NHS
West Suffolk
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 1 December 2017 at 9.15** in the Northgate Room, 2nd Floor, Quince House at West Suffolk Hospital

Roger Quince
Chairman

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Introductions and apologies for absence** To note any apologies for the meeting	Roger Quince
2.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Roger Quince
3.	**Review of agenda** To agree any alterations to the timing of the agenda	Roger Quince
4.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Roger Quince
5.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 3 November 2017	Roger Quince
6.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Roger Quince
7.	**Chief Executive's report (attached)** To accept a report on current issues from the Chief Executive	Steve Dunn
9:35 DELIVER FOR TODAY		
8.	**Integrated quality and performance report (attached)** To receive the report	Helen Beck / Rowan Procter
9.	**Finance & Workforce Performance report (attached)** To accept the monthly Finance & Workforce report	Craig Black
10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
10.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter
11.	**Learning from deaths (attached)** To accept the report	Nick Jenkins
12.	**Safeguarding children level 3 training (attached)** To accept a report	Rowan Procter
13.	**Appraisal report (attached)** To accept a report	Jan Bloomfield

14.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
10:50 BUILD A JOINED-UP FUTURE		
15.	**e-Care report (attached)** To receive an update report	Craig Black
16.	**Alliance and community services** **(a) Delivery and integration update (attached)** To receive update report **(b) System governance report (attached)** To approve report recommendations	 Dawn Godbold Steve Dunn
17.	**Pathology services (attached)** To receive an update report	Nick Jenkins
18.	**Financial Improvement Programme (attached)** To receive an update from KMPG	Craig Black
11:00 GOVERNANCE		
19.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
20.	**Audit Committee report (attached)** To approve the recommendations	Steve Turpie
21.	**Senior independent director (attached)** To approve the report recommendation	Richard Jones
22.	**Use of Trust seal (attached)** To note the report	Richard Jones
23.	**Cancer operational policy (attached)** To note the policy	Helen Beck
24.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:15 ITEMS FOR INFORMATION		
25.	**Any other business** To consider any matters which, in the opinion of the Chairman, should be considered as a matter of urgency	Roger Quince
26.	**Date of next meeting** To note that the next meeting will be held on Friday, 26 January 2018 at 9:15 am in the Committee Room.	Roger Quince
RESOLUTION TO MOVE TO CLOSED SESSION		
27.	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 l960	Roger Quince

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 3 NOVEMBER 2017

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Roger Quince	Chairman	•	
Helen Beck	Interim Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
Jan Bloomfield	Executive Director Workforce & Communications	•	
Richard Davies	Non Executive Director	•	
Steve Dunn	Chief Executive	•	
Angus Eaton	Board Advisor	•	
Neville Hounsome	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Gary Norgate	Non Executive Director	•	
Rowan Procter	Executive Chief Nurse	•	
Alan Rose	Non Executive Director	•	
Steven Turpie	Non Executive Director/Deputy Chairman	•	
In attendance			
Dawn Godbold	Director, Community Integration		
Georgina Holmes	FT Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Tara Rose	Head of Communications		
Catherine Waller	Intern Non Executive Director		

Action

GENERAL BUSINESS

The Chairman welcomed everyone to the meeting and introduced Nick Finch who had been appointed as the Freedom to Speak Up Guardian for WSFT. He also welcomed Dawn Godbold, Director of Community Services Integration, who would be attending Board meetings as WSFT moved towards a system of integrated care, and Catherine Waller, Intern NED, who would be contributing to the meeting in the same way as other Board members.

17/205 APOLOGIES FOR ABSENCE

There were no apologies for absence.

17/206 QUESTIONS FROM THE PUBLIC

- June Carpenter asked about A&E performance. It was explained that this would be discussed later in the meeting.

- Judy Cory referred to page 4 of the Chief Executive's report and the inclusion of a pharmacy outlet as part of the refurbished main hospital entrance concourse. She was concerned about the effect that the introduction of a high street pharmacy would have on the Friends' shop.

Craig Black confirmed that the pharmacy would be an outpatient pharmacy sourced from WSFT, however with the loss of WH Smith the Trust would need to consider what was not being provided elsewhere and the value to patients and visitors. It was requested that this proposal was discussed with the Friends before it was finalised.

It was explained that a paper would be going to the Board in December. Work was required in order to update and improve the front of the hospital and also Courtyard Café, but this needed to be affordable.

The Chief Executive confirmed that the Friends would be consulted as this was developed.

- Joe Pajak asked if the IT infrastructure provided a failsafe mechanism to ensure there was no duplication of prescription by WSFT and a GP. Nick Jenkins explained that this was not the case and that there was currently no plan for this. All primary care systems had a mechanism to address duplication of certain medications prescribed by secondary care.

  Richard Davies considered this to be a very important issue and explained that in general practice there was a real problem with communication with secondary care about drugs and this was a national issue. There were good systems in both primary and secondary care but communication between the two was a real issue that needed to be addressed and resolved. Nick Jenkins said that he would be meeting this afternoon with the Professional Records Standards body that had an interest in this.

- June Carpenter asked about the work being done on getting patients up and dressed. Helen Beck explained that this was good practice and was a move to avoid deconditioning. Staff were being encouraged to do this and family/carers were welcome to help but were there was no expectation that they must. They were however being asked to provide clothes for patients.

17/207 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

17/208 DECLARATION OF INTERESTS

There were no declarations of interest.

17/209 MINUTES OF THE MEETING HELD ON 29 SEPTEMBER 2017

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

Page 2, bullet 4, para 2 to be amended to read, “Nick Jenkins explained that 2.16% of patients who attended the Emergency Department re-attended”.

17/210 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following issue raised:-

Item 1466 – clarity on future provision of stroke service as part of the STP service model. Roger Quince noted the target date of 29/12/17 and asked when this would come to the Board. Nick Jenkins explained that the definitive STP decision on stroke would be well into next year.

The Chief Executive explained that a piece of work was being undertaken around prioritising stroke services and the STP was putting in resource to drive this evidence based review.

It was agreed that an update should be given to the Board meeting at the end of January.

The completed actions were reviewed and the following issue raised:-

Item 1465 – Consider how to use outpatient appointment letters to communicate to patients regarding use of chaperones. Richard Davies referred to the ongoing issues relating to the chaperone policy and the review of how this was communicated, which was rated amber in the quality report. He said that he did not wish to lose sight of these issues. Rowan Procter confirmed that these issues were being addressed and the final document would go to the Patient Experience Committee, Clinical Safety & Effectiveness Committee and Safeguarding Group.

17/211 CHIEF EXECUTIVE'S REPORT

The Chief Executive highlighted the following:-

- Significant progress was being made on the strategic intention to integrate and join up services across the system and a number of initiatives were now in place.

- The appointment of Sheila Childerhouse as the new Chair was very good news. She had experience in both commissioning and running community services which would further enable the Trust to develop its strategic aims.

- Performance continued to be challenging and a number of meetings had taken place with NHSI and NHS England. The Trust continued to focus on initiatives around this.

- Last weekend phase 2 of e-Care went live and the Chief Executive thanked everyone involved. Cerner had been very pleased with the outcome and delivery of this.

- A number of very good awards had been won by staff, including Jan Bloomfield who won the Bury Free Press Lifetime Achievement Award and Dr Lucy Grove who won Best Doctor at the national 2017 Well Child Awards.

- The CQC would be coming into the Trust on 30 November and 1 December. Staff needed to ensure that they were not complacent even though there had been a recent inspection.

Neville Hounsome referred to the North East Essex and Suffolk Pathology Service (NEESPS). He asked, from a patient safety risk point of view, if the Board could be assured that there was nothing they should be aware of, and if the Trust was happy that patient safety issues were being well managed.

Nick Jenkins considered that patient safety risks were significantly less than with TPP and continued to diminish. There was a credible plan to address these; however there would be quality risks for some time. The biggest risk related to staffing and manning the laboratory. Staff appeared to be of the calibre to do the job and he felt reassured that this was improving.

Neville Hounsome asked when there would be a presentation on Buurtzorg, ie costs and benefits. Rowan Procter explained that a presentation would be given to the Board but she would also like other staff to attend. A visit was taking place to Holland and a presentation would follow this in January or February.

The Chief Executive suggested that this should go the Quality & Risk Committee first and the finances should also go to the Scrutiny Committee. Rowan Procter explained that WSFT was working with the Kings Fund to review and appraise this. **R Procter**

Gary Norgate referred to the refurbishment of the main entrance and asked, in a capital constrained environment, if this was a priority versus the emergency department and other developments. Craig Black agreed that this was an important issue and the five year capital programme would be discussed at the next Board meeting. Work was required to address the backlog around the main entrance but this would need to be carefully considered. **C Black**

The Chief Executive explained that WSFT had put in a bid for £15m as part of the development of the emergency department, but NHSI had not yet been able to confirm this. It was hoped that the outcome would be known by the next Board meeting. There was a plan for the redevelopment of the front of the hospital but as investment was required in the emergency department funding for this would need to be looked at carefully.

Alan Rose referred to the meeting that had taken place yesterday with NHSI, attended by the Chairman and executive team. He asked the Chief Executive how he felt that WSFT was working with the regulator and what the issues were that he considered needed to be addressed. The Chief Executive said that the financial challenges and the 7-8% CIP were an issue; however, broadly WSFT was considered to be in a strong position financially. RTT, A&E and other performance issues were a concern, although NHSI acknowledged that there were plans to address these. They would support the CQC inspection and considered that there was potential for WSFT to be an outstanding organisation.

The Chief Executive felt that WSFT was seen as a strong performer by the regulator, but it needed to ensure that it was progressing in areas of concern, ie A&E and financial control. The Chairman agreed and felt that NHSI was being more supportive in a number of ways and encouraging collaboration with other organisations.

DELIVER FOR TODAY

17/212 QUALITY & PERFORMANCE REPORT

It was explained that both the original performance report and a new format of this report had been included in the Board pack this month.

The Chairman proposed looking at the original report this month, due to time constraints. He asked Board members to feedback any comments on the new version by email. He considered the new format to be a good report, apart from one or two comments.

Rowan Procter referred to the delay in closing outstanding actions relating to RCAs and glitches in achieving the target for SIRI reporting. She was satisfied about the reasons why these had not been achieved, and that sufficient information was required in order to close these.

There had been two cases of MRSA in September and these were going through a process of agreeing that they were not attributable to WSFT, which the CCG supported.

Falls had decreased significantly this month, but there was no change in practice to cause this. This decrease could be a blip as opposed to any other reason.

The new patient safety dashboard had been a positive opportunity to target areas as part of the quality assurance process with matrons and ward managers.

WSFT had been selected by NHSI to take part in a regional collaboration for nutrition, which would share best practice with other organisations.

Richard Davies asked how F5 had managed not to have any pressure ulcers for 500 days and if other ward staff could learn from this. He also referred to unavoidable pressure ulcers at end of life and felt that there was a danger of thinking that it was all right for patients to develop pressure ulcers at end of life. He asked for reassurance that everything was being done to prevent pressure ulcers at end of life.

Rowan Procter explained that F5 had written a case study which was being shared internally and externally to look at best practice. She assured the Board that patients were regularly asked if they would like to be moved or how they would like to be positioned. She explained that palliative care consultants were working six days a week and a seven day service was now being looked at. There was also a project with nurses focussing on training and providing support for end of life patients.

Angus Eaton noted that F3 had a number of red indicators and asked if this was an area of concern. Rowan Procter explained that F3 had previously been flagged as an area of concern as it had six vacancies. However, the way this area was working had been looked at and the establishment of staff had been changed this month. The indicators were now improving but this still remained a challenging ward and would continue to be monitored.

Gary Norgate thanked Rowan Procter for her continued focus on nutrition. He referred to staffing and asked for assurance that there was a plan to balance cost versus safety associated with staffing. Rowan Procter assured the Board that focus on improving finances was not a reason for staff vacancies or reduction in the fill rate. A significant recruitment drive was being undertaken. She would discuss this in greater detail under agenda item 13, nurse staffing report.

Neville Hounsome referred to page 8, pressure ulcers relating to staffing issues. It was explained that this would also be addressed under agenda item 13.

Helen Beck explained that she was personally disappointed in the 18 week position. Despite the significant amount of activity this was not being reflected in performance figures. However, numbers were reducing and patients were being treated in order. She hoped that a clearer picture would come back to the next Board meeting with an updated trajectory for improvement. **H Beck**

Alan Rose referred to the low rate of completion of appraisals and asked if this was a cause for concern and if this would improve. Jan Bloomfield explained that reporting on this had changed and there was a plan to address this. Appraisals were being undertaken but because of the reporting issue the completion figures were not accurately reflected. She was confident that an explanation could be provided to the CQC.

She assured the Board that this remained a focus and the appraisal rate was monitored regularly and managers updated on a monthly basis. She would update the Board next month. Rowan Procter reported that this had also been reiterated with nursing staff.

Angus Eaton asked for a view on the quality of appraisals to be included in the update provided to the Board. Jan Bloomfield explained that the staff survey gave a useful indication of the quality of appraisals, which had not been good but was a national issue. **J Bloomfield**

Gary Norgate referred to community equipment services and noted that it had failed four out of seven indicators this month. He asked if this was a cause for concern. Dawn Godbold explained that this related to two patients but 15 pieces of equipment. The target was missed by 30 minutes for one patient and the other patient's equipment was delivered the next day at the request of the family.

The Chief Executive explained that since this report was written there had been a never event. An investigation was taking place and would be reported in due course. This was a concern to the Trust and was being taken very seriously.

Alan Rose suggested that the Board should move to the new report for next month. It was agreed that this would be the focus, but the old report would be available for reference.

17/213 FINANCE AND WORKFORCE REPORT

The Chairman referred to 2018/19 which had been discussed at yesterday's meeting with NHSI. He explained that the NEDs' concern was that, for good reason, they considered the numbers were unachievable. However, they felt that an achievable target from the Board's perspective should be agreed. Craig Black agreed and said that this was the plan and the case had been made with the regulator yesterday. However, the message throughout the organisation was that it was absolutely committed to trying to achieve the control total for next year.

Craig Black referred to the 2018/19 CIP programme build on page 4, which illustrated the action required in order to try to achieve the control total. The graph attempted to indicate the process of developing schemes. By the end of December 2018 all schemes needed to be identified. Progress could then be monitored against this plan and reported to subsequent Board meetings. This would also be discussed on a weekly basis with NHSI.

Figures around nursing were shown on page 10. There had been a reduction in ward based nursing staff last November with the move of nurses across to Glastonbury Court. There had been an increase in activity this year which explained some of the pressure, but there had not been a significant reduction in the number of nurses on the wards.

Cash appeared higher than the original plan as the Department of Health was encouraging organisations to borrow their deficit to cover this, rather than using any slippage on their capital programme to cover their deficit. WSFT was now borrowing to the extent of its deficit.

As a result, the cash position was reasonably healthy at the moment but would dip over the next few months. He reiterated that this amount of borrowing was unsustainable and that the organisation was technically insolvent.

Neville Hounsome noted that income was slightly behind plan in September (page 5).

Craig Black explained that two things drove performance against the income plan; critical care bed days, which were purchased by NHS England and were not part of the block contract. Also dental services which WSFT had reduced in order to close the contract in September. These had been compensated in the month by an increase in out of area activity.

Neville Hounsome asked if the decrease in critical care beds was a one-off event, or an ongoing issue. Craig Black explained that this was reasonably volatile but there was nothing to suggest that demand for critical care services had changed, just that this was a lower month for activity in this area. He would expect to recover this in later months.

Gary Norgate asked about agency and bank overtime. Overtime appeared to have increased but agency had decreased; he asked if one had compensated for the other and if this was a result of demand or efficiency. Craig Black explained that agency was significantly below plan and controls had been put in place. Nick Jenkins confirmed that the intention was to reduce agency in medicine and increase overtime, using the Trust's own staff who were known and would do a good job, rather than using an unknown locum. He explained that Norfolk & Norwich had done a lot of work on this. They had had phenomenal agency spend and made dramatic cuts which had been very successful. However, they had converted good agency doctors to their own staff which supported better quality.

Steve Turpie noted that Women & Children had had a better month and asked what was concluded about the ability to increase and decrease resources.

It was explained that income would reduce next month as Lakenheath was no longer using WSFT's facilities. Nick Jenkins was working with Lakenheath to try and encourage mothers who could not have their babies there to have them at WSFT. Room for reduction or increase in staff was restricted by the need to meet the midwife to baby ratio, which meant that flexibility was limited.

Alan Rose asked about the deficit of approximately £11m this year which was then halved as a result of STF funding. He asked if a process had been set out for accessing funding for next year. Craig Black confirmed that this would be the same next year and the process for accessing this would be the same, with the same incentive programme.

Alan Rose asked if the Trust reduced its CIP it would lose STF funding. Craig Black confirmed that this would be the case and up to £5.2m of funding would not be received.

17/214 TRANSFORMATION REPORT – Q2

Helen Beck explained that specific sections gave more detail about the actions being taken around emergency department performance and winter planning. The appointment of the planned care programme lead was also driving the programme of work across the system to reduce demand.

Neville Hounsome noted the 10% increase in admissions over the last six months, with bed occupancy of 97-98%.

Alan Rose asked if there had been any immediate impact of GP streaming which had started this week. Helen Beck reported that this had started slowly and only five patients had been seen in the first couple of days but it was expected to increase this week. The facility had been open since Tuesday although building work was still going on.

Nick Jenkins did not consider that this would have a significant impact on emergency department attendances. However, it might be one of the initiatives which would contribute towards making the hospital safe during the winter.

Richard Davies said that, from his experience, if GPs were actively going into the emergency department and redirecting people they could help. Helen Beck agreed that this was the case.

17/215 WINTER PLANNING REPORT

The Chairman asked how actions in this report related to the financial plan. Craig Black explained that further work would need to be undertaken and if proposed actions were as described this would result in using all the contingency, ie staffing the escalation ward would cost £0.25m per month. However, this was required in order to keep the organisation safe. He explained that the financial plan assumed that the contingency would be spent.

Gary Norgate noted that demand had increased but not in line with the plan. Helen Beck explained that demand had increased earlier than might have been expected, ie through September and the beginning of October, but this had reduced in the last seven days. Craig Black explained that timing was the issue and the concern was that winter had started early and would have a greater impact than in previous years. There was a concern that activity may have been under estimated, taking into account activity over the last couple of months, therefore preparations were being put in place to open an escalation ward if required.

Gary Norgate asked if the Board could be assured that the 35% of breaches in the emergency department linked to operational issues were being addressed, ie if there were issues around skill mix etc. Nick Jenkins confirmed that there were no issues relating to motivation, but there were issues around skill and staffing and these were being addressed where possible. This meant having to pay more than had originally been agreed in order not to lose staff to other organisations which were paying more.

Helen Beck explained that a very experienced manager had been also seconded to work within the hospital operations centre to support flow in the emergency department and on the wards. He would also be responsible for the discharge waiting area to ensure patients moved through as beds became available.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/216 AGGREGATED QUALITY REPORT

Rowan Procter explained that this report would be merged into the new Quality & Performance report.

17/217 NURSE STAFFING REPORT

Rowan Procter reported that there had been a high level of sickness and bank usage. Staff vacancies remained the same as last year, but varied from area to area, ie there were more vacancies in theatres compared to last year.

Over the last two months there had been a higher sickness rate than last year and also a lower fill rate for registered nurses. In order to fill these gaps staff were being moved around on a daily basis, which meant new staff on wards. This was not ideal as it was better to have a regular team in an area.

The Trust was going out to the Philippines in December to recruit registered nurses and was also advertising for nursing assistants. Newly qualified nurses who had worked at WSFT had also been recruited. She assured the Board that the escalation ward would not be run by agency staff.

Angus Eaton asked if WSFT was an outlier compared to other hospitals. Rowan Procter explained that WSFT was performing very well compared to other trusts of the same size, which tended to have significantly higher vacancies. Nick Jenkins confirmed that this was also the case with recruiting of medical staff.

Jan Bloomfield stressed that this was due to this being well managed and well led and the fact that people wanted to work at WSFT.

Angus Eaton asked what the strategy was for next year to ensure that WSFT continued to be able to recruit nursing staff. The Chairman requested a paper on the medium term outlook and actions being taken to address this. **J Bloomfield**

Gary Norgate asked about the 10.3% sickness rate in maternity and if there were any concerns. Rowan Procter said that she did not have any concerns and explained that two people were on long-term sick leave. Jan Bloomfield assured the Board that HR staff were very focussed on sickness absence.

Steve Turpie asked if she was confident that the return to work process was being followed. Jan Bloomfield confirmed that she was confident; and explained that WSFT's Bradford factor trigger was very low at 100. It was taking a robust line on sickness absence and was approximately 4% lower than the national average.

17/218 MANDATORY TRAINING REPORT

Gary Norgate referred to safeguarding training level 3 and asked what the consequence was for individuals not completing this. Rowan Procter explained that targeted emails were sent out and this was escalated when training was not completed.

Helen Beck confirmed that she had sent targeted emails to General Managers and Clinical Directors and was waiting for action to come back with plans to ensure these were completed.

The Chairman agreed that this was very important. He requested a report with a plan on how this would be addressed in a different way to sending out targeted emails, highlighting areas that were not compliant and how these would be addressed. **R Procter**

17/219 SAFE STAFFING GUARDIAN REPORT

It was explained that trusts were required to report on this in this format and that Sarah Gull undertook this role for the Trust.

Angus Eaton asked Nick Jenkins if he had any concerns from the content of this report. Nick Jenkins said that he did not have any concerns and that WSFT was performing well in this area.

It was explained that the risks were ensuring that exception reporting remained the exception and did not become the norm.

Feedback from junior doctors was that it was felt unreasonable that they had to ask for permission when doing overtime in order for them to be able to do their job.

It was explained that all organisations required permission to be asked by their employees to do overtime.

Jan Bloomfield explained that there was a junior doctors forum led by Sarah Gull and although they were not happy they appreciated that the situation was worse in other trusts.

17/220 FREEDOM TO SPEAK UP GUARDIAN REPORT

The Chairman explained the background to the appointment of a Freedom to Speak Up Guardian and introduced Nick Finch who had been in this role since 1 April 2017.

He explained that since his appointment he had been meeting with staff groups and making sure that people were aware of his role and encouraging them to talk to him. He was also building up a good relationship with the regional network and National Guardians Office. He would be meeting with the CQC and also looking to forge a working relationship with new community staff

Rowan Procter considered this role to be very helpful.

Catherine Waller asked if Nick Finch was confident that staff had the same permissions about their own safety and care, eg sexual harassment. Nick Finch said that if staff had issues around this he wanted to hear about them and this would be followed up and dealt with appropriately.

Jan Bloomfield explained that there was a Bullying and Harassment policy and also a set of trusted partners, which meant there was a choice of people who staff could report issues to, ie a mix of males and females in different parts of the hospital. Issues reported in the past had been robustly dealt with.

The Chairman asked if Nick Finch was part of a team. Nick Finch explained that he met with staff and Jan Bloomfield on a regular basis and also Alan Rose. He would also be working with staff Governors and trusted partners, which he considered to be part of a team.

The Chief Executive noted that the idea was that in the first place staff should discuss any issues with their line manager and this should be enforced where appropriate. Jan Bloomfield agreed and said that people were being encouraged to go to their line manager, rather than everything becoming a whistleblowing issue.

Alan Rose asked if Nick Finch had learned anything from the Freedom to Speak Up Guardian at Colchester and Ipswich hospitals. Nick Finch explained that as this person covered two hospitals he was full time in this role, but he hadn't learned anything significant from him.

The Chairman asked how it could be assessed that staff had exhausted the normal routes and if they knew all about the various other avenues they could pursue.

Jan Bloomfield felt there was sufficient evidence in the staff survey to indicate if there was an issue that needed to be addressed. She considered that there was a failure in the system if people were going to Nick Finch, as they should be going to their line manager. There was also a 24/7 helpline, 'Care First' which they could contact.

WSFT scored well in the staff survey as being a good place to work and this showed that, although there was room for improvememnt, the Trust was doing relatively well. The Chairman agreed but said that the Trust also needed to be aware if there were any issues and everyone needed to know what the route for reporting was.

Steve Turpie proposed considering if anything else could be done to remind or report staff in light of current media coverage. It was suggested that staff should be prompted through general communications in an appropriate way, ie blog, Green Sheet. **J Bloomfield**

Gary Norgate considered this to be a very good role but asked if more than one Freedom to Speak Up Guardian was required. Jan Bloomfield explained that she met with Nick Finch on a regular basis and that there were also trusted partners and the HR team. However, this may need to be looked at in the community in the future because of the geographical challenges.

17/221 HELPFORCE INITIATIVE

Jan Bloomfield explained that there had been a very successful visit from Sir Tom Hughes-Hallet and he would be visiting the Trust again. He was very impressed by the bleep volunteers and he wanted to do a case study, as there was nowhere else in the NHS with this role

Alan Rose considered this to be a very good communications opportunity and this should be highlighted.

Rowan Procter explained there were now fully trained End of Life volunteers to sit with patients who did not have local relatives.

The new Voluntary Services Manager had started on 1 November. The Chairman suggested that the new manager should be asked to come to a Board meeting and report on the activities of the volunteers etc, eg quality presentation. **J Bloomfield**

17/222 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that Zoe Drage and Marina Hilditch, home intravenous therapy nurses, and Tracey Robertson, a housekeeper on Ward F1had received Putting You First awards this month.

Zoe Drage and Marina Hilditch were nominated for their tireless work supporting patients on long term intra venous medications which mean they could be within their own home. They often worked overtime and long hours to ensure patients came first. The nomination said, “they are unsung heroes who save the Trust money and reduce long term length of stay patients by getting the patient home with full support of the HIT team.”

Tracey Robertson was nominated as she consistently goes above and beyond the call of duty in any way she can to help patients and families feel as comfortable as possible. “She is an inspiration with her positive attitude and is such a valued member of the team, both in housekeeping and up on F1 and is a great support to her team.”

The Board congratulated the above on their dedication and commitment to improving patient experience.

17/223 CONSULTANT APPOINTMENT REPORT

The Board noted the appointment of Ashraf Sanduka, Consultant in Histopathology.

BUILD A JOINED UP FUTURE

17/224 e-CARE REPORT

Discussed under the Chief Executive's report (minute 17/211).

Go-live of phase 2 had gone well, there had been a few issues which were addressed and Cerner had brought a team of people to help with this. Phase 3 was now being worked towards.

17/225 ALLIANCE AND COMMUNITY SERVICES UPDATE

Dawn Godbold reported that the transition to the new community contract on 1 October 2017 had gone smoothly. Feedback from staff who had transferred to WSFT was very positive. Good progress had been made in introducing, familiarising and embedding new processes. This was a very important key stage in the longer term strategy for working across the system.

Alan Rose asked when the review of existing Trust governance groups, sub-committees and reporting etc would be completed. Richard Jones explained that this had been ongoing for a number of months, ie community service had a representative on the Health & Safety committee and other committees.

Rowan Procter explained that it was also proposed to merge the quality contract meetings, which it was hoped would expose opportunities.

Gary Norgate asked if key performance indicators on effective integration could now start to be developed, ie showing benefits that would indicate that community services and the Trust was truly working together. It was agreed that this would be a good idea.

Dawn Godbold explained that a benefit that was already being seen was that patients who were discharged late were now given their medication before they left in order to avoid community nurses having to travel to visit them that day.

The Chief Executive agreed that there were a number of indicators which would improve as a result of integration.

Helen Beck reported that a TEG workshop was taking place on Monday to look at integration work in greater detail and the advantages of operating in an integrated way. The Chairman proposed that a plan was required to show what the aim was and what was being achieved. Nick Jenkins said that the plan also needed to include other opportunities that might emerge as this progressed. **D Godbold**

17/226 SUSTAINABLE CARBON REDUCTION STRATEGY

The Chairman considered this to be a good report. He asked about the shuttle bus and if there were any plans to make this green. Jan Bloomfield said that this would be considered when the Trust next went out to tender.

The Chief Executive said that consideration needed to be given as to how to further raise the profile of initiatives within this strategy with staff.

GOVERNANCE

17/227 TRUST EXECUTIVE GROUP REPORT

The Chief Executive reported that there had been a two hour focus on community services.

17/228 QUALITY & RISK COMMITTEE REPORT

The Board noted the content of this report.

17/229 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were approved.

ITEMS FOR INFORMATION

17/230 ANY OTHER BUSINESS

The Chairman proposed that the executive team should work with Richard Jones on when actions arising from this meeting should be completed.

17/231 DATE OF NEXT MEETING

The next meeting would take place on Friday 1 December 2017 at 9.15am in the Northgate Room.

RESOLUTION TO MOVE TO CLOSED SESSION

17/232 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.

NHS West Suffolk NHS Foundation Trust

Board of Directors – 1 December 2017

Agenda item:	Item 6			
Presented by:	Roger Quince, Chairman			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	23 November 2017			
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
1466	Open	29/9/17	Item 6	Provide clarity on future provision of stroke service as part of STP service model	Part STP acute service discussions	NJ	25/01/2018	Green
1467	Open	29/9/17	Item 6	Provide clear action and deliver improvement in maternity WHO compliance	NJ to meet with team to ensure effective action is taken. **QUALITY REPORT**	NJ	01/12/2017	Green
1475	Open	29/9/17	Item 13	Develop a set of metrics which will provide an indication of the success of the leadership programme	Currently in discussion with private sector organisations to ensure that we follow best practice.	JB	26/01/2018	Green
1489	Open	3/11/17	Item 7	Bring 5 yr capital programme to sit alongside the concourse redevelopment business case	Following discussion at Scrutiny Committee and Council of Governors this will be received by the Board in January.	CB	26/01/2017	Green
1491	Open	3/11/17	Item 8	Provide a clear analysis of the RTT 'pot size' with updated improvement trajectory	Work is ongoing with Cerner to understand and address patients tracking list (PTL) reporting.	HB	01/12/2017	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1493	Open	3/11/17	Item 13	Bring back a medium term assessment of the forecast staffing position and plans to recruit/mitigate nursing gaps	We are currently looking for agency staff to fill nursing vacancies across the organisation. This will allow us to identifying staff that can be released from wards in order to open winter escalation beds. **A verbal update will be provided to the Board on progress.** The Trust is undertaking overseas recruitment in the Philippines during December with a target to recruit up to 50 nurses. The expectation is that these will join the Trust from March 2018. Skype interviews are also be planned. The longer term strategy around the appointment of nursing associates and nursing apprenticeships will be presented to the Board in January 2018.	JB	26/01/2018	Green
1497	Open	3/11/17	Item 21	Set out a plan for how we are managing the acute/community integration process with key milestones for delivery/success. The plan will need to include opportunities which evolve to develop shared working.	Also consider financial and service opportunities associated with community services vertical integration and incorporate these in to the rolling programme for CIPs	DG	26/01/2018	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1473	Open	29/9/17	Item 12	A number of actions were identified from the new learning from deaths report: - Consider how to show preventability over time - Consider how to track performance against other trusts – 'peer group' or national - Confirm whether Glastonbury and Newmarket deaths are included process and reporting - Provide clarity as to how duty of candour is managed, and ensure this is fully reflected within the policy	**AGENDA ITEM**	NJ	01/12/2017	Complete
1488	Open	3/11/17	Item 7	Schedule a Buurtzorg presentation for Board	Team scheduled to present at the Q&RC in January.	RP	26/01/2017	Complete
1490	Open	3/11/17	Item 8	Email out requesting feedback the new format performance report	Positive feedback received which stressed need to minimise double running of reports.	RJ	01/12/2017	Complete
1492	Open	3/11/17	Item 8	Provide an appraisal improvement plan, including any evidence re quality of appraisal	**AGENDA ITEM**	JB	01/12/2017	Complete
1494	Open	3/11/17	Item 13	Provide a clear plan for how to improve safeguarding children level 3 training compliance	**AGENDA ITEM**	JB	01/12/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1495	Open	3/11/17	Item 16	Consider routes to promote support for staff in raising concerns of harassment or bullying	The Trust has an ongoing campaign 'freedom to speak up' which is promoted throughout the Trust. In addition the Trust has in place freedom to speak up guardian, trusted partners and trade union representatives. Further support is provided through occupation health and 24/7 employee assistant programme - Care First.	JB	01/12/2017	Complete
1496	Open	3/11/17	Item 16	Provide a report from the new voluntary service manager. To provide Board visibility and oversight of the service offered and future plans	New voluntary services manager (Ian McKee) commenced on the 1 November. They are scheduled to provide a report to the Board on 2 March 2018.	JB	01/12/2017	Complete

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 1 December 2017

Agenda item:	Item 7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	23 November 2017			
Subject:	Chief Executive's Report			
Purpose:	X	For information		For approval

Executive summary:

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

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

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

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

Recommendation:

To receive the report for information

Chief Executive's Report

As we all know, our chairman **Roger Quince** comes to the end of his 10-year-tenure at the end of this December. Roger has gone above and beyond for the Trust during his time with us, and has given his unwavering dedication to our hospital, our services, and our people. He saw the Trust through the challenge of foundation trust authorisation, has driven the Board's focus on quality while continuously striving for efficiency. His approach has delivered the best CQC ratings in the region, the most engaged NHS staff in England and the most efficient acute NHS hospital in England. He has also ensured that the focus on the capital programme has allowed us to maintain and maximise our estate. Recognising his contribution the most recent addition to our estate, which houses our new sterile services department and administrative offices, has taken his name - Quince House. I would like to add my personal thanks to those of others within the Trust and our partners. We all wish Roger the very best for the future. The fact that Roger has already started the handover to his successor is testimony to his commitment to the ongoing success of our Trust. We will be delighted to welcome Sheila Childerhouse as our new chair when she joins us in January.

October's performance shows we reported six C. difficile cases in October in four separate areas. This is the highest number of cases recorded by the Trust since March 2012. We have acknowledged on the Trust risk register this may reflect the global shortage of Tazocin which has required the use of antibiotics associated with a higher risk of Clostridium difficile infection. We continue to focus on reducing patient falls and pressure ulcers, with 56 falls and 18 pressure ulcers reported in October. Referral to treatment (RTT) performance for patients on an incomplete pathway is 87% against the target of 92%. This represents a small improvement on the September figure but is behind the planned recover trajectory. Unfortunately we have reported 26 patients breaching 52 weeks. Patient choice continues to be a significant factor with many patients electing to wait longer for their treatment at the end of their pathway. I am pleased to report that we achieved the 62 day cancer standard with an excellent performance of 91.06% against a standard of 85% but failed to meet the two week wait rapid access standard with performance of 91.06% against a standard of 93% due to ongoing increased demand from dermatology. It is currently anticipated that we will achieve the two week wait standard in November due to the successful recruitment of locum medical capacity in Dermatology. ED performance significantly deteriorated to 87.37% for October although we have seen some improvement in November due to the initial actions which formed part of the winter planning report outlined at the last board meeting.

The **month 7 financial position** reports a surplus of £114k for October which is worse than plan by £36k.The reported cumulative position is therefore £114k worse than plan. The 2017-18 budgets include a cost improvement plan (CIP) of £13.3m of which £7.05m has been achieved by the end of October (54%). Delivering the control total will ensure we receive Sustainability and Transformation Funding (S&TF) of £5.2m, resulting in a year end net deficit of £5.9m. We continue to work with KPMG as part of the financial improvement programme (FIP) for 2017/18 and beyond. The focus of FIP is to ensure that robust CIPs are in place to deliver the control total for 2017/18 and a CIP pipeline for future years.

With the temperatures starting to drop and the trees losing their leaves, it feels like winter has already arrived. It feels like that in the hospital too, with our emergency department regularly seeing more than 200 patients a day. We're pulling out all the stops to make sure we're continually prepared, but we know that whatever measures we put in place, it will likely still be a high-pressured **winter across the NHS**. Together with our fellow NHS trusts, our commissioners, and local councils, we're asking people to take simple steps to help us this winter by accessing the right NHS services, at the right time, for their needs.

We're also making some changes in the hospital itself; we're looking at making two assessment bays on ward F8 (acute assessment area) open 24/7, and introducing a surgical ambulatory emergency care (AEC) service to sit alongside the medical AEC service. This will hopefully help

identify patients in the emergency department (ED) and aim to diagnose, treat and discharge or return patients to avoid unnecessary admissions. A discharge waiting area has also been created. The waiting area has bed and chair space for both male and female patients, and is open from 9am to 8pm (with the last take at 6pm). This space allows staff from the unit to identify patients on the wards who could comfortably wait in the discharge waiting area to create capacity and flow earlier in the day. We hope all of these things, combined with excellent efforts by all staff in continuing Red2Green, will help to better patient experience, reduce pressure on our emergency department and ward F7 in the evening, reduce avoidable admissions, and generally improve flow.

We continue to made 'red to green' a day-to-day part of what we do, and are embarking on a series of initiatives to help our patients get fit and well as soon as possible, e.g. ending PJ paralysis to get patients up and moving, our red bag scheme, and our support to go home service. And we're already starting to see the impact of these. The support to go home service has already saved us more than 150 bed days since it launched last month. But there is more we can do. So we want to work towards our fourth '**perfect week'** across the whole service, which we're holding from 2-9 January. Whether patient facing or not, all staff will have a role to play.

I was very proud to take part in the launch of a fantastic joint-initiative to help care home residents receive quicker and more effective care should they need to come into hospital. Care home residents in east and west Suffolk are set to benefit from the new **'Red Bag' scheme**; the bag contains important medical information, medication and personal items packed by care home staff, and transferred to the hospital via ambulance colleagues. The red bag keeps all the patient's important information in one place with the aim of speeding up the handover time between ambulance and hospital and providing a smoother and less stressful experience for the patient. It means that nurses and doctors have timely information about the patient, resulting in fewer calls to the care home and easier interaction. The initiative is a partnership between ourselves, 20 local care homes, NHS Ipswich and East Suffolk and NHS West Suffolk clinical commissioning groups, Ipswich Hospital NHS Trust and the East of England Ambulance Service NHS Trust.

We're thrilled that our recently launched '**support to go home'** service (STGH) continues to go from strength to strength. Launched in September, the joint venture is provided in partnership with Suffolk County Council, and is essentially a care bridging service to prevent delays in a patient's discharge if there is a delayed start date for their out-of-hospital package of care. So far the team has: supported 56 patients to get home; saved 281 bed days in the hospital; reduced the care package of six patients; reabled four patients to the point where care was no longer needed when handed over to the continuing care agency; and continued to support on average five to six patients at any one time. We're really seeing a positive impact as a result of this service. Our team of reablement support workers are doing a fantastic job enhancing the recovery of patients in their own home. They are committed to supporting and encouraging our patients to increase their confidence and independence with essential daily tasks. Not only is this important to our patients' but it also helps to reduce the likelihood of readmission to hospital.

Over the summer Sally Lawrence and Jenny McCaughan set up a weekly multi-disciplinary team (MDT) review of **stranded patients** (inpatients that have been in hospital for seven days or more), and those patients with the longest length of stay (31 days or more). This is part of a wider programme of work to ensure that the care we provide to patients is as coordinated and efficient as possible, to avoid unnecessary delays for inpatients, and helping us to provide emergency department (ED) and inpatient services safely over winter and beyond.

Reviews take place twice a week and are attended by nursing, care coordinators, discharge planning team, therapies, social services, the CCG and a senior manager. The group identifies patient delays and communicates these delays to the services who can resolve them. The reviews also provide a forum for communication for all staff involved in complex discharge planning (e.g. social services, discharge planning team, therapies) to ensure the whole MDT is working in parallel towards each patient's discharge. Since these MDT reviews started:

- The daily average number of stranded patients in the hospital dropped from 171 in August despite the increase in daily average admissions

- The number of stranded patients has dropped below the target of 160 on a number of occasions since the intervention
- Provisional analysis shows around a 10% drop in the daily average number of patients with a length of stay (LoS) of 31+ days since the start of this initiative.
- The average length of stay of stranded patients dropped from 17 days in August to 16 days in September and down to 15 days in October. The average length of stay of patients with a LoS of 31 days or more dropped from 48 days in August to 45 days in September, and 41 days in October.
- Examples of where these reviews have benefited our patients include expediting a PEG (percutaneous endoscopic gastrostomy) feeding tube for a patient, making the orthopaedics team aware of a patient requiring an orthopaedics plan for discharge, and asking whether a patient awaiting an echo could have their echo as an outpatient instead of an inpatient, which was taken forward and the patient discharged earlier.

Thank you to all those that attend these reviews, your contributions have enabled this initiative to have a positive impact on our inpatients.

A new **discharge waiting area** (DWA) has been developed to provide a safe and comfortable environment for patients to wait for the final step of their discharge to be completed e.g. TTOs and transport. The DWA supports patient flow by enabling beds to be freed up earlier in the day, this in turn ensures we treat the right patient, in the right place, first time. Staff are asked to:

- Identify suitable patients, ideally the day before and on the day
- Have patients ready to go to the DWA as early as possible
- View the DWA as an integral part of the patient pathway.

The Trust has an aspiration and ambition for each ward to discharge at least two **'golden' patients** out of their total daily discharges before 10.00am each day. Patients should be discharged either out of hospital or to the discharge waiting area.

Changes have been made as part of the Trust's winter planning strategy to improve **operational resilience**. We are pleased to report that Gary Ingalla is now the lead for patient flow across the Trust. Gary is supported by Paulene Gray to enable him to maintain the oversight and management of his existing services whist playing a key role in the daily management of patient flow. We also welcome Darin Geary to the role of clinical service manager in the emergency department. Darin is working alongside Mark Manning, Donna Bowd and Ravi Ayyamuthu, forming the senior management team within the department.

The **Care Quality Commission (CQC)** inspected, end of life and outpatient services at the hospital on 9 and 10 November. Feedback from their visit was positive and we look forward to the next 'well led' review which will take place on 30 November to 1 December 2017. Whilst the visit isn't anything to be concerned about, we are making sure we're prepared so we get the basics right and can showcase the things we're really proud of. What we do know is that we all love our hospital, that we are proud of the care we deliver, and are proud of where we work. We intend to show this off again to the CQC, and make this another opportunity to shine. It is expected that the inspection report will be published in February 2018.

The results of the **election for our public and staff governors** were announced on 23 November 2018. With a strong field of candidates standing for both the patient and staff constituencies I am delighted to see some familiar faces but also welcome new members to our Council of Governors. We know our governors play a vital role in the workings of our Trust; they represent the interests of staff and their community; they are the voice of the people, sharing ideas, concerns, and suggestions on a wider platform; they tell the Board what they think our hospital should offer, and work with them to ensure that community and staff needs are taken into account in the planning of services; they bring valuable perspective and contribution to the Trust's activities; and they have real influence on the strategic direction and governance of the Trust. As part of the Board agenda for today's meeting is a proposal to reflect our integration ambition by developing the management

and governance structures of WSFT. Included within these planned changes is the proposed to extend the composition of the Council of Governors to include two primary care representatives, reflecting our integrated working across the system.

We continue to work with **North East Essex and Suffolk Pathology Services (NEESPS)** to address regulatory and accreditation concerns. Following voluntary suspension of laboratory accreditation for Blood Sciences at WSFT, NEESPS have been asked to provide a plan to describe their approach to achieving full accreditation with associated timescales. Part of this plan (covering the Quality Management System) has been received but further details are required to cover the other aspects of the laboratory service. Assurances have been received the confirm that the blood transfusion service has made significant progress towards addressing the non-conformances identified by the MHRA. Histopathology has successfully addressed the non-conformances from the UKAS assessment at WSFT and are now being recommended to the decision maker to approve UKAS accreditation. Microbiology across the three NEESPS sites have been assessed together by UKAS and it is anticipated that the laboratories will maintain CPA accreditation but will not be recommended for UKAS accreditation at this stage.

Our consultant in respiratory medicine, Dr Thomas Pulimood, has been at the forefront of our **flu vaccination campaign**, and we're very grateful to him and the infection, prevention and control team for their ongoing support and efforts. We continue to promote our staff taking up their flu vaccination - so far 60.3% of staff have had the jab. We have reviewed the delivery plan to ensure we exceed the 75% by February to ensure accessibility of the flu jab team. As well as attending the occupational health department, staff can access our roaming floor walkers, bleep the flu jab team and we are working with managers so that the team attend ward or departmental meetings. We are also putting in place a process to gather information from staff who decline the jab to understand their reasons.

Initial plans for the **main entrance refurbishment** have considered and following feedback from governors and others are being developed for consideration by the Board in January 2018. The proposal is to fully refurbish the main hospital entrance concourse with an extended café, new pharmacy outlet and a new toilet block built. The proposal sets out to provide a clean, crisp, modern entry point to the hospital.

November 2017 Budget (source: NHS Providers)
The Government has increased the Department of Health's budget by £2.8bn. This funding has been made on an 'exceptional' basis, which means it is not clear whether this will be recurrently carried forward in to 2020/21. The allocation has been made directly to the Department of Health's budget, rather than NHS England's budget as we have seen in previous years which means that this is genuinely new funding, rather than taking additional funds from other non-frontline services, such as education and training budgets.

The Treasury will fund £3.5 billion of capital investment between 2017/18 and 2022-23, including:

- £2.6 billion for STPs to deliver transformation schemes that improve their ability to meet demand for local services and improvements in facilities .The government has today provisionally allocated up to 10% of this £2.6bn funding to 12 of the schemes. The rest of the funds will be allocated 'in due course'.
- £700 million to support turnaround plans in the trusts facing the biggest challenges, and to tackle the most urgent and critical maintenance issues
- £200 million to support efficiency programmes

Additional funding in addition to today's settlement will be provided for NHS staff on the Agenda for Change contract subject to the Pay Review Body recommendation. This will be linked to productivity improvements the Government wishes to see through the contract. Any pay award for doctors will not be funded by the government, but will need to be funded from existing NHS budgets.

Following today's budget, NHS Providers' view is that while any additional funding is welcome, there remains an unfunded gap between the costs currently faced by providers and increasing demand for care which needs to be addressed.

- The announcement of an additional £1.6bn revenue funding in 2018/19 and an additional £900m in 2019/20 is welcome, given the intense financial and operational pressure trusts are facing. NHS Providers will be seeking early clarity from NHS England and NHS Improvement about how this additional funding will flow to providers, including whether there will be a national planning exercise for next year given today's announcement.
- In the current financial year, an additional £335m for trusts to help meet the challenge of the approaching winter period is welcome, and yet, comes too late to have maximum impact. NHS Providers are concerned that unrealistic expectations might be set nationally about how this additional funding might be used to improve performance over winter. Members will be understandably keen to understand how and when, exactly, additional revenue this financial year and beyond will reach them – NHS Providers will update members on this as soon as possible.
- NHS Providers welcome the announcement that additional funding for Agenda for Change staff will be provided, conditional on ongoing talks over contract reform. The pay uplift will be determined as always by the NHS Pay Review Bodies. NHS Providers will actively contribute to this process. At this stage, NHS Providers understand that the pay award for doctors will not be funded by the government; instead this will need to come from existing NHS budgets.
- On capital funding, Sir Robert Naylor's review of NHS property and estates calculated that £10bn was required to fund and maintain an NHS estate that could continue to deliver safe, high-quality care for patients. While the Government today announced an additional £10bn 'package of capital investment', only £3.5bn additional funding from the Treasury has been announced. This falls short of what we know the NHS needs for backlog maintenance and transformation. Around £3.3bn is expected to come from land sales, but the Naylor Review itself, for example, calculated that 57% of the total gross risk adjusted potential financial opportunity for the sector was accounted for by the London Sustainability and Transformation Partnerships alone. In practice, trusts across the country may continue to find it difficult to access the capital they need to enable productivity improvements they are committed to delivering. This is particularly disappointing given capital investment in the NHS has fallen sharply in recent years.

Chief Executive blog

If I asked a random selection of people outside the Trust what they thought the biggest issue facing the NHS today was, I think I'd get some varied responses. I'm sure the things the media talks about often would be up there; increased demand, less money, fewer resources and the like. Those things are all true in that they certainly bring us challenges, but there's something pretty vital missing from that list – our staff.

http://www.wsh.nhs.uk/News-room/news-posts/Our-most-important-asset.aspx

Deliver for today

As well as all the work going on in the hospital and community, our clinical teams have been out and about hitting the streets of Bury in the name of public health this month. To support **World Diabetes Day** (14 November), a group of diabetes nurses and dieticians manned a stand at the Arc shopping centre from 9.00am with our My Wish Charity. They met with more than 100 members of the public, answering any diabetes-related questions that they had, and even met patients and their families that had visited our hospital diabetes clinic that morning! Our diabetes and endocrinology consultant, Nilu Hewapathirana, also did an interview on BBC Radio Suffolk to help spread awareness of the condition, with a particular focus on pregnant women and gestational diabetes. It was great to see, and these simple steps to help support our public health agenda really can make all the difference.

Eight **ward volunteer companions** are now available to sit with patients in the last days of life. They are also able to support families and carers who need to leave their loved-one for a while, or who are struggling and need someone to sit with them for a couple of hours. This service is available for all adult services. Macmillan educator Michelle Buono is visiting all clinical areas to raise awareness of the service and a quick reference guide for referral is available.

Invest in quality, staff and clinical leadership

Nursing teams have gone digital this week with a new app to make ward inspections quicker, easier and more effective - **Perfect Ward** is a smart app to support ward inspections. Those completing audits can now score questions, capture photos and write free-text comments straight into the app, meaning information is quick to record and up-to-date. Information is stored in the app rather than on the phone used, so it's always secure. Capturing the information directly on phones or tablets also means there's no longer a need to write up and send reports afterwards, saving valuable time. As soon as an inspection is complete, everyone with the app can be alerted and see the results. With automated reporting, it's also much easier to compare performance and track improvements at ward level. There are five different audits available in the app; documentation, observation, patient experience, staff and infection prevention and control. Matrons, ward managers, service managers, general managers, pharmacy, executive directors and the infection prevention team all have access to Perfect Ward, and will be using it to complete ward audits going forward. It will be used on all wards at the West Suffolk Hospital, as well as Rosemary Ward in Newmarket Hospital, and the Kings Suite at Glastonbury Court.

The **outpatients department**, in collaboration with voluntary services, has begun a new initiative to improve the experience of patients in the minor operations lists. After a patient has had their procedure, they are taken to a quiet recovery area before going home, where they're given tea, coffee and biscuits by one of our lovely volunteers. Early feedback has been very positive, with all patients rating the volunteer service they received as excellent. Kirsty Rawlings, outpatients and health records service manager, said: "It's a simple innovation, but a great example of how our clinical and voluntary teams can work together to improve patient experience. "We are hoping to roll this scheme out in Newmarket Community Hospital too in the near future. We are pleased that this is making a difference to patients that may not be feeling 100% after their procedure, and can sit, relax and have a cup of tea whilst recovering."

Our **staff choir, Lift**, is hosting its first ever concert at St Mary's Church, Bury St Edmunds on Thursday 30 November to help raise funds for the hospital's palliative care services. Dr Phillippa Lawson, respiratory consultant, founded the choir in March 2017, as a way of helping staff to de-stress and support their health and wellbeing. It currently has more than 40 members of staff who regularly attend weekly choir sessions held in the hospital chapel.

Our first cohort of staff completed the new Trust-developed multi-professional **preceptorship programme** on 7 November. Staff from varied disciplines, including nurses, midwives, occupational therapists, physiotherapists, clinical psychologists, community speech and language therapists, and community nurses, came together to receive their certificates after 10-12 months of study and training. The programme helps staff to develop their confidence as an autonomous professional, refine their clinical skills, values and behaviours and to continue their journey of life-long learning. There are six separate study days throughout the year, which each cover a specific subject such as professionalism, resilience, and integration. Well done everyone!

Sarah Gull, consultant obstetrician and gynaecologist, has been appointed as the **first guardian for safe working** to support junior doctors in their new contract. Sarah says: "The main purpose of this role is to promote safety for patients and their doctors. We all want a good working environment, where staff do not get over-tired and feel valued and listened to."

With OneLife Suffolk we are offering **free health checks for staff** aged between 40-74. These assess general health, and in particular, the risk of cardiovascular disease.

Build a joined-up future

Although our **vacancy levels** are no higher than they were last year, it's felt like a really tough few months for our staff in terms of capacity. We aren't alone in feeling this way; NHS Providers, which represents health chiefs, has recently published information saying that for two thirds of trust leaders, recruitment and staff numbers are more of a concern for them than the money.
We're endeavouring to try and fill as many registered nurse vacancies as possible, whether through substantive recruitment, bank, or agency staff.

We're hoping to source 30 additional agency nurses so that we can create some excess capacity. Whilst of course we'd prefer to fill vacancies with our own staff, we've taken the decision to use agency where needed so that we can help reduce the pressure that we know our staff are feeling. We're also casting our staff net overseas. We know that the calibre of overseas doctors and nurses is exceptionally high, and we're very proud of the diversity of colleagues from across the world that we already have in our West Suffolk team. We're hoping to bolster our ranks with 40-50 fully qualified and trained nurses from overseas over the coming months, and we already have 80-90 interested candidates lined up for interviews. Of course with international language tests and clinical assessments to go through this won't be a quick-fix, but we hope the first would arrive with us around the end of February.

The West Suffolk NHS Foundation Trust (WSFT) and West Suffolk Clinical Commissioning Group (WSCCG) are working in collaboration over the next six months to investigate and implement changes to **prescribing practices** across the Trust, and enhance changes already occurring in primary care. The project aims to reduce both the prescribing and supply of items at discharge from hospital that are used for the treatment of minor/short-term conditions, and that can be purchased 'over the counter'. It also aims to support and enhance the polypharmacy medication review and de-prescribing work that is already being undertaken in both primary and secondary care. These changes will improve the quality of patient care and are expected to result in cost-savings to both WSFT and WSCCG.

Following on from World Mental Health Day, we have been promoting ways staff can access **support for mental wellbeing**. For clinical staff, lots of people who have done health coaching training say it has had a big effect on their resilience by giving them a fresh approach to their work, and a better sense of how they can share responsibility with their patients. The benefits of physical activity for mental wellbeing are also being promoted – a brisk walk, a swim, or even a couple of circuits of the corridors looking at the paintings on display will help keep you cheerful. And finally, recognising the importance of our staff's mental wellbeing for good quality patient care, the Trust is going to work with Suffolk MIND over the next 12-18 months to provide line manager training in how to create a mentally healthy workspace.

Work has started on the site for three new **staff accommodation blocks** to replace the existing 40-year-old residences. The facility is planned to be in use by May 2019.

National news

Deliver for today

NHS England action to save lives by catching more cancers early
NHS England Chief Executive, Simon Stevens, has announced the scaling up of an innovative scheme that catches lung cancer early by scanning patients, along with new details of a more sensitive bowel cancer test that could save thousands of lives. Speaking at the Economist War on Cancer event last week (21 November) in London, he highlighted the success of the Manchester scanner scheme, where mobile scanners are detecting four out of five cases of lung cancer in the early stages when it is easier to treat. The mobile scanning trucks have picked up one cancer for every 33 patients scanned over the course of a year. NHS England is now funding scanners in

other areas as part of a national programme to diagnose cancer earlier, improve the care for those living with cancer and ensure each cancer patient gets the right care for them.

Invest in quality, staff and clinical leadership

New National Medical Director for NHS England

NHS England has announced that Professor Stephen Powis has been appointed as its new National Medical Director. Professor Powis, 57, is currently Group Chief Medical Officer at the Royal Free London NHS Foundation Trust, and will succeed Professor Sir Bruce Keogh in his national role in the New Year. He is currently a practicing hospital consultant, a Professor of Renal Medicine at University College London as well as Chief Clinical Information Officer of the Royal Free Trust.

Encouraging people to embrace self-care for life

Engaging and empowering people to look after their own health better was the theme of this year's Self Care Week, which took place in November. The week aimed to raise awareness of the huge benefits of people looking after themselves better – whether considering self-treatable conditions, long term conditions, or lifestyle choices to ensure better physical health and mental wellbeing. Organised by the Self Care Forum, information and highlights from the week by looking back at #selfcareweek on Twitter.

National Maternity and Perinatal Audit

The clinical report (2017) is based on about 696,738 births in England, Scotland and Wales. It identifies areas of good practice and opportunities for improvement in the care of women and babies in maternity services across Britain. The analysis explains that while the vast majority of women have a safe birth, and despite on-going improvements in the safety of maternity services, variation exists in a number of clinical processes and outcomes in maternity care.

Build a joined-up future

Public Health: everyone's business?

A new report has been launched in the Provider Voices series. This issue focuses on public health. Specifically, promoting the public health role as we move towards accountable care; dealing with the challenging of constrained funding; harnessing digital technology; developing the role of the public health clinician; and working to shape the wider determinants of health inequalities. The report features 12 interviews with trust leaders from hospital, mental health, ambulance sectors as well as academics, system leaders, local government representatives and those with strategic responsibility for delivery and commissioning.

Adult weight management: key performance indicators

Public Health England has published key performance indicators (KPIs) recommended for tier 2 weight management services. They should be used in line with the guide to delivering and commissioning tier 2 adult weight management services publication. Each of the KPIs are supported by a clarifying narrative.

Moving more, aging well

Currently 54% of people aged over 65 are classed as 'inactive'. In under a decade the UK population will shift and 1 in 5 people will be over 65 years of age. This report highlights the need for innovative solutions for keeping older people active and independent that could save billions of pounds in NHS and social care costs by preventing disease. It argues that community based programmes will have a 'pivotal role' to play in providing opportunities for older people to be active in their local area. It highlights the case study 'Let's Get Moving', which is an evidence-based intervention, originally created and tested by the Department of Health and recommended by NICE, as a strategy that can be implemented at the heart of primary care.

NHS West Suffolk NHS Foundation Trust

Board of Directors – 1 December 2017

Agenda item:	Item 8			
Presented by:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer			
Prepared by:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer David Matthews, Interim Head of Performance			
Date prepared:	23 November 2017			
Subject:	Trust Quality & Performance Report			
Purpose:	X	For information		For approval

This new style report provides an overview of quality and performance across the Trust. Key elements are:

- Aligned to the CQC ratings
- An Executive summary, following by detailed CQC section.
- Standardised exception reports in the detailed sections.
- Provision of benchmark information where available

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

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

Previously considered by:	The Board received a monthly quality and performance report.
Risk and assurance:	Failure effectively manage and escalate performance
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

The Board is asked to note the new IQPR Report and agree the implementation of actions as outlined

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report



Month seven: October 2017

Putting you first

CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

1 EXECUTIVE SUMMARY

ARE WE SAFE?

HCAIs - The Trust has no MRSA cases for October 2017 but there was a total of 6 Clostridium difficile cases for October 2017 (Recovery Action Plan (RAP) included in main report).

NHS Patient Safety Alerts (PSAs) – A total of 5 PSAs have been received in 2017/8, including 0 in October. All the alerts have been implemented within timescale to date.

Patient Falls- 56 patient falls occurred in October, bringing the YTD total to 388; of these falls, 23 (114 YTD), resulted in harm. (Recovery Action Plan (RAP) included in main report).

Pressure Ulcers- The number of acquired pressure ulcers continues to be above the local Trust plan of 5 per month. In October 18 cases occurred, with a YTD total of 89. *(RAP included in main report).*

ARE WE EFFECTIVE?

Mortality Indicators – A new mortality dashboard has been developed which includes learning from deaths and will be presented as a separate agenda item to the Board, second month of every quarter. This will not be included in the IQPR anymore.

Cancelled Operations for non-clinical reasons - The rate of cancelled operations for non-clinical reasons is above the 1% threshold, with performance at 1.44% in October. The YTD performance is below target at 0.98%. (Recovery Action Plan (RAP) included in main report).

Patients offered a new date within 28 days of a cancelled operation - The Trust offered 89% of patients a date within 28 days for the YTD, below the national average of 92.8% and below the plan of 95%. *(RAP included in the main report)*

Discharge Summaries- Performance to date is below the 95% target to issue discharge summaries within 48 hours. A&E has achieved a rate of 83% in October. *(RAP included in the main report)*

OP and Theatre Utilisation and productivity rates – KPMG are supporting the Trust to evaluate the effectiveness of theatres and outpatients and will be presented to the Board once complete.

ARE WE CARING?

Complaints - The number of complaints has fallen compared to last year, with a total of 85 for the YTD to October. The Trust is in the best 10% of acute trusts for the written complaints rate and has approximately 50% less complaints than its peer group of small acute Trusts.

Mixed Sex Accommodation breaches (MSA) – No MSA breaches have occurred for the YTD, against a national average of over 4 per month.

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.

ARE WE RESPONSIVE?

A&E 4 hour wait - The Trust achieved the A&E target at Qtr. 1 with performance at 95% and achieved 90.5% for Qtr. 2. In July, August and September, performance has deteriorated to 92.47%, 90.09%, & 88.94% respectively. October performance of 87.37% is mixed with some exceptionally challenging days. For the period to October, WSH's performance is approximately 3% above its peer group average. *(RAP included in main report).*

Diagnostics with 6 weeks. The Trust continues to achieve the target of providing diagnostic tests with 6 weeks for 99% of activity with performance at 100% for each month since April and performs ahead of the peer group average.

Cancer – Cancer performance improved during September & October, but one target was missed. The Trust failed the 2 week wait target with a performance of 83.4% against a target of 93% predominantly due to capacity issues within Dermatology. The Trust achieved excellent performance of 91.06% against a target of 85% for the cancer 62-day target. Both the 31-day targets were achieved in October. The YTD performance for all cancer targets is ahead of the national threshold. *(RAP included in the main report)*

Referral to Treatment (RTT) - The percentage of patients on an incomplete pathway within 18 weeks is well below the national target of 92%, with performance in October of 87%. Data quality issues and validation of the list continue. The total waiting list has reduced to 16,694 in October. In October, 26 patients breached the 52-week standard, with a YTD total of 160. RTT remains the most significant performance challenge facing the trust and KPMG and the Intensive Support Team are working with the Trust support performance improvement. *(RAP included in the main report).*

Emergency Care Flow – A national priority for acute hospitals in 2017 is to focus on improving patient flow, improving the management of patients as they move through stages of care. The new e-Care System will be used to collect some of the

key new flow indicators which are listed on the "Responsive" section of the main report. An early view of Trust performance, benchmarked against the national average has been produced by the Model Hospital website and is included in the main report.

ARE WE WELL LED?

Staff FFT – The survey for the period to October 2017 was positive with 82% of staff recommending the Trust as a place to work and 95% of staff recommending the Trust for a place to receive treatment or care. This compared with the national averages of 64% and 81% respectively. The Trust is ranked 7th best in England for a place to work and 14th best for a place to receive care, both in the top decile of Trusts in England.

Staff Turnover – Turnover rates continue to improve with a rate of 9% for October, below the Trusts aim to maintain turnover rates below 10%.

Sickness Absence – Sickness absence rates are equivalent to the local 3.5% ceiling at 3.55% for October. The Trust average is lower than the peer group average of 3.74% and the national average of 3.86%. *(RAP included in the main report).*

Agency Spend – Agency spend is well below the local plan and agency ceiling, with average spend £271k for the YTD.

ARE WE PRODUCTIVE?

Financial Position – The reported I&E for October 2017 YTD is a deficit of £3,839k, against a planned deficit of £3,725k. This results in an adverse variance of £114k YTD. The October position also includes revised income and expenditure to reflect the new contractual arrangements for providing Community Services in Suffolk. This does not impact on our overall

forecast deficit, but does reduce both income and expenditure by around £13.7m in the remainder of 17-18. Community based staffing numbers are also affected.

Cost Improvement Programme (CIP) - The October position includes a target of £7,107k YTD which represents 50.4% of the 2017-18 plan. There is currently a shortfall of £46k YTD against this plan.

Use of Space – The percentage of non-clinical floor space is 31%, below the plan of no more than 35% and the Trust does not have any unoccupied floor space planned.

2. INTEGRATED QUALITY & PERFORMANCE REPORT DASHBOARD

The new dashboard highlights key targets that form the key lines of enquiry and KPIs of NHS Improvement and the CQC. These are reviewed in detail in the individual CQC aligned sections of the report. Exception reports are included in the detailed section of this report.

WEST SUFFOLK HOSPITAL INTEGRATED QUALITY & PERFORMANCE REPORT												TRUST TOTAL										
Are we..	Ref.	KPI	ED	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	AwYTD	WTC	Traffi	Sparkline
1. Safe	1.01	NHS E / I Improvement Patient Safety Alerts Total	RP	3	1	2	0	0	1	0	1	0	0	1	2	1	0	5			
	1.02	NHS E / I Improvement Patient Safety Alerts OS	RP	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6		
	1.03	Emergency C-Section Rate	RP	<12%	15%	12%	12%	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	11%	6		
	1.04	All relevant inpatients undergoing VTE Risk assessr	RP	95%	88%	88%	87%	87%	87%	86%	87%	89%	89%	86%	90%	88%	95%	89%	2		
	1.05	Clostridium difficile infections (CDI)	RP	16	3	3	2	0	0	1	3.00	0.00	0	1	0	2	6	12	6		
	1.06	MRSA	RP	0	0	0	0	0	0	0	0.00	0.00	0	0	0	2	0	2	6		
	1.07	Patient Safety Incidents Reported	RP	NT	502	502	449	460	459	463	392	508	418	506	466	467	521	1454			
	1.08	Never Events	NJ	0	0	0	0	0	0	0	0	0	0	0	0	0		0	6		
2. Ef	2.01	Overall HSMR - DFI	NJ	<90	83%	83%	84%				88%	88%	88%	88%	85%	87%	ND	87%	6		
	2.04	Canc. Ops - Cancellations for non-clinical reasons	NJ	<1%	1%	1%	1%	1%	0%	1%	1%	1%	1%	1%	1%	1%	1%	1%	6		
3. Caring	3.01	Compliments	JB		35	56	59	33	41	28	41	52	26	56	28	17	ND	220			
	3.02	Complaints (Inpatient)	JB	19.50	15	10	17	18	12	11	10	10	10	6	16	16	17	85	6		
	3.03	Mixed Sex Accommodation Breaches	R	0.00	0	0	0	0	2	0	0	0	0	0	0	0	0	0	6		
	3.04	IP - Extremely likely or Likely to recommend	R	90%	98%	97%	95%	99%	98%	99%	98%	97%	99%	98%	98%	98%	99%	98%	6		
	3.05	OP - Extremely likely or Likely to recommend	R	90%	98%	97%	97%	97%	97%	96%	95%	96%	97%	95%	95%	96%	96%	96%	6		
	3.06	A&E - Extremely likely or Likely to recommend	R	90%	80%	85%	95%	95%	96%	96%	97%	96%	95%	95%	95%	92%	95%	95%	6		
	3.07	Maternity - How likely are you to recommend	R	85%	100%	95%	90%	91%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	6		
4. Responsive	4.01	A&E - Under 4 hr. wait	HB	95%	86%	85%	86%	87%	84%	93%	95%	95%	96%	92%	90%	89%	87%	92%	4		
	4.02	RTT: % incomplete pathways within 18 weeks	HB	92%	92%	92%	92%	90%	90%	90%	82%	80%	83%	84%	86%	86%	87%	84%	2		
	4.03	52-week waiters	HB	0%	1	0	0	7	7	8	15	14	15	35	26	29	26	160	2		
	4.04	Diagnostics within 6 weeks	HB	99%	96%	99%	95%	96%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.05	Cancer: 2w wait for urgent GP Referrals	HB	93%	97%	98%	98%	90%	98%	98%	94%	92%	97%	95%	96%	91%	83%	93%	4		
	4.06	Cancer 2w wait breast	HB	93%	98%	99%	93%	88%	96%	94%	94%	99%	89%	98%	100%	98%	100%	97%	6		
	4.07	Cancer 31 d First Treatment	HB	96%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.08	Cancer 31 d Drug Treatment	HB	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.09	Cancer 31 d Surgery	HB	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.10	Cancer 62 d GP referral	HB	85%	89%	85%	86%	85%	88%	83%	89%	83%	86%	85%	86%	87%	91%	87%	6		
	4.11	Cancer 62 d Screening	HB	90%	100%	100%	96%	100%	89%	97%	100%	100%	90%	100%	100%	91%	100%	97%	6		
5. Well Led	5.02	Staff F&F Test % Recommended - care (Qrtly)	JB	75%	NA	NA	94%	NA	NA	93%	NA	NA	95%	NA	NA	95%	NA	95%	6		
	5.03	Staff F&F Test % Rec'mend - place to work (Qrtly)	JB	75%	NA	NA	ND	NA	NA	79%	NA	NA	83%	NA	NA	82%	NA	83%	6		
	5.04	Turnover (Rolling 12 mths)	JB	<10%	10%	10%	10%	10%	11%	10%	10%	10%	10%	10%	10%	10%	9%	10%	6		
	5.05	Sickness Absence	JB	<3.5%	3.93%	4.41%	4.48%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.60%	4		
	5.06	Executive Team Turnover	JB	<10%	0%	29%	0%	0%	0%	0%	0%	17%	0%	0%	0%	10%	9%	5%	6		
	5.07	Agency Spend	CB		565	476	422	459	354	258	307	316	289	336	244	220	187	271	6		
	5.08	Monitor Assurance Governance Rating	JB	2	3	3	4	4	4	3	3	3	3					3			
6. Productiv	6.01	I&E Margin	CB	Var	-2.76%	-3.39%	-4.93%	-5.13%	-5.10%	-1.50%	ND	-4.90%	-4.30%	-3.90%	0.13%	-3.04%	-2.55%	-3.09%			
	6.03	Capital service capacity	CB	Variable	0.25	- 0.65	- 2.59	- 6.74	- 2.81	1.41	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	- 0.32			
	6.04	Liquidity (days)	CB	Var	- 7.78	- 11.30	- 16.45	- 19.70	- 21.76	- 7.28	ND	- 12.15	- 15.72	- 10.94	- 11.03	- 12.70	- 15.14	- 15.14			
	6.05	Long-Term Borrowing	CB		29.96	30.96	32.06	33.06	36.06	44.30	44.27	45.70	45.70	45.70	45.70	47.62	47.62	47.62	6		
	6.06	Variance to CIP plan	CB		-814	-1826	-2550	-3268	-3247	0	40	0	-40	10	0	-54	-10				
7.Maternity	7.01	Total number of deliveries (births)	0	210	219	195	234	198	197	238	215	192	213	215	233	236	205	1509	6		
	7.02	% of all caesarean sections	0	<22.7%	21%	18%	19%	16%	13%	19%	15%	21%	16%	16%	22%	18%	17%	18%	6		
	7.03	Midwife to birth ratio	0	1.3	1.29	1.28	ND	1.28	1.28	1.33	1.30	1.27	1.29	1.30	1.33	1.33	1.29	1.30	4		
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
	7.05	Completion of WHO checklist	0	1	95%	82%	96%	93%	87%	89%	84%	93%	84%	94%	82%	98%	98%	90%	4		
	7.06	Maternity SIs	0	NT	2	0	3	0	1	1	1	0	0	0	0	1	1	3			
	7.07	Maternity Never Events	0	NT	0	1	0	0	0	0	0	0	0	0	0	0	0	0			
	7.08	Breastfeeding Initiation Rates	0	0.8	82%	80%	80%	74%	80%	76%	80%	81%	88%	77%	85%	79%	81%	81%	6		
		Weightage			0	0	0	0	0	0	0	0	0	0	0	0	0	YTD	206	of	336

3. IN THIS MONTH – OCTOBER 2017, MONTH 7

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

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

In this month…. October 2017

Mth 7 We Received……	2017/18 October	2016/17 October	Variance	Var. %	Traffic
GP Referrals	6,305	6,405	-100	-2%	↓
Other Referrals	5,469	5,560	-91	-2%	↓
Ambulance Arrivals	1,830	1,786	44	2%	↑
(Included in referrals above:)					
Cancer Referrals	999	1,010	-11	-1%	↓
Urgent Referrals	2,608	2,660	-52	-2%	↓

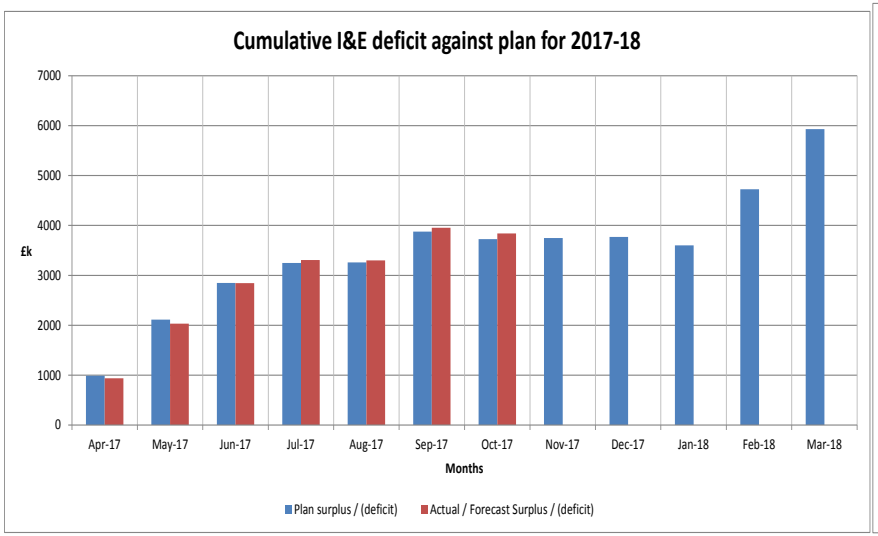
YTD We Received……	2017/18 To October	2016/17 To October	Variance	Var. %	Traffic
GP Referrals	43,754	43,566	188	0%	↑
Other Referrals	35,846	35,397	449	1%	↑
Ambulance Arrivals	12,261	11,827	434	4%	↑
(Included in referrals above:)					
Cancer Referrals	6,701	7,184	-483	-7%	↓
Urgent Referrals	17,593	19,243	-1,650	-9%	↓

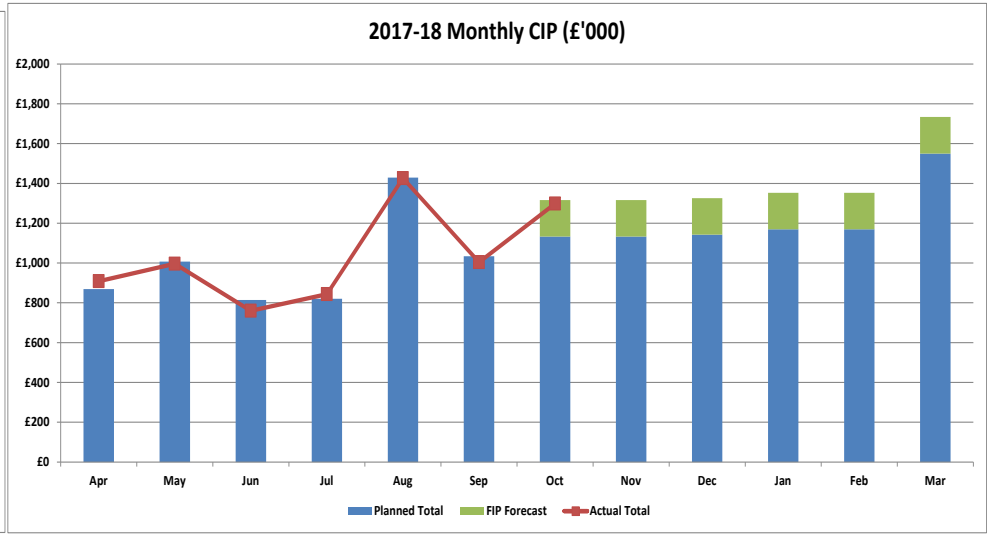
Mth 7 We Delivered……	2017/18 October	2016/17 October	Variance	Var. %	Traffic
A&E Attendances	6,057	5,814	243	4%	↑
Outpatient Attendances	25,587	22,020	3,567	16%	↑
Elective (incl Daycase)	2,866	2,949	-83	-3%	↓
Nonelective Admissions	2,599	2,465	134	5%	↑
Inpatient Discharges	6,172	6,066	106	2%	↑
New Births	205	216	-11	-5%	↓
RTT Total Incompletes	16,694	18,033	-1,339	-7%	↓

YTD We Delivered……	2017/18 To October	2016/17 To October	Variance	Var. %	Traffic
A&E Attendances	41,221	40,029	1,192	3%	↑
Outpatient Attendances	171,579	150,316	21,263	14%	↑
Elective (incl Daycase)	19,773	18,612	1,161	6%	↑
Nonelective Admissions	17,133	17,155	-22	0%	↓
Inpatient Discharges	41,492	39,740	1,752	4%	↑
New Births	1,509	1,514	-5	0%	↓

4. FINANCE SUMMARY

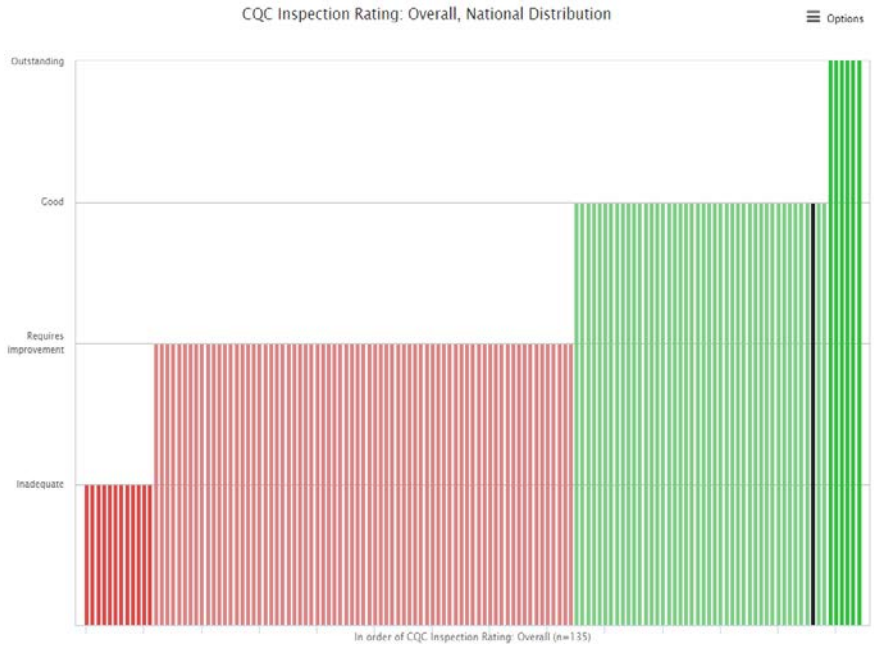
The financial position to October 2017 (Mth 7) shows a £4m deficit, which is £114k behind the financial plan. The income position was slightly behind plan in October. Inpatients over performed within the month (Elective), with outpatient being the largest are of underperformance. The cash position remains close to the revised plan, but will become more challenging as the year progresses, requiring improved debtor/creditor management and CIP delivery. The overall Use of Resources rating remains at 3.

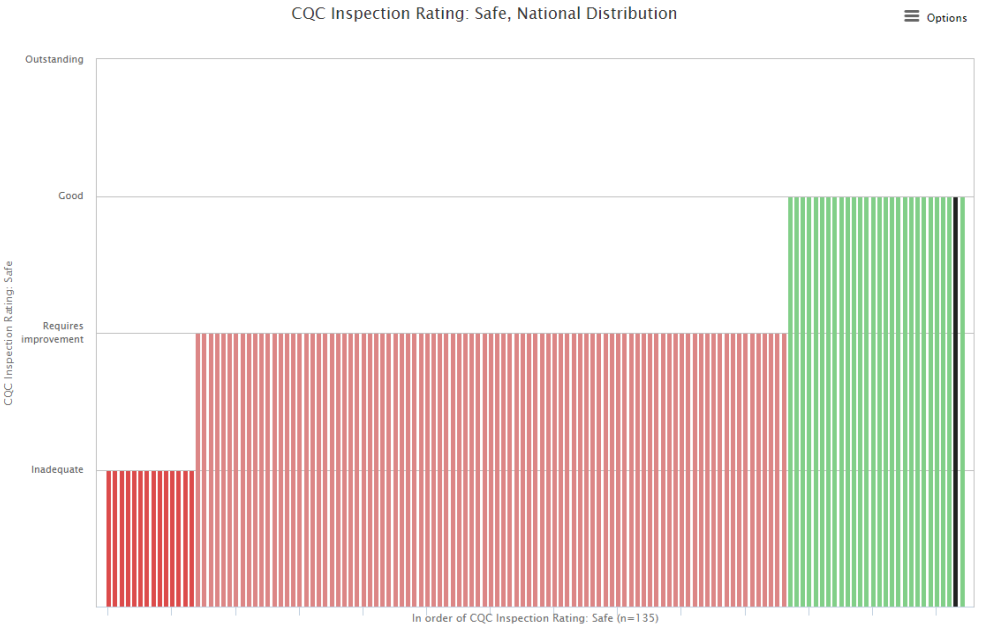


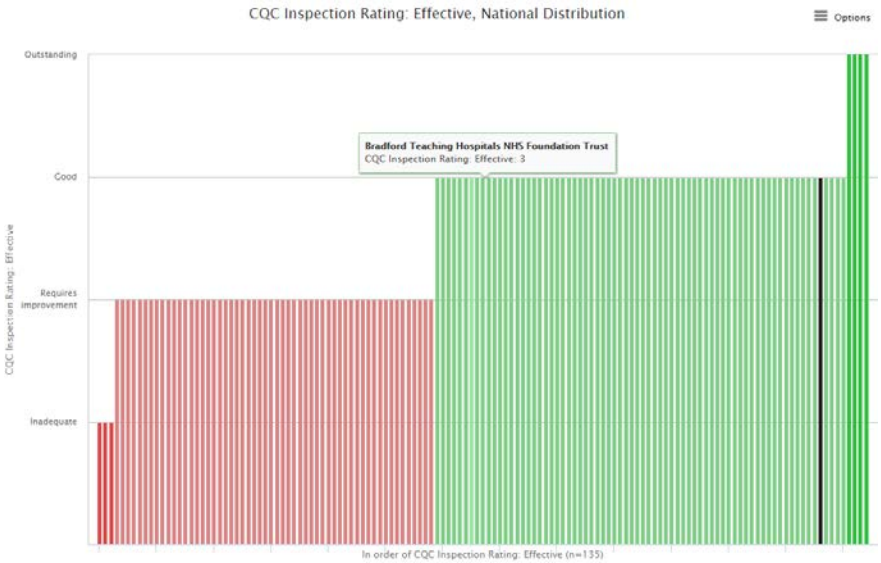


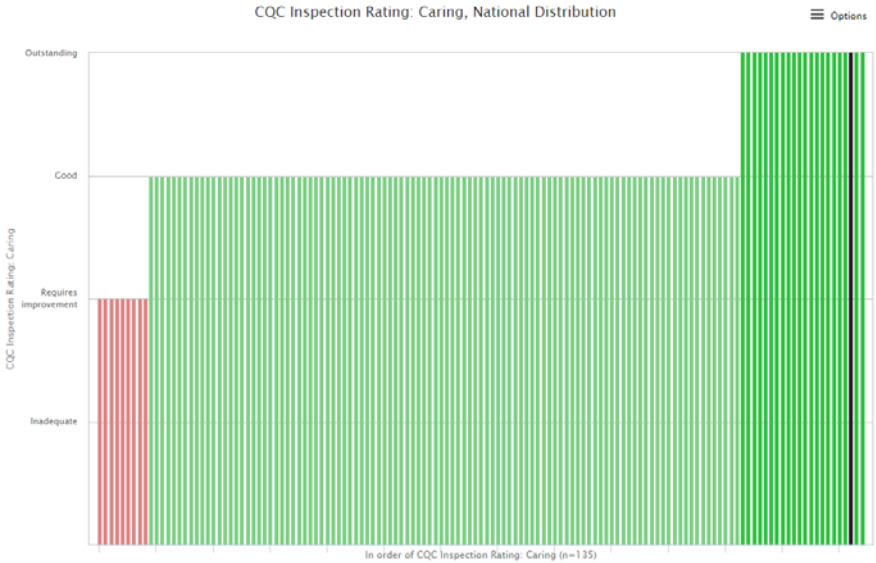
5. CQC OVERVIEW

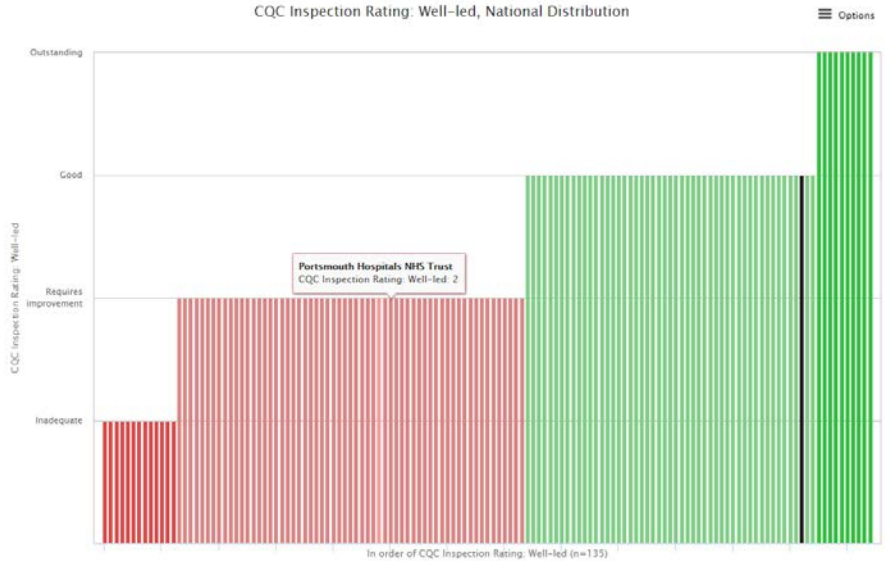
The CQC have launched the Model Hospital website in *alpha* form which highlights comparative indicators in a number of key areas. The Quality of Care compartment: includes the CQC ratings as the principal assessment indicators, with additional indicators, including the Friends and Family Test, Ambulance outcomes, and Mental Health Services. The graphs below provide an oversight of the Trusts comparative performance against these key areas. *(Source – Model Hospital)*

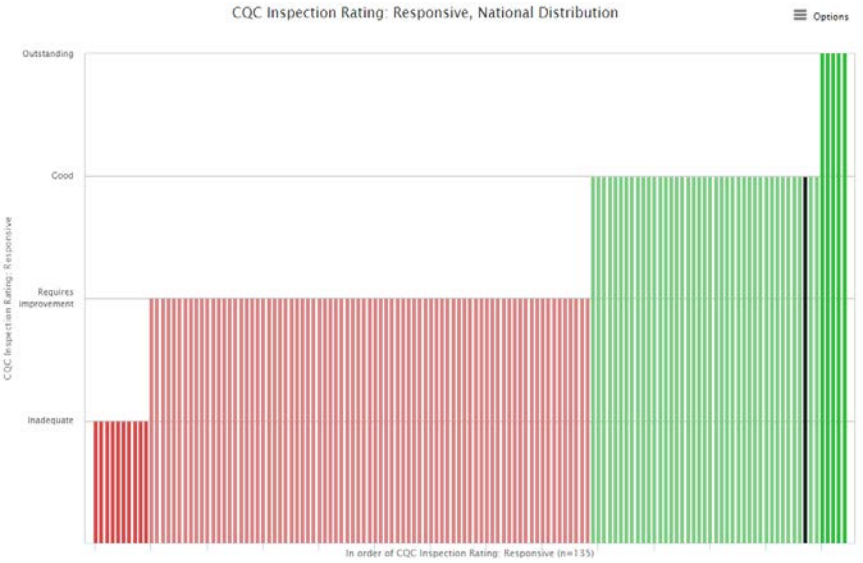





CQC Inspection Rating: Effective, National Distribution
Options
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Effective
Bradford Teaching Hospitals NHS Foundation Trust
CQC Inspection Rating: Effective: 3
In order of CQC Inspection Rating: Effective (n=135)


CQC Inspection Rating: Caring, National Distribution
Options
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Caring
In order of CQC Inspection Rating: Caring (n=135)


CQC Inspection Rating: Well-led, National Distribution
Options
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Well-led
Portsmouth Hospitals NHS Trust
CQC Inspection Rating: Well-led: 2
In order of CQC Inspection Rating: Well-led (n=135)


CQC Inspection Rating: Responsive, National Distribution
Options
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Responsive
In order of CQC Inspection Rating: Responsive (n=135)

CQC - QUALITY OF CARE BENCHMARK DASHBOARD

The Quality of Care dashboard highlights comparisons with national and peer group averages. The peer group comprises 24 similar hospitals to West Suffolk, national categorised as small acute hospitals. Appendix 2. *(Source – Model Hospital)*

Quality of Care, Single Oversight Framework

CQC Inspection Ratings (latest as at reporting date)	Period	Trust Actual	Info	Variation	Trend
CQC Inspection Rating: Overall	Latest	Good			No trendline available
CQC Inspection Rating: Caring	Latest	Outstanding			No trendline available
CQC Inspection Rating: Effective	Latest	Good			No trendline available
CQC Inspection Rating: Responsive	Latest	Good			No trendline available
CQC Inspection Rating: Safe	Latest	Good			No trendline available
CQC Inspection Rating: Well-led	Latest	Good			No trendline available

Friends and Family Test scores	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Staff Friends and Family Test % Recommended - Care	Q4 2016/17	93.5%	-	-		No variation available	
A&E Scores from Friends and Family Test - % positive	May 2017	96.0%	89.2%	88.9%			
Inpatient Scores from Friends and Family Test - % positive	May 2017	96.8%	96.7%	96.6%			
Maternity Scores from Friends and Family Test -question 2 Birth % positive	May 2017	100.0%	100.0%	98.2%			

Organisational health	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Aggressive Cost Reduction Plans	Jun 2017	5.1%	4.5%	4.7%			

Caring	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Mixed Sex Accommodation Breaches	Jun 2017	0	0	0			

Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
VTE Risk Assessment	Q4 2015/16	99.96%	96.13%	95.88%			

Safe	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
Clostridium Difficile - variance from plan	Jun 2017	-1.0	-1.0	0.0			

6. DETAILED SECTIONS - SAFE

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

Are we.		Ref.	KPI	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	YTD(Apr17-Mar18)	WTG	Traffic	Trend
Safe	Dashboard	1.01	NHS E / I Patient Safety Alerts - Total	NT	1	2	0	0	1	0	1	0	0	1	2	1	0	5			
		1.02	NHS E / I Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6		
		1.03	Emergency C-Section Rate	14%	15%	12%	12%	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	11%	6		
		1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	88%	88%	87%	87%	87%	86%	87%	88%	89%	88%	90%	86%	94.84%	89%	2		
		1.05	Clostridium difficile infections (CDI)	16	3	3	2	0	0	1	3	0	0	1	0	2	6	12	6		
		1.06	MRSA (Hospital)	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	6		
		1.07	Patient Safety Incidents Reported	NT	502	502	449	460	459	463	392	508	418	506	466	467	521	1454			
		1.08	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0	6		
	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	99%	2		
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	100%	86%	100%	100%	95%	100%	96%	100%	100%	100%	96%	100%	100%	99%	2		
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	100%	100%	100%	98%	98%	98%	100%	100%	100%	100%	97%	100%	98%	99%	2		
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	93%	96%	99%	93%	98%	95%	100%	97%	98%	93%	97%	99%	99%	98%	2		
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		1.14	HII Compliance 4b: Preventing surgical site infection perioperative	100%	100%	87%	100%	100%	100%	100%	100%	85%	100%	95%	100%	100%	100%	97%	2		
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	78%	97%	2		
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	90%	85%	93%	95%	95%	82%	81%	92%	94%	88%	93%	97%	91%	92%	2		
		1.18	HII Compliance 7: Clostridium Difficile - prevention of spread	100%	NA	NA	NA	NA	NA	NA	ND	ND	ND	ND	ND	ND	ND				
	Incidents	1.19	Safety Thermometer - Harm-Free Care (New Harms)	95%	98%	98%	99%	97%	98%	98%	99%	98%	99%	99%	98%	97%	98%	98%	3		
		1.20	No of SIRIs	NT	9	11	11	14	6	8	9	5	7	7	6	5	11	50			
		1.21	RIDDOR Reportable Incidents	NT	0	2	0	0	0	0	0	0	1	0	1	0	2	4			
		1.22	Catheters and New UTIs	NT	0.00	0.25	0.00	0.25	0.26	0.78	0.29	0.29	0.27	0.00	0.00	0.00	0.15	0.14			
		1.23	E. coli Infections	NT	15	16		19	9	9	2	0	2	2	0	0	0	6			
		1.25	Patient Falls	<48	67	62	65	61	54	71	54	52	50	69	68	39	56	388	1		
		1.26	Patient Falls resulting in harm	<10	19	18	19	11	14	16	9	17	20	17	18	10	23	114	1		
		1.27	Falls - Per 1000 bed days	5.60	ND	ND	ND	5	5	5	5	5	ND	ND	ND	ND	ND	10	3		
		1.28	Number of avoidable serious injuries/deaths resulting from falls	NT	ND	0	ND	0	0	ND	0	0	ND	ND	0	0	0	0	3		
		1.29	Number of medication errors	NT	4	9	16	23	18	25	64	80	69	78	70	69	70	500			
		1.30	Actual patient harm resulting from medication incidents	0.01	4	8	15	23	16	20	1	0	0	0				1			
		1.31	Pressure Ulcers - Inpatients	<5	24	22	14	22	10	4	9	8	13	7	13	15	18	83	1		
		1.32	Pressure Ulcers - Avoidable ward-acquired PUs	NT	7	ND	ND	ND	ND	ND	4	3	4	ND	ND	ND	ND				
	Reporting	1.33	MRSA Quarterly Std (including admission and LOS screens)	90%	NA	NA	89%	NA	NA	91%	NA	NA	92%	NA	NA	93%	NA	93%	3		
		1.34	MRSA - Decolonisation (Trust level treatment and post screening)	90%	92%	95%	96%	93%	90%	90%	92%	93%	95%	95%	90%	91%	98%	93%	3		
		1.35	MRSA - RCA Reports	NA	0%	0%	0%	0%	0%	0%											
		1.36	MSSA	NT	ND	1	0	1	2	1	0	1	0	0	0	0	0	1			
		1.37	SIRI final reports due in month submitted beyond 60 working days	0	0	0	0	0	0	0	0	1	0	0	0	4	5	10	2		
		1.38	SIRIs reported > 2 working days from identification as red	0	1	0	0	0	0	2	0	0	0	0	1	2	3	6	3		
		1.39	RAG active/accepted risk assessments not in date	0	1	1	1				ND	ND	ND	3	0	1	5	15	3		
		1.40	Datix Risk Register Red / Amber actions overdue	0							ND	ND	ND	22	0	0	0	22			
		1.41	Outstanding actions complete in date for Red/Amber entries on Dat	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	3		
		1.42	Quarterly standard principle compliance	90%	NA	NA	93%	NA	NA	95%	NA	NA	95%	NA	NA	95%	NA	95%	3		
		1.43	Rapid access chest pain clinic access within 2 wks.	100%	94%	73%	90%	52%	100%	100%	100%	98%	100%	95%	97%	97%	96%	98%	2		
		1.44	Verbal Duty of Candour outstanding at month-end	0%	1	1	1		ND	ND	3	0	0	0	2	0	1	6	2		
		1.45	Hand Hygiene Audits	95%	98%	99%	100%	99%	99%	98%	98%	99%	99%	100%	99%	96%	99%	99%	2		
		1.46	Quarterly antibiotic audit	98%	NA	NA	92%	NA	NA	93%	NA	NA	91%	NA	NA	94%	NA	92%	3		
		1.47	RCAs beyond deadline for completion	=<4	8	11	15	9	9	8	3	1	3	4	1	7	2	21	3		
		1.48	% of Green Patient Safety incidents investigated	NT	62%	59%	60%	69%	64%	60%	60%	66%	54%	53%	68%	58%	67%	61%			
		1.49	PEWS documentation and escalation compliance	NT	100%	100%	100%	100%	100%	100%	80%	100%	90%	100%	100%	90%	ND	93%	2		
		1.50	Quarterly Environment/Isolation	90%	NA	NA	93%	NA	NA	91%	NA	NA	91%	NA	NA	92%	NA	92%	3		
		1.51	Quarterly VIP score documentation	90%	NA	NA	83%	NA	NA	79%	NA	NA	84%	NA	NA	80%	NA	82%	2		
		1.52	Isolation data (Trust Level only)	95%	92%	95%	93%	90%	95%	89%	90%	95%	90%	90%	88%	88%	90%	90%	2		
		1.53	Pain Mgt. Quarterly internal report	80%	71%	NA	NA	68%	NA	NA	75%	NA	NA	67%	NA	NA	67%	66%	1		
		1.54	Nutrition Risk Assessment 48hrs	95%	81%	84%	83%	84%	83%	90%	91%	87%	89%	82%	89%	93%	89%	89%	2		
		1.55	Median of NRLS upload (No. of days)	41	52	ND	ND	50	50	51	ND	87	64	65	58	55	48	377	1		

6. EXCEPTION REPORTS – SAFE

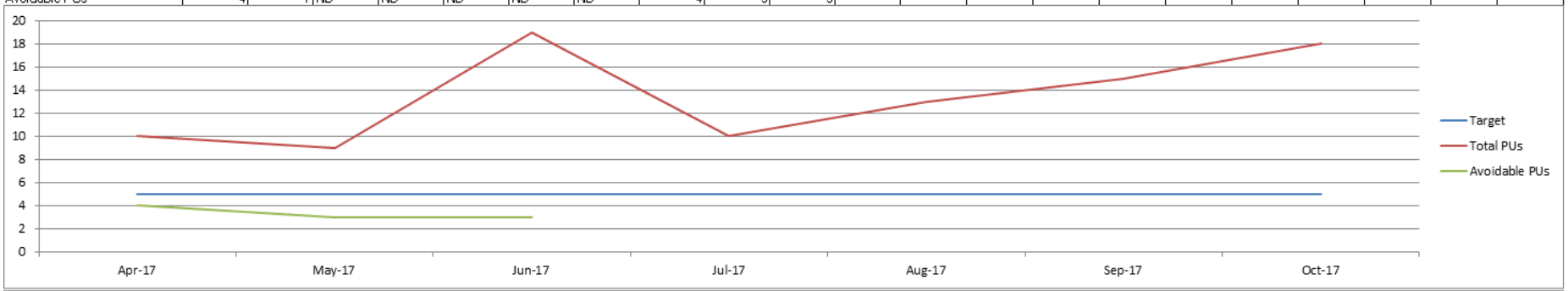
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Pressure Ulcers
Standard	Below 5 PU pm and <30% avoidable
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Background

October has seen a further increase in hospital acquired pressure ulcers (HAPUs) from the previous month. There were eighteen in total, a rise from fifteen in September. However, some areas, F3, and G8 saw a reduction in HAPUs, with G3 having no reported damage.
Wards F4 and F6 continue to have no reported hospital acquired pressure damage, managing 16 and 5 months respectively, a highly commendable achievement.
Acuity and capacity has been high in October, with escalation areas in use, placing wards and departments under increasing pressure against a backdrop of staff shortages due to vacancy and sickness. This is, no doubt, having an impact on patient safety and the quality of care and is representative of the increasing number HAPUs. Staffing deficits are reviewed by the senior nursing team daily to mitigate the risks.

Trend												Recovery Trajectory									
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Target	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Total PUs	13	24	22	14	22	10	4	10	9	19	10	13	15	18							
Avoidable PUs	4	7	ND	ND	ND	ND	ND	4	3	3											



Key Recovery Actions

Description	Owner	Start	End
The Tissue Viability team continue to maintain excellent visibility and support for ward teams, promoting pressure ulcer prevention via bite size teaching sessions, one to one education and promoting awareness and improvement of staff knowledge and practice in promoting skin health and integrity. The Pressure Ulcer Prevention focus group continues to focus on promoting accurate risk assessment and early preventative measures. Led by Senior Matron Danni Elliott, with the support of the Tissue Viability Nurse specialists, the aim of this group is to promote the concept of sharing good practice amongst teams and ultimately improve knowledge and awareness to eliminate the occurrence of avoidable pressure damage. The focus group also promotes the use of the patient safety dashboard, using the compliance report to monitor the timeliness of risk assessments and initiation of care plans. This is a useful tool for Ward Managers and Matrons to promote compliance and ultimately, improve patient care. Early indicators demonstrate that this report is already influencing an improvement in compliance with risk assessment. The 2017/18 Trust quality priority target for avoidable pressure ulcers is to improve upon the 2016/17 year end performance of 30%.	RP	Apr-17	Mch 18

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Infection Control: MRSA and Clostridium Difficile
Standard	MRSA 0, C.difficile ceiling 16
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

There were six cases of Hospital attributable CDT in October. CDT cases occurred on: G8 (three cases), G3 (one case), Clinical Decisions Unit (one case), Rosemary Ward Newmarket Community Hospital (one case).
This is the highest number of cases recorded by the Trust since March 2012. The Trust was under trajectory in Q1 & Q2 but is now over trajectory. As acknowledged on the Trust risk register this may reflect the Global shortage of Tazocin which has required the use of antibiotics associated with a higher risk of Clostridium difficile infection. Overall summary as of October 2017, 12 reported cases five of which are Non Trajectory, three are Trajectory and four are awaited.

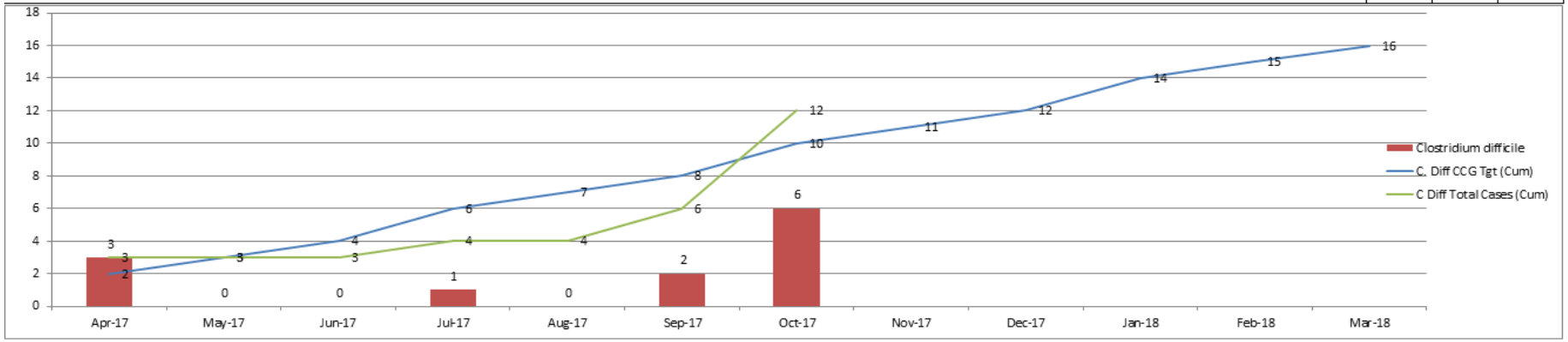
The Trust has no recorded MRSA bacteraemia in October 2017. Both cases have been investigated and have been submitted to NHS England for consideration as 'Third Party' assignment.

Trend | Recovery Trajectory

Indicator	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18									
C. Diff CCG Tgt (Cum)	2	3	4	6	7	8	10	11	12	14	15	16									
Clostridium difficile	3	0	0	1	0	2	6														
C Diff Total Cases (Cum)	3	3	3	4	4	6	12														
MRSA	0	0	0	0	0	2	0														

Key Recovery Actions

Description	Owner	Start	End
To continue with vigilance to identify symptoms of C difficile for early identification and testing.	RP	Sep-17	Nov-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	VTE
Standard	95%
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	

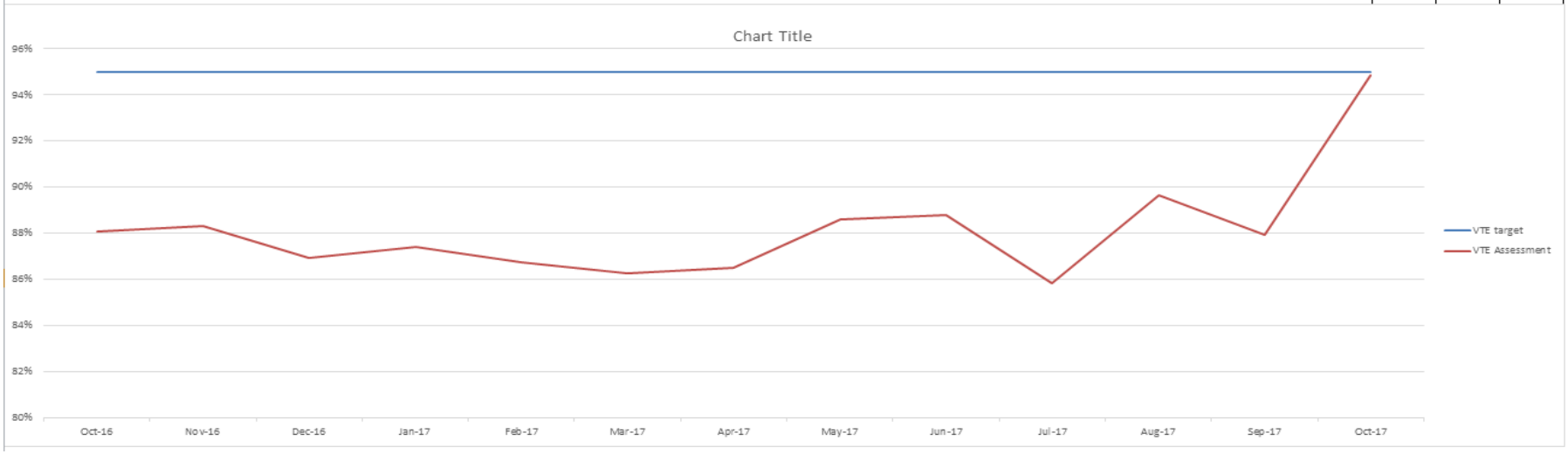
Background

Venous thromboembolism (VTE) is a significant international patient safety issue. The first step in preventing dealth and disability from VTE is to identify those at risk so that preventative treatments (prophylaxis) can be given. The Trust has been unable to fully collate VTE data in 2016/17, but quality audits suggested that the Trust was delivering close to the 95% target. Since April 2017 data has been sent to UNIFY2 and performance has been below 90% for the YTD. In October, the position was 94.84% against a threshold of 95%.

Trend													Recovery Trajectory								
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
VTE target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
VTE Assessment	88%	88%	88%	87%	87%	87%	86%	87%	89%	89%	86%	90%	88%	95%							

Key Recovery Actions

Description	Owner	Start	End
We have now managed to fully apply the national guidance to understand the issues. We are now showing just under the 95% threshold and the doctor per ward will be asked for an action plan to deliver improvements on their ward.	RP	Sep-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Median NRLS upload 6 month rolling average
Standard	41 days
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

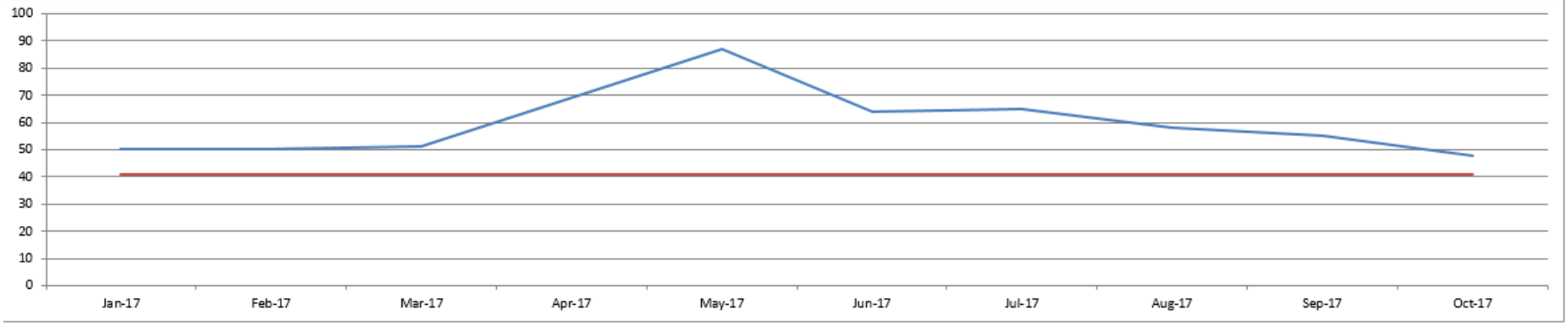
Background

In the most recent six-month period the median upload was 48 days which continues to improve but has not yet met the local target of 41 days which has been updated to reflect the recently issued NRLS report (Oct16-Mat17).

Trend												Recovery Trajectory								
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Median of NRLS Upload (No of Days)					50	50	51		87	64	65	58	55	48							
Target					41	41	41		41	41	41	41	41	41							

Key Recovery Actions

Description	Owner	Start	End
The next NRLS closure date (for the period Apr-Sept 2017) was the 30th November. As in previous periods there was a considerable amount of follow up required to ensure the deadline was met. NHS Improvement is now publishing monthly information reports including timeliness indicators which demonstrate improving performance in the more recent months.	RP	Aug-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Patient Safety Incidents Reported
Standard	
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

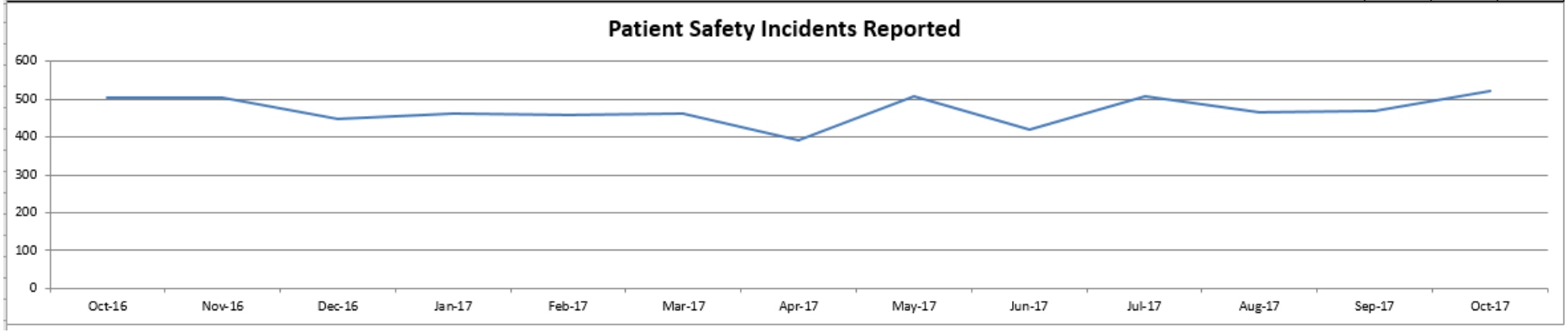
There were 645 incidents reported in October including 523 patient safety incidents (PSIs). This was higher than September and reflects the increased reporting now that the Community services have joined the trust. This is above the NRLS median threshold. The number of 'harm' incidents remains low although it has risen as a consequence of Community reporting, mainly relating to pressure ulcers.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Patient Safety Incidents Reported	443	502	502	449	460	459	463	392	508	418	506	466	467	521							

Key Recovery Actions

Description	Owner	Start	End
	RP	Aug-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	HII Compliance 2b: Peripheral cannula ongoing
Standard	100%
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

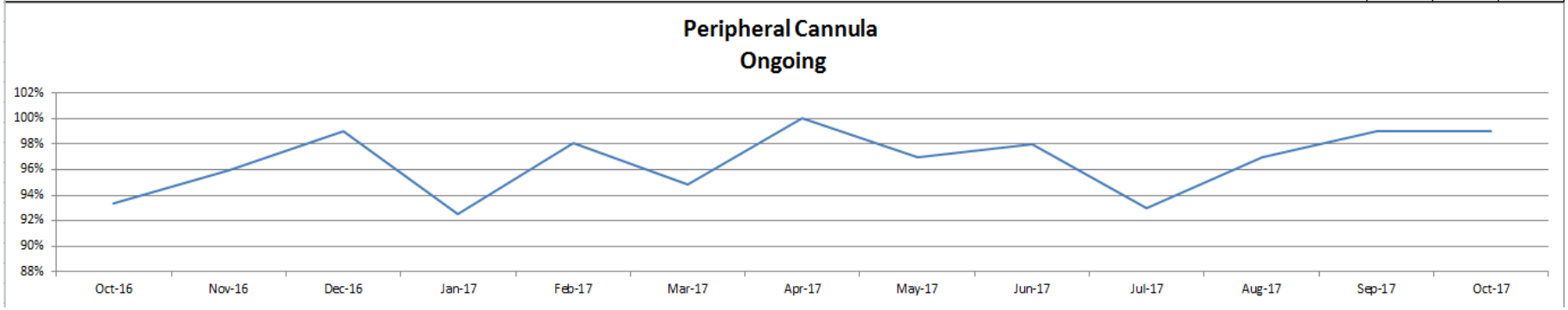
Background

A score of 99 was achieved for October which remained the same as 99 in September and as such this has resulted in a continued Amber RAG-rating. Failing to document indication for continued insertion lowered the score from the desired target range.

Trend / Recovery Trajectory																				
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Peripheral Cannula Ongoing	98%	93%	96%	99%	93%	98%	95%	100%	97%	98%	93%	97%	99%	99%							
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							

Key Recovery Actions

Description	Owner	Start	End
Compliance with documentation, following changes to eCare still poses a challenge. The Senior Matron team continue to discuss performance at the Monthly Quality Meeting and share examples of good practice and strategies adopted to improve compliance. Senior Matrons to continue to undertake regular discussions with Senior Ward Nursing Teams at 1:1's and Ward Team Meetings to highlight current performance and discuss options in improving practice. Specific action plans to be supported and monitored by Senior Matrons and Head of Nursing for areas with persistent poor performance. Continuing episodes of staffing deficits coupled with the need for the provision of escalation capacity have impacted upon the accurate and timely completion of assessments and documentation. The Senior Matron and Operational Teams attempt to mitigate the impact of these pressures on compliance through staff re-deployment in line with activity and acuity being experienced.	RP	Aug-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	HII Compliance 6B: Urinary catheter ongoing care
Standard	100%
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

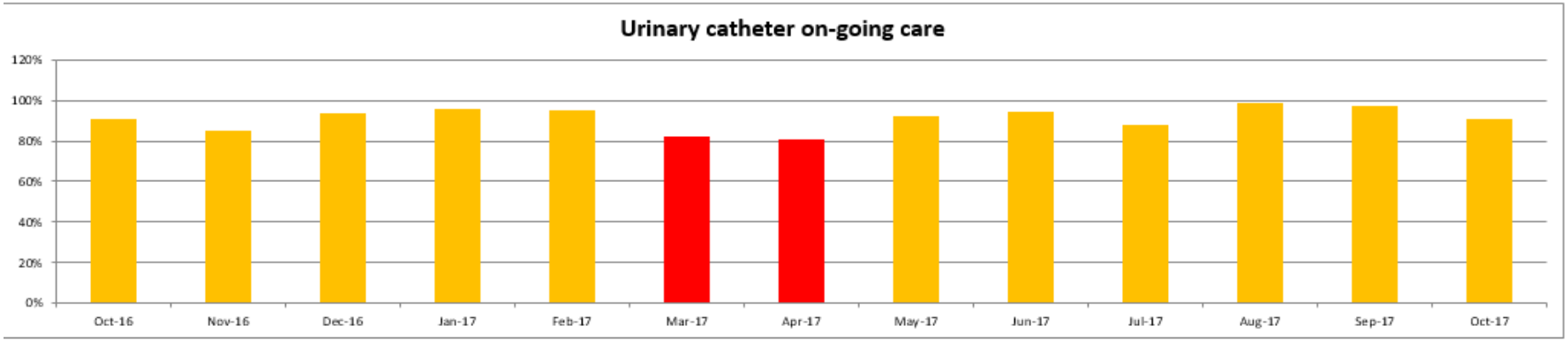
A score of 91% in October was a deterioration from 97% in September. This deterioration was due to a single ward area. All other wards were compliant at 100%.

Trend / Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Urinary catheter ongoing car	96%	90%	85%	93%	95%	95%	82%	81%	92%	94%	88%	99%	97%	91%							
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100							

Key Recovery Actions

Description	Owner	Start	End
Despite the further drop in compliance in October, there has been a continued trend of improvement in compliance in ongoing catheter care in the past few months in the majority of wards and departments. This has been achieved by targeted education and monitoring in specific wards which were persistently failing to comply with the expected level of care and documentation. The Senior Matron and Infection Prevention Team are working with the ward team who continue to improve the practice and documentation. This is promoted with the senior nurses at ward level, via 1:1 meetings and teaching sessions and engaging the team to comply with the harm free action plan. The Infection Prevention Team have also been linking with the Urology Nurse specialists to promote improved practice with catheter care and the introduction of 'Catheter passports', highlighting insertion dates and length of insertion as patients transition from acute care and the community.	RP	Aug-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	HII Compliance 6a: Urinary catheter insertion
Standard	100%
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

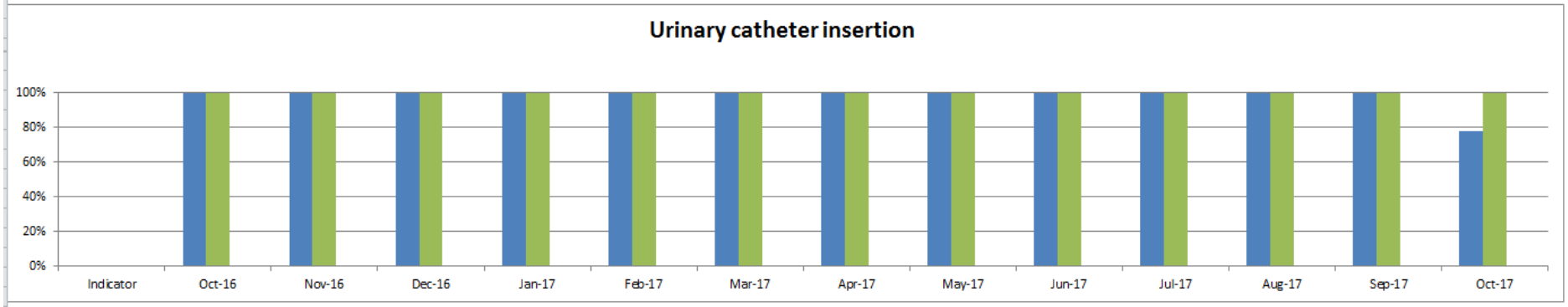
Failing to accurately document the process in relation to catheter insertion was reflected in the deteriorated performance. One clinical area scored particularly badly due to the small number of catheters inserted and the failings in regards to documentation. This had been particularly out of character for the area concerned, which has always demonstrated good performance.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Urinary catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	78%							
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							

Key Recovery Actions

Description	Owner	Start	End
Compliance with documentation following changes to eCare still remains a challenge. The Senior Matron team continue to discuss performance at the Monthly Quality Meeting and share learning and different approaches so as to improve performance in challenging areas. Staffing deficits coupled with high levels of acuity have impacted upon the accurate and timely completion of documentation following catheter insertion. The Senior Matrons for the relevant areas will work closely with the Ward Teams to ensure that documentation and practice returns to the usual high standards, normally demonstrated.	RP	Aug-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Falls
Standard	Less than 48 and less than 10 resulting in harm
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Background

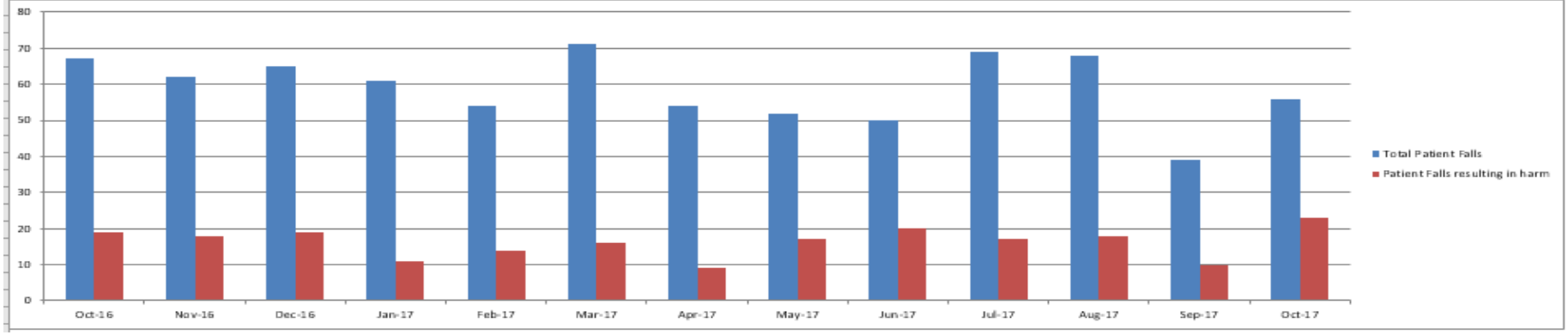
There were 56 falls in October (up from 39 in September), consisting of no major or moderate harm. This has resulted in a RAG rating of Red due to more than 48 falls occurring. This current increase is reflective of the previous trend of the 5 months prior to the performance of September. Newmarket Hospital had 3 falls in October an increase form 2 falls in September. Glastonbury Court had 6 falls in October an increase from 2 falls in September. The falls for Newmarket Hospital and Glastonbury Court are reported separately. A total of 2 patients were assisted to floor in October (3 in September) preventing them from falling.
There were 6 patients in total who fell more than twice in October (6 in September), 3 patients fell x 3 and 3 patients fell x 2. In the majority of these cases, cognitive impairment played a significant factor in the patients falling. Where possible patients had been nursed in visible areas and Wanderguards had been utilised. The inability to fill requests for 'Specials' had impacted upon the ability to prevent falls occurring.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Total Patient Falls	61	67	62	65	61	54	71	54	52	50	69	68	39	56							
Patient Falls resulting in harm	22	19	18	19	11	14	16	9	17	20	17	18	10	23							
Percentage of falls resulting in h	36%	28%	29%	29%	18%	26%	23%	17%	33%	40%	25%	26%	26%	41%							

Key Recovery Actions

Description	Owner	Start	End
The Falls Focus Group continues to meet on a bi-monthly basis, information form this group is then fed back in to the Trust higher level Falls Group led by Dr Suresh. Work is ongoing with regards to the updating of the current Datix and eCare systems so as to ensure that they are reflective of current recognised best and local practice to ensure that they are responsive in tackling the issue of patients falling. It is planned that a lying and standing blood pressure task will be set for all patients admitted to the Trust who are over 65 years of age as per NICE guidance. Various options are now available for staff to utilise in relation to appropriate patient footwear e.g. slippers, slipper socks and TED stocking with sole treads. It is hoped that the utilisation of the relevant footwear medium will promote safe mobilisation as well as reduce the risk of patients slipping and falling. The cost involved with this initiative should be minimal if fewer falls are demonstrated and patient safety is optimised. A staff pocket guide is currently under development to assist staff in the completion of lying and standing blood pressures as well as the commencement of appropriate tasks in reducing falls and minimising the impact if they have occurred. Funding has been secured for the reproduction of these guides, at present a proof copy is awaited prior to ordering. The previous use of staff pocket guides had been positively demonstrated in regards to MEWS scoring and Sepsis identification. The reproduction of the Royal College of Physicians Falls Prevention Guides is currently being explored, so that these can be available for both patients and relatives to assist with the reduction and prevention of falls in line with the recognised best practice. The Trust has taken part in the National Falls Audit and we anticipate results to be available later in the year. The Trust are at present unable to provide data on Falls per 1000 bed days though the eCare team from Cerner are currently working on rectifying the situation.	Dr Suresh	Aug-17	Mar-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Rapid access - Chest pain clinic
Standard	100%
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Background

Achieved 96.32% against a threshold of 100%.

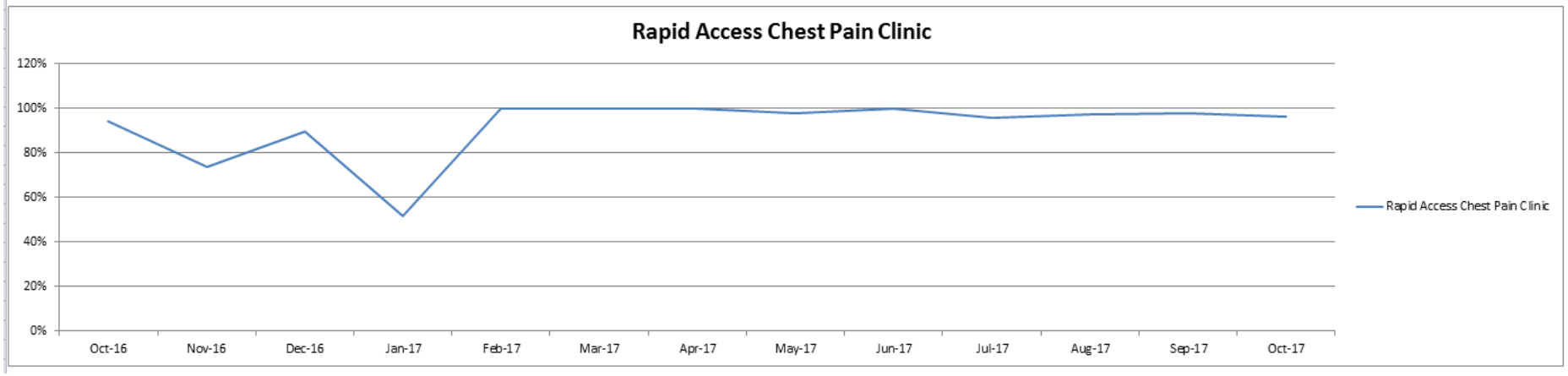
Five out of 136 patients breached - again due to high numbers of referrals. Extra clinics have been put on to absorb the number of referrals.

Trend / Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Rapid Access Chest Pain Clini	97%	94%	73%	90%	52%	100%	100%	100%	98%	100%	95%	97%	97%	96.32%							

Key Recovery Actions

Description	Owner	Start	End
We will continue to provide extra clinics to meet the number of referrals and continue to monitor the situation on a daily basis in order to prevent breaches.	Jane Allen	Sep-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Nutrition: Assessment and monitoring
Standard	95%
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

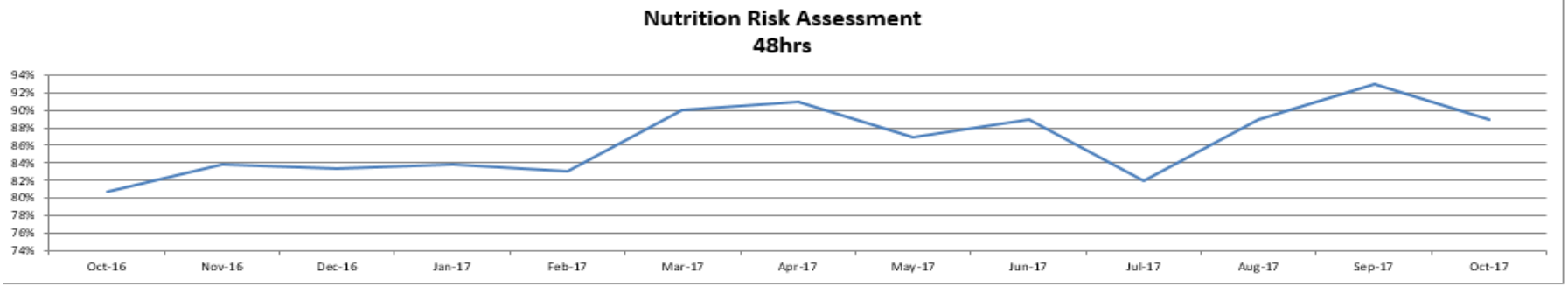
The month of October has seen a slight decline in compliance in weighing patients and completing the nutrition risk assessment and MUST score from 93% in September to 89% in October. This remains at an amber rating. The majority of wards have managed, with support and encouragement from the Senior Matron team and the Ward Managers, to improve their performance, however, there remain some pockets of poor compliance amongst teams, specifically with weighing patients every 7 days. These areas are being supported by the specific Senior Matron to encourage and improve compliance.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Nutrition Risk Assessment 48hrs	83%	81%	84%	83%	84%	83%	90%	91%	87%	89%	82%	89%	93%	89%							
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%							

Key Recovery Actions

Description	Owner	Start	End
The Senior Matron team continue to support and promote compliance in order to sustain and further improve this area of practice amongst all ward teams. The team discuss performance at monthly meetings to consider strategies for performance improvement. Senior Matrons continue with regular discussions with ward nursing teams, on both, an individual basis, and within groups, highlighting and monitoring performance. Individual action plans continue to be put in place and supported by Senior Matrons and Head of Nursing for areas with persistent poor performance. The Nutrition focus group, commenced in September, continues to support joint working with the Dieticians, specialist nutrition nurse, ward nurses and nursing assistants and the sharing of good practice. The group is working to raise awareness of the importance of accurate risk assessments and improve the delivery of diet and nutritional support for patients within our care. An action plan has been developed and shared with all ward areas to promote compliance with weighing patients and improving on recording of risk assessments. This month, the group identified the need to relaunch protected mealtimes at ward level. The group will focus on this with the support of the communication team, Catering manager, Dietetic team and Senior Matrons. A further initiative has been the introduction of a monthly report from the patient safety dashboard. This report captures the care of all patients admitted and focuses on Nutrition, as well as, pressure ulcer and falls prevention. Data from this report is shared with the Senior Matrons, Ward Managers and ward teams and identifies compliance with nutrition risk assessment recording, which is so far encouraging, demonstrating improving compliance. The West Suffolk NHS Foundation Trust has been selected by NHSI to take part in the Nutrition collaborative, which is launched this month in London. This is an exciting initiative for the Trust and will aid the ongoing improvements in patient care related to Nutrition. Helen Beard, Head of nursing for Surgery will lead this initiative.	RP	Aug-17	Dec-17



7. 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	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	YTD(Apr17-Mar18)	WTG	Tr	Trend
	Dash	2.01	Overall HSMR - DFI	<90	83%	83%	84%				88%	88%	88%	88%	85%	87%	ND	87%	6		
	Dash	2.04	Canc. Ops - Cancellations for non-clinical reas	1%	1.30%	0.83%	1.28%	1.35%	0.49%	0.93%	0.62%	0.56%	1.05%	1.00%	1.21%	0.97%	1.44%	0.98%	6		
	Mortality	2.09	No of Deaths	NT	83	98	102	103	99	95	72	69	71	62	76	70		420			
	Mortality	2.10	Percentage of deaths	NT	1.45%	1.65%	1.89%	1.85%	1.82%	1.47%	1.34%	1.20%	1.25%	1.12%	1.36%	1.23%		1.3%			
	Mortality	2.11	Cardiac arrests	NT	5	6	7	3	8	13	4	6	4	2	3	6	4	29			
	Mortality	2.12	Cardiac arrests identified as a SIRI	-	0	0	1	1	1	0	0	0	1	0	0	0	0	1	1		
2. Effective	Incidents/Reports	2.13	CAS (central alerts system) alerts overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3		
2. Effective	Incidents/Reports	2.15	WHO Checklist (Qrtly)	100%			97%				NA	NA	99%	NA	NA	99%	NA	99%	3		
2. Effective	Incidents/Reports	2.16	TA (Technology appraisal) business case beyo	0%							0	0	0	0	0	0	0				
2. Effective	Incidents/Reports	2.19	Av. Elective LOS (excl. 0 days)		2.59	3.14	3.03	3.11	2.49	2.92	2.75	3.26	2.7	2.54	2.79	2.73	2.93	2.81			
2. Effective	Incidents/Reports	2.20	Av NEL LOS (excl 0 days)		8.45	8.3	8.65	8.88	8.83	7.73	7.59	7.85	7.66	7.47	7.93	7.53	8.08	7.73			
2. Effective	Incidents/Reports	2.21	% of NEL 0 day LOS		17%	17%	20%	18%	18%	20%	19.40%	18.57%	20.32%	18.62%	17.33%	17.39%	18.88%	19%			
2. Effective	Incidents/Reports	2.22	NHS number coding	99%	100%	100%	100%	100%	100%	100%	99.74%	99.66%	99.69%	99.44%	99.50%	99.59%	99.60%	100%			
2. Effective	Incidents/Reports	2.23	Fractured Neck of Femur : Surgery in 36 hours	85%	89%	92%	97%	97%	97%	88%	97%	96%	96%	85%	97%	97%	96%	95%			
2. Effective	Incidents/Reports	2.25	Discharge Summaries (OP 85% 3d,)	85%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND				
2. Effective	Incidents/Reports	2.26	Discharge Summaries (A&E 95% 1d)	95%	97%	95%	99%	98%	98%	97%	98%	98%	88%	87%	86%	86%	83%	89%	1		
2. Effective	Incidents/Reports	2.27	Discharge Summaries (IP 95% 1d)	95%	93%	93%	92%	94%	93%	92%	92%	93%	93%	ND	ND	ND	ND	93%	2		
2. Effective	Incidents/Reports	2.28	Choose and Book - Available Slots	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
2. Effective	Incidents/Reports	2.29	All Cancer 2ww services available on C&B	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
2. Effective	Incidents/Reports	2.30	Canc. Ops - Patients offered date within 28 da	100%	94%	100%	90%	100%	92%	97%	93%	94%	93%	88%	75%	92%	85%	89%	1		
2. Effective	Incidents/Reports	2.31	Canc. Ops. - No. Cancelled for a 2nd time	NT	0	0	0	ND	0	0	0	0	0	0	0	0	0	0	3		

7. EXCEPTION REPORTS – EFFECTIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Discharge Summaries
Standard	95%
Name	Helen Beck
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

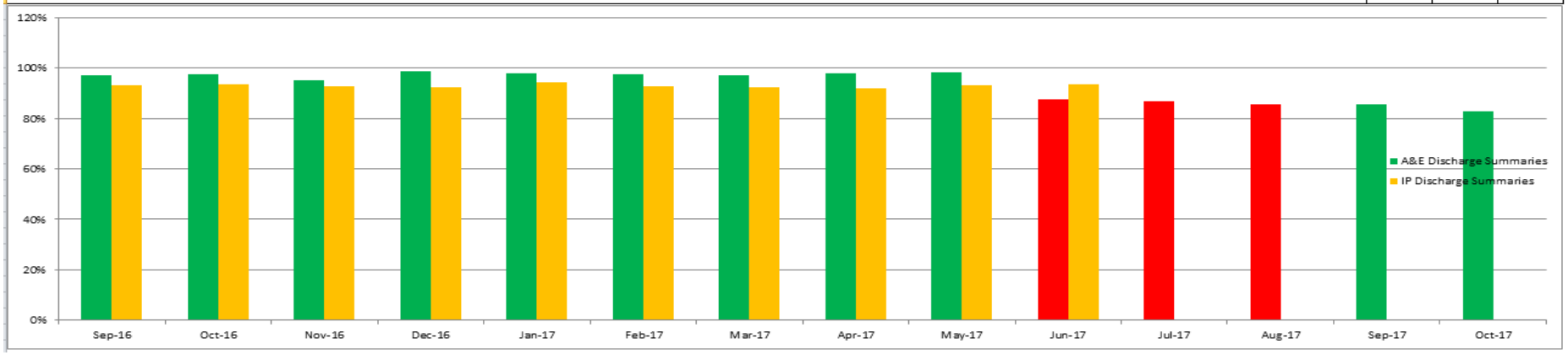
Clear and complete documentation in a patient's health record is directly linked to the quality of care they receive. Detailed and accurate documentation helps reduce negative outcomes, by ensuring that all clinical staff caring for patients have access to the information they need to deliver a good standard of care. Effective communication between secondary and primary care is vital to ensure a smooth and seamless transition of care for all patients when they leave hospital.
The information conveyed at the time of discharge from hospital has always been an important element of communication between secondary and primary care.
The immediate discharge summary is therefore among the most crucial pieces of documentation in the health record, as it is the basis of communication between secondary and primary care and essential for ensuring quality and continuity of care.

Trend / Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
A&E Discharge Summaries	97%	97%	95%	99%	98%	98%	97%	98%	98%	88%	87%	86%	86%	83%							
IP Discharge Summaries	93%	93%	93%	92%	94%	93%	92%	92%	93%	93%	ND	ND	ND	ND							

Key Recovery Actions

Description	Owner	Start	End
A range of initiatives are taking place to improve A&E discharge letters within 24 hours. 1. The locum cap has been increased and it is expected to generate cover in 50% of vacant posts. 2. ACPs are being used to suppport gaps in the rota. 3. ENPs are supporting treatment of minor injuries. 4. A demand and capacity review has identified attendances per hour and breaches per hour. This will be used to flex working arrangements to cover peak breach times. There was no IP data due to technical issues. This is expected to be resolved by Nov 2017, as data will be available since Phase 2 go-live	Nick Jenkins	Jun-17	Nov-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancelled Operations for non-clinical reasons
Standard	Less than 1%
Name	Helen Beck
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Effective
National Rank	NA

Background

Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission. Current Position - 1.44% against a threshold of 1%.

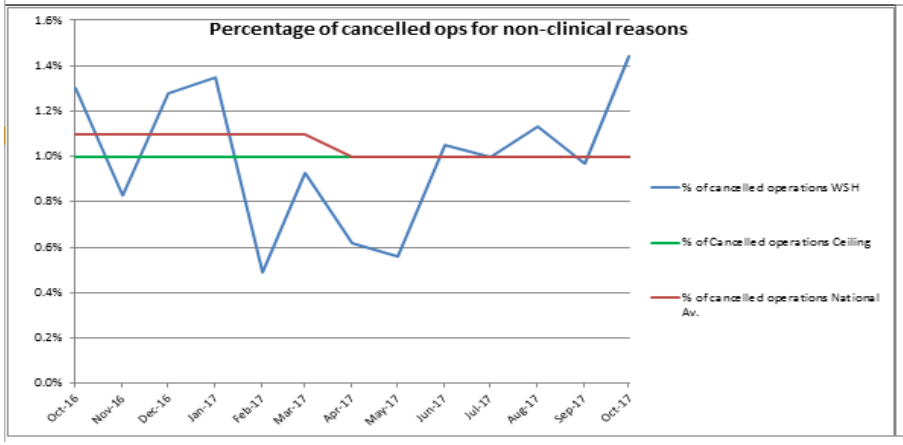
Patients offered date within 28 days of cancelled operation - Current Position: 84.62 against a threshold of 100%.

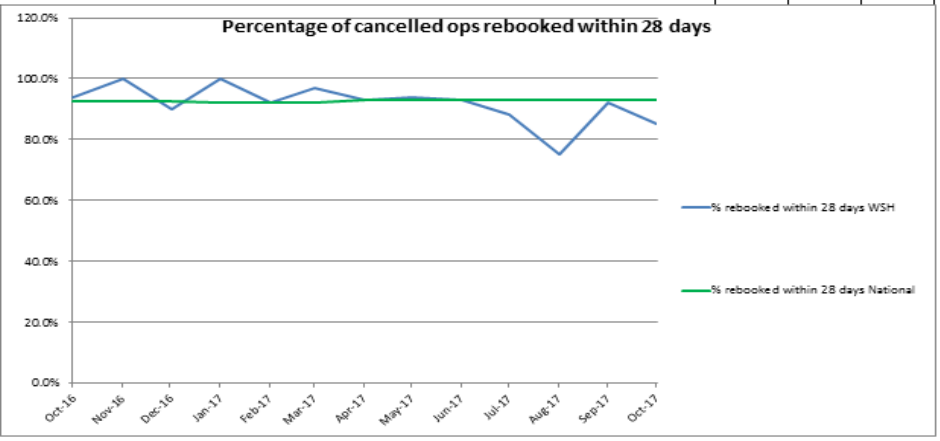
Trend / Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
% of cancelled operations WSH	0.9%	1.3%	0.8%	1.3%	1.4%	0.5%	0.9%	0.6%	0.6%	1.1%	1.0%	1.1%	1.0%	1.4%							
% of Cancelled operations Ceiling	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1%	1%	1%							
% of cancelled operations National	1.0%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%							
% rebooked within 28 days WSH	91.0%	94.0%	100.0%	90.0%	100.0%	92.0%	97.0%	93.0%	94.0%	93.0%	88.0%	75%	92%	85%							
% rebooked within 28 days National	93.7%	92.7%	92.7%	92.7%	92.1%	92.1%	92.1%	92.8%	92.8%	92.8%	92.8%	92.8%	92.8%	92.8%							

Key Recovery Actions

Description	Owner	Start	End
Provider cancellation of Elective Care operation – During the month of October an increased level of non-clinical cancellations were experienced due to high levels of emergency activity and staffing difficulties in theatres. Active recruitment to vacancies in theatres continues, however the situation has been compounded by increased levels of long term sickness absence in the department. Patients offered date within 28 days of cancelled operation –In October there were 6 patients cancelled on the day of their surgery who were unable to be re-booked within 28 day. One case was a joint procedure between ENT and Ophthalmology and was unable to be re-booked with n 28 days due to surgeon availability coinciding the remaining five cases were prevented from being re-booked in time owing to capacity constraints with the specialities. Review of Cancelled Ops has been added to the agenda for the weekly Trust level access meeting.	HB	Jul-17	Dec-17





Emergency Flow

The new indicators in the Effective dashboard will be populated using the new Cerner System. NHS Improvement has produced a high-level flow benchmark analysis which is set out below (Trust data up to Sep 2017). This is the first time we have input our data, which we would continue going forward to identify areas of focus.

DETAILED REPORTS - CARING

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

Are we..		Ref.	KPI	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	YTD(Apr17-Mar18)	WTG	Traffic	Trend
3. Caring	Dashboard	3.01	Compliments		35	56	59	33	41	28	41	52	26	56	28	17	ND	220			
		3.02	Complaints (Inpatient)	20	15	10	17	18	12	11	10	10	10	6	16	16	17	85	6		
		3.03	Mixed Sex Accommodation Breaches	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	6		
		3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	98%	97%	95%	99%	98%	99%	98%	97%	99%	98%	98%	98%	99%	98%	6		
		3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	98%	97%	97%	97%	97%	96%	95%	96%	97%	95%	95%	96%	96%	96%	6		
		3.06	A&E - Extremely likely or Likely to recommend (FFT)	85%	80%	85%	95%	95%	96%	96%	97%	96%	95%	95%	95%	92%	95%	95%	6		
		3.07	Maternity - How likely are you to recommend our ward to friends and family?	85%	100%	95%	90%	91%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	6		
		3.08	Community - Extremely likely or likely to recommend										98%					98%			
	Other Friends and Family Test Scores	3.09	IP overall experience result	85%	92%	92%	92%	94%	93%	94%	93%	92%	94%	94%	93%	93%	96%	94%	3		
		3.10	OP overall experience result	85%	93%	92%	91%	92%	92%	91%	92%	85%	88%	89%	91%	89%	95%	90%	3		
		3.11	A&E overall experience result	85%	94%	93%	95%	96%	93%	94%	94%	96%	94%	94%	95%	94%	93%	94%	3		
		3.12	A&E children overall experience result	85%	ND	ND	ND	ND	98%	100%	ND	100%	94%	ND	ND	ND	ND	97%	3		
		3.14	Short-stay overall result	85%	99%	99%	99%	99%	99%	98%	99%	99%	100%	99%	99%	99%	99%	99%	3		
		3.15	Short-stay Extremely likely or Likely to recommend	90%	100%	98%	100%	100%	100%	100%	99%	99%	100%	100%	99%	99%	99%	99%	3		
		3.16	Maternity - overall	85%	98%	98%	97%	94%	96%	100%	98%	99%	100%	100%	100%	100%	100%	100%	3		
		3.17	Maternity - postnatal ward recommendation to F&F	90%	100%	95%	90%	91%	100%	100%	100%	100%	100%	ND	ND	100%	100%	100%	3		
		3.18	Maternity - birthing unit recommendation to F&F	90%	100%	100%	100%	ND	ND	ND	100%	100%	100%	ND	ND	100%	100%	100%	3		
		3.19	Maternity -antenatal community care rec. to F&F	90%	100%	99%	100%	99%	100%	95%	97%	98%	100%	ND	ND	100%	96%	98%	3		
		3.20	Maternity -post-natal community care rec. to F&F	90%	100%	93%	98%	100%	100%	100%	100%	98%	ND	ND	ND	100%	98%	99%	3		
		3.21	Children's services overall result	85%	96%	97%	93%	99%	95%	ND	100%	ND	ND	ND	98%	98%	99%	99%	3		
		3.22	F1 Parent overall result	85%	100%	ND	98%	97%	99%	97%	97%	99%	99%	95%	98%	98%	99%	98%	3		
		3.23	F1 Parent - Extremely likely or Likely to recommend (FFT)	90%	97%	ND	96%	96%	100%	100%	100%	100%	100%	92%	100%	100%	100%	99%	3		
		3.24	Stroke Care - Overall FFT	85%	95%	96%	93%	94%	95%	95%	94%	ND	98%	99%	100%	99%	100%	98%	3		
		3.25	Stroke Care - How likely is it that you would recommend the service to friends and family?	90%	100%	100%	100%	100%	100%	100%	93%	ND	95%	100%	100%	95%	100%	97%	3		
		3.26	Dementia Environment - Patient Score (annual)	76%				NA	NA	76%	NA	NA	NA	NA	NA	NA	NA				
	Complaints Handling	3.27	Complaints acknowledged within 3 working days	90%	50%						ND	90%	100%	100%	93%	94%	100%	96%	3		
		3.28	Complaints responded to within 25 working days	90%	81%	88%	100%	86%	86%	100%	100%	90%	75%	100%	85%	67%	81%	85%	2		
		3.29	Number of second letters received	1	3	3	2	2	2	1	3	0	2	1	1	1	2	10	2		
		3.30	Health Service Referrals accepted by Ombudsman		1	0	0	0	0	0					0	0	0				
		3.31	No. of complaints to Ombudsman upheld	0							0	2	0	1	0	0	0	3	2		
		3.32	Red complaints actions beyond deadline for completion	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3		
		3.33	No. of PALS contacts	NA	102	115	122	171	189	230	172	188	169	176	137	167	190	1199			
		3.34	No. of PALS contacts becoming formal complaints	<=5	0	0	2	0	0	1	0	0	0	1	4	2	3	10	3		
	Other	3.37	Environment & cleanliness - Patient Satisfaction Overall	75%	92%	93%	96%	89%	91%	89%	90%	91%	97%	90%	91%	92%	95%	92%	3		
		3.38	Catering - Patient Satisfaction with food - overall	75%	78%	78%	84%	80%	83%	82%	83%	81%	85%	78%	85%	81%	87%	83%	3		

EXCEPTION REPORTS - CARING

There are no exceptions to report to the Board.

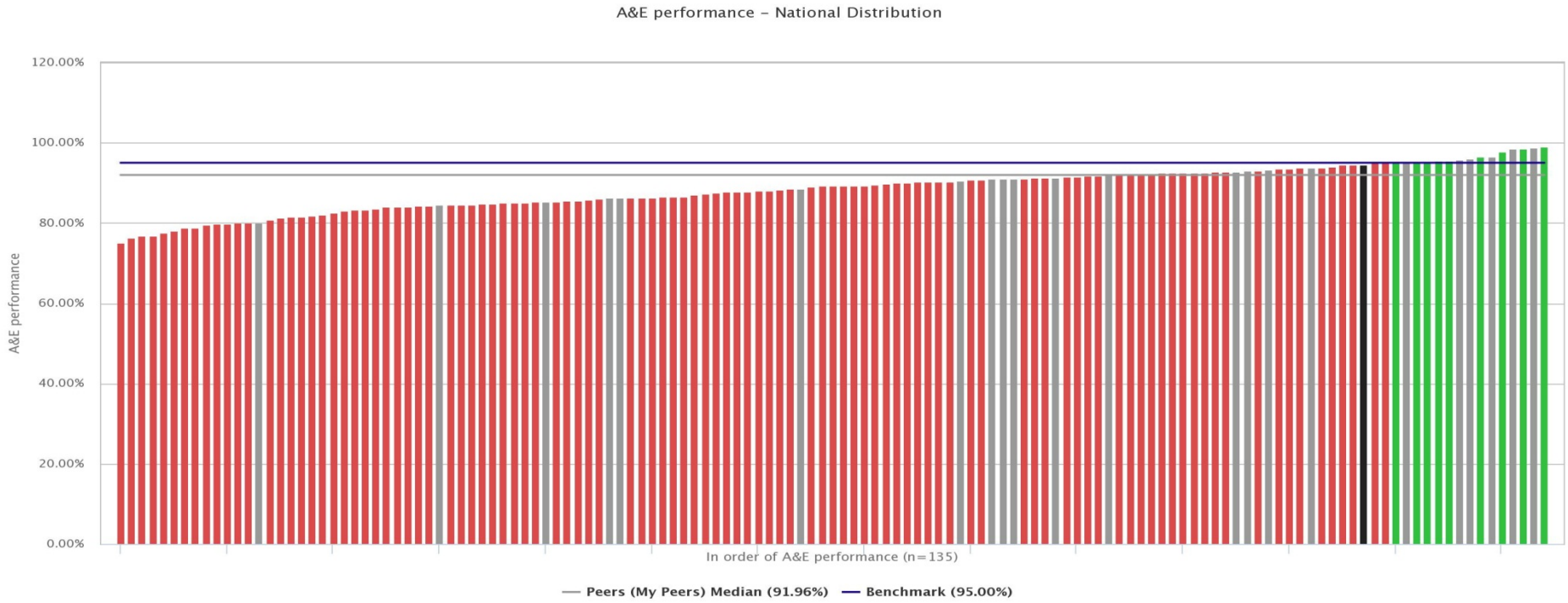
DETAILED REPORTS - RESPONSIVE

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

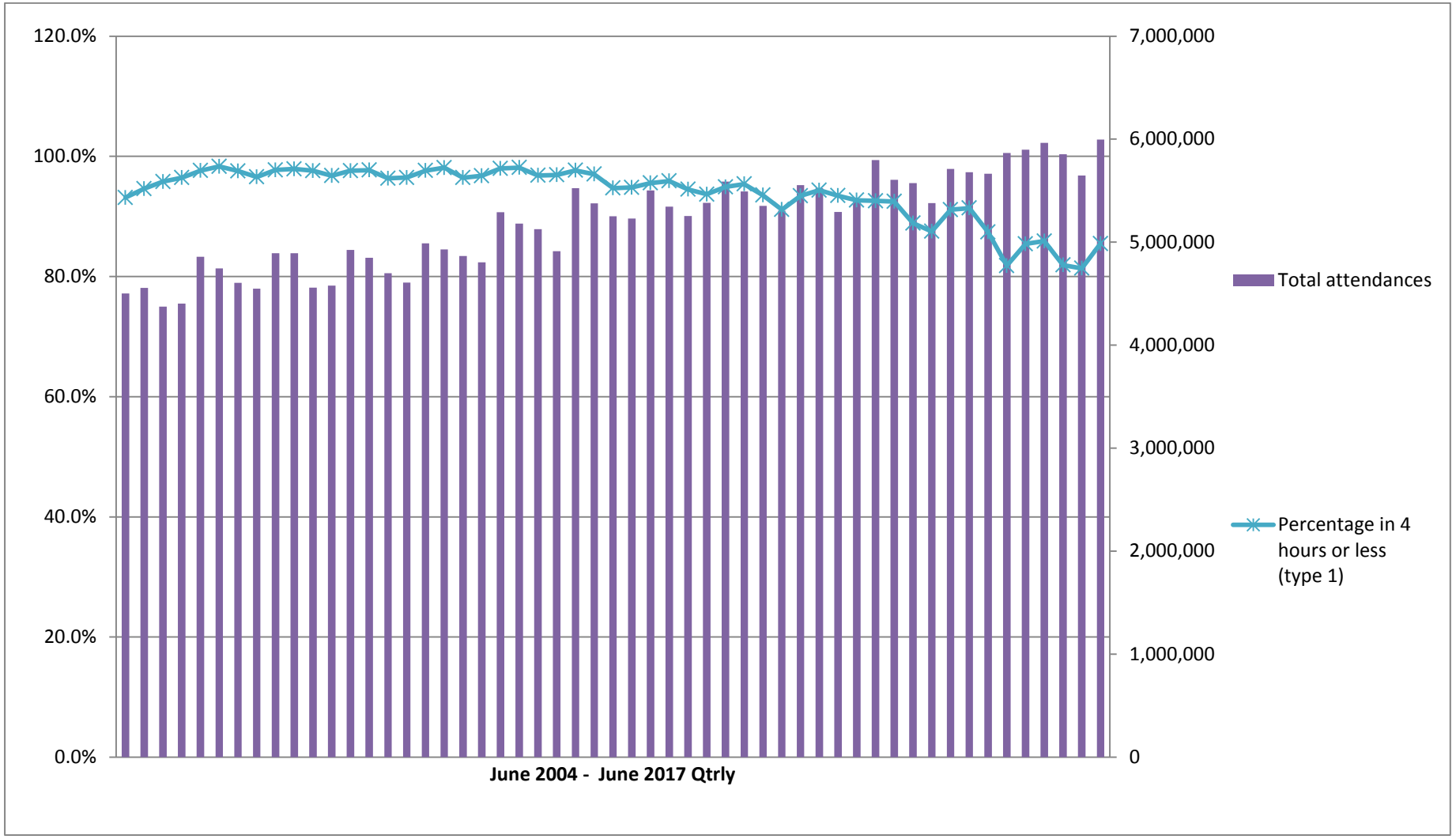
Are we..		Ref.	KPI	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD(Apr16-Mar17)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	YTD(Apr17-Mar18)	WTG	Traffic	Trend
4. Responsive	Dashboard	4.01	A&E under 4 hr. wait	95%	86%	85%	86%	87%	84%	93%	89%	95%	95%	96%	92%	90%	89%	87%	92%	4		
		4.02	RTT: % incomplete pathways within 18 weeks	92%	92%	92%	92%	90%	90%	90%	91%	82%	80%	83%	84%	86%	86%	87%	84%	2		
		4.03	52 week waiters	0	1	0	0	7	7	8	24	15	14	15	35	26	29	36	160	2		
		4.04	Diagnostics within 6 weeks	99%	96%	99%	95%	96%	99%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	6		
		4.05	Cancer: 2w wait for urgent GP Referrals	93%	97%	98%	98%	90%	98%	98%	95%	94%	92%	97%	95%	96%	91%	83%	93%	4		
		4.06	Cancer 2w wait breast	93%	98%	99%	93%	88%	96%	94%	91%	94%	99%	89%	98%	100%	98%	100%	97%	6		
		4.07	Cancer 31 d First Treatment	96%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
		4.08	Cancer 31 d Drug Treatment	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
		4.09	Cancer 31 d Surgery	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
		4.10	Cancer 62 d GP referral	85%	89%	85%	86%	85%	88%	83%	86%	89%	83%	86%	85%	86%	87%	91%	87%	6		
		4.11	Cancer 62 d Screening	90%	100%	100%	96%	100%	89%	97%	97%	100%	100%	90%	100%	100%	91%	100%	97%	6		
	Emergency Care &Emergency f	4.20	Number of Delayed Transfer of Care - (DTOCs)	NT	589	443	565	566	464	294	544	417	411	511	481	565	337	250	425			
		4.21	A&E time to treatment in department (median) for patients arriving by	NT	58	46	56	50	48	53	443	35	43	52	52	50	62	59	353	3		
		4.22	A&E - Single longest Wait (Admitted & Non-Admitted)	6 Hrs.	12:25	15:00	17:28	13:19	12:25	22:32	14:50	09:57	13:57	10:10	13:53	11:46	12:01	15:44	12:29			
		4.23	A&E -Waits over 12 hours from DTA to Admission	12 Hrs.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3		
		4.24	A&E - Admission waiting 4-12 hours from dec. to admit		5	9	3	3	12	5	46	14	3	6	5	5	14		28	1		
		4.25	A&E - To inpatient Admission Ratio	27%	32%	34%	34%	35%	34%	32%	33%	32%	31%	31%	31%	32%	34%	34%	32%	3		
		4.26	A&E Service User Impact (re-attendance in 7 days <5% & time to trea	1 met	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	3		
		4.27	A&E/AMU - Amb. Submit button complete	80%	92%	88%	90%	90%	84%	88%	88%	93%	91%	92%	91%	90%	90%	88%	91%	3		
		4.28	A&E - Amb. Handover above 30m	30m	45	36	46	39	53	48	306	21	38	31	39	19	15	ND	163	3		
		4.29	A&E - Amb. Handover above 60m	60m	7	10	13	21	34	18	107	3	16	9	7	16	30	ND	81	3		
		4.30	A&E - Type 1&2 high risk patients reviewed by a EMC	14%	86%	83%	94%	80%	89%	100%	86%	94%	87%	93%	ND	ND	ND	ND	91%	3		
	RTT	4.31	RTT - 18w Admitted (Completed)	90%	68%	70%	71%	68%	69%	69%	70%	69%	68%	70%	73%	70%	74%	72%	71%	1		
		4.32	RTT - 18w Non-admitted (Completed)	95%	88%	86%	89%	88%	85%	85%	86%	86%	87%	87%	88%	86%	85%	87%	87%	1		
		4.33	RTT waiting List		18033	18164	17663	17816	18126	18127	144982	22110	22144	19931	18676	17346	17236	16694	19162			
		4.34	RTT waiting list over 18 weeks		1413	1436	1407	1729	1833	1834	12417	3929	4492	3316	2629	2441	2467	2171	3064			
	Stroke	4.35	Stroke - % Patients scanned within 1 hr.	77%	78%	78%	81%	76%	69%	88%	79%	87%	80%	72%	82%	79%	78%	76%	79%	3		
		4.36	Stroke - % patients scanned within 12 hrs.	96%	100%	100%	97%	100%	91%	100%	98%	98%	98%	95%	95%	96%	90%	97%	96%	2		
		4.37	Stroke - % Patients admitted directly to stroke unit within 4 hrs.	75%	76%	84%	77%	84%	63%	75%	77%	89%	71%	76%	78%	79%	83%	72%	78%	3		
		4.38	Stroke - % greater than 80% of treatment on a stroke unit	90%	92%	83%	89%	92%	91%	88%	89%	98%	88%	88%	94%	98%	93%	89%	92%	3		
		4.39	Stroke - % of patients treated by the SESDC	48%	41%	47%	68%	47%	42%	34%	44%	50%	48%	75%	46%	33%	51%	50%	51%	3		
		4.40	Stroke -% of patients assessed by a stroke specialist physician within	80%	93%	93%	86%	82%	84%	94%	88%	93%	86%	95%	92%	88%	85%	83%	89%	3		
		4.41	Stroke -% of patients assessed by a nurse and therapist within 24 hrs	75%	88%	87%	89%	77%	80%	72%	81%	87%	80%	90%	88%	90%	92%	77%	86%	3		
		4.42	Stroke -% of eligible patients given thrombolysis	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		4.43	Stroke -% of stroke survivors who have a 6mth follow up	50%	ND	ND	ND	50%	ND	ND	50%	ND	58%	ND	ND	ND	58.00%	ND	58%	3		
		4.44	Stroke -Provider rating to remain within A-C	C	ND	ND	ND	B	ND	ND	B	ND	C	ND	ND	ND	D	ND	C			
	Othe	4.45	RCA Actions beyond deadline for completion	4	8	11	15	9	9	8	60	3	1	3	4	1	7	2	21	3		
		4.46	Sepsis - 1 hr neutropaenic sepsis	50%	88%	88%	90%	72%	94%	80%	85%	64%	47%	63%	69%	83%	62.50%	78.95%	67%	3		

EXCEPTION REPORTS – RESPONSIVE

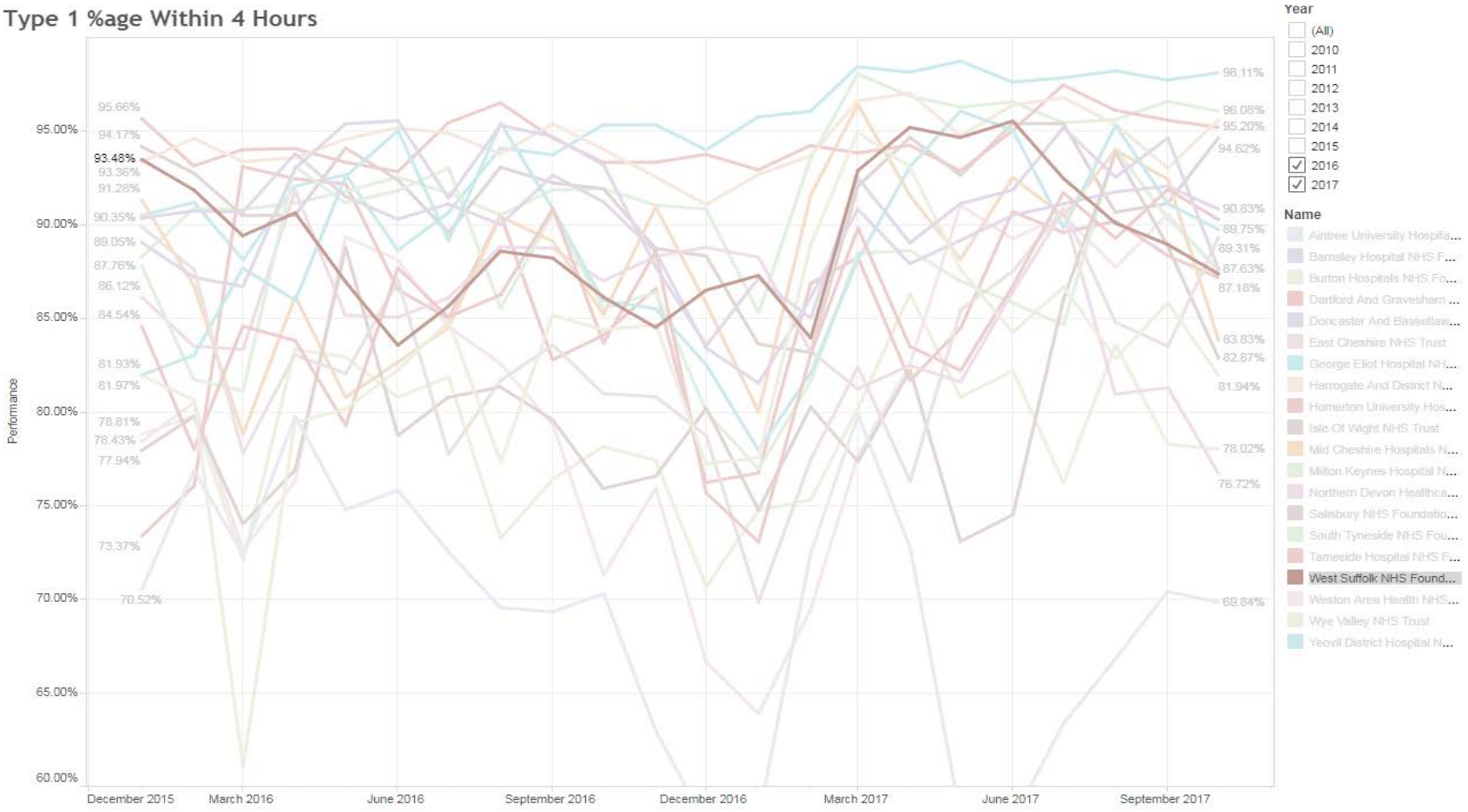
A&E performance has fallen from 95.1% in Qtr. 1 to 90.5% in Qtr. 2 at West Suffolk. The first table shows the relative performance of West Suffolk compared with peers and the national average. The second chart show national attendances and A&E 4 hour performance over time and the final table reviews the recent performance of West Suffolk and associated recovery actions.



National A&E attendances and A&E 4-hour performance since June 2004.



A&E Type 1 Percentage within 4 hours depicted in a report compared with Small Trust List. (Source Data – NHS I)



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E 4 hour wait
Standard	95%
Name	Helen Beck
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	18th best

Background

87.37% against a threshold of 95%

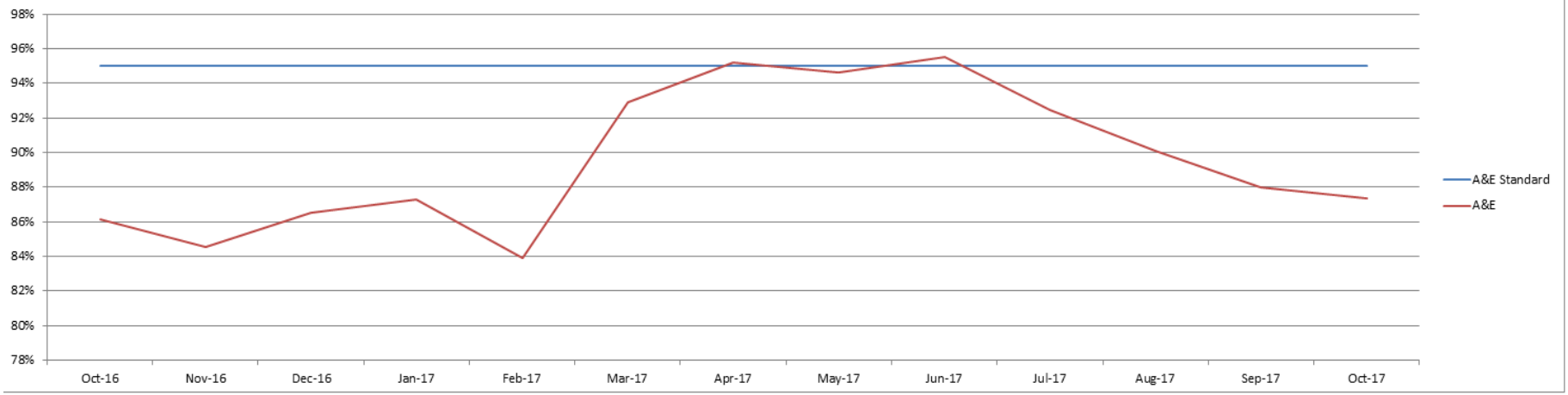
Throughout October the ED performance position was variable, ranging from at worse 70% - 97%. For 3 days we achieved the 95% target of less than 4 hours length of stay. The total attendees continues to rise, on an daily average of 195 attendees, a slight increase from last month at 191. As the month progressed the Trust continued to experience capacity issues. Medical staffing deficits continue to challenge the department, despite aggressive recruitment strategies to fill the vacant gaps. This resulted in delays to be seen by a clinical decision maker, coupled with insufficient capacity.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
A&E Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%							
A&E	88%	86%	85%	86%	87%	84%	93%	95%	95%	96%	92%	90%	88%	87%							

Key Recovery Actions

Description	Owner	Start	End
There is an overarching recovery plan in place to improve the suboptimal performance. The planned discharge waiting area is now open and saw a throughput of 65 patients in the first week which is having a positive impact on flow and bed availability. We have appointed the head of patient flow and this has reduced bed breaches. Bed capacity remains an issue and we are working on agency recruitment to open the escalation area.	HB	Jul-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Sepsis - 1-hr neutropaenic sepsis
Standard	100%
Name	Helen Beck
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Background

Acute Oncology Service: 1 hour to needle from diagnosis of neutropaenic sepsis

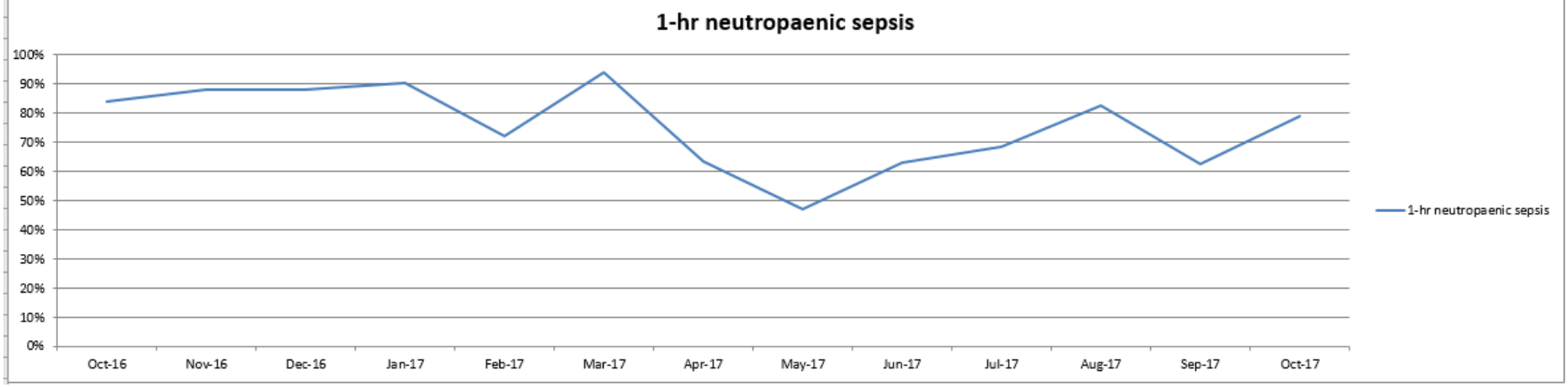
Macmillan – 100%
ED - 66.67%
Overall Trust figure of 78.95% against a threshold of 100%

Trend / Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
1-hr neutropaenic sepsi	81%	84%	88%	88%	90%	72%	94%	64%	47%	63%	69%	83%	63%	79%							

Key Recovery Actions

Description	Owner	Start	End
The performance figure for 1 hour to needle from diagnosis of neutropenic sepsis October Data showed an improvement of 16.5% from last month's drop to 62.5% and was back to the results shown in the previous 2 months improvement AMU and the Macmillan Unit had no breaches during October. The Emergency Department had 3 neutropenic sepsis patient breeches. The breach cases will be undergoing detailed review. These issues will be escalated to the Emergency Department Clinical and Nursing management to address within the departments.	HB	Sep-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Stroke
Standard	
Name	Helen Beck
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	NA

Background

Stroke: % of patients scanned within 1 hour of clock start: 75.68% against a threshold of 77% (Contract) - There was a variety of reasons for not meeting the target for October, with no particular theme. Reasons included medical registrar delays, no stroke alert, patient too sick to scan and different initial diagnosis.

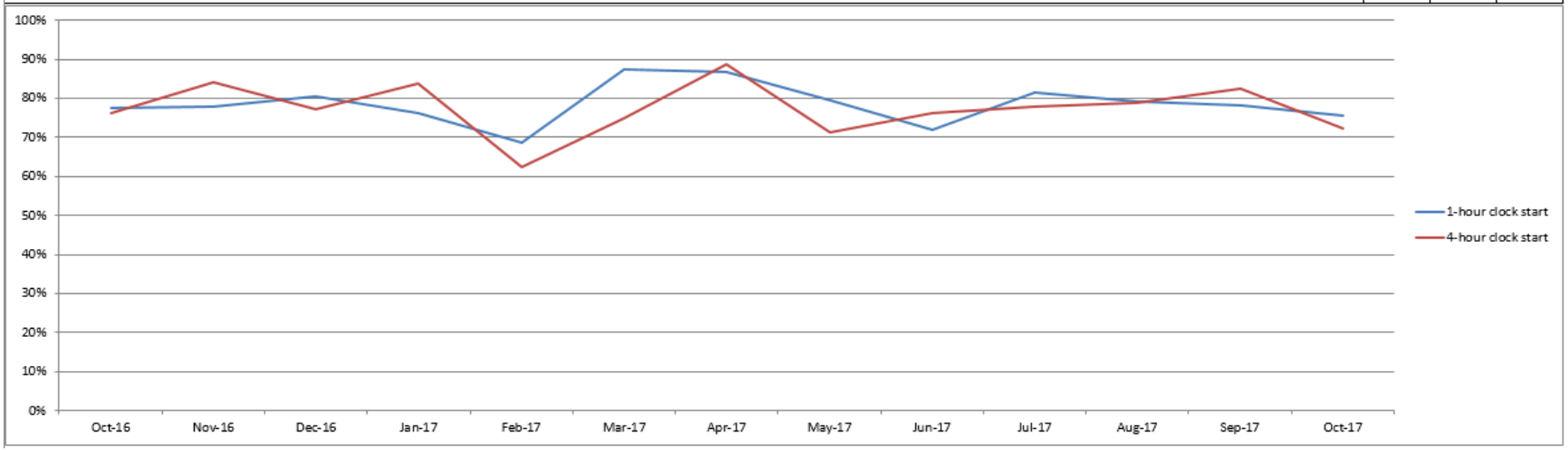
Stroke: % of patients admitted directly to Stroke Unit within 4 hours of clock start: 72.22% against a threshold of 75% (Contract) - Again a variety of reasons, including failure to alert ESOT, patient too agitated and several patients were admitted to F7 as stroke unit full, although medical patients could have been moved out.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
1-hour clock start	84%	78%	78%	81%	76%	69%	88%	87%	80%	72%	82%	79%	78%	76%							
4-hour clock start	81%	76%	84%	77%	84%	63%	75%	89%	71%	76%	78%	79%	83%	72%							

Key Recovery Actions

Description	Owner	Start	End
Stroke: % of patients scanned within 1 hour of clock start: 75.68% against a threshold of 77% (Contract) - Service Manager will speak to Dr Rajagopal to ask that he reminds the registrars of need to place high importance on stroke alerts. Stroke: % of patients admitted directly to Stroke Unit within 4 hours of clock start: 72.22% against a threshold of 75% (Contract) - Service Manager has spoken to patient flow manager to ask that he reminds the team of the importance of admitting directly to G8 within 4 hours.	RP	Sep-17	Nov-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer: 2-week wait for urgent GP Referrals
Standard	93%
Name	Helen Beck
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Background

Cancer: Two week wait from referral to date first seen (8), comprising: all urgent referrals (cancer suspected)

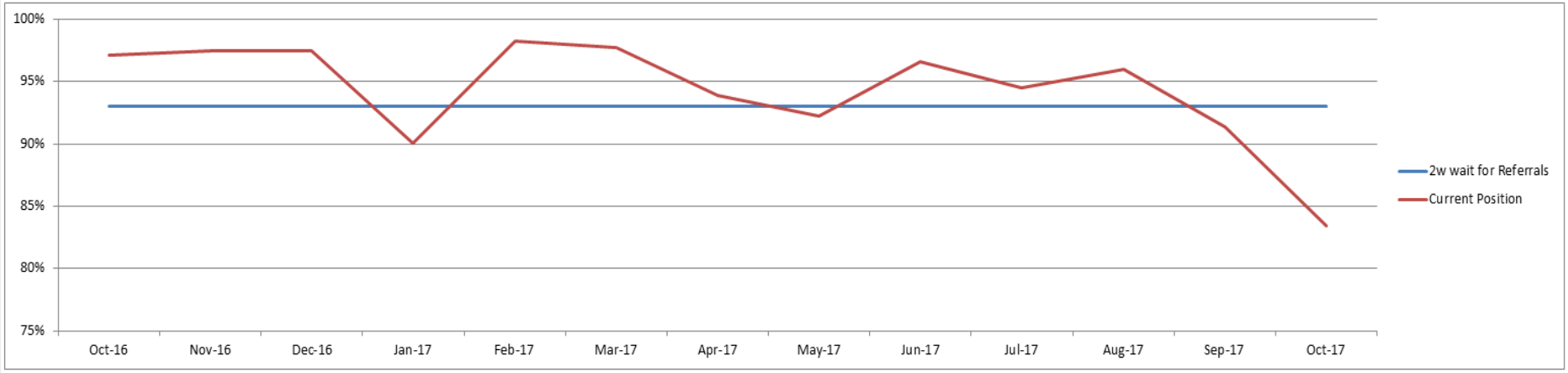
Current Position - 83.40% against a threshold of 85% - This was due to capacity issues in managing the sustained high demand with GP suspected Skin cancer 2WW referrals whose volume overwhelmed the service and whose numerical weighting was sufficient to impact the overall Trust position significantly. Following significant efforts from clinicians and all involved in this service, they have recovered the situation and, as of 23rd November, Skin 2WW stands at 99.5% with a Trust overall figure of 98.04%.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
2w wait for Referrals	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%							
Current Position	95%	97%	98%	98%	90%	98%	98%	94%	92%	97%	95%	96%	91%	83.4%							

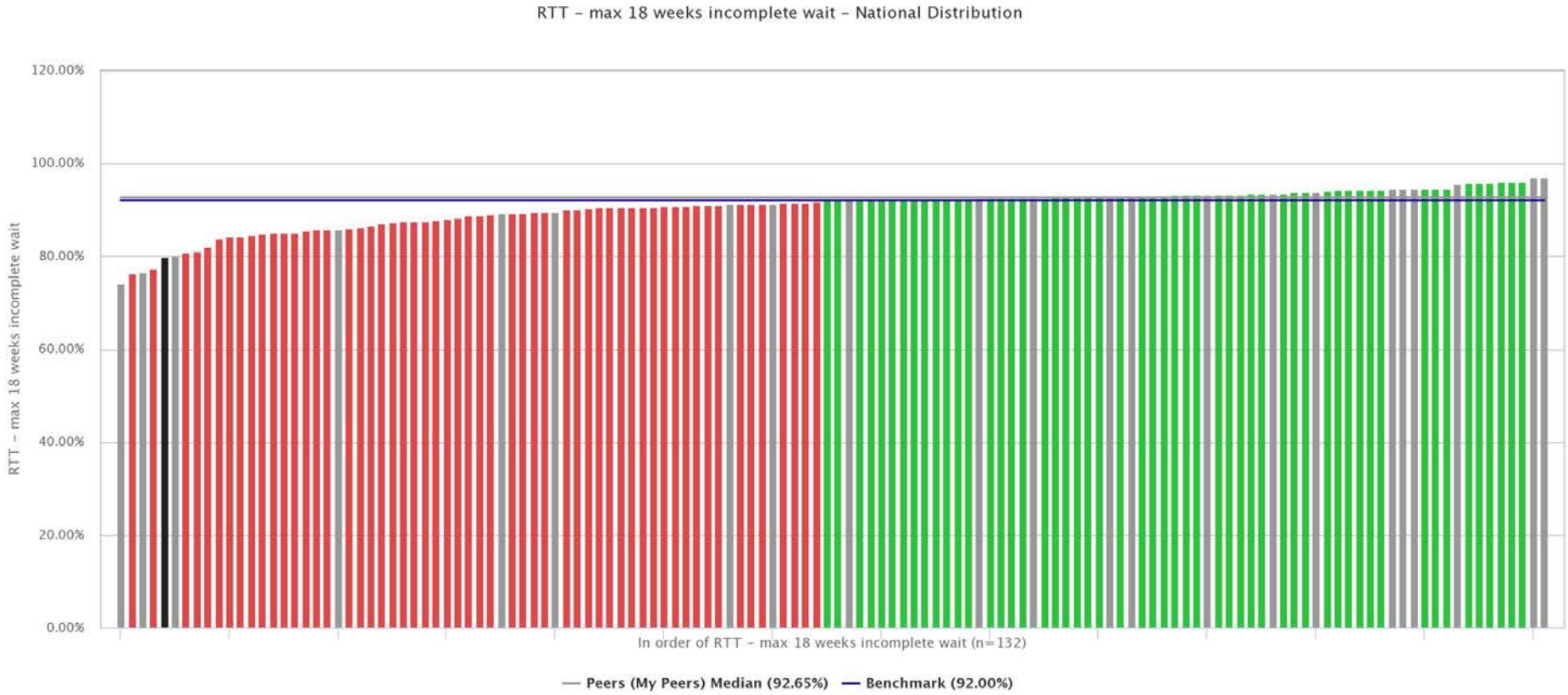
Key Recovery Actions

Description	Owner	Start	End
The Trust is seriously engaged with the CCG at various levels to improve on demand management. A locum Dermatology consultant is also brought in to enhance outpatient capacity recently. Consequently, some improvement is expected in this standard from the time of November monthly reporting.	HB	Jul-17	Nov-17

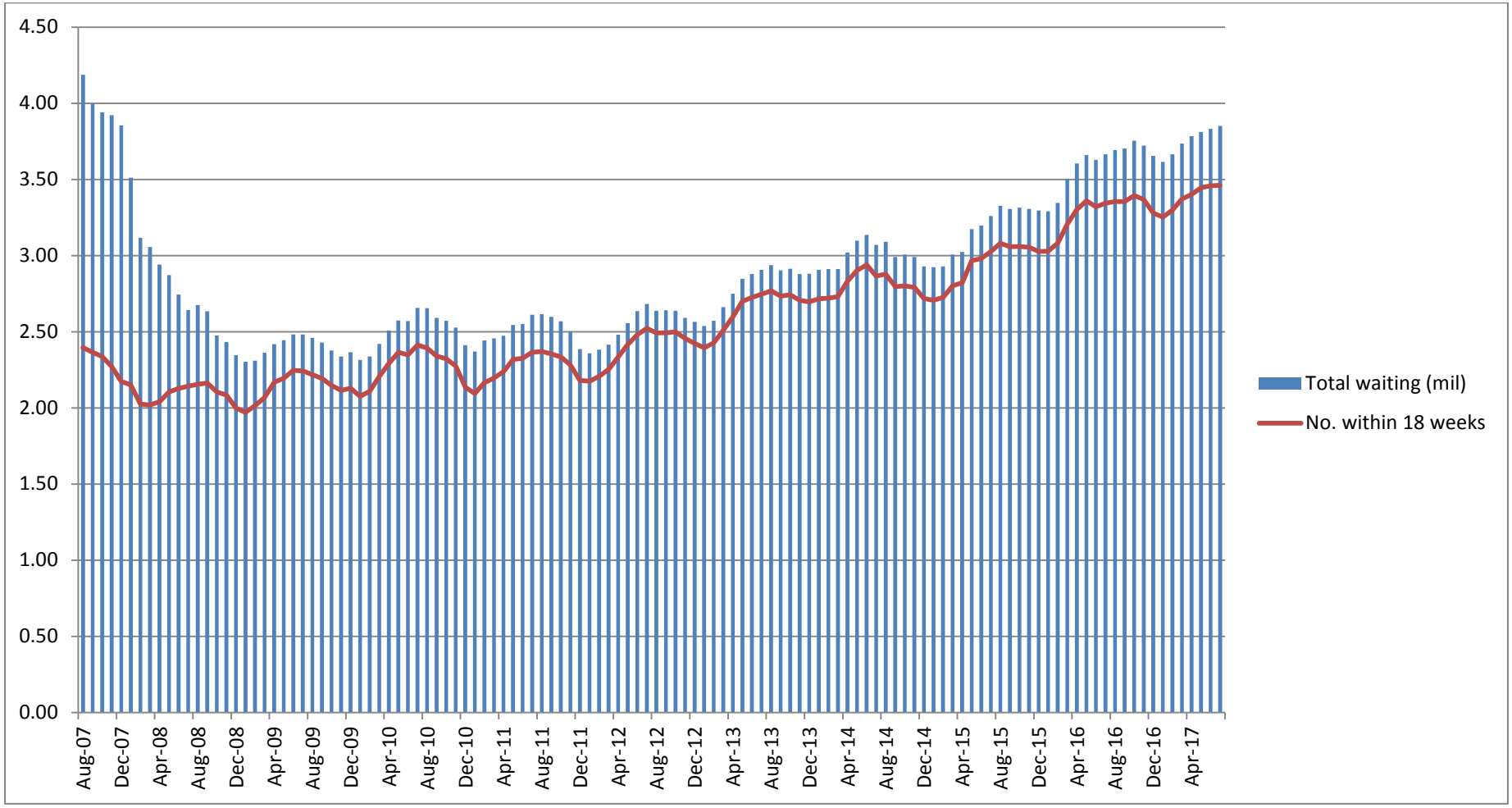


Referral to Treatment

Progress is being made to reduce the number of people on the RTT waiting list and to treat 92% of patients from point of referral to treatment in aggregate – patients on an incomplete pathway. However, the Trust remains a national outlier in term of overall performance as demonstrated in the slide below.



The national picture demonstrates that the percentage of patients being treated within 18 weeks is improving, but the number of patients on an incomplete waiting list is rising, causing some recent pressure on RTT performance.



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT - Incomplete waiting list
Standard	92%
Name	Helen Beck
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	6th Worst

Background

Current Position: 87.00% against a threshold of 92%.

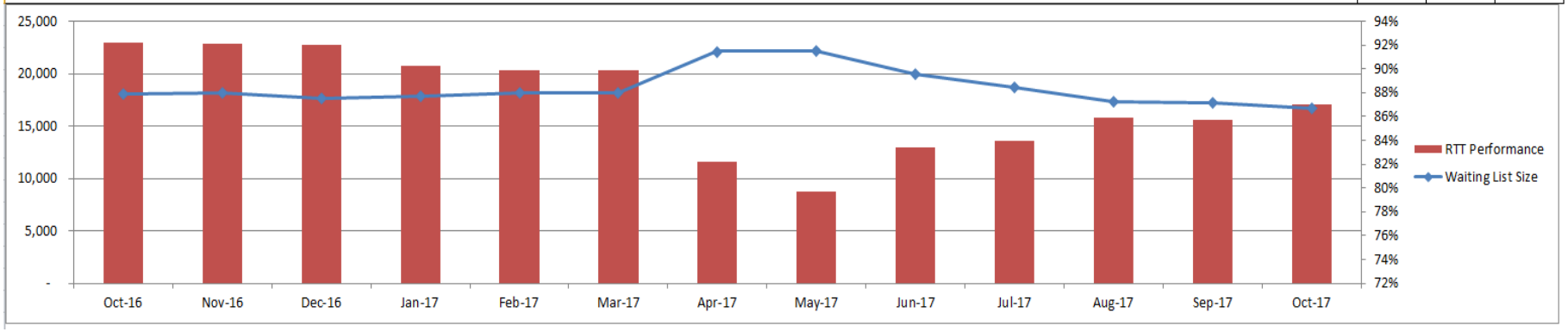
The October position demonstrates an improved performance from September's position (85.69%). The waiting list at the end of October has a total of 16,694 patients (17,236 at the end of September) with 2,171 patients breaching 18 weeks (2,467 in September). There remain persistent data quality issues within this number leading to a reported position which we believe is slightly worse than our actual position. There continue to be significant capacity constrains within ENT, Vascular, Urology, and Dermatology services.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Waiting List Size	18,840	18,033	18,164	17,663	17,816	18,126	18,127	22,110	22,144	19,931	18,676	17,346	17,236	16,694							
RTT Performance	92%	92%	92%	92%	90%	90%	90%	82%	80%	83%	84%	86%	86%	87%							

Key Recovery Actions

Description	Owner	Start	End
A series of co-ordinated validation exercises focusing on the elective waiting list to try and address persistent and intransigent data quality and pathway problems. These are being supported by the information team, telephone appointment centre (TAC) and waiting list office (WLO), and the operational management team. This has resulted in the closure of a number of pathways through into November. Work is also ongoing with Cerner to address a number of outstanding fixes within the patient tracking list (PTL) and to create automated scripts to clean up identified data quality issues. It is anticipated that this work will be concluded by the next reporting period which will give a more robust report and enable the development of a revised trajectory for recovery of the 92% performance standard. NHSI IST continue to assist the trust with demand and capacity modelling to support work around meeting the RTT targets; this is being further supported by colleagues from KPMG. Work continues across all specialities to maximise opportunity for additional capacity and support clinicians in delivering additional activity to reduce waiting times for patients. This continues to be challenged by high levels of emergency activity but operational teams are working closely with clinical teams to mitigate the impact as far as possible.	HB	Jul-17	TBC



DETAILED REPORTS – WELL-LED

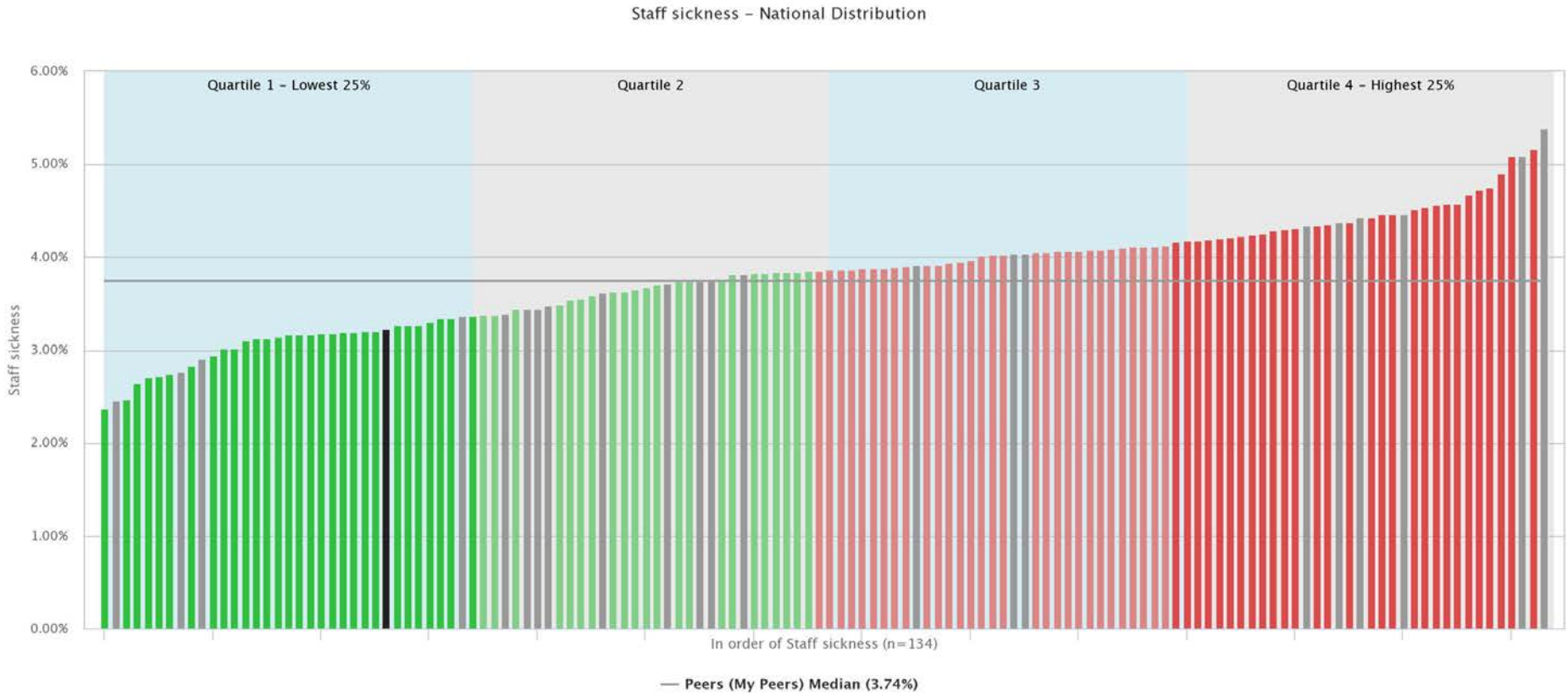
Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we.		Ref.	KPI	ED	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	YTD(Apr 17-Mar18)	WTG	Traffic	Trend
5. Well Led	Dashboard	5.01	NHS Staff Survey (Staff Engagement score -Annual)	JB	75%																	
		5.02	Staff F&F Test % Recommended - care (Qrtly)	JB	75%	NA	NA	94%	NA	NA	93%	NA	NA	95%	NA	NA	95%	NA	95%	6		
		5.03	Staff F&F Test % Recommended - place to work (Qrtly)	JB	75%	NA	NA	ND	NA	NA	79%	NA	NA	83%	NA	NA	82%	NA	83%	6		
		5.04	Turnover (Rolling 12 mths)	JB	<10%	10%	10%	10%	10%	11%	10%	10%	10%	10%	10%	10%	10%	9%	10%	6		
		5.05	Sickness Absence	JB	<3.5%	3.93%	4.41%	4.48%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.60%	4		
		5.06	Executive Team Turnover	JB	<10%	0%	29%	0%	0%	0%	0%	0%	17%	0%	0%	0%	9.8%	9%	5%	6		
		5.07	Agency Spend	CB		565	476	422	459	354	258	307	316	289	336	244	220	187	271	6		
		5.08	Monitor Use of Resources Rating	CB		3	3	4	4	4	3	3	3	3					3			
	Agency, WTE &	5.09	Agency Spend Cap	CB		565	476	422	459	354	258	307	316	289	336	244	220	187	1899			
		5.11	Bank/agency Spend percentage	CB								2.6%	2.6%	2.5%	2.6%	3.6%	3.6%	3.4%	3.0%			
		5.12	Proportion of Temporary Staff	CB								11%	11%	10%	10%	10%	9.6%		10%			
		5.14	Total Vacancies	JB										8%					8%			
		5.16	% Staff on Maternity/Paternity Leave	JB		2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%			
	Corporate	5.23	% use of Core First (Qtrly)	JB		ND	ND	ND	ND	ND	ND	2%	ND	ND	5%	ND	ND		5%			
		5.25	Grievance reviews	JB		4											6	6	6			
		5.26	Grade Reviews (Subset of Grievance Reviews)	JB									5	5					5			
		5.27	Recruitment Timescales - Av no. of weeks to recruit	JB	7	6							6	5	5.40	6.40	7	6.90	7	3		
		5.28	DBS checks	JB	95%	93%	93%	93%	93%	93%	93%	93%	93%	93%	98%	98%	99%	98%	96%	3		
		5.29	Staff appraisal Rates (From Sept 17)	JB	90%	92%	92%	92%	92%	92%	92%		92%	92%	ND	ND	53%	51%	72%	1		
		5.38	Trust Participation in on-going National Audits (Qtrly)	NJ	90%	NA	NA	100%	NA	NA		NA	NA	94%	NA	NA	96%	NA	95%	3		
	Training	5.39	Infection Control Training (classroom)	JB	85%	94%	94%	94%	94%	94%	95%	95%	96%	95%	95%	96%	94%	95%	95%	3		
		5.40	Infection Control Training (eLearning)	JB	185%	86%	87%	87%	87%	88%	88%	88%	88%	90%	90%	88%	83%	85%	88%	3		
		5.41	Manual Handling Training (Patient)	JB	80%	77%	78%	80%	82%	80%	79%	81%	83%	84%	83%	83%	80%	80%	82%	3		
		5.42	Manual Handling Training (Non Patient)	JB	80%	71%	75%	86%	87%	84%	83%	81%	81%	83%	83%	82%	86%	84%	83%	3		
		5.43	Staff Adult Safeguarding Training	JB	80%	87%	87%	87%	86%	87%	88%	88%	89%	90%	90%	89%	89%	90%	89%	3		
		5.44	Safeguarding Children Level 1	JB	90%	87%	86%	87%	86%	87%	86%	86%	86%	87%	88%	87%	86%	88%	87%	2		
		5.45	Safeguarding Children Level 2	JB	90%	86%	85%	86%	86%	87%	87%	87%	88%	90%	90%	87%	88%	89%	88%	2		
		5.46	Safeguarding Children Level 3	JB	90%	80%	83%	81%	81%	79%	78%	85%	83%	81%	81%	76%	73%	79%	80%	2		
		5.47	Health & Safety Training	JB	80%	86%	86%	87%	86%	87%	88%	88%	89%	89%	89%	89%	89%	90%	89%	3		
		5.48	Security Awareness Training	JB	80%	86%	87%	87%	87%	87%	88%	88%	89%	90%	90%	89%	89%	90%	89%	3		
		5.49	Conflict Resolution Training (eLearning)	JB	80%	76%	77%	76%	77%	81%	83%	81%	83%	85%	86%	80%	80%	81%	82%	3		
		5.50	Conflict Resolution Training	JB	180%	73%	73%	74%	74%	74%	75%	75%	75%	77%	77%	76%	75%	76%	76%	2		
		5.51	Fire Training (eLearning)	JB	280%	86%	87%	87%	86%	86%	85%	85%	86%	87%	87%	85%	85%	85%	86%	3		
		5.52	Fire Training (classroom)	JB	80%	88%	88%	89%	89%	89%	89%	90%	90%	90%	90%	90%	89%	90%	90%	3		
		5.53	IG Training	JB	80%	80%	81%	82%	82%	82%	82%	80%	81%	85%	84%	85%	84%	87%	84%	3		
		5.54	Equality and Diversity	JB	80%	90%	91%	91%	91%	92%	93%	93%	94%	95%	95%	93%	92%	93%	93%	3		
		5.55	Majax Training	JB	80%	85%	85%	85%	85%	86%	86%	86%	86%	88%	88%	87%	86%	88%	87%	3		
		5.56	Medicines Management Training	JB	80%	86%	85%	85%	85%	86%	87%	87%	87%	88%	88%	87%	87%	86%	87%	3		
		5.57	Slips, trips and falls Training	JB	80%	83%	83%	83%	82%	84%	85%	84%	85%	87%	87%	85%	85%	86%	86%	3		
		5.58	Blood-borne Viruses/Inoculation Incidents	JB	80%	82%	82%	82%	81%	84%	85%	84%	84%	85%	86%	84%	84%	85%	85%	3		
		5.59	Basic life support training (adult)	JB	80%	78%	78%	81%	81%	80%	81%	83%	85%	85%	85%	84%	82%	81%	83%	3		
		5.60	Blood Products & Transfusion Processes (Refresher)	JB	80%	75%	77%	77%	76%	78%	80%	80%	82%	83%	82%	79%	79%	80%	81%	3		

A separate report is being presented on Appraisal to the board in addition to the information above.

EXCEPTION REPORTS – WELL LED

The Trust has set a target of no more than 3.5% of sickness across all staff groups. Performance is consistently just above this threshold, but the Trust performs well against national and peer group levels.



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Sickness
Standard	4%
Name	Jan Bloomfield
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Well Led
National Rank	28th best

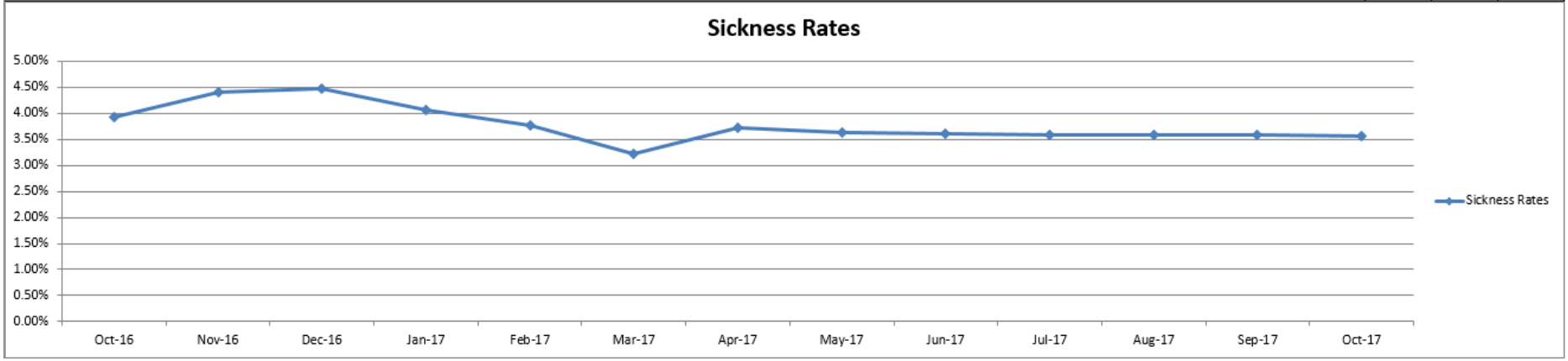
Background

The October position shows sickness rates at 3.55% against the 3.5% target. The Trust has seen a general redcution in sickness levels over the last 12 months.

Trend												Recovery Trajectory								
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Sickness Rates	3.91%	3.93%	4.41%	4.48%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%							

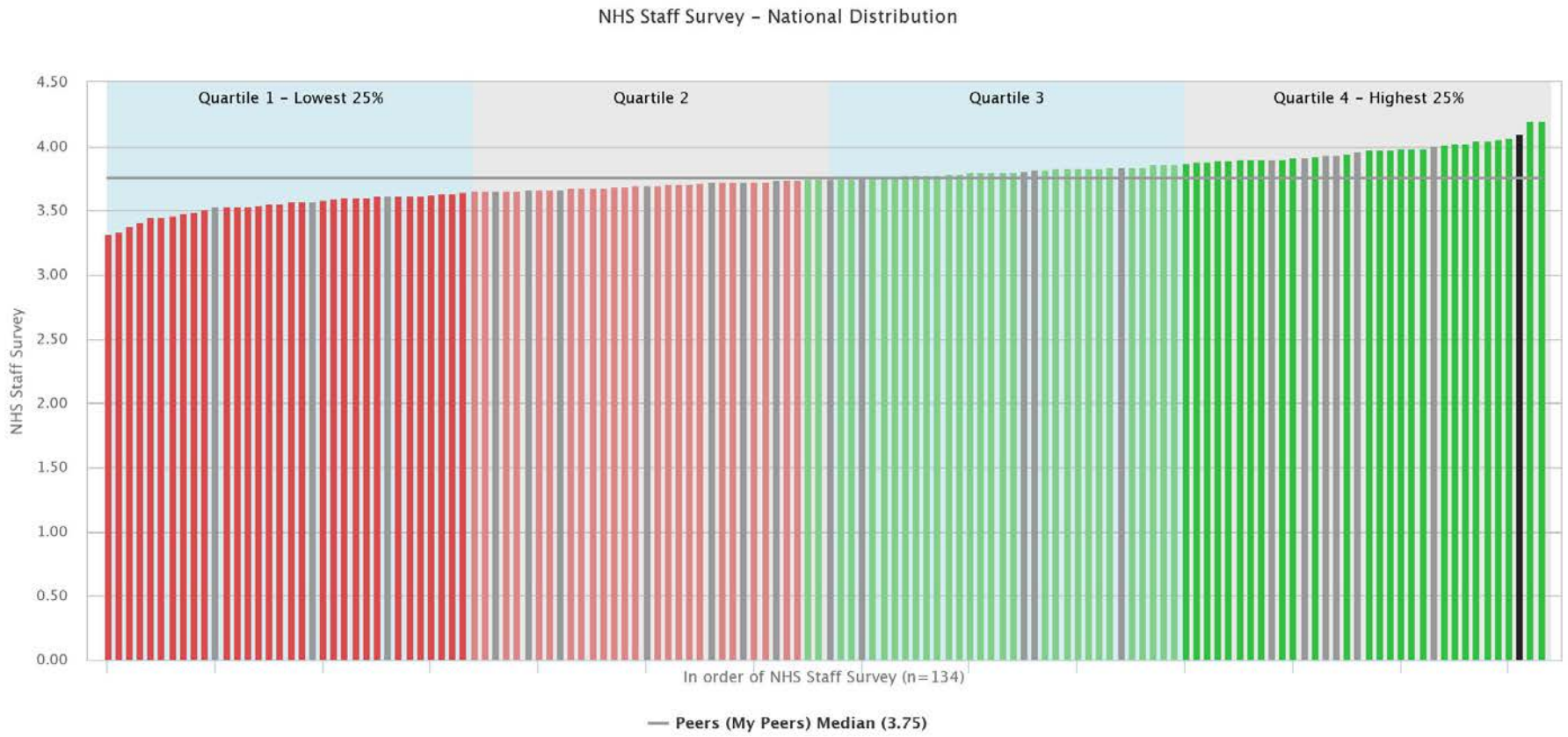
Key Recovery Actions

Description	Owner	Start	End
Absence is down again this month. It is a positive, when compared to September 2015 – 3.59% and October 2016 – 3.93%	JB	Apr-17	Mar-18



Staff F&FT

The Trust performance for staff recommending West Suffolk as a place to work and be cared for remains very high, with performance in the top 3 Trusts in England.



DETAILED REPORTS – PRODUCTIVE

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

Are we..		Ref.	KPI	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	YTD(Apr17-Mar18)	WTG	Traffic	Trend
6. Productive	Dashboard	6.01	I&E Margin	Var	-2.76%	-3.39%	-4.93%	-5.13%	-5.10%	-1.50%	ND	-5%	-4.3%	-3.9%	0.1%	-3.04%	-2.55%	-3%			
		6.02	Distance from Financial Plan	Var							ND	0.0%	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%			
		6.03	Capital service capacity	Var	0.25	- 0.65	- 2.59	- 6.74	- 2.81	1.41	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	- 0.32			
		6.04	Liquidity (days)		- 7.78	- 11.30	- 16.45	- 19.70	- 21.76	- 7.28	ND	- 12.15	- 15.72	- 10.94	- 11.03	- 12.70	- 15.14	- 15.14			
		6.05	Long Term Borrowing (£m)	3.5%	29.96	30.96	32.06	33.06	36.06	44.30	44.27	45.70	45.70	45.70	45.70	47.62	47.62	47.62	6		
		6.06	CIP Plan Variance (£000s)	1.9	-814	-1,826	-2,550	-3,268	-3,247	0	40	0	-40	10	0	-54	-10				
	Activity	6.07	A&E Activity		5554	5100	5308	5064	4740	5570	5576	5971	5922	6125	5828	5742	6057	41221			
		6.08	NEL Activity		2465	2529	2623	2480	2350	2750	2409	2440	2429	2375	2385	2496	2599	17133			
		6.09	OP - New Appointments		5957	6912	5556	6119	5697	6849	5125	6244	6148	5706	5635	5633	6177	40668			
		6.10	OP- Follow-Up Appointments		11457	13036	10218	11999	11483	12790	9541	11667	11543	11147	11333	11115	11787	78133			
		6.11	Electives (Incl Daycase)		2949	3251	2553	2877	2819	3303	2593	3004	2898	2797	2829	2786	2866	19773			
	Finance	6.13	Agency Rating (spend £000)		565	476	422	459	354	258	307	316	289	336	244	220	187	1899			
		6.14	Financial Position (YTD)	Var	4048	5686	9228	10649	11736	3327	-937	-2906	-2758	-3290	-3300	-3953	-3956	-3956			
		6.15	Financial Stability Risk Rating	Var	3	3	4	4	4	3	3	3	3	3	3	3	3	3			
		6.16	Cash Position (YTD £000s)	Var	6843	4539	4302	3598	1538	1352	7,955	5093	2689	7460	3300	4846	2654	2654			
	Ratios	6.17	% Consultant to Consultant Referrals		ND	ND	ND	ND	ND	ND	10%	10%	10%	12%	13%	10%	10.86%	10.8%			
		6.18	New to FU Ratios	1.9	2.08	2.01	2.15	2.11	2.12	2.07	1.86	1.87	1.88	1.96	2.01	1.97	1.91	1.92			
		6.20	Non-Clinical Floor Space	<35%						29%	31%	31%	31%	31%	31%	31%	31%	31%	3		
		6.21	Unoccupied Floor Space	<2.5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	CIPs	6.22	Plan (£000s) YTD	Var	5,256	6,700	8,019	9,554	10,912	12,500	840	1000	820	810	1420	1094	1123	7107			
		6.23	Actual (£000s) YTD		4,442	4,874	5,469	6,286	7,665	12,500	880	1000	780	820	1420	1040	1113	7053			

EXCEPTION REPORTS – PRODUCTIVE

There are no exceptions to report to the Board. The finance report contains full details.

MATERNITY

		Ref.	KPI	Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	YTD(Apr17-Mar18)	WTG	Traffic	Trend
Maternity	Dashboard	7.01	Total number of deliveries (births)	210	213	224	219	195	234	198	197	238	215	192	213	215	233	236	205	1509	6		
		7.02	% of all caesarean sections	<22.7%	19%	23%	21%	18%	19%	16%	13%	19%	15%	21%	16%	16%	22.32%	18.22%	17.07%	18%	6		
		7.03	Midwife to birth ratio	1:30	1:29	1:29	1:29	1:28	ND	1:28	1:28	1:33	1:30	1:27	1:29	1:30	1:33	1:33	1:29	1:30	4		
		7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		7.05	Completion of WHO checklist	100%	77%	90%	95%	82%	96%	93%	87%	89%	84%	93%	84%	94%	82%	98%	98%	90%	4		
		7.06	Maternity SIs	NT	1	1	2	0	3	0	1	1	1	0	0	0	0	1	1	3			
		7.07	Maternity Never Events	NT	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	-			
		7.08	Breastfeeding Initiation Rates	80%	74%	80%	82%	80%	80%	74%	80%	76%	80%	81%	88%	77%	85%	79%	81%	81%	6		
		7.09	Elective Caesarean Sections	10%	9%	9%	5%	6%	7%	8%	5%	7%	5%	10%	4%	7%	9%	6%	6%	7%	3		
		7.10	Emergency Caesarean Sections	<13%	10%	14%	15%	12%	12%	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	11%	2		
		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%	0%	86%	1		
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	85%	82%	90%	93%	81%	71%	70%	89%	92%	93%	93%	83%	57%	82%	88%	84%	3		
	Safe	7.14	Homebirths	2%	3%	3%	3%	4%	ND	2%	3%	2%	1%	4%	2%	3%	3%	2%	4%	3%	3		
		7.15	Midwifery led birthing unit (MLBU) births	>13%	16%	23%	18%	17%	21%	24%	19%	16%	18%	17%	17%	19%	16%	15%	17%	17%	3		
		7.16	Labour Suite births	75%	80%	75%	80%	79%	76%	74%	78%	82%	81%	79%	80%	78%	82%	83%	79%	80%	3		
		7.17	Induction of Labour	NT	33%	25%	37%	34%	34%	34%	36%	37%	43%	41%	41%	37%	38%	34%	35%	38.4%			
		7.18	Instrument Assisted Deliveries (Forceps and VentoUse)	NT	6%	5%	3.85%	6.25%	4.35%	4.60%	4.85%	6.20%	4.45%	6.80%	4.85%	4.20%	3%	4.65%	4.15%	5%			
		7.19	Critical Care Obstetric Admissions	0	0	0	0	0	0	0	0	1	1	1	0	1	0	1	0	4	2		
		7.20	Eclampsia	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3		
	Effective	7.21	Shoulder Dystocia	2	4	7	6	5	7	3	2	8	2	4	3	5	3	7	6	4	1		
		7.22	Post-partum Hysterectomies	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	2		
		7.23	Women requiring a blood transfusion of 4 units or more	0	0	0	ND	ND	ND	ND	0	ND	1	0	0	0	0	0	0	1	2		
		7.24	3rd and 4th degree tears (all deliveries)	12	6	11	9	7	4	5	4	7	8	9	6	10	4	4	6	47	3		
	Caring	7.25	Maternal death	NT	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1			
		7.26	Stillbirths	NT	0	1	2	0	3	0	1	0	1	0	0	0	0	1	2	4			
		7.27	Complaints		1	5	0	0	1	0	0	0	0	0	1	2	1	0	ND	4			
		7.28	No. of babies admitted to Neonatal Unit (>36+6)	NT	14	17	12	16	20	8	8	0	15	9	17	18	13	15	15	102			
	Responsive	7.29	No. of babies transferred for therapeutic cooling	0	0	0	0	1	0	1	1	1	0	0	0	0	0	0	1	1	3		
		7.30	% of babies admitted to NNU with normal temperature	80%	100%	94%	100%	100%	100%	100%	100%	100%	87%	66%	88%	100%	100%	86%	81%	87%	3		
		7.31	One to one care in established labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		7.32	Reported Clinical Incidents	60	67	67	68	54	48	54	49	64	51	62	46	64	43	52	61	379	2		
		7.33	Hours of dedicated consultant cover per week	60	60	60	60	60	75	63	81	60	93	110	99	99	96	99	99	695	3		
		7.34	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	70	3		
		7.35	OPD cover for Theatre 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		7.36	No. of women identified as smoking at booking	NA	ND	ND	ND	ND	ND	ND	ND	ND	27	35	37	32	30	37	27	225			
		7.37	No. of women identified as smoking at delivery	NT	ND	ND	ND	ND	ND	ND	ND	ND	20	30	26	32	27	25	25	185			
		7.38	UNICEF Baby friendly audits	NT	ND	ND	24	26	10	10	10	10	10	10	10+	10+	10+	10+	10+	20			
		7.39	No. of parents receiving a Safer Sleeping Suffolk Thermometer	NT	ND	ND	49	108	ND	156	157	165	143	170	174	205	155	192	151	1190			
	Other	7.40	No. of bookings (First visit)	NA	252	272	254	255	226	262	247	275	208	262	244	272	245	265	259	1755			
		7.41	Access - Assessment of need by 12w	95%	95%	94%	97%	97%	95%	93%	95%	96%	95%	95%	98%	95%	100%	93%	99%	96%	3		
		7.42	Return of women with perinatal problems		ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	0			
		7.43	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			

EXCEPTION REPORTS - MATERNITY

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity WHO Checklist
Standard	100%
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Maternity WHO Checklist
National Rank	

Background

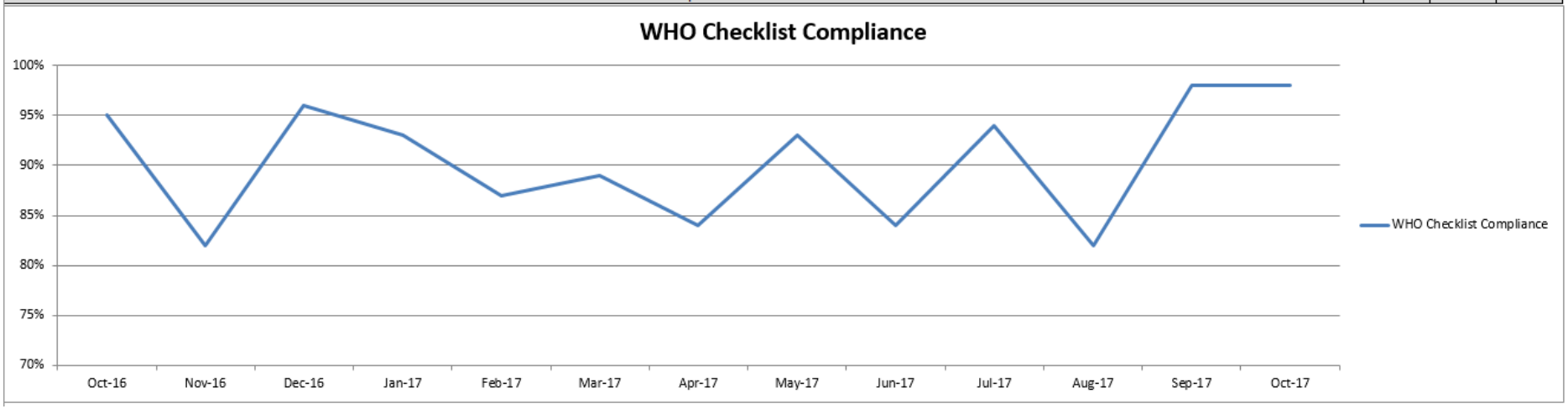
Following daily monitoring and awareness raising at every multidisciplinary handover the WHO checklist completion rate was 98% in October 2017, one form failed the audit for completion. This has been addressed with the individual member of staff.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
WHO Checklist Compliance	90%	95%	82%	96%	93%	87%	89%	84%	93%	84%	94%	82%	98%	98%							

Key Recovery Actions

Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity Ratio
Standard	1:30 Ratio
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

Background

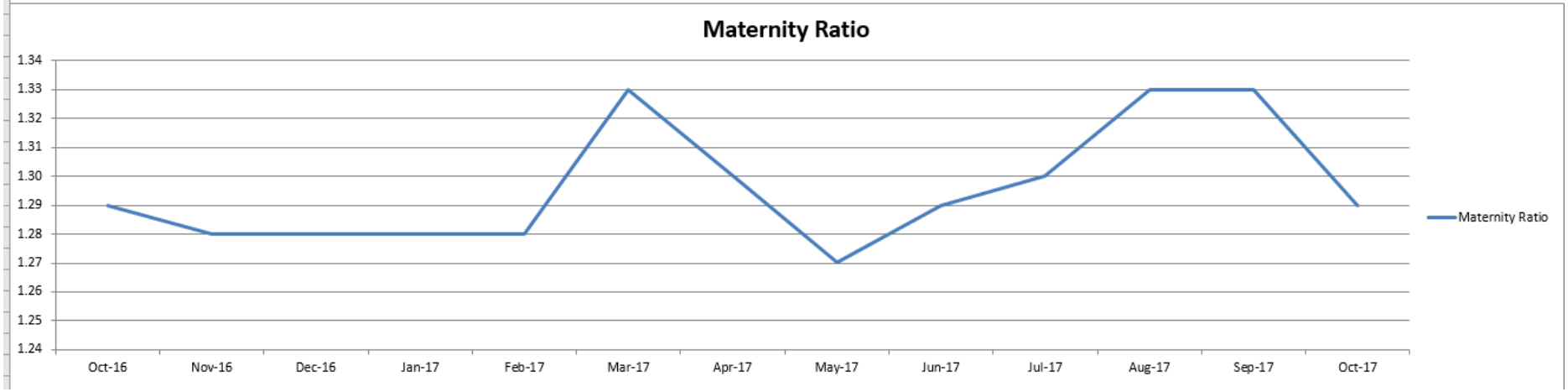
Tha maternity ratio achieved the threshold of 1.29 for October.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Maternity Ratio	1.29	1.29	1.28	1.28	1.28	1.28	1.33	1.30	1.27	1.29	1.30	1.33	1.33	1.29							

Key Recovery Actions

Description	Owner	Start	End
All women who delivered in October 2017 received one to one care in labour	RS	Jul-17	Nov-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity - Grade 1 Caesarean Section
Standard	100%
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

Background

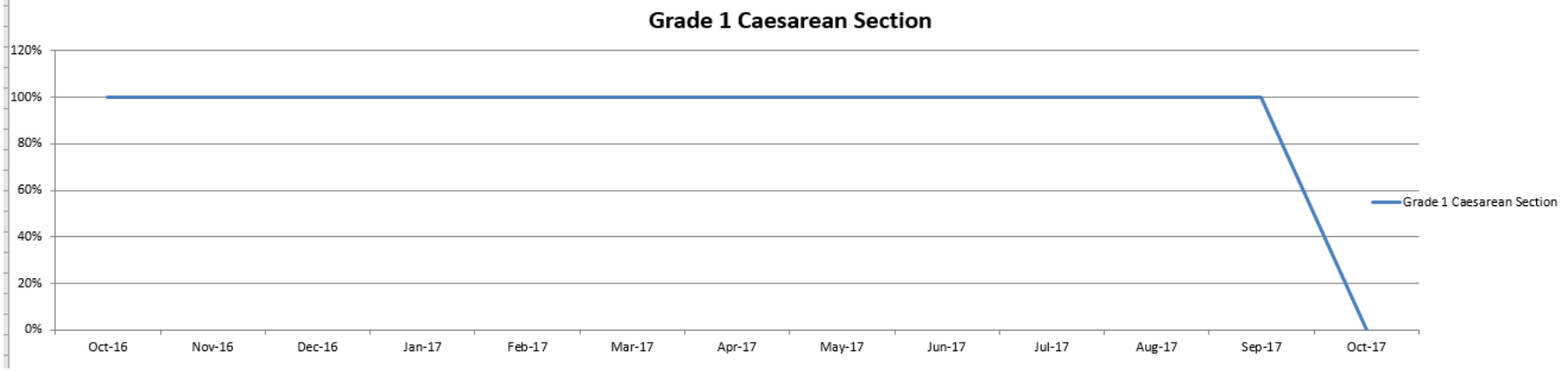
Only one Grade 1 caesarean section was undertaken in October 2017 unfortunately there was a delay in the surgery due to complications with achieving adequate pain relief. Baby was born with good APGARs and no adverse outcome.

Trend / Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Grade 1 Caesarean Section	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%							

Key Recovery Actions

Description	Owner	Start	End
	RS	Jul-17	Nov-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity - Shoulders Dystocia
Standard	100%
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

Background

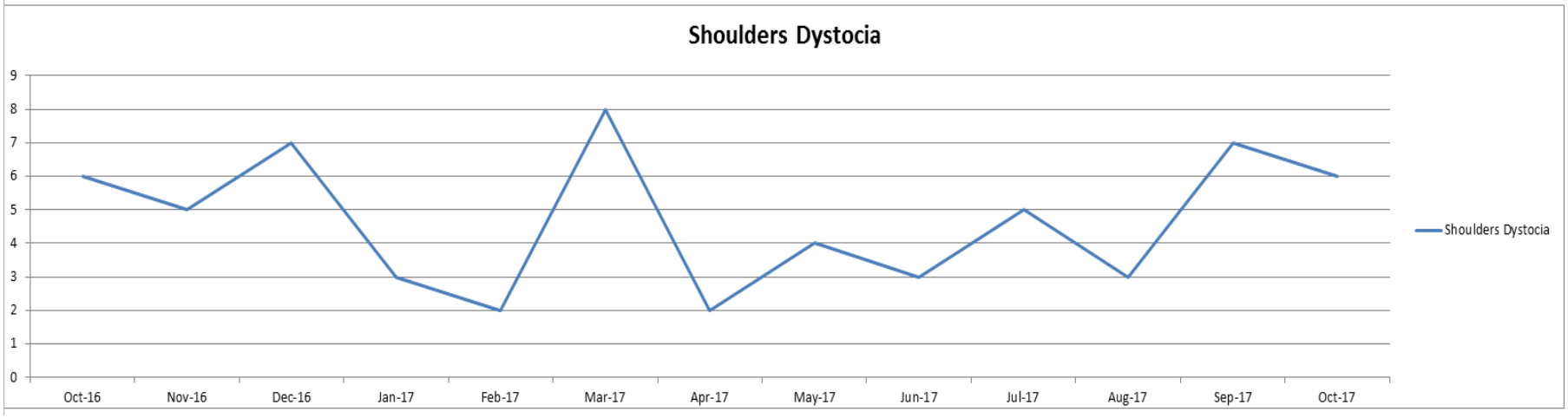
There were eight cases of shoulder dystocia in October 2017; this was higher than would be expected.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Shoulders Dystocia	7	6	5	7	3	2	8	2	4	3	5	3	7	6							

Key Recovery Actions

Description	Owner	Start	End
Following discussion at the Women's Clinical Governance Steering Group an audit has been commissioned which will be presented to the meeting in January 2018 and an action plan will be developed if appropriate.	RS	Jul-17	Jan-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity - Babies transferred for therapeutic cooling
Standard	0%
Name	Rowan Procter
Month	01-Oct-17
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

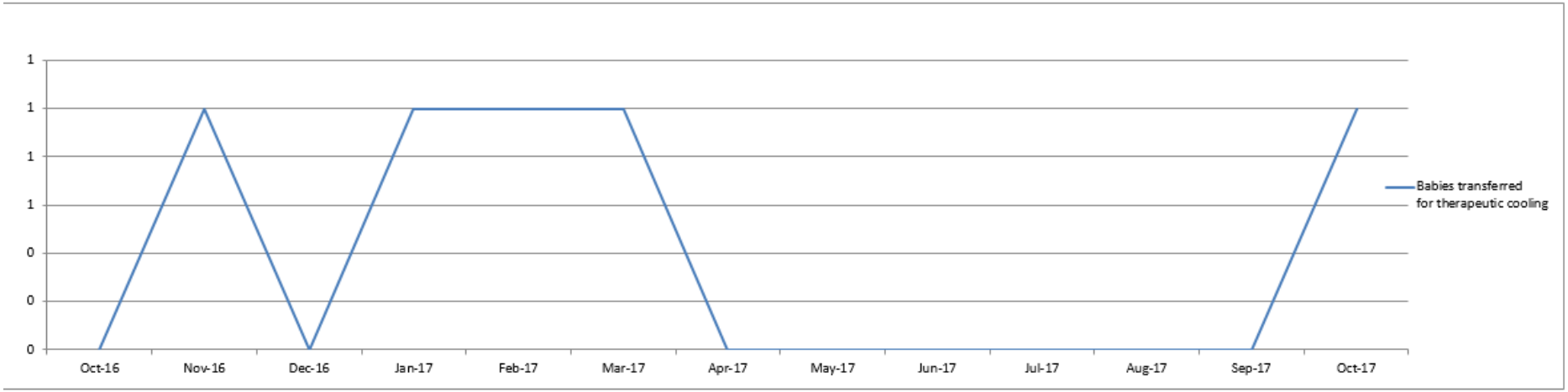
Background

One baby was transferred out to a tertiary centre for therapeutic cooling in October 2017.

Trend												Recovery Trajectory								
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Babies transferred for therapeutic cooling	0	0	1	0	1	1	1	0	0	0	0	0	0	1							

Key Recovery Actions

Description	Owner	Start	End
Following a decision made in April 2017 these cases are now reported as serious incidents and an investigation is currently ongoing.	RP	Oct-17	Dec-17



COMMUNTY INFORMATION

The Community dashboard is being developed by the consortium, and will be added when available. The current report is included in the current Quality and Performance Report.

APPENDIX 1: INDICATOR CHANGES

Comparison of KPI changes from the existing Performance Report

New Indicators	* CQC Indicator
Safe	
1.01	NHS E / I Patient Safety Alerts - Total
1.02	NHS E / I Patient Safety Alerts outstanding*
1.08	Never Events*
1.21	RIDDOR Reportable Incidents
1.29	Actual patient harm resulting from medication incidents
1.47	Severity of NRLS (or median NRLS upload 6 mths RA)
Effective	
2.03	Emergency Re-admissions within 30d*
2.05	OP Clinic Utilisation Rate
2.06	OP Clinic Productivity Rate
2.07	Theatre Utilisation Rate
2.08	Theatre Productivity Rate
2.15	CAS (central alerts system) alerts overdue
2.16	Pathology & Imaging BMs
2.16	Pathology & Imaging BMs
2.17	WHO Checklist (Qrtly)

2.19	No of ward days with Norovirus
2.20	Number of Black Alerts
2.21	Delayed Transfers of Care (DTOCs)
2.22	Av. Elective LOS (exl. 0 days)
2.23	Av NEL LOS (exl 0 days)
2.24	% of NEL 0 day LOS
2.25	NHS number coding
2.26	Fractured Neck of Femur : Surgery in 36 hours
2.27	Proportion of patients discharged to pre-admission address
2.32	All Cancer 2ww services available on C&B
Caring	
3.01	Compliments*
3.16	FFT - Maternity - overall
3.17	Maternity - post natal ward recommendation to F&F
3.18	Maternity - birthing unit recommendation to F&F
3.19	Maternity -antenatal community care rec. to F&F
3.20	Maternity -post-natal community care rec. to F&F
3.34	ITU Wardable patients
3.35	ITU Wardable patients over xx hours
3.36	Certification against compliance with requirements regarding access to healthcare for people with a learning disability
3.37	Ward Cleanliness - Patient Satisfaction Overall*
3.38	Catering - Patient Satisfaction with food - overall
Responsive	
4.12	Incomplete cancer 104 day waits*
4.13	Flow: % of Ambulance handover to ED within 15m
4.14	Flow: % of clinical assessments started within 30m
4.15	Flow: % clinically streamed to an alternative service
4.16	Flow: % MH needs assessed by MH team within 60m

4.18	Flow: % Emergency Admissions with care plan within 14hrs
4.19	Flow: % High Risk Emergency Admissions with care plan within 4hrs
4.20	Flow: % of discharges before midday
4.16	A&E - To inpatient Admission Ratio
4.16	A&E - Admission waiting 4-12 hours from dec. to admit*
4.24	RTT waiting List*
4.25	RTT waiting list over 18 weeks*
4.37	Sepsis - 1 hr neutropenic sepsis
Well Led	Some of these may be included in separate reports
5.01	NHS Staff Survey (Staff Engagement score -Annual)*
5.02	Staff F&F Test % Recommended - care (Qrtly)
5.03	Staff F&F Test % Recommended - place to work (Qrtly)
5.06	Executive Team Turnover
5.08	Monitor Assurance Governance Rating
5.12	Proportion of Temporary Staff
5.14	Total Vacancies
5.15	Corporate & Admin Costs as %
5.16	% Staff on Maternity/Paternity Leave
5.17	% Fill rate of Reg. Nurse shifts
5.20	% staff completing the staff survey
5.21	% use of Core First (Qtrly)
5.22	Delivering Workforce Race Equality Stds
5.27	Staff appraisal Rates (From Sept 17)
5.28	CHPPD (Care Hours Per Patient Day)
5.29	Flu Uptake Rates*
5.31	Infection Control Training
5.32	Manual Handling Training (Patient)
5.33	Manual Handling Training (Non Patient)
5.34	Staff Adult Safeguarding Training

5.35	Safeguarding Children Level 1 - 3 Years
5.36	Safeguarding Children Level 2
5.37	Safeguarding Children Level 3 - 1 Year
5.38	Health & Safety Training
5.39	Security Awareness Training
5.40	Conflict Resolution Training
5.41	Fire Training
5.42	IG Training
5.43	Equality and Diversity
5.44	Majax Training
5.45	Medicines Management Training
5.46	Slips, trips and falls Training
5.47	Blood Borne Viruses/Inoculation Incidents
5.48	Basic life support training
5.49	Blood Products & Transfusion Processes (Refresher)
Productive	
6.06	A&E Activity
6.07	NEL Activity
6.08	OP First Appointments
6.09	OP Follow Up Appointments
6.10	Day Cases
6.11	Electives
6.18	NHS Supply Chain Costs
6.19	Non Clinical Floor Space
6.20	Unoccupied Floor Space
Maternity	
7.13	Number of midwives*

KPIs REMOVED

Maternity (Mainly due to no data and/or no targets)

Total Women Delivered
Twins
Vaginal breach deliveries
Non-operative vaginal deliveries
Water births
Forceps delivery
Ventouse deliveries
Failed instrument delivery
Unsuccessful trial of Instrumental Delivery
Use of sequential instruments
Total no. of women eligible for Vaginal birth after Caesarean section (VBAC)
Postpartum Haemorrhage 1000-2000 mls
Postpartum Haemorrhage 2000-2499 mls
Postpartum Haemorrhage 2500+ mls
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)
4th and 4th degree tears (Instrumental Deliveries) - *But 3rd and 4th tears - All vaginal deliveries remain*
Cases of Meconium aspiration
Cases of hypoxia
Massive Obstetric Haemorrhage protocol
Maternal Postnatal readmissions
Babies assessed as needing BCG Vaccine
Babies who receive BCG vaccine following assessment

APPENDIX 2: PEER HOSPITAL LIST USED BY CQC

Airedale NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Bedford Hospital NHS Trust
Burton Hospitals NHS Foundation Trust
Dartford and Gravesham NHS Trust
Dorset County Hospital NHS Foundation Trust
East Cheshire NHS Trust
George Eliot Hospital NHS Trust
Harrogate and District NHS Foundation Trust
Hinchinbrook Health Care NHS Trust
Homerton University Hospital NHS Foundation Trust
Isle of Wight NHS Trust
Kettering General Hospital NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northern Devon Healthcare NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Salisbury NHS Foundation Trust
South Tyneside NHS Foundation Trust
Tameside and Glossop Integrated Care NHS Foundation Trust
Weston Area Health NHS Trust
Wye Valley NHS Trust
Yeovil District Hospital NHS Foundation Trust
West Suffolk NHS Foundation Trust

NHS West Suffolk NHS Foundation Trust

Board of Directors – 1st December 2017

Agenda item:	Item 9			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	22nd November 2017			
Subject:	Finance and Workforce Board Report – October 2017			
Purpose:	x	For information		For approval

Executive summary:
The reported I&E for October 2017 is a surplus of £114k (YTD £3,839k deficit), against a planned surplus of £150k (YTD planned deficit of £3,724k) This results in an unfavourable variance of £36k (YTD £114k adverse).

We are therefore on plan to achieve our control total this year, which will mean we also receive STF funding of £5.2m. Therefore £2.4m of this funding is included in the October position in line with NHSI guidance. However, our current Q3 A&E performance is below the 90% target for the receipt of Sustainability and Transformation Funding.

We continue to work with KPMG as part of the financial improvement programme (FIP) for 2017-18 and beyond. The focus of FIP is to ensure that robust CIPs are in place to deliver the control total for 2017-18 and a CIP pipeline for future years. This Programme has identified further CIP that increases this year's forecast to £14.4m. To date we have identified £4.2m of risk adjusted CIP schemes for 2018-19.

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

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

West Suffolk NHS
NHS Foundation Trust

FINANCE AND WORKFORCE REPORT

October 2017 (Month 7)

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

Financial Summary

I&E Position YTD	£3.8m	loss
Variance against plan YTD	-£0.1m	
Movement in month against plan	£0.0m	
EBITDA position YTD	-£0.1m	deficit
EBITDA margin YTD	-0.2%	deficit
Cash at bank	£2,653k	

Executive Summary

- The Month 7 YTD position is £114k behind plan.

Key Risks

- Delivering the cost improvement programme.
- Containing the increase in demand to that included in the plan (2.5%).
- Our current Q3 A&E performance is below the 90% target for the receipt of Sustainability and Transformation Funding.
- Working across the system to minimise delays in discharge and requirement for escalation beds

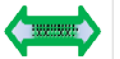
SUMMARY INCOME AND EXPENDITURE ACCOUNT - October 2017	Oct-17 Budget £m	Oct-17 Actual £m	Oct-17 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance £m
NHS Contract Income	17.7	17.6	(0.0)	130.6	130.0	(0.5)	208.0	211.8	3.8
Other Income	2.9	2.7	(0.1)	17.4	19.0	1.6	31.0	28.4	(2.6)
Total Income	20.5	20.4	(0.1)	148.0	149.0	1.1	239.0	240.2	1.2
Pay Costs	12.4	12.3	0.0	84.8	84.5	0.3	147.2	145.8	1.4
Non-pay Costs	8.0	7.9	0.1	65.9	67.2	(1.3)	94.3	96.8	(2.5)
Operating Expenditure	20.4	20.3	0.1	150.7	151.8	(1.0)	241.4	242.6	(1.2)
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	2.5	2.5	0.0
EBITDA	0.2	0.1	(0.0)	(2.8)	(2.7)	0.0	(5.0)	(4.9)	0.1
EBITDA margin	3.3%	3.1%	(0.2%)	(0.3%)	(0.2%)	0.1%	0.1%	0.1%	0.0%
Depreciation	0.4	0.4	0.0	2.4	2.5	(0.1)	4.8	4.4	0.4
Finance costs	0.1	0.1	(0.0)	0.9	1.0	(0.1)	1.4	1.8	(0.4)
SURPLUS/(DEFICIT) pre S&TF	(0.4)	(0.4)	(0.0)	(6.1)	(6.3)	(0.2)	(11.1)	(11.1)	(0.0)
S&T funding - Financial Performance	0.4	0.4	0.0	1.6	1.7	0.1	3.6	3.6	0.0
S&T funding - A&E Performance	0.2	0.2	0.0	0.7	0.7	0.0	1.6	1.6	0.0
SURPLUS/(DEFICIT) incl S&TF	0.2	0.1	(0.0)	(3.7)	(3.8)	(0.1)	(5.9)	(5.9)	(0.0)

FINANCE AND WORKFORCE REPORT – October 2017

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	X

FINANCE AND WORKFORCE REPORT – October 2017

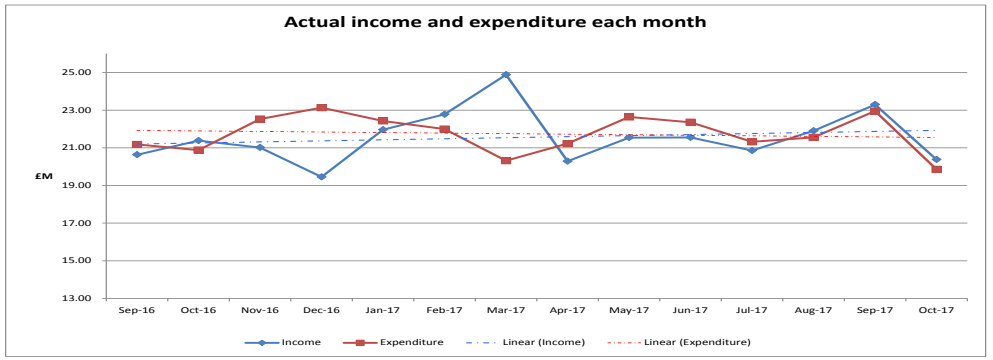
Income and Expenditure summary as at October 2017

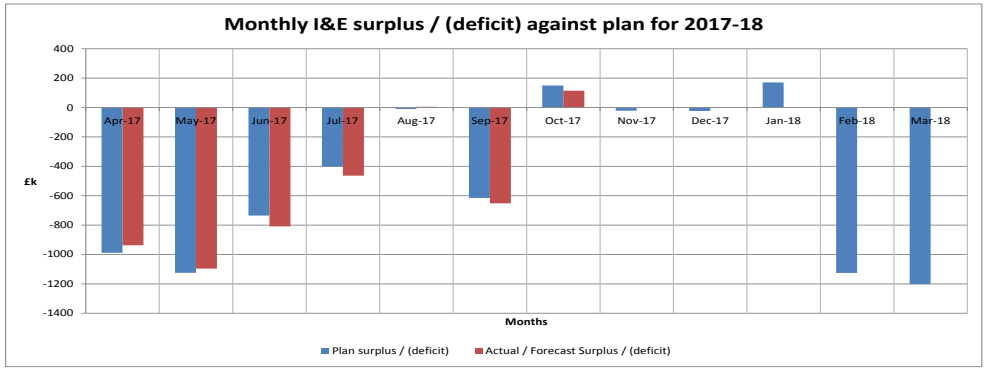
The reported I&E for October 2017 YTD is a deficit of £3,839k, against a planned deficit of £3,725k. This results in an adverse variance of £114k YTD.

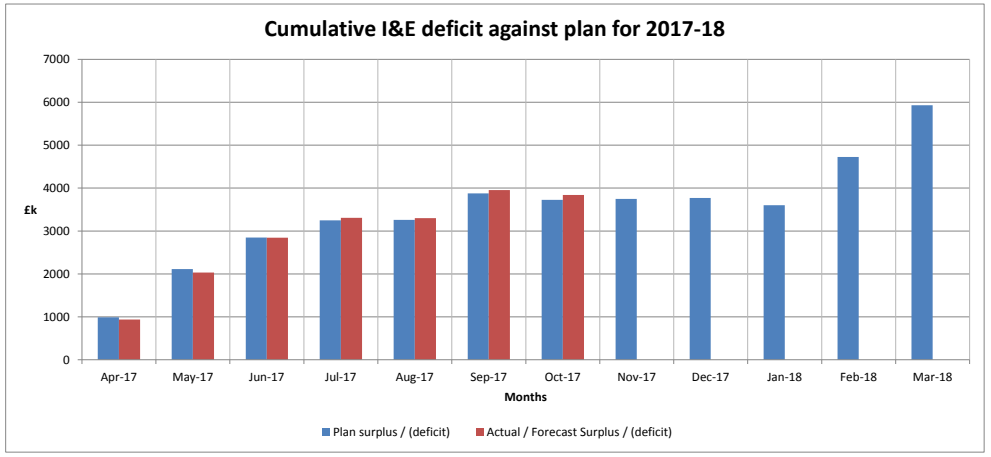
The October position also includes revised income and expenditure to reflect the new contractual arrangements for providing Community Services in Suffolk. This does not impact on our overall forecast deficit, but does reduce both income and expenditure by around £13.7m in the remainder of 17-18. Community based staffing numbers are also affected.

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)	150	114	(36)	↓	Green
YTD surplus / (deficit)	(3,725)	(3,839)	(114)	↓	Green
Forecast surplus / (deficit)	(5,928)	(5,928)	0	↔	Green
EBITDA YTD	(444)	(311)	134	↓	Green
EBITDA (%)	(0.3%)	(0.2%)	0.1%	↓	Amber
Use of Resources (UoR) Rating fav / (adv)	3	3	0	↔	Amber
Clinical Income YTD	(130,572)	(130,033)	(539)	↓	Amber
Non-Clinical Income YTD	(19,729)	(21,420)	1,691	↓	Green
Pay YTD	84,827	84,537	290	↓	Green
Non-Pay YTD	69,199	70,756	(1,556)	↓	Amber
CIP target YTD	(7,290)	(7,244)	(46)	↓	Green







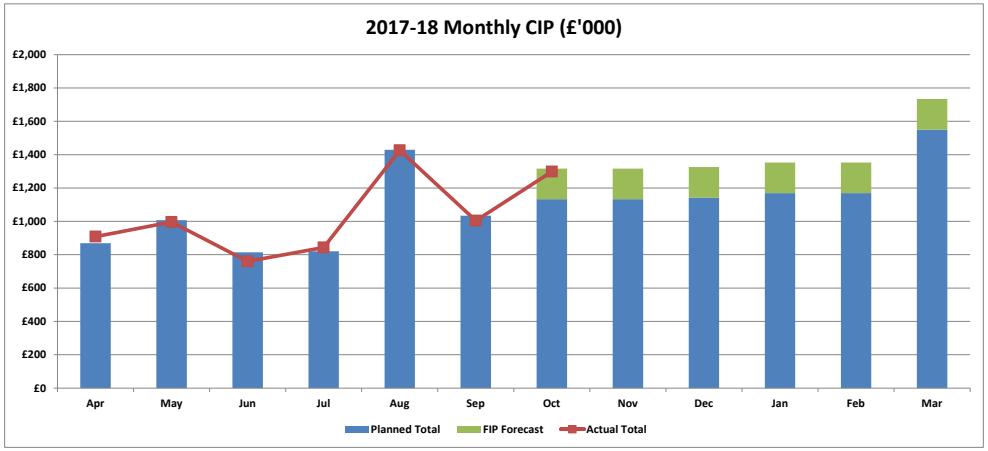
FINANCE AND WORKFORCE REPORT – October 2017

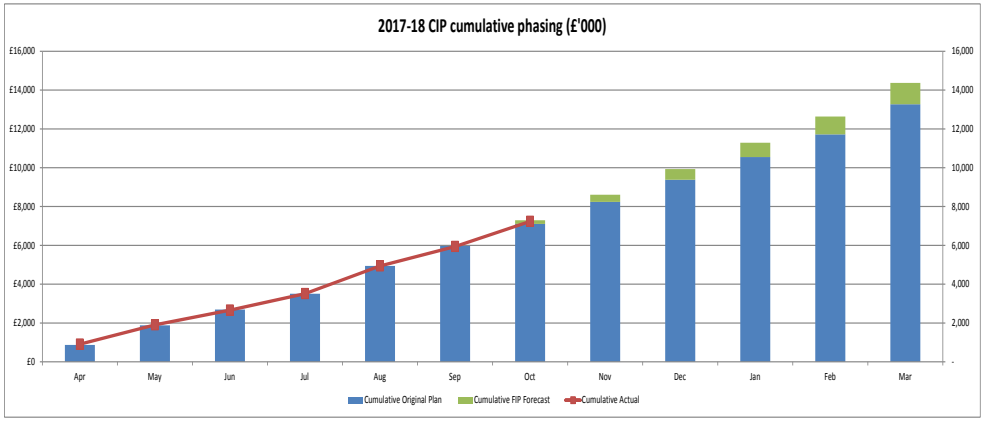
Cost Improvement Programme (CIP)

The October position includes a target of £7,107k YTD which represents 50.4% of the 2017-18 plan. There is currently a shortfall of £46k YTD against this plan.

Recurring/Non Recurring	Summary	2017-18 Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Activity growth	297	163	77
	Car Park Income	400	233	167
	Other Income	167	93	71
	Consultant Staffing	326	158	151
	Additional sessions	192	112	67
	Staffing Review	2,722	1,157	1,638
	Agency	482	281	156
	Procurement	1,801	883	675
	Community Equipment Service	465	233	74
	Contract review	8	4	5
	Drugs	326	114	154
	Capitalisation	480	280	170
	Other	2,047	1,342	1,309
	Theatre Productivity	400	66	66
	Patient Flow	700	117	125
Recurring Total		**10,812**	**5,237**	**4,905**
Non-Recurring	Activity growth	300	300	300
	Other Income	19	11	15
	Additional sessions	10	6	29
	Staffing Review	20	12	-
	Contract review	41	24	26
	Estates and Facilities	389	227	227
	Non-Recurring	396	396	396
	Capitalisation	350	225	325
	Other	383	233	402
	GDE revenue	1,650	619	619
Non-Recurring Total		**3,558**	**2,052**	**2,339**
Grand Total		**14,371**	**7,290**	**7,244**

The FIP Programme has identified further CIP that increased this year's forecast to £14.4m. The over performance will be used in part to offset the KPMG fee. This has been phased from October 2017 as below.





In order to deliver the Trusts pre-STF control total of £7.7m deficit in 2018-19 we need to deliver a CIP of £18.3m (8%).

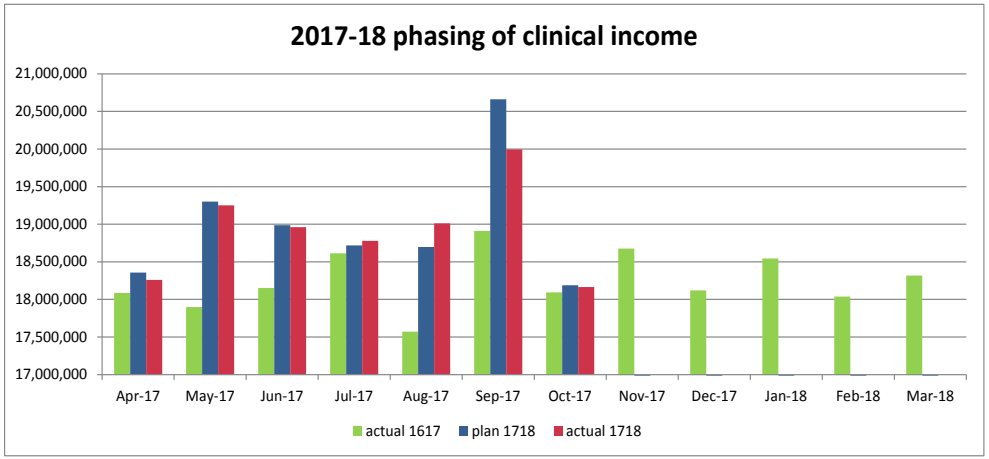
To date we have identified £4.2m of risk adjusted CIP schemes for 2018-19. Once these are fully worked up and in place we anticipate they will deliver around £10m of CIP in 18-19

FINANCE AND WORKFORCE REPORT – October 2017

Income Analysis

The chart below summarises the phasing of the clinical income plan for 2017-18, including Community Services. This phasing is in line with activity phasing and does not take into account the block payment. This graph includes the reduction in income relating to community services from October to March.

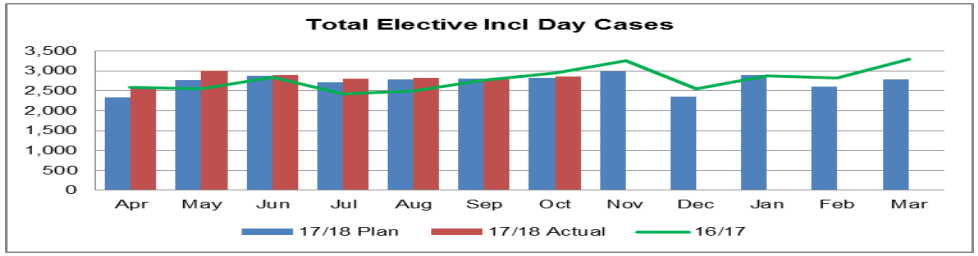
Income earned from within Suffolk is on plan since we have block contracts with Suffolk CCGs for their activity. However, variances can be seen within Divisions with any balances reflected within the Corporate Division.

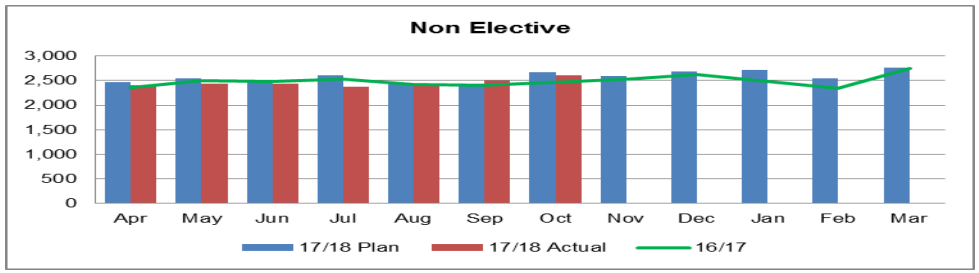


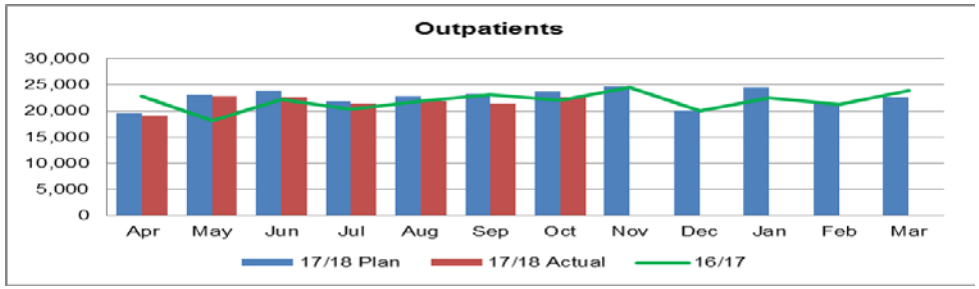
The income position was slightly behind plan in October. Inpatients over performed within the month (Elective), with outpatient being the largest are of underperformance.

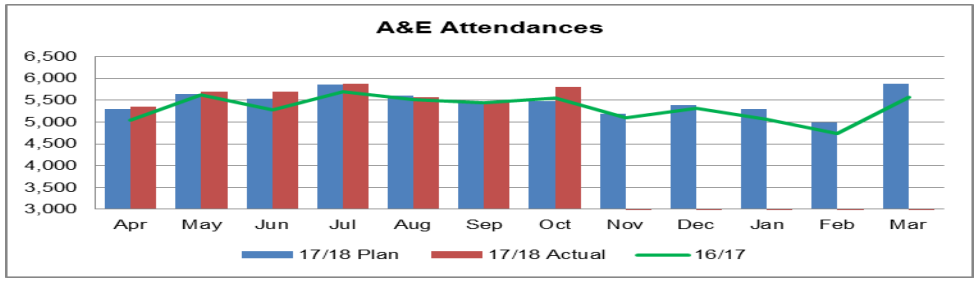
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	680	752	72	4,819	5,060	242
Other Services	2,245	2,244	(1)	17,018	15,044	(1,974)
CQUIN	314	315	1	2,092	2,123	31
Elective	2,753	2,805	52	18,308	19,333	1,025
Non Elective	5,322	5,375	53	35,130	36,703	1,573
Emergency Threshold Adjustment	(293)	(399)	(105)	(2,025)	(2,656)	(631)
Outpatients	2,849	2,738	(111)	18,987	18,337	(650)
Community	5,379	5,379	0	37,655	37,655	0
Total	**19,249**	**19,210**	**(39)**	**131,984**	**131,600**	**(384)**

Activity, by point of delivery



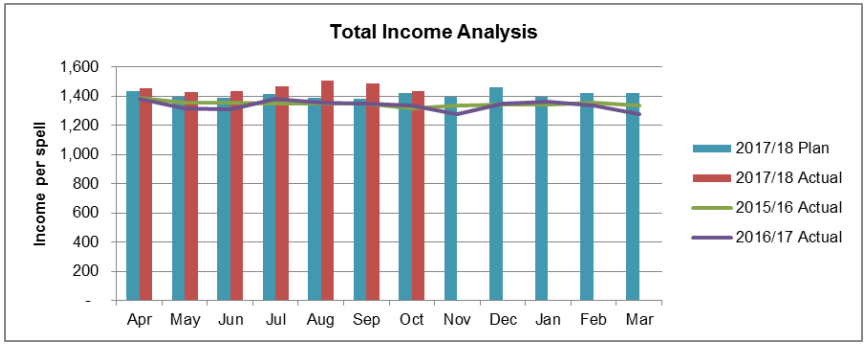


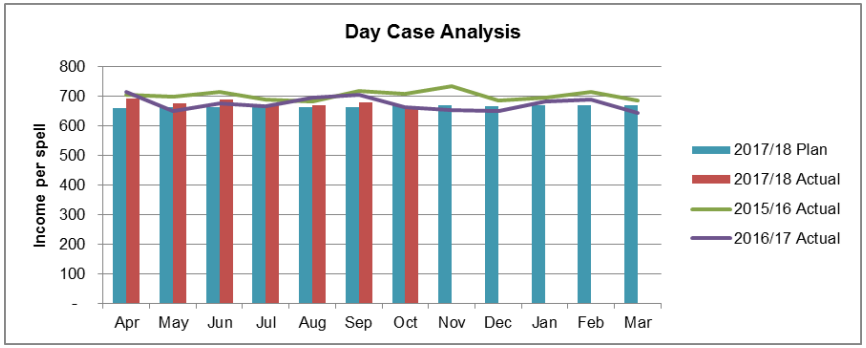


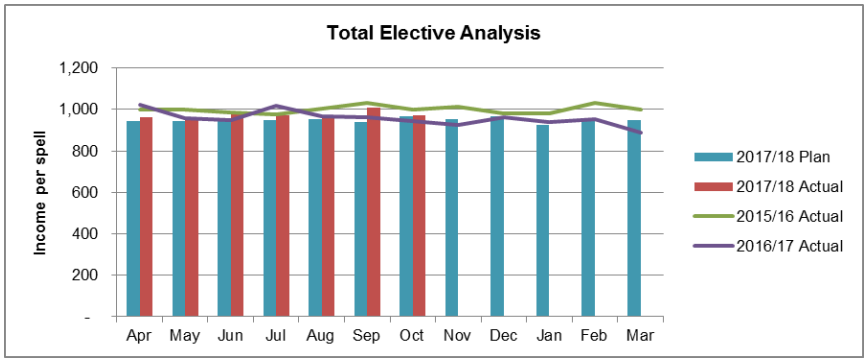


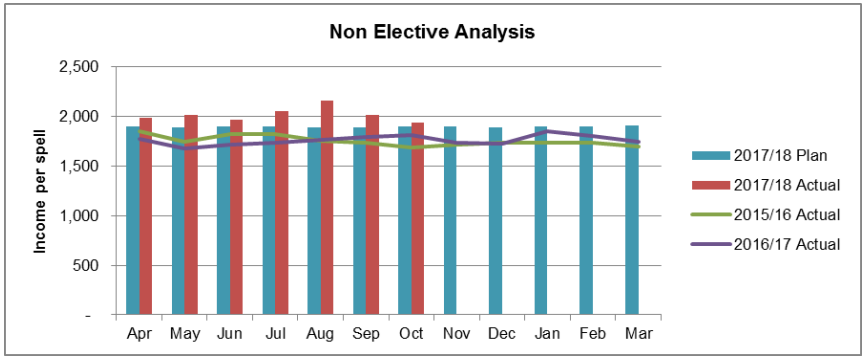
FINANCE AND WORKFORCE REPORT – October 2017

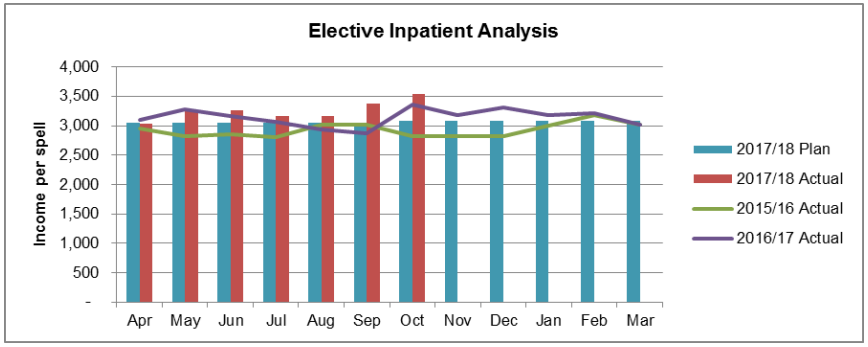
Trends and Analysis

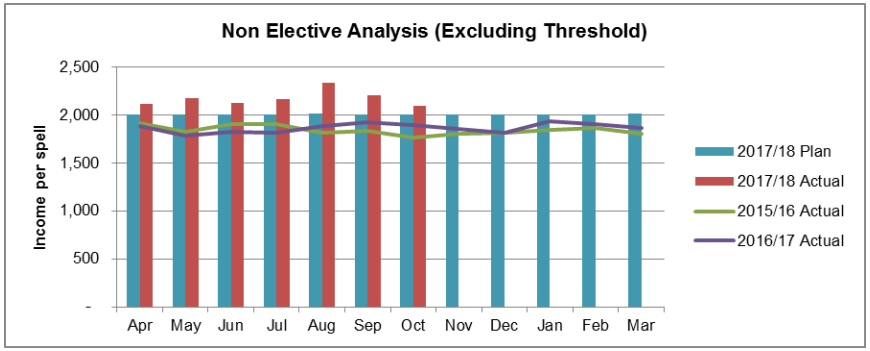












FINANCE AND WORKFORCE REPORT – October 2017

Workforce

Monthly Expenditure Acute services only				
As at October 2017	Oct-17	Sep-17	Oct-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,810**	**10,906**	**10,807**	**76,551**
Substantive Staff	9,711	9,706	9,616	67,901
Medical Agency Staff (includes 'contracted in' staff)	41	100	289	797
Medical Locum Staff	306	169	137	1,585
Additional Medical sessions	238	233	171	1,857
Nursing Agency Staff	45	39	182	374
Nursing Bank Staff	182	247	227	1,358
Other Agency Staff	87	47	50	481
Other Bank Staff	121	175	174	1,005
Overtime	126	95	50	670
On Call	56	50	44	367
Total temporary expenditure	1,202	1,157	1,324	8,493
Total expenditure on pay	**10,913**	**10,862**	**10,940**	**76,393**
Variance (F/(A))	(103)	44	(133)	157
Temp Staff costs % of Total Pay	11.0%	10.6%	12.1%	11.1%
Memo : Total agency spend in month	173	187	521	1,652

Monthly whole time equivalents (WTE) Acute Services only			
As at October 2017	Oct-17	Sep-17	Oct-16
	WTE	WTE	WTE
Budgeted WTE in month	**3,017.8**	**3,021.0**	**3,040.6**
Employed substantive WTE in month	**2747.72**	**2748.12**	**2,738.3**
Medical Agency Staff (includes 'contracted in' staff)	7.28	8.26	20.1
Medical Locum	16.96	14.26	11.7
Additional Sessions	19.06	20.36	15.7
Nursing Agency	9.15	7.94	29.1
Nursing Bank	60.5	78.14	77.2
Other Agency	18.39	16.2	22.3
Other Bank	59.27	87.8	82.3
Overtime	35.16	29.61	32.7
On call Worked	8.01	7.02	7.7
Total equivalent temporary WTE	**233.8**	**269.6**	**298.7**
Total equivalent employed WTE	**2,981.5**	**3,017.7**	**3,037.0**
Variance (F/(A))	36.3	3.3	3.6
Temp Staff WTE % of Total Pay	7.8%	8.9%	9.8%
Memo : Total agency WTE in month	34.8	32.4	71.5
Sickness Rates (Oct/Sep)	3.56%	2.68%	3.87%
Mat Leave	2.4%	2.3%	2.2%

Monthly Expenditure Community Service				
As at October 2017	Oct-17	Sep-17	Oct-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,539**	**1,125**	**1,015**	**8,276**
Substantive Staff	1,384	1,035	957	7,662
Medical Agency Staff (includes 'contracted in' staff)	7	11	0	84
Medical Locum Staff	3	3	3	23
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	(10)	0	2	(7)
Nursing Bank Staff	17	15	4	99
Other Agency Staff	17	22	41	170
Other Bank Staff	7	12	17	70
Overtime	6	5	4	34
On Call	1	1	1	9
Total temporary expenditure	48	69	73	482
Total expenditure on pay	**1,432**	**1,104**	**1,030**	**8,144**
Variance (F/(A))	107	21	(6)	133
Temp Staff costs % of Total Pay	3.4%	6.3%	7.1%	5.9%
Memo : Total agency spend in month	14	33	44	247

Monthly whole time equivalents (WTE) Community Services			
As at October 2017	Oct-17	Sep-17	Oct-16
	WTE	WTE	WTE
Budgeted WTE in month	**501.92**	**377.25**	**334.3**
Employed substantive WTE in month	**453.5**	**345.6**	**316.9**
Medical Agency Staff (includes 'contracted in' staff)	0.5	0.7	0.0
Medical Locum	0.4	0.4	0.4
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.1	0.1	0.4
Nursing Bank	5.4	4.8	1.2
Other Agency	5.6	5.6	8.0
Other Bank	2.1	3.5	4.6
Overtime	2.2	1.9	2.3
On call Worked	0.0	0.0	(0.0)
Total equivalent temporary WTE	**16.1**	**16.9**	**16.9**
Total equivalent employed WTE	**469.6**	**362.6**	**333.8**
Variance (F/(A))	32.4	14.7	0.4
Temp Staff WTE % of Total Pay	3.4%	4.7%	3.96%
Memo : Total agency WTE in month	6.1	6.3	1.3%
Sickness Rates (Oct /Sept)	3.51%	4.32%	3.96%
Mat Leave	1.4%	1.3%	1.3%

* Note the Acute tables includes Collaborative Procurement Hub staff on WSH Contracts
* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

FINANCE AND WORKFORCE REPORT – October 2017

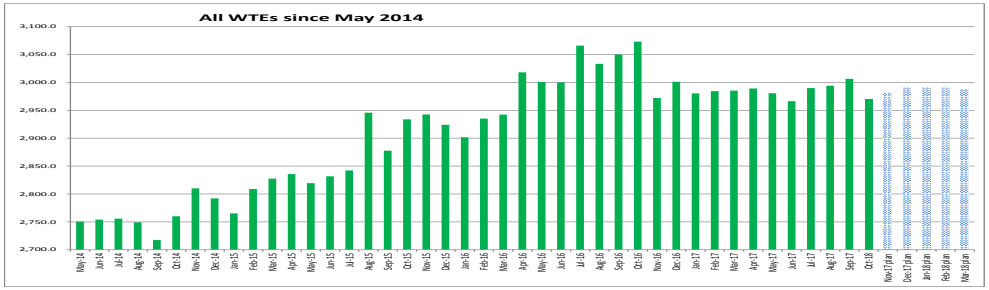
Staffing levels

The community staffing tables above include increases in community staffing from October 2017 in line with the new community contract.

However, the following graphs exclude Community staff and Glastonbury Court but include Capitalised staff. The impact of opening Glastonbury Court in November 2016 can be seen but if this were included around 28 WTE would be added to the actual WTEs.

They have been rebased to reflect hours worked by junior doctors before the new junior doctors contract was implemented.

The planned establishment from November onwards is the level of staffing required to achieve the original CIP, although this needs to be updated to reflect the proposals in FIP. As at October 2017 we employed 36.3 WTE less than planned and 55.5 WTE less than in October 2016.

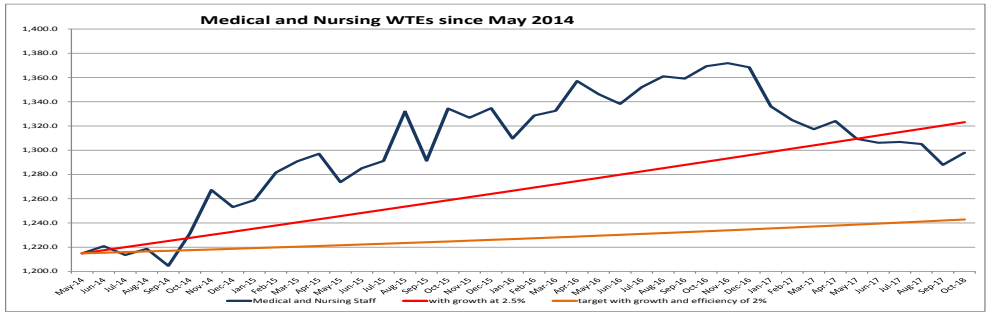


Since May 2014, (excluding Community staff) the Trust has employed 218 more WTEs, an increase of 7.9%. During this period activity has grown by around 8.5%

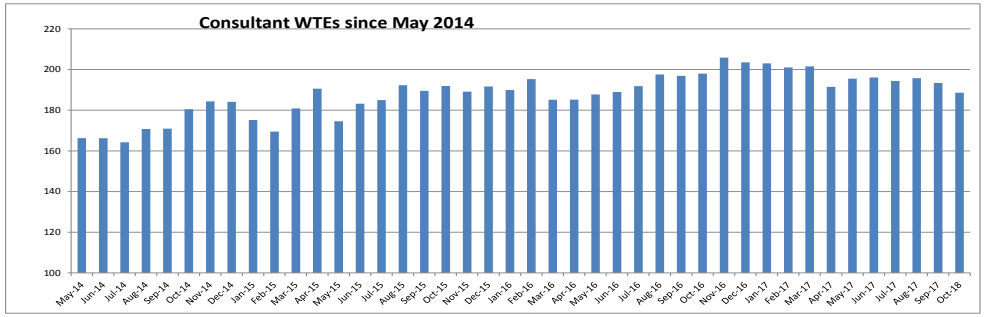
The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 83 WTEs (blue line). This includes around 22 WTE Consultants which are analysed further below.

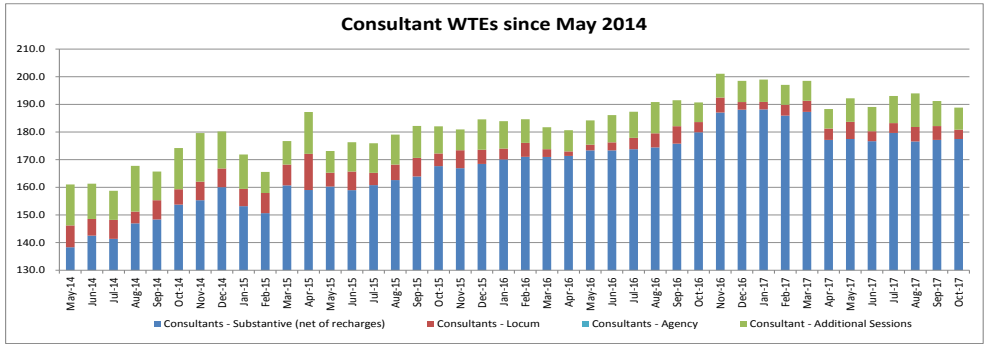
There has been a decrease of 17.2 WTE during October, most significantly in Bank Band 2 Nursing Assistants. Medical staff have increased by 19.5 WTE since April 2017, due to increases in junior doctors.

If medical and nursing staffing levels had increased in line with our growth in activity of broadly 2.5% we would currently be employing 108 more WTEs (red line). In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 28 WTE fewer than at October 2017

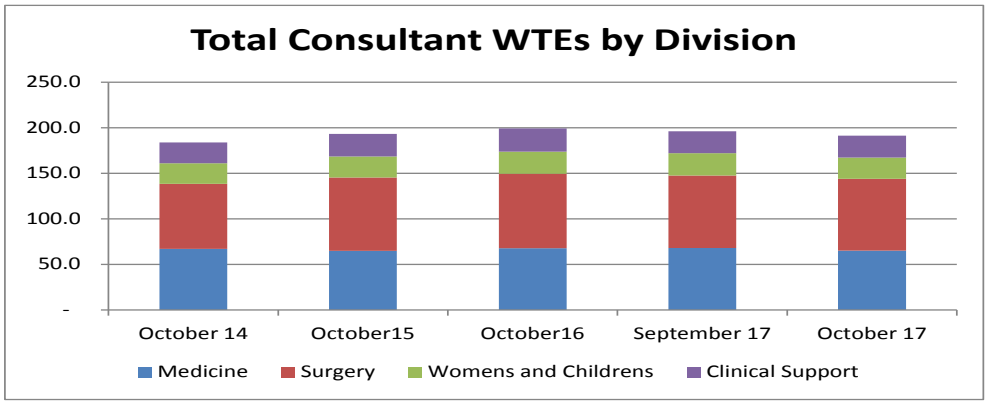


The graphs below highlight the increase in Consultant WTEs of 13.4% since April 2014. Substantive staff has increased by 40 WTEs whilst temporary staff have decreased by 5 WTEs.





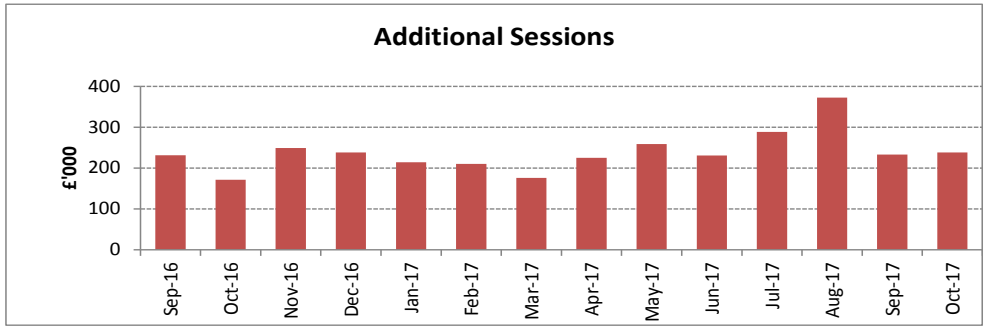
FINANCE AND WORKFORCE REPORT – October 2017

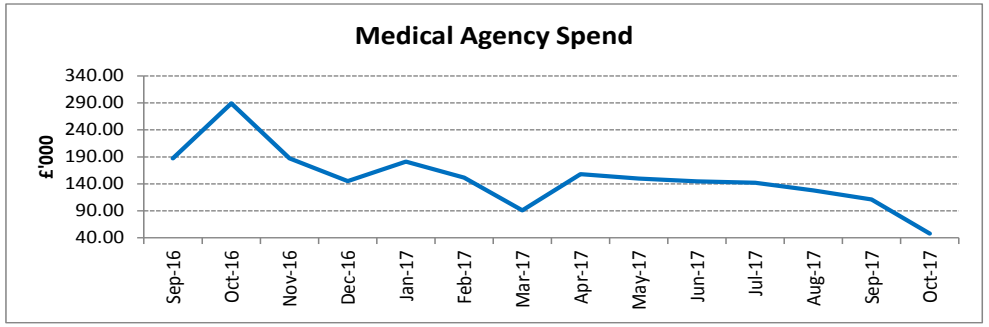


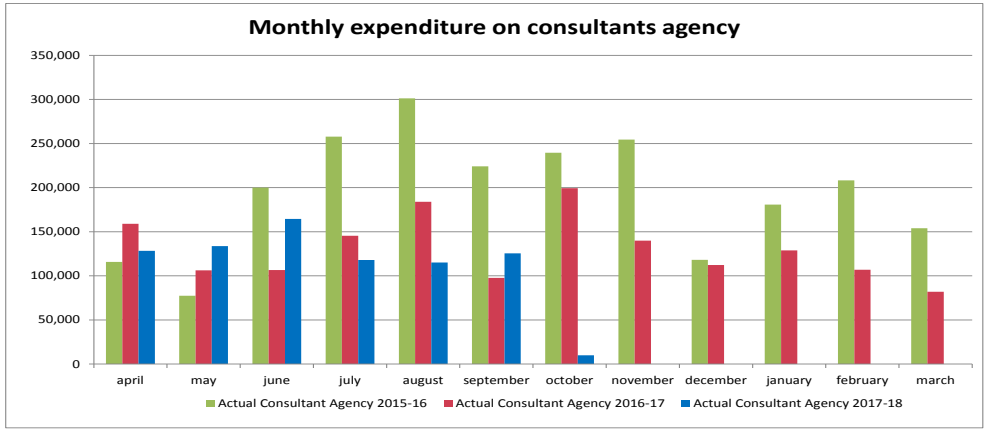
Division	Specialty	Sum of Sep-15	Sum of Sep-16	Sum of Jul-17	Sum of Aug-17	Sum of Sep-17	Sum of Oct-17
Medicine	A&E Medical Staff	5.8	8.5	8.1	8.2	8.2	7.5
	Cardiology	4.3	5.2	5.9	6.0	6.2	4.8
	Chest Medicine	4.1	4.1	4.0	4.0	4.2	3.8
	Chronic Pain Service	0.8	0.9	0.7	0.7	0.7	0.8
	Clinical Haematology	3.8	4.4	4.4	4.4	4.4	4.4
	Dermatology	5.2	4.5	5.0	3.5	4.3	3.5
	Diabetes	3.9	3.6	4.4	4.3	4.3	4.3
	Eau Medical Staff	9.6	7.5	7.2	9.6	7.2	7.6
	Gastroenterology	5.9	7.0	7.5	7.2	7.5	7.1
	General Medicine	7.7	7.3	5.8	4.6	5.3	5.4
	Nephrology	0.5	0.1	1.5	1.6	1.6	1.5
	Neurology	2.5	2.5	2.6	2.7	2.7	2.7
	Oncology	3.1	3.2	3.4	3.4	3.4	3.4
	Palliative Care	0.1	0.3	0.3	0.3	0.3	0.3
	Rheumatology	3.3	4.0	4.0	3.9	3.9	4.0
	Stroke	4.7	3.3	3.5	4.0	3.7	4.1
Medicine Total		**61.3**	**62.2**	**66.5**	**68.4**	**67.9**	**65.1**
Surgery	Anaesthetics	31.6	35.6	33.6	34.4	33.5	33.6
	E.N.T.	3.2	3.3	3.3	3.3	3.3	3.3
	General Surgery	13.1	10.3	9.8	9.8	9.8	9.8
	Ophthalmology	7.4	8.7	8.3	7.9	7.8	7.7
	Oral & Maxofacial Surg	1.6	1.0	0.0	0.0	0.1	-
	Plastic Surgery	3.1	2.4	3.0	2.3	2.4	3.4
	Trauma & Orthopaedic	13.2	13.9	14.2	14.7	14.0	14.5
	Urology	6.7	6.1	6.2	6.5	7.5	5.0
	Vascular Surgery	-	1.1	1.1	1.1	1.1	1.3
Surgery Total		**79.8**	**82.3**	**79.5**	**80.1**	**79.7**	**78.7**
Women and Childrens	Obstetrics	11.0	12.6	13.3	13.4	13.2	13.0
	Paediatrics	11.5	12.1	11.3	11.3	11.3	10.4
Women and Childrens Total		**22.5**	**24.6**	**24.6**	**24.7**	**24.4**	**23.4**
Clinical Support	Chemistry	0.6	0.8	-	0.6	0.3	-
	Histopathology	7.6	7.7	8.5	9.3	8.3	9.0
	Microbiology	3.3	3.3	3.2	3.2	3.2	3.5
	MRI	0.9	0.9	0.9	0.9	0.9	0.9
	Xray - Wsh	12.0	13.3	12.1	12.3	12.4	12.5
Clinical Support Total		**24.3**	**26.0**	**24.6**	**26.2**	**25.0**	**25.9**
Grand Total		**188.0**	**195.2**	**195.2**	**199.4**	**197.0**	**193.2**

Pay Trends and Analysis

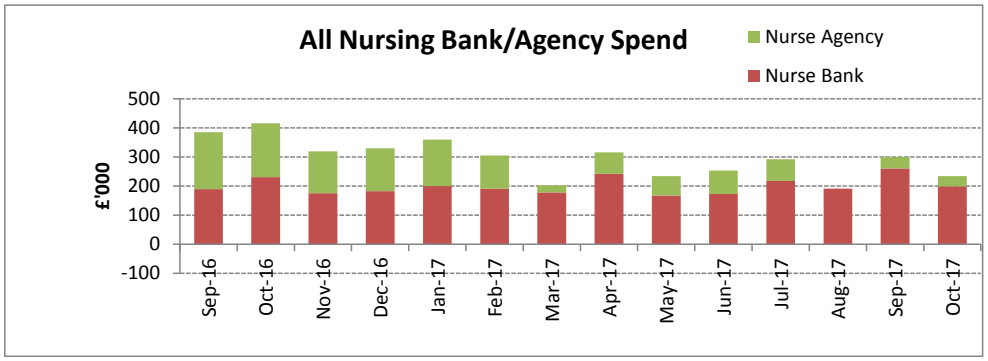
The Trust underspent pay budgets by £4k in October (£290k YTD).

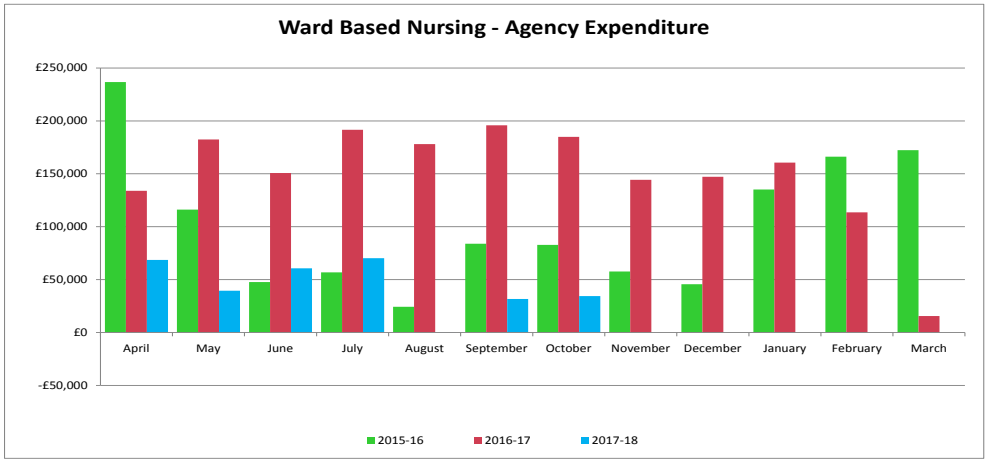


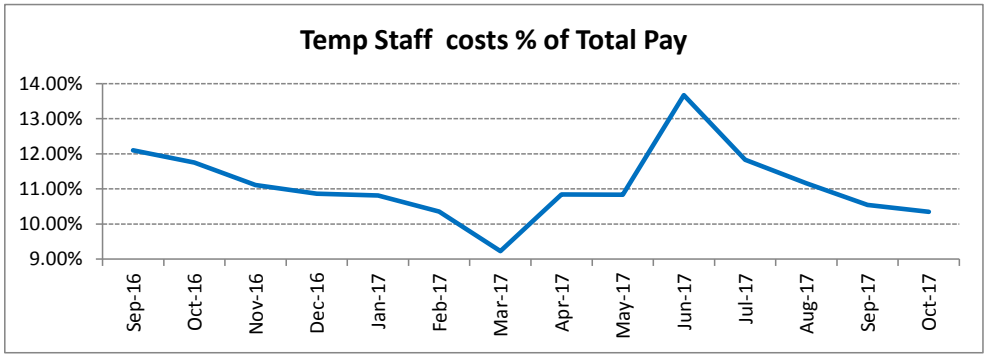




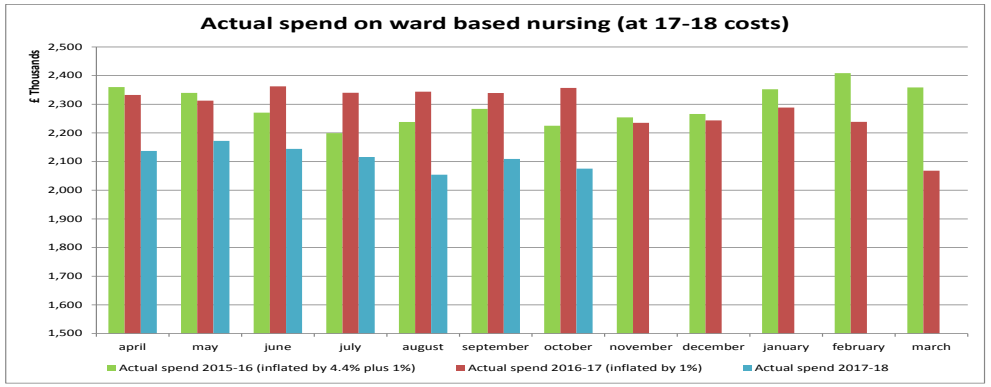
FINANCE AND WORKFORCE REPORT – October 2017

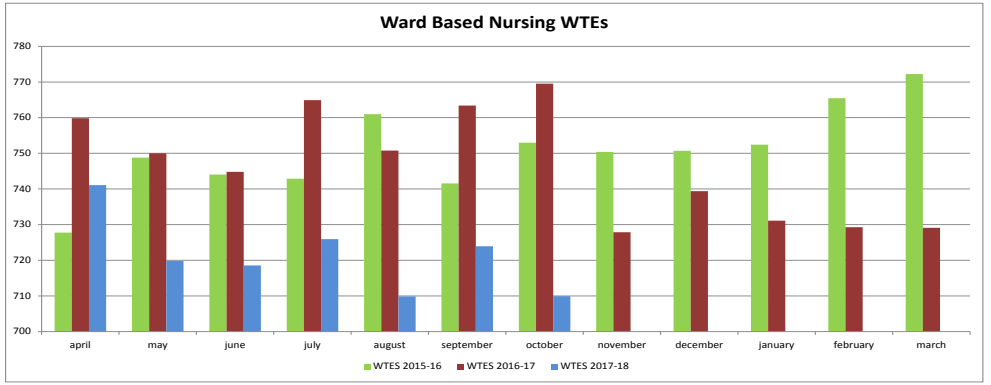


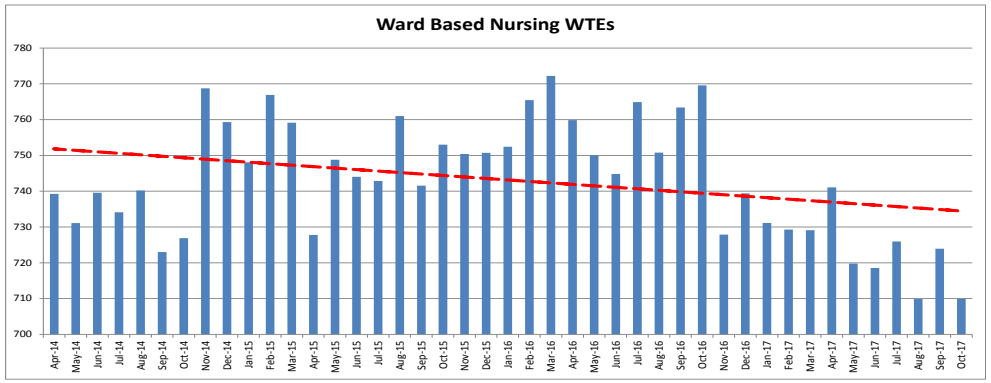




Ward Based Nursing







FINANCE AND WORKFORCE REPORT – October 2017

Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Oct-17 Budget £k	Oct-17 Actual £k	Oct-17 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(5,652)	(5,756)	104	(38,327)	(38,775)	447
Pay Costs	3,279	3,290	(11)	23,578	23,514	63
Non-pay Costs	1,434	1,397	37	9,129	9,245	(116)
Operating Expenditure	**4,713**	**4,687**	**26**	**32,706**	**32,759**	**(53)**
SURPLUS / (DEFICIT)	**939**	**1,069**	**130**	**5,621**	**6,015**	**394**
SURGERY						
Total Income	(4,901)	(5,016)	115	(33,377)	(34,077)	700
Pay Costs	2,935	2,972	(36)	20,825	21,052	(227)
Non-pay Costs	1,048	1,140	(92)	7,310	7,758	(448)
Operating Expenditure	**3,983**	**4,111**	**(128)**	**28,135**	**28,810**	**(675)**
SURPLUS / (DEFICIT)	**918**	**904**	**(13)**	**5,242**	**5,267**	**26**
WOMENS and CHILDRENS						
Total Income	(2,198)	(2,250)	51	(14,355)	(14,165)	(189)
Pay Costs	1,105	1,137	(32)	7,732	7,828	(96)
Non-pay Costs	142	261	(119)	965	1,061	(95)
Operating Expenditure	**1,247**	**1,398**	**(151)**	**8,698**	**8,889**	**(191)**
SURPLUS / (DEFICIT)	**952**	**852**	**(99)**	**5,657**	**5,276**	**(380)**
CLINICAL SUPPORT						
Total Income	(1,001)	(970)	(31)	(6,796)	(6,518)	(279)
Pay Costs	1,674	1,738	(64)	11,800	11,780	20
Non-pay Costs	1,258	1,107	152	7,519	7,735	(216)
Operating Expenditure	**2,932**	**2,844**	**88**	**19,319**	**19,515**	**(195)**
SURPLUS / (DEFICIT)	**(1,931)**	**(1,875)**	**57**	**(12,523)**	**(12,997)**	**(474)**
COMMUNITY SERVICES						
Total Income	(8,334)	(8,406)	72	(73,760)	(75,595)	1,834
Pay Costs	1,539	1,432	107	8,276	8,144	133
Non-pay Costs	1,394	1,548	(154)	26,504	28,408	(1,904)
Operating Expenditure	**2,933**	**2,980**	**(47)**	**34,780**	**36,552**	**(1,772)**
SURPLUS / (DEFICIT)	**5,401**	**5,426**	**25**	**38,981**	**39,043**	**62**
ESTATES and FACILITIES						
Total Income	(371)	(350)	(21)	(2,634)	(2,394)	(240)
Pay Costs	747	722	26	5,234	5,127	107
Non-pay Costs	614	599	15	4,138	4,217	(79)
Operating Expenditure	**1,361**	**1,321**	**41**	**9,372**	**9,344**	**28**
SURPLUS / (DEFICIT)	**(990)**	**(970)**	**20**	**(6,738)**	**(6,950)**	**(211)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	1,414	1,854	(440)	18,948	20,070	(1,121)
Pay Costs	1,070	1,055	15	7,381	7,092	288
Non-pay Costs (net of contingency and reserves)	2,128	1,859	269	10,355	8,803	1,551
Finance & Capital	525	524	1	3,281	3,529	(248)
Operating Expenditure	**3,723**	**3,438**	**285**	**21,016**	**19,424**	**1,592**
SURPLUS / (DEFICIT)	**(5,137)**	**(5,292)**	**(155)**	**(39,964)**	**(39,495)**	**469**
TOTAL (including penalties, contingency and reserves)						
Total Income	(21,043)	(20,894)	(149)	(150,302)	(151,453)	1,153
Contract Penalties	0	0	0	0	0	0
Pay Costs	12,349	12,345	4	84,827	84,537	290
Non-pay Costs	8,019	7,911	108	65,919	67,227	(1,308)
Finance & Capital	525	524	1	3,281	3,529	(248)
Operating Expenditure (incl penalties)	**20,893**	**20,780**	**113**	**154,026**	**155,292**	**(1,266)**
SURPLUS / (DEFICIT)	**150**	**114**	**(36)**	**(3,725)**	**(3,839)**	**(114)**

Medicine (Annie Campbell)

The Division over performed by £130k in October (£394k YTD)

The Division over-performed on clinical income by £105k in the month, primarily led by strong performance on ED attendances in terms of numbers and acuity (£72k), and the resulting non-elective inpatient work (£53k). The latter would have been significantly better but for the allocation of the emergency threshold.

Elective inpatients were also above plan with the main contributors being Pain denervations and Nephrology, the latter supported by the new Nephrologist post.

Outpatients were the only issue for the division. Dermatology was behind plan as a result of vacancies and lack of agency cover, and Nephrology due to a delay in the activity due to be repatriated from Addenbrookes.

The Division was underspent by £25k in the month. Agency costs continue to be contained, and in some areas (notably Cardiology and Respiratory Medicine) this should improve as vacancies are filled. However, there is a concern with nursing costs in order to meet the challenge of winter pressures which may be at a substantial, unbudgeted, premium.

Non-pay costs were underspent by £37k in the month. However, transport and security remain issues.

The Divisional CIP performance is forecast to achieve its target thanks to continued reduced agency spend. However, the major contributor is the resolution of the Community Diabetes Funding. The other major element (growth) has been achieved due to the Division over-performing on contract income year to date (£250k), whilst being underspent on its expenditure budget (£154k).

Surgery (Simon Taylor)

The Division has under performed by £13k in September (over performed by £26k YTD)

Income over achieved against plan by £115k with the main overachievement being in emergency long stay. Elective care achieved plan with General Surgery and Ophthalmology both significantly over achieving, however Orthopaedics were significantly below plan.

Pay was over spent by £36k. The main cost pressure has been temporary spend due to vacancies and additional sessions to support RTT recovery.

Non-pay was overspent by £92k. The majority of the overspend is in theatres. This has been mostly due to increased activity to support the RTT position. There has been a further pressure on the wards due to difficulties in getting some antibiotics.

Surgery CIP's have over achieved by £59k YTD. This is due to favourable variances on several CIP's due to some delivery of CIP's earlier than planned and also surgery achieved a higher vacancy management than plan. Surgery is actively working to create a comprehensive CIP plan for 2018-19. This is being done through collaboration with clinical leads in CIP workshops.

Women and Children's (Rose Smith)

Women and Children's reported an under performance of £99k in-month (£380k YTD).

Clinical income reported £51k ahead of plan in-month and is £189k behind plan YTD. The maternity pathway income from surrounding Trusts helped to lift the in-month income variance above plan for the month.

Pay reports a £32k overspend in-month and £96k overspend YTD. There have been in-month overspends on registrar posts in Obstetrics & Gynaecology which continue to put pressure on the service. A business case for a hybrid consultant is being worked on to provide a long term solution to a staffing issue that is becoming a persistent problem.

Non pay reports a £119k overspend in-month and a £95k overspend YTD. The in-month overspend was primarily driven by maternity pathway charges anticipated from surrounding Trusts.

Clinical Support (Rose Smith)

Clinical Support reported an over performance of £57k in-month (under performance of £474k YTD).

Clinical income for Clinical Support reported a £31k under performance in-month and is £279k behind plan YTD. This can be attributed to lower than planned activity for radiology direct access and breast screening.

Pay is £64k overspent in-month and is £20k underspent YTD. The pathology service has had difficulty in filling the gaps in the senior medical rotas and is currently employing locums in Microbiology and Histopathology. An advert has been released on NHS jobs for a NHS locum microbiologist in an attempt to reduce this spend whilst a longer term solution is sought. Radiology continues to use consultant grade additional sessions which has added a further £12k in-month cost pressure.

Non pay reported a £152k under spend in-month and £216k overspend YTD due to a backdated claim for reserve funding relating to pathology services.

Community Services (Dawn Godbold)

Community Services reported a £25k over performance in-month (£62k YTD).

Contract Income reported a £72k over recovery in-month, mainly due to better than expected non contracted income. This was partially offset against a settlement with Cambridgeshire and Peterborough CCG of £34k

Pay reported £107k underspend in-month and £133k underspend YTD, mainly due to underspends within Paediatric Services, £50k, Local Area Teams, £50k, and Specialist Services, £34k. These underspends, have been offset by a £24k overspend within Estates, mainly due to additional and bank hours worked the previous month. This overspend is expected to decrease next month with a number of sites having now transferred to Ipswich Hospital.

Non pay reported £154k over spend in-month and £1,904k overspend YTD. The settlement of the NHS Property Services dispute has resulted in a non-recurring cost which has been partially offset by a benefit relating to Community Dental Services invoicing.

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.

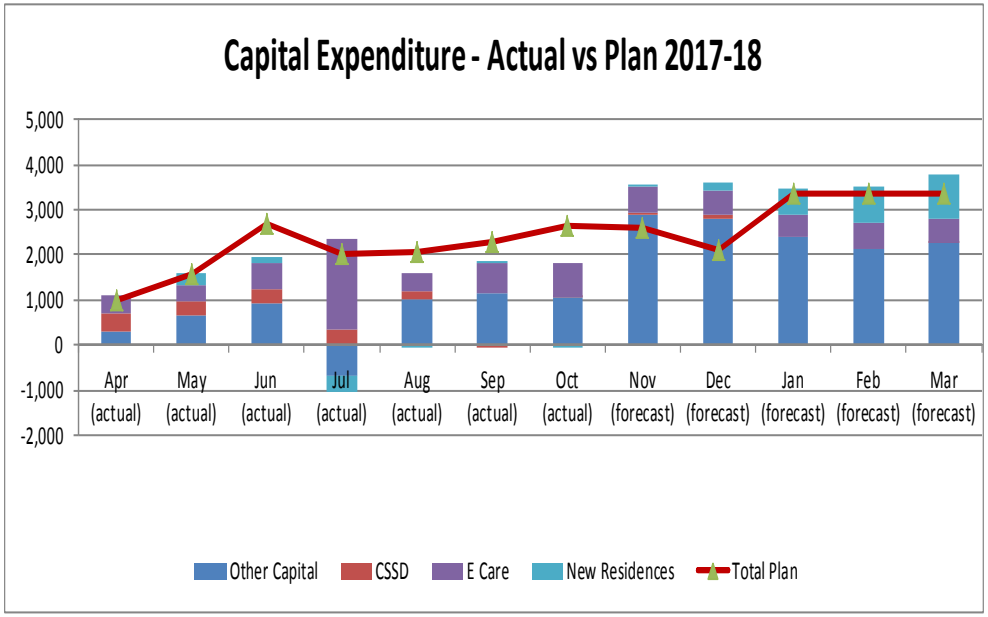
Metric	Value	Score
Capital Service Capacity rating	-0.324	4
Liquidity rating	-15.138	4
I&E Margin rating	-2.55%	4
I&E Margin Variance rating	0.03%	1
Agency	-45.73%	1
Use of Resources Rating after Overrides		**3**

The Trust is scoring an overall UoR of 3 again this month but liquidity has decreased from a 3 to a 4 due to a reduction in our working capital balance.

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.

FINANCE AND WORKFORCE REPORT – October 2017

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2017-18 £'000
E Care	415	382	567	1,990	369	654	769	580	548	499	548	499	7,821
CSSD	384	283	319	352	197	-10	8	42	75	0	0	25	1,675
New Residences	0	284	140	-373	-33	68	-9	57	176	566	800	1,008	2,684
Other Schemes	296	665	922	-684	1,009	1,150	1,054	2,895	2,809	2,397	2,149	2,255	16,915
Total forecast / Forecast	1,095	1,613	1,947	1,285	1,542	1,862	1,822	3,574	3,608	3,462	3,497	3,787	29,095
Total Plan	1,012	1,568	2,673	2,034	2,058	2,283	2,643	2,612	2,103	3,365	3,365	3,363	29,082

The capital programme for the year is shown in the graph above.

The capital budget for the year was approved by the Trust Board in March 2017 at £28,082k. Following the bid for ED Primary Care Streaming this has been increased by £1m (the value of the bid). The balance of this scheme is being funded from the capital contingency fund. The £1m PDC funding for the ED Primary Care was received during July.

The CSSD build is nearing completion and the build expenditure forecast is in line with its budget of £1.6m for the year. The delay in the implementation has meant that the value of interest capitalised has increased. Once the CSSD is in operation this will revert to a revenue cost. The final expenditure for this project (except for retentions) will be paid in December with retentions paid at a later date..

Expenditure on e-Care for the year to date is £5,146k and is in line with the revised E-Care budget. The E-Care programme budget reflects the increased scope associated with the Global Digital Excellence (GDE) funding. The first tranche of this funding £3.3m was received in July. Current indications are that the second tranche of funding will be received in January 2018, however past history would indicate that this timing is not guaranteed.

The forecasts for all projects have been reviewed by the relevant project managers. The expenditure profiles of these schemes have been rephased. There are no significant financial risks to the budgets reported. Year to date the overall expenditure of £11,167k is below the plan of £14,272k. Following a review of all the major estates capital schemes there is likely to be slippage on a number of key projects but this is still being quantified. However all the managed service agreements are currently being reviewed to ensure the correct accounting treatment is being applied to any embedded leases. Any finance leases identified would not have an impact on cash but would increase our borrowing and capital expenditure, offsetting some of the slippage.

FINANCE AND WORKFORCE REPORT – October 2017

Statement of Financial Position at 31st October 2017

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2017 £000	Plan 31 March 2018 £000	Plan YTD 31 Oct 2017 £000	As at 31 Oct 2017 £000	Variance YTD 31 Oct 2017 £000
Intangible assets	15,611	19,711	18,435	18,820	385
Property, plant and equipment	74,053	94,189	82,993	79,436	(3,557)
Trade and other receivables	0	0	0	0	0
Other financial assets	0	0	0	0	0
Total non-current assets	**89,664**	**113,900**	**101,428**	**98,257**	**(3,171)**
Inventories	2,693	2,600	2,700	2,924	224
Trade and other receivables	18,345	11,700	14,921	18,203	3,282
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	5,000	2,653	(2,347)
Total current assets	**22,390**	**15,300**	**22,621**	**23,780**	**1,159**
Trade and other payables	(23,434)	(28,195)	(25,908)	(23,093)	2,815
Borrowing repayable within 1 year	(534)	(1,796)	(2,048)	(2,302)	(254)
Current ProvisionsProvisions	(61)	(61)	(84)	(89)	(5)
Other liabilities	(1,325)	(295)	(3,500)	(6,112)	(2,612)
Total current liabilities	**(25,354)**	**(30,347)**	**(31,540)**	**(31,596)**	**(56)**
Total assets less current liabilities	**86,700**	**98,853**	**92,509**	**90,441**	**(2,068)**
Borrowings	(44,375)	(55,951)	(49,094)	(47,618)	1,476
Provisions	(181)	(158)	(163)	(185)	(22)
Total non-current liabilities	**(44,556)**	**(56,109)**	**(49,257)**	**(47,803)**	**1,454**
Total assets employed	**42,144**	**42,744**	**43,252**	**42,638**	**(614)**
Financed by					
Public dividend capital	59,232	65,732	63,565	63,565	(0)
Revaluation reserve	3,621	3,621	3,621	3,621	(0)
Income and expenditure reserve	(20,709)	(26,609)	(23,934)	(24,548)	(614)
Total taxpayers' and others' equity	**42,144**	**42,744**	**43,252**	**42,638**	**(614)**

Property Plant and Equipment (PPE)

The slippage on Property, Plant and Equipment (PPE) is mainly on Residences. Other slippage includes the Roof Replacement Programme, the Labour Suite, Fire Compartmentation and the Catheterisation Laboratory.

As already outlined the slippage on the capital programme is currently being quantified which would be offset by any embedded finance leases identified within our managed service contracts.

Trade and Other Receivables

These have reduced by £1.7m in October. This is mainly due to receipts from NHS England relating to the 2016/17 contract settlement and West Suffolk CCG relating to their contribution towards the settlement with NHS Property Services. Receivables are still above plan. A significant receivable at the end of October was STF income owed from DH, which we have drawn down as a loan in November in lieu of payment being received.

Cash

The cash balance has decreased to £2.7m at the end of October. Although this is less than the plan No additional borrowing was drawn down in October.

Trade and Other Payables

The balance on trade and other payables has increased since September by £1.7m but is below plan by £2.8m. The Trust continues to manage its relationship with suppliers carefully and does not deliberately delay invoice payments for cash flow reasons.

Other liabilities

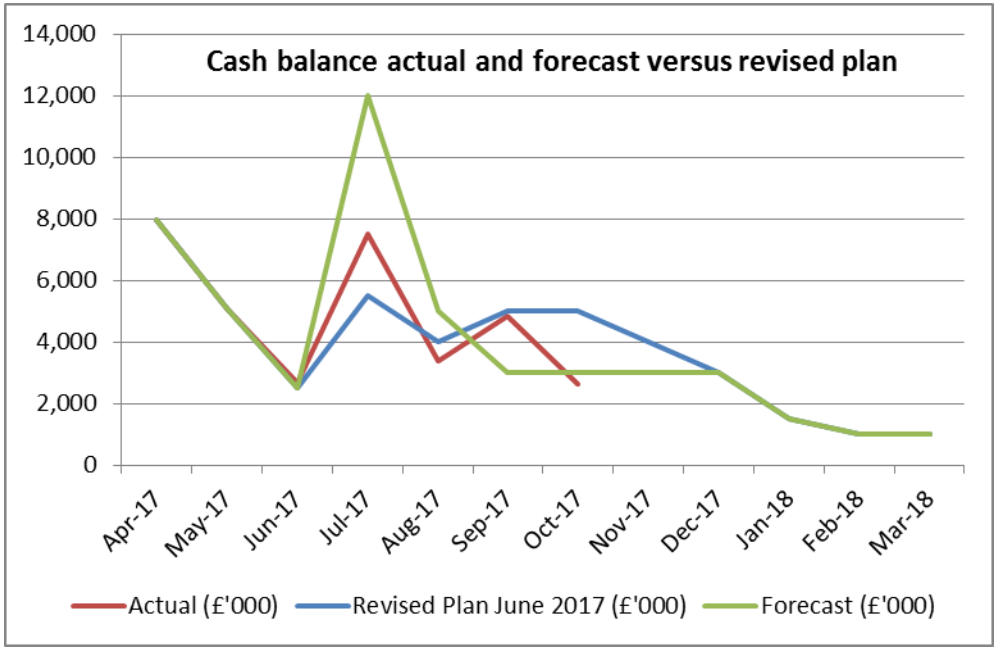
This balance will continue to reduce between now and the end of the financial year. The payments for the block contract are weighted towards the earlier months in the financial year for cash purposes but the income cannot be recognised until it has been earned in terms of patient care being delivered. The block contract cash payments reduced from September and will reduce further in March 2018.

Borrowing

Our borrowing was less than planned at the end of October because we delay borrowing whenever possible to minimise interest charges. Our cash balance was sufficient to do this in October.

FINANCE AND WORKFORCE REPORT – October 2017

Cash Balance Forecast for the year



The graph illustrates the cash trajectory year to date, plan and revised forecast.

The Trust is required to keep a minimum balance of £1 million which will be a significant challenge as the year progresses. It will require improvements to our receivable balances and also a tangible reduction in cash outflow from the implementation of CIP schemes.

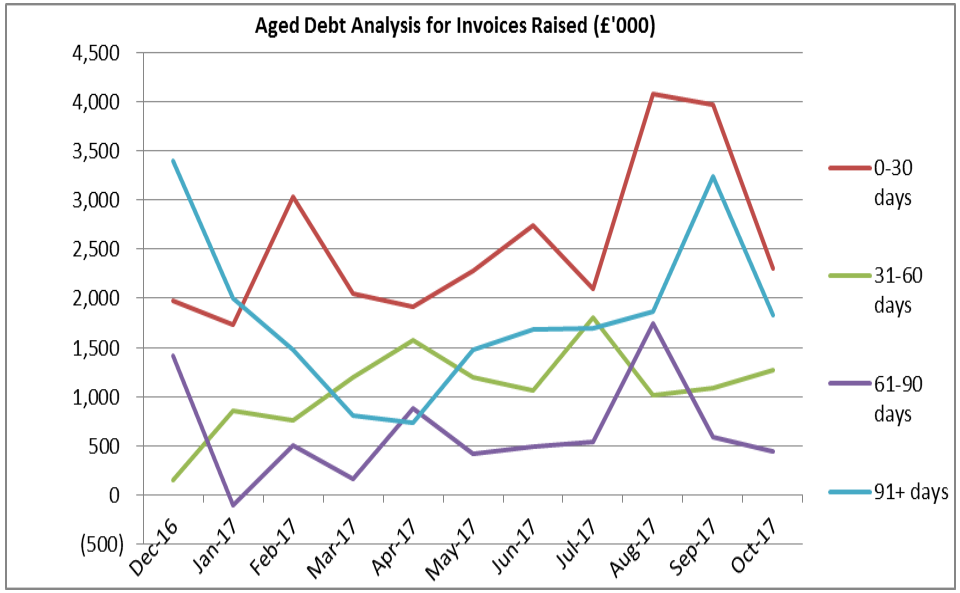
Longer Term Cash Forecast

The Trust has requested an additional £19 million revenue support in 2018/19 in order to maintain the planned capital programme but this is not yet agreed. It is expected that a revised plan for 2018/19 will be requested shortly.

Debt Management

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



The overall level of invoices raised but overdue has reduced by £3.0 million in October. The main reason for the reduction was receipts from NHS England relating to the 2016/17 contract settlement and West Suffolk CCG relating to their contribution towards the settlement with NHS Property Services.

Approximately half of the debt outstanding for over 90 days relates to charges to other NHS organisations, £300k of this debt was paid at the beginning of November. Other significant amounts outstanding in this category relate to the closedown of the old tPP pathology service and Insurance Companies for private healthcare treatment.

Trust Board – 1st December 2017

Agenda item:	10			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sinead Collins, Clinical Business Manager			
Date prepared:	22nd November 2017			
Subject:	Quality and Workforce Dashboard – Nursing			
Purpose:	X	For information		For approval

Executive summary:
The aim of the Quality and Workforce Dashboard is to enhance the understanding ward and theatre staff have of the service they deliver, identify variation in practice, investigate and correct unwarranted variation and lead change to demonstrate value. This dashboard has been created to give the Trust Board a quick overview staff levels and quality indicators of areas within the trust. It also complies with national expectation to show staffing levels within Open Trust Board Papers

For in depth review of areas, please inquire for the Matrons' governance reports that are completed monthly for their divisions. Included are any updates in regards to the nursing review

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:	*Senior Nursing team*
Risk and assurance:	*Daily mitigation discussions and staffing review*
Legislation, regulatory, equality, diversity and dignity implications	*Safer staffing guidelines*

Recommendation:
Observations in October's and progress of nurse staffing review made below.

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	-	High agency use. High NA vacancy. High sickness
F7	-	High bank and agency use. High RN vacancy. High sickness
F8	-	High bank use. High RN vacancy. High sickness
CCS	-	High RN vacancy
Theatres	-	High RN vacancy. High sickness
DSU	-	High sickness and bank use
G1	4 medication errors	High sickness
G3	-	High bank use. High NA vacancy.
G4	7 medication errors	High bank use & sickness
G5	3 pressure ulcers and 5 falls (with harm)	High bank use & sickness
G8	4 medication errors and 3 falls (with harm)	High bank use & sickness
F1	4 medication errors	High bank use
F3	6 medication errors and 4 falls (with harm)	High agency use.
F4	-	High bank use.
F6	-	High agency use. High sickness
F9	-	High bank use & vacancy in RNs. High sickness
F10	5 pressure ulcers	-
Maternity	-	High bank use & sickness
F12	-	High bank use
Kings Suite	-	High bank use
Rosemary Ward	3 falls (with harm)	High bank use

Vacancies – There has been a significant vacancies in registered staff. This has been highlighted operationally leading into the winter period and HR are aware. A discharge ward has been opening, with 15 patients on average using it per day.

Roster effectiveness – Out of 26 areas, 14 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is 8 areas lower than September and is a great improvement – has been put down to less annual leave been taken

Sickness – Out of 27 areas, 19 are over the Trust Standard of 3.5% (one less than last month) (Day surgery unit & ward are counted as one area).

Update on progress of Nurse Staffing Review

Nurse Specialist review is currently with KPMG and Service Managers to action.

Due to different sizes of wards and external requirements, e.g. CCU has shared roles. KPMG, Service Managers and HR are in the process of agreeing the appropriate % of annual leave per ward and there will then be a performance process in place.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Oct-17			Establishment for the Financial Year 2017/18						Data for Oct 2017												
										Workforce											Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day (June 2017)	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night			Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	81.79	70.47%	29.53%	N/A	1 - 4	1 - 5	108.4%	94.8%	132.7%	106.7%	3.26%	6.50%	1.49	-5.40	6.30%	N/A	18.10%	N/A	3	1
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	76.4%	83.4%	98.6%	96.0%	14.46%	3.52%	-6.10	-0.15	8.90%	6.50	22.70%	2	3	0
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	59.2%	N/A	103.3%	N/A	9.47%	0.00%	-6.40	0.80	8.00%	N/A	27.70%	0	3	1
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	85.5%	82.8%	N/A	N/A	1.63%	0.00%	-6.13	0.00	4.30%	22.12	17.50%	0	5	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	103.8%	101.1%	N/A	N/A	2.11%	0.00%	-4.80	-2.70	11.60%	N/A	25.60%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	141.8%	78.6%	69.5%	N/A	1.49%	0.00%	-0.95	-0.10	2.30%	N/A	15.60%	0	2	N/A
WSFT	Day Surgery Unit	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	61.7%	N/A	67.8%	N/A	0.19%	0.00%	1.00	-0.46	10.40%	N/A	27.20%	0	1	0
	Day Surgery Wards													12.49%	0.00%	-0.60	0.10	16.40%		30.30%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	101.9%	97.0%	63.4%	N/A	2.70%	0.00%	0.40	-0.70	3.00%	11.22	22.20%	0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	96.5%	98.4%	70.4%	N/A	1.20%	0.30%	0.00	0.00	9.50%	7.84	22.60%	1	4	0
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	93.2%	87.1%	79.8%	103.7%	10.63%	0.00%	-1.10	-4.20	5.30%	I/D	18.10%	0	2	1
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	80.0%	68.2%	115.7%	119.2%	14.42%	0.00%	0.44	-2.00	11.50%	5.96	25.10%	2	7	2
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	73.3%	80.4%	105.7%	103.0%	7.62%	1.16%	1.36	-0.60	8.30%	4.58	21.60%	3	2	5
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	75.8%	78.7%	97.5%	103.2%	8.44%	0.58%	-1.94	-0.40	6.60%	6.03	24.50%	1	4	3
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	89.8%	132.6%	129.0%	N/A	7.14%	0.00%	-0.45	2.50	3.00%	N/A	14.60%	N/A	4	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	95.4%	95.7%	136.3%	100.9%	4.55%	4.02%	-2.20	-1.30	3.90%	5.18	18.70%	1	6	4
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	91.8%	91.4%	112.7%	232.2%	17.67%	1.92%	-3.84	-1.30	2.40%	6.99	13.40%	0	3	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	85.0%	92.5%	112.8%	122.7%	4.65%	0.00%	-1.44	1.54	4.65%	5.46	17.00%	1	1	1
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	86.5%	95.3%	93.0%	100.8%	3.47%	6.76%	-3.04	-1.10	10.30%	7.18	28.00%	1	3	0
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	76.8%	95.7%	89.2%	94.3%	10.23%	0.00%	-6.00	-1.70	6.00%	4.57	22.50%	0	1	0
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	108.2%	75.2%	95.2%	100.0%	1.67%	0.00%	-2.50	-0.10	3.50%	5.91	18.50%	5	3	1
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	121.2%	93.2%	83.1%	69.3%	11.87%	0.00%	0.33	2.16	7.10%	N/A	24.40%	0	1	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1												0	0	0
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre					1 - 2	1 - 2												0	1	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	92.2%	79.1%	29.4%	132.3%	16.19%	0.58%	-1.84	-0.60	4.10%	7.71	27.40%	0	0	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	100.1%	99.6%	N/A	N/A	0.00%	0.00%	-0.70	-0.40	0.00%	N/A	9.20%	0	2	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	9.00	80.00%	20.00%	N/A	5 - 8	N/A	95.4%	N/A	81.1%	N/A	0.00%	0.00%	-0.20	0.00	0.50%	N/A	12.60%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	103.4%	84.5%	22.6%	45.2%	0.90%	0.00%	1.00	-1.40	1.00%	14.09	19.00%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	98.4%	95.2%	89.7%	106.5%	10.15%	0.00%	0.00	-0.47	4.15%	6.40	N/A	1	0	3
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	100.0%	98.4%	90.8%	100.0%	9.59%	0.0%	0.10	-1.10	1.00%	4.80	19.10%	0	0	1
																-44.11	-19.08	Target - 3.5%		Trust standard is 20%			

Explanations

WSFT have some significant environmental layout challenges and additional activity that are not reflected in the SNCT(F14/G1/G8/F12/CCU/NCH)
Some units do not use electronic rostering therefore there is no data for those units
In vacancy column: - means vacancy and + means overestablished. This month refer to report however
Roster effectiveness is a sum of Sickness, Annual leave and Study Leave
DSU has been split into ward and unit only by HR, that is why only a section has been split in this dashboard

Key	
N/A	Not applicable
ETC	Eye Treatment Centre
I/D	Inappropriate data

NHS
West Suffolk
NHS Foundation Trust

Trust Board – 1st December 2017

Agenda item:	11			
Presented by:	Dr Nick Jenkins, Medical Director			
Prepared by:	Dr Helena Jopling, Public health registrar			
Date prepared:	15th November 2017			
Subject:	Learning from Deaths			
Purpose:	X	For information		For approval

Executive summary:

At the meeting on 26th May 2017, the Board received a report on the national Learning from Deaths guidance issued by the National Quality Board and the changes that WSFT needed to make to its mortality review process as a result.

The Board approved a programme of work which included:

- adoption of a trust policy on Learning from Deaths
- recruitment of medical reviewers to perform objective reviews of patient care using an evidence-based method
- measures to increase the involvement of relatives and carers in improvements resulting from learning from deaths
- alterations to the way in which information about problems in care associated with deaths in the trust is reported.

The milestones all trusts need to meet are:

- publication of a trust-wide policy by the end of September 2017
- publication of information, on a quarterly basis in a public board meeting, describing the number of deaths, the number which have been reviewed and the number in which a degree of preventability has been identified, by the end of December 2017
- publication of information about how the learning from reviews of deaths has had an impact on the quality of patient care in the 2017/18 annual report.

At its meeting on 29th September 2017, the Board approved the trust policy and received the first published information for quarter one 2017/18.

This report presents information for quarter two 2017/18.

Actions from 29th September Board meeting

Five actions were requested following the discussion on 29th September:

1. Consider how to show preventability over time

   Real-world implementation of mortality review (as opposed to in research settings) is increasing suggesting that in most months the number of cases with >50% likelihood of preventability will be zero:

   - of 7370 cases reviewed over 4 years in 4 acute hospitals in the north-east of England, 34 (0.5%) were found to have > 50% likelihood of having been preventable[1]
   - following the implementation of the Learning from Deaths programme in the West of England Academic Health Science Network area, between April and July 2017 only one case out of 1630 deaths reviewed (0.06%) was assessed as having > 50% likelihood of having been preventable[2].

   To reflect this emerging experience, and the use of >50% likelihood of preventability as the most meaningful indicator, the graph in the bottom left of the dashboard has been altered this quarter to show cumulative incidence of >50% preventability over the course of the year, rather than monthly incidence. The benchmarks have also been added to the right of the graph to allow the Board to consider WSFT's level of preventability in context.

2. Consider how to track performance against other trusts – 'peer group' or national

   One of the characteristics of the Learning from Deaths programme is that it does not allow trusts' preventability statistics to be compared directly against one another. Trusts are allowed to select which cases they will review on the basis of criteria set out in their published Learning from Deaths policies. Some trusts, generally due to constraints on people's time to do the reviews, are adopting screening tools which detect deaths with a higher probability of being subject to a problem in care. This by definition reduces their denominator, and by extension means they are likely to have a higher incidence of identified preventability. WSFT wishes to continue its established good practice of reviewing all deaths which occur under our care and management; as such we will have a large denominator and a correspondingly low incidence of preventability. This approach allows us to benchmark against published research findings rather than compare against other trusts in real-time.

3. Confirm whether Glastonbury Court and Newmarket Hospital deaths are included in the process and reporting

   Deaths amongst patients being cared for in Glastonbury Court and Newmarket Hospital will soon be included in the process for case review and information reported. They are not yet, though, because the information flows need to be established so that the Learning from Deaths team can be informed when a death has occurred and the medical records can be made available for reviewers. We will work through these processes over the coming months and hope to be able to present complete data for both these settings by quarter 4.

4. Provide clarity as to how duty of candour is managed, and ensure this is fully reflected within the policy

5. Under the new process, in every case where a problem in care is identified, the details will be entered on to the Datix system. An assessment of the level of harm caused will be done by the clinical governance team and the pathway following that assessment robustly includes duty of candour where applicable. The Learning from Deaths process has been designed

[1] Roberts AP, Morrow G, Walkley M, et al. From research to practice: results of 7300 mortality retrospective case record reviews in four acute hospitals in the North-East of England. *BMJ Open Qual* 2017;**6**:e000123

[2] Royal College of Physicians. National Mortality Review November 2017. Newsletter

specifically to streamline in with the trust's existing approaches to the Serious Incident Framework and duty of candour regulations. An amendment to make this explicit in the policy will be fielded to the Learning from Deaths group on 18th December 2017.

Outcomes of reviews of deaths, quarter two, 2017/18

- In quarter 2 there were 217 inpatient deaths
- 194 have been reviewed
- 185 were judged to be definitely not preventable
- 6 were judged to have slight evidence of preventability
- 2 were judged to be possibly preventable, 50-50 but a close call
- 1 was judged to have been probably preventable.

Of the eight with some evidence of preventability, four have been subject to an investigation under the Serious Incident Framework. All eight are awaiting peer review by the Learning from Deaths group.

Importantly, the death which was judged to be probably preventable was in a person with a learning disability – one of the groups the Learning from Deaths programme special attention to. The case has been investigated under the Serious Incident Framework and also referred to the national Learning Disabilities Mortality Review programme (www.bristol.ac.uk/sps/leder). The learning points are not ready to be reported yet because those processes are still underway. We anticipate being able to report on this case next quarter.

Quality of care

Once the medical reviewers are recruited and the structured judgment review method has been adopted for mortality reviews, the greyed out chart in the dashboard will present the judgments that medical reviewers make about the overall quality of care received by every person who has died and had a review of their care. It can't be populated at the moment. Recruitment of the medical reviewers is underway with interviews being held on 29th November. We anticipate having the new method fully in use by the end of March 2018, hence quality of care will be able to be reported in quarter one 2018/19.

Learning themes identified

In this quarter there have been no new learning themes identified.

Actions in response to previous learning

In last quarter's report, the Board heard that the death of a person with a severe mental illness had revealed that in the trust, people who are vulnerable because of mental illness are not always assessed in a timely manner for their risk of self-harm or suicide, and the Missing Person's procedure can be difficult to follow if the individual absconds.

In response, a task and finish group has been formed to review the appropriate policies to support the care of this vulnerable group.

The group is chaired by a general manager and comprises a governance manager, the portering services manager, the head of emergency planning and a head of nursing.

Summary Hospital Mortality Index (SHMI)

The dashboard presents the most recent published data for the whole-trust SHMI. The SHMI in quarter

four 2016/17 was 97.85, within the expected range.

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

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

Previously considered by:	*Learning from Deaths group*
Risk and assurance:	*Safety risk if the trust fails to identify problems in care which lead to patient harm and preventable death, and fails to act to reduce them.* *Reputational risk if the trust fails to report preventable deaths and fails to demonstrate action to reduce them.*
Legislation, regulatory, equality, diversity and dignity implications	*None*

Recommendation:

To note the information on the Learning from Deaths dashboard and the narrative in this summary.
To note the actions taken in response to previous learning themes identified.

Board of Directors (Public) – 1 December 2017

Agenda item:	12			
Presented by:	Jan Bloomfield, Executive Director Workforce & Communications			
Prepared by:	Lisa Sarson, Named Nurse Safeguarding Children			
Date prepared:	14 November 2017			
Subject:	Safeguarding Children Level 3 Training Compliance			
Purpose:		For information	✓	For approval

Executive summary:

All employees are required to complete Safeguarding Children mandatory training, completed via the e-learning package which covers level one and two and is valid for three years.

Identified staff from Women & Children, specialist roles or therapies and the Emergency Department (ED) require level three training which is valid for one year. This currently equates to 309 staff members.

The Trust has set compliance for all three levels at 90%. Obviously the smaller the number of staff the greater the percentage carried to them. One member on long term sick or a new starter or returned from leave can impact on a departments compliance and it has to be acknowledged that for all other subjects apart from Information Governance this is mitigated by the level being set at 80%. If you took the years figures and benchmarked against the 80% target we would have been compliant all year to date for levels one and two and for 7/11 months for level three.

To date the Named Nurse for Safeguarding Children (NNSC) has delivered 16 face to face sessions at nurse and clinical assistant training and three departmental sessions at level one and two and 22 level three sessions comprising of peer review, F1/ED Dr induction, paediatric and ED nursing annual training. The only month training with limited accessibility is August. The Named Midwife or NNSC whilst post vacant will have delivered 10 sessions over the year.

The difficulties with achieving compliance has been regularly monitored but was strongly highlighted at CSEC in September. From that meeting came the assistance of executives to ensure directorates raised the issue at monthly meetings and took on some responsibility of ensuring staff met compliance.

Nursing and midwifery staff have planned annual updates. This is not the case for other professionals. The training department will be assisting with advertising, recording and booking centrally for 2018 onwards.

Sessions arranged for the rest of the year

ED staff: 29 November 2017 and Dr induction 7 December 2017
Midwives: 14 November 2017 and 14 December 2017
Physiotherapists: 6 December 2017
Dieticians: 13 December 2017

All outstanding staff will be emailed to request they attend one of these sessions or arrange with the NNSC/NM a date when staff can attend the departments.
Names of staff that require Safeguarding Children Level 3 will also be sent to managers each month who will be required to complete risk assessments locally for each staff member who is non-compliant.

If the appropriate staff attends the training courses mentioned above, it is estimated that compliance should reach around 91% by the end of December 2017.

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:	*Training compliance reported to WSHFT Safeguarding Children Committee/CSEC and quarterly reporting to CCGs.* *This specific report direct to Board*
Risk and assurance:	*The risk is in staff being considered non- compliant and potentially not identifying when a child or young person is at risk of significant harm. The assurance is availability of training both face to face and via e-learning.*
Legislation, regulatory, equality, diversity and dignity implications	*Compliance with Trust policy and Intercollegiate guidance on roles and competencies*

Recommendation:

- The Board is asked to acknowledge the report and consider any actions members can make to influence improved compliance.
- The Board is asked to acknowledge that compliance would have been achieved should the target replicate that of other mandatory subjects (Information governance excepted)

Board of Directors (Public) – 1 December 2017

Agenda item:	13			
Presented by:	Jan Bloomfield, Executive Director Workforce & Communications			
Prepared by:	Denise Needle, Deputy Director of Workforce (Development)			
Date prepared:	21 November 2017			
Subject:	Appraisal process and compliance levels			
Purpose:	✓	For information	✓	For approval

Executive summary:

The 2016 staff survey identified that the Trust was below average for staff being appraised in the last 12 months, with 83% against the national average of 87%, and represented one of the bottom 5 scores. An action plan was developed to identify the issues surrounding this feedback (see appendix A). This report seeks to outline the progress made to date with improving the appraisal process, explain the changes in the reporting of appraisal and outline areas still to be tackled.

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:	Considered at individual directorate performance review meetings.
Risk and assurance:	Potential Patient safety issues as well as recruitment and retention of staff. The actions identified in the report seek to minimise this occurring, therefore the following level of assurance can be given: satisfactory.
Legislation, regulatory, equality, diversity and dignity implications	Appraisal is seen as best practice for all staff groups, and is seen as a mandatory requirement for medical staff, as it is part of revalidation.

Recommendation:

Acceptance of the action plan to further improve compliance and Trust Board to champion appraisal compliance.

Background

The 2016 staff survey identified that the Trust was below average for staff being appraised in the last 12 months, with 83% against the national average of 87%, and represented one of the bottom 5 scores.

An action plan was developed to identify the issues surrounding this feedback (see appendix A).

This report seeks to outline the progress made to date, explain the changes in the reporting of appraisal and outline areas still to be tackled.

Key aspects of the appraisal process

- An annual appraisal meeting takes place for all staff (*apart from doctors in training who have a more regular system of appraisal as part of their learning*)
- Doctors have their own process aligned to revalidation. WSFT use an electronic system called SARD to record and monitor.
- All other staff use a new improved paper based document, which is found on the intranet.
- The line manager appraises staff at a face to face annual meeting, records discussions on trust paperwork. Staff have a copy and manager keeps a copy. (*HR no longer require a paper copy)*
- Workforce team informed of appraisal date by the manager. This is then recorded on the electronic staff record (ESR) system.
- Ad hoc audits undertaken of appraisal records to ensure compliance with process and quality check. Agreed with internal audit.
- Managers are informed of their department compliance on a monthly basis, using ESR system. The report shows who is in date and who has expired, and offers a column to update the information and return it.
- The Trust Board and Directorates are sent overall compliance figures monthly, as part of performance reporting (*directorate performance scorecard*).

Recent changes affecting compliance levels

Initially a database was created to report on Trust appraisal levels, as limited reporting methods existed at the time. The purpose of the database was to generate an overall picture of appraisal based on incomplete Electronic Staff Record (ESR) data. A flaw being discovered within the database around date generation has led to a change in reporting methods.

The information within the database was measured over a 14 month rolling period; we believe this was to allow time for appraisals to reach the Workforce Information Team from wards and departments. Multiple data extracts were then used in the database. Appraisal dates for doctors, new starters and those on maternity leave or career breaks were automatically generated. When an assignment effective date changed in ESR the database generated a new date restarting the 14 month reporting period.

The new reporting method utilises Business Intelligence (BI), the national standard reporting suite for ESR; and only reports on data held in ESR. The data from BI provides a more reliable figure; in terms of whether the appraisal process was followed and the relevant departments informed when an appraisal has taken place. Staff are excluded from the extract when appropriate rather than dates being generated; this improves data accuracy and the ability to identify the reasons for gaps in the data. Data is measured now over a 12 month period as per the trust policy and comes from one extract. The report is part of a

national dashboard and brings West Suffolk Hospital reporting processes in line with other trusts in England.

The issue of incomplete ESR data still exists, hence the reduction in the appraisal percentage. The differences between how the database and BI process the data has highlighted the ongoing gap in the process flow and does not give an indication of the actual number of appraisals that have taken place. This assumption is based on information from previous staff surveys that indicates over 80% of staff have received an appraisal.

Plans are being draw up to manage the gaps in the appraisal process which includes an escalation process. Long term plans also include access to an electronic appraisal process within ESR and access for both managers and staff to appraisal records in the form of Employee Self Service. In September 2017 the method used to report to the board and directorates was upgraded to recognise issues with historical accuracy; issues around, staff movement within the trust, maternity leave, career breaks, new starters, doctors in training etc. Reports are now all taken directly from ESR.

This has led to a much truer picture of what is recorded in ESR. In October 2017 this was 50.83%.

This does not necessarily mean that we have dropped our compliance rates by 40%. The 2016 staff survey indicated that staff appraisal was at 83%. We also have anecdotal evidence that appraisal is not being reported to the HR Workforce Team as and when they occur. Reporting therefore seems to be the challenge.

Unlike mandatory training, (where the system records e-learning, and the trainers report attendance at face to face sessions), appraisal relies on the managers returning the information as and when an appraisal takes place. This will form a key part of the future actions to improve compliance.

Key improvements to the policy and process since 2016

- New user friendly paperwork (Appendix B)
- Better reporting to line managers
- Auditing process put in place, to remove the need for appraisal documents to be sent to HR.
- Training programme reviewed and updated
- Revised policy in light of the above, published October 2017

Is a change of culture also needed?

Appraisal compliance has been an ongoing issue for the last 15+ years.

Through recent appraisal training, some feedback has been received from clinical staff that they do not have the time to complete appraisals; however we need to change manager's mind-sets that by undertaking effective appraisals staff will feel more valued, motivated and this may support staff retention.

Recent comment:

*"I think the appraisal process is very easy to follow and there should be no need for incentives to increase compliance rates as it is part of our job role as Band 7 **********!!*

*The Service Managers should be discussing overdue appraisals with their Ward Managers at the monthly meetings (as ********does with me) and they should be performance managed as to why the appraisals aren't getting done!"*

Appraisal training recommends that appraisers should not undertake any more than 10 appraisals per year, therefore this equates to 1 appraisal per month for 30-60 minutes. This is not an unreasonable target to achieve, and the Trust would benefit as a whole.

We are now able to break down appraisal compliance by department (see appendix C). Only 5 departments were compliant (90% +) at the time the report was taken.
The appraisal experience is equally important to the levels of compliance that is achieved. With this in mind we have completely revised the training offered, we intend to develop written guidance for those managers who have not had training for many years, and we will survey the staff as to their experiences.

Future actions proposed to improve compliance levels

The Trust will be looking to;

- Send a targeted email from the HR/ workforce team to all those managers with areas below 50%, asking for their plan to improve compliance.
- Trigger an email to the manager from HR/ workforce team, copied into the service and general manager when appraisals are one month overdue (RED)
- Trigger an email to the manager from the appropriate director, again copied to the service manager and general manager when appraisals are two months overdue (BLACK)
- Publish a reminder to staff and managers of the need to report their appraisal meetings, and the cut-off date for the month. We intend to use the green sheet, core brief and emails.
- Develop the ESR system in the medium term to allow for an electronic appraisal process as part of manager self-service.
- Developing a refresher leaflet for all existing managers who may not have had recent training in appraisal.
- We will also audit the appraisal experience by randomly (and anonymously) sending out surveys (using survey monkey) to staff when they have recently had an appraisal.

Recommendation

The Trust Board members are asked to;

1. accept this report as an update on the process and policy
2. agree to the future actions proposed,
3. Champion appraisal completion where ever possible

17.11.17

Appraisal Action Plan

Appendix A

Action	Commentary	Proposed actions	Progress report	Lead	Timescale
Review Appraisal policy	2015 Staff survey again puts the WSFT in the bottom 20% for Acute trusts with regard to appraisal take up. The Trust approach to appraisal therefore needs to be reviewed. In addition we also need to incorporate the community staff into our processes.	1. Set up a task and finish group to lead the appraisal review. 2. Identify keys areas of improvement to the process, policy and paperwork etc. (see action plan) 3. Produce paper for the trust board of directors 4. Consult users, both appraisers and appraisees on proposed changes 5. Develop amended policy and obtain approval.	**Complete** **On-going** **Complete** **Complete** **Complete**	Denise Needle Appraisal Task & Finish Group Denise Needle Appraisal T&F group Denise Needle	02.03.16 March 2016 April – June 2016 2016 Summer 2016 September 16
Develop further the processes for recording and monitoring appraisal compliance	Appraisal compliance is recorded in ESR, and is reported to various levels of management on a monthly basis. Recently this has been cascaded down to the lowest level of management to help ensure completion. Support is being offered by HR to aid compliance.	1. Continue to support managers with compliance issues 2. Continue to provide monthly reporting to managers, divisions and the Trust board of directors. 3. To institute a process for auditing compliance at ward and department level. 4. Look to produce in-depth analysis of where compliance is low, by department, staff group etc.	**On-going** **On-going** **In place** **In place**	Hannah Denby/ Sarah Shaw Denby/ Sarah Shaw Denby/ Sarah Shaw Denby/ Sarah Shaw	On-going On-going April 2016 April 2016
Review appraisal paperwork	Anecdotal feedback suggests that the current paperwork is daunting for both managers and staff. It offers the opportunity for free text, to record discussions at the appraisal meeting. Staff and managers have suggested a more user friendly system would be easier to use.	1. Develop a more user friendly set of paperwork, ideally on one side of A4. 2. Consult with a range of users via various methods. 3. Consult with trade unions	**Complete** **Complete** **Complete**	Hannah Denby Denise Needle Denise Needle	Draft completed by April 2016 April – June 2016 June 2016

Develop electronic 360 survey	A number of staff in the organisation work with many different people in the course of their work, 360 degree surveys can be a very useful tool in gathering feedback for the appraisal process. The trusts current tool is labour intensive and time consuming.	1. To look at the feasibility of developing an electronic tool to be used for 360 degree questionnaires.	**T&F group agreed that this action should be postponed until ESR Enhance is implemented**	Appraisal Task & Finish Group	September 2016
Look at the number of WSH initiatives to be incorporated into appraisal process.	The Trusts appraisal process currently incorporates the following 2 initiatives; • Knowledge and Skills Framework (KSF) • Patients First Values It is also proposed that we add health and wellbeing and leadership behaviours. Staff have commented that this is confusing.	1. Identify whether the KSF needs to be discussed at appraisal. Or whether it is better placed in discussions around capability. 2. Discussion to take place at HRO's meeting re KSF and patients first	**Agreed**	Appraisal Task & Finish Group	NEXT HROs
Implement ESR enhance for appraisal	ESR is being upgraded nationally through the ESR Enhance programme. WSFT is a national pilot site for this project. In summer 2016 the trust will test the new functionality, which includes self-service. This will potentially allow the trust to implement an electronic option for recording appraisal information straight to ESR. There are a number of benefits, including the revalidation process for nursing staff.	1. Develop implementation plan for using ESR Enhance to record appraisal discussions.	**T&F group agreed that this action should be postponed until ESR Enhance is implemented**	Workforce Team	Autumn 2016 (dependent upon national rollout)
Review training programme in light of above actions.	All of the above enhancements will need to be communicated to both existing and new appraisers, and of course appraisees.	1. Review appraisal training programmes 2. Communicate changes to all staff 3. Run short refresher sessions for managers/ appraisers.	**Complete** **Complete** **Complete**	Denise Needle Denise Needle Denise Needle	Autumn 2016 Autumn 2016 Autumn 2016

PRIVATE & CONFIDENTIAL Individual Performance Review (IPR / Appraisal) – Record of Discussion					
Employee name:			**Employee job title:**		
Department / Team:			**Date of IPR / Appraisal meeting:**		
Name of reviewer / manager:			**Employee's incremental date:**		
Foundation gateway year date: (i.e. date of first increment after commencement)		**Final gateway year date:** (Date of increment prior to final increment i.e. second from last increment)		**Revalidation date, if applicable** (for NMC Registered Nursing Staff only)	

Is the employee performing as expected in all areas of the KSF outline and in line with the Trust's Seven Ambitions? (Refer to intranet for KSF descriptions for the appropriate Agenda for Change band (http://staff.wsha.local/Intranet/Documents/A-D/AppraisalAndKSFDocuments/AppraisalAndKSFForms.aspx) – please contact HR if you are unable to access the intranet)	**Improvement Required (Agreed objectives to be recorded on Page 3)**	**Meets Expectation**	**Exceeds Expectations (Discuss and record examples on Page 2)**
	Tick the applicable boxes:		
Communication: Effectively communicating the needs and requirements of patients, carers, staff and others to provide excellent care and service. Effective communication is a two way process. It involves identifying what others are communicating and the development of effective relationships as well as one's own communication skills.			
Personal and People Development: Developing oneself using a variety of means and contributing to the development of others during on-going work activities. This might be through structured approaches (e.g. appraisal and development review, mentoring, professional/clinical supervision) and/or informal and ad hoc methods (such as enabling people to solve arising problems and appropriate delegation).			
Health, Safety & Security: Maintaining and promoting the health, safety and security of everyone in the organisation or anyone who comes into contact with it either directly or through the actions of the organisation. It includes tasks that are undertaken as a routine part of one's work such as moving and handling			

Service Improvement: Improving services in the interests of the users of those services and the public as a whole. The services might be services for the public (patients, clients and carers) or services that support the smooth running of the organisation (such as finance, estates).The services might be single or multi-agency and uni or multi-professional. Improvements may be small scale, relating to specific aspects of a service or programme, or may be on a larger scale, affecting the whole of an organisation or service.			
Quality: Maintaining high quality in all areas of work and practice, including the important aspect of effective team working. Quality can be supported using a range of different approaches including codes of conduct and practice, evidence-based practice, guidelines, legislation, protocols, procedures, policies, standards and systems. This dimension supports the governance function in organisations – clinical, corporate, financial, information, staff etc.			
Equality and diversity: It is the responsibility of every person to act in ways that support equality and diversity. Equality and diversity is related to the actions and responsibilities of everyone – users of services including patients, clients and carers; work colleagues; employees, people in other organisations; the public in general.			

KEY DISCUSSION POINTS	NOTES
Job Description Have there been any significant changes?	
Previous Objectives Were previous objectives met?	
Factors hindering achievements (if any) since last appraisal / performance review meeting How can any issues be resolved?	

Key achievements since last appraisal / performance review meeting: Details of any areas ticked as “exceeds expectations should be recorded here:	

Training / Development opportunities since last appraisal / performance review meeting: Does the employee require any additional training/development?	
Areas for improvement (if applicable): Details of areas ticked as “improvement required” on the previous page should be recorded here:	
Summary of overall work performance / Any other comments:	
DEPARTMENT OBJECTIVES	**NOTES**
Discuss the overall department objectives:	

Employee's SMART Objectives & Training* **(These should be linked to the Department Objectives)** **(SMART- Specific, Measurable, Achievable, Realistic, Time-frame)** ***Please see last page for Skill Plus courses available***		**Development Needs** (Linked to KSF)	**Timeframe**
Objective 1	To undertake job role as per job description and to agreed standards		Over IPR / appraisal period
Objective 2			
Objective 3			
Objective 4			
Objective 5			
Objective 6			
Objective 7 (please add further objectives as necessary)			
Mandatory Training Detail areas which need to be completed during the review period:			

Additional support: Does the employee require any further support to achieve the objectives listed above? Is Health & Wellbeing Support required (i.e. Occupational Health, Care First or Physiotherapy)?		

This document should represent a true reflection of the discussion and agreement reached during the meeting and should be signed as confirmation by the following staff:				
	Job Title:		**Date Signed:**	
	Department:			
	Job Title:		**Date Signed:**	

Appraiser / Line Manager Signature:		**Department:**			
Departmental / Service Manager's Name: (if applicable)		**Job Title:**		**Date Signed:**	
Departmental / Service Manager's Signature: (if applicable)		**Department:**			

Once this form has been fully completed and signed, please email workforce.information@wsh.nhs.uk confirming name of employee, date appraisal / IPR completed and name of the reviewer. You do not need to send a copy of the form to Workforce Information at this stage.

An audit on completed appraisals / IPR's will be conducted by the Workforce Team on an annual basis; you will be required to provide copies of appraisal / IPR documentation for a random % of your team therefore these must be stored securely.

Skill Plus courses available to all Trust staff:

For further information or to book a place on one of the following courses please email Education.Training@wsh.nhs.uk

- Achieving Effective Staff Appraisals and KSF Review
- Coping with Pressure
- Critiquing Research Papers
- Financial Awareness Training
- Health Coaching (two day workshop)
- Introduction to Medical Terminology
- Managing Employee Attendance
- Managing Projects
- Mid-Career Workshop
- Pre-Retirement Workshop
- Recruitment and Selection (Band 5 and Above Only)
- Report Writing and Business Case Preparation
- Writing for Publication

NHS
West Suffolk
NHS Foundation Trust

Trust Board – 1 December 2017

Agenda item:	15			
Presented by:	Craig Black, Director of Resources			
Prepared by:	Sarah Jane Relf, e-Care/GDE Operational Lead			
Date prepared:	20 November 2017			
Subject:	To receive update on e-Care/global digital exemplar (GDE) programme			
Purpose:	X	For information		For approval

Executive summary:

The Trust Digital Agenda has, in November, passed a notable milestone which saw e-Care Phase 2 reach go-live. The new release saw Paediatrics fully embedded into the Trust electronic patient record along with many new clinical pathways and templated documentation which links directly to the GDE milestones. The Trust also introduced Patient Flow electronically linking clinical activity to work requests for both housekeepers and porters, thus increasing operational efficient and saving clinical time.

Updated plans for Phase 3 were approved by the Trust Board at the end of September which will deliver greater clinical functionality as detailed in 3.4 below. In initiating the planning work a small number of quick project will start immediately, most notable our first direct connection of medical device data as a direct input to e-Care.

As part of the GDE programme and fully embedded within the e-Care roadmap two key focus areas are mobility and optimisation. The former will see clinicians using tablet computers at the bedside whereas the latter will look to improve workflow consistency and efficiency whilst minimising unwanted variation.

Across the health community the Trust continues to drive up data sharing connecting an every growing number of local GP's to e-Care and developing a 'first of type' link with the EPIC EPR at CUH. Also available now is the e-Care Patient Portal and during 2018 work will commence to prepare this for live use. In parallel the Trust will commence the deployment of a Population Health solution next year which in time will bring together data from many sources. This allows us to measure the health outcomes of our local populous and so drive health commissioning to reduce health inequities or disparities.

Finally much work is currently underway on the technology specific components with new or updated infrastructure, improved security and extended connectivity. Of note the Trust, as an STP partner, is driving a solution called GovRoam into Newmarket hospital which allows any authorised healthcare professional to connect to a range of systems such that the access to pertinent clinical information to make informed decisions about patient's care. Newmarket is the STP proof of concept and once proven plans exist to extend GovRoam across the whole STP, subject to local funding.

In summary the Digital Agenda at WSFT is developing in line with expectations. Whilst there are risks but these are being managed through a close relationship with key stakeholders and regular monitoring of progress against targets.

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
Previously considered by:	**e-Care programme group. e-Care/GDE updates also go to scrutiny committee**						
Risk and assurance:	*none*						
Legislation, regulatory, equality, diversity and dignity implications	*none*						
Recommendation: The e-Care Programme Board is asked to note progress with e-Care and Global Digital Excellence programmes.							

To receive update on e-Care/Global Digital Exemplar (GDE) programme

1. Purpose

1.1 This paper provides the trust board with an update on e-Care implementation and the global digital exemplar (GDE) programme overall. As requested by the board the paper also provides a picture of the ultimate benefits we are aiming to achieve from the programme i.e. 'what will good look like'.

2. Background

2.1 West Suffolk Hospitals NHS Foundation Trust (WSFT) journey to digital maturity began in April 2013 when the trust board approved an outline business case to procure a new electronic patient record (EPR) system. In July 2014, Cerner Millennium was selected as preferred supplier for the EPR and the board approved the full business case to proceed with implementation. We branded this deployment and our digital transformation activities as e-Care.

2.2 After an initial 'big bang' launch in May 2016 we have continued to build new and enhanced functionality into e-Care as shown below:

Phase 1 – May 2016	• Replacement of the Patient Administration System (PAS). • Introduction of FirstNet within the emergency department • Introduction of electronic medicines management (EPMA) • Basic clinical documentation • Limited OrderComms functionality – requesting radiology and cardiology.
Phase 2 – May to Nov 2017	• Full pathology OrderComms functionality • Sepsis/acute kidney infection (AKI) alerting June 2017 • VTE assessment and management • Antimicrobial review alerting and management • Paediatrics • Capacity management (managing the flow of patients through the hospital) • Enhanced clinical documentation (including new care plans and care pathways) • Medication enhancements – such as duplicate paracetamol alerts, new more intuitive workflow for discharge summaries and new diabetic care plan

2.3 In recognising our achievements, the trust was one of 16 hospitals in the country chosen to become a flagship GDE site. GDE status was awarded to hospitals considered to be the most advanced technologically. We received £10million portion of national GDE funding as a result. Our GDE programme covers four main pillars:

Pillar 1	Digital acute trust	Completing the internal journey of digitisation.
Pillar 2	Supporting the integrated care organisation	Creating the digital platform to support the regional ambitions of integrated care and population health
Pillar 3	Exemplar digital community	Building the organisation into a centre of digital excellence and acting as mentor and guide for other developing organisations.
Pillar 4	Hardware and infrastructure	Ensuring that we have a robust and compliant infrastructure at the foundation of the programme.

The remainder of this paper provides an update on progress against each of these pillars and a picture of what we are ultimately striving for with this programme.

3. Pillar one – digital acute trust

3.1 On 29 October, we introduced major new functionality into e-Care. This included paediatrics who are now fully live with e-Care including medicines management. The department had worked hard to prepare for the go live and were very engaged during development stages. This has paid dividends and has resulted in a very successful implementation with the department very quickly adjusting to these new ways of working.

3.2 Patient flow (part of the wider capacity management module from Cerner) was also launched on 29 October. This was a major change for how we manage inpatient flow through the hospital and provided a new workflow for porters and housekeeping staff. This was a more challenging go live where staff initially struggled to use the new workflows. However, with the support of a dedicated floorwalker team the initial 'teething' problems have mostly been addressed and staff are adjusting. Once the basic workflows are fully embedded we will be supporting the patient flow team to maximise the benefits from the new functionality.

3.3 Additional new clinical documentation (including care plans and care pathways) and medication enhancements were also introduced in the October go live. From a technical perspective, all of these enhancements were introduced with very minimal issues. We are currently working closely with clinicians to make amendments and improvements based on their early feedback having now used the new functionality in reality and are working to ensure full adoption across the trust.

3.4 We will shortly be launching phase three which will introduce further functionality and spread. We are currently in final stages of negotiation with Cerner and other suppliers but the programme should include the following:

- VitalsLink – devices by which staff can measure observations which is then pulled directly into the patient record.
- Endoscopy
- Ophthalmology
- Maternity
- Theatres
- Anaesthetics
- Infection control
- Voice recognition pilots
- Power Chart Touch – mobile solutions for clinicians giving access to the patient record via smartphones and tablets
- Upgraded PAS

The final phase 3 scope will be confirmed once negotiations have concluded in the next few weeks.

3.5 Whilst it is good to introduce new functionality it is also very important that we also focus on optimisation i.e. supporting staff to use the system in the most effective way. We have recruited two dedicated e-Care coaches that will work alongside staff to support them with this. We are also currently developing an optimisation strategy that will outline our approach and priorities.

4. Pillar two – supporting the integrated care organisation

4.1 There are three main elements that underpin pillar two.

Patient portal	Providing a secure patient portal which would provide people with access to their own e-Care health record. There is the potential for people to be able to view test results, send online messages to their doctor and ultimately for us to integrate apps

	that enable people to manage and track their own conditions.
Health Information Exchange (HIE)	Our aim is to integrate e-Care with other care providers across the county, creating one record for each patient's medical history that is available to all clinicians in real time. This would minimise duplication of work and speed up communications between health professionals.
Population health	Introducing a population health management platform that will provide us with rich data source which can inform the priorities of our new integrated neighbourhood teams and provide us with intelligence that can underpin how we deliver services across partners.

4.2 The build of the initial patient portal will be ready by the end of this year. We will be launching the patient portal initially to our own staff as a pilot so that we can take the learning before we proceed with wider public rollout. The pilot will be in place for early next year.

4.3 The HIE is already working in 23 GP practices providing GPs with a view only access to the e-Care electronic patient record. A key aspiration is to make HIE two way so that we can see information in the primary care patient record as well. In the future, we will be extending the reach of HIE interface to include:

- EPIC (in use at Cambridge University Hospitals NHS Foundation Trust)
- Lorenzo (in use at Papworth Hospital NHS Foundation Trust, The Ipswich Hospital NHS Trust and Norfolk and Suffolk NHS Foundation Trust)
- Suffolk County Council systems

4.4 With regards to population health, our focus to date has been on researching and identifying the potential for population health based on experience and learning from elsewhere. At this stage, this is predominantly from outside of the UK although we are looking to work closely with and learn from Wirral health system wherever possible. We are holding a meeting with colleagues from the West Suffolk Clinical Commissioning Group and Suffolk County Council on 06 December to review this learning and to agree next priority steps to take us forward.

5. Pillar three

5.1 The GDEs are expected to produce best practice and technical guidance for other NHS trusts to follow, and to help advise, support and inspire them to become fully digital. Milton Keynes University Hospital NHS Foundation Trust has been formally identified as 'fast follower' to WSFT. This means that we will work closely with Milton Keynes to pass on our learning and experience. In addition, we are aiming to spread our learning more widely and recently held a very successful event that focussed on our approach to allied health professional functionality within e-Care. More than 60 people from across the UK attended this popular event. We will be looking to hold further events over the next year.

6. Pillar four

6.1 It is vital that we update the digital infrastructure across our Trust in order for the initiatives described above to become reality. Significant work has already happened under pillar four in line with agreed plan. Of particular note, we are focussing on our digital security and on improving connectivity between health and social care organisations to support the high quality delivery of care and improve the patient journey. We are also working to provide secure digital access to our on-call clinicians, enabling them to review patient results when necessary, therefore avoiding an initial delay to treatment while the clinician is travelling to hospital. These are just some of the examples of the technical projects that sit under pillar four.

7. The reason for this journey

7.1 The board has asked for an understanding of what we are ultimately looking to achieve with the GDE and e-Care programme. In the final section of this report we have captured some

examples of our vision for the future i.e. why we are doing this. It should be noted that this is a ten-year transformational programme and therefore some of these benefits may take years to become a reality. In addition being a GDE site enables us to explore emerging innovations and to try new things, which means some of these benefits may be much more challenging to achieve. And of course, many new opportunities will become available as technology develops even further. The end point picture may therefore change over time. However, the potential described here gives a good indication of where our ambitions lie and why we are pursuing these goals.

7.2 **Imagine if ……. we could prevent citizens from becoming unwell and needing hospital care**

- Citizens will be taking much greater responsibility for their own health utilising a range of self-care technological solutions. This could be as simple as a downloadable 'app' which offers advice and support on a long term condition right up to wearable devices that could transmit readings and information directly into the patient record.
- We will be using the multitude of data that will be available from all health and social care partners to underpin a risk stratification model whereby we can identify those citizens that require a much greater degree of support and intervention. Services will be prioritised to these individuals with a view to keeping them healthy and well and therefore out of hospital. We will also use this data to provide a rich platform for research and general improvements to health outcomes.
- We will have lots of different ways that citizens could engage with hospital clinicians without needing to physically attend the hospital. This might be using the patient portal to send messages to the consultants or using Voice Over Internet Provider (VoIP) solutions to hold teleconsultations with clinicians.

7.3 **Imagine if ……. all organisations involved in the care of our citizens were using a single shared personal record**

- The GP and community teams would know immediately if one of their patients has been admitted to the hospital, the reasons why and what we are doing to treat them. They could write directly into the shared record to support the care of the patient whilst in the hospital and would know in real time what treatment is being provided – therefore being better prepared to wrap the right care around the patient when they return home.
- We would no longer need to ask the patient for information when admitting them to hospital. Relevant and accurate clinical information (such as current medication and long term problems) would be immediately available within the shared record and would automatically pull through into e-Care. This would be particularly helpful if the patient arrives as an emergency and is unable to provide this information.

7.4 **Imagine if …….. we were delivering the highest possible levels of safety for our patients**

- We are already using functionality within e-Care to drive down the number of adverse drug events. New functionality such as dose range checking, duplicate prescribing alerts, drug allergies and wrist band scanning on administration are already working within the system. Moving forward we will reduce the risks even further by introducing closed loop medication (where all parts of the medications management are supported electronically i.e. ordering, verifying, preparing and administering medications).
- We are already using the system to identify deteriorating patients (for sepsis and acute kidney injury) and the system guides the clinician to enact the appropriate response. We now need to work with clinicians to agree an appropriate and effective level of alerting and decision support to guide the highest levels of quality.
- We will shortly be introducing new Vital Signs technology where nursing staff will use new devices to take observations that will then be automatically uploaded into the e-Care patient record in real time, thereby avoiding any transcription errors and enabling faster and easier identification of trends.

7.5 **Imagine if ……. there were no clinical variation**

- Patients will follow standardised care pathways for the majority of conditions and

treatments ensuring optimal levels of care and reducing the length of stay required. We have recently launched three new care pathways and will look to extend this much further as part of the e-Care programme.

- We will develop our clinical informatics capability enabling us to report on and identify variation in care delivered so that we can support all teams and clinicians to perform at the highest level standards.

7.6 **Imagine if …… we were working as efficiently and effectively as we could**

- Our staff are already telling us of the benefits of having up to date information, available whenever and wherever they need up – no more wasted time waiting for paper notes that another clinician may be using.
- We will shortly be making the patient record available to clinicians on their mobile devices giving them even greater accessibility in real time. Eventually clinicians will be able to dictate directly into these devices and this information will automatically be inserted into the correct place in the patient record, including the ability to create letters and notes.
- We will aim to eradicate waste. We already have alerts in the system that signal to staff if they are ordering tests that have already been ordered by another member of staff. This will avoid the wastage of unnecessary duplicate tests.
- Patients will eventually be able to manage their own appointments through the patient portal which will reduce 'did not attends'.
- Patients will use the portal to complete questionnaires prior to attending the hospital therefore streamlining the clerking process and ensuring that the clinicians have all relevant information at the point they are seeing the patient.

WSFT Board Meeting – 1 December 2017

Agenda item:	16a			
Presented by:	Dawn Godbold, Director of Integration and Community Services			
Prepared by:	Dawn Godbold, Director of Integration and Community Services			
Date prepared:	23 November 2017			
Subject:	Community services and alliance update			
Purpose:	x	For information		For approval

Executive summary:

Context

The community services contract has been awarded to the Trust for a minimum of seven years from 1 October 2017. This gives the trust the opportunity to fully integrate services across the acute and community interface and to implement its ambition to operate within an integrated health and care system.

Key Points

- The community services staff and functions continue to embed into the trust
- There are a number of areas of good practice where transformation and integrated working are well underway
- A group has been established to explore options and make recommendations for alternative internal structures that will support and enable integrated working
- The governance of the Alliance and wider system is developing well
- The process for application to become an Accountable Care System (ACS) is underway

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	

Previously considered by:	*Monthly reports to Board* *Weekly updates to Executive Directors meetings* *Regular updates to Trust Executive Group* *Ad hoc reports/presentations to Council of Governors, Scrutiny Committee and staff groups*
Risk and assurance:	*None*
Legislation, regulatory, equality, diversity and dignity implications	*None*

Recommendation:

That the Board note and support:

- The progress on the emerging alliance governance arrangements
- The approach and progress being made on options for internal restructuring of divisions to include community services
- The process and application to become an ACS

Community Services Update

West Suffolk NHS Foundation Trust Board

1 December 2017

1.0 Introduction

1.1 The community services contract transferred to the trust on 1 October 2017. The trust is the lead contract provider working jointly with alliance partners under a memorandum of understanding.

1.2 The West Suffolk Alliance is comprised of West Suffolk NHS Foundation Trust, Suffolk County Council, Suffolk GP Federation and Norfolk and Suffolk Mental Health Services Trust.

1.3 The alliance had its first contract monitoring meeting on 23 November 2017.

2.0 Current Position

2.1 The community services continue to become embedded into the trust. There is now community representation on all of the relevant committees and forums within the trust. Two members of community staff have put themselves forward for staff governor elections.

2.2 Work is underway to ensure community data and information is included in all of the relevant trust reporting mechanisms and information packs.

3.0 Transformation and Integration

3.1 Discussions internally on what our approach to integration should be have commenced. A paper has been presented to the trust executive group. A task and finish group has been initiated with all divisions and community represented. The group will meet fortnightly and explore options for new configurations of divisions.

3.2 The group is jointly led by the Chief Operating Officer and the Director of Integration and Community Services. The group members will involve other members of their teams as widely as possible in the work. The group will explore and make recommendations on a small number of options for consideration by the end of December 2017.

3.2 A number of transformation projects that demonstrate good integrated working are underway between acute and community colleagues, some of which also involve wider system partner as well. Examples of which are:

- Professional Leads of OT and Physio previously only supporting WSFT acute staff now also taking on professional development of OT and Physio in the community. All physiotherapy and OT staff now has access to clinical specialists, multi-professional preceptorship, learning opportunities and peer working as required.
- Post disaggregation SLT is now a fully integrated service across both acute and community boundaries with one professional lead. All preceptorship, professional development and support will also be fully integrated. All SLT staff will have access to eCare and SystmOne. The three newly recruited SLT posts will work across the acute and community. A number of staff from the acute site will also now do clinics in the community. Specialist SLT staff will work to support any patient or staff member across the acute and community.
- SLT linked with SLT LD mental health service lead to provide joined up care for complex patients. Support To Go Home (STGH) is a care bridging service which is a joint venture between WSFT and Suffolk County Council. The service aim is to prevent delays in discharges from the hospital or a community bed if there is a delay in the commencement of a planned care package which to date had predominantly been with Home First. Service provision and documentation links cross acute and social services.
- Staff rotations for acute OTs into community, mental health and social services. Potential to improve recruitment across all boundaries as it is is easier to recruit new graduates when there are more diverse learning opportunities.
- Physiotherapy rotations into community and AHPS MSK.
- Development of an integrated respiratory service across acute and community boundary. Provides increased staffing resource for the community to aid admission prevention and management of patient in locality. Key role in education to enable management of patient by locality staff.
- Jointly developed pathways for acute and community staff for Total Knee Replacement and Total Hip Replacement.
- Lymphoedema service: Joint venture between community staff, GP Fed and acute to deliver comprehensive, quality service.
- Dietetics is already a fully integrated service across acute and community boundary where staff are able to work flexibly across dependent on need. It is supported by one professional lead. With the alliance there is now the opportunity to work closely with the dietitian for eating disorders in the mental health service. Currently there is professional isolation.
- A significant amount of work and change has happened by Paediatrics OT, Physiotherapists and SLT and across acute and community have joined together to provide the appropriate care and most convenient location.
- Frailty and Falls: development of pathways and identifying gaps in the pathway. This work is also linked to developing the community element of the newly opened frailty unit.
- Trusted Assessment: this is a countywide project for which there is a steering group, working on actions and policy. This will reduce duplicate assessments for patients and carers, creating clinical capacity.
- Warm Handover: this relates to the exchange of information between organisations, both statutory and VCS for patients and users of our services as well as professionals.

- Safe and Proactive work – eight pathways
- Work is underway with the county council to allow both health and social care clinicians to be able to order specific items of equipment on behalf of each other. This will reduce time delays for patients waiting for equipment to be ordered and create clinical capacity.
- A highly successful Dutch model of care at home – known as Buurtzorg – is being explored in West Suffolk through a "Test and Learn Site" by a coalition of partners including, the East of England Local Government Association, NHS West Suffolk Clinical Commissioning Group, Suffolk Community Healthcare, Suffolk County Council, West Suffolk councils (Forest Heath District Council and St Edmundsbury Borough Council) and West Suffolk NHS Foundation Trust.
- One test team of up to 12 people (including nurses and nurse assistants) is being established in a neighbourhood of West Suffolk to run for 12 months, to learn, over the course of the test period, how to successfully transplant the model established in the Netherlands into the English health and care system. The Test period will take place from November 2017 – October 2018. See Appendix 1 for more detail.

4.0 Alliance Governance and Strategy

4.1 The Alliance has developed jointly with the CCG a proposal for new governance options. The ambition is to avoid duplication, create a collaborative culture, enhance joint decision making opportunities and build trust. **See separate attached paper.**

4.2 As part of our STP progress we have been invited to submit an application to move towards an Accountable Care System. There will be one single submission for our STP with a discreet West Suffolk system element.

4.3 The process is being supported by Carnell Farrer, to date we have had completed one telephone interview and submitted examples of good practice that demonstrate our maturity as an Alliance to be able to work together as a cohesive system and examples of integrated working.

5.0 Conclusion

5.1 The trust is continuing to develop and evolve its thinking in the development of the West Suffolk Alliance. The trust will continue to drive, lead and support this change both internally and externally to ensure we maximise the opportunities that collaboration and partnerships can bring.

5.2 The trust remains committed to continuously seeking out opportunities to improve services for our population, and the board is asked to note and support the progress being made.

Appendix 1

West Suffolk Buurtzorg Test and Learn – Update November 2017

1. Background

1.1 A highly successful Dutch model of care at home – known as Buurtzorg – is being explored in West Suffolk through a "Test and Learn Site" by a coalition of partners including, the East of England Local Government Association, NHS West Suffolk Clinical Commissioning Group, Suffolk Community Healthcare, Suffolk County Council, West Suffolk councils (Forest Heath District Council and St Edmundsbury Borough Council) and West Suffolk NHS Foundation Trust.

1.2 The Partners have agreed to work together, to design and deliver a project to test the Dutch model of community care known as Buurtzorg. The Buurtzorg 'Test and Learn' project is built on the shared purpose of testing a new, holistic approach to delivering community care in West Suffolk and sits within the ambitions of the West Suffolk Alliance.

2. Aim of the Test and Learn for West Suffolk

2.1 One test team of up to 12 people (including nurses and nurse assistants) is being established in a neighbourhood of West Suffolk to run for 12 months, to learn, over the course of the test period, how to successfully transplant the model established in the Netherlands into the English health and care system.

2.2 The Test period will take place from November 2017 – October 2018.

2.3 In order to successfully test the Dutch approach, partners have agreed that the Test and Learn will adhere to the principle of starting close to the Buurtzorg model and adapting with knowledge from the Test and Learn over the period of delivery. This will include:

- Enabling the Test team to provide holistic care, including both nursing and personal care
- Facilitating self-managing teams with no hierarchy, which have freedom with responsibility
- Creating the right environment in which teams can thrive with support provided through an effective back office and coach
- Allowing decision-making, where possible, to rest with the teams
- Supporting the principle of Buurtzorg practice, which includes interventions that are intense at first, preventative, holistic (health & personal care), wrap around client and their carer(s) (informal network) and pull in support from other professionals (formal network)

2.4 The Test and Learn patient profile will be adults needing care and support at home, with varying complexity of care needs to test the model robustly with the population accessing community care services in West Suffolk.

3. Funding and Governance

3.1 Funding of £200,000 has been secured from the Transformation Challenge Award, and 'match funding' of £50,000 has been agreed by each of four key stakeholders, including Suffolk County Council, West Suffolk Clinical Commissioning Group, West Suffolk NHS Foundation Trust and West Suffolk councils.

3.2 A Memorandum of Understanding and project steering group with representation from each of the partner organisations has been established to support the governance of the Test and Learn.

4. Engagement

4.1 An engagement strategy has been developed and delivered to communicate the ambitions of the Buurtzorg Test and Learn with relevant professionals, including nurses who may wish to join the team. A Test and Learn blog has been established on www.eelga.gov.uk, alongside articles published in trade press to share learning.

5. Establishing the Test Team

5.1 West Suffolk NHS Foundation Trust is acting as the employer for the Test and Learn team.

5.2 The team will be made up of between 8-12 nurses and nurse assistants, based on a 70/30 split. In recruiting the Test team, the intention is to progressively build up the team during the first 3 months of the Test, initially beginning with a team built of 4 whole time equivalents (wte).

5.3 Following a recruitment process over the summer 2017, three qualified nurses (Band 5/6) and a nurse assistant (Band 4) have been recruited – equivalent to 3.2wte. Two members of the team started in the beginning of October with the remaining two starting on 6 November 2017. The team will need to be at least 4wte prior to taking any live cases. The new recruits have been acting as advocates for the service and are leading the recruitment of additional members. The application numbers for the second phase of recruitment have already seen an increase from the initial round and interviews will take place in early November 2017.

5.4 An operational structure has been established to wrap around the team including a coach and an accountable clinical lead, as well as a 'heat shield' to act as a first point of contact with the wider system to lift-barriers and over-come obstacles the team may encounter.

6. Setting up the Test

6.1 An extended induction and set-up period will take place prior to the teams taking on a live case load to establish the operational framework for the Test.

6.2 We are working with Public World, Buurtzorg's UK partner, to establish an induction programme for the nurses which will include a study visit to the Netherlands to shadow a Buurtzorg Team in the town of Wijk Bij Duurstede, alongside training in the

UK to support self-management, outcome-based care and health coaching. The team will also shadow existing teams in health and care

6.3 Over the next two months the team will be working with partners to establish the operational framework including identifying Test locality, finding an office base, establishing local relationships with formal and informal networks, and setting-up referral and IT process.

7. Evaluation

7.1 The core focus of the Test and Learn or 'early pilot' is to understand how the model can be introduced into the English health and care system. An evaluation process is being established to focus on:

- Identifying the implementation issues around introducing the model into the English health and care system, and establishing an operational framework for an English-adapted Buurtzorg model
- Establishing early indications of the outcomes and impacts of the model on people, the workforce, and the wider system to establish a business case for wider implementation.

8. Engaging with other Buurtzorg sites in England

8.1 West Suffolk is one of only a handful of sites in England. In the East of England, two other areas are exploring a Buurtzorg inspired approach. A regional network has been established to ensure peer learning with the first meeting taking place on 19 October 2017.

Board of Director – 1 December 2017

Agenda item:	Item 16 (b)			
Presented by:	Steve Dunn, Chief Executive			
Prepared by:	Dawn Godbold, Director of Integration and Community Services Richard Jones, Trust Secretary			
Date prepared:	23 November 2017			
Subject:	System governance proposal			
Purpose:		For information	X	For approval

We have for some time described our strategic priority to integrate health and care services in the west of Suffolk. The Alliance model, with the Suffolk GP Federation, Suffolk County Council and Norfolk and Suffolk NHS Foundation Trust (NSFT), provides the vehicle to support the delivery of this priority as we continue to integrate our system's acute, community and primary health and care services.

This is the first step on a longer journey to develop a place based integrated system of care in which different organisations collaborate to deliver care. As part of this Alliance jorney it is proposed to:

1. Establish a locality team structure with devolved decision making and local budgets. Each locality team would include representatives from: statutory providers; the voluntary and community sector (VCS); Healthwatch; borough council and housing. Accountability from the locality teams being to a System Executive Group for west Suffolk.

   Annex A outlines the arrangements and has been supported by Alliance partners and West Suffolk CCG.

   <u>The Board is asked support the principles set out in Annex A.</u>

2. Reflect the integration ambition within the management and governance structures of WSFT. Included within these planned changes is the proposed to extend the composition of the Council of Governors to better reflect this integrated working.

   There are currently 25 governors on the WSFT Council of Governors with public (14), staff (5) and partner representatives (6). Public and staff governors are elected members, drawn from the public and staff membership. Together the governors form the body that represents the interests of members and partners in the local community and hold the board of directors to account for its performance.

   The existing six appointed partner governors are:

   - Two local authority governors (including the Borough Council and County Council)
   - Friends of West Suffolk Hospital
   - University of Cambridge
   - West Suffolk College (also representing University Campus Suffolk)
   - Community Action Suffolk

   The position which is currently offered to Community Action Suffolk has been empty since February 2017.

   It is recognised that through the public, staff and partners governors the Council of Governors is well

placed to fulfil its role. However, it is proposed to establish two partner governor positions to more directly reflect our integration ambition and provide a stronger voice for primary care within our community.

Recognising the voluntary and community sector will be represented within the new locality team structure it is proposed to use this governor position and create two new partner governor positions.

The proposed composition of the Council of Governors would therefore be:

- 14 Public governors (unchanged)
- 5 Staff governors (unchanged)
- 7 Partner governors (increased by one)
    - Two local authority governors (including the County Council)
    - Friends of West Suffolk Hospital governor
    - University of Cambridge governor
    - West Suffolk College governor (also representing University of Suffolk)
    - Two primary care governors

As required by the National Health Service Act 2006 the Public governors will maintain a majority on the Council of Governors.

We would propose to invite the CCG to canvas GPs and the Alliance partners to identify two primary care representatives to sit on the Council of Governors. This would send a strong signal regarding the importance of primary care and underpin future the Alliance working.

The proposed change to the WSFT constitution was supported by the Council of Governors at its meeting on 16 November 2017.

<u>The Board is asked to approve the proposed constitutional change to establish two primary care representatives on the Council of Governors as partner governors.</u>

Following approval the amendments to the constitution are effective immediately and we will seek nominations to the new positions with immediate.

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:	West Suffolk CCG West Suffolk Alliance partners Council of Governors
Risk and assurance:	Failure to effectively engage locality teams or Alliance partners in the

	governance arrangements for the Alliance model
Legislation, regulatory, equality, diversity and dignity implications	National Health Service Act 2006

Recommendation:

1. The Board is asked to support the principles set out in the proposed development (Annex A).

2. The Board is asked to approve the proposed constitutional change to establish two primary care representatives on the Council of Governors as partner governors.

Annex A: West Suffolk Alliance - Evolving our governance

1. Introduction

1.1 From the 1st October Community Services will be provided in an innovative alliance encompassing West Suffolk NHS Foundation Trust, the GP Federation, Suffolk County Council and Norfolk and Suffolk Mental Health Foundation Trust.

1.2 This is the first step on a longer journey to develop a place based integrated system of care in which different organisations collaborate to deliver care. This paper sets out how the system might evolve system governance and ways of working to reflect Alliance working and system change. The paper also describes changes that WSFT is proposing to provide a greater system focus within its governance structure.

2. Background

2.1 The '5 Year Forward View' sets out a clear and compelling direction for the NHS. It argues that the NHS must take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between community services and social care. It argues that we need to see far more care delivered locally, organised to support people with multiple health conditions, not just single diseases.

2.2 The challenges that the 'Forward View' describes are acutely felt in west Suffolk. The population served is ageing; long term conditions are increasing and costs as well as public expectations continue to rise. The overall population of west Suffolk is projected to increase by over 7% between 2013 and 2022, with a 38% increase in people aged over 70 years old.

2.3 The consequence of these facts is that west Suffolk is facing an increasingly frail and demanding elderly population who has a variety of health needs. Currently this is driving large increases in unscheduled attendances and admissions to hospitals which are reimbursed at a 30% marginal tariff rate. Year on year increases of non-elective admissions, for example, are rising by 10% this year.

2.4 If these trends continue they will challenge the future sustainability of the overall west Suffolk health system. But if we change the service model and integrate services across the community and primary care, as well as into social care, then it might be possible to ensure sustainable health and care services across west Suffolk.

2.5 As a system our foundations are strong. We have excellent primary care and an award winning hospital. We are building a new west Suffolk Alliance which is a partnership between the Suffolk GP Federation, community health services, the County Council and the hospital. We are working in a joined up

and collaborative way with our commissioning colleagues and have started to make changes to the way we plan and make decisions together.

2.6 From 1st October 2017 the Alliance will be responsible for providing significant elements of the community services, which will further enhance our model of place based care within neighbourhood networks. The award of this contract to the Alliance means that the system can more easily breakdown organisational barriers and overcome contractual constraints that can all to easily prevent joint working and care pathway re-design.

3. Strategy

3.1 Our alliance strategy has four main objectives, which are central to the wider public sector reform agenda in Suffolk:

- People manage their own health and social care with the right support when needed
- Our communities are easy and supportive places to live with a health or care need
- Higher cost interventions are replaced with lower cost interventions
- Our health and care providers are led by one clinical community

3.2 The key operational components of our service model are set out below:

- ***Neighbourhood Networks:*** These networks include the local people, groups, organisations, service users, voluntary and community section (VCS) and statutory services which a person uses to improve or maintain their vision of a good life. Health and care services will have a key role in the provision of preventative services to people.

- ***Integrated Neighbourhood Teams (INTs):*** The INTs' role is to ensure health and care interventions are planned, proactive, and reduce the need for crisis and urgent intervention. The INTs will include a core range of generalist services from community health, adult social care, primary care and mental health all brought together as one co-located team within each locality.

- ***Urgent Care:*** For people who require an urgent care response largely by secondary care the INTs will co-ordinate care to ensure that people are treated promptly by the most appropriate service, discharged and returned swiftly back to their own home from West Suffolk Hospital and by the East of England Ambulance Service.

- ***Specialist interventions*:** Some services such as interface geriatricians, specialist admission avoidance services, neurology services, community and acute hospitals and specialist dementia advice will be organised on a wider geography.

- ***Pro-active and preventative care*:** A key focus of the changes we need to make to how we provide and deliver services is to ensure that we take every opportunity to identify to encourage people to be well and keep active, take responsibility for managing their own health and empower self-management wherever possible of any health need.

- ***Community Resilience*:** This describes the development programme led in public health to support communities to support themselves. This takes on aspects of self-care, enabling people to be as independent as possible (including recovery from a health condition) by using the assets available to them personally and in their local community. This also encompasses the broader resilience of communities to provide social, cultural and leisure activities for their citizens; such activities being very relevant to the wider determinants of health and wellbeing related to, for example, social isolation, physical and mental stimulation and local access to services.

4. Establishing one clinical community and a clinically led system

4.1 Our Health and Care review strategy already requires all provider services to work in collaboration. Our vision is for:

- A health and care system embedded in an integrated public sector
- A clinically led network of GP, community and acute service providers working together. This will be an partnership of all providers, where decision making is shared
- Clear and full accountability for the whole health and care needs of our registered list of patients (population health)
- Improved recruitment and service resilience, supported by opportunities to deploy staff more flexibly, offer new workforce roles, flexible development opportunities
- A more streamlined commissioning function overseeing the new organisation

4.2 A key question is how do we operationalise the Alliance and how would the governance work? Form should follow function and we need to design the future model and management around the service vision outlined above and the perceived problems.

4.3 A key objective must be to bring clinical leaders across primary, community and secondary care to collaborate in real time rather than through the lens and posturing of contractual discussions. We want to establish a clinically led system which breaks down the barriers between primary and secondary, community services, general practice, social services and acute hospitals. To initiate this we are seeking to establish a 'one clinical community dialogue' modeled on the east Suffolk experience whereby all local GPs come together with 30-40 senior Consultants to discuss clinical quality and pathway developments.

5. Connect Programme

5.1 A key objective is to strengthen and continue to build on the local neighbourhood team model which is focused on our 6 localities (the Connect Programme).

5.2 The Connect programme describes the range of efforts across the statutory, voluntary and communities sector to develop a coordinated approach in defined geographic localities (the Connect areas), to improving and maintaining the health and wellbeing of individuals and communities.

5.3 The main elements of the Connect programme are described below:

- The Connect Programme is well established with progress made in many areas resulting in greater joint working between statutory, voluntary and community services. We have seen greater cooperation and working with primary health care, join up through Integrated Neighbourhood team meetings (INT's) of a range of public services and greater linkage with the VCS through, amongst other things, social prescribing.

- The localities for the west of Suffolk have been agreed as: Newmarket, Haverhill, Sudbury, Brandon/Mildenhall, Bury Town and Bury Rural. These groupings can be thought of as a 'Hub and Spoke' with the system leadership as (the 'Hub') and the six locality areas (the 'Spokes').

- Each locality has within it a defined grouping of GP practices; an integrated neighbourhood team (INT) and is built on and around a neighbourhood network including borough councils, housing, police and community groups. The neighbourhood and locality model needs to be cognisant of the borders and boundaries that surround these localities, particular from areas where the flow of patients into our services can be significant e.g. Stowmarket and Thetford.

- The west Suffolk system has also made a commitment to testing the Buurtzorg Model. This model hails from the Netherlands and is a holistic community nursing model that wraps all health and personal care needs around the patient through one team who are responsible for all of the patients' needs.

- The test will help to inform our design for integration between health and care practitioners and identify opportunities for further enhancing the integrated neighbourhood team model. It is envisaged the test will have a positive impact on self- care and for some patients reduce long term need.

Trust Board – 1st December 2017

Agenda item:	17			
Presented by:	Dr Nick Jenkins - Executive Medical Director			
Prepared by:	Dr Sue Partridge – Clinical Lead, Pathology Rosemary Smith - General Manager, Women & Children's and Clinical Support Services			
Date prepared:	23rd November 2017			
Subject:	Pathology Accreditation			
Purpose:	√	For information		For approval

Executive summary:
Following voluntary suspension of laboratory accreditation for Blood Sciences at WSFT, NEESPS have been asked to provide a plan to describe their approach to achieving full accreditation with associated timescales. Part of this plan (covering the Quality Management System) has been received but further details are required to cover the other aspects of the laboratory service.

To date, reassurance has been received from NEESPS regarding plans for accreditation for Blood Sciences (excluding Blood Transfusion) but we have not received documented details of these plans that give us assurance.

For Blood Transfusion assurance has been provided that significant progress has been made towards addressing the non-conformances identified in the MHRA Inspection in January 2017 and subsequently.

Histopathology has successfully cleared the non-conformances from the UKAS assessment at WSFT and are now being recommended to the decision maker to approve UKAS accreditation.

Microbiology across the three sites have been assessed together by UKAS and it is anticipated that the laboratories will maintain CPA accreditation but will not be recommended for UKAS accreditation at this stage.

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:	Executive Directors Scrutiny Committee and Board of Directors
Risk and assurance:	If the Blood Sciences laboratory does not achieve accreditation, this will impact on provision of commissioned services (CCG, Hospice, BMI, Antenatal Screening). There is potential impact on participation in future R&D activity. No assurance is possible at this stage as this is in development by NEESPS.
Legislation, regulatory, equality, diversity and dignity implications	None identified

Recommendation:

Further information is required from NEESPS to provide assurance that full laboratory accreditation for Blood Sciences at WSFT can be achieved and the associated timescales.

High level scrutiny is essential to ensure NEESPS both deliver and execute the plan.

Options for this scrutiny include:

1. *A formal letter from the CEO highlighting the concerns that there is no clear plan for achieving accreditation for Blood Sciences at WSFT*
2. *WSFT Executive to CHUFT Executive meeting*
3. *Request for NEESPS to present to WSFT Trust Board (or a subcommittee) regarding progress on the plan for accreditation*

Background

Blood Sciences within West Suffolk NHS Foundation Trust (WSFT) no longer hold valid Clinical Pathology Accreditation (CPA).

In 2009, CPA became a wholly owned subsidiary of the United Kingdom Accreditation Service (UKAS) as part of a strategy to modernise pathology services in the UK. UKAS is currently managing the transition of all CPA accredited laboratories to UKAS accreditation to the internationally recognised standard ISO 15189. CPA Accredited Laboratories have been assessed to ISO 15189 since October 2013. The ISO 15189 standards are significantly more stringent than previous CPA standards.

CPA accreditation will cease to exist after 31st March 2018, to be replaced by UKAS accreditation.

Oversight of Pathology Services by WSFT

Immediately following the MHRA inspection of Blood Transfusion services at WSFT, daily progress meetings were introduced with tPP. As actions progressed and assurance was being provided accordingly, these daily meetings were reduced to twice weekly, weekly, and now take place on a monthly basis. Additional meetings are arranged on an ad hoc basis if any concerns arise that require escalation from either NEESPS or WSFT between those meetings.

WSFT hold monthly 'Pathology Oversight Meetings' where all aspects of the delivery of pathology services are discussed, including (but not exclusively) operational, clinical, governance, and financial items. Through these meetings, NEESPS have shared an overview of the significant gaps in current compliance with UKAS standards for all disciplines of pathology services with the exception of Histopathology.

The vast majority of NEESPS' focus has been on compliance with MHRA standards on the WSFT site for Blood Transfusion, as maintaining MHRA accreditation is a statutory requirement.

Current Accreditation Status at WSFT

Microbiology

Microbiology services, provided by Public Health England (PHE) across NEESPS applied for a single licence for accreditation against ISO 15189 standards whereby Ipswich Hospital NHS Trust (IHT) is the hub laboratory and WSFT and Colchester Hospitals NHS Foundation Trust (CHUFT) are satellites of the hub lab.

The UKAS assessment of Microbiology across the three sites concluded on 10th November 2017 and while the formal report has not yet been received, the informal feedback suggested that microbiology would be recommended for maintaining CPA accreditation (following clearance of non-conformances) but not recommended for transition to UKAS accreditation.

Nationally, it is not clear what will happen to laboratories currently accredited under CPA who have not, by 31st March 2018, been assessed for transition to UKAS.

Histopathology

UKAS assessment of Histopathology services at WSFT was undertaken 1st-3rd March 2017. On 10th November 2017, the Histology Specialist Lead at WSFT received confirmation from the Assessor that 'all findings are now cleared' and that she would 'write to the decision maker to inform them that is the case'.

There are no concerns regarding the accreditation status of Histopathology at WSFT.

Blood Transfusion

In line with previous updates to the Trust Board, NEESPS and WSFT staff continue to work through the actions identified by the MHRA resulting from the inspections of the Blood Transfusion lab at WSFT. Significant progress has been made and currently the staffing levels in Blood Transfusion are more sustainable, both in and out of hours.

Significant progress has also been made against development and update of SOPs, training and compliance of staff, and the programme to address outstanding validation processes for equipment is also underway. Staffing reports continue to be submitted to the MHRA and IAG (Inspection Action Group) on a weekly basis with an exception report against the action plan also being submitted on a monthly basis.

The previously imposed suspension of CPA accreditation in response to the findings of the MHRA is still in place.

Although there are no safety concerns regarding the delivery of the Blood Transfusion service at WSFT, due to the considerable level of non-compliances identified by the MHRA, there remains a significant amount of work to be undertaken before the lab will be fully compliant with the MHRA standards. The MHRA Inspector made contact with the Blood Transfusion manager in late November 2017 to make arrangements for a repeat inspection in January 2018. It is expected that this will take the form of a full inspection over the course of two days.

Blood Sciences (excluding Blood Transfusion)

Blood Sciences at WSFT were due a UKAS assessment in November 2017. However, NEESPS advised the WSFT Executive Team that due to significant gaps in conformance with the new ISO standards coupled with severely limited staff resource, it would be preferable to voluntarily suspend the current CPA accreditation for Blood Sciences. This approach was supported by the Executive Team and subsequently by Scrutiny Committee.

The implications of this voluntary suspension are still being investigated. For example, participation in the Antenatal Screening Programme (the conditions of which include current laboratory accreditation).

NEESPS Plans for Achieving Accreditation

While a full and robust plan to achieve accreditation in all disciplines across all three sites is not yet available from NEESPS, WSFT has requested details of the approach which will be taken in developing this plan.

WSFT have been advised that there are three elements to this plan overall:

1. To close non-conformances identified at the assessments that have already taken place in IHT and CHUFT
2. To give sufficient assurance to regulators of the quality of services to allow them to continue to commission services from WSFT
3. To develop the laboratories to a sufficient standard where application for UKAS assessment is realistic

The Executive Team's agreement to voluntary suspension for Blood Sciences at WSFT was conditional upon NEESPS providing a plan with timelines for preparing the laboratories for assessment as this was not available at the time the decision was required.

NEESPS have been requested to provide details of how and when the plan to achieve element 3 will be achieved. The NEESPS response has been received and has a focus on the Quality Management System.

The various screening programmes with which WSFT laboratories are involved have also been identified by NEESPS, who have developed a schedule of work to produce the necessary action plans for element 2 above. NEESPS are in discussion with NHSI and NHSE to develop a 'Pathology Oversight Board/Group' to give oversight of this work.

Summary

The NEESPS response focuses on the requirements for building a common Quality Management System, which is UKAS compliant.

No information has been provided to date about plans to address the non-conformances identified in previous gap analyses with respect to other areas of laboratory activity.

Although the timescale for application for UKAS assessment for Blood Sciences is not yet clear, a huge amount of work remains to be undertaken. To achieve this, thorough and robust planning, as well as appropriate resources, will be required.

Further information is required from NEESPS to provide assurance that full laboratory accreditation for Blood Sciences at WSFT can be achieved and the associated timescales.

High level scrutiny is essential to ensure NEESPS both deliver and execute the plan.

Board of Directors – 1st December 2017

Agenda item:	18			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Craig Black, Executive Director of Resources			
Date prepared:	November, 2017			
Subject:	Financial Improvement Programme Wave 2 (FIP2)			
Purpose:	X	For information		For approval

Executive summary:

Despite a strong track record of historic financial delivery, the Trust opted to engage KPMG to support the identification of the 2017-19 Cost Improvement Programmes (CIP), between May and November 2017, due to the significantly increased scale of the financial challenge (particularly in 2018/19).

The first two phases included a diagnostic to identify the key CIP opportunities and the development of detailed plans on how to achieve them. The final phase (phase 3) consisted of tailored implementation support to develop and deliver the identified CIPs. The work has helped build upon what was already peer leading performance through further improvements in financial grip and control, development of key management information and governance and crucially supported outstanding sustainable improvements in clinical productivity.

This report is a summary of the work done and what has been delivered to date against the key outcomes of access, finance and quality

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					

Previously considered by:	This report was produced specifically for the trust board
Risk and assurance:	As identified in the report
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:
For information only

1.0 Financial Improvement Programme Wave 2 (FIP2) context

The Financial Improvement Programme Wave 2 (FIP2) is an opt-in programme coordinated by NHS Improvement (NHSI) for NHS provider management teams faced with significant financial challenges who wish to use external suppliers to improve their 2017/18 and 2018/19 delivery of Cost Improvement Plans (CIPs).

The Trust engaged KPMG to work together on a three phase programme between May and November 2017. The first two phases included a diagnostic to identify the key CIP opportunities and the development of a detailed plan on how to achieve them. The final phase (phase 3) consisted of a tailored implementation support to develop and deliver the identified CIPs.

This work is taking place in the context that in order for the Trust to meet its agreed control total for 2018/19 of £2.5m deficit post Sustainability and Transformation Funding (STF); the CIP target for 2018/19 is £18.3m. This target, as a percentage of turnover is significantly greater than 5% which is what is suggested as achievable in Lord Carter's review of acute providers.

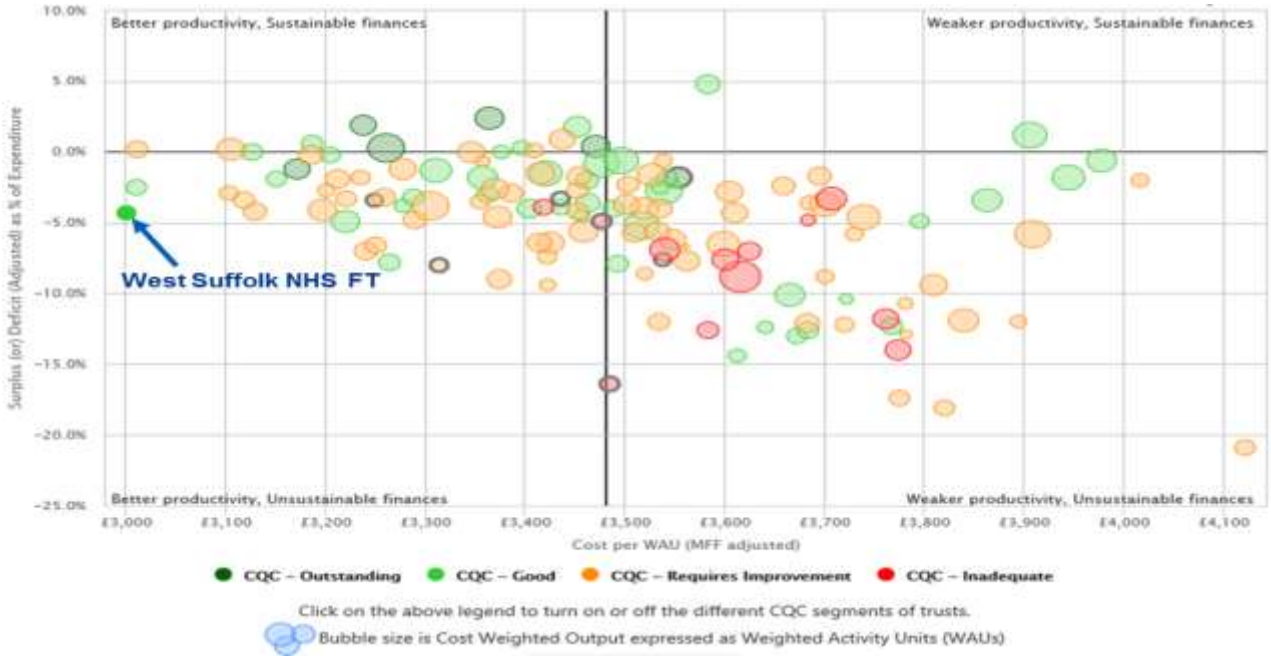
2.0 A high performing Trust in challenging financial times

The review of operational efficiency in acute hospitals chaired by Lord Carter (February 2016) has calculated that the Trust's adjusted treatment cost is 0.89. This effectively means that the Trust is approximately 11 pence less expensive per pound on national cost weighted output. Equally when one reviews the headline adjusted treatment cost data by Trust type, the Trust is the most efficient small acute provider and the fourth most efficient provider in the country.

2.1 Correlation between productivity, sustainable finances and CQC rating

The chart below is an extract from NHSI's Model Hospital and plots a number of different dimensions to give a composite picture of the Trust's performance against other non-specialist acute Trusts. The position of each Trust on the quadrant reflects its Surplus (or) Deficit as % of Operating Expenditure 2015/16 in addition to its MFF-adjusted Cost per WAU 2015/16 which is representing overall productive efficiency.

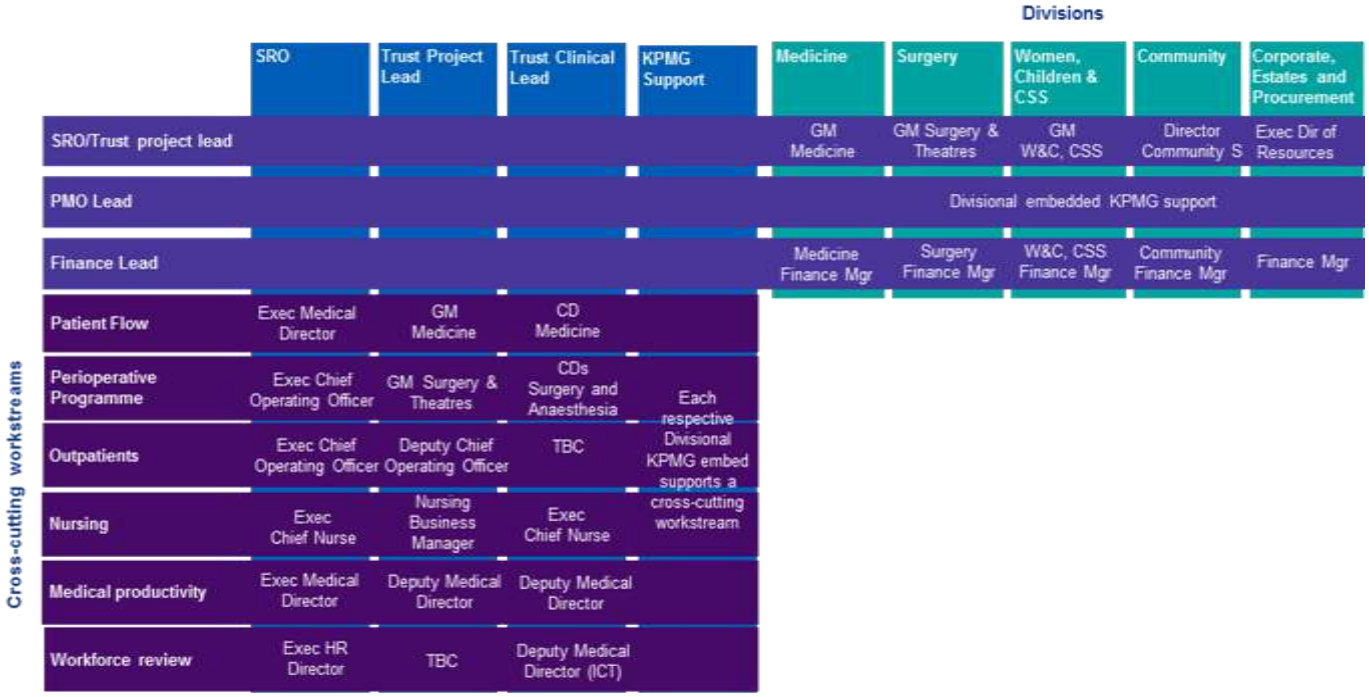
To note that this chart uses an adjusted Surplus (or) Deficit as % Expenditure figure to that used elsewhere in the Model Hospital in order to facilitate an equivalent (comparable) value between Foundation Trusts and NHS Trusts. The colour of each bubble reflects the CQC segment for each Trust and the size of the bubble reflects the Cost Weighted Output expressed as Weighted Activity Units (WAUs 2015/16).



NHSI's Model Hospital Trust's performance against other non-specialist acute Trusts

2.2 Making best use of external support to deliver change
Nonetheless, the Trust faced with an increasing financial challenge engaged with KPMG to critically challenge the Trust's existing cost improvement and efficiency programmes, identify additional opportunity from a range of other initiatives and support delivery at pace.

The model below illustrates the approach taken to embed the KPMG support within the organisation. In this way, focussed support for Divisions and cross-cutting services has been provided. KPMG have handed over the work to the respective Divisions and to the Programme Management Office (PMO). To note that the prospective PMO Managers (recruitment in progress) will be embedded in the Divisions with delivery accountability to the PMO. This is a continuation of KPMG's embedded approach which was well received by the clinical services.



Approach used to embed KPMG in the Trust

2.3 CIP Financial Position
As of October 2017, the FIP2 Programme has identified further CIP that increased this year's forecast to £14.4m. The over performance will be used in part to offset the KPMG fee. The October position includes a target of £7.107m YTD which represents 50.4% of the 2017-18 plan. In order to deliver the Trust's pre-STF control total of £7.7m deficit in 2018/19 the Trust is required to deliver a CIP of £18.3m (8%).

To date £4.2m of risk adjusted CIP schemes for 2018-19 has been identified. Once these are fully worked up and in place, it is anticipated that they will deliver around £10m of CIP in 2018/19. More detail is provided in the 'Finance and Workforce Report' for October 2017.

3.0 Clinical leadership is essential
Whilst acknowledging the expertise from KPMG was essential to bolster the Trust's capacity and capability in this area, marked improvement wouldn't have taken without clinical engagement and leadership. The two main areas of clinical transformation that the Trust has focussed upon are:

(i) operating theatres and
(ii) patient flow (that is the pathway from admission to discharge from acute care - length of stay).

3.1 Operating theatres
Together with KPMG we have established a clinically-led theatres programme of work which is positively impacting on the number people we operate on. The team identified that over a period of one year 1,921 more cases can be booked for an intervention in theatres. This means that the Trust will be able to treat more patients within the allocated time. This leads to prompt access to care for our patients at a time when resources are limited.

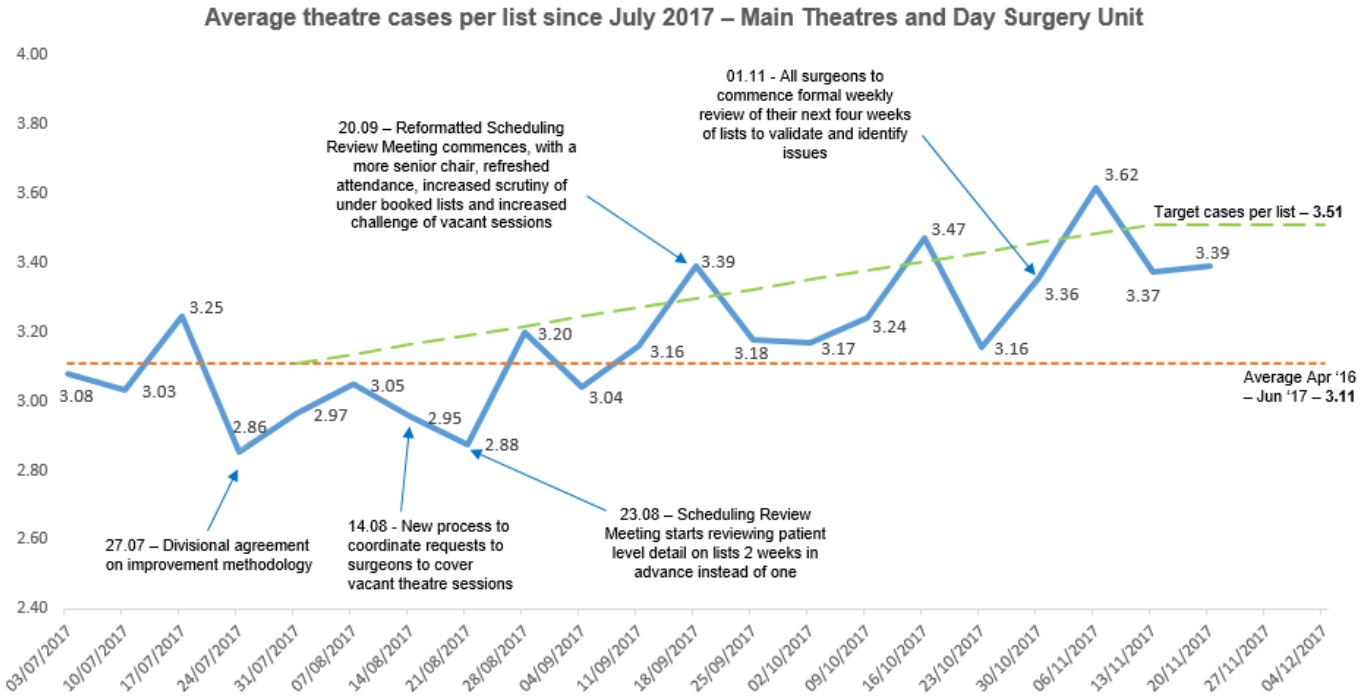
In the first instance, the team focussed on three key interventions:

i. **Bringing forward decision making** – Finding surgeons to cover vacant lists, confirming anaesthetists and scheduling patients were all taking place too close to the operating date. One by one, the elements of planning a theatre lists were brought forward. This not only allows for all lists to be booked but at the same time provides our patients with more notice when to come in for their surgery.

ii. **Identifying issues in advance** – The Trust had instances when patients were being cancelled on the day for reasons that could with additional information have been picked up sooner. A key action was to formalise arrangements for surgeons reviewing their own lists, as well as bringing forward when the theatres team complete their review.

iii. **Using data to make a difference** – The programme brought a drive to better use the data available on the Trust's system. A dashboard was built which is owned and managed by the Trust. This is empowering the team to use business intelligence effectively and to continue to progress without external support.

The chart below shows the average number of cases per list since July 2017, when work to identify and simultaneously implement actions for improvement began. There is further work still being completed around productivity, which will contribute to further improvements in cases per list.

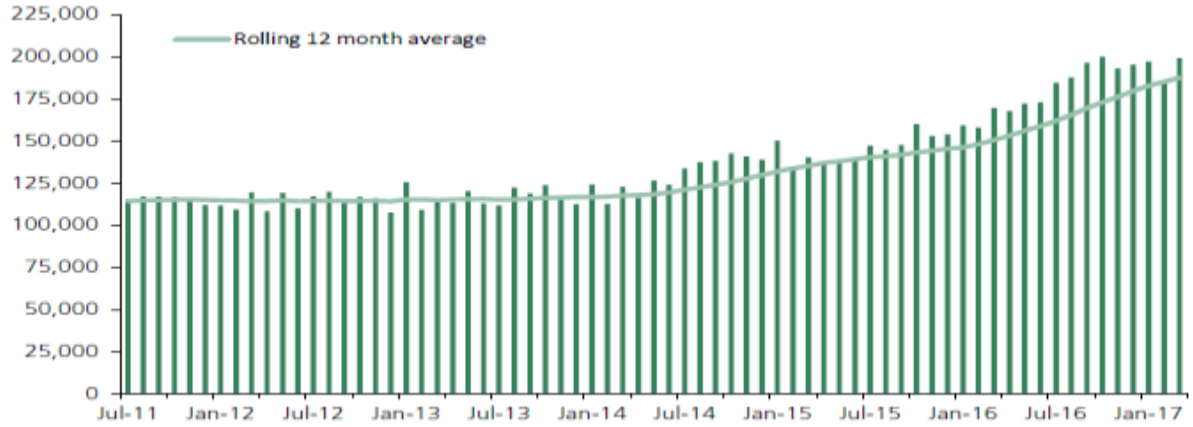


Cases per list in operating theatres since July 2017

3.2 Patient flow (length of stay)

One of the biggest challenges facing the NHS is the number of delays in transfers of care. In 2016/17 there were 2.3 million total delayed days in England. This contributes to an increase in length of stay, increases risk to patients since keeping patients in hospital longer than required can have a number of detrimental effects. Long stays can affect patient morale, mobility, and increase the risk of hospital-acquired infections. Delayed transfers of care are also costly for hospital Trusts. In addition to having to pay to provide places for patients who are ready to leave, these patients' presence can mean there are insufficient beds to carry out scheduled, elective procedures. Insufficient beds mean elective procedures need to be cancelled and the Trust loses income and hinders access to treatment to other patients.

The graph on the next page shows the total number of delayed transfers of care days on a monthly basis in England.

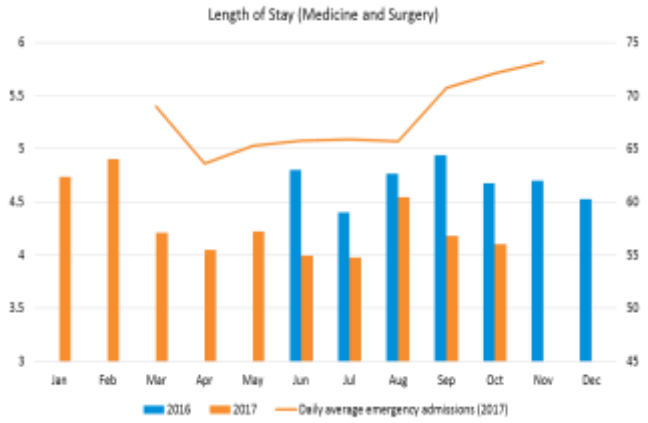


DToCs in England, source: NHS England (graph taken from House of Commons library, Briefing paper number 7415, 20 June 2017. Delayed transfers of care in the NHS).

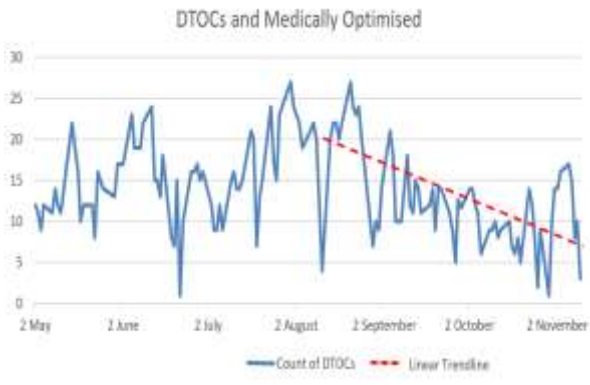
In view of these challenges, there are a range of initiatives taking place in the Trust to reduce length of stay and improve patient flow. These initiative contribute to make sure the Trust looks provides care to acutely unwell patients and efficiently and safely discharges those who do not require acute care any longer. In the past few months greater focus was placed on the many initiatives that are taking place in the hospital under the 'Flow Action Group' (FLAG) banner. The main initiatives include (list not exhaustive):

- Review of stranded patients
- Review of those patients with the longest length of stay (LoS) and delay in transfer of care (DToCs)
- Support to Go Home
- Refresher of Red to Green board rounds
- Standardising pathways of care
- Focus on Ambulatory Emergency Care (AEC)
- Discharge waiting area

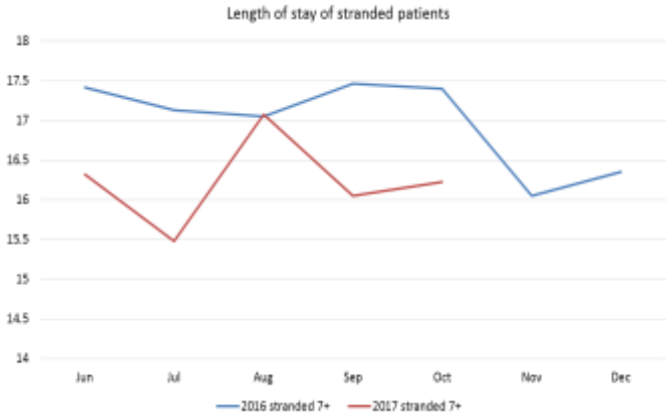
These initiatives are being led by clinical staff coming from all multi-disciplinary groups in the Trust. The results over the past few months are encouraging where from the most recent data one can see that the length of stay is reducing when compared to the same period in 2016. This reduction is partly driven by the introduction of a weekly multi-disciplinary (MDT) review of stranded and long stay patients (and also DToCs) over the summer, the introduction of the Support to Go Home service which started on 11 September 2017, and a refresher of Red to Green board rounds which took place between 16 and 27 October 2017. This length of stay reduction is being delivered against a backdrop of increased demand.



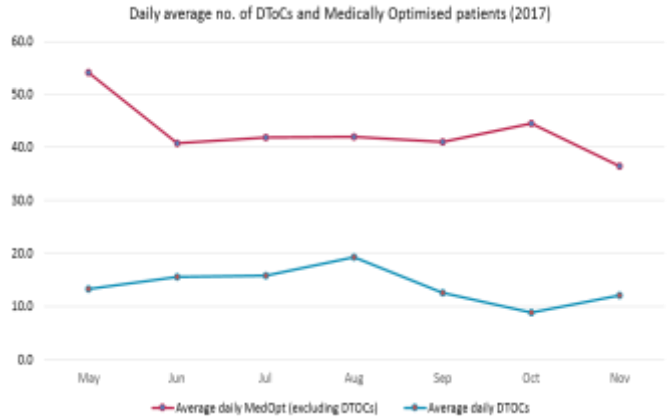
Length of stay and daily average emergency admissions



Number of DToCs since May 2017 and trend line plotted from programme interventions



LoS of stranded patients (those with a length of stay (LOS) of seven days or more.



Daily average of DToCs and medically optimised patients

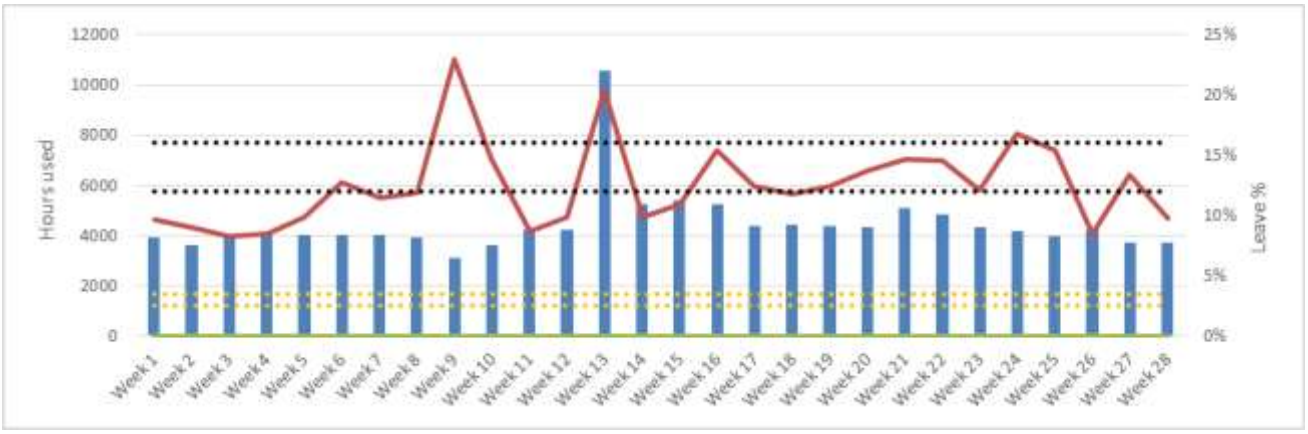
3.3 Nursing

The nursing scheme led by the Chief Nurse focuses on three main areas which are: (i) focus on annual leave approvals, (ii) review of Clinical Nurse Specialists and (iii) review of nursing allocation on wards (bay-based nursing). The aim of each of these initiatives is described below.

Focus on annual leave approvals

The Trust has a policy in place to allow annual leave to be within 12-16% threshold of the workforce. This threshold allows for all staff members to avail of their leave and at the same ensure services are staffed and delivered in line with plans. If this threshold is not followed pressures in staffing services occur which have a direct impact on patient experience, staff morale and financial stability.

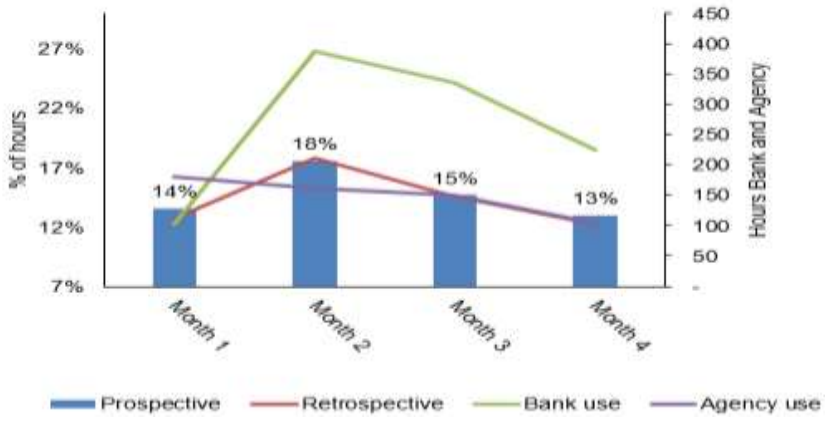
There have been instances when this policy was not well followed which increased reliance on temporary staff required to deliver services. The graph below illustrates this correlation.



Annual leave distribution and the requirement for temporary shifts (October 2016 to May 2017)

In the past few months the Executive Chief Nurse has put measures in place for services to ensure annual leave is maintained within the threshold. This has taken place through a number of initiatives which include validation of the data, communication with senior nurses where expectations are set, regular reviews and tracking of improvements. The full effect of the work will be seen in 2018/19 but in some areas this work is already having a positive impact.

The graph is from ward F3 showing the direct correlation between the % of annual leave and the reliance on bank and agency to provide the service.



Review of Clinical Nurse Specialists
All Clinical Nurse Specialists (CNS) at the Trust were asked to record a diary that shows their activity during a typical week. Completed forms were collected with a 91% response rate. Activities were categorised into either patient-oriented activities (which includes patient-facing and patient-related work), or other activities for example admin, meetings, travel etc.

The audit showed that on average, 65% of CNS time is spent doing patient-oriented work. The aim is to have this specialist group move to at least 80% of time spent on clinical, patient-related activities. The 80% is a benchmark set by the Trust and is in line with other NHS Trusts who have embarked on this initiative. This will contribute to an additional 709 hours of clinical time per week to be dedicated to patient-oriented activities.

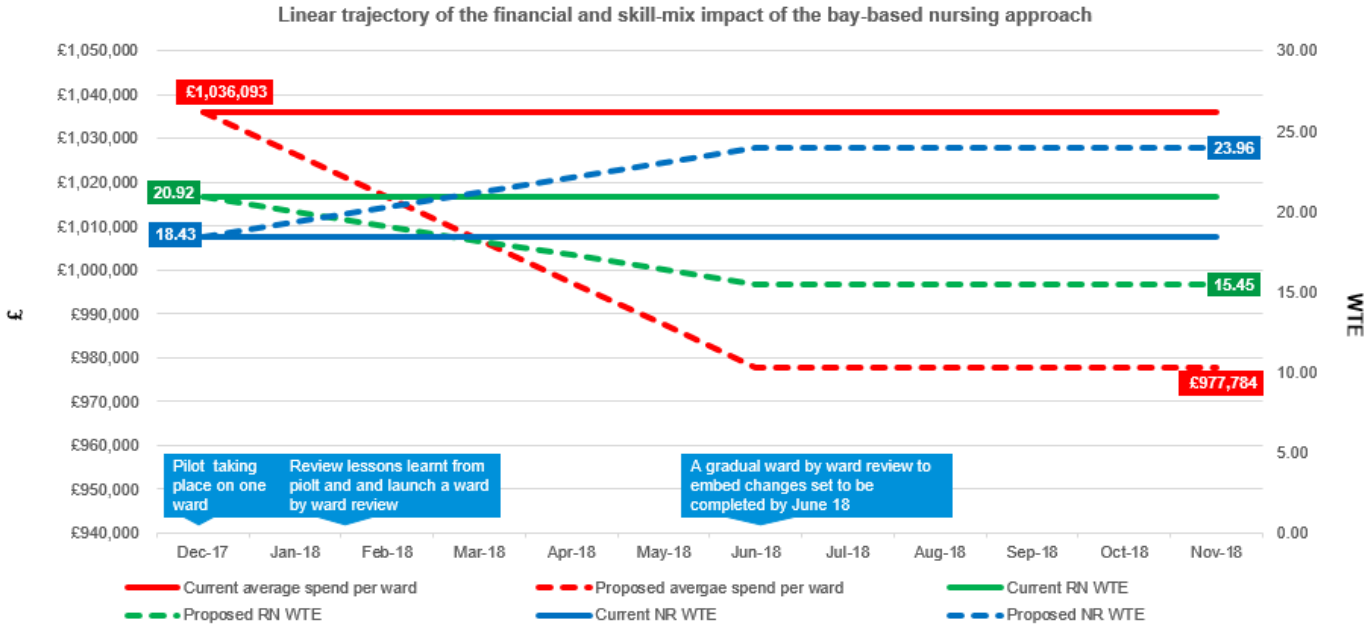
This will be achieved through a team by team review to better understand activities that take place in every clinical area and align more this specialist group of senior nurses to the frontline of patient oriented care.

Bay-based nursing
The majority of wards across the Trust operate on a two-shift model, with a long-day shift and a night shift. Ratios are set so that there are more registered nurses to non-registered nurses on a shift at one time. The Trust, like other NHS Trusts is facing a challenge to fill vacancies and therefore a shortage of registered nurses leaves expertise spread too thinly and may pose a risk to patient safety, as well as staff morale and wellbeing. Recruitment of permanent staff is proving a challenge and agency nurses are costly and provide only a temporary solution. A more sustainable solution, which avoids excessive agency spend is being worked up focussing on bay-based nursing care.

Proposed Model
The majority of wards across the Trust operate on a two-shift model, with a long-day shift and a night shift. The average nursing cost to staff one of the Trust's 12 wards is **£1.036m** with a total allocation of £12.433m. This is for registered and non-registered nurses; ratios are set so that there are more registered nurses to non-registered nurses on a shift at one time. The Trust, like other NHS Trusts is facing a challenge to fill vacancies and therefore a shortage of registered nurses leaves expertise spread too thinly and may pose a risk to patient safety, as well as staff morale and wellbeing. Recruitment of permanent staff is proving a challenge and agency nurses are costly and provide only a temporary solution. A more sustainable solution, which avoids excessive agency spend is being worked up focussing on bay-based nursing care.

The proposed model alters staffing ratios and arranges nurses according to the layout of wards. Non-registered nurses are assigned to a single bay, and are responsible for the patients within that bay for the entirety of their shift. If they have to leave their bay for any reason, one of the registered nurses will cover that bay for the time that the assigned nurse is away.

Registered nurses are then more available to offer supervision and assistance wherever necessary. This model requires a higher ratio of non-registered to registered nurses. However, it ensures that there is suitable supervision at all times. This proposed model offers a long-term solution to manage vacancy rates, instead of constantly relying on agency staff who are not permanent and are not financially sustainable.



The graph above shows the average cost of nursing per ward alongside whole time equivalents for registered (RN) and non-registered nurses (NR). The average number of wte will not change and the focus is on the skill mix.

Benefits:

Patient Experience
Patient experience is enhanced through continuous care from a single member of staff. This allows care to be more personal, with a single point of contact for patients for the duration of the shift. Continuous and consistent supervision improves communication between patients, carers and also helps to reduce patient anxiety. More time can also be spent on direct patient care, as time spent moving around the ward is reduced.

Staff experience
Staff experience is improved as individuals are given greater control over their work and have clear instructions around what their responsibilities are and what is expected of them. Supervision is on hand to ensure non-registered nurses are able to call for supervision. Registered nurses are spared from more basic tasks and can focus on offering support and training. Expertise is better utilised as registered nurses can also spend more time focusing on higher risk patients. Staff morale is also improved due to there being adequate cover on the ward despite high vacancy rates.

Patient Safety
Patient safety is improved through constant monitoring of patients, which enables proactive care and allows staff to respond more quickly to patients' needs. Continuous supervision also helps reduce the risk of falls.

Staff are distributed effectively across the wards, to ensure safe staffing levels are met, even at a time when there is a shortage of registered nurses. Staff handovers are more effective as a single person can offer a full overview for each patient.

Next steps
There is a pilot being run on one of the wards and following a review of the feedback received by the team, a ward by ward review will take place to take into account the acuity of every ward. This approach is not a one size fits all but a way to provide care within the resources available to the Trust.

3.4 Administration & Clerical Review

A review of staff groups based on pay bands and whole time equivalent (wte) took place in May. From this review it was evident that the Trust has a higher number of staff in administrative and clerical roles, especially at a band 4 level, when compared to peers. This review is being taken forward through a project which is looking at how technology can improve the clinical administration of the hospital. This work is possible in the light of the Trust implementation of E-care and being one of the Trusts designated as 'Global Digital Exemplar' (GDE).

This provides an opportunity for transformation to further deliver exceptional care, efficiently, through the use of world-class digital technology and information. As a GDE Trust there is the opportunity to share learning and experiences to enable other Trusts to follow in our footsteps as quickly and effectively as possible. This will contribute to the achievement of national strategies like 'The Five Year Forward View' and 'Personalised Health and Care 2020' were there is reference to how the transformation needed across the health and care system is required to ensure sustainable services and high quality delivery.

The work will be founded on six principles

- Honesty and transparency throughout
- Working in partnership with staff and stakeholders to agree transformation opportunities
- Avoiding redundancies through vacancy controls
- Retaining the "personal touch" i.e. avoiding totally centralised solutions
- Fairness across the organisation
- Looking to establish career structures as part of the transformation including apprenticeship opportunities

Further updates will be provided as the work evolves further in December.

4.0 Next steps

The Trust has worked with KPMG who have delivered the organisation a structured handover and exit plan to give the best chance of maintaining momentum and achieving the savings identified. This is against the background of increasing pressure on health services.

In these past few months, clinicians and managers have built a foundation and skills base throughout the process and ensured that all scheme leads and PMO support understand the schemes they are responsible for and the role of the PMO in supporting them to deliver.

Culturally the key areas of clinical transformation in operating theatres and length of stay are now wholly owned by the Trust, with Divisional teams taking responsibility for sustaining and improving on the current performance as well as identifying further opportunities.

Board of Directors – 1 December 2017

Agenda item:	Item 19			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	22 November 2017			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

6 November 2017

Steve Dunn provided an introduction to the meeting and the new **'bit size' briefing** for cascade to staff. It was noted that we have achieved more than 50% of staff taking up the flu vaccination with continued focus to improve this to protect patients and staff.

An update was provided on the plan in the New Year to undertaken a clinical-led STP level review of **stroke services**. Paul Molyneux offered to support this work. In the context of STP performance the west Suffolk cancer services statistically significant better performance was recognised.

An **overview of quality** was considered and the need to ensure action is taken to maintain appropriate staffing levels. Concerns with RTT and ED performance were discussed and recovery and escalation plans discussed.

The **winter plan** was reviewed with a key focus on:

- Flow through the hospital: the discharge waiting area on G9 will allow us to move ward discharges to earlier in the day. It was stressed that staff need to consider the discharge waiting area as part of the normal patient flow through the hospital
- Capacity: staffing plans to allow us to open winter escalation capacity were considered
- Improved performance at weekends: it was recognised that we need to focus on improving flow and discharges at weekends.

The launch of **GP streaming** within ED was noted and recognised that this would need to be monitored to ensure that the service support patient flow within the department.

It was noted that the head of **CQC inspections** would be visiting the hospital on 8 November to provide an update of the inspection methodology. The focus of preparation for the forthcoming unannounced inspection visits was discussed recognising the need to be open but positive about the care and services provided.

The **hospital concourse business** case was received which outlined the options for development of the concourse, courtyard café and WH Smiths areas. The development was considered alongside other priorities and the need for outpatient capacity. The proposed move of pharmacy to be adjacent to the outpatient environment was welcomed. The consensus was that there is a desire to improve the entrance to the hospital.

The **leadership development programme** was reviewed and the plans reviewed to deliver the

priorities:

1. Development of leadership and improvement skills at all levels of the trust
2. Development of systems leadership in West Suffolk
3. Systematic talent management processes that facilitate a clinically led and managerially supported organisation and feed into NHS talent pipelines

A presentation was received on **community services transformation and integration**. This focused on the need to develop options for how to integrate services. A task and finish group was established to progress this work.

20 November 2017

Steve Dunn provided an introduction to the meeting including an update on **quality, operational and financial performance**.

The report from the **Flow Action Group (FLAG)** highlighted progress in the reduction of length of stay. The focus of the support to go home team was recognised in this achievement and the impact they have had by reducing the ongoing requirements packages of care in patients' homes. The reduction in stranded patients had also played a part. The focus of red to green would be maintained to include earlier discharge through the discharge waiting area.

A review of options to improve **theatre utilisation** was considered. This had been subject to considerable scrutiny and the underpinning data and assumptions developed by the clinical and management team with KPMG. The background to the proposal was the improvement efficiency currently being delivered through the existing theatre facilities. The recommended action was approved – continue to increase efficiency and productivity within theatres within the existing working hours, develop options for additional trauma capacity and based on capacity and demand modelling continue to plan to open additional capacity by re-commissioning theatre 1.

The **red risk report** was reviewed with discussion and challenge for individual areas. A new red risk was received approved regarding radiologist staffing capacity. Further analysis of the mitigations for this risk will be considered.

Feedback was provided from the **CQC inspection** of end of life and outpatient services. As part of the feedback the CQC team confirmed that they would not be inspecting any other services ahead of the well led visits on 30 November and 1 December.

The **leadership framework for senior medical staff** was approved by TEG as a clear and effective proposal. The programme provides development and support at various levels: individual leadership; clinical team leadership; corporate leadership; and system leadership.

TEG received the national submission by the Trust on **electronic correspondence with primary care**. The report set out the current arrangements for information exchange. It was noted that the Trust had been successful in bid to be a pilot site for the new FHIR GP discharge information communication.

A presentation was received on the **Buurtzorg model**. This is a highly successful Dutch model of care at home which is being explored in west Suffolk through a "Test and Learn Site" by a coalition of Partners including, the East of England Local Government Association, NHS West Suffolk Clinical Commissioning Group, Suffolk Community Healthcare, Suffolk County Council, West Suffolk councils (Forest Heath District Council and St Edmundsbury Borough Council) and West Suffolk NHS Foundation Trust. The team will be made up of 8-12 nurses and nurse assistants, based on a 70/30 split delivering both personal and health care in a community setting. Starting in December the team will be working in Barrow. The work was welcomed as an exciting opportunity to truly integrate working across communities and providers.

Consideration was given to the proposed **west Suffolk system governance** arrangements. It was recognised that the proposal supports our strategic priority to integrate health and care services in the west of Suffolk. The Alliance model, with the Suffolk GP Federation, Suffolk County Council and Norfolk

and Suffolk NHS Foundation Trust (NSFT), provides the vehicle to support the delivery of this priority as we continue to integrate our system's acute, community and primary health and care services. TEG supported the principles set out in the proposal with an emphasis on developing integrated neighbourhood teams as part of one community.

The **KPMG** weekly report was received, This set out progress with CIP delivery for 2017-18 including length of stay and theatre efficiency as well as development of the £18.3m CIP for 2018-19. Work continues with divisions and corporate services to address the remaining gap in the CIPs for next year.

Relevant **policy documents** were considered and approved. These will be considered by the relevant Board subcommittees.

a) Incident reporting and management policy
b) Incident reporting and management procedure
c) Health, Safety and Welfare policy
d) Risk Assessment policy
e) Media policy

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

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

Previously considered by:	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:

The Board note the report

NHS
West Suffolk
NHS Foundation Trust

Trust Board Meeting – 1st December 2017

Agenda item:	20			
Presented by:	Steve Turpie, Non-Executive Director			
Prepared by:	Kathryn McMahon, PA			
Date prepared:	November 2017			
Subject:	Audit Committee report - meeting held on 3 November 2017			
Purpose:		For information	X	For approval

Executive summary:

The draft minutes of the meetings of the Audit Committee on 3rd November 2017 are attached. **Please note these have yet to be approved.** The key issues and actions discussed were:-

3rd November

- **Board Assurance Framework 'deep dive'**- ***General Data Protection Regulation (GDPR) Steven Snaith (Partner – Technology Risk Assurance)*** Steven took the committee through the new GDPR regulations, Sara Taylor also attended the meeting for this presentation and both discussed timeframes for the changes and advised what the changes would mean for the Trust. Actions were taken away from the discussion.

- **Governance and Assurance** – Clinical Audit was discussed and Emma Instance introduced and discussed the report with the committee. She noted how they were integrating the report data to include community services. She also discussed their overall clinical audit programme and how Community would be amalgamated into this programme.

- **Internal Audit and Counter Fraud** – the Internal Audit Progress Report and Recommendation Tracking Update for 2017/18 was discussed. Mark Kidd also took the committee through the progress report and ongoing investigations in relation to Fraud.

- **Internal Audit And Counter Fraud Services Contract** – the current three year Internal Audit and Counter Fraud Services contract expires March 2018. Following discussion with Audit Committee members it has been agreed to extend the existing contract by one year at the same cost, terms and conditions. A paper will be presented to the March Audit Committee outlining a proposed process for a competitive tender exercise for a new contract from 1 April 2019.

- **External Audit** – David Eagles gave an update on the Value Added Services for Contract sessions, noting forthcoming meetings he/colleagues were attending and discussed topics that could be used for future sessions with the Trust. Craig and Richard were to finalise a list of the most useful discussion sessions.

- **Financial Reporting** – Review of waivers was discussed together with Losses & Special Payments. There was a discussion around the reduction of the Trust's waivers. David Eagles gave contact information for someone that Louise Wishart could discuss reduction of waivers with.

- **Discussion with Auditors** – The Audit Committee closed with the NEDs having a private discussion with the Auditors.

Charitable Funds

The Charitable Funds must be submitted to the Charity Commission by the end of January. The Trust Scheme of Delegation reserves the power to approve the accounts to the Board. The Board is asked to delegate responsibility to approve the 2016/17 Charitable Fund Accounts and Letter of Representation to the auditors to the Audit Committee. A meeting will be convened on 26 January 2018 solely for this purpose. The draft accounts have already been circulated to the Charitable Fund Committee for review 24 November 2017 and the audit is in its closing stages.

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 3 November 2017
- note the extension of the current Internal Audit contract by one year
- delegate authority to approve the 2016/17 My Wish Charitable Fund Accounts to the Audit Committee.

Board of Directors – 1 December 2017

Agenda item:	Item 21			
Presented by:	Roger Quince, Chairman			
Prepared by:	Richard Jones, Trust Secretary			
Date prepared:	22 November 2017			
Subject:	Appointment of Senior Independent Director			
Purpose:		For information	X	For approval

1. Purpose

To approve the nomination of the Senior Independent Director (SID), following consultation with the Council of Governors.

2. Background

Section A.3.3 of the Code of Governance issued by Monitor in July 2014 requires the Board of Directors to appoint one of the independent Non-Executive Directors to be the Senior Independent Director for the Trust. This provision is made under the Regulator's 'comply or explain' approach to governance and the appointment requires consultation with the Council of Governors.

Annex 7 to the Trust's Constitution (paragraph 8) provides that:

> 8.1 The Council of Governors is entitled to be consulted by the Board of Directors on the appointment of the Trust's Senior Independent Director.
> 8.2 The role of the Senior Independent Director is as set out in the Trust's "Senior Independent Director Role Specification" as amended from time to time. For the avoidance of doubt the "Senior Independent Director Role Specification" does not form part of the Constitution.

The SID undertakes the regular duties of a Non-Executive Director but also acts as the point of contact with the board of directors if governors have concerns which approaches through normal channels have failed to resolve or for which such approaches are inappropriate. The SID may also act as the point of contact with the board of directors for governors when they discuss, for example, the chair's performance appraisal and his or her remuneration and other allowances.

3. Proposal

Following the appointment of Sheila Childerhouse as the Trust's Chair it was considered important to ensure an appropriate balance between the Chair and the SID in terms of skills and background. On this basis it was considered appropriate that the SID have recent commercial experience.

It is important to note that the proposed change does not in any way reflect on work undertaken by Alan Rose as the current SID.

4. Recommendation

Based on discussions with the Council of Governors on 11 October 2017 and Board member it is proposed that Gary Norgate take on the role of Senior Independent Director.

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:	Council of Governors on 11 October 2017						
Risk and assurance:	Failure to comply with Regulator's Code of Governance and Trust Constitution						
Legislation, regulatory, equality, diversity and dignity implications	Health & Social Care Act 2012, Regulator's Code of Governance and Trust Constitution						
Recommendation: The Board approve Gary Norgate take on the role of Senior Independent Director.							

Trust Board Meeting – 1st December 2017

Agenda item:	Item 22			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Kathryn McMahon, PA			
Date prepared:	November 2017			
Subject:	Use of Trust's seal			
Purpose:	X	For information		For approval

Executive summary:

To note use of the Trust Seal, pursuant to Standing Order section 8. The Trust Seal was used on the following occasions:

Seal No. 121

Deed of Variation – Signed and witnessed deeds providing access to Car Park B for the Hospice (on 14th November 2017).

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	

Previously considered by:	None
Risk and assurance:	None
Legislation, regulatory, equality, diversity and dignity implications	WSFT's Standing orders

Recommendation:

To note the use of the Trust's seal

NHS
West Suffolk
NHS Foundation Trust

Trust Board – 01/12/17

Agenda item:	23			
Presented by:	Helen Beck – chief operating officer			
Prepared by:	Alex Baldwin – deputy chief operating officer			
Date prepared:	22 November 2017			
Subject:	Cancer Operational Policy			
Purpose:	x	For information		For approval

Executive summary:

The aim of the cancer operational policy is to ensure that the Trust records, monitors, performance manages and reports data relating to the Cancer Waiting Time Service Standards (CWTSS). The policy is based on national Going Further on Cancer Waits (GFoCW) version 9.0 guidance. The policy also supports the collection of cancer data to support the Cancer Outcomes and Services Dataset in addition to national cancer audits and their reporting.

The policy further aims to ensure that:

- Patients' best interests are at the forefront of local practice and policy, at all times.
- Key staff are aware of their responsibilities.
- Cancer patients or suspected cancer patients receive treatment according to their clinical priority, and that those with the same clinical priority are treated in chronological order.
- Cancer patients are treated consistently, efficiently and equitably in accordance with Trust values and behaviour. All patients will be given the same quality of care, provided in a timely manner in line with best clinical practice irrespective of background, ethnicity, belief etc.
- That all patients receive their first appointment / treatment within the targets set out in the Cancer Reform Strategy taking in to account clinical pathways and patient choice.
- Trust administrative and clinical staff take responsibility for progressing patients along agreed clinical pathways in the timescales set our within this policy.
- All internal documentation / referrals clearly state all relevant target dates.
- Clinical support departments adhere to and monitor performance against agreed maximum waiting times for test / investigations in their department.
- Accurate data on the Trusts performance against Cancer Waiting Time Service Standards is recorded on the Somerset Cancer Register (SCR) and that such data is uploaded to the national Cancer Waiting Times database (CWTdb) within predetermined timescales.
- All data is robust and accurate and can be audited both internally and externally.

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:	Cancer Board						
Risk and assurance:	None						
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Board is asked to note the policy for information.							

NHS West Suffolk NHS Foundation Trust

Board of Directors – 1 December 2017

Agenda item:	Item 24			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	23 November 2017			
Subject:	Matters arising action sheet			
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 Chairman.

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 – 26 January 2018

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
Quality & performance report, including staff recommender scores and mandatory training	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Transformation report	✓		Written	Matrix	HB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Aggregated quality report	✓		Written	Matrix	RP
Nurse staffing report	✓		Written	Matrix	RP
Longer term nurse staffing strategy	✓		Written	Action point - 1483	JB
Pathology services report	✓	✓	Written	Matrix	NJ
Learning from deaths report – Q3	✓		Written	Matrix	NJ
Safe staffing guardian report – Q3	✓		Written	Matrix	NJ
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Foundation Trust Membership Strategy	✓		Written	Matrix	RJ
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
e-Care report	✓		Written	Matrix	CB
Alliance and community service report, including integration milestones/deliverables	✓		Written	Matrix	DG
Stroke service – update on future as part of STP	✓		Written	Action point - 1466	NJ
Hospital concourse development, as part of capital programme	✓	✓	Written	Action point - 1489	CB
Financial improvement programme (FIP) exit report		✓	Written	Matrix	CB
Scrutiny Committee report		✓	Written	Matrix	GN
Operational plan 2018/19		✓	Written	Matrix	CB/RJ
Strategic update, including Alliance, Integrated Care System (ICS) and STP		✓	Written	Matrix	SD
Governance					

Trust Executive Group report	✓		Written	Matrix	SD
Council of Governors report	✓		Written	Matrix	SC
Remuneration Committee report	✓		Written	Matrix	AE
Charitable Funds Committee report	✓		Written	Matrix	GN
Board assurance framework		✓	Written	Matrix	RJ
Review of NED responsibilities	✓		Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JB
Register of interests	✓		Written	Matrix	RJ
Well-led review		✓	Written	Action point - schedule	SD
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	RQ