Responsive

Putting you first

Cancer 62 Day



Narrative

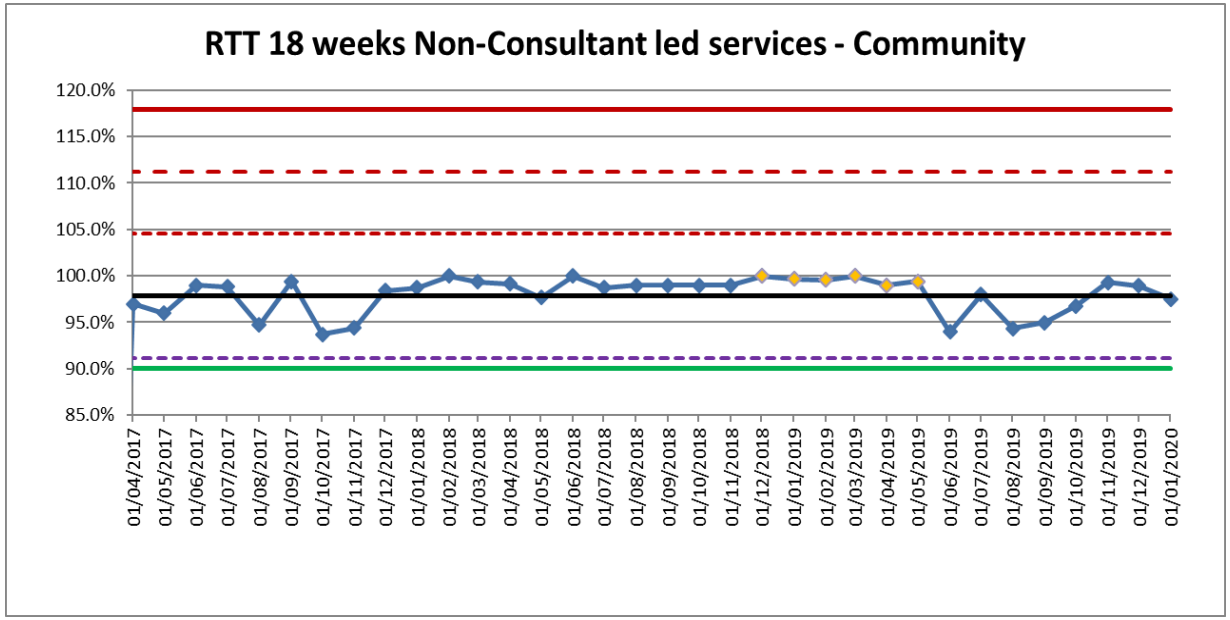
Owner	Helen Beck
What	Common Cause Variation
Why	Current performance of 74.8 %. 13 patients were treated over 62 days in the Trust in January. This is broken down to 4 Colorectal, 3 Urology, 2 Breast, 2 Skin and 1 Upper GI pathways. Shared pathways with other providers include 2 Gynaecology, 2 Head and Neck and 1 in each of Breast, Colorectal and Skin.
How	Prostate biopsies to move from Day Surgery to Johanna Finn
When	March 2020

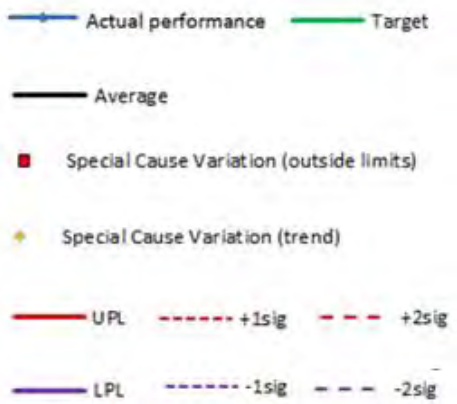
Responsive

Putting you first

RTT non consultant led

Community





Narrative

Owner	Helen Beck
What	Common Cause Variation
Why	-
How	-
When	-

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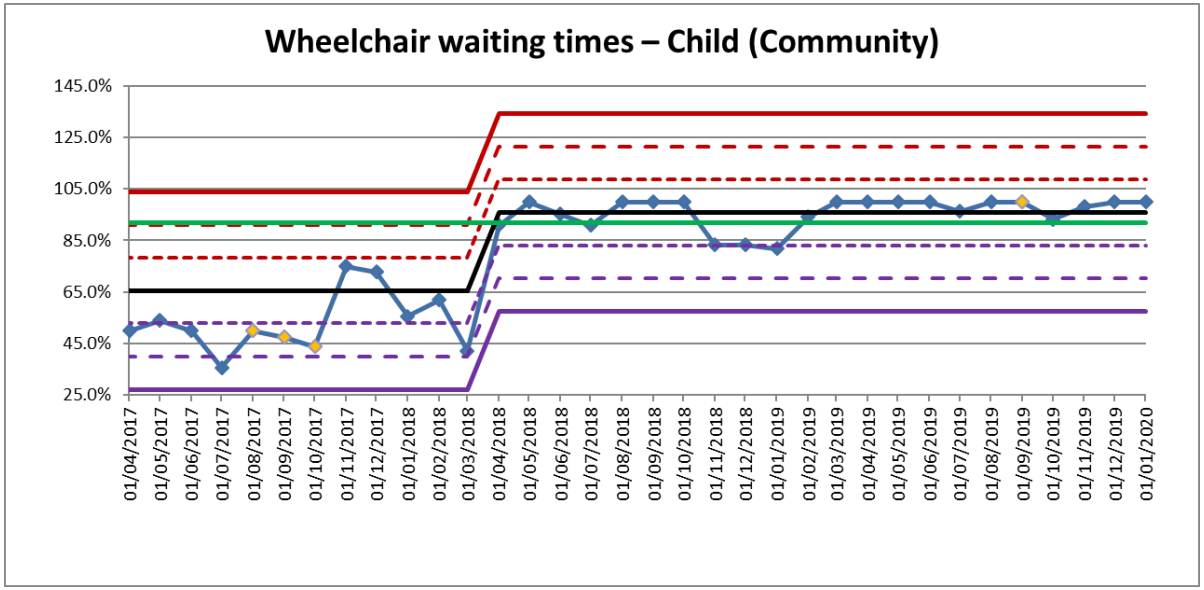
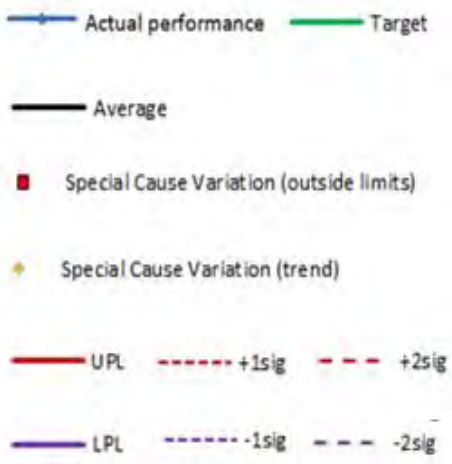
Wheelchair waiting times – Child (Community)





Narrative

Owner	Helen Beck
What	-
Why	-
How	-
When	-

Community

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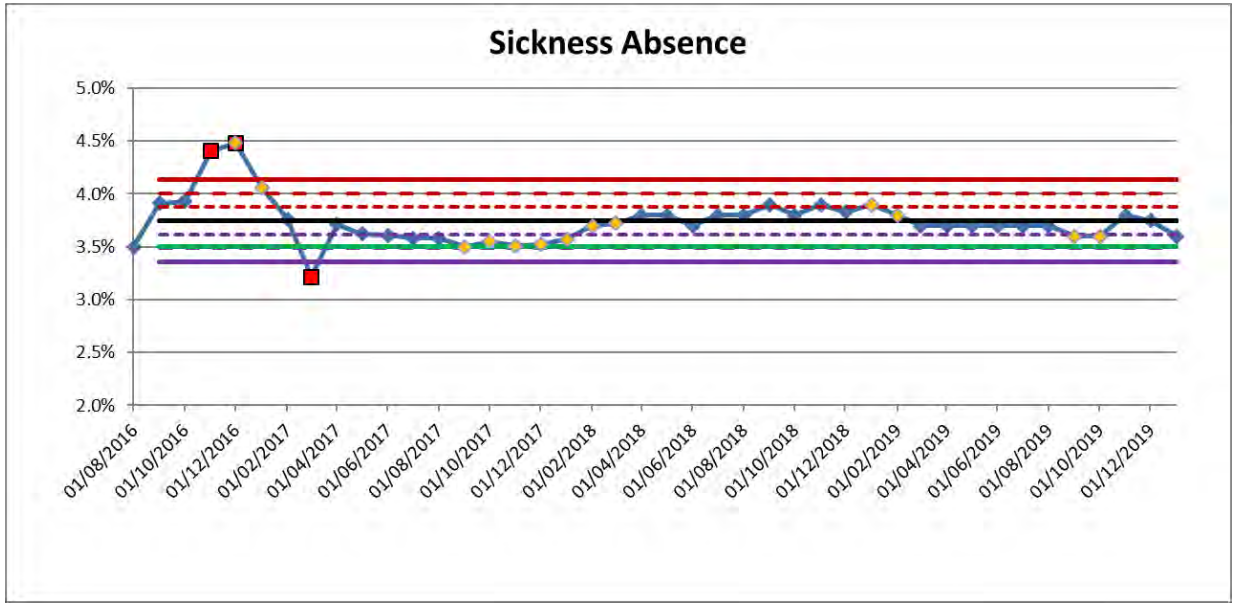
Sickness absence



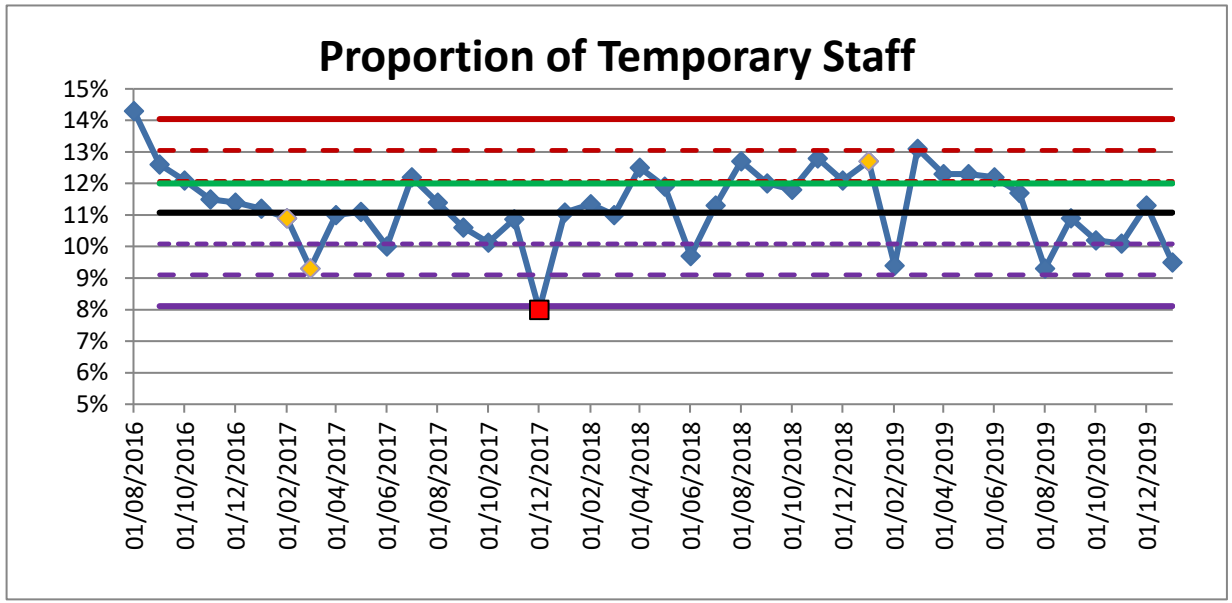
Narrative

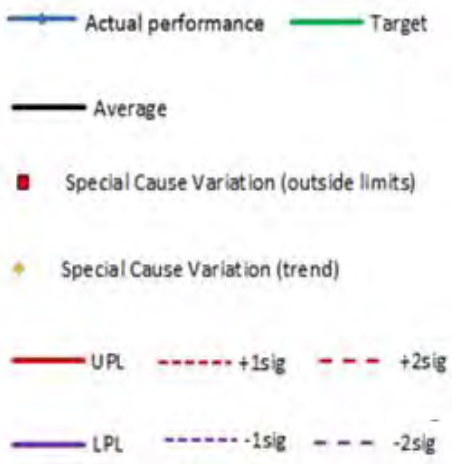
Owner	Jeremy Over
What	Common Cause Variation
Why	Current sickness absence levels are 0.3% lower than in January 2019 and when compared to other NHS organisations we are have lower rates than comparable organisations. NHS in England is 4.21%. East of England trusts 4.01%. Acute trusts in England 4.04% 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

Putting you first

Proportion of temporary staff





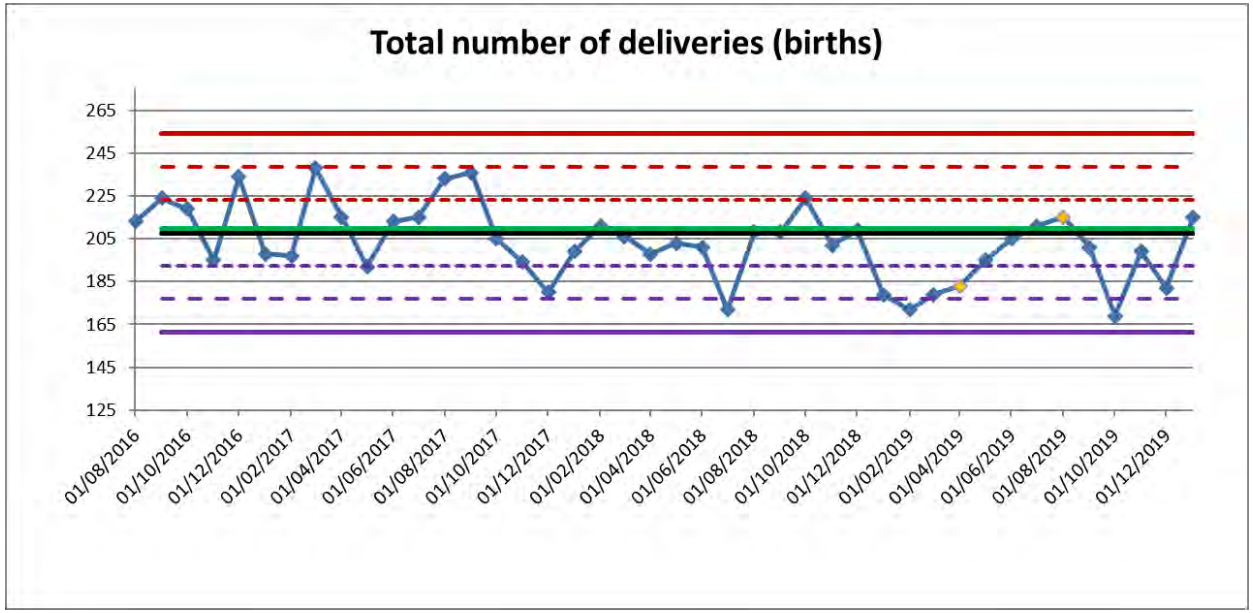
Narrative

Owner	-
What	Common Cause Variation
Why	-
How	-
When	-

Well Led

Putting you first

Total number of deliveries



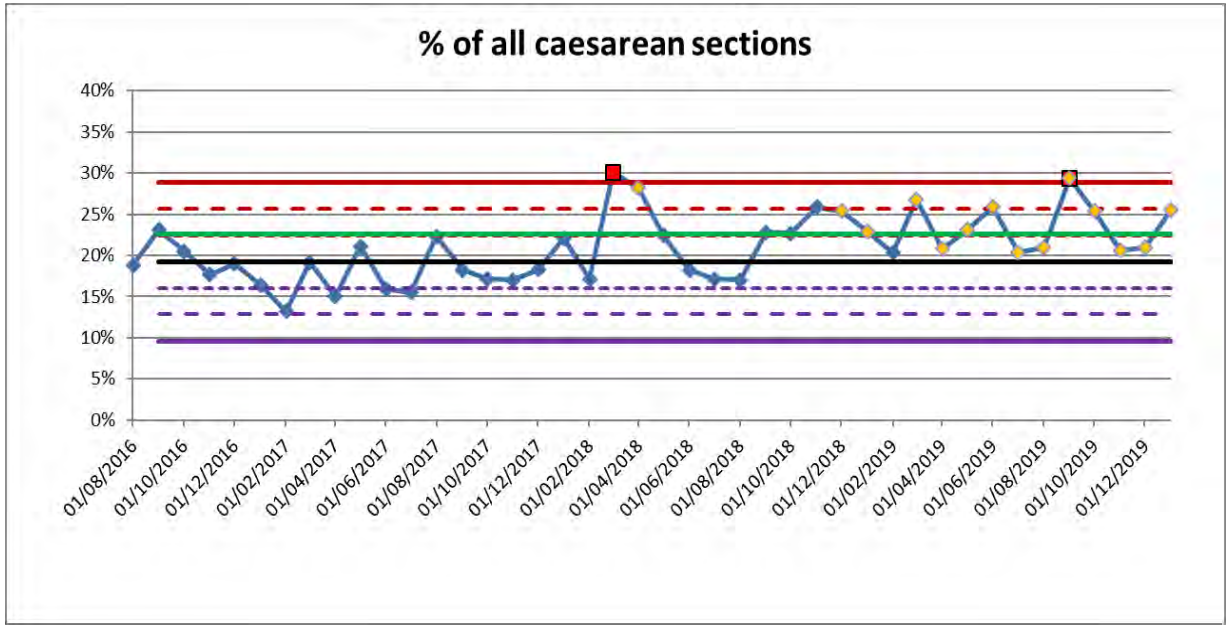
Narrative

Owner	Rowan Procter
What	Common Cause Variation, we have now got back above target.
Why	-
How	-
When	-

Maternity

Putting you first

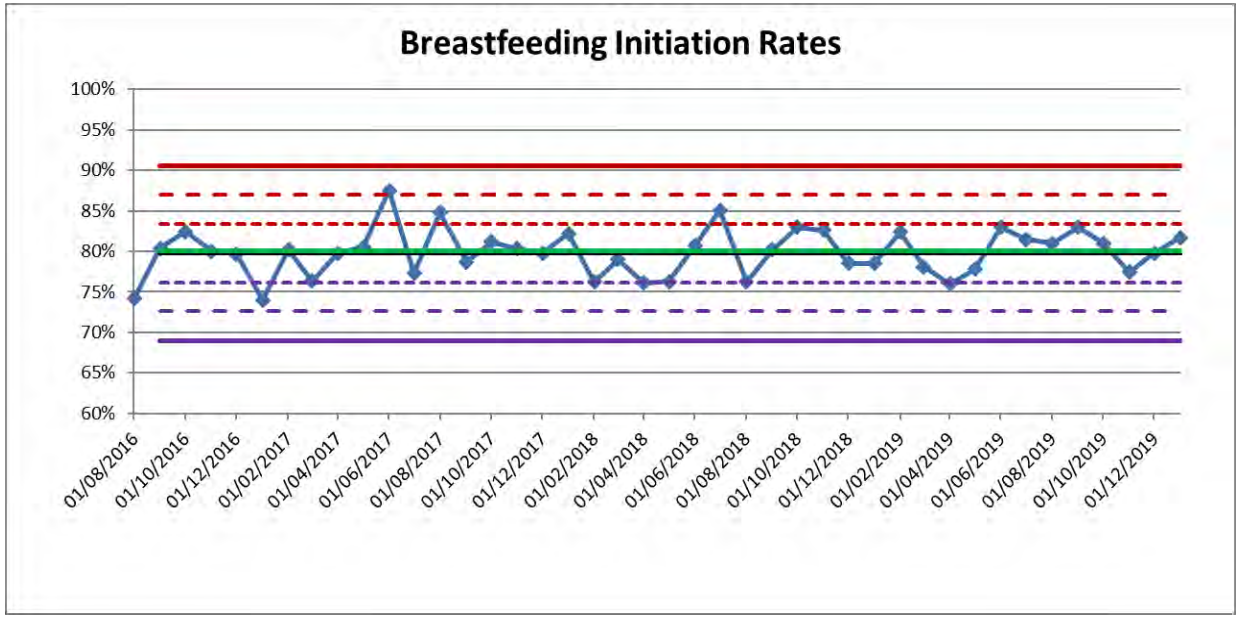
Caesarean section rate



Narrative

Owner	Rowan Procter
What	Special Cause Variation - High
Why	The data this month shows an increase in emergency caesarean sections at 16.7%. There are a possible 2 reasons for this. 1. An increase in this months delivery rate of high risk women. 2. There appears to be an increase in the number of Grade 3 Caesarean Sections. Some of these would have been booked for Elective Caesarean Sections but have commenced labour spontaneously. However the overall rate of Caesarean Sections is within the expected standard.
How	Discussed with the consultant body at the Women's health Governance Meeting. To audit the last 6 month's Grade 3 Caesarean Sections.
When	March 2020

Breast feeding initiation



Narrative

Owner	Rowan Procter
What	Common Cause Variation, Remains above target.
Why	-
How	-
When	-

Maternity

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Putting you first

Trust Board – February 2020

Agenda item:	Integrated Quality & Performance Report			
Presented by:	Rowan Procter, Executive Chief Nurse Helen Beck, Chief Operating Officer			
Prepared by:	Rowan Procter, Executive Chief Nurse Helen Beck, Chief Operating Officer Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	February 2020			
Subject:	Trust Integrated Quality & Performance Report			
Purpose:	x	For information		For approval
Executive summary:	The attached report provides an overview of the key performance measures for the Trust. A detailed section is included from page 15 onwards.			

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

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

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report



Month Ten: January 2020

Putting you first

CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

Putting you first

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

ARE WE SAFE?

Healthcare associated infections (HCAIs) – There were no MRSA Bacteraemia - Hospital Attributable cases and there were 4 attributable clostridium difficile hospital attributable cases within the month. (Exception report at page 18). The trust compliance with decolonisation increased in January to 100%.

CAS (Central Alerting System) Open (PSAs) – 9 Patient Safety Alerts were received in January. All of the alerts have been implemented within timescale this year to date.

Patient Falls (All patients) – 63 patient falls occurred in January, which is an increase from 62 in December. (Exception report at page 20).

Pressure Ulcers – 48 cases occurred in January, which is a decrease from 56 in December. (Exception report at page 21).

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons – The rate of cancelled operations for non-clinical reasons was recorded at 0.9% in January.

Cancelled Operations Patients offered date within 28 Days - The rate of cancelled operations where patients were offered a date within 28 days was recorded at 91.7% in January compared to 95.0% in December. (Exception report at page 28).

Discharge Summaries - A&E has achieved a rate of 83.6% in January, whereas inpatient services have achieved a rate of 83.0% (Non-elective) and 87.7% (Elective). (Exception report at page 27).

ARE WE CARING?

Mixed Sex Accommodation breaches (MSA) – 2 Mixed Sex Accommodation breaches occurred in January. (Exception report at page 31).

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

Complaints responded to in time – January reported performance at 82.0% compared to 57.0% in December. (Exception report at page 33).

ARE WE RESPONSIVE?

Cancer – The challenge of demand and capacity continues with three failing the target for January. These areas were Cancer: 2 week wait for urgent GP Referrals with performance at 84.5%, Cancer 2 week wait breast symptoms with performance at 78.1%, Cancer 62 d GP referral with performance at 74.0%. (Exception reports at pages 44-47).

Referral to Treatment (RTT) – The percentage of patients on an incomplete pathway within 18 weeks for January was 78.9%. The total waiting list was 20078 as at the end of January, with 12 patients who breached the 52-week standard. (Exception report at page 40-42).

ARE WE WELL LED?

Appraisal - The appraisal rate for January is 84.6%. (Exception report at page 56).

Sickness Absence – The Sickness Absence rate for January is 3.6%. (Exception report at page 55).

2. INTEGRATED QUALITY & PERFORMANCE REPORT DASHBOARD

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

INTEGRATED QUALITY & PERFORMANCE REPORT																
Are we..	Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Av/YTD
1. Safe	1.01	CAS (Central Alerting System) Open	NT	8	13	11	10	6	6	1	1	4	5	7	7	9	56
	1.02	CAS (Central Alerting System) Overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	94.6%	95.2%	95.4%	95.0%	95.4%	95.1%	95.2%	96.2%	95.6%	94.3%	95.4%	95.7%	96.2%	95.4%
	1.05	Clostridium Difficile infection - Hospital Attributable	0	0	4	1	1	2	1	1	2	3	3	3	4	4	24
	1.06	MRSA Bacteraemias - Hospital Attributable	0	0	0	0	0	1	0	0	1	0	0	0	0	0	2
	1.07	Patient Safety Incidents Reported	NT	766	625	646	670	651	602	642	657	633	715	687	648	749	6654
	1.08	Never Events	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
2.Effective	2.02	Canc. Ops - Cancellations for non-clinical reasons	1%	1.0%	1.0%	0.6%	1.9%	1.2%	1.9%	0.8%	1.6%	1.3%	1.4%	1.2%	0.9%	0.9%	1.3%
3. Caring	3.01	Compliments (Logged by Patient Experience)	NT	40	48	16	37	32	35	61	16	78	33	37	33	33	395
	3.02	Formal Complaints	20	27	18	13	17	25	16	18	10	17	20	16	15	22	176
	3.03	Mixed Sex Accommodation Breaches	0	28	0	0	0	0	4	2	0	0	0	2	3	2	13
	3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	98.0%	97.0%	97.0%	95.0%	95.0%	98.0%	97.0%	97.0%	96.0%	97.0%	98.0%	97.0%	94.0%	96.4%
	3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	97.0%	97.0%	97.0%	97.0%	96.0%	97.0%	96.0%	96.0%	96.0%	96.0%	95.0%	97.0%	96.0%	96.2%
	3.06	A&E - Extremely likely or Likely to recommend (FFT)	90%	96.0%	97.0%	99.0%	94.0%	88.0%	95.0%	87.0%	89.0%	92.0%	93.0%	89.0%	88.0%	91.0%	90.6%
	3.08	Community - Extremely likely or likely to recommend	80%	98.0%	95.0%	100%	95.0%	97.0%	95.0%	94.3%	95.2%	97.0%	97.2%	100%	100%	98.7%	96.9%
4. Responsive	4.02	RTT: % incomplete pathways within 18 weeks	92%	84.7%	83.6%	84.8%	84.8%	85.8%	85.4%	84.4%	83.3%	82.0%	81.2%	80.2%	79.8%	78.9%	82.6%
	4.03	52 week waiters	0	7	7	2	1	4	4	2	2	6	4	8	5	12	48
	4.04	Diagnostics within 6 weeks	99%	91.7%	92.2%	90.0%	87.5%	87.6%	92.8%	95.0%	95.4%	95.1%	98.6%	96.7%	95.5%	92.6%	93.7%
	4.05	Cancer: 2w wait for urgent GP Referrals	93%	93.4%	95.8%	90.5%	94.3%	93.1%	93.8%	95.3%	94.2%	93.5%	91.0%	91.6%	93.6%	84.5%	92.5%
	4.06	Cancer 2w wait breast symptoms	93%	72.1%	82.0%	63.5%	87.8%	90.6%	90.8%	91.3%	90.3%	91.8%	88.4%	83.7%	90.3%	78.1%	88.3%
	4.07	Cancer 31 d First Treatment	96%	99.2%	100%	100%	100%	98.0%	99.0%	99.0%	100%	100%	100%	99.0%	100%	100%	99.5%
	4.08	Cancer 31 d Drug Treatment	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.09	Cancer 31 d Surgery	94%	94.4%	100%	100%	100%	95.0%	100%	100%	100%	100%	100%	100%	100%	100%	99.5%
	4.10	Cancer 62 d GP referral	85%	85.5%	84.8%	90.0%	78.4%	76.9%	65.9%	83.0%	81.1%	79.9%	83.3%	85.0%	83.8%	74.4%	79.2%
	4.11	Cancer 62 d Screening	90%	100%	100%	95.2%	92.9%	90.5%	86.7%	100%	100%	82.8%	92.3%	100%	100%	100%	94.5%
	4.12	Incomplete 104 day waits	0	0	1.0	1.0	2.0	4.0	5.0	6.0	3.0	3.0	2.0	3.0	2.0	1.0	31.0

INTEGRATED QUALITY & PERFORMANCE REPORT																	
Are we..	Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Av/YTD
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)	NT	NA	7.4%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	NA	91.0%	NA	NA	NA	92.0%	NA	NA	93.0%	NA	NA	ND	NA	92.5%
	5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	NA	78.0%	NA	NA	NA	79.0%	NA	NA	75.0%	NA	NA	ND	NA	77.0%
	5.04	Turnover (Rolling 12 mths)	<10%	8.0%	7.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	5.0%	8.0%	8.1%	8.0%	7.7%
	5.05	Sickness Absence	<3.5%	3.9%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.6%	3.8%	3.8%	3.6%	3.7%
	5.06	Executive Team Turnover (Trust Management)	<20%	0.0%	0.0%	0.0%	17.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.0%	0.0%	0.0%	3.4%
	5.07	Agency Spend	550	637	330	524	426	366	482	364	530	452	399	417	381	235	4052
	5.08	Monitor Use of Resources Rating	NT	3	3	3	3	3	3	3	3	3	3	3	3	3	3
6. Productive	6.01	I&E Margin	Var	-6.10%	-5.80%	-5.50%	-5.80%	-6.70%	-7.60%	-6.90%	-7.60%	-8.00%	-5.90%	-7.50%	-5.30%	-3.70%	-3.70%
	6.03	Capital service cover	Var	-0.42	-0.25	-0.27	0.34	0.23	0.12	0.17	-0.22	-0.35	-0.37	-0.38	0.18	1.22	1.22
	6.04	Liquidity (days)	NT	15.86	15.18	26.80	24.13	24.98	22.90	32.70	37.91	41.60	41.00	32.89	32.64	25.79	25.79
	6.05	Long Term Borrowing (£m)	4	85.5	64.1	65.4	95.7	85.0	88.2	82.2	83.4	81.7	83.0	91.2	84.3	90.1	90.1
	6.06	CIP (Variance YTD £'000s)	1.9	-45	-48	0	-32	-75	-46	-70	-199	-127	-208	-223	29	17	17
7. Maternity	7.01	Total number of deliveries (births)	210	179	172	179	183	195	205	211	215	201	169	199	182	215	1975
	7.02	% of all caesarean sections	26%	22.9%	20.3%	26.8%	20.8%	23.1%	25.9%	20.4%	20.9%	29.4%	25.4%	20.6%	20.9%	25.6%	23.3%
	7.03	Midwife to birth ratio	1.32	1.28	1.26	1.27	1.27	1.28	1.29	1.30	1.31	1.29	1.26	1.28	1.26	1.30	1.28
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	95%	96.0%	95.0%	93.0%	94.0%	93.0%	97.0%	97.0%	93.0%	95.0%	95.0%	92.0%	90.0%	96.2%	94.2%
	7.06	Maternity SIs	NT	0	1	0	1	1	2	0	0	1	1	1	2	0	9
	7.07	Maternity Never Events	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates	80%	78.5%	82.4%	78.1%	76.0%	77.8%	83.0%	81.5%	81.0%	83.0%	81.0%	77.4%	79.8%	81.7%	80.2%
8. Community	1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	4.27	RTT 18 weeks Non-Consultant led services - Community	90%	99.7%	99.6%	100%	99.0%	99.4%	94.0%	98.0%	94.4%	95.0%	96.7%	99.3%	98.9%	97.5%	97.2%
	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	NA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	NA	100%
	4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	96.6%	100%	100%	100%	100%	100%	93.8%	97.3%	97.1%	100%	100%	100%	100%	98.8%
	4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.0%	98.8%	99.3%	100%	99.5%	99.3%	98.8%	99.5%	99.9%	98.9%	99.2%	98.7%	99.3%	99.3%

3. IN THIS MONTH – JANUARY 2020, MONTH 10

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

From Month Year	Jan-2020					To Month Year	Jan-2019				

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

In this month.... Jan-2020

Mth We Received.....	Jan-20	Jan-19	Variance	Var. %	Traffic	YTD We Received.....	2020	2019	Variance	Var. %	Traffic
GP Referrals	5,238	6,650	-1,412	-21.2%	↓	GP Referrals	59,463	65,947	-6,484	-9.8%	↓
Other Referrals	5,085	5,402	-317	-5.9%	↓	Other Referrals	52,615	53,932	-1,317	-2.4%	↓
Ambulance Arrivals	2,026	2,053	-27	-1.3%	↓	Ambulance Arrivals	19,575	18,192	1,383	7.6%	↑
Cancer Referrals*	1,082	1,050	32	3.0%	↑	Cancer Referrals*	10,811	10,234	577	5.6%	↑
Urgent Referrals*	2,532	2,756	-224	-8.1%	↓	Urgent Referrals*	24,376	27,113	-2,737	-10.1%	↓

Mth We Delivered.....	Jan-20	Jan-19	Variance	Var. %	Traffic	YTD We Delivered.....	2020	2019	Variance	Var. %	Traffic
ED Attendances (excluding GP Expected/Streamed)	5,553	5,361	192	3.6%	↑	ED Attendances (excluding GP Expected/Streamed)	58,600	52,365	6,235	11.9%	↑
**ED Attendances(Adjusted)	6,872	6,814	58	0.9%	↑	**ED Attendances(Adjusted)	71,471	65,946	5,525	8.4%	↑
GP Expected via ED	554	601	-47	-7.8%	↓	GP Expected via ED	5,630	5,519	111	2.0%	↑
GP Streamed	319	409	-90	-22.0%	↓	GP Streamed	3,434	4,318	-884	-20.5%	↓
GP Expected direct to AAU/AEC	446	443	3	0.7%	↑	GP Expected direct to AAU/AEC	3,807	3,744	63	1.7%	↑
A&E - To IP Admission Ratio	28.5%	31.3%	-2.9%	-2.9%	↓	A&E - To IP Admission Ratio	27.7%	27.8%	-0.1%	-0.5%	↓
Outpatient Attendances	27,642	27,766	-124	-0.4%	↓	Outpatient Attendances	294,284	256,598	37,686	14.7%	↑
Inpatient Admissions	6,399	6,597	-198	-3.0%	↓	Inpatient Admissions	61,185	60,148	1,037	1.7%	↑
Elective Admissions	3,094	3,076	18	0.6%	↑	Elective Admissions	29,260	27,661	1,599	5.8%	↑
Non Elective Admission	3,305	3,521	-216	-6.1%	↓	Non Elective Admission	32,075	32,487	-412	-1.3%	↓
Inpatient Discharges	6,402	6,571	-169	-2.6%	↓	Inpatient Discharges	61,147	60,084	1,063	1.8%	↑
Elective Discharges	3,076	3,055	21	0.7%	↑	Elective Discharges	29,484	27,645	1,839	6.7%	↑
Non Elective Discharges	3,326	3,516	-190	-5.4%	↓	Non Elective Discharges	31,688	32,439	-751	-2.3%	↓
New Births	215	178	37	21%	↑	New Births	1,975	2,003	-28	-1%	↓

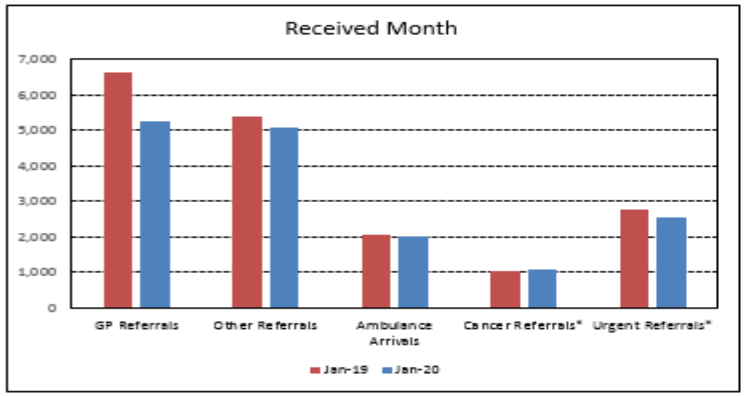
* - Included in Referrals Above

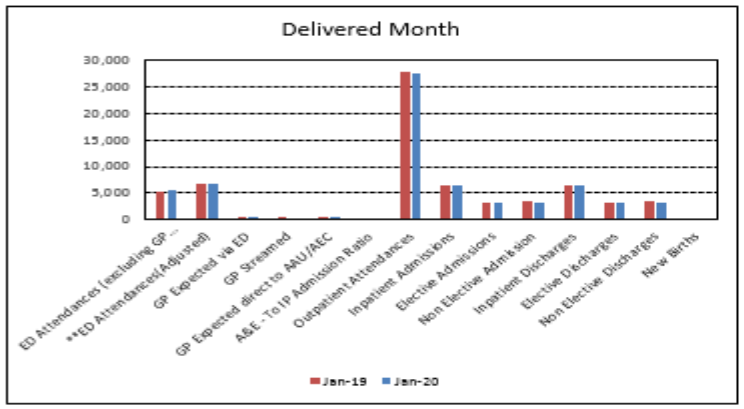
** - The ED adjusted figure adds ED attendances, GP Streamed and all GP expected (Including direct to AAU/AEC) together to reflect the position in 2017 when these were reported together.

Monthly Activity Charts.

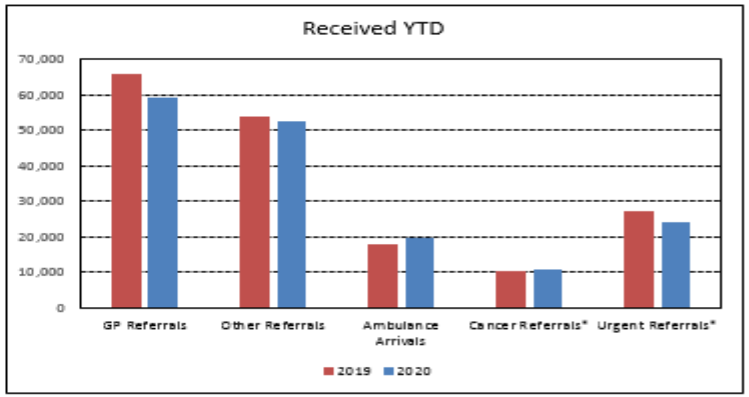
GP, others and Urgent referrals demonstrate a reduction year on year. A&E, incomplete RTT pathways and Cancer Referrals are higher than last year.

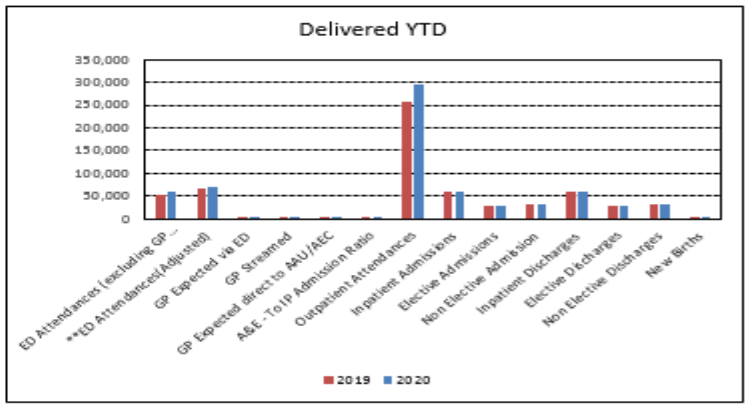
Monthly





Yearly





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DETAILED REPORTS

Putting you first

4. DETAILED SECTIONS – SAFE

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

Are we..		Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD(Apr19-Jan20)
1.Safe	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	94.4%	100%	100%	100%	100%	100%	83.0%	88.9%	100%	100%	100%	100%	97.2%
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	96.2%	96.4%	87.1%	89.0%	100%	100%	100%	100%	100%	100%	96.6%	100%	100%	98.6%
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	97.9%	100%	96.4%	100%	98.0%	100%	100%	91.0%	90.0%	97.6%	98.0%	100%	95.0%	97.0%
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	97.0%	99.3%	99.2%	100%	99.4%	100%	99.2%	100%	100%	98.8%	97.2%	99.1%	99.2%	99.3%
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.14	HII Compliance 4b: Preventing surgical site infection perioperative	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90.0%	100%	100%	99.0%
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	90.0%	ND	90.0%	100%	100%	100%	100%	100%	100%	100%	100%	98.9%
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	90.9%	100%	100%	ND	100%	100%	100%	100%	100%	100%	100%	100%	93.8%	99.3%
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	92.2%	88.8%	95.2%	96.0%	94.2%	96.1%	100%	100%	98.8%	95.0%	98.6%	100%	96.8%	97.6%
	Incidents	1.18	Safety Thermometer: % of patients experiencing new harm-free care-Trust	100%	98.3%	97.0%	97.9%	96.6%	97.8%	97.0%	99.1%	98.3%	97.1%	98.3%	97.5%	99.0%	99.0%	98.0%
		1.19	Safety Thermometer: % of patients experiencing new harm-free care - Community	100%	98.4%	97.0%	99.0%	96.1%	99.7%	98.6%	99.7%	99.3%	99.0%	99.3%	97.8%	99.0%	99.0%	98.7%
		1.20	No of SIRIs	NT	6	2	2	5	6	1	3	2	6	4	7	3	2	39
		1.21	RIDDOR Reportable Incidents	NT	1	3	3	2	2	2	0	1	2	1	2	1	2	15
		1.22	Total No of E. Coli (Trust level only)	NT	2	0	1	1	3	2	4	3	1	0	2	1	3	20
		1.23	No of Inpatient falls - Trust	NT	81	54	56	74	77	61	72	62	55	70	49	62	63	645
		1.24	No of Inpatient falls - WSH	<48	61	42	47	60	66	53	64	58	50	63	40	49	56	559
		1.25	No of Inpatient falls - Community Hospitals	NT	20	12	9	14	11	8	8	4	5	7	9	13	7	86
		1.26	Falls per 1,000 bed days	NT	5.21	3.95	4.17	5.21	5.71	4.98	5.87	5.60	4.94	ND	ND	ND	ND	5.39
		1.27	No of Inpatient falls resulting in harm - Trust	NT	25	14	15	21	15	18	22	15	17	24	16	11	14	173
		1.28	No of Inpatient falls resulting in harm - WSH	NT	22	10	13	16	14	14	20	14	17	21	15	10	12	153
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	NT	3	4	2	5	1	4	2	1	0	3	1	1	2	20
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	0	1	0	0	4	2	1	2	1	1	0	0	1	0	12
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	0	1	0	0	4	2	1	2	1	1	0	0	1	0	12
		1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.69	PU present on admission to service - Trust	NT	99	69	87	89	90	88	62	89	80	97	94	97	132	918
		1.70	PU present on admission to service – Inpatients	NT	77	49	58	60	62	64	35	72	69	67	73	70	90	662
		1.71	PU present on admission to service – Community teams	NT	22	20	29	29	28	24	27	17	11	30	21	27	42	256
		1.33	Number of medication errors	NT	79	78	72	89	76	65	89	56	83	73	81	59	84	755
		1.72	New PU - Trust	0	30	34	40	42	54	31	39	44	49	51	51	56	48	465
		1.67	New PU – Inpatients	0	11	16	21	20	25	11	19	18	19	17	28	19	24	200
		1.68	New PU – Community teams	0	19	18	19	22	29	20	20	26	30	34	23	37	24	265
		1.73	Moisture associated skin damage	0	17	18	22	18	14	24	26	21	29	42	21	29	ND	224
		1.74	Device related (% of total)	NT	2.0%	6.0%	5.0%	4.0%	5.0%	3.0%	2.0%	4.0%	0.0%	2.0%	3.0%	3.0%	ND	2.9%
		1.60	% of patients at risk of falls (with a Falls assessment)	NT	73.0%	71.9%	73.9%	73.2%	73.7%	73.1%	73.3%	74.7%	72.4%	74.3%	64.2%	64.4%	64.8%	70.8%

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Are we..		Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD(Apr19-Jan20)
1. Safe	Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	90%	NA	NA	88.0%	NA	NA	87.0%	NA	NA	91.0%	NA	NA	92.0%	NA	90.0%
		1.39	MRSA Bacteraemias - Community Attributable	0	0	0	0	0	0	0	0	0	0	1	0	1	4	6
		1.40	Clostridium Difficile infection - Community Attributable	NT	4	1	6	3	4	3	5	1	2	2	2	3	3	28
		1.41	MRSA - Decolonisation	95%	94.0%	100%	92.0%	100%	100%	94.0%	100%	95.0%	100%	90.0%	90.0%	90.0%	100%	95.9%
		1.42	MRSA - RCA Reports	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.43	MSSA (Hospital)	NT	0	0	2	0	0	1	1	2	0	0	0	0	0	4
		1.44	SIRI final reports due in month submitted beyond 60 working days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.45	SIRIs reported >2 working days from identification as red	0	0	0	1	0	0	0	1	0	1	0	2	0	0	4
		1.46	Green, Amber & Red Active / Accepted risk assessments not in date	0	79	55	55	55	53	56	53	19	0	1	1	1	4	243
		1.47	Datix Risk Register Red / Amber actions overdue	0	65	65	65	65	64	65	41	30	1	3	2	2	4	277
		1.48	Rapid access chest pain clinic access within 2 wks.	95%	100%	100%	100%	100%	100%	100%	100%	97.5%	99.0%	100%	99.1%	99.2%	100%	99.5%
		1.75	Verbal DoC undertaken within 10 working days of incident report	NT	NA	NA	NA	47.0%	60.0%	69.0%	63.0%	55.0%	30.0%	40.0%	37.0%	63.0%	78.0%	54.2%
		1.76	Total written (initial notification letter) Duty of Candour still outstanding at month-end NB: Only includes cases where verbal has already been completed	3	NA	NA	NA	4	3	5	8	5	3	0	6	5	8	47
		1.49	Verbal Duty of Candour outstanding at month-end	0	0	4	5	4	4	2	5	2	3	0	3	3	1	27
		1.50	Hand Hygiene Audits	100%	100%	100%	99.7%	100%	100%	99.5%	100%	97.0%	99.0%	100%	100%	100%	100%	99.6%
		1.51	Quarterly antibiotic audit	98%	NA	NA	87.0%	NA	NA	89.0%	NA	NA	90.0%	NA	NA	89.0%	NA	89.3%
		1.52	Serious Incident RCA actions beyond deadline for completion	0	14	8	13	25	21	26	19	14	16	8	7	22	25	183
		1.53	% of Green Patient Safety incidents investigated	NT	71.0%	72.0%	71.0%	63.0%	74.0%	63.0%	68.0%	67.0%	68.0%	76.0%	69.0%	78.0%	77.0%	70.3%
		1.54	Quarterly Environment/Isolation	90%	NA	NA	92.0%	NA	NA	92.0%	NA	NA	93.0%	NA	NA	95.0%	NA	93.3%
		1.55	Quarterly Visual Infusion Phlebitis score documentation	90%	NA	NA	85.0%	NA	NA	86.0%	NA	NA	87.0%	NA	NA	89.0%	NA	87.3%
		1.57	Pain Mgt. internal report	80%	84.5%	NA	NA	85.2%	84.1%	84.3%	83.2%	84.3%	83.5%	80.3%	81.7%	81.5%	80.9%	82.9%
		1.58	Nutrition % of patients with a MUST/PYMS assessment completed for within 24hrs	95%	83.0%	81.0%	79.0%	81.0%	81.0%	82.0%	83.0%	84.0%	85.7%	86.2%	90.0%	91.9%	90.4%	85.5%
		1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)	41	78	82	38	57	70	84	107	61	42	47	38	ND	ND	63
		1.61	E coli - Hospital Attributable	NT	2	0	1	1	3	2	4	3	1	0	2	1	3	20
		1.62	E coli - Community Attributable	NT	8	9	16	12	18	17	24	24	15	13	17	20	10	170
		1.63	Klebsiella spp. - Hospital Attributable	NT	0	1	0	1	0	0	1	1	0	0	0	0	1	4
		1.64	Klebsiella spp. - Community Attributable	NT	1	1	1	2	3	4	6	1	6	3	4	5	1	35
		1.65	Pseudomonas - Hospital Attributable	NT	0	1	0	2	0	0	0	0	0	0	1	0	0	3
		1.66	Pseudomonas - Community Attributable	NT	1	2	0	0	1	3	4	1	1	2	1	1	1	15

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SAFE – DIVISIONAL LEVEL ANALYSIS

Indicator	November			December			January		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
HII compliance 1a: Central venous catheter insertion	100	100		100			100	100	
HII compliance 1b: Central venous catheter ongoing care	100	93.3		100	100		100	100	
HII compliance 2a: Peripheral cannula insertion	100	96.0	100	100	100	100	100	89.5	100
HII compliance 2b: Peripheral cannula ongoing	100	94.8	100	100	98.4	100	100	98.7	100
HII compliance 4a: Preventing surgical site infection preoperative	100			100			100		
HII compliance 4b: Preventing surgical site infection perioperative	90.0			100			100		
HII compliance 5: Ventilator associated pneumonia	100			100			100		
HII compliance 6a: Urinary catheter insertion	100	100		100	100		100	83.3	
HII compliance 6b: Urinary catheter on-going care	100	97.4		100	100		100	95.0	
HII compliance: Antibiotic Prescribing – All care setting		81.0	100					82.0	
HII compliance: Antibiotic Prescribing – Secondary Care	71.0	83.0	100					82.0	
HII compliance: Chronic Wounds									
Total no of MRSA bacteraemias: Hospital	0	0	0	0	0	0	0	0	0
Quarterly MRSA (including admission and length of stay screens)				96.0	90.0	75.0			
Hand hygiene compliance	100	100	100	100	100	100	100	100	100
Total no of MSSA bacteraemias: Hospital	0	0	0	0	0	0	0	0	0
Quarterly Environment & Standard Principles Compliance				95.0	94.0	95.0			

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Indicator	November			December			January		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Total no of C. diff infections: Hospital	0	3	0	1	3	0	0	2	0
Quarterly Antibiotic Audit				83.1	91.2	95.0			
Quarterly VIP score documentation				86.0	90.0	94.0			
No of patient falls	11	29	0	3	46	0	7	49	0
No of patient falls resulting in harm	2	10	0	3	7	0	1	11	0
No of avoidable serious injuries or deaths resulting from falls	0	0	0	0	0	0	0	0	0
No of ward acquired pressure ulcers	11	17	0	7	12	0	6	17	1
No of avoidable ward acquired pressure ulcers									
Nutrition: Assessment and monitoring	89.9	93.6	51.9	91.2	95.6	57.5	88.7	94.4	59.7
No of SIRIs	0	2	1	0	1	2	1	1	0
No of medication errors	21	34	9	13	36	2	17	42	5
Cardiac arrests	1	4	0	0	6	0	0	4	0
Cardiac arrests identified as a SIRI	0	0	0	0	0	0	0	0	0
Pain Management	82.5	86.2	51.4	82.1	86.4	48.1	81.5	86.3	43.7
VTE: Completed risk assessment (monthly Unify audit)	97.5	93.6	98.7	96.6	95.0	98.5	97.5	95.4	95.5
Quarterly VTE: Prophylaxis compliance									
Safety Thermometer: % of patients experiencing new harm-free care	97.7	97.0	100	98.6	98.2	100	99.5	98.1	100

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Indicator	November			December			January		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Patient Satisfaction: In-patient overall result	94.0	90.0	84.0	94.0	87.0	87.0	96.0	88.0	85.0
How likely are you to recommend our services to friends and family if they need similar care or treatment	100	95.0	100	99.0	95.0	100.0	98.0	91.0	100.0
In your opinion, how clean was the hospital room or ward you were in?	98.0	95.0	99.0	98.0	94.0	99.0	98.0	92.0	98.0
How was the food choice during your hospital stay?	88.0	90.0	85.0	89.0	87.0	84.0	95.0	84.0	85.0
How was the food taste and quality during your hospital stay?	89.0	88.0	88.0	91.0	89.0	85.0	97.0	83.0	83.0
Did you feel you were treated with respect and dignity by staff?	99.0	98.0	99.0	100	97.0	97.0	100	98.0	98.0
Were staff caring and compassionate in their approach?	99.0	97.0	98.0	99.0	97.0	95.0	100	96.0	98.0
Did you find a member of staff to talk to about your worries and fears?	99.0	93.0	100	100	96.0	100	100	99.0	100
Were you involved as much as you wanted to be in decisions about your care and treatment?	97.0	90.0	90.0	98.0	92.0	92.0	99.0	91.0	89.0
Did you experience any noise in the night time?	83.0	86.0	77.0	88.0	76.0	97.0	89.0	79.0	89.0
Did you get enough help from staff to eat your meals?	99.0	98.0	100	99.0	93.0	75.0	99.0	94.0	100.0
Minutes after you used the call button did it take to get help?	84.0	72.0	96.0	87.0	72.0	94.0	93.0	77.0	94.0
Did someone from pharmacy discuss your medications with you at any time during your hospital stay?	89.0	79.0	14.0	84.0	75.0	6.0	90.0	76.0	4.0
Were you given clear written or printed information about your take-home medications?	96.0	95.0	72.0	95.0	83.0	97.0	99.0	87.0	100
Were the purposes of your take-home medications explained to you in a way you could understand?	97.0	90.0	76.0	96.0	76.0	100	97.0	84.0	93.0
Number of Inpatient surveys completed	279	178	43	262	152	33	183	199	28
Same sex accommodation: total patients	2	0	0	3	0	0	2	0	0
Complaints	4	9	0	5	5	3	6	8	4
Environment and Cleanliness	93.7	92.8	95.0	94.6	93.8	96.0	91.8	92.2	96.4

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5. Exception reports – Safe

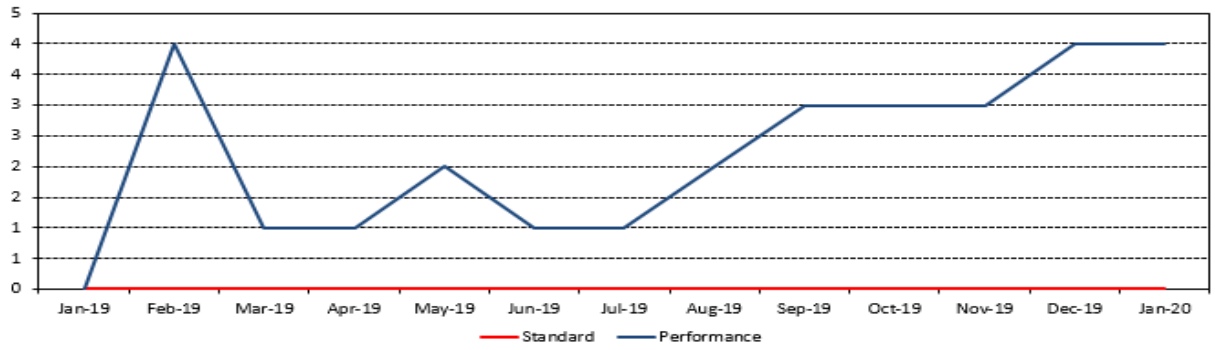
Clostridium difficile

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Safe

Supporting Narrative

Whilst there were 4 cases of Hospital attributable Clostridium difficile Infection in January, only 2 are truly attributable to the Trust. Of the other cases, one case is a relapse from December who was readmitted. This has been discussed with CCG colleagues and agreed as non-trajectory. One case was identified at 72 hours which meets the more stringent case assignment instigated by NHS England from 1/4/19, but investigation has identified this as a community case.
In January the Trust had significant admissions with Influenza A, many of whom required antibiotics for pneumonia. In previous years this has manifested in cases of Clostridium difficile infection being identified in the following months.

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



Ongoing controls in place

Clostridium difficile guideline is in date and reflects all current recommendations. Antibiotic guidelines are available on Microguide for prescribers. Antibiotic compliance is monitored as part of the quarterly audit plan. Antibiotic audit nurse and the antibiotic pharmacist attend ward governance meetings to feedback the antibiotic audit results and discuss with clinical teams. Hydrogen Peroxide Vapor fogging is utilised to decontaminate patient rooms following discharge. Chlorine is used for all routine cleaning. F12 Adult Isolation ward is used to full capacity with Clostridium difficile cases prioritised for admission/transfer to the ward.

Actions in place to recover the performance

	Owner	Start	End
The Infection Prevention Nurse team in conjunction with the Antibiotic pharmacist are in the process of establishing a weekly review of the areas in the Trust with the highest use of antibiotics associated with Clostridium difficile to ensure use is both appropriate and a plan for antimicrobial therapy is in place.	Infection Prevention Team and Pharmacy	Mar-20	Jun-20

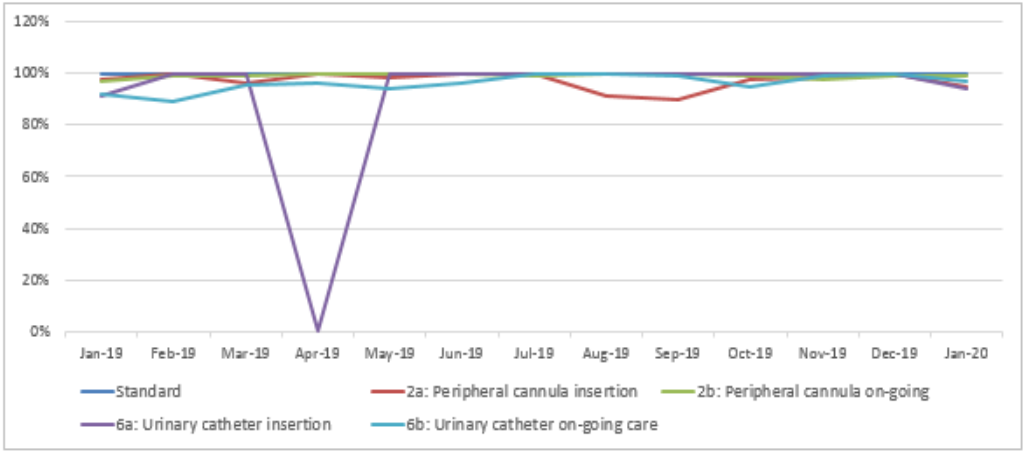
High impact intervention Compliance

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Safe

Supporting Narrative

Performance is measured against a target of 100% for each High impact intervention (High impact intervention). In January the following High impact interventions did not achieve 100% - 2a (95%), 2b (99%), 6a (94%) and 6b (97%). This was due to failures in the following wards: G1 (for 2a and 6a) and F10 (for 2b and 6b)

Month	Standard	2a: Peripheral cannula insertion	2b: Peripheral cannula on-going	6a: Urinary catheter insertion	6b: Urinary catheter on-going care
Jan-19	100%	97.9%	97.0%	90.9%	92.2%
Feb-19	100%	100%	99.3%	100%	88.8%
Mar-19	100%	96.4%	99.2%	100%	95.2%
Apr-19	100%	100%	100%	ND	96.0%
May-19	100%	98.0%	99.4%	100%	94.2%
Jun-19	100%	100%	100%	100%	96.1%
Jul-19	100%	100%	99.2%	100%	100%
Aug-19	100%	91.0%	100%	100%	100%
Sep-19	100%	90.0%	100%	100%	98.8%
Oct-19	100%	97.6%	98.8%	100%	95.0%
Nov-19	100%	98.0%	97.2%	100%	98.6%
Dec-19	100%	100%	99.1%	100%	100%
Jan-20	100%	95.0%	99.2%	93.8%	96.8%



Ongoing controls in place

On the wards the Matrons work closely with the teams to ensure performance is maintained and (where necessary) improves. High impact intervention are being looked at as part of a wider Integrated Quality & Performance Report review being led by the Head of Performance (an initial meeting took place in January) with a view to assessing performance targets (e.g. is 99% really amber?). High impact intervention indicators will potentially be used within the planned Ward accreditation project (no start date yet).

Actions in place to recover the performance

	Owner	Start	End
No specific actions in place			

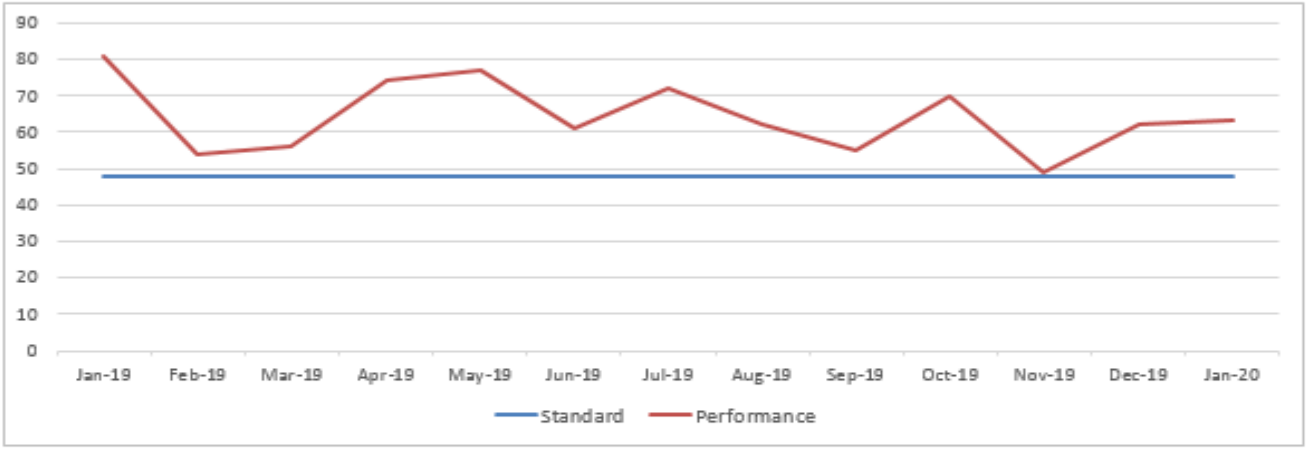
Number of Inpatient falls - WSH

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Safe

Supporting Narrative

The total number of Trust inpatient falls increased in January to 63 (56 in WSH & 7 in Community beds). There has been high levels of acuity across the wards with a high level of confused patients. There has been an increase in the number of beds with the opening of winter escalation ward - G9. Staffing levels have reduced due to sickness and covering winter escalation areas. Specialling vacancies have not been successfully covered.(i.e. providing a 'special' who is someone that looks after someone on a one-to-one basis)

Month	Standard	Performance
Jan-19	48	81
Feb-19	48	54
Mar-19	48	56
Apr-19	48	74
May-19	48	77
Jun-19	48	61
Jul-19	48	72
Aug-19	48	62
Sep-19	48	55
Oct-19	48	70
Nov-19	48	49
Dec-19	48	62
Jan-20	48	63



Ongoing controls in place

Monitoring of trends in patient falls on a monthly basis including the impact of higher levels of bed occupancy and/or patient acuity. Monitoring of frequent fallers. Completing lying and standing blood Pressure for all patients over the age of 65. Completion of falls assessment and falls care plan. The use of the falling person signs being available in bed spaces to highlight risks. The implementation of red slipper socks for those patients at risk to wear. Use of wanderguards. Requesting specialling.(i.e. providing a 'special' who is someone that looks after someone on a one-to-one basis)

Actions in place to recover the performance

	Owner	Start	End
To recruit a falls lead.	Paul Morris	Feb-20	Apr-20

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Putting you first

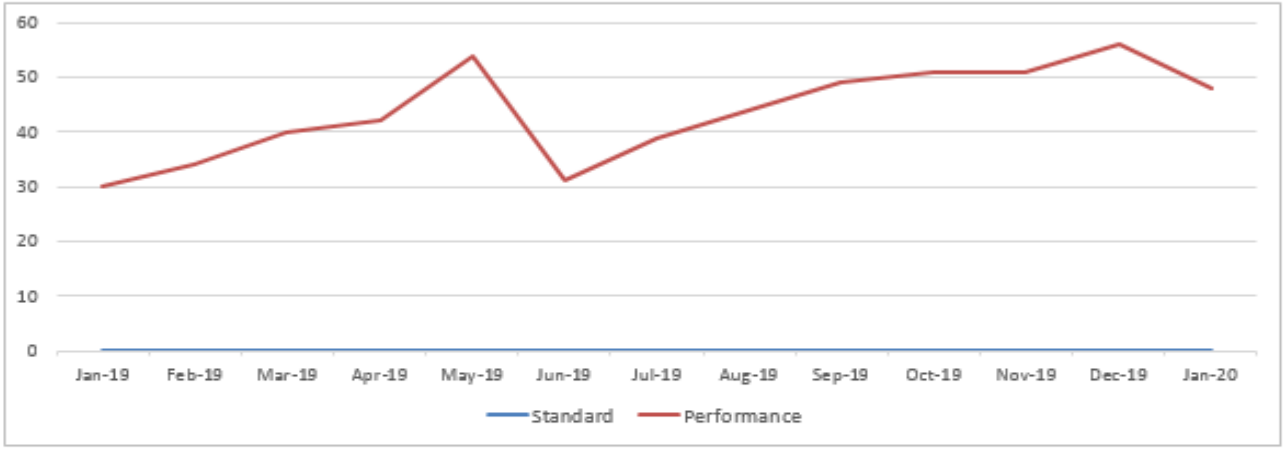
New Pressure Ulcers - Trust

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Safe

Supporting Narrative

After a month on month increase in new pressure ulcer's since Jun 19, a reduction has been observed for Jan 20. The highest incidence is within the community teams. We have also noted an increase in pressure ulcer present on admission to our services suggesting increasing complexity to the needs of our patients, which is reflected during daily escalation calls between team leads.

Month	Standard	Performance
Jan-19	0	30
Feb-19	0	34
Mar-19	0	40
Apr-19	0	42
May-19	0	54
Jun-19	0	31
Jul-19	0	39
Aug-19	0	44
Sep-19	0	49
Oct-19	0	51
Nov-19	0	51
Dec-19	0	56
Jan-20	0	48



Ongoing controls in place

Bi-monthly Pressure Ulcer Prevention and Complex Wound Group meet bi-monthly to identify underlying themes to the cause of pressure ulcers to share with teams. Robust programme of education and training across settings continues. Early review of Pressure Ulcer's encouraged to ensure that learning takes place within teams quickly.

Actions in place to recover the performance

	Owner	Start	End
Trust Pressure Ulcer Lead to meet with Quality Improvement Lead on 20.02.20 to discuss statistical basis for potential change in process of investigation of new pressure ulcers, to ensure that process is valid and themes identified for learning to be actioned.	Sharon Basson	Feb-20	Feb-20
Tissue Viability Lead (Community) to visit community team reporting consistently low level of new pressure ulcers on 26.02.20, to identify good practice to share with others.	Sharon Basson	Feb-20	Feb-20

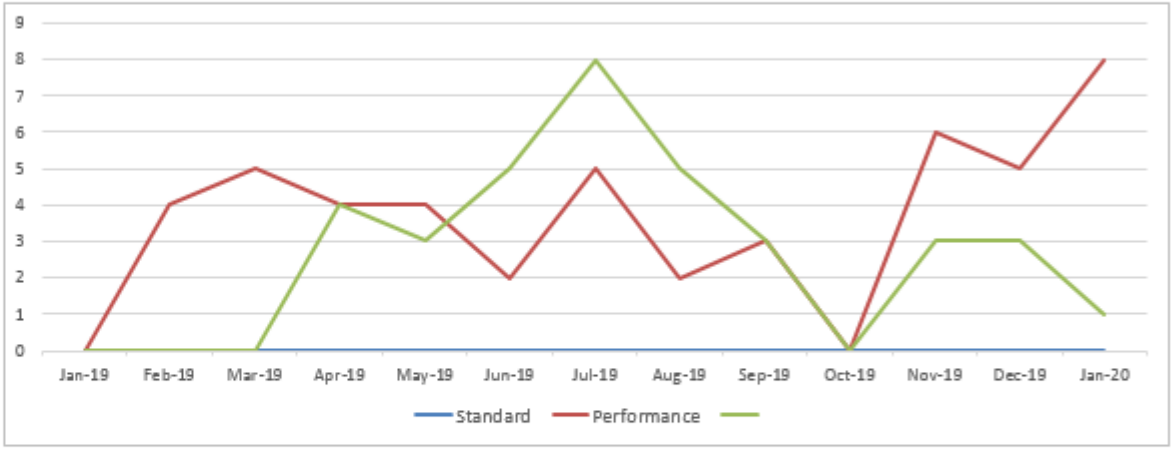
Duty of Candour overdue

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Safe

Supporting Narrative

There has been a deterioration of completion rates with eight verbal still outstanding from December and earlier at the date of this report. The overall timeliness of completion did improve in January but that relates only to cases reported in that month.

Month	Standard	Performance	
Jan-19	0	0	ND
Feb-19	0	4	ND
Mar-19	0	5	ND
Apr-19	0	4	4
May-19	0	4	3
Jun-19	0	2	5
Jul-19	0	5	8
Aug-19	0	2	5
Sep-19	0	3	3
Oct-19	0	0	0
Nov-19	0	6	3
Dec-19	0	5	3
Jan-20	0	8	1



Ongoing controls in place

Targeted follow up of the duty of candour owners by the Patient Safety team, escalation to the Divisional steering groups and Clinical Directors meeting.

Actions in place to recover the performance

	Owner	Start	End
In September options to improve all three duty of candour indicators were discussed. This is a multi-faceted issue with separate issues relating to different professions, different divisions and even record-keeping and it has been suggested that it might benefit from a Quality Improvement-style improvement plan. An initial outline for this plan has been input onto Life QI and it is planned to meet with the Quality Improvement team in the New year to seek opportunities to address various elements which may have different solutions.	Patient Safety Team	Feb-20	

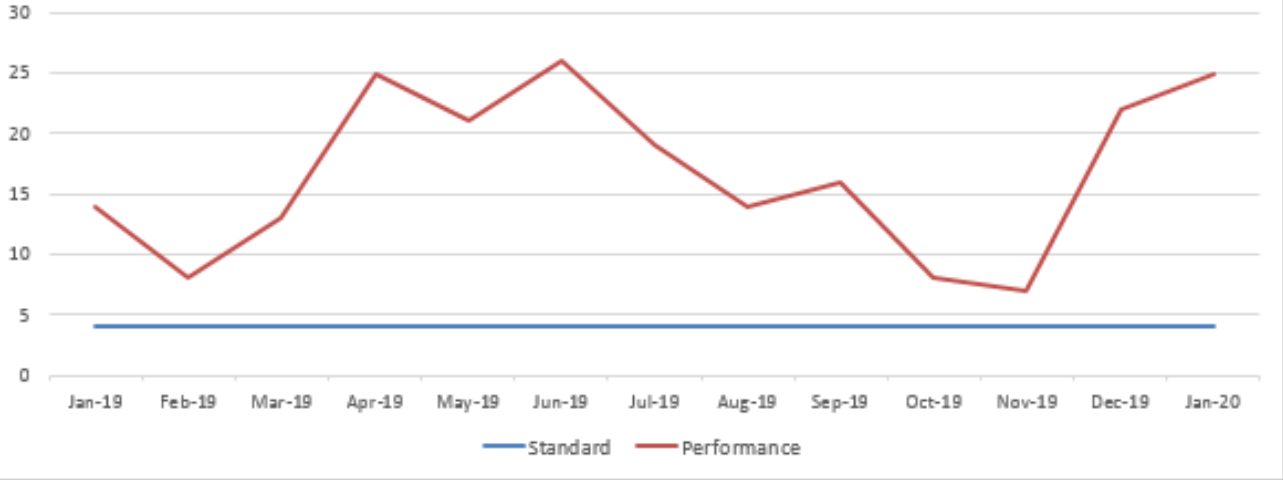
Serious incident (RCA) actions overdue

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Safe

Supporting Narrative

The number of open RCA actions has deteriorated. There are a higher number of these in the Surgical Division than the other divisions although there are not more actions originally assigned to Surgery.

Month	Standard	Performance
Jan-19	4	14
Feb-19	4	8
Mar-19	4	13
Apr-19	4	25
May-19	4	21
Jun-19	4	26
Jul-19	4	19
Aug-19	4	14
Sep-19	4	16
Oct-19	4	8
Nov-19	4	7
Dec-19	4	22
Jan-20	4	25



Ongoing controls in place

Targeted follow up of the action owners by the Patient Safety team, escalation to the Divisional steering groups and Clinical Directors meeting.

Actions in place to recover the performance

	Owner	Start	End
Consider if including actions overdue in the monthly divisional performance meetings data-set would improve compliance. This needs to be discussed with the Operational team to agree a start date (potentially from 2020/21 reporting)	Chief Operating Officer	Apr-20	

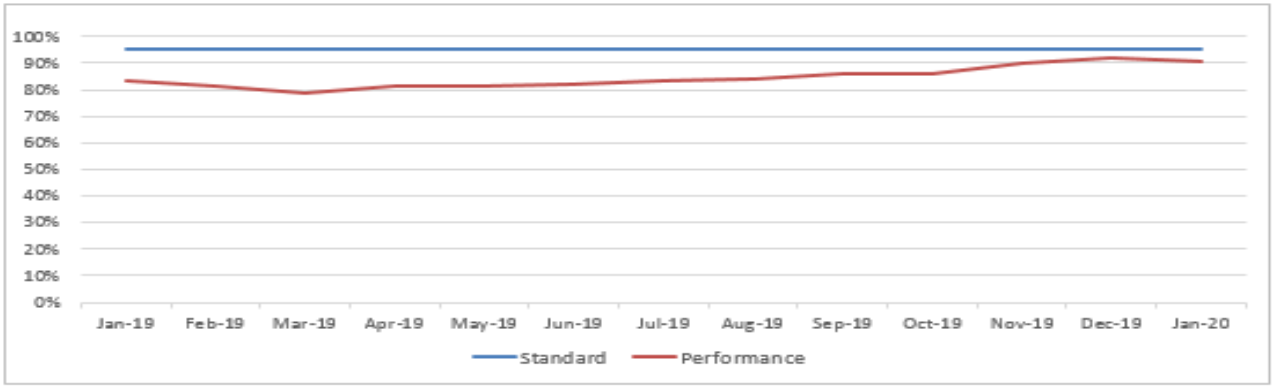
Nutrition % of patients with a MUST/PYMS assessment completed for within 24hrs

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Safe

Supporting Narrative

The chart has plateaued this month following a continuous positive upward trend over the preceding months. There has been improvement in compliance on the majority of the Medical and Surgical Wards, however some specialist areas continue to perform below the expected standard. Paediatrics is the area of most concern and there has been limited improvement despite heightened focus. In order to explore this further, a meeting has been planned with the Information Team to review the inclusions and exclusions to ensure they are valid and relevant.

Month	Standard	Performance
Jan-19	95%	83.0%
Feb-19	95%	81.0%
Mar-19	95%	79.0%
Apr-19	95%	81.0%
May-19	95%	81.0%
Jun-19	95%	82.0%
Jul-19	95%	83.0%
Aug-19	95%	84.0%
Sep-19	95%	85.7%
Oct-19	95%	86.2%
Nov-19	95%	90.0%
Dec-19	95%	91.9%
Jan-20	95%	90.4%



Ongoing controls in place

There is continued daily promotion by the Senior Matrons to improve and maintain compliance. This is being achieved with engagement of the Ward Managers and Band 6 team leads by daily review of the Ward Patient Safety Dashboard and daily assessment reports. It is envisaged that the recent changes in recording the assessments and monitoring via the patient safety dashboard will continue to improve compliance overall. The monthly and quarterly assurance audits also demonstrate continual improvement in compliance and accuracy of assessments and associated care planning. This is supported by the Dietetic team who continue a programme of education and support. Bi-annual Nutrition Advocate sessions are also planned and are assisting with promoting and maintaining compliance. The Paediatric team continue to explore methods of measure children's height, which is the main issue with being able to complete the assessment.

Actions in place to recover the performance

	Owner	Start	End
Key stakeholders to meet with the Information Team to review inclusion and exclusion criteria specific to Paediatrics	Head of Nursing, Clinical Service Manager Paediatrics	Feb-20	Mar-20
Set dates for Bi -annual Nutrition Advocate Sessions	Head of Nursing	Feb-20	Mar-20

5. DETAILED REPORTS - EFFECTIVE

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

Are we..		Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD(Apr19-Jan20)
2.Effective	Incidents/Reports	2.05	Cardiac arrests	NT	5	5	3	4	5	0	7	5	3	3	5	6	4	42
		2.06	Cardiac arrests identified as a SIRI	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		2.07	CAS (central alerts system) alerts overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		2.09	NICE guidance baseline and risk assessments not completed within 6 months of publication	10	35	33	28	19	15	17	16	16	16	19	26	32	19	195
		2.10	WHO Checklist (Qrtly)	100%	NA	NA	99.0%	NA	NA	99.0%	NA	NA	98.0%	NA	NA	98.0%	NA	98.3%
		2.11	National clinical audit report baseline & risk assessments not completed within 6 months of publication	5	26	28	29	19	16	13	13	14	14	14	20	34	42	199
		2.12	Av. Elective LOS (excl. 0 days)	NT	2.81	3.92	2.91	3.17	2.89	2.76	3.16	2.41	3.15	2.82	2.57	3.46	1.94	2.83
		2.13	Av NEL LOS (excl 0 days)	NT	7.43	8.69	8.05	8.46	8.70	8.93	8.61	7.89	8.12	8.08	8.08	9.05	8.44	8.44
		2.14	% of NEL 0 day LOS	NT	14.6%	13.8%	14.9%	14.2%	13.7%	13.3%	11.6%	13.3%	13.8%	17.2%	16.3%	16.1%	14.1%	14.4%
		2.15	NHS number coding	99%	99.7%	99.7%	99.8%	99.8%	99.8%	99.7%	99.5%	99.8%	99.8%	99.9%	99.8%	99.8%	99.8%	99.8%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	85%	97.0%	100%	92.8%	96.2%	92.9%	96.9%	100%	96.0%	100%	93.9%	100%	97.1%	92.3%	96.5%
		2.18	Discharge Summaries (A&E 95% 1d)	95%	83.7%	84.0%	81.7%	83.2%	82.8%	85.0%	83.4%	83.7%	84.9%	81.2%	84.0%	86.4%	83.6%	83.8%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	95%	76.6%	78.0%	74.9%	81.8%	80.7%	82.1%	84.3%	81.0%	86.3%	86.6%	86.6%	87.6%	83.0%	84.0%
		2.20	Elective Discharge Summaries (IP 85% 1d)	85%	84.7%	84.6%	87.9%	80.8%	87.7%	86.7%	87.8%	87.5%	90.4%	89.4%	89.8%	88.7%	87.7%	87.6%
		2.21	All Cancer 2ww services available on E-Referrals	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		2.22	Canc. Ops - Patients offered date within 28 days	100%	82.8%	100%	73.3%	79.2%	93.3%	100%	90.0%	94.9%	82.9%	100%	97.0%	95.0%	91.7%	92.4%
		2.23	Canc. Ops. - No. Cancelled for a 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – EFFECTIVE

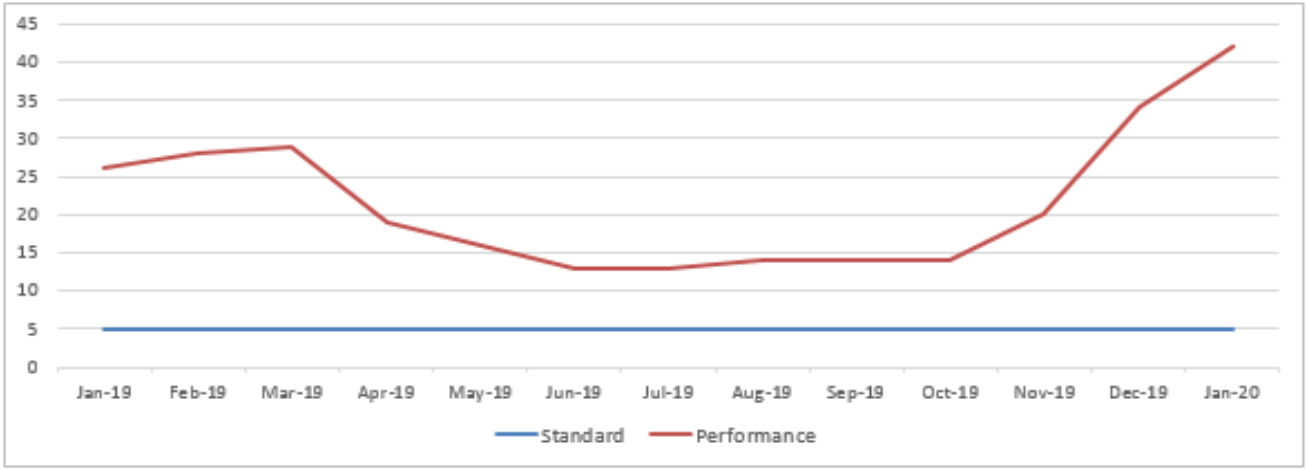
Completion of National Audit baseline assessments (number overdue)

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Effective

Supporting Narrative

A validation of the central database has been undertaken (following return of audit facilitator from maternity leave) which highlighted some anomalies in the previous six month's data. This may partly explain why the position has deteriorated although it also may be as a consequence of reduced support to the clinicians in completing their baselines over the same period. To this end it is proposed to just undertake a 'watch and wait' until March before putting extra actions into place.

Month	Standard	Performance
Jan-19	5	26
Feb-19	5	28
Mar-19	5	29
Apr-19	5	19
May-19	5	16
Jun-19	5	13
Jul-19	5	13
Aug-19	5	14
Sep-19	5	14
Oct-19	5	14
Nov-19	5	20
Dec-19	5	34
Jan-20	5	42



Ongoing controls in place

Monthly status report to Clinical Directors meeting.

Actions in place to recover the performance

	Owner	Start	End
No specific actions in place			

Putting you first

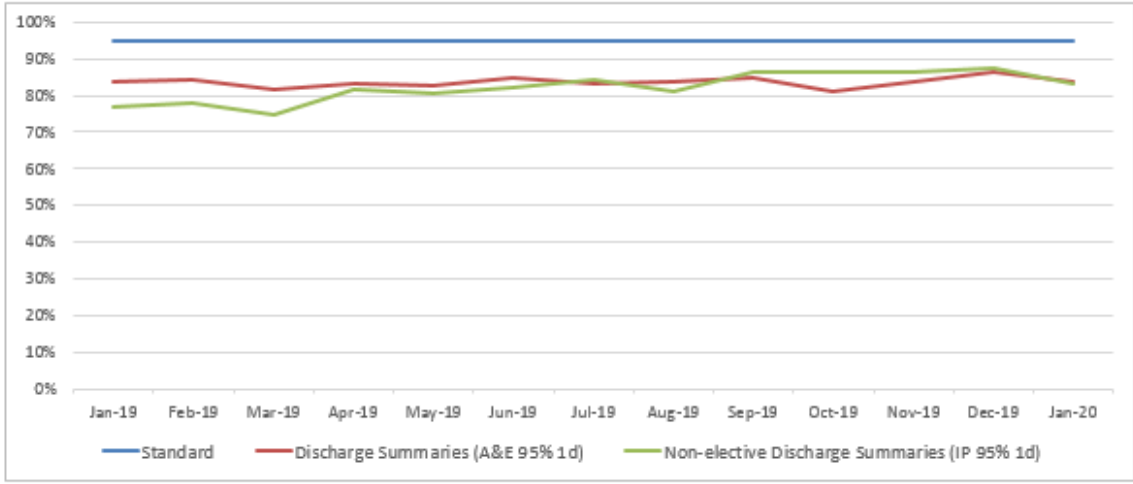
Discharge Summaries

Month	Jan-20
Executive Lead	Nick Jenkins
CQC Area	Effective

Supporting Narrative

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.

Month	Standard	Discharge Summaries (A&E 95% 1d)	Non-elective Discharge Summaries (IP 95% 1d)
Jan-19	95%	83.7%	76.6%
Feb-19	95%	84.0%	78.0%
Mar-19	95%	81.7%	74.9%
Apr-19	95%	83.2%	81.8%
May-19	95%	82.8%	80.7%
Jun-19	95%	85.0%	82.1%
Jul-19	95%	83.4%	84.3%
Aug-19	95%	83.7%	81.0%
Sep-19	95%	84.9%	86.3%
Oct-19	95%	81.2%	86.6%
Nov-19	95%	84.0%	86.6%
Dec-19	95%	86.4%	87.6%
Jan-20	95%	83.6%	83.0%



Ongoing controls in place

Actions in place to recover the performance

	Owner	Start	End
Identify and deliver relevant data at ward level to enable timely completion of discharge summaries.	Helen Beck	Jan-20	Mar-20

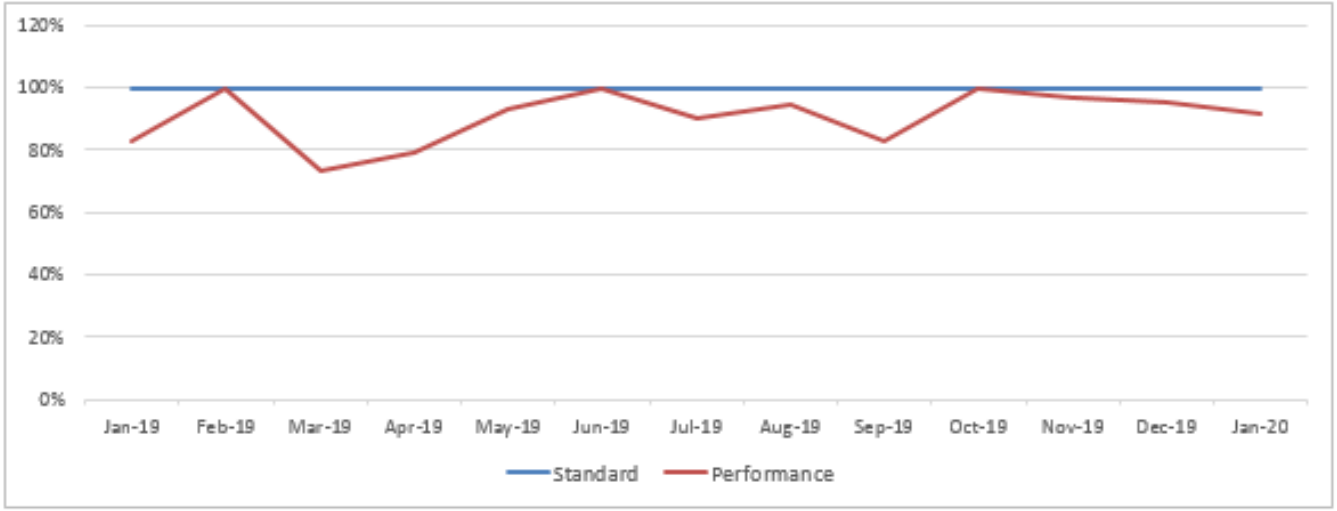
Cancelled Operations - Patients offered date within 28 days

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Effective

Supporting Narrative

There were two patients who were not able to be booked in within 28 days, one Urology patient and one Ophthalmology. The Urology patient was unable to be re-booked due to capacity and now has a date to come in for the 5th March 2020, and the Ophthalmology patient needs a particular lens and is coming back to clinic before they will be re-booked to discuss options.

Month	Standard	Performance
Jan-19	100%	82.8%
Feb-19	100%	100%
Mar-19	100%	73.3%
Apr-19	100%	79.2%
May-19	100%	93.3%
Jun-19	100%	100%
Jul-19	100%	90.0%
Aug-19	100%	94.9%
Sep-19	100%	82.9%
Oct-19	100%	100%
Nov-19	100%	97.0%
Dec-19	100%	95.0%
Jan-20	100%	91.7%



Ongoing controls in place

A weekly report is sent from the waiting list team for all 28 day rebook patients. All non-clinical cancellations are discussed at the weekly access meeting.

Actions in place to recover the performance

	Owner	Start	End
No specific actions in place			

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NHS
West Suffolk
NHS Foundation Trust

6. DETAILED REPORTS - CARING

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

Are we..		Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD(Apr19-Jan20)
3. Caring	Other Friends and Family Test Scores	3.09	IP overall experience result	90%	95.0%	94.0%	95.0%	94.0%	90.0%	92.0%	91.0%	90.0%	90.0%	90.0%	92.0%	91.0%	92.0%	91.2%
		3.10	OP overall experience result	90%	97.0%	98.0%	98.0%	98.0%	97.0%	98.0%	96.0%	96.0%	98.0%	97.0%	98.0%	97.0%	96.0%	97.1%
		3.11	A&E overall experience result	90%	95.0%	95.0%	96.0%	93.0%	85.0%	93.0%	86.0%	87.0%	91.0%	90.0%	89.0%	88.0%	88.0%	89.0%
		3.12	Short-stay overall experience result	90%	98.0%	99.0%	98.0%	98.0%	99.0%	99.0%	98.0%	99.0%	98.0%	99.0%	97.0%	98.0%	99.0%	98.4%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	90%	97.0%	97.0%	97.0%	99.0%	99.0%	99.0%	98.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	98.9%
		3.14	Maternity - overall experience result	90%	100%	96.0%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	97.0%	97.0%
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	100%	100%	96.0%	100%	98.0%	98.0%	100%	100%	100%	99.0%	99.1%
		3.16	Maternity birthing unit - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	100%	100.0%
		3.17	Maternity antenatal community - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	100%	100.0%
		3.18	Children's services overall result	90%	100%	100%	98.0%	96.0%	98.0%	98.0%	100%	100%	95.0%	100%	98.0%	100%	100%	98.5%
		3.19	F1 Parent - overall experience result	90%	97.0%	97.0%	95.0%	99.0%	98.0%	99.0%	98.0%	99.0%	97.0%	96.0%	98.0%	98.0%	99.0%	98.1%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	96.0%	98.0%	100%	100%	100%	100%	92.0%	100%	96.0%	100%	98.2%
		3.21	F1 Children - Overall experience result	90%	100%	100%	98.0%	86.0%	89.0%	98.0%	100%	100%	95.0%	100%	98.0%	98.0%	92.0%	95.6%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	90%	100%	80.0%	100%	80.0%	95.0%	100%	86.0%	100%	100%	86.0%	100%	ND	92.0%	93.2%
		3.23	King suite - extremely likely or likely to recommend	90%	100%	100%	100%	100%	100%	100%	100%	95.0%	100%	ND	100%	100%	100%	99.4%
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	90%	100%	96.0%	100%	100%	100%	94.0%	97.0%	98.0%	96.0%	100%	100%	100%	98.0%	98.3%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	90%	93.0%	93.0%	100%	100%	97.0%	90.0%	95.0%	92.0%	98.0%	100%	100%	100%	100%	97.2%
		3.27	Stroke Care - Overall Experience Result	90%	ND	89.0%	97.0%	96.0%	95.0%	97.0%	98.0%	89.0%	94.0%	97.0%	95.0%	95.0%	97.0%	95.3%
		3.28	Stroke Care - extremely likely or likely to recommend	90%	ND	93.0%	89.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	90%	100%	88.0%	84.0%	94.0%	83.0%	81.0%	94.0%	80.0%	94.0%	85.0%	94.0%	20.0%	86.0%	81.1%
		3.30	Complaints responded to within agreed timeframe	90%	75.0%	100%	94.0%	86.0%	77.0%	71.0%	60.0%	44.0%	40.0%	37.0%	58.0%	57.0%	82.0%	61.2%
		3.31	Number of second letters received	1	3	2	0	2	2	4	1	1	3	2	0	0	3	18
		3.32	Ombudsman referrals accepted for investigation	1	0	0	0	0	0	0	1	1	0	0	0	0	0	2
		3.33	No. of complaints to Ombudsman upheld	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		3.34	No. of PALS contacts	NT	231	211	228	184	190	191	252	207	223	229	187	125	157	1945
		3.35	No. of PALS contacts becoming formal complaints	<=5	2	5	4	2	5	6	4	2	0	5	3	2	0	29

Putting you first

EXCEPTION REPORTS –CARING

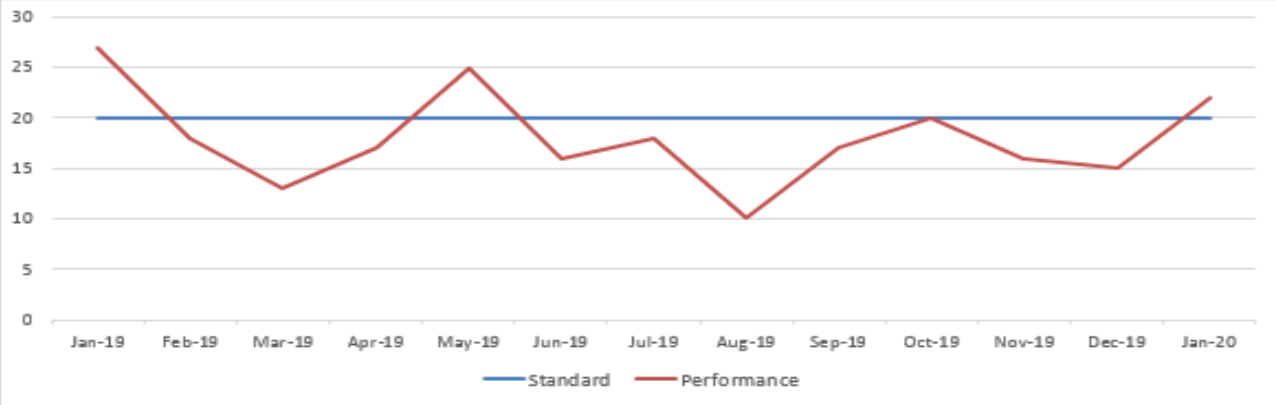
Formal Complaints

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Caring

Supporting Narrative

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.

Month	Standard	Performance
Jan-19	20	27
Feb-19	20	18
Mar-19	20	13
Apr-19	20	17
May-19	20	25
Jun-19	20	16
Jul-19	20	18
Aug-19	20	10
Sep-19	20	17
Oct-19	20	20
Nov-19	20	16
Dec-19	20	15
Jan-20	20	22



Ongoing controls in place

The Trust promotes people providing their feedback and knowing where to go to raise concerns. With a restructure of the patient experience team this will further the opportunity to identify themes in formal complaints and conduct targeted training to minimise the chances of issues arising/ensuring lessons are learnt.

Actions in place to recover the performance

	Owner	Start	End
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 and not just formal complaints and will help to address issues prior to escalation and encourage learning.	Cassia Nice	Mar-20	May-20
Capacity to analyse feedback in more detail will allow the team to conduct targeted training and education across the Trust, which is one of the team's objectives for 2020/2021.	Cassia Nice	Apr-20	Mar-21

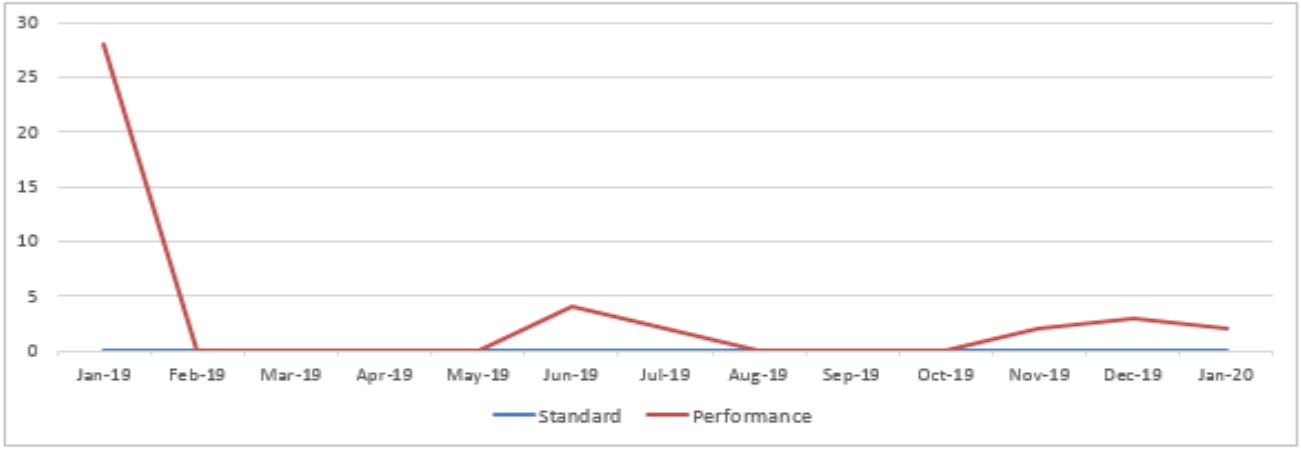
Mixed Sex Accommodation Breaches

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Caring

Supporting Narrative

There was 1 breach in Critical Care involving 2 patients. This involved a patient who was deemed as level 1 and ready for the ward but there were no ward beds available for a period more than 4 hours. This incurred a breach. A ward bed was requested immediately but capacity pressures within the organisation inhibited this. It was not possible to move the patient within the unit to avoid the breach. There was no harm to the patient and dignity was not compromised.

Month	Standard	Performance
Jan-19	0	28
Feb-19	0	0
Mar-19	0	0
Apr-19	0	0
May-19	0	0
Jun-19	0	4
Jul-19	0	2
Aug-19	0	0
Sep-19	0	0
Oct-19	0	0
Nov-19	0	2
Dec-19	0	3
Jan-20	0	2



Ongoing controls in place

Prompt requests for ward beds. Prioritisation of Critical Care Services bed requests by Patient Flow Team. Assessment of need to relocate patients within the Critical Care Services complex to avoid breaches.

Actions in place to recover the performance

	Owner	Start	End
Escalation to Senior Operational Managers to facilitate flow.	Patient Flow	Feb-20	Apr-20

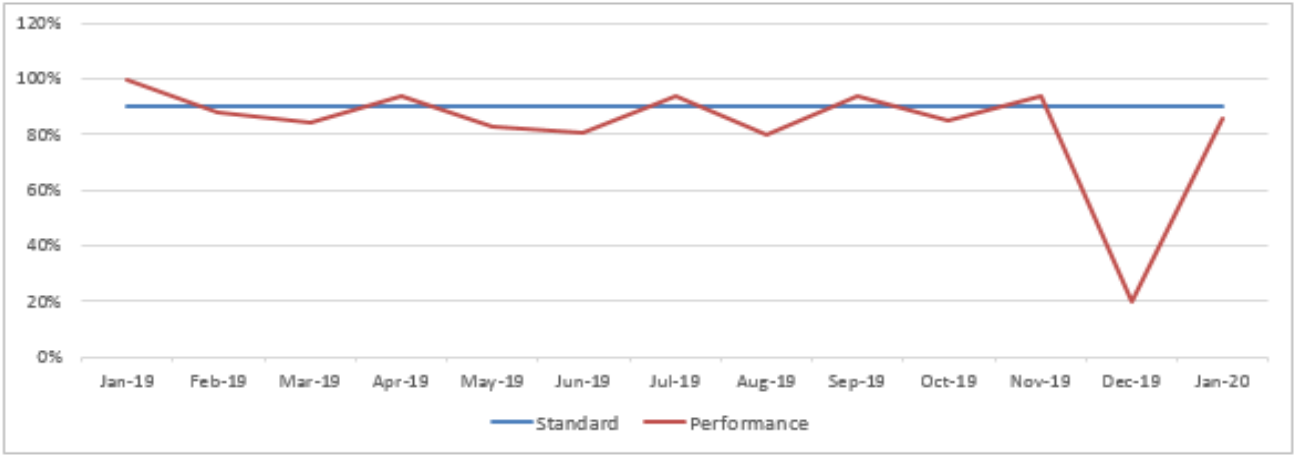
Complaints acknowledged within 3 working days

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Caring

Supporting Narrative

The patient experience team remains in a difficult situation with regard to staffing which is continuing to impact on the management of formal complaints. Currently there is limited cover for leave which impacts on this metric.

Month	Standard	Performance
Jan-19	90%	100%
Feb-19	90%	88.0%
Mar-19	90%	84.0%
Apr-19	90%	94.0%
May-19	90%	83.0%
Jun-19	90%	81.0%
Jul-19	90%	94.0%
Aug-19	90%	80.0%
Sep-19	90%	94.0%
Oct-19	90%	85.0%
Nov-19	90%	94.0%
Dec-19	90%	20.0%
Jan-20	90%	86.0%



Ongoing controls in place

Patient Experience Coordinator covering complaints administration during vacancy. The restructured patient experience team will enable cross cover and this element is not expected to fall below green once vacancies are filled. Recruitment is progressing and we anticipate recovery for this element by March 2020, therefore results to be demonstrated in April quality report.

Actions in place to recover the performance

	Owner	Start	End
Patient Experience Administrator starting in post who will administrate complaints process	Cassia Nice	Mar-20	Mar-20
Patient Experience Coordinator will continue to provide support and cover for the administrative tasks such as this	Cassia Nice	Mar-20	Mar-20

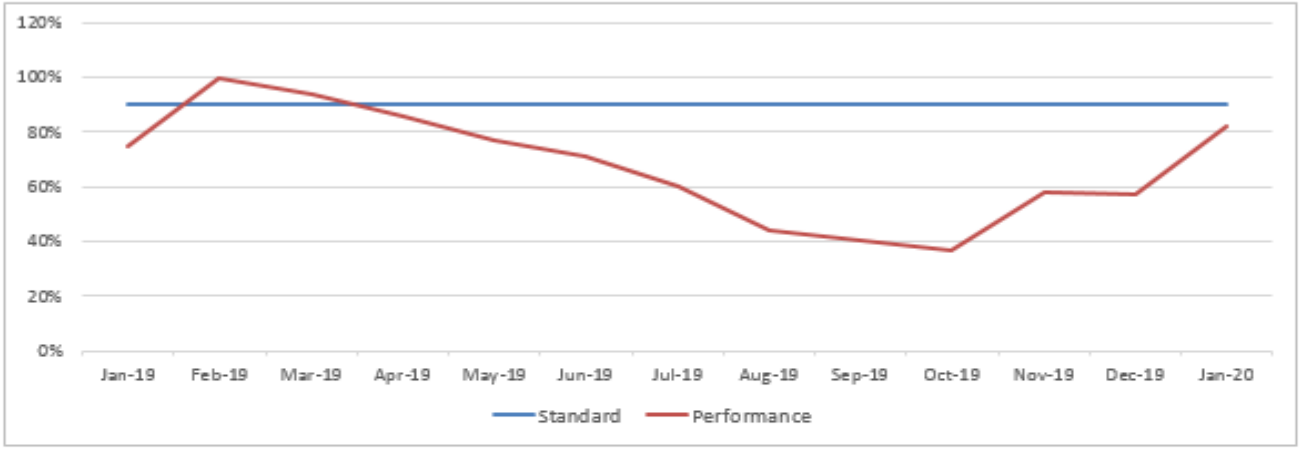
Complaints responded to within agreed timeframe

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Caring

Supporting Narrative

The patient experience team remains in a difficult situation with regard to staffing which is continuing to impact on response timeframes.

Month	Standard	Performance
Jan-19	90%	75.0%
Feb-19	90%	100%
Mar-19	90%	94.0%
Apr-19	90%	86.0%
May-19	90%	77.0%
Jun-19	90%	71.0%
Jul-19	90%	60.0%
Aug-19	90%	44.0%
Sep-19	90%	40.0%
Oct-19	90%	37.0%
Nov-19	90%	58.0%
Dec-19	90%	57.0%
Jan-20	90%	82.0%



Ongoing controls in place

Complaint response timeframes are being prioritised as highly as possible within current staffing constraints. A number of responses have been extended or are late beyond their timeframes. Ad hoc support has also been sought from staff outside of the team to construct complaint responses. Recruitment is progressing and we anticipate recovery for this element by May 2020, therefore results to be demonstrated in June quality report.

Actions in place to recover the performance

	Owner	Start	End
Appointment of Patient Advice and Liaison Service Manager who can assist with complaint responses until appointment of Complaints Manager	Cassia Nice	Feb-20	Apr-20
Appointment of Complaints Manager. Start date to be confirmed pending recruitment checks etc.	Cassia Nice	Feb-20	May-20

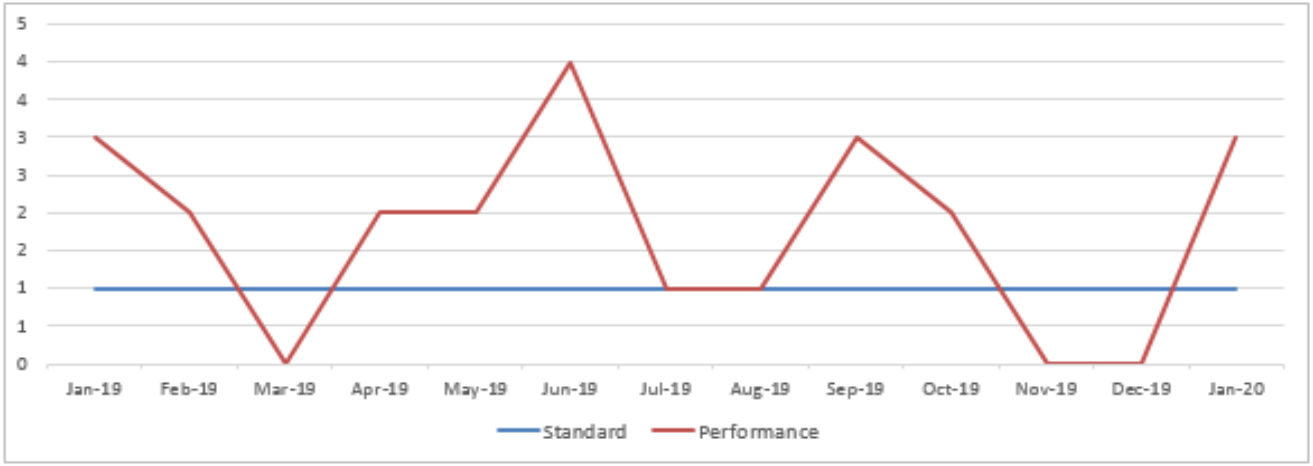
Number of second letters received

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Caring

Supporting Narrative

One second letter related to the delays in the complaint investigation process, actions of which will be addressed with the patient experience team restructure. Two other second letters relate to differing areas across the organisation but ask further queries as a result of the initial Trust response.

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



Ongoing controls in place

These complainants have been offered the chance to meet with staff to discuss their on-going concerns. We have filled vacancies in Patient Advice Liason Service which will further the opportunity for early local resolution.

Actions in place to recover the performance

	Owner	Start	End
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 and not just formal complaints and will help to address issues prior to escalation and encourage learning.	Cassia Nice	Mar-20	May-20
Capacity to analyse feedback in more detail will allow the team to conduct targeted training and education across the Trust, which is one of the team's objectives for 2020/2021.	Cassia Nice	Apr-20	Mar-21

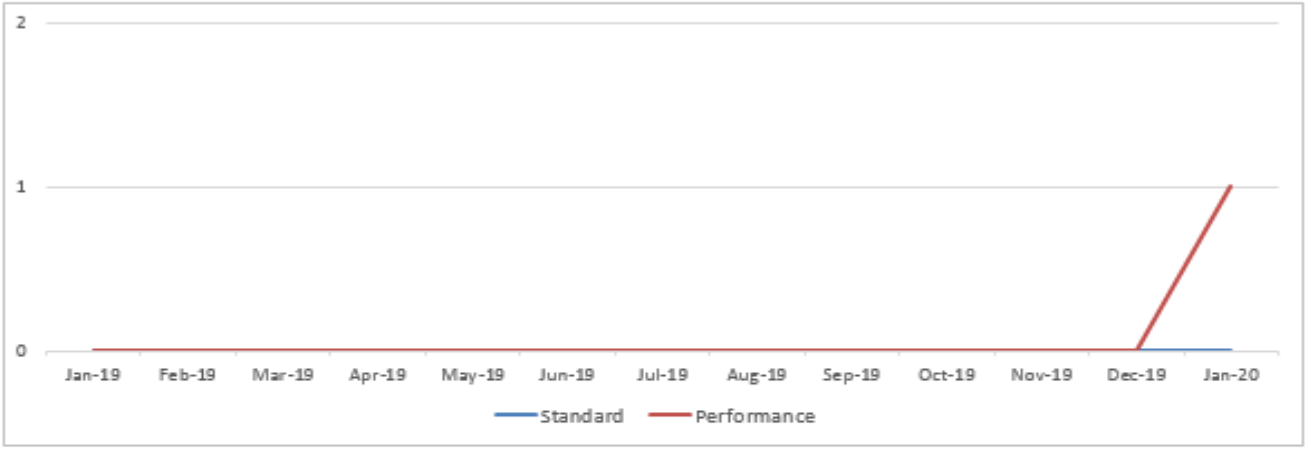
Number of complaints to Ombudsman upheld

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Caring

Supporting Narrative

The Trust attempted local resolution of this complaint which resulted in two written responses. The Parliamentary and Health Service Ombudsman have released their draft findings which is currently with staff for comment in which they have proposed to partly uphold the complaint stating 'we have found failings, but we are not able to link these to the claimed impact'.

Month	Standard	Performance
Jan-19	0	0
Feb-19	0	0
Mar-19	0	0
Apr-19	0	0
May-19	0	0
Jun-19	0	0
Jul-19	0	0
Aug-19	0	0
Sep-19	0	0
Oct-19	0	0
Nov-19	0	0
Dec-19	0	0
Jan-20	0	1



Ongoing controls in place

The Trust is liaising with the Parliamentary and Health Service Ombudsman and staff to ensure recommendations are reviewed and commented upon prior to publication of the final report. Measures will be taken to address actions identified and oversee the Parliamentary and Health Service Ombudsman recommendations.

Actions in place to recover the performance

	Owner	Start	End
Upon receipt of the final report, the Trust should write to the complainant to acknowledge the Parliamentary and Health Service Ombudsman's identified failings and apologise.	Cassia Nice	On receipt of final report	Within 30 days of final report
An action plan should be produced based on the recommendations to demonstrate what has been done to address the failings.	Cassia Nice	On receipt of final report	Within 3 months of final report

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7. DETAILED REPORTS - RESPONSIVE

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

Are we..		Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD(Apr19-Jan20)
4. Responsive	A&E	4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	20.32	14.35	13.55	14.35	13.23	20.01	17.18	20.35	11.48	14.30	12.51	17.41	17.23	15.81
		4.16	A&E -Waits over 12 hours from DTA to Admission	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
		4.17	A&E - Admission waiting 4-12 hours from dec. to admit	4	125	113	65	155	105	119	133	33	80	63	64	163	208	1123
		4.18	A&E - To inpatient Admission Ratio	32%	31.3%	31.6%	29.7%	29.0%	28.8%	27.2%	25.5%	26.1%	27.1%	28.5%	27.7%	28.4%	28.5%	27.7%
		4.19	A&E Service User Impact (re-attendance in 7 days <5% & time to treat)	1 met	1	1	1	1	1	1	1	1	1	1	1	1	1	1
		4.20	A&E/AMU - Amb. Submit button complete	80%	94.9%	96.5%	95.4%	95.3%	95.6%	96.4%	94.7%	96.0%	95.8%	96.6%	97.1%	96.0%	ND	95.9%
		4.21	A&E - Amb. Handover above 30m	0	61	33	41	46	41	41	129	31	57	87	97	112	ND	641
		4.22	A&E - Amb. Handover above 60m	0	59	10	15	13	36	28	74	3	18	56	18	49	ND	295
	RTT	4.25	RTT waiting List	18500	19601	18341	19730	20427	21061	21253	20937	20942	20831	21073	20259	20399	20078	20726
		4.26	RTT waiting list over 18 weeks	NT	2999	3005	3006	3111	2985	3101	3270	3495	3746	3954	4015	4125	4326	3613
		4.27	RTT 18 weeks Non-Consultant led services - Community	90%	99.7%	99.6%	100%	99.0%	99.4%	94.0%	98.0%	94.4%	95.0%	96.7%	99.3%	98.9%	97.5%	97.2%
		4.28	RTT 52 weeks Non-Consultant led services - Community	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Stroke	4.29	Stroke - % Patients scanned within 1 hr.	77%	83.0%	75.5%	84.4%	75.8%	75.0%	80.0%	69.6%	70.6%	63.0%	72.5%	84.8%	77.3%	77.4%	74.6%
		4.30	Stroke - % patients scanned within 12 hrs.	96%	94.3%	98.1%	95.6%	97.0%	97.2%	95.0%	95.7%	94.1%	93.5%	96.1%	91.3%	88.6%	100%	94.9%
		4.31	Stroke - % Patients admitted directly to stroke unit within 4h	75%	78.4%	61.5%	78.6%	75.0%	71.4%	81.6%	77.5%	63.6%	74.4%	75.5%	88.6%	76.7%	78.4%	76.3%
		4.32	Stroke - Greater than 80% of treatment on stroke unit	90%	94.1%	84.3%	81.0%	96.9%	88.6%	86.8%	90.0%	97.0%	88.4%	91.8%	93.2%	90.7%	96.1%	92.0%
		4.33	Stroke - % of patients treated by the SESDC	48%	63.2%	49.1%	66.7%	54.2%	73.3%	55.0%	40.0%	71.4%	39.4%	40.0%	47.6%	50.0%	51.2%	52.2%
		4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	96.2%	86.8%	91.1%	90.6%	88.9%	90.0%	84.8%	85.3%	82.6%	92.2%	89.1%	85.7%	92.5%	88.2%
		4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	87.5%	89.6%	80.0%	76.2%	75.0%	77.1%	92.9%	80.0%	83.3%	77.5%	78.4%	75.8%	79.5%	79.6%
		4.36	Stroke -% of eligible patients given thrombolysis	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		4.37	Stroke -% of stroke survivors who have 6mth f/up	50%	NA	NA	57.0%	NA	NA	68.0%	NA	NA	69.0%	NA	NA	ND	NA	68.5%
		4.38	Stroke -Provider rating to remain within A-C	C	NA	NA	C	NA	NA	C	NA	NA	A	NA	NA	ND	NA	A

Putting you first

Are we..		Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD(Apr19-Jan20)
4. Responsive	Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	ND	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	NA	100%
		4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	96.6%	100%	100%	100%	100%	100%	93.8%	100%	97.1%	100%	100%	100%	100%	99.1%
		4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.0%	98.8%	99.3%	99.2%	99.5%	99.3%	98.8%	97.3%	99.9%	98.9%	99.2%	98.7%	99.3%	99.0%
		4.42	Nursing & therapy Green referrals seen within 18 wks -Community	95%	99.5%	99.5%	99.5%	99.4%	99.5%	100%	99.6%	99.5%	99.4%	99.6%	99.8%	99.6%	99.6%	99.5%
		4.43	Wheelchair waiting times – Child (Community)	92%	81.8%	94.1%	100%	100%	100%	100%	96.3%	100%	100%	93.2%	98.1%	100%	100%	98.8%
		4.44	Wheelchair waiting times - Adult (Community)	92%	ND	ND	ND	ND	ND	ND	ND	ND	ND	85.0%	93.2%	91.4%	92.9%	90.6%
		4.45	Sepsis - 1 hr neutropenic sepsis	100%	81.0%	75.0%	87.5%	100%	91.7%	92.9%	87.5%	90.0%	87.5%	92.8%	78.6%	89.5%	73.7%	88.4%
		4.48	% of initial health assessments completed within 15 working days of receiving all relevant paperwork.	95%	NA	NA	NA	93.3%	40.0%	46.2%	50.0%	20.0%	21.1%	54.2%	88.9%	100%	86.7%	60.0%
		4.46	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care	100%	0.0%	20.0%	14.3%	33.3%	40.0%	38.5%	50.0%	20.0%	6.7%	45.8%	55.6%	66.7%	80.0%	43.7%
		4.47	Percentage of Service Users (children) assessed to be eligible for NHS Continuing Healthcare whose review health assessment is completed annually	80%	100%	100%	ND	99.0%	96.2%	100%	100%	100%	100%	96.0%	96.2%	96.2%	85.2%	96.9%

Putting you first

EXCEPTION REPORTS – RESPONSIVE

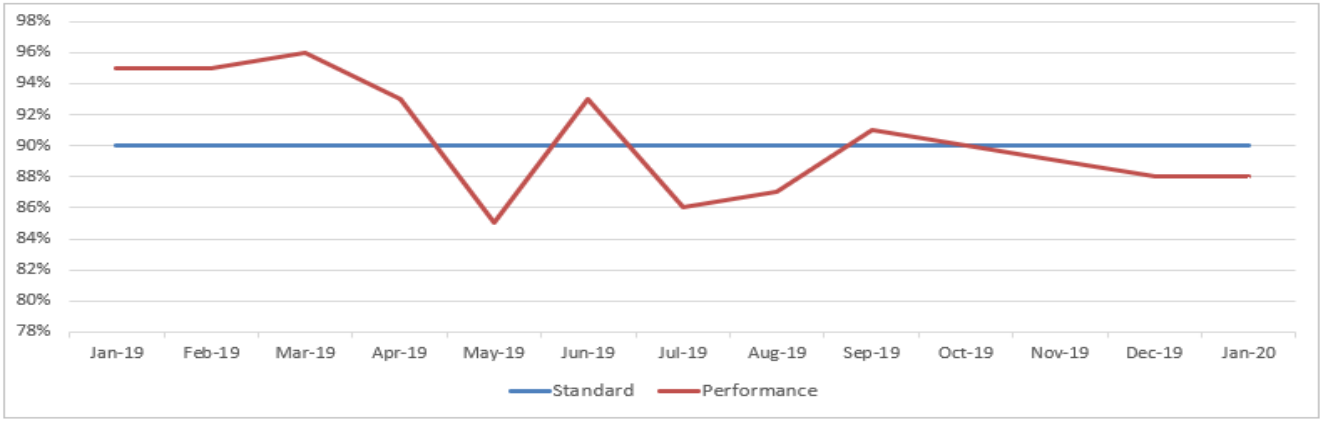
A&E overall experience result

Month	**Jan-20**
Executive Lead	**Rowan Procter**
CQC Area	**Caring**

Month	Standard	Performance
Jan-19	90%	95.0%
Feb-19	90%	95.0%
Mar-19	90%	96.0%
Apr-19	90%	93.0%
May-19	90%	85.0%
Jun-19	90%	93.0%
Jul-19	90%	86.0%
Aug-19	90%	87.0%
Sep-19	90%	91.0%
Oct-19	90%	90.0%
Nov-19	90%	89.0%
Dec-19	90%	88.0%
Jan-20	90%	88.0%

Supporting Narrative

88% of ED patients responding to Friend and Family Survey were likely or extremely likely to recommend their care which is below the target of 90%.



Ongoing controls in place

Acuity and pressures on the department will be discussed at the ED governance meeting.
Governor area observations are being conducted in the department which will allow further identification of improvements.

Actions in place to recover the performance

	Owner	Start	End
Administrative teams will be reminded of the importance of collection of friends and family and given refresher training on customer service and the importance of first impressions on patient perception of care.	Ian Pridding	Jan-20	Apr-20
Relaunch of the patient safety checklist as part of the CQC improvement plan aims to engaged clinical teams in the importances of ensuring patient safety checklist is completed when due. Regular meetings have been scheduled with the Executive lead to monitor progress and provide executive assurance on the improvement plan.	Abi Ormes/Donna Bowd	Jan-20	Apr-20
Friends and family results and themes of comments are shared as part of the governance meetings in ED. Specific examples of feedback are shared with individuals involved if possible and with the whole department through our shared learning board.	Ian Pridding	Jan-20	Apr-20

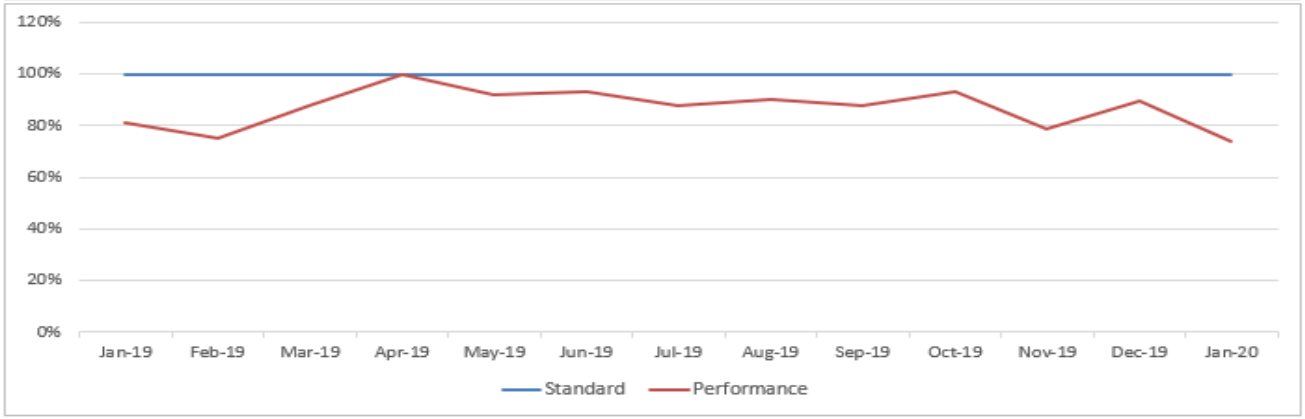
Sepsis - 1 hr neutropenic sepsis

Month	**Jan-20**
Executive Lead	**Rowan Procter**
CQC Area	**Responsive**

Supporting Narrative

Performance against national standards for Door to Needle time for Neutropenic was 73.7% for the month of January.
Of the 6 patient's who were admitted to G1, 5 patients received the required treatment within the 1 hour time scale (83.33%.)
Of the 13 patients who were admitted through ED, 9 patients were treated within the hour (69.23%) and 4 patients breached the national standard.

Month	Standard	Performance
Jan-19	100%	81.0%
Feb-19	100%	75.0%
Mar-19	100%	87.5%
Apr-19	100%	100%
May-19	100%	91.7%
Jun-19	100%	92.9%
Jul-19	100%	87.5%
Aug-19	100%	90.0%
Sep-19	100%	87.5%
Oct-19	100%	92.8%
Nov-19	100%	78.6%
Dec-19	100%	89.5%
Jan-20	100%	73.7%



Ongoing controls in place

Separate teaching and sign-off for neutropenic sepsis anti-biotic PGD by ED PDN
Detailed learning and sign-off within the Emergency Department Adult and Paediatric Competency Workbooks.
NSFP communicated to the ED Team through 'hot topics' at the start of the shift
Monthly Neutropenic Sepsis Targets to be displayed on info board in ED staff room for continued shared learning
Electronic register of neutropenic sepsis anti-biotic PGD sign-off (will be within the new ED training database which is currently being developed)
Addition to the Band 7 Floor Coordinator individual competencies, responsible for allocating the NSFP to a ED Nurse(with anti-biotic PGD sign-off) within 15 minutes of registration
To involve Floor Coordinator with answering neutropenic RCA document around explanation for individual shifts
Regular ED agency nurses to complete competencies and PGD's for neutropenic sepsis antibiotics
Opening of Rapid Assessment and Treatment Unit from 3rd February will support early identification and treatment of patients.
RCAs to be completed and common themes to be identified and learning to be shared with wider team through governance meetings and shared learning board.

Actions in place to recover the performance

	Owner	Start	End
No actions			

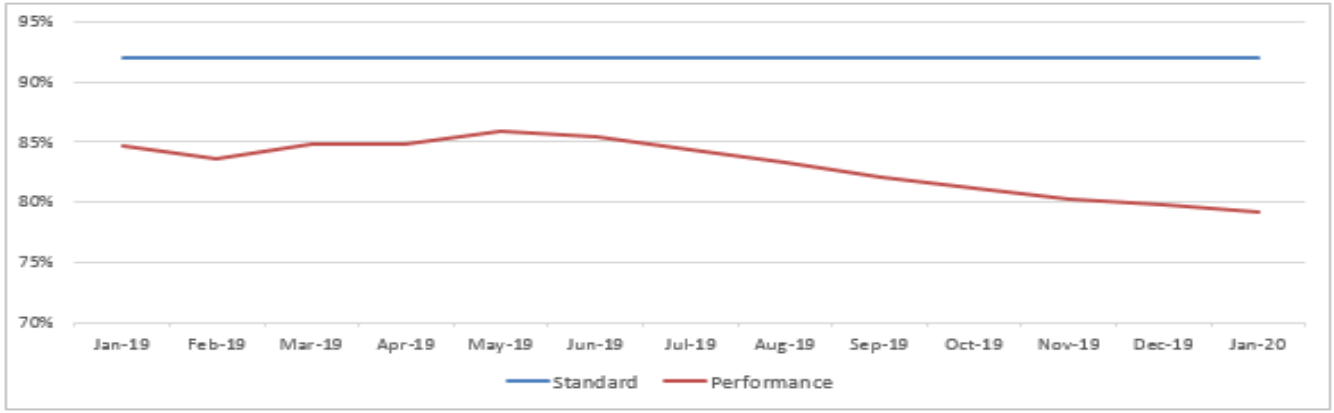
Referral to Treatment: % incomplete pathways within 18 weeks

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Supporting Narrative

Performance has remained around 79% for January, with significant underperformance in General Surgery, Trauma and Orthopaedics, Ophthalmology and Gynaecology which are all performing well below the national average.

Month	Standard	Performance
Jan-19	92%	84.7%
Feb-19	92%	83.6%
Mar-19	92%	84.8%
Apr-19	92%	84.8%
May-19	92%	85.8%
Jun-19	92%	85.4%
Jul-19	92%	84.4%
Aug-19	92%	83.3%
Sep-19	92%	82.0%
Oct-19	92%	81.2%
Nov-19	92%	80.2%
Dec-19	92%	79.8%
Jan-20	92%	79.2%



Ongoing controls in place

All patients over 30 weeks are discussed in detail at the Weekly Trust Access meeting. On-going action plans are in place for all specialities which are underperforming. An internal Referral to Treatment steering group has been set up with the Associate Director of Operations which will go through all the action plans in detail.

Actions in place to recover the performance

	Owner	Start	End
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%	Associate Director of Operations	Feb-20	Mar-20
Additional focus on the General Surgery and Colorectal General Outpatient Other PTL pathways - ensuring a process is embedded within the teams to allow patients to be correctly managed on the PTL.	Assistant Service Manager	Feb-20	Feb-20

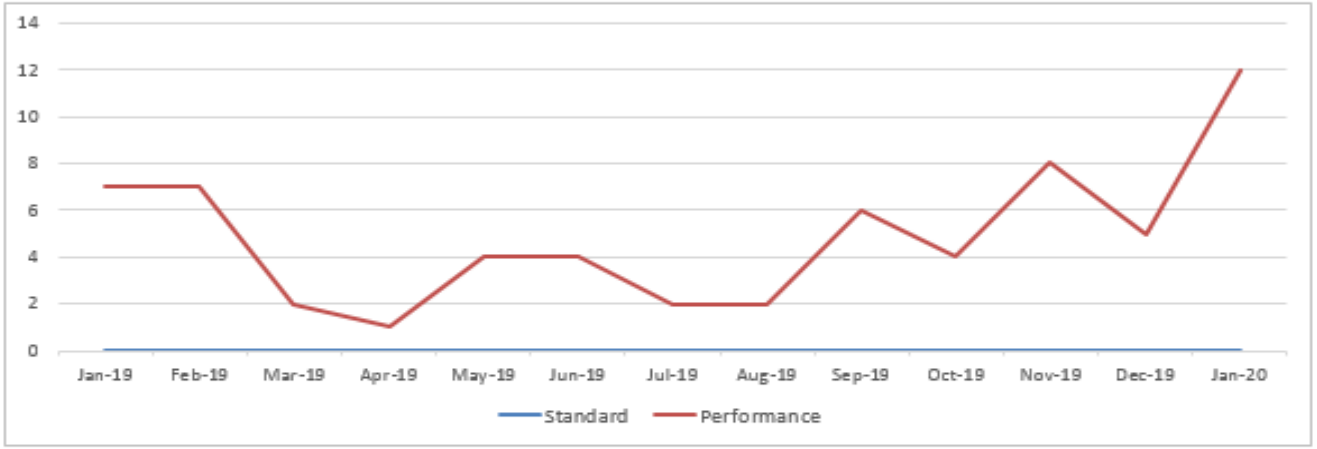
52 week waiters

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Supporting Narrative

Large increase in 52 week waits up to 12 patients, 6 of which are within Ophthalmology due to an issue which was identified around patients who are on multiple eye care pathways and therefore had incorrect RTT clock stops. 2 Gynaecology patients due to their extended pathways and then patient choice to slightly delay surgery, 1 Colorectal patient due to long diagnostic pathway delays, 1 general surgery patient again due to long diagnostic delays and clinically complex pathway, 2 Vascular patients , one which was cancelled for surgery in December due to medication issues and one re-validation which caused a significantly long RTT pathway.

Month	Standard	Performance
Jan-19	0	7
Feb-19	0	7
Mar-19	0	2
Apr-19	0	1
May-19	0	4
Jun-19	0	4
Jul-19	0	2
Aug-19	0	2
Sep-19	0	6
Oct-19	0	4
Nov-19	0	8
Dec-19	0	5
Jan-20	0	12



Ongoing controls in place

All long waiting patients are discussed at the Weekly access meeting. Root cause analysis with clinical harm review is undertaken for each patient who waits over 52 weeks. A weekly review of patients who are not on an active RTT pathway but on an elective waiting list will also be reviewed. Action plans and business cases that are in development for recovery of RTT performance, will also address the extended wait time for patients at the point they are offered surgery.

Actions in place to recover the performance

	Owner	Start	End
Meeting with Ophthalmology team on the 11th February to agree a different work flow for patients who are on multiple care pathways. This was agreed on this date and a Standard Operational Procedure will follow for ease.	Hannah Knights	Feb-20	Feb-20

41

Putting you first

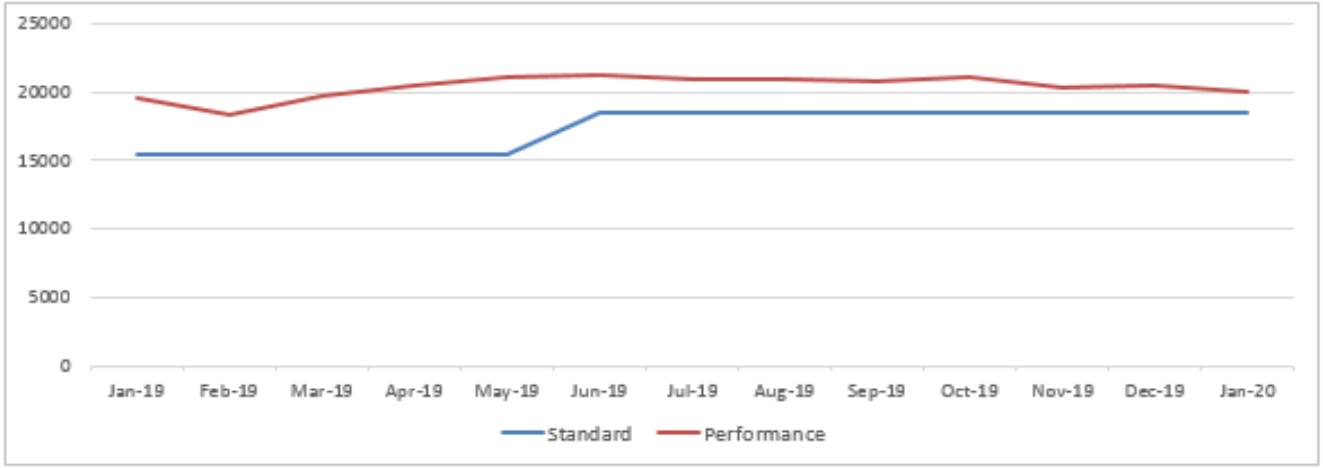
Referral to Treatment waiting List

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Supporting Narrative

Overall waiting list position remains fairly static for January with most services waiting list remaining unchanged overall.

Month	Standard	Performance
Jan-19	15396	19601
Feb-19	15396	18341
Mar-19	15396	19730
Apr-19	15396	20427
May-19	15396	21061
Jun-19	18500	21253
Jul-19	18500	20937
Aug-19	18500	20942
Sep-19	18500	20831
Oct-19	18500	21073
Nov-19	18500	20259
Dec-19	18500	20399
Jan-20	18500	20074



Ongoing controls in place

Monitor long waiting patients at weekly access meeting. Action plans in place for all services who are not compliant with the 92% standard.

Actions in place to recover the performance

	Owner	Start	End
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%	Associate Director of Operations	Feb-20	Mar-20
Additional focus on the General Surgery and Colorectal General Outpatient Other PTL pathways - ensuring a process is embedded within the teams to allow patients to be correctly managed on the PTL.	Assistant Service Manager	Feb-20	Feb-20

Putting you first

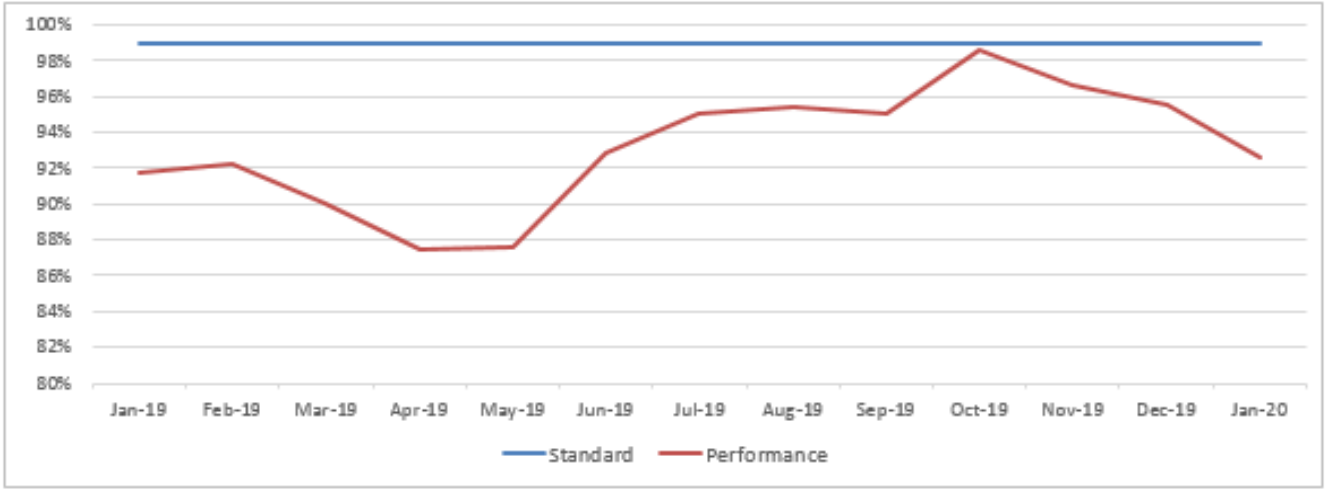
Diagnostics within 6 weeks

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Supporting Narrative

Urology cystoscopy diagnostics remains a challenge. This performance is exacerbated by shortages in workforce, however these are being positively sourced for long term solution.

Month	Standard	Performance
Jan-19	99%	91.7%
Feb-19	99%	92.2%
Mar-19	99%	90.0%
Apr-19	99%	87.5%
May-19	99%	87.6%
Jun-19	99%	92.8%
Jul-19	99%	95.0%
Aug-19	99%	95.4%
Sep-19	99%	95.1%
Oct-19	99%	98.6%
Nov-19	99%	96.7%
Dec-19	99%	95.5%
Jan-20	99%	92.6%



Ongoing controls in place

Individual areas of performance drift are discussed at PTL and Access meetings each week within surgery.

Actions in place to recover the performance

	Owner	Start	End
Cystoscopy remains a challenge however the team have identified a locum resource that will increase capacity delivering additional weekly clinics.	James Butcher	Mar-20	Apr-20
Audiology performance is steadily improving however weekly prioritisation assessment is undertaken in referrals to support performance.	Terri Garrick	Feb-20	Mar-20

Putting you first

NHS
West Suffolk
NHS Foundation Trust

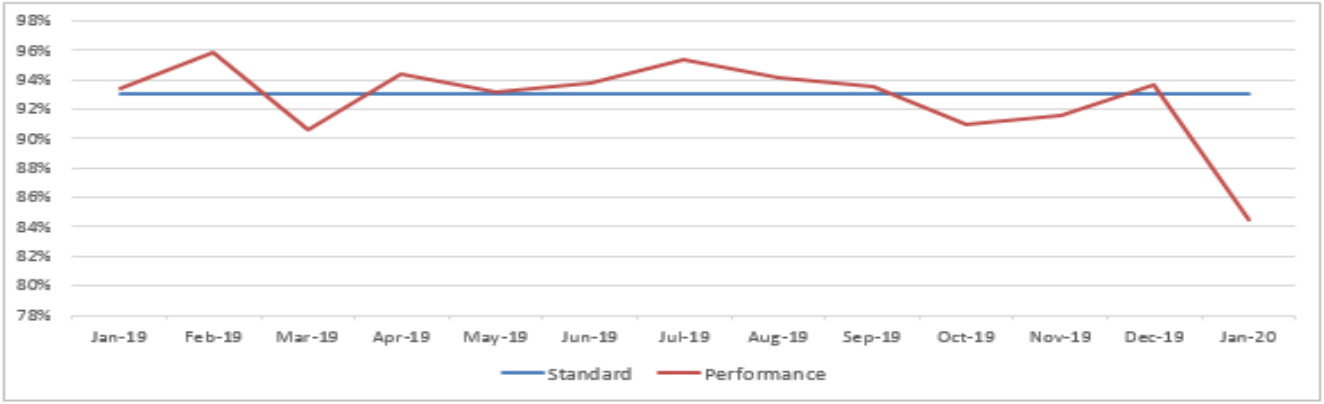
Cancer: 2 week wait for urgent GP Referrals

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Supporting Narrative

January performance reflects patient cancellations around Christmas/New Year time with limited capacity in the New year. This was more pronounced in Dermatology than other specialties, with Dermatology accounting for 57% of 147 breaches in the month. There have also been a number of breaches due to patient choice of appointment.

Month	Standard	Performance
Jan-19	93%	93.4%
Feb-19	93%	95.8%
Mar-19	93%	90.5%
Apr-19	93%	94.3%
May-19	93%	93.1%
Jun-19	93%	93.8%
Jul-19	93%	95.3%
Aug-19	93%	94.2%
Sep-19	93%	93.5%
Oct-19	93%	91.0%
Nov-19	93%	91.6%
Dec-19	93%	93.6%
Jan-20	93%	84.5%



Ongoing controls in place

Services are kept informed of avoidable near breach patients by way of a daily list generated by the Cancer services. The Telephone Appointments Centre also have a process to escalate patients awaiting an outpatient appointment.

Actions in place to recover the performance

	Owner	Start	End
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 also support demand management in the Trust	Clinical Commissioning group	Dec-19	Mar-20
Additional rapid access slots for Dermatology added where possible by utilisation of follow up slots and extending the waiting time for routine patients	Karen McKinnon	Jan-20	May-20
New fixed term dermatology Consultant who will start in May/June	Karen McKinnon	May-20	May-21

Putting you first

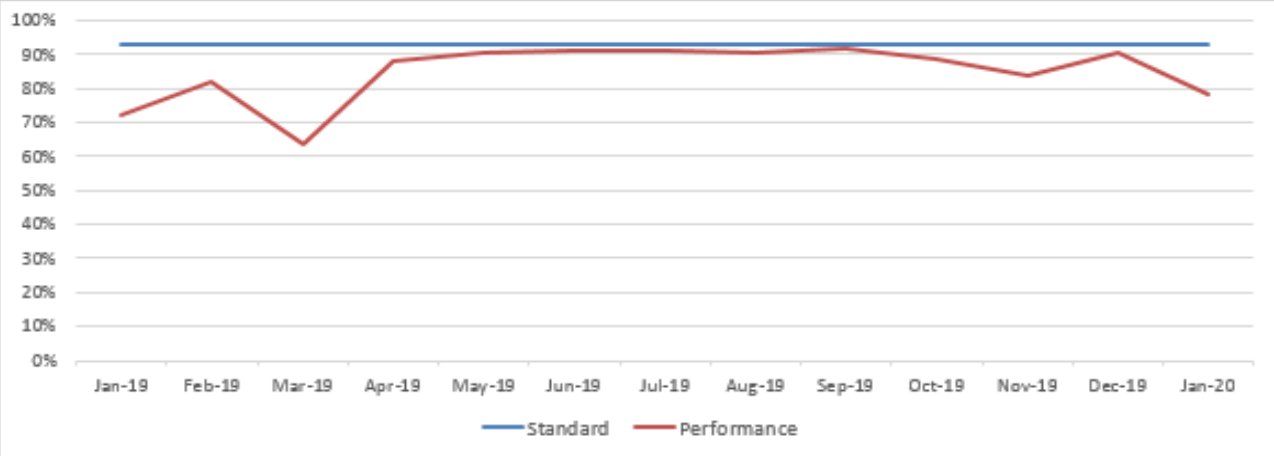
Cancer 2 week wait breast symptoms

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Supporting Narrative

Current Performance- 78.1%. 23 patients breached the 2WW standard for Breast symptomatic. 9 of these patients refused appointments prior to their breach date and the remaining 14 were unable to be offered a date before their breach, due to clinic capacity shortages.

Month	Standard	Performance
Jan-19	93%	72.1%
Feb-19	93%	82.0%
Mar-19	93%	63.5%
Apr-19	93%	87.8%
May-19	93%	90.6%
Jun-19	93%	90.8%
Jul-19	93%	91.3%
Aug-19	93%	90.3%
Sep-19	93%	91.8%
Oct-19	93%	88.4%
Nov-19	93%	83.7%
Dec-19	93%	90.3%
Jan-20	93%	78.1%



Ongoing controls in place

Regular additional clinics on an ad-hoc basis. Additional 'breast pain' clinic set up without the need of radiology to free up capacity where radiology is needed throughout the week. Regular escalation from appointments office to the Breast team.

Actions in place to recover the performance

	Owner	Start	End
New 2 week wait referral forms are in the process of final approval by the Clinical Commissioning Group for introduction across the Integrated Care System. This will help improve the quality and the appropriateness of referral and help manage the demand.	Clinical Commissioning Group	Jun-19	Mar-20
Plan to set up another fast track clinic when Radiology can provide Radiologist cover for one stop service.	Andrea Pryor	Feb-20	Mar-21

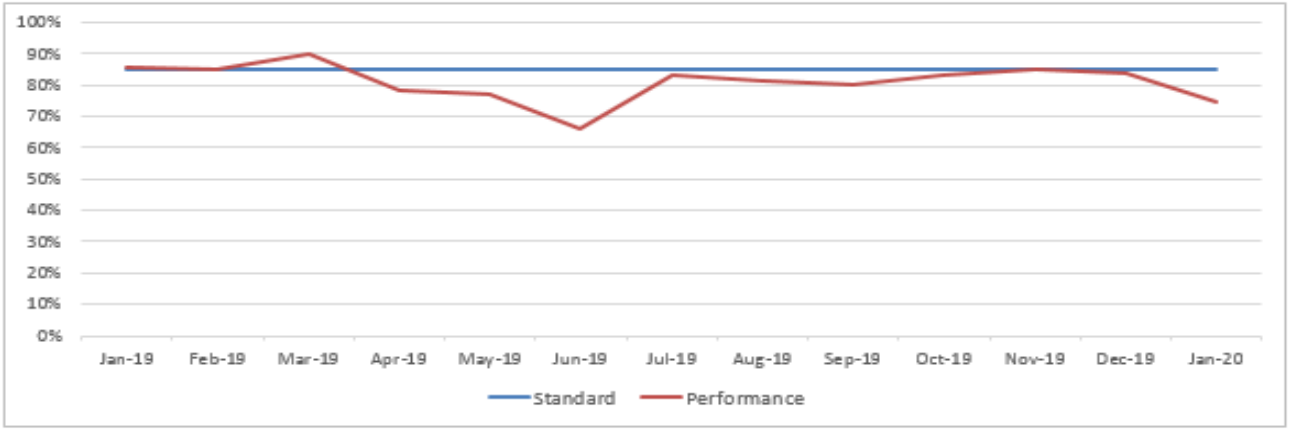
Cancer 62 day GP referral

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Supporting Narrative

Current performance of 74.8 %. 13 patients were treated over 62 days in the Trust in January. This is broken down to 4 Colorectal, 3 Urology, 2 Breast, 2 Skin and 1 Upper GI pathways. Shared pathways with other providers include 2 Gynaecology, 2 Head and Neck and 1 in each of Breast, Colorectal and Skin.

Month	Standard	Performance
Jan-19	85%	85.5%
Feb-19	85%	84.8%
Mar-19	85%	90.0%
Apr-19	85%	78.4%
May-19	85%	76.9%
Jun-19	85%	65.9%
Jul-19	85%	83.0%
Aug-19	85%	81.1%
Sep-19	85%	79.9%
Oct-19	85%	83.3%
Nov-19	85%	85.0%
Dec-19	85%	83.8%
Jan-20	85%	74.4%



Ongoing controls in place

All long waiting patients are discussed at the weekly Cancer PTL meeting. Each patient that is at risk of breaching is escalated to the services by the Cancer Services team. Recommendations from the Intensive Support Team are continuing in terms of redesign of the cancer PTL meetings. The colorectal team now have a straight to test pathway in place which will reduce the wait time to diagnosis significantly.

Actions in place to recover the performance

	Owner	Start	End
Prostate biopsies to move from Day Surgery to Johanna Finn	Assistant Service Manager	Mar-20	Mar-20
Next stage of PTL management to be agreed and embedded	Hannah Knights	Feb-20	Mar-20

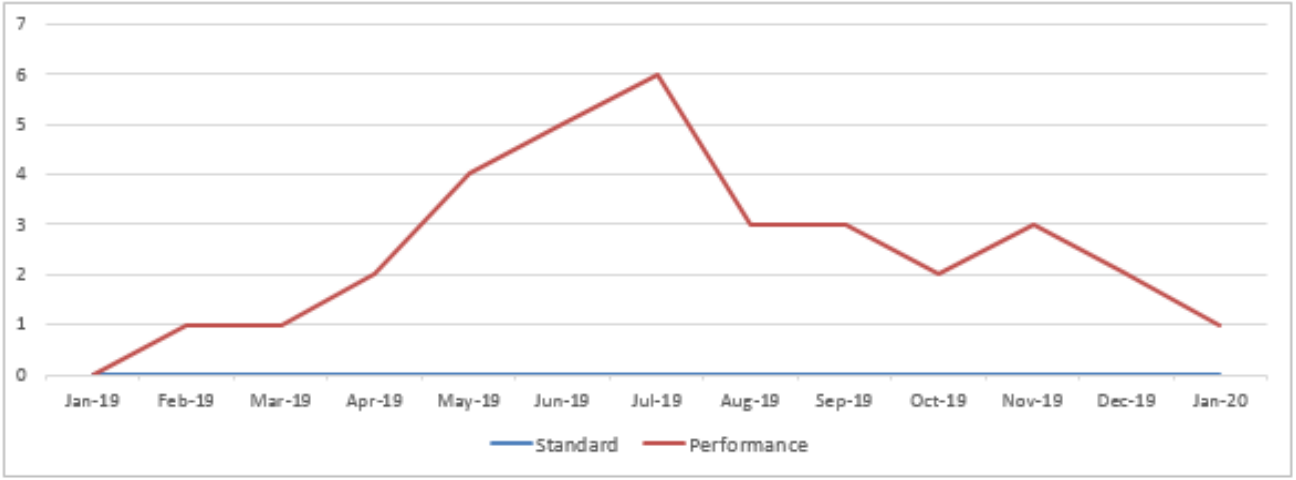
Incomplete 104 day waits

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Supporting Narrative

1 Breast pathway. This was a complex pathway as initial patient choice for nonsurgical treatment that required further investigation for suitability and patient then did not want significant intervention.

Month	Standard	Performance
Jan-19	0	0
Feb-19	0	1
Mar-19	0	1
Apr-19	0	2
May-19	0	4
Jun-19	0	5
Jul-19	0	6
Aug-19	0	3
Sep-19	0	3
Oct-19	0	2
Nov-19	0	3
Dec-19	0	2
Jan-20	0	1



Ongoing controls in place

All 104 day breach pathway timelines sent out to the Clinician and services involved for confirmation. Breach incidents entered in DATIX for Clinical and Psychological harm review and any opportunities for learning. Trust lead Clinician undertakes review of all 104 days breach patients on open pathways each week. All patients over 62 days discussed in detail at weekly cancer PTL meeting for escalation. 104 day breaches to be submitted via DATIX and full investigation to be carried out with clinical engagement and opportunities for learning.

Actions in place to recover the performance

	Owner	Start	End
No specific actions in place			

Putting you first

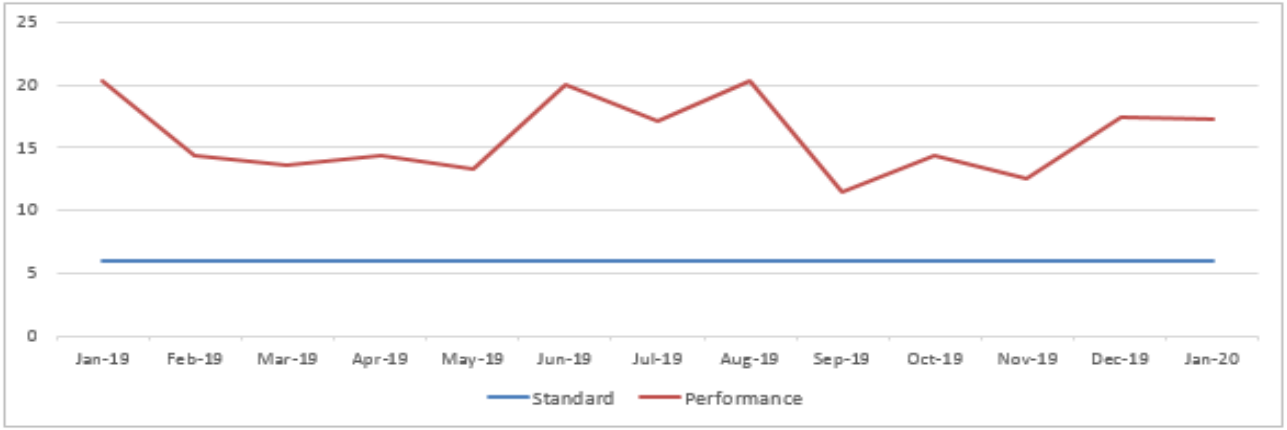
A&E - Single longest Wait (Admitted & Non-Admitted)

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Responsive

Supporting Narrative

The single longest waiter in January was a patient requiring medical admission who was in the department for 17 hours 41 minutes. Arrived to a busy department but was allocated a cubicle and triaged within 20 minutes. Long waits to see a doctor - see at approximately 6 hours and referred to medics. Bed requested at 08.46 and patient left department at 19.10.

Month	Standard	Performance
Jan-19	6	20.32
Feb-19	6	14.35
Mar-19	6	13.55
Apr-19	6	14.35
May-19	6	13.23
Jun-19	6	20.01
Jul-19	6	17.18
Aug-19	6	20.35
Sep-19	6	11.48
Oct-19	6	14.30
Nov-19	6	12.51
Dec-19	6	17.41
Jan-20	6	17.23



Ongoing controls in place

Patients awaiting beds are escalated to patient flow team and discussed at all bed meetings.

Actions in place to recover the performance

	Owner	Start	End
Implementation of escalation process for long stay to avoid 12 Length of Stay Breaches - ensure patients are escalated to ED Management team and Site Management at 8 hours to ensure a clear plan is in place to transfer or discharge patient, aiming to eradicate 12 hour length of stays where possible.	Ian Pridding	Feb-20	Apr-20
Implementation of RAT to use space differently to support early clinical assessment and decision making.	Ian Pridding	Feb-20	Apr-20
Implementation of ready for ward measure to improve data recording. Working to review handover processes with option of electronic hand over to avoid unnecessary delays.	Ian Pridding	Feb-20	Apr-20

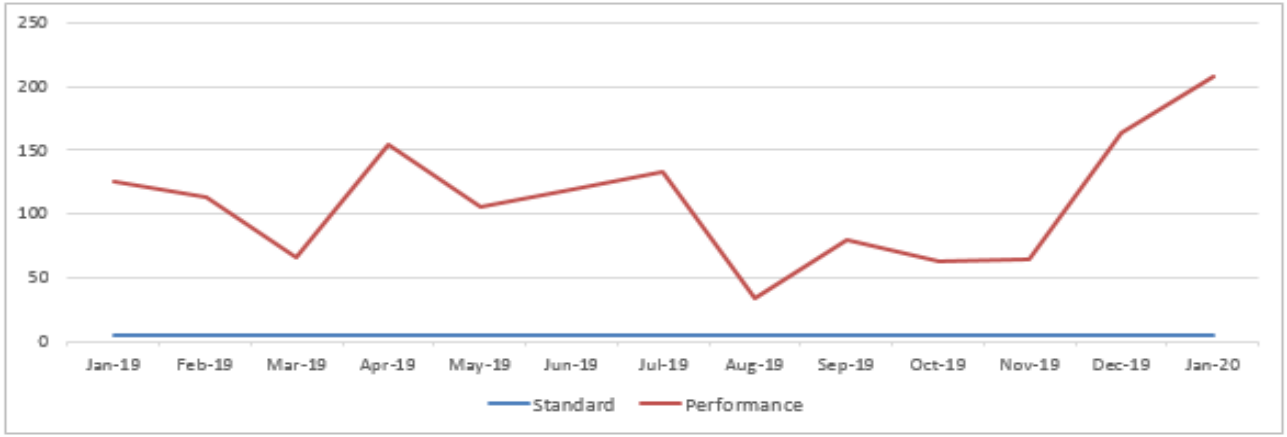
A&E - Admission waiting 4-12 hours from decision to admit

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Responsive

Supporting Narrative

The number of patients waiting between 4 and 12 hours for admission following decision to admit was 208 for January, which is an increase from December. This was due to high levels of attendances and admissions and delays for beds due to winter pressures.

Month	Standard	Performance
Jan-19	4	125
Feb-19	4	113
Mar-19	4	65
Apr-19	4	155
May-19	4	105
Jun-19	4	119
Jul-19	4	133
Aug-19	4	33
Sep-19	4	80
Oct-19	4	63
Nov-19	4	64
Dec-19	4	163
Jan-20	4	208



Ongoing controls in place

Focus on improvements to overall length of stay in department, including measurement of overall mean length of stay, external reporting of 12+hour length of stays and time between patient being 'ready for ward' and admission aiming to reduce delays for admitted patient.
Monitoring of 12 hour length of stay breaches and early escalation to avoid where ever possible.

Actions in place to recover the performance

	Owner	Start	End
Relaunch of internal professional standards to remind ED and admitting specialities of their responsibilities for patients requiring speciality review and explore improving the use of consultant admitting rights for ED.	Ian Pridding	Feb-20	Apr-20
Embed the recording and operational use of the ready for ward function and work with patient flow team to ensure appropriate escalation processes are in place for patients awaiting admission.	Ian Pridding	Feb-20	Apr-20
Work with speciality teams to improve pathways for GP expected patients who can be referred directly to speciality (e.g. AEC, SEAC, Frailty, Observations and Gynaecology)	Ian Pridding	Feb-20	Apr-20

NHS
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NHS Foundation Trust

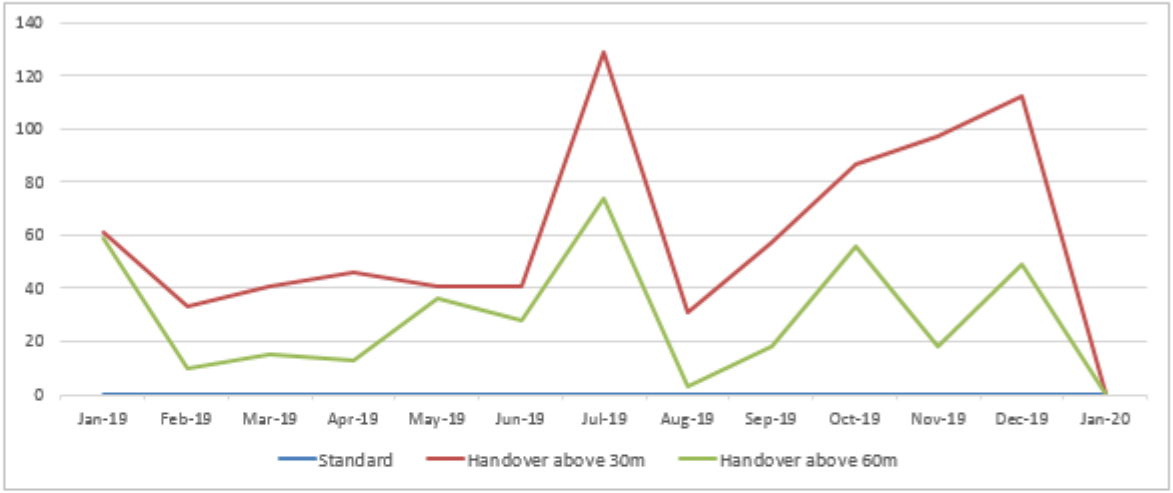
A&E - Ambulance Handover

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Month	Standard	Handover above 30m	Handover above 60m
Jan-19	0	61	59
Feb-19	0	33	10
Mar-19	0	41	15
Apr-19	0	46	13
May-19	0	41	36
Jun-19	0	41	28
Jul-19	0	129	74
Aug-19	0	31	3
Sep-19	0	57	18
Oct-19	0	87	56
Nov-19	0	97	18
Dec-19	0	112	49
Jan-20	0	ND	ND

Supporting NarRapid Assessment and Treatment ive

January data for ambulance hand over was not available at time of report. In December 112 patient waited over 30 minutes for handover and 49 waited more than an hour. Both metrics were an increase since November. High volumes of ambulances and space limitations are the key driver for this.



Ongoing controls in place

As of 3rd February, a 6 trolleyed and 4 chaired Rapid Assessment and Treatment area with a dedicated team of nursing and medical staff was established to support improvements to patient experience, reduce ambulance hand over delays and encourage early clinical decision making. This will run between 10 and 8 in the week and 12 and 6 at weekends. The Rapid Assessment and Treatment areas is running well so far and has seen a reduction in delays over 30 and 60 minutes.

Actions in place to recover the performance

	Owner	Start	End
Embed Rapid Assessment and Treatment in to business as usual and identified ways to further improve including how best to use space during times of escalation.	Ian Pridding/Abby Ormes/Ravi Ayyamuthu	Feb-20	Apr-20
Continue to monitor and report ambulance delays at daily performance huddles and assess 60 min + delays at weekly ambulance hand over governance meetings, escalating key themes and ideas for improvement.	Ian Pridding	Feb-20	Apr-20

Putting you first

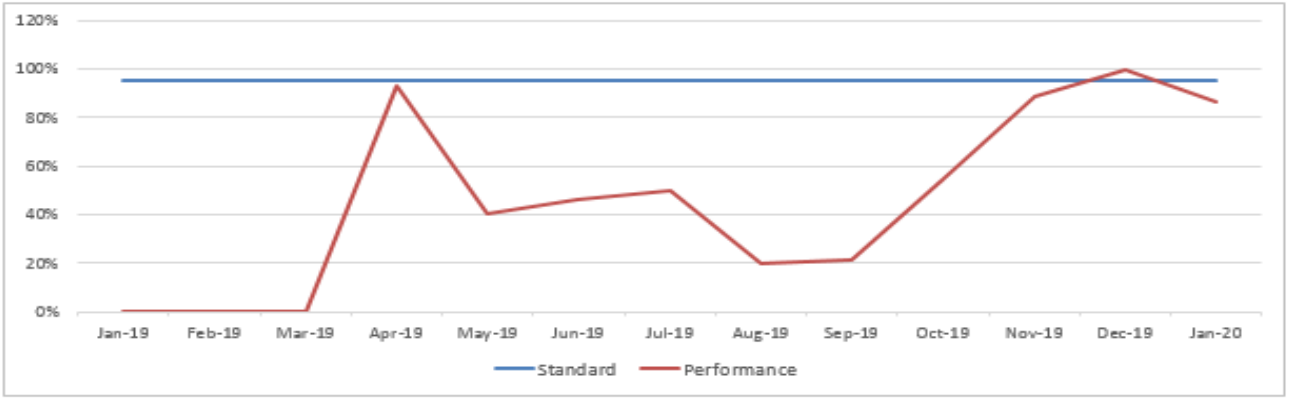
% of initial health assessments completed within 15 working days of receiving all relevant paperwork.

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Supporting Narrative

There were 15 Initial Health Assessments (IHA) completed in January, 13 of which were completed within 15 working days of the service being notified of them. The 2 assessments completed outside this standard were completed on day 16 and 20. The latter had 2 appointment dates offered which were within the 15 working day target but the carer declined these.

Month	Standard	Performance
Jan-19	95%	NA
Feb-19	95%	NA
Mar-19	95%	NA
Apr-19	95%	93.3%
May-19	95%	40.0%
Jun-19	95%	46.2%
Jul-19	95%	50.0%
Aug-19	95%	20.0%
Sep-19	95%	21.1%
Oct-19	95%	54.2%
Nov-19	95%	88.9%
Dec-19	95%	100%
Jan-20	95%	86.7%



Ongoing controls in place

Achievement of this target is reliant on timely referrals from Social Care following the decision to take a child into the care of the Local Authority. The Suffolk system accepts that in order to be compliant with 28 target, requests for Initial Health Assessments should be made within 3-5days of the child becoming a child in care. Suffolk County Council has introduced Children in Care (CIC) Admin Coordinators to liaise with Social Workers to ensure required placement assessment and consent is sent to the Integrated Community Paediatric Services (ICPS) Medical Team via the Suffolk County Council (SCC) Health Hub in a timely manner. Integrated Community Paediatric Services has an identified administrator in post (cover rota is in place when this person is on leave), to be available to receive referrals on a daily basis, liaise with Suffolk County Council Health Hub and coordinate with clinical and administration teams to book appointment at the earliest opportunity. The Named Doctor for Children in Car and the Associate Director for Integrated Community Paediatric Services is available throughout the week to offer triage and clinical advice should there be any issues with booking the child (risk issues to consider). Each Paediatriatrician is asked to block two Initial Health Assessments appointments each month. Initial Health Assessments appointments are available througout the month in each locality to ensure the child is booked onto the next available appointment with the aim that this will be within 15 working days of reciept of paperwork. It is not possible to achieve the 28 day target if there is a signficant delay in reciept of paperwork, this often occurs if children are placed in Suffolk from other Authority areas. There is a bi-monthly Health Assessment, multiagency performance group in place which monitors system performance with the aim of improving flow and quality in the assessment pathways.

Actions in place to recover the performance

	Owner	Start	End
Plan to increase medical capacity in the team (primarily impacting on west and central county locality) for a pilot period. Clinical Commissioning Group agreement reached to have General Practitioner with Special Interest (GPSI) on a salaried basis working 6days per month to trial for a six month period. Medical Staffing requested to provide a contract to enable General Practitioner with Special Interest to formally take up this offer - requested in January but delayed response.	Nic Smith-Howell	Jan-20	Feb-20

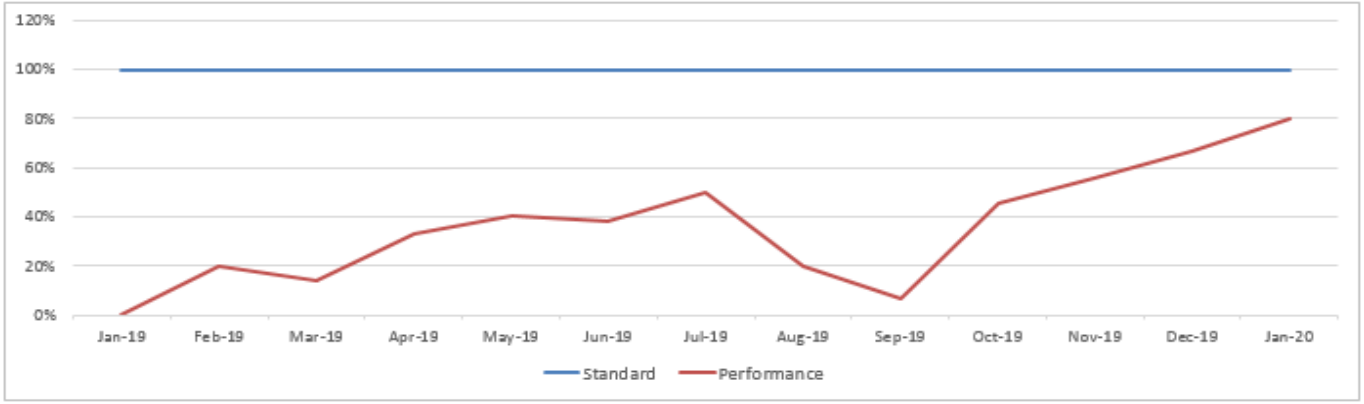
Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care

Month	Jan-20
Executive Lead	Helen Beck
CQC Area	Responsive

Supporting Narrative

15 Initial Health Assessments (IHA) were completed within January, of which 12 were completed within 28days of the child being placed in care. The 3 outside the 28 day target were completed on days 35, 39 and 39. The assessment completed on day 35 had a delay of 2 days of when the child was placed in care and the service was notified about them, in addition 2 earlier appointment dates had also been declined. There was a delay in the service being made aware of the other 2 referrals of 12 days and 27 days.

Month	Standard	Performance
Jan-19	100%	0.0%
Feb-19	100%	20.0%
Mar-19	100%	14.3%
Apr-19	100%	33.3%
May-19	100%	40.0%
Jun-19	100%	38.5%
Jul-19	100%	50.0%
Aug-19	100%	20.0%
Sep-19	100%	6.7%
Oct-19	100%	45.8%
Nov-19	100%	55.6%
Dec-19	100%	66.7%
Jan-20	100%	80.0%



Ongoing controls in place

Achievement of this target is reliant on timely referrals from Social Care following the decision to take a child into the care of the Local Authority. The Suffolk system accepts that in order to be compliant with 28 target, requests for initial Health Assessment should be made within 3-5days of the child becoming a child in care. Suffolk County Council has introduced Children in Care (CIC) Admin Coordinators to liaise with Social Workers to ensure required placement assessment and consent is sent to the Integrated Community Paediatric Services (ICPS) Medical Team via the Suffolk County Council (SCC) Health Hub in a timely manner. Integrated Community Paediatric Services has an identified administrator in post (cover rota is in place when this person is on leave),to be available to receive referrals on a daily basis, liaise with Suffolk County Council Health Hub and coordinate with clinical and administration teams to book appointment at the earliest opportunity. The Named Doctor for Children in Care and the Associate Director for Integrated Community Paediatric Services is available throughout the week to offer triage and clinical advice should there be any issues with booking the child (risk issues to consider).Each paediatrician is asked to block two initial Health Assessment appointments each month. Initial Health Assessment appointments are available throughout the month in each locality to ensure the child is booked onto the next available appointment with the aim that this will be within 15 working days of receipt of paperwork. It is not possible to achieve the 28 day target if there is a significant delay in receipt of paperwork, this often occurs if children are placed in Suffolk from other Authority areas. There is a bi-monthly Health Assessment, multiagency performance group in place which monitors system performance with the aim of improving flow and quality in the assessment pathways.

Actions in place to recover the performance

	Owner	Start	End
Plan to increase medical capacity in the team (primarily impacting on west and central county locality) for a pilot period. Clinical Commissioning Group agreement reached to have General Practitioner with Special Interest (GPSI) on a salaried basis working 6days per month to trial for a six month period. Medical Staffing requested to provide a contract to enable General Practitioner with Special Interest to formally take up this offer - requested in January but delayed response	Nic Smith-Howell	Jan-20	Feb-20

8. DETAILED REPORTS – WELL-LED

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

Are we.		Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD(Apr19 Jan20)
5. Well Led	Agency, WTE & vacancies	5.09	Agency Spend Cap	486	486	486	486	461	461	461	461	461	461	511	511	511	520	4819
		5.10	Bank Spend		1114	971	1277	992	777	926	868	1222	920	969	734	876	710	8994
		5.12	Proportion of Temporary Staff	12%	12.7%	9.4%	13.1%	12.3%	11.2%	11.5%	11.0%	13.1%	10.9%	10.2%	10.1%	11.3%	9.5%	11.1%
		5.13	Locum and Medical agency spend	NT	522	389	448	487	238	408	389	615	487	468	366	525	405	4387
		5.57	Additional sessions	NT	216	274	283	272	272	200	221	286	175	279	146	142	125	2118
		5.16	% Staff on Maternity/Paternity Leave	NT	2.80%	2.64%	2.58%	2.82%	2.67%	2.49%	2.40%	2.23%	2.01%	1.96%	2.06%	2.08%	2.05%	2.28%
	Other	5.58	New grievance or employment tribunals in the month	NT	2	0	1	1	0	0	1	0	0	3	0	1	0	6
		5.18	Recruitment Timescales - Av no. of weeks to recruit	7	5.3	4.8	5.2	6.0	6.1	5.0	8.0	5.4	5.4	5.4	5.4	5.4	6.4	5.9
		5.19	DBS checks	95%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	97.0%	97.0%	98.0%	98.0%	97.8%
		5.20	Staff appraisal Rates	90%	77.0%	76.0%	79.0%	77.0%	80.0%	81.0%	81.0%	81.0%	82.3%	83.0%	82.0%	83.6%	84.6%	81.6%

Are we.		Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD(Apr19 Jan20)
5. Well Led	Training	5.22	Infection Control Training (classroom)	90%	96.0%	96.0%	93.0%	94.0%	95.0%	95.0%	95.0%	96.0%	96.0%	96.0%	97.0%	98.0%	98.0%	96.0%
		5.23	Infection Control Training (eLearning)	90%	91.0%	91.0%	81.0%	82.0%	82.0%	89.0%	90.0%	91.0%	91.0%	90.0%	91.0%	90.0%	90.0%	88.6%
		5.24	Manual Handling Training (Patient)	90%	80.0%	77.0%	78.0%	69.0%	80.0%	78.0%	80.0%	81.0%	83.0%	84.0%	87.0%	87.0%	84.0%	81.3%
		5.25	Manual Handling Training (Non Patient)	90%	87.0%	88.0%	67.0%	56.0%	76.0%	62.0%	67.0%	70.0%	73.0%	91.0%	94.0%	93.0%	93.0%	77.5%
		5.26	Staff Adult Safeguarding Training	90%	91.0%	91.0%	85.0%	85.0%	87.0%	89.0%	88.0%	89.0%	90.0%	89.0%	90.0%	90.0%	89.0%	88.6%
		5.27	Safeguarding Children Level 1	90%	91.0%	90.0%	91.0%	91.0%	92.0%	92.0%	92.0%	93.0%	93.0%	93.0%	93.0%	92.0%	92.0%	92.3%
		5.28	Safeguarding Children Level 2	90%	91.0%	91.0%	86.0%	86.0%	90.0%	90.0%	89.0%	92.0%	92.0%	92.0%	91.0%	91.0%	92.0%	90.5%
		5.29	Safeguarding Children Level 3	90%	91.0%	91.0%	57.0%	51.0%	71.0%	61.0%	58.0%	84.0%	83.0%	84.0%	84.0%	84.0%	87.0%	74.7%
		5.30	Health & Safety Training	90%	89.0%	89.0%	87.0%	87.0%	88.0%	90.0%	90.0%	92.0%	91.0%	91.0%	92.0%	91.0%	91.0%	90.3%
		5.31	Security Awareness Training	90%	89.0%	88.0%	81.0%	83.0%	87.0%	88.0%	88.0%	91.0%	92.0%	96.0%	96.0%	96.0%	95.0%	91.2%
		5.32	Conflict Resolution Training (eLearning)	90%	86.0%	86.0%	68.0%	70.0%	74.0%	81.0%	82.0%	85.0%	88.0%	88.0%	90.0%	90.0%	89.0%	83.7%
		5.33	Conflict Resolution Training	90%	72.0%	72.0%	77.0%	74.0%	78.0%	76.0%	76.0%	75.0%	76.0%	78.0%	77.0%	77.0%	79.0%	76.6%
		5.34	Fire Training (eLearning)	90%	85.0%	83.0%	83.0%	78.0%	83.0%	83.0%	83.0%	87.0%	87.0%	87.0%	89.0%	89.0%	88.0%	85.4%
		5.35	Fire Training (classroom)	90%	89.0%	87.0%	89.0%	88.0%	89.0%	89.0%	89.0%	91.0%	90.0%	89.0%	90.0%	90.0%	90.0%	89.5%
		5.36	IG Training	95%	81.0%	83.0%	78.0%	79.0%	81.0%	94.0%	86.0%	91.0%	90.0%	91.0%	92.0%	93.0%	91.0%	88.8%
		5.37	Equality and Diversity	90%	85.0%	85.0%	87.0%	86.0%	88.0%	90.0%	90.0%	93.0%	92.0%	93.0%	94.0%	94.0%	94.0%	91.4%
		5.38	Majax Training	90%	90.0%	89.0%	78.0%	80.0%	82.0%	84.0%	84.0%	88.0%	87.0%	92.0%	92.0%	92.0%	92.0%	87.3%
		5.39	Medicines Management Training	90%	87.0%	86.0%	80.0%	81.0%	83.0%	86.0%	86.0%	86.0%	86.0%	87.0%	87.0%	86.0%	87.0%	85.5%
		5.40	Slips, trips and falls Training	90%	86.0%	86.0%	74.0%	76.0%	79.0%	82.0%	81.0%	85.0%	86.0%	86.0%	89.0%	87.0%	88.0%	83.9%
		5.41	Blood-borne Viruses/Inoculation Incidents	90%	89.0%	87.0%	78.0%	80.0%	83.0%	85.0%	85.0%	89.0%	88.0%	89.0%	89.0%	88.0%	76.0%	85.2%
		5.42	Basic life support training (adult)	90%	81.0%	80.0%	79.0%	73.0%	81.0%	81.0%	81.0%	81.0%	82.0%	83.0%	87.0%	86.0%	85.0%	82.0%
		5.43	Blood Products & Transfusion Processes (Refresher)	90%	77.0%	76.0%	65.0%	62.0%	68.0%	77.0%	75.0%	77.0%	75.0%	78.0%	78.0%	76.0%	77.0%	74.3%
		5.44	Mandatory Training Compliance	90%	85.0%	86.0%	82.0%	82.0%	85.0%	86.0%	86.0%	87.0%	88.0%	88.0%	90.0%	90.0%	89.8%	87.2%

EXCEPTION REPORTS – WELL LED

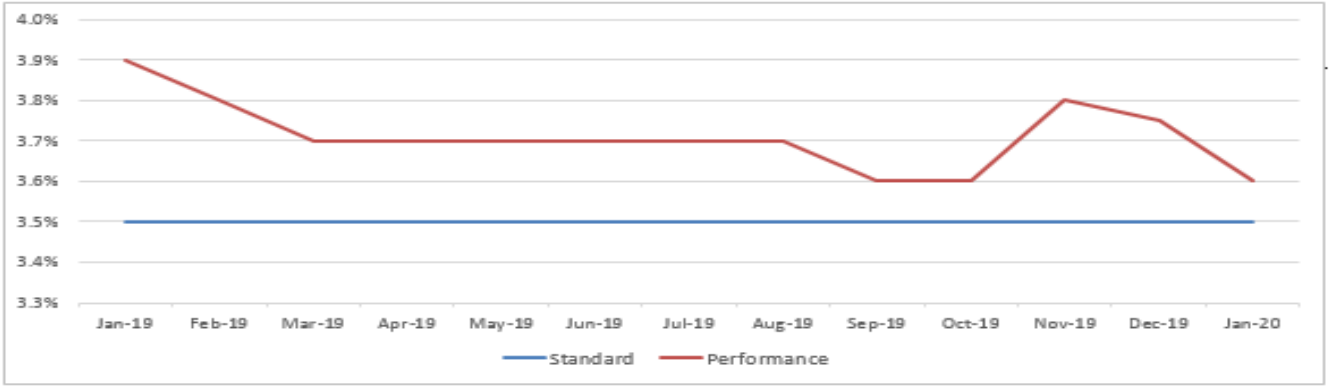
Sickness Absence

Month	Jan-20
Executive Lead	Jeremy Over
CQC Area	Well Led

Supporting Narrative

Current sickness absence levels are 0.3% lower than in January 2019 and when compared to other NHS organisations we are have lower rates than 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)

Month	Standard	Performance
Jan-19	3.5%	3.9%
Feb-19	3.5%	3.8%
Mar-19	3.5%	3.7%
Apr-19	3.5%	3.7%
May-19	3.5%	3.7%
Jun-19	3.5%	3.7%
Jul-19	3.5%	3.7%
Aug-19	3.5%	3.7%
Sep-19	3.5%	3.6%
Oct-19	3.5%	3.6%
Nov-19	3.5%	3.8%
Dec-19	3.5%	3.8%
Jan-20	3.5%	3.6%



Ongoing controls in place

Senior Managers receive monthly Key Performance Indicator reports which include sickness absence % by division. Individual line managers receive a report outlining any member of staff with a Bradford factor of 80+ to allow them to discuss attendance with members of staff. HR support is provided to all managers undertaking stage one meetings with staff with a Bradford factor of 100 or more. In addition a monthly meeting takes place with occupational health to monitor all staff off on long term sick (four weeks+). Training is provided for managers "improving employee attendance" as part of the on-going management development programme. Support for staff experiencing stress, anxiety etc. Through the better working lives project.

Actions in place to recover the performance

	Owner	Start	End
With regard to musculoskeletal problems we will review the trusts' staff physiotherapy service, as the levels of referral continue to rise.	HR department	Apr-20	Sep-20
2019 Flu campaign encourages staff to take up the vaccine, to protect patients and staff	Occupational Health	Sep-19	Mar-20

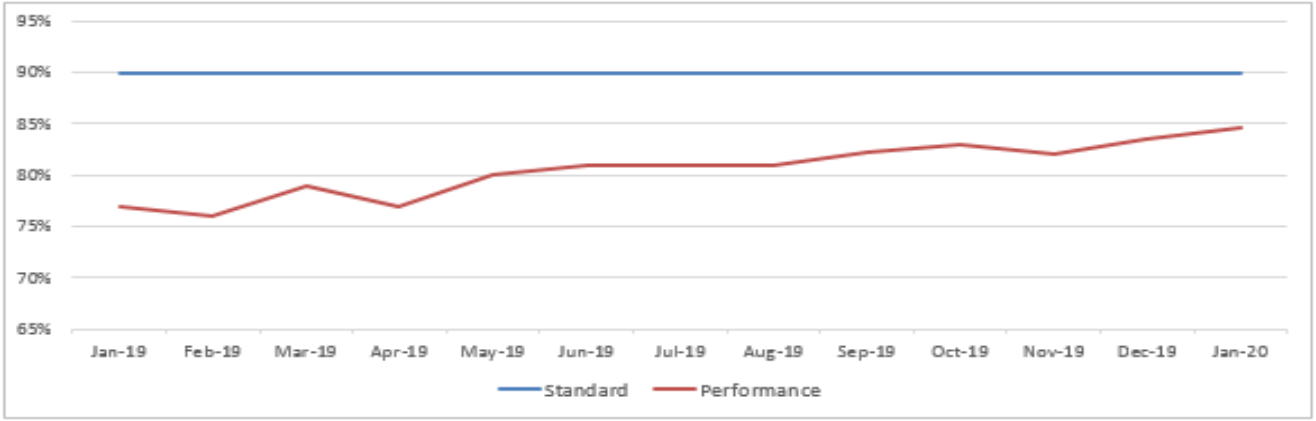
Staff appraisal Rates

Month	Jan-20
Executive Lead	Jeremy Over
CQC Area	Well Led

Supporting Narrative

Appraisal compliance has risen this month by 1.0% and by 7.6% since January last year.

Month	Standard	Performance
Jan-19	90%	77.0%
Feb-19	90%	76.0%
Mar-19	90%	79.0%
Apr-19	90%	77.0%
May-19	90%	80.0%
Jun-19	90%	81.0%
Jul-19	90%	81.0%
Aug-19	90%	81.0%
Sep-19	90%	82.3%
Oct-19	90%	83.0%
Nov-19	90%	82.0%
Dec-19	90%	83.6%
Jan-20	90%	84.6%



Ongoing controls in place

Current reporting and monitoring processes include; monthly divisional appraisal report to line managers (includes, individual staff appraisal information, Red Amber Green ratings, and compliance figures by department and division), monthly board reporting through Integrated Quality & Performance Report, quarterly report on actions to improve compliance.
Workforce and HR provide individual support to those areas struggling to improve compliance, as well as executive support to improve take up. Appraisal training for managers/ appraisers available on a monthly basis.

Actions in place to recover the performance

	Owner	Start	End
The trust is currently working towards Electronic Staff Record manager self – service , which will give all managers the responsibility to log appraisals for their own reports/ staff. This will remove the potential for appraisal information to be mislaid.	Deputy Director of Workforce	Sep-19	Apr-20
Implementation of agenda for change pay progression policy which will require all staff to have an up to date appraisal recorded on Electronic Staff Record	HR Manager	Apr-20	Mar-21

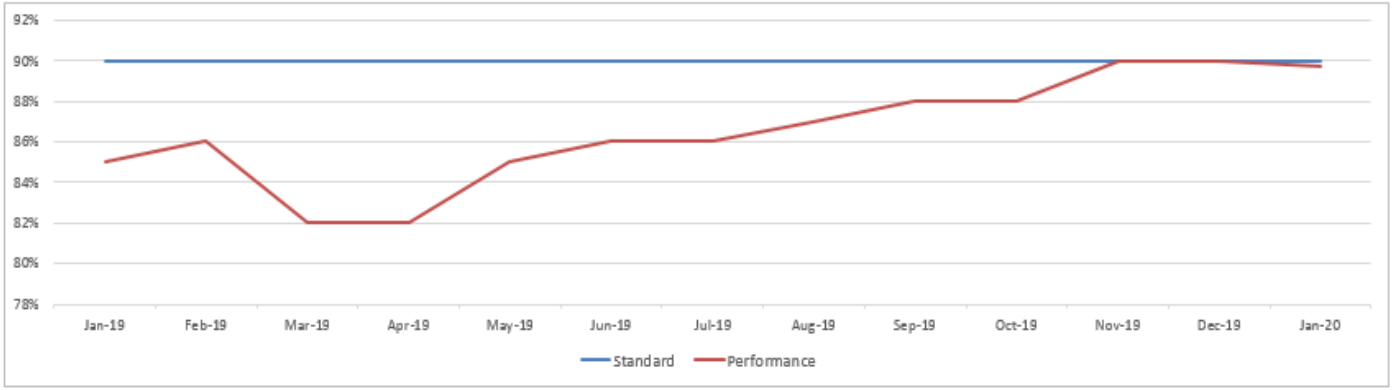
Mandatory Training Compliance

Month	Jan-20
Executive Lead	Jeremy Over
CQC Area	Well Led

Supporting Narrative

Compliance has slipped by 0.2%. This is partly due to staff not being released to undertake mandatory training update days, due to winter pressures. There have been unused spaces available on training sessions throughout January.

Month	Standard	Performance
Jan-19	90%	85.0%
Feb-19	90%	86.0%
Mar-19	90%	82.0%
Apr-19	90%	82.0%
May-19	90%	85.0%
Jun-19	90%	86.0%
Jul-19	90%	86.0%
Aug-19	90%	87.0%
Sep-19	90%	88.0%
Oct-19	90%	88.0%
Nov-19	90%	90.0%
Dec-19	90%	90.0%
Jan-20	90%	89.8%



Ongoing controls in place

Monitoring & reporting - mandatory training compliance is reported to managers on a monthly basis, by division, department and individual basis. Also by subject matter, and as part of the workforce Key Performance Indicator dashboard. A quarterly report is also provided (last Report January trust board) Staff are also able to access their own training record through Electronic Staff Record self service and recently have been able to undertake e-learning from their own devices, smart phone, tablet, lap top etc. Access to training - Induction training sessions cover off many mandatory subjects. Update days are provided on a monthly basis for specific staff groups (acute clinical staff, midwives, community clinical staff etc.) E-learning modules are available for many subjects and improvements made to accessibility of Electronic Staff record Oracle Learning Management. In addition, ad hoc sessions are provided for certain high volume subjects such as fire, equality and diversity etc.

Actions in place to recover the performance

	Owner	Start	End
Education & Training team are currently inputting the amendments made following the full mandatory training review (see item above).	Mandatory Training Team	Oct-19	Apr-20
Review of community mandatory training data following transfer of records in January 2019, as some data appears to be incorrect.	Mandatory Training Team	Oct-19	Apr-20
Implementation of Electronic Staff Record self service to managers & supervisors to allow direct access to performance information, including mandatory training compliance.	Mandatory Training Team	Apr-19	Jun-20
The Mandatory Training Team has provided over 10 additional e-learning sessions to support the August intake of Junior Doctors to be compliant with their training at the point of Induction.	Mandatory Training Team	Aug-19	Aug-20

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9. DETAILED REPORTS – PRODUCTIVE

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

Are we..		Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD(Apr19-Jan20)
6. Productive	Activity	6.07	A&E Activity	NT	6371	5741	6695	6729	6946	6692	7300	6661	6829	6841	6757	6746	6426	67927
		6.08	NEL Activity	NT	2750	2467	2604	2464	2695	2379	2496	2465	2465	2627	2533	2634	2634	25392
		6.09	OP - New Appointments	NT	7059	6419	7086	8369	8947	8536	9365	7660	9115	9631	9141	8070	9101	87935
		6.10	OP- Follow-Up Appointments	NT	12610	11107	11536	22314	19866	19733	21458	19079	19960	21665	20458	17830	21661	204024
		6.11	Electives (Incl Daycase)	NT	3202	2957	2971	2806	2974	2755	3095	2892	3037	3258	3272	2800	3230	30119
	Finance	6.12	Financial Position (YTD)	Var	-8691	-7955	-287	529	-481	-1681	-2106	-4239	-5712	-7282	-9113	-6174	257	257
		6.13	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	3
		6.14	Cash Position (YTD £000s)	Var	4924	6870	3600	11140	5825	1467	2119	1787	2061	1498	1519	1886	1891	1891
	Ratios	6.15	% Consultant to Consultant Referrals	NT	16.0%	17.0%	15.0%	17.0%	16.0%	16.0%	16.0%	15.0%	15.0%	16.0%	14.0%	16.0%	17.0%	15.8%
		6.16	New to FU Ratios	NT	2.31	2.37	2.20	2.66	2.22	2.31	2.29	2.48	2.18	2.25	2.24	2.20	2.38	2.32

Putting you first

EXCEPTION REPORTS – PRODUCTIVE

The finance report contains full details.

10. DETAILED REPORTS- MATERNITY

Are we..		Ref.	KPI	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD(Apr19-Dec19)
7 Maternity	Safe	7.09	Elective Caesarean Sections	12%	6.7%	9.3%	11.2%	9.3%	11.3%	7.8%	9.5%	9.8%	10.0%	13.0%	4.5%	9.3%	8.8%	9.3%
		7.10	Emergency Caesarean Sections	14%	16.2%	11.0%	15.6%	11.5%	11.8%	18.0%	10.9%	11.2%	19.4%	12.4%	16.1%	11.5%	16.7%	14.0%
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	76.1%	92.3%	87.0%	100%	85.0%	81.0%	82.0%	64.0%	82.0%	91.0%	66.0%	76.4%	90.0%	81.7%
		7.13	Homebirths	2%	2.2%	2.9%	2.8%	3.8%	3.1%	1.5%	2.4%	2.3%	3.0%	4.1%	3.0%	3.3%	1.9%	2.8%
		7.14	Midwifery led birthing unit (MLBU) births	20%	NA	NA	NA	24.0%	14.4%	16.1%	19.4%	12.9%	14.4%	18.9%	14.6%	9.3%	11.6%	15.6%
		7.15	Labour Suite births	77.5%	78.8%	77.9%	82.1%	71.0%	82.1%	82.0%	77.3%	85.1%	82.1%	76.9%	82.4%	87.4%	86.5%	81.3%
		7.16	Induction of Labour	29.3%	40.8%	39.0%	42.2%	35.0%	39.5%	39.0%	38.9%	35.8%	38.8%	34.3%	42.2%	45.6%	36.7%	38.6%
		7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	>14%	8.9%	12.2%	11.7%	8.2%	8.2%	12.2%	8.5%	10.7%	11.5%	9.5%	11.1%	9.3%	7.4%	9.7%
		7.18	Critical Care Obstetric Admissions	0	1	0	0	0	0	0	0	0	0	0	1	0	0	1
		7.19	Eclampsia	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
	Effective	7.20	Shoulder Dystocia	2	6	4	4	9	2	7	5	0	3	3	3	2	2	36
		7.21	Post-partum Hysterectomies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.22	Women requiring a blood transfusion of 4 units or more	0	1	0	1	1	0	0	0	0	0	0	0	0	0	1
		7.23	3rd and 4th degree tears (all deliveries)	12	6	2	0	7	2	4	6	4	3	4	3	2	3	38
	Caring	7.24	Maternal death	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
		7.25	Stillbirths	NT	0	0	0	1	1	2	0	0	0	1	0	1	0	6
		7.26	Complaints	NT	3	3	1	0	3	0	0	0	0	3	0	2	2	10
		7.27	No. of babies admitted to Neonatal Unit (>36+6)	NT	7	7	9	8	8	16	4	12	12	3	11	9	9	92
	Responsive	7.28	No. of babies transferred for therapeutic cooling	0	0	1	0	0	0	0	0	0	1	0	1	1	0	3
		7.29	One to one care in established labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.30	Reported Clinical Incidents	50	50	40	59	56	47	43	61	78	44	42	36	47	59	513
		7.31	Hours of dedicated consultant cover per week	60	105	87	98	96	105	90	102	90	96	86	96	98	ND	859
		7.32	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	100
		7.34	No. of women identified as smoking at booking	NT	20	18	28	23	25	22	23	27	22	30	34	21	37	264
		7.35	No. of women identified as smoking at delivery	NT	18	16	27	20	20	21	22	28	19	26	27	17	32	232
		7.36	UNICEF Baby friendly audits	10	NA	NA	NA	NA	24	NA	NA	NA	NA	NA	NA	53	NA	77
		7.37	Proportion of parents receiving Safer Sleeping Suffolk advice	80%	96.1%	97.0%	94.5%	95.0%	85.6%	80.0%	93.0%	81.0%	89.0%	97.0%	93.0%	86.6%	88.3%	88.9%
	Other	7.38	No. of bookings (First visit)	NT	278	226	242	231	251	241	257	232	230	235	225	192	257	2351
		7.39	Women booked before 12+6 weeks	95%	96.0%	96.4%	92.0%	95.0%	95.0%	94.0%	98.0%	97.0%	93.0%	97.0%	96.0%	95.0%	96.0%	95.6%
		7.40	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – MATERNITY

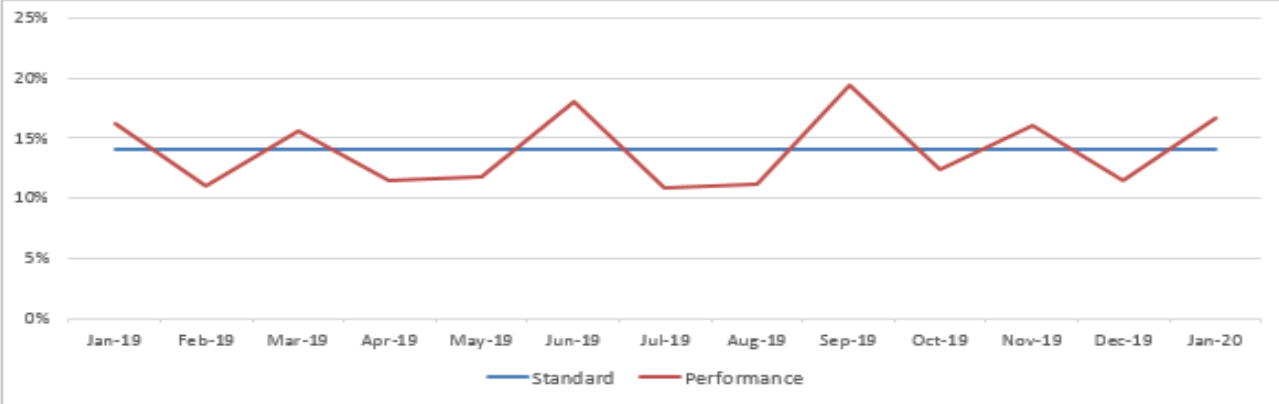
Emergency Caesarean Sections

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Maternity

Supporting Narrative

The data this month shows an increase in emergency caesarean sections at 16.7%. There are a possible 2 reasons for this. 1. An increase in this months delivery rate of high risk women. 2. There appears to be an increase in the number of Grade 3 Caesarean Sections. Some of these would have been booked for Elective Caesarean Sections but have commenced labour spontaneously. However the overall rate of Caesarean Sections is within the expected standard.

Month	Standard	Performance
Jan-19	14%	16.2%
Feb-19	14%	11.0%
Mar-19	14%	15.6%
Apr-19	14%	11.5%
May-19	14%	11.8%
Jun-19	14%	18.0%
Jul-19	14%	10.9%
Aug-19	14%	11.2%
Sep-19	14%	19.4%
Oct-19	14%	12.4%
Nov-19	14%	16.1%
Dec-19	14%	11.5%
Jan-20	14%	16.7%



Ongoing controls in place

All Grade 1 and 2 Caesarean sections are reviewed for appropriateness of delivery weekly at the multi professional case management meeting. Learning identified and shared with the obstetric and midwifery teams.
Women who are booked for an elective Caesarean Sections and go into labour spontaneously are offered a vaginal birth if deemed appropriate.

Actions in place to recover the performance

	Owner	Start	End
Discussed with the consultant body at the Women's health Governance Meeting . To audit the last 6 month's Grade 3 Caesarean Sections.	Jane Lovedale	17/02/2020	17/03/2020

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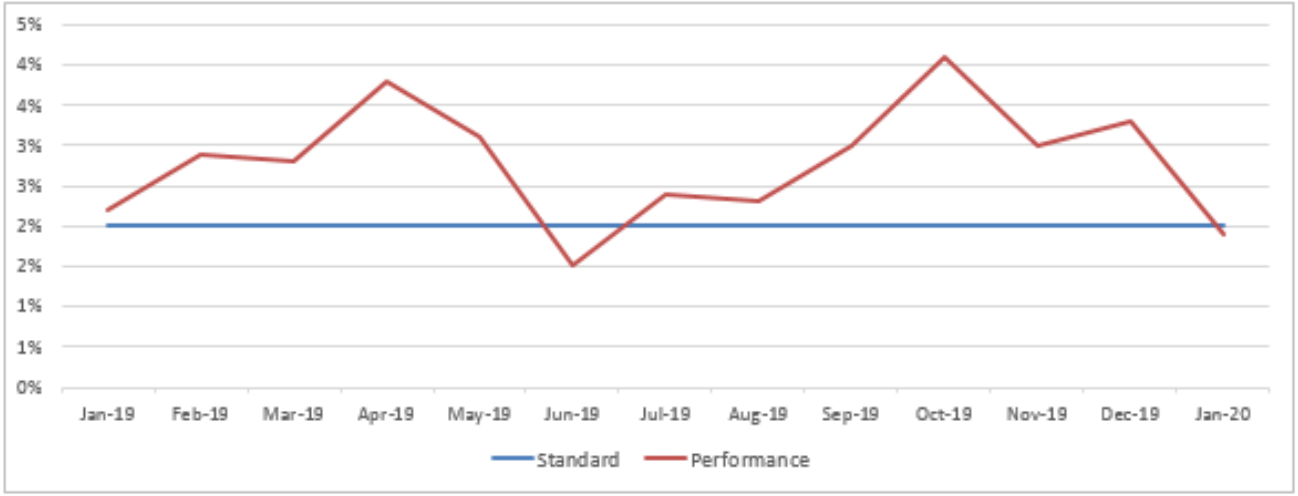
Homebirths

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Maternity

Supporting Narrative

This month the homebirth rate has dipped slightly to just below 2%. This may be due to the current home birth team having ongoing sickness over the last few month's and therefore not driving this forward as an option for women coming up to their due dates.

Month	Standard	Performance
Jan-19	2%	2.2%
Feb-19	2%	2.9%
Mar-19	2%	2.8%
Apr-19	2%	3.8%
May-19	2%	3.1%
Jun-19	2%	1.5%
Jul-19	2%	2.4%
Aug-19	2%	2.3%
Sep-19	2%	3.0%
Oct-19	2%	4.1%
Nov-19	2%	3.0%
Dec-19	2%	3.3%
Jan-20	2%	1.9%



Ongoing controls in place

Introduction of continuity of carer in April should increase homebirth as an option for delivery for low risk women. Sickness now resolved. Community teams continually promote birth at home, however this is an option for low risk women therfore there maybe a normal variation from month to month

Actions in place to recover the performance

	Owner	Start	End
No specific actions in place			

Putting you first

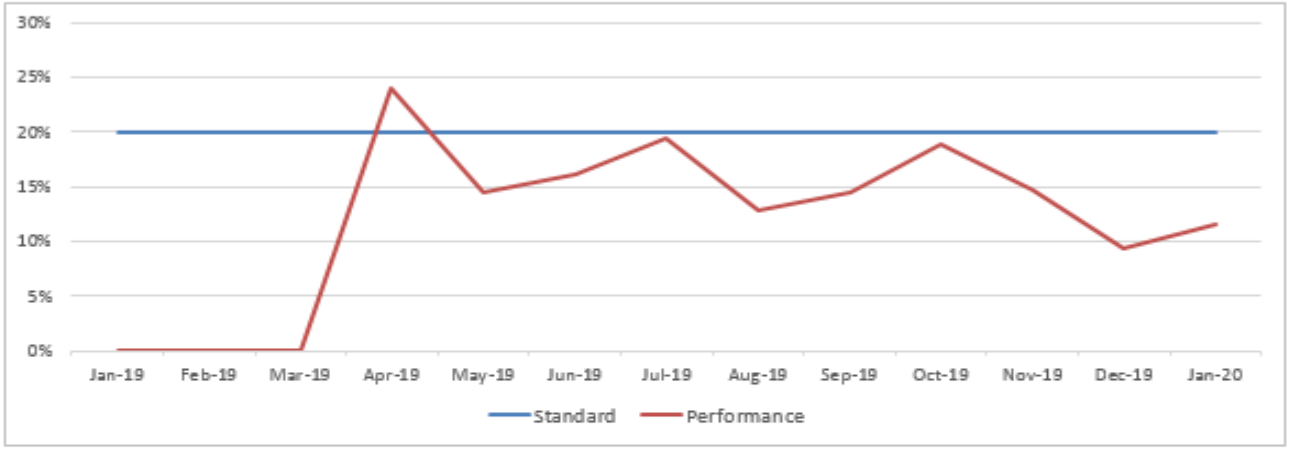
Midwifery led birthing unit (MLBU) births

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Maternity

Supporting Narrative

Although there is a slight increase in the Midwifery led birthing unit birth there is still an issue of women birthing there. The referral rate from the community teams remains static and low, missed referrals at 36 weeks antenatal care appointment. A large percentage of women have no documented place of birth. Women are being triaged on Labour Suite they are often remaining there for birth. Staff shortages are resulting in closure to the birthing unit.

Month	Standard	Performance
Jan-19	20%	NA
Feb-19	20%	NA
Mar-19	20%	NA
Apr-19	20%	24.0%
May-19	20%	14.4%
Jun-19	20%	16.1%
Jul-19	20%	19.4%
Aug-19	20%	12.9%
Sep-19	20%	14.4%
Oct-19	20%	18.9%
Nov-19	20%	14.6%
Dec-19	20%	9.3%
Jan-20	20%	11.6%



Ongoing controls in place

Datix submission for women whose birth place choice has not been offered or facilitated.
Email appropriate team when a woman was suitable but not referred.
Reiterate the criteria to the teams .
Referral forms in all antenatal care rooms .
Clear documentation in notes so they are more easily identified when admitted in labour .
Review births on a daily basis to identify low risk women who would have been suitable

Actions in place to recover the performance

	Owner	Start	End
Ongoing actions in place to recover	Karen Green	Jan-20	Apr-20

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Putting you first

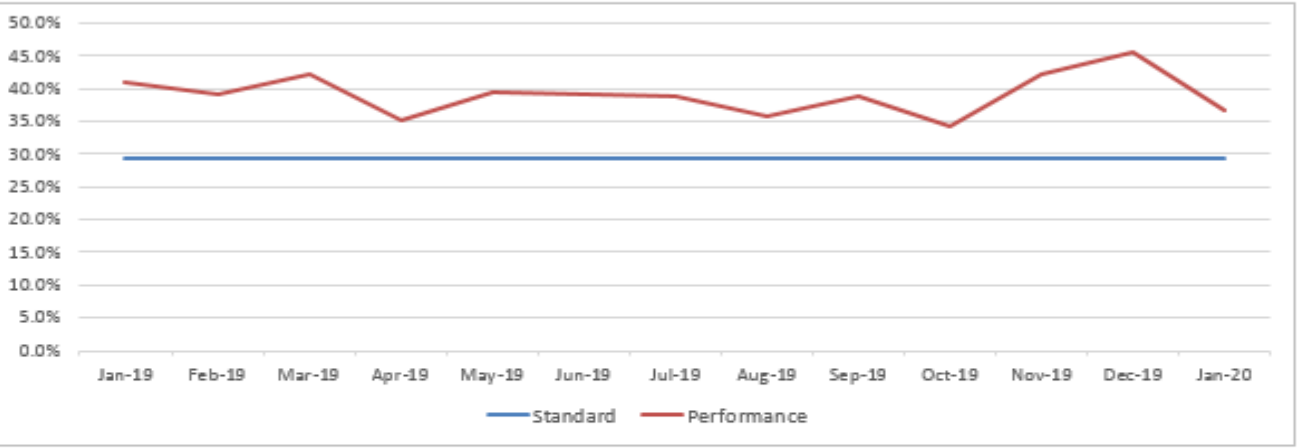
Induction of Labour

Month	Jan-20
Executive Lead	Rowan Procter
CQC Area	Maternity

Supporting Narrative

The data this month shows there were fewer Inductions of labour despite an increase in the number of births. The standard rate is taken from the national maternity & perinatal audit, this relates to data from 2017 which is prior to introduction of increased surveillance for fetal growth restriction and increased identification of gestational diabetes.

Month	Standard	Performance
Jan-19	29.3%	40.8%
Feb-19	29.3%	39.0%
Mar-19	29.3%	42.2%
Apr-19	29.3%	35.0%
May-19	29.3%	39.5%
Jun-19	29.3%	39.0%
Jul-19	29.3%	38.9%
Aug-19	29.3%	35.8%
Sep-19	29.3%	38.8%
Oct-19	29.3%	34.3%
Nov-19	29.3%	42.2%
Dec-19	29.3%	45.6%
Jan-20	29.3%	36.7%



Ongoing controls in place

Annual audit of the of Induction of Labour against national guidelines (last audit May 2019)
The maternity service follows national recommendations for Induction of Labour for high risk groups for stillbirth .e.g. gestational diabetics, prolonged rupture of membranes at term, fetal growth restriction and reduced fetal movements.

Actions in place to recover the performance

	Owner	Start	End
In view of the high rate of Induction of Labour from the 2019 National maternity and Perinatal Audit for data 2017. An action has been agreed to review the data against the new standard of 30 .6%. In adittion currently the WSH includes Induction of Labour for twins and Preterm Induction of Labour which currently should not part of the IOL standard.	Jane Lovedale	Mar-20	Apr-20

9. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 28 February 2020

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

Executive summary:
The reported I&E for January is a surplus of £6.5m, against a planned surplus of £4.9m. This results in a favourable variance of £1.6m in January (£3.6m YTD).

The position has improved significantly in January due to the inclusion of additional income associated with over performance.

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.

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
JANUARY 2020 (Month 10)

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

Financial Summary

I&E Position YTD	£0.3m	surplus
Variance against plan YTD	-£3.6m	adverse
Movement in month against plan	£1.6m	favourable
EBITDA position YTD	£1.1m	favourable
EBITDA margin YTD	0.5%	favourable
Total PSF Received	£8.313m	accrued
Cash at bank	£1.9m	

Executive Summary

- The planned surplus for the year to date was £3.9m but the actual surplus was £0.3m, an adverse variance of £3.6m.
- 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.

Key Risks

- Delivery of £8.9m CIP programme
- Receipt of additional funding as agreed
- Containing demand within budgeted capacity

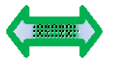
SUMMARY INCOME AND EXPENDITURE ACCOUNT - January 2020	Jan-20 Budget £m	Jan-20 Actual £m	Jan-20 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance F/(A) £m
NHS Contract Income	28.1	25.6	(2.4)	192.2	192.6	0.4	228.5	229.1	0.6
Other Income	2.8	3.0	0.2	24.0	23.4	(0.5)	28.9	29.0	0.1
Total Income	30.9	28.6	(2.3)	216.2	216.0	(0.2)	257.4	258.1	0.7
Pay Costs	14.6	14.9	(0.4)	143.3	145.8	(2.5)	172.4	174.6	(2.2)
Non-pay Costs	8.3	7.4	0.9	67.1	69.1	(2.0)	80.4	82.9	(2.5)
Operating Expenditure	22.9	22.3	0.5	210.4	214.9	(4.5)	252.8	257.5	(4.7)
Contingency and Reserves	3.1	0.0	3.1	0.0	0.0	0.0	2.7	0.0	2.7
EBITDA excl STF	4.9	6.2	1.3	5.8	1.1	(4.7)	1.9	0.6	(1.3)
Depreciation	0.7	0.6	0.1	6.7	6.2	0.5	8.1	7.4	0.7
Finance costs	0.3	0.2	0.2	3.2	2.9	0.3	3.9	3.3	0.6
SURPLUS/(DEFICIT)	**3.9**	**5.5**	**1.6**	**(4.2)**	**(8.0)**	**(3.9)**	**(10.1)**	**(10.1)**	**0.0**
Provider Sustainability Funding (PSF)									
MRET, FRF/PSF - Financial Performance	1.0	1.0	0.0	8.0	8.3	0.3	10.1	10.1	0.0
SURPLUS/(DEFICIT) incl PSF	**4.9**	**6.5**	**1.6**	**3.9**	**0.3**	**(3.5)**	**0.0**	**0.1**	**0.0**

FINANCE AND WORKFORCE REPORT – JANUARY 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 – JANUARY 2020

Income and Expenditure Summary as at January 2020

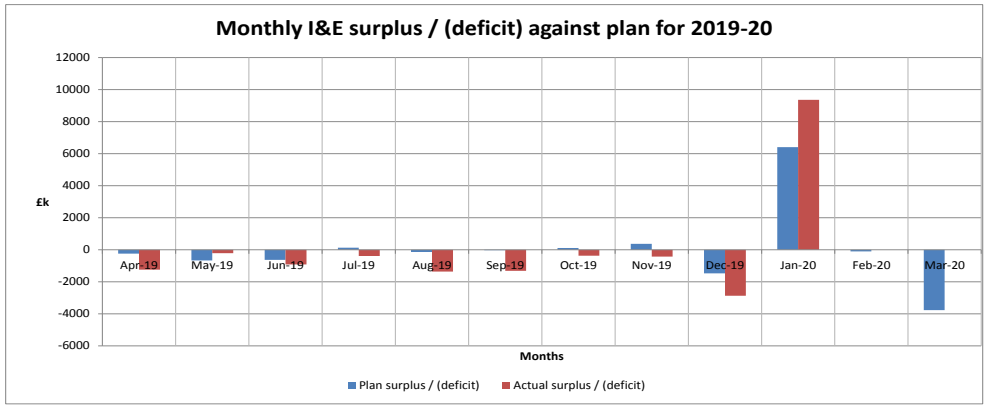
The reported I&E for January is a surplus of £6.5m, against a planned surplus of £4.9m. This results in a favourable variance of £1.6m in January (£3.6m YTD).

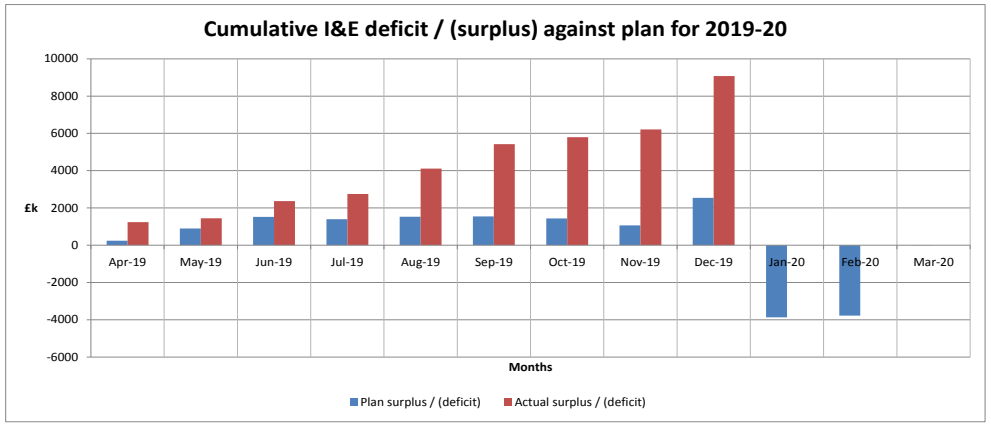
The position has improved significantly in January due to the inclusion of additional income associated with over performance.

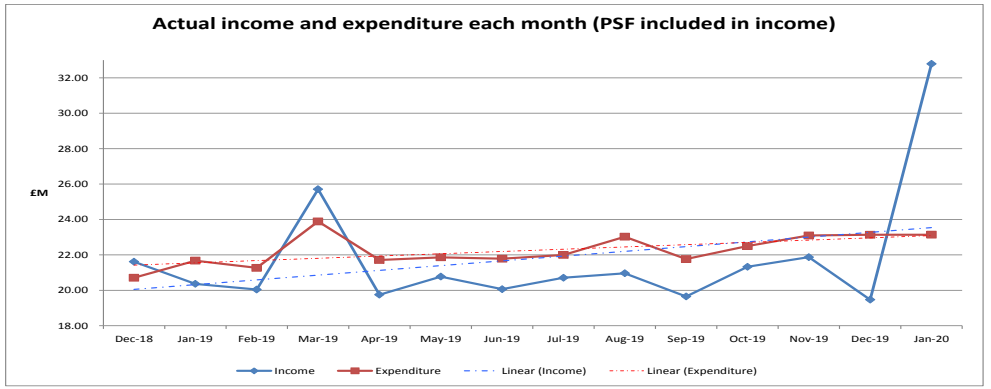
The Trust is forecasting to meet its control total for 2019-20 which is to break even. As a result the Trust anticipates receiving all PSF/FRF associated with meeting its control total.

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)	4,934	6,499	1,565	↑	Green
YTD surplus / (deficit)	3,870	285	(3,585)	↓	Red
Forecast surplus / (deficit)	9	9	(0)	↑	Amber
EBITDA (excl STF) YTD	5,779	1,076	(4,703)	↓	Red
EBITDA (%)	2.6%	0.5%	(2.1%)	↓	Red
Clinical Income YTD	(185,613)	(185,978)	365	↓	Green
Non-Clinical Income YTD	(38,589)	(38,326)	(263)	↑	Amber
Pay YTD	143,302	145,779	(2,477)	↑	Red
Non-Pay YTD	77,029	78,239	(1,211)	↓	Red
CIP target YTD	7,669	7,686	17	↓	Amber







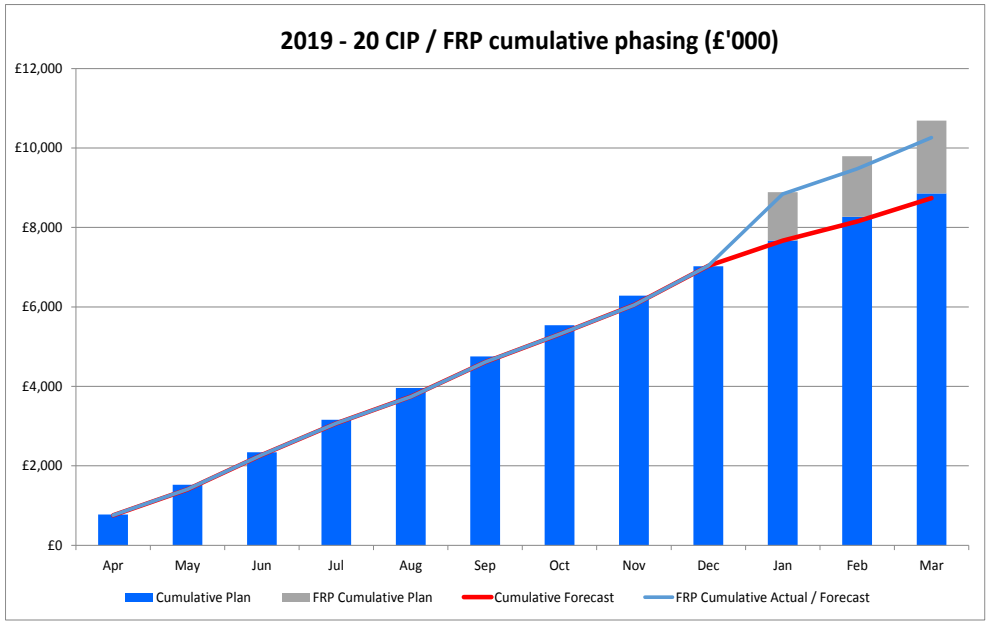
FINANCE AND WORKFORCE REPORT – JANUARY 2020

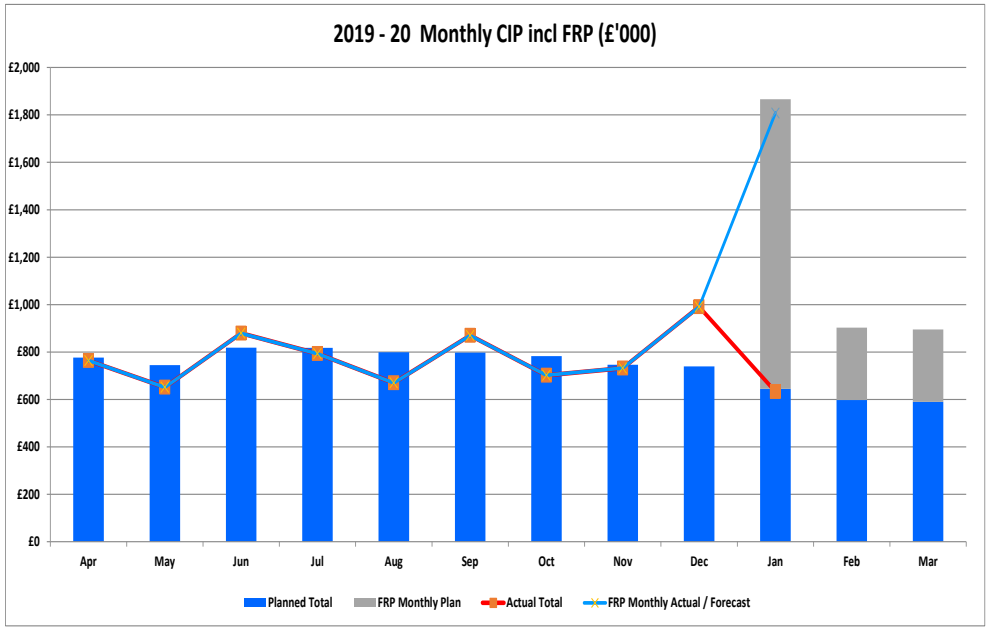
Cost Improvement Programme (CIP) 2019-20

In order to deliver the Trust's control target in 2019-20 we needed to deliver a CIP of £8.9m (4%). By January we planned to achieve £7,669k (86.6% of the annual plan) but achieved £7,686k (86.8%), £17k ahead of plan.

We have also developed a Financial Recovery Plan (FRP) to deliver £1.8m of savings this year. By January we planned to achieve £1,221k (66.7% of the FRP) but achieved £1,175k (64.1%), £46k behind plan.

Recurring/Non Recurring	2019-20 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	100	83	77
Procurement	731	608	860
Activity growth	-	-	-
Additional sessions	15	13	2
Community Equipment Service	575	552	479
Drugs	1,740	1,690	1,810
Estates and Facilities	60	50	64
Other	1,344	1,009	1,127
Other Income	1,740	1,520	1,594
Pay controls	361	300	247
Service Review	20	16	10
Staffing Review	1,076	913	794
Theatre Efficiency	178	143	71
Recurring Total	**7,940**	**6,896**	**7,135**
Non-Recurring			
Estates and Facilities	87	75	-
Other	454	379	114
Pay controls	376	319	437
Non-Recurring Total	**916**	**773**	**551**
Total CIP	**8,856**	**7,669**	**7,686**
Financial Recovery Plan			
Pay Controls	443	295	210
Additional Sessions	294	196	83
Non Pay	143	95	77
Drugs	252	168	252
Medical	58	39	35
Nursing	138	92	87
Income	131	87	128
Other Income	72	48	72
Agency	45	30	30
Other	256	170	202
Total FRP	**1,832**	**1,221**	**1,175**
Grand Total	**10,688**	**8,890**	**8,861**

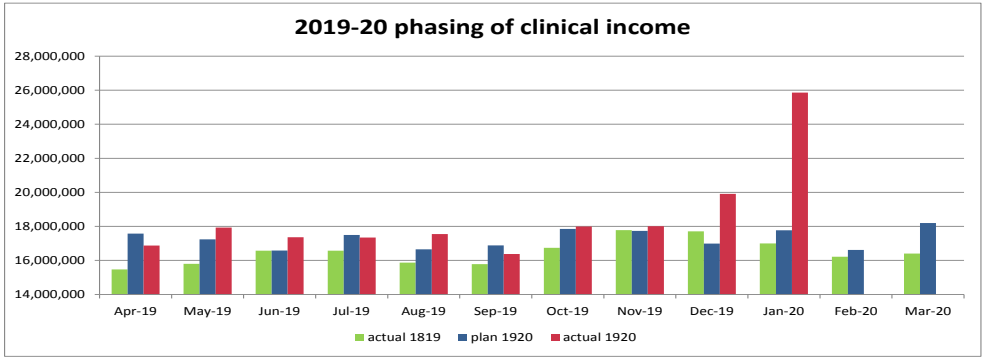




FINANCE AND WORKFORCE REPORT – JANUARY 2020

Income Analysis

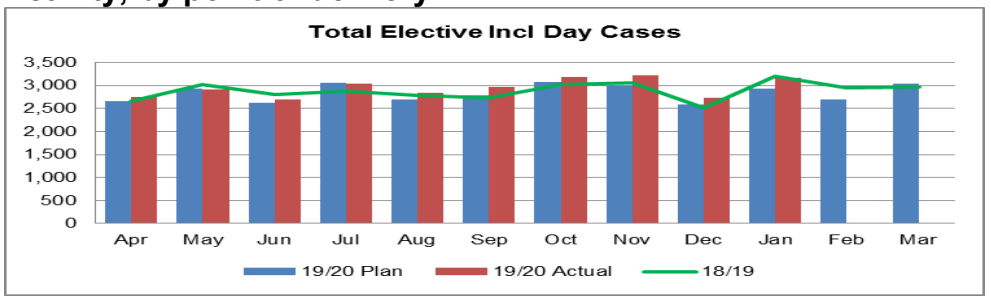
The chart below demonstrates the phasing of all clinical income plan for 2019-20, including Community Services. This phasing is in line with phasing of activity.

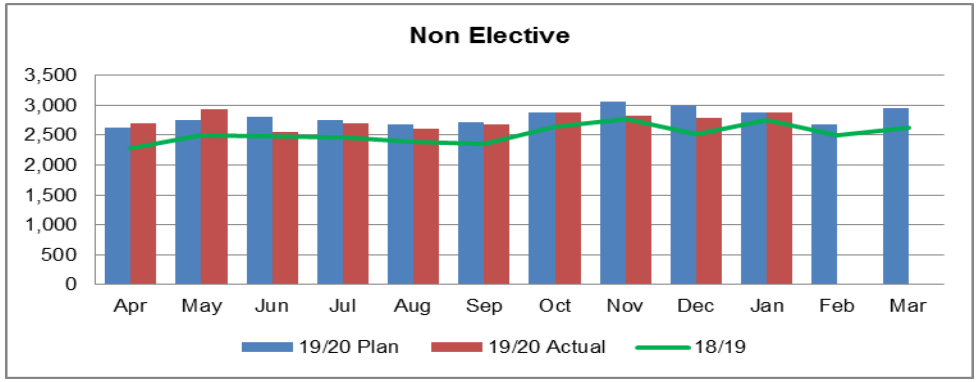


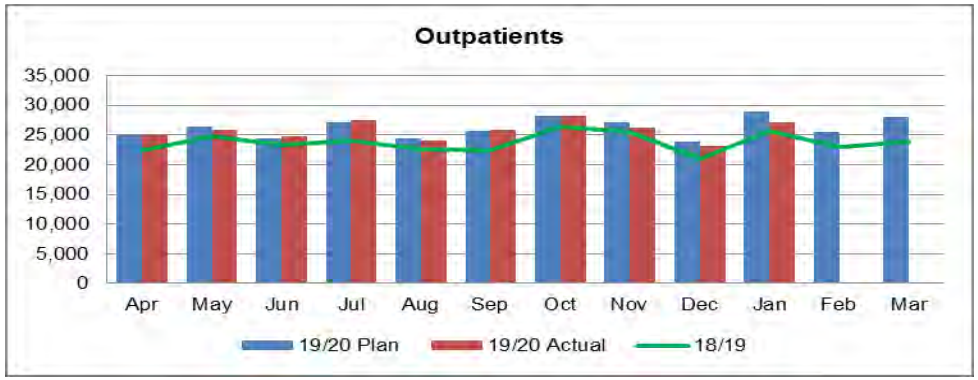
The income position was under plan for January. The main areas of underperformance were within Other Service and Outpatients.

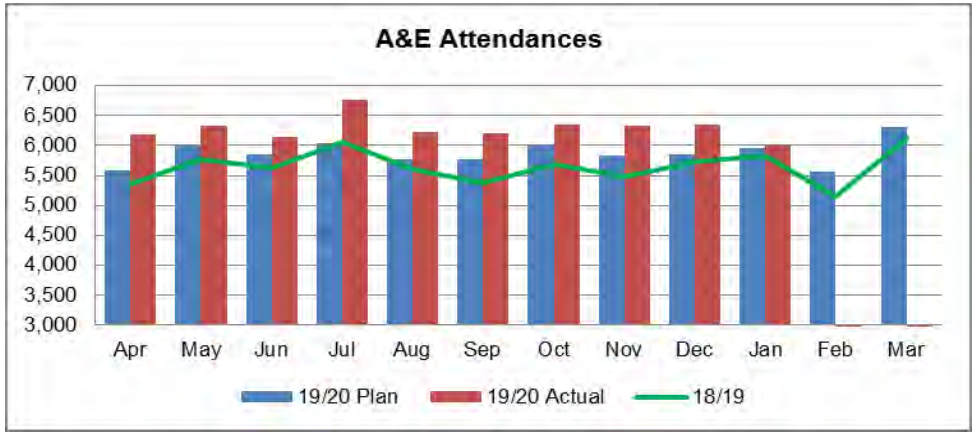
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	919	940	22	9,056	9,770	713
Other Services	11,613	8,854	(2,759)	35,520	35,222	(299)
CQUIN	180	184	4	1,726	1,726	(1)
Elective	2,699	2,802	103	27,728	27,733	5
Non Elective	6,546	6,931	386	62,445	62,250	(195)
Emergency Threshold Adjustment	(362)	(362)	0	(3,466)	(3,466)	0
Outpatients	3,476	3,281	(194)	31,421	31,157	(264)
Community	2,988	2,988	0	27,787	28,192	405
Total	**28,058**	**25,619**	**(2,439)**	**192,218**	**192,583**	**364**

Activity, by point of delivery

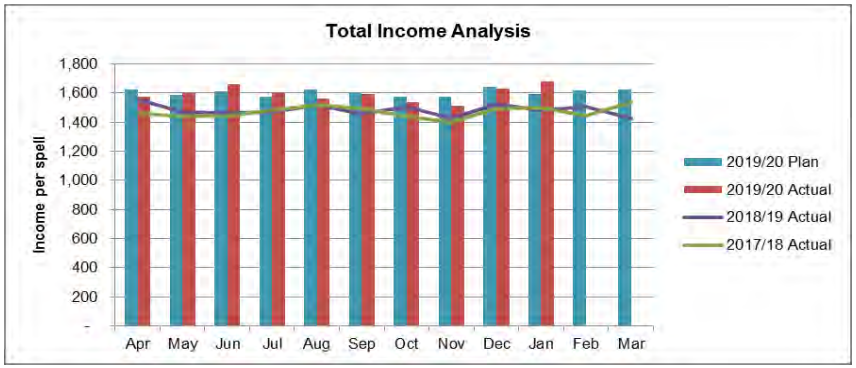


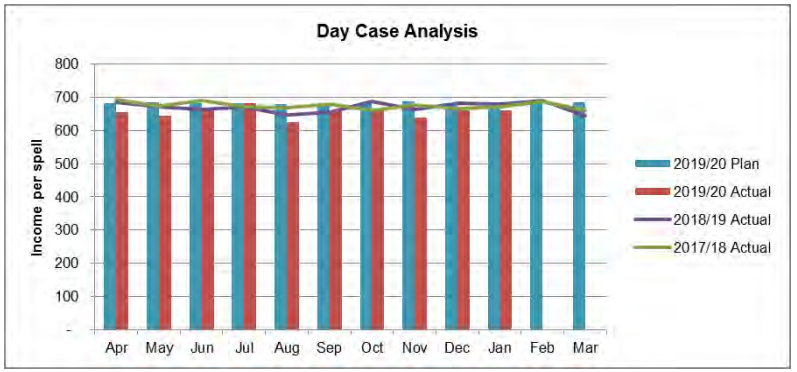


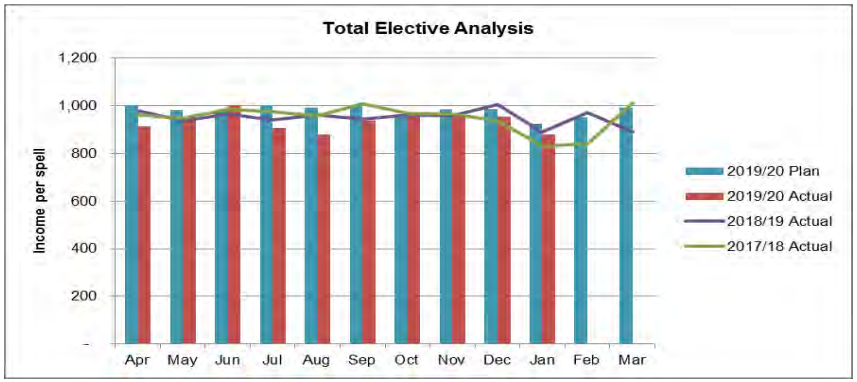


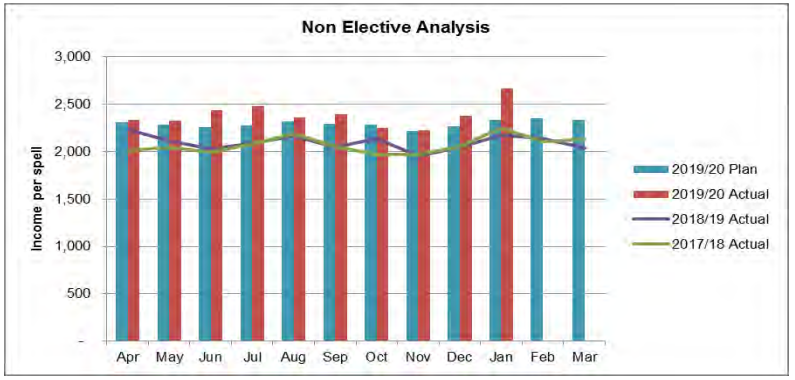


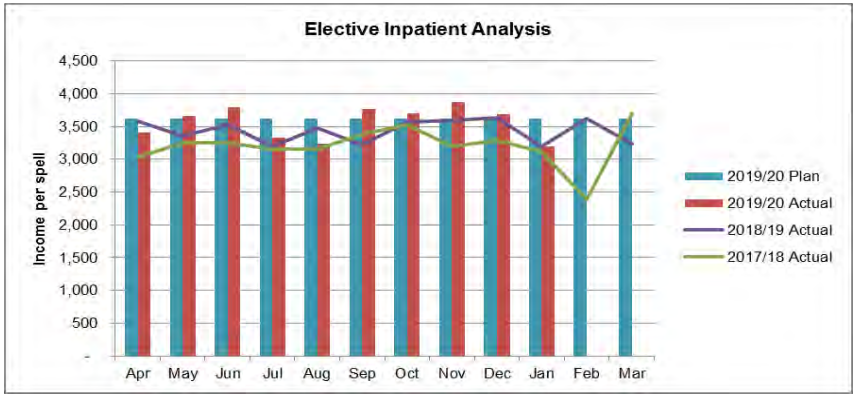
Trends and Analysis

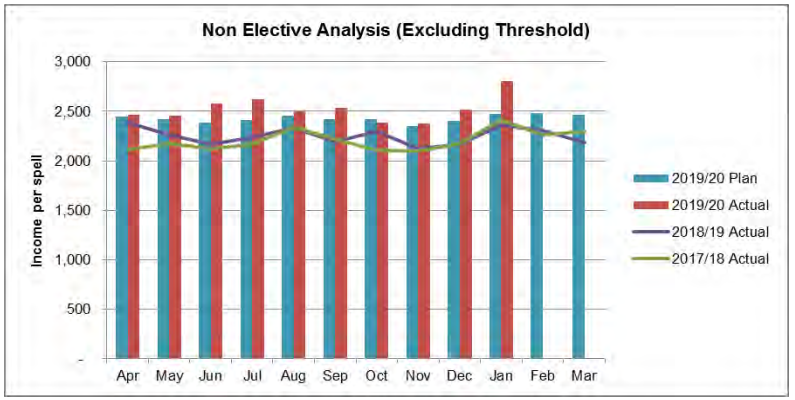












FINANCE AND WORKFORCE REPORT – JANUARY 2020

Workforce

Monthly Expenditure (£) Acute services only				
As at January 2020	Jan-20	Dec-19	Jan-19	YTD 2019/20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**12,802**	**12,723**	**11,934**	**126,021**
Substantive Staff	11,915	11,663	10,724	113,724
Medical Agency Staff (includes 'contracted in' staff)	43	160	236	1,453
Medical Locum Staff	344	350	277	2,780
Additional Medical sessions	161	189	217	2,515
Nursing Agency Staff	87	106	322	1,360
Nursing Bank Staff	290	331	216	2,810
Other Agency Staff	57	65	33	693
Other Bank Staff	155	151	114	1,433
Overtime	50	51	164	1,187
On Call	68	76	70	682
Total temporary expenditure	1,255	1,480	1,646	14,913
Total expenditure on pay	**13,169**	**13,144**	**12,370**	**128,637**
Variance (F/(A))	(367)	(420)	(436)	(2,617)
Temp Staff costs % of Total Pay	9.5%	11.3%	13.3%	11.6%
Memo : Total agency spend in month	188	331	590	3,507

Monthly Expenditure (£) Community Service Only				
As at January 2020	Jan-20	Dec-19	Jan-19	YTD 2019-20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,753**	**1,760**	**1,561**	**17,282**
Substantive Staff	1,683	1,689	1,480	16,357
Medical Agency Staff (includes 'contracted in' staff)	12	12	9	109
Medical Locum Staff	7	3	3	44
Additional Medical sessions	2	0	0	11
Nursing Agency Staff	1	16	25	145
Nursing Bank Staff	25	21	16	262
Other Agency Staff	8	8	(21)	48
Other Bank Staff	6	10	6	73
Overtime	4	4	6	57
On Call	3	3	4	35
Total temporary expenditure	68	77	48	785
Total expenditure on pay	**1,751**	**1,766**	**1,528**	**17,142**
Variance (F/(A))	1	(6)	32	140
Temp Staff costs % of Total Pay	3.9%	4.4%	3.1%	4.6%
Memo : Total agency spend in month	21	35	13	303

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at January 2020	Jan-20	Dec-19	Jan-19
	WTE	WTE	WTE
Budgeted WTE in month	**3,352.4**	**3,356.4**	**3,229.7**
Employed substantive WTE in month	3150.34	3115.16	2921.78
Medical Agency Staff (includes 'contracted in' staff)	4.24	10.37	15.13
Medical Locum	29.38	29.96	22.7
Additional Sessions	13.55	16.26	20.86
Nursing Agency	12.41	13.9	44.96
Nursing Bank	87.95	103.37	67.44
Other Agency	11.29	8.15	4.09
Other Bank	61.72	62.35	50.66
Overtime	10.32	12.52	47.99
On call Worked	6.27	6.71	8.04
Total equivalent temporary WTE	**237.1**	**263.6**	**281.9**
Total equivalent employed WTE	**3,387.5**	**3,378.8**	**3,203.7**
Variance (F/(A))	(35.1)	(22.4)	26.0
Temp Staff WTE % of Total Pay	7.0%	7.8%	8.8%
Memo : Total agency WTE in month	27.9	32.4	64.2
Sickness Rates (December/November)	4.05%	3.85%	3.95%
Mat Leave	2.12%	2.08%	2.82%

Monthly Whole Time Equivalents (WTE) Community Services Only			
As at January 2020	Jan-20	Dec-19	Jan-19
	WTE	WTE	WTE
Budgeted WTE in month	**542.07**	**542.06**	**486.25**
Employed substantive WTE in month	507.73	511.43	466.99
Medical Agency Staff (includes 'contracted in' staff)	0.74	0.74	0.58
Medical Locum	0.35	0.35	0.35
Additional Sessions	0.00	0.00	0.00
Nursing Agency	0.20	2.25	3.48
Nursing Bank	7.74	6.44	4.75
Other Agency	3.39	3.25	1.15
Other Bank	1.81	2.33	1.44
Overtime	1.19	1.42	1.99
On call Worked	0.04	0.01	0.01
Total equivalent temporary WTE	**15.5**	**16.8**	**13.8**
Total equivalent employed WTE	**523.2**	**528.2**	**480.7**
Variance (F/(A))	18.88	13.84	5.51
Temp Staff WTE % of Total Pay	3.0%	3.2%	2.9%
Memo : Total agency WTE in month	4.3	6.2	5.2
Sickness Rates (December/November)	4.13%	4.14%	4.43%
Mat Leave	3.44%	3.21%	3.72%

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Pay Trends and Analysis

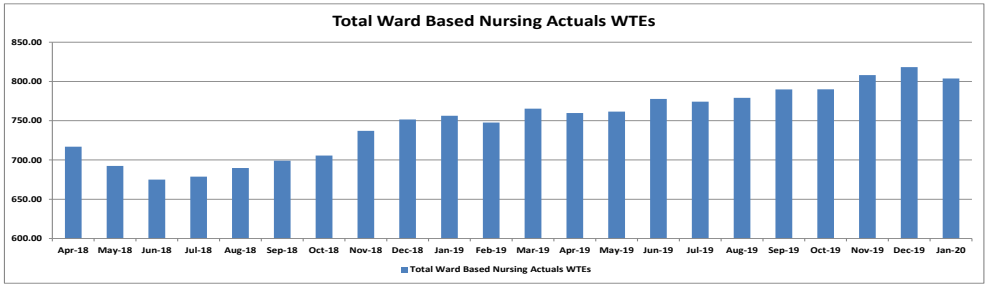
Nursing – Staffing levels

The tables below compare actual registered and unregistered nursing within ward based and non-ward based services between April 18 and January 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 47.4 WTEs (6.3 %) in ward based areas, and 86.8 WTEs since April 2018 (12.1%).

	Jan 19 to Jan 20			April 18 to January 20		
Nursing WTE Actual Increase / (Decrease)	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total
Registered	3.77	33.12	**36.89**	9.55	49.25	**58.80**
Unregistered	43.67	(3.69)	**39.98**	77.23	(3.15)	**74.08**
Total	47.44	29.43	**76.87**	86.78	46.10	**132.88**

	Jan 19 to Jan 20		
Nursing WTE % Increase / (Decrease)	Ward Based	Non Ward Based	Total
Registered	0.9%	4.9%	**3.4%**
Unregistered	12.6%	(2.08%)	**7.6%**
Total	6.3%	3.4%	**4.8%**

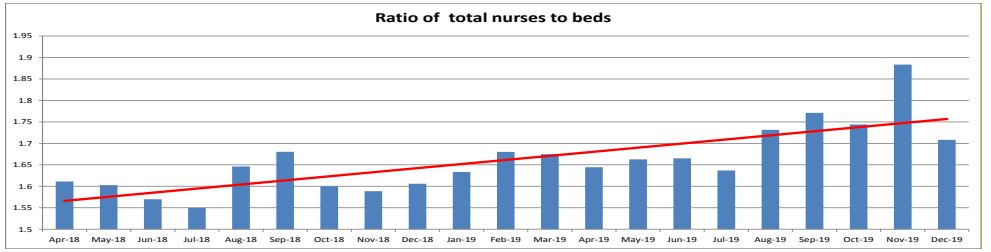


Due to increasing bed capacity the next table compares ward based nursing WTEs with average beds open in each month to demonstrate whether the increase in staffing is in line with growth in capacity. Looking at the total increase in nursing negates changes associated with the implementation of bay based nursing. It can be seen that the ratio of total nurses to beds in January 2020 is similar to April 2018 and January 2019 but has decreased from December 2019. This may relate to the part month effect of opening escalation beds on G9.

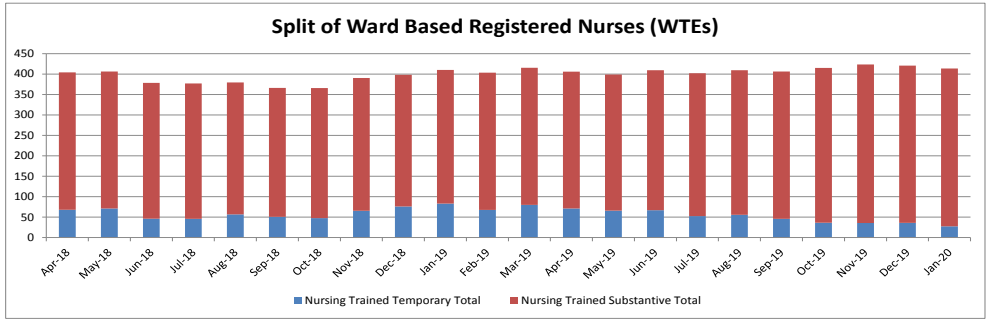
WTEs incl A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	Sep-18	Sep-19	Oct-18	Oct-19	Nov-18	Nov-19	Dec-18	Dec-19	Jan-19	Jan-20	
Average Beds (midnight count)	445	462	432	458	430	467	438	473	419	450	416	446	441	453	464	429	468	479	463	501	
Registered WTEs	404	406	406	399	378	410	377	402	380	409	366	406	366	415	390	423	398	421	410	414	
Unregistered WTEs	313	354	286	363	297	368	302	372	310	370	333	384	340	375	347	385	353	397	346	390	
Total	717	760	692	762	675	778	679	774	690	779	699	790	706	790	737	808	752	818	756	804	112.1%

All wards incl A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	Sep-18	Sep-19	Oct-18	Oct-19	Nov-18	Nov-19	Dec-18	Dec-19	Jan-19	Jan-20	yr on yr
Registered per bed (incl Agency)	0.91	0.88	0.94	0.87	0.88	0.88	0.86	0.85	0.91	0.91	0.88	0.91	0.83	0.92	0.84	0.99	0.85	0.88	0.89	0.83	93.3%
Unregistered per bed	0.70	0.77	0.66	0.79	0.69	0.79	0.69	0.79	0.74	0.82	0.80	0.86	0.77	0.83	0.75	0.90	0.75	0.83	0.75	0.78	104.1%
Total Nursing per bed	1.61	1.64	1.60	1.66	1.57	1.67	1.55	1.64	1.65	1.73	1.68	1.77	1.60	1.74	1.59	1.88	1.61	1.71	1.63	1.60	98.2%

Excluding A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	Sep-18	Sep-19	Oct-18	Oct-19	Nov-18	Nov-19	Dec-18	Dec-19	Dec-18	Dec-19	yr on yr
Registered per bed (incl Agency)	0.76	0.73	0.79	0.74	0.75	0.73	0.72	0.71	0.76	0.76	0.74	0.76	0.68	0.76	0.69	0.82	0.73	0.74	0.75	0.83	109.7%
Unregistered per bed	0.65	0.72	0.61	0.74	0.64	0.73	0.64	0.73	0.69	0.77	0.75	0.81	0.72	0.77	0.70	0.84	0.71	0.77	0.70	0.78	110.8%
Total Nursing per bed	1.42	1.45	1.41	1.48	1.39	1.46	1.36	1.44	1.44	1.52	1.49	1.56	1.40	1.53	1.39	1.66	1.44	1.51	1.46	1.60	110.3%



Excluding escalation areas there were 55.5 WTE vacancies at the end of January 2020 (54.9 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 27.5 temporary WTEs to fill the majority of vacant posts during January (35.8 WTE last month). Ward based nursing overtime has almost ceased.

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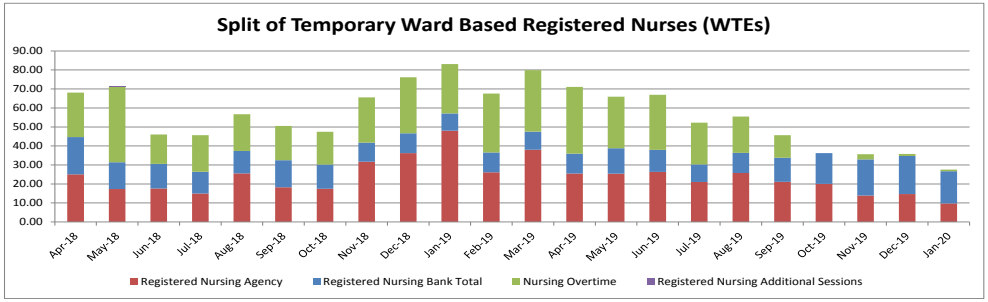
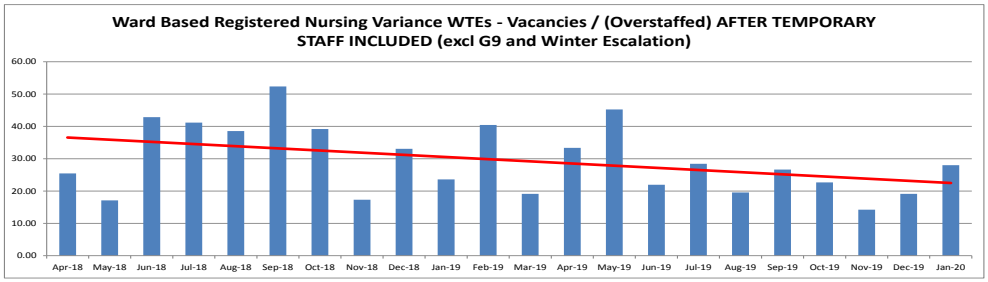
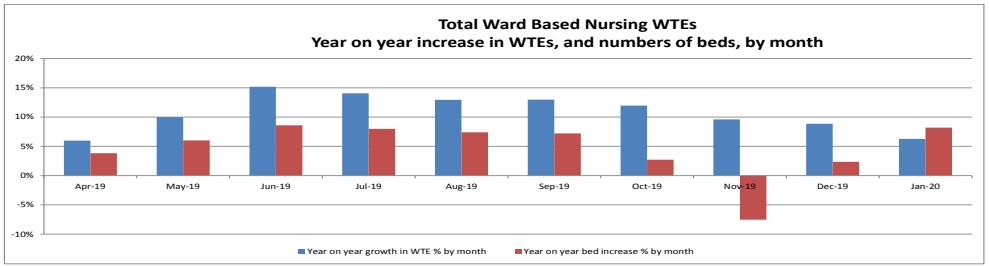


However, after using temporary nursing staff there remained 28.0 WTE uncovered Ward Based Registered Nursing Vacancies during January (19.1 WTE in December, average of 29.6 WTE from April 2018 to December 2019)



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 12% increase in staffing, and whilst the bed base has fluctuated it has usually increased by around half of this. The January position may reflect the part month effect of opening escalation beds on G9.



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 december 19	Sum of Actual december 19	NET Vacancies (over / (under)) December 19	Sum of plan january 20	Sum of Actual january 20	NET vacancies (over / (under)) January 20
Medical Services	A&E Medical Staff	6.12	7.14	1.02	6.12	7	0.88
	Accident & Emergency	64.46	59.59	(4.87)	64.46	59.54	(4.92)
	C.C.U.	0	0	0.00	0	0	0.00
	Ward F9	20.85	18.36	(2.49)	20.85	18.41	(2.44)
	Ward F12	11.27	11.19	(0.08)	11.27	9.22	(2.05)
	Ward G1 Hardwick Unit	23.74	22.61	(1.13)	23.74	22.91	(0.83)
	Cardiac Ward	22.6	20.54	(2.06)	22.6	19.34	(3.26)
	Ward G4	19.78	18.85	(0.93)	19.78	19.1	(0.68)
	Ward G5	18.93	18.99	0.06	18.93	16.42	(2.51)
	Ward G8	24.62	26.59	1.97	24.62	24.79	0.17
	Medical Treatment Unit	7.04	7.25	0.21	7.04	7.2	0.16
	Respiratory Ward	20.69	21.89	1.20	20.69	19.52	(1.17)
	Cardiac Centre	40.14	35.51	(4.63)	40.14	36.84	(3.30)
	AAU	27.3	21.71	(5.59)	27.3	24.07	(3.23)
	Ward F7 Short Stay	22.66	23.91	1.25	22.66	23.49	0.83
Medical Services Total		330.2	314.13	(16.07)	330.2	307.85	(22.35)
Surgical Services	Ward F3	19.57	19.46	(0.11)	19.57	19.78	0.21
	Ward F4	13.78	14.92	1.14	13.78	13.44	(0.34)
	Ward F5	19.59	18.92	(0.67)	19.59	18.12	(1.47)
	Ward F6	21.41	18.37	(3.04)	21.41	19.14	(2.27)
Surgical Services Total		74.35	71.67	(2.68)	74.35	70.48	(3.87)
Woman & Children S	Gynae Ward (On F14)	10.78	10.04	(0.74)	10.78	10.53	(0.25)
Woman & Children Services Total		10.78	10.04	(0.74)	10.78	10.53	(0.25)
Community	Newmarket Hosp-Rosemary ward	12.43	12.75	0.32	12.43	11.02	(1.41)
	Community - Glastonbury Court	11.69	11.72	0.03	11.69	11.57	(0.12)
Community Total		24.12	24.47	0.35	24.12	22.59	(1.53)

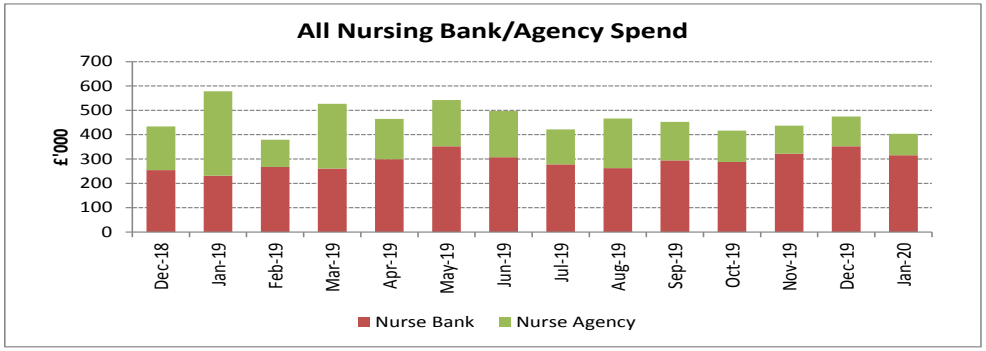
Ward Based Unregistered Nurses were over established by 35.69 WTE during January after utilising temporary unregistered nurses, broken down as below :

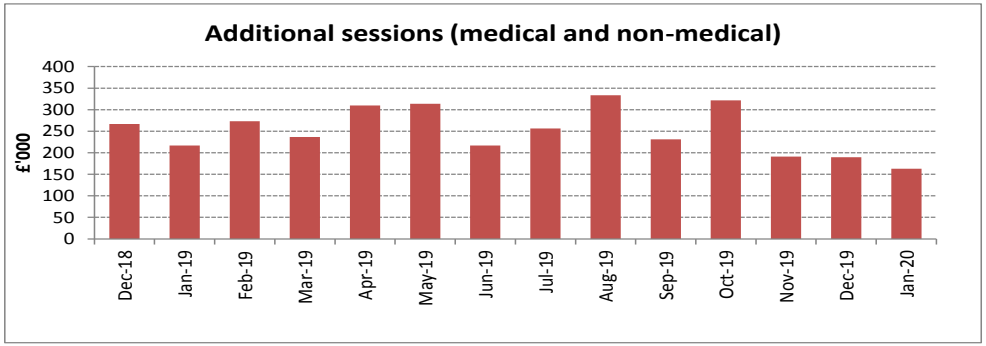
Division	Ward Area	Sum of plan december 19	Sum of Actual december 19	NET Vacancies (over / (under)) December 19	Sum of plan january 20	Sum of Actual january 20	NET Vacancies (over / (under)) January 20
Medical Services	Accident & Emergency	26.51	26.36	-0.15	26.51	25.8	(0.71)
	C.C.U.	0	0	0	0	0	0.00
	Ward F9	23.18	29.13	5.95	23.18	26.78	3.60
	Ward F12	5.15	6.6	1.45	5.15	7.76	2.61
	Ward G1 Hardwick Unit	9.01	12.34	3.33	9.01	10.37	1.36
	Cardiac Ward	25.8	28.44	2.64	25.8	26.08	0.28
	Ward G4	25.03	26.09	1.06	25.03	28.85	3.82
	Ward G5	23.18	33.08	9.9	23.18	31.65	8.47
	Ward G8	25.13	27.34	2.21	25.13	23.71	(1.42)
	Ward G9 Escalation Ward	0	0	0	0	3.7	3.70
	Respiratory Ward	21.13	23.65	2.52	21.13	22.21	1.08
	Cardiac Centre	15.2	19.08	3.88	15.2	21.11	5.91
	AAU	29.8	30.86	1.06	29.8	30.57	0.77
	Ward F7 Short Stay	31.94	28.44	-3.5	31.94	28.97	(2.97)
Medical Services Total		261.06	291.41	30.35	261.06	287.56	26.50
Surgical Services	Ward F3	23.11	26.72	3.61	23.11	26.62	3.51
	Ward F4	10.46	12.71	2.25	9.61	10.04	0.43
	Ward F5	15.36	17.11	1.75	15.36	17.28	1.92
	Ward F6	18.04	19.27	1.23	18.04	19.66	1.62
Surgical Services Total		66.97	75.81	8.84	66.12	73.6	7.48
Woman & Children Serv	Gynae Ward (On F14)	1	2.52	1.52	1	3	2.00
Woman & Children Services Total		1	2.52	1.52	1	3	2.00
Community	Newmarket Hosp-Rosemary ward	13.47	13.78	0.31	13.47	12.76	(0.71)
	Community - Glastonbury Court	12.64	13.95	1.31	12.64	13.06	0.42
Community Total		26.11	27.73	1.62	26.11	25.82	(0.29)
Grand Total		**355.14**	**397.47**	**42.33**	**354.29**	**389.98**	**35.69**

FINANCE AND WORKFORCE REPORT – JANUARY 2020

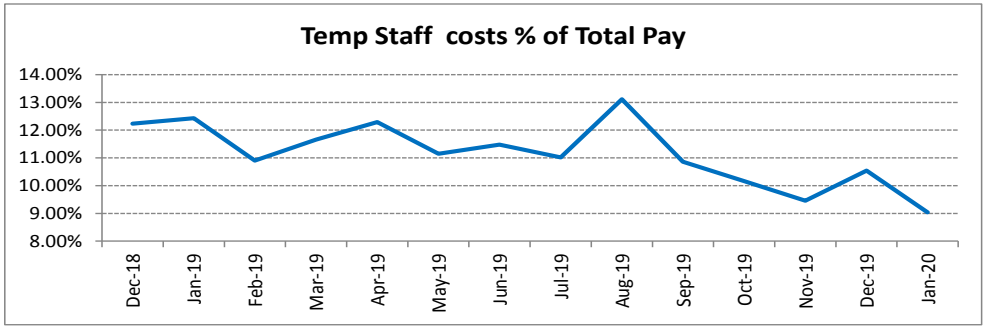
Pay Costs and Analysis

During January the Trust has overspent by £366k on pay (£2.5m YTD).

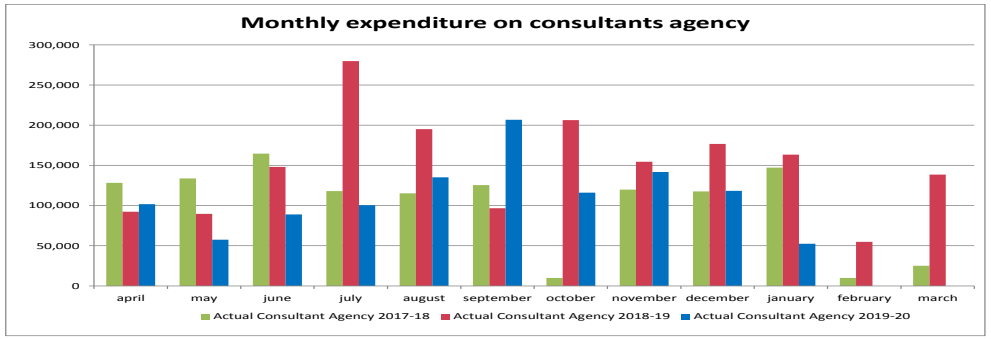




Expenditure on Additional Sessions reduced to £163k in January, the lowest month since July 2018

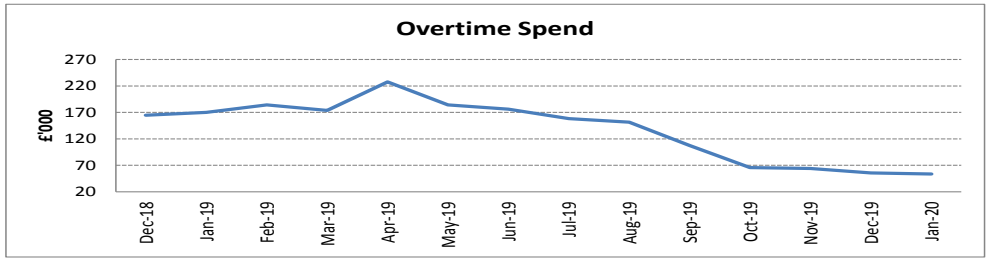


The Trusts proportion of temporary pay expenditure fell to 9.0% in January 2020 which has been our target.



Temporary Expenditure On Medical Staff 2019-20	Average M1-7	Actual Nov 19	Actual Dec 19	Actual Jan 20	Forecast 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	131	131	1,633	1,142
Diabetes	34	67	19	23	24	24	392	332
Gastroenterology	59	(6)	6	19	29	29	488	328
Stroke	23	18	72	(9)	23	23	289	253
General Surgery	31	20	27	37	29	29	360	215
Cardiology	37	31	32	22	28	28	398	210
Clinical Haematology	10	25	21	16	32	5	169	159
Plastic Surgery	22	14	5	8	8	8	199	143
Urology	15	33	18	19	19	19	212	142
Community Paeds Medical Servs	15	13	15	17	16	16	183	142
Anaesthetics	30	(6)	15	7	7	7	237	138
Care of the Elderly	21	7	22	38	18	18	253	131
Microbiology	1	6	29	24	29	29	127	127
Grand Total (for those cost centres forecasting > £100k adverse variance)	**438**	**318**	**467**	**329**	**393**	**367**	**4,938**	**3,461**

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



FINANCE AND WORKFORCE REPORT – JANUARY 2020

Summary by Division

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS (NET CONTRIBUTION) - January 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	(7,776)	(8,111)	334	(71,959)	(73,341)	1,382
Pay Costs	4,227	4,383	(156)	40,709	41,367	(659)
Non-pay Costs	1,725	1,742	(17)	16,120	15,848	272
Operating Expenditure	**5,952**	**6,125**	**(173)**	**56,829**	**57,215**	**(387)**
SURPLUS / (DEFICIT)	**1,824**	**1,986**	**161**	**15,130**	**16,125**	**996**
SURGERY						
Total Income	(5,539)	(5,658)	119	(53,483)	(52,674)	(809)
Pay Costs	3,123	3,140	(17)	31,055	31,584	(530)
Non-pay Costs	1,205	1,146	59	11,722	11,505	218
Operating Expenditure	**4,328**	**4,286**	**42**	**42,777**	**43,089**	**(312)**
SURPLUS / (DEFICIT)	**1,211**	**1,372**	**161**	**10,706**	**9,585**	**(1,121)**
WOMENS and CHILDRENS						
Total Income	(1,924)	(1,736)	(188)	(19,523)	(19,029)	(494)
Pay Costs	1,224	1,301	(77)	12,238	12,635	(396)
Non-pay Costs	145	170	(25)	1,557	1,567	(10)
Operating Expenditure	**1,369**	**1,470**	**(101)**	**13,795**	**14,202**	**(406)**
SURPLUS / (DEFICIT)	**556**	**266**	**(289)**	**5,727**	**4,827**	**(900)**
CLINICAL SUPPORT						
Total Income	(883)	(875)	(8)	(8,441)	(8,531)	90
Pay Costs	1,521	1,522	(1)	15,230	15,145	85
Non-pay Costs	1,071	1,217	(146)	10,559	11,577	(1,018)
Operating Expenditure	**2,592**	**2,739**	**(148)**	**25,789**	**26,722**	**(933)**
SURPLUS / (DEFICIT)	**(1,709)**	**(1,864)**	**(155)**	**(17,348)**	**(18,191)**	**(843)**
COMMUNITY SERVICES						
Total Income	(2,212)	(2,315)	103	(32,293)	(32,623)	330
Pay Costs	2,344	2,381	(37)	23,168	23,198	(31)
Non-pay Costs	952	1,013	(62)	9,988	10,656	(668)
Operating Expenditure	**3,295**	**3,394**	**(99)**	**33,156**	**33,854**	**(698)**
SURPLUS / (DEFICIT)	**(1,083)**	**(1,079)**	**4**	**(863)**	**(1,231)**	**(368)**
ESTATES and FACILITIES						
Total Income	(445)	(467)	21	(4,205)	(4,156)	(49)
Pay Costs	874	891	(17)	8,740	8,706	34
Non-pay Costs	635	772	(137)	6,028	6,518	(490)
Operating Expenditure	**1,509**	**1,663**	**(154)**	**14,768**	**15,224**	**(456)**
SURPLUS / (DEFICIT)	**(1,063)**	**(1,196)**	**(133)**	**(10,563)**	**(11,069)**	**(506)**
CORPORATE (excl Reserves)						
Total Income	(13,136)	(10,479)	(2,657)	(34,448)	(33,950)	(498)
Pay Costs	1,243	1,303	(60)	12,164	13,144	(980)
Non-pay Costs (net of Contingency and Reserves)	5,680	1,368	4,312	11,262	11,465	(203)
Finance & Capital	1,015	793	222	9,941	9,104	838
Operating Expenditure	**7,938**	**3,464**	**4,474**	**33,367**	**33,712**	**(345)**
SURPLUS / (DEFICIT)	**5,199**	**7,015**	**1,816**	**1,081**	**238**	**(843)**
TOTAL						
Total Income	(31,916)	(29,640)	(2,276)	(224,352)	(224,304)	(48)
Pay Costs	14,555	14,921	(366)	143,302	145,779	(2,477)
Non-pay Costs	11,413	7,428	3,985	67,238	69,136	(1,898)
Finance & Capital	1,015	793	222	9,941	9,104	838
Operating Expenditure	**26,982**	**23,141**	**3,841**	**220,481**	**224,019**	**(3,537)**
SURPLUS / (DEFICIT)	**4,934**	**6,499**	**1,565**	**3,870**	**285**	**(3,585)**

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).

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Medicine (Sarah Watson)

The division reported a favourable variance of £161k, in month (£996k YTD).

Clinical income exceeds plan by £334k 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 the budget.

In month, the winter wards recorded a £130k overspend against budget, split £107k pay costs and £23k non-pay costs, accounting for the majority of the overspends noted for the division (£156k pay, £17k non-pay). The YTD position (£277k and £55k overspent respectively) takes into account the overspend noted in May and June 2019, 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 M10 (£751k) reflects a £90k improvement since M9.

Excluding the winter wards and clinical income, the Medicine Division is now forecasting a £25k overspend (excluding clinical income) for this financial year.

Surgery (Simon Taylor)

The division reported a favourable variance of £161k in month (£1.1m adverse variance YTD).

Income overachieved by £119k in month and has underachieved (£809k) year to date (YTD). Surgery did not achieve its elective admitted patient care plan, mainly in Orthopaedics, due to reduced elective bed capacity on F4 because of winter pressures. Surgery over achieved against its non-elective plan, mainly in Orthopaedics.

Pay overspent by £17k in the month and has a £530k YTD overspend. Nursing expenditure continues to overspend however the expenditure has reduced for

two consecutive months. Medical staffing is underspent and is helped by the continued low use of additional sessions.

Non pay is underspent by £59k in month (£272k YTD). Prosthesis has underspent due to the reduction in elective orthopaedic procedures. However, drugs expenditure increased significantly due to clinical need. Work will be done to understand the change in patient mix.

Women and Children's (Rose Smith)
In January, the Division reported an adverse variance of £289k (£900k YTD).

Income reported £188k behind plan in-month (£494k YTD). The year to date position has been dictated by low levels of neonatal and non-elective activity.

Pay reported a £77k overspend in-month (£396k YTD). In-month, the overspend was driven by the medical staffing gaps in Paediatrics and RTT pressures in Gynaecology. Year to date, the Division has experienced cost pressures from covering gaps on the tier two medical staffing rota in Paediatrics, RTT medical staffing spends in Gynaecology and additional costs from opening beds on F10. The Paediatric Department are in the process of recruiting an acute consultant with the interview date planned for the 12th March.

Non-pay reported a £25k overspend in-month (£10k YTD). In-month there were a number of cost pressures ranging from recurring drugs pressures to non-recurring costs relating to door security.

Clinical Support (Rose Smith)
In January, the Division reported an adverse variance of £155k (£843k YTD).

Income for Clinical Support reported £8k behind plan in-month and £90k ahead of plan YTD. Year to date, the Division has had high levels of outpatient and breast screening activity which has driven the favourable income position.

Pay reported a £1k overspend in-month and is £85k underspent YTD. In month, the overspend was driven by cost pressures from activity pressures in Diagnostics and a locum microbiologist covering gaps in the consultant rota. Year to date, the vacancy gaps in Outpatients and Pharmacy staffing have more than offset the pay pressures experienced from the high levels of demand experienced by Radiology.

Non-pay reported a £146k overspend in-month (£1,018k YTD). In month, the overspend was driven by activity pressures in Diagnostics and slippage in the Synertec cost improvement scheme. Year to date, the demand related pressures in Radiology have put constant pressure on the Division's non-pay budget.

Community Services and Integrated Therapies (Michelle Glass)
The division reported a favourable variance of £4k in month, (£368k adverse variance YTD)

Income reported a £103k over recovery in month, (£330k YTD) following an agreement to recover some costs incurred by the Division.

There was an in-month over spend on pay of £37k, (£31k 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 meet demand, ensure service resilience and to support patient flow.

Non-pay reported an adverse variance of £62k, (£668k YTD). The in-month position reflects a backdated charge for cleaning and increased expenditure on Community Equipment and associated activity costs, 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 the final quarter of the financial year, 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.

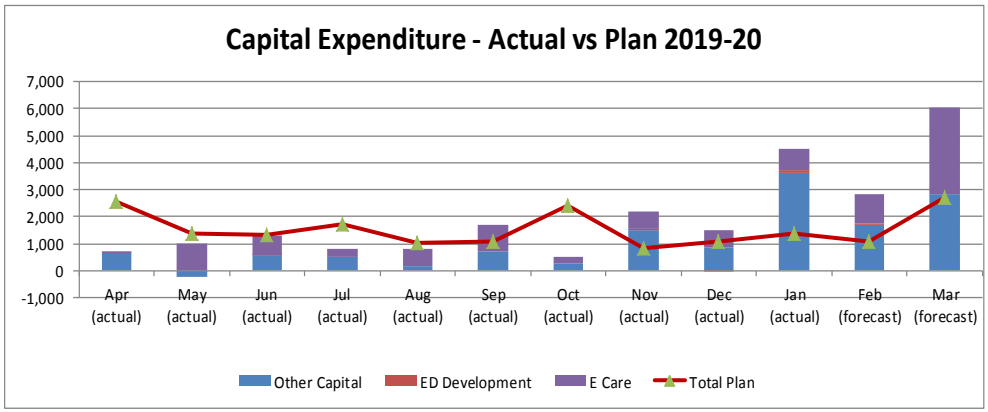
Metric	Value	Score	Plan	Forecast
Capital Service Capacity rating	1.2	4	4	4
Liquidity rating	-25.8	4	4	4
I&E Margin rating	0.10%	2	2	2
I&E Margin Variance rating	0.20%	1	1	1
Agency	-16.0%	1	1	1
Use of Resources Rating after Overrides		**3**	**3**	**3**

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 Forecast £'000	Mar Forecast £'000	Total 2019-20 £'000
E Care	34	1,019	743	290	679	1,018	214	640	608	839	1,070	3,213	10,367
ED Development	0	0	0	0	0	0	0	60	-40	99	32	0	151
Other Schemes	636	-242	534	512	138	683	278	1,494	875	3,598	1,713	2,848	13,067
Total / Forecast	670	777	1,277	802	817	1,700	492	2,194	1,444	4,536	2,814	6,060	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. This funding has meant that delayed schemes can now commence. 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. This will be challenging but is achievable and the forecast reflects meeting this requirement.

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 31st January 2020

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2019	Plan 31 March 2020	Plan YTD 31 January 2020	Actual at 31 January 2020	Variance YTD 31 January 2020
	£000	£000	£000	£000	£000
Intangible assets	33,970	35,940	35,794	35,885	91
Property, plant and equipment	103,223	115,395	114,716	118,732	4,016
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**	**154,935**	**159,671**	**4,736**
Inventories	2,698	2,700	2,700	3,002	302
Trade and other receivables	22,119	20,000	20,000	33,281	13,281
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	1,231	1,891	660
Total current assets	**29,324**	**23,750**	**23,931**	**38,174**	**14,243**
Trade and other payables	(28,341)	(32,042)	(30,082)	(32,797)	(2,715)
Borrowing repayable within 1 year	(12,153)	(3,134)	(3,134)	(18,176)	(15,042)
Current Provisions	(47)	(20)	(20)	(47)	(27)
Other liabilities	(1,207)	(992)	(2,501)	(2,265)	236
Total current liabilities	**(41,748)**	**(36,188)**	**(35,737)**	**(53,285)**	**(17,548)**
Total assets less current liabilities	**129,823**	**143,322**	**143,129**	**144,560**	**1,431**
Borrowings	(84,956)	(99,186)	(99,536)	(90,057)	9,479
Provisions	(111)	(150)	(150)	(111)	39
Total non-current liabilities	**(85,067)**	**(99,336)**	**(99,686)**	**(90,168)**	**9,518**
Total assets employed	**44,756**	**43,986**	**43,443**	**54,392**	**10,949**
Financed by					
Public dividend capital	69,113	70,430	69,793	69,934	141
Revaluation reserve	6,931	9,832	8,021	6,931	(1,090)
Income and expenditure reserve	(31,288)	(36,276)	(34,371)	(22,473)	11,898
Total taxpayers' and others' equity	**44,756**	**43,986**	**43,443**	**54,392**	**10,949**

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 for £8.5m 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 plus amounts owed by ESNEFT of £3m which are due to be settled imminently.

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 continue to increase and have increased by £1.6m since December. This is partly due to the Trust continuing to hold back payments, but also an increase in capital creditors due to us purchasing a large amount of capital items in the last quarter, for which we are waiting to receive funding for.

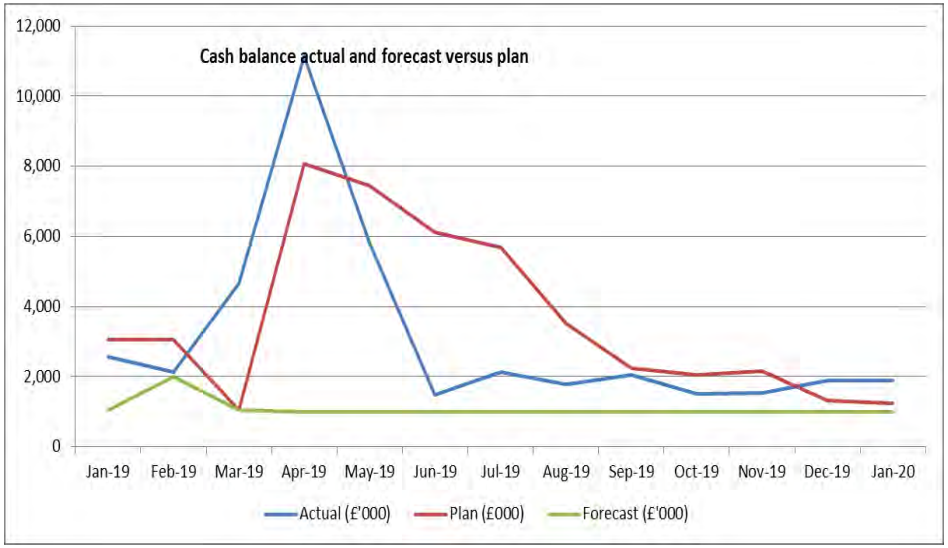
Borrowing

Our borrowing requirements continue to be kept under close review. To date the Trust has borrowed £7.6m against the reported deficit up to month 9. The Trust has also received £3m of advanced PSF in January. As the Trust is now expected to achieve a breakeven position at the end of the year, we are unable to request any further revenue borrowing. To date we have received £7.4m of capital loans. We will receive an additional £0.8m in March.

FINANCE AND WORKFORCE REPORT – JANUARY 2020

Cash Balance Forecast for the year

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



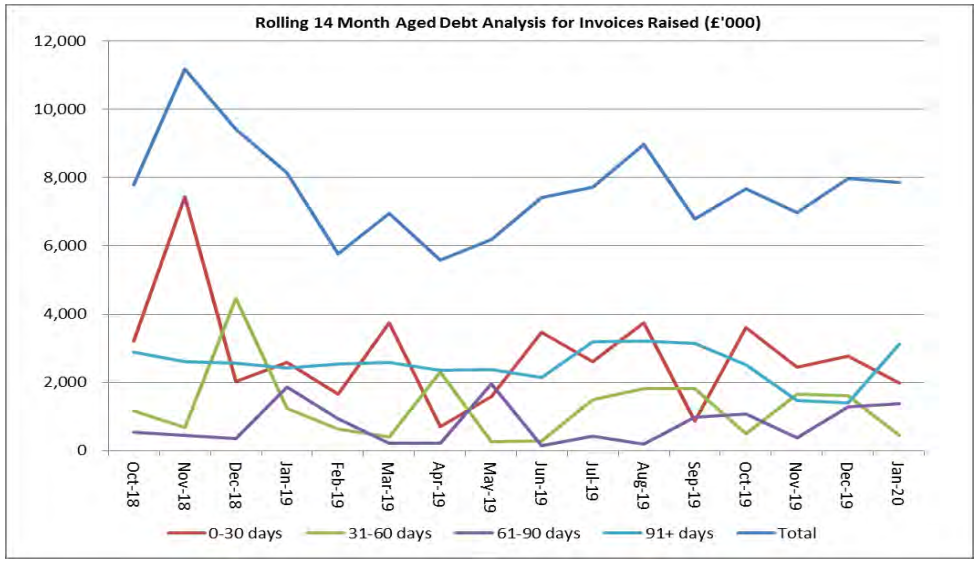
The January 2020 cash position is slightly better than planned. This is mainly due to us continuing to hold back payments towards the end of the Month.

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

We are forecasting to achieve a £1m balance at the end of each month and at the end of the year. No further borrowing will be required for 2019/20 as long as the CCG settles the large debtor balance owed to us for additional activity performed during the year. This will also mean that the Trust will be able to settle a large number of historic creditor balances with other NHS Organisations.

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 £1m since October. Over 77% of these outstanding debts relate to NHS Organisations, with over 56% 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.

The above does not include the £10m due from the CCG, which is expected to be settled in March.

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

10. CQC inspection report

To RECEIVE the CQC report and approve the recommendations

For Report

Presented by Rowan Procter

Board of Directors – 28 February 2020

Agenda item:	10			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Rowan Procter, Executive Chief Nurse			
Date prepared:	20 February 2020			
Subject:	CQC inspection report			
Purpose:		For information	X	For approval

1. Introduction

The Trust's inspection report (Annex A) was **published by the Care Quality Commission** (CQC) on Thursday, 30 January 2020. The issues raised by the CQC have been covered in a number of sessions with the Governors prior to publication of the final report.

It is clear that there will be ongoing focus from the media in relation to the **internal investigation**. A review of this investigation process is being commissioned by NHS Improvement, and overseen by Ed Argar MP, Minister of State at the Department of Health and Social Care. An independent review with maximum transparency is the right way forward, and we are in support of this approach and again, hope to learn from the results. It remains very challenging that personal which forms part of an internal investigation is being played out within the media – we will continue to try to balance transparency with the rights of individuals to confidentiality.

2. Summary of findings

The CQC rated us 'requires improvement' overall, with 'good' for being effective and caring, and 'requires improvement' for being responsive, well-led, and safe. Of our individual service ratings:

- 42 are rated 'good' or 'outstanding'
- 11 are rated as 'requires improvement'
- One is rated as 'inadequate'.

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

There are four main themes of concerns:

- **Culture**, particularly relating to some people not feeling able to raise concerns
- **Organisational responsiveness**, particularly around our referral to treatment times, and how quickly the Trust handled an investigation into a patient surveillance issue

- **Maternity services**, following the Trust being issued with a warning notice immediately after the inspection. Our maternity teams have worked incredibly hard over the last month to address concerns raised by the CQC and are reporting back to inspectors weekly on progress – they've made improvements on all actions and some are now already at 100%.
- **Missing some of the basics**, like some areas not being up-to-date on mandatory training, and not fully managing infection risks, medicines management, or record keeping well enough.

But **staff have rightly been praised**:

- Staff 'treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions'
- Staff 'gave patients and those close to them help, emotional support and advice when they needed it to minimise their distress.'
- 'Doctors, nurses and other healthcare professionals worked together as a team to benefit patients'
- 'The Trust promoted equality and diversity within and beyond the organisation'

3. Improvement plans

The CQC report contained a total of 74 findings - **32 MUSTs and 42 SHOULDs**. Critically the focus has been on addressing the **immediate safety concerns** and plans are being discussed with key groups for how we **look at our culture and openness**.

The immediate response to ensure **improvement in maternity services** ensured that all requirements following the warning notice were implemented with immediate effect. To ensure embedding weekly audits are undertaken until assurance of sustained improvement can be made. The most recent weekly audits for the areas of concern show:

- maternity early obstetric warning scores (**MEOWS**) shows three of the five areas achieving 100% compliance. The exceptions relate to Labour Suite where three out of 65 observations were incomplete (temperature, urine and BP only) and F11 where five out of 78 observations was incomplete - urine (4) and blood pressure (1).
- newborn early warning trigger & track (**NEWTT**) achieved 96% compliance. One observation was not signed and one missed oxygen saturation (completed fully at next set of observations). In line with our action plan these omissions were discussed with the individual staff members involved.
- For **domestic violence**, 89% of women audited had unaccompanied/ accompanied status documented (missing data was in the antenatal clinic) and 97% of women who were unaccompanied were asked about domestic violence and this was documented. Missing data per location (one in antenatal clinic).
- For **CO monitoring**, one woman (antenatal clinic) did not have CO monitoring at 36 weeks, therefore 97% compliance. For those women who indicated they were smoking or had given up smoking in the last 12 months, all had their CO monitoring completed therefore 100% compliance. Of this group, 100% were offered smoking cessation referral and a smoking discussion was documented.

The Trust wide audit tool has been implemented in maternity services and will be used as the objective audit tool. This objective audit will be undertaken as part of:

- the weekly quality review that is led by the executive chief nurse and includes, Chair, CEO, Governor, CCG representative
- Peer review
- Quarterly Trust wide mock CQC visits which includes – senior clinical teams and Trust board

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 (please not some CQC findings have been subdivided to provide greater clarity).

Exec lead	No. findings[1]
Craig Black	3
Helen Beck	18
Jeremy Over	13
Nick Jenkins	5
Rowan Procter [2]	37
Steve Dunn	2

[1] Note that some findings have been subdivided therefore the numbers do not tally to the number of findings in the CQC report.
[2] *20 of 37 relate to maternity services*

A **master spreadsheet** captures all of the CQC findings and holds summary details, such as accountability and summary of improvement. This is underpinned by an improvement plan for each of the CQC findings prepared by the responsible executive.

The Trust's response to the CQC report will be presented at a **Quality Summit** on 4 March. This will include representation from regulators and the regional team in order to assess the plans and consider the resource requirements to deliver the planned improvements.

4. Monitoring and assurance

Progress against the CQC findings will be **monitored through a weekly report** to the Executive directors. This will be populated by summary report from each executive with escalation of any actions off trajectory for delivery. This escalation will outline the problem encountered and proposed remedial action. Monthly progress reports will also be monitored by the Scrutiny Committee and Board. Regular reporting will also be put in place so that the NEDs are able to provide assurance to the Governors of plans and improvement.

As part of the improvement plan the action to address each of the CQC findings will identify the source of assurance for the effectiveness of the action taken. In addition, it is proposed to develop the weekly Quality Walkabouts to provide a structured assessment of ward and departments environments and test:

1. Patient experience
2. Staff engagement
3. Observations/environment

Further details of this proposed development are provided in Annex A of this report.

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 to note the report and formally receive the CQC inspection report
2. The Board to approve the proposed arrangements for implementing and monitoring improvements, with the final approval plan, following the forthcoming Quality Summit, being received by the Board in March
3. The Board approve the proposed pilot use of the Perfect Ward App to test CQC improvement compliance

Annex A: Quality Walkabout proposal
Annex B: Final CQC inspection report

Annex A: Quality walkabout proposal

1. Background

The primary purpose of our quality walkabouts remains the opportunity to engage with staff and patients in a structured way in order to hear issues and concerns. The approach has also allowed us to test some of the key aspects of quality and compliance.

2. Proposal

We have always tried to maintain an aspect of informality to the walkabouts to support the engagement with staff and patients. However, there is an opportunity to use the quality walkabouts to focus aspects of compliance testing, including issues raised within the CQC report. With this in mind it is proposed to use the Trust's Perfect Ward app to structure the Quality Walkabouts based on the App's inspection reports for:

4. Patient experience (see Annex 1 for sample questions)
5. Staff engagement
6. Observations/environment

The Perfect Ward App is currently being developed so that from March it will also allow actions to be captured contemporaneously as part of the process. Through this use of the Perfect Ward App at the end of a quality walkabout it is anticipated that a report can be generated which can be shared with those that took part in the walkabout as well as the area's manager.

This feels like the right thing to do but we would like to test the approach and run some rapid plan, do, study act (PDSA) cycles to test and refine the approach and inform a decision as to whether the approach works for all involved.

3. Recommendation

Rowan Procter leads PDSA cycles to develop and test the use of the Perfect Ward App to structure and report on quality walkabout within the Trust. The evaluation to include feedback from governors, NEDs, executives and ward staff and be used to inform the decision to adopt the approach. A report on the pilot to be reported to the Council of Governors meeting in May 2020.

Evaluation criteria for the pilot to include:

- availability of an appropriate and timely summary report following each walkabout
- clarity on action to be taken based on each walkabout findings
- ability to provide assurance that actions identified as part of walkabouts have been taken

Annex 1: Perfect Ward App

Patient experience inspection type questions

Caring /complaints
Do you have any concerns about the care you are receiving?
If you've had a concern about the care you are receiving, have you spoken to any member of the team?

Cleanliness
Do you see staff cleaning their hands? (In Community: are you aware of staff washing their hands?)
Is the ward/unit and bathroom/toilet always clean?
Any concerns re: ward furniture or fittings or play equipment?

Meeting nutritional needs
Are you offered different choices of food & drink?
Is drinking water always available?
Are you offered a chance to clean your hands before eating?
Do staff help you to eat or drink?

Person centred care
Do you understand explanations given to you by clinical staff today?
Have you been involved in discussions about your care?
Do staff introduce themselves?
Do staff treat you with dignity and respect?
Do you know who your Consultant is?
Do you know how to get your examination results?
Do staff give you help with hygiene needs?
Were you happy with your wait within the department?
Do you know the plan for your discharge?
Do you know who to contact if you needed support?
Do you know who is looking after you today?
[If you needed help with feeding your baby, has someone been able to help?]
Does the same staff member visit to carry out your care on a regular basis?

Safe & appropriate care
Did staff make efforts to make sure the environment is peaceful and calm?
Do staff check your identity before giving medications?
Are medications given on time?
Do staff explain your medications to you in a way you understand?
Is your call bell always been within reach?

West Suffolk NHS Foundation Trust

Inspection report

Hardwick Lane
Bury St Edmunds
Suffolk
IP33 2QZ
Tel: 01284713000
www.wsh.nhs.uk

Date of inspection visit: 24.09.2019 to 30.10.2019
Date of publication: 30/01/2020

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**
Use of resources rating for this trust	**Good**
Combined quality and resource rating for this trust	**Requires improvement**

Summary of findings

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Background to the trust

West Suffolk NHS Foundation Trust (WSFT) provides hospital and community healthcare services to people mainly in the west of Suffolk and is an associate teaching hospital of the University of Cambridge. WSFT was awarded foundation trust status in December 2011.

WSFT serves a predominantly rural geographical area of roughly 600 square miles with a population of around 242,000. The main catchment area for the trust extends to Thetford in the north, Sudbury in the south, Newmarket to the west and Stowmarket to the east. Whilst mainly serving the population of Suffolk, WSFT also provides care for parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

The community services cover a range of adult community services, specialist community services for children, young people and families and community hospitals inpatients. Services are delivered in a variety of settings including people's own homes, care homes, community hospital inpatient units and clinics, day centres, schools, GP surgeries and health centres.

Services provided by the trust are mostly commissioned by NHS West Suffolk Clinical Commissioning Group. The trust also has established working relationships with other providers of health and social care services across Suffolk and parts of Cambridgeshire. WSFT is a part of the Suffolk and North East Essex STP.

Acute core services provided by the trust include: urgent and emergency care, medical care (including older people's care), surgery, critical care, maternity, services for children and young people, end of life care, outpatients, gynaecology and diagnostic imaging.

The last inspection of the trust was undertaken between 9 November and 1 December 2017. This inspection comprised of two core services, end of life care and outpatients', and well led. At the 2017 inspection the trust was rated outstanding overall. Achieving outstanding ratings in effective, caring and trust wide well led. Safe, responsive and well led at service level were rated as good.

We inspected the trust between the 24 September and 30 October 2019. The core service inspection took place on the 24 and 25 September 2019, with three further unannounced inspections on the 8, 9 and 11 October 2019. A well led inspection at provider level took place between the 28 and 30 October 2019.

During this inspection we spoke with 237 staff of various grades including nurses, doctors, senior managers, allied health professionals, health care assistants, ward managers, ambulance staff, health visitors, occupational therapists, physiotherapists, audiologists, speech and language therapists, nursery nurses, locality leads, physiotherapy and occupational therapy staff, administrative staff and volunteers. We spoke with 70 patients and relatives and reviewed 135 patient records.

We found significant concerns and risks to patients within the maternity service which we raised with the trust at the time of inspection. Following the well led inspection, we undertook enforcement in respect of the maternity and midwifery service to enable the improvement of safety within the service. We issued a warning notice under Section 29A of the Health and Social Care Act 2008 on the 14 November 2019 and told the trust it must improve by 31 January 2020.

Summary of findings

Overall summary

Our rating of this trust went down since our last inspection. We rated it as Requires improvement

What this trust does

West Suffolk NHS Foundation Trust provides acute, maternity and community health services across the following three locations; West Suffolk Hospital, Newmarket hospital and Glastonbury Court.

Acute services are provided at West Suffolk Hospital and encompass urgent and emergency care, planned medical and surgical care, critical care, consultant led maternity, neonatal and paediatric care, end of life care and diagnostic and therapy services. There is a purpose built Macmillan unit for the care of people with cancer, a dedicated eye treatment centre and a day surgery unit. WSH has a total of 442 inpatient beds, 25 day case bed,10 children's beds and 14 operating theatres, including three in day surgery and two in the eye treatment centre.

Rosemary Ward at the Newmarket Community Hospital (NCH) is a 19 bedded reablement service.

Glastonbury Court is a care home in Bury St Edmunds run by Care UK. WSFT has commissioned one of the 20 bedded units to provide ongoing assessment and reablement.

The trust employs 3,418 staff (March 2019 figures), including 378 medical, 824 nursing and 2216 'other'.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected five of the acute core services and all three of the community services provided by this trust as part of our continual checks on the safety and quality of healthcare services.

We also inspected the well-led key question for the trust overall. We summarise what we found in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust went down. We rated it as requires improvement because:

Summary of findings

- We rated safe, responsive and well led as requires improvement and effective and caring as good. Ratings for all five key questions, safe, effective, caring, responsive and well led had gone down. The rating for the well led question at trust level had gone down from outstanding to requires improvement.
- We rated three of the trust's five acute core services as requires improvement (maternity, medical care and outpatients) and two as good (urgent and emergency care and surgery). Overall ratings for urgent and emergency care and surgery had remained the same, medical care and outpatients had gone down. We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. In rating the trust, we took into account the current ratings of the three services not inspected this time. We rated all three community services as good overall, with safe, effective, caring, responsive and well led rated good. Community health services had not been rated previously.
- Processes for identifying, recording, escalating and managing risks across the organisation were not always fully effective or undertaken in a timely manner . There were inconsistent approaches to managing safety. Not all services controlled infection risk well. Completion of patient risk assessments, documentation and record keeping varied. Medicines management, including security and storage of medicines was inconsistent. Staff training and compliance in key skills fell below trust target, specifically for medical staff. Clinical and internal audit processes were not always fully effective across all services.
- Services do not always meet people's needs. People could not always access services for assessment, diagnosis or treatment when they needed to. The trust continued to underperform across a large range of national access standards, in particular those related to the national 18 week referral to treatment (RTT) standard, the six week diagnostic standard and access standards related to suspected and confirmed cancer management. Action to address this were not effective and at a global trust level, the number of patients on the RTT waiting list was substantially higher than 12 months previously, reflecting a lack of systemic waiting list control.
- Not all systems produced reliable information that supported staff to develop and improve performance. Ongoing issues with e-Care had impacted on the ability and accuracy to report service performance specifics, such as referral to treatment time and theatre utilisation.
- Not all staff felt respected, supported and valued or felt that they could raise concerns without fear. Communication and collaboration to seek solutions had not always been effectively undertaken. An open culture was not always demonstrated
- The style of executive leadership did not represent or demonstrate an open and empowering culture. There was an evident disconnect between the executive team and several consultant specialties. Whilst priorities and issues were known and understood these were not always managed in a consistent way.

However:

- Services had enough staff to care for patients. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them in their work.

Summary of findings

Our full Inspection report summarising what we found and the supporting Evidence appendix containing detailed evidence and data about the trust is available on our website – .

Are services safe?

Our rating of safe went down. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- There was limited assurance that systems, processes and procedures across all services, were reliable or appropriate to keep people safe. Risks to patients who used services were not always assessed, monitored and managed appropriately, particularly within the maternity services and the emergency department.
- Safety concerns were not consistently identified or addressed quickly enough. Incidents were not always reported in a timely manner and wider lessons were not identified or shared effectively to improve patient safety. Not all services used monitoring results to improve patient safety.
- Within outpatient services there was lack of robust systems to identify and track patients requiring a follow up appointment or those on surveillance pathways. Actions had not been undertaken in a responsive manner once concerns were known. This had resulted in significant patient safety risk within the vascular service, and an extended period of time where potential risk across other specialties remained unknown.
- Staff did not always keep appropriate records of patients' care and treatment. Staff did not always complete risk assessments documentation which meant a delay in escalating, removing or minimising risks.
- Medicines management was inconsistent. Processes to store medicines securely did not always follow relevant national guidance.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe. This included community health services for children and young people where facilities for audiology assessments in the Ipswich child development centre were not fit for purpose.
- Consistent and effective documentation for mortality and morbidity meetings was not recorded in all services. An internal review into learning from deaths identified that areas for improvement into wider learning and overview of themes remained.
- Mandatory training compliance rates, specifically for medical staff, continued to fall below trust targets.

However:

- Services had enough medical, nursing and support staff with the right qualifications, skills, training and experience to provide care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Are services effective?

Our rating of effective went down. We took into account the current ratings of services not inspected this time. We rated it as good because:

- The majority of services provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Summary of findings

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide multidisciplinary care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However:

- Not all national audits had actions plans to address all areas of concern that required improvement.
- There were concerns within maternity services there was a risk that not all women were receiving effective care or treatment. There was a lack of consistency in the effectiveness of the care, treatment and support that women received. Concerns included out of date guidelines, monitoring of women's pain and ensuring staff were competent for their roles. Midwifery appraisal rates were not met and there were no supervision meetings in place to provide staff support and development.
- Within the community inpatient services, staff were unaware of the monitoring that the trust performed for the effectiveness of care and treatment. They were unable to use the findings to make improvements in outcomes for patients.

Are services caring?

Our rating of caring went down. We took into account the current ratings of services not inspected this time. We rated it as good because:

- Across all services staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff gave patients and those close to them help, emotional support and advice when they needed it to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. A family centred approach was observed in the community children and young people service. Staff recognised the importance of confidentiality and enabling people to manage their own health and care where possible.

Are services responsive?

Our rating of responsive went down. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- People could not always access services for assessment, diagnosis or treatment when they needed to. Waiting times from referral to treatment varied, with some specialties better and some worse than national standards.
- The trust continued to underperform across a large range of national access standards, in particular those related to the national 18 week referral to treatment (RTT) standard, the six week diagnostic standard and access standards related to suspected and confirmed cancer management.
- There was no process in place for monitoring patients requiring a follow up appointment. The outpatients service were unaware of the number of patients who may have been lost to follow up. There was no process in place to monitor the average waiting times for a follow up appointment.

Summary of findings

- Delays in diagnostic test results meant that clinic appointments were often wasted.
- Complaints were not investigated and closed within the deadline set in the trust's internal policy.

However:

- It was easy for people to give feedback and raise concerns about care received. Concerns and complaints were taken seriously, investigated and lessons learned shared with staff.

Are services well-led?

Our rating of well-led went down. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- The leadership, governance and culture do not always support the delivery of high quality person centred care. Leaders did not always use systems to identify and escalate relevant risks and issues. Actions were not always identified or monitored effectively to ensure mitigation was in place.
- Within maternity services we raised concern over the skills and abilities of leaders to run the service. Leaders were not effective at implementing meaningful changes that improved safety culture within the organisation.
- Not all staff felt respected, supported and valued or felt that they could raise concerns without fear. Communication and collaboration to seek solutions had not always been effectively undertaken. An open culture was not always demonstrated. Staff that raised concerns were not always appropriately supported or treated with respect. Concerns were not consistently investigated.
- Risk, issues and poor performance were not always dealt with appropriately or quickly enough. The risk management approach was applied inconsistently. Clinical and audit processes were inconsistent in their implementation and impact.
- Leaders and teams did not always use systems to manage performance effectively. Issues with the accuracy and availability of data, affected managers' ability to manage performance effectively at times. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Patient information systems were not fully integrated across the community services. Information used in reporting, performance management was not always accurate, valid or reliable.
- Within the community services, the cascade of governance issues through team meetings were not always in place and there was a lack of clinical audit. Local processes to collect, analyse and review data to improve performance and patient care were not embedded.

However:

- Across services leaders actively engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- The trust had in place a clear vision, focused priorities and ambitions that were unchanged from our previous 2017 inspection. The vision, values and strategy had been developed with all relevant stakeholders and was understood by leaders and staff across the organisation.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Use of resources

We rated use of resources as good because:

Summary of findings

The NHS foundation trust compares well (nationally), across most productivity metrics covered in this assessment, which indicates better utilisation of its workforce and facilities. It has a good track record of managing expenditure within its financial plans and has achieved its control totals for each of the last three years, however at the time of the assessment the NHS trust was reporting an adverse variance to its financial plan and had identified significant risks to achieving its control total for 2019/20, which largely due to demand and workforce related cost pressures.

Please see the separate use of resources report for details of the assessment and the combined rating. The report is published on our website at www.cqc.org.uk/provider/RGR/Reports.

Combined quality and resources

We rated combined quality and resources as requires improvement because:

- We rated safe, responsive and well-led as requires improvement; and effective and caring as good.
- We took into account the current ratings of the three core services at West Suffolk hospital not inspected at this time.
- We rated three services as requires improvement across the trust overall. We rated the remaining two acute services as good. We rated the three community health services as good.
- The overall rating for the trust's acute location went down.
- The trust was rated good for use of resources.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services, and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in community health services for children and young people.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including 32 breaches of legal requirements that the trust must put right. We found 45 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued five requirement notices to the trust and undertook enforcement action in relation to significant concerns within the maternity and midwifery service. That meant the trust had to send us a report saying what action it would take to meet these requirements. We issued a warning notice under Section 29A of the Health and Social Care Act 2008 on the 14 November 2019 and told the trust it must improve by 31 January 2020.

Our action related to breaches of legal requirements at a trust-wide level and seven of the eight core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

Summary of findings

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found the following outstanding practice:

Community health services for children and young people.

- An emotional well-being care pathway had been developed, in conjunction with other services.
- Multi-disciplinary and multi-agency working was particularly strong.
- Physiotherapists were linking with sports gyms in the locality to jointly provide gym groups for five to 11 year olds and 11 to 18 year olds with cerebral palsy.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with 32 legal requirements. This action related to the trust overall and seven services.

Trust wide

- 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. Regulation 17 (1)(2a,e).
- The trust must ensure the culture supports the delivery of high quality sustainable care, where staff are actively encouraged to speak up raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care. Regulation 12 (1)(2i).
- 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. Regulation 12 (1)(2).
- The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. There must be robust processes in place to ensure that implementation and impact of clinical, internal and national audit processes, mortality reviews, incident and complaints are monitored and reviewed to drive service improvement. Regulation 17(1)(2).
- 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. Regulation 17(1)(2).

Summary of findings

- 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. Regulation 17 (1)(2,a).
- 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. Regulation 17(1)(2).
- The trust must continue to develop information technology systems and integration across the community services. Regulation 17(1)(2).
- 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. Regulation 12 (1)(2a,b)
- The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance. Regulation 20.
- The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation. Regulation 5.
- 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. Regulation 12 (1)(2c).

Urgent and emergency services

- 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. Regulation 12 (1)(2a,b,h).
- The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy. Regulation 12 (1)(2g).
- The trust must ensure that staff records in relation to equipment and medication checks are completed. Regulation 12 (1)(2e).

Medical care (including older people's care)

- 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. Regulation 12(1)(2g).
- The trust must ensure that all bank and agency staff have documented local inductions. Regulation 18 (2)(a).

Surgery

- The trust must ensure that medicines are stored securely within the main and day surgery theatre department. Regulation 12(1)(2g).

Maternity

- The trust must improve monitoring ambient room temperatures in drugs rooms. Regulation 12(1)(2g).
- The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly. Regulation 17(1)(2c).
- The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy. Regulation 12 (1)(2a,b).
- The trust must ensure that women are asked about domestic violence in line with trust policy. Regulation 12 (1)(2a,b).

Summary of findings

- The trust must ensure that they implement a nationally recognised monitoring vital observations tool for women attending triage on labour suite and the maternity day assessment. Regulation 12 (1)(2a,b).
- The trust must ensure they implement a national recognised monitoring vital observations tool for new born babies on the labour suite and F11 ward. Regulation 12 (1)(2a,b).
- The trust must ensure they carry out daily checks of resuscitation equipment. Regulation 12 (1)(2e).
- The trust must ensure clinical guidelines are up to date. Regulation 17 (1)(2b)

Outpatients

- The trust must ensure patients can access the service when they need it and receive the right care promptly in line with national targets. Regulation 12 (1)(2a,b).
- The trust must ensure diagnostic test results are available in a timely manner. Regulation 12 (1)(2a,b).
- The trust must ensure there is an effective process in place for monitoring patients requiring a follow up appointment and for those on surveillance pathways. Regulation 12 (1)(2a,b).

Community health services for adults

- The trust must ensure staff complete and record patient pain assessments in patient records. Regulation 17(1) (2c).

Community health services for children and young people

- The trust must ensure all staff complete mandatory training including safeguarding training. Regulation 12 (1)(2c).

Action the trust SHOULD take to improve

We told the trust that it should take action either because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Trust wide

- 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. Regulation 12.
- The trust should ensure that effective processes are in place to promote and protect the health and wellbeing of all staff. Regulation 18.
- The trust should ensure that complaints are responded to in a timely manner, within trust policy. Regulation 16.

Urgent and emergency services

- The trust should ensure all staff follow inspection, prevention and control procedures and bare below the elbow guidance at all times. Regulation 12.

Medical care (including older people's care)

- The trust should ensure that cleaning chemicals hazardous to health are stored in an appropriate locked location. Regulation 12.
- The trust should ensure that all sharps and syringes are stored securely away from patients and visitors. Regulation 12.
- The trust should ensure shared learning from never events with staff across the hospital. Regulation 12.

Summary of findings

- The trust should display safety thermometer data and utilise this to improve services. Regulation 17.
- The trust should ensure that appropriate action plans to address national audit shortfalls are implemented and effectively monitored. Regulation 17.
- The trust should ensure team meetings are undertaken to share information with ward staff. Regulation17.
- The trust should consider displaying information on how patients and visitors can lead healthier lives.
- The trust should continue to work to reduce the number of bed moves at night for non-clinical reasons.
- 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.

Surgery

- The trust should ensure effective processes are in place for oversight of referral to treatment times across all specialties with action plans in place to improve the specialties where national standards are not being met. Regulation 17.

Maternity

- The trust should ensure that the labour suite coordinator is supernumerary. Regulation 18.
- The trust should ensure a higher percentage of staff complete mandatory training including PROMPT. Regulation 12.
- The trust should ensure team meetings are held to share information with ward staff. Regulation17.
- The trust should ensure there is effective audit of the use of the World Health Organisations (WHO) and five steps to safer surgery checklist and take actions on results that do not meet trust standards. Regulation 17.
- The trust should ensure that staff report all incidents in line with trust policy. Regulation 12.
- The trust should ensure that they close incident investigations within trust deadlines. Regulation 17.
- The trust should consider displaying safety performance information.
- The trust should ensure that action plans are created and followed for national and local audits. Regulation 17.
- The trust should ensure that appraisal rates are met for staff. Regulation 18.
- The trust should ensure that processes are in place for the supervision of midwives. Regulation18.
- The trust should ensure the collection of friends and family data in all areas. Regulation 17.
- The trust should ensure consumable equipment is not opened prior to use to prevent infection prevention and control risks. Regulation 12.
- The trust should ensure an evidence-based bereavement care pathway is put in place. Regulation 12.
- The trust should ensure that women's pain scores are consistently completed. Regulation 17.

Outpatients

- The trust should consider security enabled doors in the paediatric outpatient department.
- The trust should consider a system to monitor the average waiting times for a follow up appointment.

Community health services for adults

Summary of findings

- The trust should continue to improve mandatory training completion rates to meet the trust's target completion rate of 90%.
- The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.

Community health services for children and young people

- The trust should ensure that governance and oversight are strengthened to ensure performance and local audit are monitored and measured to improve practice. Regulation 17.
- The trust should ensure that processes are in place and effective to monitor compliance with best practice and national guidance relevant to the service. Regulation 17.
- The trust should ensure records are maintained to show cleaning has been completed in line with cleaning schedules. Regulation 12.
- The trust should ensure that facilities for audiology assessments in the Ipswich child development centre improve. Regulation 15.

Community health inpatient services

- The trust should consider using an acuity tool to assess whether there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The trust should continue to improve mandatory training in key skills to all staff to meet trust targets.
- The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.
- The trust should ensure that patients individual needs and preferences are taken into account when planning care. Regulation 9.
- The trust should ensure that all senior leaders have the skills to access and use patient outcome data to improve services. Regulation 18.
- The trust should ensure that individual goals and outcome measures are routinely monitored and audited to improve care. Regulation 17.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust went down. We rated well-led as requires improvement because:

- There was an apparent disconnect between the executive team and several consultant specialties. Some staff felt that concerns were not recognised, which was impacting on consultant involvement with running of services. Staff stated the executive team listened but did not hear.
- We were not assured that the significance of the concerns being raised, and subsequent consultant disengagement, had been fully acknowledged by the executive directors. Proactive actions to attempt to address and repair leadership relationships in an effective, timely manner had not taken place.

Summary of findings

- There were some inconsistencies in the record completion of all of the relevant checks and appraisals required under Regulation 5: Fit and Proper Persons.
- Not all staff felt the culture encouraged openness and honesty. Not all staff felt respected, supported and valued or felt that they could raise concerns without fear. This impacted negatively on the ability of staff to challenge and discuss options for mitigating risk.
- Communication and collaboration to seek solutions had not been effectively undertaken in a number of specialties where concerns relating to clinical risk and safety had been raised.
- We were not assured that the trust had acted in line with its own policy or taken reasonable steps to ensure Regulation 20: Duty of candour, had been appropriately applied by being fully open and transparent in relation to vascular lost to follow up concerns.
- Certain actions taken in relation to internal investigations were unusual and of concern. Communications to staff were perceived by some staff as threatening in nature, with a focus on apportioning blame. We were concerned that these actions could discourage staff from raising concerns and could potentially limit wider analysis of patient safety issues.
- Processes for identifying, recording, escalating and managing risks across the organisation were not always fully effective or undertaken in a timely manner. Clinical and internal audit processes were not always fully effective across all services.
- There had been a delayed response to investigate and address concerns in relation to vascular lost to follow up patients, conducting relevant harm reviews and providing adequate assurance that wider risk to patients has been mitigated.
- Processes for booking patents for follow up appointments and ensuring surveillance pathways were effective were not robust. The trust responded to our ongoing concerns and took steps to improve.
- There were continued concerns with the integration between the trust's digital partner and several of the trust systems. Demands being placed on internal information technology teams to continually seek alternative solutions and workarounds were significant.
- The trust was underperforming across a large range of national access standards, in particular those related to the national 18 week referral to treatment (RTT) standard, the six week diagnostic standard and access standards related to suspected and confirmed cancer management. Whilst steps had been taken to introduce performance recovery plans at subspecialty level, there was very limited evidence that such plans were delivering the necessary traction of improvement.
- Appropriate and accurate information was not always being effectively processed, which impacted on the reliability and analysis of data. Not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Participation in and learning from internal and external reviews, including those related to mortality or the death of a person, were not fully established

However:

- The trust has an established, experienced executive leadership team that had remained stable since our previous inspection in 2017. There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. All executive and non-executive directors were clear of their areas of responsibility and were visible and approachable in the service for patients and staff.

Summary of findings

- Leaders across the organisation had the skills and abilities to run services. There was a leadership and talent management strategy in place, that incorporated talent acquisition, development and career support and succession management.
- The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff were focused on the needs of patients receiving care. The trust promoted an open culture and were working on actions to improve reporting. The trust promoted equality and diversity within and beyond the organisation. The trust had a trans awareness in healthcare workshop on 21 May 2019, joined the NHS Rainbow badge scheme in June 2019, had a disabled staff network and an equality, diversity and inclusion (EDI) group.
- The trust had established governance processes throughout the organisation. The trust strategy and policy for risk management outlined clear roles and accountabilities at all levels throughout the organisation. Since our previous inspection in 2017 the trust had finalised, aligned and integrated the governance structures for the community services.
- Observational visits by board members and governors were undertaken as weekly quality walkabouts that covered both the hospital and community settings. A programme of presentations and patient stories relating to the quality priorities and strategic /service developments were delivered to the board and its subcommittees.
- Leaders across the organisation engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. .A joint based post of director of integration and partnerships had been established in January 2019 with West Suffolk clinical commissioning group.
- The NHS staff survey results 2018, published on 26 February 2019, identified as an overall indicator of staff engagement that the trust score of 7.4 was above the average (7.0) when compared with trusts of a similar type. This figure had remained constant since 2016.
- There were systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work.
- The trust had started recruiting partners of military personnel from the nearby airbase. The hospital and the base were working together to provide training on the differences between the NHS and the American healthcare system.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ Jan 2020	Good ↓ Jan 2020	Good ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓↓ Jan 2020	Requires improvement ↓↓ Jan 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency care	Requires improvement →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020
Medical care (including older people's care)	Requires improvement ↓ Jan 2020	Good ↓ Jan 2020	Good ↓ Jan 2020	Good →← Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020
Surgery	Requires improvement ↓ Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020
Critical care	Good Aug 2016	Outstanding Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Outstanding Aug 2016	Good Aug 2016
Maternity	Requires improvement Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Inadequate Jan 2020	Requires improvement Jan 2020
Services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good Jan 2018	Good Jan 2018	Outstanding Jan 2018	Good Jan 2018	Outstanding Jan 2018	Outstanding Jan 2018
Outpatients	Requires improvement ↓ Jan 2018	Not rated	Good →← Jan 2018	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018
Overall trust	Requires improvement ↓ Jan 2020	Good ↓ Jan 2020	Good ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓↓ Jan 2020

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↓ Jan 2020	Good ↓ Jan 2020	Good ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓↓ Jan 2020
Community	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Overall trust	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Community health services for children and young people	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Community health inpatient services	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Overall*	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2019	Good Jan 2019	Good Jan 2020

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Acute health services

Background to acute health services

The trust provides all eight core services at West Suffolk Hospital.

We inspected five of the eight acute core services: urgent and emergency care, medical care (including older people's care), surgery, maternity and outpatients.

Summary of acute services

Requires improvement  

Our rating of these services went down. We rated them as requires improvement.

The summary of West Suffolk Hospital services appears in the overall summary of this report.

West Suffolk Hospital

Hardwick Lane
Bury St Edmunds
Suffolk
IP33 2QZ
Tel: 01284713538
www.wsh.nhs.uk

Key facts and figures

West Suffolk Hospital is a small district general hospital in Bury St Edmunds, England. It is managed by the West Suffolk NHS Foundation Trust. The hospital has a total of 442 inpatient beds, 25 day case bed and 10 children's beds. There is a purpose-built Macmillan Unit for the care of people with cancer, a dedicated eye treatment centre and a day surgery unit where children and adults are treated. Access to specialist services is offered to local residents by networking with tertiary centres.

Services are provided 24 hours a day, seven days a week. Services at the hospital include: urgent and emergency care, medical care (including older people's care), surgery, critical care, maternity, services for children and young people, end of life care, outpatients, gynaecology and diagnostic imaging.

We inspected the hospital on the 24 and 25 September 2019. Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We also undertook a further three unannounced inspections on the 8, 9 and 11 October 2019. Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

We inspected five acute core services: urgent and emergency care, medical care (including older peoples care), surgery, maternity and outpatients.

During this inspection we spoke with 169 staff of various grades including nurses, doctors, senior managers, allied health professionals, health care assistants, ward managers, ambulance staff, administrative staff and volunteers.

We spoke with 45 patients and relatives and reviewed 78 patient records.

Summary of services at West Suffolk Hospital

Requires improvement ↓

Our rating of services went down. We rated them as requires improvement because:

- We rated safe, responsive and well led as requires improvement and rated effective and caring as good.
- Out of the five hospital services inspected we rated three as requires improvement and two as good. In rating the hospital overall, we took into account the current ratings of services not inspected this time.

Summary of findings

- The ratings for medical care and outpatients went down, whilst the ratings for urgent and emergency services and surgery stayed the same. Maternity was rated as requires improvement. We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.
- There was limited assurance about safety across all five services we inspected. Processes for identifying, recording, escalating and managing risks across the organisation were not always fully effective or undertaken in a timely manner. Safety concerns included, but were not limited to, infection control, the timeliness of patient risk assessments, patient record keeping, recording and storing of medicines, emergency equipment checks, and mandatory training compliance rates for medical staff. Staff training and compliance in key skills fell below trust target, specifically for medical staff.
- Within the maternity service there was a lack of consistency in the effectiveness of the care, treatment and support that people received.
- Services did not always meet people's needs. People could not always access services for assessment, diagnosis or treatment when they needed to.
- The leadership, management and governance across the services did not always support high quality patient care. Arrangements for governance and performance management were not always effective. Clinical and internal audit processes were not fully utilised to improve services. Not all systems produced reliable information that supported staff to develop and improve performance.

However:

- Services had enough staff to care for patients. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care.
- Staff across all five services inspected treated patients with compassion, kindness, dignity and respect. Patients were involved as partners in their care.

Urgent and emergency services

Good ➔➔

Key facts and figures

Details of emergency departments and other urgent and emergency care services

•West Suffolk Hospital accident and emergency department

•West Suffolk Hospital clinical decision unit

(Source: Routine Provider Information Request (RPIR) – Sites tab)

From April 2018 to March 2019, there were 74,400 attendances to the emergency department (ED) at West Suffolk Hospital. The highest attendance total for one day was 256 and the lowest was 141. Fifteen percent of the attendances were children.

The department includes two separate entrances for walk-ins and for ambulances. There are three separate waiting areas: one for GP streaming patients, one for the main emergency department and another for children.

Within the main treatment area there are: three bays for resuscitation (one for children); a high visibility bay; four bays for high dependency patients; one room for infection prevention; nine bays for low dependency patients; four see and treat bays; two paediatric rooms; one eye treatment room; and two triage rooms.

The clinical decisions unit (CDU) consists of two three bedded bays and four reclining chairs. There is a policy for identifying appropriate patients for placement in the CDU.

There is also a dedicated radiology room within the emergency department.

Due to the number of core services inspected, our inspection of West Suffolk Hospital was announced. Prior to our inspection we reviewed data we held about the service along with information we requested from the service. The emergency and urgent care service was rated as good overall following its last inspection in March 2016.

During our inspection, we spoke with 39 members of staff including doctors, nurses, health care assistants, ambulance staff and non-clinical staff. We visited the adult and children's emergency department, clinical decisions unit and the chaplaincy.

We spoke with seven patients including two children and reviewed 32 patient records and considered other pieces of information and evidence to come to our judgement and ratings. The service was participating in NHS England and NHS Improvement's Clinical Review of Standards field test of revised access standards. Reporting against the four-hour standard is not required by NHS England and Improvement during the field testing, which started in May 2019. CQC continue to inspect urgent and emergency care for the 14 pilot hospitals on the basis of risk, and rate responsiveness without the four hour standard data.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Urgent and emergency services

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's wider vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- The service did not always control infection risk well, we identified staff not bare below the elbows, wearing jewellery and not following the services infection control policy.
- Staff recording checks on controlled medicines, refrigeration temperatures and equipment were not consistent.
- Staff did not consistently complete patient safety checklists and general risk assessments, for example falls risks. Recording emergency equipment checks were not consistent.
- The management of risk around non completion of patient risk assessment and safety check lists required significant improvement.
- Leaders did not always use systems to manage performance effectively.
- Audit systems for record keeping were not effective in improving compliance with patient safety check lists.

Is the service safe?

Requires improvement  

Our rating of safe stayed the same. We rated it as requires improvement because:

- Although we found the service largely performed well, it did not meet legal requirements relating to Regulation 12, Safe care and treatment, meaning we could not give it a rating higher than requires improvement.
- The service did not always control infection risk well. Records in relation to cleaning of children's toys were not up to date and we observed some staff did not follow the trusts infection control procedures.
- Staff did not complete risk assessments for each patient swiftly which meant a delay in removing or minimising risks and updating assessments.
- Staff did not always keep detailed records of patients' care and treatment.
- Records in relation to the storage and checking of medicines and refrigeration temperatures were not always up to date. Recording emergency equipment checks were not consistent.

- The service provided mandatory training however not everyone completed it. Compliance rates were below trust target, specifically for medical staff.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The design, maintenance and use of facilities, premises, and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.
- The service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately.
- Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care and staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Urgent and emergency services

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- We observed examples of staff responding with kindness when patients needed help and support, even during exceptionally busy periods. Staff offered reassurance to patients who were in pain or frightened and we observed staff promoting patients.
- Staff gave patients and those close to them help, emotional support and advice when they needed it. During our inspection we talked with a trust chaplain who visited the department to offer emotional support for patients and their families, as well as supporting families though trauma and loss of a loved one.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Throughout our inspection, we observed staff introducing themselves and their role to patients they were caring for within the ED. Staff made sure patients and those close to them understood their care and treatment.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences.
- People could access the service when they needed it and waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- There was a visible leadership within the department, staff roles and responsibilities were coordinated effectively to manage patient care.

Urgent and emergency services

- Managers we spoke with were clear on the service's wider vision and mission and were universally supportive of the development of the new emergency department facilities.
- Staff we spoke with were universally proud to work for the service and there was a focus on collaboration to improve outcomes for patients.
- Leaders operated governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However:

- The management of risk around non completion of patient risk assessment and safety check lists required improvement.
- Audit systems for record keeping were not effective in improving compliance with patient safety check lists.
- Leaders did not always use systems to manage performance effectively.
- The service did not have a local strategy to turn it into action.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

Medicine provides services within 13 ward/clinical areas at West Suffolk Hospital.

- Ward G8 is a unit specialising in care of the stroke patient. It consists of four hyperacute stroke beds, 24 acute beds and six medical beds.
- The cardiac centre opened in November 2018 and consists of seven coronary care unit beds, 15 cardiac beds, a catheterisation laboratory and six recovery beds.
- G4 is an acute medical ward (32 beds) including two side-rooms for patients requiring isolation. It has a sub-speciality in care of the elderly and provides a dementia friendly environment.
- G5 is an acute medical ward (33 beds) including three side-rooms for patients requiring isolation, with a sub speciality of diabetes and nephrology.
- G9 is a winter escalation ward and in the summer is used as part of a deep cleaning programme.
- F8 is an acute respiratory unit (25 beds) divided between the respiratory therapy unit (RTU) comprised of 10 beds and acute medical/respiratory beds, comprised of 15 inpatient beds. This also includes three side rooms for patients requiring isolation. There is capacity for one recovery trolley and a chaired area for patients being assessed / treated in the pleural clinic.

(Source: Routine Provider Information Request (RPIR) – Acute context)

Due to the number of core services inspected, our inspection of West Suffolk Hospital was announced. Prior to our inspection we reviewed data we held about the service along with information we requested from the service. Medical care service was rated as outstanding overall following its last inspection in March 2016.

During our inspection, we spoke with 39 members of staff including doctors, nurses, health care assistants, allied health professionals and non-clinical staff. We visited the following wards: G1, G3, G4, G5, G8, the cardiac unit, the medical treatment unit, the acute assessment unit the discharge waiting area, F8, F9 and F12.

We spoke with 11 patients and reviewed seven patient records and considered other pieces of information and evidence to come to our judgement and ratings.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Hazardous cleaning chemicals were not always stored securely.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- Leaders and teams had systems to manage performance. However, they did not always identify and escalate relevant risks and issues or identify actions to reduce their impact.
- There was no formalised local induction to the ward for bank and agency nursing staff.

Medical care (including older people's care)

- Not all leaders had the skills and abilities to run the service as some were new in post. However, a programme of support was in place to help them gain experience.
- The service did not always collect data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Team meetings were not held regularly to discuss and learn from the performance of the service. Not all staff were aware of the freedom to speak up guardian.
- Not all staff completed mandatory training in key skills and processes were not fully effective to ensure compliance targets were met. Compliance for medical staff with training specific for their role on how to recognise and report abuse fell below trust targets.

However:

- Staff used equipment and control measures to protect patients, themselves and others from infection.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Compliance for medical staff with training specific for their role on how to recognise and report abuse fell below trust targets.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- There was no formalised local induction to the ward for bank and agency nursing staff.

Medical care (including older people's care)

- The service collected data for monitoring, but this was not fully utilised to improve safety.
- Not all staff completed mandatory training in key skills and processes were not fully effective to ensure compliance targets were met.

However,

- Nursing staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. However, hazardous cleaning chemicals were not always stored securely. They kept equipment and the premises visibly clean.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Good  

Our rating of effective went down. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Medical care (including older people's care)

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

However:

- Staff did not always give patients practical support and advice to lead healthier lives.
- Not all national audits had actions plans to address all areas of concern that required improvement.

Is the service caring?

Good ↓

Our rating of caring went down. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However,

- Complaints were not investigated and closed within the deadline set in the trust's internal policy.

Medical care (including older people's care)

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- A number of leaders had been recently recruited into post, however they were being given support to develop in their new role.
- Team meetings were not held regularly to discuss and learn from the performance of the service.
- Leaders and teams had systems to manage performance. However, they did not always identify and escalate relevant risks and issues or identify actions to reduce their impact.
- The service did not always collect data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Not all staff were aware of the freedom to speak up guardian.

However,

- Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Governance processes were in place, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities.
- The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Good ➔➔

Key facts and figures

The trust provided the following information about their surgical services:

The surgical division has 131 beds, including 32 ring fenced elective beds on ward F4 to support the orthopaedic joint replacement service. All core inpatient services are provided at the West Suffolk Hospital main site. Core specialities delivered by the division include: breast, urology, plastics, vascular, ear, nose and throat (ENT), trauma & orthopaedics, general surgery including colorectal surgery, ophthalmic, audiology, and support of cancer services.

The division provides support for the entire pre-, peri- and post-operative patient pathway with a dedicated pre-assessment unit for elective surgery management. The division also hosts the newly integrated tissue viability service.

Primarily, the emergency pathway is supported by wards F3 and F6, and the elective pathway is supported by wards F4 and F5. The emergency pathway is also supported by the surgical assessment unit on ward F6 which offers a direct point of access for GP surgical referrals and fast track assessment of surgical emergency department (ED) admissions. This unit is undergoing a planned change to form part of the trust wide emergency assessment model and is operating in a limited capacity while this change is implemented.

Each core service is also supported by clinical nurse specialists supporting the surgical pathway alongside consultant colleagues.

(Source: Acute Routine Provider Information Request (RPIR) – Acute context)

The trust had 23,641 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 6,512 (27.5%), 14,425 (61.0%) were day case, and the remaining 2,704 (11.4%) were elective.

(Source: Hospital Episode Statistics (HES))

During the inspection, we spoke with 35 staff of various grades including nurses, doctors, senior managers, allied health professionals, clinical support workers, administrative staff and volunteers. We spoke with eight patients and relatives. We observed interactions between patients and staff, considered the environment and looked at ten care records, including patients' medical notes and nursing notes. We also reviewed other documentation from stakeholders and nationally published performance data for the trust.

The service was last inspected in August 2016. At that inspection, outpatients was rated good overall.

The inspection team consisted of a lead inspector and two specialist advisors.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Nursing staff did completed training in key skills. Staff protected patients from abuse in line with trust policy. Safety incidents were managed within set timeframes and staff reported incidents in line with trust policy. Staff assessed risks to patients and there were systems in place to identify deteriorating patients. Staff collected safety information and use it to improve services.

Surgery

- The service had processes in place to ensure that care was evidence based. Managers monitored the effectiveness of the service and ensured action was taken in response to national audits. Managers ensured that staff were competent for their roles. Staff assessed and monitored patients regularly to see if they were in pain.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to complain. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders had the skills and abilities to effectively lead the service and operated effective governance processes throughout the service. Leaders and teams used systems to manage performance effectively.

However:

- Staff did not always complete training in key skills. Staff did not protect patients from abuse in line with trust policy.
- The service did not have effective systems and processes to safely prescribe, administer, record and store medicines.
- People could not always access the service when they needed it, and some had to wait too long for treatment. However, there were robust plans for dealing with delays.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Although we found the service largely performed well, it did not meet legal requirements relating to Regulation 12, Safe care and treatment, meaning we could not give it a rating higher than requires improvement.
- The service did not have effective systems and processes to safely store medicines. There were inconsistent practices across the service for medicines management, including inconsistent audit controls, and no clear risk assessment to explain why there was variation.
- Not all staff reported incidents appropriately or in a timely manner. Whilst managers investigated incidents wider analysis to identify learnings was not always undertaken.
- Not all medical staff received and keep up-to-date with their mandatory training.
- Compliance for medical staff with training specific for their role on how to recognise and report abuse fell below trust targets.

However,

- The service provided mandatory training in key skills to all staff and most nursing staff completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Nursing staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Surgery

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service had effective systems and processes to safely prescribe, administer and record medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.

Surgery

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards for three specialities.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Surgery

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However,

- Not all the service felt that they had an open culture where patients, their families and staff could raise concerns without fear.
- Not all incidents were raised in a timely manner,

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Requires improvement

Key facts and figures

The maternity service at West Suffolk Hospital delivers approximately 2,500 babies per year and offers a choice of three birth settings: around 2.5% of women delivered each year choose to birth at home; around 20% of women birth in the co-located low risk midwifery led birthing unit (MLBU); with the remainder delivering on the consultant led labour suite.

The service is provided by a team of consultant obstetricians who provide consultant presence on labour suite, supported by training grade doctors and midwives who work across the inpatient areas. Community maternity services are provided by four teams of midwives who also provide care in the midwifery-led birthing unit.

The maternity service has a number of specialist midwives. A perinatal mental health midwife works in partnership with the perinatal team at the local mental health trust. The service has a midwife who leads on bereavement and offers ongoing support to women and partners who have suffered a pregnancy loss. This is supported by a specialist bereavement counselling service. The service also has a practice development midwife to assist midwives with their mandatory training and competencies and a safeguarding midwife who staff could seek safeguarding advice from.

(Source: Routine Provider Information Request (RPIR) – Acute context)

Due to the number of core services inspected, our inspection of West Suffolk Hospital was announced. Prior to our inspection we reviewed data we held about the service along with information we requested from the service.

During our inspection, we spoke with 30 members of staff including nurses, midwives, obstetricians, anaesthetists, sonographers, maternity care assistants and non-clinical staff.

We spoke with eight women using the service and one relative. We reviewed 21 women's records and considered other pieces of information and evidence to deliver our judgement and ratings.

Following the well led inspection we undertook enforcement action, in relation to the maternity service, and told the trust it must improve. We issued a warning notice, on the 14 November 2019, under Section 29A of the Health and Social Care Act 2008. This identified specific areas that the trust must improve and set a date for compliance as 31 January 2020. The trust initiated an immediate action improvement plan.

Summary of this service

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated it as requires improvement because:

- Staff did not always complete training in key skills. Staff did not protect patients from abuse in line with trust policy. Safety incidents were not always managed within set timeframes and staff did not always report incidents in line with trust policy. Staff did not always assess risks to patients and the service did not have adequate processes in place to identify deteriorating women in the maternity day assessment unit and triage. Staff did not collect safety information and use it to improve services.

Maternity

- The service did not have processes in place to ensure that care was evidence based. Managers did not monitor the effectiveness of the service and ensure action was taken in response to national audits. Managers did not ensure that staff were competent and had access to clinical supervision. Staff did not always assess and monitor women regularly to see if they were in pain.
- Leaders did not have the skills and abilities to effectively lead the service and did not operate effective governance processes throughout the service. There was a lack of clarity among leaders around executive responsibility for the service. Leaders and teams did not always use systems to manage performance effectively. Not all performance data was displayed for staff to understand, make decisions and improvements.

However:

- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to complain. People could access the service when they needed it and did not have to wait too long for treatment.

Is the service safe?

Requires improvement

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated safe as requires improvement because:

- The service had low levels of compliance in maternity specific mandatory training such as Practical Obstetric Multi-Professional Training (PROMPT) and Gestation Related Optimal Weight (GROW) training.
- Staff were not following the service's policy on domestic abuse and had not conducted any baby abduction drills.
- Staff did not always complete and update risk assessments for each woman and baby. Staff were not using a nationally recognised vital observation tool to identify new born babies and women in the triage and maternity day assessment unit at risk of deterioration.
- Staff did not record and monitor women's carbon monoxide levels in line with trust policy.
- Staff were not consistently taking all observations required and scoring correctly on the Modified Early Obstetric Warning Score (MEOWS) charts on the labour suite and maternity ward.
- The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- The service did not always safely store and prescribe medicines. Staff did not consistently record women's weights when prescribing medicines and the service did not record the ambient air temperature of their medicine rooms.
- The service did not always manage safety incidents well. Staff recognised incidents and near misses but did not always report them appropriately. The service did not always meet their own pathway deadlines for investigating incidents.

- The service did not use monitoring results well to improve safety. Safety information was not shared with staff, women and visitors.

However, we also found:

- The service generally controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support.

Is the service effective?

Requires improvement

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated effective as requires improvement because:

- 23 of the service's clinical guidelines were out of date which meant that treatment was not always based on national guidance and best practice.
- Staff did not always assess and monitor women regularly to see if they were in pain.
- We were not assured that staff monitored the effectiveness of care and treatment or used the findings to make improvements and achieve good outcomes for women.
- We were not assured that the service made sure staff were competent for their roles. The service did not meet targets for midwifery appraisal rates and leaders within the service did not hold supervision meetings with midwives to provide support and development.

However, we also found:

- Staff gave women enough food and drink to meet their needs and improve their health. The service made adjustments for women's religious, cultural and other needs.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.
- Key services were available seven days a week to support timely care.
- Staff gave women practical support and advice to lead healthier lives.

- Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Is the service caring?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated caring as good because:

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.
- Staff supported women, families and carers to understand their condition and make decisions about their care and treatment.

However, we also found:

- Women and their families were not always given the opportunity to provide feedback on the service and their treatment.

Is the service responsive?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated responsive as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of women’s individual needs and preferences. Staff made reasonable adjustments to help women access services.
- Women could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

However:

- The service did not always complete complaint investigations complaint within timelines set in trust policy.

Maternity

Is the service well-led?

Inadequate

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated well led as inadequate because:

- We were not assured that the service leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety culture within the organisation.
- Leaders did not operate effective governance processes, throughout the service. Leaders within the service did not have oversight of Modified Early Obstetrics Warning Score charts, carbon monoxide monitoring records or domestic violence records within the service.
- Leaders and teams did not always use systems to manage performance effectively. Service leaders were unaware that feedback had not been collected for the friends and family test for both the labour suite and birthing unit for the past 12 months.
- Leaders and teams did not always identify relevant risks within the service and therefore did not identify actions to reduce their impact.
- Not all performance data was displayed for staff to understand, make decisions and improvements. The service did not submit data to the maternity safety thermometer or display the services maternity dashboard so that staff and women could see the services safety performance.
- Leaders did not always engage actively with staff. Leaders within the service told us that they had stopped team meetings for the labour suite and F11 ward because attendance was poor and difficult to embed among staff.
- We did not see evidence that the service's strategy was regularly monitored and reviewed.

However, we also found:

- Staff told us the leaders were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.
- There was strong evidence that they collaborated with partner organisations to help improve services for patients.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Requires improvement 

Key facts and figures

West Suffolk NHS Foundation Trust provides its main outpatients services at West Suffolk Hospital. It also provides outpatients clinics at services based at Newmarket Hospital and in local health centres. These satellite services are managed by the same team who oversee main outpatients. We did not inspect any of the other locations during this inspection.

The trust had 601,339 first and follow up outpatient appointments from March 2018 to February 2019.

The main outpatient services are managed in the division of women and children's and clinical support services. The current structure includes an associate director of operations, a clinical director and a head of nursing. They are supported by a senior operations manager and a service manager.

There are consultant, allied health professional and nurse-led outpatient clinics across a range of specialities, which are provided in the outpatients' department and in separate dedicated clinics around the hospital. Outpatient clinics are held from Monday to Friday from 8am until 5.30pm. There are some evening weekday clinics and regular Saturday appointments provided dependant on specialty.

We carried out an announced inspection on 24, 25, and 27 September 2019. We visited all the outpatient clinics taking place on those days in the outpatient department at West Suffolk hospital.

During the inspection, we spoke with 26 staff of various grades including nurses, doctors, senior managers, allied health professionals, clinical support workers, administrative staff and volunteers. We spoke with 11 patients and relatives. We observed interactions between patients and staff, considered the environment and looked at eight care records, including patients' medical notes and nursing notes. We also reviewed other documentation from stakeholders and nationally published performance data for the trust.

The service was last inspected in November 2017. At that inspection, outpatients was rated good overall.

The inspection team consisted of a lead inspector and two specialist advisors.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Leaders did not always understand and manage the priorities and issues the service faced.
- There was lack of local oversight in relation to some of the issues identified during our inspection. For example, there was lack of local oversight in relation to processes in place for monitoring patients requiring a follow up appointment or those on surveillance pathways. We found there were a large number of vascular patients affected by lost to follow up issues, with the potential for serious harm. The service were unaware of the number of patients who may have been lost to follow up.
- Not all risks and issues were identified, escalated or effectively acted upon to reduce their impact. The lack of robust systems to ensure patients on surveillance pathways, or requiring follow up, was known but actions had not been undertaken in a responsive manner. This had resulted in a potentially significant patient safety risk within the vascular service, and an extended period of time where potential risk across other specialties remained unknown.

Outpatients

- There was a lack of ownership by senior leaders within the service, despite systems to manage risk and performance being in place.
- People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment varied, with some specialties better and some worse than national standards. The percentage of patients waiting more than 18 weeks from referral to treatment on non-admitted and incomplete pathways was below the England average.
- Delays in diagnostic test results meant that clinic appointments were often wasted.
- There was no process in place to monitor the average waiting times for a follow up appointment.
- The service took longer than the trust target to investigate and close complaints.

However:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided timely care and treatment. Patients received pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Although we found the service largely performed well, it did not meet legal requirements relating to Regulation 12, Safe care and treatment and Regulation 17 Good governance, meaning we could not give it a rating higher than requires improvement.

Outpatients

- There was no effective process in place for monitoring patients requiring a follow up appointment or those on surveillance pathways. We found there were a large number of vascular patients affected by lost to follow up issues, with the potential for serious harm.
- The paediatric outpatient department did not have lockable or security enabled external doors to prevent children leaving the department unaccompanied. Staff told us that as the doors were heavy to push they would be too difficult for a small child, and that parents were expected to be responsible for their own children. There had been no risk assessment undertaken.
- Compliance with mandatory training did not always meet the trust target.

However:

- The service provided mandatory training in key skills to all staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Appropriate systems were in place to assess risk, recognise and respond to deteriorating patients within the service. Systems were in place to appropriately assess and manage patients with mental health concerns.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave new staff a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service planned for emergencies and staff understood their roles if one should happen.

Is the service effective?

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Patients had access to water to meet their needs and improve their health.

Outpatients

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- There was some flexibility in the provision of key services to support timely patient care as outpatient services were not seven day.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement ➔

Our rating of responsive went down. We rated it as requires improvement because:

- People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment varied, with some specialties better and some worse than national standards. The percentage of patients waiting more than 18 weeks from referral to treatment on non-admitted and incomplete pathways was below the England average.
- Delays in diagnostic test results meant that clinic appointments were often wasted.
- There was no process in place for monitoring patients requiring a follow up appointment. The service were unaware of the number of patients who may have been lost to follow up.
- There was no process in place to monitor the average waiting times for a follow up appointment.

- The service took longer than the trust target to investigate and close complaints.

However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Leaders did not always understand and manage the priorities and issues the service faced.
- We found there was lack of local oversight in some issues raised during our inspection. There was no process in place for monitoring patients requiring a follow up appointment. The service were unaware of the number of patients who may have been lost to follow up. There was no process in place to monitor the average waiting times for a follow up appointment.
- Not all risks and issues were identified, escalated or effectively acted upon to reduce their impact. The lack of robust systems to ensure patients on surveillance pathways, or requiring follow up, was known but actions had not been undertaken in a responsive manner. This had resulted in a potential significant patient safety risk within the vascular service, and an extended period of time where potential risk across other specialties remained unknown.
- There was a lack of ownership by senior leaders within the service, despite systems to manage risk and performance being in place. The trust responded following the concerns raised and steps were identified to improve and strengthen governance processes moving forward to ensure adequate monitoring and oversight of follow up appointments and patients on surveillance pathways.
- Due to issues with the integration of various systems, senior leaders estimated that they were 9 to 12 months away from reliable data for referral to treatment time.

However:

- Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Outpatients

- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Information that was collected by the service was readily available and analysed. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community health services

Background to community health services

The trust provides three core community health services: community health services for adults, community services for children and young people and community health inpatient services.

We inspected all three services.

The community services are delivered in various localities across West Suffolk and from a variety of settings including people's own homes, care homes, community hospital inpatient units and clinics, day centres, schools, GP surgeries and health centres.

Inpatient services are delivered from Rosemary ward at Newmarket hospital and the King Suite at Glastonbury Court.

Summary of community health services

Good

The summary of community health services appears in the overall summary of this report.

Community health services for adults

Good

Key facts and figures

The trust provided the following information about their community services for adults:

Community nursing teams consist of registered and non-registered staff who provide nursing care to patients in their own homes across the west of Suffolk. This care is largely planned but also incorporates an element of unplanned care, both during core hours and overnight.

Teams are based in various localities across the West:

- Bury Town
- Bury Rural
- Haverhill
- Sudbury
- Newmarket
- Brandon/Mildenhall

Services are led by qualified district nurses who have achieved the specialist practitioner qualification. The teams also include occupational therapists and physiotherapists which report professionally to one professional lead that covers acute and community.

Referrals are made via a care co-ordination centre, which can be accessed by patients, GPs and other health professionals.

A number of specialist community nursing services are provided across the county at outreach clinic settings with patients also being seen in their own homes, if appropriate. A number of these specialist nurses are non-medical prescribing (NMP) who work closely with consultant colleagues.

The speech and language therapy service is provided from four locations and patients' homes. It links into the six different localities to ensure joined up working.

The dietetic service is provided from 17 locations and patients' home and includes a home enteral feed service.

This was the first inspection of community adult services since the trust was awarded the contact for the provision of the service in 2017.

Our inspection of West Suffolk Foundation Trust was announced. Prior to our inspection we reviewed data we held about the service along with information we requested from the trust.

During the inspection we spoke with 21 members of staff including nurses, therapists, health care assistants and non-clinical staff. We spoke with 7 patients and their relatives, reviewed 21 patient records and considered other pieces of information and evidence to come to our judgement and ratings.

Community health services for adults

Summary of this service

We rated the service as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff checked patients had enough to eat and drink. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Good

We rated as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Community health services for adults

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However, we also found:

- Staff had not completed mandatory training in line with the trust's 90% mandatory training target.

Is the service effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not record patient pain levels required to monitor the effectiveness of pain-relieving medicines or identify patients that required an increase in their pain-relieving medicines.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff did not document objective pain scores to monitor the effectiveness of pain management.
- Managers had not completed annual staff appraisals in line with the trust's completion target of 90%.

However, we also found:

- Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Is the service caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal and cultural needs.

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good

We rated responsive as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Good

We rated well-led as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Community health services for adults

- All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community health services for children and young people

Good

Key facts and figures

Community paediatric services consist of eight core paediatric services which operate as part of an integrated model of delivery primarily to children and young people with medical, developmental, neuro-disabling and cognitive disabilities and longer-term health conditions.

A service specification reflects an integrated working framework and evidences a personalised approach to the delivery of care that is responsive to the complexity of children, young people and their families' needs.

The services are:

1. Paediatric medical team (seven locations)
2. Paediatric physiotherapy team (22 locations)
3. Paediatric occupational therapy team (five locations)
4. Paediatric speech and language therapy team (24 locations)
5. Children's community nursing team (five locations)
6. Community audiology (three locations)
7. Child and family clinical psychology service (four locations)
8. Suffolk communication aids resource centre (based at Thomas Wolsey School)

The trust's integrated therapies team also provides paediatric dietetics at seven locations plus home enteral feed service and a physiotherapy musculoskeletal service.

(Source: Community Routine Provider Information Request (RPIR) – CHS Context; Routine Provider Information Request (RPIR) – Sites)

We inspected the service on the 24 September 2019 and 25 September 2019. The inspection was announced (staff knew we were coming), to ensure that everyone we needed to talk to was available. As part of the inspection, we visited the Bury St Edmunds child development centre, the Ipswich child development centre, St Helen's House and the Allington clinic.

During the inspection, we spoke with 26 staff of various grades, including consultants, nurses, health visitors, occupational therapists, physiotherapists, audiologists, speech and language therapists, nursery nurses and administrative staff. We spoke with eight children and young people and/or their family members, observed care and treatment and looked at eight patient's care records. We also reviewed minutes of meetings, performance information about the service and other relevant data.

This was our first inspection of the service.

Summary of this service

We rated this service as good because:

Community health services for children and young people

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff did not always complete the mandatory training required to ensure they maintained their knowledge and skills.
- Patient information systems were not integrated and made it difficult for staff to maintain contemporaneous records. Data was not always available to enable staff to manage performance effectively.
- Facilities for audiology assessments in the Ipswich child development centre did not meet national standards.

Is the service safe?

Good

We rated safe as good because:

- Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe at three of the four locations we inspected. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Community health services for children and young people

- Staff kept detailed records of children and young peoples' care and treatment. Patient records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However,

- The service provided mandatory training in key skills to all staff, but managers did not always make sure everyone completed it.
- Although staff knew how to recognise, and report abuse they were not always up to date with this training.
- Staff did not always complete records to show cleaning had been completed.
- Facilities for audiology assessments in the Ipswich child development centre were not fit for purpose.

Is the service effective?

Good

We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of children and young people subject to the Mental Health Act 1983.
- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.
- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

However,

- Managers did not always check to make sure staff followed guidance.

Community health services for children and young people

Is the service caring?

Good

We rated caring as good because:

- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Is the service responsive?

Good

We rated responsive as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

However,

- Trust targets for responding to complaints were not always met.
- Contracted times for health assessments of children in care were not always met.

Is the service well-led?

Good

We rated it as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Community health services for children and young people

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders operated effective governance processes, at divisional level.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However,

- The cascade of governance issues through team meetings were not always in place and there was no clinical audit plan for the service.
- Leaders and teams did not always use systems to manage performance effectively. Issues with the accuracy and availability of data, affected managers' ability to manage performance effectively at times. Mandatory training data was not always accurate and managers did not have oversight of compliance with national clinical guidance.
- Patient information systems were not fully integrated, were not accessible and staff could not always access the records they needed.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community health inpatient services

Good

Key facts and figures

Information about the sites and teams, which offer services for inpatients at this trust, is shown below:

Location	Team/ward/satellite name	Number of inpatient beds
Newmarket Hospital	**Rosemary Ward**	**19**
Glastonbury Court	**King Suite**	**20**

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust provided the following information about their community inpatients services:

Rosemary Ward, Newmarket Hospital has a bed base of 19 beds and serves the population of West Suffolk in the delivery of reablement care. There was no formalised admission criteria, but patients must be over 18 and registered with a Suffolk GP. In addition, they must be medically optimised for discharge at the point of admission and have either reablement, rehabilitation, end of life or complex discharge planning needs, which cannot be met at home. Some active treatments are also available, if these are not able to be delivered in the patient's own home.

King Suite, Glastonbury Court is a 20 bedded unit within a care home in Bury St Edmunds, which is staffed by the trust's team members. King Suite offers similar care and support as that noted above for Rosemary Ward.

Both areas are nurse-led units with a full multidisciplinary team supporting the delivery of care. This enables patients to regain independence as appropriate or receive end of life care in a comfortable setting if home is not a suitable place of care. Close ties are retained with West Suffolk Hospital and links continue to be made with wider community health teams.

(Source: CHS Routine Provider Information Request (RPIR) – Context CHS)

Care at the community hospitals is delivered by nursing, healthcare and therapy staff. The trust uses the community beds to support improved flow across the local health economy through collaborative working with local GP practices. The ward areas are nurse led and staffed with multidisciplinary teams (MDT) supporting holistic patient care. Medical cover is provided by local GPs with a once weekly consultant ward round.

Each community hospital provides person centred care with the aim of supporting patients to regain functional ability in order to return to their usual place of residence. The hospital teams work with social workers and community nursing and rehabilitation teams to support early discharge where appropriate, or to facilitate transitions into on-going care/ nursing homes.

The community inpatient service has not been previously been inspected as a core service.

We carried out an announced inspection from 24 to 25 of September 2019. We visited both inpatient sites during this inspection. During our inspection we spoke with 21 staff including nurses, therapy leads, ward managers, locality leads,

physiotherapy and occupational therapy staff, healthcare assistants, and housekeeping staff. We spoke with 10 patients and viewed 17 sets of patient records and 11 medicine records. We attended a multidisciplinary (MDT) team meeting. We observed mealtimes and patient and staff interactions. We also reviewed data provided by the trust both prior and post our inspection.

Summary of this service

We rated the service as good because:

Staff understood how to protect patients from abuse and assessed and managed patient risks well. The service controlled infection risk well and maintained a clean environment. Staff kept good care records and managed medicines well. The service managed safety incidents well, learned and shared lessons from them. Staff collected safety information and used it to improve the service. However, as no acuity tool was used it was difficult to assess to whether the were enough staff to keep patients safe and mandatory training compliance was inconsistent.

The service followed best practice based on national guidance and ensured staff were competent for their role. Staff ensured that patients had enough to eat and drink and provided pain relief to patients as needed. Staff worked well together for the benefit of patients, gave advise on how to lead healthier lives, and supported them to make decisions about their care. Managers monitored the effectiveness of the service.

Staff treated patients with compassion and kindness, respected their privacy and dignity and provided emotional support to patients and families. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

The service planned care to meet the needs of local people and coordinated care with other services and providers. The service ensured that patients and relatives could give feedback and treated concerns and complaints seriously. However, there was a lack of individualised care and needs.

The service was manged by leaders with the skills and abilities to run the service and who operated effective governance and risk management processes. Staff were clear about their roles and accountabilities and felt respected, supported and valued. Leaders managed services well using reliable information systems and supported staff to develop their skills. Staff were committed to improving services, however not all senior staff were aware how they could find the data they needed, to understand performance, make decisions and improvements.

Is the service safe?

Good

We rated safe as good because:

The service had been through a period of high vacancy, but recent appointments had improved staffing numbers. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

Community health inpatient services

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff.

However, we also found:

- The service provided mandatory training in key skills to all staff however, compliance was not always consistent although it was improving.
- Staff did not use an acuity tool to assess the level of care needed which made it difficult to assess whether there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Is the service effective?

Good

We rated effective as good because:

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

However, we also found:

- Staff were unaware of the monitoring that the trust performed for the effectiveness of care and treatment. They were unable to use the findings to make improvements in outcomes for patients.

Is the service caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal and cultural needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good

We rated responsive as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- People could access the service when they needed it and received the right care promptly.
- Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However, we also found:

- The service was not inclusive and took little account of patients' individual needs and preferences.

Is the service well-led?

Good

We rated well led as good because:

We rated well-led as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Community health inpatient services

- The division had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders but this did not include the community inpatient service. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. There was not a strong emphasis on the safety and well-being of staff.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. However not all senior staff were aware how they could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

However:

- Knowledge, development and support of individuals at ward manager level was not consistent.
- Local processes to collect, analyse and review data to improve performance and patient care were not embedded. Outcome targets were not consistently monitored, and routine audit was not used to monitor patients progress during rehabilitation.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Maternity and midwifery services Personal care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Surgical procedures

Treatment of disease, disorder or injury

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Personal care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Our inspection team

Fiona Allinson, CQC Head of Hospital Inspections chaired this inspection and Tracey Wickington, CQC Inspection manager led it. An executive reviewer supported our inspection of well-led for the trust overall.

The team included 11 further inspectors, one executive reviewer, 20 specialist advisers, one CQC pharmacist specialist and one CQC clinical leadership fellow and maternity specialist advisor.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

11. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

For Report

Presented by Rowan Procter

Trust Board – 28 February 2020

Agenda item:	11			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Rowan Procter, Executive Chief Nurse, and Duane M. Elmy, Business Manager			
Date prepared:	17th February 2020			
Subject:	Quality and Workforce Report & Dashboard – Nursing			
Purpose:	X	For information		For approval

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

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

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

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

Recommendation:
This paper is to provide overview of November's and December's position about nursing staff and actions taken to mitigate, future plans and update on national requirements.
The dashboard provides summary of nursing staffing levels and effect on nurse sensitive indicators
Provides an update on implementation of NHSI Document 'Developing workforce safeguards – October 2018'

Overview of January's nurse staffing position

Are we safe?
Acute Daily Safety Huddles continue with particular focus on Senior Matrons and Zone Holders operating the 'buddy' system, to maintain good oversight of staffing across inpatient areas over the 7-day period. The pilot involving West Suffolk Professionals working on Saturday mornings is reported to be of benefit, allowing Senior Matrons to delegate contact to Nurse Agencies, however this has been dependent on the availability of WSP colleagues. This pilot will require evaluation with WSP senior colleagues.

Community colleagues continue to work with the submission of paper duty rosters, which managers can access via a Cloud-based system, these are supported by Daily Escalation Calls and twice weekly system wide calls to ensure good allocation of resources. Health Roster implementation is planned. Senior clinicians are actively supporting those teams with high vacancy rates and agency approval has been confirmed for a short period in order to support patient safety, approval for this is required by the Executive Chief Nurse. Work has also commenced around developing a process of cross working for community teams and Community Inpatient Beds, to increase resilience across this Division.

Both inpatient escalation areas remain open, with established nursing teams and experienced Ward Managers and Senior Matrons in situ.

Are we responsive?
The Heads of Nursing for Medicine, Surgery and Community continue to meet with senior operational managers, West Suffolk Professionals Manager and the Healthroster Lead on a weekly basis, to review forthcoming rosters. This has resulted in an improvement in the management of rosters and an increase in the fill rate of temporary staff.

Matron oversight of the rosters at ward level has resulted in some improvements in overall roster management, however reduced skill mix remains a challenge at both, ward level and in the specialist areas.

CHPPD figures similar to comparable wards in other hospitals.

Bank/Agency figures for ward F10 are available this month, however please note that these are not a true representation as they only cover part month.

Future planning – Nursing staff

Information as at 14th February 2020:

- 14 Further overseas nurses have passed their OSCE and are now working as Band 5 Nurses since last month bring the total to 98
- 12 OSCES are booked for the 13th/14th February 2020
- 13 OSCES are booked for the 26th/27th February 2020
- 12 OSCES are booked for the 21st/23rd April 2020

We are expecting a further 10 overseas nurses to commence their OSCES preparation when they arrive on the 26th February 2020

Future Arrivals:

- 11 Nurses being processed and due to arrive between March – May 2020

WSFT Existing Staff:

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

Overseas Nurse Leavers: -

One overseas Nurse has left the Trust in January 2020

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Nov-19		Establishment for the Financial Year 2019/20		Data for November 2019																	
					Workforce													Nursing Sensitive Indicators					
Trust	Ward/Area Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Fill rate Registered %		Fill rate Unregistered %		Bank Use %	Agency use %	Overall Care Hours Per Patient Day	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)	Red Incidents	Complaints	Compliments
			Registered	Unregistered	Day	Night	Day	Night				Registered	Unregistered									
WSFT	ED	Emergency Department	54.91	23.43	91.6%	111.3%	88.6%	177.1%	8.2%	14.6%	N/A	-11.20	0.70	4.70%	12.70%	1.20%	N/A	7	0	0	6	4
WSFT	AAU	Acute Admission Unit	27.30	29.59	93.1%	86.1%	73.6%	115.9%	6.5%	5.3%	16.3	-5.40	0.30	3.30%	14.10%	4.90%	0	7	2	0	3	0
WSFT	F7	Short Stay Ward	22.84	30.94	107.8%	97.7%	86.3%	94.9%	11.8%	3.8%	7.2	-0.90	-4.60	9.00%	12.80%	4.70%	0	1	1	0	2	0
WSFT	CCS	Critical Care Services	41.07	1.88	98.7%	93.7%	N/A	N/A	1.8%	3.6%	26.2	1.60	0.00	6.00%	12.60%	4.10%	4	9	1	0	0	1
WSFT	Theatres	Theatres	61.68	22.27	102.2%	99.4%	N/A	N/A	1.7%	0.0%	N/A	-0.40	-2.80	4.70%	13.50%	1.30%	N/A	0	0	0	0	0
WSFT	Recovery	Theatres	21.23	0.96	148.3%	114.7%	89.5%	N/A	2.2%	0.0%	N/A	0.10	1.00	1.00%	14.60%	4.30%	0	1	N/A	0	0	0
WSFT	Day Surgery Unit	Theatres	28.43	8.59	150.0%	N/A	140.5%	N/A	0.9%	0.0%	N/A	1.70	6.10	7.20%	10.40%	0.00%	0	0	1	0	0	1
	Day Surgery Wards		11.76	1.79					9.3%	0.0%		-0.60	0.10	9.60%	8.50%	4.50%						
WSFT	ETC	Opthalmology	TBC	TBC	77.8%	N/A	78.9%	N/A	1.4%	0.0%	N/A	-5.50	0.20	3.60%	8.50%	4.70%	N/A	3	0	0	1	0
WSFT	PAU	Pre-assessment	TBC	TBC	70.0%	N/A	97.4%	N/A	0.9%	0.0%	N/A	0.00	1.30	7.20%	8.50%	2.90%	N/A	0	0	0	0	0
WSFT	Endoscopy	Endoscopy	TBC	TBC	189.1%	N/A	157.1%	N/A	0.0%	0.0%	N/A	-1.00	0.00	4.20%	14.50%	1.90%	N/A	0	0	0	0	0
WSFT	Cardiac Centre	Cardiology	38.14	15.20	91.1%	91.2%	101.3%	117.7%	4.0%	0.1%	9.8	-3.10	2.40	4.30%	8.70%	2.30%	3	2	2	0	0	7
WSFT	G1	Palliative Care	23.96	8.31	84.6%	115.1%	105.1%	N/A	12.9%	2.8%	11.8	-4.30	4.50	11.90%	8.70%	3.20%	0	5	0	0	0	0
WSFT	G3	Endocrine & Medicine	TBC	TBC	126.8%	151.3%	157.8%	145.4%	13.2%	4.4%	6.6	-5.00	0.30	6.60%	9.90%	0.00%	2	0	0	0	0	0
WSFT	G4	Elderly Medicine	19.16	24.36	85.5%	86.3%	102.3%	112.2%	18.3%	3.3%	5.9	-4.90	0.10	5.90%	8.70%	3.20%	2	2	6	0	2	4
WSFT	G5	Elderly Medicine	18.41	22.66	97.8%	97.2%	94.6%	151.2%	21.8%	1.9%	6.1	-1.80	-0.20	4.50%	10.70%	2.60%	5	5	4	0	0	0
WSFT	G8	Stroke	23.15	28.87	90.0%	95.2%	106.8%	133.5%	16.6%	2.3%	7.8	-1.30	1.70	4.10%	14.60%	6.50%	3	2	5	0	1	0
WSFT	F1	Paediatrics	18.13	7.16	123.5%	105.8%	96.7%	N/A	20.0%	0.0%	18.2	-1.80	-1.00	7.60%	14.80%	3.60%	N/A	5	N/A	1	0	7
WSFT	F3	Trauma and Orthopaedics	19.58	22.27	83.7%	98.9%	106.2%	115.9%	20.3%	0.8%	6.2	-3.0	-0.60	8.00%	12.00%	0.00%	7	9	3	1	0	0
WSFT	F4	Trauma and Orthopaedics	12.78	10.59	77.8%	97.0%	82.0%	116.4%	16.6%	0.0%	7.4	-0.3	-1.30	1.60%	11.60%	0.20%	0	2	1	0	0	1
WSFT	F5	General Surgery & ENT	19.58	14.51	99.2%	97.8%	94.3%	101.2%	8.6%	3.9%	5.6	-1.4	2.50	3.80%	14.60%	0.00%	1	2	2	0	0	10
WSFT	F6	General Surgery	19.57	14.51	91.6%	91.1%	105.3%	109.4%	12.9%	0.8%	5.2	-1.5	2.80	8.20%	14.60%	1.90%	0	0	6	0	0	0
WSFT	F8	Respiratory	19.90	20.13	110.3%	98.3%	102.6%	101.0%	4.2%	0.0%	6.9	-2.20	1.20	4.00%	14.80%	0.00%	2	2	2	0	0	0
WSFT	F9	Gastroenterology	20.32	22.56	100.3%	97.3%	84.5%	130.6%	21.9%	1.5%	5.7	-2.50	0.60	7.80%	12.70%	3.80%	0	1	1	0	1	0
WSFT	F10	Ecalation	TBC	TBC	0.0%	0.0%	0.0%	0.0%	TBC	TBC	TBC			TBC	TBC	TBC	0	0	0	0	0	0
WSFT	F11	Maternity															0	1	0	0	0	0
WSFT	MLBU	Midwifery Led Birthing Unit	49.58	13.89	89.0%	93.0%	83.0%	100.0%	8.8%	0.0%	N/A	3.50	-0.30	1.80%	12.10%	3.30%	0	0	0	0	0	0
WSFT	Labour Suite	Maternity															0	4	0	0	0	0
WSFT	Antenatal/Gynae Clinic	Maternity	TBC	TBC	88.5%	N/A	70.9%	N/A	3.3%	0.0%	N/A	1.90	-0.40	3.20%	11.00%	0.00%	N/A	0	0	0	1	0
Community	Community Midwifery	Maternity	TBC	TBC	54.8%	N/A	48.1%	N/A	4.6%	0.0%	N/A	-3.50	0.00	3.60%	13.30%	7.00%	0	0	0	0	0	0
WSFT	F12	Infection Control	11.02	5.00	84.8%	88.6%	106.9%	116.7%	8.5%	1.2%	8.3	-1.90	0.90	9.50%	12.30%	0.00%	0	0	0	0	0	2
WSFT	F14	Gynaecology	11.18	1.00	101.7%	96.2%	N/A	N/A	24.3%	1.1%	13.1	-2.50	1.00	9.50%	13.30%	0.00%	0	0	0	0	0	0
WSFT	MTU	Medical Treatment Unit	7.04	1.80	94.3%	N/A	81.9%	N/A	7.6%	0.0%	N/A	0.80	0.60	3.50%	11.90%	5.90%	0	0	0	0	0	0
WSFT	NNU	Neonatal	20.85	3.64	110.6%	73.6%	30.6%	77.2%	2.3%	0.0%	69.8	-1.80	-1.00	1.80%	19.50%	3.20%	N/A	0	N/A	1	0	0
WSFT	Outpatients	Outpatients	TBC	TBC	95.1%	N/A	165.2%	N/A	3.6%	0.0%	N/A	0.50	-2.40	10.60%	12.10%	3.30%	N/A	1	0	0	0	1
WSFT	Radiology Nursing	Radiology	TBC	TBC	81.7%	N/A	128.1%	N/A	7.1%	0.0%	N/A	-0.40	-1.40	2.90%	3.40%	3.40%	N/A	1	1	0	1	0
WSFT	DWA	Discharge Waiting area	TBC	TBC	10.6%	N/A	36.4%	N/A	26.7%	19.8%	N/A	-1.20	-1.00	0.00%	5.00%	0.00%	0	3	0	0	0	0
Newmarket	Rosemary Ward	Step - down	12.34	13.47	119.8%	100.2%	116.8%	101.4%	3.5%	9.3%	5.7	-2.20	0.80	6.00%	15.10%	0.00%	0	0	9	0	0	0
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64	120.5%	93.6%	103.4%	107.1%	7.1%	2.2%	5.2	-1.20	-0.10	10.30%	13.50%	0.00%	0	0	0	0	0	0
					95.62% AVG	95.03% AVG	98.82% AVG	114.18% AVG				-62.70 TOTAL	12.00 TOTAL	5.60% AVG	11.93% AVG	2.44% AVG	29 TOTAL	75 TOTAL	47 TOTAL	3 TOTAL	18 TOTAL	0 TOTAL

Trust	Team Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Patient facing contact (hrs)	Unplanned requests	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (New)	Nursing/Midwifery Administrative Medication Errors	Red Incidents	Missed Visits	Complaints	Compliments
			Registered	Unregistered			Registered	Unregistered									
Community	Bury Town	Community Heath Team	17.59	5.60	1436.33	84	-3.80	0.00	4.77%	Not available comprehensively till Healthroster implemented	Not available this month	9	3	1	4	1	0
Community	Bury Rural	Community Heath Team	10.00	1.20	762.40	30	-1.40	-0.60	6.96%			6	2	0	0	0	0
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91	822.38	38	-2.20	0.00	7.88%			1	0	0	0	0	0
Community	Newmarket	Community Heath Team	8.10	2.75	547.58	25	-1.78	-0.60	1.38%			1	1	0	0	0	0
Community	Sudbury	Community Heath Team	18.03	8.36	1392.72	74	-3.48	-1.20	4.43%			3	1	0	2	0	0
Community	Haverhill	Community Heath Team	8.97	4.23	938.33	47	-2.60	0.00	12.16%			0	0	0	0	0	0
Community	Admission Prevention Service	Specialist Services	11.28	3.45	85.17	1	0.00	0.00	6.28%			0	0	0	0	0	0
Community	Specialist Services	Cardiac Rehab and Heart Failure	TBC	TBC	506.65	4			0.00%			0	0	0	0	0	0
Community	Children	Community Paediatrics	16.37	15.01	1309.27	0	0.00	-2.00	2.20%			N/A	0	0	0	0	0
					7800.83 TOTAL	303.00 TOTAL	-15.26 TOTAL	-4.40 TOTAL	5.12% AVG	#DIV/0! AVG	#DIV/0! AVG	20 TOTAL	7 TOTAL	1 TOTAL	6 TOTAL	1 TOTAL	0 TOTAL

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

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

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Jan-20		Establishment for the Financial Year 2019/20		Data for January 2020																	
					Workforce													Nursing Sensitive Indicators					
Trust	Ward/Area Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Fill rate Registered %		Fill rate Unregistered %		Bank Use %	Agency use %	Overall Care Hours Per Patient Day	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)	Red Incidents	Complaints	Compliments
			Registered	Unregistered	Day	Night	Day	Night				Registered	Unregistered									
WSFT	ED/CDU	Emergency Department	54.91	23.43	88.3%	107.8%	94.0%	177.5%	4.3%	2.6%	N/A	-12.10	0.10	3.90%	8.80%	1.70%	N/A	6	1	0	3	2
WSFT	AAU	Acute Admission Unit	27.30	29.59	97%	95%	70%	107%	6.8%	4.1%	11.3	-2.50	-2.70	7.60%	14.20%	3.70%	1	6	4	1	2	0
WSFT	F7	Short Stay Ward	22.84	30.94	109.4%	99.1%	80.0%	98.6%	12.5%	1.4%	6.4	-1.90	-6.70	5.30%	14.20%	2.90%	2	3	2	0	1	0
WSFT	CCS	Critical Care Services	41.07	1.88	99.3%	94.1%	N/A	N/A	3.5%	0.0%	23.9	-1.00	0.00	3.80%	15.30%	2.10%	1	3	0	0	0	0
WSFT	Theatres	Theatres	61.68	22.27	103.8%	97.4%	N/A	N/A	2.1%	0.0%	N/A	0.80	-2.80	5.00%	15.40%	1.30%	N/A	3	0	0	0	0
WSFT	Recovery	Theatres	21.23	0.96	143.3%	116.3%	90.9%	N/A	1.8%	0.0%	N/A	-1.20	0.50	3.90%	14.40%	4.30%	0	0	0	0	0	0
WSFT	Day Surgery Unit	Theatres	28.43	8.59	125.5%	N/A	98.0%	N/A	0.0%	0.0%	N/A	6.00	0.30	6.70%	34.70%	0.00%	0	0	1	0	0	0
	Day Surgery Wards		11.76	1.79					7.5%	0.0%		-1.30	0.10	18.70%	26.90%	4.80%						
WSFT	ETC	Opthalmology	TBC	TBC	29.2%	N/A	84.6%	N/A	0.6%	0.0%	N/A	-1.80	0.80	0.90%	26.50%	5.00%	N/A	0	0	0	0	0
WSFT	PAU	Pre-assessment	TBC	TBC	61.2%	N/A	86.4%	N/A	0.0%	0.0%	N/A	-1.00	0.10	9.60%	24.70%	3.30%	N/A	0	0	0	0	0
WSFT	Endoscopy	Endoscopy	TBC	TBC	165.9%	N/A	130.3%	N/A	0.0%	0.0%	N/A	-2.00	-4.00	4.30%	21.10%	2.00%	N/A	0	0	0	1	0
WSFT	Cardiac Centre	Cardiology	38.14	15.20	101.0%	87.2%	94.2%	111.3%	4.4%	0.0%	9.5	-3.10	2.90	4.40%	14.60%	2.60%	3	1	1	0	1	0
WSFT	G1	Palliative Care	23.96	8.31	82.7%	100.6%	91.2%	100.0%	13.0%	1.7%	10.3	-5.70	3.50	14.20%	14.60%	2.60%	1	5	0	0	0	0
WSFT	G3	Endocrine & Medicine	TBC	TBC	94.8%	128.2%	117.7%	147.2%	16.4%	1.4%	5.9	-3.90	-5.30	5.80%	14.50%	0.00%	1	3	3	0	0	0
WSFT	G4	Elderly Medicine	19.16	24.36	87.0%	90.1%	82.9%	101.4%	15.2%	1.3%	5.4	-2.50	1.10	6.70%	9.20%	1.40%	1	5	0	0	1	0
WSFT	G5	Elderly Medicine	18.41	22.66	98.0%	97.8%	87.0%	154.0%	28.0%	3.5%	5.8	-3.80	-1.80	7.30%	12.50%	0.00%	2	2	0	0	0	0
WSFT	G8	Stroke	23.15	28.87	91.2%	92.0%	98.6%	115.6%	11.7%	3.1%	7.2	-0.70	-3.30	6.00%	15.40%	1.30%	0	1	1	0	0	0
WSFT	G9	Escalation	TBC	TBC	33.3%	36.5%	30.8%	37.7%	TBC	TBC	8.6	12.70	19.60	TBC	TBC	TBC	0	1	0	0	0	0
WSFT	F1	Paediatrics	18.13	7.16	125.3%	106.4%	94.0%	N/A	17.4%	0.0%	15.9	0.60	-0.70	12.40%	14.10%	3.40%	N/A	2	N/A	0	1	1
WSFT	F3	Trauma and Orthopaedics	19.58	22.27	96.8%	90.9%	93.3%	131.2%	16.9%	2.9%	5.9	-3.0	-0.60	7.00%	11.70%	2.40%	1	4	1	0	0	0
WSFT	F4	Trauma and Orthopaedics	12.78	10.59	92.3%	91.6%	62.4%	111.6%	6.9%	3.3%	7.5	-1.8	-2.30	9.00%	14.60%	0.00%	0	4	0	0	0	0
WSFT	F5	General Surgery & ENT	19.58	14.51	99.2%	92.0%	98.2%	109.9%	5.0%	0.4%	5.4	-1.8	-0.10	4.30%	13.10%	0.00%	1	3	0	1	0	0
WSFT	F6	General Surgery	19.57	14.51	95.1%	91.4%	86.0%	105.8%	14.9%	2.0%	4.9	-2.6	0.70	5.90%	12.20%	2.10%	3	0	0	0	2	0
WSFT	F8	Respiratory	19.90	20.13	100.1%	94.5%	95.5%	101.2%	4.9%	7.0%	6.7	-4.00	-2.40	4.30%	11.10%	0.00%	1	2	0	0	0	0
WSFT	F9	Gastroenterology	20.32	22.56	99.2%	101.9%	78.2%	115.7%	17.3%	0.4%	8.6	-2.50	-2.10	5.70%	8.30%	7.20%	3	1	1	1	1	0
WSFT	F10	Escalation	TBC	TBC	82.9%	100.6%	104.1%	108.5%	12.6%	7.1%	6.4	12.60	23.40	6.20%	16.70%	0.00%	0	5	3	0	1	0
WSFT	F11	Maternity															1	1	0	0	2	0
WSFT	MLBU	Midwifery Led Birthing Unit	49.58	13.89	92.9%	90.2%	86.7%	84.9%	7.9%	0.0%	N/A	3.70	-1.90	8.30%	11.30%	3.40%	0	0	0	0	0	0
WSFT	Labour Suite	Maternity															0	1	0	0	0	0
WSFT	Antenatal/Gynae Clinic	Maternity	TBC	TBC	86.1%	N/A	75.9%	N/A	1.5%	0.0%	N/A	1.90	-0.40	1.90%	24.70%	0.00%	N/A	0	0	0	0	0
Community	Community Midwifery	Maternity	TBC	TBC	55.8%	N/A	38.1%	N/A	3.2%	0.0%	N/A	-3.70	0.00	8.50%	14.10%	6.30%	0	0	0	0	0	0
WSFT	F12	Infection Control	11.02	5.00	92.2%	93.8%	99.3%	103.8%	7.1%	0.0%	8.5	-2.80	1.10	1.90%	11.50%	0.00%	0	0	0	0	1	0
WSFT	F14	Gynaecology	11.18	1.00	107.4%	97.9%	N/A	N/A	18.4%	0.0%	12.7	-1.00	1.00	2.30%	15.10%	0.00%	0	0	0	0	0	0
WSFT	MTU	Medical Treatment Unit	7.04	1.80	94.0%	N/A	73.6%	N/A	4.4%	0.0%	N/A	0.80	-0.20	2.60%	22.70%	5.90%	0	1	0	0	0	0
WSFT	NNU	Neonatal	20.85	3.64	114.9%	85.0%	29.0%	51.6%	2.1%	0.0%	36.8	-0.20	-1.00	2.40%	12.10%	7.90%	N/A	1	N/A	0	0	0
WSFT	Outpatients	Outpatients	TBC	TBC	103.4%	N/A	135.4%	N/A	2.5%	0.0%	N/A	1.30	-4.20	14.10%	22.60%	4.60%	N/A	0	0	0	1	0
1	Radiology Nursing	Radiology	TBC	TBC	74.3%	N/A	127%	N/A	1.3%	0.0%	N/A	-0.40	-2.00	3.80%	20.50%	3.50%	N/A	2	0	0	0	0
WSFT	DWA	Discharge Waiting area	TBC	TBC	27.0%	N/A	53.9%	N/A	48.2%	1.9%	N/A	-0.20	0.00	3.90%	28.60%	0.00%	0	2	0	0	0	0
Newmarket	Rosemary Ward	Step - down	12.34	13.47	95.7%	100.2%	104.6%	97.8%	5.1%	6.5%	5.6	-3.20	-1.30	6.20%	15.40%	4.30%	0	0	2	0	1	0
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64	97.2%	99.1%	101.9%	104.8%	4.8%	1.8%	5.1	-2.20	-1.20	8.90%	11.20%	0.00%	0	0	0	0	0	0
					93.05%	95.47%	88.36%	111.46%				-33.50	8.20	6.32%	16.45%	2.43%	22	68	20	3	19	3
					AVG	AVG	AVG	AVG				TOTAL	TOTAL	AVG	AVG	AVG	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL

Trust	Team Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Patient facing contact (hrs)	Unplanned requests	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (New)	Nursing/Midwifery Administrative Medication Errors	Red Incidents	Missed Visits	Complaints	Compliments
			Registered	Unregistered			Registered	Unregistered									
Community	Bury Town	Community Heath Team	17.59	5.60	**1,482.28**	104	-1.90	0.00	1.00%	Not available comprehensively till Healthroster implemented	Not available this month	4	0	0	3	0	0
Community	Bury Rural	Community Heath Team	10.00	1.20	764.17	39	-1.60	-0.60	11.04%			4	0	0	0	0	0
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91	846.55	43	-1.00	-1.00	3.82%			1	1	0	0	0	0
Community	Newmarket	Community Heath Team	8.10	2.75	693.75	37	-1.78	-0.60	2.65%			5	0	0	0	0	0
Community	Sudbury	Community Heath Team	18.03	8.36	1,502.98	60	-3.85	-1.20	8.43%			9	1	0	1	0	0
Community	Haverhill	Community Heath Team	8.97	4.23	963.85	55	0.50	0.00	14.15%			0	0	0	0	1	0
Community	Admission Prevention Service	Specialist Services	11.28	3.45	67.48	0	-1.40	-0.80	15.25%			0	0	0	0	0	0
Community	Specialist Services	Cardiac Rehab and Heart Failure	TBC	TBC	490.37	2	0.00	0.00	0.00%			0	1	0	0	0	0
Community	Children	Community Paediatrics	16.37	15.01	1110.15	0	0.00	0.00	6.21%			N/A	2	0	0	0	0
					7921.58	340.00	-11.03	-4.20	6.95%	#DIV/0!	#DIV/0!	23	5	0	4	1	0
					TOTAL	TOTAL	TOTAL	TOTAL	AVG	AVG	AVG	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL

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

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

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Nov-19		Establishment for the Financial Year 2019/20		Data for November 2019																	
					Workforce												Nursing Sensitive Indicators					
Trust	Ward/Area Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Fill rate Registered %		Fill rate Unregistered %		Bank Use %	Agency use %	Overall Care Hours Per Patient Day	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)	Red Incidents	Complaints	Compliments
			Registered	Unregistered	Day	Night	Day	Night				Registered	Unregistered									
WSFT	ED	Emergency Department	54.91	23.43							N/A						N/A					
WSFT	AAU	Acute Admission Unit	27.30	29.59																		
WSFT	F7	Short Stay Ward	22.84	30.94																		
WSFT	CCS	Critical Care Services	41.07	1.88			N/A	N/A														
WSFT	Theatres	Theatres	61.68	22.27			N/A	N/A			N/A						N/A					
WSFT	Recovery	Theatres	21.23	0.96				N/A			N/A								N/A			
WSFT	Day Surgery Unit	Theatres	28.43	8.59		N/A		N/A			N/A											
	Day Surgery Wards		11.76	1.79																		
WSFT	ETC	Opthalmology	TBC	TBC		N/A		N/A			N/A						N/A					
WSFT	PAU	Pre-assessment	TBC	TBC		N/A		N/A			N/A						N/A					
WSFT	Endoscopy	Endoscopy	TBC	TBC		N/A		N/A			N/A						N/A					
WSFT	Cardiac Centre	Cardiology	38.14	15.20																		
WSFT	G1	Palliative Care	23.96	8.31				N/A														
WSFT	G3	Endocrine & Medicine	TBC	TBC																		
WSFT	G4	Elderly Medicine	19.16	24.36																		
WSFT	G5	Elderly Medicine	18.41	22.66																		
WSFT	G8	Stroke	23.15	28.87																		
WSFT	F1	Paediatrics	18.13	7.16				N/A									N/A		N/A			
WSFT	F3	Trauma and Orthopaedics	19.58	22.27																		
WSFT	F4	Trauma and Orthopaedics	12.78	10.59																		
WSFT	F5	General Surgery & ENT	19.58	14.51																		
WSFT	F6	General Surgery	19.57	14.51																		
WSFT	F8	Respiratory	19.90	20.13																		
WSFT	F9	Gastroenterology	20.32	22.56																		
WSFT	F11	Maternity	49.58	13.89							N/A											
WSFT	MLBU	Midwifery Led Birthing Unit																				
WSFT	Labour Suite	Maternity																				
WSFT	Antenatal/Gynae Clinic	Maternity	TBC	TBC		N/A		N/A			N/A						N/A					
Community	Community Midwifery	Maternity	TBC	TBC		N/A		N/A			N/A											
WSFT	F12	Infection Control	11.02	5.00																		
WSFT	F14	Gynaecology	11.18	1.00			N/A	N/A														
WSFT	MTU	Medical Treatment Unit	7.04	1.80		N/A		N/A			N/A											
WSFT	NNU	Neonatal	20.85	3.64													N/A		N/A			
WSFT	Outpatients	Outpatients	TBC	TBC		N/A		N/A			N/A						N/A					
WSFT	Radiology Nursing	Radiology	TBC	TBC		N/A		N/A			N/A						N/A					
WSFT	DWA	Discharge Waiting area	TBC	TBC		N/A		N/A			N/A											
Newmarket	Rosemary Ward	Step - down	12.34	13.47																		
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64																		
					#DIV/0! AVG	#DIV/0! AVG	#DIV/0! AVG	#DIV/0! AVG				0.00 TOTAL	0.00 TOTAL	#DIV/0! AVG	#DIV/0! AVG	#DIV/0! AVG	0 TOTAL	0 TOTAL	0 TOTAL	0 TOTAL	0 TOTAL	0 TOTAL

Trust	Team Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Patient facing contact (hrs)	Unplanned requests	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (New)	Nursing/Midwifery Administrative Medication Errors	Red Incidents	Missed Visits	Complaints	Compliments
			Registered	Unregistered			Registered	Unregistered									
Community	Bury Town	Community Heath Team	17.59	5.60						Not available comprehensively till Healthroster implemented	Not available this month						
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Community	Newmarket	Community Heath Team	8.10	2.75													
Community	Sudbury	Community Heath Team	18.03	8.36													
Community	Haverhill	Community Heath Team	8.97	4.23													
Community	Admission Prevention Service	Specialist Services	11.28	3.45													
Community	Specialist Services	Cardiac Rehab and Heart Failure	TBC	TBC													
Community	Children	Community Paediatrics	16.37	15.01								N/A					
					0.00 TOTAL	0.00 TOTAL	0.00 TOTAL	0.00 TOTAL	#DIV/0! AVG	#DIV/0! AVG	#DIV/0! AVG	0 TOTAL	0 TOTAL	0 TOTAL	0 TOTAL	0 TOTAL	0 TOTAL

Explanations	
	Fill Rate: an indication of patient safety - national target 80% (less than = red), Trust internal target 85% (equal and greater than = green)
	In vacancy column: - means vacancy and + means over established. Excludes maternity leave as separate column
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	F10 (F14) gynae inpatients ward no of beds 16 and 2 SR - and have a ward attender section

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

12. Nurse strategy update report

To ACCEPT the report

For Report

Presented by Rowan Procter

Trust Board – 28 February 2020

Agenda item:	12			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Duane M. Elmy, Business Manager			
Date prepared:	17th February 2020			
Subject:	Nursing & Midwifery Strategy 2016-2021: Update			
Purpose:		For information		For approval

Executive summary:

Led by the Executive Chief Nurse, the nursing and midwifery strategy was developed by April 2016 in collaboration with the relevant team members setting out the ambitions and priorities over the coming years, which is now just finished its first year.

It reflects and supports the national framework 'Leading Change, Adding Value: A framework for nursing, midwifery and care staff' was released in May 2016 and it closely aligns with the 'Five Year Forward View' as set out by Simon Stevens, Chief Executive, NHS England. Developing Workforce Safeguarding guidance has been released at the end of the 2018, and the aim of the document is to make sure we are adhering to this as well as working more closely with other departments and their reviewing.

The strategy aligned with the national nursing/midwifery and wider healthcare strategies to ensure nursing and midwifery continues to forge ahead, delivering the best care to patients, advancing and learning in tandem with national agendas whilst being sufficiently cognisant of local population needs.

This paper outlines the progress to date from April 2018 – March 2019 against the local nursing strategy and provides further detail in relation to the national direction.

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

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

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

Recommendation:
Description of update in detail given below.

The nursing strategy continues to drive improvements in care delivery and workforce redesign. The nursing & midwifery team continued to work alongside strategy in 2018/19 which ensured steps towards continually improving care, putting patients at the heart of what we do whilst ensuring our workforce are developed and valued for their contribution.

1. Purpose

The Nursing and Midwifery Strategy (2016-2021) was developed by April 2016 in collaboration with the relevant team members setting out the ambitions and priorities over the coming years, which is now just finished its first year. This strategy is under-pinned by our 'Putting you first' values and the ambitions set out in the Trust's vision, 'Our patients, Our hospital, Our future, together'

It reflects and supports the national framework for nursing midwifery and care staff 'Leading Change, Adding Value', which pledges to close the gaps between health and social care by targeting health and wellbeing, care and quality and funding and efficiency. We are committed to delivering the ten commitments of this national framework.

2. Progress

2.1. West and East Community split and move

WSFT are continuing to develop and integrate their services, with a HoN and Senior Matron being added to the Nursing structure to cover Adult Integrated Services

2.2. SAFER Patient Flow Bundle - Red2Green

The Red2Green Board Round has become part of normal practice.

2.3. Education

The organisation continues to explore and expand its links with local universities and colleges. The four-year apprenticeship nursing students are in their second year and progressing well.

The first cohort of nursing associates started their two-year programme in February 2020.

Bespoke courses that the organisation have commissioned include 'mental health for young people', managing suicidal conversations' and 'mental health and emotional first aid'.

We have supported the growth of the Nursing Directorate Education Team to ensure that our staff and students within the community environment receive the same level of support as those in the acute setting.

The overseas recruitment has been successful and to date 111 overseas nurses have gained their NMC registration. This includes two healthcare assistants who were already working within the Trust.

2.4. Staff levels and skills mix

The method of bay bed nursing has been implemented but also adapted depending on the ward. A review nursing is required by WSFT on an annual basis at least, along with doctors, AHPs – this is in line with Developing Workforce Safeguard objectives.

2.5. Nursing Current Awareness

Nursing Current Awareness is a list of useful sources of information still updated and reviewed. This has been organised to reflect the Trust's ambitions and also echoes

issues, such as frailty, which feature in the monthly Nursing and Midwifery Council meetings

2.6. Patient experience update

The team have recently done a review using CQC assessment tool, where WSFT scored fairly highly but have room for improvement in regards to reasonable adjustments

2.7. Nursing – related complaint reduction

Due to PALs the issues being dealt with earlier there has been a reduction in complaints

2.8. Reduction in HCAI

Reducing hospital-associated infections continues to be one of the main priorities for our patients and the public. In addition, it remains a key priority for the NHS as a whole and for our commissioners. Within the Trust we continue to strive for further improvement, with a focus on the timely identification and management of patients with infections and at risk of infection.

2.9. New ward/areas

In 2018, moves and development occurred to expand and improve our services. The three cardiac units/wards within the hospital where moved in to a newly developed area. A specific discharge waiting area was developed to help improve patient flow. The second phase of AAU is now completed. Two winter escalation wards were opened at the start of winter 2019/2020 these remain open at this moment in time. This has caused some strain on nurse cover but the HON, Matrons are liaising on a daily basis the Bank service, with HR and operations in order to mitigate patient safety risk.

2.10. Access to a leadership development and competency assessment AND Develop talent management programme to support the future workforce

The leadership development and talent management action plan continue for all levels of the Trust and contribute to the development of systems leadership in West Suffolk. This is owned by one of deputy's leads for workforce

This includes: The Key Leaders programme for 20 senior leaders across the organisation; the 2030 Leadership Programme for aspiring future senior leaders; co-ordinated participation in regional and national leadership development programmes; support for the further development of effective developmental coaching and mentoring at all levels of the Trust; and a series of leadership seminars.

2.11. Peer support system of nurses who require extra support

This continues being offered to new ward managers due to recent changes and is where experienced ward mangers support and meet with new ward managers. The same method has been implemented when new matrons start

2.12. Professional accountability flow diagram has changed

Please refer to Appendix A for altered flow diagram

2.13. Expert Navy Courses

The Expert Navy four-day programme is for ward managers and aspiring band 6 nurses. We continue to look for one band 6 from each area that we feel has the potential and aspiration for a band 7 role in the future. Feedback has continued to be very positive re this course.

This course was held twice in 2019 with approximately 60 nurses and midwives attending. The next course will start in April with a cohort of 35.

2.14. Perfect Ward app changes

The Perfect Ward app is gradually being rolled out to all areas within the trust and the community. A working group has been formed to explore the use of Perfect Ward to help with the recommended accreditation programme from NSHI.

https://improvement.nhs.uk/resources/guide-developing-and-implementing-ward-and-unit-accreditation-programmes/

Action planning will be introduced directly within the app in the very near future.

3. Next Steps

A fair amount of progress has been made in this year, but there are still improvements to be made. As well as continuing to develop areas where required, the Nursing Directorate will look to progress:

- Work with operations, finance, HR to improve reporting vacancies
- Leads to continue to use CREWS (Caring, Responsive, Effective, Well-Led, Safe) method to share information
- Nursing Directorate to work with all departments to ensure we develop towards meeting NHS Developing workforce safeguards objectives
- Retention methods and developing good wellbeing services for our nursing and midwifery staff

4. Embedding the strategy

As previously mentioned, the Nursing & Midwifery Strategy was developed by Nurses and Midwives working at all levels within the Trust. Therefore, all leaders of nursing or midwifery teams are continually finding areas to focus on and issues and/or areas of development and working with the appropriate staff to continue their hard work.

5. Conclusion & Recommendations

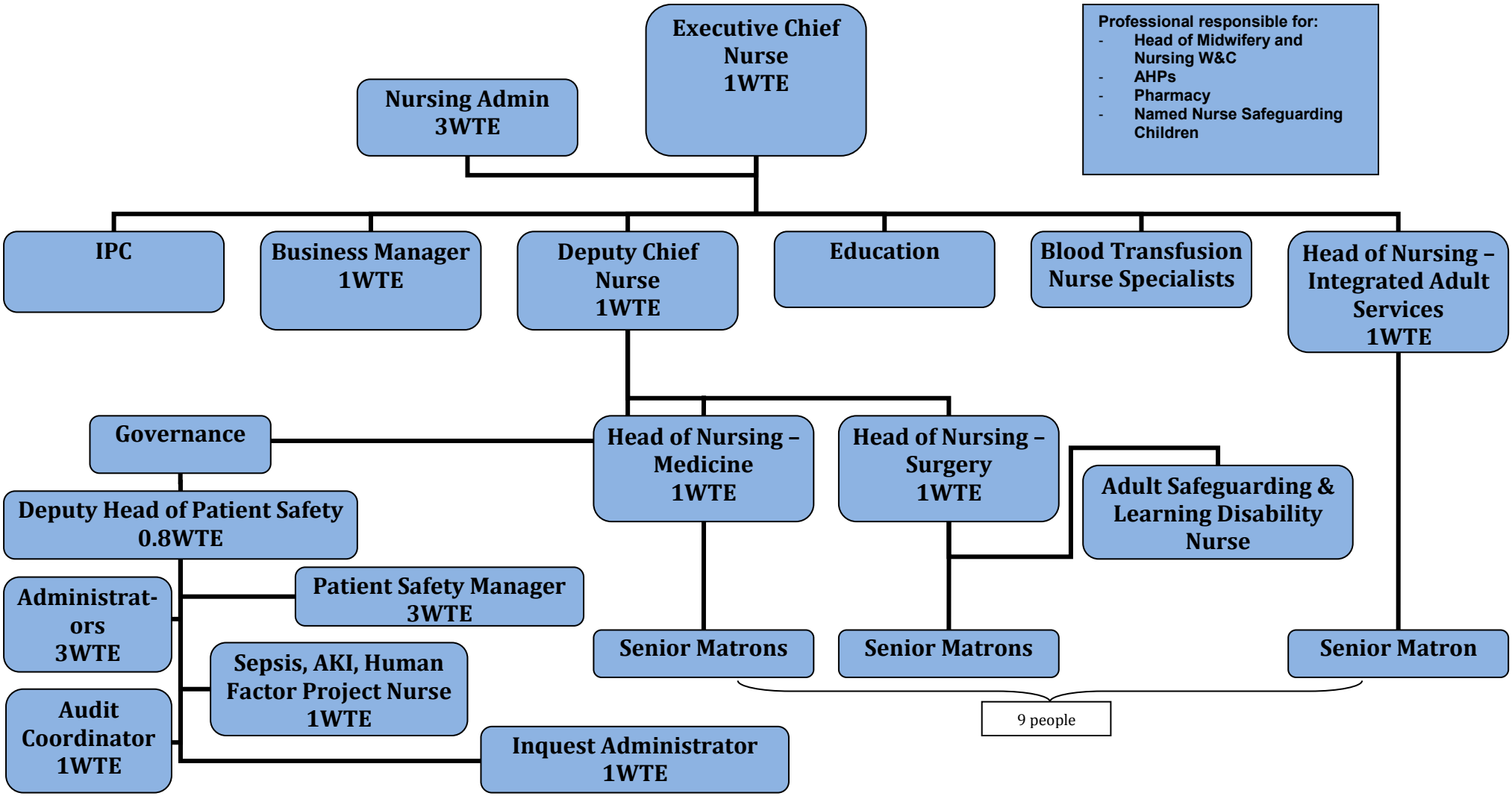
The nursing strategy continues to drive improvements in care delivery and workforce redesign. The nursing & midwifery teams will continue to work alongside strategy in 2020 as well as continuingly adapting practice to NHS Standards which will ensure steps towards constantly improving care, putting patients at the heart of what we do whilst ensuring our workforce are developed and valued for their contribution.

However, the strategy is due a review and will reflect the organisational strategy refresh that is also starting to take place

The Board are asked to note:

- The clear commitment amongst Trust staff to progress the principles within the Strategy especially through this continued difficult period that has again this year extended passed winter.
- The central focus for this workforce is recruiting, developing and maintaining them so that patients truly central to all care delivery.
- Many of the principles can only be achieved through collaborative working with colleagues working in Higher Education and CCGs, evidenced within the progress made to date.
- It is essential that internal department cohesively work together to achieve NHS Developing workforce Safeguard objectives
- The challenge now is to maintain the focus and quality while preparing for the next winter period.
- The Strategy should provide staff with a point of focus and help with decision making for the key priorities that need to be progressed

Appendix A – Professional Accountability at WSFT



13. Consultant appointment

None to report this month

For Report

Presented by Jeremy Over

14. Putting you first award

To NOTE a verbal report of this month’s winner

For Report

Presented by Jeremy Over

15. Staff Survey and improving our culture

To ACCEPT the report

For Report

Presented by Jeremy Over

Board of Directors – Friday 28 February 2020

Agenda item:	15			
Presented by:	Jeremy Over, Director of Workforce and Communications			
Prepared by:	Jeremy Over, Director of Workforce and Communications			
Date prepared:	12 February 2020			
Subject:	Staff Survey and Improving our Culture			
Purpose:	✓	For information		For approval

Executive summary:

Attached to this briefing paper is a slide deck that the Director of Workforce & Communications will present at the Board meeting on 28 February. Also attached is the full staff survey report for information and reference.

During recent weeks we have received and have been reflecting on our CQC report and staff survey results. This agenda item helps to bring together the learning arising from both of these and provides a briefing for the Board on how we are taking these forward in conversations with staff across WSFT.

The annual NHS Staff Survey was undertaken during October and November 2019. All NHS organisations participate simultaneously in what is the largest and most comprehensive staff feedback exercise across the health service. Each organisation appoints an external contractor to administer a common 90-question survey. The raw data is then triangulated and benchmarked for comparator organisations.

The CQC report published four weeks ago requires us to make improvements, further to an inspection process that took place during the autumn. Fundamentally this includes in relation to our leadership and how it supports staff and builds the best culture for WSFT. The report makes several recommendations related to this and, as senior leaders in the organisation, we will all have started to think about how we individually and collectively respond.

No organisation is perfect. Even those hospital trusts with the best scores in the staff survey do not have perfect scores. There is always scope for improvement. The top-line scores for each question are also averages. There will be some individuals and teams that report better experience than the average, and there will be others that report worse. It is also important to look at the results compared to our own previous scores, as well as that of other, comparator organisations.

The West Suffolk staff survey has, in recent years, produced results that compare favourably with other NHS organisations. The 2019 results suggest that this remains the case, with some notable further improvement in many of the scores. For instance, in recommending WSFT as a place to work and receive care – these scores are very close to being the best scores in the country.

Some of the scores might appear surprising compared with some of the headlines arising from the CQC report. For instance, the 'safety culture' score (which includes questions around speaking up safely) is very close to being equal to the top score in the country. The staff survey results clearly do not trump the CQC report, and vice versa, and they must be looked at in the round to explore what they are collectively telling us. The presentation slides start to do that – for instance as we drill down into the results at staff group and divisional / departmental level.

Next steps:

1. Share the report with staff and stakeholders
2. Reflect on the results as part of post-CQC conversations with staff
3. Drill-down further into the results at staff group, division and department level
4. Identify staff groups and areas of the Trust that:
    a. Report the best staff experience at WSFT – to learn from best practice and spread wider
    b. Report a relatively poor staff experience at WSFT – to provide them with support
5. Consult with staff and staff representatives to agree priorities for action

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

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

Previously considered by:	N/A
Risk and assurance:	The NHS staff survey is a primary indicator of staff morale and staff experience. The CQC report and recommendations highlight areas of risk and assurance. This includes feedback from staff and observations from inspectors. Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.
Legislation, regulatory, equality, diversity and dignity implications	Certain themes in the staff survey and CQC report are pertinent indicators related to legislation such as the Equality Act, and regulations such as freedom to speak up / protected disclosures.

Recommendation:

For information and discussion.

NHS
West Suffolk
NHS Foundation Trust

WSFT Staff Survey 2019

Supporting staff, improving our culture

Board of Directors: Friday 28 February 2020

Putting you first

Why this is important…

NHS
West Suffolk
NHS Foundation Trust

Hospitals where staff feel more engaged and supported have better outcomes, lower mortality, reduced infections, fewer mistakes and are more efficient

Prof M West (2012): King's Fund

Introduction

- Probably the largest & most comprehensive staff feedback exercise in the world (!) – 570,000 responses nationally
- Survey period: October-November 2019
- 11 themes, 90 questions
- Sample vs census: we undertook the latter, giving all staff the opportunity to take part
- 2,100 responses; 52% response *(+4% on 2018; the England average is 48%)*
- www.nhsstaffsurveys.com

A reminder…

- No organisation is perfect
- Even those NHS organisations with the best scores do not have perfect scores
- The ‘headline’ scores for each question are averages – there will be individuals and teams that report better experience than the average, and there will be others that report worse
- The best thing we can do with these results is use them to improve the experience of every single staff member at WSFT

WSFT: eleven themes

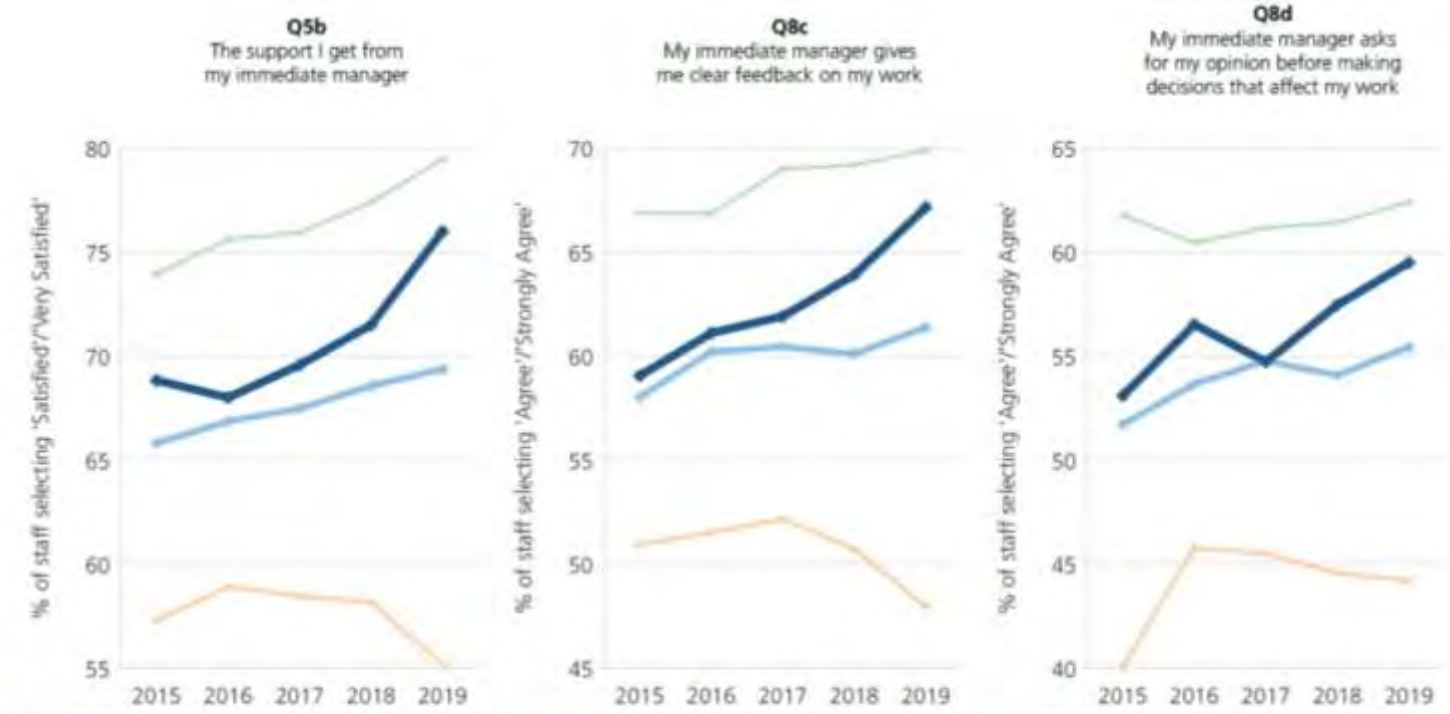
- Staff engagement score of 7.5 / 10.0 – equal to best in the country
- Morale (6.6) and Safety Culture (7.1) scores are close (0.1) to best in country score
- 8 of 11 themes have improved for WSFT compared with 2018; the other 2 are unchanged
- All 11 are better than the national averages
- 3 of 11 themes have improved significantly (Morale; Immediate Managers; & Quality of Appraisals)

WSFT: positive signs

NHS West Suffolk NHS Foundation Trust

Theme	Why
Better support to staff from their immediate managers	Significant and sustained 5-year improvement trend related to staff's views of support from their line manager
Improving scores related to speaking up safely	Significant and sustained 5-year improvement trend related to feeling secure in raising safety concerns
Opinions of WSFT as a place to work & receive care	Close to 'best acute trust' score for both measures (1-2% gap) – c.15% better than the national averages
AHP, A&C & Healthcare Scientist staff-groups	Staff survey scores for these staff groups are consistently better than the WSFT average
Positive staff experience in our Community Services	Survey scores from our staff in Community services represent the best on a divisional basis across WSFT

Supportive immediate managers – trends (1/2)



	2015	2016	2017	2018	2019
Best	74.0%	75.6%	76.0%	77.4%	79.5%
Your org	68.8%	68.0%	69.6%	71.5%	76.0%
Average	65.8%	66.9%	67.5%	68.6%	69.4%
Worst	57.3%	58.9%	58.4%	58.2%	55.2%

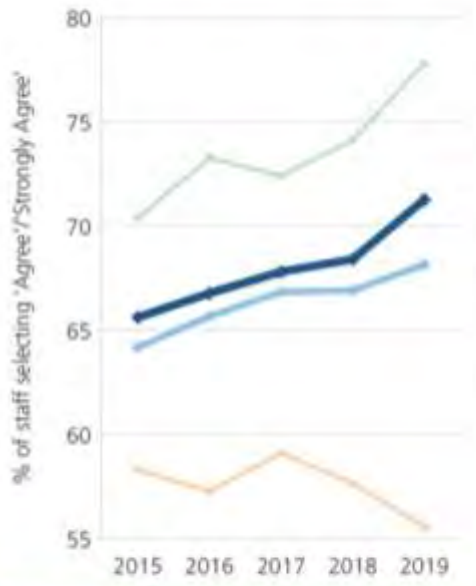
	2015	2016	2017	2018	2019
Best	66.9%	66.9%	69.0%	69.2%	69.9%
Your org	59.1%	61.1%	61.9%	63.9%	67.2%
Average	58.0%	60.2%	60.5%	60.1%	61.4%
Worst	50.9%	51.5%	52.2%	50.7%	48.0%

	2015	2016	2017	2018	2019
Best	61.8%	60.5%	61.2%	61.4%	62.4%
Your org	53.1%	56.5%	54.7%	57.5%	59.5%
Average	51.7%	53.7%	54.8%	54.1%	55.4%
Worst	40.0%	45.8%	45.5%	44.5%	44.2%

Supportive immediate managers – trends (2/2)

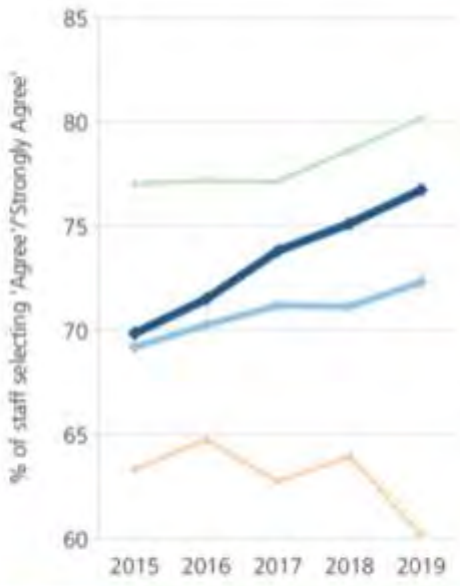
West Suffolk NHS Foundation Trust

Q8f
My immediate manager takes a positive interest in my health and well-being



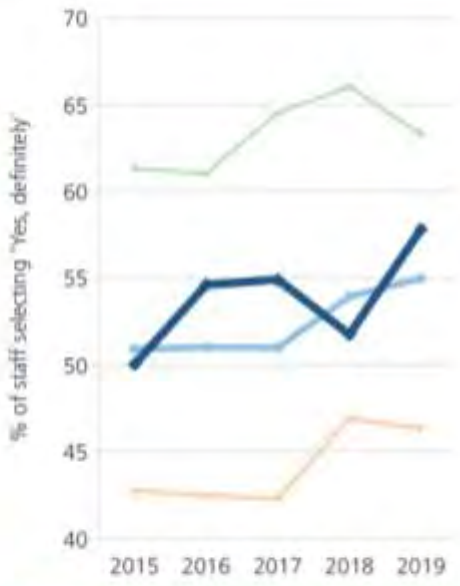
	2015	2016	2017	2018	2019
Best	70.4%	73.3%	72.4%	74.1%	77.8%
Your org	65.6%	66.8%	67.8%	68.4%	71.3%
Average	64.2%	65.6%	66.8%	66.9%	68.1%
Worst	58.3%	57.2%	59.1%	57.6%	55.5%

Q8g
My immediate manager values my work



	2015	2016	2017	2018	2019
Best	77.0%	77.2%	77.1%	78.6%	80.2%
Your org	69.8%	71.5%	73.8%	75.1%	76.7%
Average	69.2%	70.2%	71.2%	71.1%	72.3%
Worst	63.3%	64.7%	62.7%	63.9%	60.2%

Q19g
My manager supported me to receive this training, learning or development

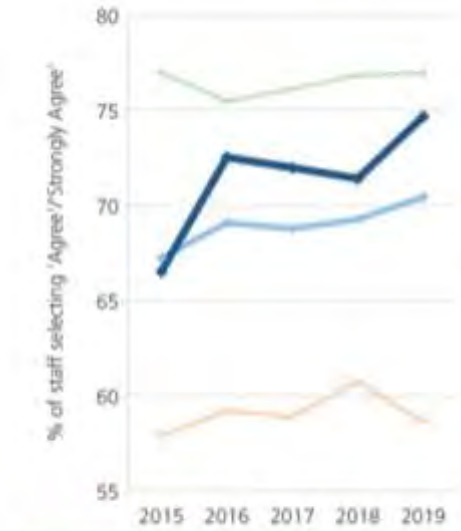


	2015	2016	2017	2018	2019
Best	61.3%	61.0%	64.5%	66.0%	63.3%
Your org	50.0%	54.6%	54.9%	51.7%	57.8%
Average	50.9%	51.0%	51.0%	53.9%	55.0%
Worst	42.7%	42.5%	42.3%	46.9%	46.3%

Safety culture & ‘recommend WSFT’ trends

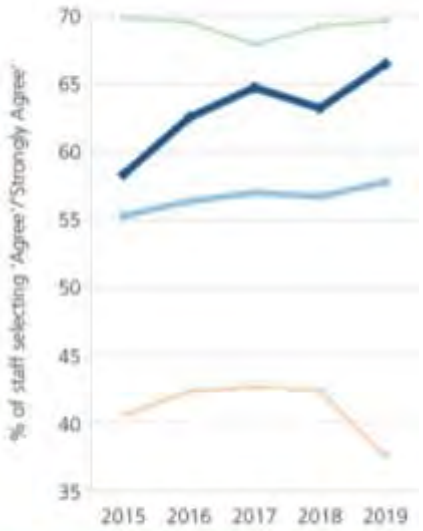
West Suffolk NHS Foundation Trust

Q18b
I would feel secure raising concerns about unsafe clinical practice



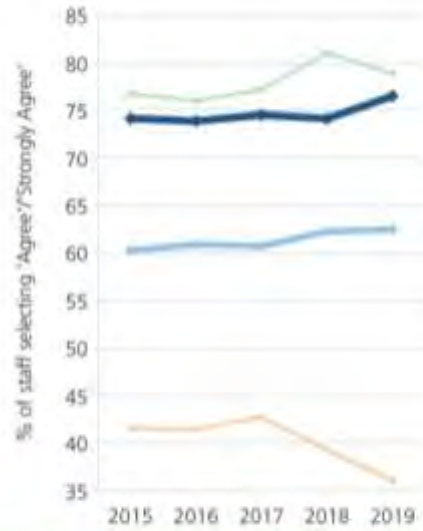
	2015	2016	2017	2018	2019
Best	77.0%	75.5%	76.1%	76.9%	77.0%
Your org	66.5%	72.5%	72.0%	71.4%	74.7%
Average	67.2%	69.1%	68.8%	69.3%	70.4%
Worst	57.9%	59.2%	58.9%	60.8%	58.6%

Q18c
I am confident that my organisation would address my concern



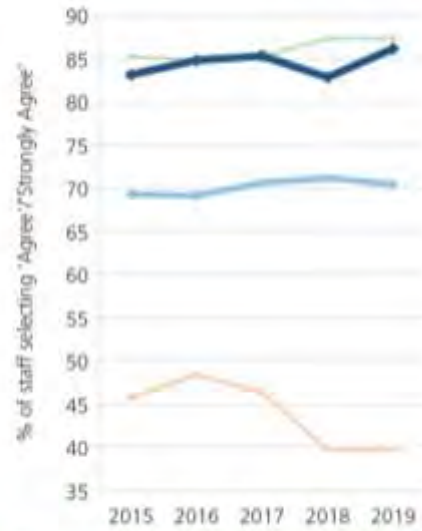
	2015	2016	2017	2018	2019
Best	69.9%	69.5%	67.9%	69.2%	69.6%
Your org	58.3%	62.5%	64.7%	63.2%	66.4%
Average	55.2%	56.3%	56.9%	56.7%	57.7%
Worst	40.6%	42.3%	42.6%	42.4%	37.6%

Q21c
I would recommend my organisation as a place to work



	2015	2016	2017	2018	2019
Best	76.8%	76.0%	77.2%	81.1%	78.9%
Your org	74.2%	73.9%	74.6%	74.1%	76.5%
Average	60.3%	60.9%	60.7%	62.3%	62.5%
Worst	41.6%	41.4%	42.7%	39.3%	36.0%

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2015	2016	2017	2018	2019
Best	85.3%	84.8%	85.3%	87.3%	87.4%
Your org	83.2%	84.8%	85.3%	82.8%	86.2%
Average	69.3%	69.1%	70.6%	71.2%	70.5%
Worst	45.8%	48.4%	46.4%	39.7%	39.7%

WSFT: areas of concern

NHS West Suffolk NHS Foundation Trust

Theme	Why
Staff reporting feeling stressed at work	Rise in % reporting stress at work (+4% over 2 years) – in line with national average but not acceptable
Staff feeling able to deliver the care they aspire to give	8% gap between WSFT and best acute Trust in country – what would help to close this gap for staff?
BME staff experiencing discrimination	22 of 185 (12%) BME staff who completed survey felt they had experienced this. Double % of white staff.
Experience of staff with a disability	Disabled staff report a worse experience compared with non-disabled (esp. feeling bullied or harassed)
Bullying, harassment & abuse reported by N&M staff	This staff group report generally positive scores but are below WSFT average for bullying & harassment
Safety culture responses from M&D and Estates staff	The scores for these staff groups are worse than our overall position for speaking up safely questions
Bullying, harassment & abuse in Women & Children's	The score for bullying & harassment in this divisional area is notably worse than the WSFT average

Bringing together our CQC report & staff survey results

- Consider them alongside each other – what can we learn?
- 48% of our staff did not respond to the staff survey
- The scores are not perfect; and there will be staff / teams who report worse experience than the average
- Use the two together in conversations with staff to understand what is happening for them
- Use both to identify the specific staff groups / departments that need enhanced support

What the CQC said…

NHS
West Suffolk
NHS Foundation Trust

"Not all staff felt respected, supported and valued or felt that they could raise concerns without fear of retribution. This has been exacerbated by the way the trust has managed recent issues of concern."

The CQC found that "the style of executive leadership did not demonstrate an open and empowering culture. There was an evident disconnect between the executive team and some consultants"

"Safety concerns were not consistently identified or addressed quickly enough, and incidents were not always reported in a timely manner. Wider lessons were not identified or shared effectively to improve patient safety."

Reflecting on what we already do

NHS West Suffolk NHS Foundation Trust

Improving our culture, supporting staff - 3 themes

We want to make West Suffolk a great place to work for every member of our team. A place that learns lessons, makes improvements and supports all our staff with compassion, kindness and always striving to do the right thing for patients and colleagues

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

More and better listening to staff feedback to inform how we lead and improve

NHS West Suffolk NHS Foundation Trust

1. We will have a series of staff conversations with all our staff around our values and culture and how we can support the development of a culture of openness and speaking up, and communicate our progress

2. We will use the staff survey and the Medical Engagement Scale survey to identify areas for further support, engagement and communication

3. We will support the Better Working Lives group to develop enhanced support for our doctors taking into account staff conversations, impact of technological change, burnout surveys and medical engagement feedback

4. Consider and take forward ideas already forthcoming from staff, for example looking at the support for staff involved in serious incidents or inquests; enhanced clinical psychologist support for staff; implementing Schwartz Rounds for staff to share their experiences of working in the NHS; and continue to listen to ideas and feedback

Focused and better support for specific issues and teams identified in the CQC report

5. There will be an independent review by NHS Improvement of the handling of a data breach investigation which we will learn from and embed any recommendations

6. We will work with the National Speak Up Guardian's Office to grow our speak up culture and learn from their expertise

7. We will facilitate additional conversations and specific support for teams identified in the CQC report to address their concerns, for instance Pathology and Paediatrics

8. We will review our HR policies and procedures to ensure they are kinder and more compassionate

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

NHS
West Suffolk
NHS Foundation Trust

9. Consider how we learn from work elsewhere in the NHS on growing a just and learning culture – where all staff feel supported and empowered to learn when things don't go as expected.

10. We will bring together all of our Q.I. initiatives as part of increased support and profile to improving quality, for example our work programmes encompassing human factors and learning from deaths

11. The Board has embarked on an externally facilitated development programme and will be undertaking a programme of 360 feedback as part of a commitment to listening and improving

12. We will ensure that our leadership programmes support the development of an open and empowering approach to leadership and culture, including how the 5 O'clock club prioritises speakers to support this

Discussion & next steps

All staffs' thoughts and ideas will be invaluable to getting this right

Conversations have informed the steps taken thus far and we are asking staff for their feedback on these plans

- What do they think?
- What else would they like to see?
- What are the practical ways they would like to see all this taken forward?
- Would they like to be involved?

Survey Coordination Centre

NHS England

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey

Benchmark Report

Contents

Introduction

This benchmark report for West Suffolk NHS Foundation Trust contains results for themes and questions from the 2019 NHS Staff Survey, and historical results back to 2015 where possible. These results are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations.

Please note: q1, q10a, q19f, q23d-q28a and q29-q31b are not weighted or benchmarked because these questions ask for demographic or factual information.

Full details of how the data are calculated and weighted are included in the Technical Document, available to download from our results website.

The structure of this report

Introduction

- Introduction
- Using the report
- Organisation details

Provides a brief introduction to the report, including the graphs used throughout.

The '**Organisation details** ' page contains key information about the organisation's survey and its benchmarking group.

Theme results

- Overview
- Trends
- Detailed information

The eleven themes provide a high level overview of the results for an organisation.

The '**Detailed information**' sub-section contains the question results that feed into each theme.

Question results

- Your job
- Your managers
- Your health, well-being and safety at work
- Your personal development
- Your organisation
- Background details

Results from all questions, structured by the questionnaire sections.

Workforce Equality Standards

- Introduction
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)

Shows data required for the NHS Staff Survey indicators used in the Workforce Equality Standards.

Appendices

- Response rate trends
- Significance testing of themes
- Tips on action planning and interpreting results
- Additional reporting outputs

'**Significance testing of themes**' contains comparisons for the 2019 and 2018 theme scores.

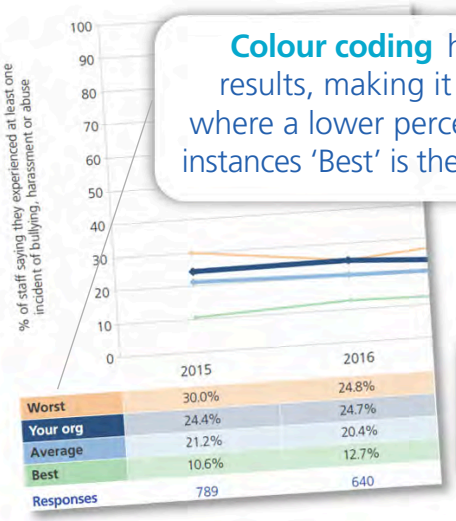
Using the report

Key features

Question number and text (or the theme) specified at the top of each slide

Slide headers are **hyperlinked** throughout the document. '2019 NHS Staff Survey Results' takes you back to the contents page (which is also hyperlinked to each section), while the rest of the text highlighted in bold can be used to navigate to sections and sub-sections

Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Themes are always on a 0-10pt scale where 10 is the best score attainable



	2015	2016
Worst	30.0%	24.8%
Your org	24.4%	24.7%
Average	21.2%	20.4%
Best	10.6%	12.7%
Responses	789	640

Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table

Keep an eye out!

Number of responses for the organisation for the given question

	2015	2016	2017	2018	2019
Best	90.0%	95.2%	93.1%	96.2%	94.3%
Your org	90.0%	88.0%	89.2%	90.8%	90.2%
Average	83.6%	86.7%	86.8%	88.0%	89.2%
Worst	68.3%	73.2%	79.1%	70.1%	82.1%
Responses	776	640	702	736	811

124

'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results**

Tips on how to read, interpret and use the data are included in the Appendices

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey

Organisation details

Completed questionnaires **2,077**

2019 response rate **52%**

See response rate trend for the last 5 years

Survey details

Survey mode **Mixed**

Sample type **Census**

This organisation is benchmarked against:

Acute Trusts

2019 benchmarking group details

Organisations in group: **85**

Median response rate: **47%**

No. of completed questionnaires: **259,296**

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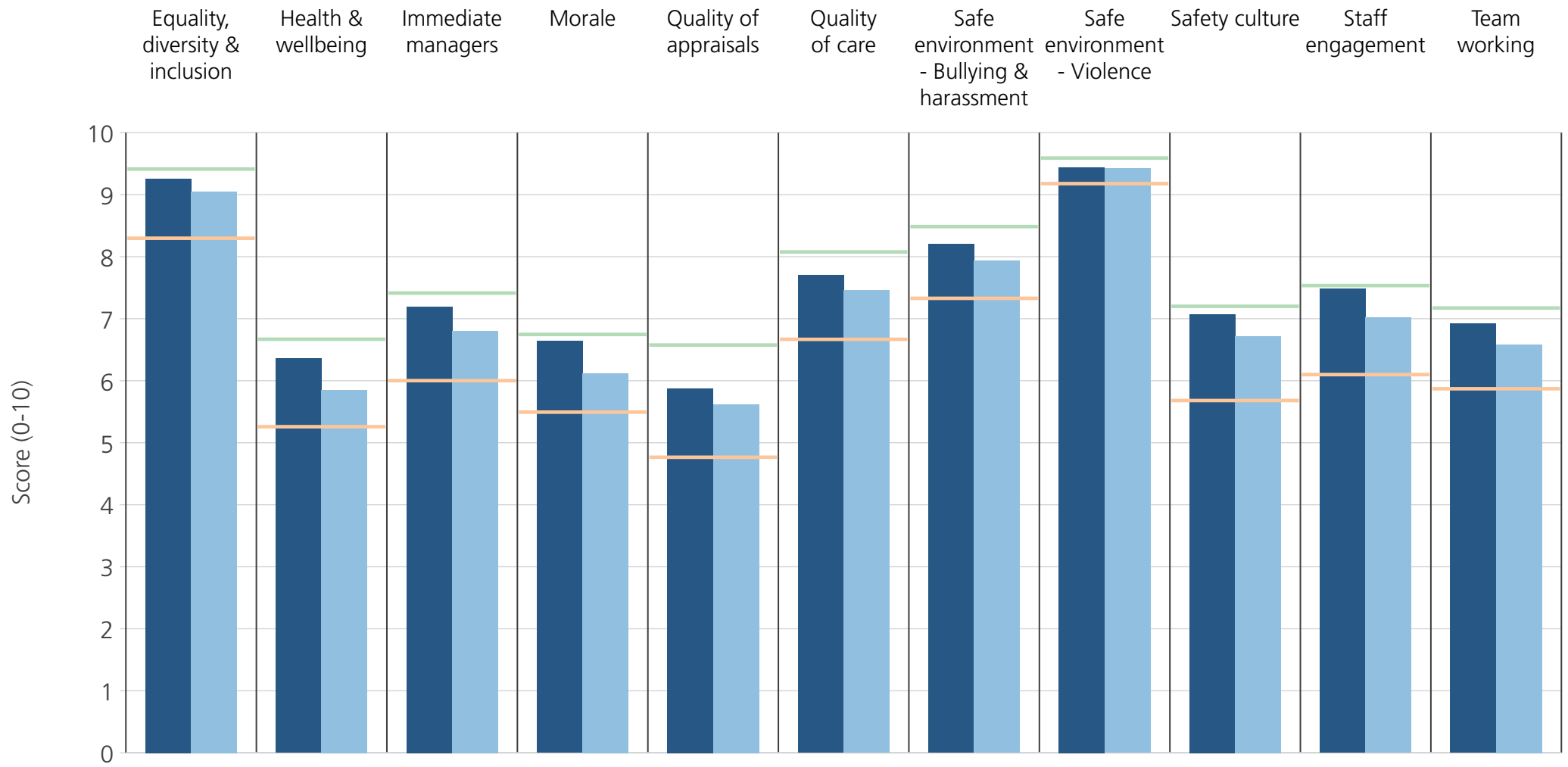
Theme results

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.3	6.4	7.2	6.6	5.9	7.7	8.2	9.4	7.1	7.5	6.9
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	2,032	2,047	2,046	2,007	1,783	1,815	2,018	2,026	2,024	2,068	2,035

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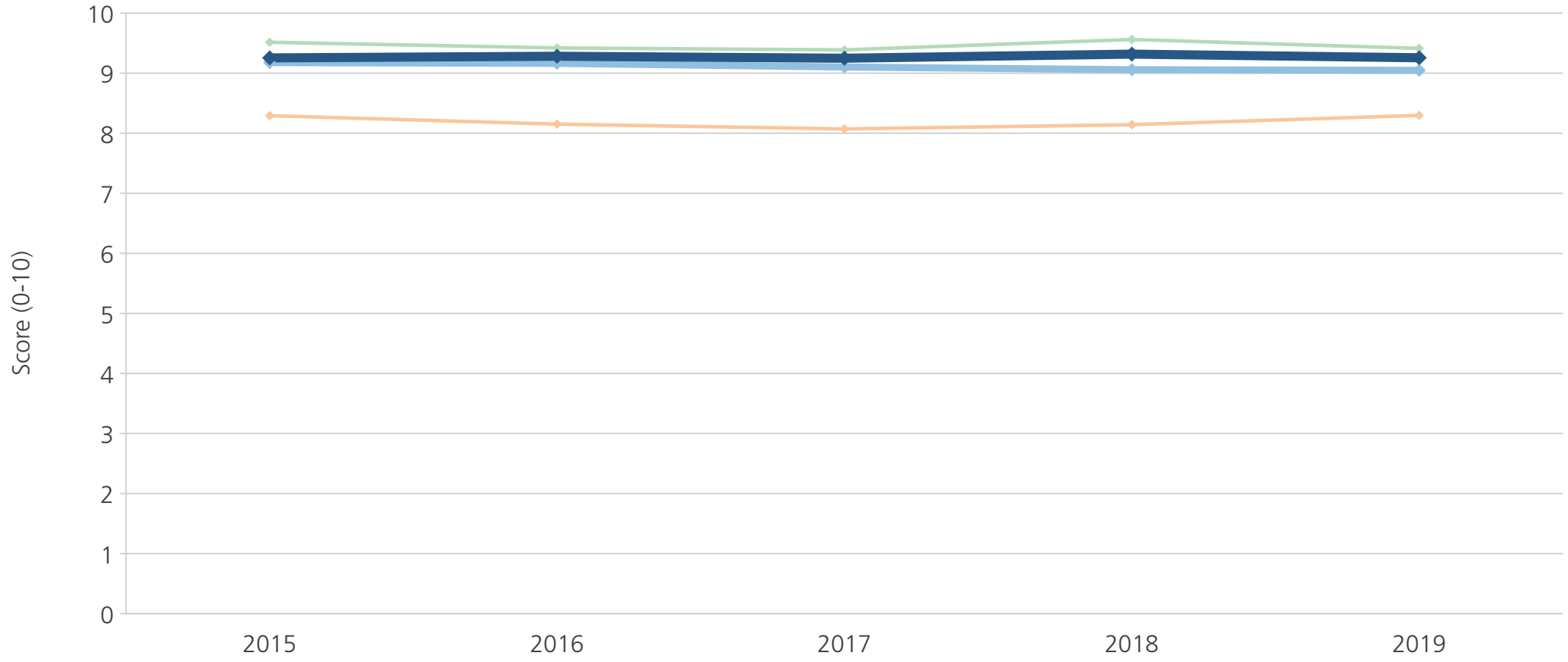
NHS England

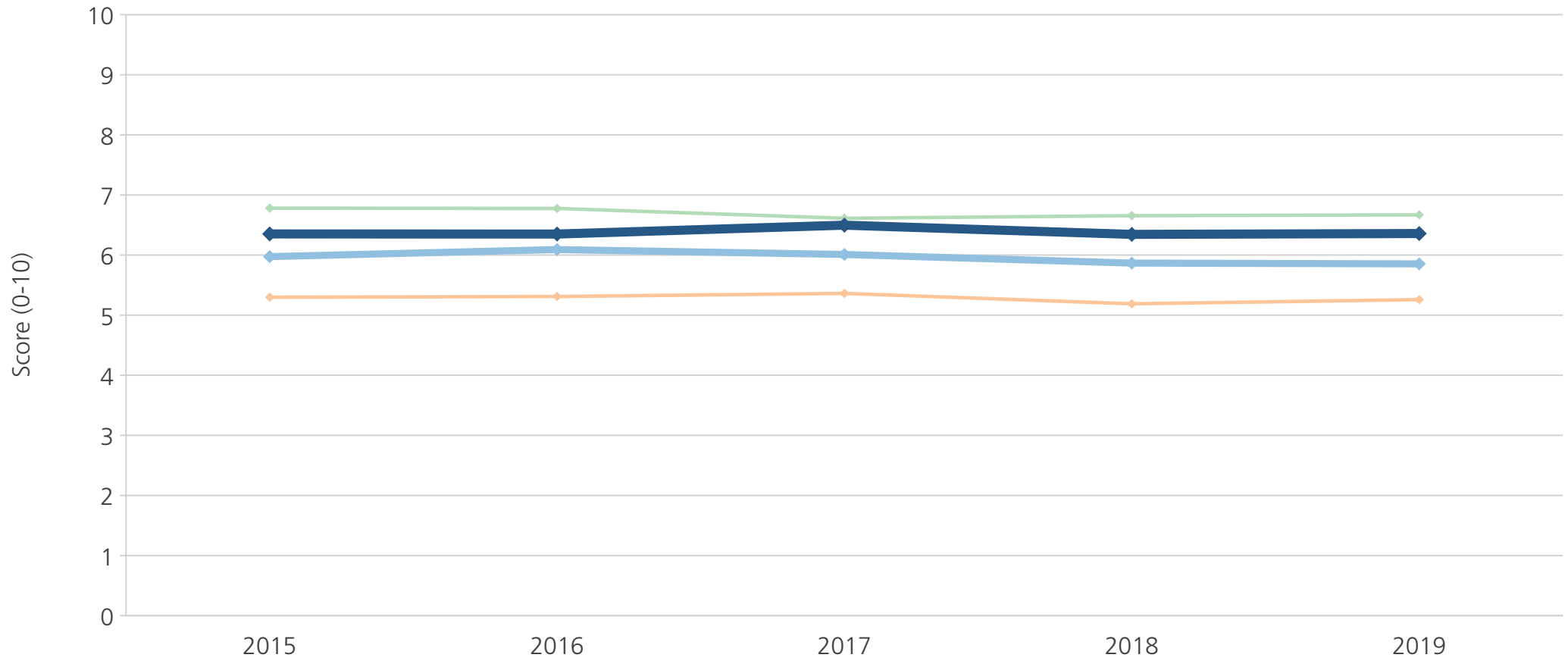
Theme results – Trends

West Suffolk NHS Foundation Trust

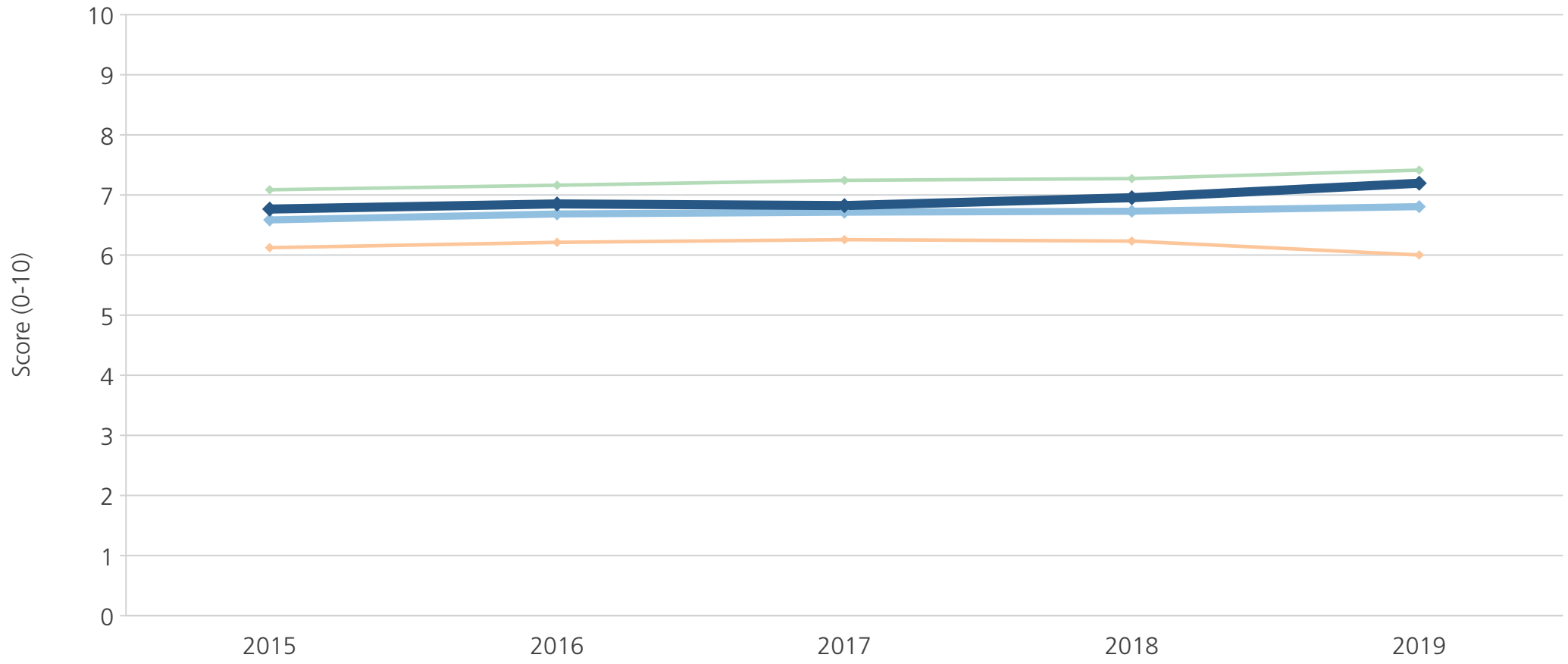
2019 NHS Staff Survey Results



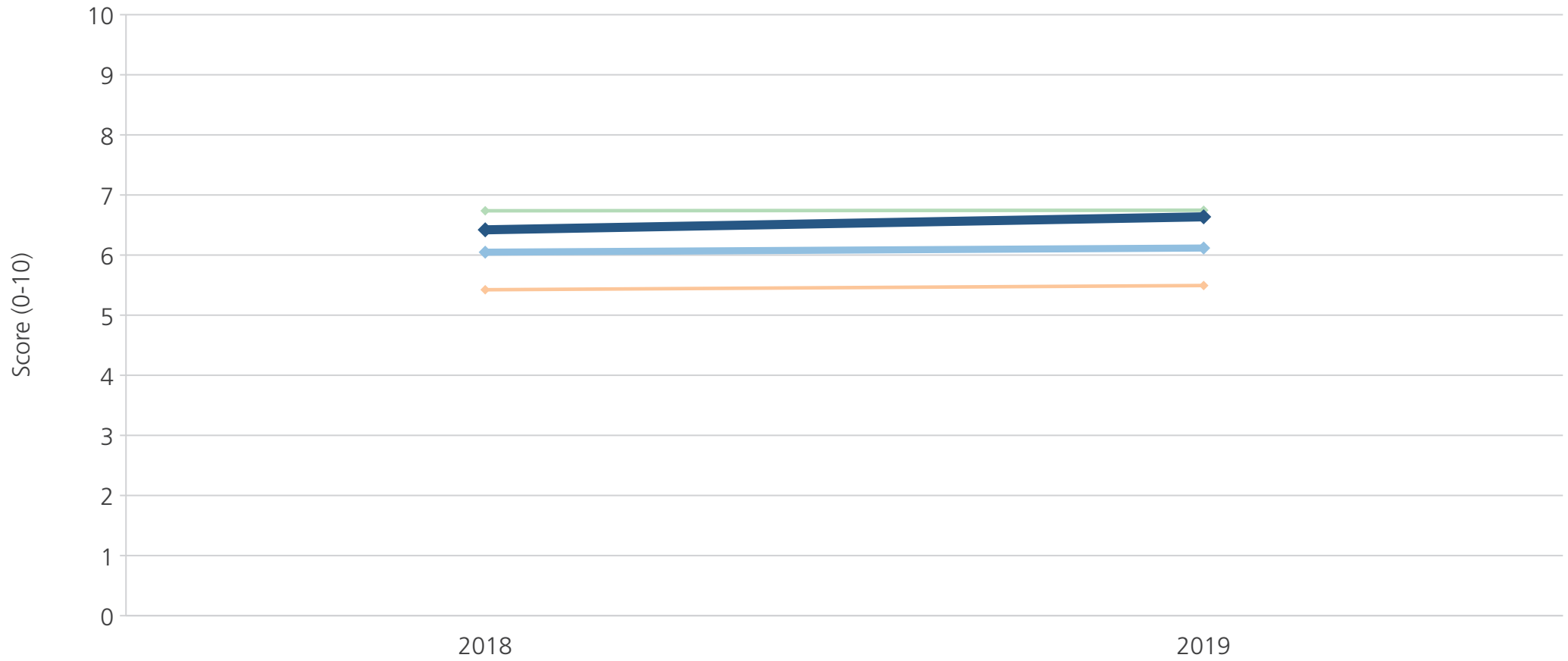
	2015	2016	2017	2018	2019
Best	9.5	9.4	9.4	9.6	9.4
Your org	9.3	9.3	9.2	9.3	9.3
Average	9.2	9.2	9.1	9.1	9.0
Worst	8.3	8.2	8.1	8.1	8.3
Responses	456	616	586	579	2,032



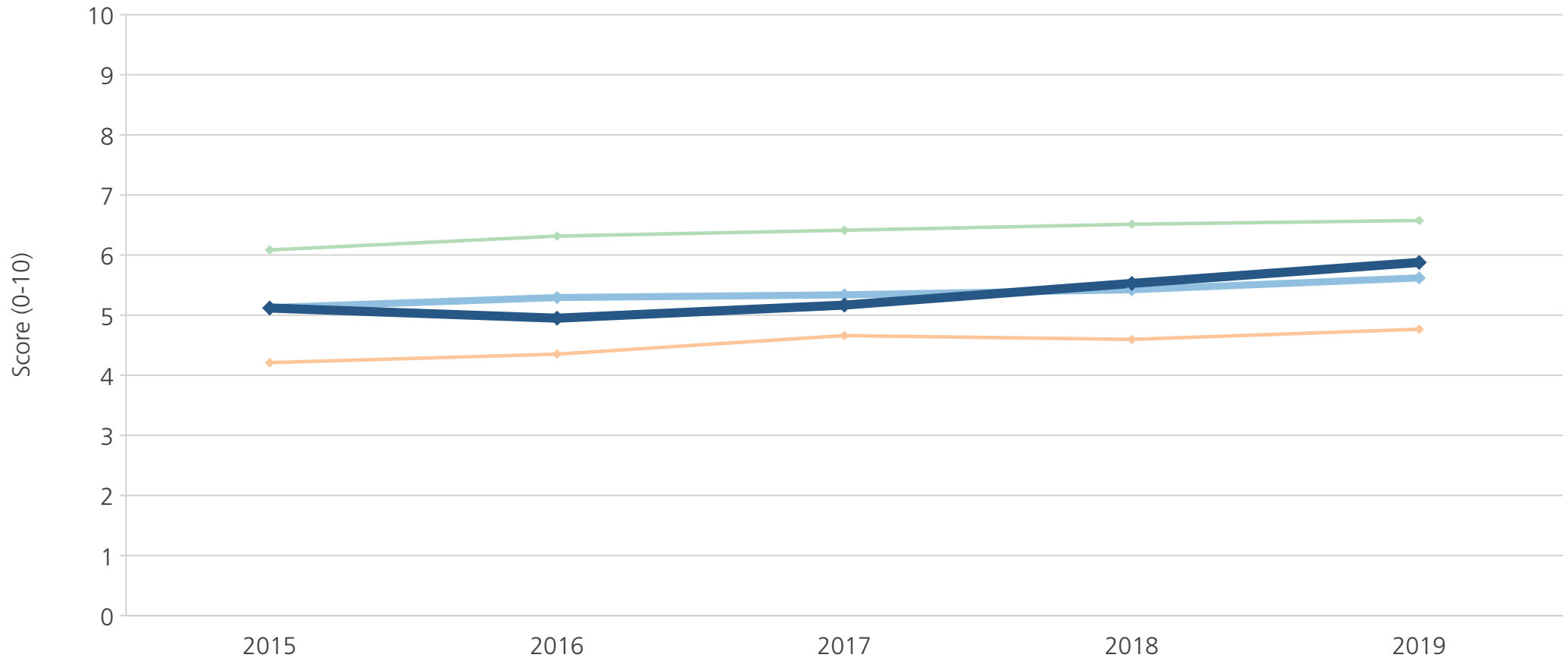
	2015	2016	2017	2018	2019
Best	6.8	6.8	6.6	6.7	6.7
Your org	6.4	6.3	6.5	6.3	6.4
Average	6.0	6.1	6.0	5.9	5.9
Worst	5.3	5.3	5.4	5.2	5.3
Responses	460	618	593	584	2,047



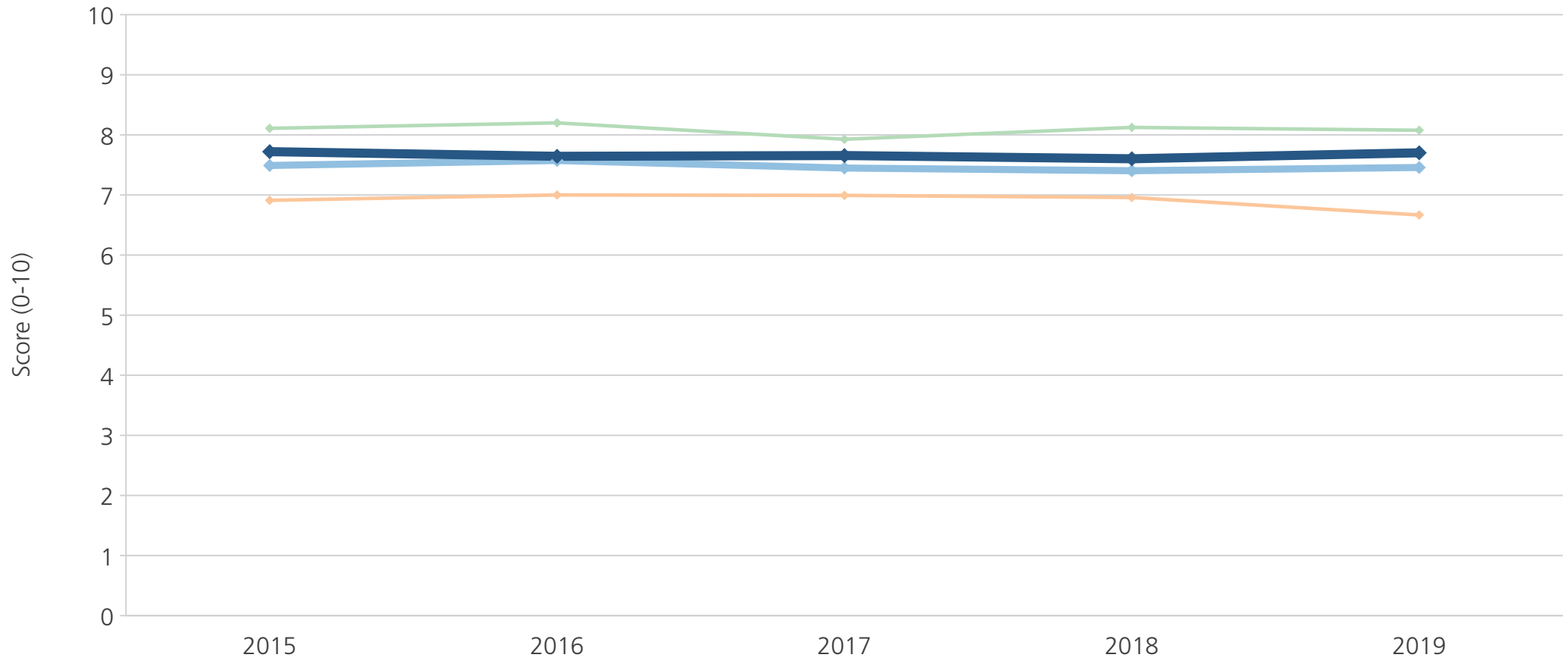
	2015	2016	2017	2018	2019
Best	7.1	7.2	7.2	7.3	7.4
Your org	6.8	6.9	6.8	7.0	7.2
Average	6.6	6.7	6.7	6.7	6.8
Worst	6.1	6.2	6.3	6.2	6.0
Responses	461	618	592	583	2,046



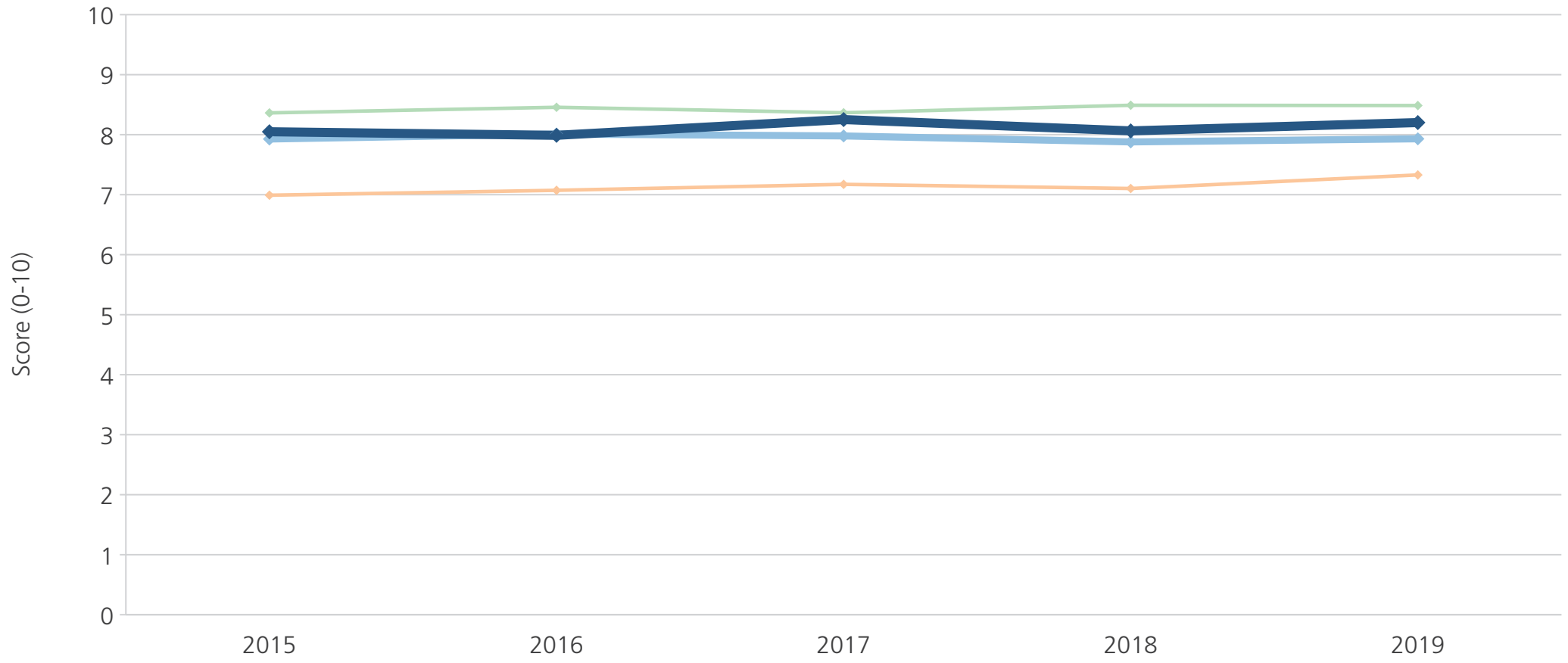
	2018	2019
Best	6.7	6.7
Your org	6.4	6.6
Average	6.0	6.1
Worst	5.4	5.5
Responses	569	2,007



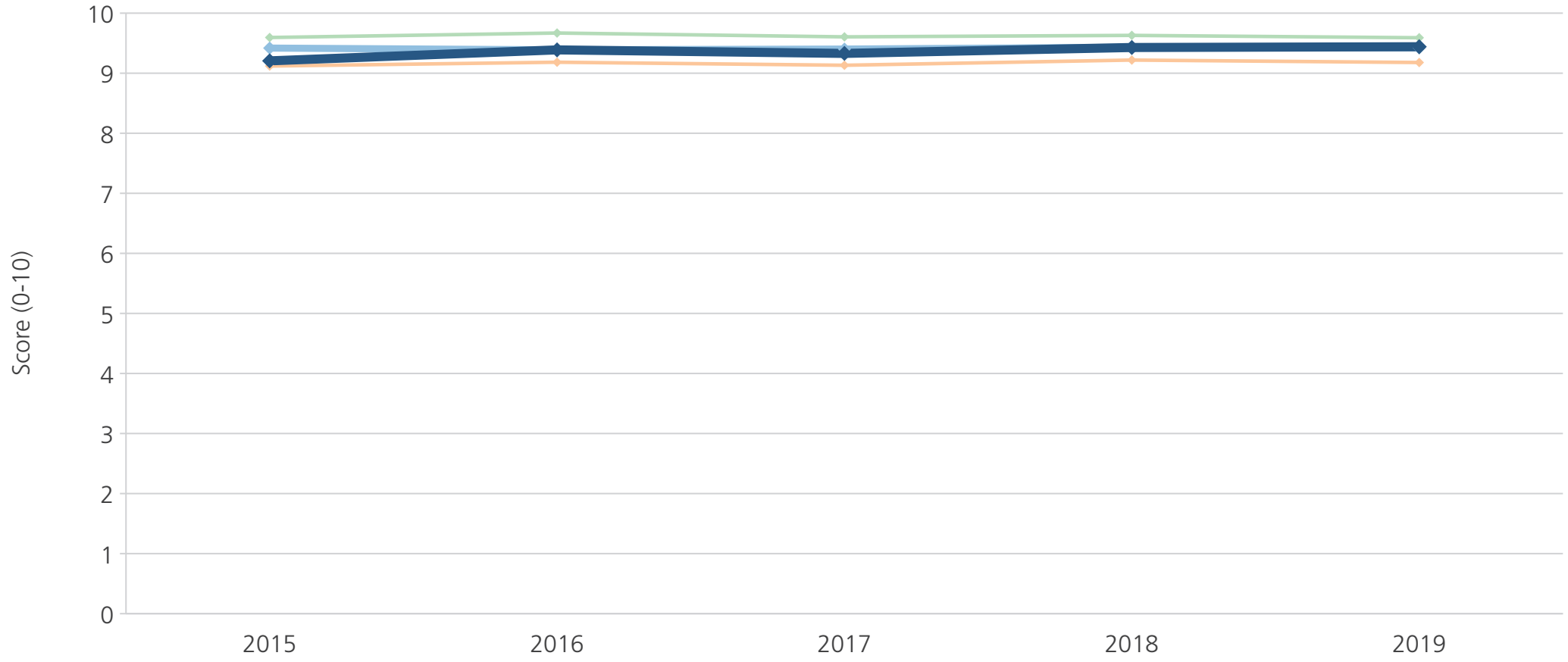
	2015	2016	2017	2018	2019
Best	6.1	6.3	6.4	6.5	6.6
Your org	5.1	4.9	5.2	5.5	5.9
Average	5.1	5.3	5.3	5.4	5.6
Worst	4.2	4.4	4.7	4.6	4.8
Responses	341	482	433	496	1,783



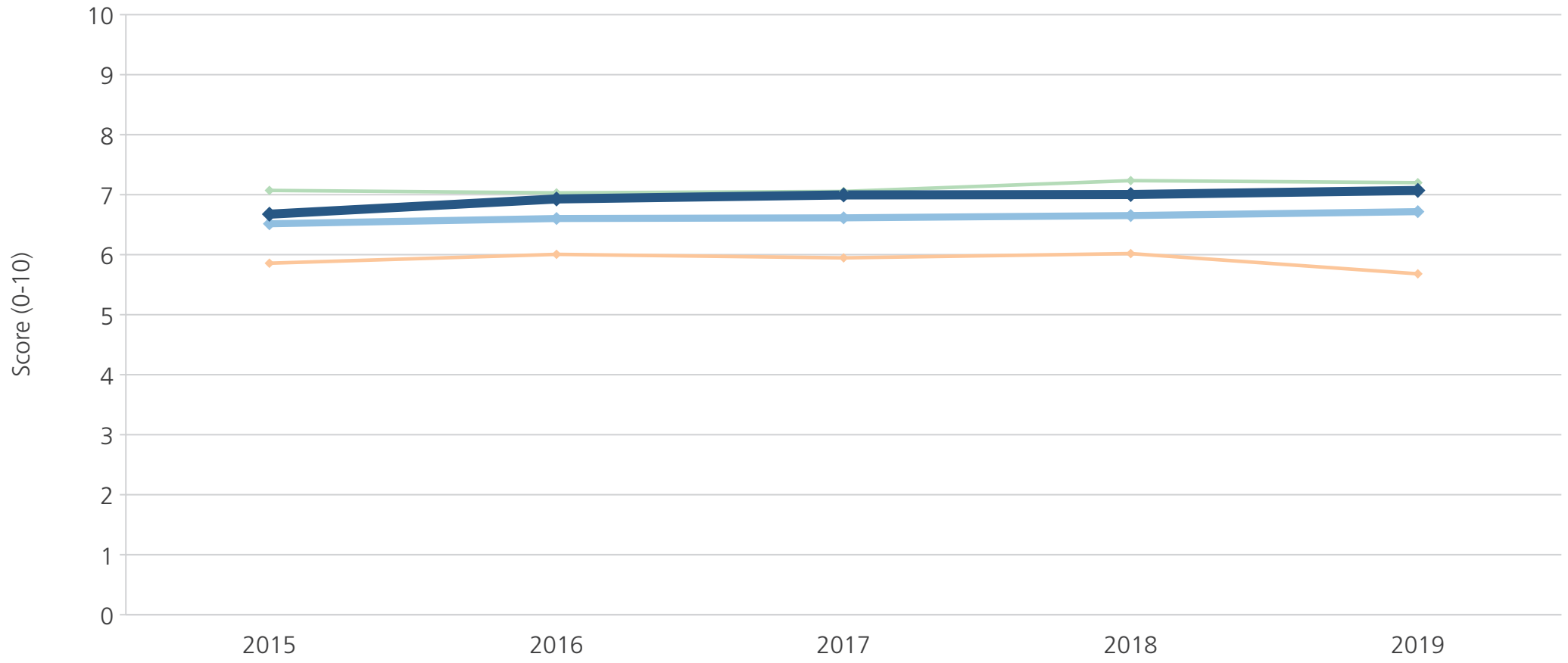
	2015	2016	2017	2018	2019
Best	8.1	8.2	7.9	8.1	8.1
Your org	7.7	7.6	7.7	7.6	7.7
Average	7.5	7.6	7.4	7.4	7.5
Worst	6.9	7.0	7.0	7.0	6.7
Responses	408	550	517	519	1,815



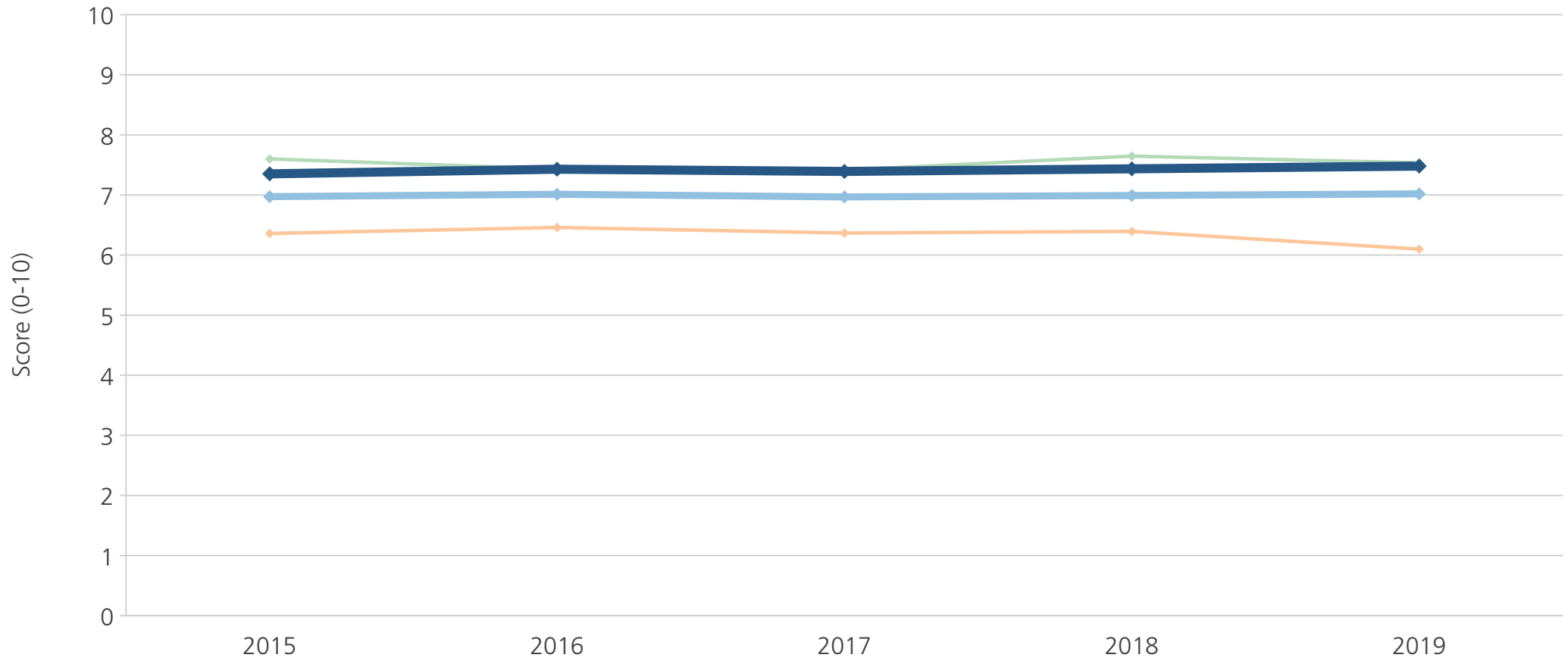
	2015	2016	2017	2018	2019
Best	8.4	8.5	8.4	8.5	8.5
Your org	8.0	8.0	8.3	8.1	8.2
Average	7.9	8.0	8.0	7.9	7.9
Worst	7.0	7.1	7.2	7.1	7.3
Responses	453	611	582	575	2,018



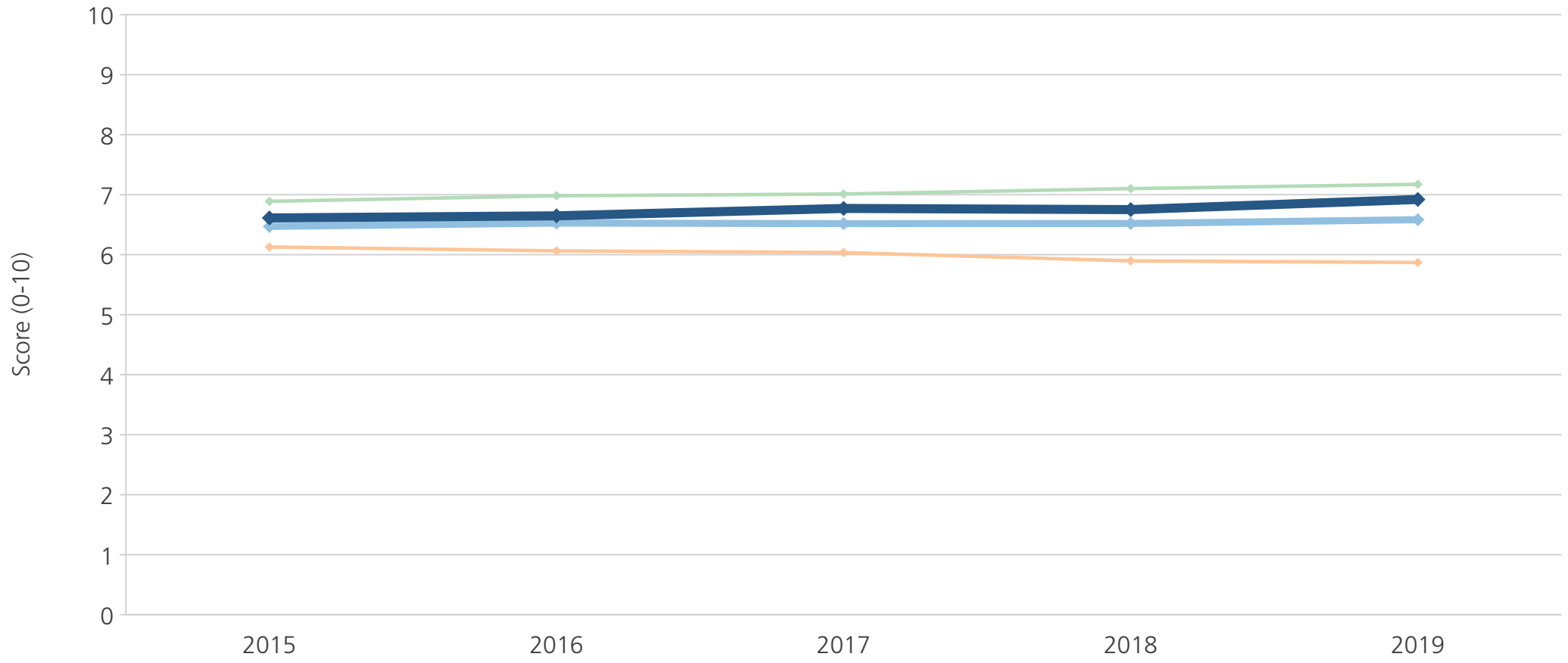
	2015	2016	2017	2018	2019
Best	9.6	9.7	9.6	9.6	9.6
Your org	9.2	9.4	9.3	9.4	9.4
Average	9.4	9.4	9.4	9.4	9.4
Worst	9.1	9.2	9.1	9.2	9.2
Responses	451	611	579	571	2,026



	2015	2016	2017	2018	2019
Best	7.1	7.0	7.1	7.2	7.2
Your org	6.7	6.9	7.0	7.0	7.1
Average	6.5	6.6	6.6	6.7	6.7
Worst	5.9	6.0	5.9	6.0	5.7
Responses	456	613	590	576	2,024



	2015	2016	2017	2018	2019
Best	7.6	7.4	7.4	7.6	7.5
Your org	7.4	7.4	7.4	7.4	7.5
Average	7.0	7.0	7.0	7.0	7.0
Worst	6.4	6.5	6.4	6.4	6.1
Responses	461	620	596	593	2,068



	2015	2016	2017	2018	2019
Best	6.9	7.0	7.0	7.1	7.2
Your org	6.6	6.6	6.8	6.8	6.9
Average	6.5	6.5	6.5	6.5	6.6
Worst	6.1	6.1	6.0	5.9	5.9
Responses	458	612	587	588	2,035

Survey Coordination Centre

NHS England

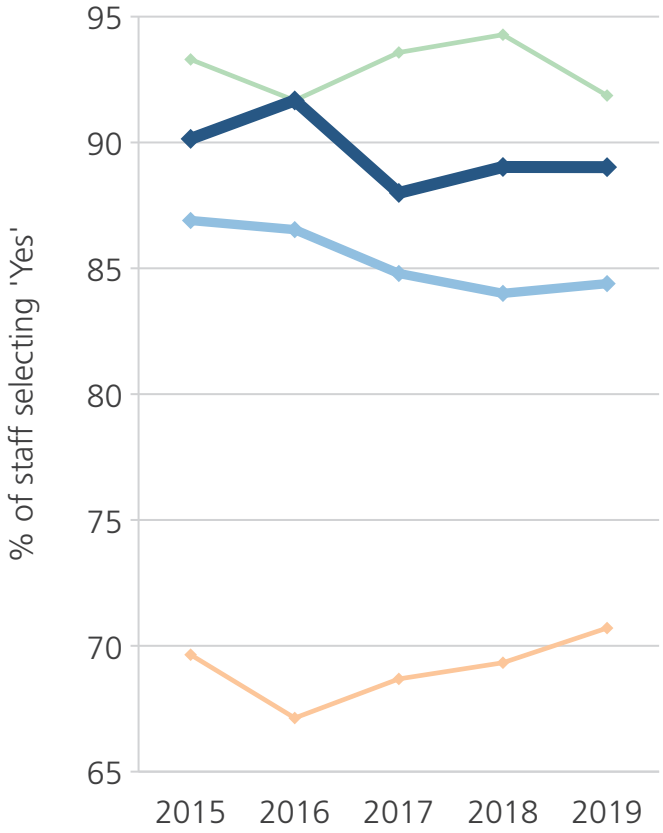
Theme results – Detailed information

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results

Q14

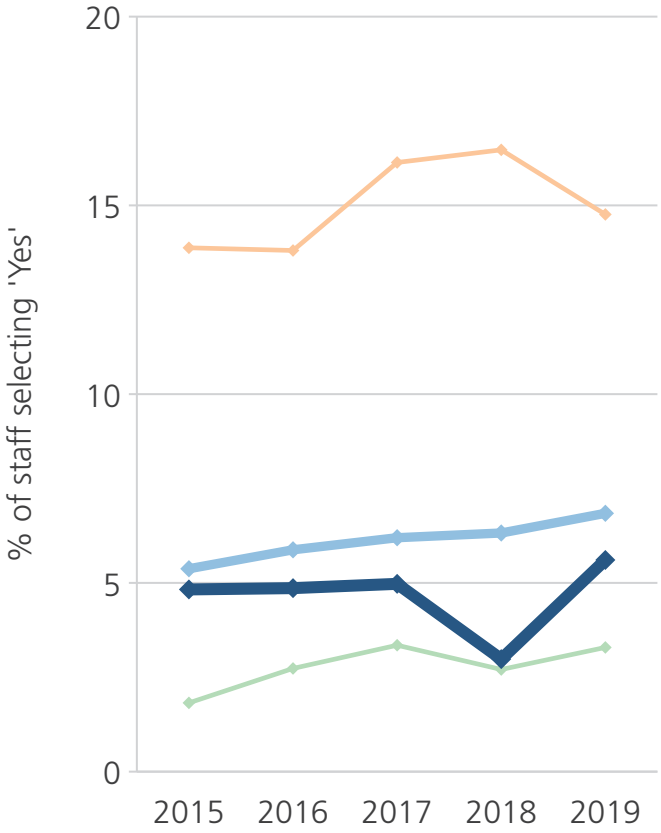
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2015	2016	2017	2018	2019
Best	93.3%	91.7%	93.6%	94.3%	91.9%
Your org	90.1%	91.7%	88.0%	89.0%	89.0%
Average	86.9%	86.5%	84.8%	84.0%	84.4%
Worst	69.6%	67.1%	68.7%	69.3%	70.7%

Q15a

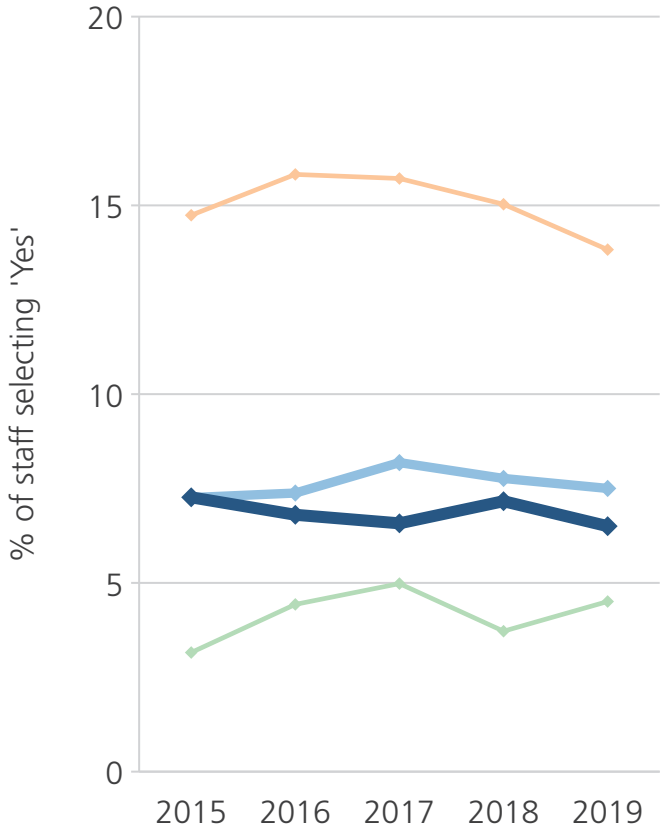
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	13.9%	13.8%	16.1%	16.5%	14.8%
Your org	4.8%	4.9%	5.0%	3.0%	5.6%
Average	5.4%	5.9%	6.2%	6.3%	6.8%
Best	1.8%	2.7%	3.3%	2.7%	3.3%

Q15b

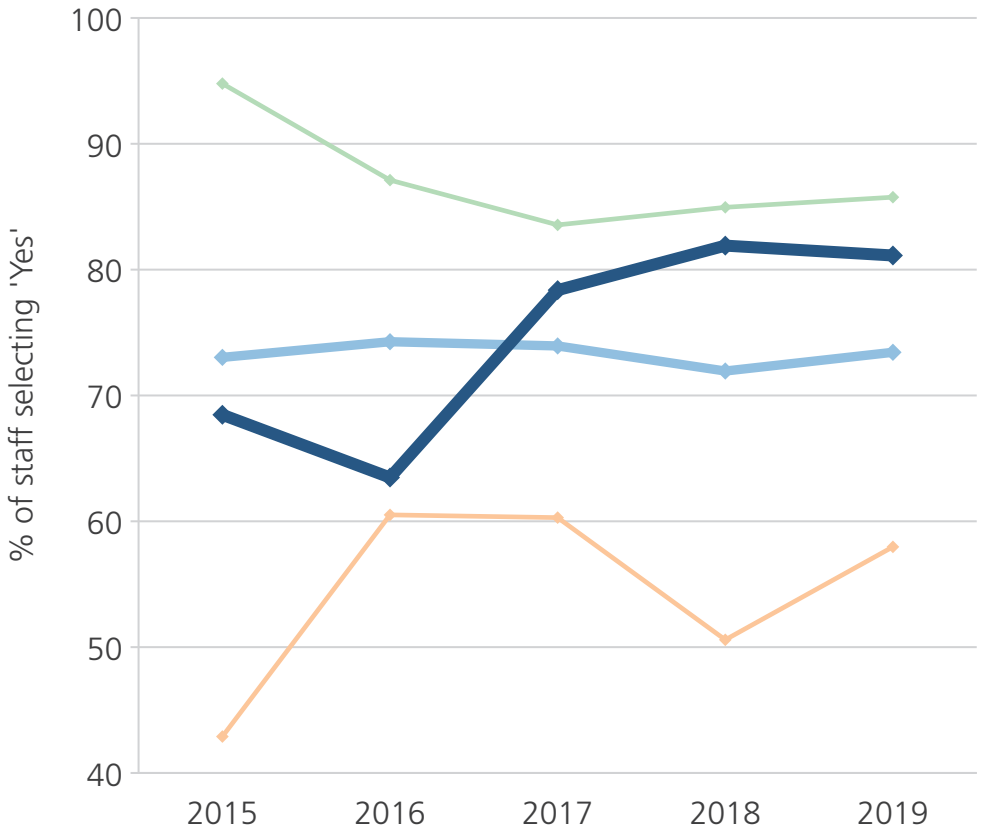
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2015	2016	2017	2018	2019
Worst	14.7%	15.8%	15.7%	15.0%	13.8%
Your org	7.3%	6.8%	6.6%	7.2%	6.5%
Average	7.3%	7.4%	8.2%	7.8%	7.5%
Best	3.2%	4.4%	5.0%	3.7%	4.5%

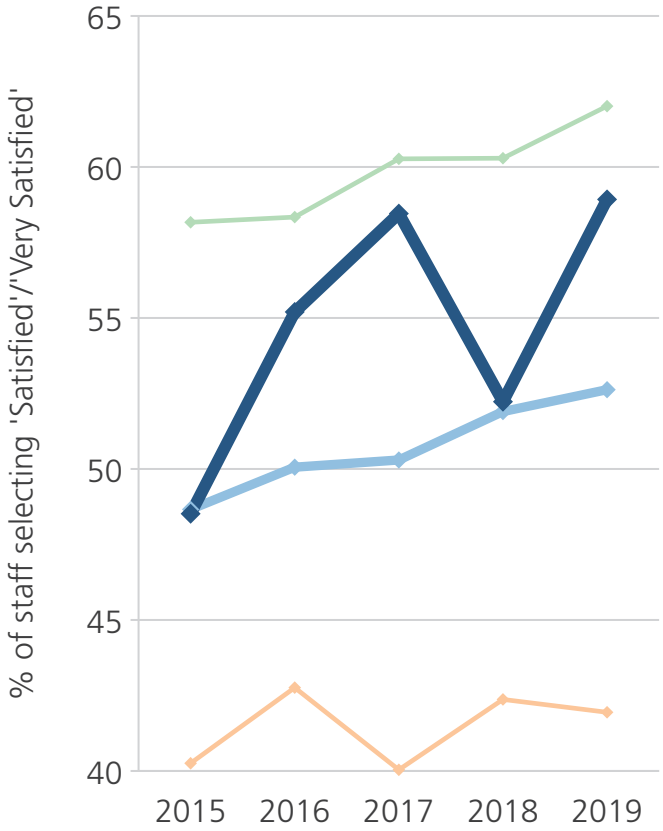
Q28b

Has your employer made adequate adjustment(s) to enable you to carry out your work?



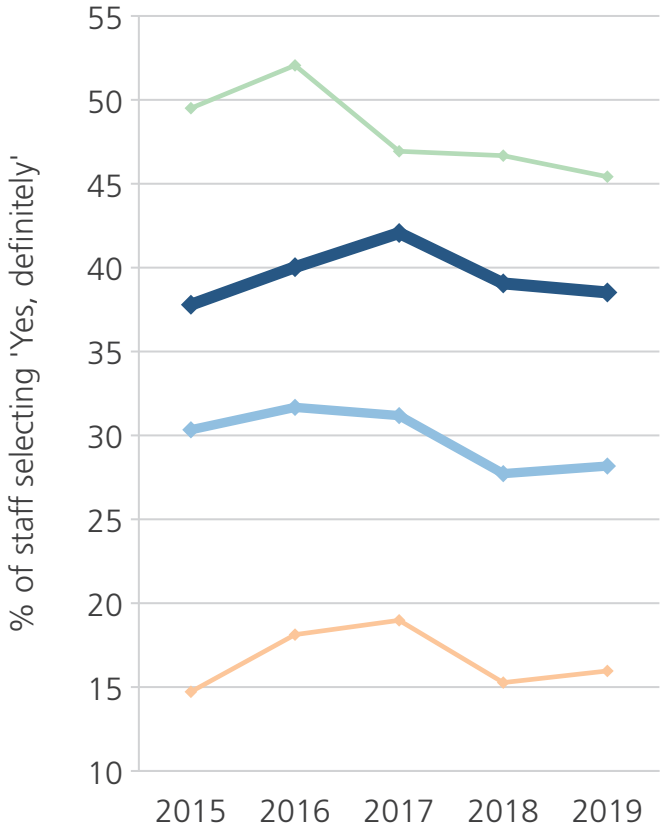
	2015	2016	2017	2018	2019
Best	94.8%	87.1%	83.6%	85.0%	85.8%
Your org	68.5%	63.5%	78.4%	81.9%	81.1%
Average	73.0%	74.3%	73.9%	71.9%	73.4%
Worst	42.9%	60.5%	60.3%	50.6%	58.0%

Q5h
The opportunities for flexible working patterns



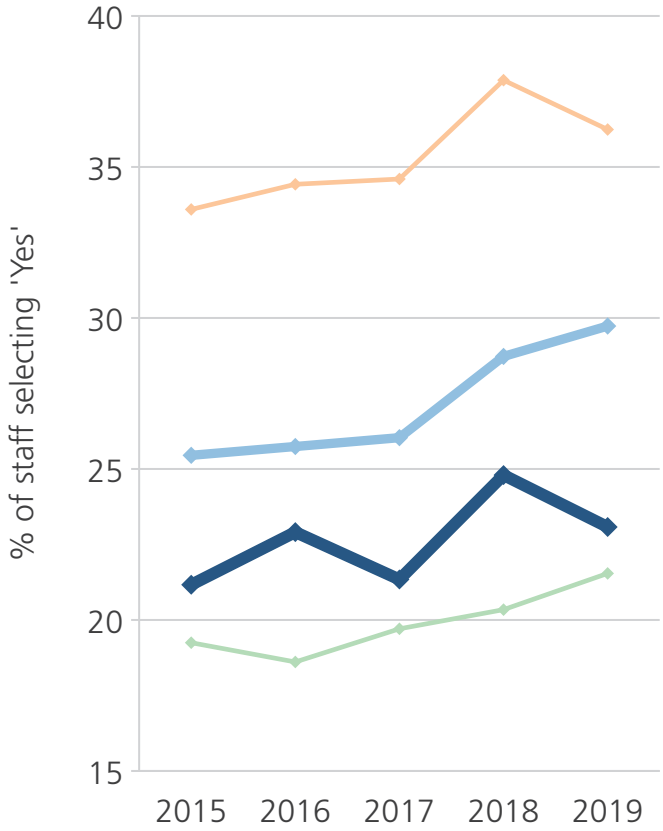
	2015	2016	2017	2018	2019
Best	58.2%	58.3%	60.3%	60.3%	62.0%
Your org	48.5%	55.2%	58.5%	52.2%	58.9%
Average	48.7%	50.1%	50.3%	51.9%	52.6%
Worst	40.3%	42.8%	40.0%	42.4%	41.9%

Q11a
Does your organisation take positive action on health and well-being?



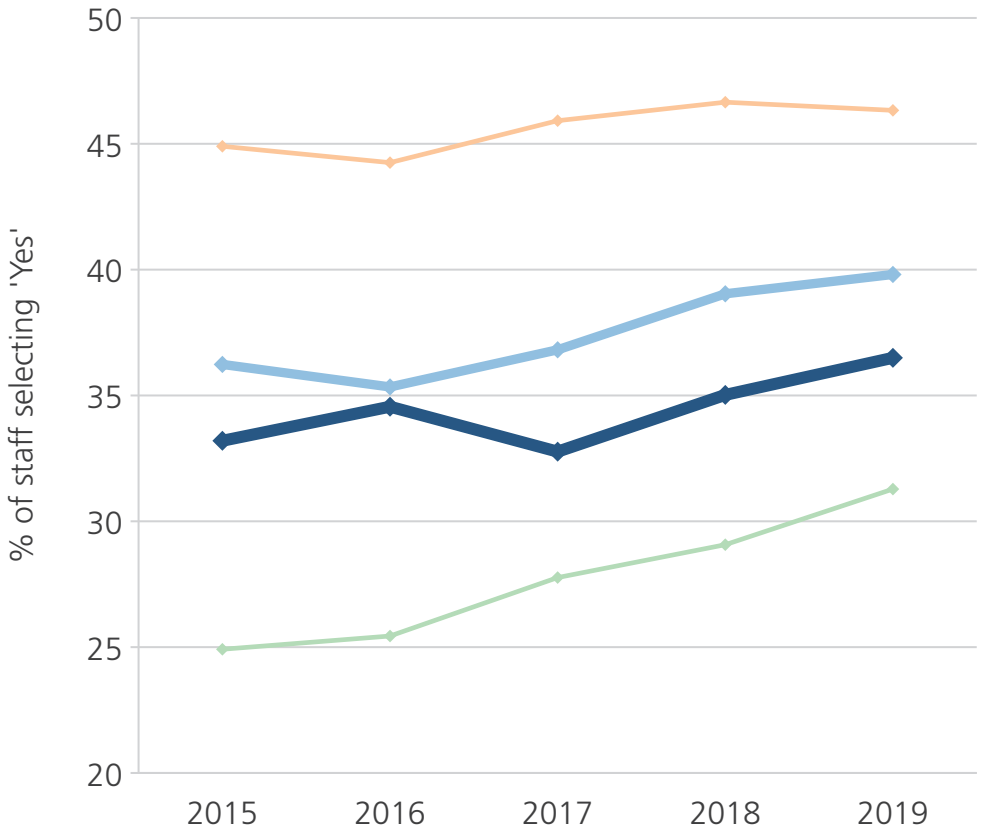
	2015	2016	2017	2018	2019
Best	49.5%	52.1%	46.9%	46.7%	45.4%
Your org	37.8%	40.0%	42.1%	39.1%	38.5%
Average	30.3%	31.7%	31.2%	27.7%	28.2%
Worst	14.7%	18.1%	19.0%	15.3%	16.0%

Q11b
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



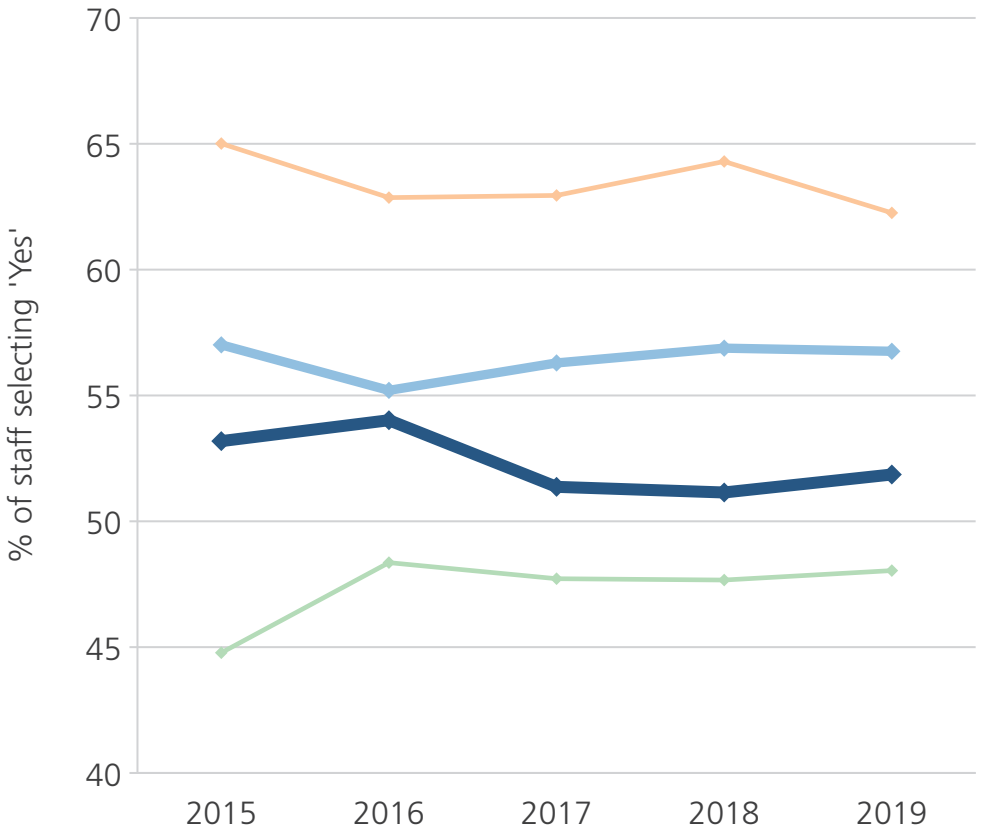
	2015	2016	2017	2018	2019
Worst	33.6%	34.4%	34.6%	37.9%	36.2%
Your org	21.2%	22.9%	21.3%	24.8%	23.1%
Average	25.5%	25.7%	26.0%	28.7%	29.7%
Best	19.2%	18.6%	19.7%	20.3%	21.5%

Q11c
During the last 12 months have you felt unwell as a result of work related stress?



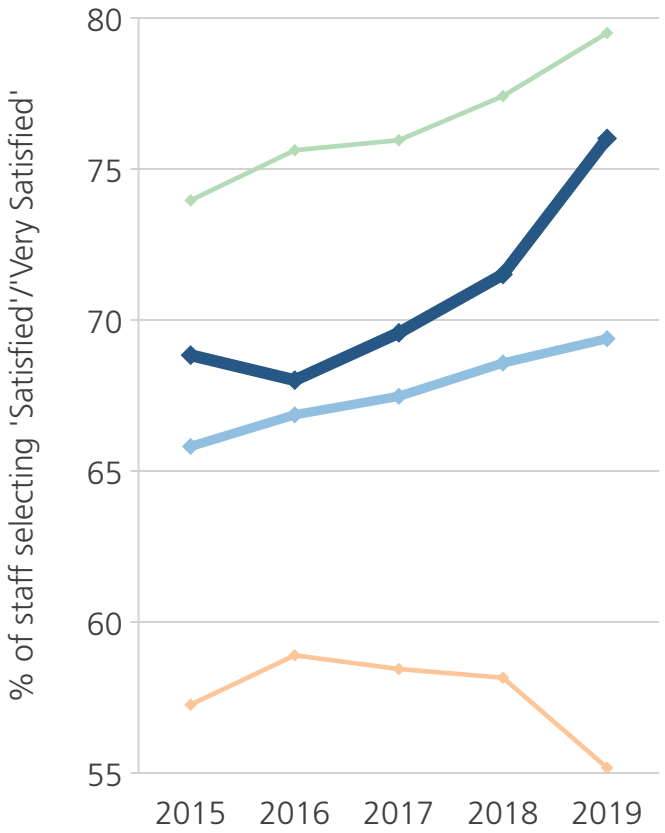
	2015	2016	2017	2018	2019
Worst	44.9%	44.3%	45.9%	46.7%	46.3%
Your org	33.2%	34.6%	32.8%	35.0%	36.5%
Average	36.2%	35.3%	36.8%	39.0%	39.8%
Best	24.9%	25.4%	27.8%	29.1%	31.3%

Q11d
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



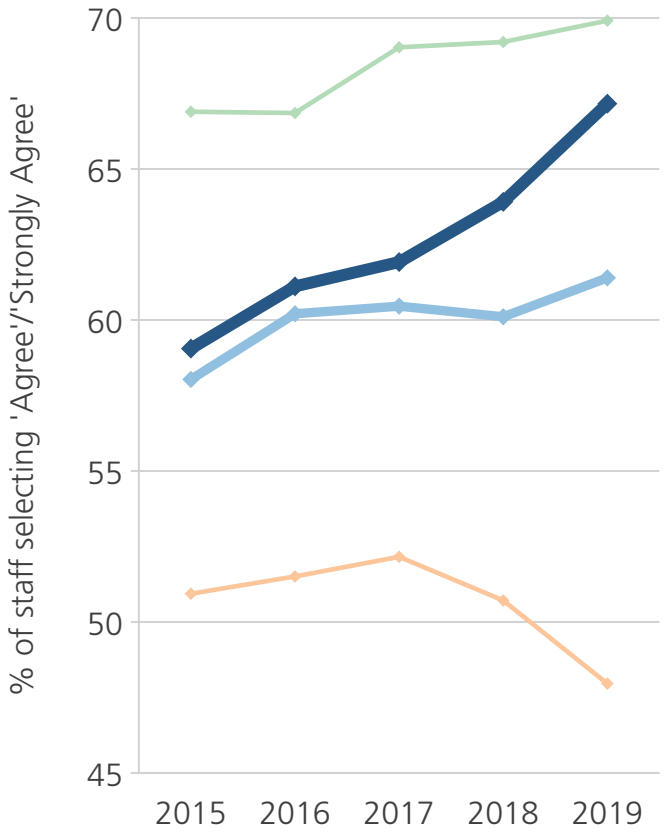
	2015	2016	2017	2018	2019
Worst	65.0%	62.9%	62.9%	64.3%	62.3%
Your org	53.2%	54.0%	51.4%	51.1%	51.9%
Average	57.0%	55.2%	56.3%	56.9%	56.8%
Best	44.8%	48.4%	47.7%	47.7%	48.0%

Q5b
The support I get from my immediate manager



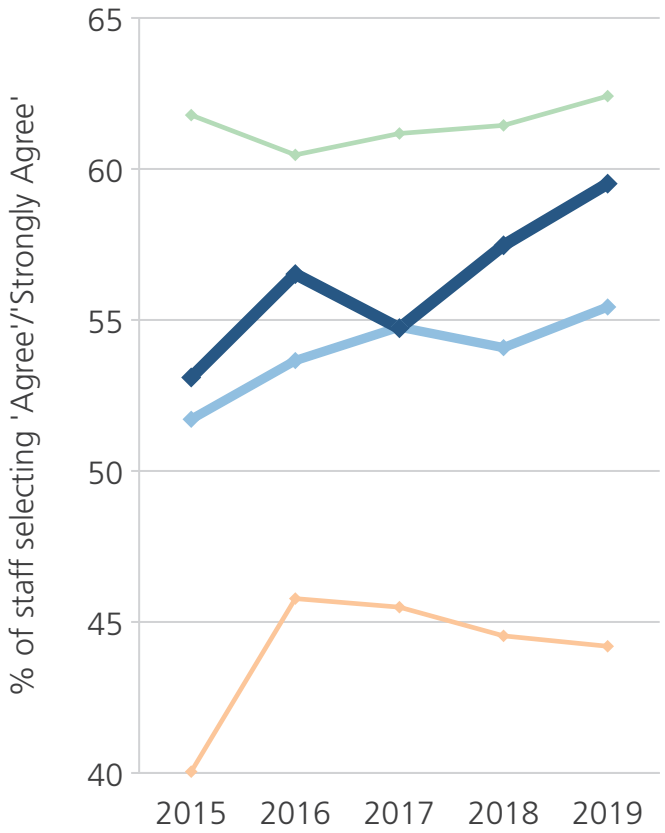
	2015	2016	2017	2018	2019
Best	74.0%	75.6%	76.0%	77.4%	79.5%
Your org	68.8%	68.0%	69.6%	71.5%	76.0%
Average	65.8%	66.9%	67.5%	68.6%	69.4%
Worst	57.3%	58.9%	58.4%	58.2%	55.2%

Q8c
My immediate manager gives me clear feedback on my work



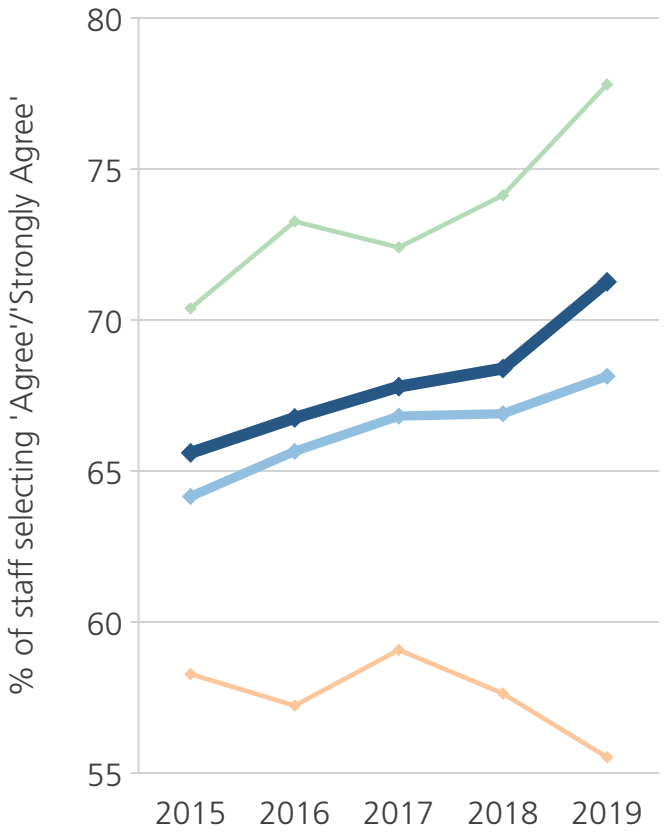
	2015	2016	2017	2018	2019
Best	66.9%	66.9%	69.0%	69.2%	69.9%
Your org	59.1%	61.1%	61.9%	63.9%	67.2%
Average	58.0%	60.2%	60.5%	60.1%	61.4%
Worst	50.9%	51.5%	52.2%	50.7%	48.0%

Q8d
My immediate manager asks for my opinion before making decisions that affect my work



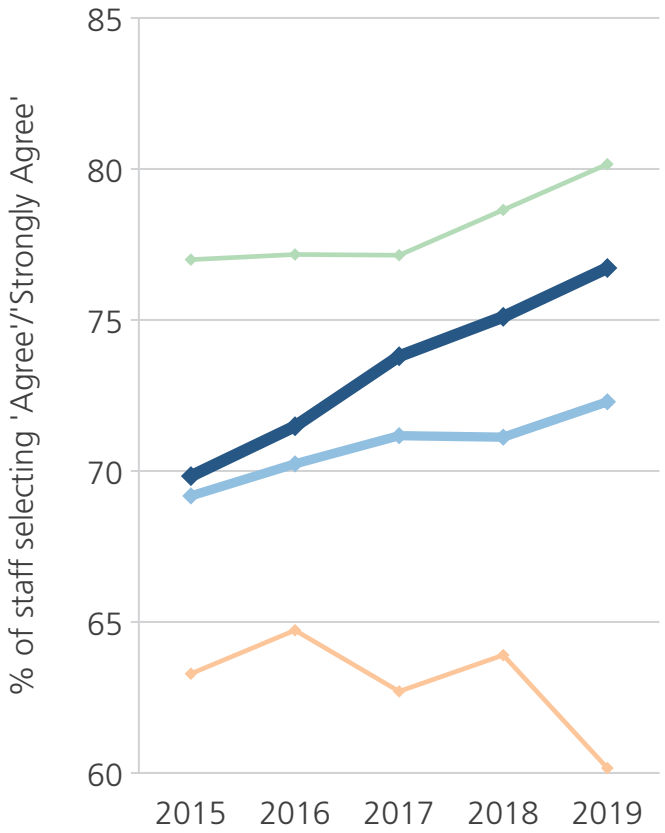
	2015	2016	2017	2018	2019
Best	61.8%	60.5%	61.2%	61.4%	62.4%
Your org	53.1%	56.5%	54.7%	57.5%	59.5%
Average	51.7%	53.7%	54.8%	54.1%	55.4%
Worst	40.0%	45.8%	45.5%	44.5%	44.2%

Q8f
My immediate manager takes a positive interest in my health and well-being



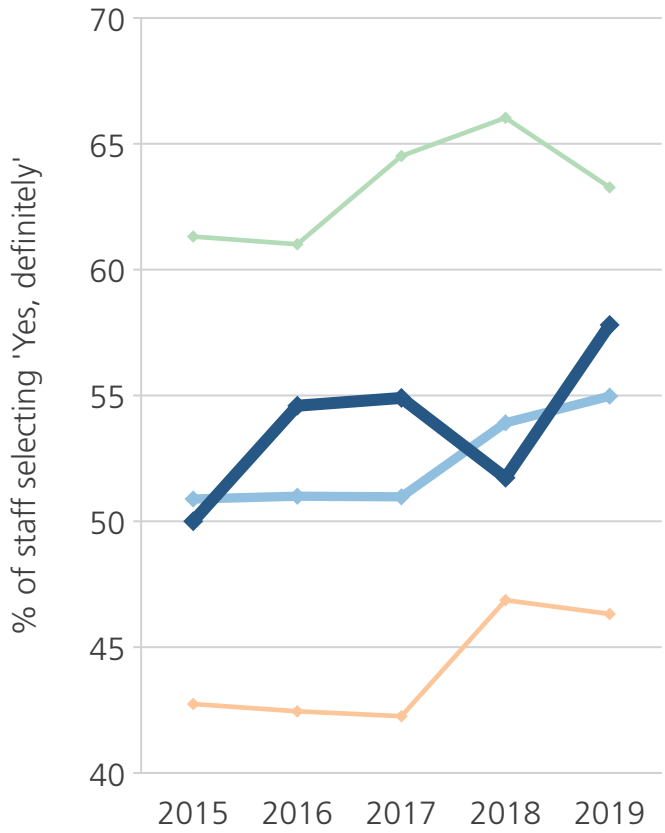
	2015	2016	2017	2018	2019
Best	70.4%	73.3%	72.4%	74.1%	77.8%
Your org	65.6%	66.8%	67.8%	68.4%	71.3%
Average	64.2%	65.6%	66.8%	66.9%	68.1%
Worst	58.3%	57.2%	59.1%	57.6%	55.5%

Q8g
My immediate manager values my work



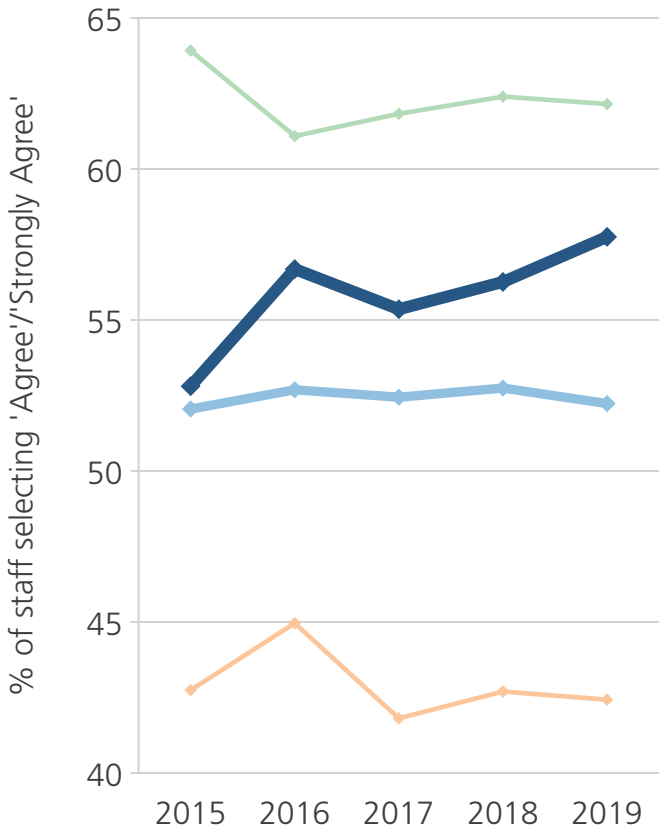
	2015	2016	2017	2018	2019
Best	77.0%	77.2%	77.1%	78.6%	80.2%
Your org	69.8%	71.5%	73.8%	75.1%	76.7%
Average	69.2%	70.2%	71.2%	71.1%	72.3%
Worst	63.3%	64.7%	62.7%	63.9%	60.2%

Q19g
My manager supported me to receive this training, learning or development



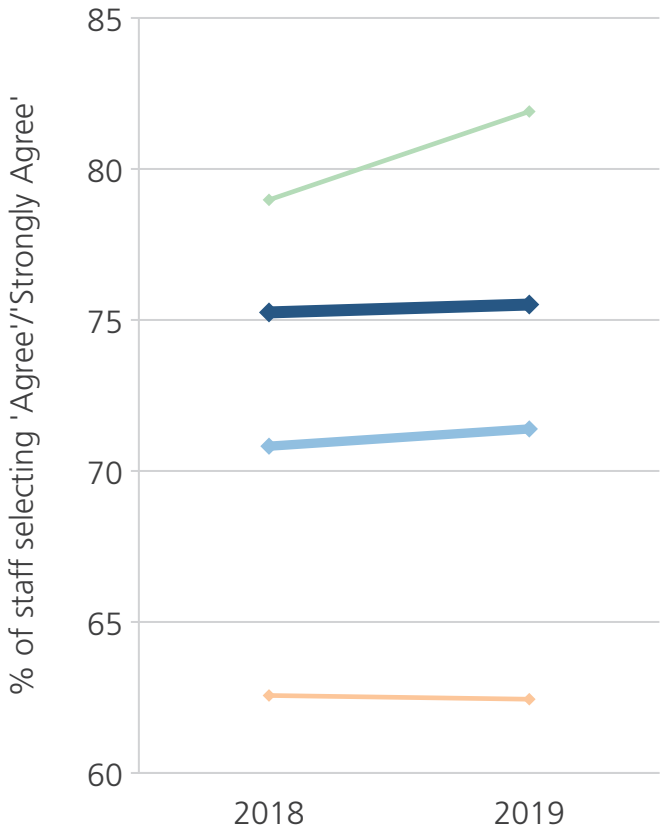
	2015	2016	2017	2018	2019
Best	61.3%	61.0%	64.5%	66.0%	63.3%
Your org	50.0%	54.6%	54.9%	51.7%	57.8%
Average	50.9%	51.0%	51.0%	53.9%	55.0%
Worst	42.7%	42.5%	42.3%	46.9%	46.3%

Q4c
I am involved in deciding on changes introduced that affect my work area / team / department



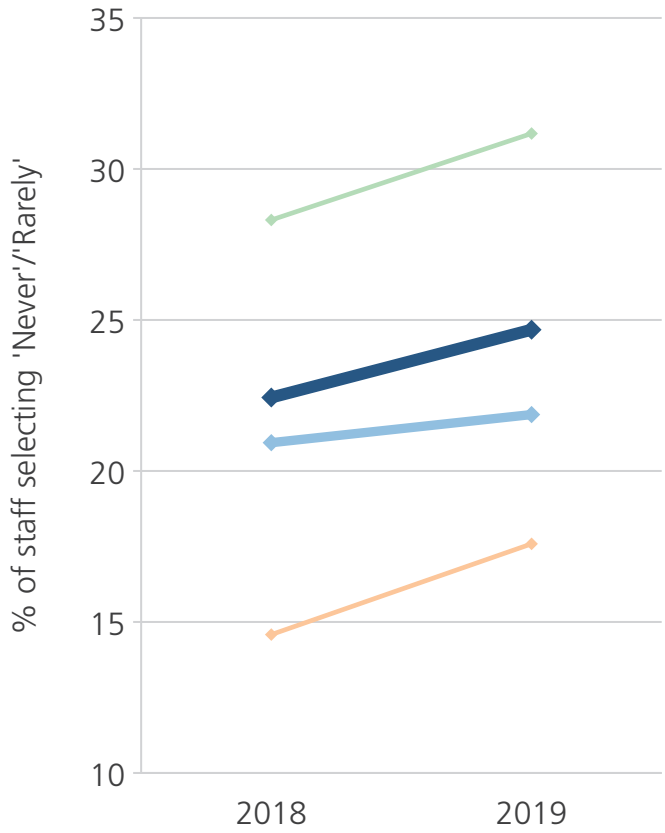
	2015	2016	2017	2018	2019
Best	63.9%	61.1%	61.8%	62.4%	62.1%
Your org	52.8%	56.7%	55.4%	56.3%	57.8%
Average	52.1%	52.7%	52.4%	52.7%	52.2%
Worst	42.7%	45.0%	41.8%	42.7%	42.4%

Q4j
I receive the respect I deserve from my colleagues at work



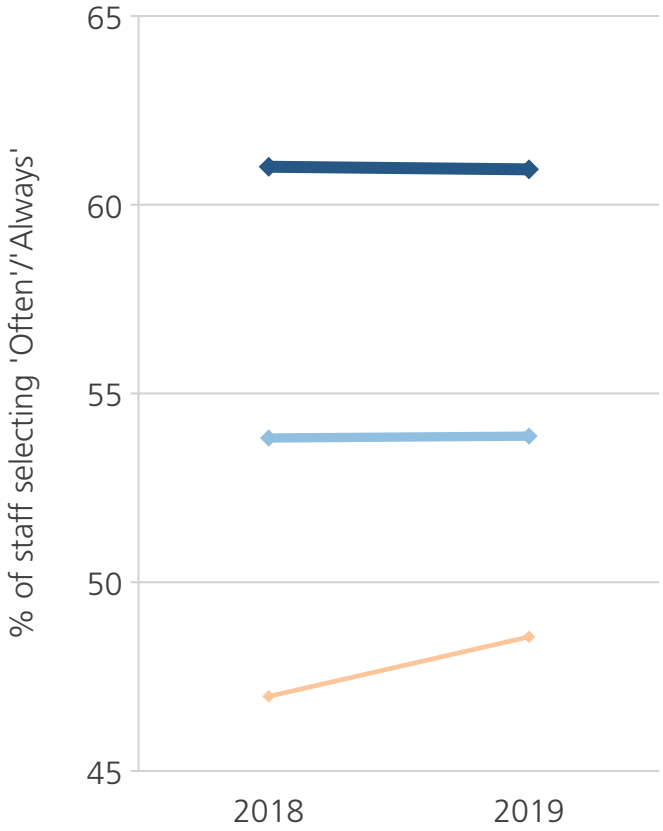
	2018	2019
Best	79.0%	81.9%
Your org	75.2%	75.5%
Average	70.8%	71.4%
Worst	62.6%	62.4%

Q6a
I have unrealistic time pressures



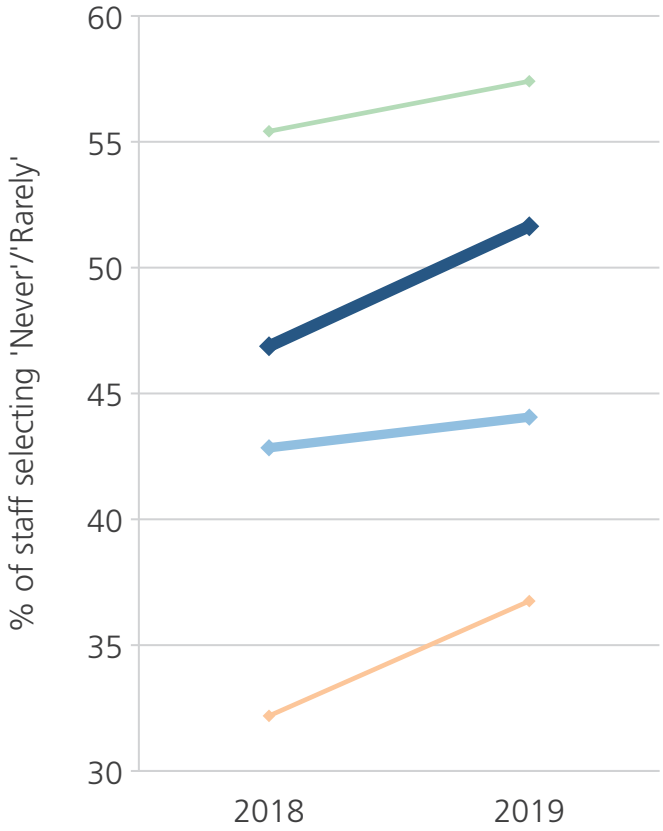
	2018	2019
Best	28.3%	31.2%
Your org	22.4%	24.7%
Average	20.9%	21.9%
Worst	14.6%	17.6%

Q6b
I have a choice in deciding how to do my work



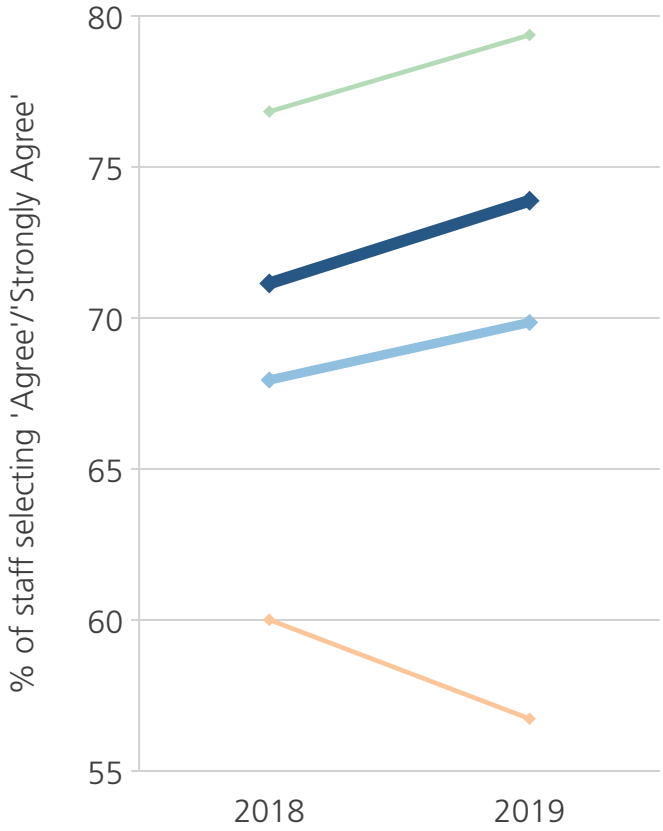
	2018	2019
Best	61.0%	60.9%
Your org	61.0%	60.9%
Average	53.8%	53.9%
Worst	47.0%	48.6%

Q6c
Relationships at work are strained



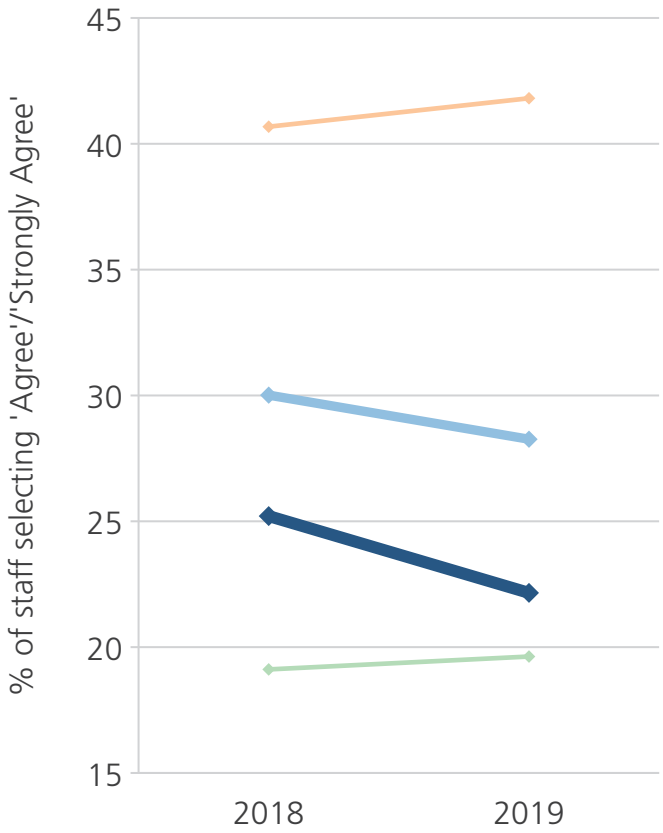
	2018	2019
Best	55.4%	57.4%
Your org	46.9%	51.6%
Average	42.8%	44.1%
Worst	32.2%	36.8%

Q8a
My immediate manager encourages me at work



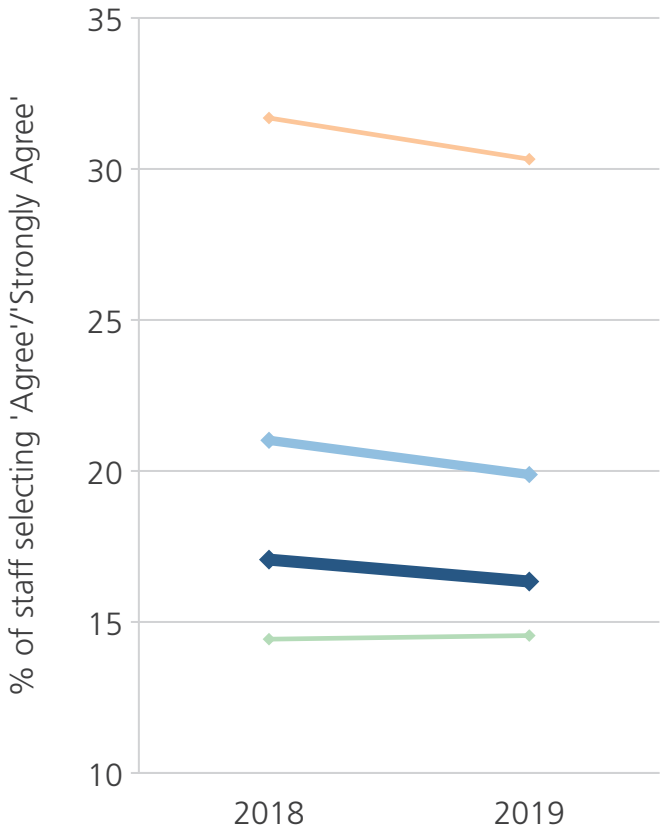
	2018	2019
Best	76.8%	79.4%
Your org	71.1%	73.9%
Average	67.9%	69.9%
Worst	60.0%	56.7%

Q23a
I often think about leaving this organisation



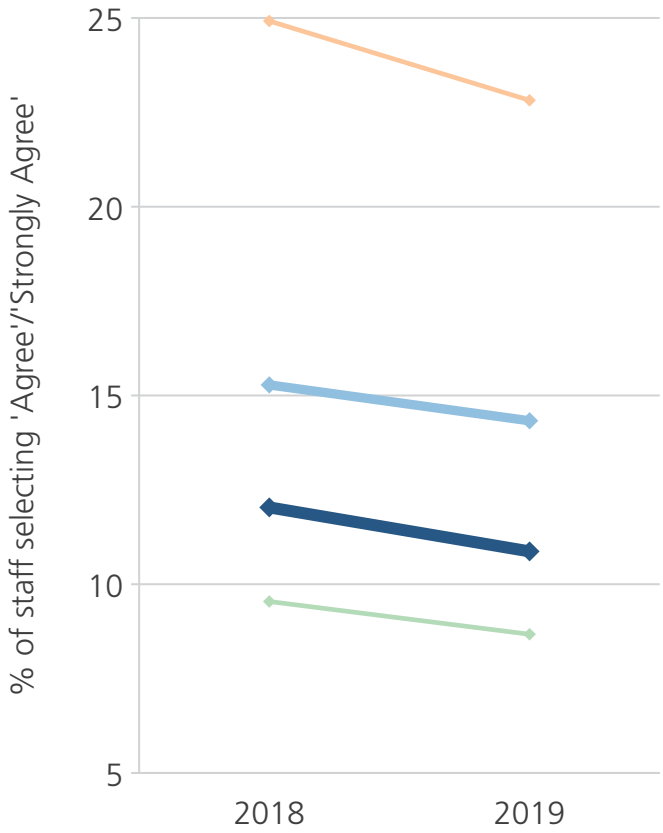
	2018	2019
Worst	40.7%	41.8%
Your org	25.2%	22.2%
Average	30.0%	28.3%
Best	19.1%	19.6%

Q23b
I will probably look for a job at a new organisation in the next 12 months



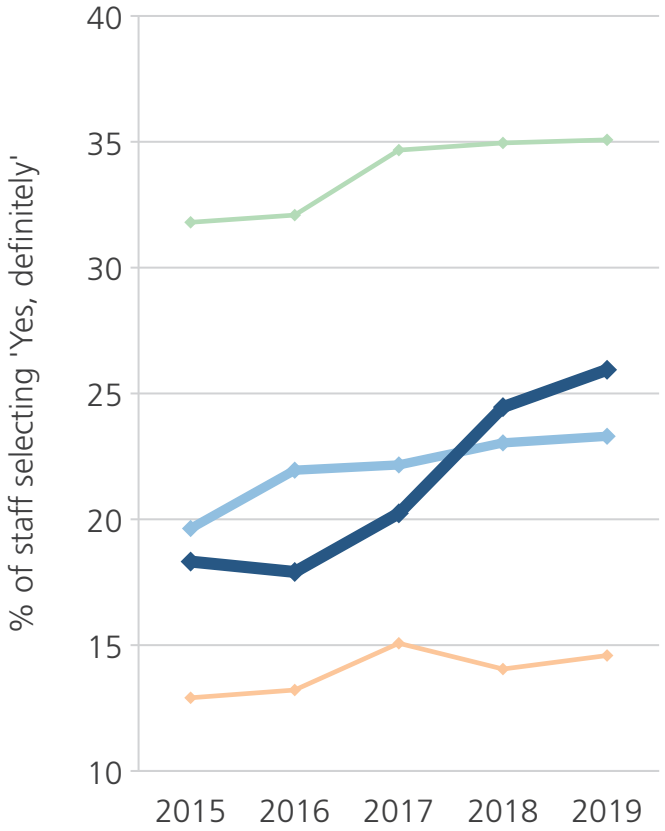
	2018	2019
Worst	31.7%	30.3%
Your org	17.1%	16.3%
Average	21.0%	19.9%
Best	14.4%	14.5%

Q23c
As soon as I can find another job, I will leave this organisation



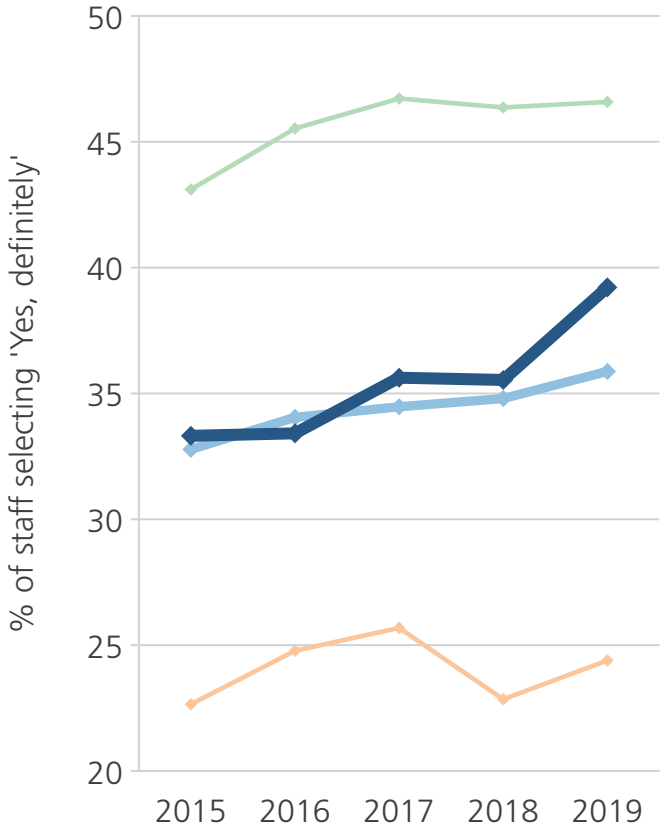
	2018	2019
Worst	24.9%	22.8%
Your org	12.0%	10.9%
Average	15.3%	14.3%
Best	9.5%	8.7%

Q19b
It helped me to improve how I do my job



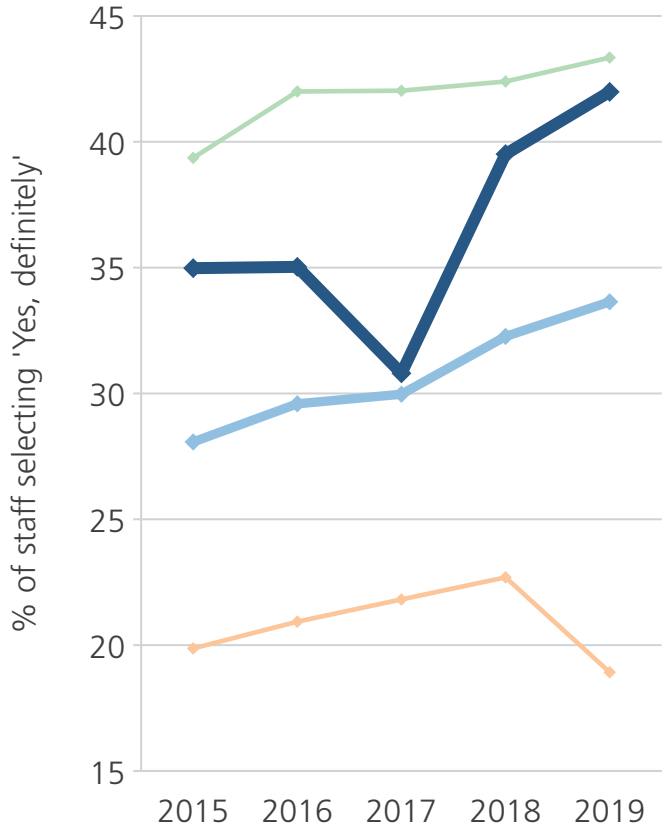
	2015	2016	2017	2018	2019
Best	31.8%	32.1%	34.7%	35.0%	35.1%
Your org	18.3%	17.9%	20.2%	24.5%	25.9%
Average	19.6%	22.0%	22.2%	23.0%	23.3%
Worst	12.9%	13.2%	15.1%	14.1%	14.6%

Q19c
It helped me agree clear objectives for my work



	2015	2016	2017	2018	2019
Best	43.1%	45.5%	46.7%	46.4%	46.6%
Your org	33.3%	33.4%	35.6%	35.5%	39.2%
Average	32.8%	34.1%	34.5%	34.8%	35.9%
Worst	22.6%	24.8%	25.7%	22.8%	24.4%

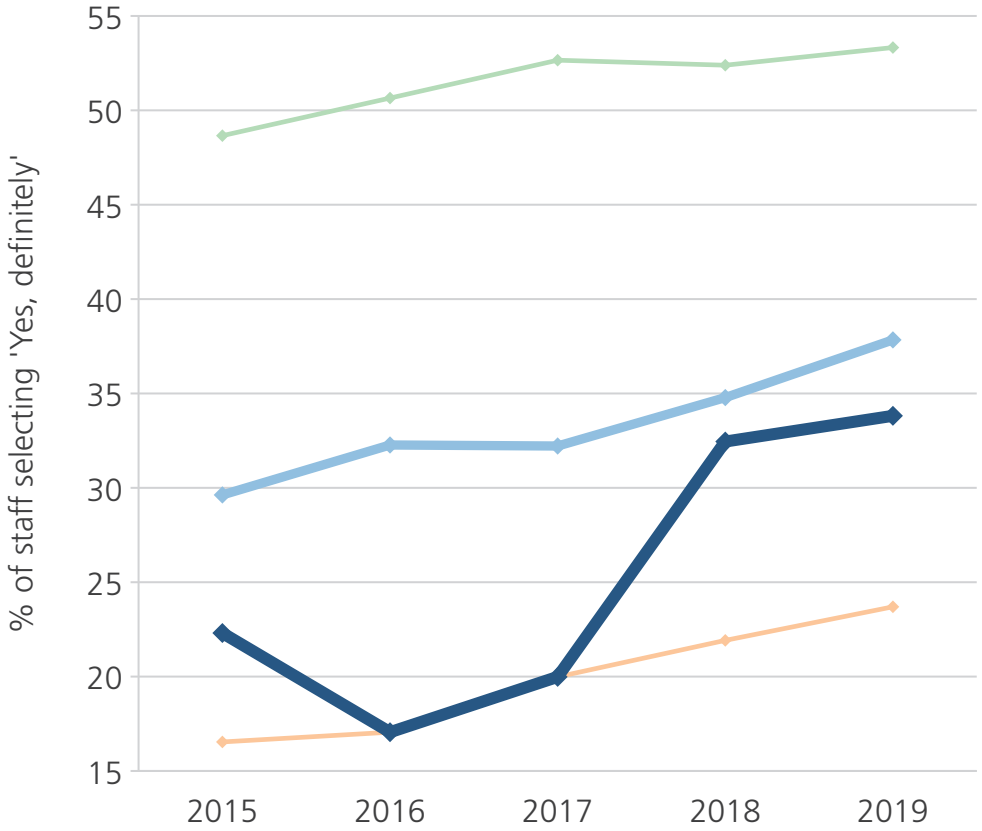
Q19d
It left me feeling that my work is valued by my organisation



	2015	2016	2017	2018	2019
Best	39.4%	42.0%	42.0%	42.4%	43.3%
Your org	35.0%	35.0%	30.8%	39.5%	42.0%
Average	28.1%	29.6%	30.0%	32.3%	33.6%
Worst	19.9%	20.9%	21.8%	22.7%	18.9%

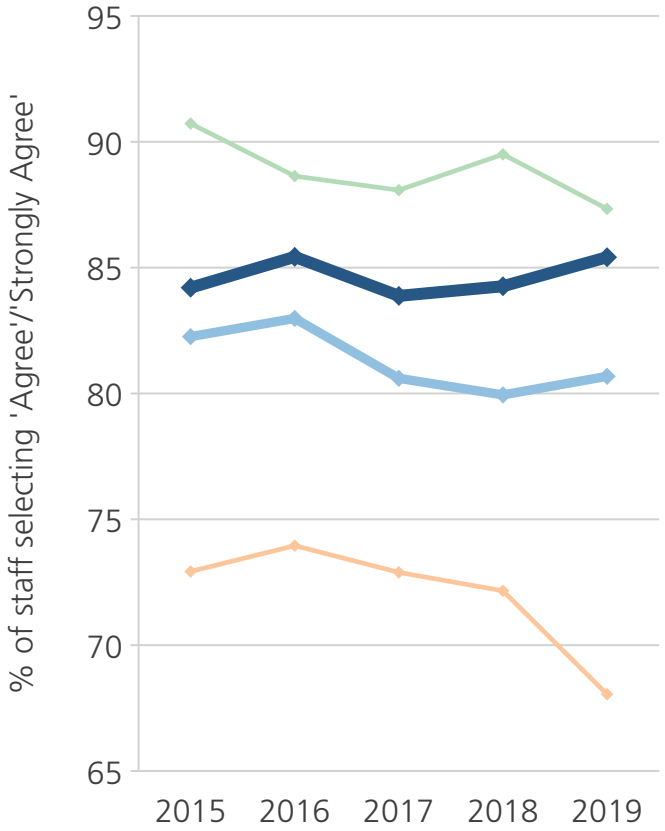
Q19e

The values of my organisation were discussed as part of the appraisal process



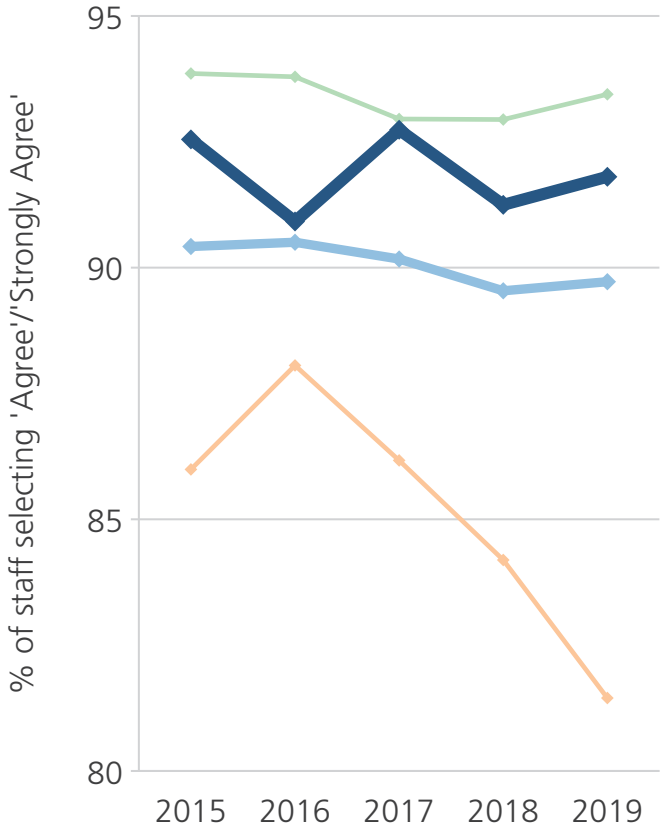
	2015	2016	2017	2018	2019
Best	48.7%	50.7%	52.7%	52.4%	53.3%
Your org	22.3%	17.1%	20.0%	32.5%	33.8%
Average	29.6%	32.3%	32.2%	34.8%	37.8%
Worst	16.5%	17.1%	20.0%	21.9%	23.7%

Q7a
I am satisfied with the quality of care I give to patients / service users



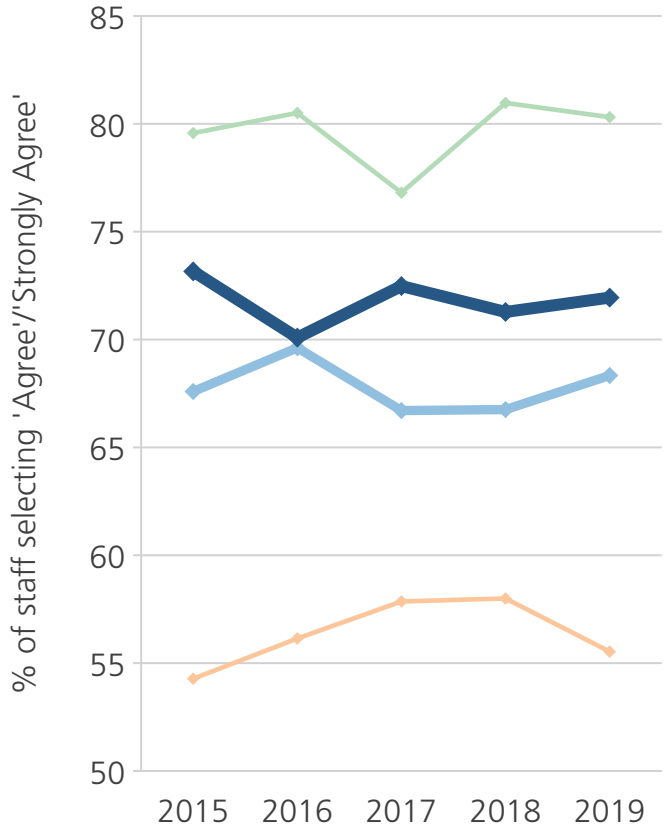
	2015	2016	2017	2018	2019
Best	90.7%	88.6%	88.1%	89.5%	87.3%
Your org	84.2%	85.4%	83.9%	84.3%	85.4%
Average	82.3%	83.0%	80.6%	79.9%	80.7%
Worst	72.9%	74.0%	72.9%	72.2%	68.0%

Q7b
I feel that my role makes a difference to patients / service users



	2015	2016	2017	2018	2019
Best	93.9%	93.8%	93.0%	92.9%	93.4%
Your org	92.5%	90.9%	92.7%	91.2%	91.8%
Average	90.4%	90.5%	90.2%	89.5%	89.7%
Worst	86.0%	88.1%	86.2%	84.2%	81.4%

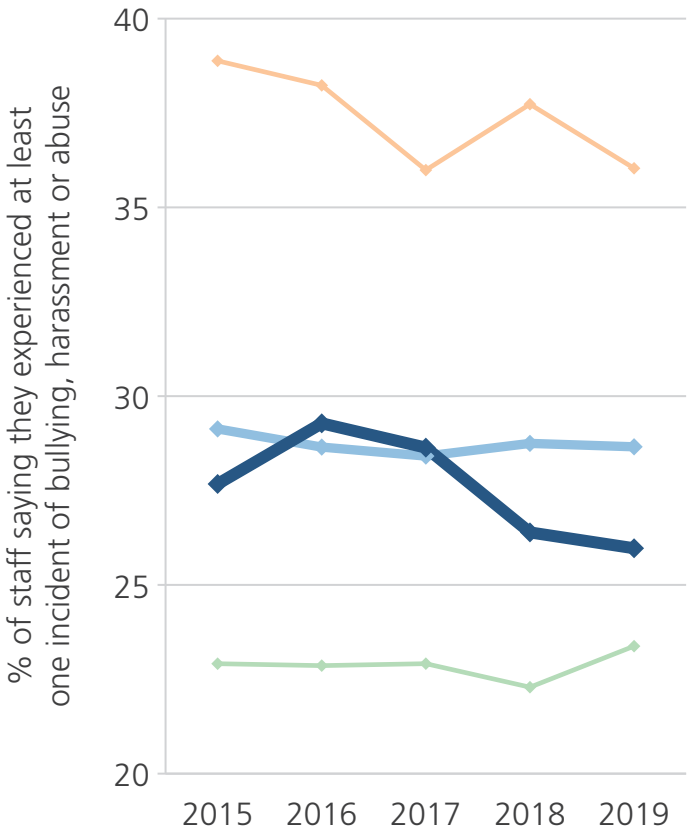
Q7c
I am able to deliver the care I aspire to



	2015	2016	2017	2018	2019
Best	79.6%	80.5%	76.8%	81.0%	80.3%
Your org	73.2%	70.1%	72.5%	71.3%	71.9%
Average	67.6%	69.6%	66.7%	66.8%	68.3%
Worst	54.3%	56.1%	57.9%	58.0%	55.5%

Q13a

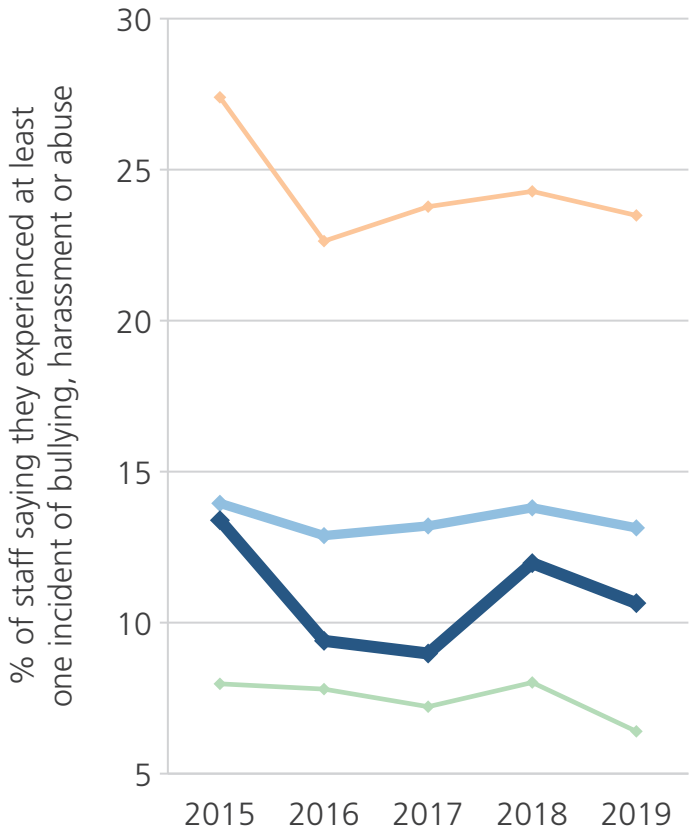
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	38.9%	38.2%	36.0%	37.7%	36.0%
Your org	27.7%	29.3%	28.6%	26.4%	26.0%
Average	29.1%	28.7%	28.4%	28.7%	28.7%
Best	22.9%	22.9%	22.9%	22.3%	23.4%

Q13b

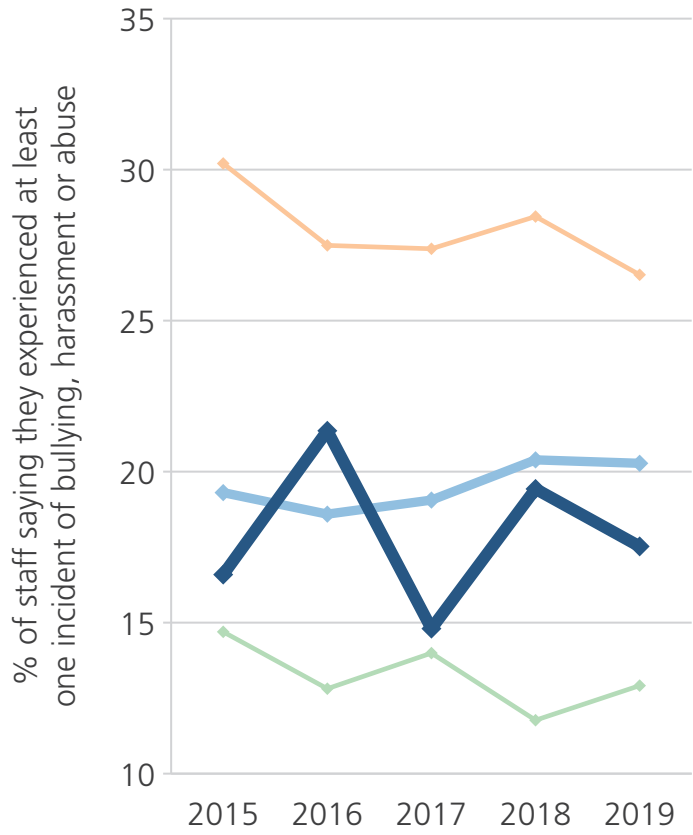
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2015	2016	2017	2018	2019
Worst	27.4%	22.6%	23.8%	24.3%	23.5%
Your org	13.4%	9.4%	9.0%	12.0%	10.6%
Average	14.0%	12.9%	13.2%	13.8%	13.1%
Best	8.0%	7.8%	7.2%	8.0%	6.4%

Q13c

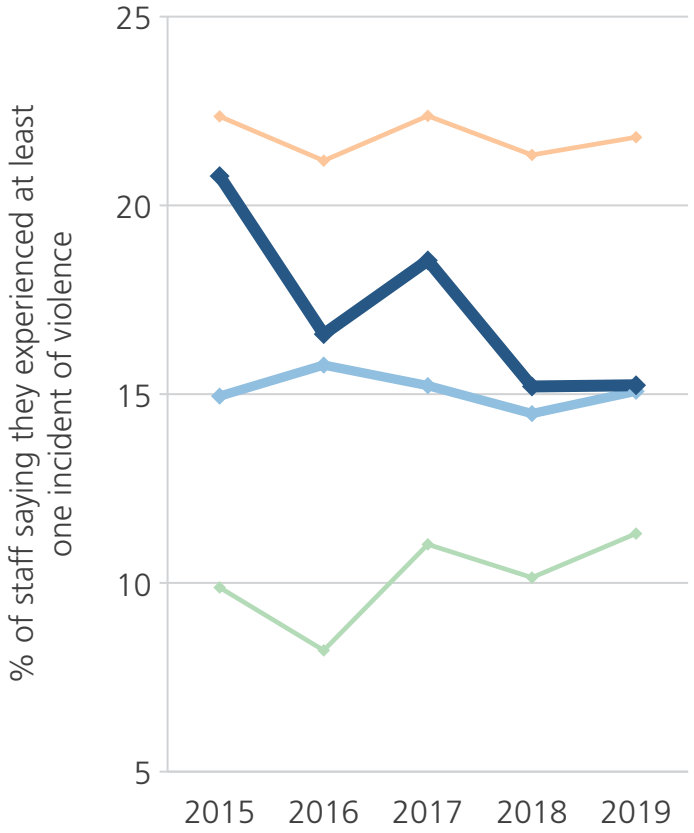
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



	2015	2016	2017	2018	2019
Worst	30.2%	27.5%	27.4%	28.4%	26.5%
Your org	16.6%	21.4%	14.8%	19.4%	17.5%
Average	19.3%	18.6%	19.1%	20.4%	20.3%
Best	14.7%	12.8%	14.0%	11.8%	12.9%

Q12a

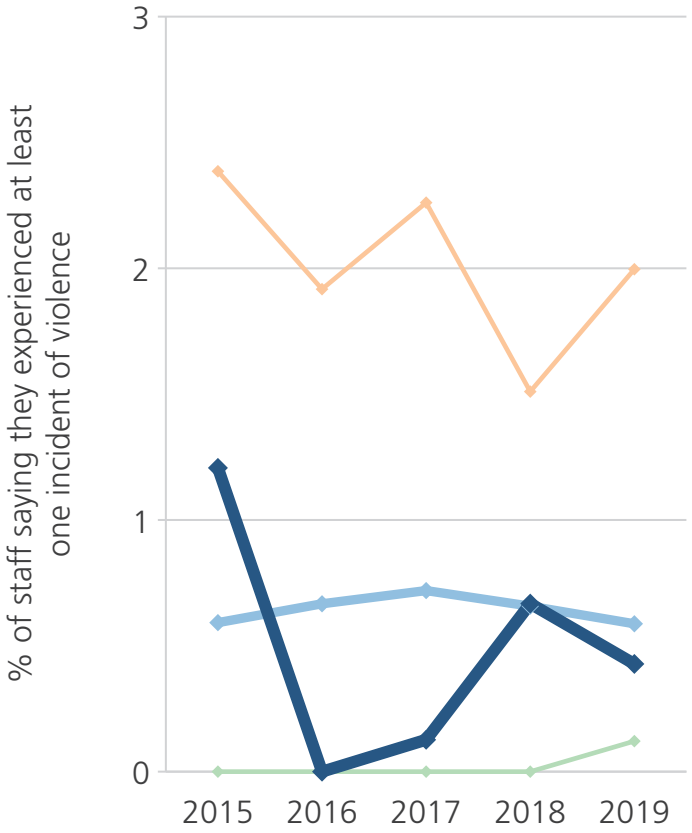
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	22.4%	21.2%	22.4%	21.3%	21.8%
Your org	20.8%	16.6%	18.5%	15.2%	15.2%
Average	14.9%	15.8%	15.2%	14.5%	15.1%
Best	9.9%	8.2%	11.0%	10.1%	11.3%

Q12b

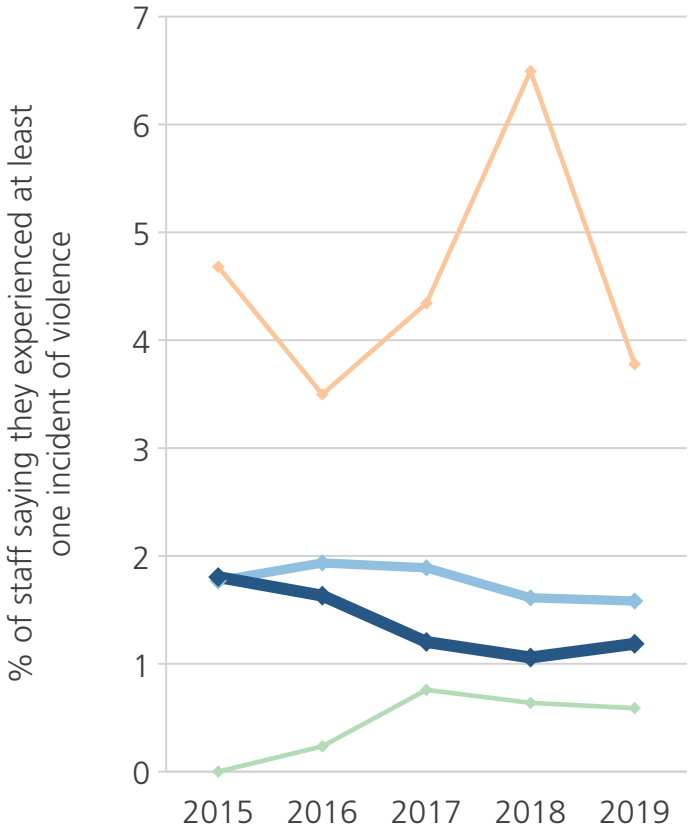
In the last 12 months how many times have you personally experienced physical violence at work from managers?



	2015	2016	2017	2018	2019
Worst	2.4%	1.9%	2.3%	1.5%	2.0%
Your org	1.2%	0.0%	0.1%	0.7%	0.4%
Average	0.6%	0.7%	0.7%	0.7%	0.6%
Best	0.0%	0.0%	0.0%	0.0%	0.1%

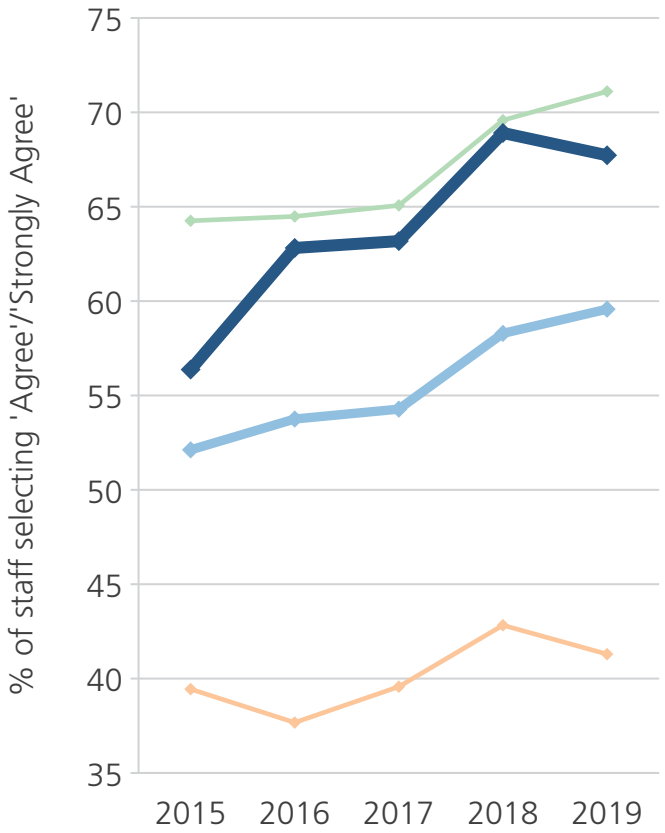
Q12c

In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



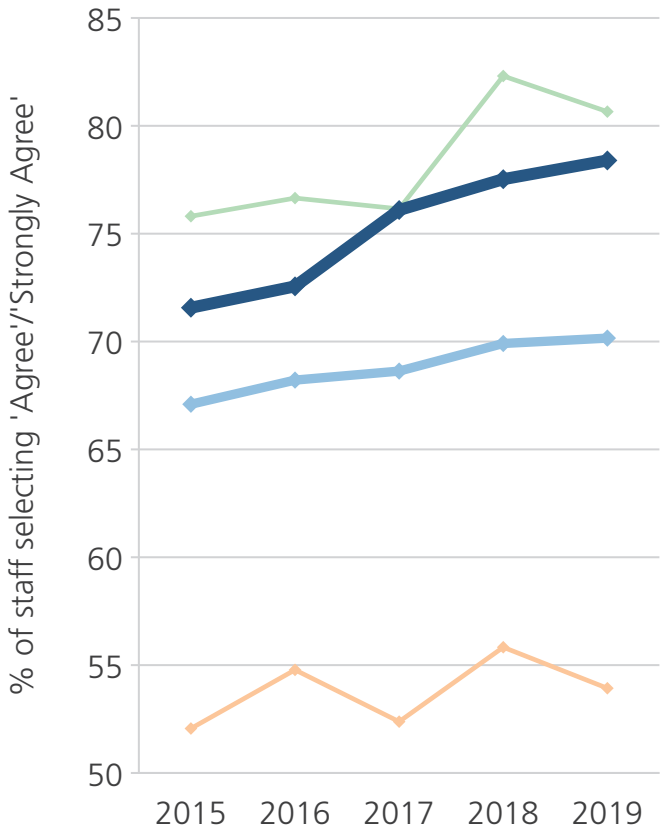
	2015	2016	2017	2018	2019
Worst	4.7%	3.5%	4.3%	6.5%	3.8%
Your org	1.8%	1.6%	1.2%	1.1%	1.2%
Average	1.8%	1.9%	1.9%	1.6%	1.6%
Best	0.0%	0.2%	0.8%	0.6%	0.6%

Q17a
My organisation treats staff who are involved in an error, near miss or incident fairly



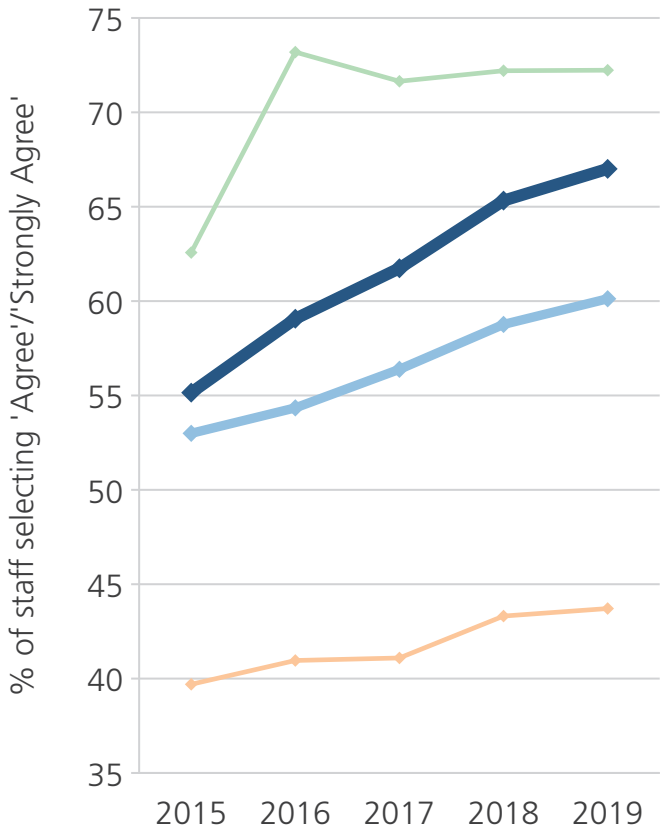
	2015	2016	2017	2018	2019
Best	64.3%	64.5%	65.1%	69.6%	71.1%
Your org	56.4%	62.8%	63.2%	68.9%	67.7%
Average	52.1%	53.8%	54.3%	58.3%	59.6%
Worst	39.4%	37.7%	39.6%	42.8%	41.3%

Q17c
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



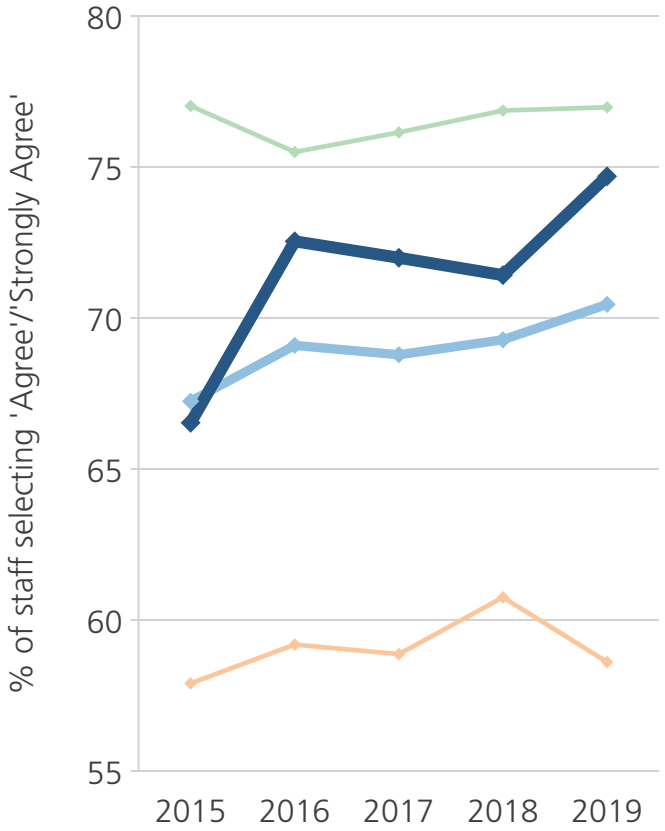
	2015	2016	2017	2018	2019
Best	75.8%	76.7%	76.2%	82.3%	80.7%
Your org	71.6%	72.6%	76.1%	77.5%	78.4%
Average	67.1%	68.2%	68.6%	69.9%	70.2%
Worst	52.1%	54.8%	52.4%	55.8%	53.9%

Q17d
We are given feedback about changes made in response to reported errors, near misses and incidents



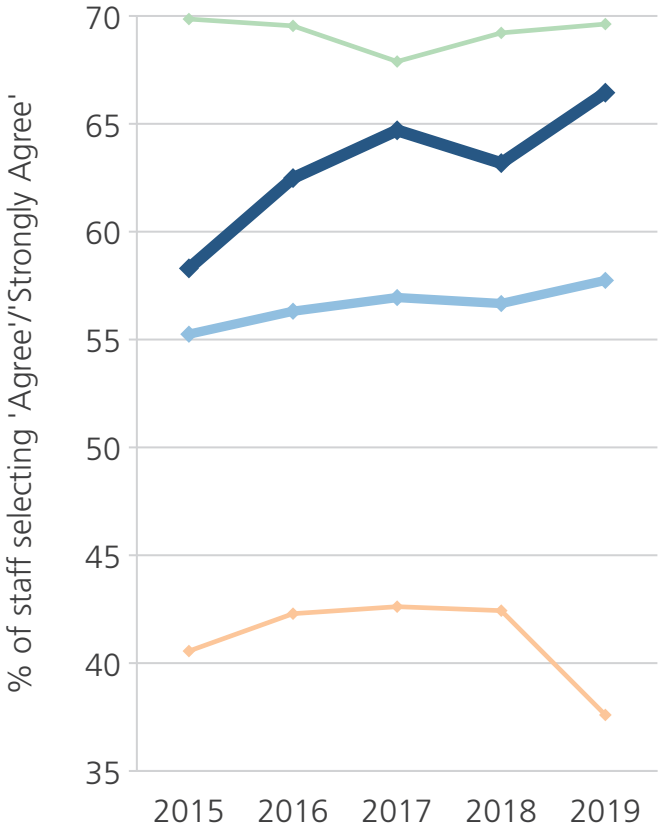
	2015	2016	2017	2018	2019
Best	62.6%	73.2%	71.6%	72.2%	72.2%
Your org	55.1%	59.1%	61.7%	65.3%	67.0%
Average	53.0%	54.3%	56.4%	58.8%	60.1%
Worst	39.7%	41.0%	41.1%	43.3%	43.7%

Q18b
I would feel secure raising concerns about unsafe clinical practice



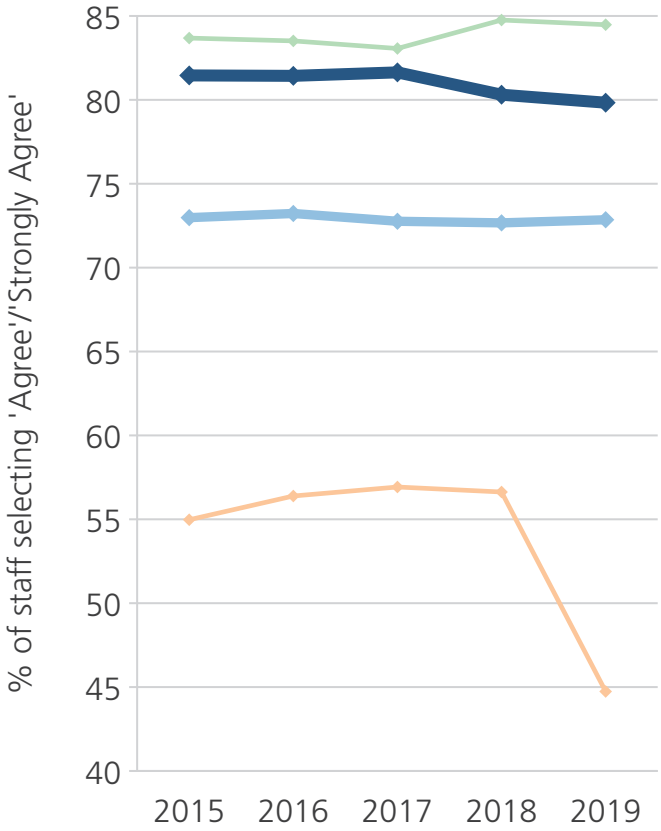
	2015	2016	2017	2018	2019
Best	77.0%	75.5%	76.1%	76.9%	77.0%
Your org	66.5%	72.5%	72.0%	71.4%	74.7%
Average	67.2%	69.1%	68.8%	69.3%	70.4%
Worst	57.9%	59.2%	58.9%	60.8%	58.6%

Q18c
I am confident that my organisation would address my concern



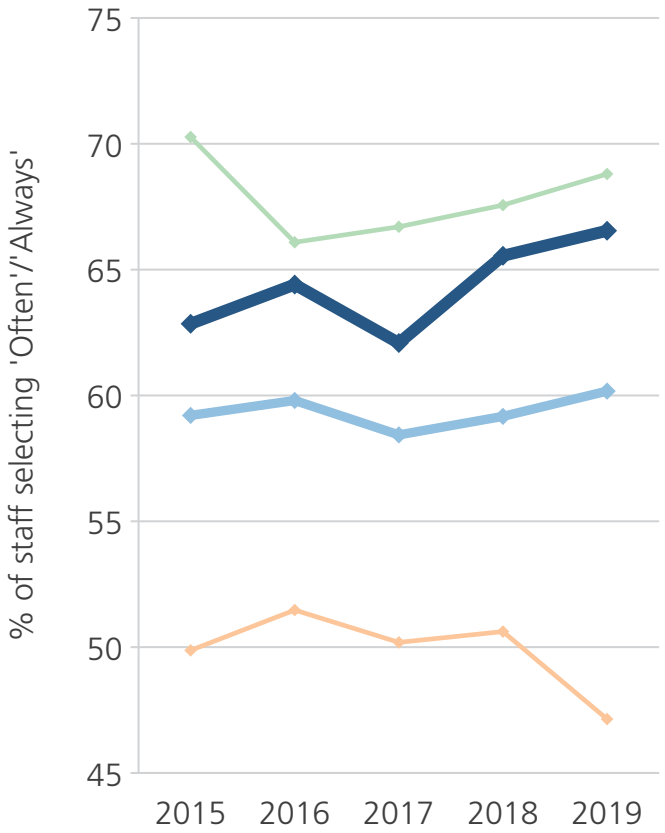
	2015	2016	2017	2018	2019
Best	69.9%	69.5%	67.9%	69.2%	69.6%
Your org	58.3%	62.5%	64.7%	63.2%	66.4%
Average	55.2%	56.3%	56.9%	56.7%	57.7%
Worst	40.6%	42.3%	42.6%	42.4%	37.6%

Q21b
My organisation acts on concerns raised by patients / service users



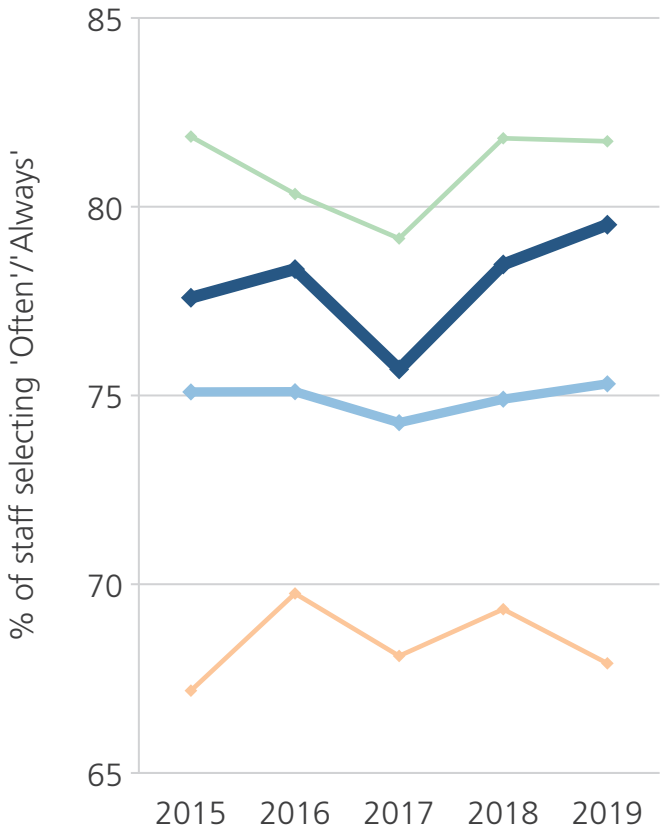
	2015	2016	2017	2018	2019
Best	83.7%	83.5%	83.1%	84.8%	84.5%
Your org	81.5%	81.4%	81.6%	80.3%	79.8%
Average	73.0%	73.2%	72.8%	72.7%	72.9%
Worst	55.0%	56.4%	56.9%	56.6%	44.7%

Q2a
I look forward to going to work



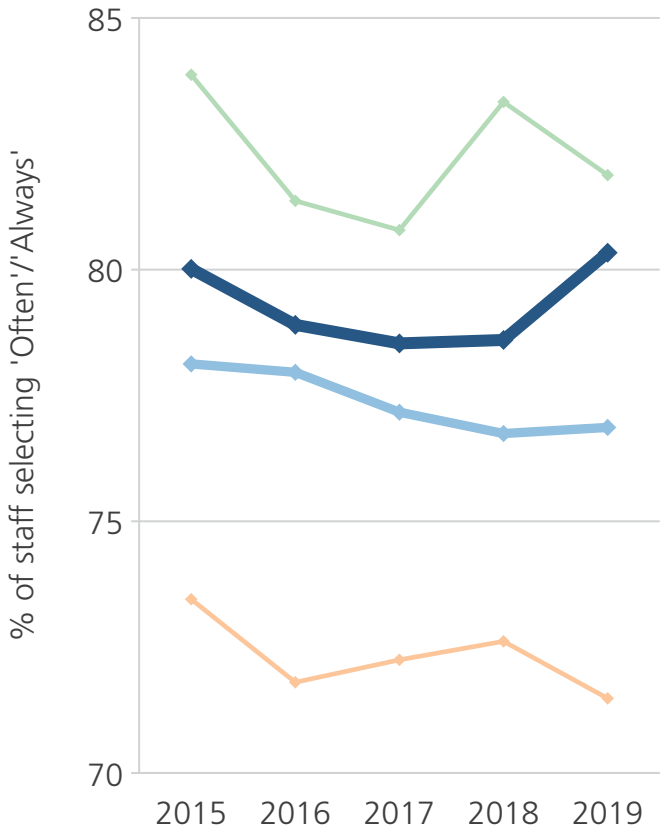
	2015	2016	2017	2018	2019
Best	70.3%	66.1%	66.7%	67.6%	68.8%
Your org	62.8%	64.4%	62.1%	65.6%	66.5%
Average	59.2%	59.8%	58.4%	59.2%	60.2%
Worst	49.9%	51.5%	50.2%	50.6%	47.1%

Q2b
I am enthusiastic about my job



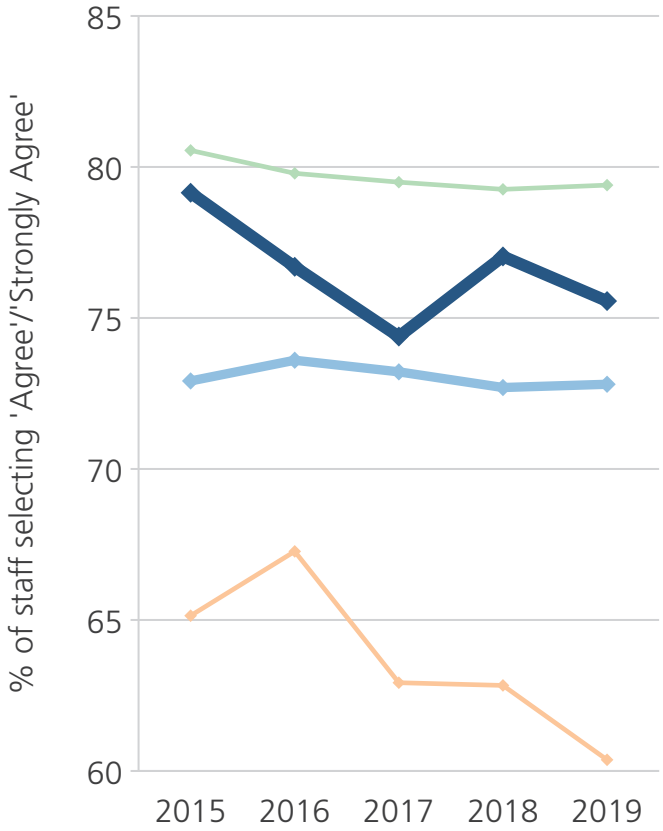
	2015	2016	2017	2018	2019
Best	81.9%	80.3%	79.2%	81.8%	81.7%
Your org	77.6%	78.3%	75.7%	78.5%	79.5%
Average	75.1%	75.1%	74.3%	74.9%	75.3%
Worst	67.2%	69.8%	68.1%	69.3%	67.9%

Q2c
Time passes quickly when I am working



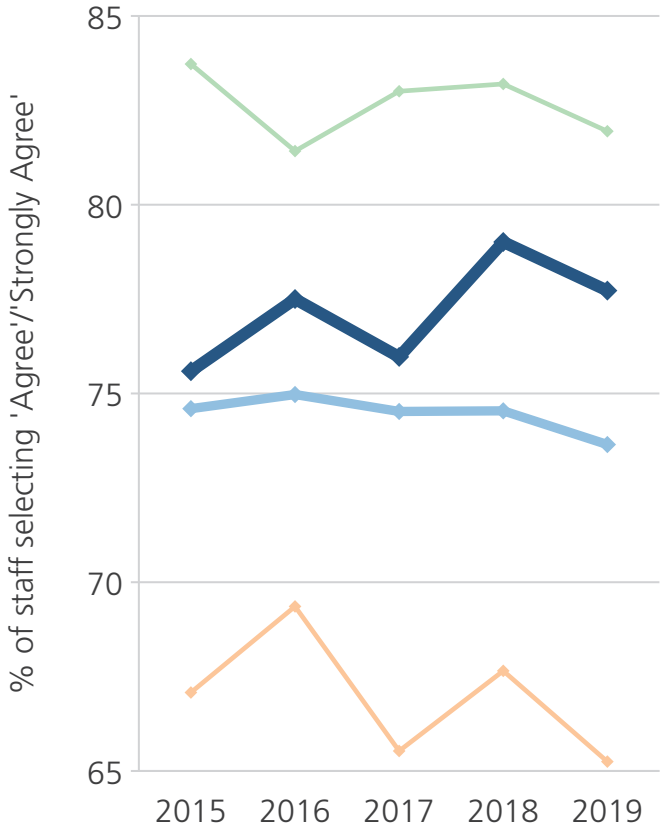
	2015	2016	2017	2018	2019
Best	83.9%	81.4%	80.8%	83.3%	81.9%
Your org	80.0%	78.9%	78.5%	78.6%	80.3%
Average	78.1%	78.0%	77.2%	76.7%	76.9%
Worst	73.5%	71.8%	72.2%	72.6%	71.5%

Q4a
There are frequent opportunities for me to show initiative in my role



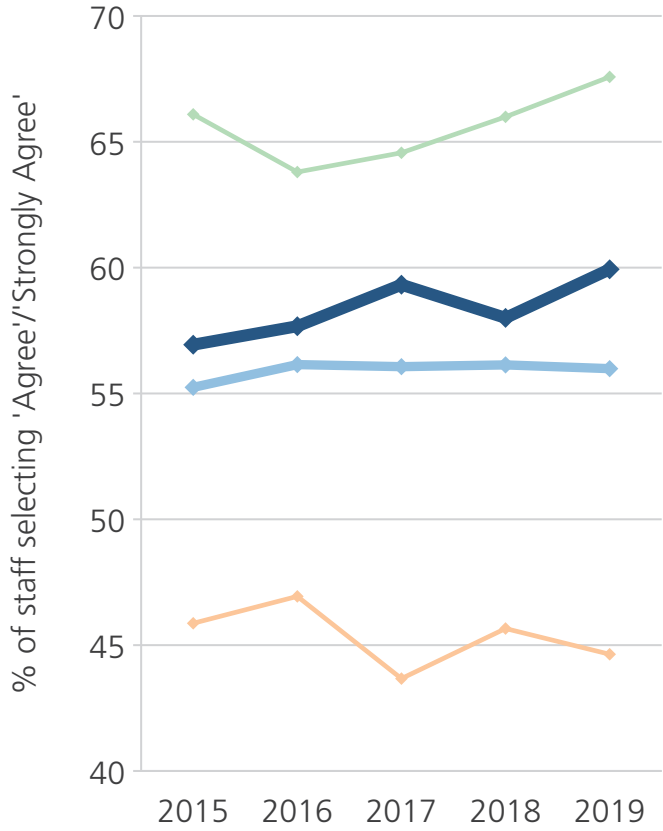
	2015	2016	2017	2018	2019
Best	80.5%	79.8%	79.5%	79.3%	79.4%
Your org	79.1%	76.7%	74.4%	77.0%	75.6%
Average	72.9%	73.6%	73.2%	72.7%	72.8%
Worst	65.1%	67.3%	62.9%	62.8%	60.4%

Q4b
I am able to make suggestions to improve the work of my team / department



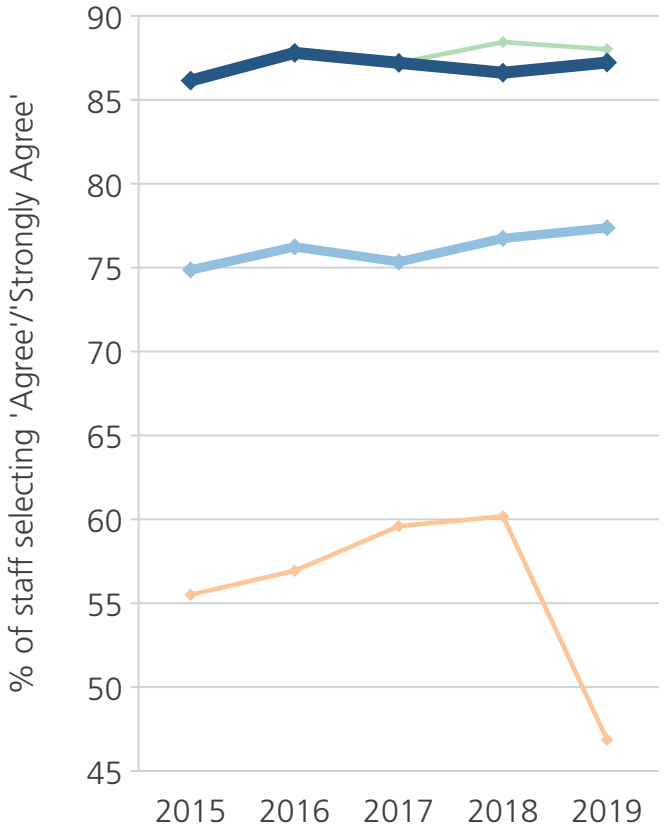
	2015	2016	2017	2018	2019
Best	83.7%	81.4%	83.0%	83.2%	81.9%
Your org	75.6%	77.5%	76.0%	79.0%	77.7%
Average	74.6%	75.0%	74.5%	74.5%	73.6%
Worst	67.1%	69.4%	65.5%	67.7%	65.2%

Q4d
I am able to make improvements happen in my area of work



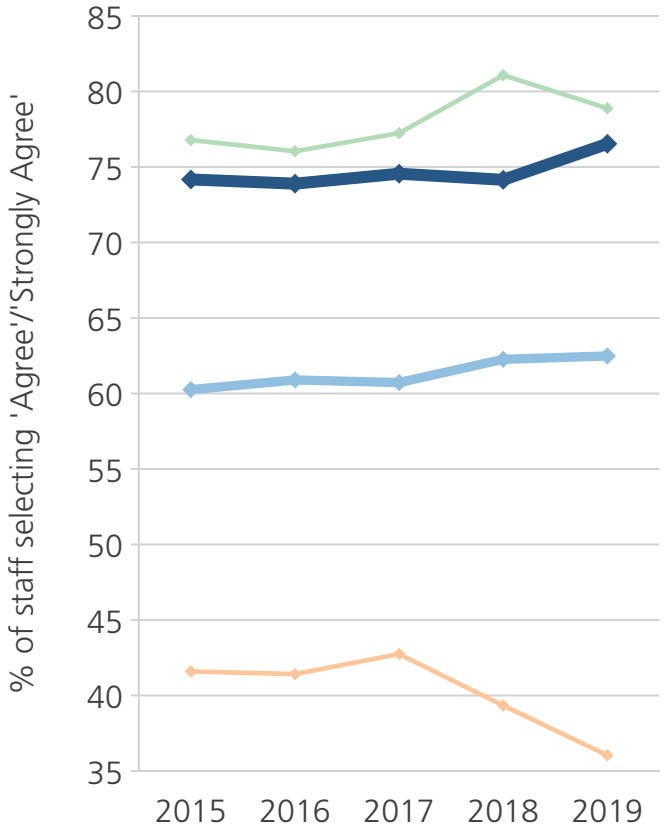
	2015	2016	2017	2018	2019
Best	66.1%	63.8%	64.6%	66.0%	67.6%
Your org	56.9%	57.7%	59.3%	58.0%	59.9%
Average	55.2%	56.1%	56.1%	56.1%	56.0%
Worst	45.9%	46.9%	43.7%	45.7%	44.6%

Q21a
Care of patients / service users is my organisation's top priority



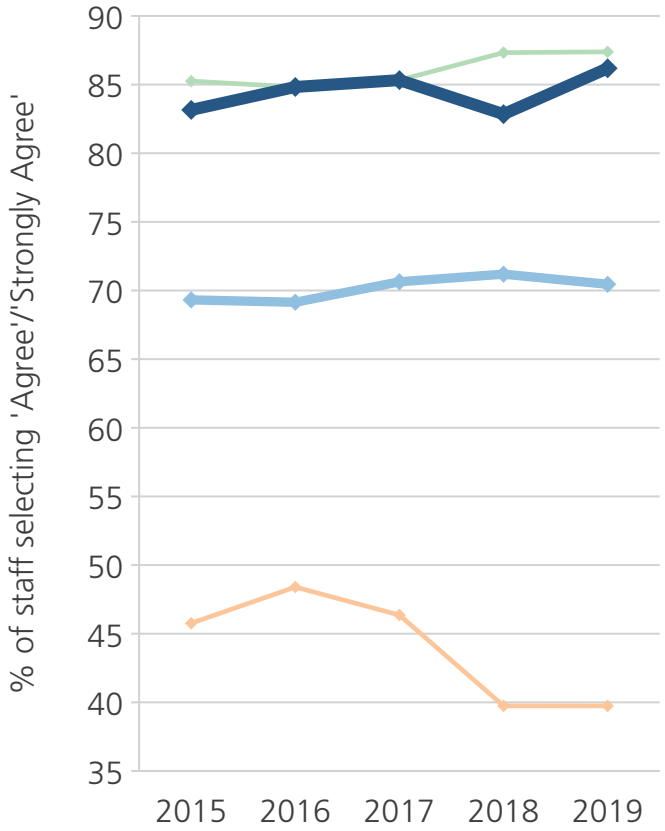
	2015	2016	2017	2018	2019
Best	86.1%	87.8%	87.2%	88.4%	88.0%
Your org	86.1%	87.8%	87.2%	86.6%	87.2%
Average	74.9%	76.2%	75.3%	76.7%	77.4%
Worst	55.5%	56.9%	59.6%	60.2%	46.9%

Q21c
I would recommend my organisation as a place to work



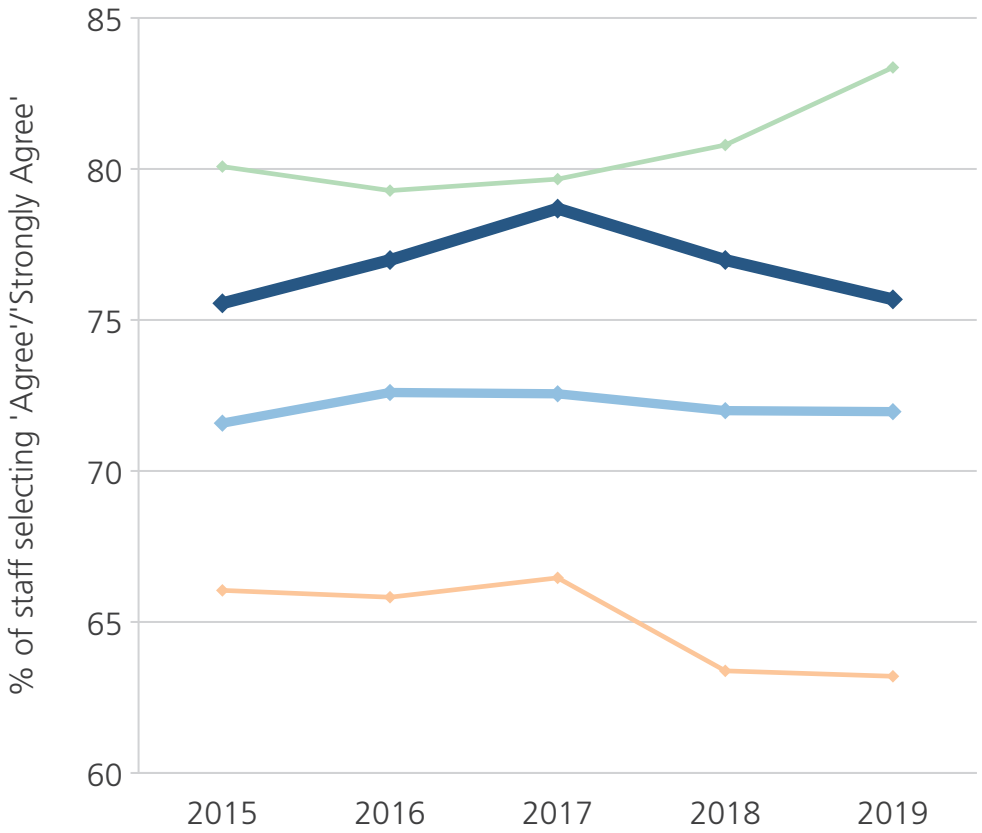
	2015	2016	2017	2018	2019
Best	76.8%	76.0%	77.2%	81.1%	78.9%
Your org	74.2%	73.9%	74.6%	74.1%	76.5%
Average	60.3%	60.9%	60.7%	62.3%	62.5%
Worst	41.6%	41.4%	42.7%	39.3%	36.0%

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



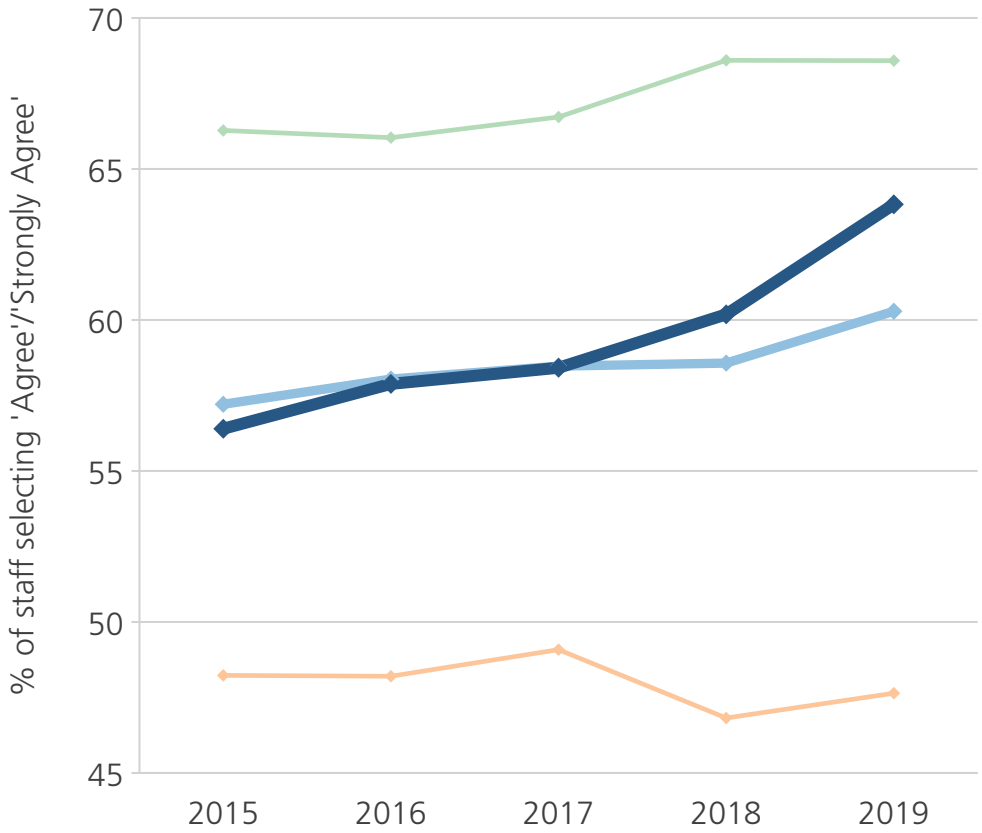
	2015	2016	2017	2018	2019
Best	85.3%	84.8%	85.3%	87.3%	87.4%
Your org	83.2%	84.8%	85.3%	82.8%	86.2%
Average	69.3%	69.1%	70.6%	71.2%	70.5%
Worst	45.8%	48.4%	46.4%	39.7%	39.7%

Q4h
The team I work in has a set of shared objectives



	2015	2016	2017	2018	2019
Best	80.1%	79.3%	79.7%	80.8%	83.4%
Your org	75.6%	77.0%	78.7%	77.0%	75.7%
Average	71.6%	72.6%	72.6%	72.0%	72.0%
Worst	66.0%	65.8%	66.5%	63.4%	63.2%

Q4i
The team I work in often meets to discuss the team's effectiveness



	2015	2016	2017	2018	2019
Best	66.3%	66.0%	66.7%	68.6%	68.6%
Your org	56.4%	57.9%	58.4%	60.2%	63.8%
Average	57.2%	58.0%	58.5%	58.6%	60.3%
Worst	48.2%	48.2%	49.1%	46.8%	47.6%

Survey Coordination Centre

NHS England

Question results

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results

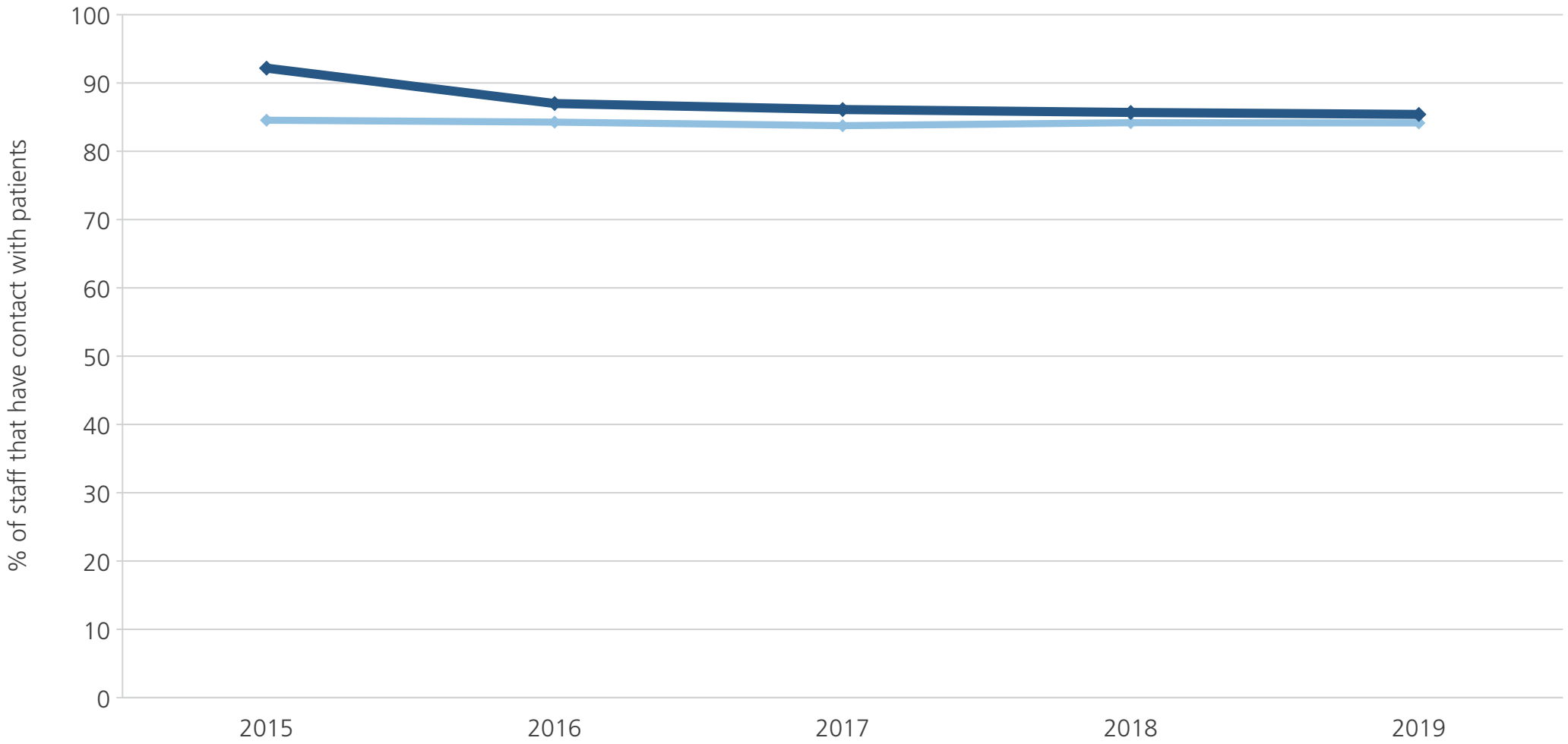
Survey Coordination Centre

NHS England

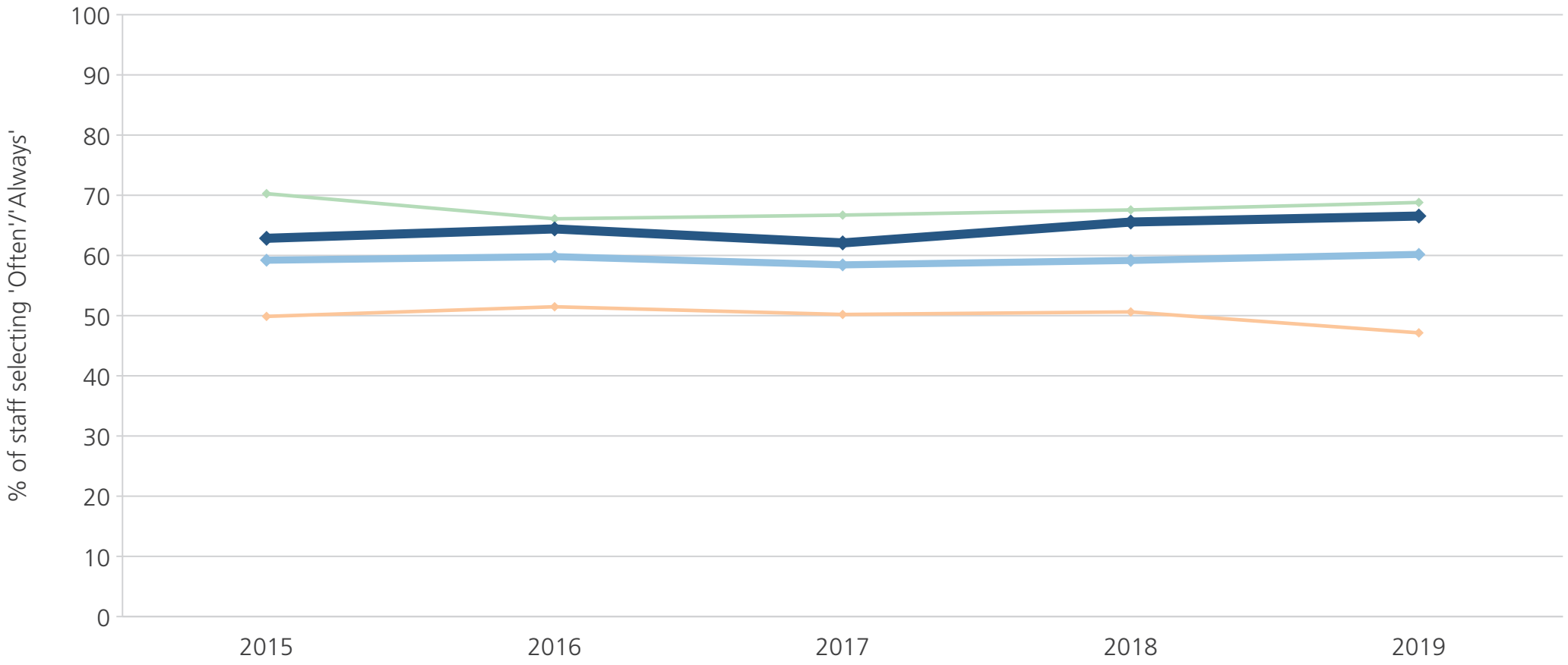
Question results – Your job

West Suffolk NHS Foundation Trust

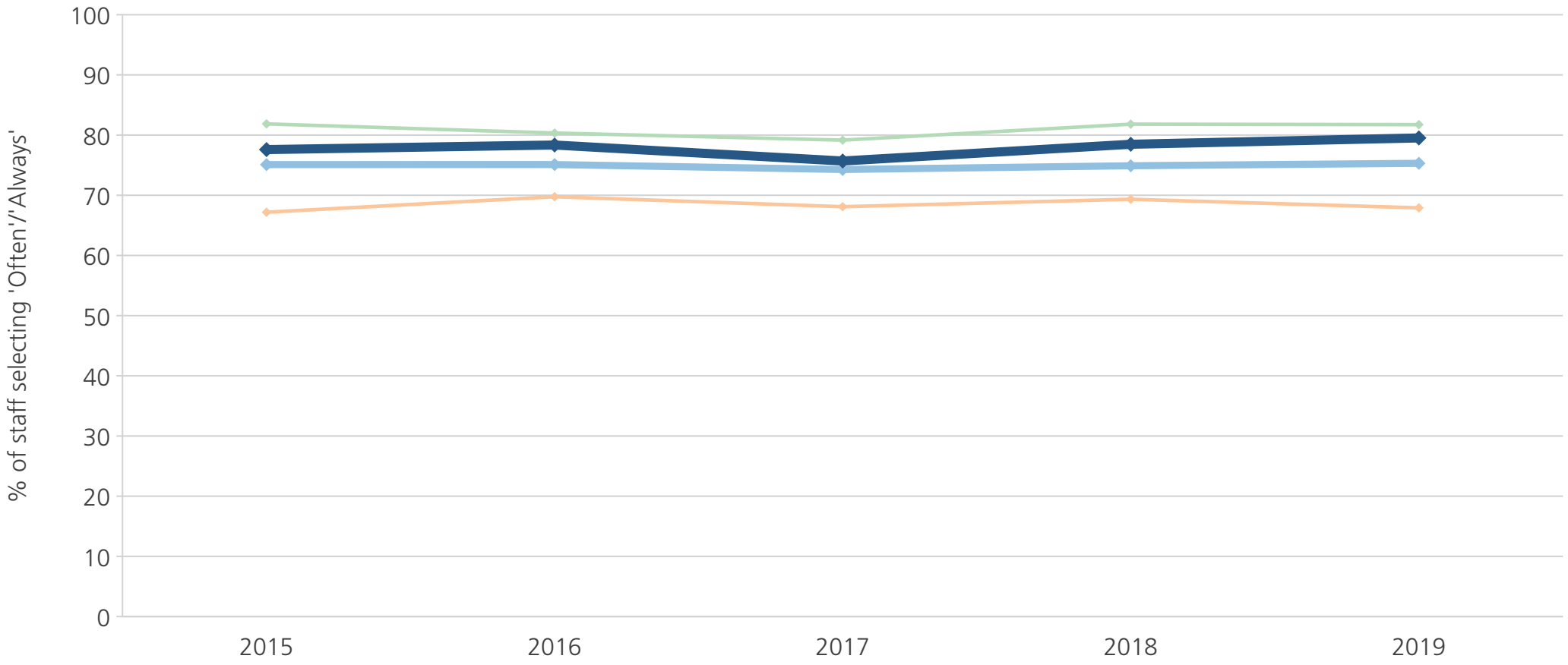
2019 NHS Staff Survey Results



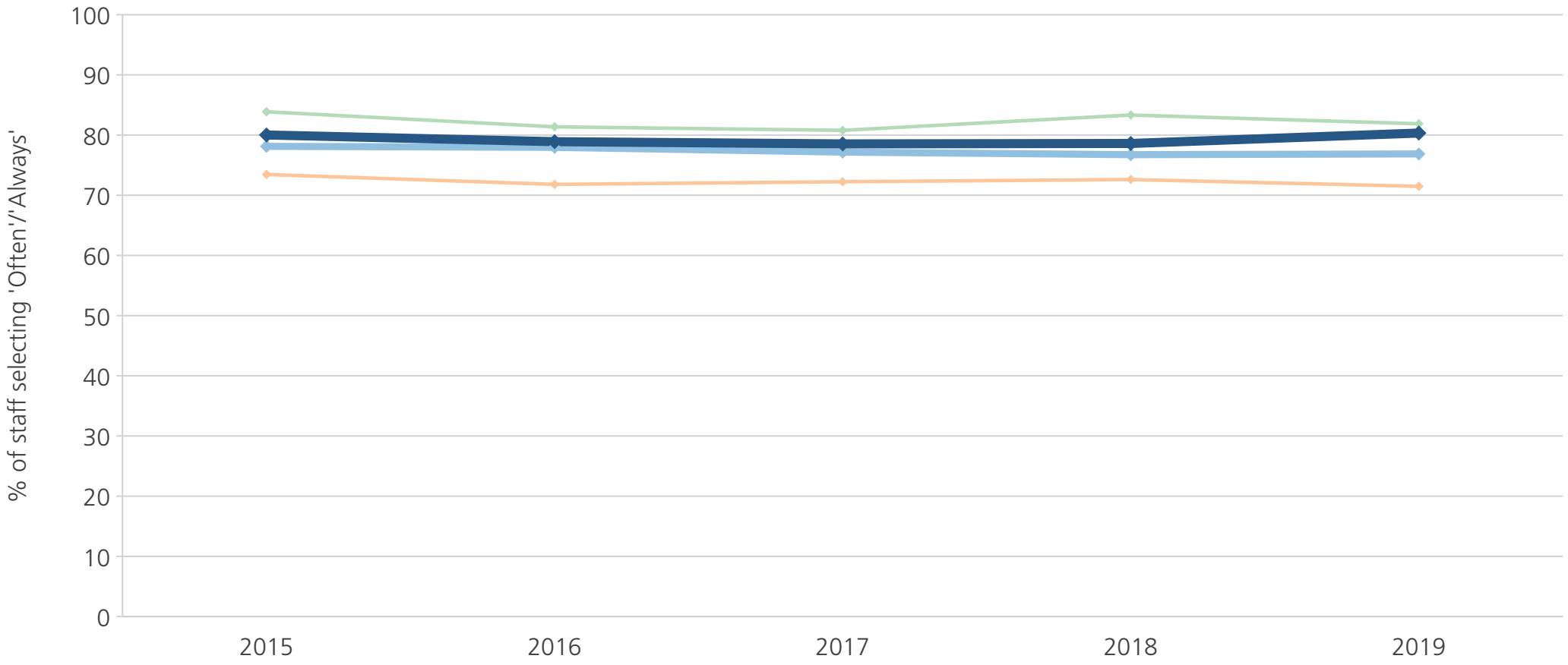
	2015	2016	2017	2018	2019
Your org	92.2%	87.0%	86.1%	85.7%	85.4%
Average	84.5%	84.3%	83.7%	84.2%	84.2%
Responses	460	615	576	573	2,068



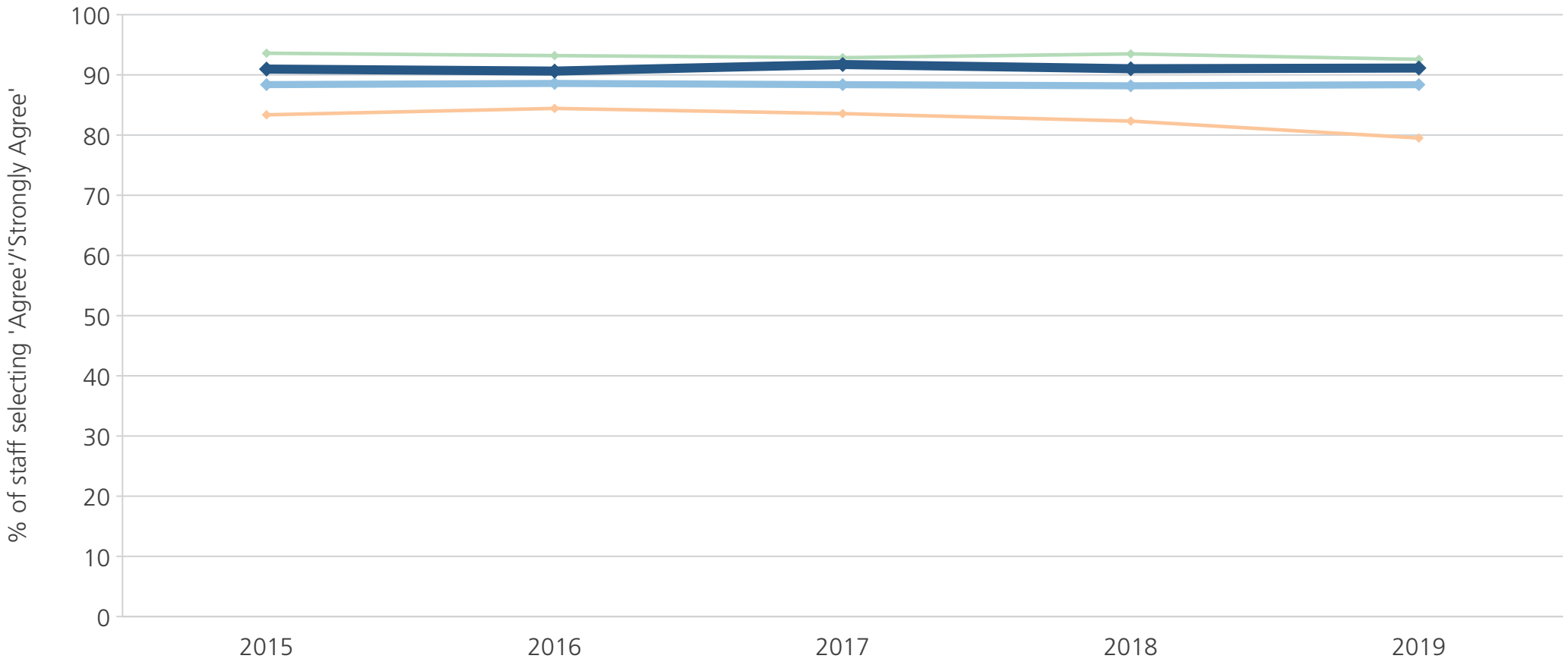
	2015	2016	2017	2018	2019
Best	70.3%	66.1%	66.7%	67.6%	68.8%
Your org	62.8%	64.4%	62.1%	65.6%	66.5%
Average	59.2%	59.8%	58.4%	59.2%	60.2%
Worst	49.9%	51.5%	50.2%	50.6%	47.1%
Responses	457	622	591	593	2,060



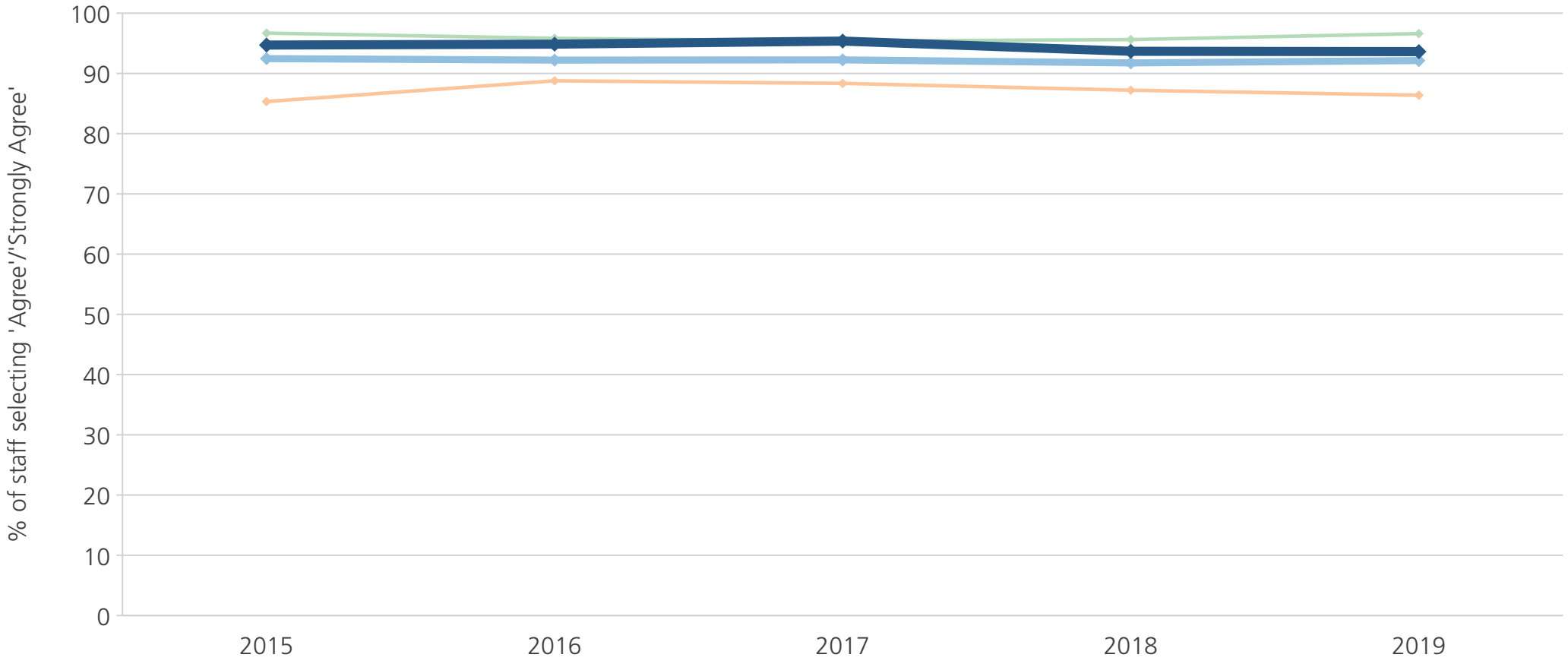
	2015	2016	2017	2018	2019
Best	81.9%	80.3%	79.2%	81.8%	81.7%
Your org	77.6%	78.3%	75.7%	78.5%	79.5%
Average	75.1%	75.1%	74.3%	74.9%	75.3%
Worst	67.2%	69.8%	68.1%	69.3%	67.9%
Responses	457	610	586	594	2,052



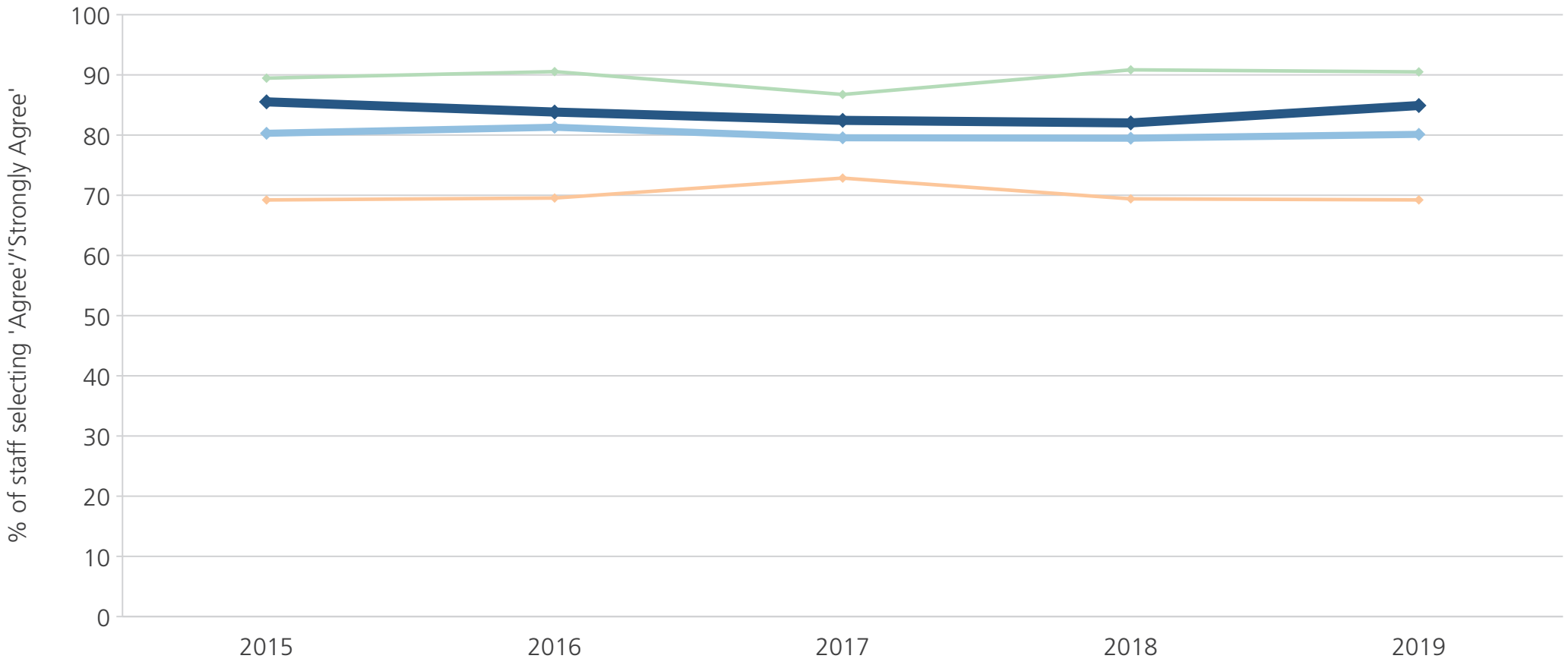
	2015	2016	2017	2018	2019
Best	83.9%	81.4%	80.8%	83.3%	81.9%
Your org	80.0%	78.9%	78.5%	78.6%	80.3%
Average	78.1%	78.0%	77.2%	76.7%	76.9%
Worst	73.5%	71.8%	72.2%	72.6%	71.5%
Responses	455	612	579	594	2,056



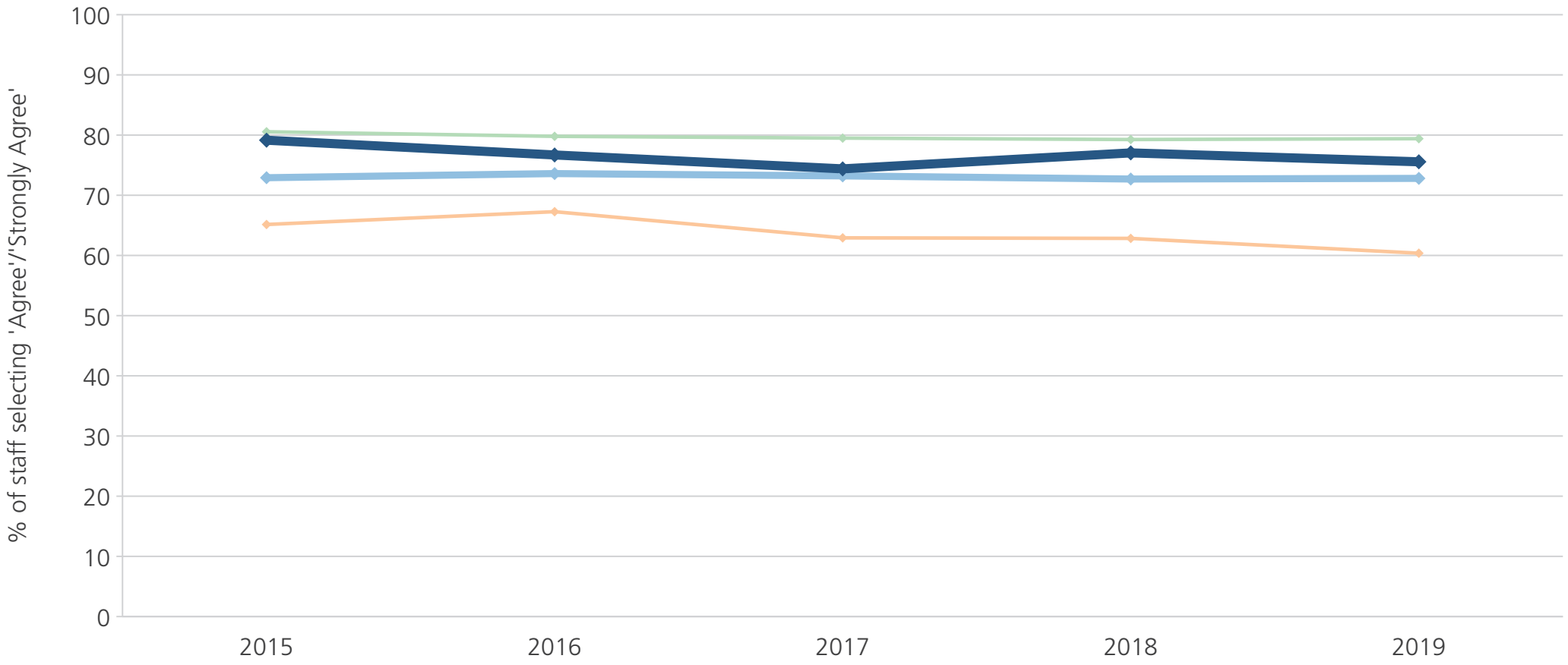
	2015	2016	2017	2018	2019
Best	93.6%	93.2%	92.9%	93.5%	92.6%
Your org	91.0%	90.6%	91.7%	91.0%	91.1%
Average	88.4%	88.6%	88.4%	88.2%	88.4%
Worst	83.4%	84.4%	83.6%	82.3%	79.5%
Responses	460	623	586	593	2,061



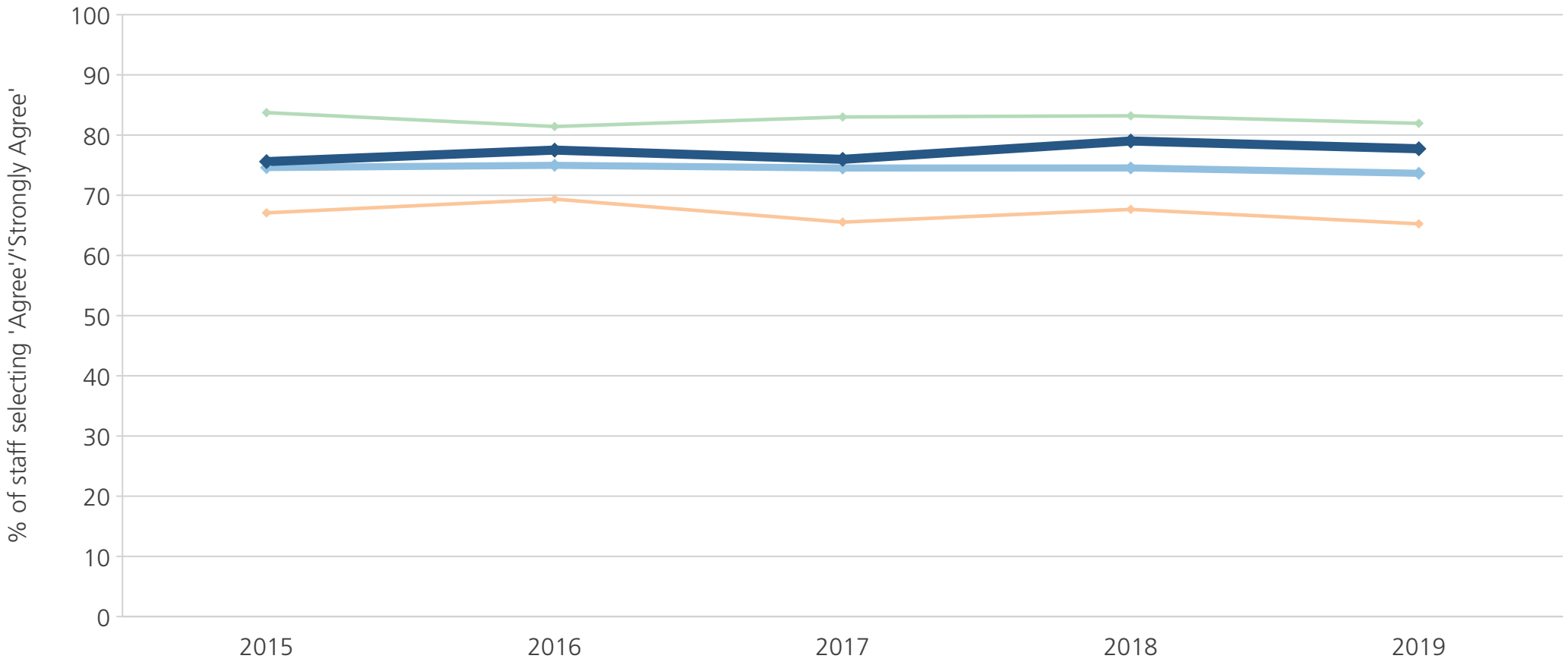
	2015	2016	2017	2018	2019
Best	96.7%	95.8%	95.4%	95.6%	96.6%
Your org	94.7%	94.9%	95.4%	93.7%	93.6%
Average	92.5%	92.2%	92.2%	91.7%	92.1%
Worst	85.3%	88.8%	88.3%	87.2%	86.4%
Responses	460	614	576	595	2,057



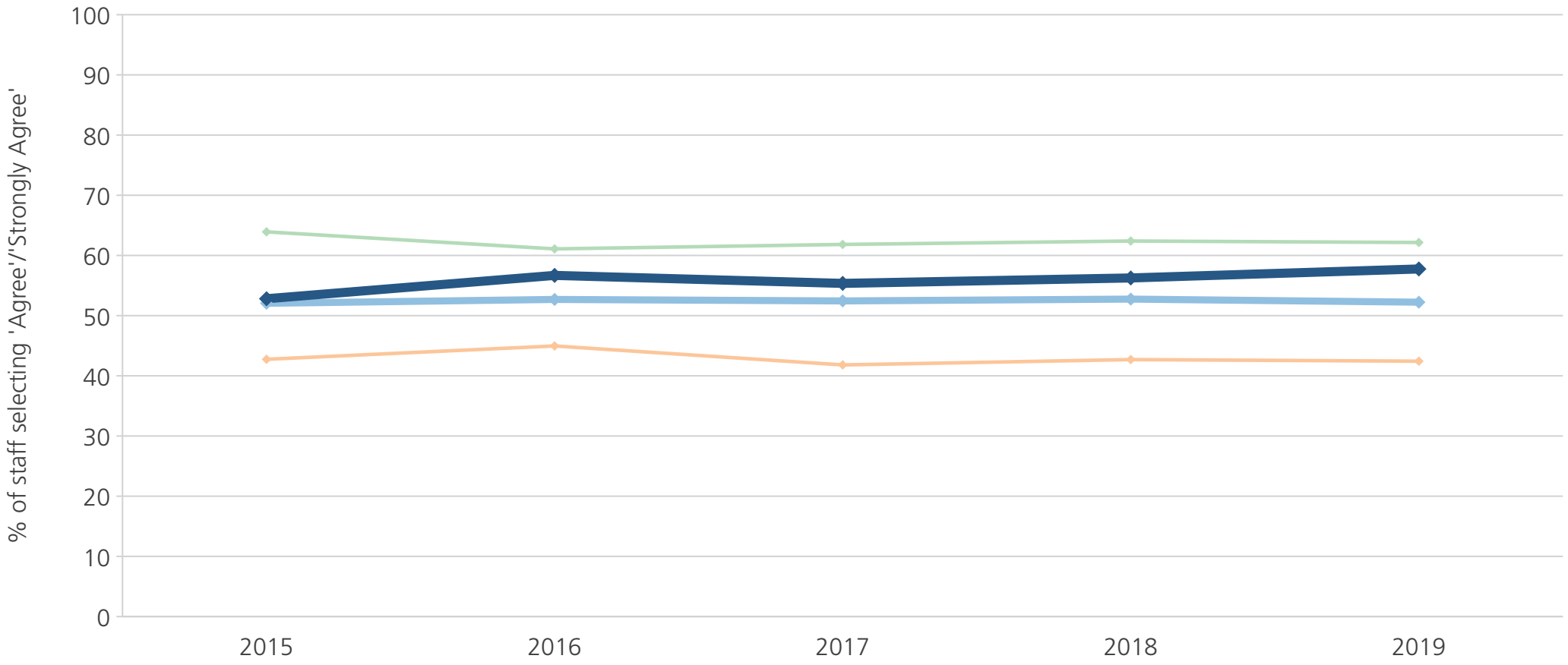
	2015	2016	2017	2018	2019
Best	89.5%	90.5%	86.7%	90.8%	90.5%
Your org	85.5%	83.8%	82.4%	82.0%	84.9%
Average	80.3%	81.3%	79.5%	79.5%	80.1%
Worst	69.2%	69.5%	72.9%	69.4%	69.2%
Responses	456	613	591	593	2,058



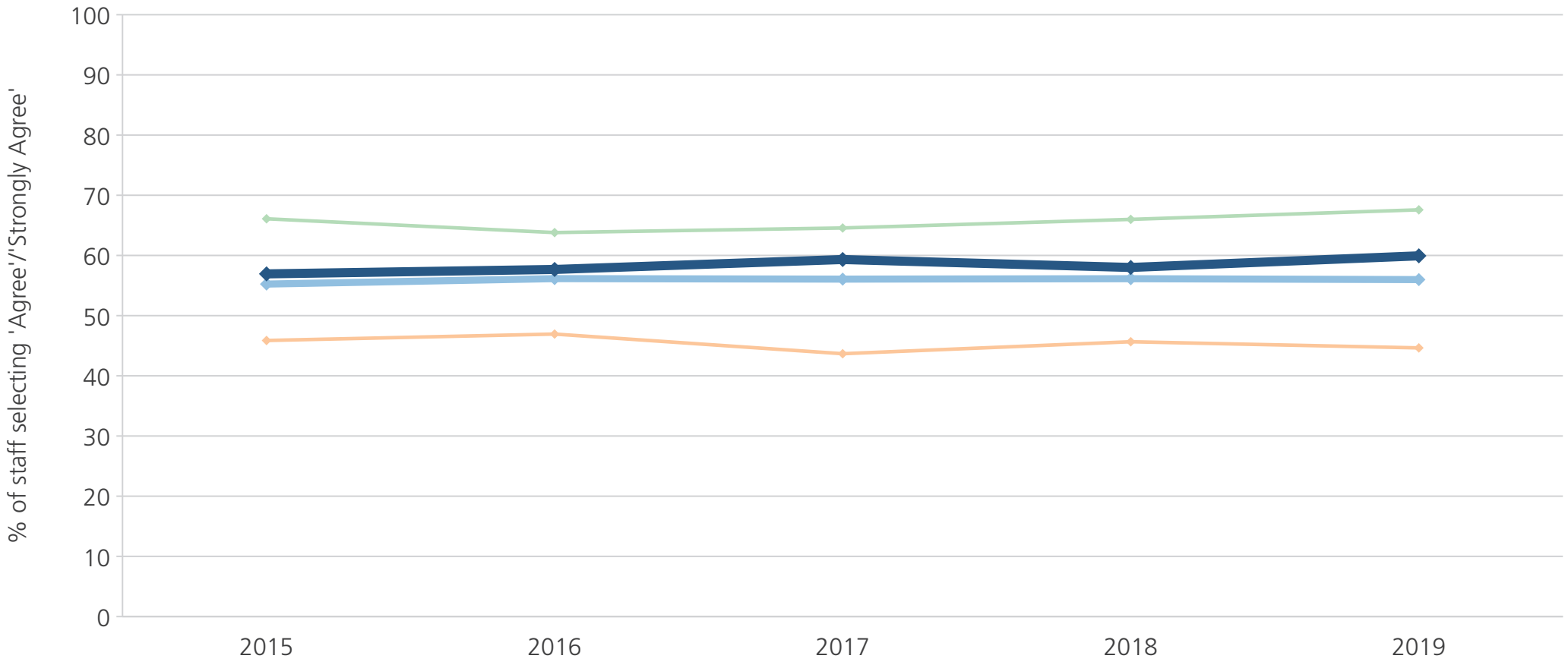
	2015	2016	2017	2018	2019
Best	80.5%	79.8%	79.5%	79.3%	79.4%
Your org	79.1%	76.7%	74.4%	77.0%	75.6%
Average	72.9%	73.6%	73.2%	72.7%	72.8%
Worst	65.1%	67.3%	62.9%	62.8%	60.4%
Responses	457	616	592	592	2,067



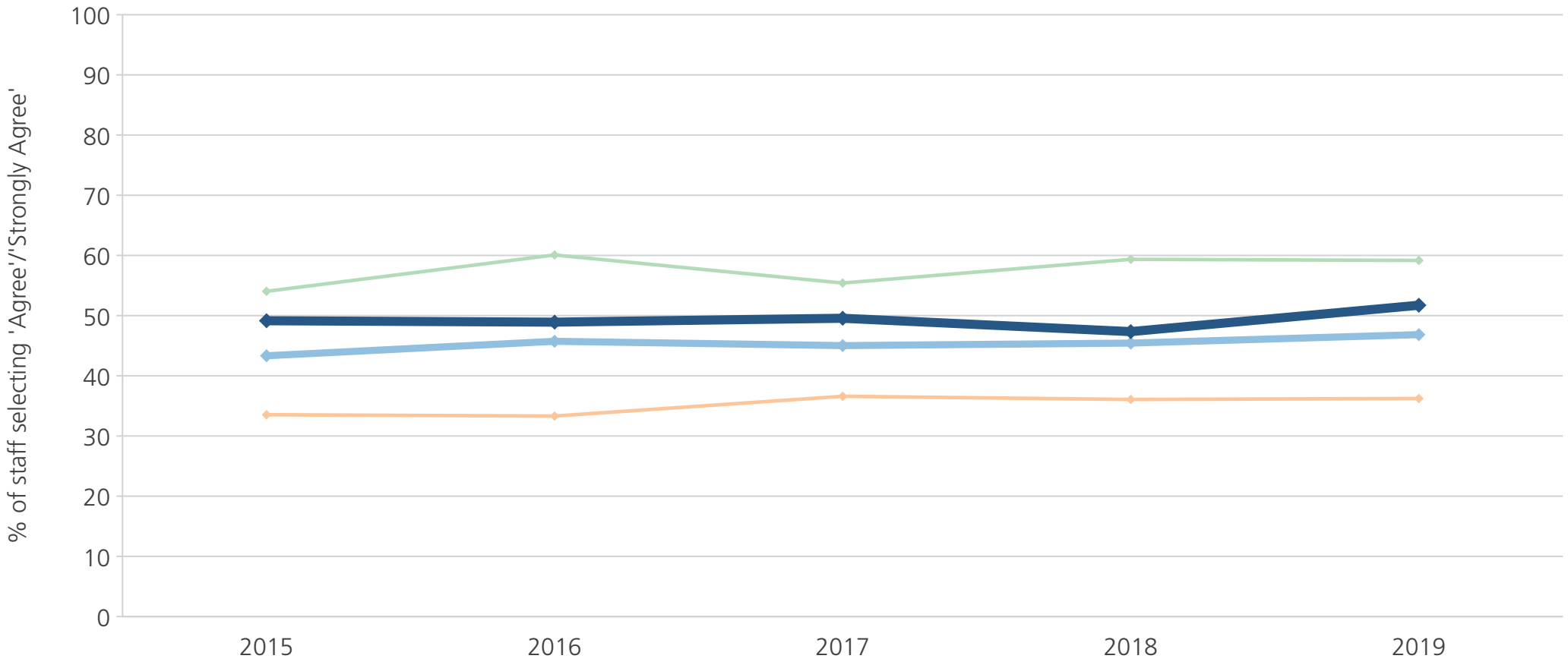
	2015	2016	2017	2018	2019
Best	83.7%	81.4%	83.0%	83.2%	81.9%
Your org	75.6%	77.5%	76.0%	79.0%	77.7%
Average	74.6%	75.0%	74.5%	74.5%	73.6%
Worst	67.1%	69.4%	65.5%	67.7%	65.2%
Responses	460	615	593	592	2,066



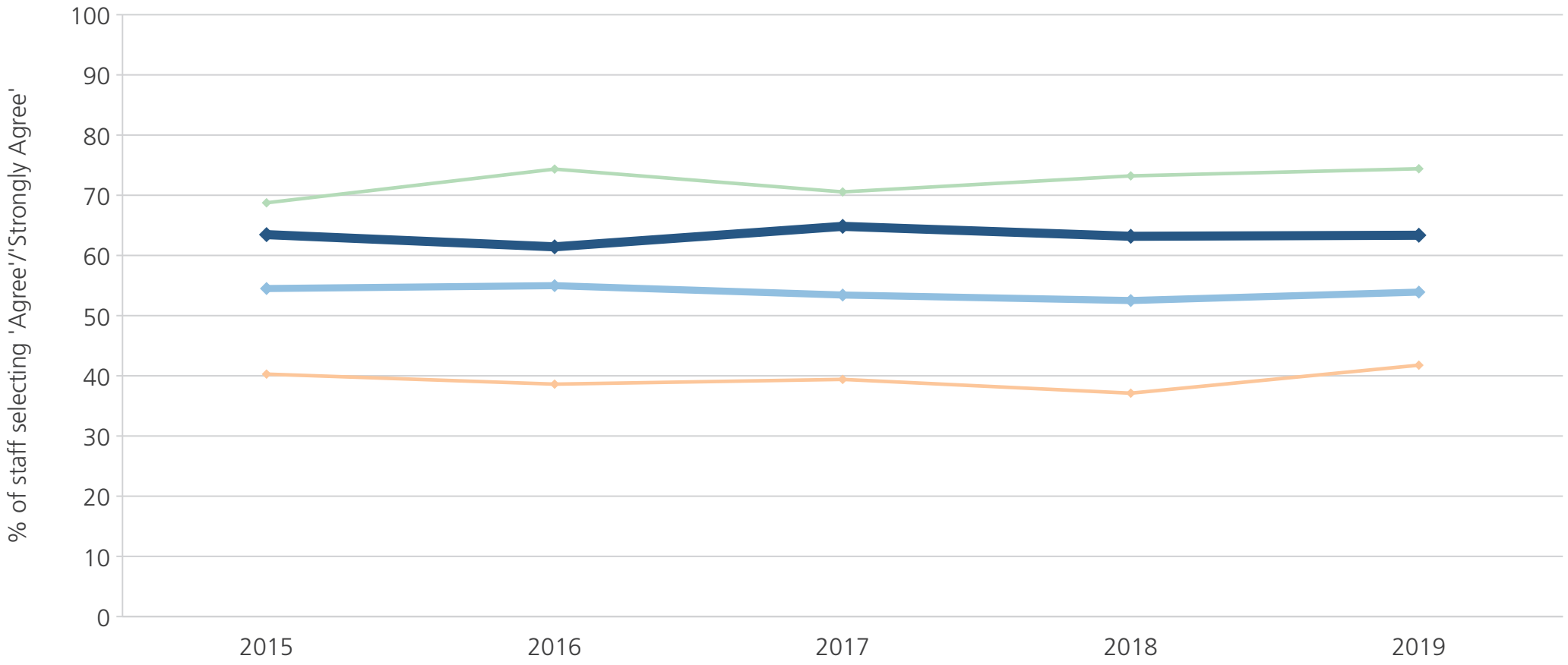
	2015	2016	2017	2018	2019
Best	63.9%	61.1%	61.8%	62.4%	62.1%
Your org	52.8%	56.7%	55.4%	56.3%	57.8%
Average	52.1%	52.7%	52.4%	52.7%	52.2%
Worst	42.7%	45.0%	41.8%	42.7%	42.4%
Responses	460	618	594	592	2,067



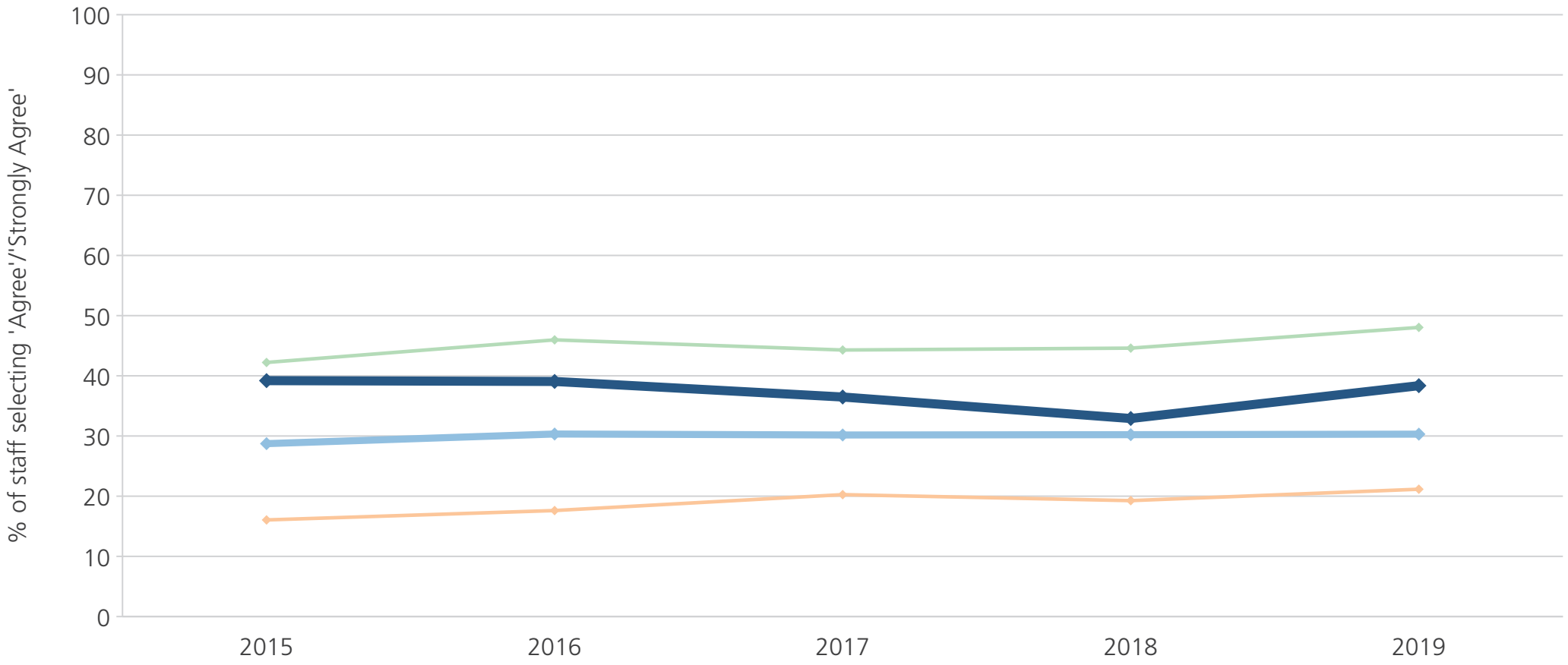
	2015	2016	2017	2018	2019
Best	66.1%	63.8%	64.6%	66.0%	67.6%
Your org	56.9%	57.7%	59.3%	58.0%	59.9%
Average	55.2%	56.1%	56.1%	56.1%	56.0%
Worst	45.9%	46.9%	43.7%	45.7%	44.6%
Responses	458	618	594	592	2,068



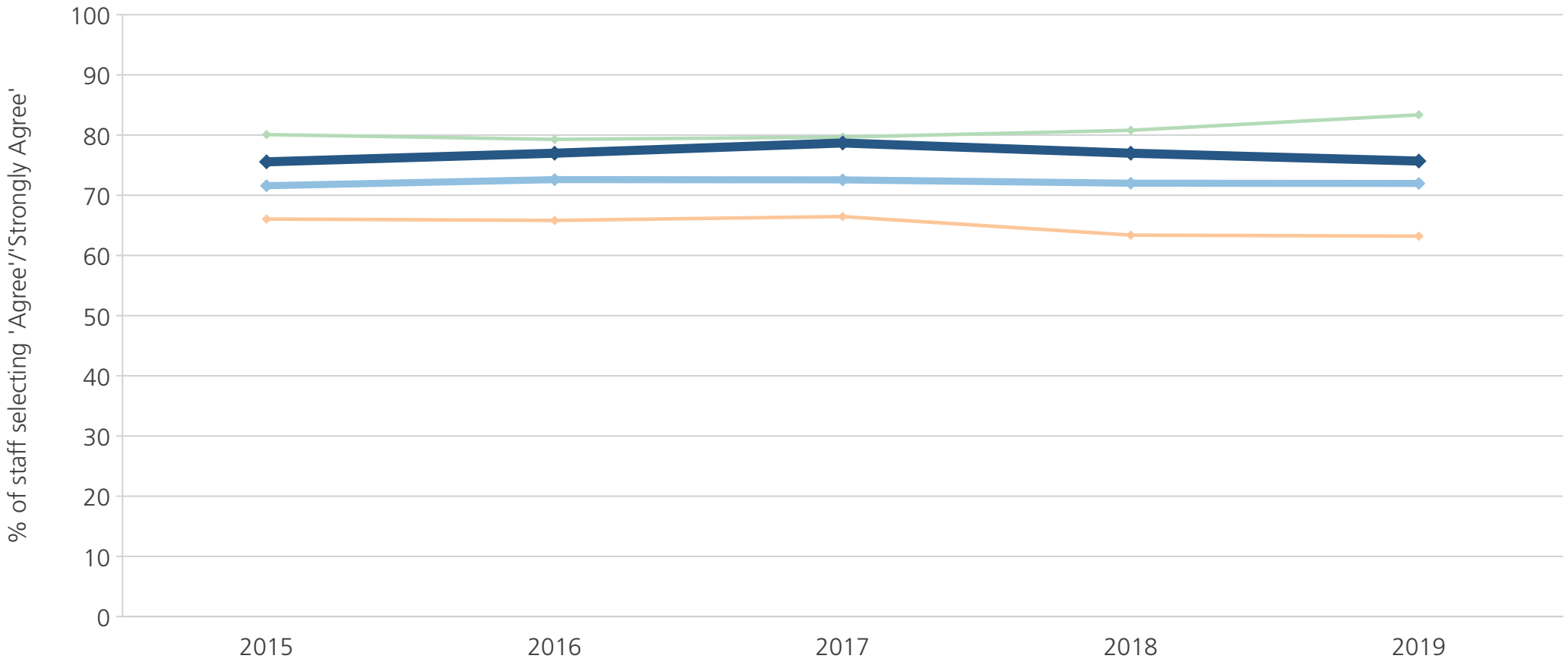
	2015	2016	2017	2018	2019
Best	54.0%	60.1%	55.4%	59.4%	59.2%
Your org	49.1%	48.9%	49.6%	47.3%	51.7%
Average	43.3%	45.7%	45.0%	45.4%	46.8%
Worst	33.5%	33.3%	36.6%	36.1%	36.2%
Responses	458	616	590	591	2,059



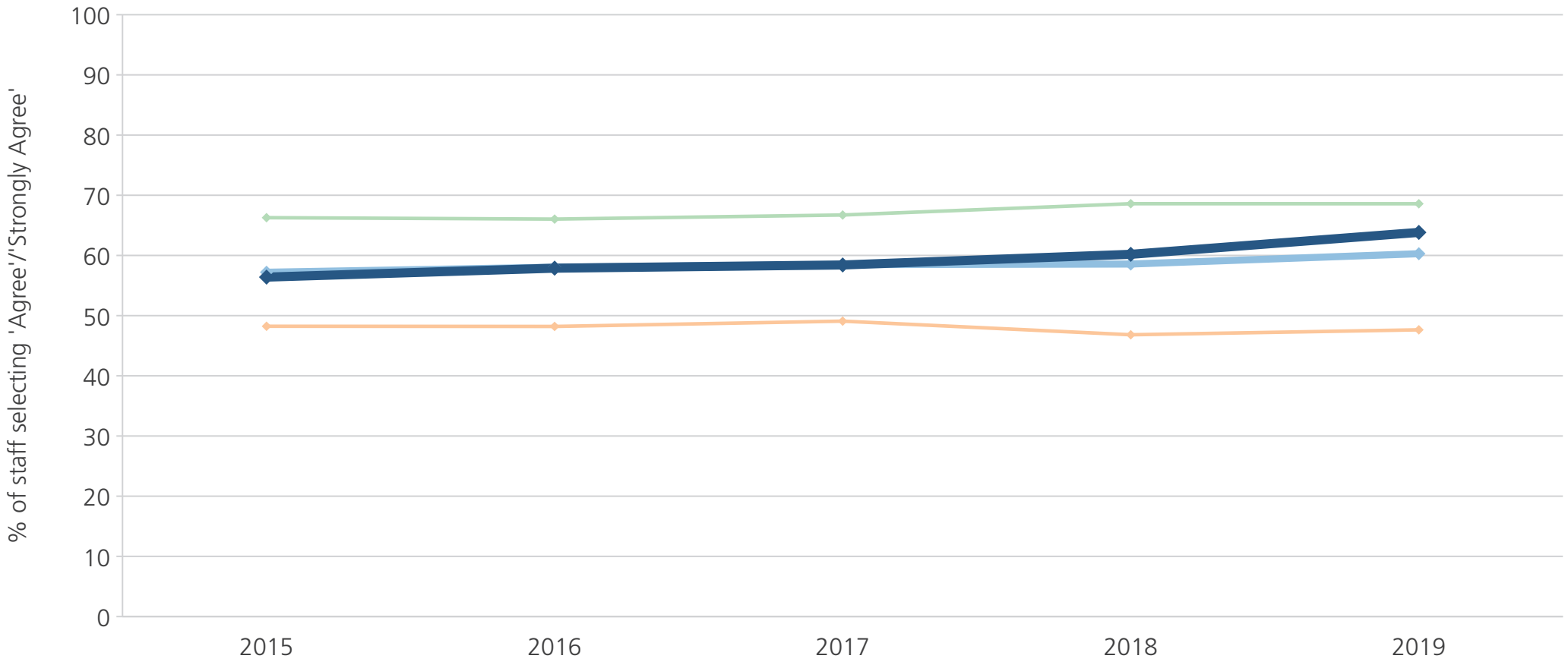
	2015	2016	2017	2018	2019
Best	68.7%	74.3%	70.6%	73.2%	74.4%
Your org	63.5%	61.4%	64.8%	63.2%	63.4%
Average	54.5%	55.0%	53.4%	52.5%	53.9%
Worst	40.3%	38.6%	39.4%	37.1%	41.8%
Responses	457	618	589	592	2,063



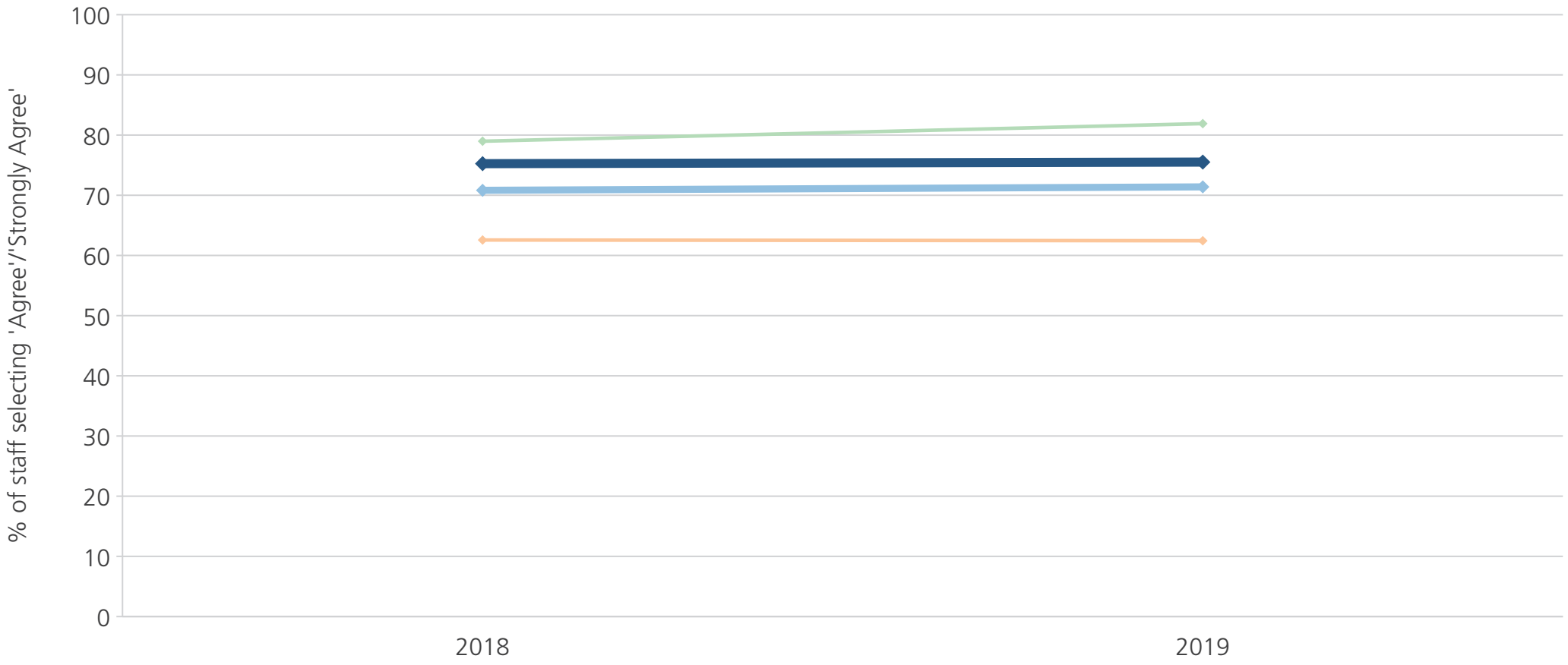
	2015	2016	2017	2018	2019
Best	42.2%	46.0%	44.3%	44.6%	48.0%
Your org	39.2%	39.1%	36.5%	32.9%	38.4%
Average	28.7%	30.3%	30.2%	30.2%	30.3%
Worst	16.1%	17.6%	20.3%	19.3%	21.2%
Responses	456	614	590	593	2,061



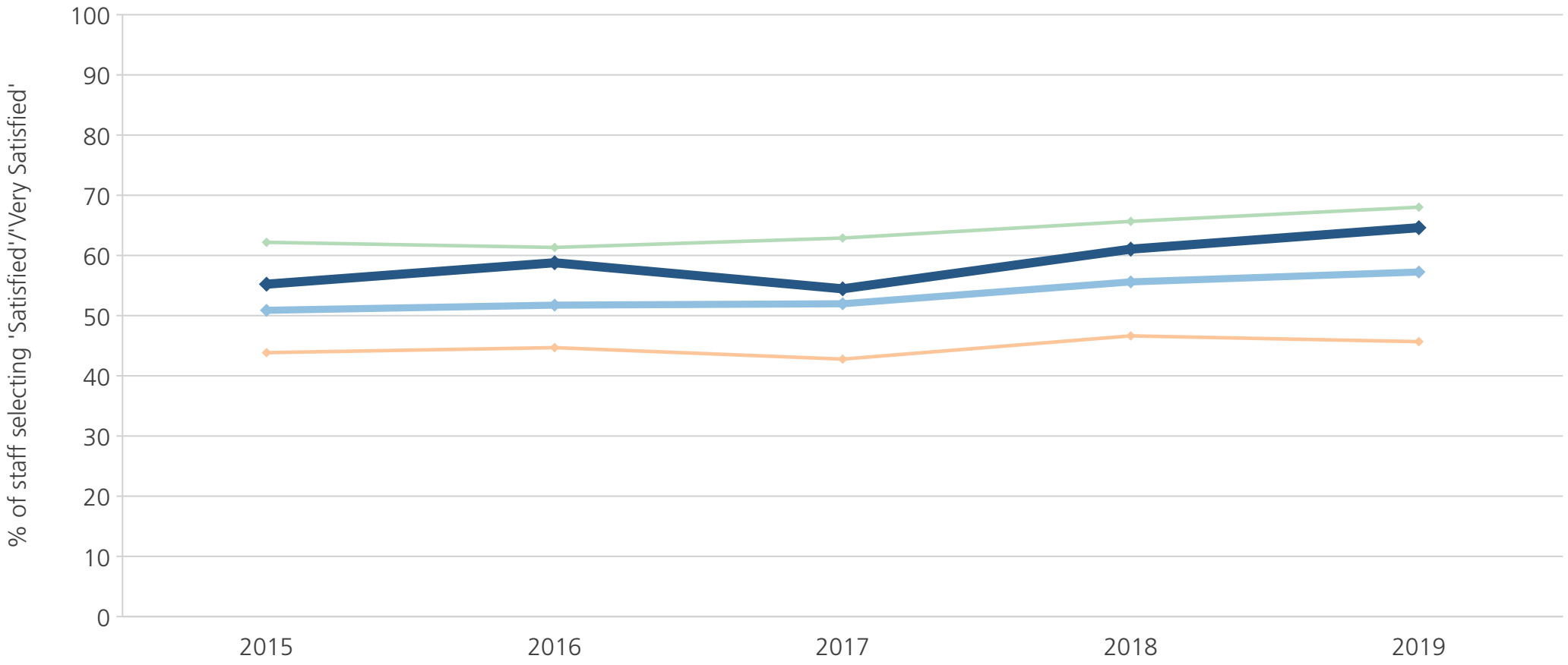
	2015	2016	2017	2018	2019
Best	80.1%	79.3%	79.7%	80.8%	83.4%
Your org	75.6%	77.0%	78.7%	77.0%	75.7%
Average	71.6%	72.6%	72.6%	72.0%	72.0%
Worst	66.0%	65.8%	66.5%	63.4%	63.2%
Responses	459	616	594	590	2,042



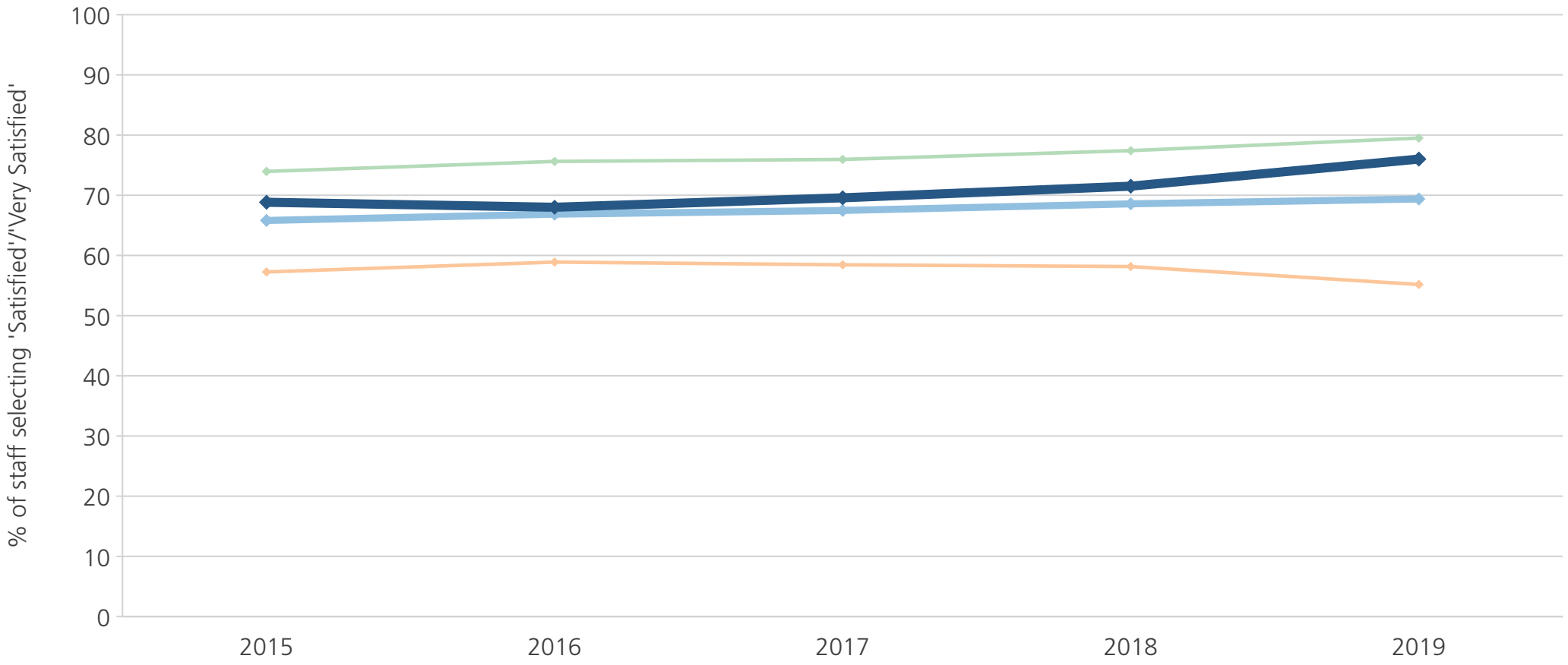
	2015	2016	2017	2018	2019
Best	66.3%	66.0%	66.7%	68.6%	68.6%
Your org	56.4%	57.9%	58.4%	60.2%	63.8%
Average	57.2%	58.0%	58.5%	58.6%	60.3%
Worst	48.2%	48.2%	49.1%	46.8%	47.6%
Responses	460	615	590	591	2,061



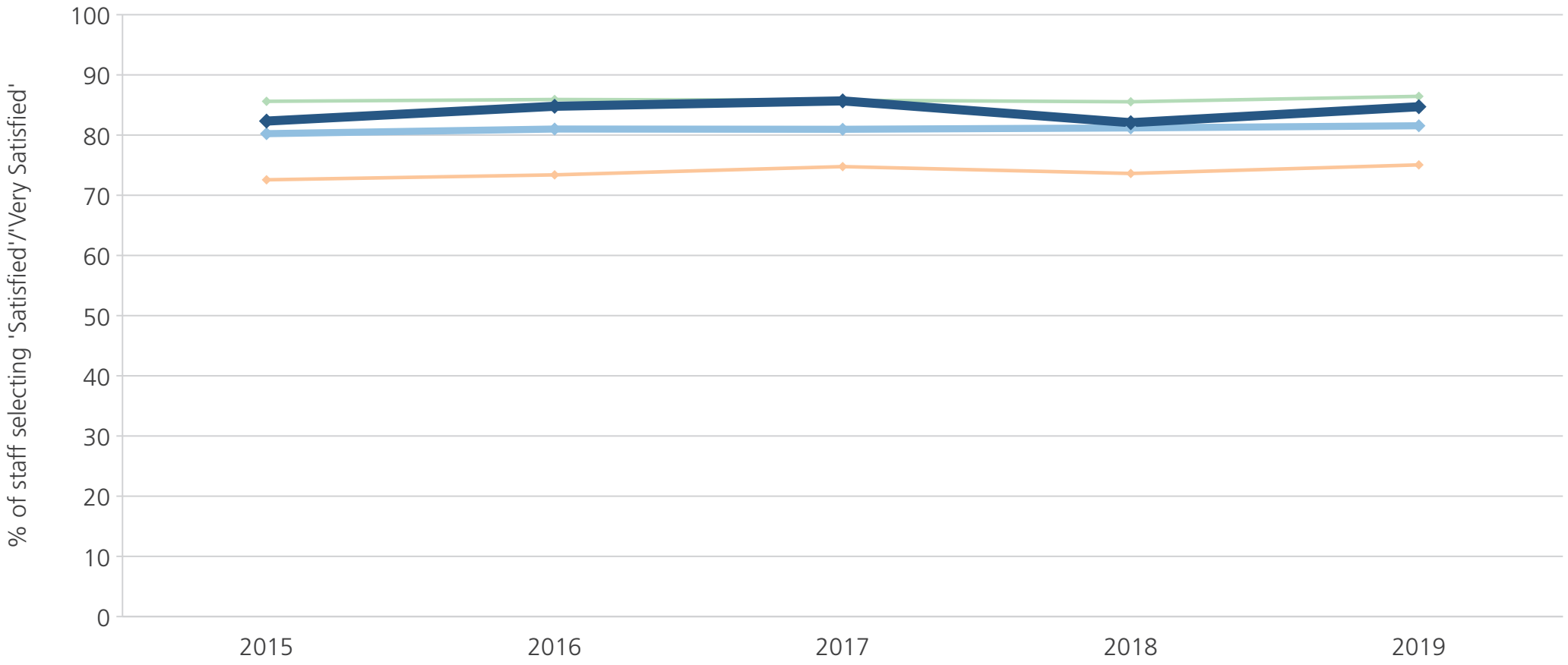
	2018	2019
Best	79.0%	81.9%
Your org	75.2%	75.5%
Average	70.8%	71.4%
Worst	62.6%	62.4%
Responses	593	2,067



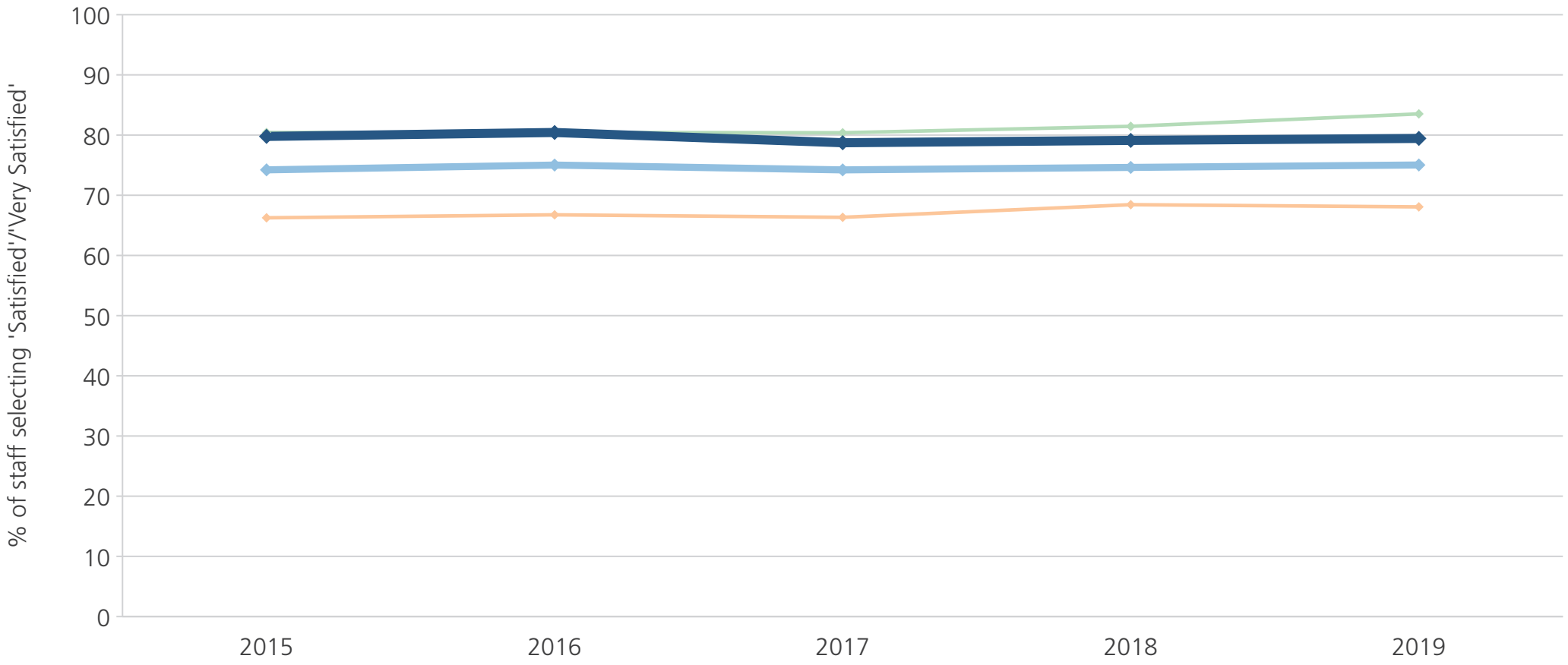
	2015	2016	2017	2018	2019
Best	62.2%	61.3%	62.9%	65.7%	68.0%
Your org	55.2%	58.8%	54.5%	61.0%	64.6%
Average	50.9%	51.7%	52.0%	55.6%	57.2%
Worst	43.8%	44.7%	42.8%	46.6%	45.7%
Responses	459	617	594	591	2,060



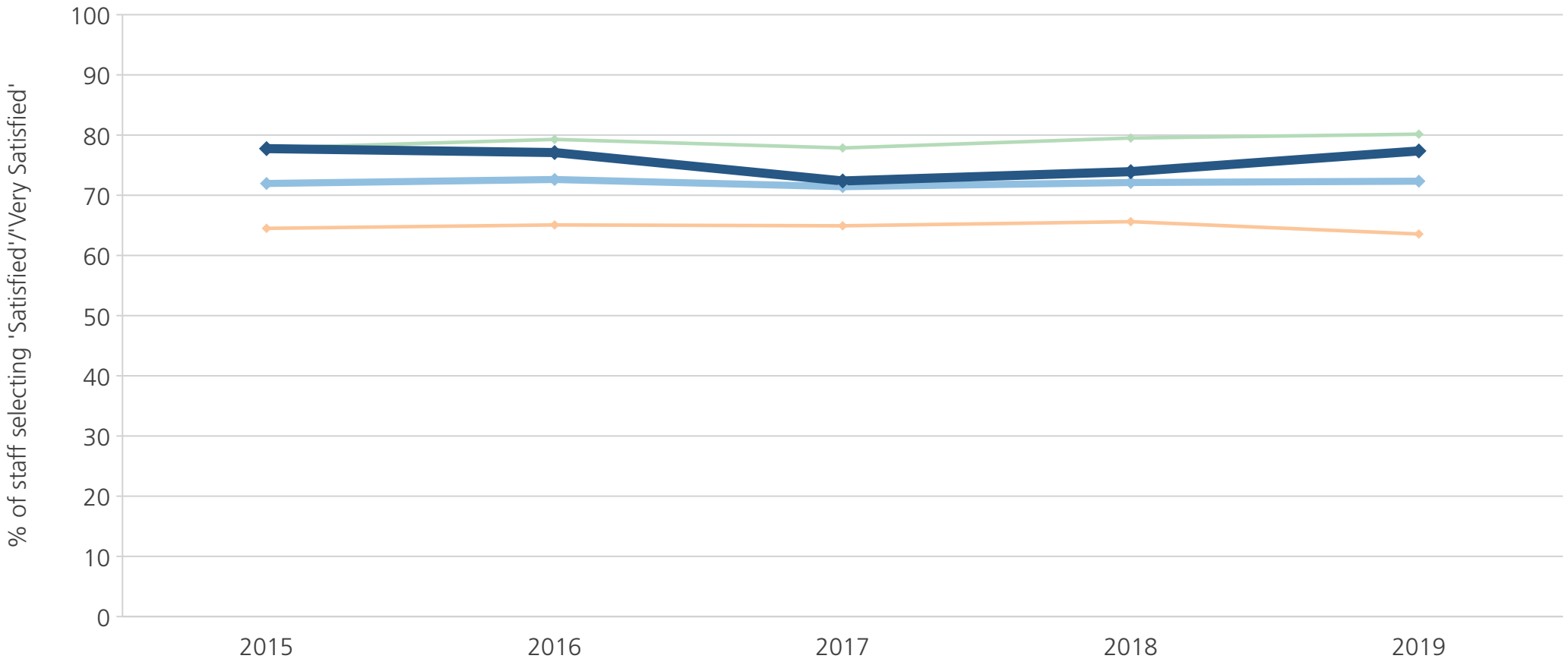
	2015	2016	2017	2018	2019
Best	74.0%	75.6%	76.0%	77.4%	79.5%
Your org	68.8%	68.0%	69.6%	71.5%	76.0%
Average	65.8%	66.9%	67.5%	68.6%	69.4%
Worst	57.3%	58.9%	58.4%	58.2%	55.2%
Responses	453	618	596	588	2,056



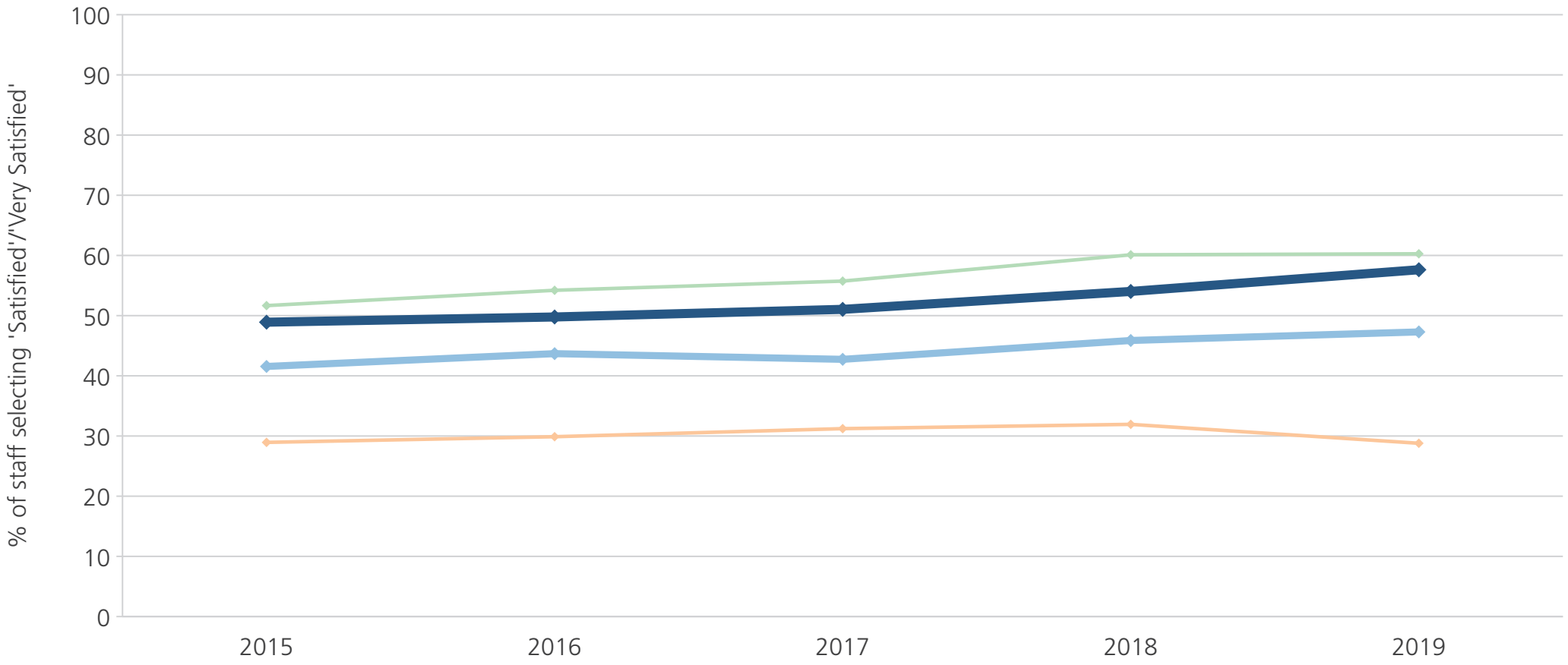
	2015	2016	2017	2018	2019
Best	85.6%	85.9%	85.8%	85.5%	86.4%
Your org	82.3%	84.8%	85.7%	82.1%	84.7%
Average	80.2%	81.0%	81.0%	81.2%	81.5%
Worst	72.6%	73.4%	74.8%	73.6%	75.0%
Responses	457	615	595	590	2,056



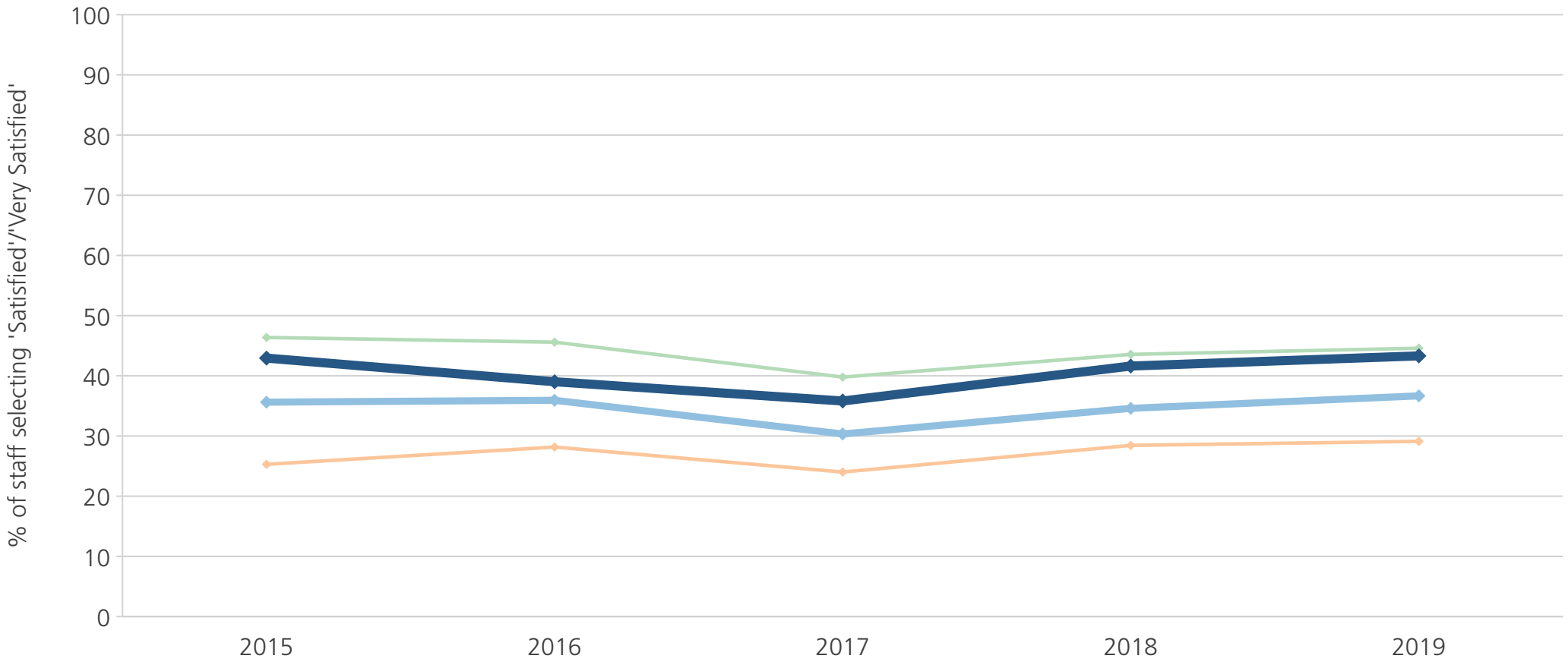
	2015	2016	2017	2018	2019
Best	80.4%	80.4%	80.4%	81.5%	83.5%
Your org	79.8%	80.4%	78.7%	79.1%	79.4%
Average	74.2%	75.0%	74.2%	74.6%	75.0%
Worst	66.3%	66.8%	66.3%	68.4%	68.1%
Responses	460	611	594	588	2,058



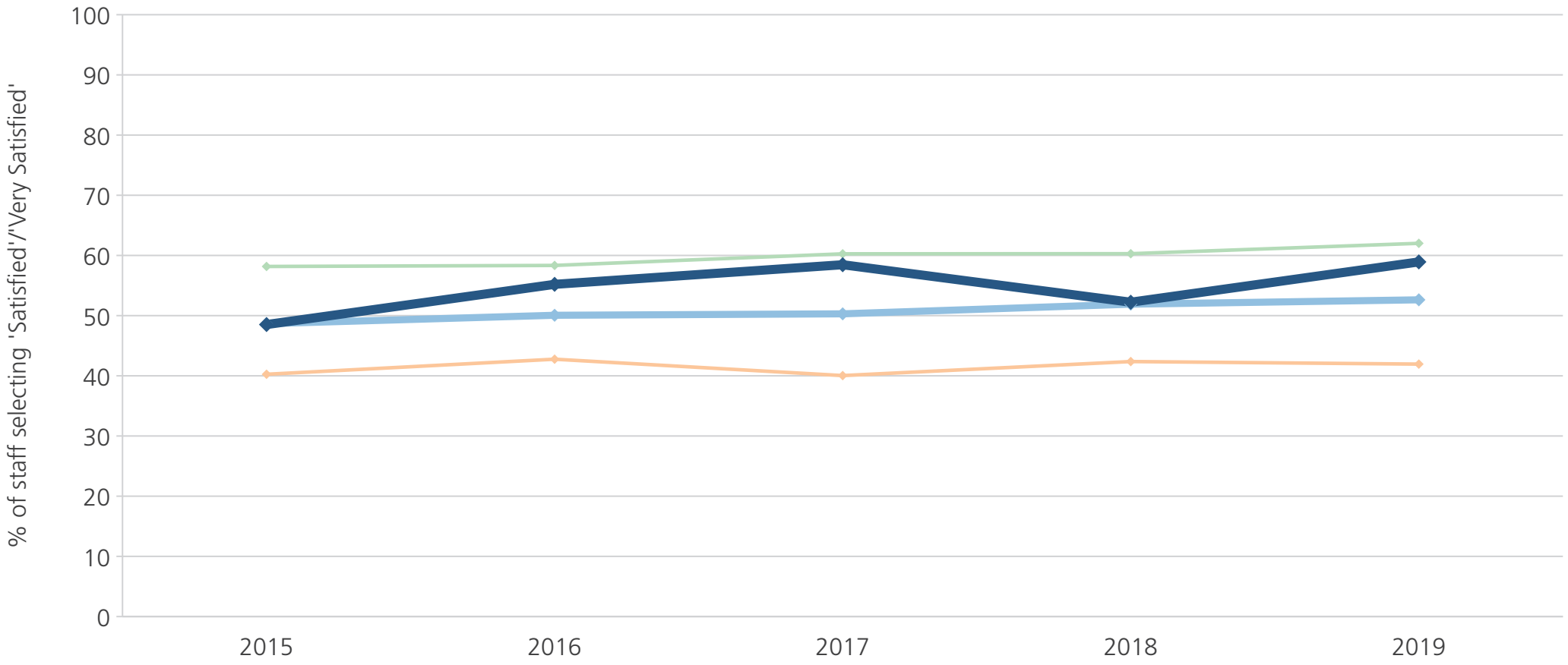
	2015	2016	2017	2018	2019
Best	77.9%	79.3%	77.9%	79.5%	80.1%
Your org	77.7%	77.1%	72.4%	73.9%	77.4%
Average	72.0%	72.6%	71.4%	72.1%	72.3%
Worst	64.5%	65.1%	64.9%	65.6%	63.6%
Responses	457	618	593	586	2,055



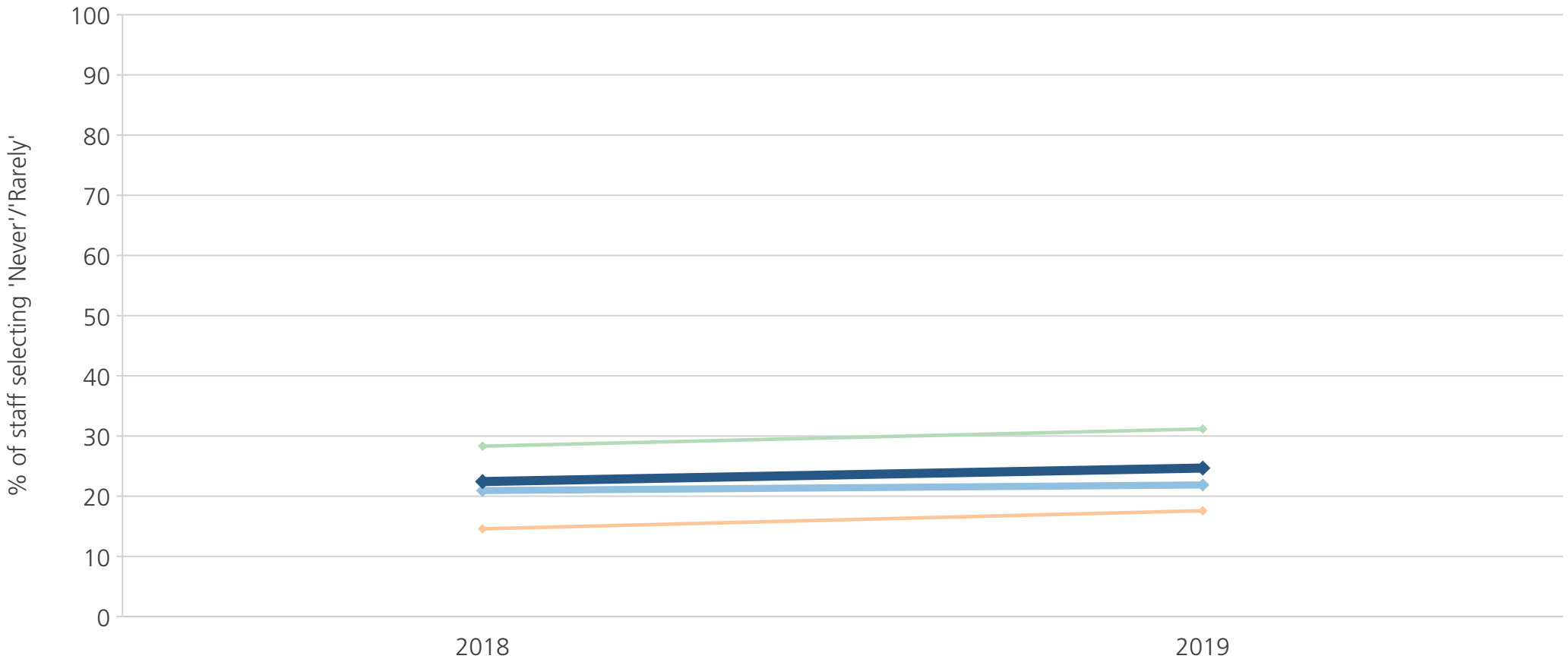
	2015	2016	2017	2018	2019
Best	51.7%	54.2%	55.7%	60.1%	60.3%
Your org	48.9%	49.8%	51.0%	54.0%	57.6%
Average	41.6%	43.7%	42.7%	45.9%	47.3%
Worst	28.9%	29.9%	31.2%	31.9%	28.8%
Responses	458	614	595	588	2,048



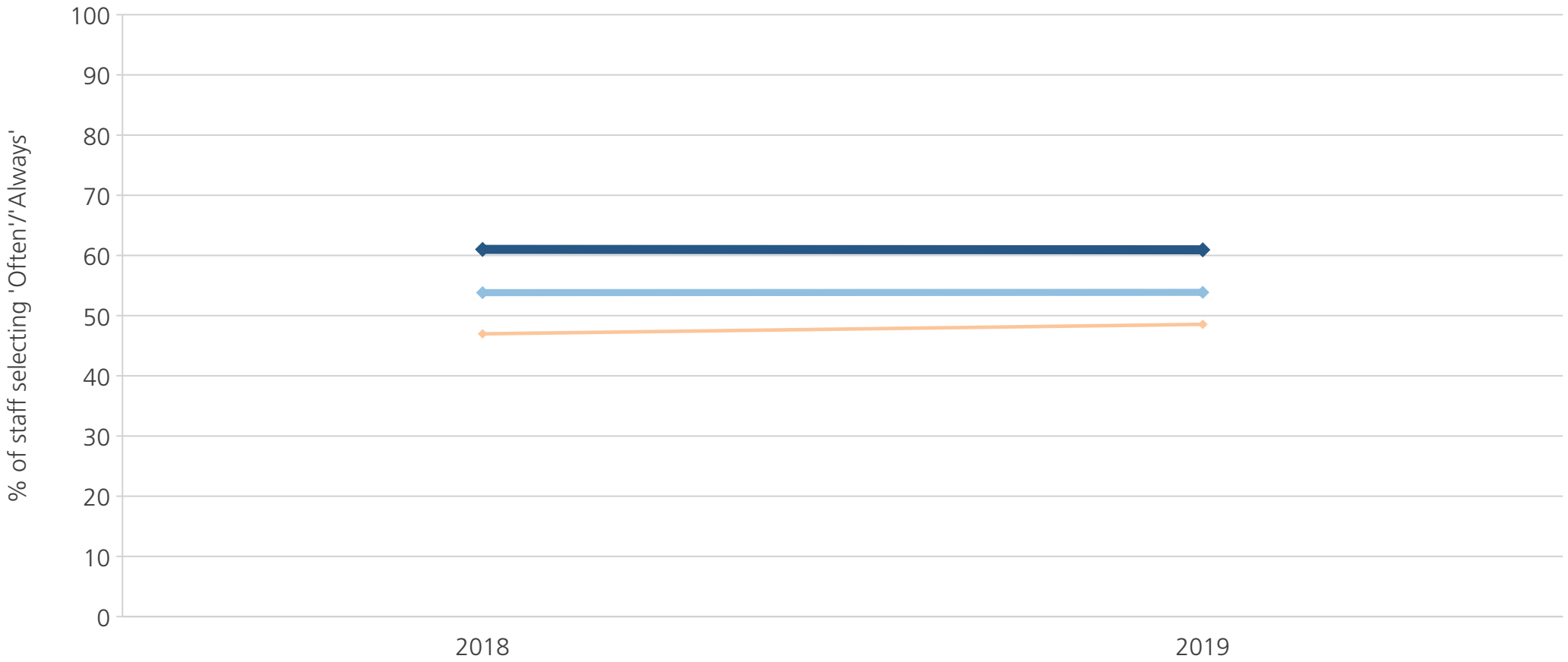
	2015	2016	2017	2018	2019
Best	46.4%	45.6%	39.8%	43.6%	44.6%
Your org	42.9%	39.0%	35.8%	41.6%	43.3%
Average	35.6%	35.9%	30.3%	34.6%	36.7%
Worst	25.3%	28.2%	24.0%	28.4%	29.1%
Responses	458	616	592	590	2,056



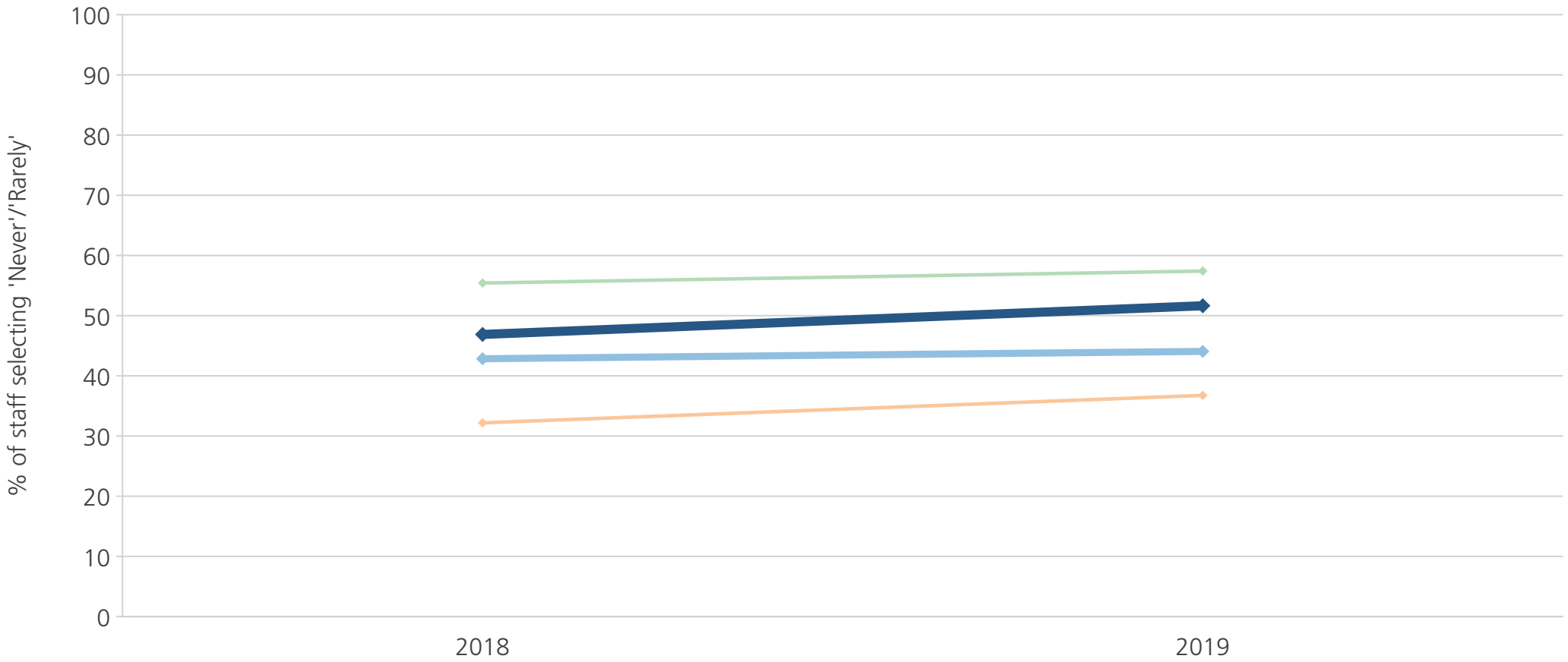
	2015	2016	2017	2018	2019
Best	58.2%	58.3%	60.3%	60.3%	62.0%
Your org	48.5%	55.2%	58.5%	52.2%	58.9%
Average	48.7%	50.1%	50.3%	51.9%	52.6%
Worst	40.3%	42.8%	40.0%	42.4%	41.9%
Responses	456	615	593	588	2,054



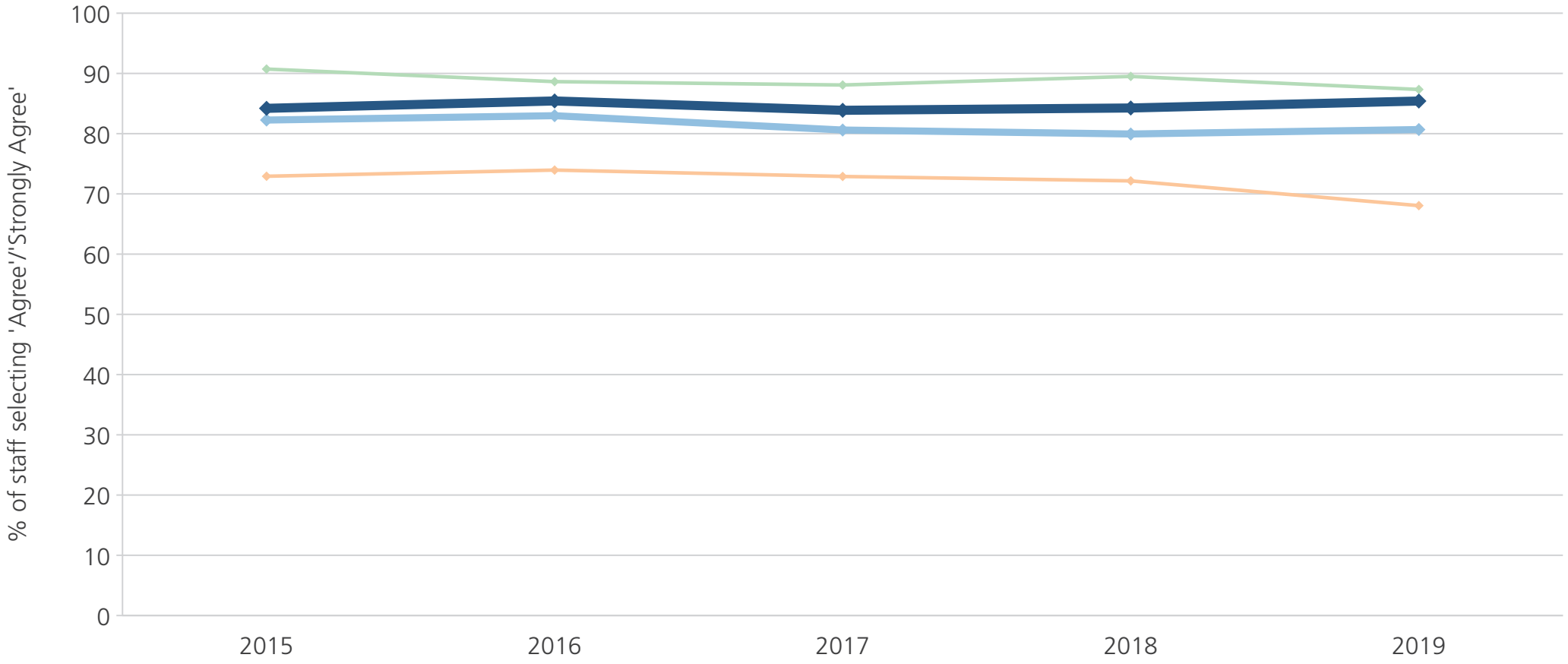
	2018	2019
Best	28.3%	31.2%
Your org	22.4%	24.7%
Average	20.9%	21.9%
Worst	14.6%	17.6%
Responses	589	2,048



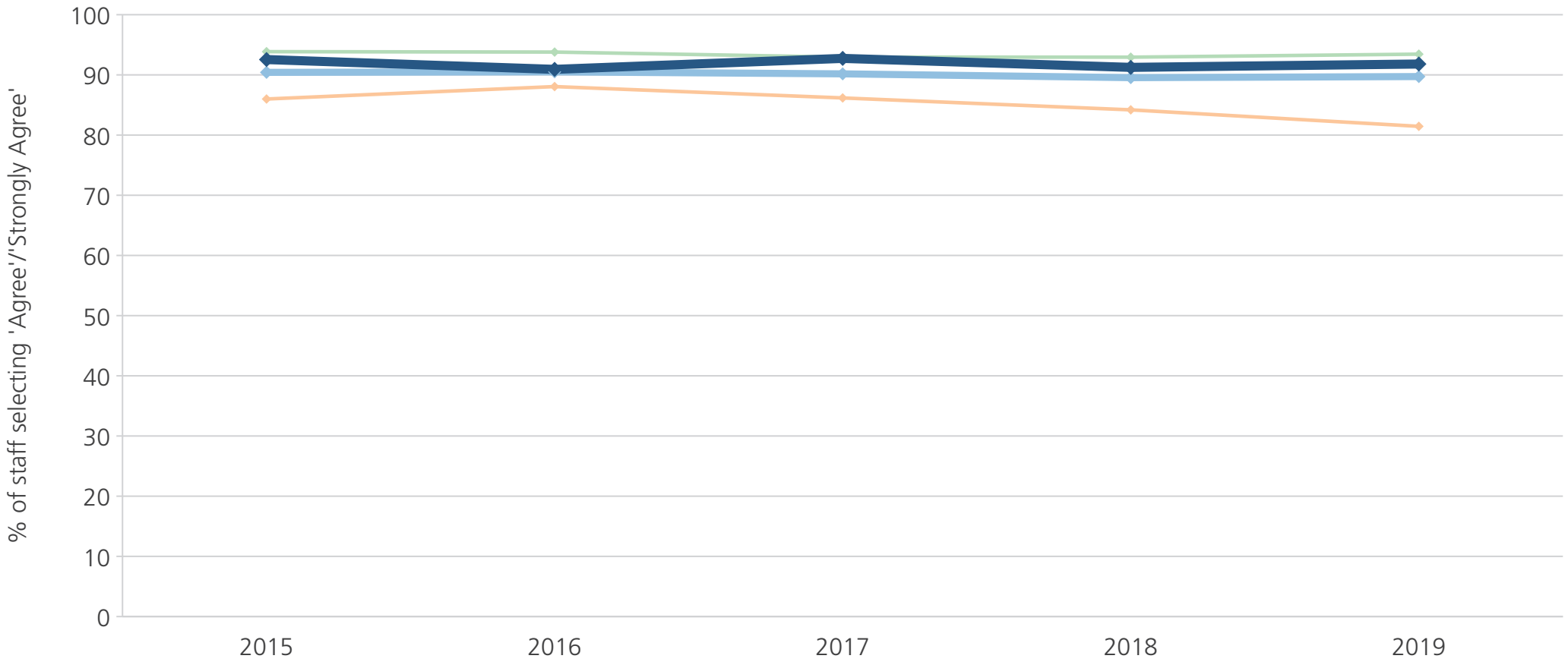
	2018	2019
Best	61.0%	60.9%
Your org	61.0%	60.9%
Average	53.8%	53.9%
Worst	47.0%	48.6%
Responses	583	2,046



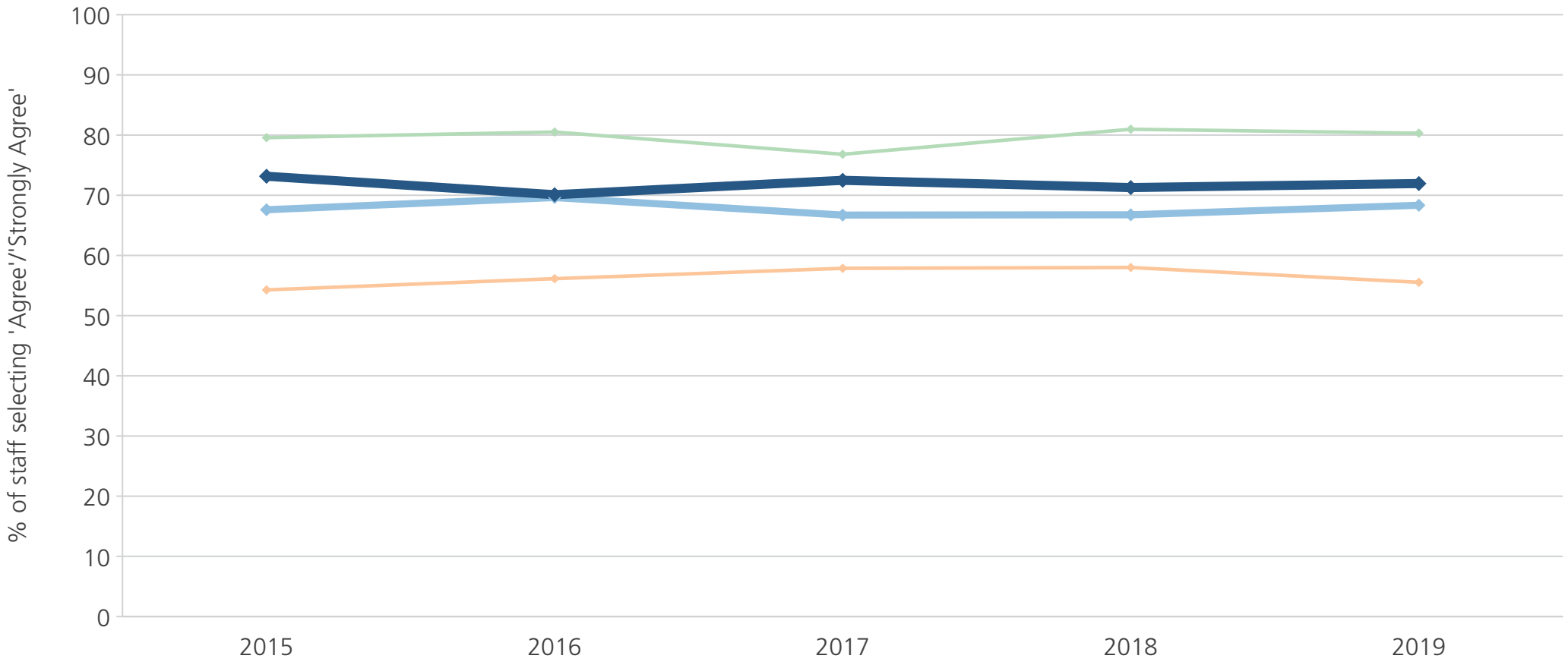
	2018	2019
Best	55.4%	57.4%
Your org	46.9%	51.6%
Average	42.8%	44.1%
Worst	32.2%	36.8%
Responses	585	2,040



	2015	2016	2017	2018	2019
Best	90.7%	88.6%	88.1%	89.5%	87.3%
Your org	84.2%	85.4%	83.9%	84.3%	85.4%
Average	82.3%	83.0%	80.6%	79.9%	80.7%
Worst	72.9%	74.0%	72.9%	72.2%	68.0%
Responses	406	542	516	517	1,800



	2015	2016	2017	2018	2019
Best	93.9%	93.8%	93.0%	92.9%	93.4%
Your org	92.5%	90.9%	92.7%	91.2%	91.8%
Average	90.4%	90.5%	90.2%	89.5%	89.7%
Worst	86.0%	88.1%	86.2%	84.2%	81.4%
Responses	428	571	556	544	1,937



	2015	2016	2017	2018	2019
Best	79.6%	80.5%	76.8%	81.0%	80.3%
Your org	73.2%	70.1%	72.5%	71.3%	71.9%
Average	67.6%	69.6%	66.7%	66.8%	68.3%
Worst	54.3%	56.1%	57.9%	58.0%	55.5%
Responses	397	534	505	507	1,787

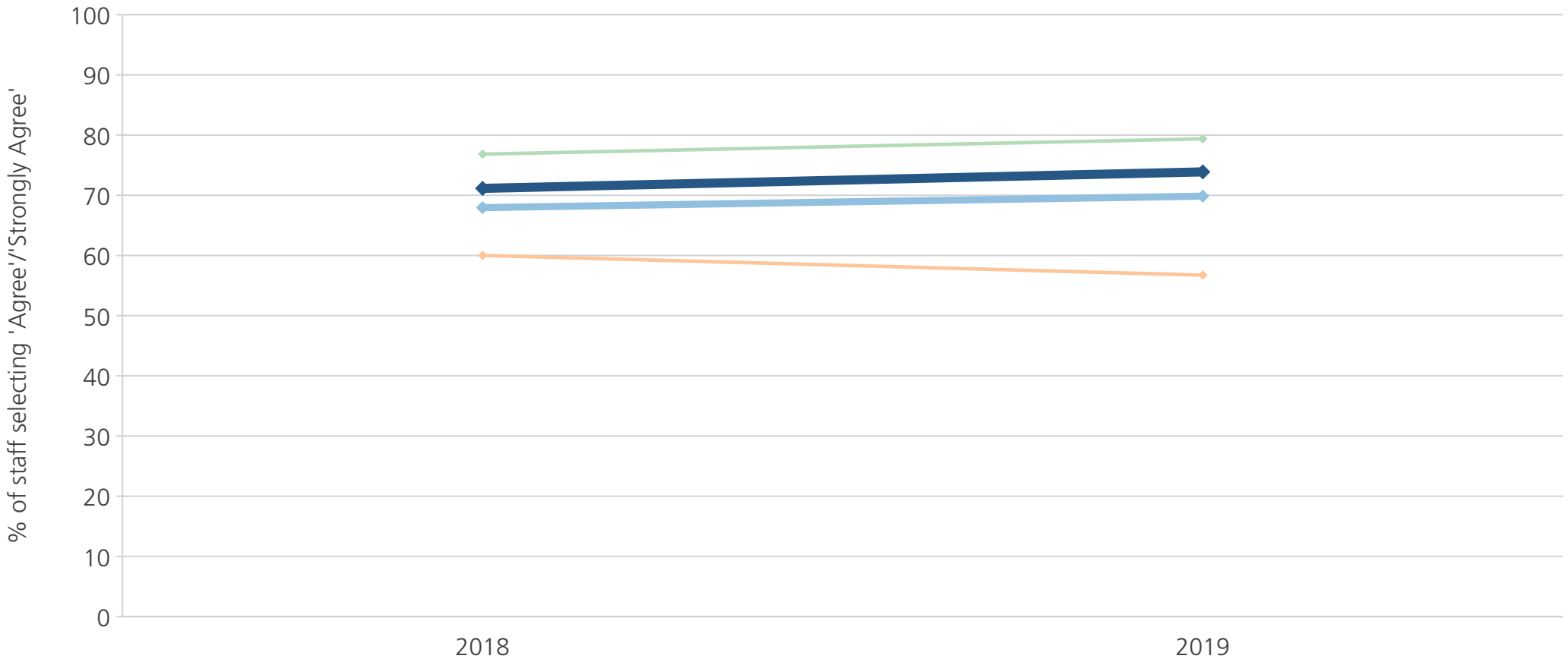
Survey Coordination Centre

NHS England

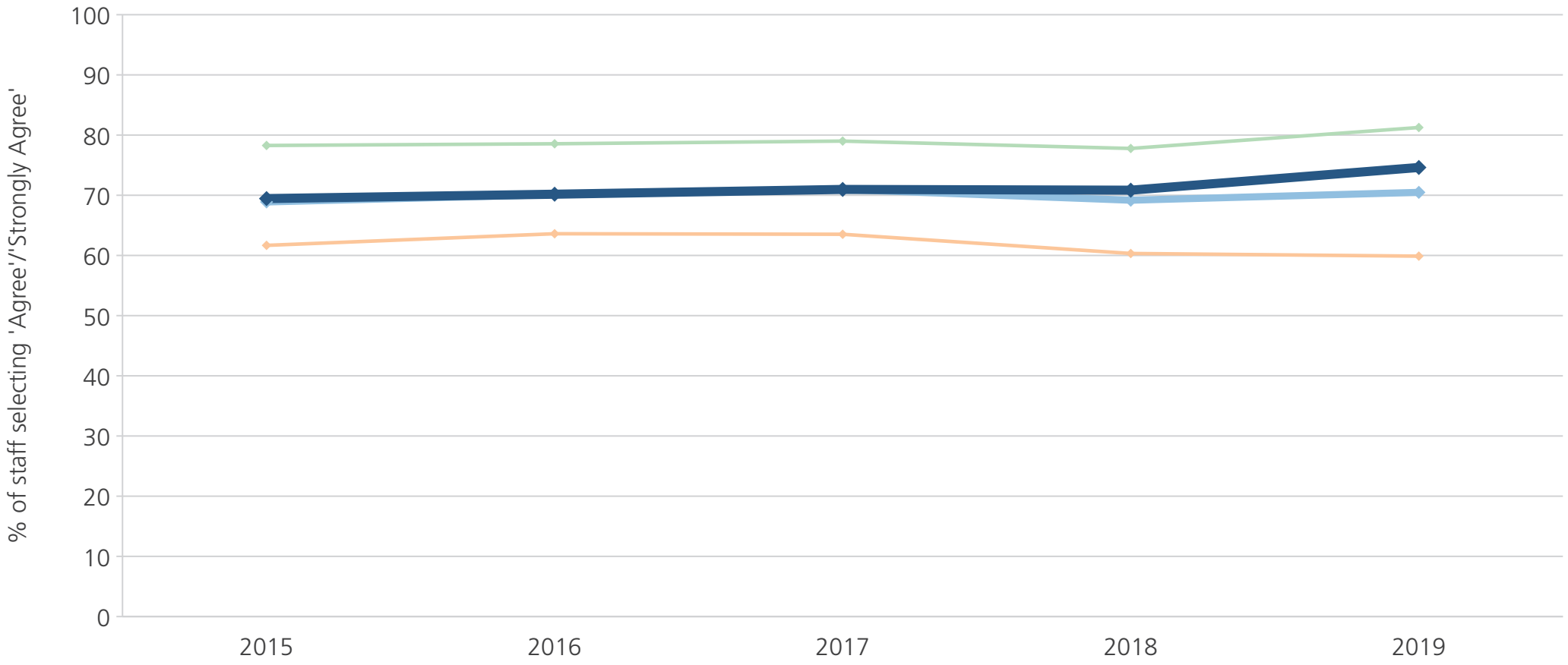
Question results – Your managers

West Suffolk NHS Foundation Trust

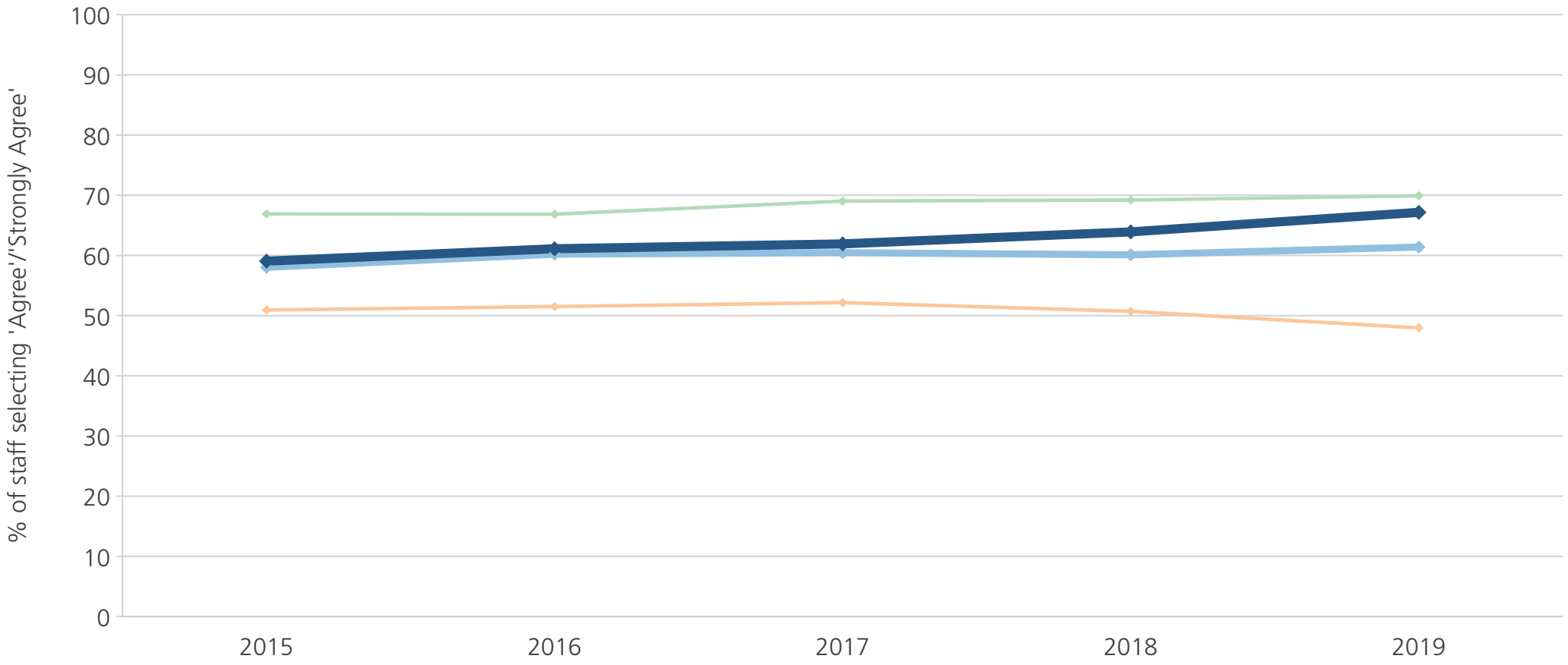
2019 NHS Staff Survey Results



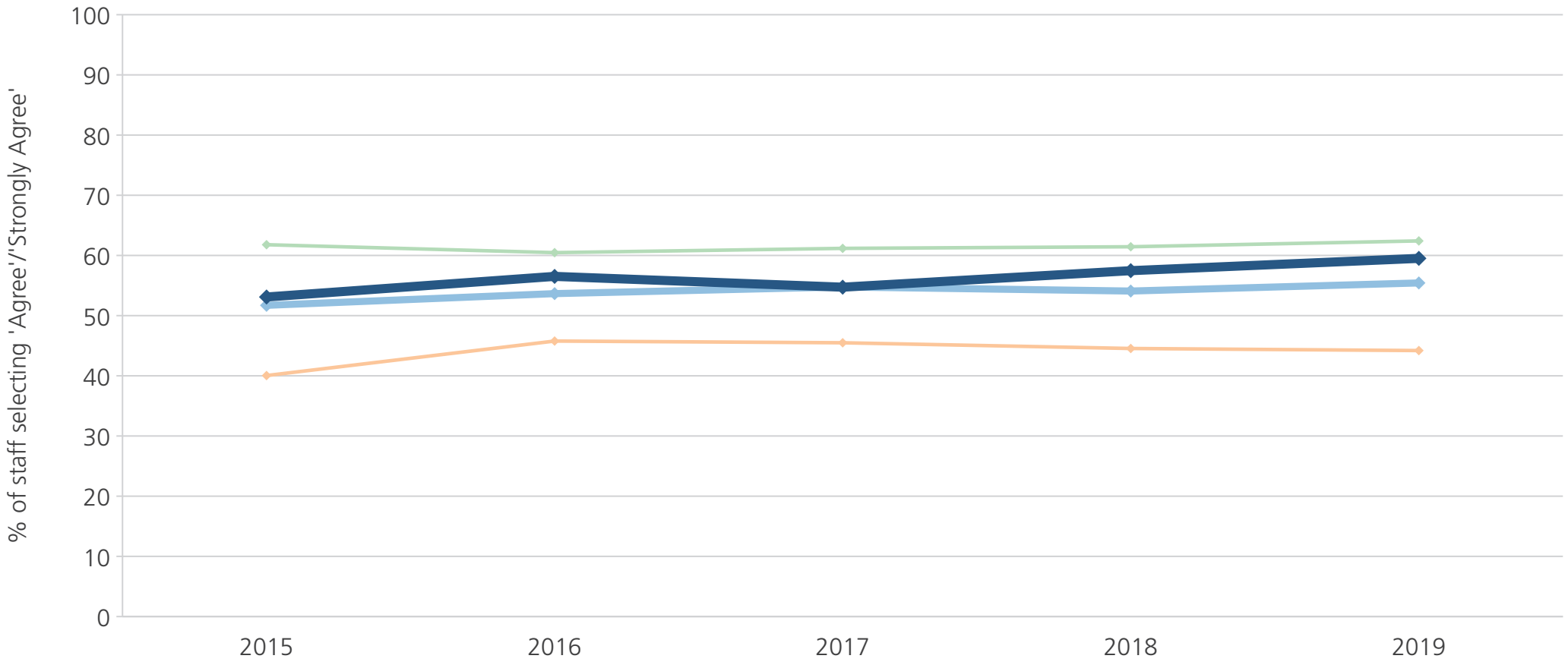
	2018	2019
Best	76.8%	79.4%
Your org	71.1%	73.9%
Average	67.9%	69.9%
Worst	60.0%	56.7%
Responses	581	2,046



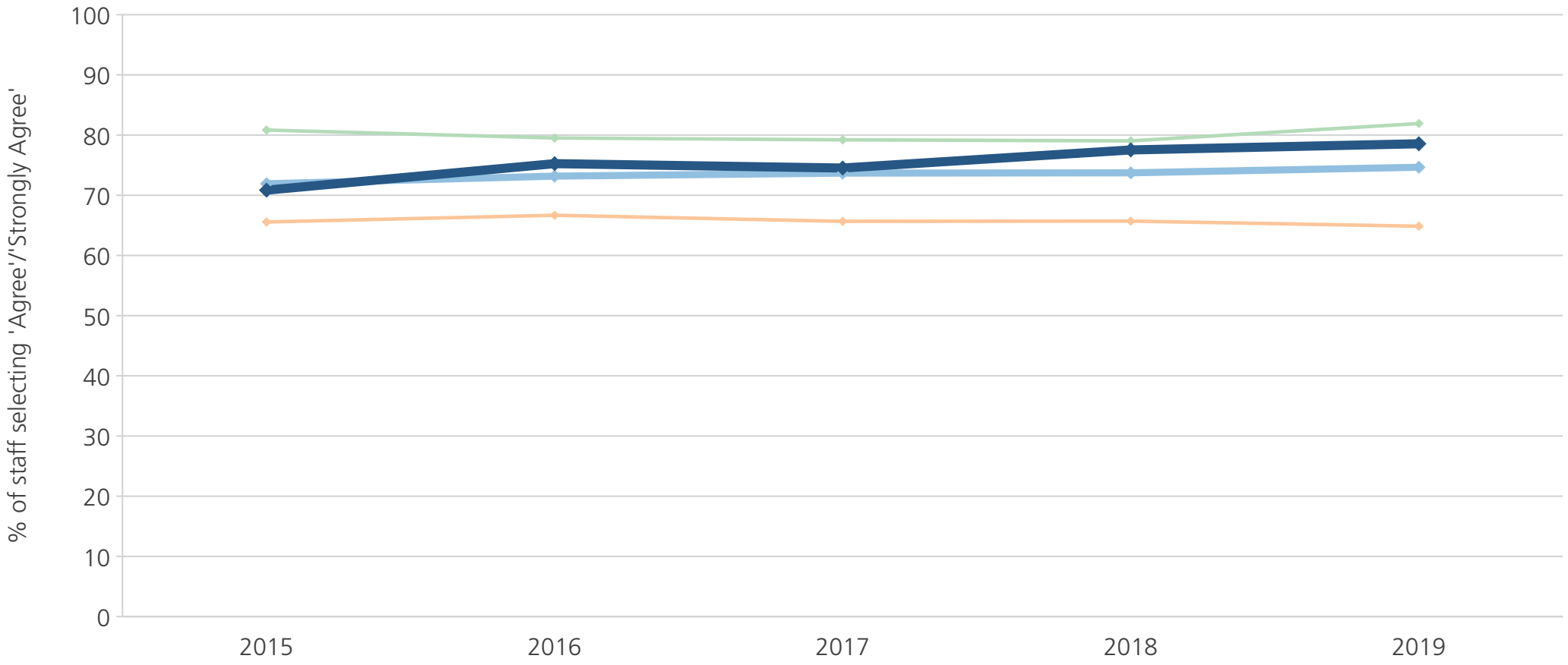
	2015	2016	2017	2018	2019
Best	78.3%	78.6%	79.0%	77.8%	81.3%
Your org	69.4%	70.2%	71.0%	70.8%	74.6%
Average	68.9%	70.1%	71.0%	69.2%	70.5%
Worst	61.7%	63.6%	63.5%	60.3%	59.9%
Responses	457	616	591	582	2,042



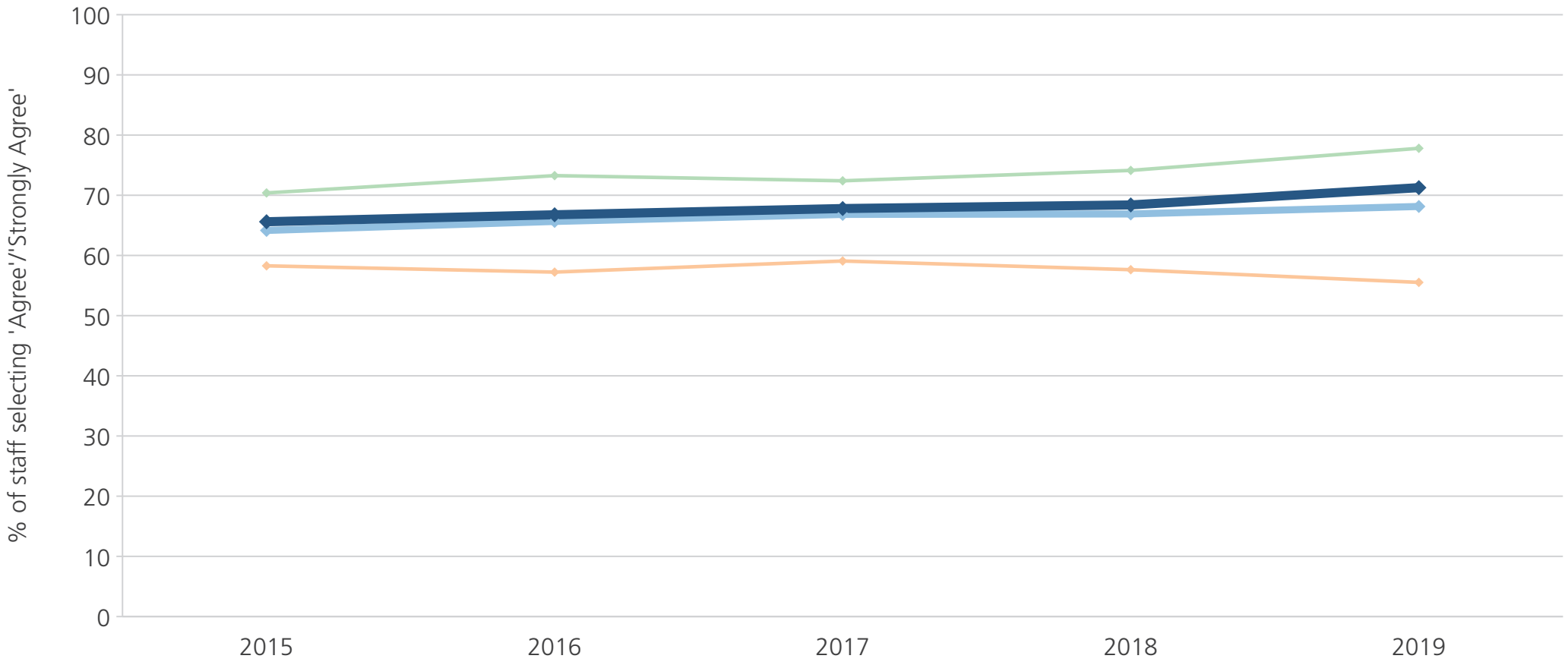
	2015	2016	2017	2018	2019
Best	66.9%	66.9%	69.0%	69.2%	69.9%
Your org	59.1%	61.1%	61.9%	63.9%	67.2%
Average	58.0%	60.2%	60.5%	60.1%	61.4%
Worst	50.9%	51.5%	52.2%	50.7%	48.0%
Responses	460	615	591	580	2,045



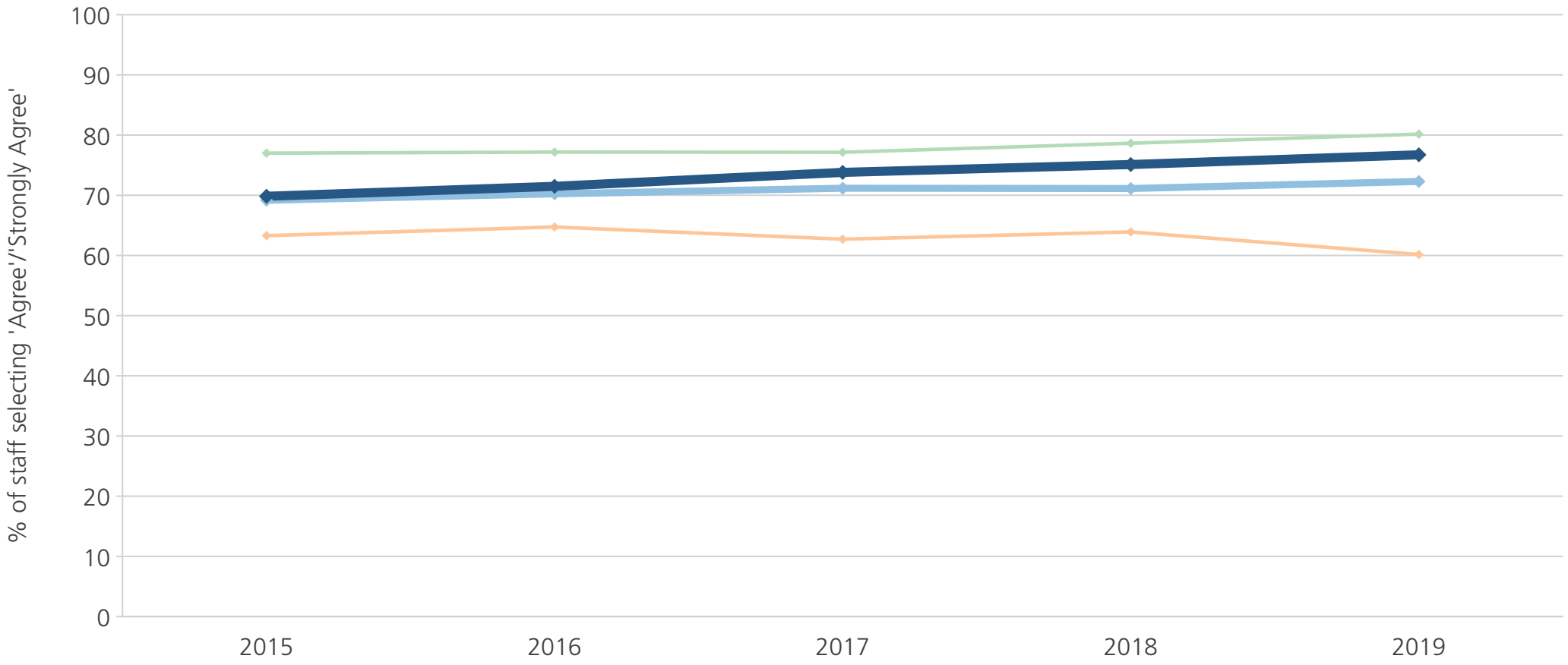
	2015	2016	2017	2018	2019
Best	61.8%	60.5%	61.2%	61.4%	62.4%
Your org	53.1%	56.5%	54.7%	57.5%	59.5%
Average	51.7%	53.7%	54.8%	54.1%	55.4%
Worst	40.0%	45.8%	45.5%	44.5%	44.2%
Responses	458	613	589	580	2,044



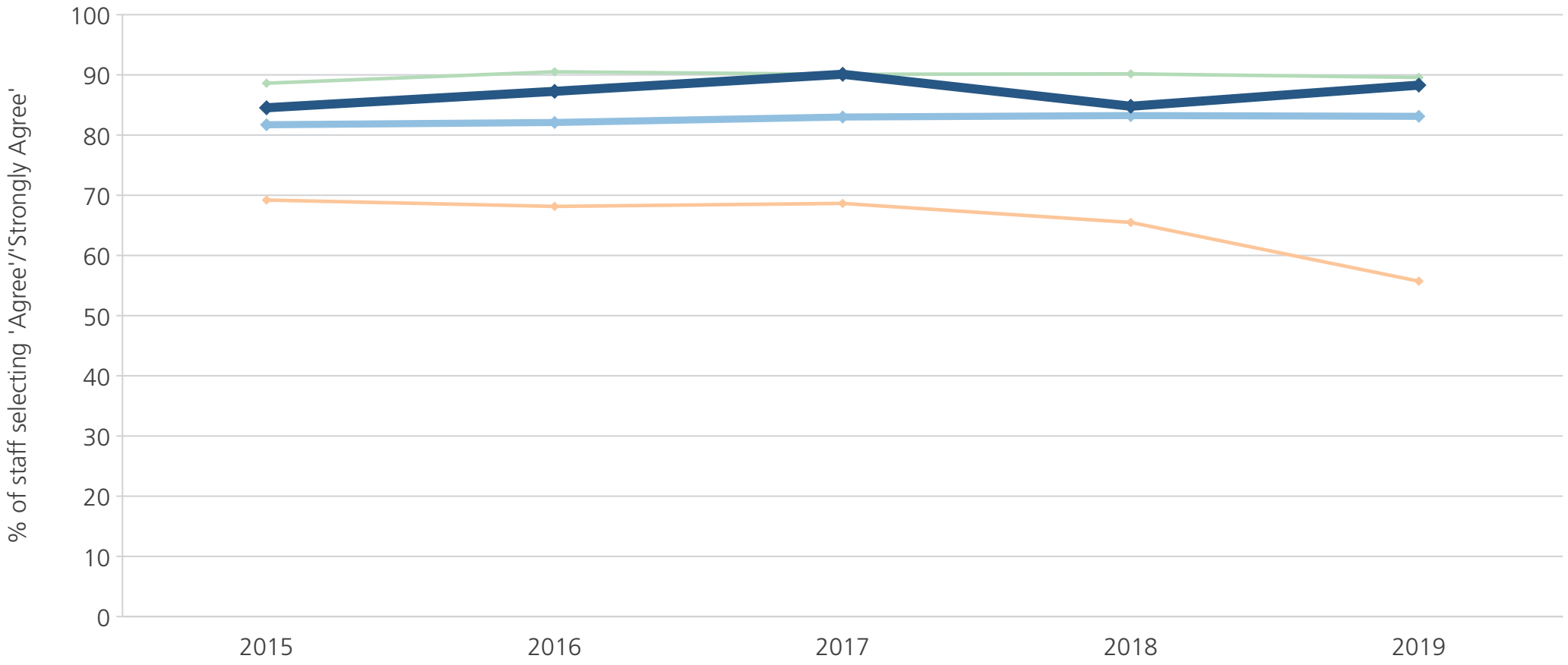
	2015	2016	2017	2018	2019
Best	80.8%	79.5%	79.2%	79.0%	81.9%
Your org	70.8%	75.3%	74.5%	77.5%	78.6%
Average	71.9%	73.2%	73.7%	73.7%	74.7%
Worst	65.6%	66.7%	65.7%	65.7%	64.9%
Responses	456	614	591	579	2,039



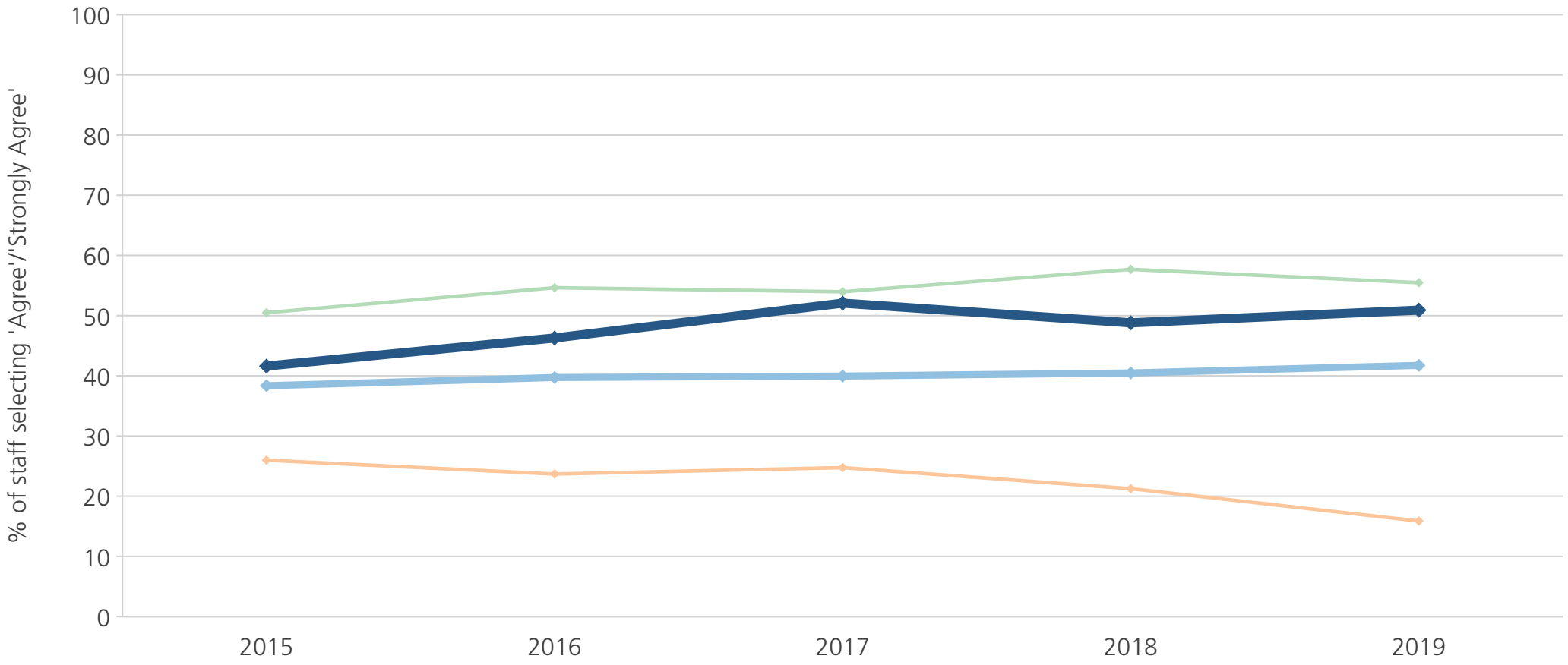
	2015	2016	2017	2018	2019
Best	70.4%	73.3%	72.4%	74.1%	77.8%
Your org	65.6%	66.8%	67.8%	68.4%	71.3%
Average	64.2%	65.6%	66.8%	66.9%	68.1%
Worst	58.3%	57.2%	59.1%	57.6%	55.5%
Responses	461	612	590	580	2,042



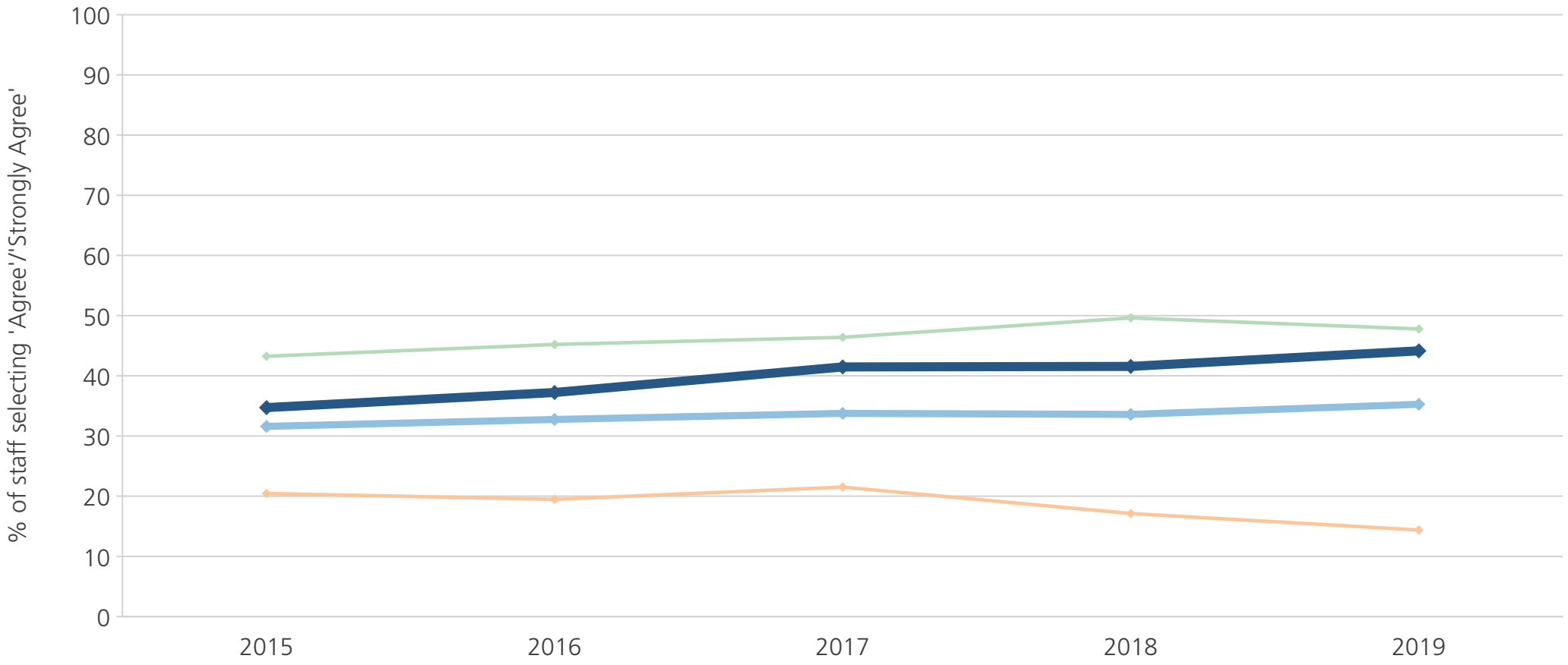
	2015	2016	2017	2018	2019
Best	77.0%	77.2%	77.1%	78.6%	80.2%
Your org	69.8%	71.5%	73.8%	75.1%	76.7%
Average	69.2%	70.2%	71.2%	71.1%	72.3%
Worst	63.3%	64.7%	62.7%	63.9%	60.2%
Responses	458	610	591	581	2,040



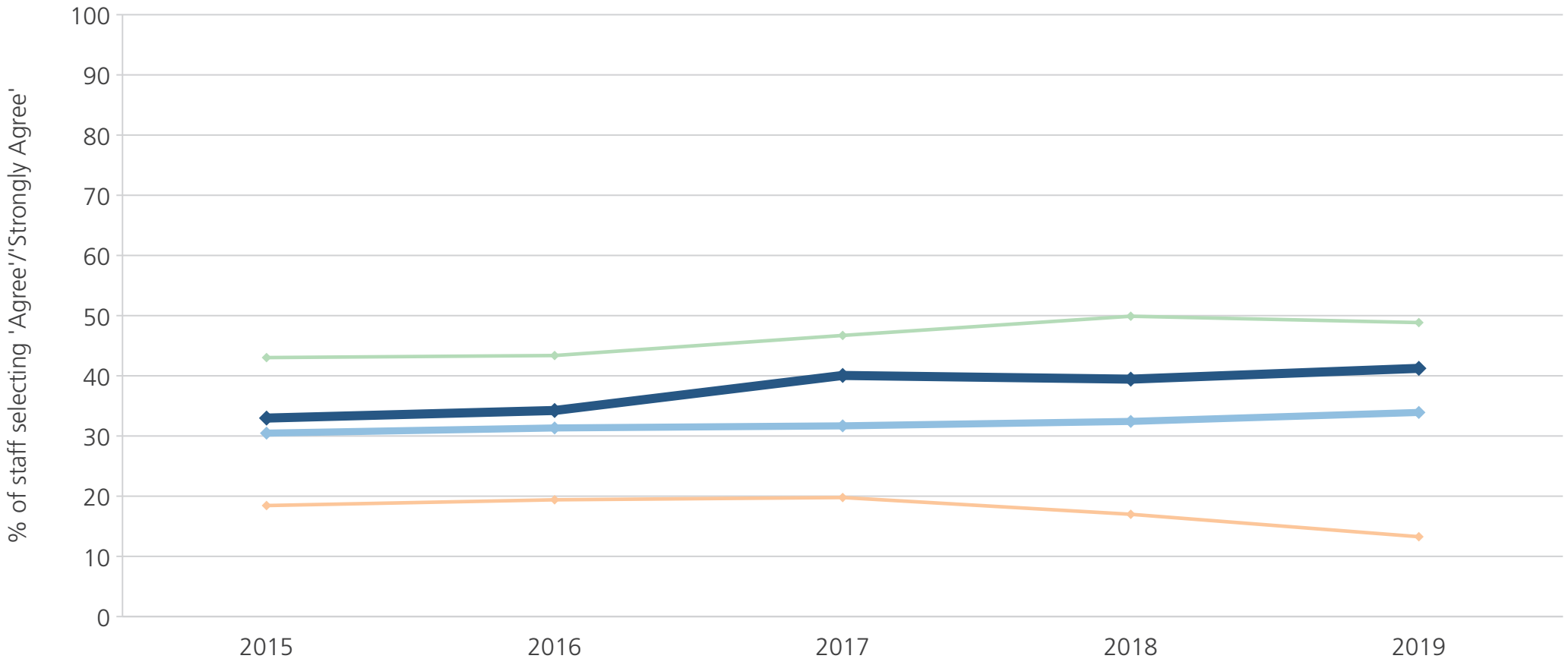
	2015	2016	2017	2018	2019
Best	88.6%	90.5%	90.1%	90.2%	89.6%
Your org	84.5%	87.3%	90.1%	84.8%	88.3%
Average	81.7%	82.1%	83.0%	83.2%	83.1%
Worst	69.2%	68.1%	68.6%	65.5%	55.7%
Responses	459	612	592	582	2,044



	2015	2016	2017	2018	2019
Best	50.5%	54.6%	54.0%	57.7%	55.5%
Your org	41.6%	46.3%	52.1%	48.8%	50.9%
Average	38.4%	39.7%	40.0%	40.5%	41.7%
Worst	26.0%	23.7%	24.8%	21.2%	15.9%
Responses	458	613	591	579	2,046



	2015	2016	2017	2018	2019
Best	43.2%	45.2%	46.4%	49.6%	47.8%
Your org	34.7%	37.2%	41.5%	41.6%	44.1%
Average	31.6%	32.7%	33.8%	33.6%	35.3%
Worst	20.4%	19.5%	21.5%	17.1%	14.4%
Responses	456	611	589	581	2,045



	2015	2016	2017	2018	2019
Best	43.0%	43.4%	46.7%	49.9%	48.8%
Your org	33.0%	34.2%	40.1%	39.4%	41.2%
Average	30.5%	31.3%	31.7%	32.4%	33.9%
Worst	18.4%	19.4%	19.8%	17.0%	13.3%
Responses	456	606	589	580	2,043

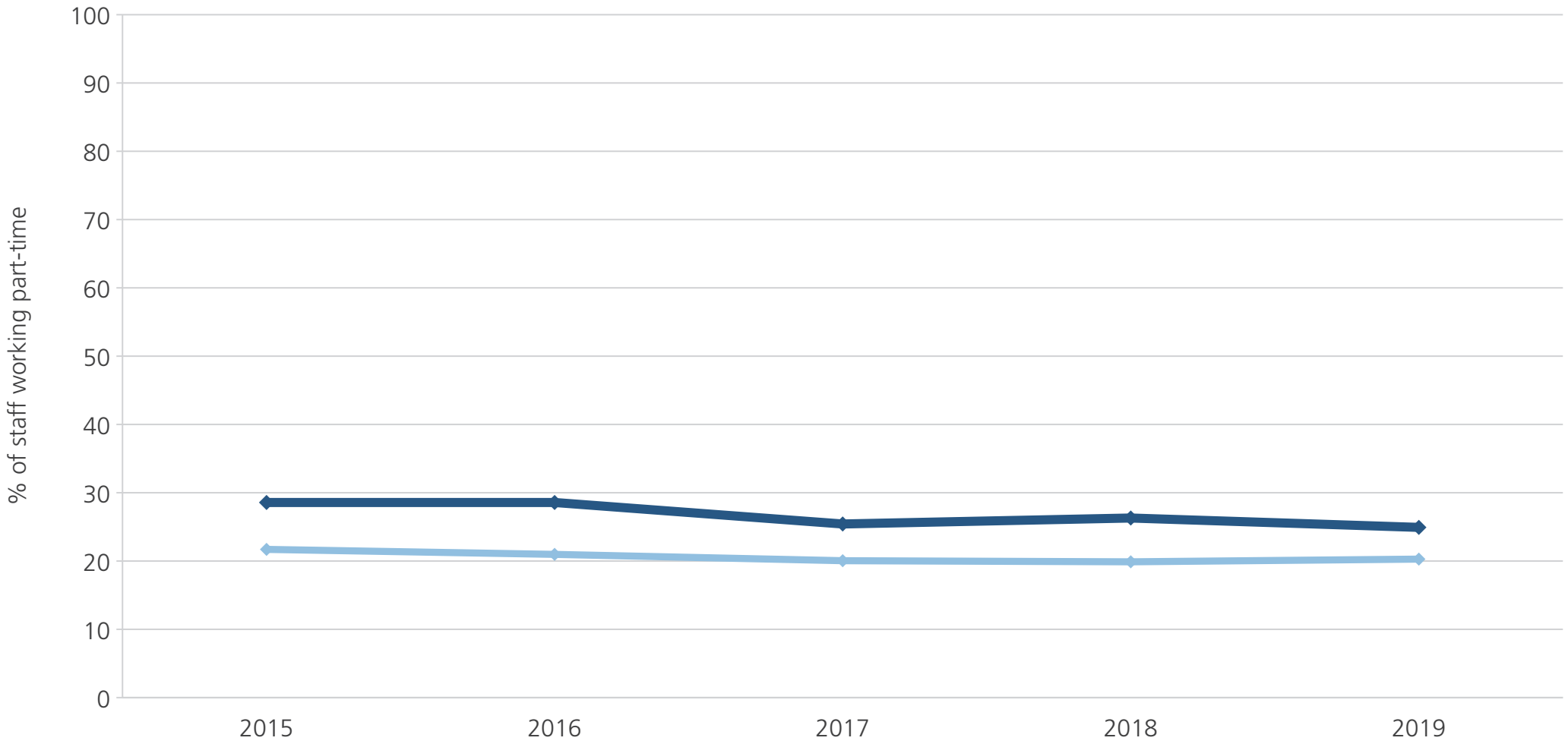
Survey Coordination Centre

NHS England

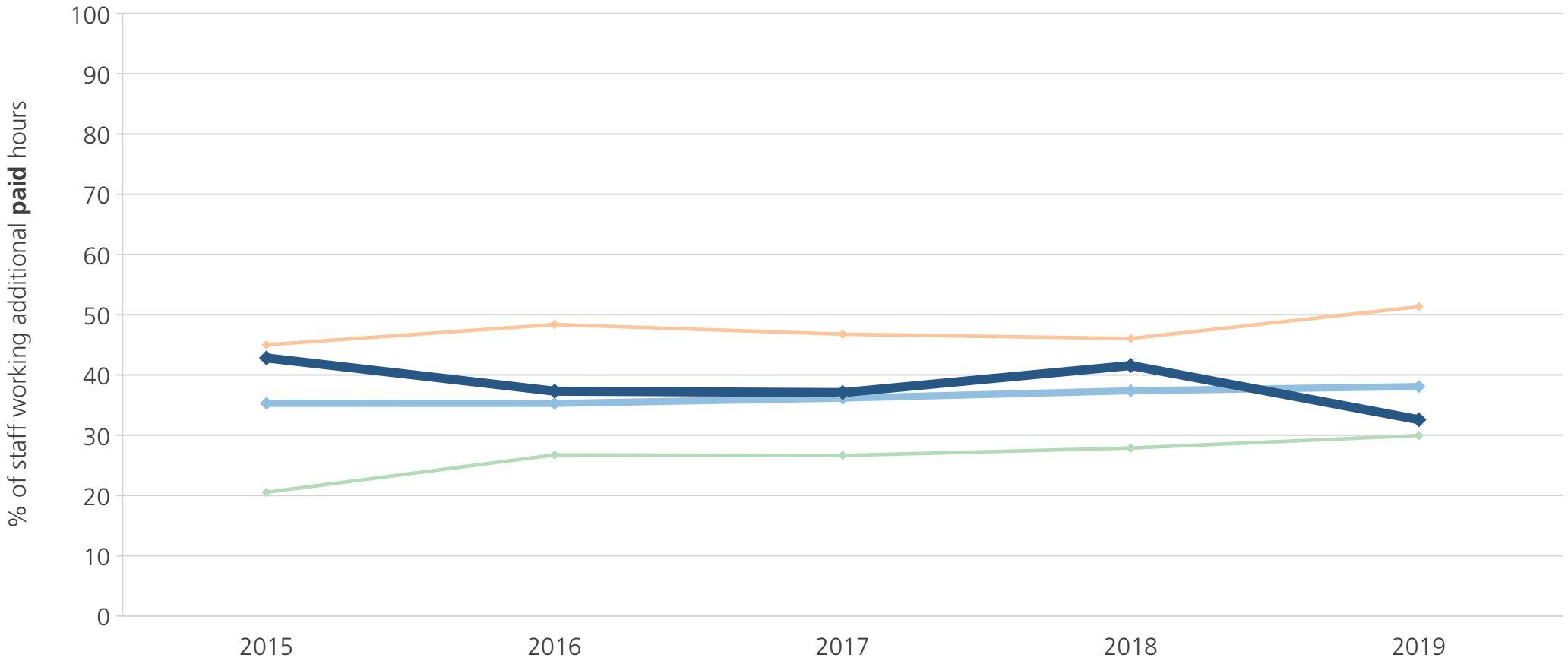
Question results – Your health, well-being and safety at work

West Suffolk NHS Foundation Trust

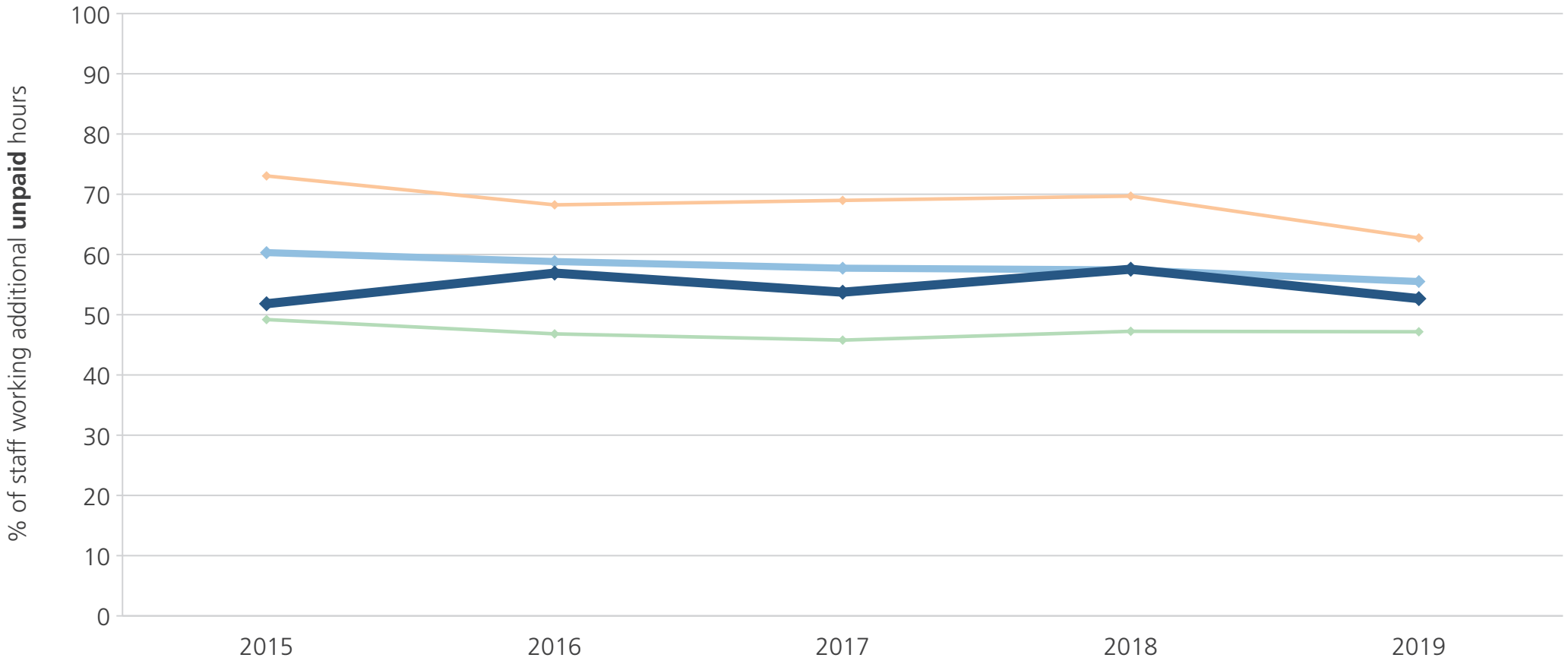
2019 NHS Staff Survey Results



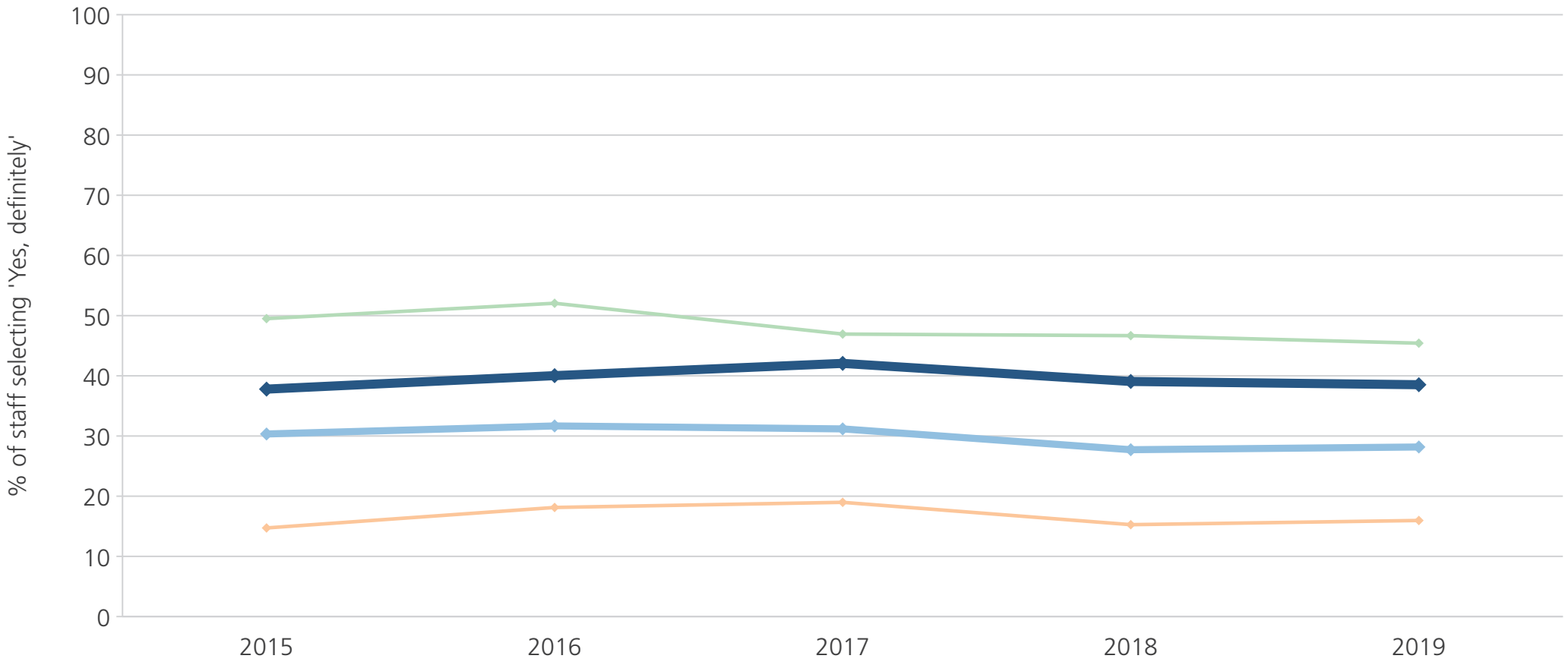
	2015	2016	2017	2018	2019
Your org	28.6%	28.6%	25.4%	26.3%	24.9%
Average	21.7%	21.0%	20.0%	19.9%	20.3%
Responses	455	609	590	578	2,026



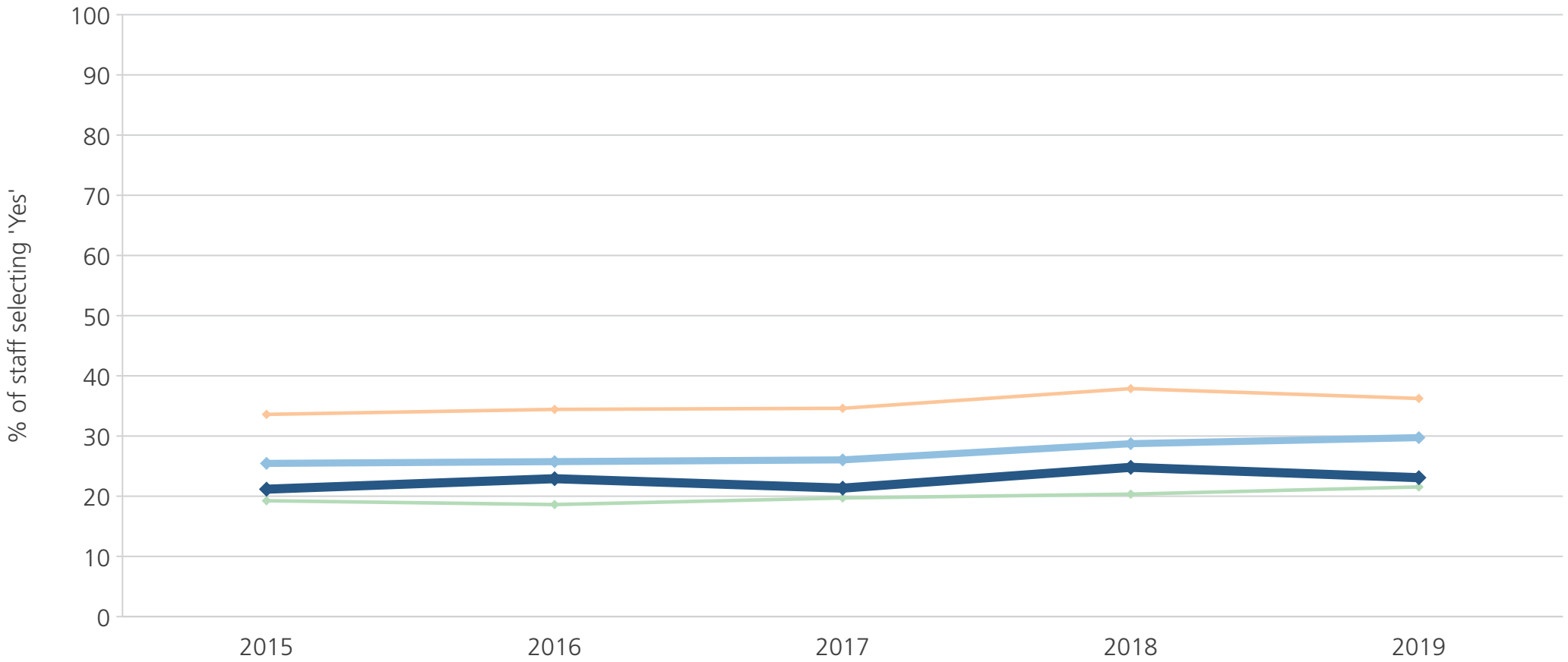
	2015	2016	2017	2018	2019
Worst	45.0%	48.4%	46.8%	46.1%	51.3%
Your org	42.8%	37.3%	37.1%	41.6%	32.6%
Average	35.3%	35.3%	36.2%	37.4%	38.1%
Best	20.5%	26.7%	26.6%	27.9%	29.9%
Responses	437	579	569	564	2,025



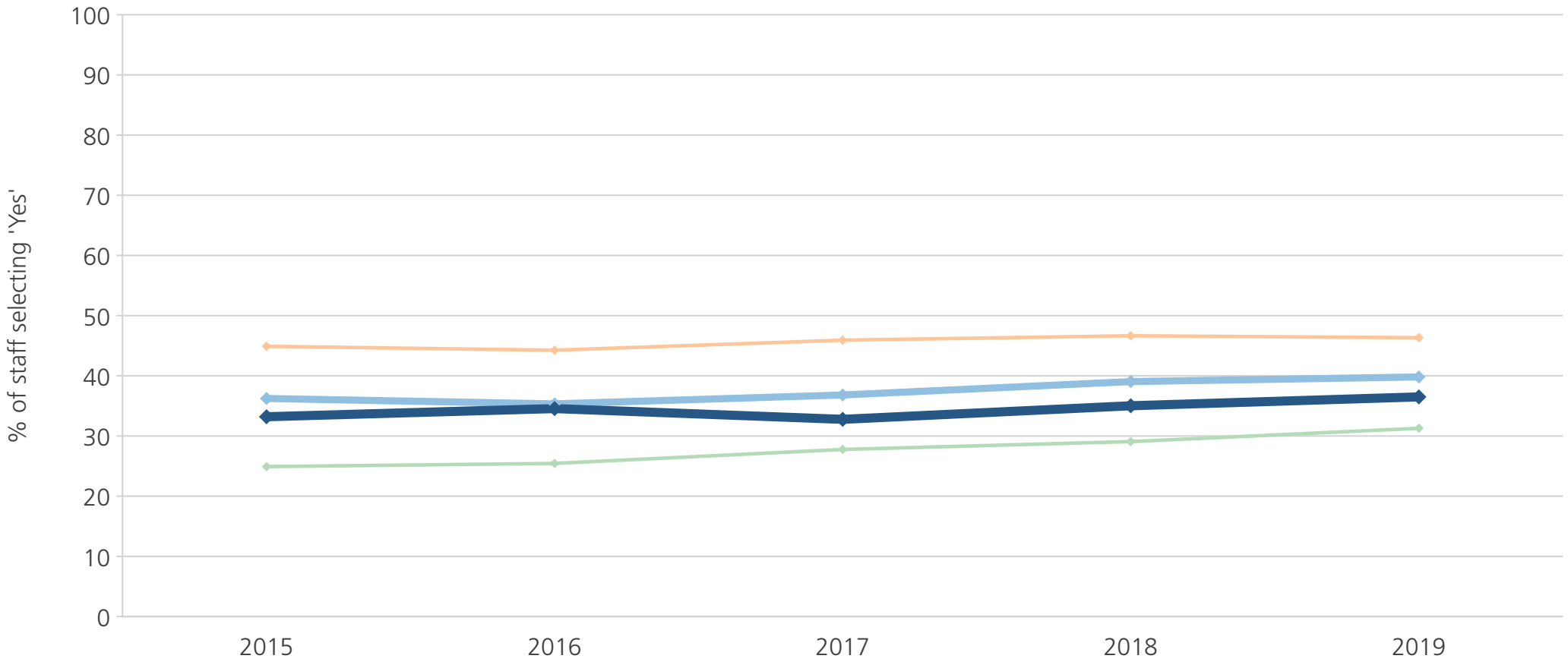
	2015	2016	2017	2018	2019
Worst	73.0%	68.2%	69.0%	69.7%	62.7%
Your org	51.8%	56.9%	53.7%	57.6%	52.7%
Average	60.3%	58.8%	57.7%	57.4%	55.5%
Best	49.2%	46.8%	45.8%	47.2%	47.2%
Responses	436	577	572	568	2,010



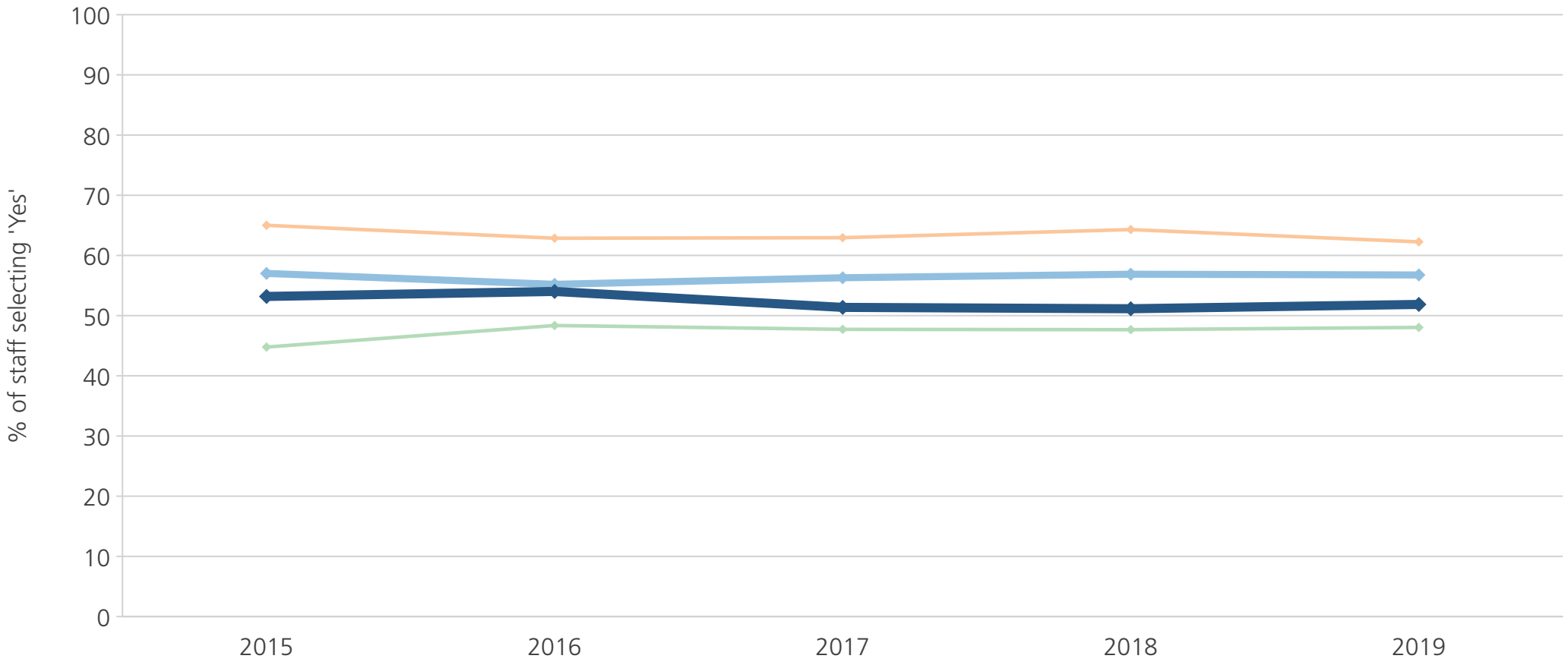
	2015	2016	2017	2018	2019
Best	49.5%	52.1%	46.9%	46.7%	45.4%
Your org	37.8%	40.0%	42.1%	39.1%	38.5%
Average	30.3%	31.7%	31.2%	27.7%	28.2%
Worst	14.7%	18.1%	19.0%	15.3%	16.0%
Responses	454	603	574	584	2,024



	2015	2016	2017	2018	2019
Worst	33.6%	34.4%	34.6%	37.9%	36.2%
Your org	21.2%	22.9%	21.3%	24.8%	23.1%
Average	25.5%	25.7%	26.0%	28.7%	29.7%
Best	19.2%	18.6%	19.7%	20.3%	21.5%
Responses	459	613	587	583	2,044

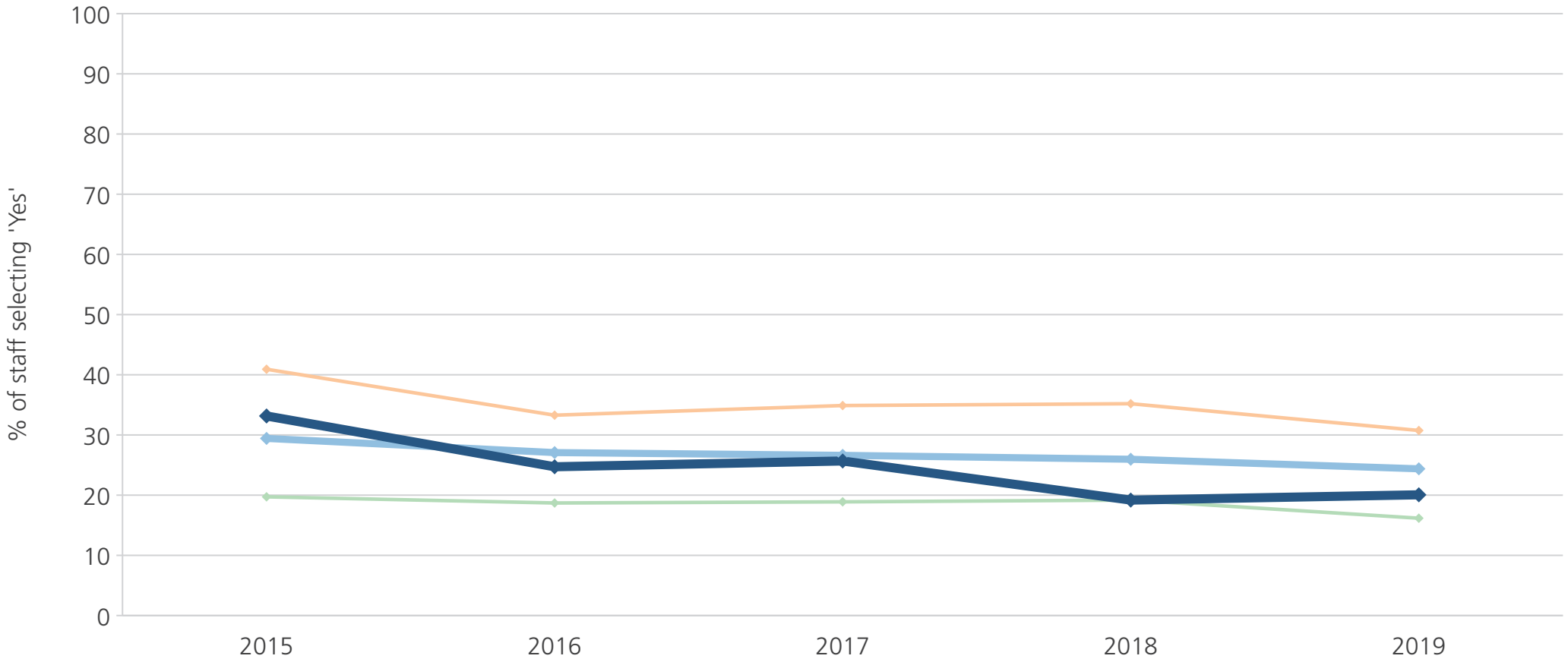


	2015	2016	2017	2018	2019
Worst	44.9%	44.3%	45.9%	46.7%	46.3%
Your org	33.2%	34.6%	32.8%	35.0%	36.5%
Average	36.2%	35.3%	36.8%	39.0%	39.8%
Best	24.9%	25.4%	27.8%	29.1%	31.3%
Responses	458	610	591	584	2,044



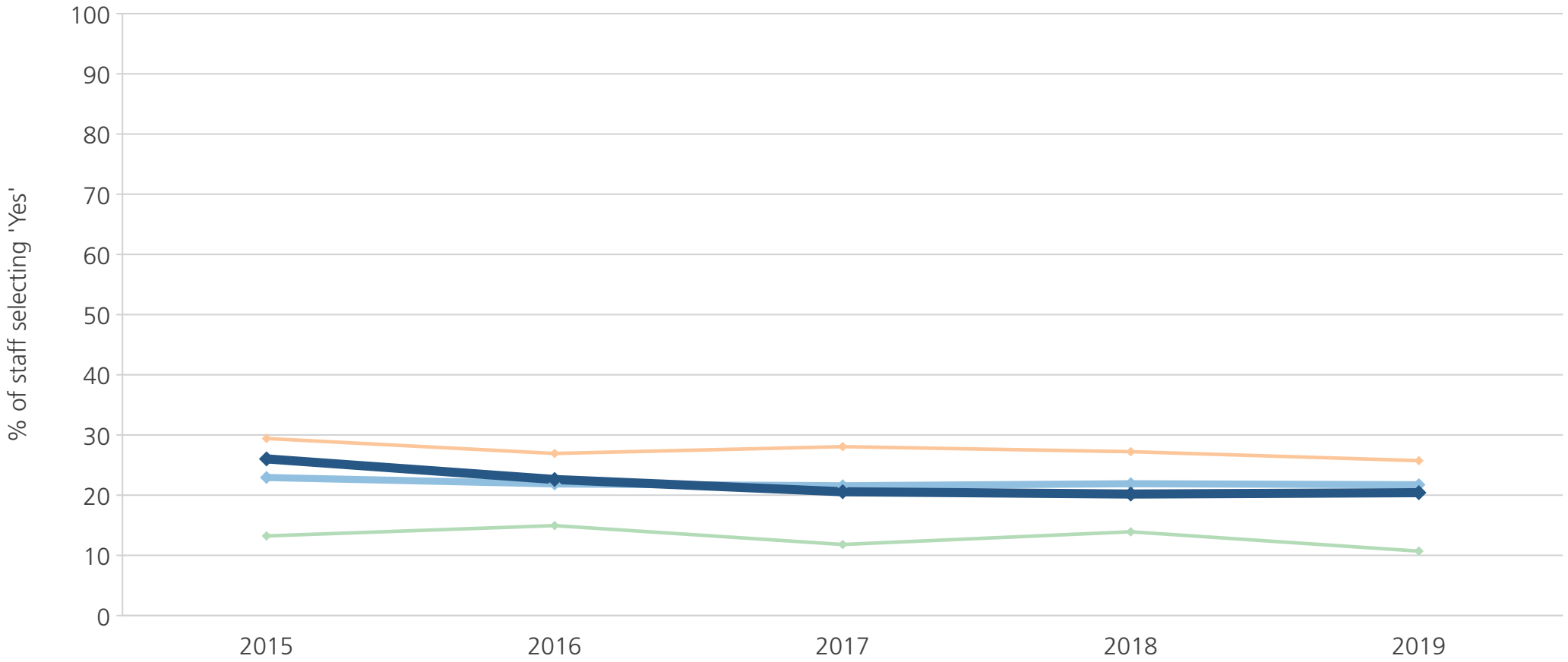
	2015	2016	2017	2018	2019
Worst	65.0%	62.9%	62.9%	64.3%	62.3%
Your org	53.2%	54.0%	51.4%	51.1%	51.9%
Average	57.0%	55.2%	56.3%	56.9%	56.8%
Best	44.8%	48.4%	47.7%	47.7%	48.0%
Responses	457	612	591	583	2,043

This question was only answered by people who responded to Q11d.



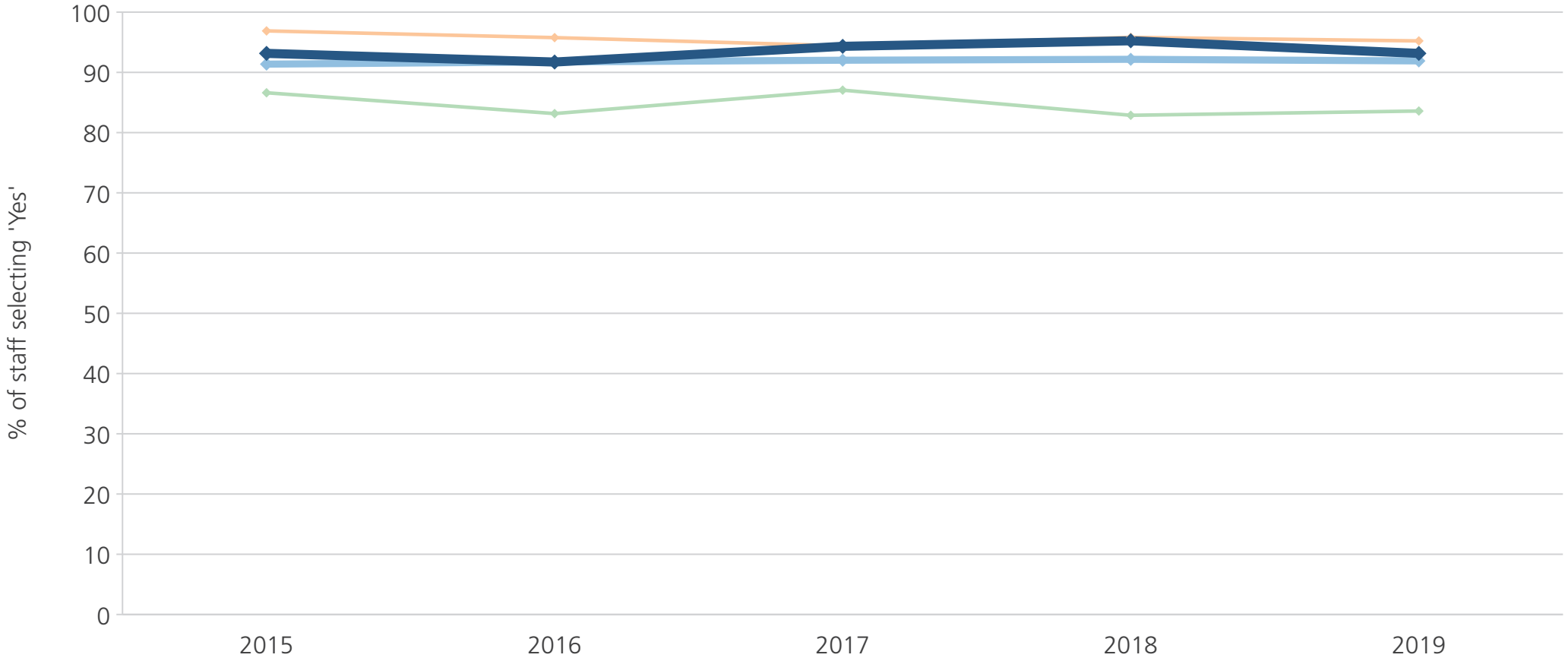
	2015	2016	2017	2018	2019
Worst	40.9%	33.3%	34.9%	35.2%	30.7%
Your org	33.2%	24.7%	25.7%	19.2%	20.1%
Average	29.4%	27.1%	26.6%	26.0%	24.4%
Best	19.7%	18.7%	18.9%	19.2%	16.2%
Responses	234	312	291	290	1,055

This question was only answered by people who responded to Q11d.

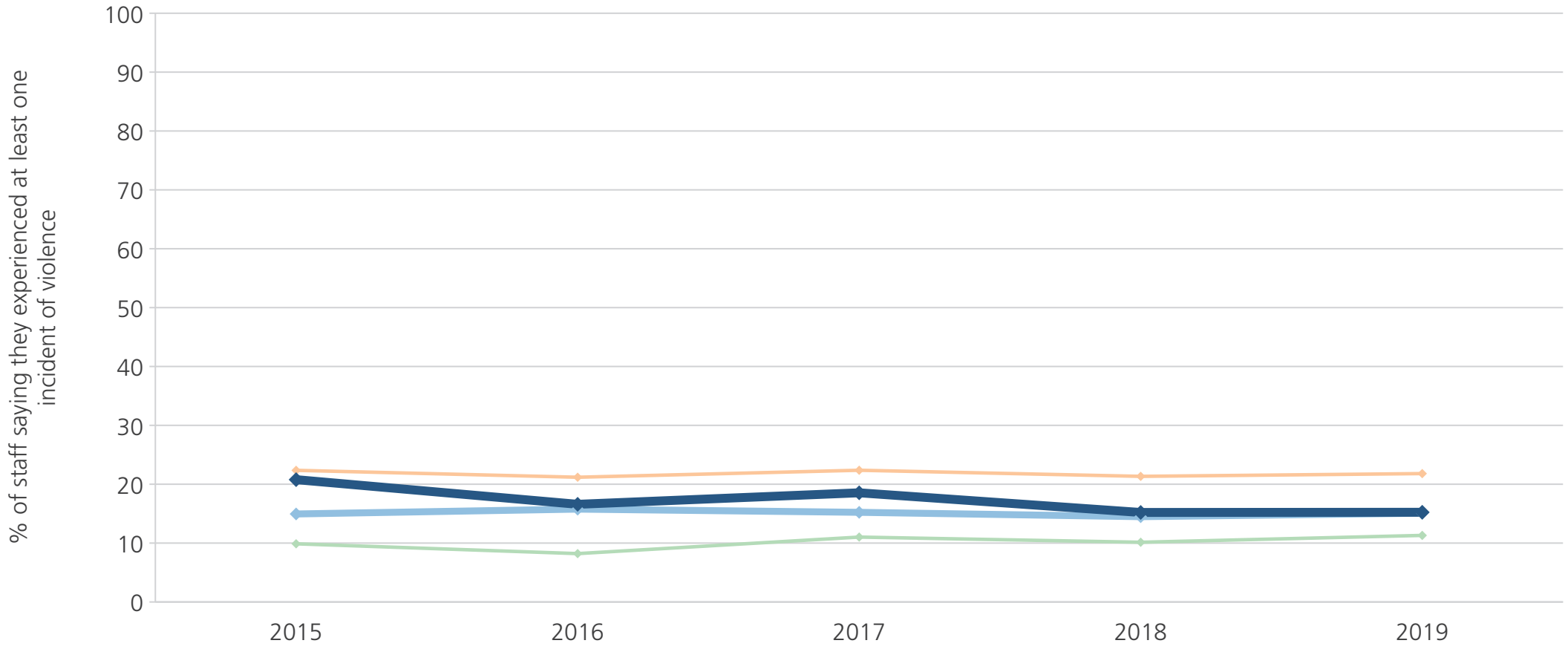


	2015	2016	2017	2018	2019
Worst	29.4%	26.9%	28.1%	27.2%	25.7%
Your org	26.0%	22.6%	20.6%	20.2%	20.4%
Average	22.9%	21.9%	21.6%	21.9%	21.7%
Best	13.2%	14.9%	11.8%	13.9%	10.7%
Responses	238	309	287	287	1,052

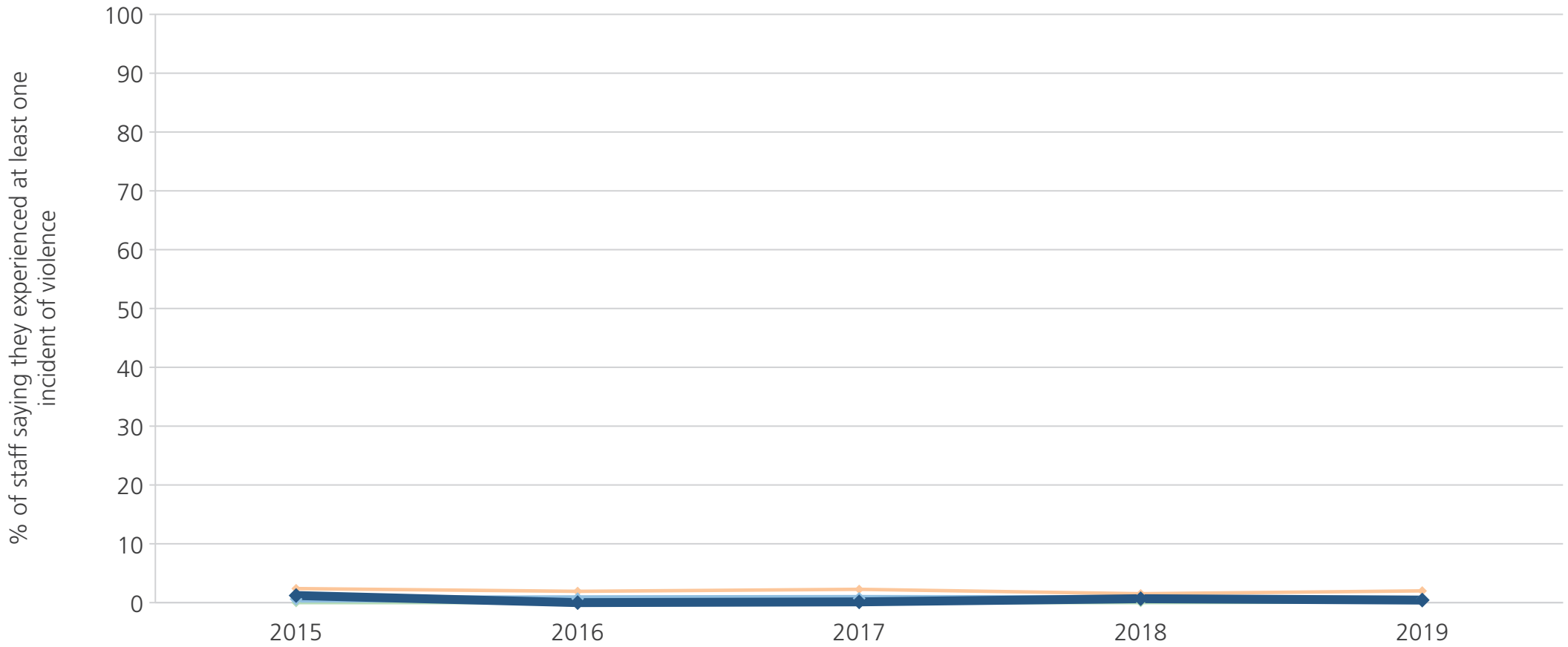
This question was only answered by people who responded to Q11d.



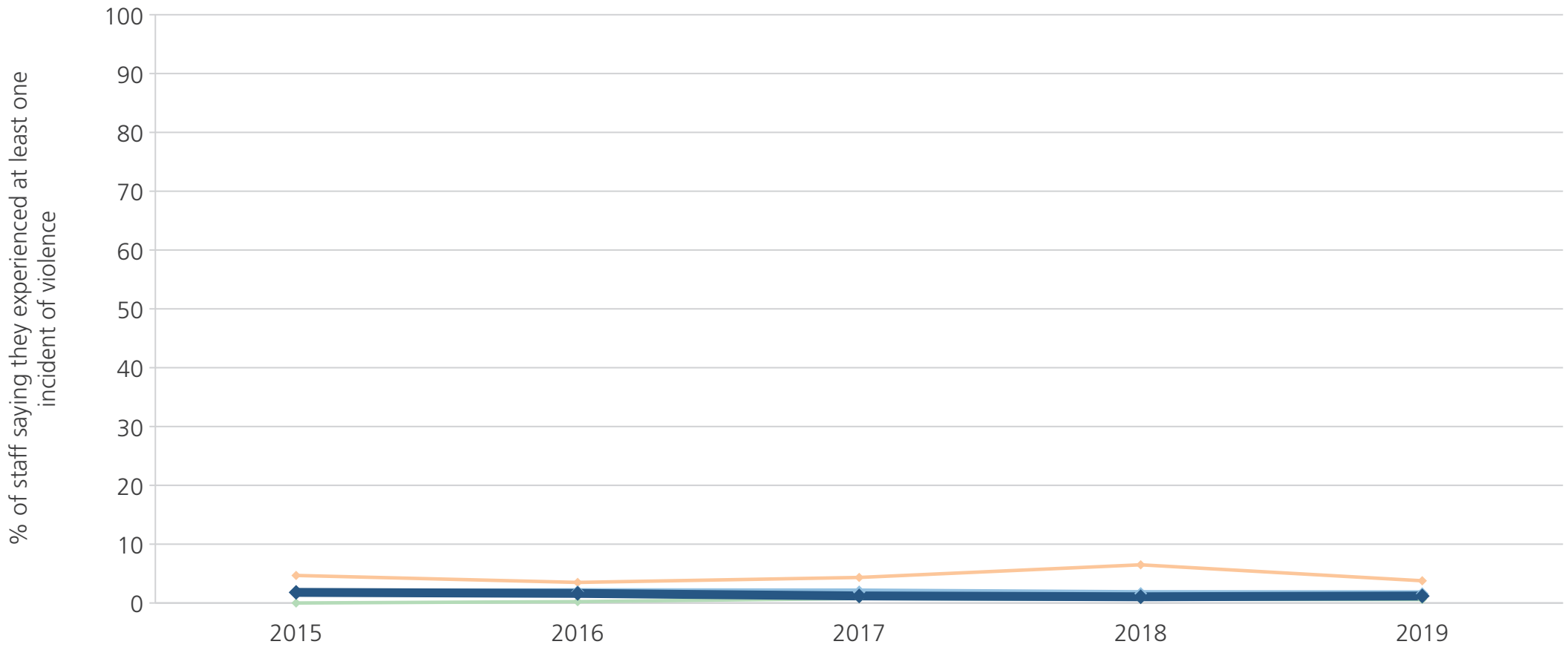
	2015	2016	2017	2018	2019
Worst	96.9%	95.8%	94.4%	95.8%	95.2%
Your org	93.2%	91.7%	94.3%	95.2%	93.1%
Average	91.4%	91.7%	92.0%	92.2%	91.9%
Best	86.6%	83.2%	87.0%	82.9%	83.6%
Responses	237	321	293	290	1,057



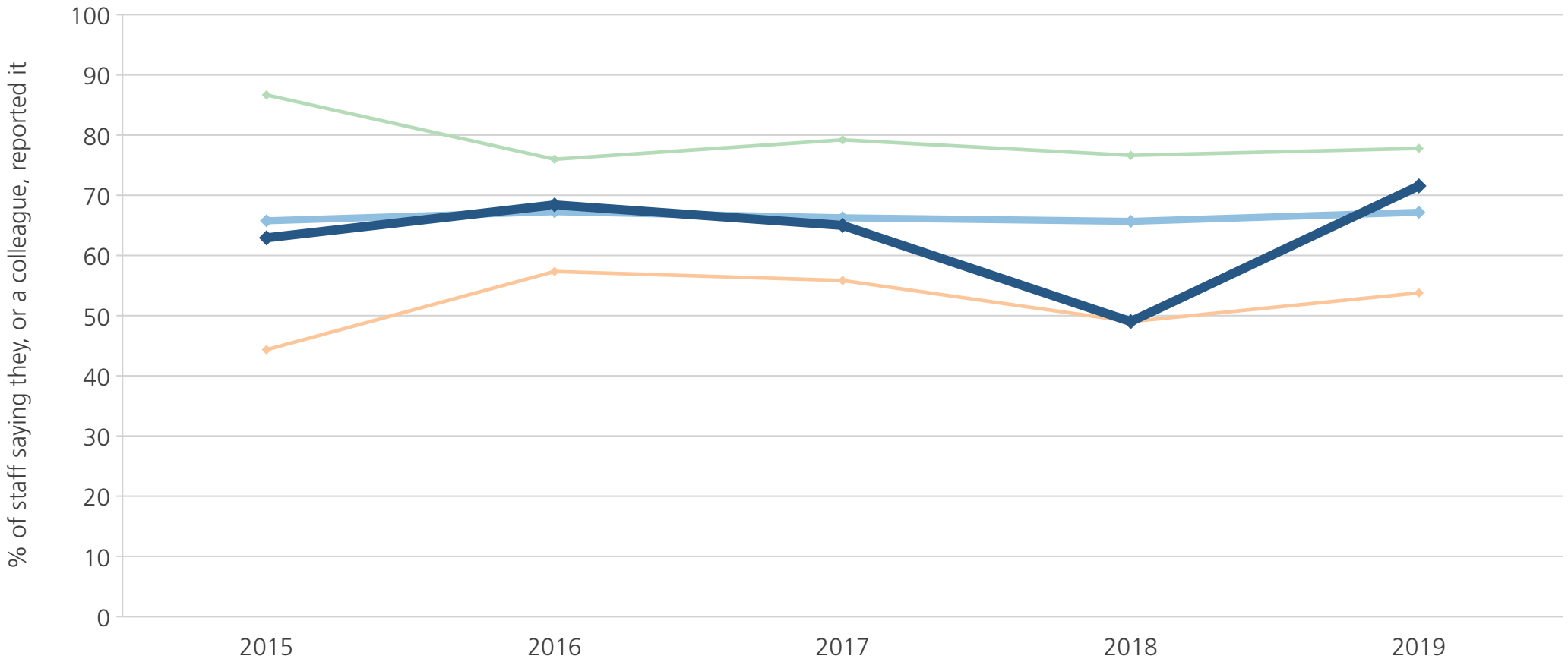
	2015	2016	2017	2018	2019
Worst	22.4%	21.2%	22.4%	21.3%	21.8%
Your org	20.8%	16.6%	18.5%	15.2%	15.2%
Average	14.9%	15.8%	15.2%	14.5%	15.1%
Best	9.9%	8.2%	11.0%	10.1%	11.3%
Responses	456	616	588	579	2,037



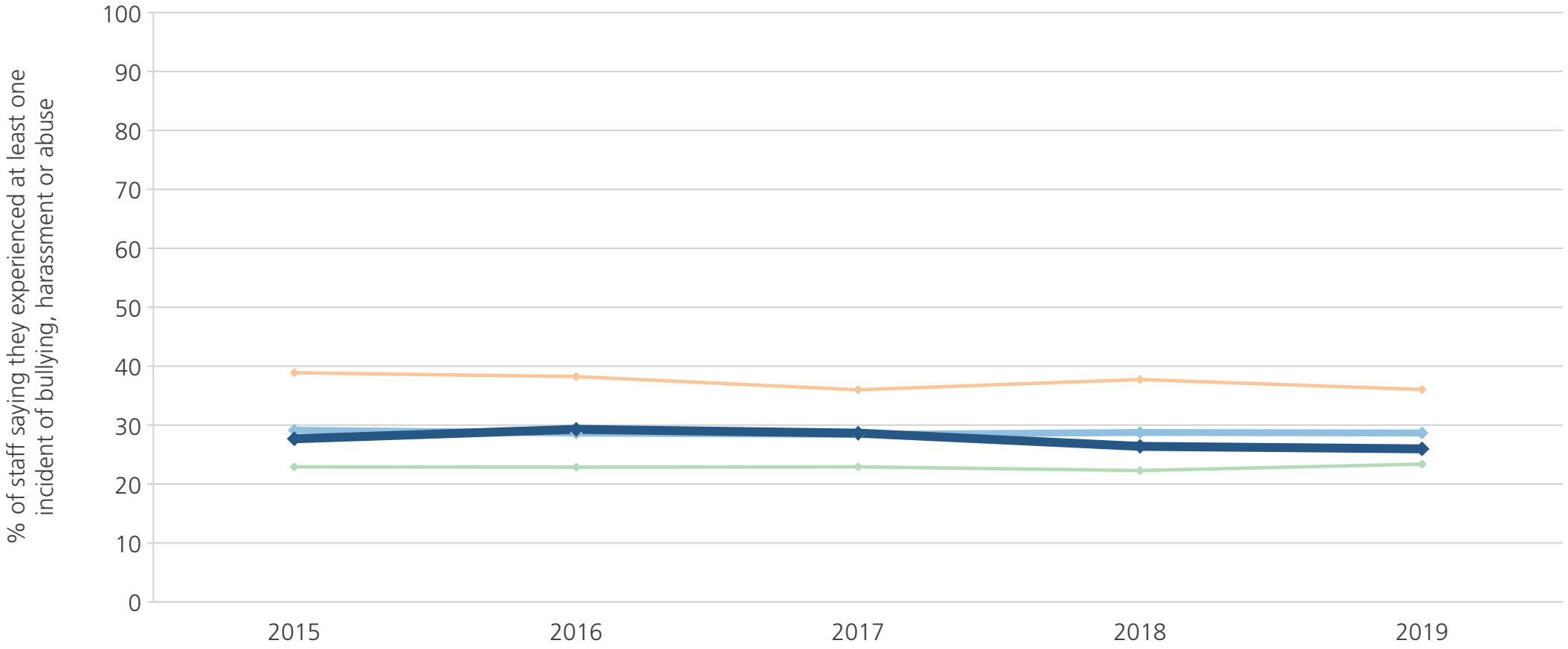
	2015	2016	2017	2018	2019
Worst	2.4%	1.9%	2.3%	1.5%	2.0%
Your org	1.2%	0.0%	0.1%	0.7%	0.4%
Average	0.6%	0.7%	0.7%	0.7%	0.6%
Best	0.0%	0.0%	0.0%	0.0%	0.1%
Responses	450	609	576	566	2,022



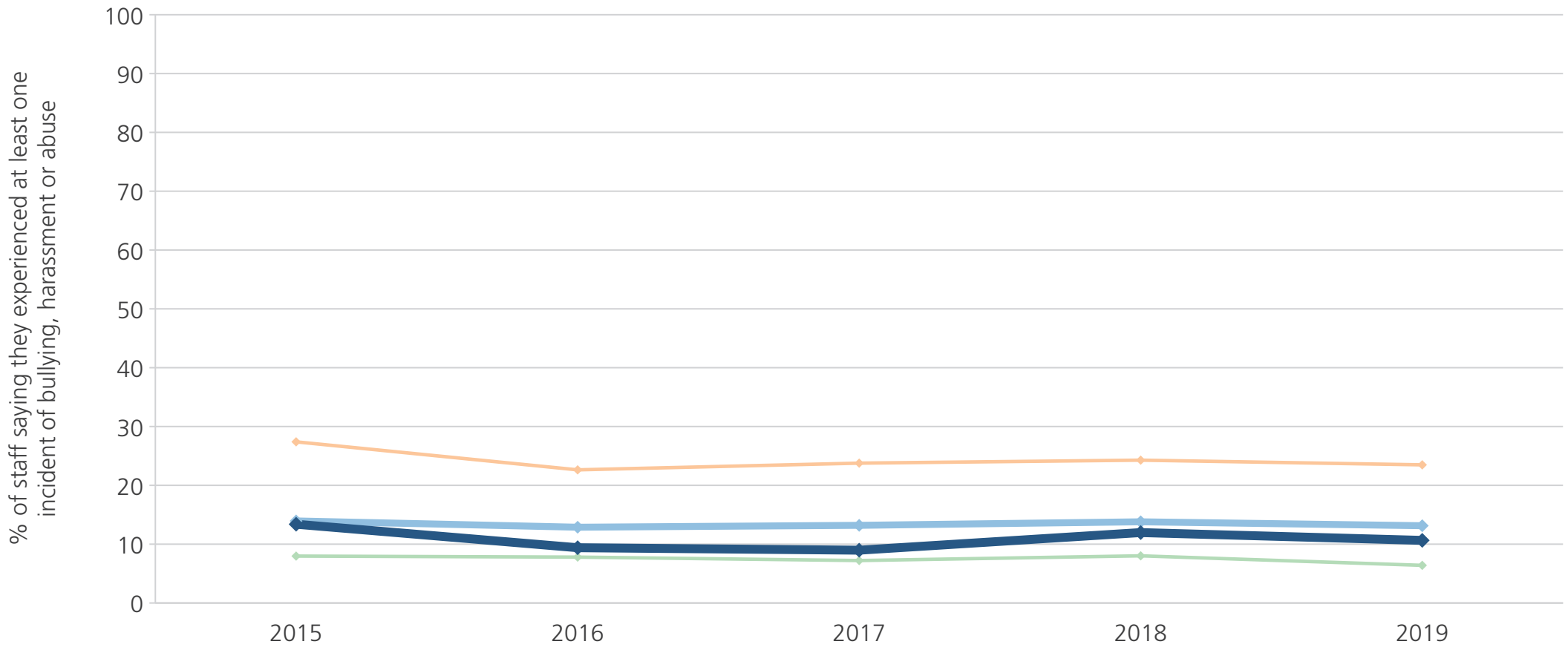
	2015	2016	2017	2018	2019
Worst	4.7%	3.5%	4.3%	6.5%	3.8%
Your org	1.8%	1.6%	1.2%	1.1%	1.2%
Average	1.8%	1.9%	1.9%	1.6%	1.6%
Best	0.0%	0.2%	0.8%	0.6%	0.6%
Responses	446	601	576	571	2,022



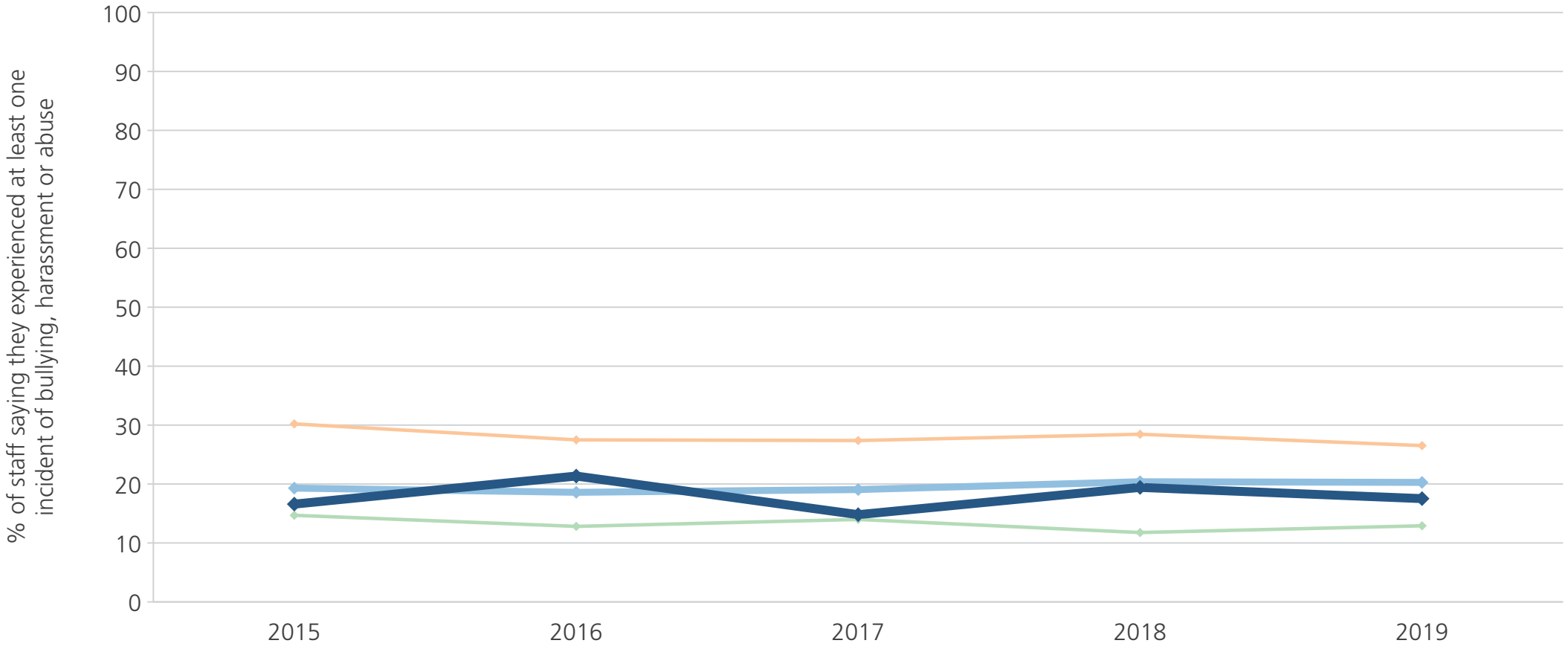
	2015	2016	2017	2018	2019
Best	86.7%	76.0%	79.2%	76.6%	77.8%
Your org	62.9%	68.4%	65.0%	49.0%	71.6%
Average	65.8%	67.3%	66.3%	65.7%	67.2%
Worst	44.3%	57.3%	55.8%	49.0%	53.8%
Responses	96	84	90	70	273



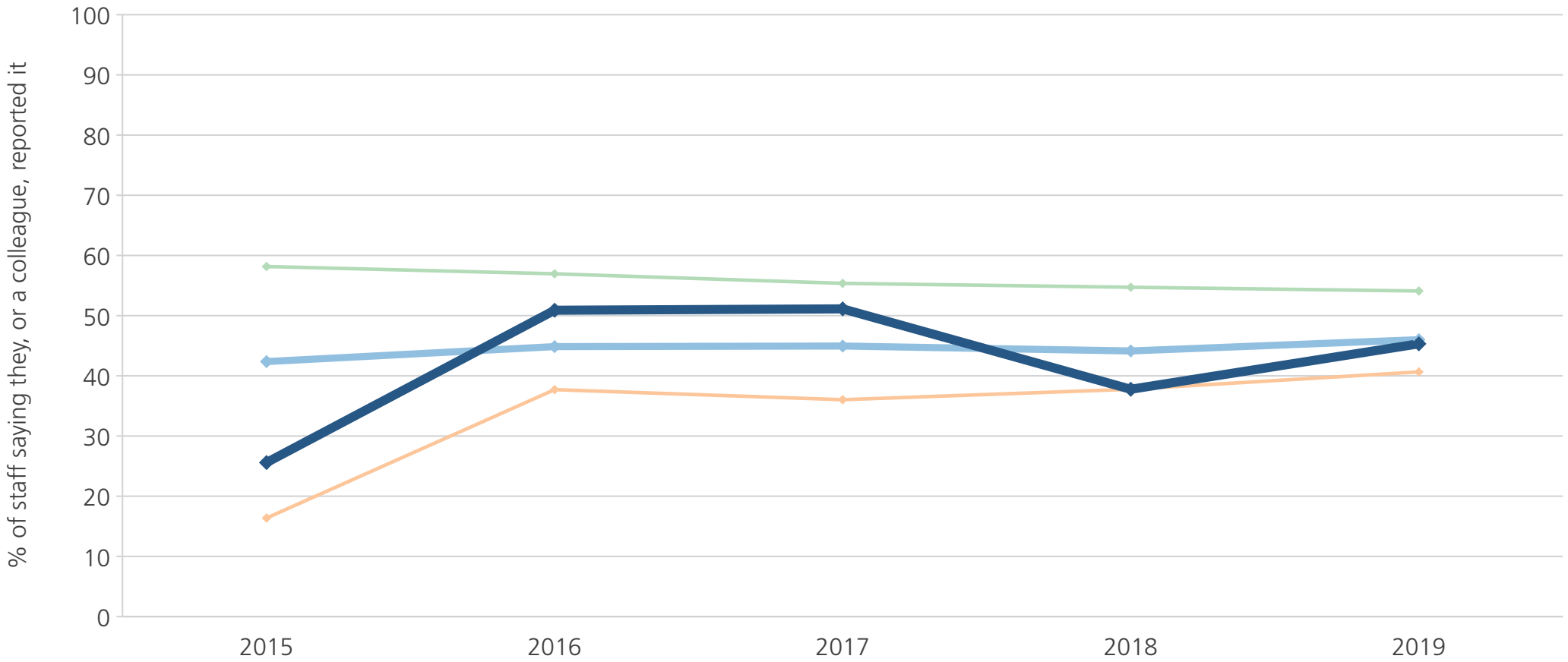
	2015	2016	2017	2018	2019
Worst	38.9%	38.2%	36.0%	37.7%	36.0%
Your org	27.7%	29.3%	28.6%	26.4%	26.0%
Average	29.1%	28.7%	28.4%	28.7%	28.7%
Best	22.9%	22.9%	22.9%	22.3%	23.4%
Responses	454	614	583	579	2,025



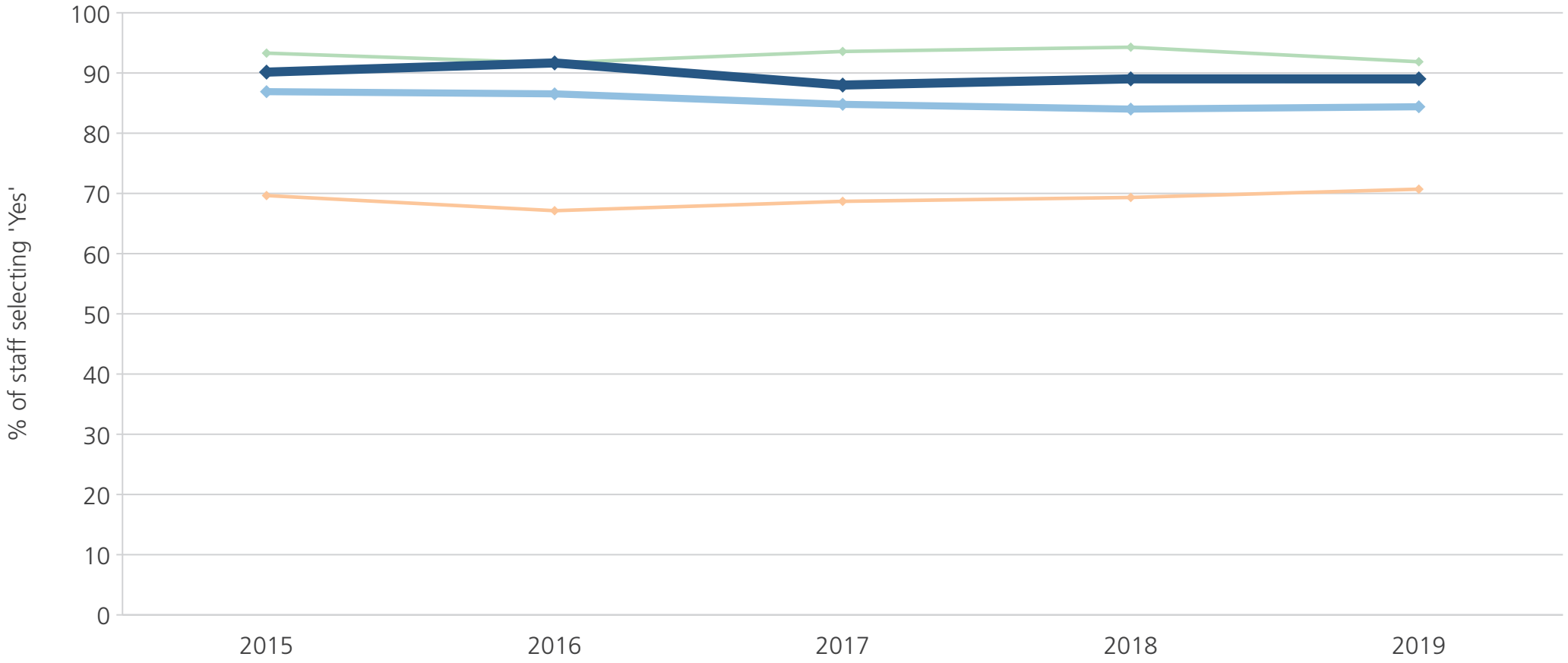
	2015	2016	2017	2018	2019
Worst	27.4%	22.6%	23.8%	24.3%	23.5%
Your org	13.4%	9.4%	9.0%	12.0%	10.6%
Average	14.0%	12.9%	13.2%	13.8%	13.1%
Best	8.0%	7.8%	7.2%	8.0%	6.4%
Responses	448	609	581	571	2,017



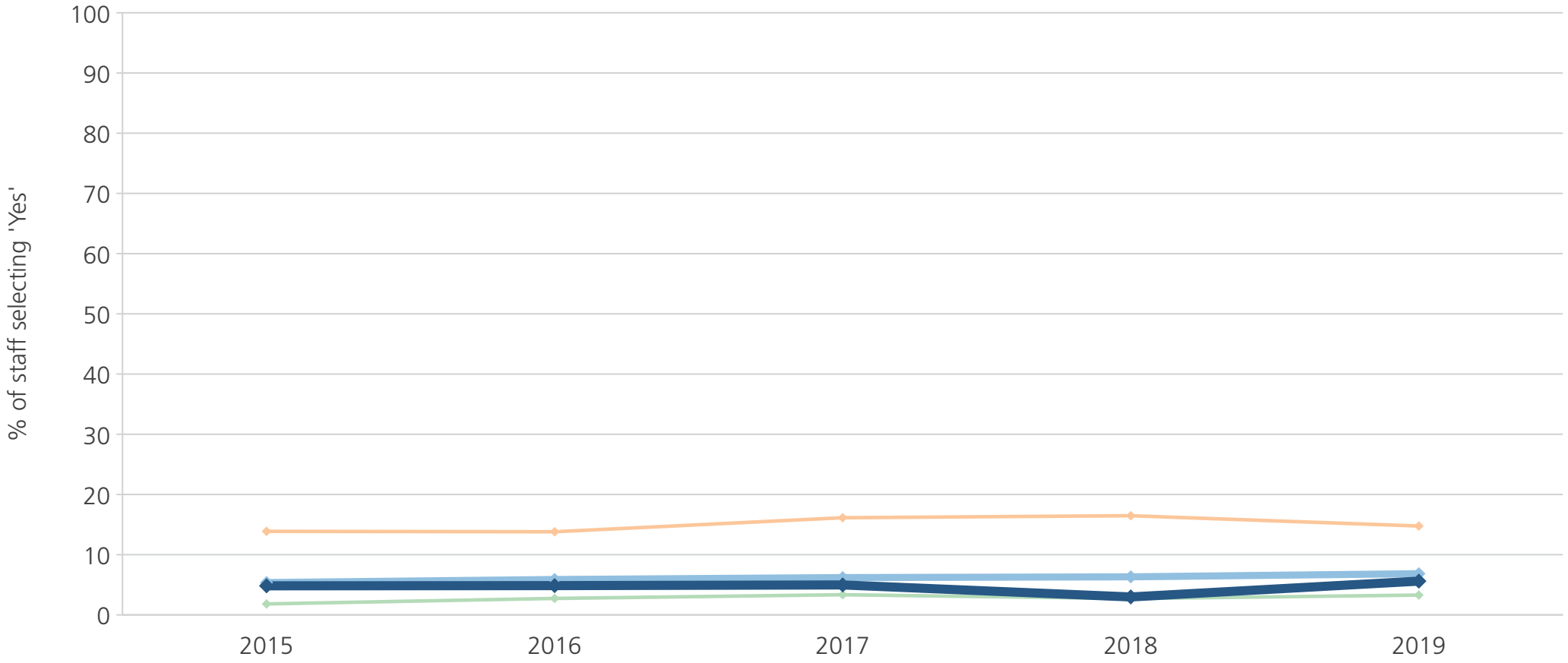
	2015	2016	2017	2018	2019
Worst	30.2%	27.5%	27.4%	28.4%	26.5%
Your org	16.6%	21.4%	14.8%	19.4%	17.5%
Average	19.3%	18.6%	19.1%	20.4%	20.3%
Best	14.7%	12.8%	14.0%	11.8%	12.9%
Responses	443	609	581	572	2,020



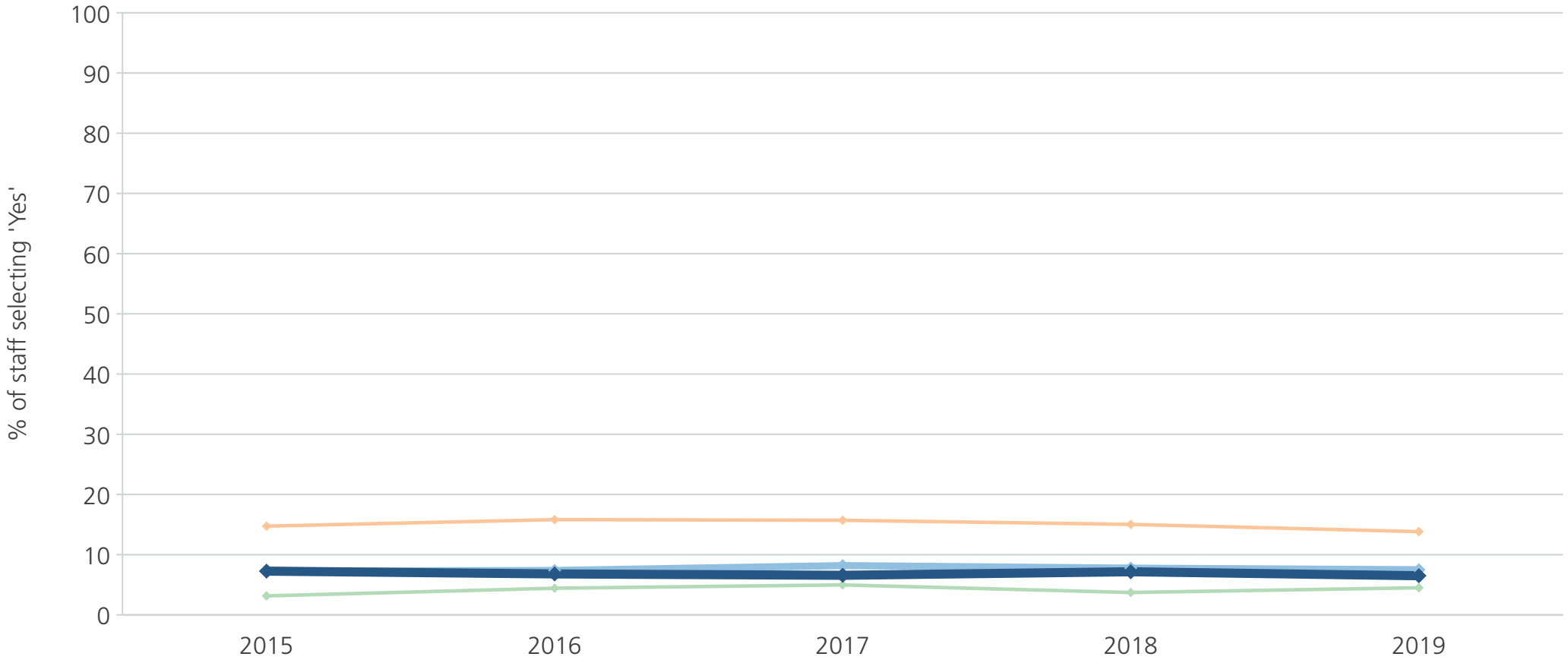
	2015	2016	2017	2018	2019
Best	58.2%	57.0%	55.4%	54.7%	54.1%
Your org	25.6%	50.9%	51.1%	37.8%	45.3%
Average	42.4%	44.9%	45.0%	44.1%	46.0%
Worst	16.4%	37.7%	36.0%	37.8%	40.7%
Responses	101	222	190	183	685



	2015	2016	2017	2018	2019
Best	93.3%	91.7%	93.6%	94.3%	91.9%
Your org	90.1%	91.7%	88.0%	89.0%	89.0%
Average	86.9%	86.5%	84.8%	84.0%	84.4%
Worst	69.6%	67.1%	68.7%	69.3%	70.7%
Responses	323	440	417	409	1,448

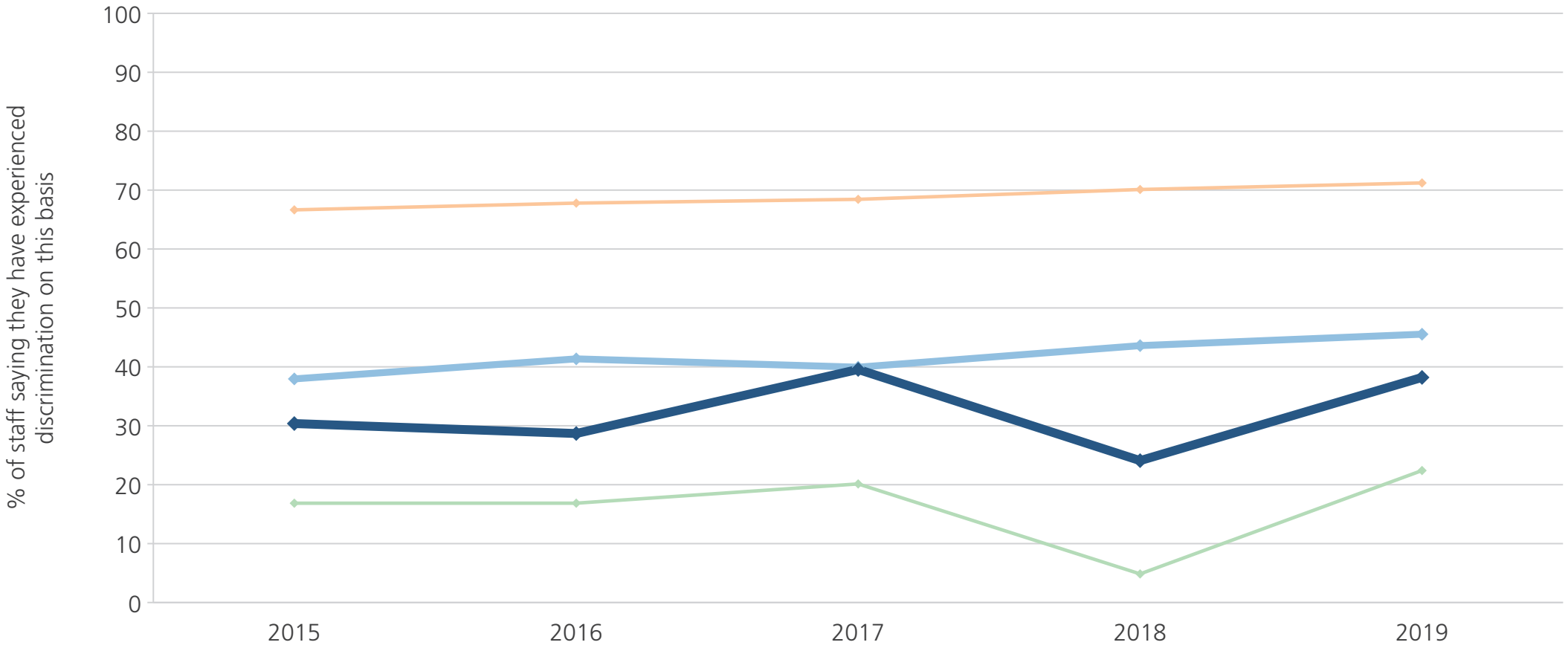


	2015	2016	2017	2018	2019
Worst	13.9%	13.8%	16.1%	16.5%	14.8%
Your org	4.8%	4.9%	5.0%	3.0%	5.6%
Average	5.4%	5.9%	6.2%	6.3%	6.8%
Best	1.8%	2.7%	3.3%	2.7%	3.3%
Responses	456	611	590	579	2,035



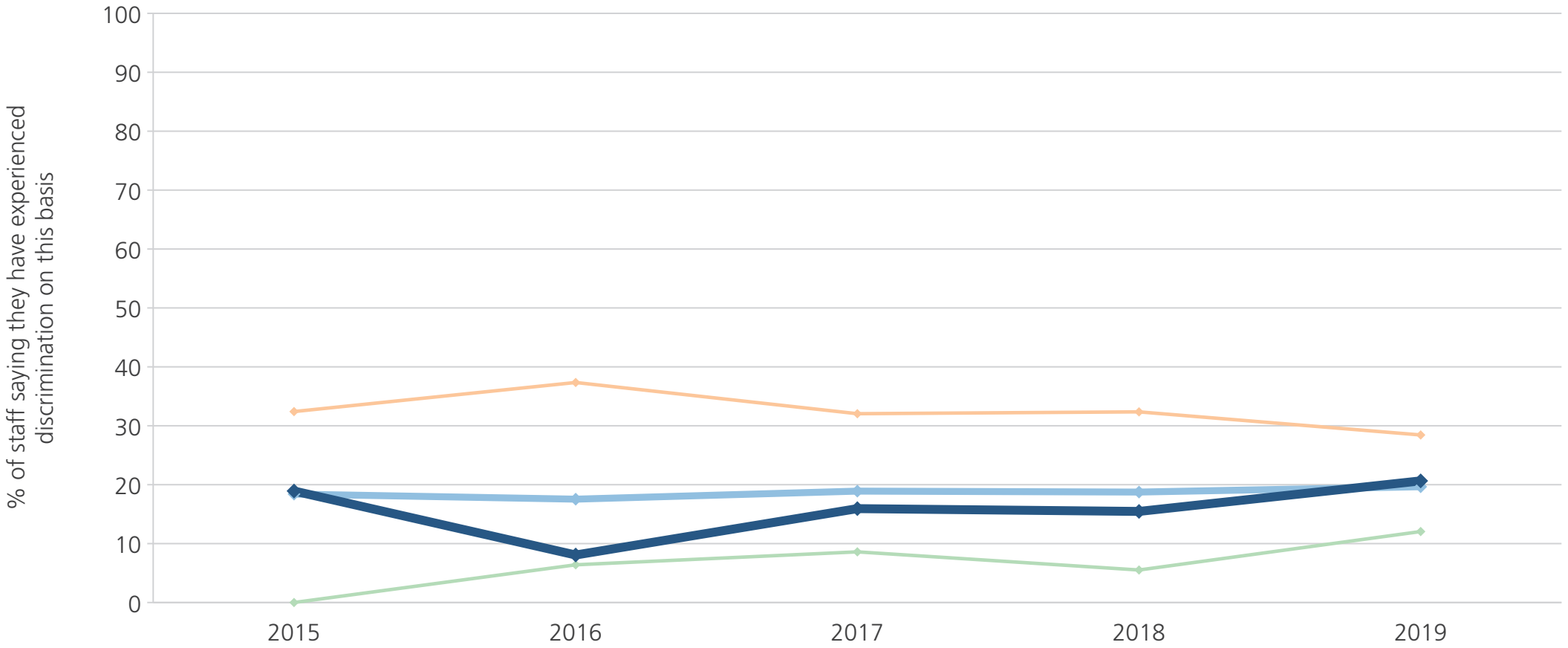
	2015	2016	2017	2018	2019
Worst	14.7%	15.8%	15.7%	15.0%	13.8%
Your org	7.3%	6.8%	6.6%	7.2%	6.5%
Average	7.3%	7.4%	8.2%	7.8%	7.5%
Best	3.2%	4.4%	5.0%	3.7%	4.5%
Responses	450	612	582	578	2,022

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



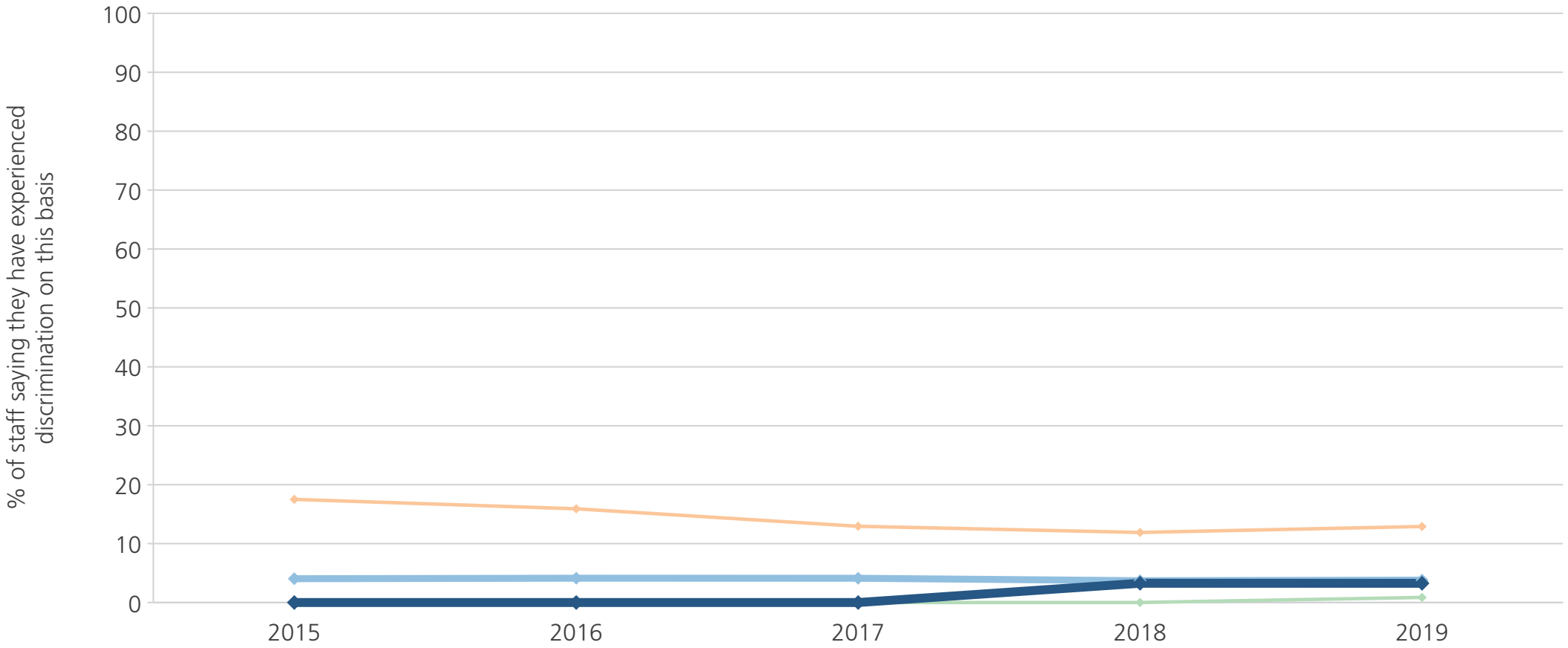
	2015	2016	2017	2018	2019
Worst	66.6%	67.8%	68.4%	70.1%	71.2%
Your org	30.4%	28.7%	39.6%	24.1%	38.2%
Average	38.0%	41.4%	39.9%	43.6%	45.5%
Best	16.9%	16.9%	20.1%	4.9%	22.4%
Responses	48	57	55	47	200

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



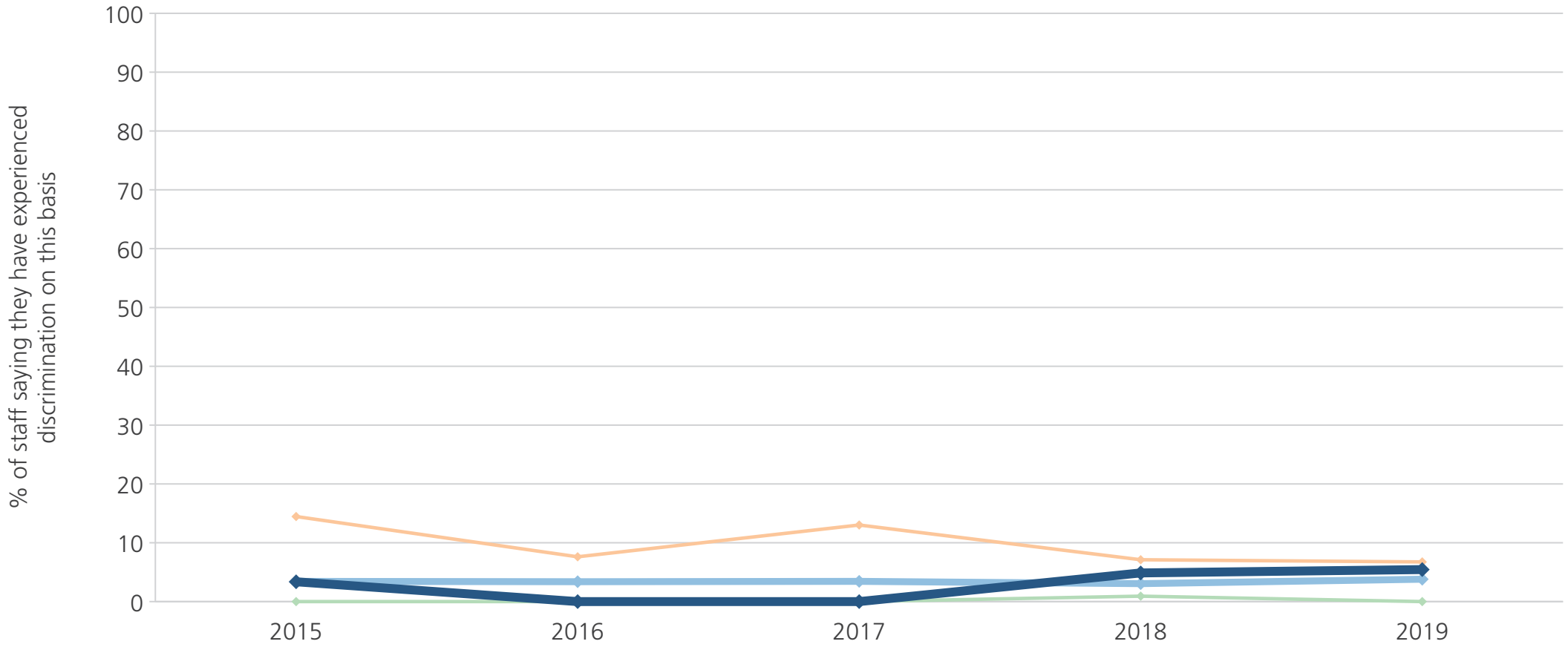
	2015	2016	2017	2018	2019
Worst	32.4%	37.3%	32.0%	32.4%	28.4%
Your org	18.9%	8.1%	15.9%	15.5%	20.6%
Average	18.4%	17.5%	18.9%	18.7%	19.7%
Best	0.0%	6.4%	8.6%	5.5%	12.0%
Responses	48	57	55	47	200

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



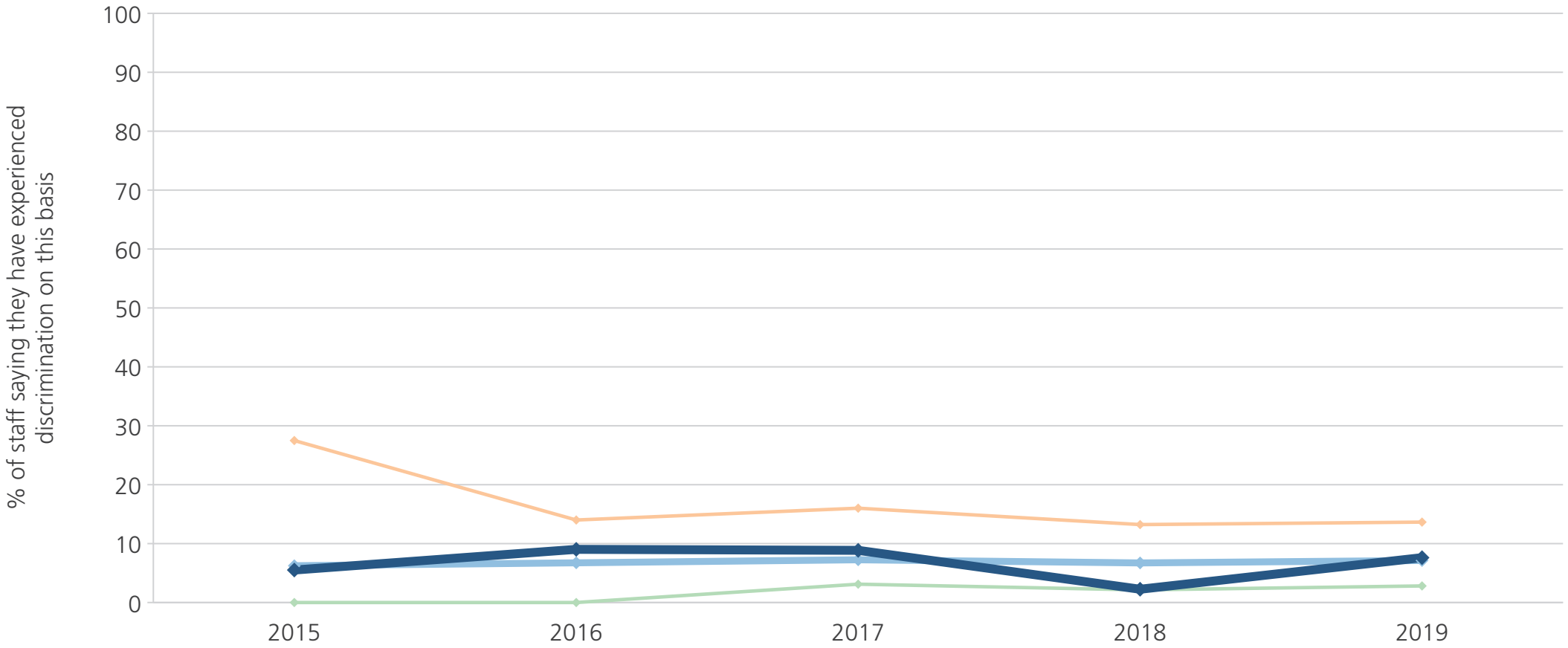
	2015	2016	2017	2018	2019
Worst	17.5%	15.9%	12.9%	11.9%	12.9%
Your org	0.0%	0.0%	0.0%	3.3%	3.3%
Average	4.0%	4.1%	4.1%	3.7%	3.8%
Best	0.0%	0.0%	0.0%	0.0%	0.9%
Responses	48	57	55	47	200

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



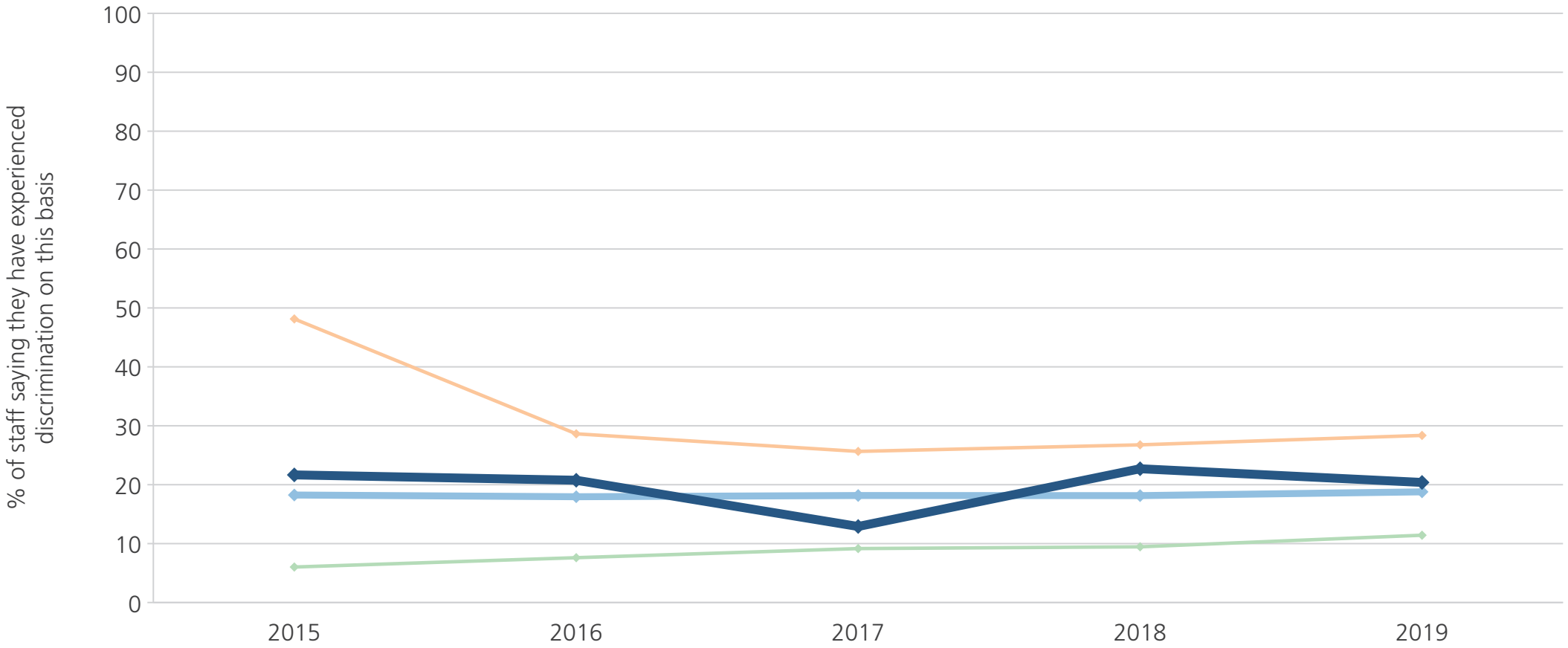
	2015	2016	2017	2018	2019
Worst	14.5%	7.6%	13.0%	7.1%	6.7%
Your org	3.4%	0.0%	0.0%	4.9%	5.4%
Average	3.4%	3.4%	3.4%	3.1%	3.8%
Best	0.0%	0.0%	0.0%	0.9%	0.0%
Responses	48	57	55	47	200

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



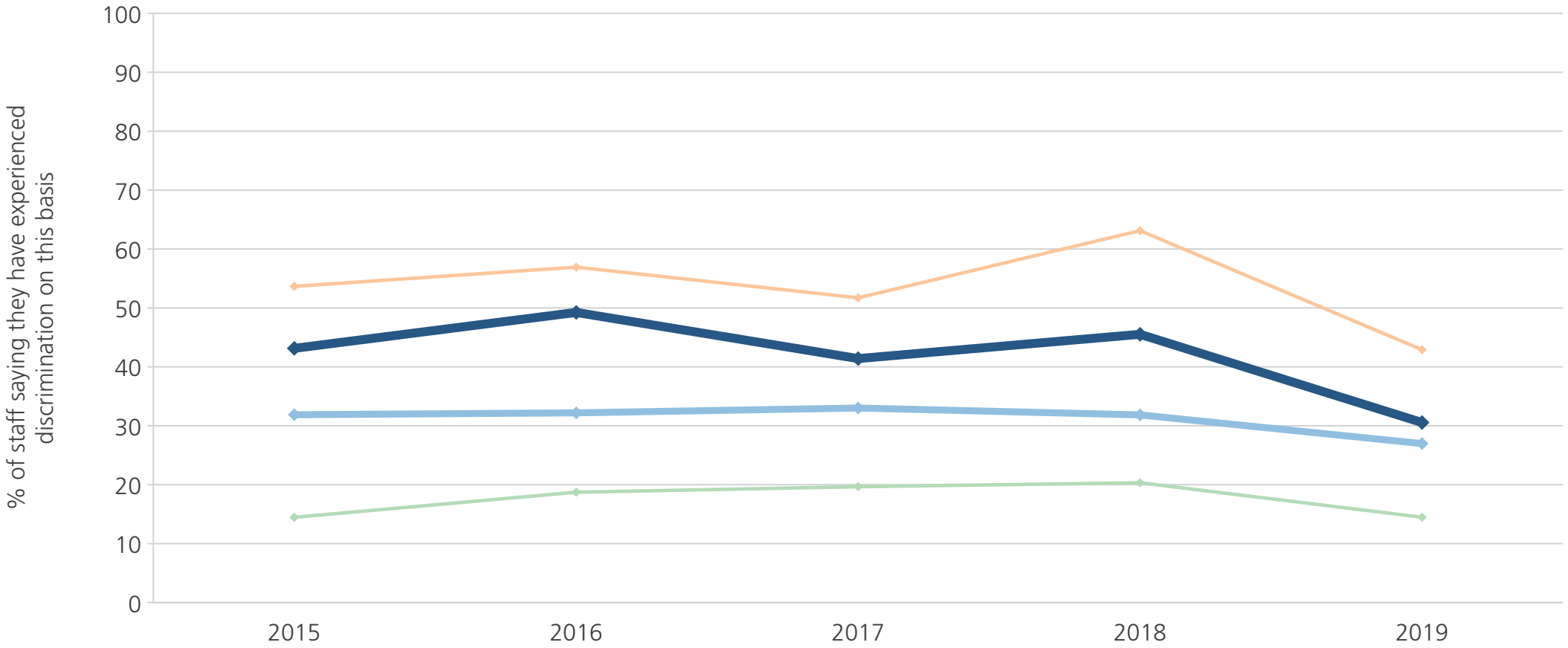
	2015	2016	2017	2018	2019
Worst	27.5%	14.0%	16.0%	13.2%	13.6%
Your org	5.5%	9.0%	8.9%	2.3%	7.6%
Average	6.2%	6.7%	7.3%	6.7%	7.1%
Best	0.0%	0.0%	3.1%	2.1%	2.8%
Responses	48	57	55	47	200

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.

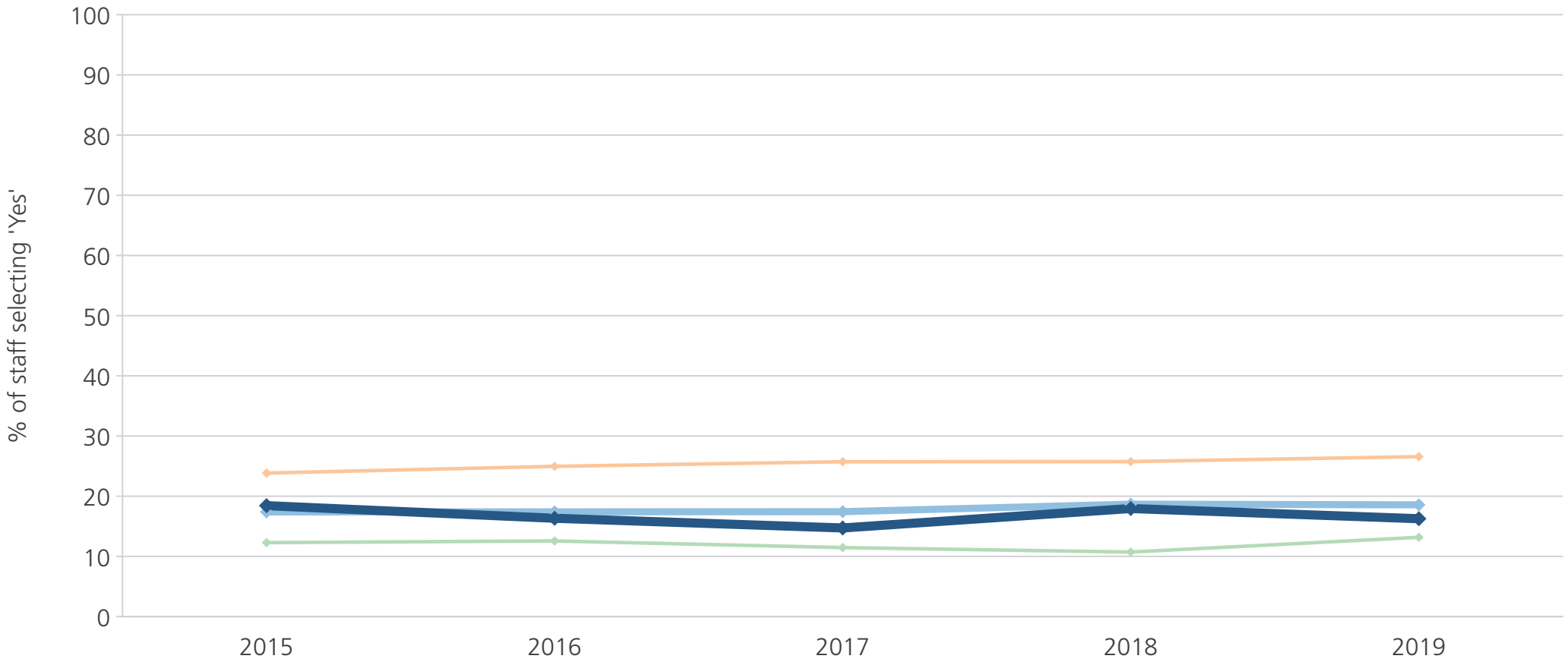


	2015	2016	2017	2018	2019
Worst	48.1%	28.6%	25.6%	26.8%	28.4%
Your org	21.7%	20.8%	12.9%	22.7%	20.4%
Average	18.2%	18.0%	18.2%	18.1%	18.8%
Best	6.0%	7.6%	9.2%	9.5%	11.4%
Responses	48	57	55	47	200

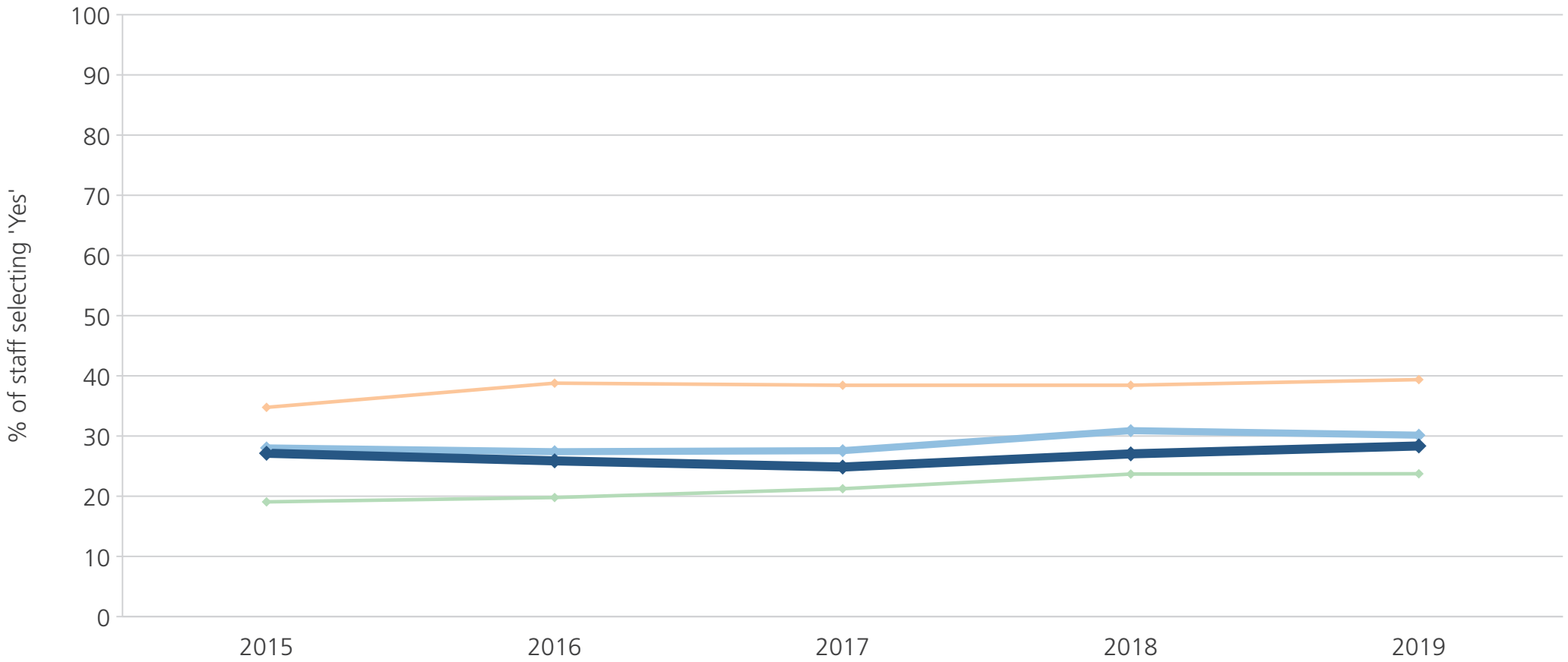
This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



	2015	2016	2017	2018	2019
Worst	53.7%	56.9%	51.7%	63.1%	42.9%
Your org	43.1%	49.2%	41.4%	45.5%	30.5%
Average	31.9%	32.2%	33.0%	31.8%	27.0%
Best	14.5%	18.7%	19.7%	20.3%	14.5%
Responses	48	57	55	47	200

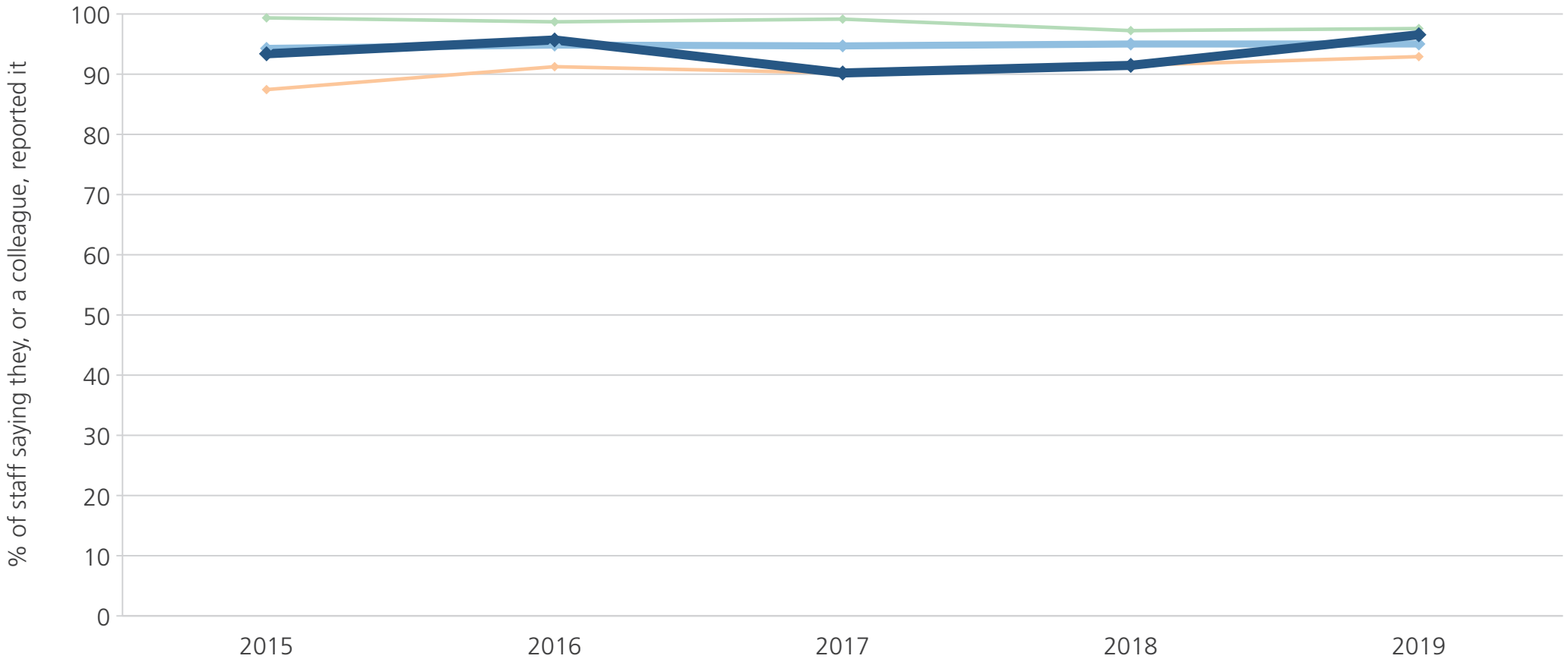


	2015	2016	2017	2018	2019
Worst	23.8%	25.0%	25.7%	25.8%	26.6%
Your org	18.4%	16.3%	14.7%	18.0%	16.3%
Average	17.4%	17.4%	17.4%	18.7%	18.6%
Best	12.3%	12.6%	11.5%	10.7%	13.2%
Responses	456	597	547	570	2,010

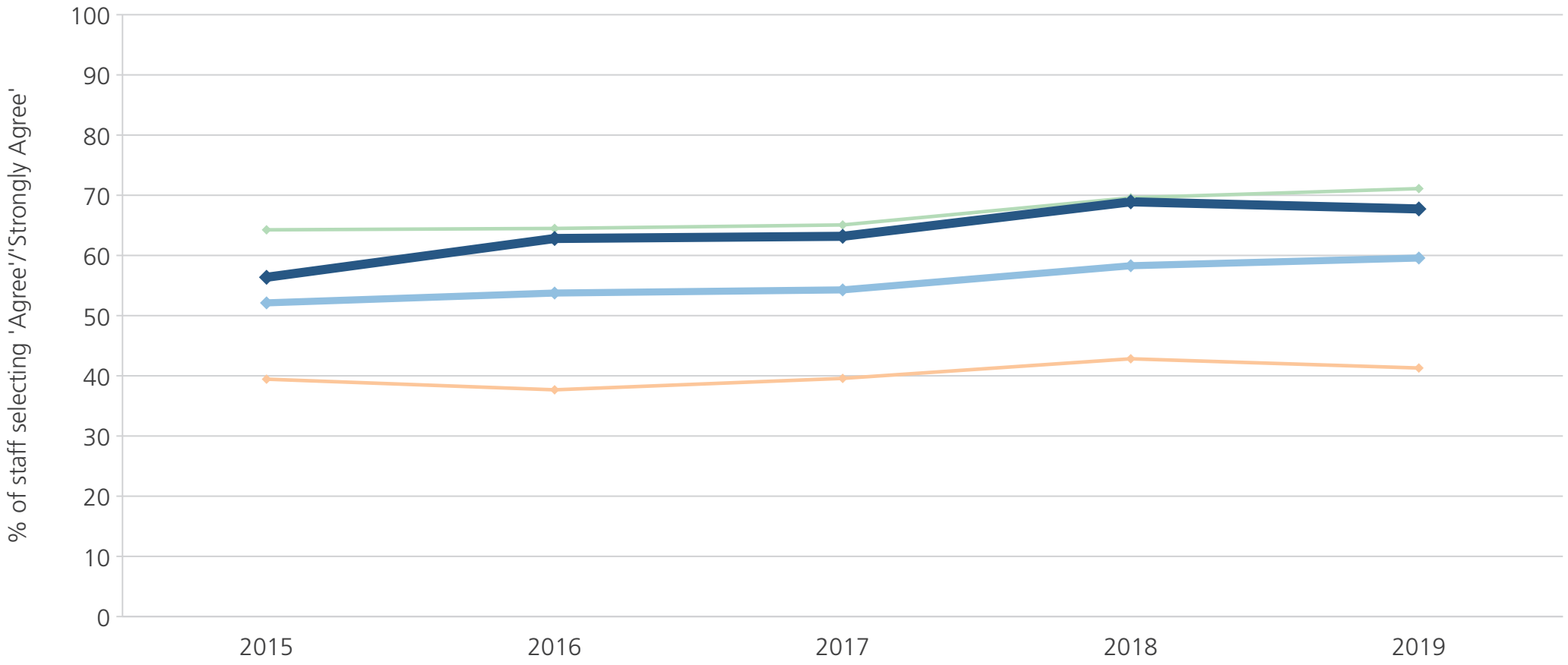


	2015	2016	2017	2018	2019
Worst	34.8%	38.8%	38.4%	38.4%	39.4%
Your org	27.1%	25.9%	24.8%	27.0%	28.3%
Average	28.0%	27.4%	27.6%	30.9%	30.1%
Best	19.1%	19.8%	21.2%	23.7%	23.7%
Responses	450	588	548	569	2,004

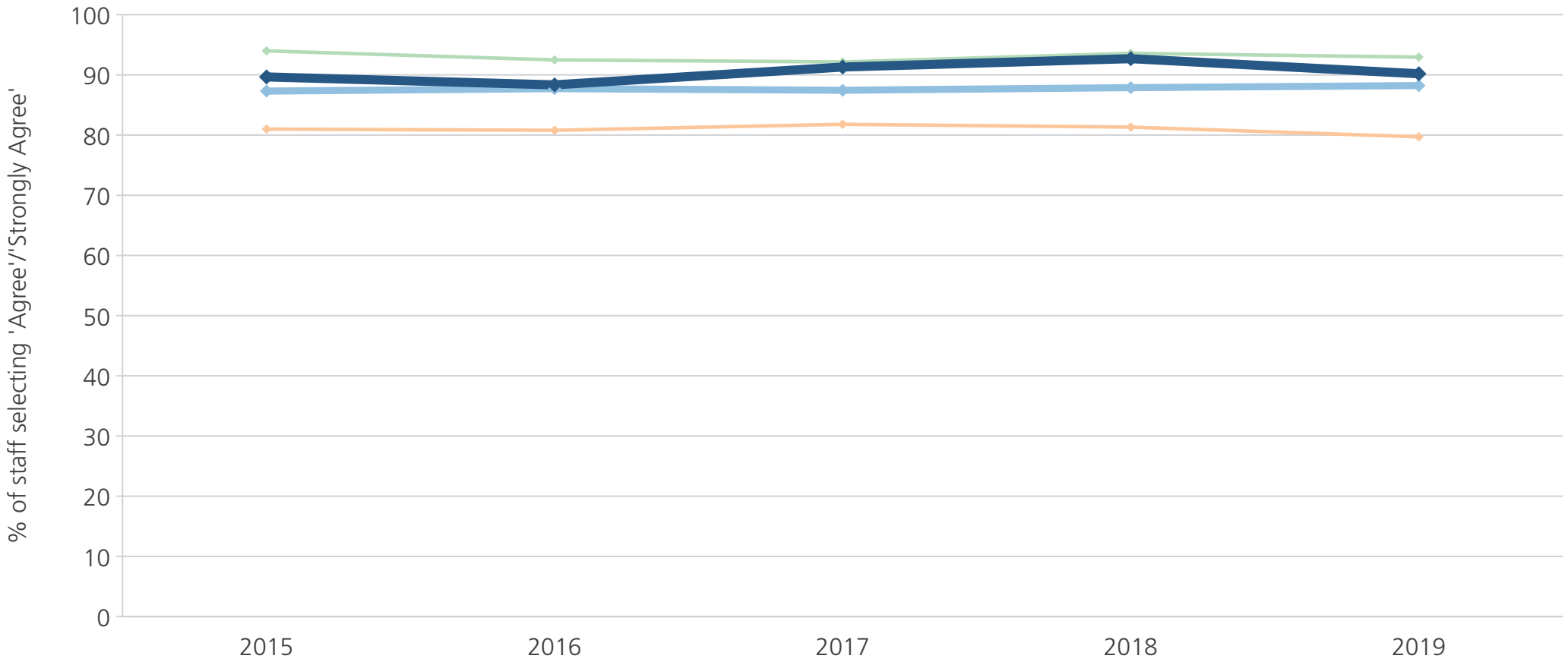
This question was only answered by staff who reported observing at least one error, near miss or incident in the last month.



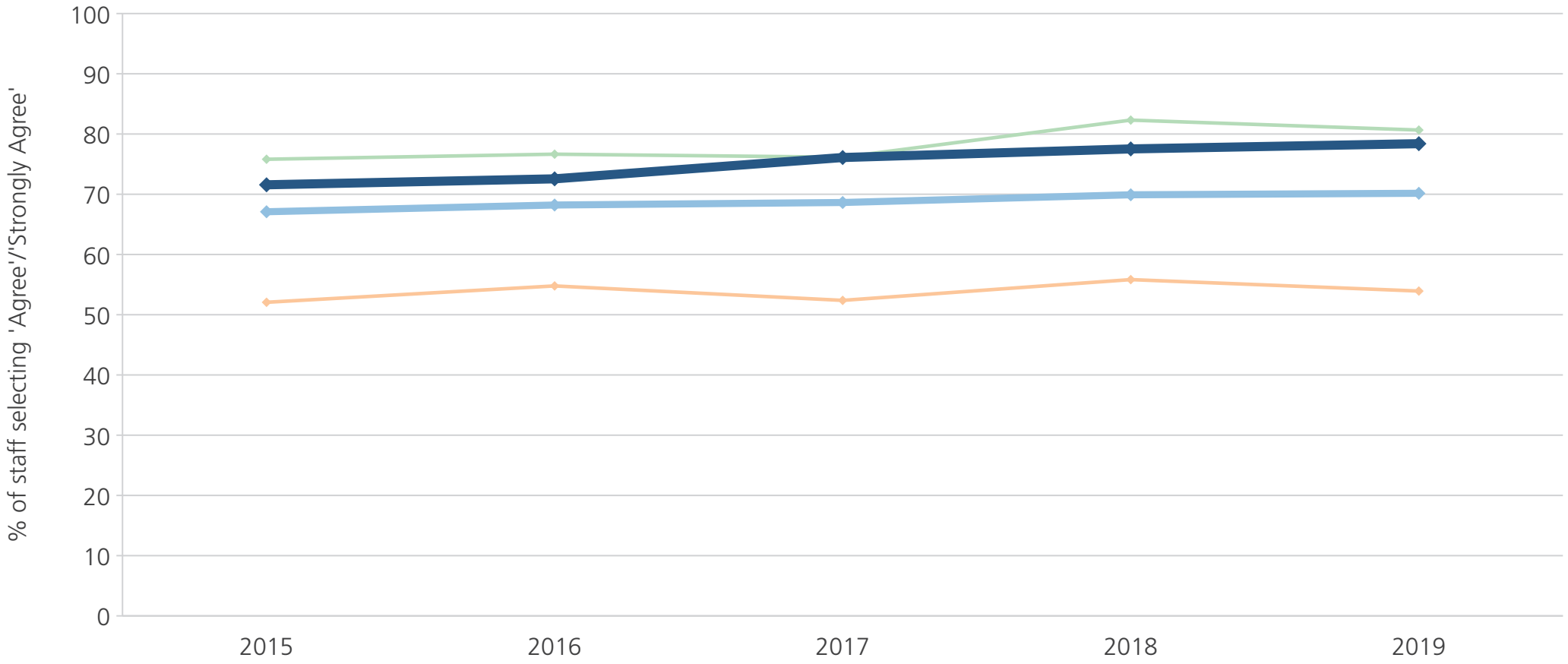
	2015	2016	2017	2018	2019
Best	99.4%	98.7%	99.2%	97.2%	97.6%
Your org	93.4%	95.7%	90.2%	91.5%	96.6%
Average	94.3%	94.8%	94.7%	95.0%	95.0%
Worst	87.4%	91.2%	90.2%	91.5%	92.9%
Responses	141	156	137	163	586



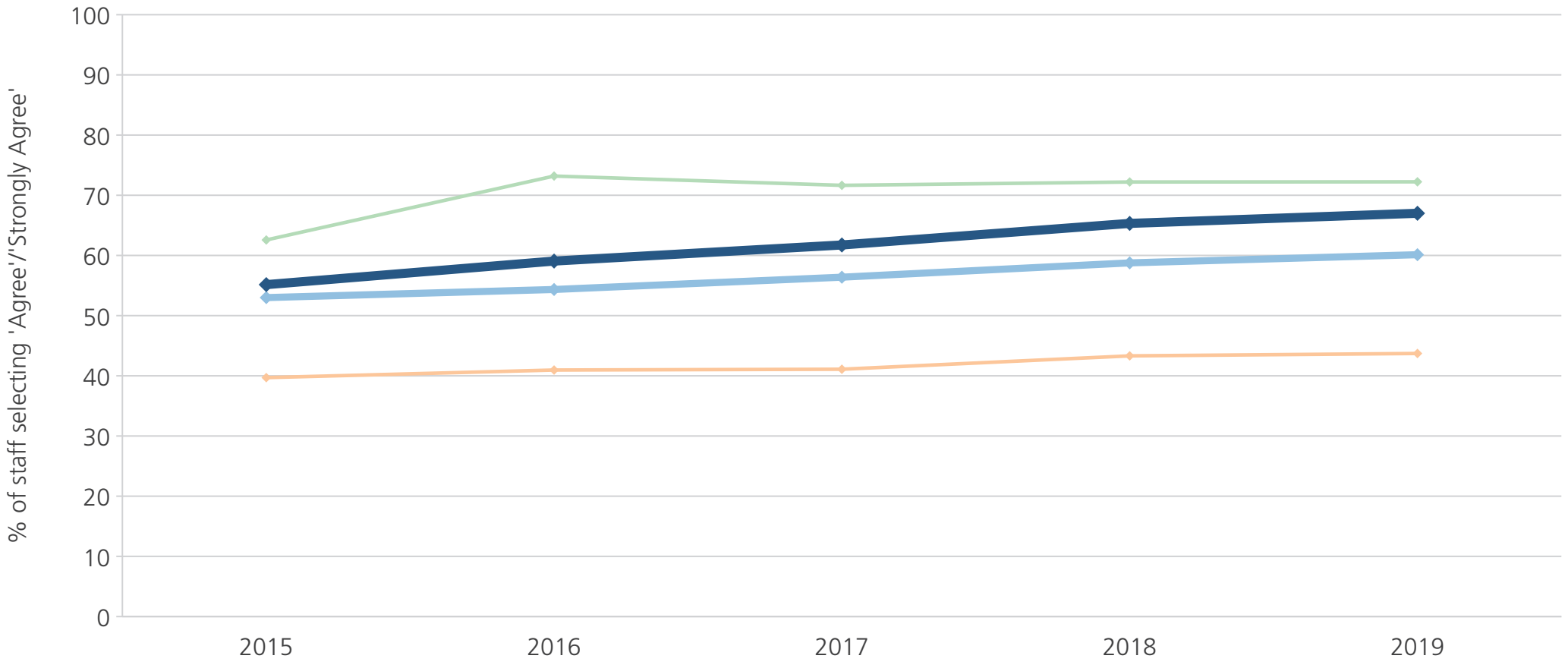
	2015	2016	2017	2018	2019
Best	64.3%	64.5%	65.1%	69.6%	71.1%
Your org	56.4%	62.8%	63.2%	68.9%	67.7%
Average	52.1%	53.8%	54.3%	58.3%	59.6%
Worst	39.4%	37.7%	39.6%	42.8%	41.3%
Responses	395	529	478	455	1,565



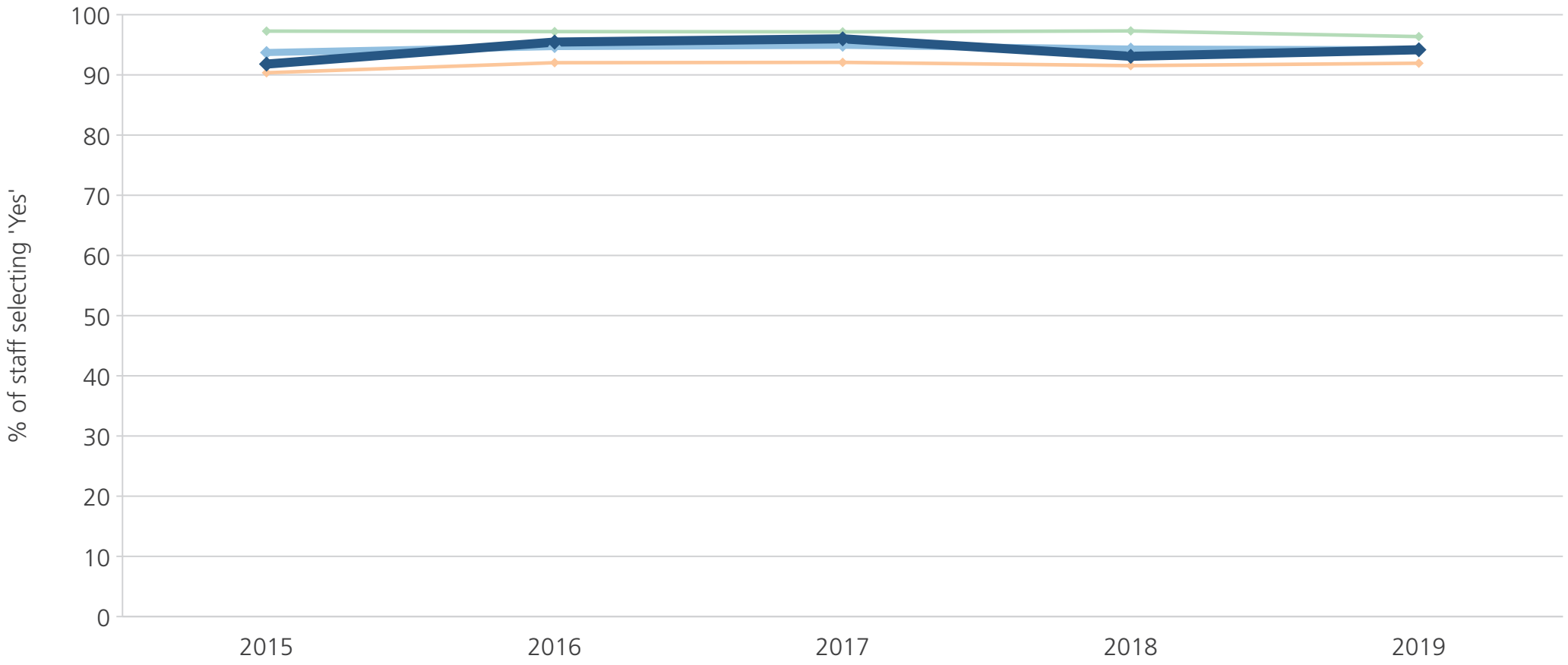
	2015	2016	2017	2018	2019
Best	94.0%	92.5%	92.2%	93.6%	93.0%
Your org	89.7%	88.3%	91.3%	92.7%	90.2%
Average	87.3%	87.7%	87.4%	87.9%	88.2%
Worst	81.0%	80.8%	81.8%	81.3%	79.7%
Responses	448	600	572	560	1,979



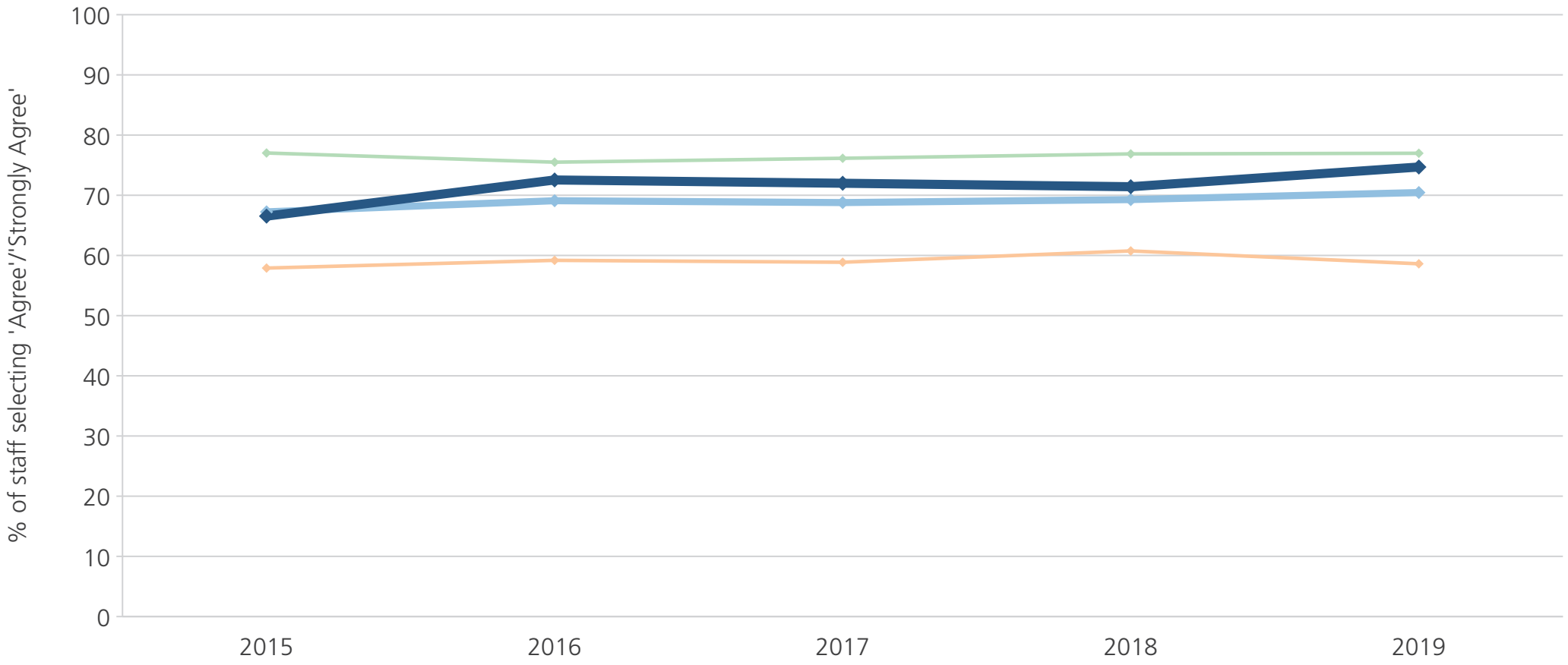
	2015	2016	2017	2018	2019
Best	75.8%	76.7%	76.2%	82.3%	80.7%
Your org	71.6%	72.6%	76.1%	77.5%	78.4%
Average	67.1%	68.2%	68.6%	69.9%	70.2%
Worst	52.1%	54.8%	52.4%	55.8%	53.9%
Responses	433	569	529	523	1,831



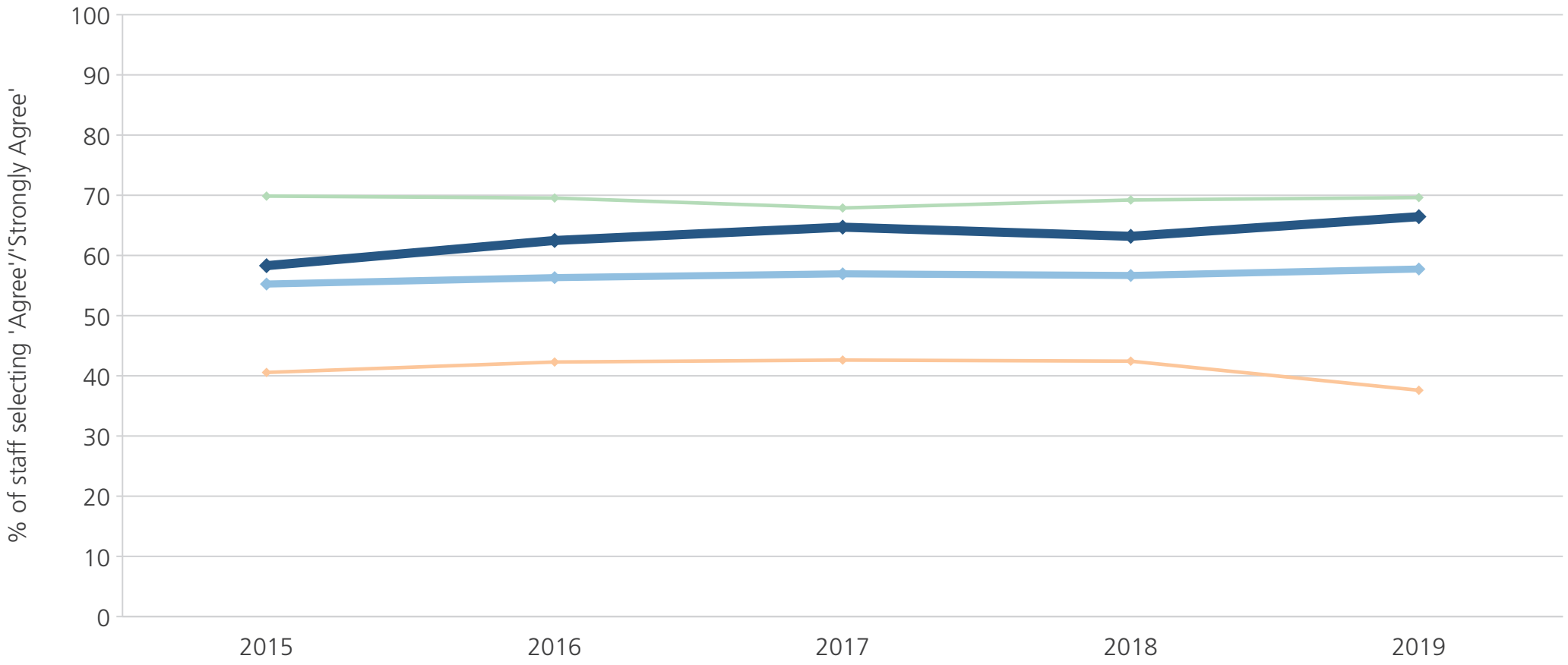
	2015	2016	2017	2018	2019
Best	62.6%	73.2%	71.6%	72.2%	72.2%
Your org	55.1%	59.1%	61.7%	65.3%	67.0%
Average	53.0%	54.3%	56.4%	58.8%	60.1%
Worst	39.7%	41.0%	41.1%	43.3%	43.7%
Responses	426	573	535	524	1,806



	2015	2016	2017	2018	2019
Best	97.3%	97.2%	97.1%	97.3%	96.4%
Your org	91.8%	95.5%	96.0%	93.1%	94.2%
Average	93.7%	94.7%	94.9%	94.3%	94.2%
Worst	90.4%	92.0%	92.1%	91.5%	91.9%
Responses	408	546	528	526	1,832



	2015	2016	2017	2018	2019
Best	77.0%	75.5%	76.1%	76.9%	77.0%
Your org	66.5%	72.5%	72.0%	71.4%	74.7%
Average	67.2%	69.1%	68.8%	69.3%	70.4%
Worst	57.9%	59.2%	58.9%	60.8%	58.6%
Responses	453	608	583	572	2,018



	2015	2016	2017	2018	2019
Best	69.9%	69.5%	67.9%	69.2%	69.6%
Your org	58.3%	62.5%	64.7%	63.2%	66.4%
Average	55.2%	56.3%	56.9%	56.7%	57.7%
Worst	40.6%	42.3%	42.6%	42.4%	37.6%
Responses	448	605	580	573	2,018

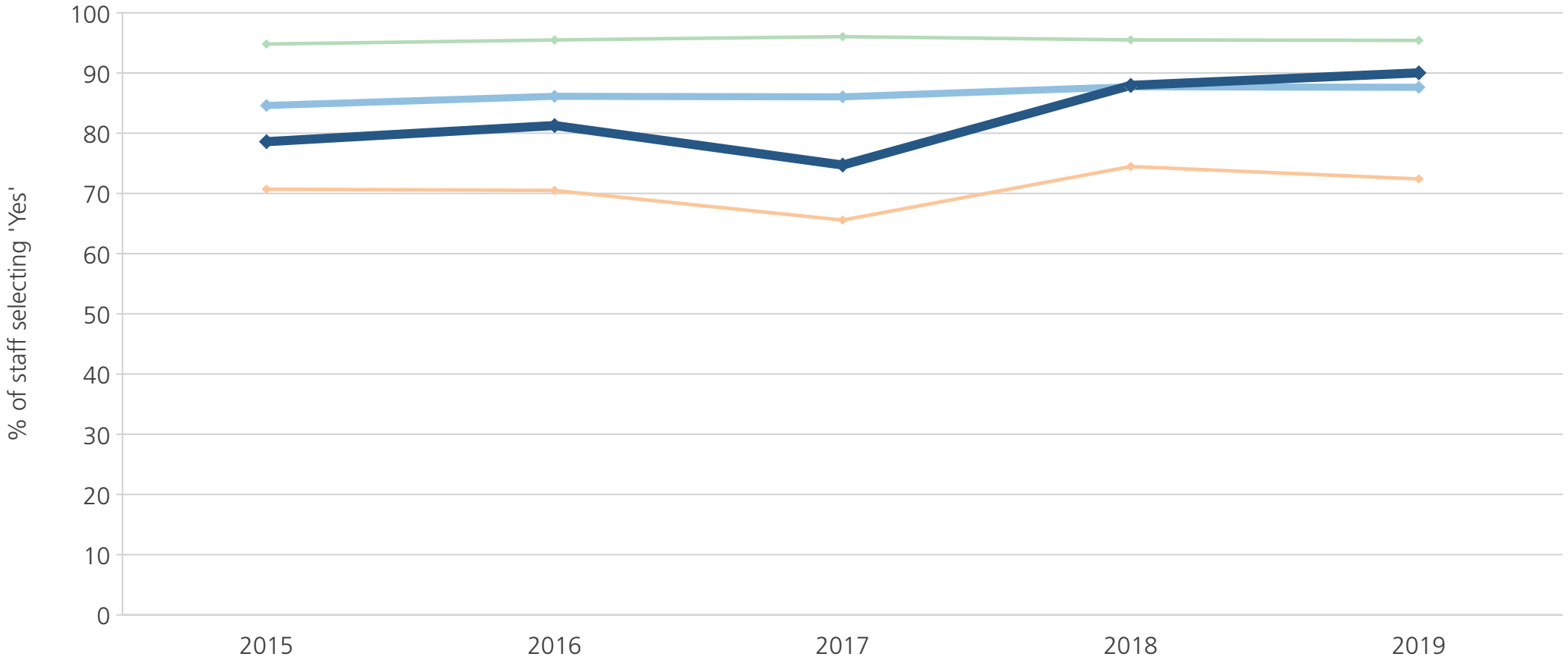
Survey Coordination Centre

NHS England

Question results – Your personal development

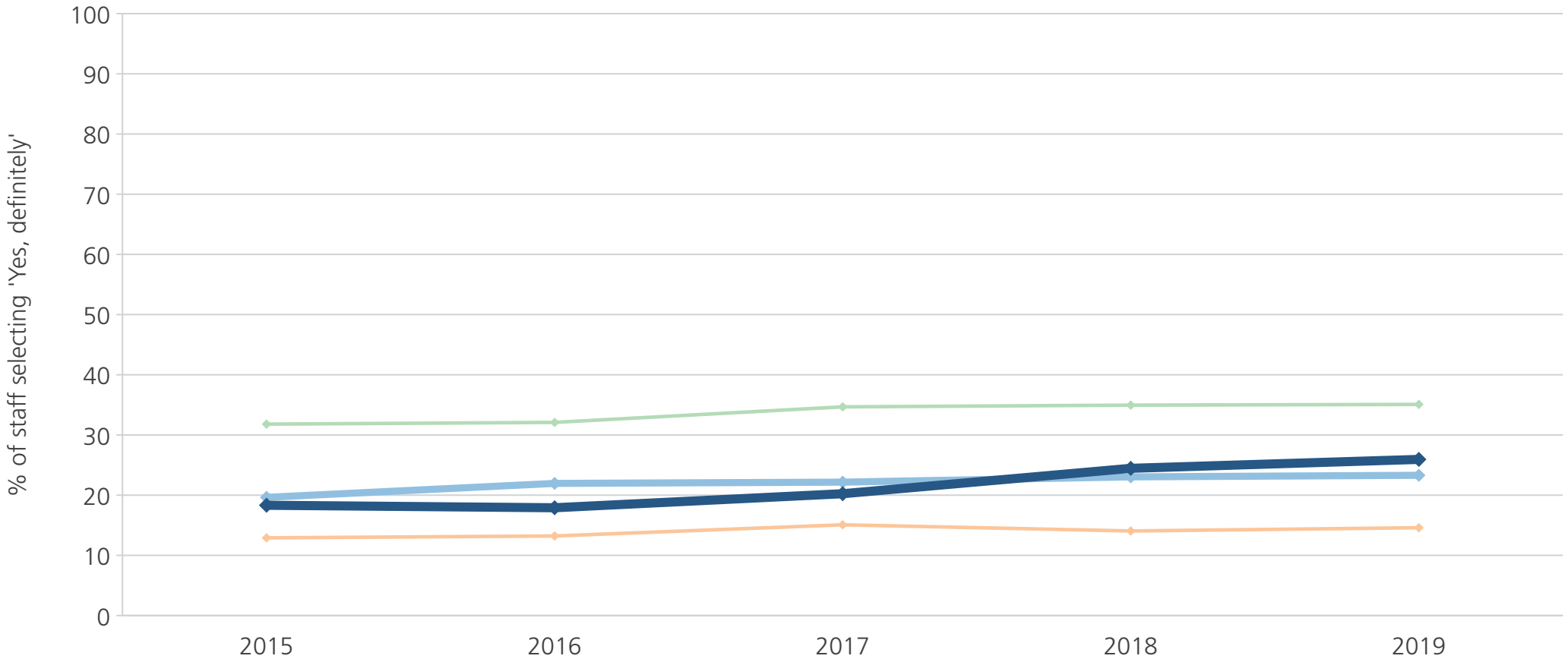
West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results



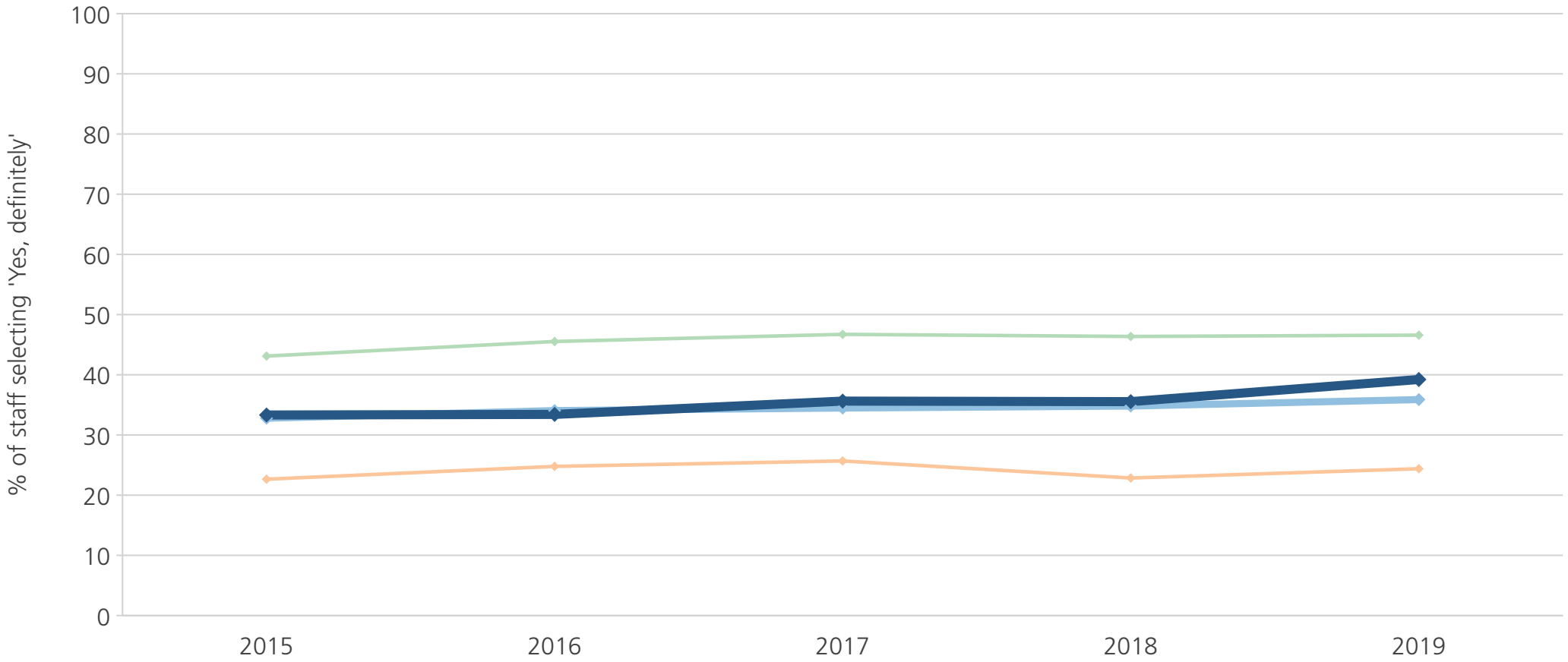
	2015	2016	2017	2018	2019
Best	94.8%	95.5%	96.0%	95.5%	95.4%
Your org	78.6%	81.3%	74.7%	87.9%	90.0%
Average	84.6%	86.1%	86.0%	87.7%	87.6%
Worst	70.7%	70.5%	65.6%	74.5%	72.4%
Responses	441	596	577	570	1,975

This question was only answered by staff who selected 'Yes' on q19a.



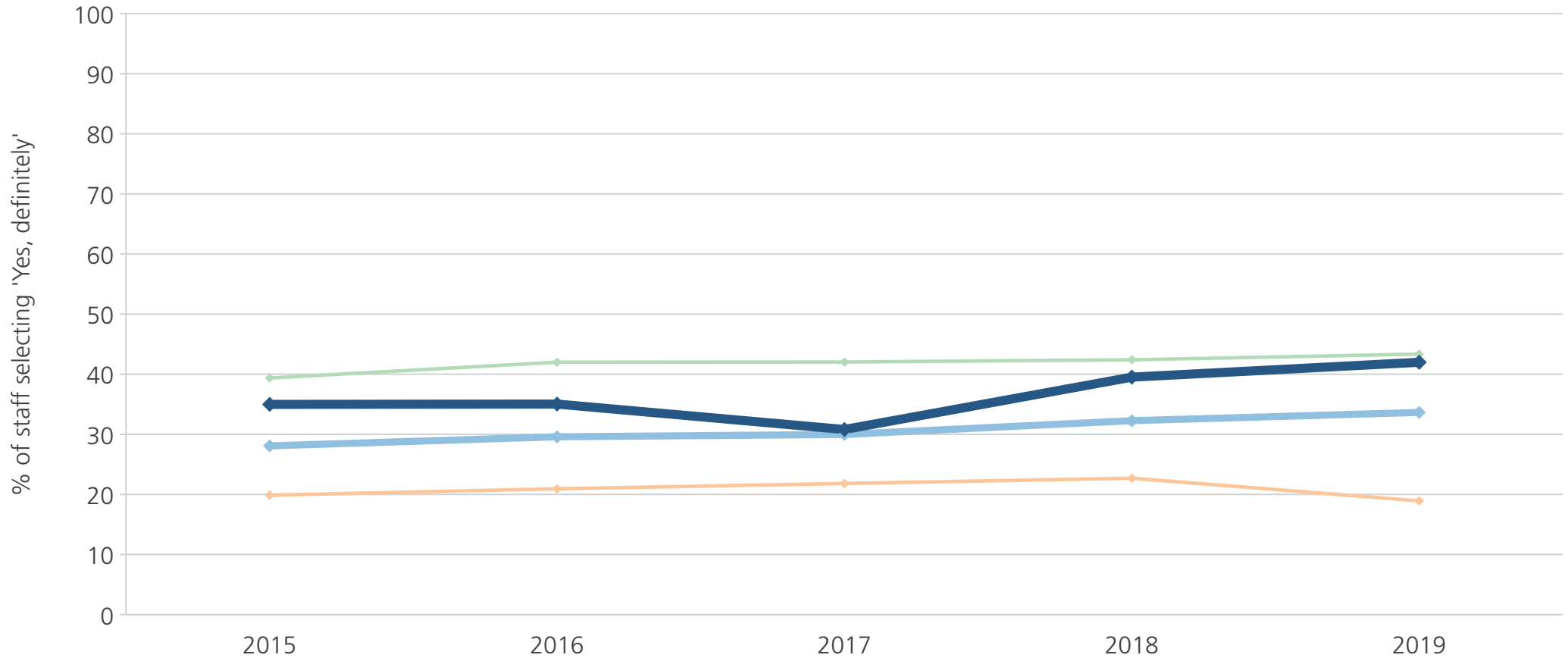
	2015	2016	2017	2018	2019
Best	31.8%	32.1%	34.7%	35.0%	35.1%
Your org	18.3%	17.9%	20.2%	24.5%	25.9%
Average	19.6%	22.0%	22.2%	23.0%	23.3%
Worst	12.9%	13.2%	15.1%	14.1%	14.6%
Responses	341	480	432	496	1,782

This question was only answered by staff who selected 'Yes' on q19a.



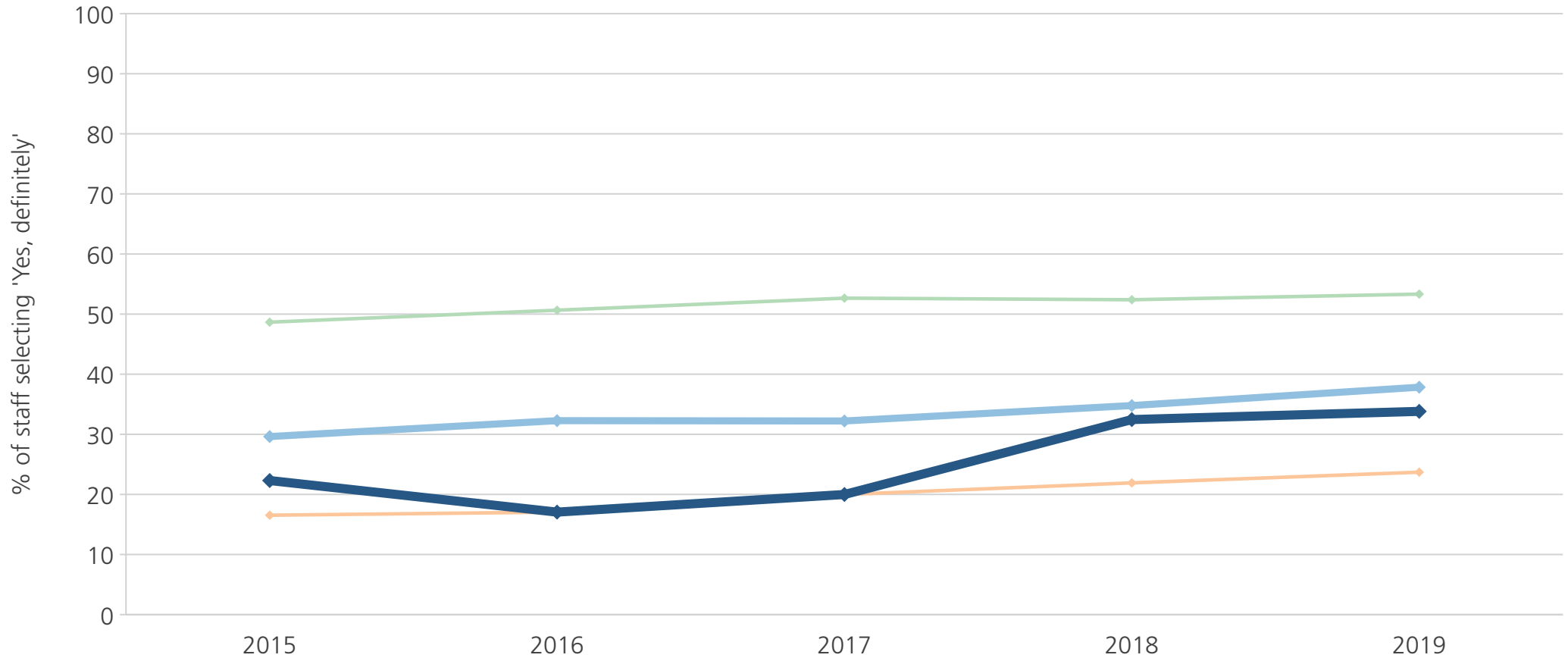
	2015	2016	2017	2018	2019
Best	43.1%	45.5%	46.7%	46.4%	46.6%
Your org	33.3%	33.4%	35.6%	35.5%	39.2%
Average	32.8%	34.1%	34.5%	34.8%	35.9%
Worst	22.6%	24.8%	25.7%	22.8%	24.4%
Responses	336	475	433	494	1,780

This question was only answered by staff who selected 'Yes' on q19a.



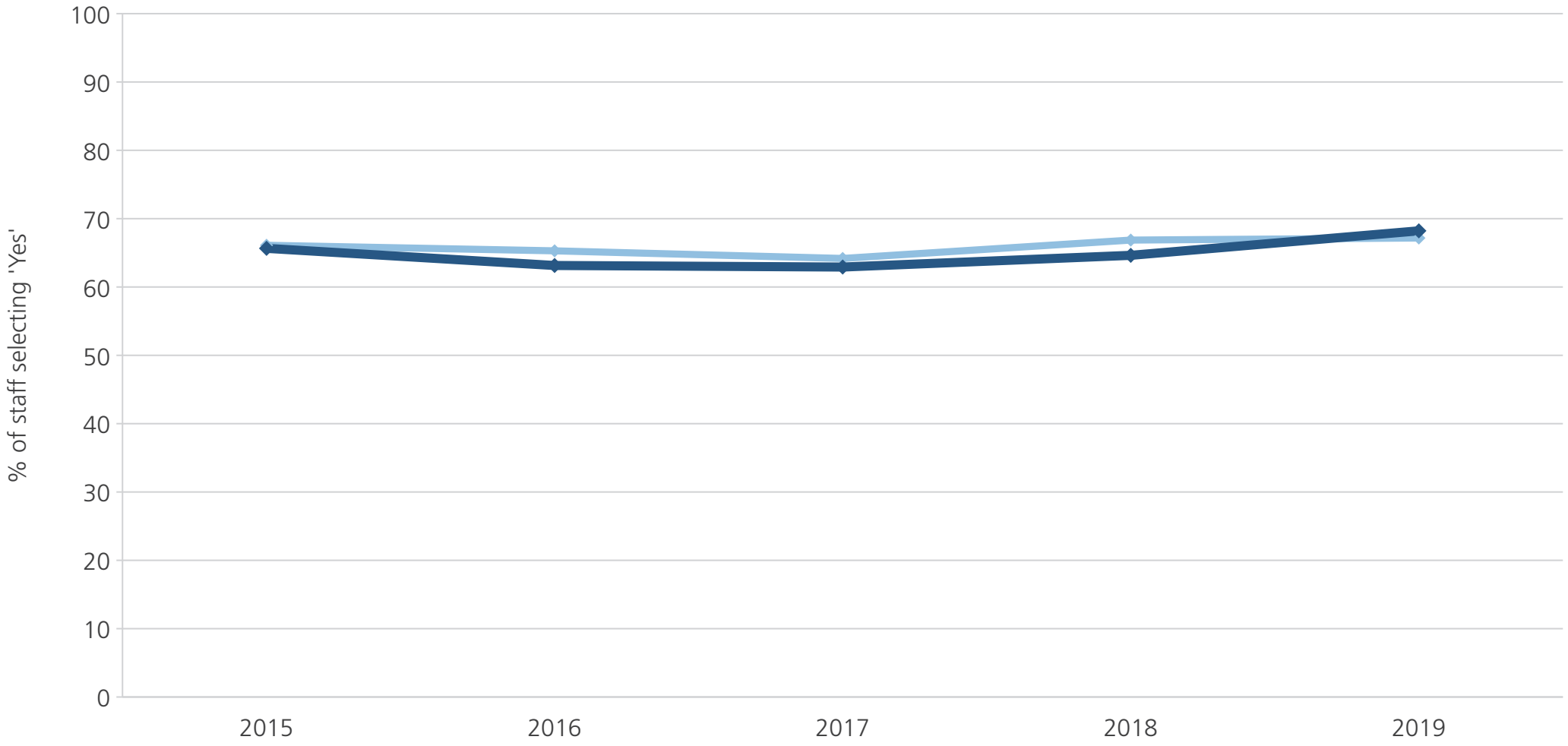
	2015	2016	2017	2018	2019
Best	39.4%	42.0%	42.0%	42.4%	43.3%
Your org	35.0%	35.0%	30.8%	39.5%	42.0%
Average	28.1%	29.6%	30.0%	32.3%	33.6%
Worst	19.9%	20.9%	21.8%	22.7%	18.9%
Responses	338	478	433	495	1,780

This question was only answered by staff who selected 'Yes' on q19a.



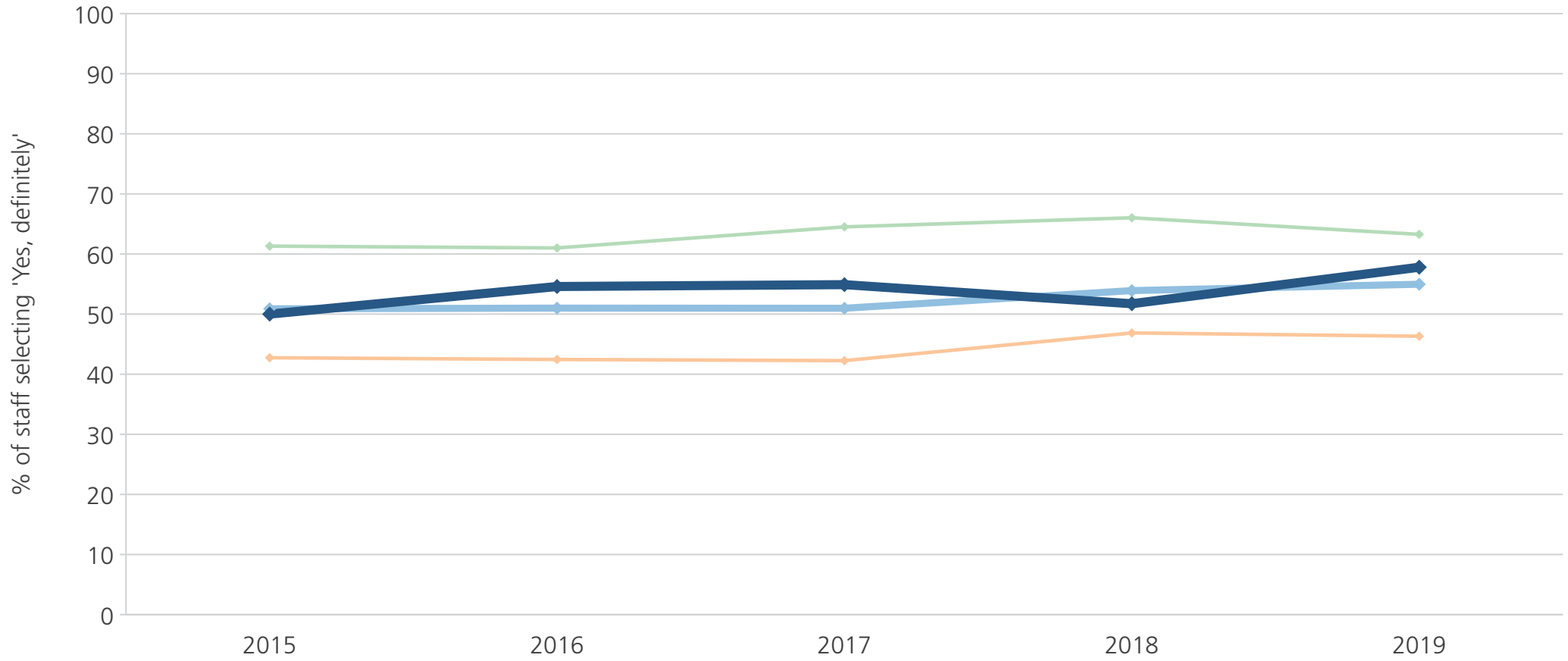
	2015	2016	2017	2018	2019
Best	48.7%	50.7%	52.7%	52.4%	53.3%
Your org	22.3%	17.1%	20.0%	32.5%	33.8%
Average	29.6%	32.3%	32.2%	34.8%	37.8%
Worst	16.5%	17.1%	20.0%	21.9%	23.7%
Responses	333	473	426	484	1,774

This question was only answered by staff who selected 'Yes' on q19a.

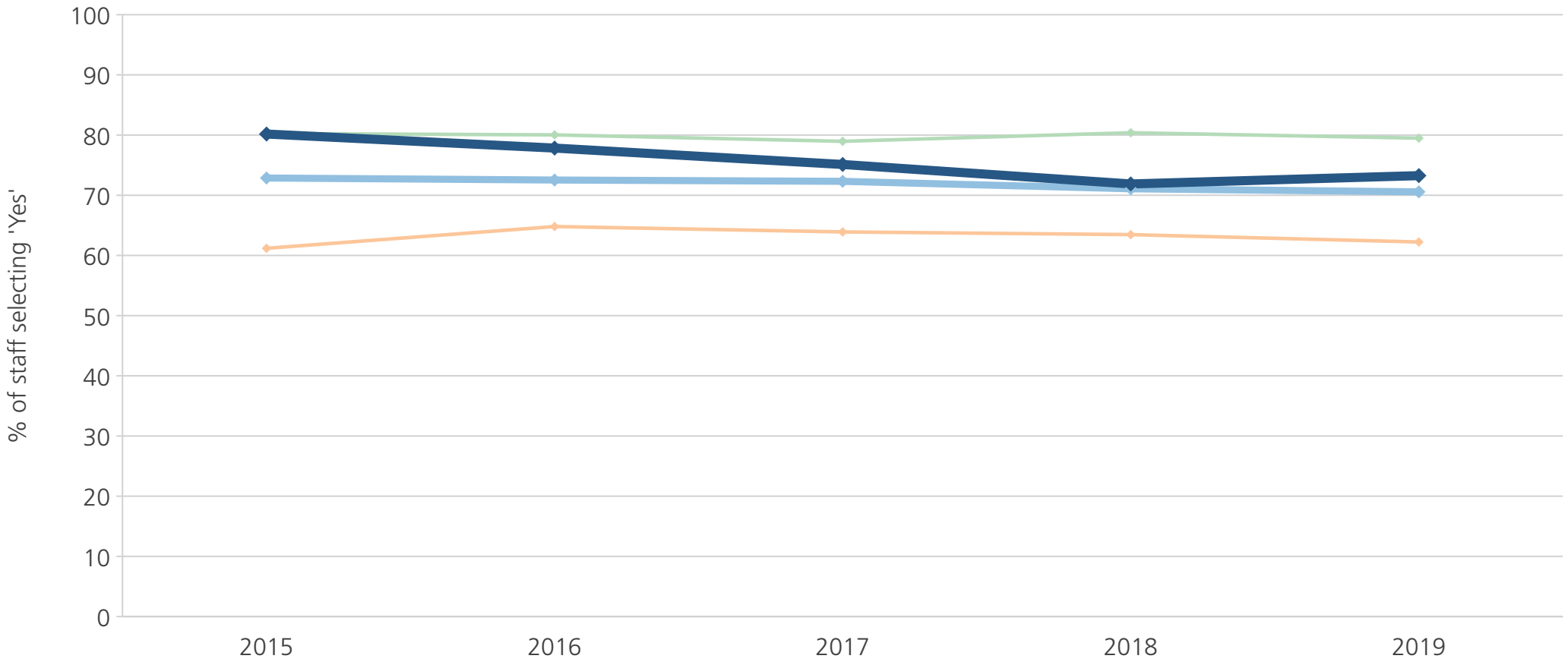


	2015	2016	2017	2018	2019
Your org	65.7%	63.1%	62.9%	64.6%	68.2%
Average	66.1%	65.3%	64.2%	66.9%	67.2%
Responses	329	464	418	475	1,762

This question was only answered by staff who selected 'Yes' on q19f.



	2015	2016	2017	2018	2019
Best	61.3%	61.0%	64.5%	66.0%	63.3%
Your org	50.0%	54.6%	54.9%	51.7%	57.8%
Average	50.9%	51.0%	51.0%	53.9%	55.0%
Worst	42.7%	42.5%	42.3%	46.9%	46.3%
Responses	212	282	260	288	1,184



	2015	2016	2017	2018	2019
Best	80.3%	80.0%	79.0%	80.4%	79.5%
Your org	80.2%	77.8%	75.1%	71.9%	73.3%
Average	72.9%	72.5%	72.3%	71.1%	70.6%
Worst	61.2%	64.8%	63.9%	63.5%	62.2%
Responses	442	597	582	554	1,961

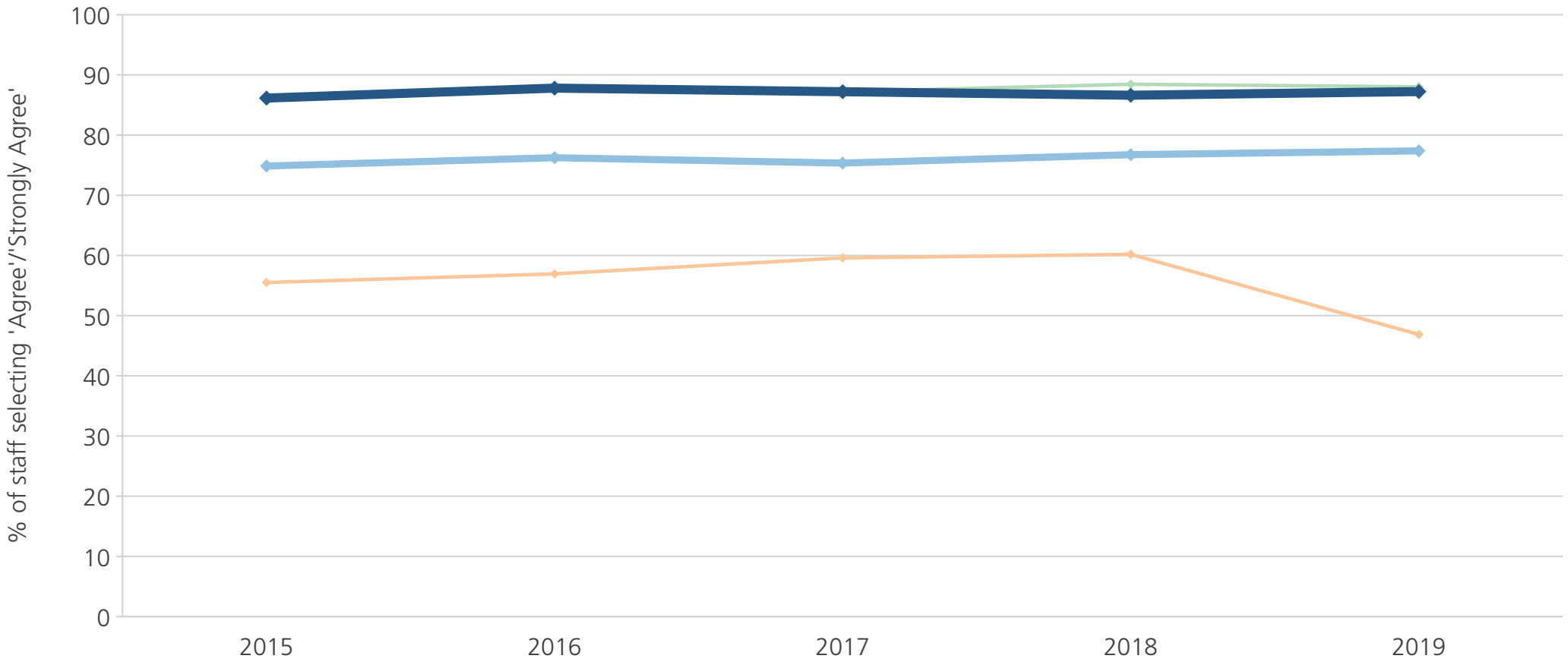
Survey Coordination Centre

NHS England

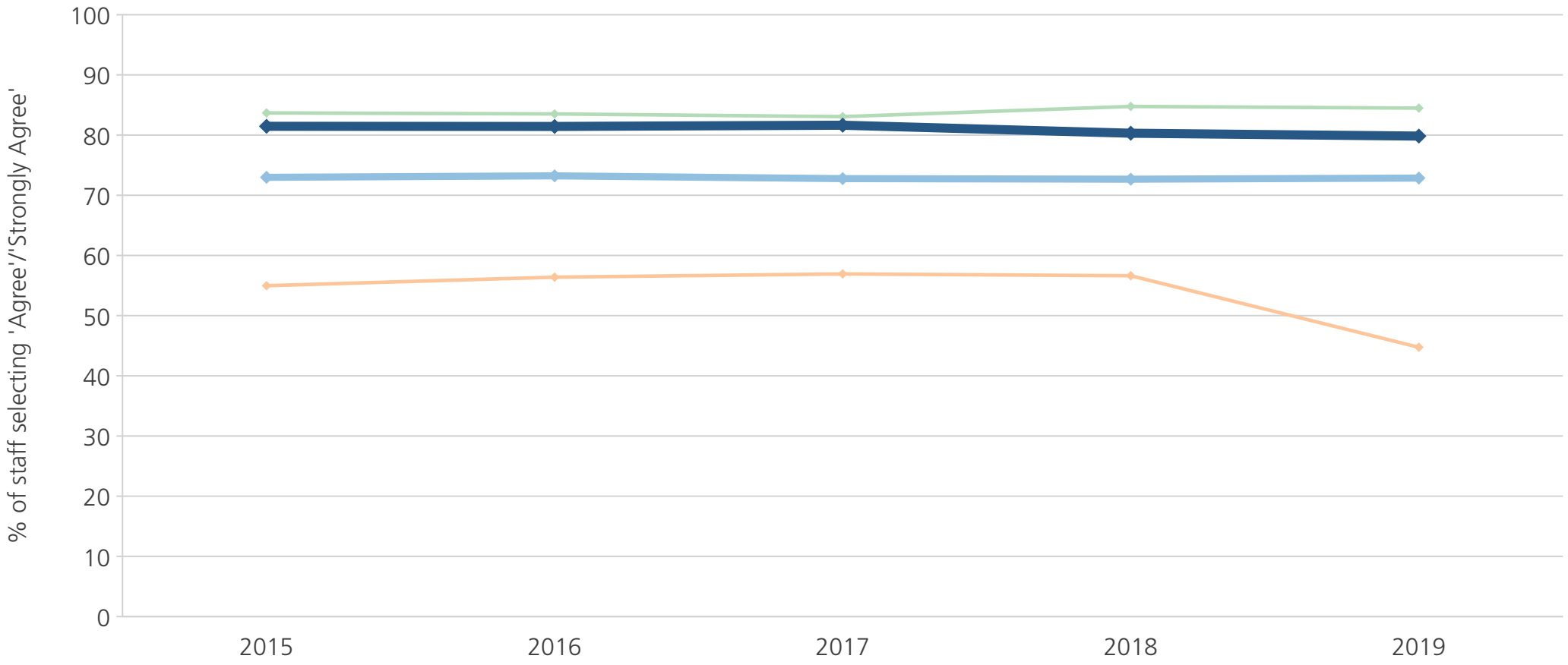
Question results – Your organisation

West Suffolk NHS Foundation Trust

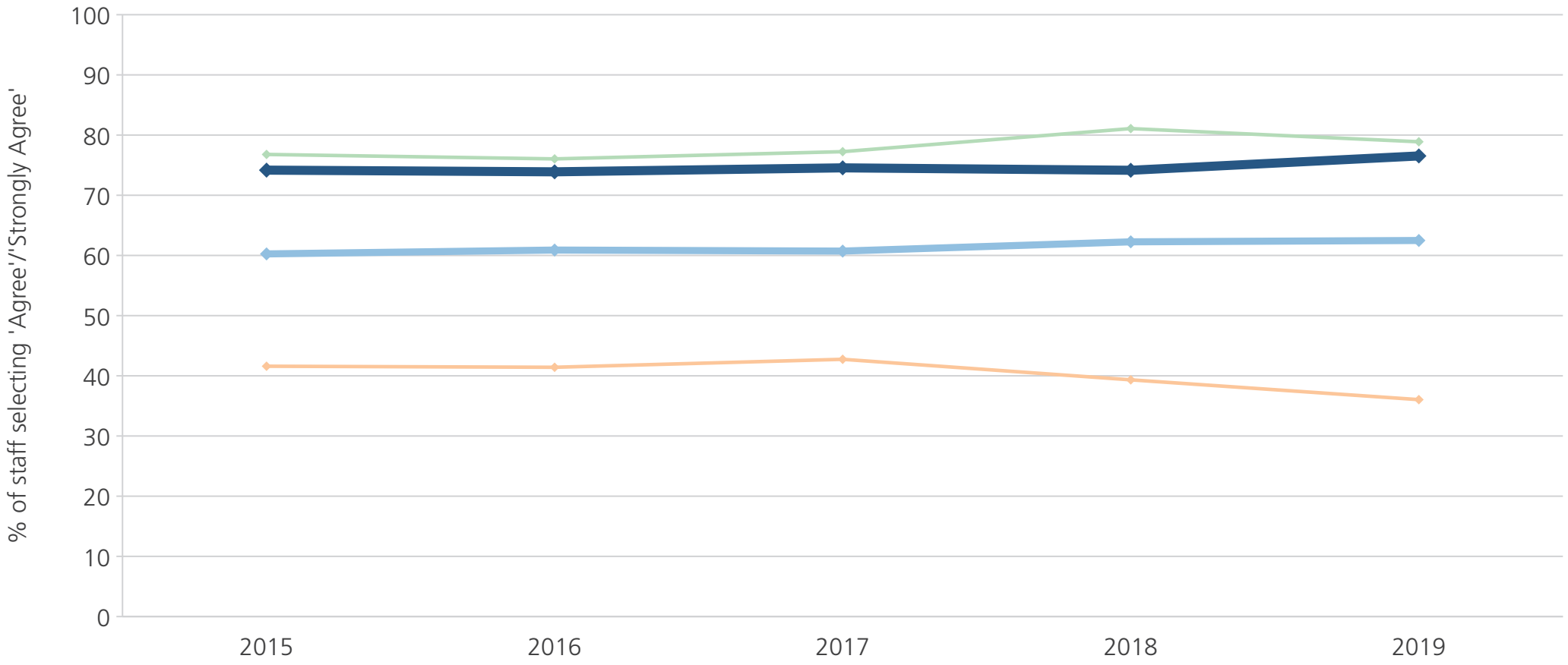
2019 NHS Staff Survey Results



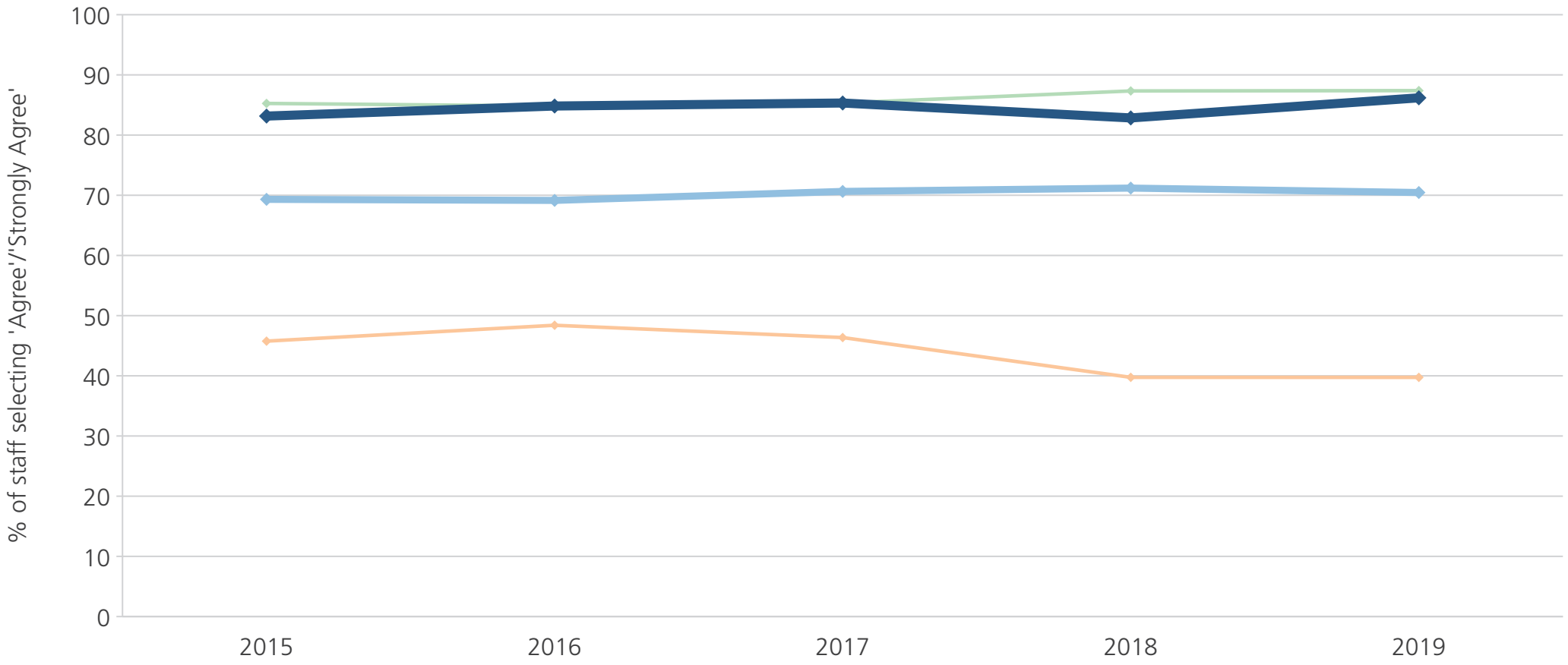
	2015	2016	2017	2018	2019
Best	86.1%	87.8%	87.2%	88.4%	88.0%
Your org	86.1%	87.8%	87.2%	86.6%	87.2%
Average	74.9%	76.2%	75.3%	76.7%	77.4%
Worst	55.5%	56.9%	59.6%	60.2%	46.9%
Responses	454	609	590	576	2,008



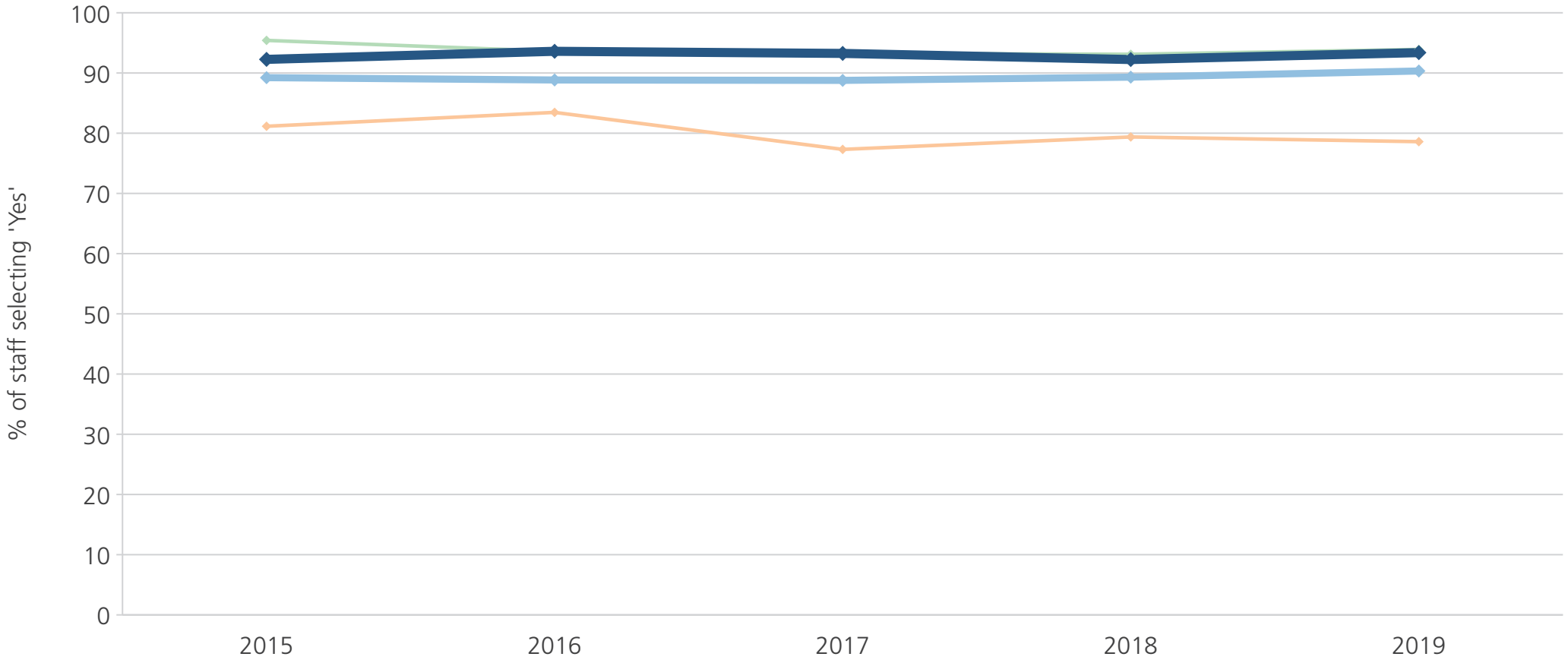
	2015	2016	2017	2018	2019
Best	83.7%	83.5%	83.1%	84.8%	84.5%
Your org	81.5%	81.4%	81.6%	80.3%	79.8%
Average	73.0%	73.2%	72.8%	72.7%	72.9%
Worst	55.0%	56.4%	56.9%	56.6%	44.7%
Responses	454	603	589	574	2,003



	2015	2016	2017	2018	2019
Best	76.8%	76.0%	77.2%	81.1%	78.9%
Your org	74.2%	73.9%	74.6%	74.1%	76.5%
Average	60.3%	60.9%	60.7%	62.3%	62.5%
Worst	41.6%	41.4%	42.7%	39.3%	36.0%
Responses	455	607	590	573	2,001

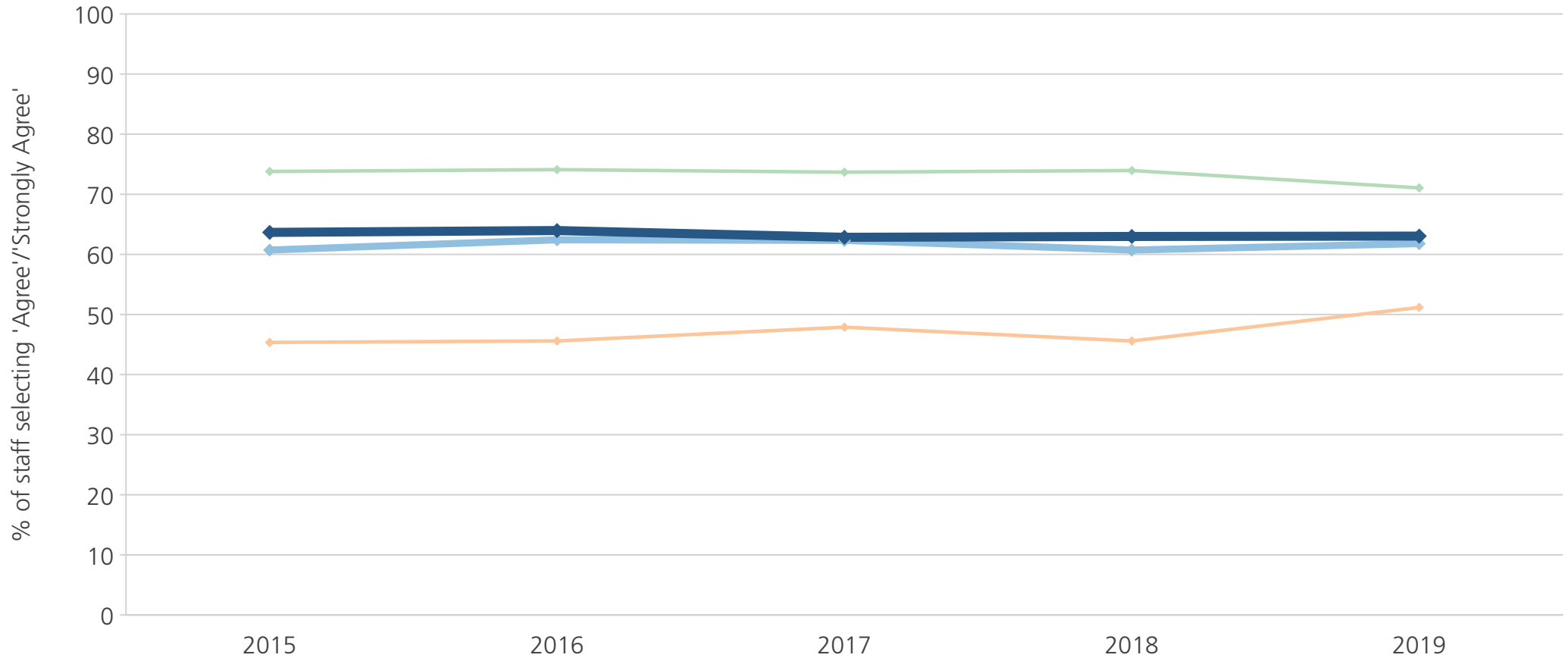


	2015	2016	2017	2018	2019
Best	85.3%	84.8%	85.3%	87.3%	87.4%
Your org	83.2%	84.8%	85.3%	82.8%	86.2%
Average	69.3%	69.1%	70.6%	71.2%	70.5%
Worst	45.8%	48.4%	46.4%	39.7%	39.7%
Responses	455	604	588	576	2,006



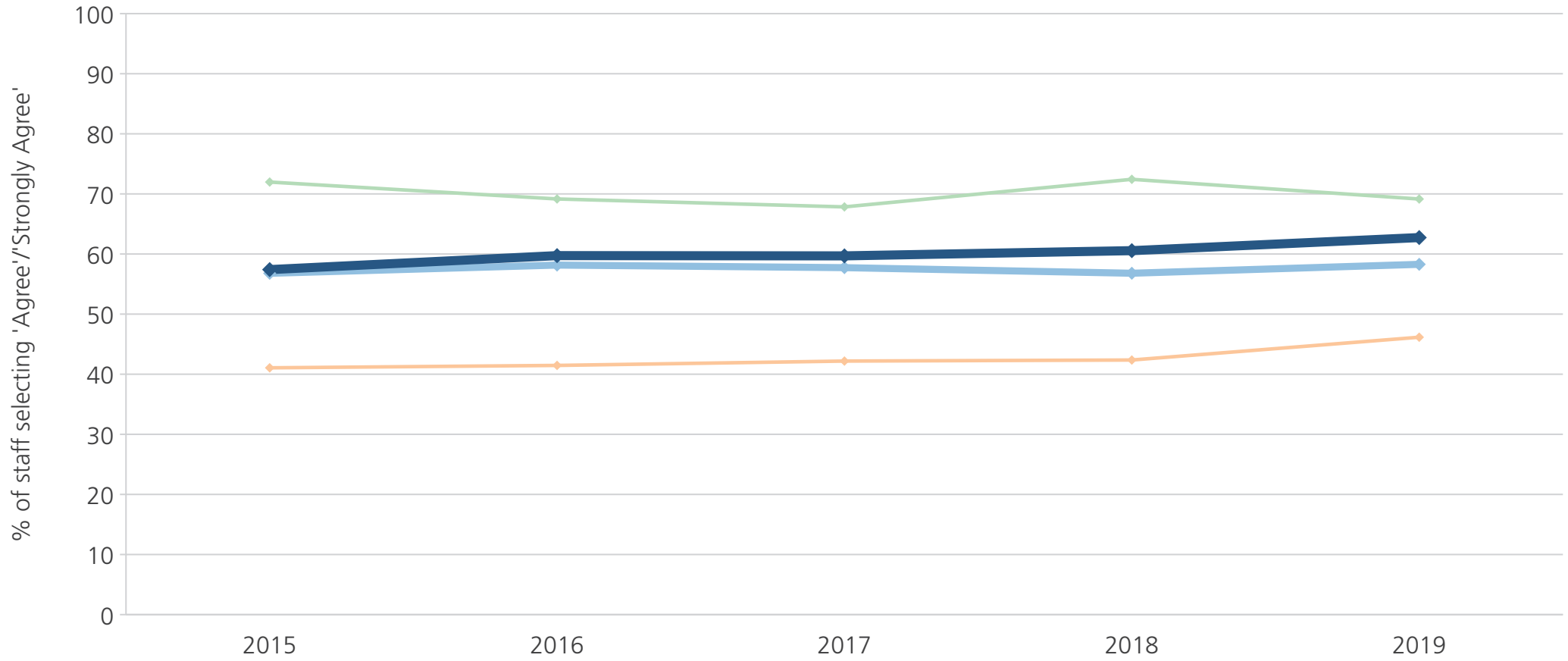
	2015	2016	2017	2018	2019
Best	95.4%	93.6%	93.3%	93.1%	93.9%
Your org	92.3%	93.6%	93.3%	92.2%	93.4%
Average	89.2%	88.8%	88.8%	89.3%	90.3%
Worst	81.2%	83.5%	77.3%	79.4%	78.6%
Responses	328	430	413	398	1,384

This question was only answered by staff who selected 'Yes' on q22a.

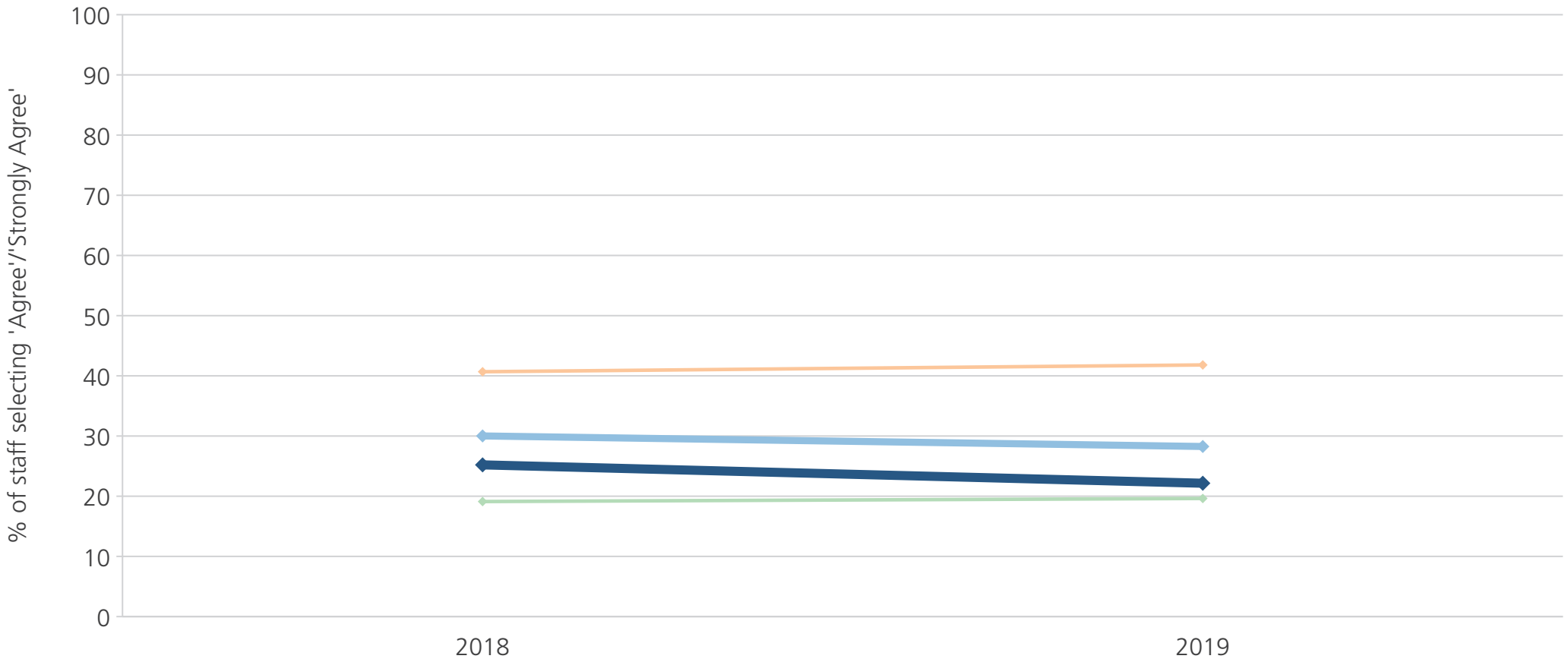


	2015	2016	2017	2018	2019
Best	73.8%	74.1%	73.7%	74.0%	71.1%
Your org	63.7%	64.0%	62.8%	63.0%	63.0%
Average	60.7%	62.4%	62.3%	60.7%	61.8%
Worst	45.4%	45.6%	47.9%	45.6%	51.2%
Responses	289	380	368	353	1,225

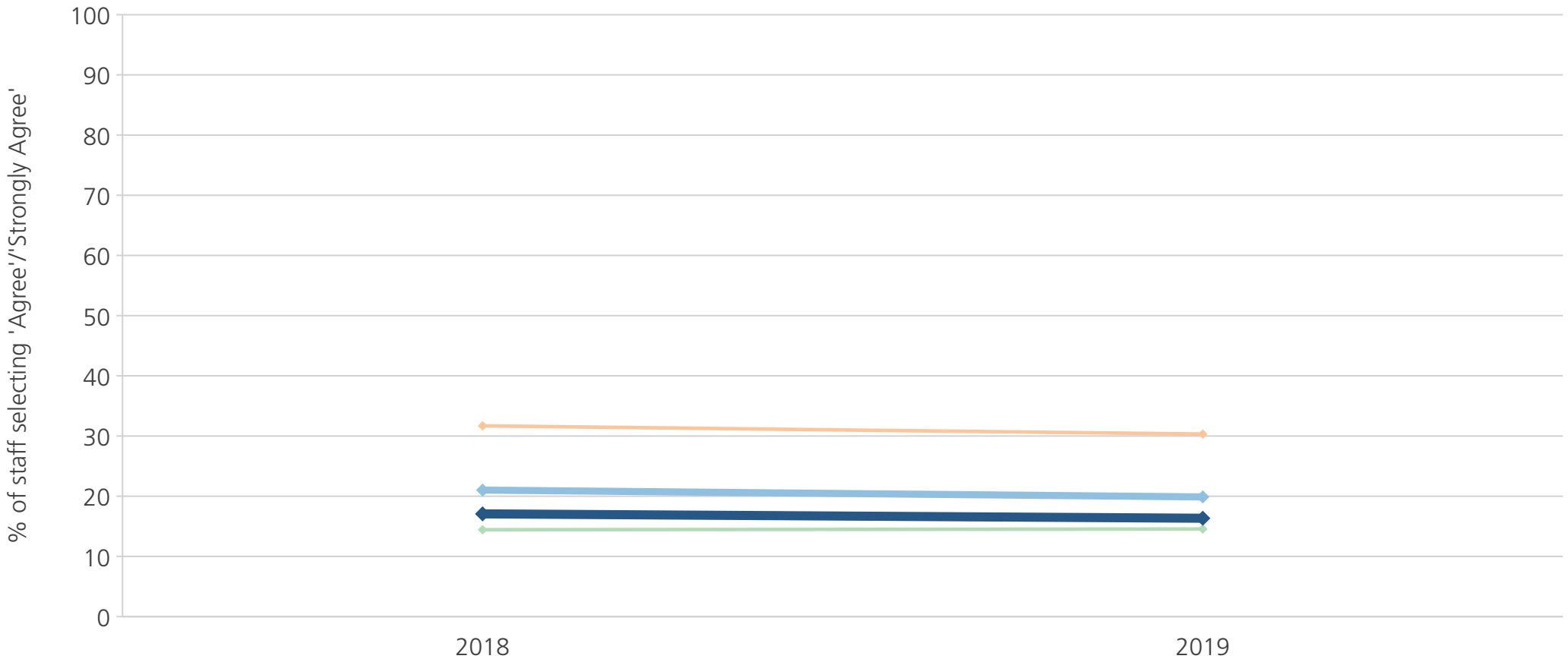
This question was only answered by staff who selected 'Yes' on q22a.



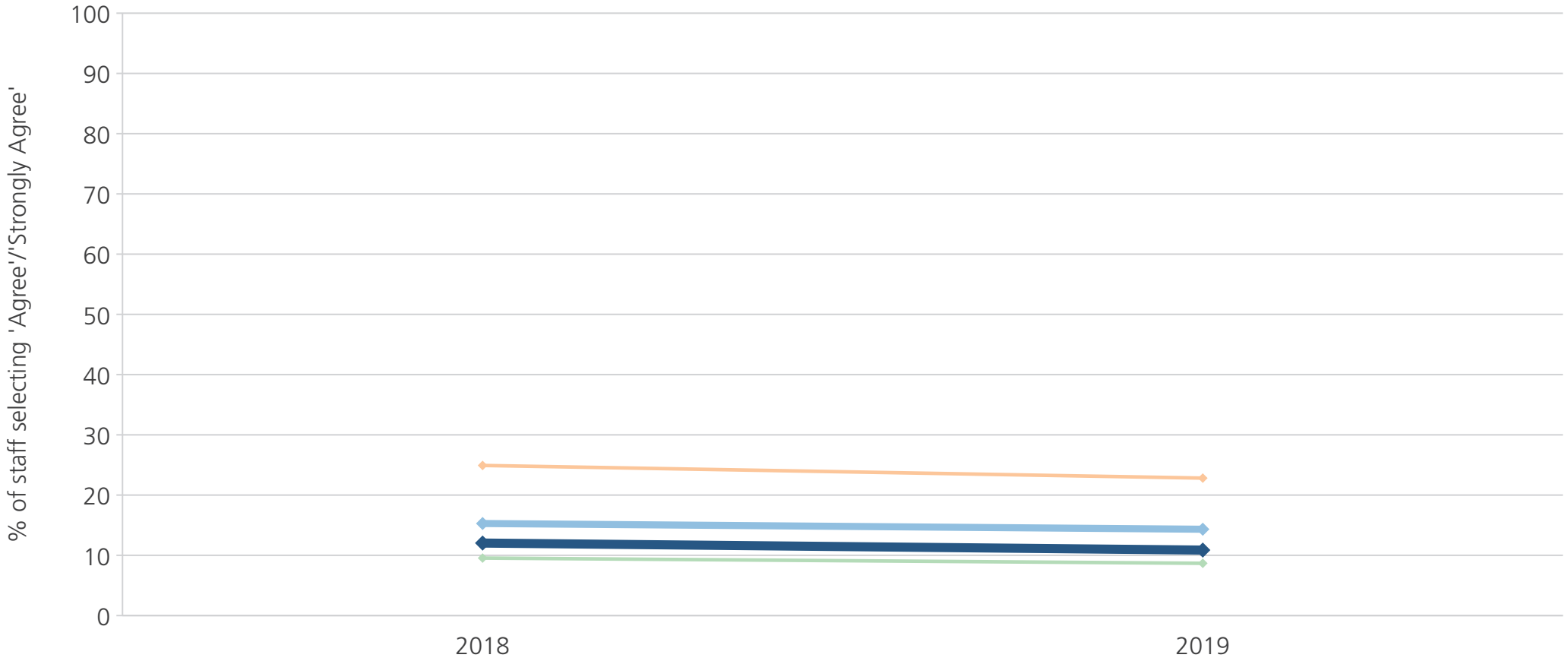
	2015	2016	2017	2018	2019
Best	72.0%	69.2%	67.8%	72.4%	69.1%
Your org	57.4%	59.7%	59.7%	60.6%	62.7%
Average	56.8%	58.2%	57.7%	56.8%	58.3%
Worst	41.1%	41.5%	42.2%	42.4%	46.2%
Responses	266	353	333	328	1,142



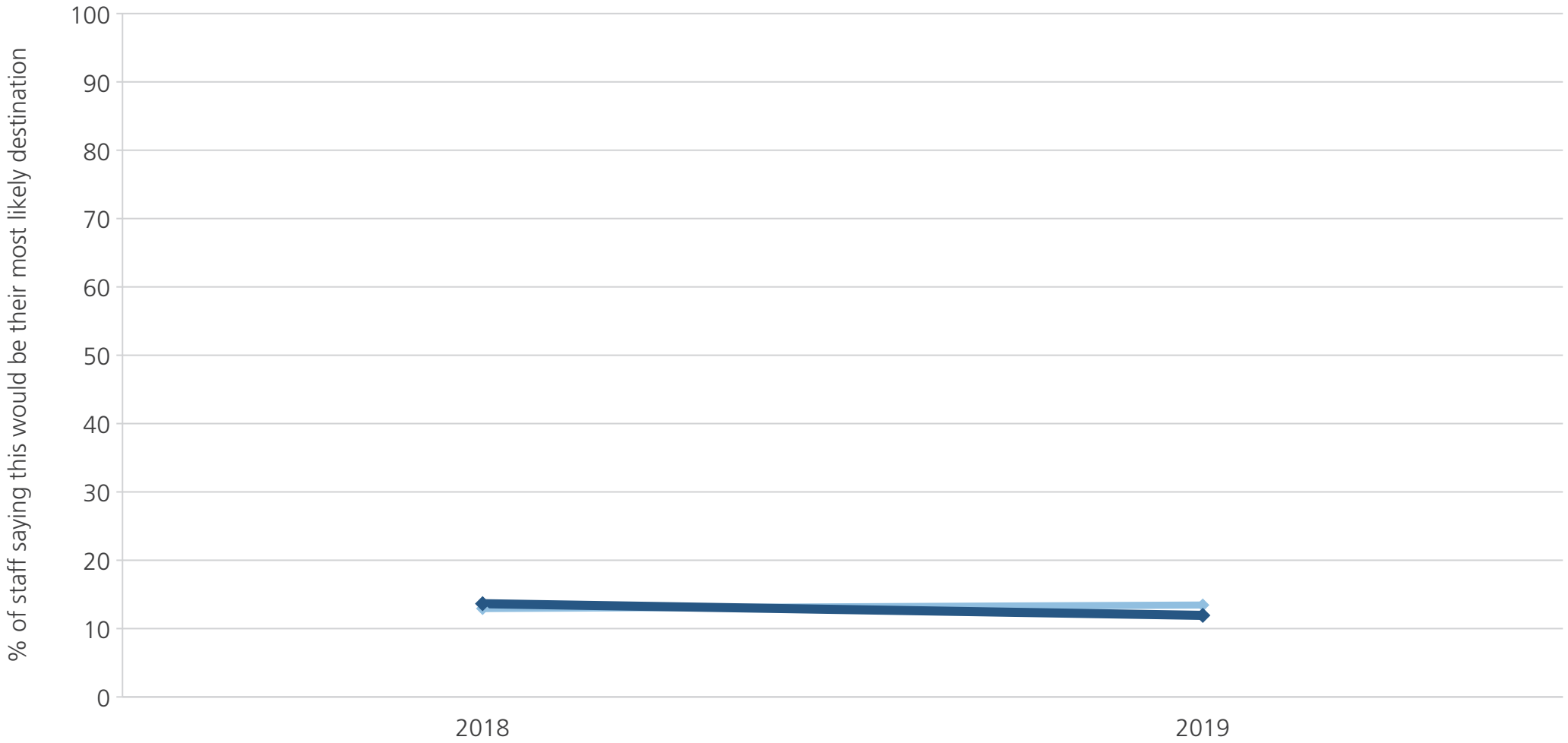
	2018	2019
Worst	40.7%	41.8%
Your org	25.2%	22.2%
Average	30.0%	28.3%
Best	19.1%	19.6%
Responses	570	2,012



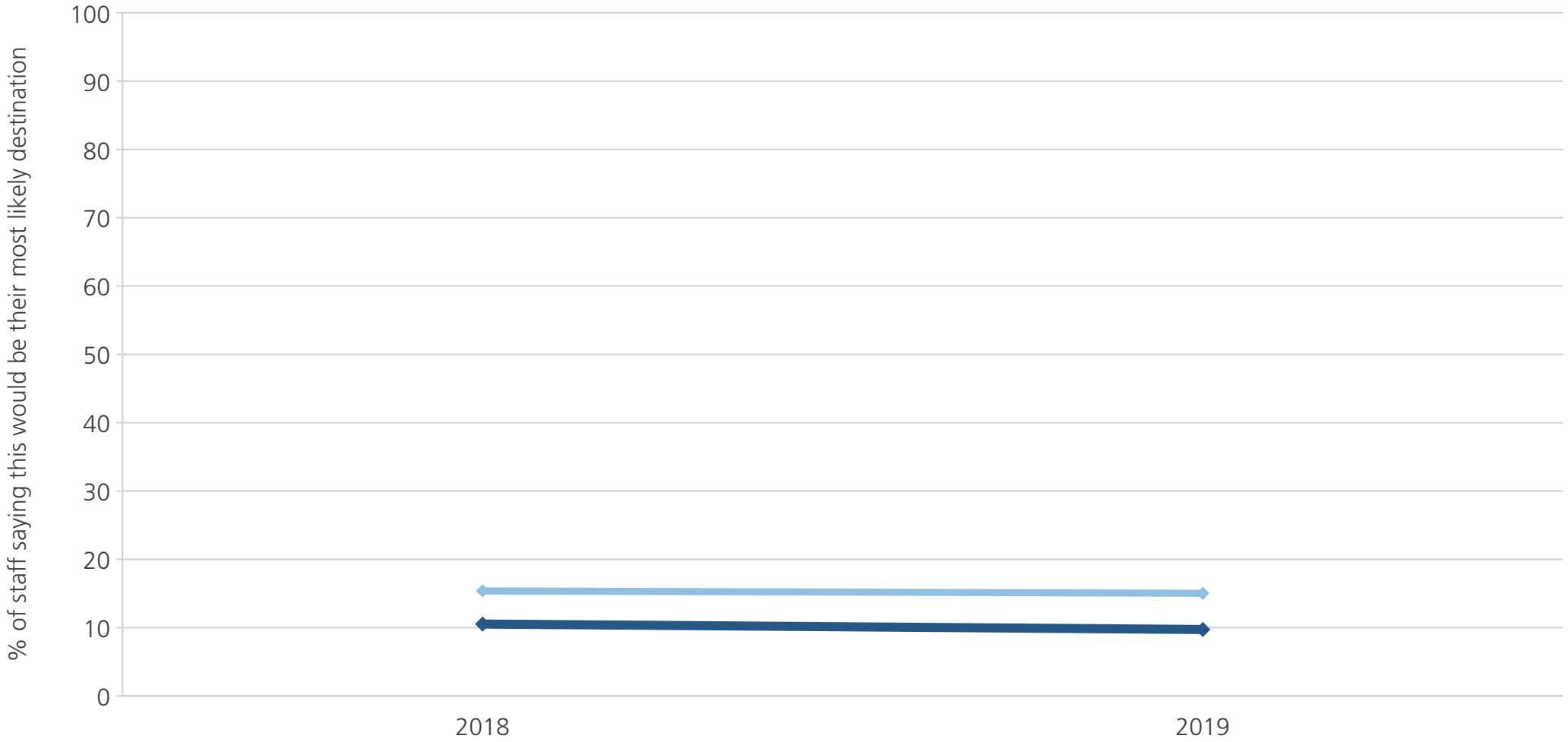
	2018	2019
Worst	31.7%	30.3%
Your org	17.1%	16.3%
Average	21.0%	19.9%
Best	14.4%	14.5%
Responses	568	2,010



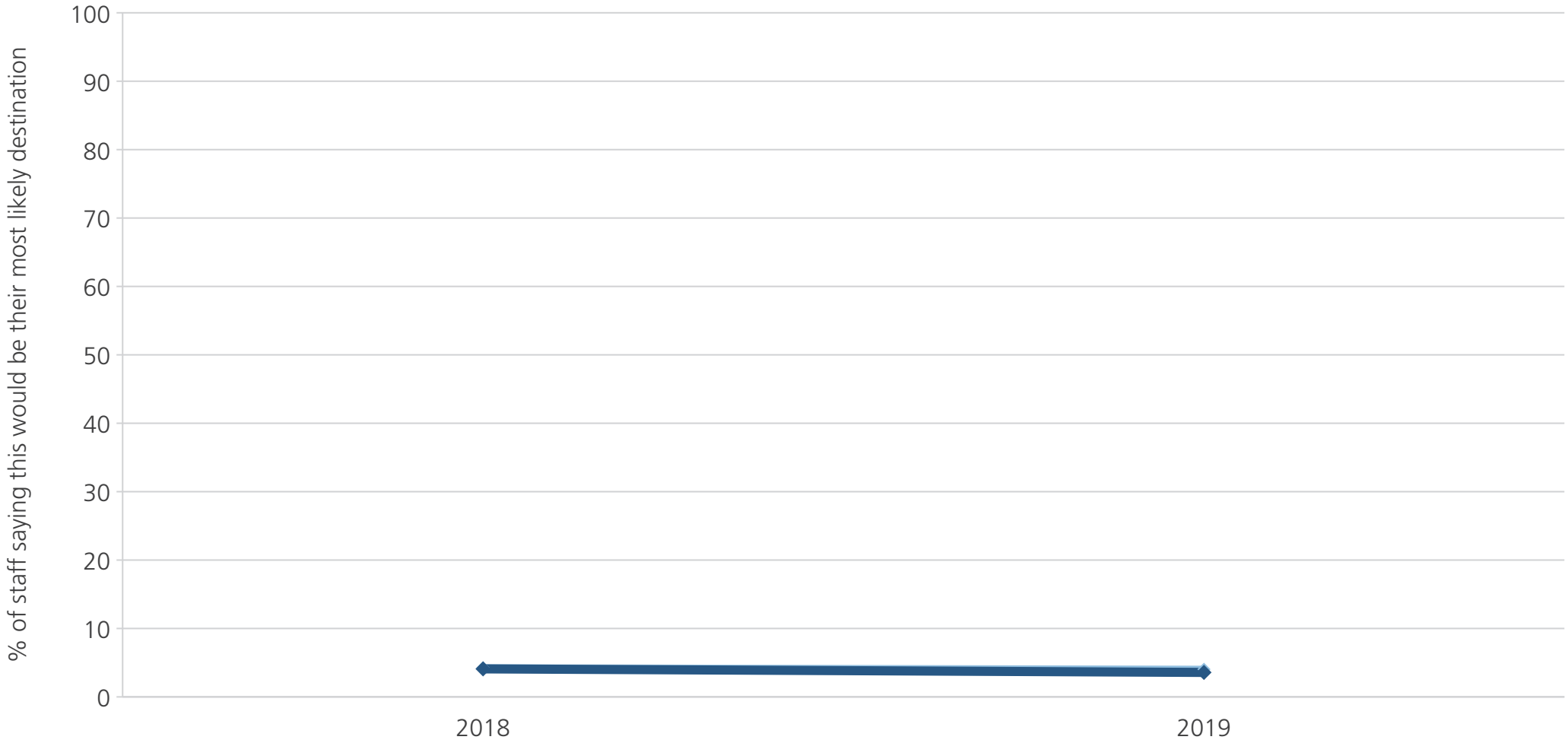
	2018	2019
Worst	24.9%	22.8%
Your org	12.0%	10.9%
Average	15.3%	14.3%
Best	9.5%	8.7%
Responses	555	2,007



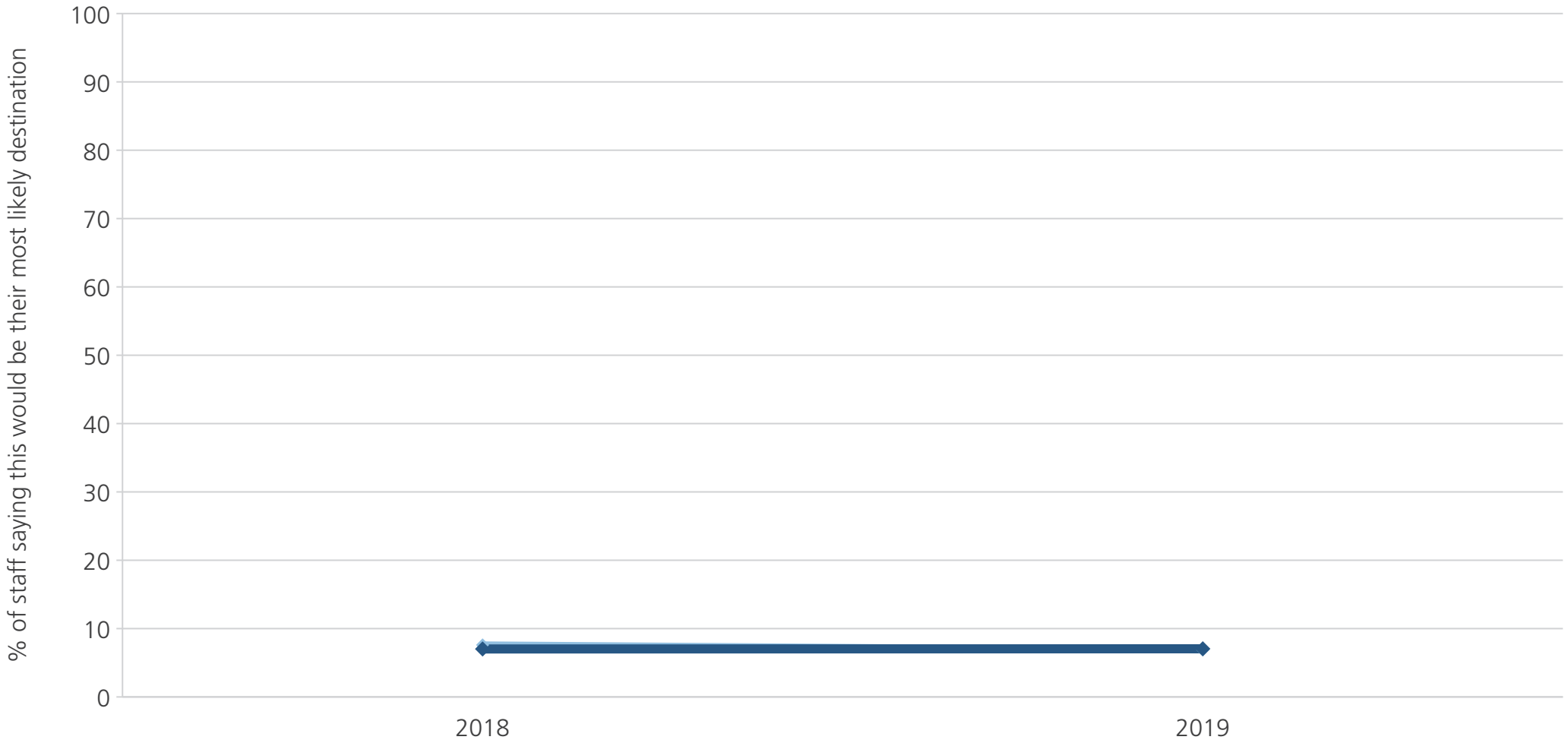
	2018	2019
Your org	13.6%	11.9%
Average	12.9%	13.4%
Responses	513	1,902



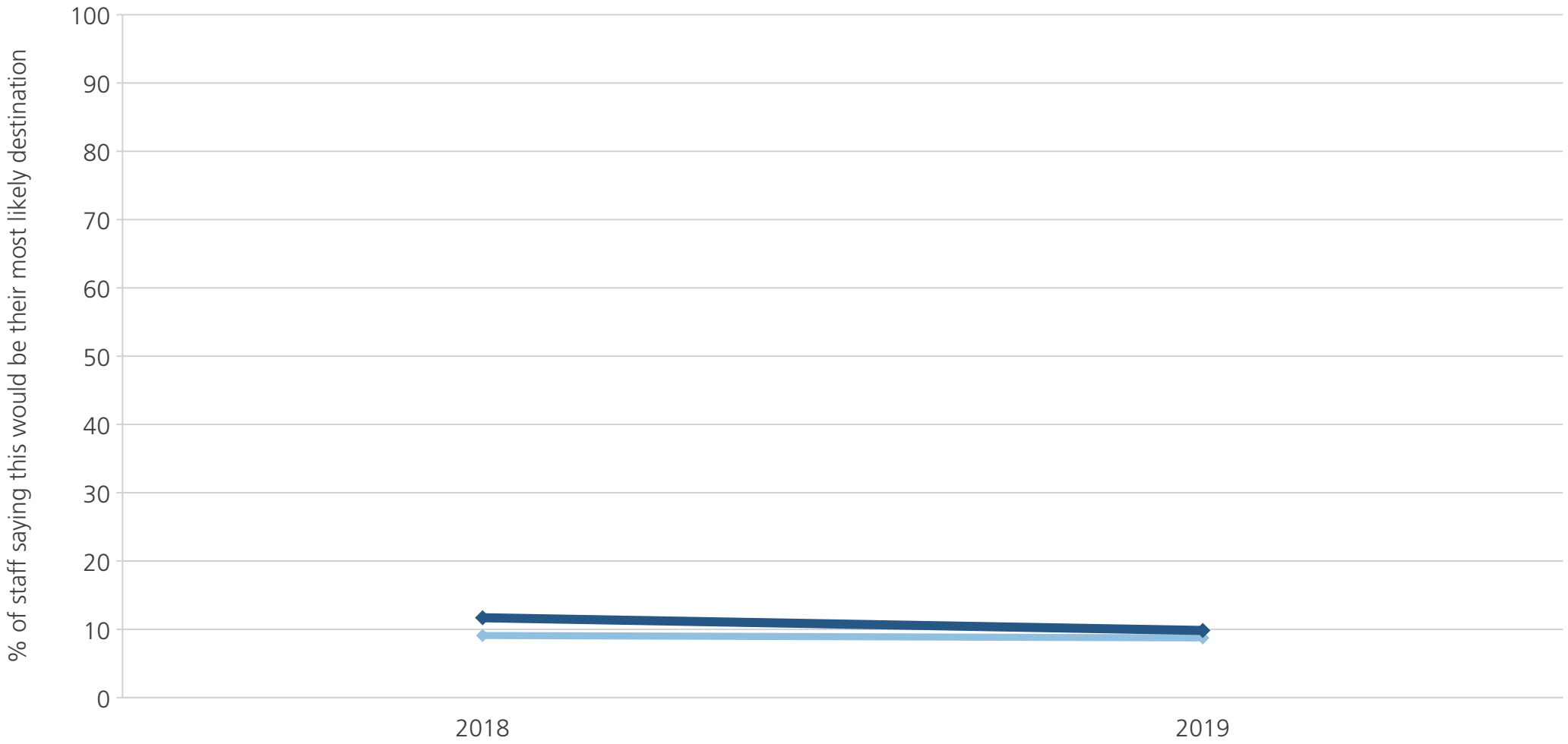
	2018	2019
Your org	10.5%	9.7%
Average	15.4%	15.0%
Responses	513	1,902



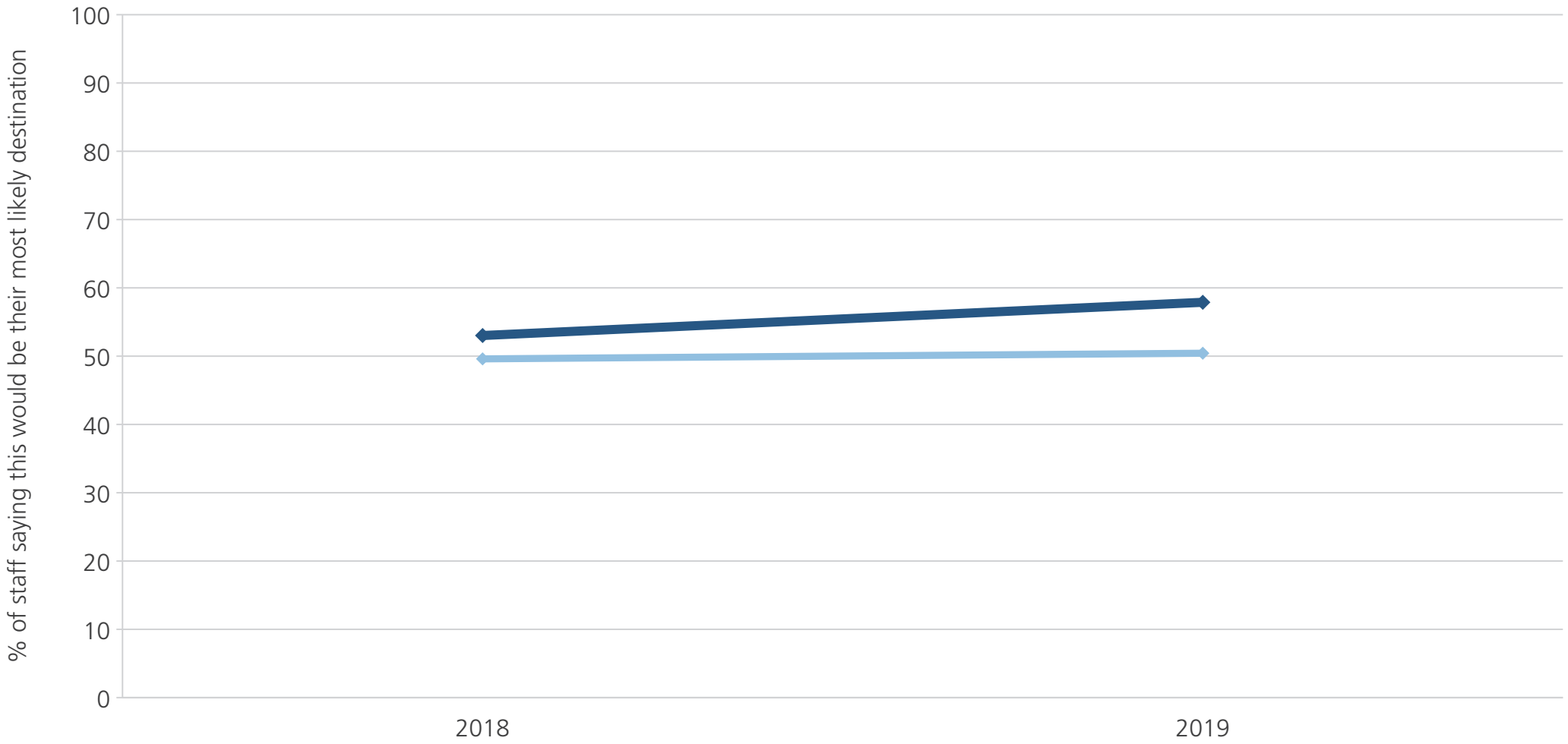
	2018	2019
Your org	4.1%	3.6%
Average	4.3%	4.0%
Responses	513	1,902



	2018	2019
Your org	7.0%	7.0%
Average	7.6%	6.9%
Responses	513	1,902



	2018	2019
Your org	11.7%	9.8%
Average	9.1%	8.7%
Responses	513	1,902



	2018	2019
Your org	53.0%	57.9%
Average	49.6%	50.4%
Responses	513	1,902

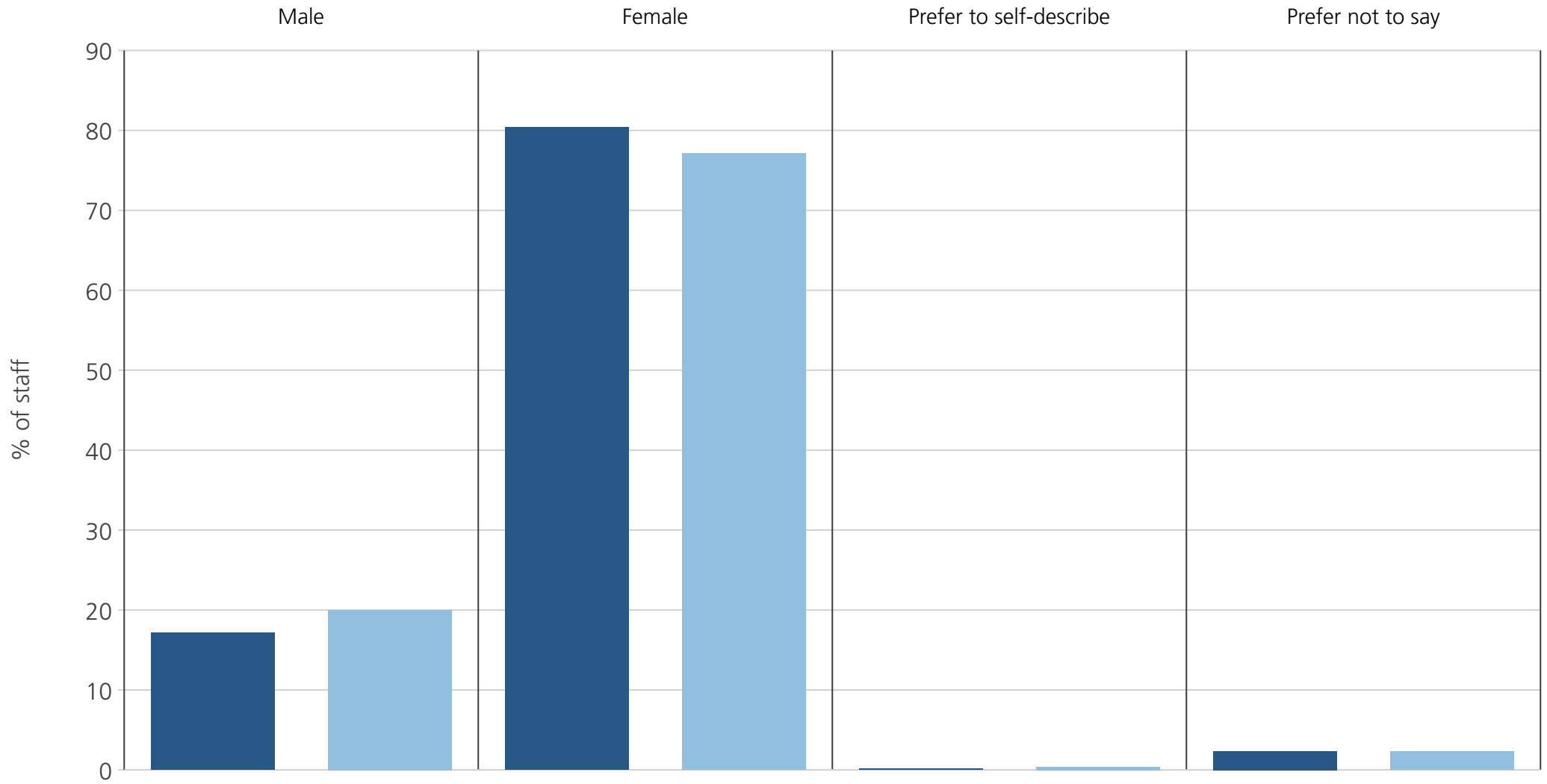
Survey Coordination Centre

NHS England

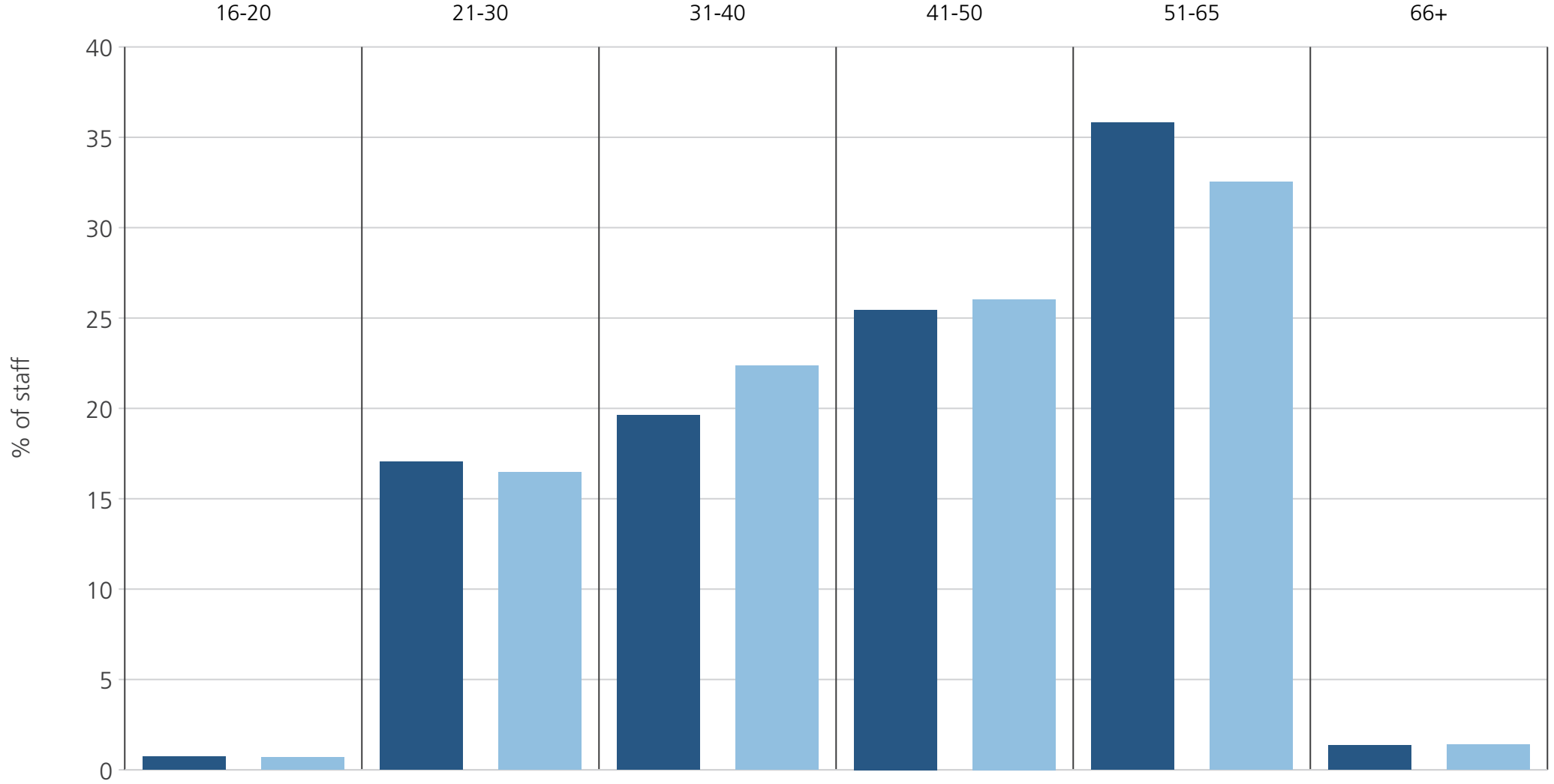
Question results – Background details

West Suffolk NHS Foundation Trust

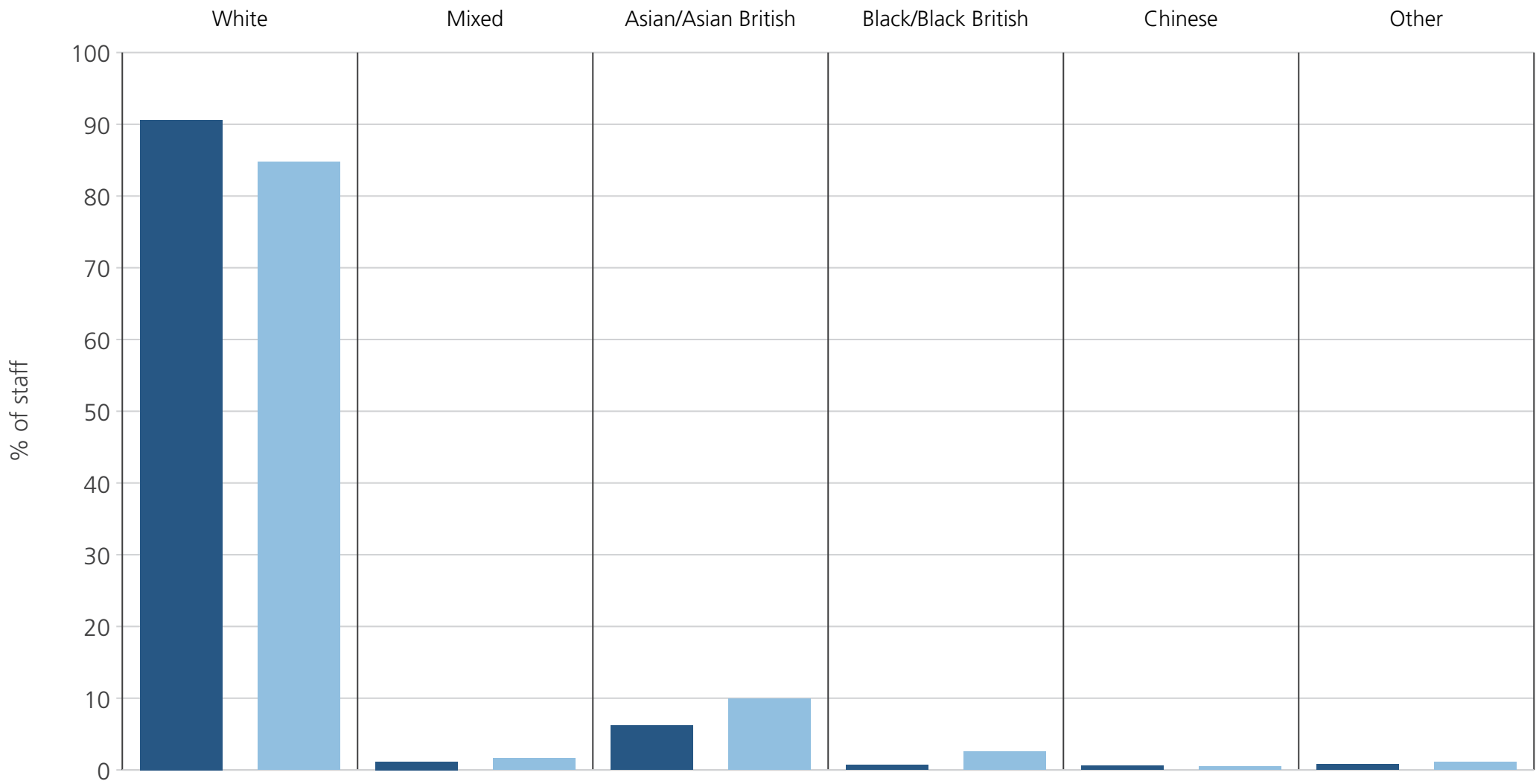
2019 NHS Staff Survey Results



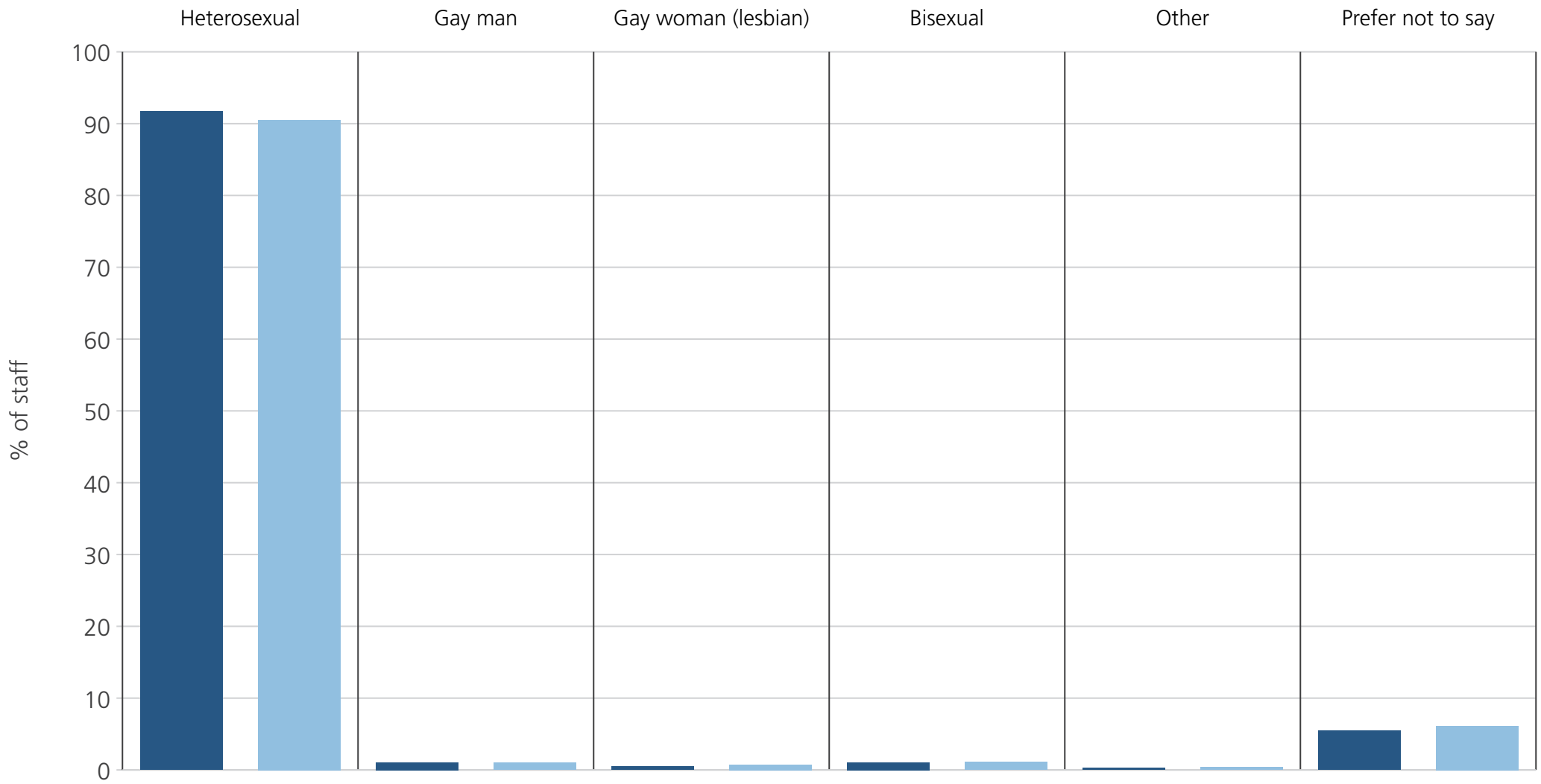
	Male	Female	Prefer to self-describe	Prefer not to say
Your org	17.1%	80.4%	0.1%	2.3%
Average	20.0%	77.1%	0.4%	2.3%
Responses	2,006	2,006	2,006	2,006



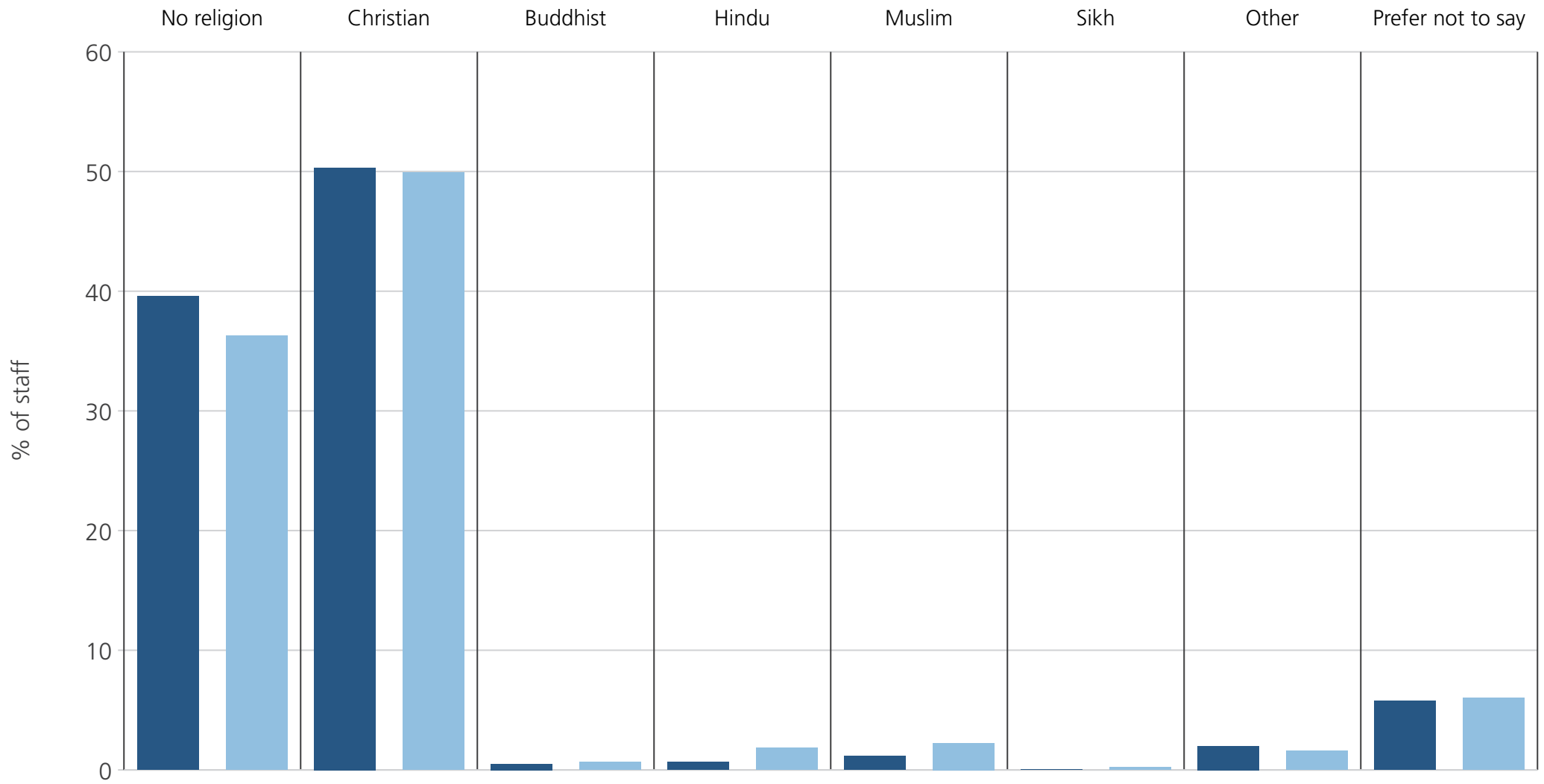
	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.7%	17.0%	19.6%	25.4%	35.8%	1.3%
Average	0.7%	16.5%	22.4%	26.0%	32.5%	1.4%
Responses	2,008	2,008	2,008	2,008	2,008	2,008



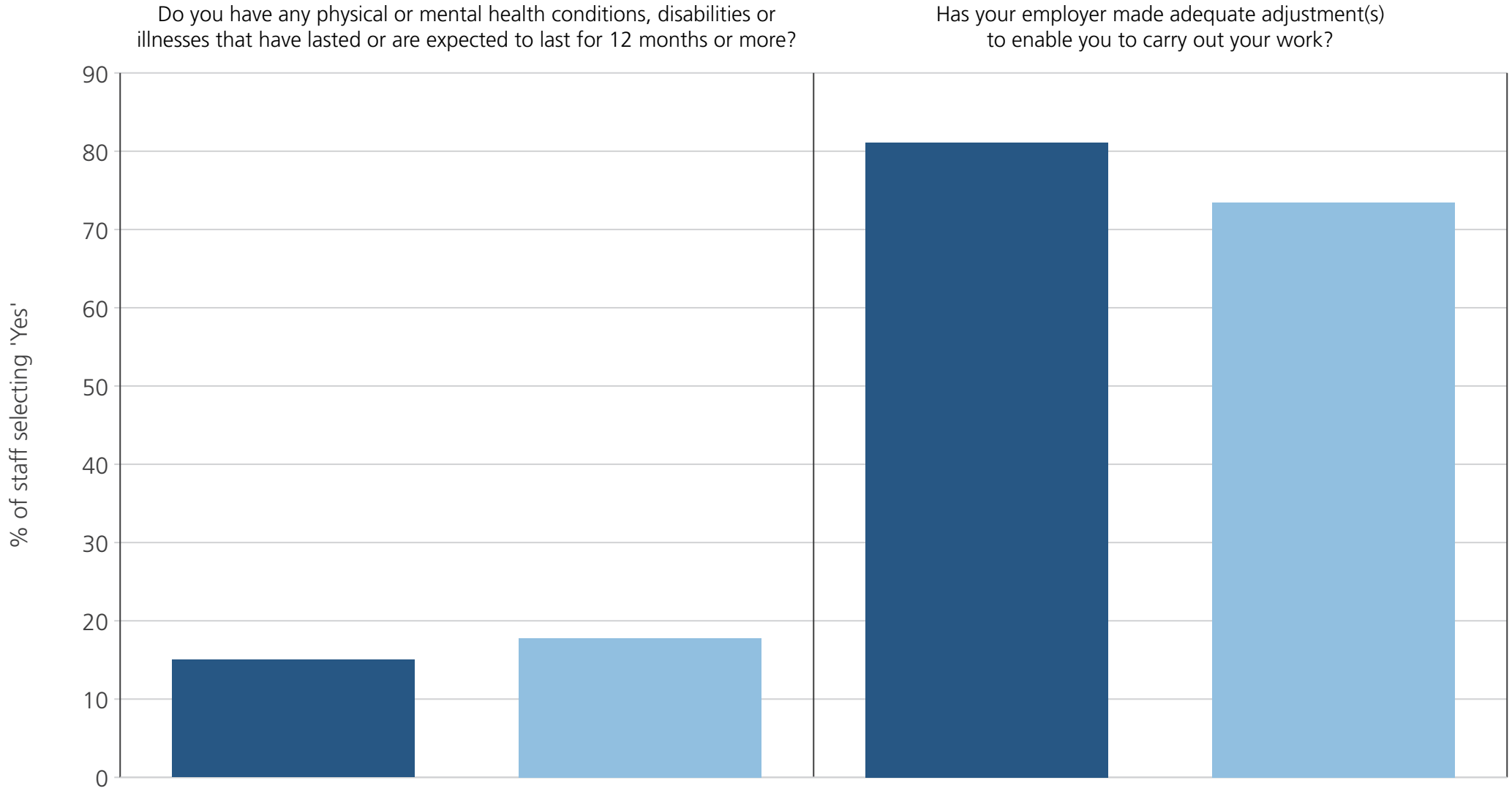
	White	Mixed	Asian/Asian British	Black/Black British	Chinese	Other
Your org	90.6%	1.2%	6.2%	0.7%	0.6%	0.8%
Average	84.8%	1.6%	10.0%	2.6%	0.5%	1.1%
Responses	1,983	1,983	1,983	1,983	1,983	1,983



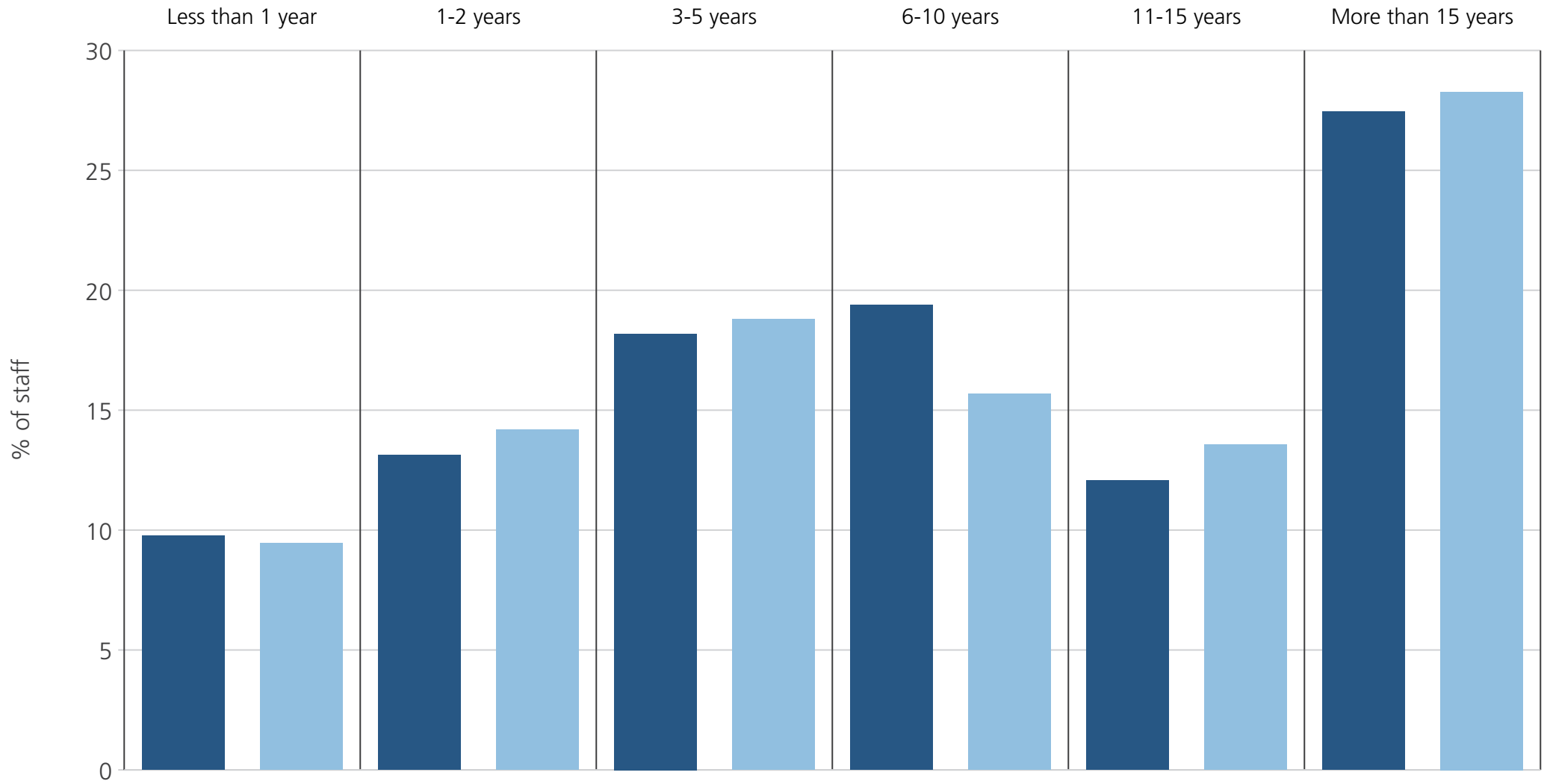
	Heterosexual	Gay man	Gay woman (lesbian)	Bisexual	Other	Prefer not to say
Your org	91.7%	1.1%	0.5%	1.1%	0.3%	5.5%
Average	90.5%	1.0%	0.7%	1.1%	0.4%	6.1%
Responses	1,987	1,987	1,987	1,987	1,987	1,987



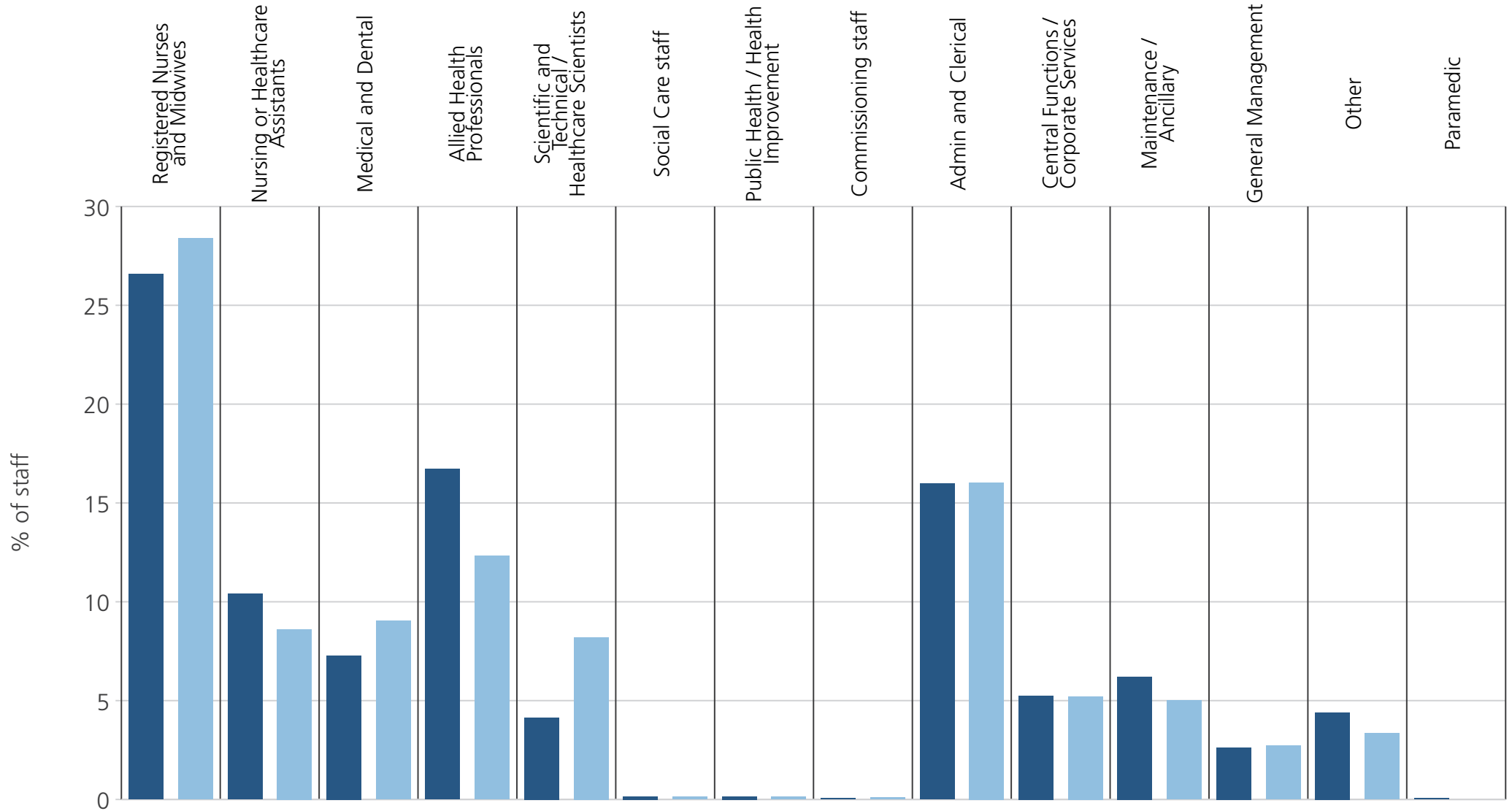
	No religion	Christian	Buddhist	Hindu	Muslim	Sikh	Other	Prefer not to say
Your org	39.6%	50.3%	0.5%	0.7%	1.2%	0.1%	2.0%	5.8%
Average	36.3%	49.9%	0.7%	1.8%	2.3%	0.2%	1.6%	6.0%
Responses	1,999	1,999	1,999	1,999	1,999	1,999	1,999	1,999



	Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?	Has your employer made adequate adjustment(s) to enable you to carry out your work?
Your org	15.0%	81.1%
Average	17.8%	73.4%
Responses	2,011	162



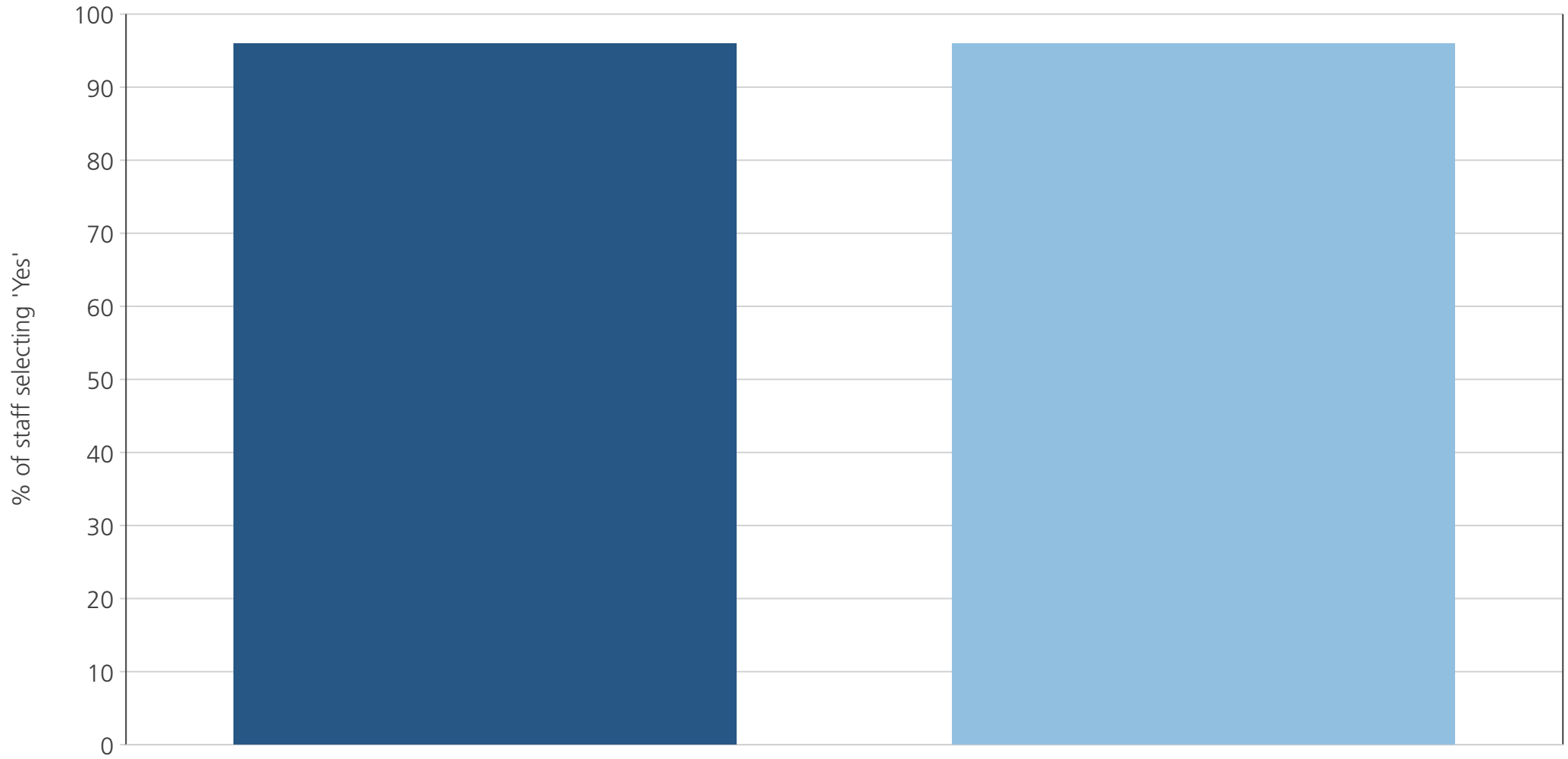
	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	9.8%	13.1%	18.2%	19.4%	12.1%	27.5%
Average	9.5%	14.2%	18.8%	15.7%	13.6%	28.3%
Responses	1,996	1,996	1,996	1,996	1,996	1,996



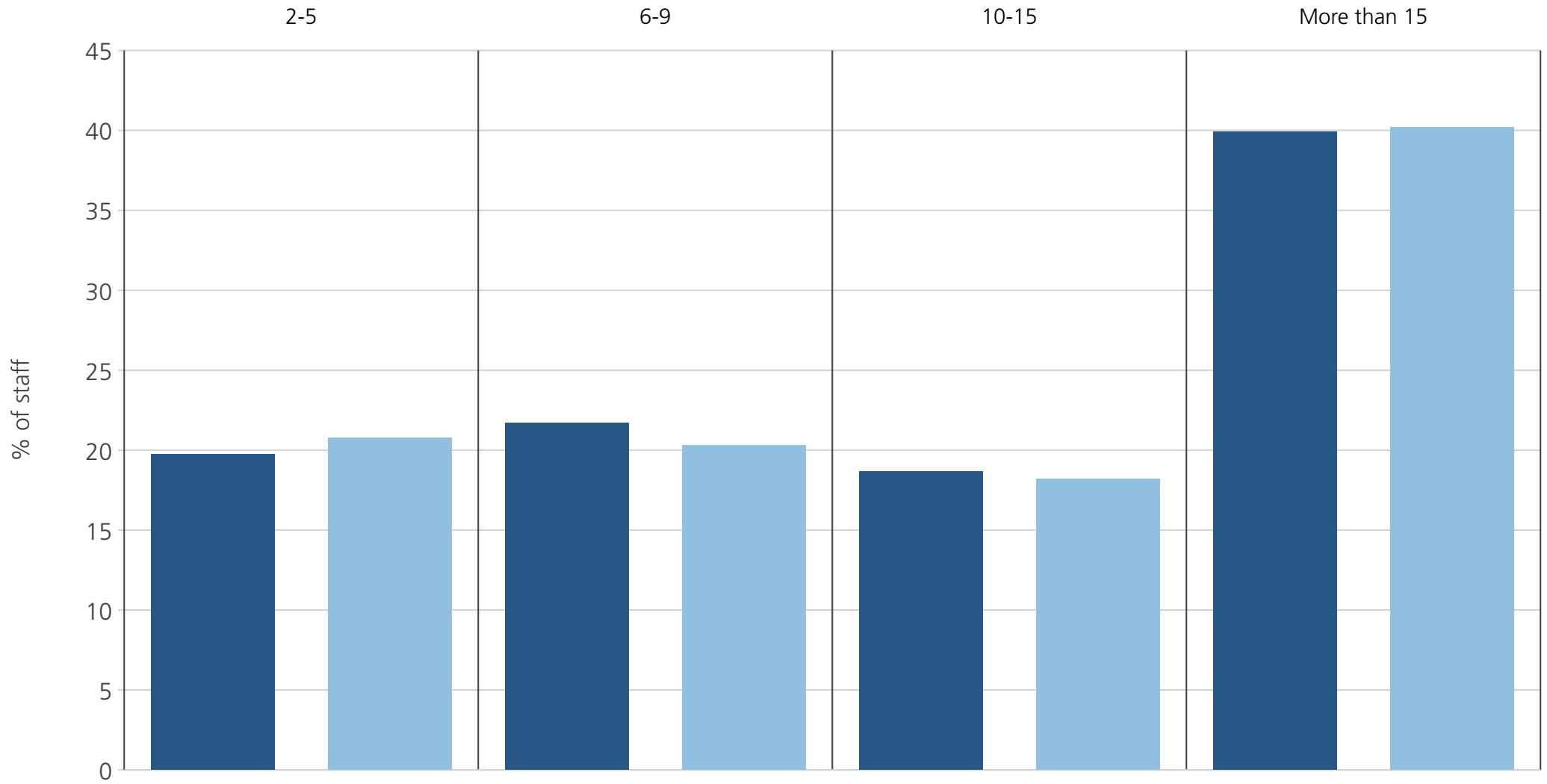
	Registered Nurses and Midwives	Nursing or Healthcare Assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical / Healthcare Scientists	Social Care staff	Public Health / Health Improvement	Commissioning staff	Admin and Clerical	Central Functions / Corporate Services	Maintenance / Ancillary	General Management	Other	Paramedic
Your org	26.6%	10.4%	7.3%	16.7%	4.1%	0.2%	0.2%	0.1%	16.0%	5.3%	6.2%	2.6%	4.4%	0.1%
Average	28.4%	8.6%	9.0%	12.3%	8.2%	0.1%	0.1%	0.1%	16.0%	5.2%	5.0%	2.7%	3.3%	0.0%
Responses	1,979	1,979	1,979	1,979	1,979	1,979	1,979	1,979	1,979	1,979	1,979	1,979	1,979	1,979

159

Do you work in a team?



Your org	96.0%
Average	96.0%
Responses	2,001



	2-5	6-9	10-15	More than 15
Your org	19.7%	21.7%	18.7%	39.9%
Average	20.8%	20.3%	18.2%	40.2%
Responses	1,914	1,914	1,914	1,914

Survey Coordination Centre

NHS England

Workforce Equality Standards

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results

Workforce Equality Standards

This section contains data required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Full details of how the data are calculated are included in the Technical Document, available to download from our results website.

Workforce Race Equality Standard (WRES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2017, 2018 and 2019 trust/CCG and benchmarking group median results for q13a, q13b&c combined, q14, and q15b split by ethnicity (by white / BME staff).

Workforce Disability Equality Standard (WDES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2018 and 2019 trust/CCG and benchmarking group median results for q5f, q11e, q13, and q14 split by disabled staff compared to non-disabled staff. It also shows results for q28b (for disabled staff only), and the staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

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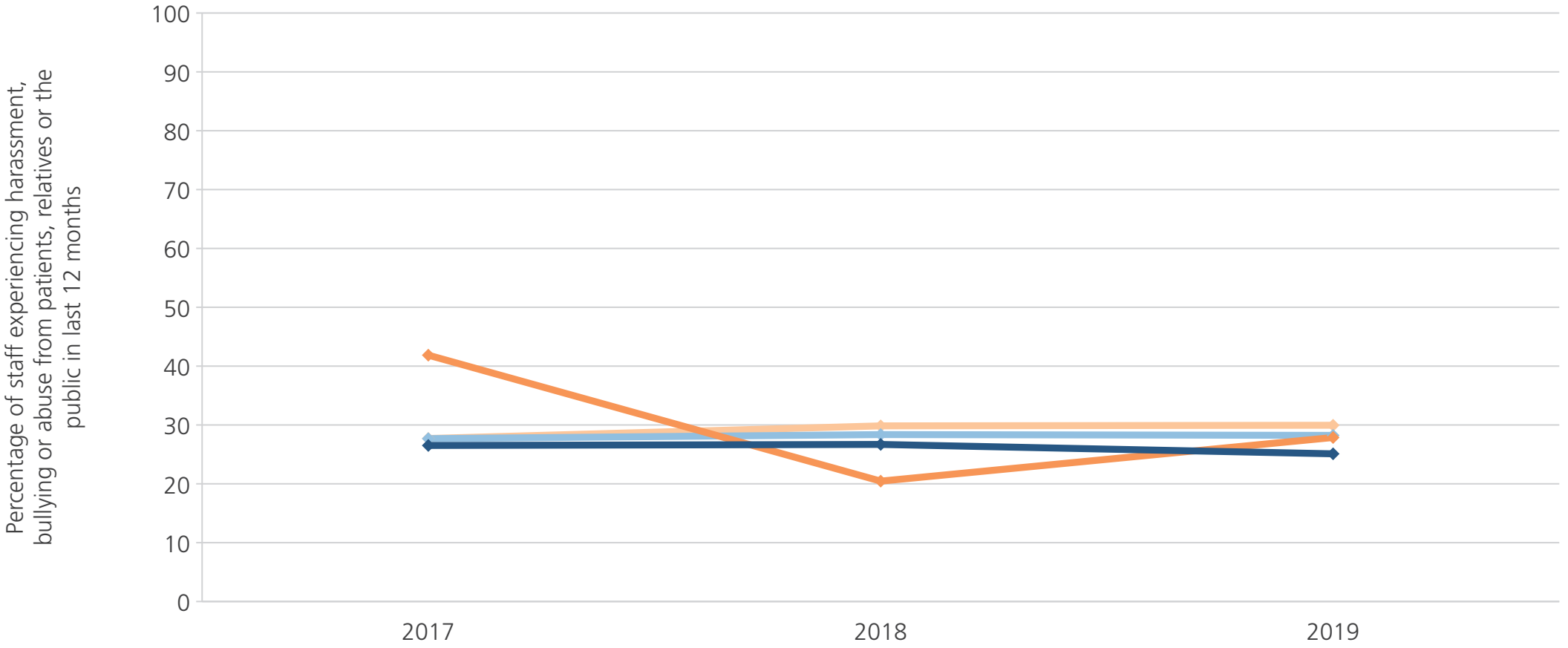
NHS England

Workforce Race Equality Standard (WRES)

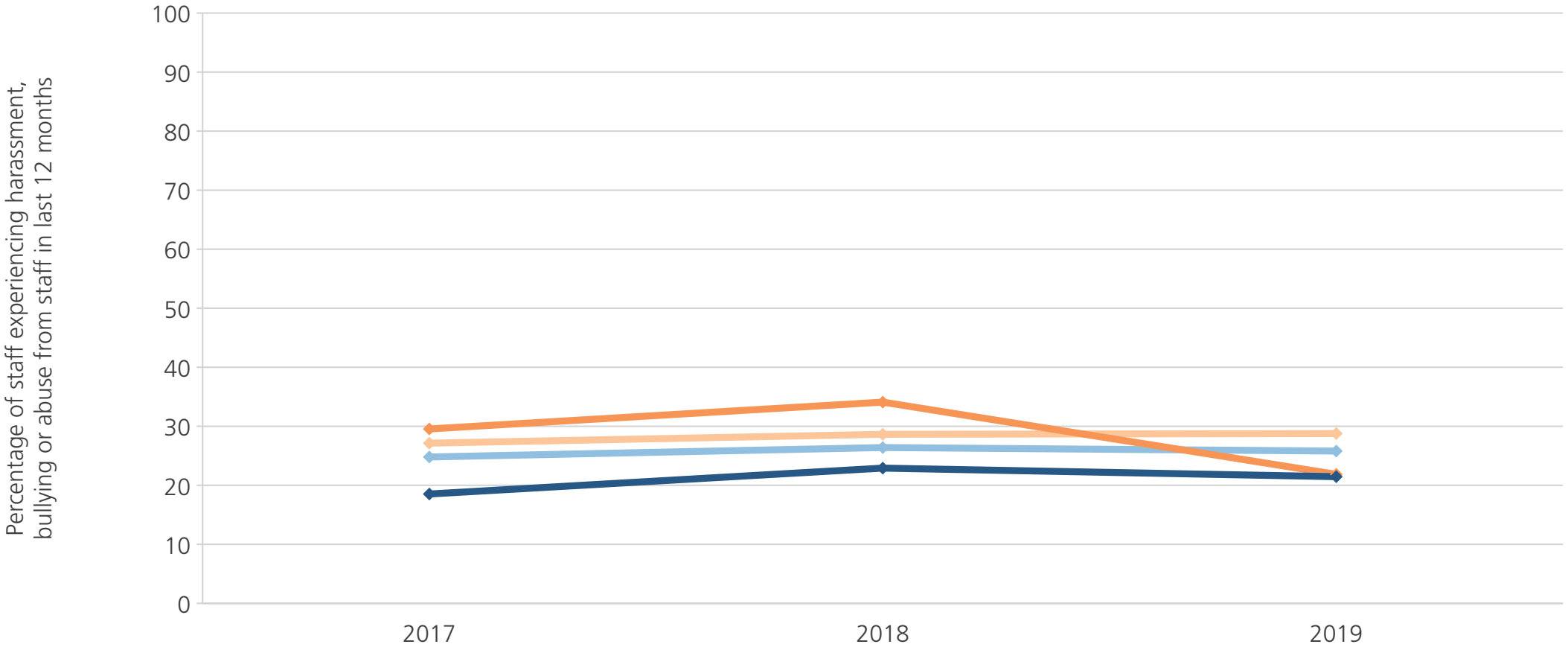
West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results



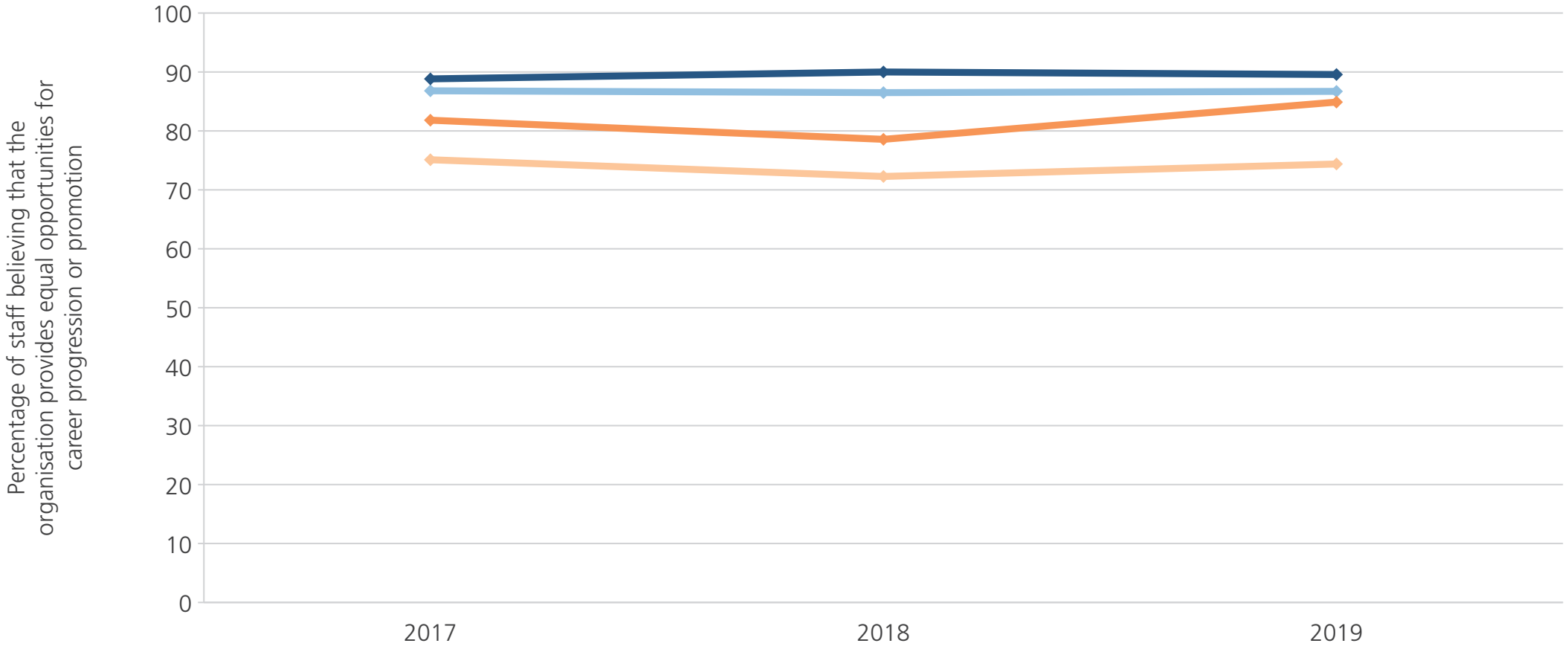
	2017	2018	2019
White: Your org	26.5%	26.7%	25.1%
BME: Your org	41.9%	20.5%	27.9%
White: Average	27.7%	28.4%	28.2%
BME: Average	27.7%	29.8%	29.9%
White: Responses	528	517	1,781
BME: Responses	43	44	183

Average calculated as the median for the benchmark group



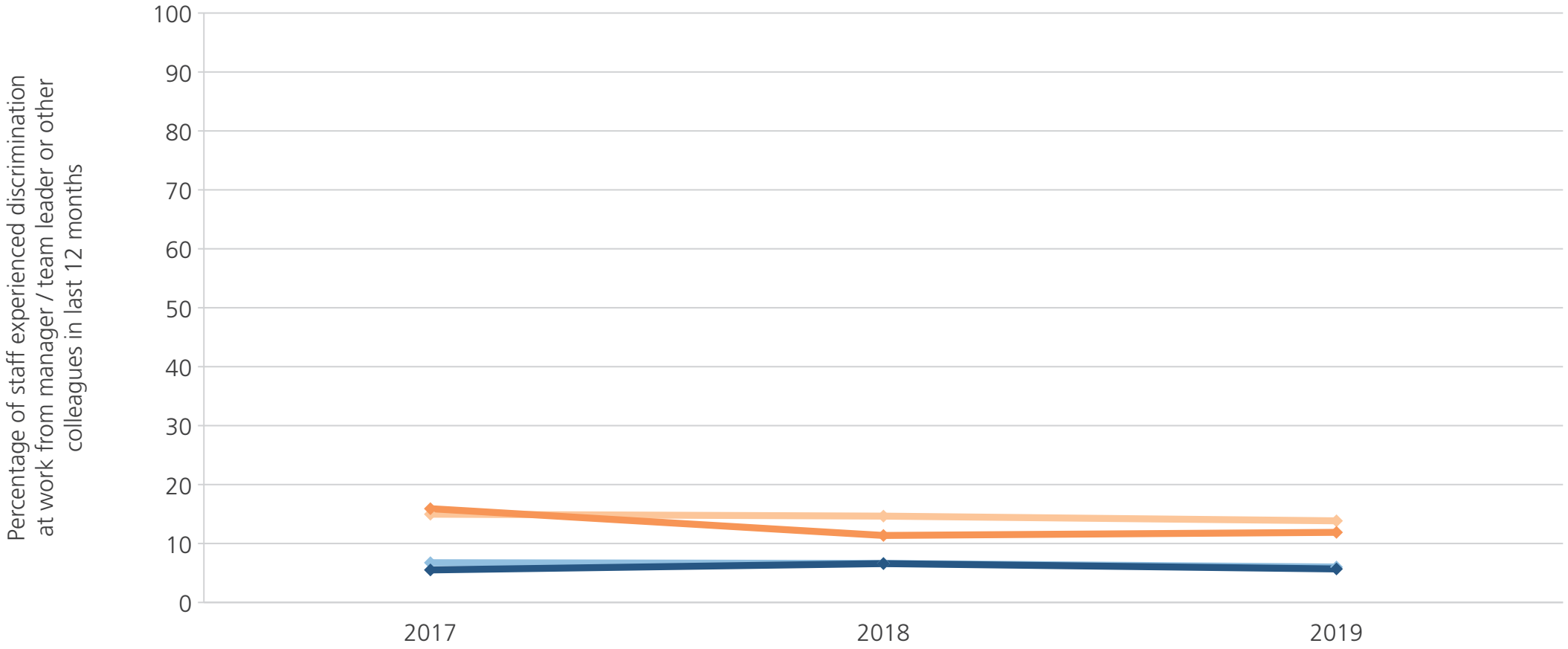
	2017	2018	2019
White: Your org	18.5%	22.9%	21.5%
BME: Your org	29.5%	34.1%	21.9%
White: Average	24.8%	26.4%	25.8%
BME: Average	27.1%	28.6%	28.8%
White: Responses	529	515	1,780
BME: Responses	44	44	183

Average calculated as the median for the benchmark group



	2017	2018	2019
White: Your org	88.8%	90.0%	89.6%
BME: Your org	81.8%	78.6%	84.9%
White: Average	86.8%	86.5%	86.7%
BME: Average	75.1%	72.3%	74.4%
White: Responses	376	370	1,275
BME: Responses	33	28	139

Average calculated as the median for the benchmark group



	2017	2018	2019
White: Your org	5.5%	6.6%	5.7%
BME: Your org	15.9%	11.4%	11.9%
White: Average	6.7%	6.6%	6.0%
BME: Average	15.0%	14.6%	13.8%
White: Responses	526	516	1,777
BME: Responses	44	44	185

Average calculated as the median for the benchmark group

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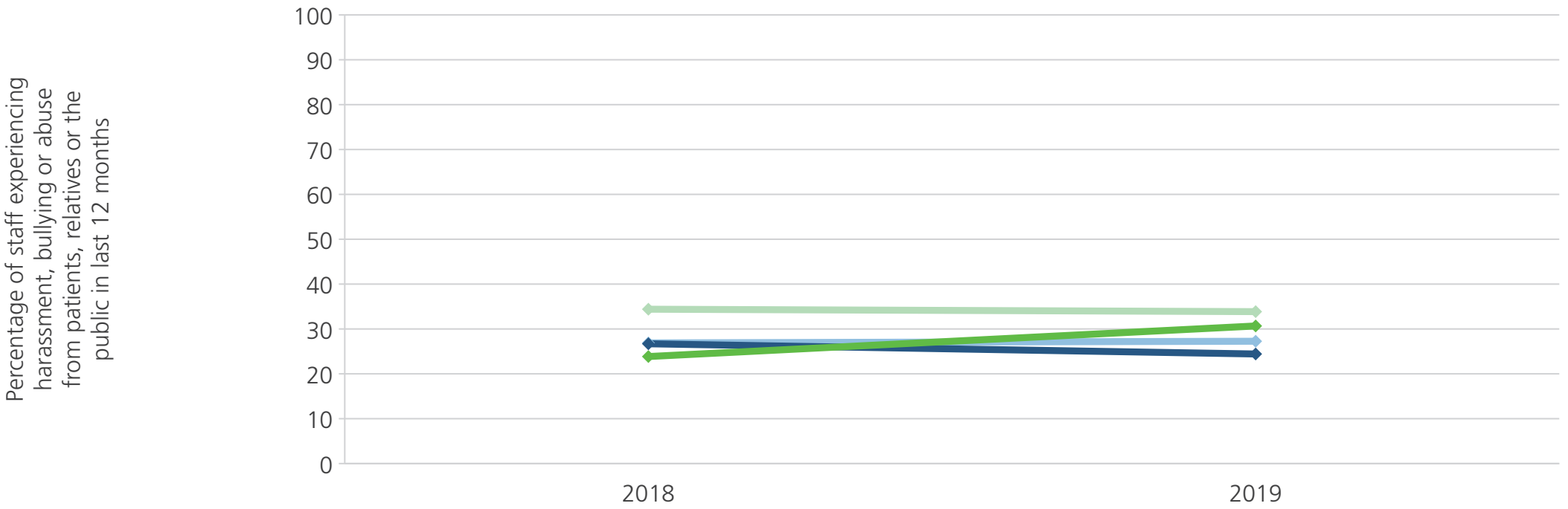
Workforce Disability Equality Standard (WDES)

West Suffolk NHS Foundation Trust

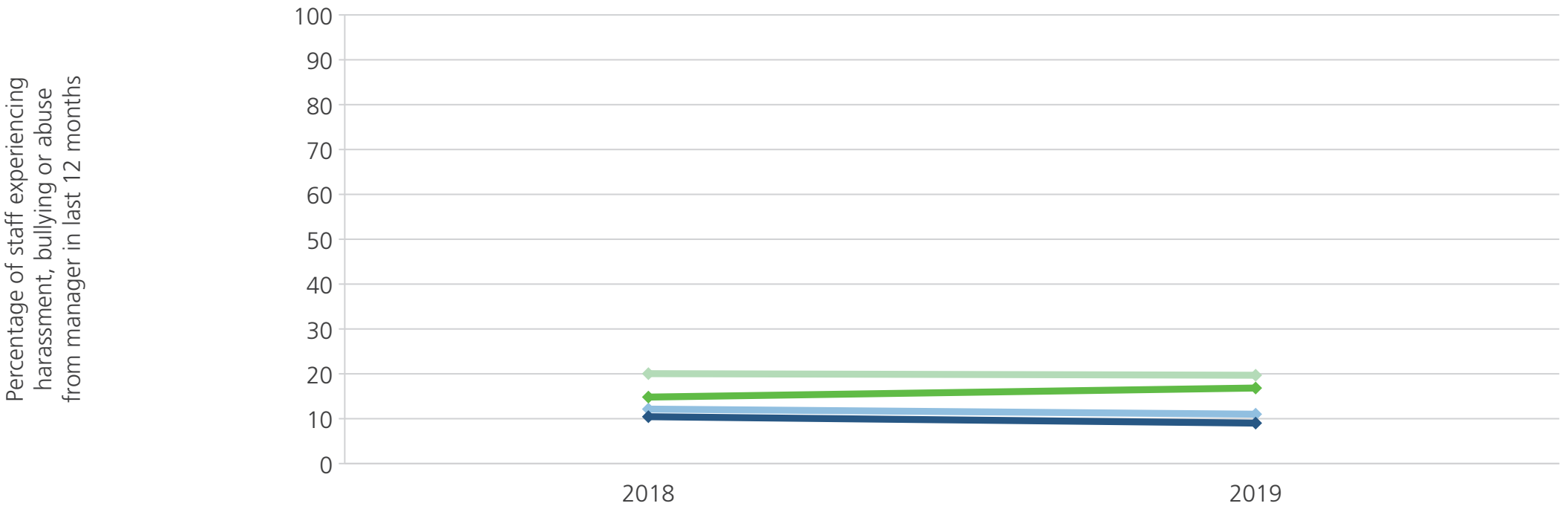
2019 NHS Staff Survey Results



Disabled staff: Your org	23.9%	30.7%
Non-disabled staff: Your org	26.7%	24.4%
Disabled staff: Average	34.4%	33.9%
Non-disabled staff: Average	26.9%	27.3%

Disabled staff: Responses	109	300
Non-disabled staff: Responses	457	1,691

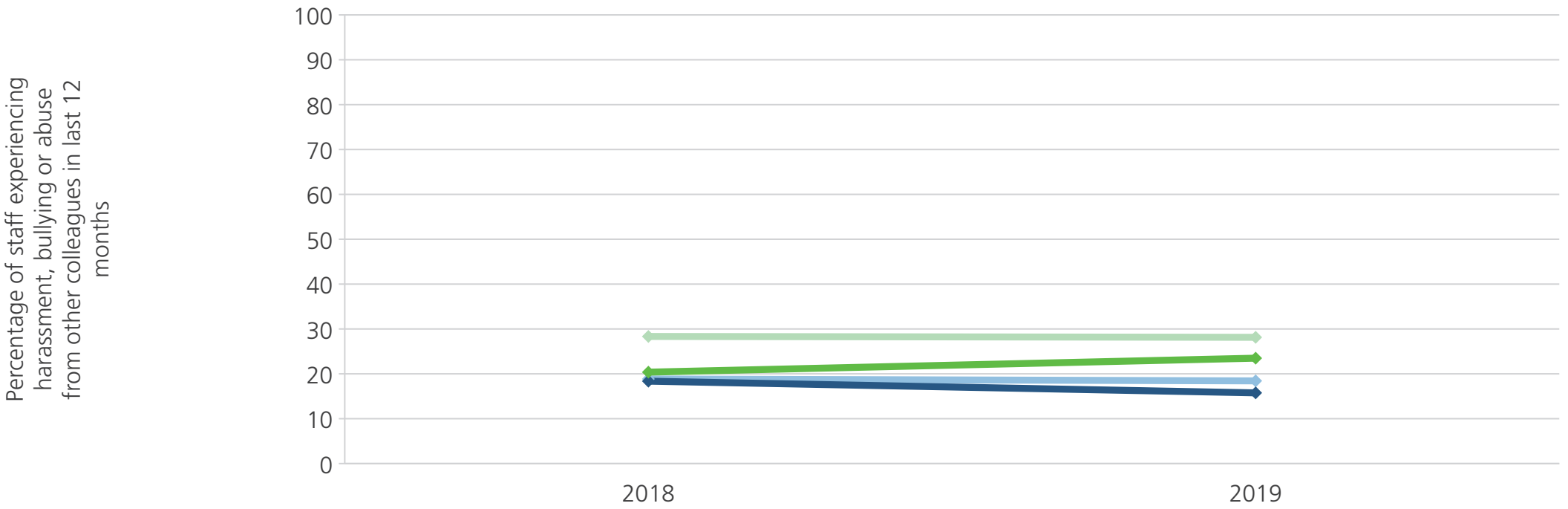
Average calculated as the median for the benchmark group



Disabled staff: Your org	14.8%	16.8%
Non-disabled staff: Your org	10.4%	9.0%
Disabled staff: Average	20.0%	19.7%
Non-disabled staff: Average	12.1%	11.0%

Disabled staff: Responses	108	297
Non-disabled staff: Responses	450	1,686

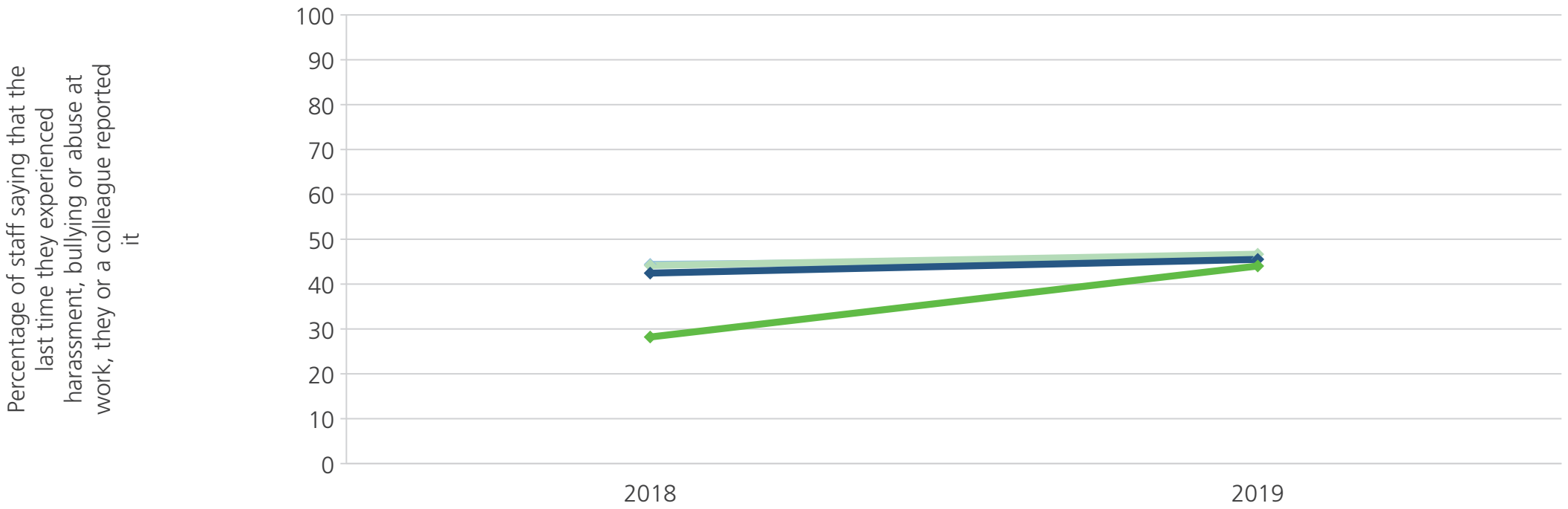
Average calculated as the median for the benchmark group



	2018	2019
Disabled staff: Your org	20.4%	23.5%
Non-disabled staff: Your org	18.4%	15.8%
Disabled staff: Average	28.3%	28.1%
Non-disabled staff: Average	18.9%	18.4%

Disabled staff: Responses	108	298
Non-disabled staff: Responses	452	1,688

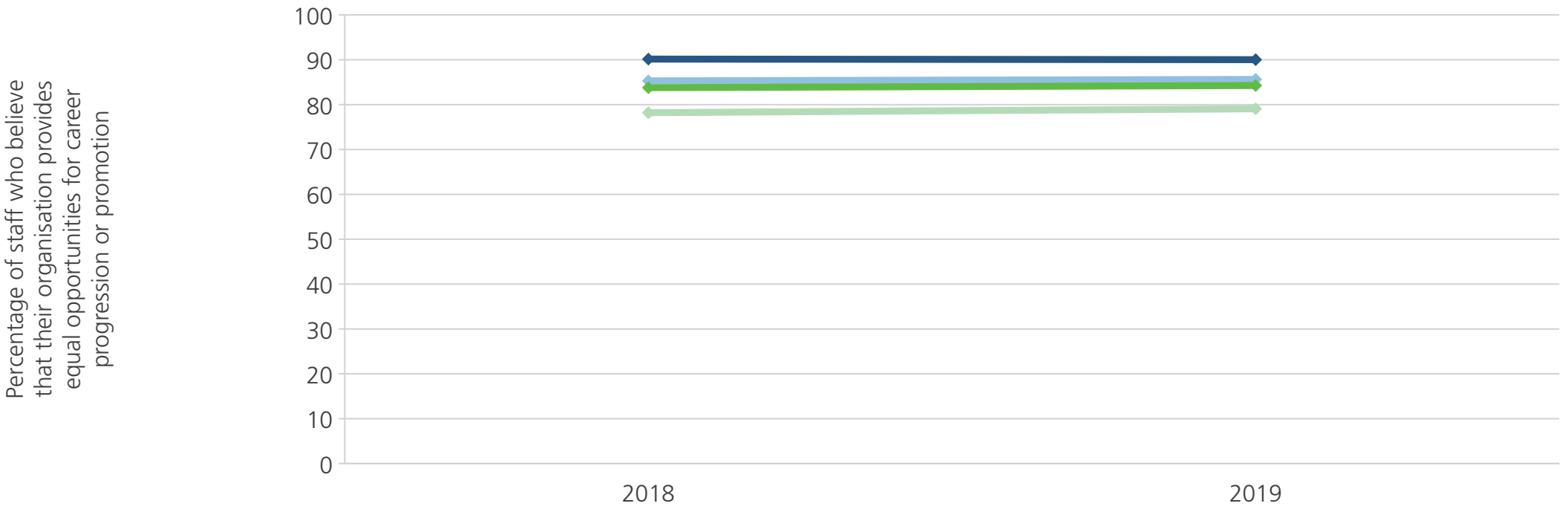
Average calculated as the median for the benchmark group



Disabled staff: Your org	28.2%	44.0%
Non-disabled staff: Your org	42.4%	45.5%
Disabled staff: Average	44.2%	46.7%
Non-disabled staff: Average	44.4%	45.6%

Disabled staff: Responses	39	134
Non-disabled staff: Responses	139	534

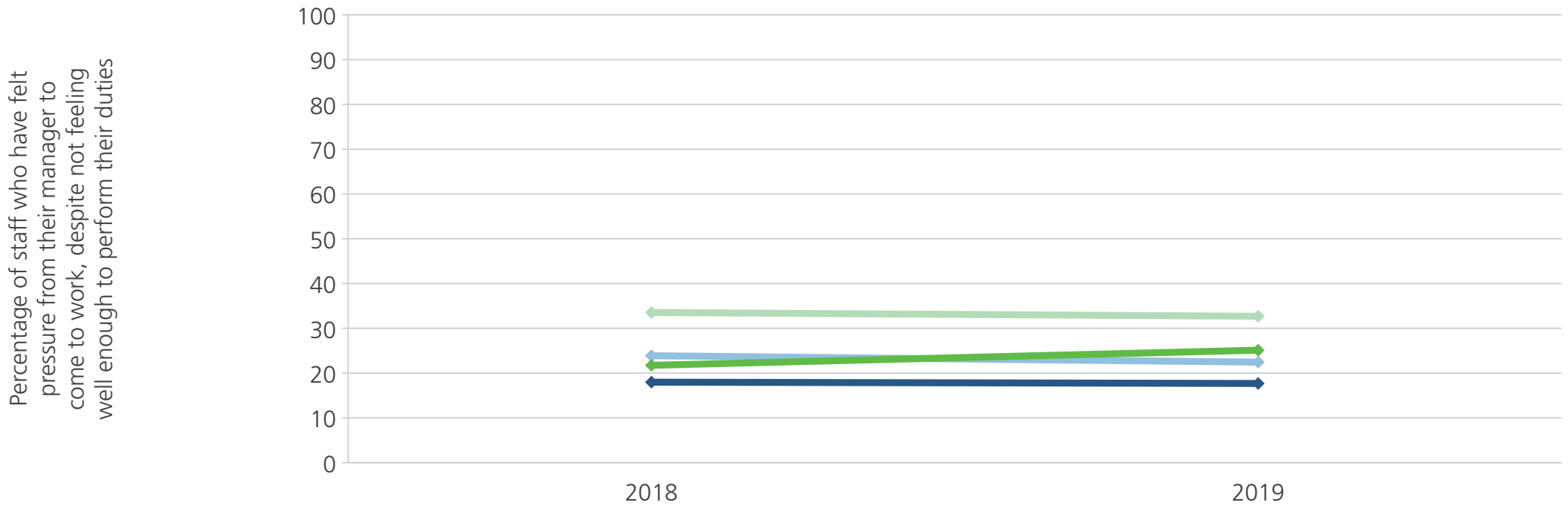
Average calculated as the median for the benchmark group



Disabled staff: Your org	83.8%	84.3%
Non-disabled staff: Your org	90.2%	90.0%
Disabled staff: Average	78.2%	79.1%
Non-disabled staff: Average	85.3%	85.6%

Disabled staff: Responses	74	216
Non-disabled staff: Responses	325	1,213

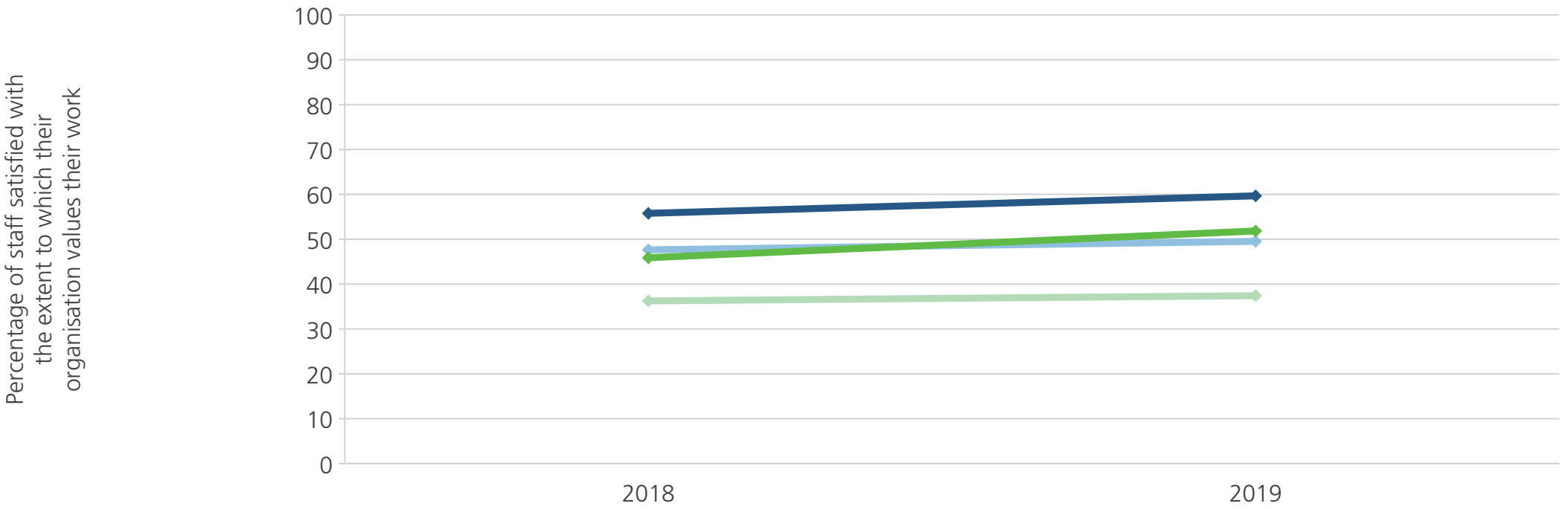
Average calculated as the median for the benchmark group



Disabled staff: Your org	21.7%	25.1%
Non-disabled staff: Your org	18.0%	17.7%
Disabled staff: Average	33.5%	32.7%
Non-disabled staff: Average	23.9%	22.4%

Disabled staff: Responses	69	215
Non-disabled staff: Responses	217	820

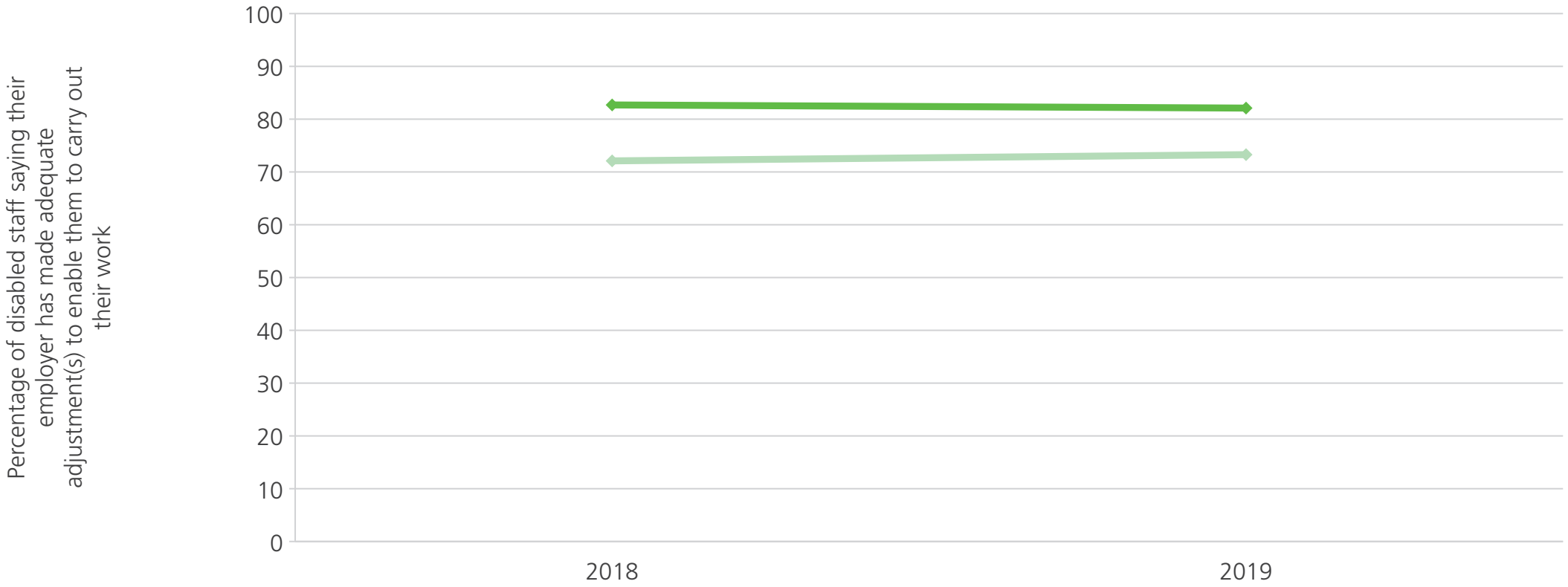
Average calculated as the median for the benchmark group



Disabled staff: Your org	45.9%	51.8%
Non-disabled staff: Your org	55.8%	59.7%
Disabled staff: Average	36.3%	37.4%
Non-disabled staff: Average	47.6%	49.5%

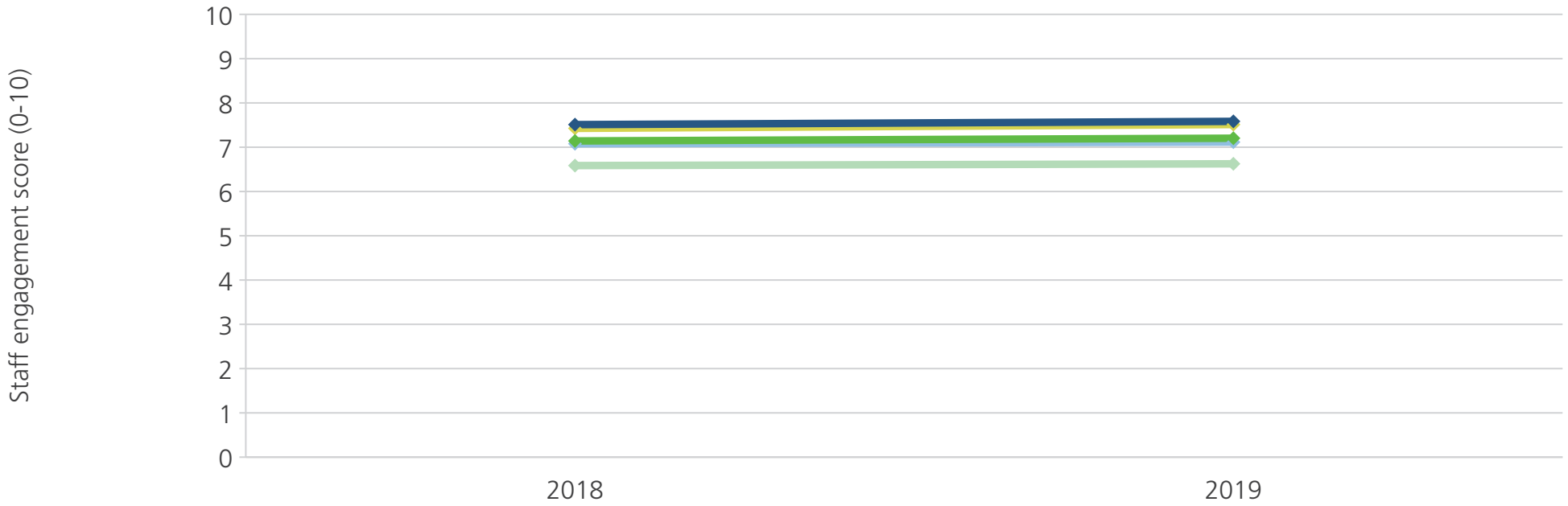
Disabled staff: Responses	109	299
Non-disabled staff: Responses	459	1,696

Average calculated as the median for the benchmark group



	2018	2019
Disabled staff: Your org	82.7%	82.1%
Disabled staff: Average	72.1%	73.3%
Disabled staff: Responses	52	162

Average calculated as the median for the benchmark group



Organisation average	7.4	7.5
Disabled staff: Your org	7.1	7.2
Non-disabled staff: Your org	7.5	7.6
Disabled staff: Average	6.6	6.6
Non-disabled staff: Average	7.1	7.1

Organisation Responses	593	2,068
Disabled staff: Responses	110	302
Non-disabled staff: Responses	459	1,706

Average calculated as the median for the benchmark group

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Appendices

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results

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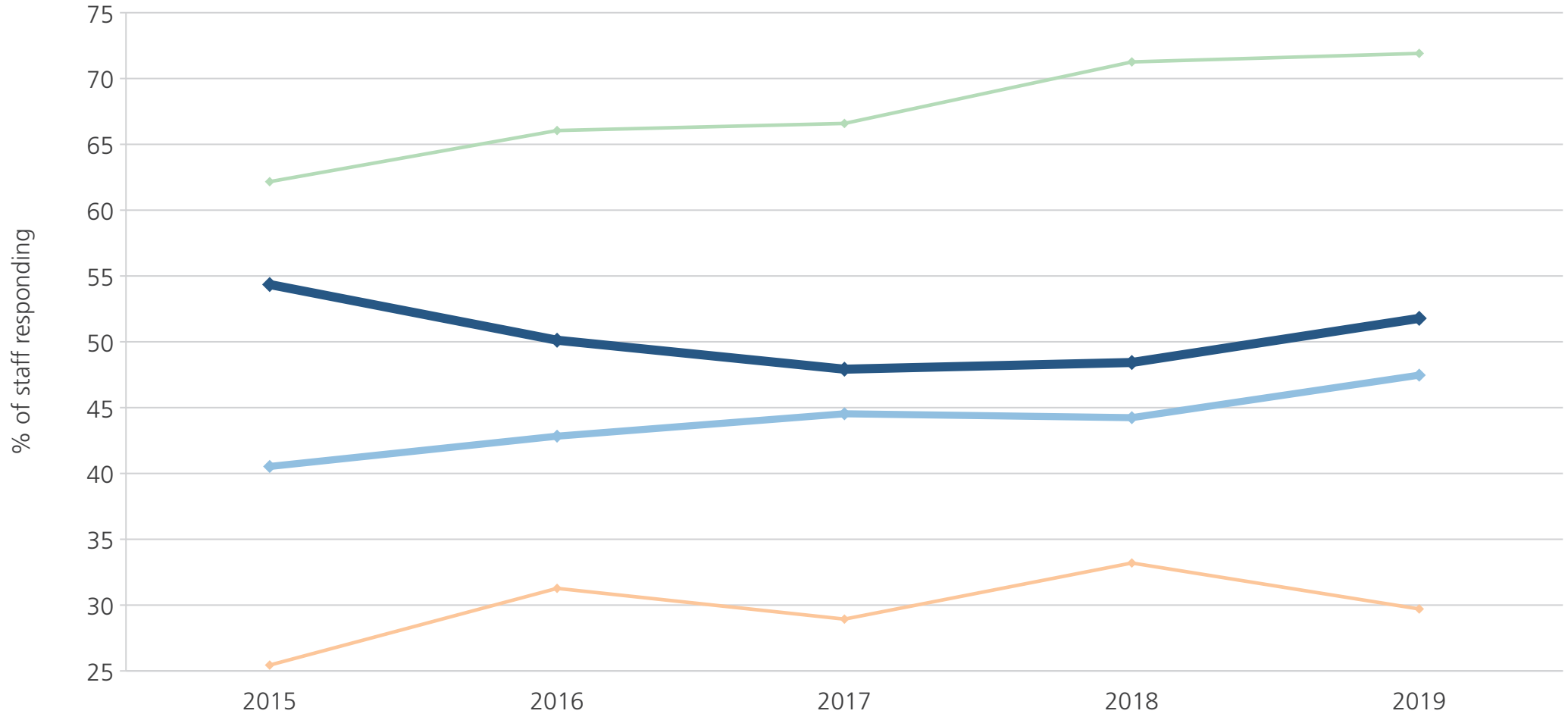
Appendix A: Response rate

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results



Best	62.2%	66.0%	66.6%	71.3%	71.9%
Your org	54.4%	50.1%	47.9%	48.4%	51.8%
Median	40.5%	42.8%	44.5%	44.2%	47.5%
Worst	25.4%	31.3%	28.9%	33.2%	29.7%

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Appendix B: Significance testing - 2018 v 2019 theme results

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2019 score is significantly higher than last year's, whereas ↓ indicates that the 2019 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	579	**9.3**	2032	Not significant
Health & wellbeing	**6.3**	584	**6.4**	2047	Not significant
Immediate managers	**7.0**	583	**7.2**	2046	↑
Morale	**6.4**	569	**6.6**	2007	↑
Quality of appraisals	**5.5**	496	**5.9**	1783	↑
Quality of care	**7.6**	519	**7.7**	1815	Not significant
Safe environment - Bullying & harassment	**8.1**	575	**8.2**	2018	Not significant
Safe environment - Violence	**9.4**	571	**9.4**	2026	Not significant
Safety culture	**7.0**	576	**7.1**	2024	Not significant
Staff engagement	**7.4**	593	**7.5**	2068	Not significant
Team working	**6.8**	588	**6.9**	2035	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

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NHS England

Appendix C: Tips on using your benchmark report

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results

Data in the benchmark reports

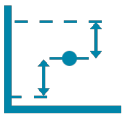
The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data, but have been included to aid users transitioning from the previous version of the benchmark report and those who are new to the Staff Survey.

Key points to note

There are a number of differences in this benchmark report compared to the style of benchmark reports prior to the 2018 survey, which are worth noting

- Key Findings have been replaced by themes. The themes cover eleven areas of staff experience and present results in these areas in a clear and consistent way. All of the eleven themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together.

- A key feature of the reports is that they **provide organisations with up to 5 years of trend data** across theme **and** question results. Trend data provides a much **more reliable indication of whether the most recent results represent a change from the norm** for an organisation than comparing the most recent results to those from the previous year. Taking a longer term view will help organisations to identify trends over several years that may have been missed when comparisons were drawn solely between the current and previous year.



- **Question results are benchmarked** so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single graph.

1. Reviewing theme results

When analysing theme results, it is easiest to start with the **theme overview** page to quickly identify areas which are doing better or worse in comparison to other organisations in the given benchmarking group.

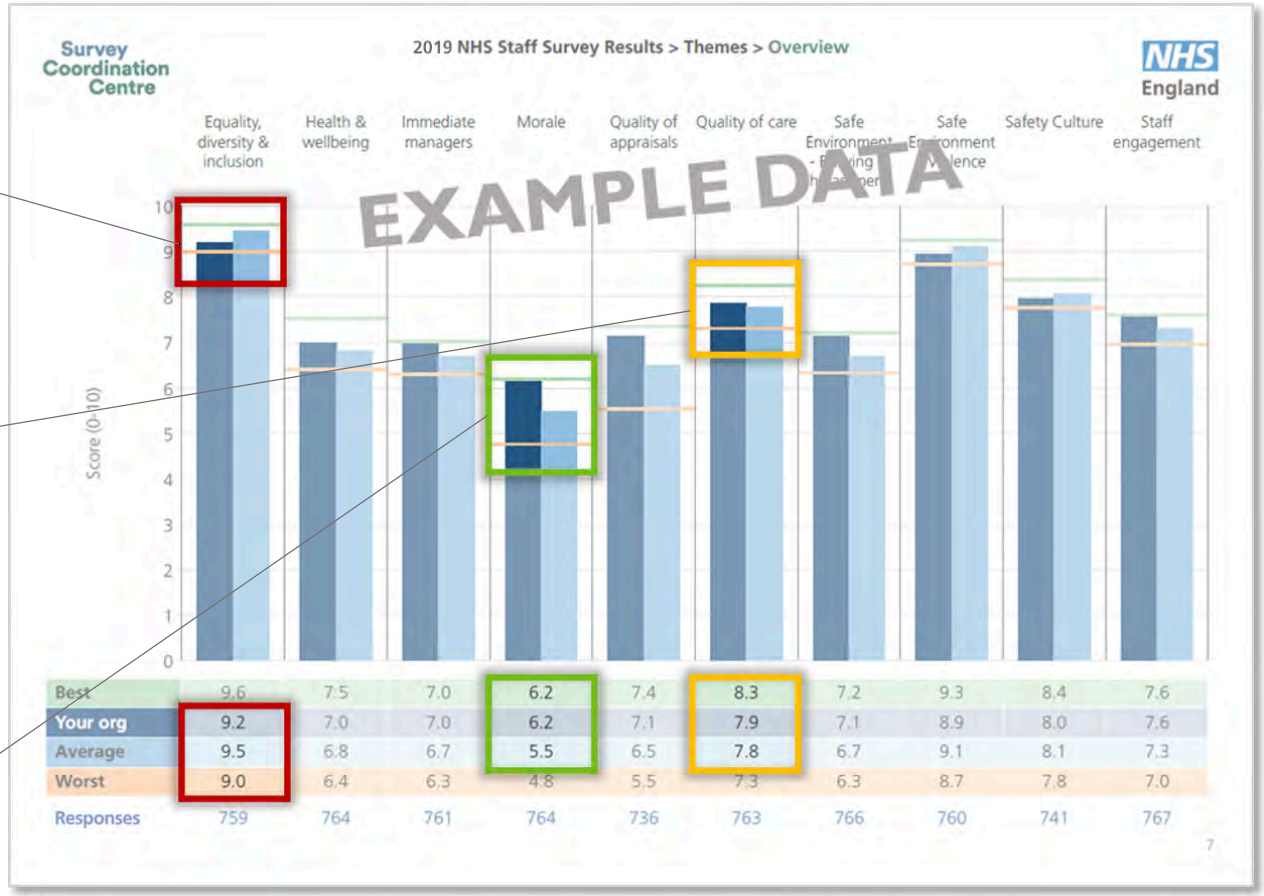
It is important to **consider each theme result within the range of its benchmarking group 'Best' and 'Worst' scores**, rather than comparing theme scores to one another. Comparing organisation scores to the benchmarking group average is another important point of reference.

Areas to improve

- By checking where the 'Your org' column/value is lower than the benchmarking group 'Average' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst' score. The closer your organisation's result is to the worst score, the more concerning the result.
- Results where your organisation's score is only marginally better than the 'Average', but still lags behind the best result by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify themes which show a positive outcome for your organisation, where 'Your org' scores are distinctly higher than the benchmarking group 'Average' score.



Only one example is highlighted for each point

- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best' score.

2. Reviewing theme results in more detail

Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.

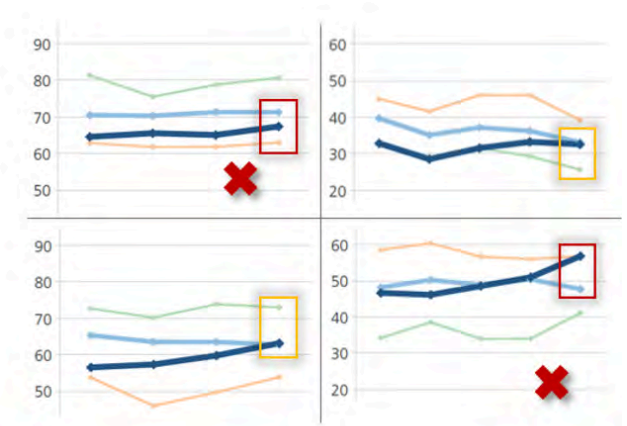
	2015	2016	2017	2018	2019
Best	6.3	6.5	6.3	6.3	6.2
Your org	5.7	5.8	5.8	6.0	6.2
Average	5.8	5.7	5.8	5.6	5.5
Worst	4.7	4.8	4.4	4.8	4.8
Responses	344	803	668	738	764

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review questions feeding into the themes

In order to understand exactly which factors are driving your organisation's theme score, you should review the questions feeding into the theme. The **'Detailed information'** section contains the questions contributing to each theme, grouped together, thus they can be reviewed easily without the need to search through the 'Question results' section. By comparing 'Your org' scores to the benchmarking group 'Average', 'Best' and 'Worst' scores for each question, the **questions which are driving your organisation's theme results can be identified**.

For themes where results need improvement, action plans can be formulated to **focus on the areas where the organisation's results fall between the benchmarking group average and worst results**. Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



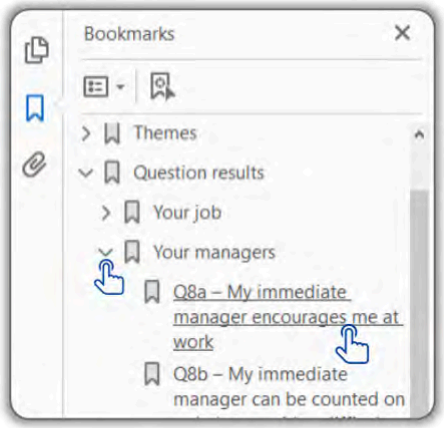
✖ = Negative driver, org result falls between average & worst benchmarking group result for question

3. Reviewing question results

This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 170 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data. It's also worth noting that new for 2019 is a PDF summary version of this benchmark report. This presents the same data as this main benchmark report, but does not include the detailed question level reporting.

Identifying questions of interest

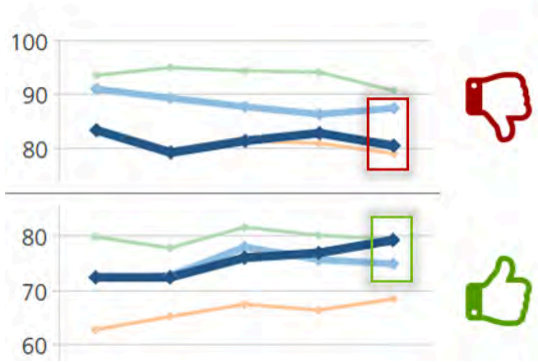
Use the bookmarks bar to navigate directly to questions of interest



- **Pre-defined questions of interest – key questions for your organisation**
  - Most organisations will have questions which have traditionally been a focus for them. Questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can now be assessed on the backdrop of benchmark and historical trend data.
  - **Note:** The bookmarks bar allows for easy navigation through the report, allowing subsections of the report to be folded, for quick access to questions through hyperlinks.

- **Identifying questions of interest based on the results in this report**

  The methods recommended to review your theme results can also be applied to pick out question level results of interest. However, **unlike themes where a higher score always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).



- **To identify areas of concern**: look for questions where the organisation value falls between the benchmarking group average and the worst score, particularly questions where your organisation result is very close to the worst score. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years, but consider the context of how the trust has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.
- **When looking for positive outcomes**: search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

Survey Coordination Centre

NHS England

Appendix D: Additional reporting outputs

West Suffolk NHS Foundation Trust

2019 NHS Staff Survey Results

Additional reporting outputs

Below are links to other key reporting outputs which complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Document: Contains technical details about the NHS Staff Survey data, including: data cleaning, weighting, benchmarking, theme, historical comparability of organisations and questions in the survey.

Other local results

Benchmark summary reports: A PDF summary version of this benchmark report, that produces the same data, but does not include the detailed question level reporting.

Local Breakdowns: Dashboards containing results for each organisation broken down by demographic characteristics. Data is available for up to five years where possible.

Directorate Reports: Reports containing theme results split by directorate (locality) for West Suffolk NHS Foundation Trust.

National results

National Trend Data and **National Breakdowns**: Dashboards containing national results – data available for five years where possible.

16. Non-emergency patient transport

To NOTE the report

For Reference

Presented by Helen Beck

Trust Board – February 2020

Agenda item:	16			
Presented by:	Helen Beck, chief operating officer			
Prepared by:	Alex Baldwin, deputy chief operating officer			
Date prepared:	21st February 2020			
Subject:	Non-emergency patient transport (NEPTS)			
Purpose:	x	For information		For approval

Executive summary:

The purpose of this paper is to provide the Board with an updated position on the dedicated Discharge Vehicle model that has been implemented on a 3 month trial from 2 December 2019, as well as an update on recent performance of the E-zec NEPTS contract.

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

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

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

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

Update

E-zec Medical requested that the current way of delivering NEPTS in Suffolk was revised, as the changes proposed and implemented as part of the Remedial Action Plan were not producing the required performance improvements expected by commissioners. This was agreed as a way forward by all commissioners in October 2019.

On 2 December 2019, the Discharge Vehicle model went live in Suffolk which involves discharge vehicles and crews being ring-fenced and has enabled the Trust to have direct influence over utilising the capacity available. There are 3 vehicles available to the Trust (Monday to Friday) as well as capacity at the weekends.

Across Suffolk the revised model includes an additional 25 road based staff (crew), (25% increase) and an additional 14 vehicles (30% increase). Prior to 2 December, all 14 vehicles were mobilised and recruitment of the 25 staff is ongoing. Of the 25 additional staff, 12 appointments have been made. The remaining vacancies will be recruited to in February:

In the interim period until recruitment reaches establishment and to ensure full capacity is available, the contract is supported by 3rd party staff; approximately 5 – 7 crews daily, as well as additional resource to support peak times (e.g. wheelchair accessible taxis/taxis from approved organisations, where clinically appropriate).

The revised model also allows increased focus and capacity for outpatient appointments by E-zec control.

E-Zec continue to be responsible for and oversee patient transport activity as a whole in order to maximise service efficiencies as well as managing capacity and demand outside of the core hours and when discharge demand is high.

Key points

Initial feedback since the model has gone live has been broadly positive.

KPI's for the month of December have shown some improvements although it is noted that more data should be gathered in order to evaluate success.

The number of complaints received by the Trust, E-zec and the CCG have reduced however it is too early to establish if this is a direct result of the changes in service delivery.

Whilst discharges from the Trust are working well, outpatients remains a focus with E-zec working closely with larger patient groups such as Oncology and Renal to make further improvements.

The Trust, CCG and E-Zec have recently presented to the Suffolk Health Overview and Scrutiny Committee (October 2019 and January 2020). Whilst it was acknowledged that there were a number of improvements still to be made, they were particularly complimentary at the speed in which operational changes had been made with immediate signs of success.

Next steps have been discussed with associate commissioners and E-zec, and it is agreed that a sensible way forward would be to extend the trial in order to gather more data and feedback to support a permanent change.

Performance – December 2019:

KPI no.	Key Performance Indicator	Target	Sep-19 %	Oct-19 %	Nov-19 %	Dec-19 %
LQR_001	In-bound Journeys - % Service Users arriving between 5 and 60 minutes prior to their booked appointment time.	95%	64.06%	67.43%	66.69%	72.63%
LQR_002a	Journey Times - % Service Users on the vehicle between 0 and 90 minutes.	90%	90.25%	92.10%	90.23%	94.68%
LQR_002b	Journey Times - % Service Users travelling within the Ipswich and East Suffolk CCG and West Suffolk CCG combined footprint on the vehicle between 0 and 60 minutes.	85%	78.65%	77.72%	77.63%	80.98%
LQR_003a	Outbound Outpatient Journeys - % Service Users waiting no more than 60 minutes after their booked and confirmed collection time.	95%	78.81%	82.15%	86.05%	91.03%
LQR_003b	Outbound Discharge & Transfer Journeys - % Service Users waiting no more than 60 minutes after their booked and confirmed collection time.	95%	63.08%	68.42%	66.07%	75.30%
LQR_006	Unplanned short notice/same day booking in hour's service (after 1600 the previous day on the day requests) - % Short Notice Journeys Honoured by the Provider.	100%	98.66%	99.29%	98.16%	99.44%
LQR_007	End of Life Transfers from acute hospitals to their choice of placement - % Bookings met within 2 hours of the original request.	95%	84.62%	100.00%	100.00 %	100.00%
LQR_008	Front Door and Assessment Area Discharges - % Service Users collected no more than 60 minutes after initial contact or requested time.	90%	42.11%	60.00%	74.42%	66.67%
LQR_009	Timed Care Packages - % Service Users returned to their place of residence in time for their timed care package.	95%	99.07%	99.26%	99.32%	99.64%
LQR_010	Call Handling - % Calls received by the Health Care Professional Line answered within 2 minutes	95%	94%	96%	95%	96%
LQR_011	Call Handling - % Calls received by the patient line answered within 3 minutes	95%	94%	98%	97%	96%
LQR_004	Unplanned short notice/same day booking in hour's service (after 1600 the previous day on the day requests) - % patients collected within a total 4 hour timeframe from initial request.	90%	98.80%	98.53%	99.04%	98.36%

Next steps

The ongoing actions relating to the initial action plan will continue to be monitored, alongside work to embed the service redesign. The deputy chief operating officer alongside CCG Contracts and Clinical Quality teams will continue to provide scrutiny and monitor progress.

It is recommended that the pilot be extended by an additional 3 months so that further data can be gathered prior to making a permanent change.

Recommendations

- Continue with current monitoring and scrutiny against initial action plan to ensure all previously noted areas of concern are addressed, alongside reviewing the impact of the new service model on discharge and outpatient performance.
- Agree to extend the pilot by an additional 3 months to the end of May 2020.
- Further update to Trust Board in May 2020 to share further feedback on service redesign, provide an update on performance levels, and agree to a permanent change in service delivery or return to the original model.

11:10 BUILD A JOINED-UP FUTURE

17. New hospital development

To accept the update and timeline for development

For Report

Presented by Craig Black

Trust Board - 28 February 2020

Agenda item:	17			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Jacqui Grimwood, Estates and Facilities Development Manager			
Date prepared:	21 November 2019			
Subject:	Strategic and Outline Business Case - New Hospital			
Purpose:	✓	For information		For approval

EXECUTIVE SUMMARY:

1.0 INTRODUCTION

This paper outlines the business case process, resources and programme for the preparation of the business case for the re-provision of a new hospital. The work undertaken during the development of the business case will ensure the estate responds to the clinical vision for healthcare delivery across west Suffolk. The emphasis of the business case will be on working with Alliance colleagues to provide a focus for early intervention and keeping people out of hospital and of course the business case will specifically meet the objective of the development of a health and social care campus.

2.0 BUSINESS CASE CONTENT

All centrally funded public spending proposals including those subject only to departmental approval are required to use the Treasury approach and all major projects considered by the Treasury and Cabinet Office, through the Project Assessment Unit. Projects approved by Treasury must be prepared and presented using the Treasury's Five Case Model method.

The business case must evidence:

- That the new hospital is supported by a compelling case for change that provides holistic fit with other parts of the organisation and public sector - the *strategic case*
- That the new hospital represents best public value - the *economic case*
- That the proposed deal is attractive to the market place, can be procured and is commercially viable - the *commercial case*
- That the proposed spend is affordable - the *financial case*
- That what is required from all parties is achievable - the *management case*

The Five Case Model is a framework for *thinking* in terms how interventions can be best delivered. It sets out three basic questions:

Where are we now? - understanding the existing policy, strategy and programmes in terms of agreed services and policy outcomes - *existing arrangements*.

Where do we want to be? - understanding what the goals are in terms of agreed services and policy outcomes - *business needs*.

How are we going to get there? - understanding potential options for scope, solution, delivery, implementation and funding of the underpinning policies and programmes; How we deliver the chosen policies and programmes in partnership with others; What the costs will be over the short, medium and long term; Whether we have the resources within the public sector (HR, marketing, information technology etc) to deliver.

The re-provision of the hospital has been included in wave two of the Health Infrastructure Plan (HIP),

21 schemes have been given the green light to go to the next stage of developing their plans (with the aim of being ready to deliver between 2025-2030); specifically, seed funding for the development of the business case. At this stage there is a lack of clarity regarding the scale, scope and extent of the business case process. This paper assumes that the Trust will be required to follow the process outlined in section 2.

In 2015 the Trust looked at three options for the re-provision of the hospital. As such, some of the work has already been completed to inform a strategic outline business case, but needs to be refreshed to take account of current thinking.

3.0 BUSINESS CASE PROCESS

The key stages in the development and delivery of an investment proposal are as follows:

Stage	Business case development process
0	Determining a strategic policy or programme which provides the context through preparing the strategic outline programme (SOP): The purpose of this stage is to verify that the strategic context for the proposed intervention is current, rational, approved in principle and still accepted. <u>*Status*</u> *Some pre-SOC work has been undertaken and could be uplifted to form an outline SOC.*
1	Scoping the scheme and preparing the strategic outline case (SOC): The purpose of this stage is to confirm the strategic context of the proposal and to make a robust case for change, providing stakeholders and customers with an early indication of the 'preferred' way forward <u>*Status*</u> *A significant part of the groundwork for the SOC has been completed.* *Further work is needed regarding the proposed/on-going model of care and how that links/fits within the wider health economy, along with significant modelling of the activity and capacity impacts this would have on the whole health economy.* *This is a key part of the strategic case and would need evidence of wider consultation/support within the health economy particularly as the Trust aspires to provide a "health campus" including primary, community and social services.*
2	Planning the scheme and preparing the outline business case (OBC): The purpose of this stage is to revisit earlier SOC assumptions and analysis in order to identify a 'preferred option' which demonstrably optimises value for money. It also sets out the likely deal; demonstrates its affordability; and details the supporting procurement strategy, together with management arrangements for the successful delivery of the proposal. The model of care needs to be further developed with operational policies/planning and design details for each service. Developing this detail along with a public sector comparator/exemplar scheme will require significant user engagement which can be the difficult aspects when working to timescales. Again, evidence of health economy and public engagement/consultation will be required, particularly where services are re-locating - another time consuming element.

	Other elements will be outline planning and residual estate issues, depending on whether any services (hospital or wider health/social) will be retained on the original site.
3	Procuring the solution and preparing the full business case (FBC): The purpose of the FBC is to revisit and where required rework the OBC analysis and assumptions building in and recording the findings of the formal procurement. This case at its conclusions recommends the most economically advantageous offer, documents the contractual arrangements, confirms funding and affordability and sets out the detailed management arrangements and plans for successful delivery and post evaluation. It should be noted to provide the costs for this element of the business case a substantial element of the detailed design needs to have been undertaken and this attracts a significant cost.

A summary work plan has been developed, see Appendix A. The plan identifies the level of tasks needed to achieve the content required to inform the business case.

4.0 STAKEHOLDER INVOLVEMENT

Consultation needs to be incorporated with key stakeholders as part of the development of the business case.

If the hospital is re-located to an alternative site public consultation will be required.

Stakeholder engagement has been incorporated into the engagement workstream, see Appendix C.

5.0 RESOURCES

The programme structure will be fully integrated into the Trust's governance arrangements and will report to the Trust Board, Scrutiny Committee and Trust Executive Group throughout the development of the business case see proposed structure shown in Appendix C.

The Chief Executive Officer (Senior Responsible Owner for this project), Director of Resources, Medical Director and the Trust's Chair will ensure strong leadership for the project.

The Programme will be supported by a Programme Director and a fully resourced Programme Office and Core Team, of appropriately experienced and qualified individuals. The programme will be managed in line with best practice ensuring that roles and responsibilities are clearly defined. Decision making will be transparent and will be documented to ensure a robust audit trail is maintained.

5.1 Programme Board

The Programme Board will be the decision-making body for the management of the business case programme. This will be the key group in defining the scope of the project and the proposals for its delivery. This will include resource and programme management across all the tasks necessary to successfully deliver the business case.

5.2 Programme Owner and Sponsor

The programme is 'owned' by the Board of West Suffolk NHS Foundation Trust. However, given the impact on the whole health economy other healthcare partners will also be crucial participants to ensure an integrated vision for the provision and model of care.

The Senior Responsible Owner (SRO) The Chief Executive Officer undertakes the SRO role for this project. The SRO is personally accountable for the success of the project ensuring that the project meets its objectives and delivers benefits. The SRO will ensure that the project maintains business focus in a changing healthcare context and that risks are managed effectively.

5.3 Programme Director
The Programme Director is responsible for strategic management and decision making on behalf of the SRO and setting high standards for delivery of the project - appointment TBC.

5.4 Programme Manager
The Programme Manager will coordinate the activities of the Programme Office and Core Team on a day to day basis and is responsible for ensuring that procurement and engagement runs smoothly - appointment TBC.

5.5 Project Management Office
A Project Management Office will be established to support the Project Director, Project Manager and Work Stream Leads. Their role will include writing the business case, supporting work streams and the development and issue of project documentation (position statements, update reports, risk/issue logs etc). This team will be a key link between the project and those delivering the individual clinical and support services. As such they will also be important in providing a route for communication and consultation with staff not directly involved in delivering the project.

5.6 Project Work Streams
In order to successfully manage this programme a number of project groups will be established, these are outlined in Appendix C, along with an indication of key areas of responsibility for each work stream e.g. IT, estates, clinical - post holders TBC.

5.7 Internal Advisors
Key members of the team responsible for supporting information to deliver the business case will come from a wide range of staff across the organisation. These include clinicians, service managers, financial, facilities management, estates and human resource professionals. Appendix B details the level of time commitment that will be required for each stage of the work plan.

5.8 External Advisors
The Trust through its approved Professional Services Framework Contract of technical consultants can appoint and manage the external advisors as required. The range of advisers commissioned will vary over time as will the scope of their activities and includes:
- Framework/contract lead consultant
- Architects
- Cost consultants
- Health planners
- Structural Engineers
- Mechanical and Electrical
- Town Planning consultants
- Transport consultants
- BREEAM consultants

6.0 COSTS
It is anticipated that the costs associated with delivering the business case will be in the region of £5.1m; this has been broken down into internal and external resources. By way of a comparator Brighton and Sussex University Hospitals NHS Trust completed their business case for a scheme valued at £486m for 77,000m², the costs to develop their business case in 2008 was £3.9m.

6.1 Internal Resources
A high level assessment has been undertaken based on the tasks identified in the work plan (Appendix A) to establish the level of internal resources required to support the development of the business case. The assumed backfill costs are circa £2.2m. Staffing for the Project Management Office has also been included. The detail regarding the roles and level of time needed, for each role over the 24 month period is shown in the Internal Resource Pan at Appendix B.

Back filling of all posts is optional and costs could be reduced though omitting elements of cover. However, the impact on the staff in post undertaking additional work relating to the business case must

be considered, for example, increased pressure could potentially result in inefficiency leading to programme delay or have a negative impact on productivity and morale.

6.2 External Resources
External advisors and a range of technical reports will be required to inform the business case (see 5.8).

The Trust has submitted a bid to NHSE/I for £5.16m as part of the Health Infrastructure Plan bidding process to access seed funding to facilitate resourcing of the business case process.

7.0 PROGRAMME
The programme has been split into 6 stages (with Scrutiny Committee sign off for each stage), these are:

Phase	Programme
1. Development of project initiation document	January 20 - May 20
2. Project team mobilisation	May 20 - October 20
3. Development of strategic context	November 20 - January 22
4. Defining the brief and short listing	February 22 -June 22
5. Identification of preferred option	July 22 - December 22
6. Detailed analysis of preferred option	January 23 - September 23

Note all timescales *exclude* the external approval process by DH, Treasury and external regulators.

8.0 RISKS/ISSUES TO CONSIDER
Early risks identified to date that need inclusion on the risk register are:
- Gaining commissioner support within the timescales
- Collaborative working with the local authority within the timescales
- Trust stakeholder engagement and buy-in
- Recruitment and retention of key clinical staff to resource the proposed models of care
- Financial analysis may demonstrate that one or more of the shortlisted options are unaffordable, potentially leading to reconsidering shortlisting decision and delay
- Lack of revenue affordability to local health economy of capital requirement and of whole system change adversely impacts identification of preferred option

9.0 ITEMS APPROVED BY TRUST SCRUTINY COMMITTEE
- Proposed structure for the delivery of the business case
- Immediate appointment of the Project Director to establish a programme office to manage the development of the business case.
- Appointment of a Clinical Director to provide clinical leadership for the development of the clinical model.
- Appointment of Workstream Leads
- Backfill of the above positions if posts are appointed to internally.

See Appendix C for proposed governance structure.

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

Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	✓	✓	✓	✓	✓	✓	✓
Previously considered by:	Scrutiny Committee - 13/11/13, 08/01/14, 12/03/14, 09/04/14, 14/05/14, 09/07/14, 08/10/14, 10/12/14, 11/02/15, 11/03/15, 10/06/15, 11/11/15, 11/12/19 Trust Board - 25/04/14 Trust Board workshop 02/10/14, 24/10/15 Trust Executive Group 6/1/2020						
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							

Recommendation:
The Committee is requested to note the contents of this paper and acknowledge the scale of the work and resources required to draft the business case.

Appendix A Detailed work stage plan

Ref	Work Stages	Activity
0	**Approval to Commence Business Case**	
		High level overview of process, resources and costs.
	Scrutiny Committee Gateway	
1	**Outline Business Case Project Initiation Document**	
		Set out the scope of the business case indicating aims and objectives Programme to deliver business case Project organisation and structure Definition of roles and responsibilities Management procedures and budgets Risk management Quality assurance Stakeholder engagement
	Scrutiny Committee Gateway	
2	**Mobilisation**	
		Project start up Establish PMO Establish project documentation/processes Commence project kick off meetings Commence stakeholder engagement
3	**Development of Strategic Context**	
		Project initiation /start-up Receive, format and validate baseline activity information and datasets Prepare and facilitate clinical workshop 1: clinical vision, service model, future demand & referral patterns Prepare draft service, demand and capacity report Prepare and facilitate clinical workshop 2: models of care, throughput and utilisation Initial demand and activity modelling Prepare and facilitate clinical workshop 3: capacity and functional requirements Initial agreement and application of best practice benchmarks Update service, demand and capacity report Locality and catchment area analysis and modelling Set up agreed service and functional units in capacity model Produce activity and capacity projections Review and finalise demand and capacity models Prepare final draft of service, demand and capacity report Feedback to Project Team and key stakeholders Finalise and issue final service, demand and capacity report
	Scrutiny Committee Gateway	

Ref	Work Stages	Activity
4	**Defining the Brief and Short Listing**	
	Clinical Brief: Whole Hospital	Initial drafting of functional brief document Review with clinical leads Clinical leads to liaise with colleagues and provide information Revision of functional brief document Review with clinical leads Sign off by clinical leads and project team
	Clinical Brief: Departmental	Initial drafting of departmental documents Review with departmental leads Departmental leads to liaise with colleagues and provide information Revision of functional brief document Review with departmental leads Sign off by departmental leads
	Functional Relationship Diagram - Whole Hospital	Initial meeting with clinical team Initial drafting of departmental relationships Presentation to clinical team Revision of departmental relationships Sign off by clinical team
	Schedule of Accommodation	Initial draft Review with project team Revision of schedule of accommodation Meetings with each departmental team Sign off by departmental leads Sign off by project team
	Functional Relationship Diagrams - Departmental	Initial meeting with each departmental lead Initial drafting of room relationships Presentation to departmental leads Revision of room relationships Sign off by departmental leads Sign off by project team
	Scrutiny Committee Gateway	
5	**Identification of Preferred Option**	
		Review shortlist of options Review clinical model, clinical brief and design standards Review of functional content/ schedule of accommodation Site data collection for each option

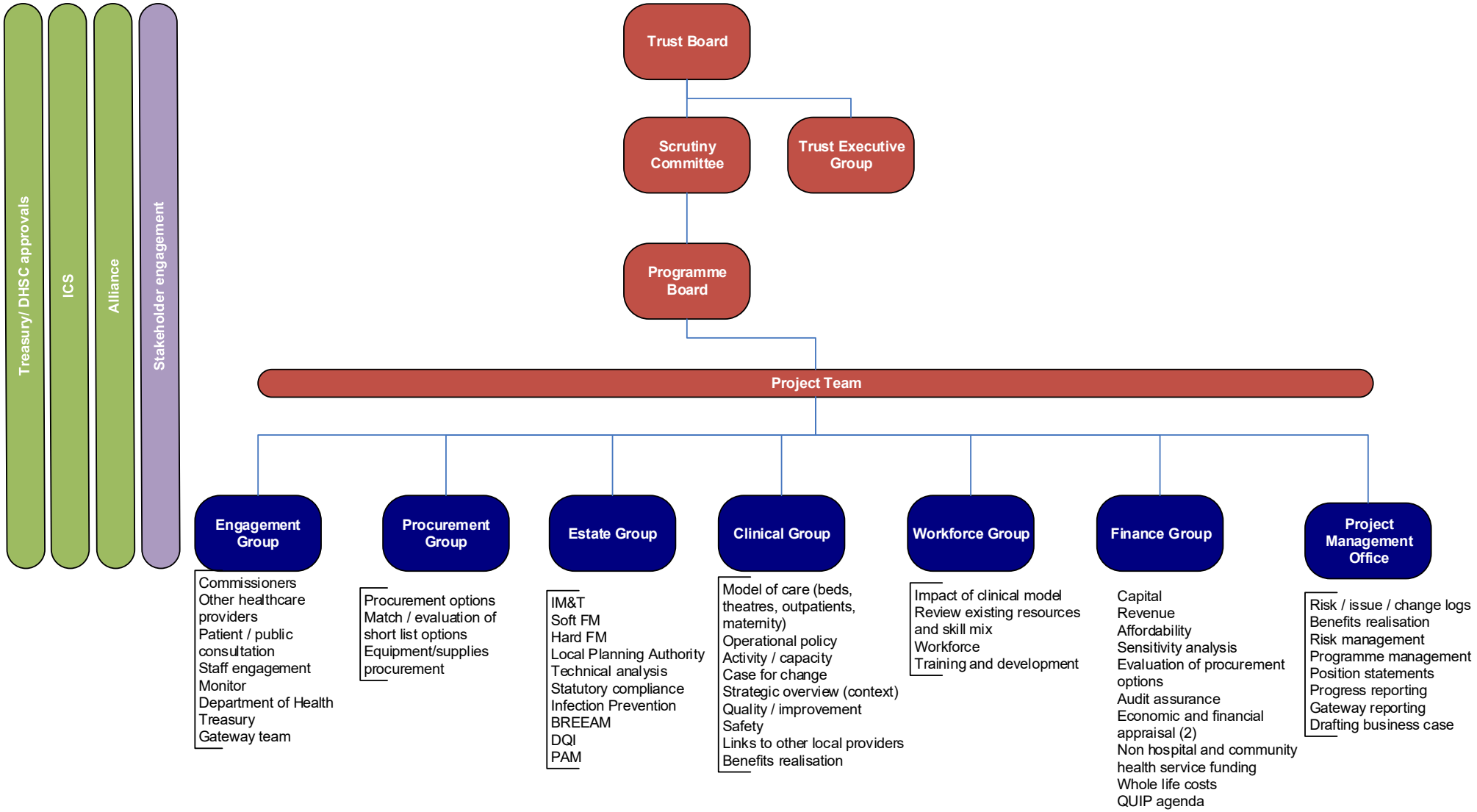
Ref	Work Stages	Activity
		Review Local Authority planning issues for each option Project Team Meeting Site data collection for each option Development of adjacency diagrams for each option Stakeholder engagement meeting to review adjacency diagrams for each option Stakeholder engagement meeting to review masterplan, 1:500 layout plans and any phasing for each option Develop high level capital cost for each option Develop high level revenue cost for each option Financial appraisal of options Non-financial appraisal of options Sensitivity analysis Determine preferred option Develop stage report Issue report identifying preferred option
	Scrutiny Committee Gateway	
6	**Detailed Analysis of Preferred Option**	
		Review clinical model, clinical brief and design standards Review operational policies Review of functional content/ schedule of accommodation Review site data Development of adjacency diagrams Project team meeting Review clinical model, clinical brief and design standards Review operational policies Review of functional content/ schedule of accommodation Review site data Review Local Authority planning issues Development of adjacency diagrams Stakeholder engagement meeting to review adjacency diagrams Development of 1:200 department layout plans Stakeholder engagement meeting to review 1:200 department layout Review services strategy/integration Review structural strategy Develop site plan Development of 1:200 department layout and phasing plans Initial BREEAM review Risk assessment Review services strategy/integration Review structural strategy Develop typical room data sheets and 1:50 room loaded plans Cost review Stakeholder engagement meeting to review site plan, 1:200 department layout plans and 1:50 typical room loaded plans

Ref	Work Stages	Activity
		Design quality indicator assessment Prepare outline planning application Develop site plan Prepare outline planning application Submit outline planning application Develop transition plan Develop benefits realisation plan Develop IM and T strategy Develop training and development plan Develop economic and financial details Develop procurement strategy and programme Develop Outline Business Case Design quality indicator assessment Develop transition plan Develop benefits realisation plan Submit Outline Business Case
	Scrutiny Committee Gateway	

Appendix B Internal resource plan

Stage	1			2			3								4												5								10%			
Event	Develop OBC Project Initiation Do			Mobilisation of project team and r			Development of strategic context	Project Board Meetings	Project Team Meetings	Project kick of meeting	Service vision and models of care	Stakeholder meetings	Checkpoint calls/meetings			Defining the brief and short listing	Project Board Meetings	Project Team Meetings	Project kick of meeting	Work Stream Meeting	Clinical brief - whole hospital	Clinical brief - departmental	Functional relationships - whole h	Schedule of accommodation	Functional relationship diagrams -	Checkpoint calls/meetings		Identification of preferred option	Project Board Meetings	Project Team Meetings	Work Stream Meeting	Stakeholder meetings	Design Team Meetings	Short listing workshop	Total hours	Contingency (time) 10%	Rate	Cost	Backfill
Role																																						
Chief Executive Officer								10								10												18					7.5	81.50	8	95	8,482	
Director of Resources								10		4	12		4			10		4		127.5	127.5	9.5		9	4			18					7.5	391.00	39	82	35,268	
Director of Nursing								10								10												18			27		7.5	135.50	14	63	9,402	
Chief Operating Officer								10		4	12		4			10		4		127.5	127.5	9.5		9	4			18			27		7.5	445.00	45	69	33,964	
Medical Director								10		4	12		4			10		4		127.5	127.5	9.5		9	4			18			27		7.5	445.00	45	95	46,314	
Non-Executive Director								10					4			10												18					7.5	85.50	9	6	593	
Clinical Lead Medicine								10		4	12		4			10		4		127.5	127.5	9.5		9	4			18			27		7.5	445.00	45	76	37,051	
Clinical Lead Surgery								10		4	12		4			10		4		127.5	127.5	9.5		9	4			18			27		7.5	445.00	45	76	37,051	
Clinical Lead Women's and Children's								10		4	12		4			10		4		127.5	127.5	9.5		9	4			18			27		7.5	445.00	45	76	37,051	
Clinical Lead Clinical Support								10		4	12		4			10		4		127.5	127.5	9.5		9	4			18			27		7.5	445.00	45	76	37,051	
Head of IM&T									20									4	20											24	27		7.5	173.50	17	50	9,631	9,631
Emergency Care Clinical Lead									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Paediatric Clinical Lead									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Obstetrics Clinical Lead									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Theatres/Critical Care Clinical Lead (inc DSU/Admissions)									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Planned Care Clinical Lead									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Diagnostics Clinical Lead (Radiology/Endoscopy/Cath Lab)									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Outpatients Clinical Lead									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Pathology/Mortuary Clinical Lead									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Pharmacy Clinical Lead									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Teaching/Research Lead									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Community Clinical Lead									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Health Records Lead									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Nursing Lead Medicine									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Nursing Lead Surgery									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Nursing Lead Specialist									20	4	12		4					4	20	127.5	127.5	9.5	9	9	4					24	27		7.5	488.00	49	76	40,632	40,632
Project Director																																		3,600.00	360	82	324,720	324,720
Project Manager 1																																		3,600.00	360	63	249,785	249,785
Project Manager 2																																		3,600.00	360	50	199,828	199,828
Project Manager 3																																		3,600.00	360	32	124,892	124,892
Administrator 1																																		3,600.00	360	16	62,446	62,446
Administrator 2																																		3,600.00	360	16	62,446	62,446
Work Stream Lead Estate									20	4							20	4	20	112.5	12		5	4					24	24	27	36	7.5	503.00	50	38	20,940	20,940
Work Stream Lead Finance									20	4							20	4	20										24	24	27		7.5	249.50	25	38	10,387	10,387
Work Stream Lead Procurement									20	4							20	4	20										24	24	27		7.5	249.50	25	25	6,925	6,925
Work Stream Lead Clinical									20	4	12		4				20	4	20	127.5	127.5	9.5	9	9	4				24	24	27		7.5	568.00	57	63	39,410	39,410
Work Stream Lead Workforce									20	4							20	4	20										24	24	27		7.5	249.50	25	32	8,656	8,656
Work Stream Lead Engagement									20	4							20	4	20										24	24	27		7.5	249.50	25	25	6,925	6,925
Senior HR Advisor																																		2,250.00	225	22	54,640	54,640
Estate Advisor																																		2,250.00	225	19	46,835	46,835
HR Advisor																																		2,250.00	225	19	46,835	46,835
Senior Finance Advisor																																		2,250.00	225	22	54,640	54,640
Finance Advisor																																		2,250.00	225	19	46,835	46,835
Fire Advisor																				112.5	12		5	4							27	36	7.5	275.00	28	25	7,632	7,632
Infection Prevention Advisor																				112.5	12		5	4							27	36	7.5	275.00	28	25	7,632	7,632
Security Advisor																				112.5	12		5	4							27	36	7.5	275.00	28	22	6,678	6,678
Soft FM Advisor																				112.5	12		5	4							27	36	7.5	275.00	28	25	7,632	7,632
Hard FM advisor																				112.5	12		5	4							27	36	7.5	275.00	28	25	7,632	7,632
Procurement Advisor																																	7.5	2,257.50	226	19	46,991	46,991
Total hours		0	0		0	0		100	440	112	276	0	96	0	0		100	120	116	440	3607.5	3004.5	218.5	174	231	92	0		180	144	528	918	216	285	49,408.50	4,941		2,352,676	2,070,447

Appendix C Governance Arrangements



11:20 GOVERNANCE

18. Trust Executive Group report

To ACCEPT the report

For Report

Presented by Stephen Dunn

Board of Directors – 28 February 2020

Agenda item:	18			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	20 February 2020			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

3 February 2020

Steve Dunn provided an **introduction** to the meeting emphasising the reflections on the CQC report findings and the need for the senior leaders from TEG to be visible in the organisation in order to listen to and support staff. The meeting noted that EU had taken place and the latest guidance and the Trust's plans on Coronavirus were reviewed.

The achievement of the 80% target for **staff flu vaccination** was welcomed as a significant achievement.

Quality, operational and financial performance was reviewed from the recent reports. It was recognised that hospital and community services were under significant demand and plans prepared for the winter are supporting the operational response. A number of areas of challenge were considered in more detail, including falls referral to treatment (RTT). The change to the use of the clinical decision unit to support the rapid assessment and treatment of patients was reviewed and felt to be working well. The receipt of additional funding to reflect the activity we have experienced was welcomed.

The **red risk report** was received. There were six new red risks, mitigating actions to control the risks were reviewed. Four red risks were downgraded, this included the EU exit risk. The corporate and operation risks were also reviewed which are subject to executive review and discussion at divisional performance review meetings.

The **learning from deaths business case** was reviewed. The change to support the medical examiner roles was supported and it was agreed that the requirements for learning from deaths form part of the budget setting process.

Discussion took place on the **CQC report** and development of the improvement plan, this included the action to address the 'must' and 'should' findings.

Business cases were discussed and approved for the appointment of consultants in **plastic surgery and neurology**.

Feedback was received from the intensive support team (IST) **cancer performance review**. This highlighted that there were a number of areas of good practice, together with priority areas of improvement, including pathway standardisation, improved monitoring and a structured training programme for all relevant staff.

Discussion took place of the **budget setting for 2020/21**. The next Transformation Steering Group will be key to reviewing and prioritising the list of planned developments prior to submission to the Board in March.

The **primary care vertical integration** proposal was reviewed. This was recognised as an exciting opportunity to work differently with local primary care to promote the interests of the local population.

17 February 2020

Steve Dunn provided an **introduction** to the meeting focussing on the forthcoming quality summit with NHSE/I and external stakeholders on 4 March 2020. The progress to address the 2019-20 year-end financial position was also recognised.

The work to develop the **CQC improvement plan** was reviewed, included engaging the CCG to provide assurance on the focus of the action to deliver sustained improvement against the CQC findings. A detailed discussion took place on the cultural piece that is being developed in response to CQC feedback. This included the themes that were emerging from staff conversations and discussions with staff on how to respond.

An update was received on the **human factors** quality priority for 2019/20. It was noted that training and support continued with extension of the human factor faculty within the Trust. The significant progress was welcomed and future plans supported.

Following presentation at the Quality & Risk Committee a presentation was received on the use and development of **co-production**. This initiative is being supported by Healthwatch Suffolk to support effective engagement of users in planned and potential service developments.

The latest **staff survey results** were presented with highlighted some excellent results for the Trust, but also some areas for improvement which will need to be further analysed.

Discussion took place on the plans to respond the national funding announcement, including access to seed funding for the Trust to develop a full business case for a **new development** to replace the existing hospital building. In the first instance this is being addressed through the development of a strategic outline case (SOC) for the development options. It is planed that the SOC is completed by April 2020.

The **financial losses and waivers** report was reviewed, including the rationale for some of the waivers.

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

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

Previously considered by:	The Board receives a monthly report from TEG
Risk and assurance:	Failure to effectively communicate or escalate operational concerns.

Legislation, regulatory, equality, diversity and dignity implications	None
Recommendation: 1. The Board note the report	

19. Audit Committee report

To accept the report

For Report

Presented by Angus Eaton

Trust Board Meeting – 28 February 2020

Agenda item:	19			
Presented by:	Angus Eaton, NED and Chair of the Audit Committee			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	19 February 2020			
Subject:	Audit Committee report - meeting held on 31 January 2020			
Purpose:		For information	X	For approval

Executive summary:

The Audit Committee was held on 31 January 2020. The key issues and actions discussed were:-

- **Board Assurance Framework 'deep dive' – 'Improving our Culture and Staff Support' –** A discussion was held around the proposed audit to be undertaken on 'Freedom to Speak Up'. This is to be completed by Internal Audit. The scope of the review was discussed, which will incorporate the 'must do' recommendations raised by the CQC. The Director of Workforce also provided an update on what the Trust was doing in terms of addressing the recommendations raised by the CQC in terms of 1. Speak up and 2. Open and transparent culture and relations with medical staff.

- **Internal Audit and Counter Fraud** - The Internal Audit Progress Report confirmed that one further Audit Report had been issued since the last Audit Committee on Asset Management from the 2019/20 Audit Plan. The Report received a substantial assurance opinion. Three further reviews are in progress and the final reports will be issued before the next Audit Committee in April.

  Internal Audit talked the Committee through the outstanding Internal Audit recommendations. Since the previous Committee, 11 outstanding recommendations had been cleared. There now remains 17 un-cleared recommendations, 11 of which are overdue.

  Internal Audit also presented their Audit Plan for 2020/21. The content was discussed in detail and further discussions will be held with Executive Leads before the Plan is finalised.

  An update was provided by LCFS. Since the last Committee, a few fraud prevention notices have been received, however these had all been dealt with an appropriate action take. The 2020/21 LCFS Workplan is currently being developed and will be brought to the April Audit Committee.

- **External Audit** – The 2019/20 Audit Plan was presented. External Audit confirmed that the risks included in the Plan were largely standard. External Audit asked the Committee to confirm that they were not aware of any fraud, which the Committee confirmed. External Audit also confirmed that no conflicts of interests had been identified. The Committee approved the Audit Plan.

- **Financial Reporting** – A paper was presented to the Committee on changes to accounting policies and going concern considerations. There had been no significant change since the prior

year. The going concern principles remain the same and this would be considered further at the year end.

- **Debt write offs** – The Committee approved the write off of debts amounting to £87,407. This predominately related to Overseas Visitor Patients where the Trust has been unable to recover the debt.

- **Quality Report Limited Assurance Report 2019/20** – The Committee were advised on the likely performance indicators which will be subject to Audit, however this is to be confirmed. The Governors are required to choose a local indicator to be tested by External Audit and this will be decided at the Governors Meeting on 11 February.

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

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

Previously considered by:	*This report has been produced for the monthly Trust Board meeting only*
Risk and assurance:	*None*
Legislation, regulatory, equality, diversity and dignity implications	*None*

Recommendation:
The Board is asked to:

- Receive and note the Audit Committee report for meeting held on 31 January 2020.

20. Council of Governors meeting report

To accept the report

For Approval

Presented by Sheila Childerhouse

Board of Directors – 28 February 2020

Agenda item:	20			
Presented by:	Sheila Childerhouse			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	20 February 2020			
Subject:	Report from Council of Governors, 11 February 2020			
Purpose:		For information	X	For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 11 February 2020. The report is presented to the board of directors for information to provide insight into these activities. Key points from the meeting were:

- The Chair welcomed and introduced Jeremy Over, Director of HR and Communications.
- A written report was received from the Chair which provided a summary of the focus of the meetings and activities that she had been involved in over the last three months.
- The Chief Executive's report provided an update on the challenges facing the Trust and recent achievements. He referred to the CQC report and apologised for the outcome of this and explained actions that were being taken to address the issues identified.
- Responses to governors' issues raised were received and the recommendations noted.
- The finance and quality and performance reports were reviewed and questions asked on areas of challenge.
- The timetable for producing the Operational Plan and Annual Quality Report was explained. Six governors volunteered to act as readers.
- Governors agreed that the local indicator to test the reliability of data reported in the Annual Quality Report would be emergency readmissions within 28 days of discharge from hospital.
- The link to the CQC report was noted and it was reported that this had been discussed in the closed session of this meeting.
- The results of the governor review were received and the actions based on the findings noted.
- An update was received on the West Suffolk Alliance together with a report on vertical integration between WSFT and Glemsford surgery.
- A report from the nominations committee was received. Governors approved the appraisal process and revised job description and person specification for the Chair and non-executive directors.
- The summary of the governors' register of interests was received and reviewed.
- Reports were received from the engagement committee, lead governor and staff governors.

<table>
<tr><td rowspan="2">Trust priorities
[Please indicate Trust priorities relevant to the subject of the report]</td><td colspan="2">Deliver for today</td><td colspan="2">Invest in quality, staff and clinical leadership</td><td colspan="3">Build a joined-up future</td></tr>
<tr><td colspan="2">X</td><td colspan="2">X</td><td colspan="3">X</td></tr>
<tr><td rowspan="2">Trust ambitions
[Please indicate ambitions relevant to the subject of the report]</td><td>Deliver personal care</td><td>Deliver safe care</td><td>Deliver joined-up care</td><td>Support a healthy start</td><td>Support a healthy life</td><td>Support ageing well</td><td>Support all our staff</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Previously considered by:</td><td colspan="7">Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.</td></tr>
<tr><td>Risk and assurance:</td><td colspan="7">Failure of directors and governors to work together effectively. Attendance by non executive directors at Council of Governor meetings and vice versa. Joint workshop and development sessions.</td></tr>
<tr><td>Legislation, regulatory, equality, diversity and dignity implications</td><td colspan="7">Health & Social Care Act 2012. Monitor’s Code of Governance.</td></tr>
<tr><td colspan="8">Recommendation:

• The Board is asked to note the summary report from the Council of Governors.</td></tr>
</table>

21. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 28 February 2020

Agenda item:	21			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	20 February 2020			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

The attached provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points.

The final agenda will be drawn-up and approved by the Chair.

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

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

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

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 27 March 2020

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Integrated quality & performance report, including appraisal (with consultants)	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Quality and learning report	✓		Written	Matrix	RP/NJ
"Putting you first award"	✓		Verbal	Matrix	JO
Consultant appointment report	✓		Written	Matrix – by exception	JO
7 day services report	✓		Written	Matrix	RP
CQC inspection improvement plan	✓	✓	Written	Action point	RP
Education report - including undergraduate training (6-monthly)	✓		Written	Matrix	JO
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
Budget setting and capital programme 2020-21		✓	Written	Matrix	CB
Operational plan draft submission		✓	Written	Matrix	SD
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Charitable funds committee report	✓		Written	Matrix	GN
Annual governance review		✓	Written	Matrix	RJ
Review of NED responsibilities	✓		Written	Matrix	SC
Board assurance framework review		✓	Written	Matrix	RJ
Scrutiny Committee report		✓	Written	Matrix	GN
Confidential staffing matters		✓	Written	Matrix – by exception	JO
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:30 ITEMS FOR INFORMATION

22. 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

23. Date of next meeting

To note that the next meeting will be held on Friday, 27 March 2020 at 9:15 am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

24. 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