West Suffolk NHS
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 26 May 2017 at 9.15** in the Committee Room, at West Suffolk Hospital

Roger Quince
Chairman

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Apologies for absence** To note any apologies for the meeting – Richard Davies	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 28 April 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.	**Quality & Performance reports (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.	**Transformation report (attached)** To receive the report	Helen Beck
10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
11.	**Aggregated quality report (attached)** To accept the aggregated analysis including serious incidents, red complaints and PALs enquiries	Rowan Procter / Nick Jenkins
12.	**Revised mortality reporting (attached)** To approve the report recommendations	Nick Jenkins
13.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter

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
11:00 GOVERNANCE		
16.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
17.	**Appointment of senior independent director (attached)** To note the appointment of Alan Rose	Roger Quince
18.	**External 'well led' review proposal (attached)** To approve the report recommendations	Richard Jones
19.	**Use of Trust seal (attached)** To receive the report	Richard Jones
20.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:15 ITEMS FOR INFORMATION		
21.	**Any other business** To consider any matters which, in the opinion of the Chairman, should be considered as a matter of urgency	Roger Quince
22.	**Date of next meeting** To note that the next meeting will be held on Friday, 30 June 2017 at 9:15 am in the Committee Room.	Roger Quince
RESOLUTION TO MOVE TO CLOSED SESSION		
23.	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

West Suffolk NHS
NHS Foundation Trust

Item 5

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 28 APRIL 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	•	
In attendance			
Anna Hollis	Communications Manager		
Georgina Holmes	FT Office Manager *(minutes)*		
Richard Jones	Trust Secretary		

Action

GENERAL BUSINESS

17/75 APOLOGIES FOR ABSENCE

Apologies for absence were noted above.

The Chairman welcomed and introduced Alan Rose who had replaced Rosie Varley and Angus Eaton who had been appointed as Board Advisor. He explained that although Angus Eaton was not formally a Non-Executive Director, he would contribute in every way and it was intended that he would take over from Steve Turpie as chair of the Audit Committee when his term of office came to an end.

17/76 QUESTIONS FROM THE PUBLIC

- Liz Steele referred to the availability of wi-fi for patients in hospitals, and asked how near WSFT was to ensuring that all patients, including elderly patients with dementia had access to wi-fi and ipads. The Chief Executive explained that wi-fi across the Trust was currently being upgraded, which would ensure that it was fully accessible across the hospital. There was already free access to public wi-fi for patients and he suggested that the Trust should consider increased the number of devices that were available for patients to use. It was confirmed that there were ipads available for patients in some areas of the hospital, eg G4. Rowan Procter explained that this had been piloted and she was now awaiting feedback.

- Joe Pajak asked how the Board would ensure that the new arrangements for TPP operated efficiently and effectively and that issues were escalated appropriately and managed effectively. The Chairman explained that this had been considered in detail to ensure effective management from the beginning and would be discussed in the closed session of the meeting.

17/77 REVIEW OF AGENDA

The agenda was reviewed and the Chairman explained that the closed agenda was very full therefore he proposed ensuring that all other items had been discussed prior to Sarah Gull presenting agenda item 15 at 11.00am.

17/78 DECLARATION OF INTERESTS

There were no declarations of interest.

17/79 MINUTES OF THE MEETING HELD ON 3 MARCH 2017

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

Item 17/59 (page 4), action Nick Jenkins.

17/80 MATTERS ARISING ACTION SHEET

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

Ref 1331 – provide Board with a stroke services option appraisal and sustainability report. Nick Jenkins explained that he and Craig Black had met with the stroke team this week and the report would not be ready for the May Board meeting. It was hoped that is would be available for the June meeting.

Ref 1370 – confirm with new clinical director whether a Trust paediatric strategy group was still required. Steve Turpie reported that he had had a discussion with Dr Lakshman and this item could now be closed.

Ref 1393 – consider timing for an STP workshop with Board and Governors. It was confirmed that this had been arranged for Thursday 18 May 2017.

Gary Norgate referred to item 17/61 in the minutes of the previous meeting and the provision of further information on additional sessions at the meeting in June. Richard Jones confirmed that this was on the forward plan for this meeting.

17/81 CHIEF EXECUTIVE'S REPORT

The Chief Executive highlighted the following:-

- The year-end figure was even better than reported in the finance report and this would be discussed under agenda item 9. He commended the finance team for all their work on this.

- A bid for GP streaming in A&E had been successful and the Trust had been awarded £1m towards funding this.

- A&E performance over the bank holiday period had been good. WSFT had been the best performing hospital in the region and tenth best nationally.

- Escalation meetings with the regulators on both finance and A&E performance were no longer taking place as performance in both areas had improved. NHSI were now satisfied that WSFT was in a more sustainable position.

- G9 would be closing earlier than planned, which would also result in a financial saving. The staff on this ward had been excellent and this had been the best escalation ward during the winter period that the Trust had ever had.

- The campaign for recycling equipment had been very successful with nearly £1m of equipment having been returned.

- There had been a major focus on diagnostics and the position had now been recovered with 99% of patients receiving rapid access to diagnostics.

- A letter had been received from the Secretary of State, Jeremy Hunt, congratulating WSFT on its performance on the staff survey. Results of this survey would be followed up across various areas of the organisation.

- Progress was being made on the blood transfusion service but this would take time.

Gary Norgate referred to the Red2Green campaign and explained that he had attended a ward round with Nick Jenkins and had been very impressed with this initiative and the level of diligence. He particularly noted the importance of the care co-ordinator who played a key role in this, as well as the importance of a formal arrangement for the supply of physiotherapy support. Rowan Procter confirmed that she was taking a paper on this to the CCG executive board on Wednesday.

The Chief Executive explained that this was still work in progress, with varying engagement which continued to be addressed. This included feeding back to staff on the benefits and positive affect that this was having.

Alan Rose referred to the requirement for there to be a GP involved in triage and asked if there was a GP at the front of WSFT's emergency department. It was explained that this was not the case but the £1m capital bid that had just been awarded would enable this to happen. Currently there were GPs located at the front of the emergency department, but they were co-located, not embedded. The service would not be provided by WSFT, but would be commissioned by the CCG.

Alan Rose asked if this would affect performance numbers. Nick Jenkins explained that patients would still be included in the numbers, however if the GPs did not do an efficient job this could affect four hour performance. He hoped that this would enable a better service to be given to patients who either required GP treatment or to be treated in the emergency department. He stressed that this would still be an emergency department, not another GP facility. An emergency department nurse would make the decision as to whether patients should see a GP or be seen by the emergency department.

Neville Hounsome asked if this service would be in place by the October deadline. Nick Jenkins explained that the Trust had had to commit to achieving this by October in order to receive the £1m funding and the aim was for this to be operational for 1 October.

DELIVER FOR TODAY

17/91 QUALITY & PERFORMANCE REPORT

Rowan Procter reported that all duty of candour actions had now been completed and closed. Overdue RCA actions had been escalated to Clinical Directors and there was a process and time frame for these to be escalated to the executive team if they

continued to be overdue.

There was a national shortage of the antibiotic of choice; therefore the process had had to be changed to use other antibiotics. I was possible that this could improve antibiotic compliance statistics for the next six months as more regular audits would be undertaken.

There had been one case of *c.difficile* in March, but this was within the limits of *c.difficile* due to lapse of care. The total for the year was five, versus a trajectory of 22.

Surgery had made considerable progress with performance in pressure ulcer prevention.

Gary Norgate noted the improved performance on nutrition assessment and monitoring. He asked if there was an underlying concern about the number of falls at Glastonbury Court. Rowan Procter explained that there needed to be a balance between allowing patients to mobilise versus keeping them immobile. The aim of Glastonbury Court was to mobilise patients.

Nick Jenkins explained to the Board that there was a worldwide shortage of the antibiotic Tazocin, which WSFT used a lot of for serious infections. This meant that this would not be available to patients apart from cancer patients on chemotherapy and ITU patients. The alternative antibiotic that was being used caused more *c.difficile* than Tazocin. It was expected that this shortage would continue until at least July.

Rowan Procter referred to children in care and explained that there as now a clear escalation route for breaches in receiving an initial health assessment within 28 days. She confirmed that social workers and foster parents were aware of the requirement for these children to have an assessment within 28 days.

Neville Hounsome was pleased to see that there had been improvement in the completion of the WHO checklist in maternity. He asked if it was the same people who made more than one mistake or if this was a systemic issue. Rowan Procter said that she would look into this and report back to the Board next month. **R Procter**

Richard Davies referred to the ward dashboard and noted that some wards had more red areas than others; he asked if this was due to the different types of ward. Rowan Procter explained that there was an issue on F9 with peripheral cannulas, but there was a higher incidence of cannulisation on this ward. This was the same with G3.

The Chairman noted the continuing issue of patients not being informed about delays in being seen. He did not consider this to be acceptable and asked Rowan Procter to look into this, as there was a need to understand where the problem lay. **R Procter**

The Chairman asked about the number of births and how this related to the block contract and if the Trust should be aiming to attract more women to give birth at WSFT. Craig Black explained that the aim was to deliver the highest possible service and the block contract worked on an estimated number of deliveries. WSFT had consistently delivered to plan with little movement in the number of births, ie approximately 2700 each year. The Chief Executive explained that if people came from out of area the Trust would still qualify for PbR (Payment by Result).

The Chairman asked how the NHSLA premium was calculated. Craig Black explained that this was based on staff numbers which were also related to the level of activity. The insurance premium cost approximately £600 per birth, but the tariff was only £1k. Therefore every hospital in the country lost money on obstetrics. However, other areas

of this service made a profit, therefore it balanced out overall.

Alan Rose asked about mortality. He noted the good SHMI and HSMR numbers nationally, but that there were a couple of outliers in specialties; he asked if more detail was available on this.

Nick Jenkins explained that this would change next month as HSMR and SHMI were poor indicators. A lot of work was being undertaken as a result of the Department of Health's drive on learning from deaths. From quarter two Trusts would be required to have a policy on talking about how to learn from deaths and from quarter three they would be required to report to the public Board meeting with statistics on how many deaths there had been in hospital where learning should have occurred. Nick Jenkins would be bringing a paper on this to the Board next month.

Steve Turpie asked for an update on paediatric speech and language therapy (SALT). He noted this had progressed initially but had become more static over the last three to four months. He asked that this report included assurance around the future and that the previous issues would not recur. Also provision of SALT to special schools. **H Beck**

Angus Eaton referred to the safety thermometer and noted that this was volatile. He asked if there was an underlying factor to this volatility. The Chairman explained that this was a snapshot of data on one day across all Trusts each month.

The Chief Executive asked if e-Care would be able to track this on a daily basis in the future, so variations could be identified on an ongoing basis. Helen Beck thought that technically this would be possible; however the benefit and priority for reporting purposes would need to be looked at. The Chairman considered that this was would be too much detail for the Board but it would be very good management information. He suggested that this should be re-visited in the future. **H Beck**

Helen Beck reported that overall the Trust was on target to achieve RTT reporting in July. The number of 52 week waits for March was eight, which was as anticipated; however this would be difficult to resolve over the coming weeks due to capacity issues in a number of areas. The number for April was 14, but some of these were the same patients who would continue to be recorded until they were treated. It was anticipated that this figure would remain the same for May.

These were mainly in ENT due to capacity. She had asked for the entire ENT PTL to be revalidated so there was a clear picture of the situation, and she hoped to be able to provide a more accurate picture around ENT in at the Board meeting in June.

The Chairman referred to the issue in the emergency department with oncology patients and requested that this should be fully understood and addressed. Nick Jenkins confirmed that they were trying to work through this, as ideally these patients should not come into the emergency department, but should be admitted directly to oncology. Rowan Procter explained that one of the issues was the one hour requirement and for the venous access PICC line to be done safely.

The Chief Executive asked about patients who breached this and the effect in relation to potential patient harm or increased length of stay. Rowan Procter confirmed that these were being reviewed.

Gary Norgate asked about 52 week waits and if it was known why these patients were delayed. Helen Beck explained that there should be an accurate total number for the RTT position by July.

The reasons for the delays were known about and these were being tracked and managed, however with some patients there were variations in their pathways. Over 50% of all these patients were in ENT and the Trust was working with the CCG on actions to resolve this.

17/92 FINANCE AND WORKFORCE REPORT

Craig Black explained that the finance report was the final month of the year and the underlying position in March was good due to a reduction in temporary spend.

The final position reported a deficit of £4.3m, which was £700k ahead of plan. This position was partly due to the achievement of non-recurrent CIPs; however there were still concerns about the underlying position within the organisation.

Since preparing this report the position had changed, as on Monday evening (24 April) the Trust was given £850k to reflect the fact that it had over-achieved against the control total. Therefore the actual position which was submitted in the final accounts on Wednesday was a deficit of £3.442m.

The Chairman considered this to be very good, particularly as this performance had continued into April. Steve Turpie agreed that this was a great result but cautioned against being complacent, as this was still a deficit. Everyone needed to continue to be aware of the real challenges.

Gary Norgate noted the graph on page 7 and the level of staff required in order to achieve the Trust's productivity target.

The Chief Executive said that although this was good performance, the Trust had not achieved its stretch CIP and this would be focussed on next year.

Jan Bloomfield explained that Craig Black had talked to the Clinical Directors about the impact of this to ensure that the message did not change about the underlying problem. Therefore the message going out to staff, particularly consultants, was that there was still a lot to do. This message had been carefully communicated across the organisation.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/93 AGGREGATED QUALITY REPORT

The Board noted the content of this report.

17/94 NURSE STAFFING REPORT

Rowan Procter reported that ward G9 had now closed. There were currently 33 vacancies for registered nurses and 12 vacancies for nursing assistants. In context, at the regional Director of Nurses meeting a couple of weeks ago WSFT had benchmarked very well compared to other organisations of a similar size.

A considerable amount of work was being undertaken by the new ward manager on F3, which would be taking on band 4s and running the ward in a different way. They were also working with HR on the recruitment of nursing assistants.

The Chairman suggested that the reduction in vacancies was also a reflection of the staff survey.

Jan Bloomfield explained that the Trust was not being complacent and last week newly qualified nurses had been invited to look around the hospital and there had been 17 applications from those who had visited.

She had also spoken to the HR Director at Colchester about a recruitment campaign in the Philippines, to try and save on costs and share intelligence on their previous visits.

She explained that a priority was also to focus on retention of nursing staff and undertake exit interviews, particularly for band 5s, to understand why they were leaving.

Alan Rose considered the applications from the nurses who had recently visited to be a good news story. However colleges were concerned about a reduction in applications for nursing positions due to the withdrawal of bursaries.

Rowan Procter explained that the Trust was putting more focus on apprenticeships and in-house training of staff, including development of nursing assistants.

Richard Davies asked if there was a lack of people coming into nurse training places. Alan Rose said that this was not currently an issue, but there was a concern about the future. Applications had reduced and there was a medium term concern about this.

Gary Norgate asked about non-productive time and what the level of this should be. Rowan Procter explained that this was mandatory training, management days etc. There was not a set amount of time for this, but mandatory training was considered to be a priority. Gary Norgate asked if there should be a benchmark for this. The Chief Executive said that the Trust standard was 20%. Jan Bloomfield explained that HealthRoster had a number of indicators for this.

Neville Hounsome referred to vacancies for registered nurses and asked about the negative figures for unregistered nurses. Rowan Procter explained that this needed to be corrected and re-standardised. **R Procter**

17/95 MANDATORY TRAINING REPORT

Jan Bloomfield explained that performance was looking positive and this was the best position, apart from safeguarding, since the Trust had started to report on mandatory training. She referred to appendix D which showed dementia training was at 93%, which was a CQUIN requirement. There was some concern about compliance with induction; however the toughest period was always quarter four due to releasing staff over the winter period.

Helen Beck explained that the pro-active report was also very helpful in achieving performance.

Neville Hounsome agreed that induction training was a concern and also conflict resolution which, given the feedback from the staff survey, was an area that needed to be focussed on. Jan Bloomfield explained that this was more about the availability of trainers and courses being full. Most of the incidents referred to in the staff survey were not about conflict resolution but dementia training, which was more important.

Rowan Procter reported that the Trust was trialling new training on managing

challenging behaviour in areas where there was greatest concern.

The Chief Executive asked for clarification on the figures in Appendix A and Appendix B as they did not appear to reconcile. Jan Bloomfield said that she would confirm these.

He also asked if there was an issue with information governance. Richard Jones said that he would confirm this as this could be a timing issue. Jan Bloomfield explained that this was a big challenge as information governance training was annual rather than three yearly.

Angus Eaton asked about learning from mandatory training and reviewing this. Jan Bloomfield explained that there was a mandatory training committee which constantly reviewed this. This was also reviewed regionally to enable seamless transfer of staff across the health service.

Rowan Procter explained that there was also bespoke training for areas of concern, although this might not be mandatory.

Nick Jenkins said that mandatory training for doctors would also be reviewed, particularly around e-Care.

17/96 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that Broderick Pooley, Deputy Hotel Services Manager, and the in-house catering team had received the Putting You First Award this month.

The nomination commended the team on the wide choice and quality of the food that they delivered free to patients, as well as the fantastic selection for visitors and staff. In addition their ability to organise, prepare and serve 375 Christmas meals to staff over two days, as well as continuing to serve meals to patients and visitors. "Just fantastic, a credit to one and all. Phenomenal, the one word that sums it all up …"

The Board agreed with this commendation and congratulated Broderick and his team on this award.

17/97 NURSING STRATEGY UPDATE

Rowan Procter explained that this was an update on the progress that had been made since this strategy was launched a year ago. This was a five year strategy; therefore there were still areas where work needed to be undertaken. She confirmed that side rooms and wards F12 and G5 would be updated to be dementia friendly. The ward checklist had been updated and initiatives would continue to be reviewed.

The leadership programme had been shared with Directors of Nursing across the region and they were looking at different ways of working as a result of the withdrawal of CPD funding, ie a shared leadership nursing programme.

12 May was national nurses' day; there would be a chapel service and fruit would be delivered to nurses across the organisation.

Alan Rose noted that a lot of work was being undertaken; however he had hoped to see more about future plans and next steps, ie more ambitious.

Angus Eaton asked if WSFT was making the most of 12 May from a PR perspective. Jan Bloomfield confirmed that she would follow this up; she explained that this was also dementia awareness week and Shining Lights was taking place on 11 May.

The Chairman agreed that the Trust should capitalise on 12 May and take the opportunity to educate people about the role of modern nurses. The Chief Executive suggested that WSFT try to get radio and TV coverage for this. **R Procter**

Rowan Procter confirmed that she had sent information on what WSFT was doing for 12 May to both regional and national NHS organisations.

It was agreed that the Board would receive an annual update on this strategy and it would include data and narrative against milestones. **R Jones / R Procter**

17/98 GUARDIAN REPORT

Sarah Gull introduced herself and explained that she had been a consultant in Obs & Gynae since 1993. The new Terms and Conditions of Service (TCS) for junior doctors, which were introduced in 2016, included the requirement for there to be a guardian of safe working hours for junior doctors. A report was to be presented to the Board every three months and this was the first report which was based on a template from NHS England.

There were currently only 30 doctors on 2016 TCS, but this would increase to 150 by August 2017.

If a junior doctor felt that they were working more than their contractual duties they should complete an exception report using Allocate software, which was already in place at WSFT. To date there had been 30 exception reports raised, split evenly between medicine and surgery. These reports included narrative and should provide a constructive way of looking at practice and what could be improved and learnt from these.

Junior doctors should also report if they were not able to take their breaks, ie 30 minutes over a five hour session. To date no reports relating to this had been received.

A pilot was currently being undertaken to look at junior doctors being ward based. This meant they would be part of a ward rather than attached to a consultant.

She explained that a lot of data was unavailable for this report as the HR department were not able to provide data for locums. It was hoped that more detail would be available for the next report. She thanked the department for their support.

Rowan Procter reported that this had also raised issues around inconsistent bleeps from nursing staff on a ward, which she was investigating.

Alan Rose said that this linked to the culture of transparency, human factors and the freedom to speak up.

Neville Hounsome considered this report to be very helpful and provided the right level of detail. He asked how this was fed back to doctors. Sarah Gull explained that this was fed back to the junior doctors' forum. Jan Bloomfield said that this quarterly report would also go to the Trust Negotiating Committee.

Alan Rose asked how issues were addressed, ie name and shame. Nick Jenkins confirmed that these were addressed; both he and Sarah Gull were aware of where or who issues needed to be addressed with. He considered that the management of the process was working well between the two of them and that she was doing an excellent job.

Steve Turpie said that from the Board's perspective the biggest concern was whether the organisation was safe. Sarah Gull confirmed that the eight outstanding issues had now been addressed and she did not consider that there was a safety issue.

Nick Jenkins explained that this was also encouraging team work and teaching junior doctors to prioritise. He referred to the fines system and explained that this would be completed for the second report to the Board; it would also highlight any alerts.

Jan Bloomfield explained that as well as Nick Jenkins and Sarah Gull she also monitored this and HR would alert her if they noted any concerns. A system had also been introduced where a junior doctor could talk to a consultant if they had any issues or concerns which were not necessarily about working hours.

The Chief Executive asked if there was likely to be any duplication with Datex. It was considered that this should not be an issue.

BUILD A JOINED UP FUTURE

17/99 e-CARE REPORT

Craig Black reported that the key issues were funding, which had not yet been received, reporting issues around RTT and an issue with discharge summaries which would be discussed in the closed session.

The next major milestone was the weekend of 20/21 May when Ordercomms would go live. A significant amount of work was being undertaken to co-ordinate a number of different organisations to come together over the weekend. There would be a similar on-call arrangement and on site management to when e-Care went live last May (2016).

He had had a discussion with the Department of Health yesterday about how WSFT would like to receive funding in 2017/18, although funding for 2016/17 had not yet been received. This was expected imminently.

Angus Eaton asked if there were contingency plans in place in case there were any major issues when Ordercomms went live. Craig Black confirmed that there were plans in place and a significant amount of testing and learning from other organisations had been undertaken. There were points in the process where this could be stopped if things were not working as they should be. He explained that this would significantly enhance the ability to report.

Gary Norgate confirmed that rigorous testing had paid off when e-Care went live last May.

GOVERNANCE

17/100 TRUST EXECUTIVE GROUP REPORT

The Chief Executive assured the Board that the downside of non-recurrent CIPs had been clearly discussed and highlighted.

17/101 QUALITY & RISK COMMITTEE REPORT

Richard Jones explained that one of the concerns had been around the progress of health and safety compliance audits. A Health & Safety committee meeting had taken

place last week where this was discussed and addressed.

Nick Jenkins requested that in future amendment to terms of reference should be shown as tracked changes.

The Board approved the updated terms of reference.

17/102 AGENDA ITEMS FOR NEXT MEETING

It was noted that the stroke option paper would now go to the Board in June.

The scheduled agenda items for the next meeting were approved.

ITEMS FOR INFORMATION

17/103 ANY OTHER BUSINESS

There was no further business.

17/104 DATE OF NEXT MEETING

The next meeting would take place on Friday 26 2017 at 9.15am in the Committee Room.

RESOLUTION TO MOVE TO CLOSED SESSION

17/105 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.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 26 May 2017

AGENDA ITEM:	Item 6
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	19 May 2017
SUBJECT:	Matters arising action sheet
PURPOSE:	Approval

EXECUTIVE SUMMARY:
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

Linked Strategic objective (link to website)	6. To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	The Board received a monthly report of new, ongoing and closed actions.
Risk description: (including reference Risk Register and BAF if applicable)	Failure effectively implement action agreed by the Board
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Report provides audit trail between minutes and action points, with status tracking. Action not removed from action log until accepted as closed by the Board.
Legislation / Regulatory requirements:	
Other key issues:	

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
1331	Open	30/9/16	Item 9	Provide Board with a stroke services option appraisal and sustainability report	Following discussion in October Board meeting it was agreed that this should consider the provision of care out of hospital. An initial review was considered by the executive team on 16 Nov. Based on this discussion a full option appraisal to be considered by the Board. Agreed at April meeting to discuss with CCG the provision of stroke services in the community as part of community services negotiations.	HB	30/06/2017	Green

Completed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1368	Open	27/1/17	Item 8	Bring back explanation for the red rating for anaesthetics within the HSMR specialty tree (p21)	Preliminary analysis has confirmed that there is no basis of concern for the underlying patient data. A new mortality report format is being developed based on the new national reporting requirements issued on 21/3/17. **Agenda item.**	NJ	26/05/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1387	Open	3/3/17	Item 14	Update CQC action plan to reflect the position re wardable patients and RTT performance.	Plan updated. RTT reporting and performance is considered by the Board as part of Quality & Performance report. Monitoring of wardable patients in critical care is now part of the capacity report (issued three times a day). The surgical division are incorporating monitoring as part of their performance dashboard. A full update on the action plan will be reported to the Q&R Committee in June.	RP	26/05/2017	Complete
1388	Open	3/3/17	Item 14	Report on proposed changes to CQC self-assessment process (as part of quality improvement)	Discussion taken place with operational leads and external organisations to consider options/best practice. **Scheduled to report proposals/pilot in Jun '17.**	RP	30/06/2017	Complete
1393	Open	31/3/17	Item 2	Consider timing for an STP workshop with Board and Governors	Scheduled for 18 May 2017	RJ	26/05/2017	Complete
1394	Open	31/3/17	Item 7	Richard Davies to be the lead NED for the recent never event investigation.	Communicated to governance team.	RP	26/05/2017	Complete
1395	Open	31/3/17	Item 7	Maternity WHO analysis to include further detail of performance and remedial action	Included in April's Quality Report. **Confirmed with maternity lead no pattern of individuals not complying with checklist**	NJ	26/05/2017	Complete
1401	Open	28/4/17	Item 8	Investigate 'delays in being seen' as reported within the patient experience dashboard	**Improved performance for April - further detail in quality report**	RP	26/05/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1402	Open	28/4/17	Item 8	Update on SLT services, to include: performance against original plan, work with local authority and assurance for future delivery	**Agenda item**	HB	30/06/2017	Complete
1403	Open	28/4/17	Item 8	When e-Care reporting has been resolved scheduled consideration of what and how we are reporting against quality indicators	As agreed this has been scheduled as part of the Board's forward plan for consideration in September '17. considered	RJ	26/05/2017	Complete
1404	Open	28/4/17	Item 11	Within the nursing staffing report consider how to use the Trust standard for non-productive time. Also address '+' and '-' indicators in report.	Updated report on agenda with further work being undertaken on templates. Non-productive time will be part of the KPMG review.	RP	30/06/2017	Complete
1405	Open	28/4/17	Item 14	Agreed to schedule the nurse staffing review on an annual basis to include data and narrative against milestones	**Included in reporting schedule**	RJ	26/05/2017	Complete
1406	Open	28/4/17	Item 14	Develop plans for promotion of international nursing day - 12 May	The was addressed through a number of routes including 'Green sheet', Twitter, Radio Suffolk interview and NMCC.	RP	26/05/2017	Complete

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 26 May 2017

AGENDA ITEM:	Item 7
PRESENTED BY:	Steve Dunn, Chief Executive Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	19 May 2017
SUBJECT:	Chief Executive's Report
PURPOSE:	Information

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.

April's **performance pack** shows that we have maintained operational performance for emergency flow reflecting the focus on red2green. However the referral to treatment (RTT) performance, which continues to be estimated, shows a significant deterioration for patients on an incomplete pathway - 82.23% against a target of 95%. I regret to say that 15 patients breached the 52 week wait target in April.

Reflecting our focus on flow we have organised the first **Red2Green East of England network meeting** which will be held on Friday 16 June. ECIST's Pete Gordon will be at the event, which is an opportunity to share good practice. Staff from Ipswich Hospital, Kings Lynn, Peterborough, Norfolk and Norwich, Luton and Dunstable and James Paget have confirmed their attendance. The network meeting will be held in Bury St Edmunds.

The **month 1 financial position** reports a deficit of £938k for April which is better than plan by £52k.The 2017-18 budgets include a CIP of £13.3m of which £908k has been achieved in April. Delivering the control total will ensure the Trust receives Sustainability and Transformation Funding (S&TF) of £5.2m, resulting in a year-end net deficit of £5.9m.

NHS Improvement (NHSI) confirmed they have **closed the investigation** into the Trust's compliance with its licence. It found that there was not sufficient evidence of wider failings in Trust governance to support formal regulatory action. The investigation was opened in February 2017 following the Trust forecasting an £7.1m overspend against its 16/17 control total. In addition, the Trust had not accepted its 17/18 and 18/19 control totals. The investigation did not identify any evidence that the issues relating to the forecast overspend demonstrated governance concerns which were sufficient to put the trust in breach of its licence, and did identify that actions had now been taken to recover the financial position and to enable achievement of the 16/17 control total of £5.0m. NHSI has residual concerns around future savings and the pace at which action can be taken to improve the position recurrently.

To address NHSI's concerns we are working with KPMG as part of the **national financial improvement programme (FIP)** commissioned by NHSI. The programme will critically challenge our existing cost improvement and efficiency programmes, identify additional opportunities from a range of other initiatives and support delivery at pace. Through this approach the programme will support delivery of our control total in-year and establish a programme to ensure long term sustainability.

Thankfully Trust was not affected by the **ransomware cyber-attack** which took hold of the NHS this month. All our clinical patient services were running as normal. As a precautionary measure we temporarily shut down some systems and put restriction in place for some email traffic. Our IT team have been phenomenal since the attack took place. They pulled out all the stops and worked solidly over the weekend, to ensure our systems continue to be protected. This included installing security updates to over 2,500 PCs and all servers. They deserve a huge thank you for all their efforts.

Final testing and preparations continued for the planned go-live of **e-Care OrderComms** over the weekend of 20/21 May 2017. However it was recognised that the ransomware issue over the last week diverted a considerable amount of IT resource across multiple partners which has materially affected the ability to complete the build and deliver the full testing programme required for a safe go live. On this basis go-live has been delayed and we will assess resources and requirements in the coming days to agree a new date for a safe go-live. I am sure you will understand the reason behind this decision which I am personally very supportive of as patient safety must always come first.

On Friday 5 May, our pathology service transferred from the Pathology Partnership (tPP) to **North East Essex and Suffolk Pathology Services (NEESPS)**. This is a partnership of Ipswich, Colchester and West Suffolk hospitals and our vision is to deliver innovative high-performing pathology services that are clinically-led and responsive to the needs of our patients. It is business as usual in our laboratories, however staff in this service are transferring to Colchester Hospital University NHS Foundation Trust (CHUFT) as their new employer. Colchester is the host of the new service, which is designed to deliver the benefits of scale of three hospitals working together while being close enough to clinical services and patients to provide an excellent service to our customers. My thanks, as ever, to all of you who work in this service or support it, for your patience and ongoing hard work as we go through this change.

I am delighted that our endoscopy unit has been **accredited by the joint advisory group** for GI endoscopy (JAG). The JAG assessment ensure the quality of patient care in endoscopy through the accreditation of services by defining and maintaining the standards by which endoscopy is practised, and is hosted by the Royal College of Physicians.

It was a pleasure to host NHS England's **NHS England's executive group meeting**. I was able to tell them about all the great work and high quality services our amazing staff deliver, and some of you were part of a lively debate, which covered many topics. I also showed Simon Stevens around the hospital, where he viewed our wonderful dementia friendly memory walk, and learned about our e-Care system and how it underpins our ambition to further improve our quality. Trust staff also participated in a Q&A with NHS England executives Simon Stevens, chief executive, Jane Cummings, chief nurse and Professor Sir Bruce Keogh, medical director.

Finally I am delighted that we have been named as one of the country's top hospitals once more. This is a direct result of our fantastic clinical outcomes and patient care. The accolade is a testament to the consistent hard work and dedication of our staff over the years, who are committed to making sure all of our patients have the best experience they can when using the hospital. Received for the third year running, the award recognises the safe, effective and high quality care we provide. The hospital was one of 40 from across the country to receive the accolade from independent healthcare intelligence company Caspe Healthcare Knowledge Systems (CHKS) during its top hospitals 2017 awards ceremony in London on Wednesday 10 May. The CHKS top hospitals award recognises and rewards the best performing client trusts across the UK, following the evaluation of over 22 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. The indicators are revised annually to take into account any newly-available performance information.

Chief Executive blog
http://staff.wsha.local/Blog/Happy1stbirthdaye-Care!.aspx

DELIVER FOR TODAY

Digital Dave
The Trust supported Dementia Awareness Week including the latest dementia friendly initiative, Dave, a state-of-the-art digital reminiscence therapy system. Dave helps patients with dementia and elderly inpatients to have a more comfortable stay by providing access to archives of historic photos, music, games and even by allowing patients to take their own photos.

Community hospital opens new look café
Visitors to Newmarket Community Hospital found its that popular restaurant had had a makeover earlier this month. The White Lodge Café re-opened on 3 May with new décor and furniture including comfortable sofas and armchairs. The café offers light meals and snacks from breakfast to afternoon tea, including daily specials, fresh salads, and homemade soup. New to the menu is freshly-brewed coffee, a greater variety of hot and cold drinks, 'grab and go' meals, and other sweet and savoury items. Improvements to the café, which is open Monday to Friday, 8.00am - 4.00pm, have been made by the Suffolk community facilities team and their colleagues, and will benefit staff, patients and visitors using this important community hub.

Artist donates mural
The day surgery unit has been transformed with an aquatic mural splashed across windows and walls. Donated by local born artist Amanda Turner, the bright scene is a welcome distraction for patients who come to the unit for treatment. The digital piece of art spans six internal windows and is printed on transparent film, so that it acts like a stained glass window, with the natural light shining through and changing the effects throughout the day.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Anaesthetic team shortlisted for award
The anaesthetic team at West Suffolk NHS Foundation Trust (WSFT) was shortlisted for Anaesthesia Team of the Year in the British Medical Journal (BMJ) awards 2017, an award sponsored by the Royal College of Anaesthetists (RCoA). The 9th annual BMJ awards, they recognise and celebrate the inspirational work of healthcare teams across the country. The anaesthetic team at the hospital is driving quality improvement across the Trust by introducing new ways of working. Anaesthetists now play a lead clinical role in every area where surgical patients' care is designed and managed.

International Nurses Day
Executive chief nurse Rowan Procter was interviewed on BBC Radio Suffolk's breakfast show about international nurses' day. Rowan gave a positive account of what it's like to be a modern day nurse at WSFT and highlighted what opportunities are available locally to get into nursing.

Shining Lights
The annual 'Shining Lights' staff awards were held on 11 May, celebrating the achievements of staff over the past year. With a record 220 nominations received from hospital staff and the public, the awards were given to individuals or teams who have shown particularly outstanding dedication and excellence in the care of their patients, or the initiative to drive through service improvements in the hospital or out in the community. The awards were held in a spruced up Time Out. In total 17 awards were up for grabs, including employee of the year, clinical team of the year, inspirational leadership, rising star, My WiSH Charity star and volunteer of the year.

Charge nurse Will Ferreira was crowned employee of the year following his drive of an innovative project to improve patient safety and raise awareness of ways staff can help minimise the chance of patients developing pressure ulcers. Colleagues said of Will: "Will has shown great enthusiasm when educating ward staff to recognise and care for patients with pressure ulcers. He really is someone to aspire to". The clinical team of the year went to the community diabetes nurse team, who are supporting practice nurses working in GP surgeries to provide the most up-to-date advice and treatments choices for people with diabetes. As a result of the hard work and dedication of those

involved in the partnership, West Suffolk Clinical Commissioning Group has risen from 209th to 81st in the country for the support given to patients with diabetes in just two years.

BUILD A JOINED-UP FUTURE

Sugary drinks ban
The Trust responded to NHS England's sugary drinks ban at hospitals. Dr Helena Jopling, public health registrar, set out how the Trust has already implemented restrictions on the sale of sugary drinks in our retail outlets and cafes, and banned the promotion of such items across the Trust. Helena also featured on BBC Radio Suffolk's Breakfast Show, and discussed national eat what you want day, providing a health perspective on the issue and encouraged a sensible approach to diet and nutrition.

Buurtzorg nursing model
The Buurtzorg nursing model is to be piloted in the community in the coming months. Rowan Procter and Sharon Bass are leading on this exciting new model of care for our patients in the community which provides a unique district nursing model that has gained international acclaim for being entirely nurse-led and cost effective.

NATIONAL NEWS

DELIVER FOR TODAY

Referral-to-treatment waiting times and forecast
This report estimates that the number of people waiting longer than 18 weeks for planned operations could exceed 800,000 by 2020. The analysis finds that demand for elective operations is rising, with the number of people waiting for treatment forecast to hit 5 million in 2020. The report recommends that patients be made aware of their right to choose where they receive NHS treatment in order to help patients access care as quickly as possible.

Implementing shared decision making in the NHS: lessons from the MAGIC programme
In 2010, the Health Foundation in the UK commissioned the MAGIC (Making Good Decisions in Collaboration) programme to design, test, and identify the best ways to embed shared decision making into routine primary and secondary care using quality improvement methods. In this paper, the authors draw on the learning from the three year programme and subsequent experience to summarise the key challenges of implementing shared decision making and to offer some practical solutions. (The BMJ, April 2017)

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

My experience as a patient revealed how the NHS needed a digital overhaul
The NHS saved my life. Now I want to ensure patients and clinicians have the technology, services and insight necessary to deliver the right care – Juliet Bauer. (The Guardian Healthcare Network, April 2017)

Quality principles for NHS apprenticeships
The National Skills Academy for Health and Health Education England have developed a new set of principles to ensure excellent practice in apprenticeship provision across UK health care organisations. The principles have been designed to help health care employers and those leading on the development of apprenticeships to understand what it takes to achieve high-quality outcomes and the standards they should be expected to evidence through their organisational approach to apprenticeships. Free registration is required for full access to this guidance. NB You will have to register your details before you can access the Quality Principles.

BUILD A JOINED-UP FUTURE

NHS hospitals won't be paperless before 2027
A new report from Digital Health Intelligence concludes that the government's target for all NHS hospitals to become paperless will not be met before 2027. (Digital Health, April 2017)

Integration and Better Care Fund policy framework 2017 to 2019
This document sets out how health, social care and other public services will integrate and provides an overview of related policy initiatives and legislation. It includes the policy framework for the implementation of the statutory Better Care Fund in 2017 to 2019 and also sets out our proposals for going beyond the Fund towards further integration by 2020. (DH, March 2017)

Smoking may be banned in new council homes
Smoking could be banned in some new council homes in a bid to protect the health of children, a UK public health expert has said. The agreement would be voluntary rather than mandatory, although it would be part of the tenancy contract for new family housing. A ban on smoking in public places, including restaurants and bars, was introduced in England in 2007. The government then commissioned a review of the evidence on the impact of the law in England. This was carried out by Prof Linda Bauld from the University of Stirling and the UK Centre for Tobacco Control Studies.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 26th May 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
DATE PREPARED:	May 2017
SUBJECT:	Trust Quality & Performance Report
PURPOSE:	To Update The Board On Current Quality Issues And Current Performance Against Targets

EXECUTIVE SUMMARY:

This commentary provides an overview of key issues during the month and highlights where performance fell short of the target values as well as areas of improvement and noticeable good performance.

- This month the Trust had 3 C Diff (1 in March). Falls for the month were 53 (71in March and 6 pressure ulcers (4 in March) - pages 6-7.
- Overdue Duty of Candour are 3 – page 9
- RTT performance continues to be estimated; however as we work through the process we are seeing improved data accuracy which has led to a revision in the estimated position for patients on an incomplete pathway. The revised estimated shows a significant deterioration in position which is now reported at 82.23% against a target of 95%. – page 21
- This month we have reported 15 x 52 week breaches against a target of 0. – page 21
- This month we have included a new section reporting on 104 day breaches against the 62 day referral to treatment cancer standard. This section recognises the need for increased rigour around the review of these cases and increased visibility by the board. – page 21

Linked Strategic objective (link to website)	
Issue previously considered by: (e.g. committees or forums)	
Risk description: (including reference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatory requirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	

Recommendation:
The Board is asked to note the Trust Quality & Performance Report and agree the implementation of actions as outlined.

1. CLINICAL QUALITY

This section identifies those areas that are breaching or at risk of breaching the Clinical Quality Indicators, with the main reasons and mitigating actions.

Patient Safety Dashboard

Indicator	Target	Red	Amber	Green	Feb	Mar	Apr
HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	95	100	96
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	99	98	100
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	98	95	100
HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	100	100	100
HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	100	100	100
HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	= 100	100	100	100
HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	95	82	81
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<85	85-99	= 100	NA	100	100
Total no of MRSA bacteraemia: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	0
Total no of MRSA bacteraemia: Community acquired (Trust level only)	No Target	No Target	No Target	No Target	0	ND	1
Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	NA	91	NA
MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	90	90	92
Hand hygiene compliance	= 95%	<85	85-99	= 100	99	100	98
Total no of MSSA bacteraemia: Hospital	No Target	No Target	No Target	No Target	2	1	ND
Quarterly Standard principle compliance	90%	<80	80-90%	90-100	NA	95	NA
Total no of C. diff infections: Hospital	= 16 per yr	No Target	No Target	No Target	0	1	3
Total no of C. diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	5	3	ND
Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	NA	93	NA
Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	9	9	2
Isolation data (Trust level only)	= 95%	<85	85-94	95-100	95	89	90
Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	NA	91	NA
Quarterly VIP score documentation	= 90%	<80	80-89	90-100	NA	79	NA
PEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	100	100	80
No of patient falls	= 48	>=48	No Target	<48	55	71	53
Falls per 1,000 bed days (Trust and Divisional levels only)	= 5.6	>5.8	5.6-5.8	<5.6	4.98	5.35	ND
No of patient falls resulting in harm	No Target	No Target	No Target	No Target	14	16	9
No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	ND	0
Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	0.09	0.15	ND
No of patients with ward acquired pressure ulcers	< 5	>=5	No Target	<5	10	4	6
No of patients with avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target	3	0	ND
Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	83.11	90	91
No of SIRIs	No Target	No Target	No Target	No Target	7	8	9
No of medication errors	No Target	No Target	No Target	No Target	54	60	64
Cardiac arrests	No Target	No Target	No Target	No Target	8	13	0
Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	1	0	0
Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	NA	NA	75
Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	NA	95	NA
Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	98.43	98.19	98.53
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4	9	8	3
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC	64	60	60
Median NRLS upload 6 month rolling average [NEW]	46days	>46	No Target	0-46	50	51	ND
SIRIs reported > 2 working days from identification as red	0	>1	1	0	0	2	0
SIRI final reports due in month submitted beyond 60 working days	0	>1	1	0	0	0	0

Indicator	Target	Red	Amber	Green	Feb	Mar	Apr
Active risk assessments in date	100%	<75%	75 – 94%	>=95%	100	100	100
Outstanding actions in date for Red / Amber entries on Datix risk register	100%	<75%	75 – 94%	>=95%	100	100	100
Total Verbal Duty of Candour outstanding at month-end [NEW]	0	>3	1 - 3	0	ND	ND	3

Exception reporting for indicators in the Patient Safety Dashboard

All indicators in the Patient Safety dashboard which are red, amber for two consecutive months or are an amber quarterly indicator will have narrative below.

Data notes:

All indicators which have been unable to provide data in 2016/17 due to information systems have been temporarily removed from the above dashboard and noted below. When data is available they will be reinstated in the dashboard.

Indicators related to SIRIs and Duty of Candour have been updated to more accurately reflect the performance being monitored by the CCG.

Data items *Falls per 1000 Beds days and Falls with moderate/severe harm/death per 1000 bed days* which had not been previously available from e-Care have been provided as a working estimate for Q4 2016/17 with an aim to provide final figures for reporting from April 2017 onwards.

Data items *VTE: Completed risk assessment* and *Gynaecology (F14) 30-day readmissions* have not been possible to collate due to the transfer over to e-Care. The Information team are exploring ways to ensure this data is provided for future months.

Data items *Elective MRSA screening* and *MRSA Emergency Screening* information currently cannot be supplied following the implementation of Clinisys laboratory system. (Until Nov15 elective screening had been above 98%). We are awaiting an update from the Pathology service (NEESPS) on their development of a replacement search function. This acknowledged risk was upgraded to 'red' on the risk register in February, the meeting to assess the risk held in accordance with policy, has re-graded it as Amber, but at the top of the scale with controls in place. Ongoing review of the risk and progress towards a solution continue; testing of the proposed solution has not so far proved successful.

1.1 HII compliance 6b: Urinary catheter on-going care

a) Current Position

A score of 81 in April was similar to 82 in March and was RAG-rated as red for the second month in a row. This was based on 11 episodes of non-compliance where documentation of care was missing

b) Recommended action

Continued support from e-Care team and matron team to ensure staff are aware of how to record care given on e-Care. Matrons will be checking weekly to ensure an improvement on compliance.

1.2 MRSA decolonisation (treatment and post screening) (Trust Level only)

a) Current Position

The Trust achieved 92% compliance in April 17. Within the reported figure are patients who receive more than 1 day of decolonisation to ensure a robust process is reported. There were two patients who received a single day and are not included.

b) Recommended action

IPT will continue to work with pharmacy to ensure compliance. Attaching a copy of the incomplete record to the feedback form appears to be useful and having a beneficial effect. The paper record is planned for inclusion into the electronic record but there is not an agreed date for this yet.

1.3 Isolation data (Trust level only)

a) Current Position

One patient with MRGN bloodstream and foot wound on G5 unable to isolate due to higher risk infections in the ward. Single rooms required G5 specialist medical care. Patient chronically colonised with MRSA has failed multiple decolonisation attempts required NIV support within a bay clinical need outweighing other considerations, patient commenced on daily Octenisan wash for remainder of admission.

b) Recommended action

All measures in place to mitigate onward transmission from lower risk source.

1.4 Nutrition: Assessment and monitoring

a) Current Position

A score of 91 in March was just higher than 90 in March and continues to be amber RAG rated and this will continue to be a major focus for the next few months. Weigh scales have been replaced and this has also had an impact on our overall result.

There were 11 omissions of weight on admission, 11 omissions of nutritional assessment on admission, 4 patients were not reweighed after 7 days and 1 patient did not get a re assessment after 7 days, the wards involved were: G5, G4, G1, F5, F14, F3, G9 and F9

b) Recommended action

The matron team will continue to focus on this important audit, spot checking admission weights nutritional assessments and be present at meal times.

1.5 Pain Management: Quarterly internal report

a) Current Position

Pain audit has improved to 75% overall and is now RAG rated as Amber. Surgery and Women & Children were RAG rated as Green, whereas Medical is RAG rated as Red

b) Recommended action

Each matron has received ward specific feedback and will be addressing the issues at ward level

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1.6 Total no of C. difficile infections: Hospital

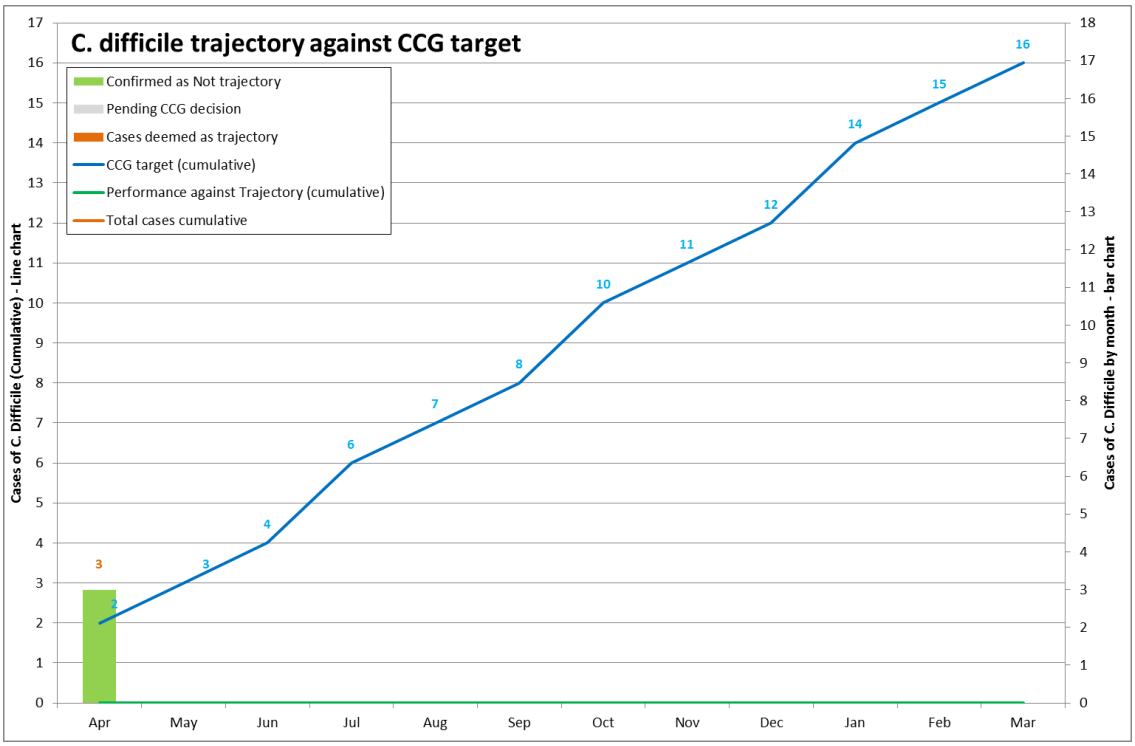
a) Current Position

Performance against trajectory is as follows: There were three cases of hospital attributable CDT in April. All of these three cases have been deemed non trajectory by our commissioners (no lapses of care) whereby they will not accrue a penalty, there are no trajectory cases and none are pending.

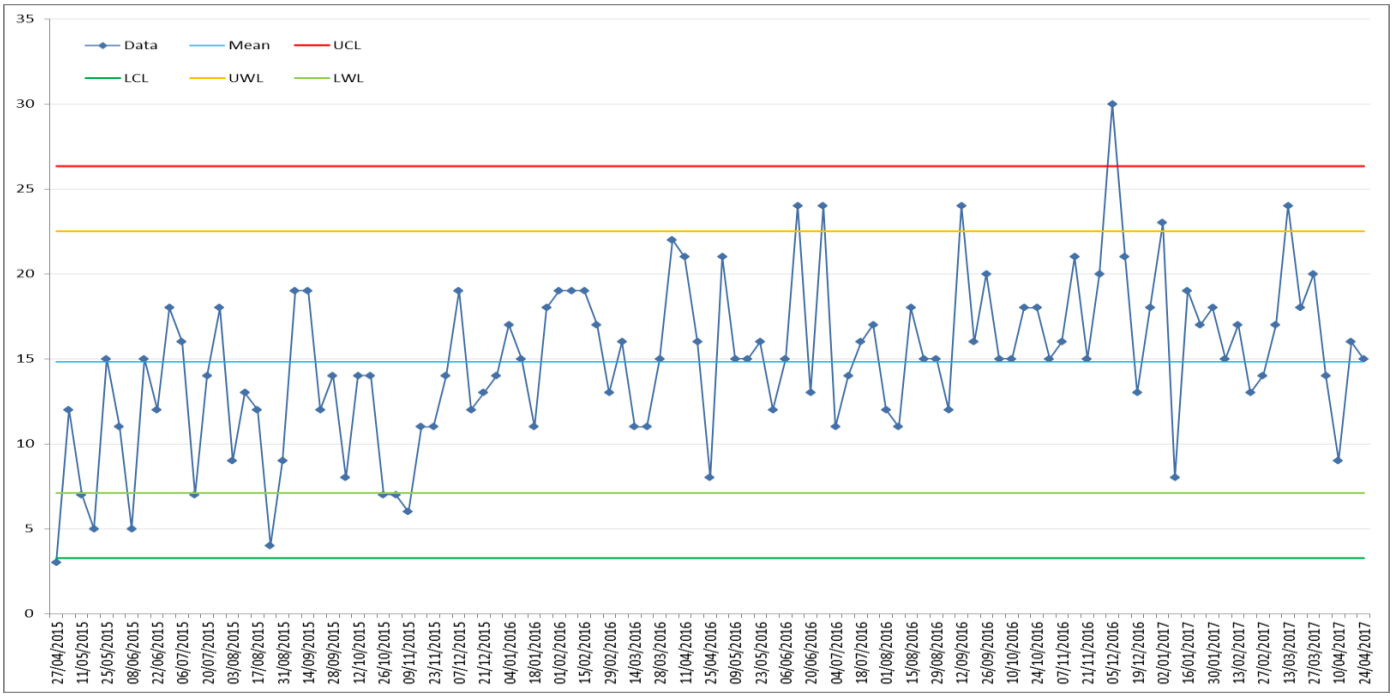
The graph below has been updated to demonstrate the Trust performance against the trajectory target set by the CCG.

b) Recommended Action

To continue with vigilance to identify symptoms of C difficile for early identification and testing.



1.7 No of Patient Falls & No of Patient Falls Resulting In Harm or Serious Injury



The SPC chart above shows a data point above the Upper confidence limit for the w/c 5th December 2016. This related to 29 incidents and included one patient who fell four times and one who fell three times in that week.

There were 53 falls in April (71 in March), none with major harm

Two patients fell at Newmarket Hospital (two in March). Four patients fell at Glastonbury Court (six in March), these falls are reported separately.

Two patients were assisted to the floor (four in March) preventing them from falling.

G8 experienced 13 falls this month, four patients fell twice, on investigation many patients were undergoing rehab on the ward during this month and one patient was young and independent but often lost balance due to a brain injury

Two patients fell more than twice in their inpatient stay this month, (two in March).

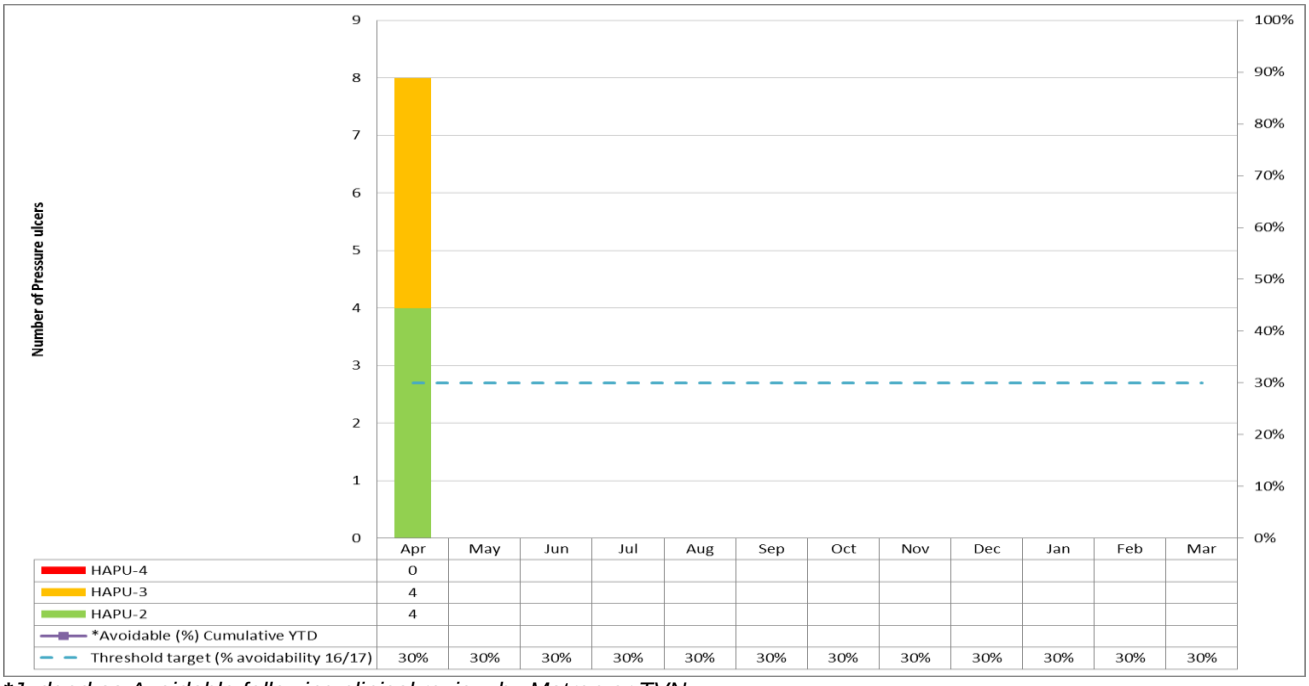
Patients who fell more than twice in the last three months at their usual place of residence and prior to admission have not been possible to collate due to the transfer over to e-Care. The Information Team are exploring ways to ensure this data is provided for future months.

We can now report our falls per 1000 bed days for January – 5.19, February – 4.98 and March - 5.35 the National average is 6.63 (2015)

Falls with moderate/severe harm/death per 1000 bed days for January – 0.09, February – 0.09 and March – 0.15 the National average is 0.19 (2015).

The Trust has taken part in the National Falls Audit and we anticipate results to be available later in the year.

1.8 No of Patient with Ward Acquired Grade 2/3/4 Pressure Ulcers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
HAPU-4	0											
HAPU-3	4											
HAPU-2	4											
*Avoidable (%) Cumulative YTD												
Threshold target (% avoidability 16/17)	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%

Judged as Avoidable following clinical review by Matron or TVN

Grade 2 / 3 / 4 Pressure Ulcers / Deep Tissue Injury (DTI)

There were four HAPU-2 in April. G4, G5, G9 and F10 had one ulcer each.

There were four HAPU-3 in April. F3, F6, G8 and CDS had one ulcer each.

There were two DTI reported in April.

HAPU-3 have been automatically reportable as an SI from October 2016. A pathway to ensure timely investigation, review and submission has been agreed by Tissue Viability and the Matrons.

Avoidable harm

The Trust achieved the 2016/17 quality priority target for avoidable pressure ulcers *Maintain the incidence of avoidable pressure ulcers, avoidable inpatient falls and hospital acquired VTE below the baseline for*

2014/15. The target has been included in the 2017/18 annual report quality priority list with the 2016/17 year end performance of 30% as the target to improve upon in 2017/18

At the end of April there had been 10 HAPU 2, 3 or 4 reported. 0 (0%) of these have been classified as avoidable and 6 (60%) as unavoidable with another 2 pending confirmation of grading as these cases are currently under investigation and these have a 60 working day deadline in line with the Serious incident framework.

Pressure ulcer prevention

Development to the React to Red campaign at the Pressure ulcer prevention group continues. This Meeting provides a forum to discuss regular updates and learning whilst measuring performance. PU prevention continues to concentrate on timely and accurate skin assessments. The Tissue Viability team give sensitive feedback to all staff that may need support with the assessments. Teaching sessions are also regularly arranged and provided at development days for all clinical staff.

Within the next Quarter we will be launching a campaign based on data showing that we have had an increase in Heel damage throughout the Trust..

Our Clinical photographer is now taking pictures of all Hospital Acquired Pressure Ulcers and uploading them for clear and accurate documentation on each wound. Due to an increase in Deep Tissue Injury's and a high demand for Topical Negative Pressure treatment Link Nurse days have recently been carried out with intensive training on these two subjects.

1.9 Safety Thermometer: % of patients experiencing harm-free care

a) Current Position

The National 'harm free' care composite measure is defined as the proportion of patients without a pressure ulcer (ANY origin, category II-IV), harm from a fall in the last 72 hours, a urinary tract infection (in patients with a urethral urinary catheter) or new VTE treatment.

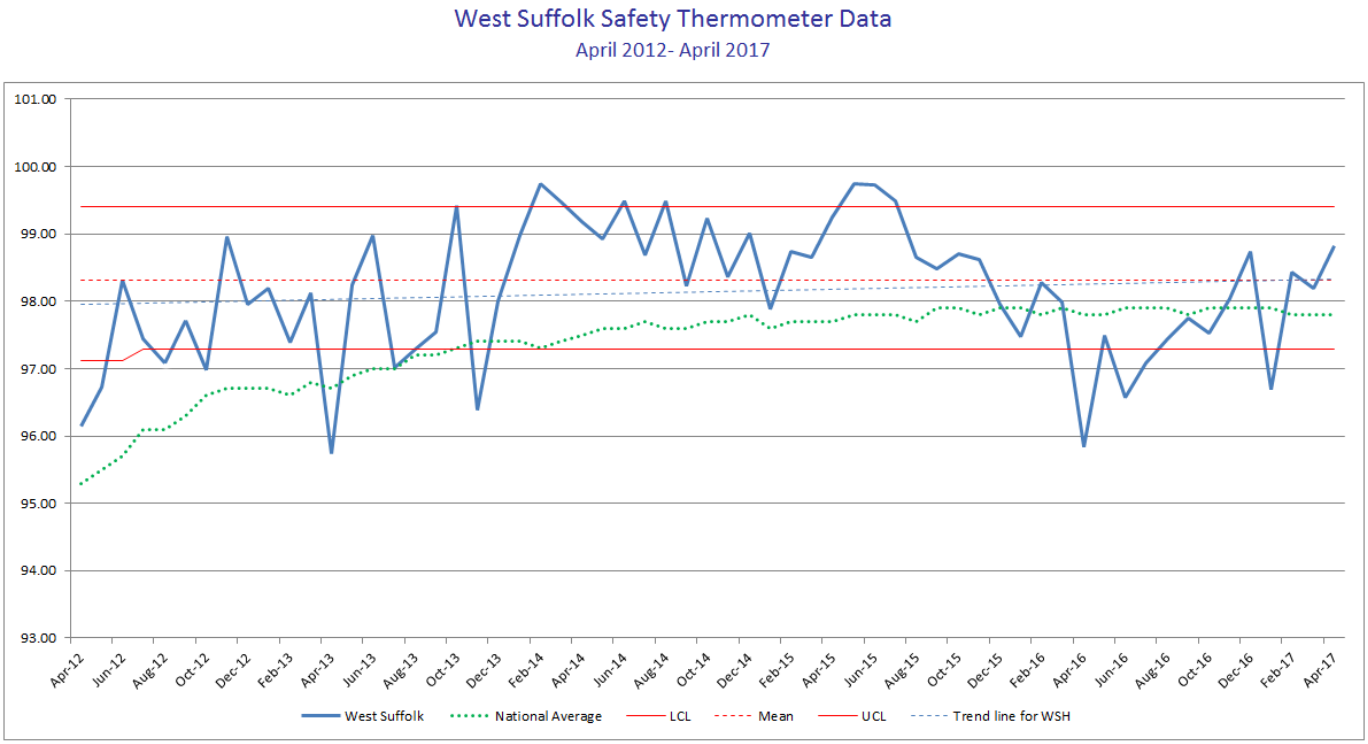
	May-6	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Harm Free	94.97	93.63	92.31	92.25	92.71	92.31	92.61	93.16	91.35	93.72	94.06	94.12
Pressure Ulcers – All	3.27	3.43	5.31	3.88	5.03	5.49	5.67	3.80	5.34	4.71	3.62	5.00
Pressure Ulcers - New	1.26	1.47	1.06	1.29	1.01	1.65	1.23	0.51	1.53	1.05	0.52	0.88
Falls with Harm	0.50	0.49	0.53	0.00	0.75	0.55	0.49	0.76	0.76	0.00	0.00	0.00
Catheters & UTIs	1.26	1.96	2.12	3.62	1.51	2.20	1.23	2.28	2.04	1.31	1.81	1.18
Catheters & New UTIs	0.50	0.98	0.53	0.78	0.50	0.00	0.25	0.00	0.25	0.26	0.78	0.29
New VTEs	0.25	0.49	0.80	0.52	0.00	0.27	0.00	0.00	0.76	0.26	0.52	0.00
All Harms	5.03	6.37	7.69	7.75	7.29	7.69	7.39	6.84	8.65	6.28	5.94	5.88
New Harms	2.51	3.43	2.92	2.58	2.26	2.47	1.97	1.27	3.31	1.57	1.81	1.18
Sample	398	408	377	387	398	364	406	395	393	382	387	340
Surveys	18	18	18	18	18	17	18	18	18	18	18	18

As of April 2017, NHS South, Central and West Commissioning Support Unit (SCW) now manage the NHS Safety Thermometer on behalf of NHS Improvement, including the collection and publication of the NHS Safety Thermometer data.

The data can be manipulated to just look at "new harm" (harm that occurred within our care) and with this parameter, our Trust score for April 2017 is **1.18 %** therefore, our new harm free care is **98.82%** The National new harm for April 2017 is **2.06%** or (**97.94**%).

It should be noted that the Safety Thermometer is a spot audit and data is collected on a specific day each month.

The SPC chart below shows the Trust Harm free care compared to the national benchmark for the period April 2012 to April 2017. Although the Trust figures are rising they still remain below the National Average for the fifth month.



b) Recommended Actions

To continue to monitor actual harm against national benchmarks

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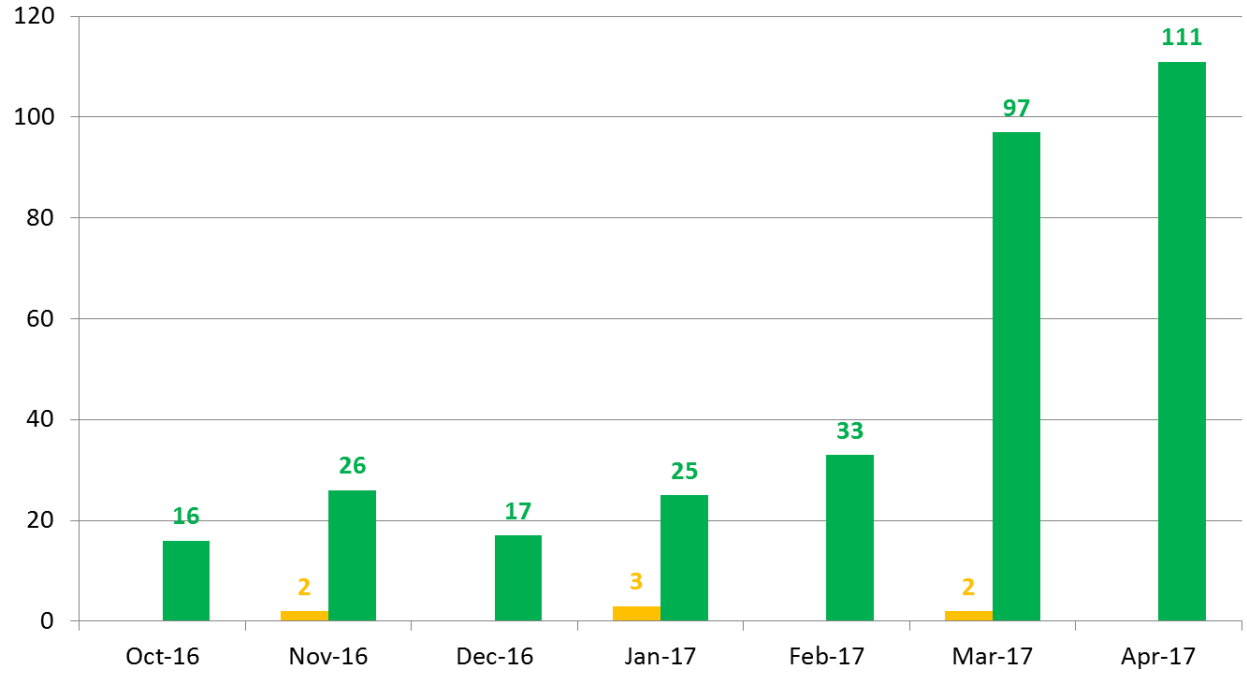
1.10 Incidents with investigation overdue

a) Current Position

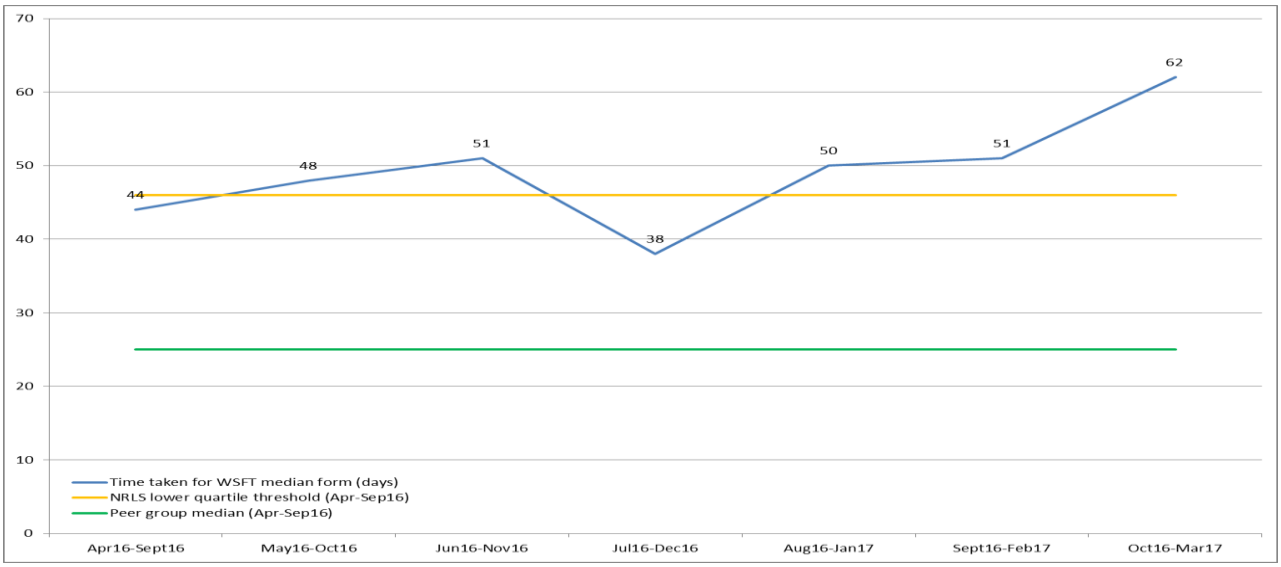
Graph: Green and Amber incidents overdue* by month.



*Overdue - Amber incidents for current reporting month are still within 30 day deadline so are not included on the graph

The graph above shows the number of green and amber incidents that are still awaiting investigation. NB: The next six monthly NRLS submission deadline is the 25th May and all incidents up to 31st March need to have been uploaded by that date.

325 (60%) of the April green incidents had been investigated at the time of this report compared to (60%) last month.



Graph: 50% of patient safety incidents uploaded to the NRLS

The graph shows the peer group median as a best practice (25 days green) and the threshold for the lower quartile in the most recent NRLS benchmark issued in May 2017 (<46 days amber) as an in-year target. For 2017/18 it is proposed to show performance as a rolling six month average as this is a more realistic way to demonstrate performance over time. The NRLS national report for the period Apr-Sept 2016 shows a considerable improvement in the Trust position with more detail provided in the 'Aggregated' report.

1.11 Duty of Candour (DoC)

a) Current Position

The KPI has been adjusted for 2017/18 to show the total verbal DoC outstanding at month-end. The RAG rating remains unchanged. There are currently three cases requiring verbal Duty of Candour which are reported as overdue at the end of April.

b) Recommended Action

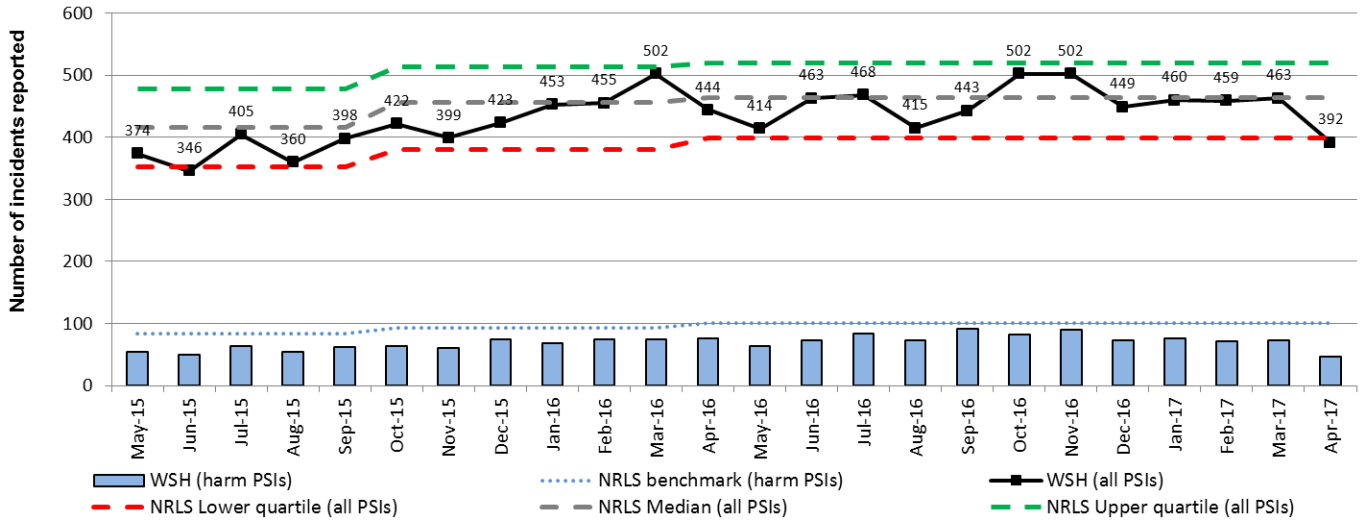
The individuals responsible for providing Duty of Candour have been contacted; non-compliance with Duty of Candour is escalated to the Clinical Directors.

1.12 Patient Safety Incidents reported

The rate of PSIs is a nationally mandated item for inclusion in the Quality Accounts. The NRLS target lines shows how many patient safety incidents WSH would have to report to fall into the upper / median and lower quartiles for the peer group. The most recent benchmark issued is for the period Apr – Sept16 and the graph thresholds have been updated to reflect the new parameters.

There were 460 incidents reported in April including 392 patient safety incidents (PSIs). This was the lowest level since November 2015 falls below the lower quartile threshold for the peer group. A review of the details behind this drop in reporting is provided in the 'Aggregated' report.

Graph: Patient Safety Incidents reported



1.13 Patient Safety Incidents (Severe harm or death)

The percentage of PSIs resulting in severe harm or death is a nationally mandated item for inclusion in the Quality Accounts. The peer group average (serious PSIs as a percentage of total PSIs) is from the NRLS period Oct15 - Mar16. The most recent benchmark issued is for the period Apr – Sept16 and the graph thresholds have been updated to reflect the new parameters. The benchmark line applies the peer group percentage serious harm to the peer group median total PSIs to give a comparison with the Trust's monthly figures. The WSH percentage data is plotted as a line which shows the rolling average over a twelve month period.

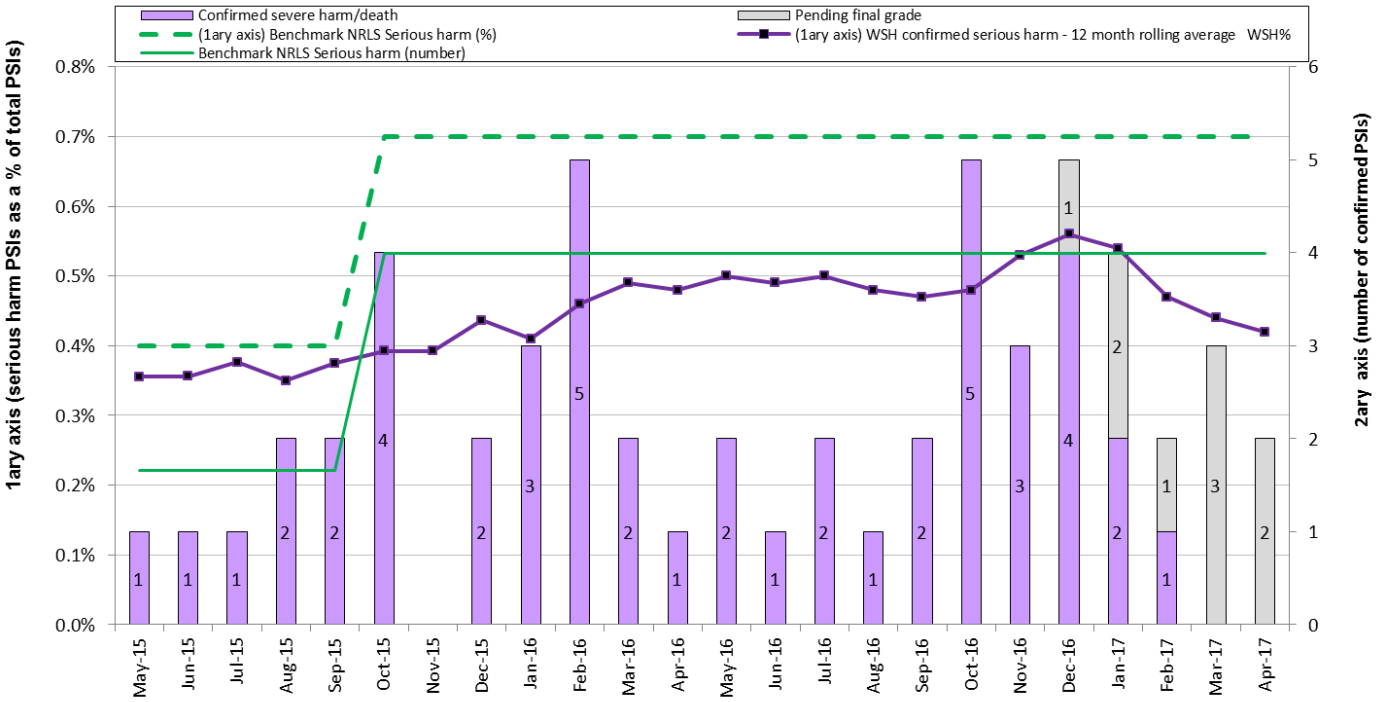
The Trust percentage sits below the NRLS average. The number of serious PSIs (confirmed and unconfirmed) is plotted as a column on the secondary axis.

In April there were two cases reported: one intrauterine death and one delay in diagnosis both of which are awaiting RCA to confirm harm grading.

The remaining seven incidents from previous months still awaiting RCA to confirm harm grading include:

- two delay in diagnosis
- one unexpected death
- two mortality reviews
- one maternal death
- two falls with fracture

Graph: Patient Safety Incidents (Severe harm or death)



Please note this graph shows the incidents according to the month the incident occurred in. The incident may have been reported as a SIRI in a different month especially if the case was identified retrospectively e.g. through a complaint or inquest notification.

Patient Experience Dashboard

In line with national reporting (on NHS choices via UNIFY) the scoring for the Friends and Family test changed from April 2015. It is now scored & reported as a % of patients recommending the service i.e. answering extremely likely or likely to the question "How likely is it that you would recommend the service to friends and family?"

A target of 90% of patients recommending the service has been set.

Indicator	Target	Red	Amber	Green	Feb	Mar	Apr
Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	93	94	91
(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	98	99	98
Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	73	73	71
Patient Satisfaction: outpatient overall result	= 85%	<75	75-84	85-100	92	91	96
(Out-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	97	93	100
Were you informed of any delays in being seen?	= 85%	<75	75-84	85-100	69	65	79
Were you offered the company of a chaperone whilst you were being examined?	= 85%	<75	75-84	85-100	72	74	91
Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	99	98	99
(Short-stay) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	99	99	99
Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	93	94	97
(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	96	96	97
Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	98	100	100
(A&E Children) How likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	98	96	97
Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	96	100	98
How likely is it that you would recommend the post-natal ward to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	100	100
How likely are you to recommend our labour suite to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	ND	ND	100
How likely are you to recommend our antenatal department to friends and family?	= 90%	<80	70-89	90-100	100	95	97
How likely are you to recommend our post-natal care to friends and family?	= 90%	<80	70-89	90-100	100	100	100
How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	ND	ND
Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	95	ND	99
Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	99	97	97
(F1 Parent & Young Person) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	100	100

Indicator	Target	Red	Amber	Green	Feb	Mar	Apr
Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	95	95	94
(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	100	93

Additional Patient Experience indicators

Indicator	Target	Red	Amber	Green	Feb	Mar	Apr
Response within 25 working days or negotiated timescale with complainant	100%	<75%	75 – 89%	>=90%	86	100	100
Number of second letters received	0	>6	2 - 6	0 - 1	2	1	3
Health Service Referrals accepted by Ombudsman	0	>=2	1	0	0	0	0
Red complaints actions beyond deadline for completion	0	>=5	1 - 4	0	0	0	0
Number of PALS contacts becoming formal complaints	0	>=10	6 - 9	<=5	0	1	0

Exception reporting for indicators in the Patient Experience Dashboard

All indicators in the Patient Experience dashboard which are red or amber for two consecutive months will have narrative below.

1.14 Inpatient: Noise at night

a) Current Position

The score has deteriorated to 71 from 71 in March, continuing to flag as a red area.

a) Recommended Action

May 2017 will see updates in patient satisfaction questionnaires. This question will now ask patients to tell us what kind of noise they experienced, allowing us to target the issues more specifically.

1.15 Out-patient: Were you informed of any delays in being seen?

a) Current Position

This score has greatly improved from 65 (red) to 79 (amber).

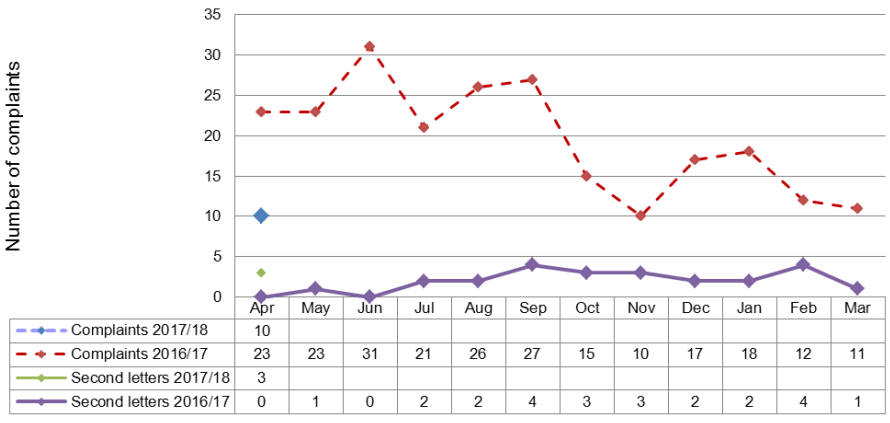
b) Recommended Action

Twenty new patient pagers have been ordered to allow patients to leave the department where there are significant delays. They are also exploring a messaging system with IT in order to communicate delays.

1.16 Complaints

10 complaints were received in April. The breakdown of these complaints is as follows by Primary Division: Medical (6), Surgical (4) compared with 11 in March. The top two most common area are as follows:

Patient Care – including Nutrition/Hydration	=4
Clinical Treatment – Surgical group	=4
Clinical Treatment – Accident & Emergency	3



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Complaints 2017/18	10											
Complaints 2016/17	23	23	31	21	26	27	15	10	17	18	12	11
Second letters 2017/18	3											
Second letters 2016/17	0	1	0	2	2	4	3	3	2	2	4	1

1.17 PALS

In April 2017 there were 172 recorded PALS contacts. This number denotes initial contacts and not the number of actual communications between the patient/visitor which can, in some particular cases, be multiple.

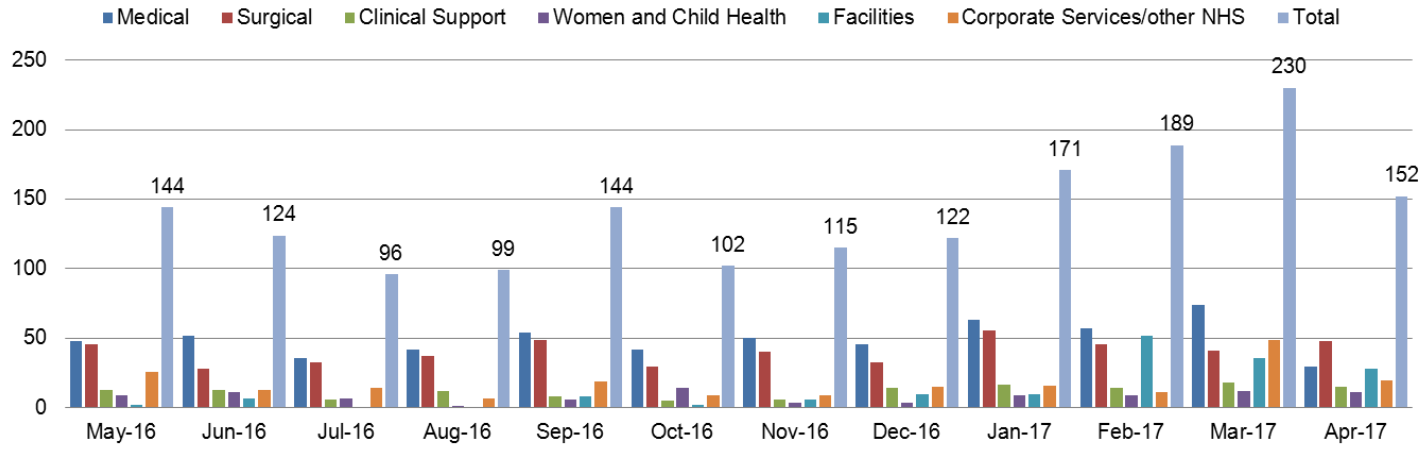
A breakdown of contacts by Directorate from May 16 – Apr 17 is given in the chart and a synopsis of enquiries received for the same period is given below. Total for each month is shown as a line on a second axis.

Trust-wide the most common three reasons for contacts are shown as follows:

- Queries, advice & request information (41)
- Facilities (39)
- Appointments; including delays and cancellations (30)

The category of 'Queries, advice & request information" appeared as the top issues in April, the main theme in this data was signposting to other organisations. Facilities: the main theme was the cost of car parking for disabled drivers and disability issues regarding wheelchair access from car park A to the hospital.

One contact throughout April was felt to be highly complex, Four contacts were of complex nature and Twenty one contacts were non-routine, the remainder being classed as routine enquiries.



Clinical Effectiveness Dashboard

All indicators in the Clinical Effectiveness dashboard which are red or amber for two consecutive months will have narrative below.

Indicator	Target	Red	Amber	Green	Feb	Mar	Apr
TA (Technology appraisal) business case beyond agreed deadline	0	>9	4 – 9	0 – 3	0	0	0
WHO checklist (Quarterly)	100%	<90	90 – 94	>=95	NA	99	NA
Trust participation in relevant ongoing National audits (Quarterly)	100%	<75	75 – 89	>=90	NA	95	NA
Gynaecology (F14) 30 day readmissions	No target	No target	No target	No target	ND	ND	ND
Babies admitted to NNU with normal temperature on arrival (term)	100%	<50%	50-80%	>80%	100	100	87
12 month Mortality standardised rate (Dr Foster)	100%	>100	90-100	<90	87.2	88.38	88.12
CAS (central alerting system) alerts overdue	0	>=1	No target	0	0	0	0

Maternity dashboard

Following a presentation to the Board in October it was agreed to receive more information within the performance pack on activities within the W&C division. This was very much about ensuring that the board maintains awareness of what is happening rather than any underlying concerns. The dashboard is reproduced below and elements already reported in the main quality report dashboard have been removed to prevent duplicate reporting. Where an element is co-reported in the Performance section of the report these indicators have been removed from the dashboard below to prevent duplicate reporting.

	Red	Amber	Green	Feb-17	Mar-17	Apr-17
ACTIVITY – Births						
Total Women Delivered	> 250 or < 200	>216 or <208	>208 or <216	197	234	213
Total Number of Babies born at WSH	> 250 or < 200	>216 or <208	>208 or <216	197	238	215
Twins	No target	No target	No target	0	4	2
Homebirths	< 1%	2% or less	2.5%	3%	2.1%	1.4%
Midwifery Led Birthing Unit (MLBU) Births	<=10%	13% or less	20%	19.3%	15.8%	17.8%
Labour Suite Births	<=64%	69% to 74%	75%	77.7%	82.1%	80.8%
BBAs	No target	No target	No target	1	2	1
Normal Vaginal deliveries	No target	No target	No target	151	160	160
Vaginal Breech deliveries	No target	No target	No target	1	0	2
Non operative vaginal deliveries	No target	No target	No target	152	ND	0
Water births	No target	No target	No target	16	16	15
Total Caesarean Sections	> 22.6%	No target	<22.6%	13.2%	19.2%	15%
Total Elective Caesarean Sections	>=13%	11 - 12%	10%	4.6%	6.5%	4.7%
Total Emergency Caesarean Sections	>=15%	13 - 14%	12%	8.6%	12.4%	10.3%
Second stage caesarean sections	No target	No target	No target	5	2	4
Forceps Deliveries	No target	No target	No target	5.1%	6%	6.1%
Ventouse Deliveries	No target	No target	No target	4.6%	6.4%	2.8%
Inductions of Labour	No target	No target	No target	36%	37.2%	42.7%
Failed Instrumental Delivery	No target	No target	No target	3	1	1.4
Unsuccessful Trial of Instrumental Delivery	No target	No target	No target	0	0	0
Use of sequential instruments	No target	No target	No target	ND	ND	ND
Grade 1 Caesarean Section (Decision to Delivery Time met)	<=95%	96 - 99%	100%	100%	100%	100%
Grade 2 Caesarean Section (Decision to delivery time met)	<=75%	76 - 79%	80%	70%	89%	92%
Total no. of women eligible for Vaginal Birth after Caesarean Section (VBAC)	No target	No target	No target	18	24	13
Number of women presenting in labour for VBAC against number achieved.	No target	No target	No target	9	8	6
ACTIVITY – Bookings						
Number of Bookings (1st visit)	No target	No target	No target	247	275	208
Women booked before 12+6 weeks	<=90%	91 - 94%	95%	95%	96.3%	95%
CLINICAL OUTCOMES - Maternal						
Postpartum Haemorrhage 1000 - 2000mls	No target	No target	No target	11	22	13
Postpartum Haemorrhage 2,000 - 2,499mls	No target	No target	No target	1	0	1
Postpartum Haemorrhage 2,500mls+	No target	No target	No target	0	0	1
Post-partum Hysterectomies	1	1	0	0	0	1
Women requiring a blood transfusion of 4 units or more	1	1	0	0	ND	1
Critical Care Obstetric Admissions	1	1	0	0	1	1
Eclampsia	1	1	0	0	0	0
You have	5 or more	3-4	2	2	8	2
3rd and 4th degree tears (All vaginal deliveries)	No target	No target	No target	4	7	8
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)	10	7-9	6	2	6	7
3rd and 4th degree tears (Instrumental Deliveries)				2	1	1
Maternal death	1	No target	No target	0	1	0
Female Genital Mutilation (FGM)	No target	No target	No target	0	0	0
Clinical Outcomes –Neonatal						
Number of babies admitted to Neonatal Unit (>36+6)	No target	No target	No target	8	0	15
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	No target	No target	No target	1	3	1
Number of Babies transferred for therapeutic cooling	1	No target	0	1	1	0
Cases of Meconium aspiration	No target	No target	No target	0	1	0
Cases of hypoxia	No target	No target	No target	1	0	0
Cases of Encephalopathy (grades 2 and 3)	No target	No target	No target	1	2	0
Stillbirths	No target	No target	No target	1	0	1
Postnatal activity						

	Red	Amber	Green	Feb-17	Mar-17	Apr-17
Return of women with perineal problems, up to 6 weeks postnatally	No target	No target	No target	ND	ND	ND
Workforce						
Weekly hours of dedicated consultant cover on Labour Suite	<=55 hrs	56-59	60hrs or >	81	60	93
Midwife/birth ratio	>=1:32	No target	1:30	1:28	1:33	1:30
Supervisor to Midwife Ratio	No target	No target	No target	1:19	1:19	
Consultant Anaesthetists sessions on Labour Suite	< 8 sessions	8-9 sessions	10 sessions	10	10	10
ODP cover for Theatre 2	80%	90%	100%	100%	100%	100%
Anaesthetist response to request for epidural for pain relief within 30 mins	< 70%	70 - 79%	>=80%	ND	ND	ND
Risk incidents/complaints/patient satisfaction						
Reported clinical Incidents	>40	40-59	60 and above	49	64	51
Serious incidents	No target	No target	No target	1	1	1
Never events	No target	No target	No target	0	0	0
Complaints	No target	No target	No target	0	0	0
1 to 1 Care in Labour	<=95%	96 - 99%	100%	100%	100%	100
Unit closures	No target	No target	No target	0	0	0
Massive Obstetric Haemorrhage protocol	No target	No target	No target	ND	ND	1
Maternal Postnatal readmissions	No target	No target	No target	ND	ND	
Completion of WHO Checklist	80%	90%	100%	87%	89%	84%
Babies assessed as needing BCG vaccine	No target	No target	No target	16	ND	ND
Babies who receive BCG vaccine following assessment	No target	No target	No target	14	ND	ND
Number of Women identified as smoking at booking	No target	No target	No target	ND	ND	27
Number of Women identified as smoking at delivery	No target	No target	No target	ND	ND	20
UNICEF Baby Friendly Audits	No target	No target	No target	10	10	10
Proportion of parents receiving a Safer Sleeping Suffolk Thermometer.	No target	No target	No target	157	165	143

Exception reporting for red indicators in the Clinical Effectiveness Dashboard

1.18 Post-partum Hysterectomies / Women requiring a blood transfusion of 4 units or more / Critical Care Obstetric Admissions

In April one patient required 2 returns to theatre and on the second occasion a post-partum hysterectomy. She had received blood transfusions prior to this and was admitted to HDU for recovery. An investigation has been undertaken which felt that this case had been managed well.

1.19 Maternity - Completion of WHO Checklist

The maternity service is striving to improve its compliance with the completion of WHO checklist and uses every opportunity to discuss the importance of this process. In April 2017 there were a total of 32 forms completed and 27 were fully correct. The remaining 5 had areas of non- compliance and these are followed up with the individual clinicians. There is no noted trend of the same clinicians month on month not achieving compliance.

The Ward Analysis Report for all Clinical Quality Indicators is provided at Appendix 1.

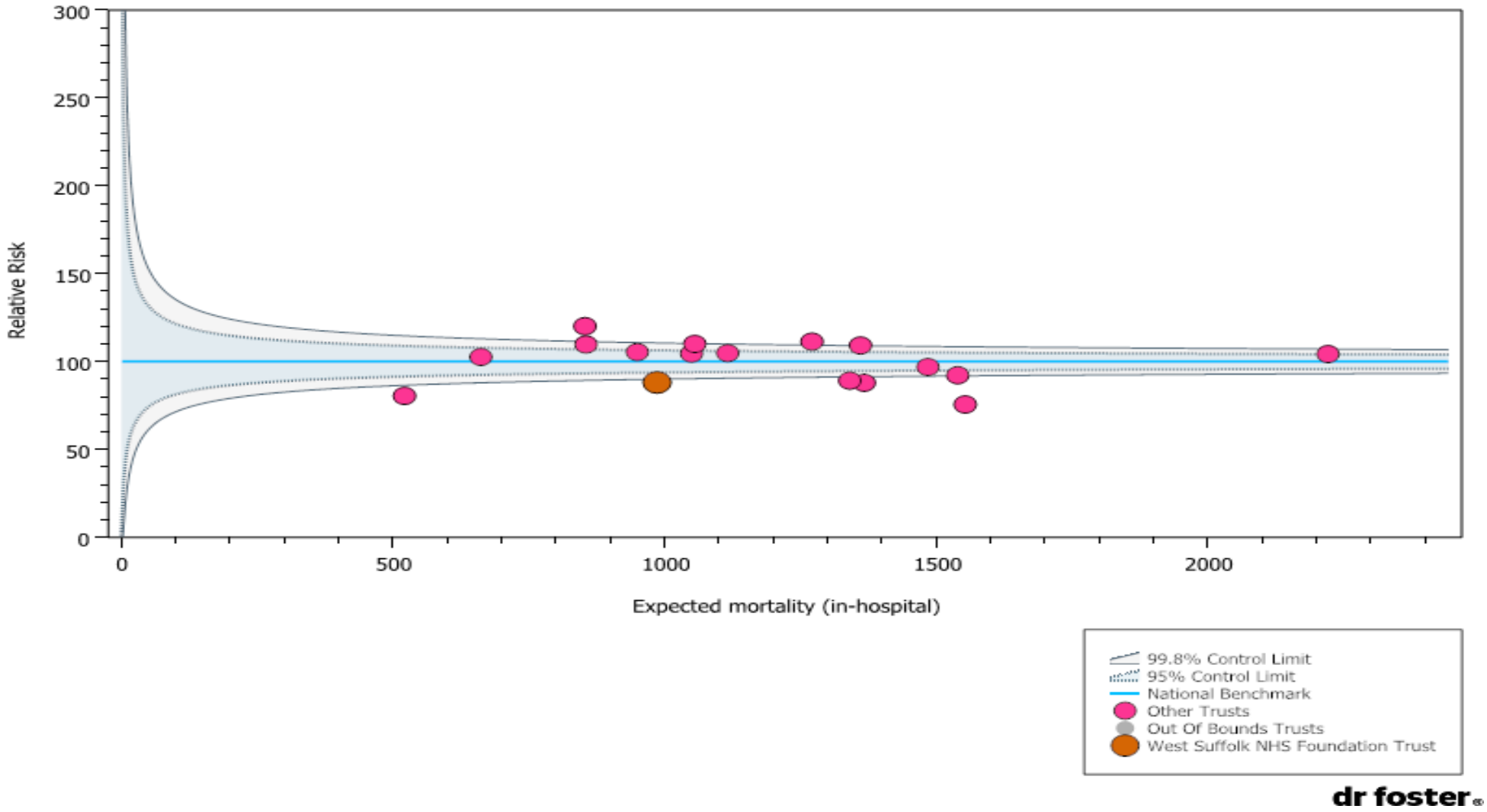
2. MORTALITY DATA

Mortality (Individual Months)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
No of Deaths	77	55	72	85	78	77	69	80	122	134	105	84
No of Discharges	5,153	5,026	5,072	5,493	4,921	5,298	5,642	5,269	5,313	5,311	4,838	5,360
% Deaths	1.49%	1.09%	1.42%	1.55%	1.59%	1.45%	1.22%	1.52%	2.30%	2.52%	2.17%	1.57%
HSMR*	82.1	71.1	83.4	107.2	106.7	94.9	78.1	94.4	104.9	106.5	108.6	86.7
Mortality (Individual Months)	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
No of Deaths	79	73	70	55	70	52	67	73	78	109	91	84
No of Discharges	5,032	5209	5273	5730	5188	5483	5637	5568	5402	5375	5439	5725
% Deaths	1.57%	1.40%	1.33%	0.96%	1.35%	0.95%	1.19%	1.31%	1.44%	2.03%	1.67%	1.47%
HSMR*	89.5	75.3	86.5	62.4	86.1	63.5	66.8	74.2	71.9	87.4	91.0	
	Apr-16	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
No of Deaths	71	87	71	58	74	82	83	98	102	103	99	95
No of Discharges	5,321	5427	5691	5410	5400	5674	5733	5950	5401	5577	5426	6444
% Deaths	1.33%	1.60%	1.25%	1.07%	1.37%	1.45%	1.45%	1.65%	1.89%	1.85%	1.82%	1.47%
HSMR*												
	Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**
No of Deaths	72											
No of Discharges	5,378											
% Deaths	1.34%											
HSMR*												

HSMR BENCHMARK IS USING FY 15 -16

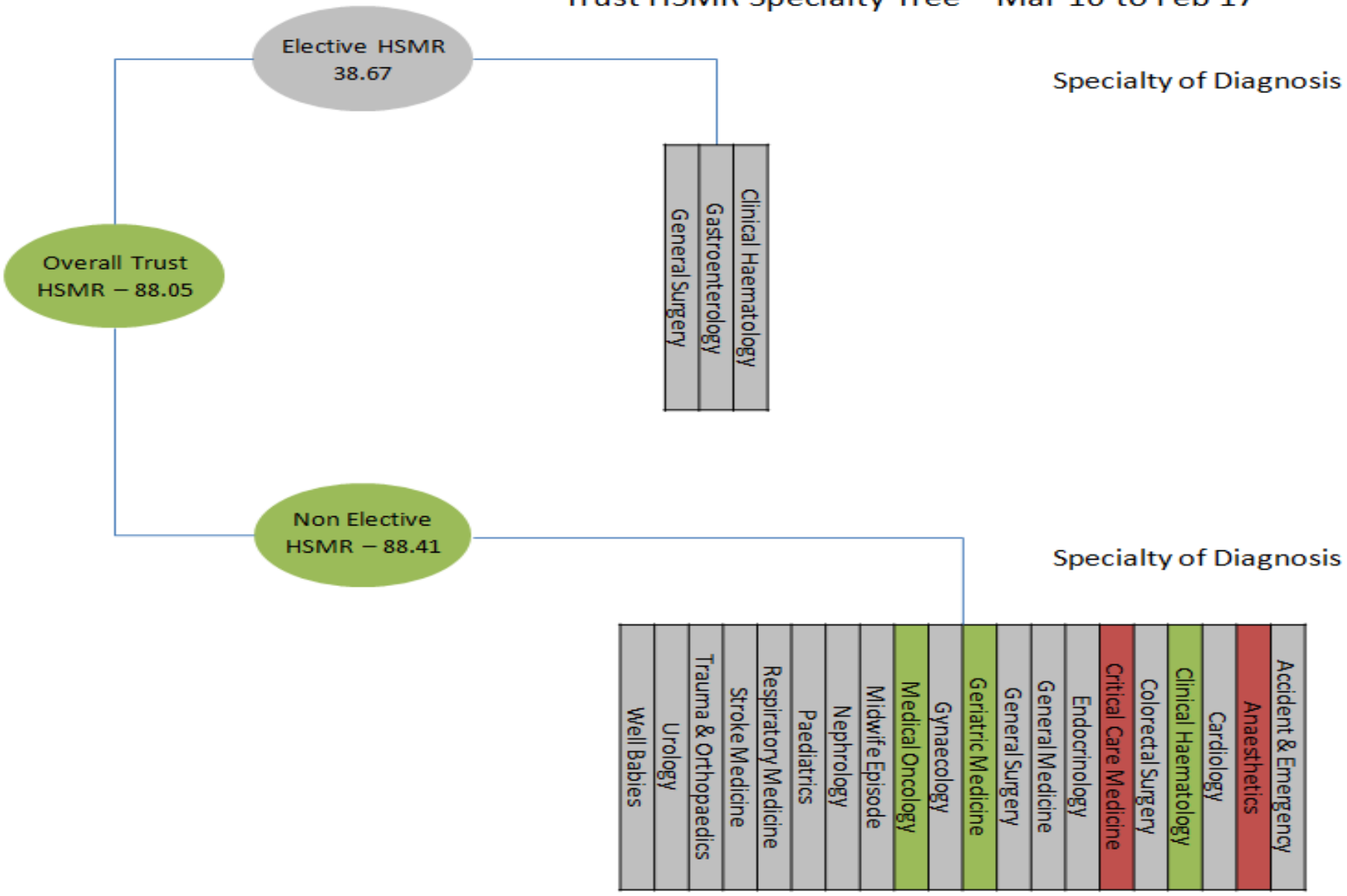

Overall
Non-Elective
Elective
SHMI
HSMR
Overall SHMI - Rolling 12 Months
Non Elective SHMI - Rolling 12 Months
Elective SHMI - Rolling 12 Months
Overall HSMR - Rolling 12 Months
Non Elective HSMR - Rolling 12 Months
Elective HSMR - Rolling 12 Months

HSMR – Feb 16 - Jan 17



West Suffolk NHS Foundation Trust v Other Acute providers in East of England

Trust HSMR Specialty Tree – Mar 16 to Feb 17



Lower than Expected

Within expected Range

Higher than Expected

3. MONITOR ASSURANCE FRAMEWORK

The Governance Rating table shows three failures of the governance rating against Monitor's Risk Assessment Framework.

Monitor Compliance Framework					
Performance Indicator	**Threshold**	**Month**	**QTD**	**Weighting**	**Lead Exec**
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	**82.23%**	82.23%	1.0	Helen Beck
Number of RTT Waits over 52 weeks for incomplete pathways	0	**15**	15	-	Helen Beck
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	**95.20%**	95.20%	1.0	Helen Beck
All cancers: 62-day wait for first treatment (5) from:Urgent GP referral for suspected cancer - **See Further detail below**	85%	**88.35%**	88.35%	1.0	Helen Beck
All cancers: 62-day wait for first treatment (5) from: NHS Cancer Screening Service referral	90%	**100.00%**	100.00%		Helen Beck
All cancers: 31-day wait for second or subsequent treatment, comprising: Surgery	94%	**100.00%**	100.00%	1.0	Helen Beck
All cancers: 31-day wait for second or subsequent treatment, comprising: anti-cancer drug treatments	98%	**100.00%**	100.00%		Helen Beck
All cancers: 31-day wait for second or subsequent treatment, comprising: radiotherapy - Not applicable to WSFT					
All cancers: 31-day wait from diagnosis to first treatment	96%	**100.00%**	100.00%	0.5	Helen Beck
Cancer: two week wait from referral to date first seen (8), comprising: all urgent referrals (cancer suspected)	93%	**93.90%**	93.90%	0.5	Helen Beck
Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)	93%	**94.02%**	94.02%		Helen Beck
Outcomes:					
Clostridium (C.) difficile - meeting the C.difficile objective - MONTH	2	**3**		1.0	Rowan Proctor
Clostridium (C.) difficile - meeting the C.difficile objective - QUARTER	4		**3**		Rowan Proctor
Clostridium (C.) difficile - meeting the C.difficile objective - ANNUALLY	16		**3**		Rowan Proctor
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	-	-	0.5	Rowan Proctor

Governance Rating	2.0

West Suffolk NHS Foundation Trust Cancer Waits Performance Report - March 2017					
GP Suspected Cancer, Cancer Screening Referral Receipt to Start of 1st Treatment: 62 Days Waiting Times Standard 85%				Performance %	
Cancer Type	<62 days	>62 days	Total	Trust	England~
Breast	6		6	100	95.9
Gynae	3+1x.5		3.5	100	80.2
Haem	1		1	100	79.9
Head & Neck		1+1x.5	1.5	0	70.6
Lower GI	4	2+1x.5	6.5	61.5	72.7
Lung	10	1+2x.5	12	83.3	73.7
Other	1x.5		0.5	100	81.8
sarcoma	1x.5		0.5	100	81.2
Skin	19	3	22	86.4	97.2
Upper GI	3+1x.5	2x.5	4.5	77.8	74.8
Urology	20+1x.5	3+2x.5	24.5	83.7	76.7
Total	66+5x.5	10+8x.5	82.5	83	82.9

Governance Rating	Rated Green if no issues are identified and Red where monitor are taking enforcement action. Where Monitor have identified a concern at a trust but not yet taken action, they provide a written description stating the issue at hand and the action they are considering.

3.1 Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway

a) Current Position

The March position was finalised at 89.88% (estimated) with the April position confirmed as 82.23% (estimated) against a threshold of 92%. The deterioration in performance reflects the further validation of the PTL which is providing a more accurate picture of the current waiting times.

Due to ongoing significant capacity issues within ENT, Vascular, Urology, Dermatology, patients are waiting over 30 weeks for first OPA in ENT, and patients are waiting over 28 weeks for Surgery within Vascular and Urology. There is a sustained increase in rapid access referrals in Dermatology, coupled with staffing deficits making it difficult to prioritise routine patients.

b) Recommended Action

Detailed action plans for each of the above specialties have been developed with CCG input where appropriate with further validation work of the new PTL continuing. Referral guidance has had a positive effect in ENT and the developing trend will be closely monitored. In additional the urology team are working with the CCG to develop referral guidance for this speciality too. A revised structure and timetable for the trust access meeting has been agreed and the process is under review to provide sustained rigour in addressing the challenge to RTT waiting times across all specialities. Funding for an access manager has been agreed to support this work and complemented by planned 18 week pathway coordinator post specifically for ENT.

3.2 Number of RTT waits over 52 weeks for incomplete pathways

a) Current Position

15 against a threshold of 0

There are 8 ENT patients over 52 weeks due to capacity issues, three of these patients are new to the PTL and have been identified by the ongoing validation work. There is also one ophthalmology patient who was identified through validation and a second awaiting confirmation of outcome. There is one gynaecology patient and one oral surgery patient both of whom have been delayed due to capacity, and there are three vascular patients. Of the three vascular patients, one requires the availability of a specific surgeon, the second became unfit for surgery, and the third is a complex case which has now been brought forward.

b) Recommended Action

New PTL now highlighting long waiting patients and are being actively monitored by the senior team to ensure patients are being booked in turn.

3.3 104 Day Cancer Waits

a) Current Position

This is a new section within the board report this month recognising the requirement for increased visibility around this metric.
Within the month of April there are no patients who have exceeded 104 days against the 62 day cancer standard.

b) Recommended Action

Processes exist within the Trust to undertake RCAs for all cancer breaches with clinical harm reviews being requested for all 104 day breaches. Work is underway between the Medical Director and the Interim Chief Operating Officer to review the current process and provide

increased rigour around the process and increased visibility of the outcomes of specific RCAs and general themes emerging from the process.

3.4 Clostridium (C.) difficile – meeting the C.difficile objective – MONTH/QUARTER

a) Current Position

1 for month against a threshold of 2
1 for QTD against a threshold of 4
22 for YTD against a threshold of 16

b) Recommended Action

See page 5 of the report.

4. CONTRACTUAL AND KEY PERFORMANCE INDICATORS

This section identifies those area that are breaching or at risk of breaching the Key Performance Indicators, with the main reasons and mitigating actions.

Performance Indicator	Threshold	In Month Performance	YTD	Comments	Lead Exec	Feb	Mar	Apr	Change mth on mth	On Plan To Achieve	Area of Concern	Forecast to Breach
A&E												
A&E Time to treatment in department (median) for patients arriving by ambulance - CDM	Median time to treatment above 60 minutes	35	35		Helen Beck	48	53	35	↗			
A&E - Single longest total time spent by patients in the A&E department, for admitted and non-admitted patients	Should not exceed 6 hours	09:57	09:57		Helen Beck	12:25	22:32	09:57	↗			
A&E Trolley Waits not longer than 12 hours	0 Patients waiting over 12 hours from DTA to Admission	0	0		Helen Beck	0	0	0	↔			
A&E - Threshold for admission via A&E	i) if the monthly ratio is above the corresponding 2012/13 monthly ratio for two month in a six month period ii) if year end is greater than 27%	31.76%	31.76%		Helen Beck	33.61%	32.04%	31.76%	↗			
A&E - Service User Impact Indicators	To satisfy at least one of the following Service User Impact Indicators: 1. Unplanned Reattendances within 7 days below 5% (Reattendances for the same condition) 2. Time to treatment in department (median) for all Service Users arriving by ambulance.	ONE MET	ONE MET		Helen Beck	ONE MET	ONE MET	ONE MET	↔			
A&E & AMU - Ambulance submit button complete	80%	92.96%	92.96%		Helen Beck	83.61%	88.27%	92.96%	↗			
A&E - Ambulance Handovers above 30 minutes	0 handovers over 30 minutes - £200 per breach	ND	0		Helen Beck	53	48	ND				
A&E - Ambulance Handovers above 60 minutes	0 handovers over 60 minutes - £1000 per breach	ND	0		Helen Beck	34	18	ND				
Percentage of patients presenting at type 1 and 2 (major) A & E sites in certain high risk categories who are reviewed by an emergency medicine consultant before being discharged	14.00%	94.12%	94.12%		Helen Beck	89.47%	100.00%	94.12%	↘			
RTT												
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks	99.00%	92.63%	92.63%		Helen Beck	95.56%	95.55%	92.63%	↘			
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90.00%	69.22%	69.22%		Helen Beck	68.84%	68.87%	69.22%	↗			
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.00%	86.15%	86.15%		Helen Beck	84.73%	84.75%	86.15%	↗			
Stroke												
% of patients scanned within 1 hour of clock start	77% (Contract) 57.5% (Upper Quartile)	86.67%	86.67%		Helen Beck	68.75%	87.50%	86.67%	↘			
% of patients scanned within 12 hours of clock start	96% (Contract) 96% (Upper Quartile)	97.78%	97.78%		Helen Beck	90.63%	100.00%	97.78%	↘			
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75% (Contract) 70% (Upper Quartile)	88.89%	88.89%		Helen Beck	62.50%	75.00%	88.89%	↗			
>80% treated on a stroke unit >90% of their stay	90%	97.67%	97.67%		Helen Beck	90.63%	87.50%	97.67%	↗			
% of patients treated by a stroke skilled early supported discharge team	48% (Contract) 48% (Upper Quartile)	50.00%	50.00%		Helen Beck	42.31%	34.48%	50.00%	↗			
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80% (Contract) 79% (Upper Quartile)	93.33%	93.33%		Helen Beck	84.38%	93.75%	93.33%	↘			
% of applicable patients who are assessed by a nurse and at least one therapist within 24 hours, all relevant therapists within 72 hours and have rehabilitation goals agreed within 5 days of clock start.	75% (Contract) 70.5% (Upper Quartile)	87.18%	87.18%	INDICATION ONLY - FINAL SSNAP LEVEL AVAILABLE WHEN RESULTS ARE AVAILABLE FROM SSNAP	Helen Beck	80.00%	72.41%	87.18%	↗			
% of eligible service users given thrombolysis	100% (RCA to be provided for breaches)	100.00%	100.00%		Helen Beck	100.00%	100.00%	100.00%	↔			
All stroke survivors to have a 6 month follow up assessment.	50%	ND	-	Reports are generated by SSNAP every 4 months - this is as at November 2016, reported for February Board	Helen Beck				-			
Provider rating to remain between A-C in each of the 9 domains covered in SSNAP where the Provider is at this level. For the one domain (SaLT) where the Provider is at level E, this will be improved to level to C by March 2017.	To remain at or above: National average or current performance (A-C) Improve performance to level C by end of the year (SaLT)	ND	B		Helen Beck				-			
Discharge Summaries												
Discharge Summaries - Outpatients	85% sent to GP's within 3 days	ND	ND		Nick Jenkins	ND	ND	ND	-			
Discharge Summaries - A&E	95% of A&E Discharge Summaries to be sent to GPs within one working day	98.13%	98.13%		Nick Jenkins	97.73%	97.29%	98.13%	↗			
Discharge Summaries - Inpatients	95% sent to GP's within 1 day	91.98%	91.98%		Nick Jenkins	92.80%	92.23%	91.98%	↘			
Choose & Book												
All 2 Week Wait services delivered by the Provider shall be available via Choose & Book (subject to any exclusions approved by NHS East of England)	100%	100.00%	100.00%		Helen Beck	100.00%	100.00%	100.00%	↔			
Cancelled Operations												
Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	i) 1% of all elective procedures	0.62%	0.62%		Helen Beck	0.49%	0.93%	0.62%	↗			
Patients offered date within 28 days of cancelled operation	100%	93.33%	93.33%		Helen Beck	92.31%	96.55%	93.33%	↘			
No urgent operation should be cancelled for a second time	0 2nd Urgent Cancellations	0	0		Helen Beck	0	0	0	↔			

Maternity												
Access to Maternity services (VSB06)	90% of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy.	94.71%	94.71%		Rowan Proctor	95.14%	96.36%	94.71%	↘			
Maintain maternity 1:30 ratio	1:30	01:30	01:30		Rowan Proctor	01:28	01:33	01:30	↗			
Pledge 1.4: 1:1 care in established labour	1:1	100.00%	100.00%		Rowan Proctor	100.00%	100.00%	100.00%	↔			
Breastfeeding initiation rates.	80%	79.81%	79.81%		Rowan Proctor	80.21%	76.37%	79.81%	↗			
Reduction in the proportion of births that are undertaken as caesarean sections.	22.70%	15.02%	15.02%		Rowan Proctor	13.47%	18.99%	15.02%	↗			
Other contract / National targets												
Mixed Sex Accomodation breaches	0 Breaches	0	0		Helen Beck	2	0	0	↔			
Consultant to Consultant referral	Commisioner to audit if concern about levels of consultant referrals	13.51%	13.51%		Helen Beck	ND	ND	13.51%	↗			
MRSA - emergency screening	100% Screened within 24 hours	TBC	TBC	Figures currently unavailable due to issues with TPP providing us with the data required	Rowan Proctor	TBC	TBC	TBC	-			
MRSA - Elective screening	100% Screened prior to admission		TBC		Rowan Proctor	TBC	TBC	TBC	-			
Rapid access - chest pain clinic	100% of patients should have a maximum wait of two weeks	100.00%	100.00%		Helen Beck	100.00%	100.00%	100.00%	↔			
Acute oncology service: 1 hour to needle from diagnosis of neutropenic sepsis	100%	66.67%	66.67%	MacMillan	Helen Beck	100.00%	100.00%	66.67%	↘			
		71.43%	71.43%	ED	Helen Beck	90.91%	72.73%	71.43%	↘			
		63.64%	63.64%	Overall Trust (Inc AMU)	Helen Beck	94.12%	80.00%	63.64%	↘			
New to Follow up	Thresholds set at each speciality - overall Trust Threshold is 1.9	2.00	2.00		Helen Beck	2.12	2.07	2.00	↘			
Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test	99%	99.86%	99.86%		Helen Beck	99.42%	99.89%	99.86%	↘			
All relevant inpatients undergoing a VTE Risk assessment	95%	TBC	TBC		Helen Beck	TBC	TBC	TBC	-			

Key: ↗ performance improving, ↘ performing deteriorating, ↔ performance remains the same.

4.1 A&E - Single longest total time spent by patients in the A&E department, for admitted and non-admitted patients

a) Current Position

The Trust remained outside the contractual target of not exceeding 6 hours total time spent in A&E. The target was not met due to one patient who was critically unwell and unsafe for transfer. In addition the patient was not for resuscitation or ITU, therefore a bed was requested on the AMU. The Trust was under significant capacity pressures at this time.

b) Recommended Action

The Trust continues to improve patient flow initiatives in order to create sufficient capacity 24/7.

4.2 A&E – threshold for admission via A&E

a) Current Position

31.76% against a threshold of 27%

b) Recommended Action

The Trust is seeing a month on month improvement in performance. However, the Trust continues to experience high attendance rates. As a result 'sicker' patients are presenting to our hospital requiring a more intense or prolonged period of therapy.

Actions in place include:

- Active challenge within the department is now common place to ensure patients are not unnecessarily admitted to wards.
- The revised CDU policy is promoting a more 'appropriate' cohort of patients being admitted.
- The department is creating a daily 'pulling' approach for ambulatory emergency care patients. We can see from this month's threshold that we have improved performance against the target.

4.3 Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks

a) Current Position

92.63% against a threshold of 99%.

Due to ongoing significant capacity issues within ENT, Vascular, Urology, Dermatology. Patients waiting 30+ weeks for first OPA in ENT, and patients waiting over 28 weeks for Surgery within Vascular and Urology. Sustained increased rapid access referrals in Dermatology, coupled with staffing deficits making it difficult to prioritise routine patients.

b) Recommended Action
Detailed action plans for each of the above specialties are being developed with CCG input where appropriate. Validation of new PTL continues.

4.4 Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted

a) Current Position
69.22% against a threshold of 90%.

b) Recommended Action
Patients are being treated in longest waiting order, due to some patients being identified due to validation the this has seen more breaches appear and therefore more patients who have already breached 18 weeks being treated. New PTL and proactive manual validation are underway providing a clearer picture of the waiting times.

4.5 Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted

a) Current Position
86.15% against a threshold of 95%.
Predominantly due to excessive waits for first appointment in both ENT and Dermatology.

b) Recommended Action
Ongoing work with the CCG and frequent monitoring of the action plans for these specialities. Planned recruitment of and 18 week pathway coordinator for the ENT service which has also seen an initial positive reduction in referrals following the introduction of referral guidance for GP's.

4.8 Discharge Summaries – Inpatients

a) Current Position
91.98% against a threshold of 95%.

Patients offered date within 28 days of cancelled operation

a) Current Position
93.33% against a threshold of 100%
This represents one patient who was scheduled for a joint procedure between general surgery and gynaecology and had their procedure cancelled due to insufficient theatre time on the day, the previous case on the list was more complex than anticipated and took longer to complete. Unfortunately the patient was unable to be re-booked within 28 days with both specialities required for the procedure.

b) Recommended Action
This patient was rebooked for surgery at the earliest opportunity and underwent their procedure on the 17th of May 2017.

4.11 Breastfeeding initiation rates

a) Current Position

79.80% against a threshold of 80%

b) Recommended Action

The maternity service is not able to identify specific drivers which influence the rate of breast feeding initiation month by month but continues to work towards sustained improvement. The service is preparing for Baby Friendly Imitative (BFI) Stage 3 assessment in July 2017 and as part of this preparation undertakes on going audits of parents and staff and has in place a work plan to address the findings of the audits.

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

a) Current Position

Macmillan – 66.67%
ED - 71.43%
Overall Trust figure of 63.64% against a threshold of 100%

b) Recommended Action

The performance figure for 1 hour to needle from diagnosis of Neutropenic Sepsis April Data included, the Macmillan Unit that had one breach , the Emergency Department that had three breaches and AMU had one breach. These breaches are undergoing a more detailed review.

Macmillan

There were only 3 patients, so failing one has a big impact on performance. This patient had already been to ED in the early hours of the morning and had IV AB's within an hour. He then presented in the early evening to G1 with a further temperature and on oral AB's and anti-fungal. He is a complex haematology patient who would have been discussed with a medic.

Nursing staff have been reminded to document discussions and reason why the target was not meet.

ED

- Formalised feedback to ED staff re: non-compliance (post non-compliance RCA completion).
- Enhanced ED engagement with AOS – innovations and enhancement opportunities to be discussed and actioned.
- Pre alert to ED from AOS team is to be formally escalated to ED Band 7 Coordinator and AMU F7/8 Coordinator to raise awareness of patient being expected ? sepsis.

5. WORKFORCE

This section identifies those areas that are breaching or at risk of breaching the Workforce Indicators, with the main reasons and mitigating actions.

Performance Indicator	Threshold	April	Comments
Workforce			
Sickness absence rate	<3.5%	3.71%	
Turnover	<10%	10.30%	
Reviews	Grievance/Banding reviews	5	12 months rolling
Recruitment Timescales	Average number of weeks to recruit = 7	5	
DBS Checks	To complete 95% of required DBS checks	98.50%	
All Staff to have an appraisal	Both general and consultant staff each have a target of 90% to have had an appraisal within the previous 12 months. Appraisal is a rolling programme	ND	Appraisal figures are currently not available due to HR system issues.

5.1 Sickness Absence Rate

a) Current Position
3.95% against a threshold of <3.5%.

b) Recommended Action
Short term Sickness absence has continued to increase due to various winter ailments affecting staff in significant numbers. HR will continue to monitor and report sickness absence to managers.

5.2 Turnover

a) Current Position
10.43% against a threshold of <10%.

b) Recommended Action
Turnover has reduced this month by .29%. The Workforce team will continue to investigate turnover to identify any trends.

5.3 Staff Recommender Scores

Q	Question	Base	This quarter %	Target %	Target met this quarter	Chg.vs last quarter	Q4 2017
Q1	How likely are you to recommend this organisation to friends and family if they needed care or treatment?	782	93	67		0	94
Q2	How likely are you to recommend this organisation to friends and family as a place to work?	778	87	61		7	79

6. RECOMMENDATION

The Board is asked to note the Trust Quality & Performance Report and agree the implementation of actions as outlined.

Appendix A – Community Data

- The following narrative provides an overview of the performance of the community services. The bullet points are the points of note from April performance, the second section provides the detail of the contractual KPI position.

- Our FFT for April was 98% from 777 responses. There were 3 ‘extremely unlikely’ to recommend and 2 ‘unlikely’ to recommend. See page 5 of the patient experience report for the detail.

- We received 1 formal complaint in April for a Community Health Team relating to palliative care experience. See page 10 of the patient experience report for more detail.

- The number of patients whose discharge was delayed during April has increased again to 60. The number waiting for domiciliary care packages increased to 38, a rise for the 3rd consecutive month.

- Overall there has been a further small improvement in paediatric SLT waiting times for both the schools and clinic services. There is a board report detailing the progress with recovery and plans for redesign.

- The CCC have continued to improve their Speed of Answer target, whilst accepting all Paediatric referrals.

- The Community Equipment Service achieved all of their targets for April.

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**Apr 2017**	**April Comments / Queries 2017**	**Feb 2017**	**Mar 2017**
SCH		**D4-qoc1**	Number and % of service users who rated the service as 'good' or 'better'.	85%	Quarterly report from Provider		Quarterly report		97.71%
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'better'.	85%	Quarterly report from Provider		Quarterly report		94.78%
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'well informed'.	85%	Quarterly report from Provider		Quarterly report		93.46%
SCH		**D5-acc4**	18 week referral to treatment for non-Consultant led services 15 services: Paed OT, PT, SALT, Adult, Wheelchairs, Podiatry, Biomechanics, Stoma nurses, Neuro nurses, Parkinson's, SCARC, Environmental, H Failure, Hand Therapy & Continence	95% patients to be treated within 18 weeks	Monthly report from Provider	99.93%		100.00%	99.62%
SCH		**D5-acc8**	18 week referral to treatment for Consultant led services Inpatient rules - Foot and Ankle Outpatient rules - Paediatrics (E&W)	95% patients to be treated within 18 weeks	Monthly report from Provider	99.40%		96.57%	98.69%
SCH		**PU-001-a PU-001-b**	No increase in the number of Grade 2 and Grade 3 pressure ulcers (as per agreed definition), developed post 72 hours admission into SCH care, compared to 12/13 outturn. This measure includes patients in in - patient and other community based settings. Zero grade 4 avoidable pressure ulcers (as per agreed definition) developed post 72 hours admission into SCH care, unless the patient is admitted with a grade 3 pressure ulcer, and undergoes debridement (surgical / non surgical) which will cause a grade 4 pressure ulcer. This will be evident through Serious Incident reporting.	No increase in 12/13 outturn. Zero	Monthly	0		0	0
SCH	Dementia	**c-gen4**	All community clinical staff to receive relevant dementia awareness training	95%	Monthly report from Provider	94.81%		92.57%	94.34%
SCH	Canc by Prov	**c-gen7**	% of clinics cancelled by the Provider Q3 2012-13 establish baseline. Where benchmarking of community services shows a DNA rate worse then the best quartile. Q4 2012-13 agree an appropriate reduction on baseline. Pcanc-01 ONLY - Q1 2013/14 establish baseline. Where benchmarking of community services shows a DNA rate worse than the best quartile: Q2 reduction of 2.5% on baseline, Q4 reduction of 10% on baseline		Quarterly report from Provider		Quarterly report		1.58%
SCH	Safeguarding - children	**c-safe1**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.11%		95.86%	96.74%
SCH	Safeguarding - adults	**c-safe2**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.02%		95.59%	96.92%
SCH	Disch summ	**dis summ-CQUIN**	% of discharge summaries from the following services; Community Hospital, Adult SaLT, Community Intervention & Leg ulcer service, that are provided to GP practices within 3 days of discharge from the service (previously within 1 day of discharge).	95%	Monthly report from provider	100.00%		100.00%	97.56%
InPt		**D3-str3**	% of patients requiring a joint community rehabilitation Care Plan have one in place ahead of discharge from acute hospital.	75%	Monthly report from Provider	100.00%		100.00%	100.00%
InPt		**D3-str4**	% of appropriate stroke survivors whose community rehabilitation treatment programme started within 7 days of leaving acute hospital, or ESD, where agreed as part of the care plan (SSNAP). The definition of 'Appropriate Patients' is - all patients requiring continued therapy input.	75%	Monthly report from Provider	100.00%		100.00%	100.00%
InPt	MRSA	**c-inf1**	Number of cases	No cases	Monthly report from Provider	0		0	0
InPt	MRSA	**c-inf2**	Completed RCAs on all community cases of MRSA	100%	Monthly report from Provider	N/A		N/A	N/A
InPt	C-Diff	**c-inf4**	Completed RCAs on all community hospital outbreaks of C difficile	100%	Monthly report from Provider	N/A		N/A	N/A
InPt	Comm Hosp	**s-ip7**	Number of inpatient falls resulting in moderate or significant harm	No more than 1.25 per month (15 per annum) falls/1000bed days	Monthly report from Provider	N/A		N/A	0.54
InPt	Step Up Adm Prevention Comm Beds	**s-apcb1**	The community beds will be available for access across the 24 hour 7 days a week	100%	Monthly report from provider	100.00%		100.00%	100.00%
InPt	Step Up Adm Prevention Comm Beds	**s-apcb6**	All Service Users will have a management plan agreed with them and their family/carer where applicable within 24 hours from arrival.	98%	Monthly report from provider	100.00%		95.83%	100.00%
IHT		**D2-ltc4**	% of people with COPD who accept a referral to a pulmonary rehabilitation programme who complete the prescribed course and are discharged within 18 weeks of initial referral by a GP/health professional.	95%	Monthly report from Provider	95.45%		88.89%	100.00%
IHT	CCC	**D4-int1**	Care coordination centre - % of telephone calls answered within 60 seconds	95% in 60secs	Monthly report from Provider	96.93%	# of calls handled: 15,268 # of calls answered in 0-60 seconds: 14,799 **% 0-60 seconds: 96.93%** Number of abandoned calls: 233 Abandoned calls %: 1.5% Average Wait Time: 11 seconds	95.84%	96.01%
IHT		**D4-ccc6**	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed.	85%	Monthly questionnaires for the first Quarter of operation and quarterly thereafter		Quarterly report		98.05%
IHT	Card Rehab	**s-card5**	Number of service users successfully discharged from phase 3.	600 per annum	Monthly report from Provider	no longer reporting as of July 16		no longer reporting as of July 16	no longer reporting as of July 16
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses offered	At least 500 courses offered per year	Monthly report from Provider	60 offered		67 offered	82 offered
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses completed	At least 250 courses completed per year	Monthly report from Provider	20 completed		18 completed	32 completed

Adult KPI's										
Host	Service	Technical Reference	Quality Requirement	Threshold	Method of measurement	Apr 2017	April Comments / Queries 2017	Feb 2017	Mar 2017
IHT	COPD	s-copd5	Community pulmonary rehabilitation - review offered 6 months after completing the course	95%	Monthly report from Provider	100.00%		100.00%	100.00%
IHT	Comm Continence	s-cc3	% of Service Users re-assessed at 6 weeks	98%	Monthly report from Provider	no longer reporting as of November 16		no longer reporting as of November 16	no longer reporting as of November 16
IHT	Comm Continence	s-cc4	% of Service Users re-assessed at 12 monthly intervals (previously 6 monthly intervals)	98%	Monthly report from Provider	99.65%		99.62%	99.86%
IHT	H Failure	s-hf4	% of Service Users seen within 14 days of receipt of referral	85% within 14 days referral	Monthly report from Provider	no longer reporting as of July 16		no longer reporting as of July 16	no longer reporting as of July 16
IHT	IDPT	s-disch1	Triage and assessment of referrals within 1 Operational Day	98%	Monthly report from Provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
IHT	IDPT	s-disch2	Urgent discharge achieved (<24 hours from referral to the team) for Service Users terminally ill and wishing to die at home	85%	Monthly report from Provider	100.00%		N/A	100.00%
IHT	MIU	s-miu3	Timeliness Indicators: 1) Total time spent in A& E department 2) Time to initial assessment (95th percentile) 3) Time to treatment in department (median) 1) 95% of Service Users waiting less than 4 hours 2) 95th percentile time to assessment above 15 minutes 3) median time to treatment above 60 minutes		Monthly Secondary Uses Services (SUS) data, A&E Commissioning data set (CDS)	#1 = 100%		#1 = 100%	#1 = 100%
IHT	MIU	s-miu4	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who rated the service as "good" or better	85%	Quarterly report from provider		Quarterly report		98.46%
IHT	MIU	s-miu4	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "supported".	85%	Quarterly report from provider		Quarterly report		100.00%
IHT	MIU	s-miu4	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "well informed".	85%	Quarterly report from provider		Quarterly report		94.44%
IHT	MIU	s-miu5	Total time spent in A+E department 95% of Service Users waiting less than 4 hours for admitted Service Users and with the same threshold for non-admitted measured over each Quarter rather than monthly (or, where the Quarter does not begin on 1 July, measured over each three-month period beginning on 1 July)	95%	Monthly Secondary Uses Services (SUS) data, A&E Commissioning data set (CDS)	100.00%		100.00%	100.00%
IHT	IDPT	s-disch4	Transfer from acute hospital to community based provision from receipt of referral within a timescale not exceeding 48 hours providing the Service User is medically and physically fit for discharge	80% of Service Users medically and physically fit for discharge	Monthly report from provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
Mede	CES	c-gen8	Response times from receipt of referral: Within 4 hours – Service Users at end of life (GSF prognostic indicator)	98% for all standards	Monthly report from Provider	100% (199/199)		100.00% (194/194)	97.03% (229/236)
Mede	CES	c-gen8	Same Working day - Urgent equipment	98.00%	Monthly report from Provider				
Mede	CES	c-gen8	Next Working day - Urgent equipment	98.00%	Monthly report from Provider	98.68% (598/606)		99.24% (783/789)	99.77% (859/861)
Mede	CES	c-gen8	Within 2 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider				
Mede	CES	c-gen8	Within 3 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider				
Mede	CES	c-gen8	Within 5 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider				
Mede		c-gen8	Within 7 working days - to support hospital discharge or prevent admission		Monthly report from Provider	99.74% (1923/1928)		99.28% (2060/2075)	99.75% (2386/2392)
Mede	CES	c-gen8	Within 10 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider	98.37% (423/430)		98.68% (524/531)	99.31% (579/583)
Mede	CES	c-gen9	Collection times: % of urgent next day collections for deceased Service Users	98% for all standards	Monthly report from Provider	99.00% (198/200)		98.64% (217/220)	96.42% (269/279)
Mede	CES	c-gen9	% of urgent collections within 2 working days	98.00%	Monthly report from Provider				
Mede	CES	c-gen9	% of urgent collections within 3 working days	98.00%	Monthly report from Provider	100.00% (402/402)		99.37% (471/474)	99.38% (480/483)
Mede	CES		% of urgent collections within 5 working days	98.00%	Monthly report from Provider				
Mede	CES	c-gen9	% of collections within 10 working days	98.00%	Monthly report from Provider	99.17% (4674/4713)		98.32% (4850/4933)	98.90% (5946/6012)
Mede	Medical Appliances	s-ma1	% of appointments available within 6 weeks	95%	Monthly report from provider	100.00%		100.00%	100.00%
Mede	Medical Appliances	s-ma2	% of urgent cases seen within one working day	100%	Monthly report from provider	No Urgent referrals received		No Urgent referrals received	No Urgent referrals received
Mede	Wheelchair	s-wchair1	All Service Users have a first appointment/contact seen after initial response time according to priority / need: High Priority	within 6 weeks 100%	monthly report from provider	N/A		100.00%	N/A
Mede	Wheelchair	s-wchair1	Medium Priority	within 12 weeks 100%	monthly report from provider	N/A		N/A	N/A
Mede	Wheelchair	s-wchair1	Low Priority	within 18 weeks 100%	monthly report from provider	100.00%		100.00%	100.00%
NCHC		D2-ltc2-a	% of people that have been identified by case finding, (using risk stratification, or other means), and deemed suitable for intervention by the MDT, and referred to SCH, that have a care lead.	95%	Monthly report from Provider	100.00%		100.00%	100.00%

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**Apr 2017**	**April Comments / Queries 2017**	**Feb 2017**	**Mar 2017**
NCHC		**D2-ltc2-b**	% of people identified via case finding, that have a care plan (including self-care) that has been shared with the GP practice within two weeks of the patient coming onto the caseload. The GP practice will require a copy of the care plan, and the information will be shared with the MDT, which includes a GP. For clarity, the definition of an MDT is; 'A virtual or real team of health and care practitioners, who could be, or are involved in patient's care. An MDT does not necessarily mean a physical meeting.'	95%	Monthly report from Provider	N/A		100.00%	100.00%
NCHC		**D5-ccc7**	% of referrals seen following triage; Emergency - 2 hrs	Emergency - 100%	Monthly report from Provider	100.00%		100.00%	100.00%
NCHC		**D5-ccc7**	Urgent 4 hrs	Urgent - 95%	Monthly report from Provider	98.13%		99.46%	100.00%
NCHC		**D5-ccc7**	Intermediate - 72 hrs	Intermediate - 95%	Monthly report from Provider	98.44%		97.87%	98.18%
NCHC		**D5-ccc7**	18 weeks	18 weeks - 95%	Monthly report from Provider	99.77%		99.10%	99.54%
NCHC		**D4-int1**	Community Health Team Leads and/or Local Area Managers to work with GP practices and establish direct working relationships that aid mutual understanding and aim to improve the quality of services to patients. A schedule of face to face meetings is to be agreed and adhered to by both parties and a joint action plan is to be produced that shall be regularly reviewed.	80%	Quarterly report from Provider		Quarterly report		
NCHC	PHP	**c-php1**	Number of Service Users with the following Long term conditions with a Personal Health plan (Parkinson's Disease, Multiple sclerosis, Muscular Dystrophy, Chronic Obstructive Pulmonary Disease, all other chronic respiratory diseases, Coronary Heart Disease, Heart Failure).	80% completed	Monthly	100.00%		100.00%	100.00%
NCHC	EAU CIS	**eau-cis-IHT**	% of patients seen within 2 hrs. of initial referral. The Senior Nurse (part of the CIS) allocated to the EAU at IHT will begin patient assessment within 2 hrs of consultant referral.	98%	monthly report from provider	N/A		N/A	N/A
NCHC	Verification of expected death training	**c-gen2**	Number of qualified nursing staff trained in Service User areas, community nursing teams and local Healthcare teams (to include all clinical staff from within planned care, urgent care, & intensive case management as the integrated service model is implemented)	90%	Monthly report from provider		No longer reported		
WSH	Adult SALT	**s-salt1**	All new referrals are triaged within 5 Operating Days of receipt of referral;	98%	Monthly report from Provider	99.21%		100.00%	98.79%
WSH	Adult SALT	**s-salt2**	Service Users seen within the following timescales after triage: Priority 1 within 10 Operating Days	Priority 1 - 100%	Monthly report from Provider	100.00%		100.00%	100.00%
WSH	Adult SALT	**s-salt2**	Priority 2 within 20 Operating Days	Priority 2 - 95%	Monthly report from Provider	100.00%		99.00%	98.00%
WSH	Adult SALT	**s-salt2**	Priority 3 within 18 weeks	Priority 3 - 95%	Monthly report from Provider	100.00%		100.00%	100.00%
WSH	Parkinson's Disease	**s-pd2**	% service users on caseload who have an annual specialist review	95%	Monthly report from provider	100.00%		100.00%	100.00%
WSH	Ass Tech	**s-at2**	All long term service users to have a minimum annual review	100%	Monthly report from provider	100.00%		100.00%	100.00%
WSH	Ass Tech	**s-at4**	Delivery of equipment within agreed time frames	95%	Monthly report from provider	100.00%		100.00%	100.00%

Children's Services KPIs									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of Measurement**	**Apr 2017**	**Apr Comments/ Queries 2017**	**Feb 2017**	**Mar 2017**
WSH	All Paediatric Services	**GP-1**	18 week RTT for Consultant led services	95% to be treated within 18 weeks	Monthly pledge 2 reporting by Children's Service	97.48%		93.51%	97.25%
WSH	All Paediatric Services	**GP-1**	18 week RTT for non-Consultant led services	95% to be treated within 18 weeks	Monthly pledge 2 reporting by Children's Service	99.53%		100.00%	98.01%
WSH	All Paediatric Services	**PaedSLT-4**	All Children to have a Personal Health plan completed where required.	100% Service Users offered a PHP 80% completed a PHP	Monthly report from provider by Children's Service	100.00%		100.00%	100.00%
WSH	All Paediatric Services	**D4-qoc1 D4-qoc2 GP-4**	Quarterly Service User satisfaction surveys based on Suffolk Community Healthcare's processes prior to Effective Start Date. Number and % of service users who rated the service as "good" or better	85%	Quarterly report from provider	Now included in the Patient Experience			
WSH	All Paediatric Services	**D4-qoc1 D4-qoc2 GP-4**	Number and % of service users who responded that they felt "supported" and "well informed".	85%	Quarterly report from provider	Now included in the Patient Experience			
WSH	All Paediatric Services	**GP-6**	Safeguarding - % eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report by provider	99.53%		99.53%	99.54%
WSH	All Paediatric Services	**GP-9** **PDL-01**	Discharge Letters - to be sent within 24 hours of discharge from a community hospital and 72 hours of discharge from all other caseloads	95%	Monthly	100.00%		100.00%	100.00%
WSH		**PaedSLT-5**	Personalised Care Planning - Percentage of Transition (to adults) Care Plans completed		Annual - Systmone				
WSH	Newborn Hearing Screening Service (West)	**NBHS-2**	Timely screening – where consented screens to be completed by four weeks of age	95%	Monthly Activity Report	98.96%		98.37%	100.00%
WSH	Newborn Hearing Screening Service (West)	**NBHS-3**	Screening outcomes set within 3 months	≥99%	Monthly Activity Report	98.19%		99.16%	100.00%
WSH	Community Children's Nursing	**CCN-14** **cps-ip02**	% of children identified as having high level needs being actively case managed.	>75%	Systmone	100.00%		100.00%	100.00%
WSH	Leapfrog Therapeutic Service	**Leap-8**	Outcomes achieved for children utilising the services	Annual report produced	Annual report		Annual report		
WSH	Therapy Focus Suffolk	**TFS-6**	All relevant staff that have been 'Bobath' update trained	100%	Annual report		Annual report		
WSH	Single Point of Access	**PSPOA-03**	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed	85%	Monthly questionnaires for the first Quarter of operation and quarterly		Quarterly report		
WSH	Single Point of Access	**PSPOA-04**	% of service users who were satisfied with the length of time waiting for assessment	85%	Quarterly report from Provider		Quarterly report		
WSH	Single Point of Access	**PSPOA-05**	% of referrers who were satisfied with the length of time waiting for assessment	85%	Quarterly report from Provider		Quarterly report		
WSH	Access	**cps-a02**	Children/young people in special schools receive speech and language interventions	100%	Systmone	100% 106 contacts		100.00% 167 contacts	100% 284 contacts
WSH	Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	Systmone	100.00% 88 contacts		100.00% 141 contacts	100.00% 166 contacts
WSH	Children in Care	**CiC-001c**	Initial Health Assessment appointments that are OFFERED within 28 days of receiving ALL relevant paperwork	100% in 28 days	Monthly report from Provider	47.06%	8 out of 17 patients who had an IHA in April were offered their first appt within 28 days of the service being made aware of the child. Of the remaining 9, 3 were offered an appt within 30 days. The 2 longest waits were due to personal circumstances of the child or inappropriateness to be seen in clinic.	93.33%	91.67%
WSH	Children in Care	**CiC-001b**	Initial Health Assessments that are completed within 28 days of receiving ALL relevant paperwork	100% in 28 days	Monthly report from Provider	35.29%	6 out of 17 children had an IHA completed within 28days of the service being made aware of the child. A number of reasons that the earliest appt was unable to be attended are : Access to appropriate clinician Interpreter unavailable Child missing from care Young person in police custody Incorrect placement address	86.67%	66.67%
WSH	Children in Care	**CiC-001a**	The Provider will aim to achieve 100% compliance with the guidance to ensure that all CiC will have a Specific, Measurable, Achievable, Realistic and Time-scaled (SMART) health care plan completed within 28 days of a child becoming looked after.	100% in 28 days	Monthly report from Provider	6.25%	Of the 16 children with an IHA completed outside 28 days of becoming CiC, 8 referrals to the service were delayed by 27-52days.	6.67%	25.00%

1 Dementia Awareness Training for clinical staff – All community clinical staff to receive relevant dementia awareness training

a) Current Position

Currently 94.81% against 95% target.

This has improved slightly from 94.34% in March to 94.81%.

b) Recommended Action

- Non-compliant staff are being targeted.
- Reasons for non-attendance at booked sessions are being interrogated by the Lead Nurse.
- Communication has been sent to all staff that requires them to ensure that all their mandatory training is up to date ahead of transition of the contract.

2 CIC-001a&b Children in Care – WSH – Children in Care receiving a completed Initial Health Assessment within 28 days of becoming looked after and receiving a completed IHA within 28 days of SCH receiving ALL relevant paperwork

a) Current Position

CiC-001a – 6.25% against a 100% target

CiC-001b – 35.29% against a 100% target

CiC -001c – 47.08% against a 100% target

17 Initial Health Assessments were completed in April. 1 was completed within 28 days of becoming CiC, 6 were completed within 28 days of the service receiving ALL the paperwork and 8 appointments were offered within 28 days. There was a delay of greater than 14 days from the child becoming CiC and the service being notified for 13 of the 17 referrals which directly impacted on the statutory compliance target. There were a number of reasons that the earliest appointment was unable to be offered:

- Access to appropriate clinician
- Interpreter unavailable
- Child missing from care
- Young person in police custody
- Incorrect placement address
- Personal circumstances

b) Recommended Action

- The revised paperwork has not been implemented by social care. The Associate Director is following up with the Social care manager on this subject.
- Therefore the follow-up meeting with the social care managers has not been held.

	Units	Target	Red	Amber	Green	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Patient Experience												
Service users who rated the service as 'good' or 'better' (Quarterly)	Nos.	No Target										
	%	85%	<80%	80%-85%	>=85%							
Service users who responded that they felt 'better'	Nos.	No Target				159	179	115	141	158	137	132
	%	85%	<80%	80%-85%	>=85%	94%	94%	94%	96%	96%	93%	94%
Service users who felt 'well informed'	Nos.	No Target				187	190	144	182	200	177	198
	%	85%	<80%	80%-85%	>=85%	93%	90%	96%	96%	91%	94%	96%
10% of long term condition patients feel "better supported" to self manage their conditions (Quarterly)	Nos.	No Target										
	%	No Target										
Falls (Inpatient Units)												
Total numbers of inpatient falls (includes rolls and slips)	Nos.	No Target				26	59	60	51	33	48	30
Rolls out of Bed		No Target				1	1	5	2	5	1	1
Slip out of chair		No Target				0	3	3	8	3	5	0
Assisted Falls/ near misses		No Target				4	0	1	0	3	6	1
% of total falls resulting in harm	%	No Target				15%	29%	22%	31%	24%	23%	32%
Numbers of falls resulting in moderate harm	Nos.	No Target				0	0	0	0	0	1	0
Numbers of falls resulting in severe harm	Nos.	No Target				0	0	2	2	0	1	0
Numbers of patients who have had repeat falls	Nos.	No Target				6	10	13	11	7	8	6
% of RCA reports for repeat fallers	%	100%	90%-95%	95%-100%	=100%	100%	100%	100%	100%	100%	100%	100%
Numbers of falls per 1000 bed days (* includes Hazel Crt falls)		<1.25/1000 beddays	>1.50	1.25-1.50	<=1.25	7.6	17.3	17.4	13.9	10.5*	13.8*	8.96
Pressure Ulcers												
Pressure Ulcers – In Our Care Community												
Grade 2		100 pa	>110	100-110	<=100	18	13	23	26	31	27	30
Grade 3		26 pa	>30	27-29	<=26	10	10	6	8	13	10	5
Grade 4		0 pa	>1	1	0	0	0	1	2	1	2	1
Pressure Ulcers – In our care In-patient												
Grade 2		13 pa	>17	13-17	<=13	2	4	5	2	3	4	0
Grade 3		2 pa	>4	02-Apr	<=2	1	2	0	1	1	0	1
Grade 4		0 pa	>1	1	0	0	0	1	0	0	0	0
Safeguarding People Who Use Our Services From Abuse												
Number of adult safeguarding referrals made		No Target				5	3	5	4	2	3	2
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				100%	100%	100%	100%	100%	100%	100%

	Units	Target	Red	Amber	Green	Oct	Nov	Dec	Jan	Feb	Mar	Apr
MRSA												
Bacteraemia – Number of cases		0	>2	>0 to 2	=0	0	0	0	0	0	0	0
MRSA RCA reports		100%	<95%	95%-100%	=100 %	0	0	0	0	0	0	0
Clostridium Difficile												
C.Diff number of cases		4 for 6 months	>4 YTD		<=4 YTD	0	0	0	0	0	0	0
C.Diff associated diseases (CDAD) RCA reports		100%	<95%	95%-100%	=100 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Infection Control												
Infection control training		100%	<83%	83%-100%	=100 %	88.39%	90.17%	91.00%	89.87%	85.99%	89.70%	86.51%
Essential Steps Care Bundles Including Hand Hygiene												
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	99.00%	98.00%	99.00%	98.00%	99.00%	98.00%	99.00%
Isolation room audit		100%	<95%	95%-100%	=100 %	100%	100%	100%	N/A	N/A	100%	100%
Management of Medication -SCH NRLS Reportable Incidents												
Total number of medication incidents in month		No Target				4	9	16	23	18	25	19
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				4	8	15	23	16	20	15
(also includes those not attributed to SCH management)	Low harm	No Target				0	1	1	0	2	5	3
Number of medication incidents involving Controlled Drugs		No Target				1	1	0	0	7	5	1

Incidents												
NRLS (i.e. patient safety) reportable incidents in month		No Target				160	191	178	217	223	229	184
Number of Never Events in month		No Target				0	0	0	0	0	0	0
Number of Serious Incidents (SIs) that occurred in month		No Target				11	12	9	13	15	12	7
Number of SIs reported to CCG in month *4 STEIS for 2 pts (2 each)		No Target				11	10	9	13	17	17*	7
Percentage of SI reports submitted to CCG on time in month		No Target				0%	100%	100%	100%	100%	100%	100%
Duty of Candour Applicable Incidents		No Target				11	9	10	13	13	16	8

Severity of NPSA Reportable Incidents												
None		No Target				117	125	119	140	122	145	122
Low		No Target				32	54	50	64	87	69	54
Moderate		No Target				11	12	6	9	13	11	7
Major		No Target				0	0	3	4	1	4	1
Catastrophic		No Target				0	0	0	0	0	0	0

Training Compliance												
Adult Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	96.45%	97.25%	96.94%	97.04%	95.59%	96.74%	96.02%
Children Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	96.81%	97.52%	97.12%	97.04%	95.86%	96.92%	96.11%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	96.30%	94.62%	94.10%	94.62%	92.57%	94.34%	94.81%
WRAP						35.50%	44.48%	44.47%	45.27%	51.73%	67.33%	64.48%
MCA / DoLs- Training compliance						64.80%	71.46%	70.97%	69.76%	68.46%	67.33%	73.59%

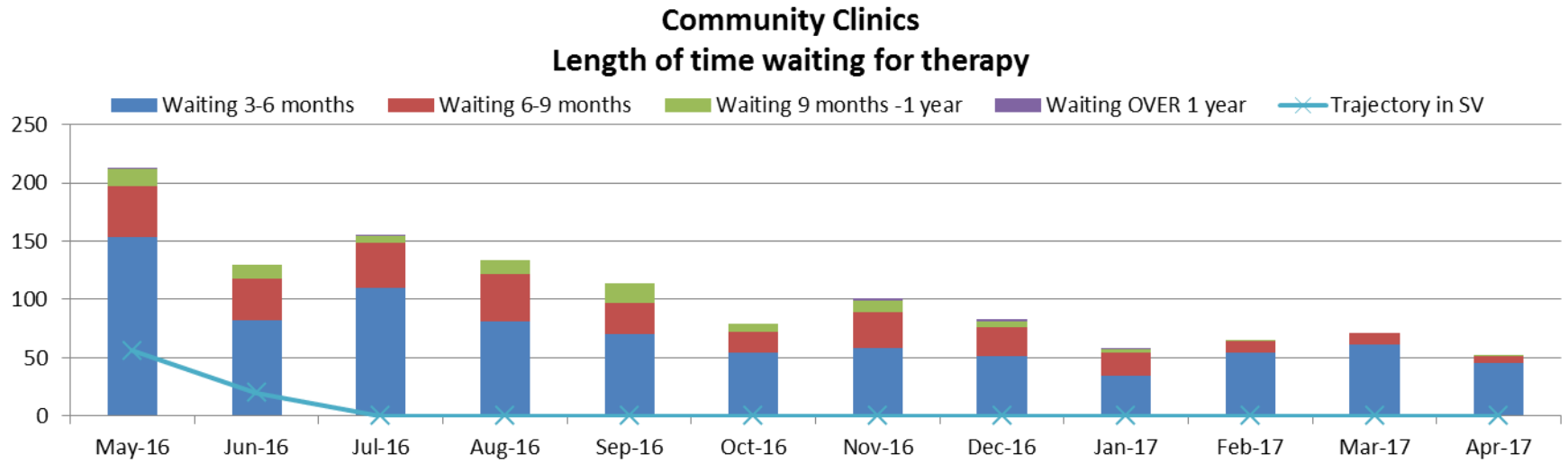
Compliments/Complaints

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Total compliments	52	21	33	19	46	21	38	28	36	27	61	50	46
Formal complaints (No.)	**4**	**2**	**6**	**7**	**5**	**1**	**1**	**2**	**2**	**3**	**5**	**1**	**1**
Acknowledged within 3 working days (No.)	2	2	3	5	4	1	1	1	2	3	5	1	1
Acknowledged within 3 working days (%)	50%	100%	50%	71%	80%	100%	100%	50%	100%	100%	100%	100%	100%
Responded to within 25 working days (No.)	1	1	4	4	2	0	1	1	0	2	0	1	-
Responded to within 25 working days (%)	25%	50%	67%	57%	40%	0%	100%	50%	0%	67%	0%	100%	-
Responded to outside 25 working days (No.)	3	1	2	3	3	1	0	1	2	1	5	0	-
Responded to outside 25 working days (%)	75%	50%	33%	43%	60%	100%	0%	50%	100%	33%	100%	0%	-
Complaints upheld (No.)	2	1	2	4	2	1	-	-	-	1	2	1	-
Complaints partially upheld (No.)	2	-	3	3	2	-	-	-	-	-	3	-	-
Complaints not upheld (No.)	-	1	1	-	1	-	1	2	2	2	-	-	-
Average response time (days)	30.5	33.0	29.6	27.6	32.8	31.0	19.0	36.5	38.5	24.0	28.0	7.0	-

Paediatric Speech and Language Service Waiting times

Community Clinic

Clinic Waiting lists												
Reports run 03/05/2017	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Length of wait Community Clinics *(pre-school caseload)*	**No. of children waiting May 2016**	**No. of children waiting June 2016**	**No. of children waiting July 2016**	**No. of children waiting August 2016**	**No. of children waiting September 2016**	**No. of children waiting October 2016**	**No. of children waiting November 2016**	**No. of children waiting December 2016**	**No. of children waiting January 2017**	**No. of children waiting February 2017**	**No. of children waiting March 2017**	**No. of children waiting April 2017**
Waiting up to 3 months	135	191	167	150	156	151	176	158	176	165	162	166
Waiting 3-6 months	154	82	110	81	70	54	58	51	35	54	61	45
Waiting 6-9 months	43	36	39	41	27	18	31	25	19	10	10	6
Waiting 9 months -1 year	15	12	6	12	17	7	10	5	3	1	0	1
Waiting OVER 1 year	1	0	1	0	0	0	2	2	1	0	0	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**348**	**321**	**323**	**284**	**270**	**230**	**277**	**241**	**234**	**230**	**233**	**218**
Already had PoC	70	66	119	97	72	75	67	72	55	60	85	53
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*	**418**	**387**	**442**	**381**	**342**	**305**	**344**	**313**	**289**	**290**	**318**	**271**

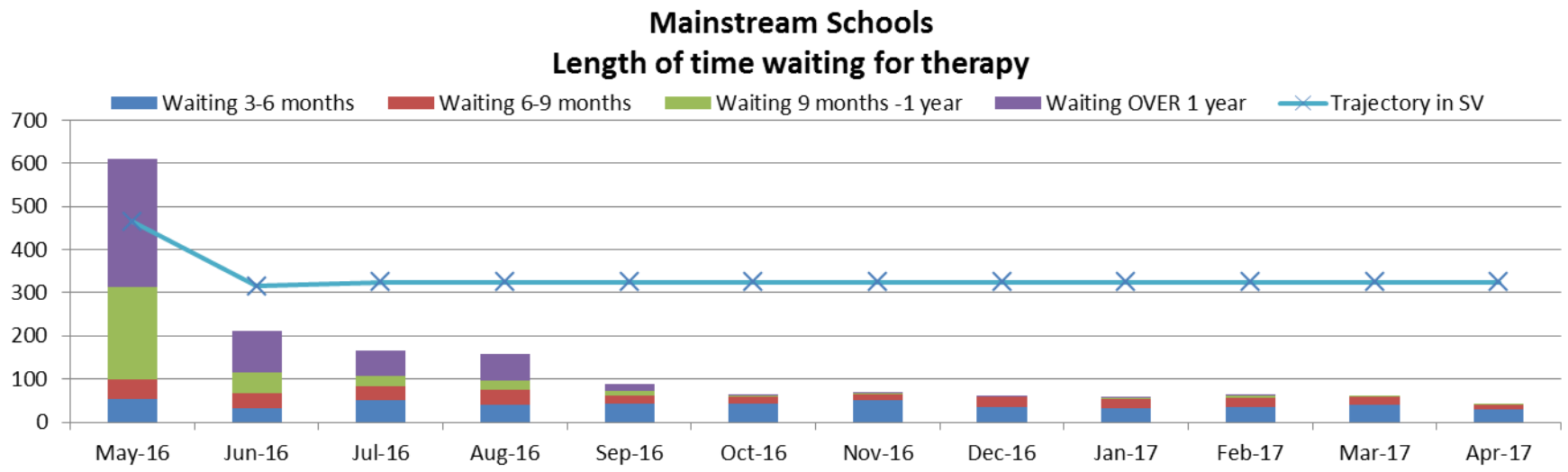


Mainstream Schools

Schools Waiting lists

No waiting data by months prior to May

Length of wait Mainstream Schools *(pre-school caseload)*	No. of children waiting May 2016	No. of children waiting June 2016	No. of children waiting July 2016	No. of children waiting August 2016	No. of children waiting September 2016	No. of children waiting October 2016	No. of children waiting November 2016	No. of children waiting December 2016	No. of children waiting January 2017	No. of children waiting February 2017	No. of children waiting March 2017	No. of children waiting April 2017
Waiting up to 3 months	142	126	117	119	88	72	68	59	56	56	73	87
Waiting 3-6 months	54	32	50	41	44	42	51	36	31	36	41	29
Waiting 6-9 months	46	36	33	33	18	16	13	22	22	21	18	11
Waiting 9 months -1 year	212	48	23	23	10	3	2	2	4	4	3	4
Waiting OVER 1 year	298	95	60	61	17	3	2	2	2	1	0	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**752**	**337**	**283**	**277**	**177**	**136**	**136**	**121**	**115**	**118**	**135**	**131**
Already had PoC	*unavailable*	264	356	396	395	377	392	332	277	266	248	210
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*	**752**	**601**	**639**	**673**	**572**	**513**	**528**	**453**	**392**	**384**	**383**	**341**



Appendix B – Provider Management Group Report

The following content provides a summary of the meeting and main points of discussion.

1. Contract performance update

The performance for March was reviewed, main points to note are:

- Friends & Family Test score remains very good; 1 formal complaint received for March regarding an out-patient phlebotomy clinic.
- Delayed Transfers of Care - slight decrease in numbers for February, however, has increased for March. The report being provided to PMG in June will highlight areas of concern and reasons for high numbers.
- A strategic Community Hospitals Review project is starting next month STP wide and Suffolk County Council will be asked to commit to a 2-3% rate of DTOC across the whole system, including DTOC within community hospitals.
- Further increases have been seen re: re-admissions to acute hospitals from community beds. A report is being provided to the June PMG which will look at the drivers for this. The report will look at time spent in the acute hospital, appropriateness of transfers, time spent in community hospitals before readmission to acute hospitals and whether patients were step-up or step-down.
- 18 Week Referral to Treatment target met for Paediatric Consultant service.
- There has been a further increase in Datix forms from Norfolk staff relating to staffing capacity and wound care products. A formal letter of concern has been received from the CCG that is being responded to as well as a report being compiled.

2. Provider Updates

West Suffolk Hospital

- A separate timeline and group will look at the transition and delivery of Paediatric services from 1 October 2017, in the meantime Paediatrics are continuing to work with Suffolk County Council and the Family 2020 strategy.
- Adult Speech and Language Therapy pilot has started taking referrals for patients with dementia and low level Learning Disabilities. They are now working in conjunction with mental health services to support these patients.
- The coffee shop is due to open at Newmarket Hospital mid-May.

Ipswich Hospital Trust

- Care Co-ordination Centre – the speed of answer has increased for April to 96.93% and the abandon rate is 1.5%. Large increases in call volumes were received over the Easter holiday. Most analyst vacancies have now been filled; however, there are two supervisor vacancies and a quality and risk vacancy to be appointed to.
- Paediatric referrals are now being routed through the CCC; initial teething problems have been ironed out and significant benefits are expected to be seen.
- A slight concern with regards to waiting times for the heart failure service due to staff sickness and increased demand has been highlighted with IHT through their contract meetings. Mitigating actions have been agreed.

Norfolk Community Health & Care

- The scheduling and allocation of therapies pilot has been completed with good results; all reds and amber referrals are being seen within timescales and there has been increased clinical

activity time. Waiting lists for appointments have been reduced and all patients now have an allocated appointment.
- The second cohort of Band 3 staff are currently being trained, however, this will be the last group as it will not be possible to recruit any more due to time constraints of the remaining contract.
- A regular meeting has been put in place with NCHC managers and the transition team to ensure a smooth transition and exit from the contract and Norfolk are represented on both the HR and the Communications and Engagement work stream.

Medequip

- Gross equipment spend was over £1 million, having collected £68K work of equipment with a recycling rate of 71%. The cost of special orders amounted to £119K.
- 1238 Planned Preventative Maintenance (PPM) are still outstanding, it is now proving difficult to contact these patients. Numerous contacts have been attempted and letters are being sent. The backlog is still high in comparison to other contracts; would expect this figure to be 400-500. Discussion followed about the process that should be followed in relation to this. A draft process for approval will be written for sign-off by PMG.
- Figures to date show April as having the highest collection percentage to date, following the promotion and publicity to return equipment, with a collection figure of 72.5%
- The single site solution has just been granted approval to proceed.

3. Risk Report

- The risk report was noted; there were no red risks.

4. CIP/SIP update reports

- The current programme of schemes has been jointly reviewed with the CCG, some schemes have completed and others will be part of the ongoing transformation plans.
- An overall assessment of all projects and an end of year community services report was requested for the next Joint Venture Board meeting.

5. I.T. update report

- The group received an update from Paul Berriman I.T manager on the current performance.
- 90.91% of calls logged with NEL (IT service provider) in March have been resolved; the service level is 95%. 89.39% of calls logged were fixed first time.
- Pathology – Electronic requesting and results - proof of concept project scheduled for Allington phlebotomy team early May and Bluebird Lodge team in June.
- In preparation for transition an up-to-date asset list is being compiled by NEL; this will list details of model numbers, quantities and age of kit etc. There is a need to secure long-term funding for community services in the future. It was noted there has been a historical lack of investment and capital funding for I.T across the contract; this will be added to the next JVB agenda.

6. Paediatric capacity

- The group received a report from Nick Smith-Howell the Associate Director of Community Paediatric Services.
- Overall there has been a reduction in the number of medical posts. There have been skill mix changes since 2010 and as a result the workforce has reduced, with posts being replaced where possible with middle-grade doctors/nurses.

- A full-time Consultant vacancy post is being funded at the moment, split between East and West, however it is proving difficult to recruit to, with three unsuccessful recruitment attempts. Alternative options are being considered and a risk analysis will be carried out. It may be possible to recruit to a part-time child psychologist post.
- Over the last five years there has been a steady rise in demand. The most significant impacts have been an increase for autism referrals.
- Discussion is required with the CCG with regards to safeguarding assessments and capacity within the team, there is a difference in the pathways due to this. The environments in the West are unsuitable to hold assessments. Discussion is required with the CCG re: pathways. Nic Smith-Howell intends to share this paper at the contract and quality sub-group meeting in order to initiate discussions. PMG supported the paper being presented to and discussed with the CCG at the next contract meeting
- Emotional Health & Well Being assessments are impacting on clinician's time.
- It is possible to increase capacity by changing the skill mix; however, increased referrals are being received. Opportunities to shift resources from acute to community are not a viable option.

							Surgery							
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU
Patient Experience: in-patient		Patient Satisfaction: In-patient overall result	= 85%	<75		85-100	90	99	94	98	NA	NA	NA	NA
		(In-patient) How likely is it that you would recommend the service to friends and family?	= 95%	<80		90-100	100	100	98.81	100	NA	NA	NA	NA
		In your opinion, how clean was the hospital room or ward that you are in?	= 85%	<75		85-100	98	100	98	100	NA	NA	NA	NA
		Did you feel you were treated with respect and dignity by staff?	= 85%	<75		85-100	100	100	99	100	NA	NA	NA	NA
		Were Staff caring and compassionate in their approach?	= 85%	<75		85-100	100	100	100	97	NA	NA	NA	NA
		Were you ever bothered by noise at night from other patients?	= 85%	<75		85-100	35	99	73	85	NA	NA	NA	NA
		(In-patient) Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<75		85-100	98	100	94	100	NA	NA	NA	NA
		Were you involved as much as you wanted to be in decisions about your condition and treatment?	= 85%	<75		85-100	93	100	95	100	NA	NA	NA	NA
		Were you given enough privacy when discussing your care?	= 85%	<75		85-100	100	100	96	100	NA	NA	NA	NA
		Did you get enough help from staff to eat your meals?	= 85%	<75		85-100	100	100	98	100	NA	NA	NA	NA
		(In-patient) Were you given enough privacy when being examined or treated?	= 85%	<75		85-100	100	100	99	100	NA	NA	NA	NA
		Timely call bell response	= 85%	<75		85-100	80	89	87	96	NA	NA	NA	NA
		Same sex accommodation: total patients	= 0	>2		= 0	0	0	0	0	0	0	0	0
		Complaints	= 0	>2		= 0	0	0	0	1	0	0	0	0
		Environment and Cleanliness	= 90%	<80		90-100		93			90	88	99	

							Surgery		Medicine	
Group		Indicator	Target	Red	Amber	Green	F4	DSU	F7	F8
Patient Experience: short-stay		Patient Satisfaction: short-stay overall result	= 85%	<75		85-100	99	98	99	0
		(Short-stay) How likely is it that you would recommend the service to friends and family?	= 95%	<70		90-100	99.21	100	100	0
		(Short-stay) Were you given enough privacy when being examined and treated?	= 85%	<75		85-100	100	100	100	0
		(Short-stay) Were staff professional, approachable and friendly?	= 85%	<75		85-100	100	94	100	0
		Were you told who to contact if you were worried after leaving hospital?	= 85%	<75		85-100	100	100	100	0
		(Short-stay) Overall how would you rate the care you received in the department?	= 85%	<75		85-100	98	100	96	0
		Number of short stay surveys completed	No Target	No Target		No Target	126	16	8	0

							Medicine
Group		Indicator	Target	Red	Amber	Green	ED
Patient Experience: A&E		Patient Satisfaction: A&E overall result	= 85%	<75		85-100	94
		(A&E) How likely is it that you would recommend the service to friends and family?	= 95%	<80		90-100	96.97
		Were A&E staff professional, approachable and friendly?	= 85%	<75		85-100	98
		Were you given enough privacy when discussing your condition at reception?	= 85%	<75		85-100	92
		Did Doctors and Nurses listen to what you had to say?	= 85%	<75		85-100	97
		Did staff tell you who to contact if you were worried about your condition after leaving A&E?	= 85%	<75		85-100	94
		Did a member of staff tell you what danger signs to watch for when going home?	= 85%	<75		85-100	91
		Number of A&E surveys completed	No Target	No Target		No Target	601

							Surgery	Medicine	Women & Children
Group		Indicator	Target	Red	Amber	Green			
		Patient Satisfaction: A&E Children questions overall result	= 85%	<75		85-100			
		(A&E Children) How likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?	= 95%	<80		90-100			

Patient Experience: A&E (Children questions)		Did the Doctor or Nurse listen to what you had to say?	≥ 85%	<75		85-100	Currently no data for this
		Were staff friendly and kind to you and your family?	≥ 85%	<75		85-100	
		Did we help with your pain?	≥ 85%	<75		85-100	
		Did staff explain the care you need at home?	≥ 85%	<75		85-100	
		Number of A&E children surveys completed	No Target	No Target		No Target	

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F11
Patient Experience: Maternity		Patient Satisfaction: Maternity overall result	≥ 85%	<75		85-100	NA
		How likely is it that you would recommend the post-natal ward to friends and family if they needed similar care or treatment?	≥ 95%	<70		90-100	NA
		How likely are you to recommend our labour suite to friends and family if they needed similar care or treatment?	≥ 75%	<70		75-100	100
		How likely are you to recommend our antenatal department to friends and family?	≥ 75%	<70		75-100	96.97
		How likely are you to recommend our post-natal care to friends and family?	≥ 75%	<70		75-100	100
		(Maternity) Were staff professional, approachable and friendly?	≥ 85%	<75		85-100	NA
		(Maternity) Did you find someone on the hospital staff to talk to about your worries and fears?	≥ 85%	<75		85-100	NA
		Were you involved as much as you wanted to be in decisions about your care and treatment?	≥ 85%	<75		85-100	NA
		(Maternity) Were you given enough privacy when being examined or treated?	≥ 85%	<75		85-100	NA
		Did you hold your baby in skin to skin contact after the birth (baby naked apart from the nappy and a hat, lying on your chest)?	≥ 85%	<75		85-100	NA
		Were you given adequate help and support to feed your baby whilst in hospital?	≥ 85%	<75		85-100	NA
		How many minutes after you used the call button did it usually take before you got the help you needed?	≥ 85%	<75		85-100	NA
		Has a member of staff told you about medication side effects to watch for when you go home?	≥ 85%	<75		85-100	NA
		Have hospital staff told you who to contact if you are worried about your condition after you leave hospital?	≥ 85%	<75		85-100	NA
		In your opinion, how clean was the hospital room or ward that you were in?	≥ 85%	<75		85-100	NA
		Number of maternity surveys completed	No Target	No Target		No Target	125

							Women & Children
Group		Indicator	Target	Red	Amber	Green	MLBU
Patient Experience: Birthing Unit		How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	≥ 95%	<80		90-100	NA
		Did you feel that your community midwife gave you sufficient information about the birthing unit prior to you being referred?	≥ 85%	<75		85-100	NA
		If you phoned for advice prior to admission to the birthing unit did you feel that the advice given to you was useful and appropriate?	≥ 85%	<75		85-100	NA
		Do you feel that the 'home from home' environment had a positive effect on your birthing experience?	≥ 85%	<75		85-100	NA
		Did you have confidence and trust in the midwives caring for you during labour?	≥ 85%	<75		85-100	NA
		Were your birthing partners made to feel welcome by the midwives on the birthing unit?	≥ 85%	<75		85-100	NA
		Were you at any time left alone by your midwife at a time when you felt worried?	≥ 85%	<75		85-100	NA
		Thinking about your care during labour and birth, were you involved in the decisions about your care?	≥ 85%	<75		85-100	NA
		Overall how would you rate the care you received on the MLBU during your labour and birth?	≥ 85%	<75		85-100	NA
		Number of birthing unit surveys completed	No Target	No Target		No Target	NA

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
		Patient Satisfaction: Children's Services Overall Result	≥ 85%	<75		85-100	100
		(Young children) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	≥ 95%	<70		90-100	100
		Did you understand the information given to you regarding your treatment and care?	≥ 85%	<75		85-100	100

Patient Satisfaction: Young Children		Were you as involved as you wanted to be in decisions about your care and treatment?	= 85%	<75	[illegible]	85-100	100
		Did the Doctor or Nurses explain what they were doing in a way that you could understand?	= 85%	<75	[illegible]	85-100	100
		Were you offered age/need appropriate activities?	= 85%	<75	[illegible]	85-100	100
		Was your experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	[illegible]	85-100	100
		Was your experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	[illegible]	85-100	100
		If you were in pain, did the Doctor or Nurse do everything they could to help with the pain?	= 85%	<75	[illegible]	85-100	100
		Were staff kind and caring towards you?	= 85%	<75	[illegible]	85-100	100
		Is the environment child - friendly?	= 85%	<75	[illegible]	85-100	100
		Overall, how would you rate your experience in the Paediatric Unit?	= 85%	<75	[illegible]	85-100	100
		Number of young children surveys completed	No Target	No Target	[illegible]	No Target	9

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
F1 Parent		Patient Satisfaction: F1 Parent overall result	= 85%	<75	[illegible]	85-100	97
		(F1 Parent) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 95%	<70	[illegible]	90-100	100
		Did you understand the information given to you regarding your child's treatment and care?	= 85%	<75	[illegible]	85-100	100
		Were you and your child as involved as you wanted to be in decisions about care and treatment?	= 85%	<75	[illegible]	85-100	85
		Did the Doctor or Nurses explain what they were doing in a way that your child could understand?	= 85%	<75	[illegible]	85-100	94
		Were there appropriate play activities for your child (such as toys, games and books)?	= 85%	<75	[illegible]	85-100	100
		Was your child's experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	[illegible]	85-100	100
		Was your child's experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	[illegible]	85-100	100
		If your child was in pain, did the doctor or nurse do everything they could to help with the pain?	= 85%	<75	[illegible]	85-100	96
		Were staff kind and caring towards your child?	= 85%	<75	[illegible]	85-100	100
		Is the environment child-friendly?	= 85%	<75	[illegible]	85-100	100
		Overall, how would you rate your experience in the Children's Unit?	= 85%	<75	[illegible]	85-100	95
		Number of F1 parent surveys completed	No Target	No Target	[illegible]	No Target	20

							Medicine
Group		Indicator	Target	Red	Amber	Green	G8
Patient Experience: Stroke		Patient Satisfaction: Stroke overall result	= 85%	<75	[illegible]	85-100	94
		(Stroke) How likely is it that you would recommend the service to friends and family?	= 95%	<70	[illegible]	90-100	93.33
		Have you been told you have had a stroke, which lead to your admission to hospital?	= 85%	<75	[illegible]	85-100	93
		Have you been involved in planning your recovery / rehabilitation?	= 85%	<75	[illegible]	85-100	83
		While you were in the Stroke Department how much information about your condition or treatment was given to you?	= 85%	<75	[illegible]	85-100	93
		Have you received the help you require while eating?	= 85%	<75	[illegible]	85-100	75
		Do you feel cared for?	= 85%	<75	[illegible]	85-100	100
		Were you given enough privacy when being examined or treated or when your care was discussed with you?	= 85%	<75	[illegible]	85-100	100
		Number of stroke surveys completed	No Target	No Target	[illegible]	No Target	15

Group		Indicator	Target	Red	Amber	Green	Surgery								Medicine														Women & Children			
							F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	G5	F9	F10	G1	G3	G4	G8	MTU	F12	WEW - G9	F7	F8	F1	F11	F14	MLBU
Patient Safety		HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA
		HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	No Data	100	No Data	100	NA	NA	NA	NA	No Data	No Data	100	No Data	100	100	No Data	No Data	NA	100	100	No Data	NA	NA	NA	No Data	NA
		HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	No Data	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	No Data	100	NA	NA	NA
		HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	100	100	100	100	NA	NA	NA	NA	100	100	100	No Data	100	100	100	100	NA	100	100	NA	NA	100	NA	100	NA
		HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	NA	100	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
		HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	NA	100	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
		HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
		HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	100	NA	NA	100	NA	NA	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA
		HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	100	100	100	100	NA	NA	NA	NA	NA	100	75	75	No Data	33	No Data	80	75	NA	100	100	NA	NA	NA	NA	80	NA
		HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<80	80-99	= 100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
		Total no of MRSA bacteraemias: Hospital	= 0 per yr	>0	No Target	= 0	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
		Hand hygiene compliance	= 95%	<85	85-94	= 100	100	100	100	100	100	NA	100	100	74	100	89	100	NA	100	100	100	100	100	100	100	79	100	100	91	100	100
		Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
		Total no of C. diff infections: Hospital	= 16 per year	No Target	No Target	No Target	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
		No of patient falls	= 48	>48	No Target	<48	6	1	1	2	0	NA	NA	NA	1	0	7	3	3	2	4	2	15	0	1	0	4	1	NA	0	0	NA
		No of patient falls resulting in harm	No Target	No Target	No Target	No Target	0	0	0	1	0	NA	NA	NA	0	0	1	1	0	1	1	0	2	0	1	0	0	0	NA	0	0	NA
		No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	0	0	0	0	NA	NA	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	NA	0	0	NA
		No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	1	0	0	1	0	NA	NA	NA	NA	0	0	0	1	0	0	1	1	0	0	1	0	0	NA	0	0	NA
		No of avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
		Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	90	100	80	100	100	NA	NA	NA	NA	100	70	80	No Data	70	100	87	100	NA	100	100	No Data	No Data	NA	NA	90	NA
		No of SIRIs	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	2	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0
		No of medication errors	No Target	No Target	No Target	No Target	2	0	1	2	2	0	1	0	2	0	1	3	3	7	3	0	5	0	1	4	10	1	1	3	1	1
		Cardiac arrests	No Target	No Target	No Target	No Target	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
		Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	82	93	95	93	NA	NA	NA	NA	NA	NA	26	86	77	66	33	63	78	NA	88	72	49	76	100	54	91	NA
		VTE: Completed risk assessment (monthly Unify audit)	> 98%	< 98	No Target	> 98	0.0	0.0	0.0	0.0	0.0	No Data	No Data	0.0	No Data	0.0	No Data	0.0	0.0	0.0	0.0	0.0	0.0	No Data	0.0	No Data	0.0	0.0	No Data	0.0	0.0	0.0
		Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
		Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	93.75	100	100	96.3	100	No Data	No Data	No Data	No Data	100	No Data	100	100	100	100	100	100	No Data	100	83.69	100	No Data	No Data	100	100	No Data
Patient Experience: In-patient		Same sex accommodation: total patients	= 0	>2	1-2	= 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

West Suffolk NHS
NHS Foundation Trust

Board of Directors - April 2017

AGENDA ITEM:	Item 9
PRESENTED BY:	Craig Black, Executive Director of Resources
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
DATE PREPARED:	19 May 2017
SUBJECT:	April Board report
PURPOSE:	Review

EXECUTIVE SUMMARY:
The reported I&E for April 2017 is a deficit of £938k, against a planned deficit of £990k. This results in a favourable variance of £52k.

We are therefore on plan to achieve our control total this year, which will mean we also receive STF funding of £5.2m. Therefore £433k of this funding is included in the April position.

The April position includes a CIP target of £869k which represents 7% of the 2017-18 plan (£13.3m). This was exceeded by £39k in month. KPMG are currently working with us to identify further savings which will ensure this year's CIP is delivered and that robust plans are in place for 2018-19.

Linked Strategic objective (link to website)	**To provide value for money for the taxpayer and to maintain a financially sound organisation**
Issue previously considered by: (e.g. committees or forums)	
Risk description: (including reference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatory requirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	None
Recommendation:	The Board is asked to review this report

West Suffolk NHS
NHS Foundation Trust

FINANCE AND WORKFORCE REPORT

April 2017 (Month 1)

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

Financial Summary

I&E Position YTD	£0.9m	loss
Variance against plan YTD	£0.1m	favourable
Movement in month against plan	£0.1m	favourable
EBITDA position YTD	£0.2m	surplus
EBITDA margin YTD	0.00%	surplus
Cash at bank	£7,956k	

Executive Summary

- The Month 1 position is just ahead of plan.

Key Risks

- Delivering the cost improvement programme
- Containing the increase in demand to that included in the plan (2.5%).
- Receiving Sustainability and Transformation Funding – dependent on Financial and Operational performance
- Working across the system to minimise delays in discharge and requirement for escalation beds

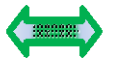
SUMMARY INCOME AND EXPENDITURE ACCOUNT - April 2017	Apr-17			Year to date			Year end forecast		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	17.9	17.9	0.0	17.9	17.9	0.0	225.8	225.5	(0.3)
Other Income	2.0	2.0	0.0	2.0	2.0	0.0	24.7	25.1	0.4
Total Income	**19.8**	**19.9**	**0.0**	**19.8**	**19.9**	**0.0**	**250.5**	**250.6**	**0.1**
Pay Costs	11.9	11.9	0.0	11.9	11.9	0.0	142.8	142.8	0.0
Non-pay Costs	8.9	8.9	0.0	8.9	8.9	0.0	110.0	110.0	0.0
Operating Expenditure	**20.8**	**20.8**	**0.0**	**20.8**	**20.8**	**0.0**	**252.7**	**252.7**	**0.0**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	2.5	2.5	0.0
EBITDA	**(1.0)**	**(1.0)**	**0.1**	**(1.0)**	**(1.0)**	**0.1**	**(4.8)**	**(4.7)**	**0.1**
EBITDA margin	(5.1%)	(4.8%)	0.3%	(5.1%)	(4.8%)	0.3%	(1.9%)	(1.9%)	0.0%
Depreciation	0.3	0.3	(0.0)	0.3	0.3	(0.0)	5.1	5.1	0.0
Finance costs	0.1	0.1	(0.0)	0.1	0.1	(0.0)	1.3	1.3	0.0
SURPLUS/(DEFICIT) pre S&TF	**(1.4)**	**(1.4)**	**0.0**	**(1.4)**	**(1.4)**	**0.0**	**(11.1)**	**(11.0)**	**0.1**
S&T funding - Financial Performance	0.3	0.3	0.0	0.3	0.3	0.0	3.6	3.6	0.0
S&T funding - A&E Performance	0.1	0.1	0.0	0.1	0.1	0.0	1.6	1.6	0.0
SURPLUS/(DEFICIT) incl S&TF	**(1.0)**	**(0.9)**	**0.1**	**(1.0)**	**(0.9)**	**0.1**	**(5.9)**	**(5.8)**	**0.1**

FINANCE AND WORKFORCE REPORT – April 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	✗

FINANCE AND WORKFORCE REPORT – April 2017

Income and Expenditure summary as at April 2017

The reported I&E for April 2017 is a deficit of £938k, against a planned deficit of £990k. This results in a favourable variance of £52k.

Cost Improvement Programme (CIP)

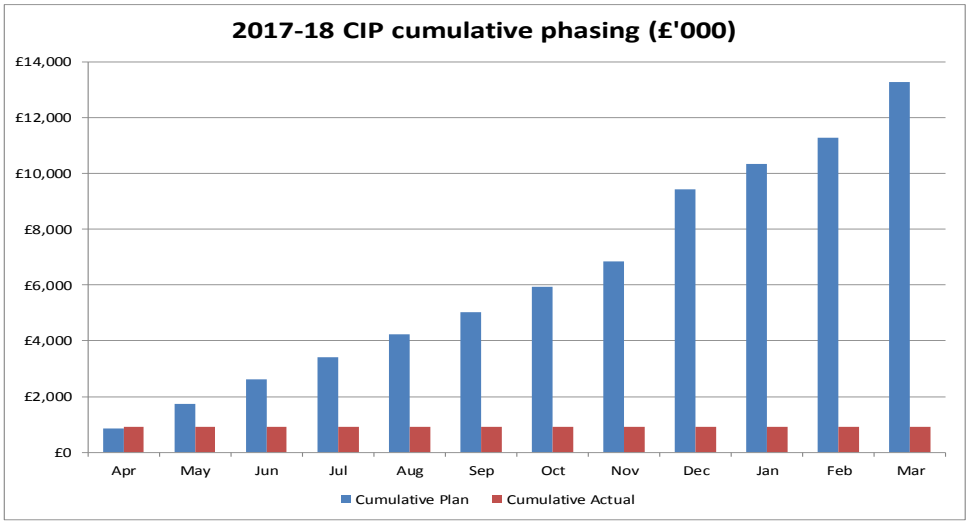
The April position includes a target of £869k which represents 7% of the 2017-18 plan. This was exceeded by £39k in month.

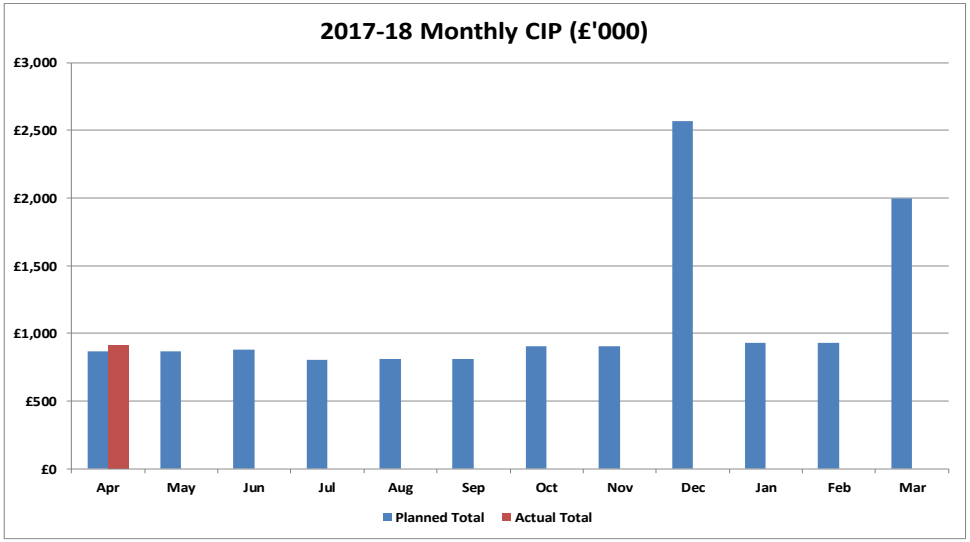
We continue to have a block contract with WS CCG and I&E CCG for 2017-18 removing the risk of underperformance and penalties. Therefore the CIP must come from cost reductions, productivity gains or from patients currently being treated outside of Suffolk. We have a good record of delivering CIPs, averaging almost 4% per year over the last 5 years. However, this years target of £13.3m represents 6% of turnover

KPMG are currently working with us to identify further savings which will ensure this year's CIP is delivered and that robust plans are in place for 2018-19.

Progress against all 2017-18 CIP is summarised below**.**

Recurring/Non Recurring	Summary	2017-18 Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Activity growth	297	21	6
	Car Park Income	400	33	33
	Other Income	186	13	13
	Consultant Staffing	326	16	16
	Additional sessions	202	17	10
	Staffing Review	2,650	158	255
	Agency	482	40	14
	Procurement	1,801	117	135
	Community Equipment Service	465	33	28
	Contract review	50	3	5
	Drugs	326	10	48
	Estates and Facilities	389	32	-
	Capitalisation	1,080	90	90
	Other	2,272	286	255
Recurring Total		**10,925**	**869**	**908**
Non-Recurring	GDE funding	1,650	-	-
	Other Non-Recurring	696	-	-
Non-Recurring Total		**2,346**	**-**	**-**
Grand Total		**13,271**	**869**	**908**

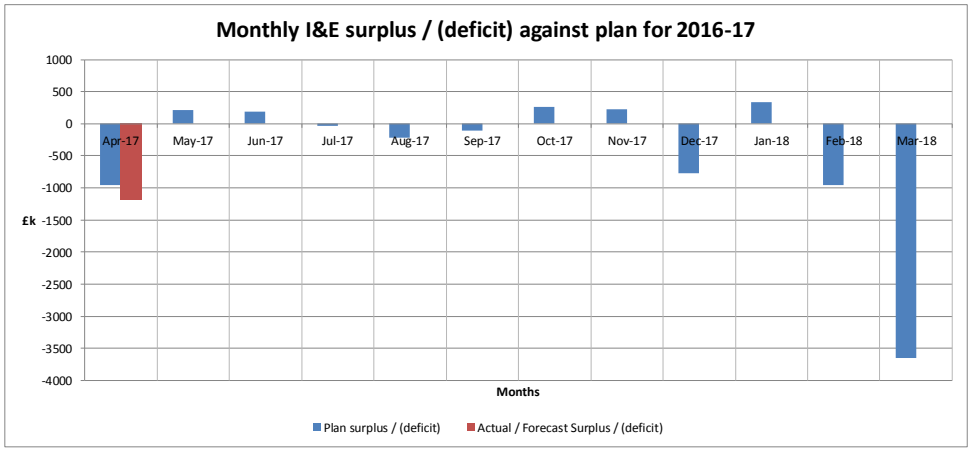


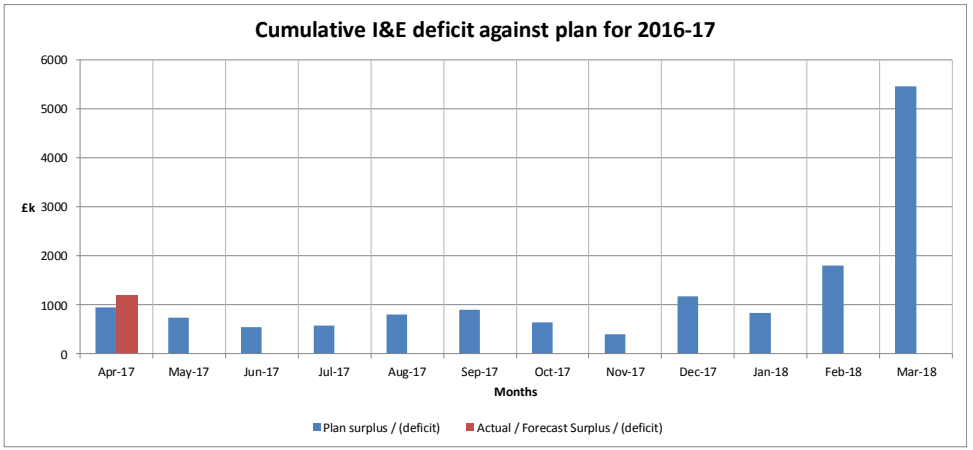


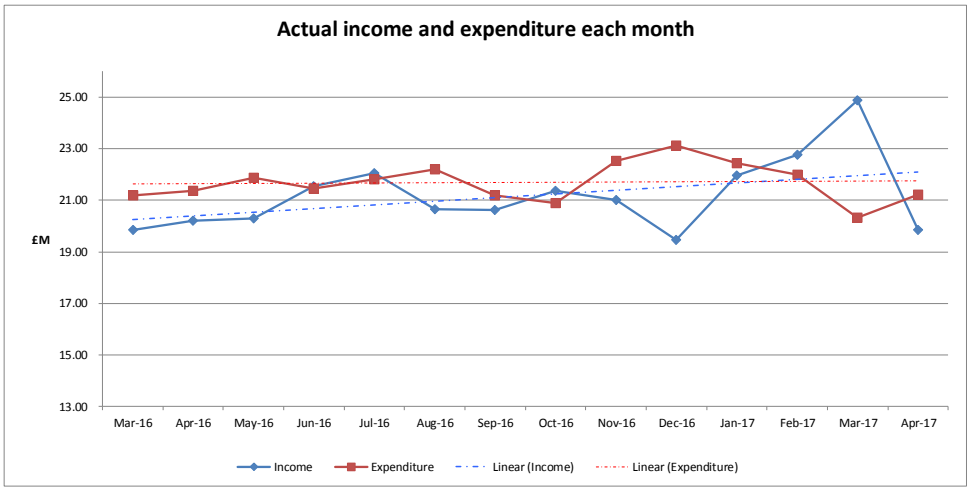
FINANCE AND WORKFORCE REPORT – April 2017

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)	(990)	(938)	52	↑	Green
YTD surplus / (deficit)	(990)	(938)	52	↑	Green
Forecast surplus / (deficit)	(5,928)	(5,928)	0	↑	Green
EBITDA YTD	(576)	(411)	166	↑	Green
EBITDA (%)	(0.0%)	(0.0%)	0.0%	↔	Amber
Use of Resources (UoR) Rating fav / (adv)	n'a	n'a	n'a	↔	Amber
Clinical Income YTD	(17,860)	(17,840)	(20)	↑	Amber
Non-Clinical Income YTD	(2,412)	(2,446)	34	↑	Amber
Pay YTD	11,905	11,874	32	↑	Green
Non-Pay YTD	9,357	9,350	7	↑	Green
CIP target YTD	(869)	(908)	39	↔	Green

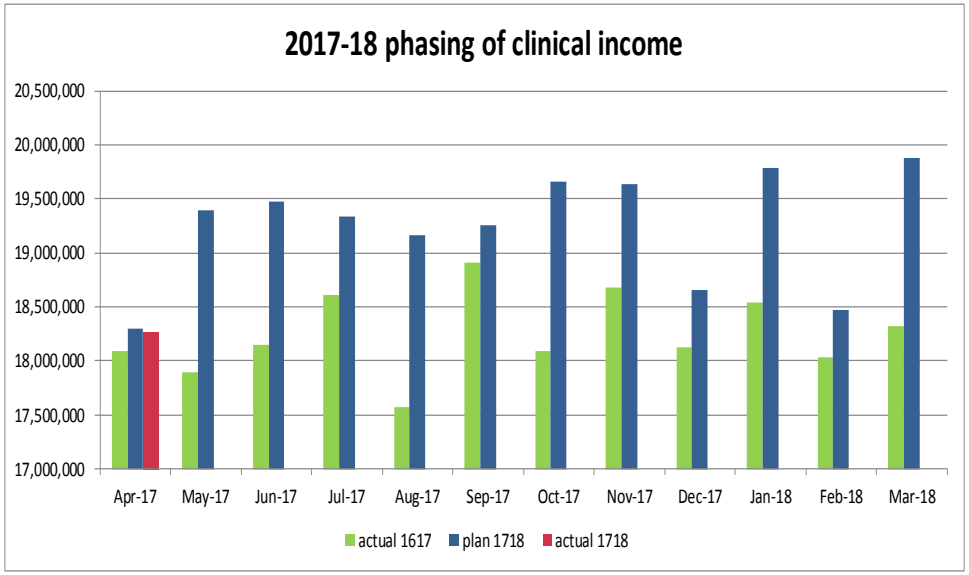






Income Analysis

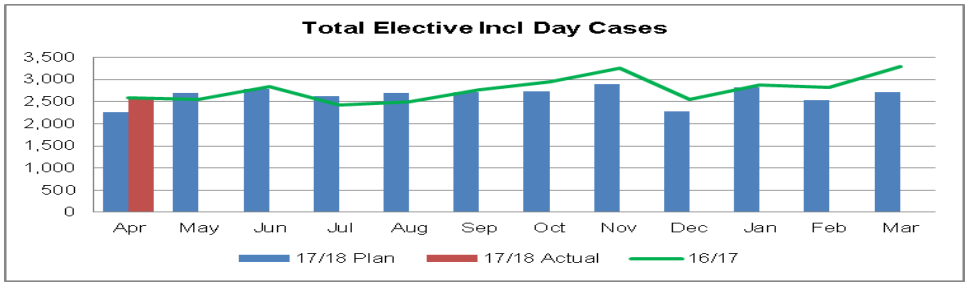
The chart below summarises the phasing of the clinical income plan for 2017-18, including a full year for Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.

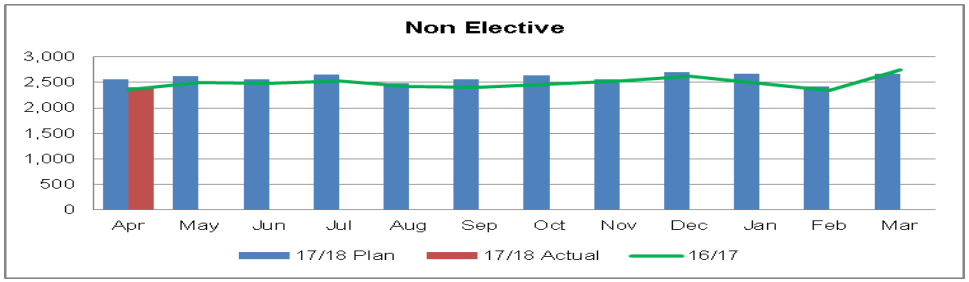


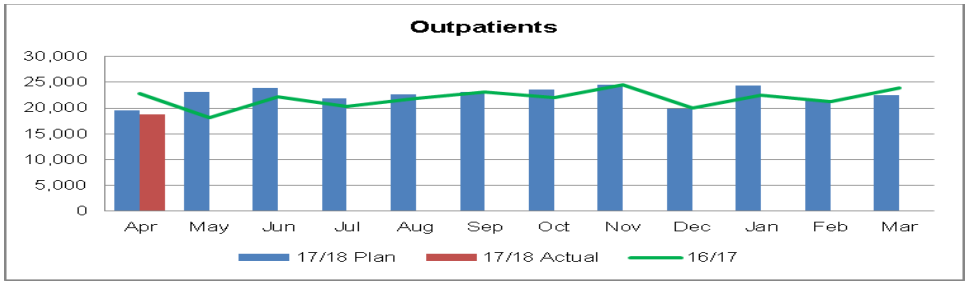
The income position was slightly behind plan in April. Non Elective activity and income was lower than planned with Elective over performing against the planned level.

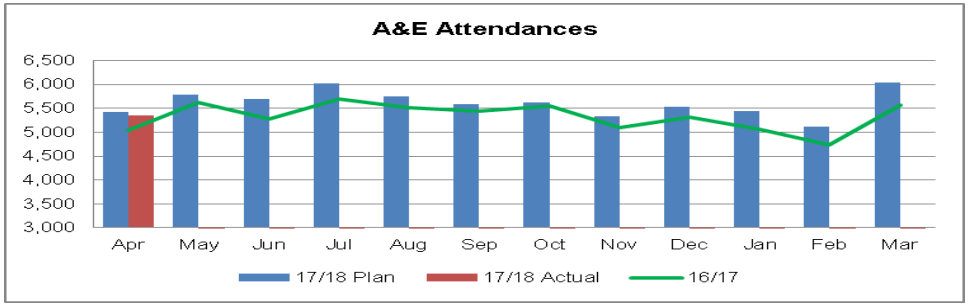
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	675	652	(23)	675	652	(23)
Other Services	1,996	2,076	80	1,996	2,076	80
CQUIN	283	279	(3)	283	279	(3)
Elective	2,211	2,487	275	2,211	2,487	275
Non Elective	5,310	4,978	(332)	5,310	4,978	(332)
Emergency Threshold Adjustment	(347)	(300)	47	(347)	(300)	47
Outpatients	2,353	2,289	(64)	2,353	2,289	(64)
Community	5,379	5,379	0	5,379	5,379	0
Total	**17,860**	**17,840**	**(20)**	**17,860**	**17,840**	**(20)**

Activity, by point of delivery

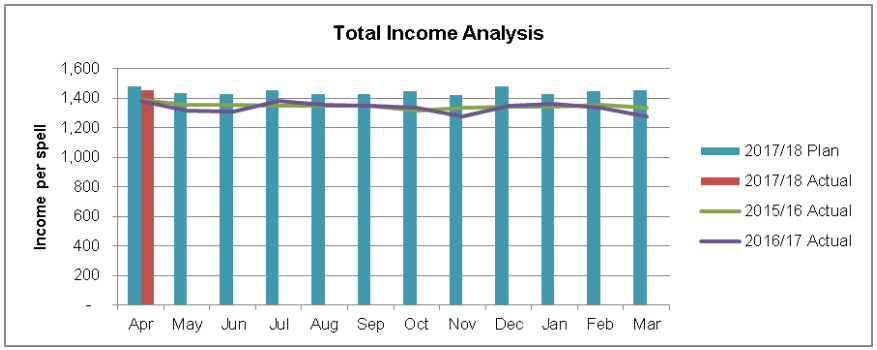


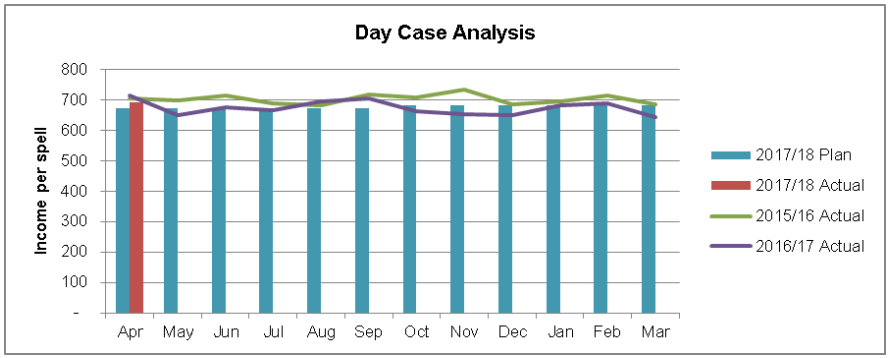


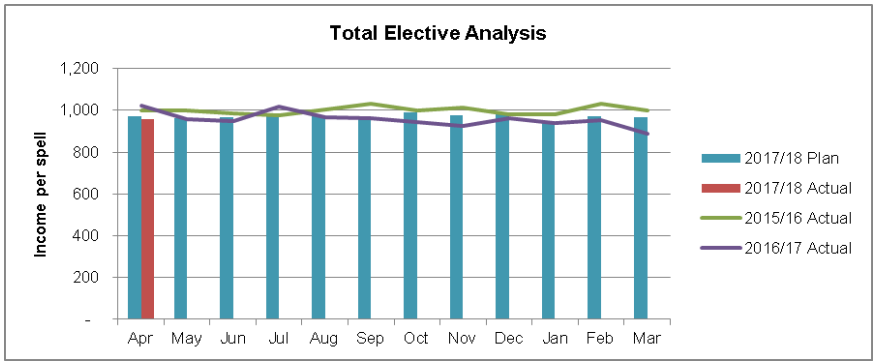


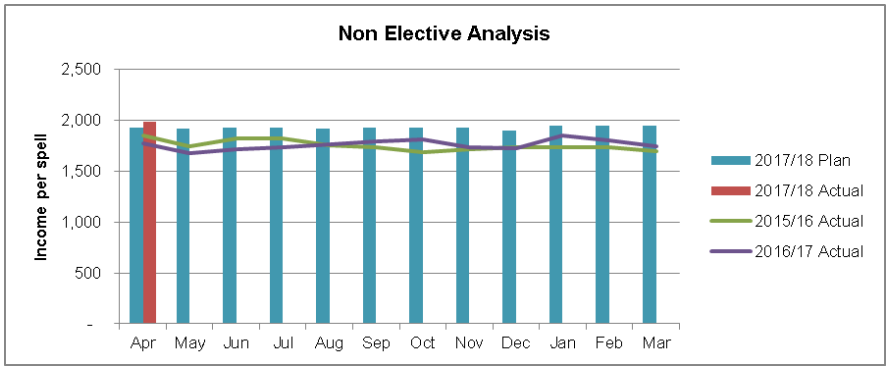


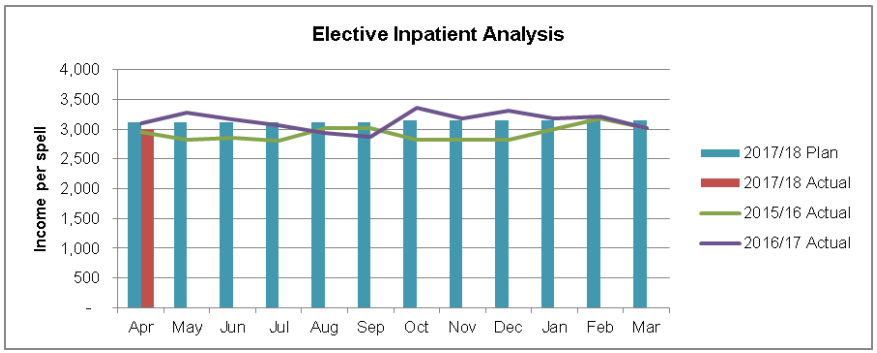
Trends and Analysis

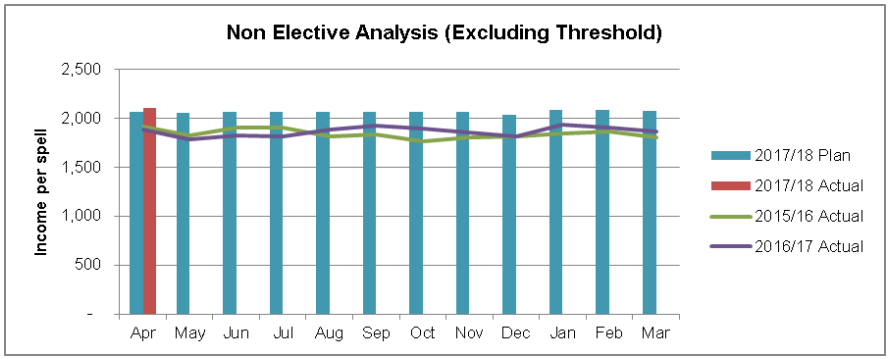












FINANCE AND WORKFORCE REPORT – April 2017

Workforce

Monthly Expenditure Acute services only				
As at April 2017	Apr-17	Mar-17	Apr-16	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,798**	**11,839**	**10,797**	**10,798**
Substantive Staff	9,553	9,570	9,363	9,383
Medical Agency Staff (includes 'contracted in' staff)	143	81	218	143
Medical Locum Staff	166	153	112	166
Additional Medical sessions	223	176	228	223
Nursing Agency Staff	72	(7)	127	72
Nursing Bank Staff	228	201	300	228
Other Agency Staff	45	130	88	45
Other Bank Staff	152	113	131	152
Overtime	109	92	110	109
On Call	44	41	54	44
Total temporary expenditure	1,181	980	1,368	1,181
Total expenditure on pay	**10,734**	**10,550**	**10,730**	**10,564**
Variance (F/(A))	64	1,289	67	234
Temp Staff costs % of Total Pay	11.0%	9.3%	12.7%	11.2%
Memo : Total agency spend in month	260	204	434	260

Monthly Expenditure Community Service				
As at April 2017	Apr-17	Mar-17	Apr-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,106**	**1,078**	**1,019**	**1,106**
Substantive Staff	1,053	1,074	946	1,053
Medical Agency Staff (includes 'contracted in' staff)	14	10	15	14
Medical Locum Staff	3	3	6	3
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	2	1	6	2
Nursing Bank Staff	15	8	9	15
Other Agency Staff	34	43	59	34
Other Bank Staff	12	9	7	12
Overtime	4	5	3	4
On Call	2	2	1	2
Total temporary expenditure	86	81	106	86
Total expenditure on pay	**1,139**	**1,155**	**1,053**	**1,139**
Variance (F/(A))	(33)	(78)	(6)	(33)
Temp Staff costs % of Total Pay	7.5%	7.0%	10.1%	7.5%
Memo : Total agency spend in month	50	54	80	50

Monthly whole time equivalents (WTE) Acute Services only			
As at April 2017	Apr-17	Mar-17	Apr-16
	WTE	WTE	WTE
Budgeted WTE in month	**3,095.6**	**3,019.2**	**3,041.4**
Employed substantive WTE in month	**2737.36**	**2732.49**	**2,672.9**
Medical Agency Staff (includes 'contracted in' staff)	8.52	7.65	12.1
Medical Locum	12.32	13.86	10.7
Additional Sessions	22.15	18.42	17.4
Nursing Agency	11.47	11.49	19.8
Nursing Bank	73.21	65.77	96.4
Other Agency	12.73	28.27	20.8
Other Bank	75.33	57.44	65.0
Overtime	50.88	44.75	51.6
On call Worked	8.51	6.83	9.2
Total equivalent temporary WTE	**275.1**	**254.5**	**303.0**
Total equivalent employed WTE	**3,012.5**	**2,987.0**	**2,975.9**
Variance (F/(A))	83.1	32.3	65.5
Temp Staff WTE % of Total Pay	9.1%	8.5%	10.2%
Memo : Total agency WTE in month	32.7	47.4	52.7
Sickness Rates (February/January)	2.31%	3.66%	3.8%
Mat Leave	2.3%	2.2%	2.0%

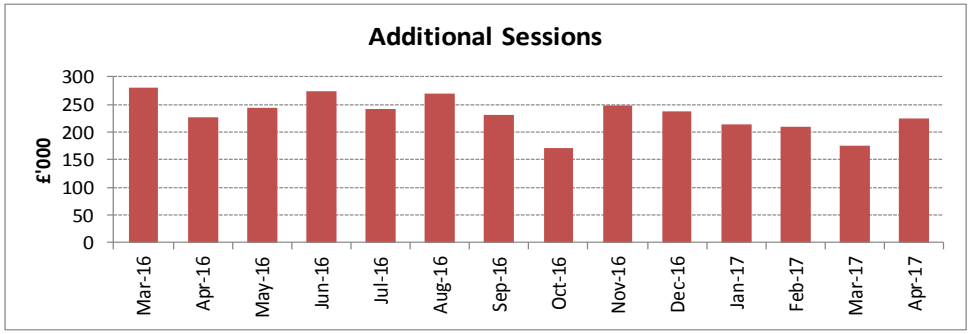
Monthly whole time equivalents (WTE) Community Services			
As at April 2017	Apr-17	Mar-17	Apr-16
	WTE	WTE	WTE
Budgeted WTE in month	**380.57**	**359.2**	**333.5**
Employed substantive WTE in month	**344.5**	**342.7**	**310.4**
Medical Agency Staff (includes 'contracted in' staff)	1.5	1.1	1.6
Medical Locum	0.4	0.4	0.8
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.4	0.2	1.1
Nursing Bank	4.6	2.9	2.8
Other Agency	9.2	13.0	13.2
Other Bank	3.3	2.6	2.5
Overtime	2.3	2.5	1.7
On call Worked	0.0	0.1	0.0
Total equivalent temporary WTE	**21.6**	**22.6**	**23.6**
Total equivalent employed WTE	**366.2**	**365.3**	**333.9**
Variance (F/(A))	14.4	(6.1)	(0.4)
Temp Staff WTE % of Total Pay	5.9%	6.2%	7.1%
Memo : Total agency WTE in month	11.1	14.3	15.8
Sickness Rates (February/ January)	2.31%	4.59%	
Mat Leave	1.1%	0.8%	

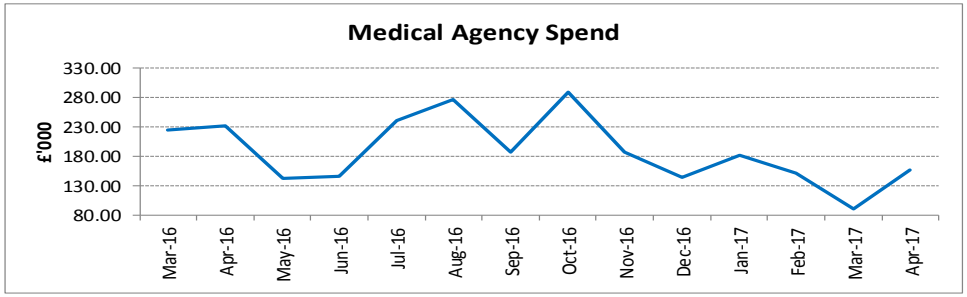
* Note the Acute tables includes Collaborative Procurement Hub staff on WSH Contracts
* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

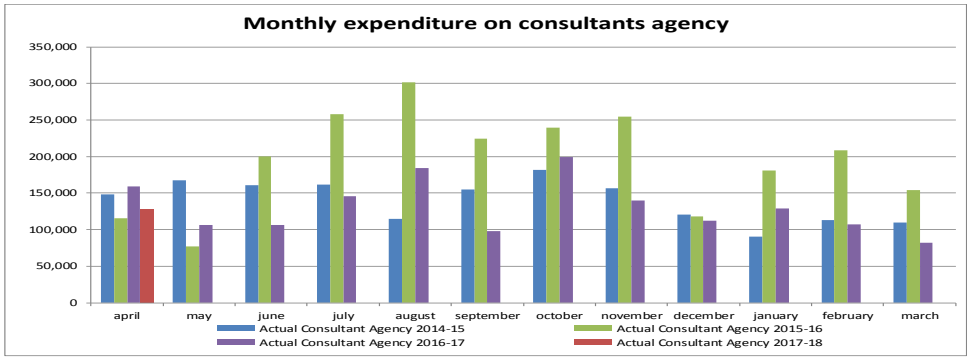
Staffing levels

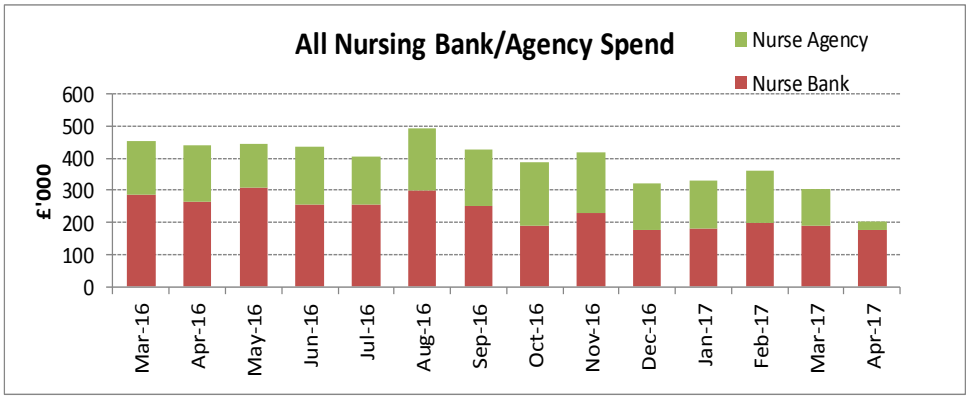
Pay Trends and Analysis

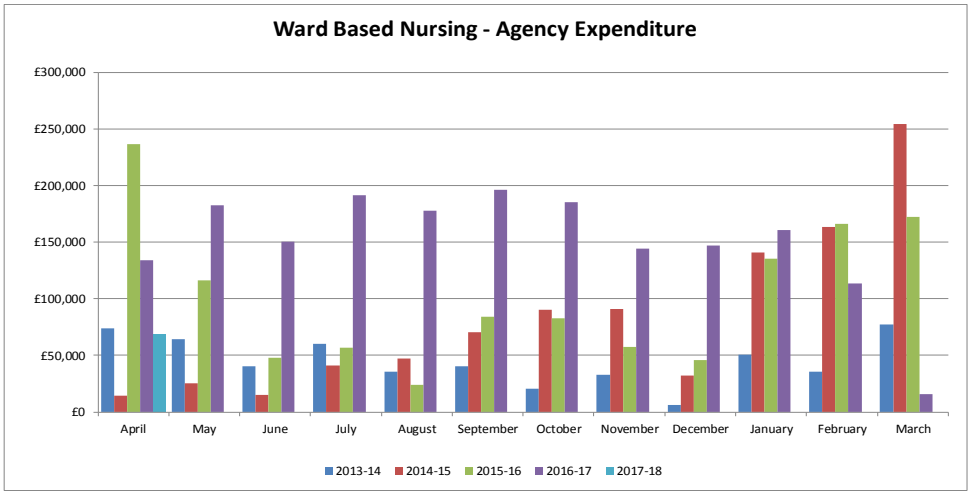
The Trust underspent pay budgets by £32k in April. Pay expenditure was £170k higher than in March and was all within temporary pay. However, March was particularly low due to year end adjustments. Compared with February pay was around £100k lower.

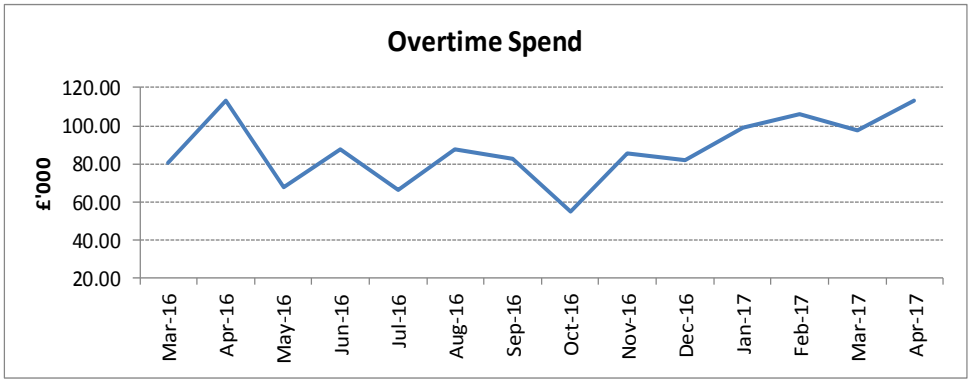




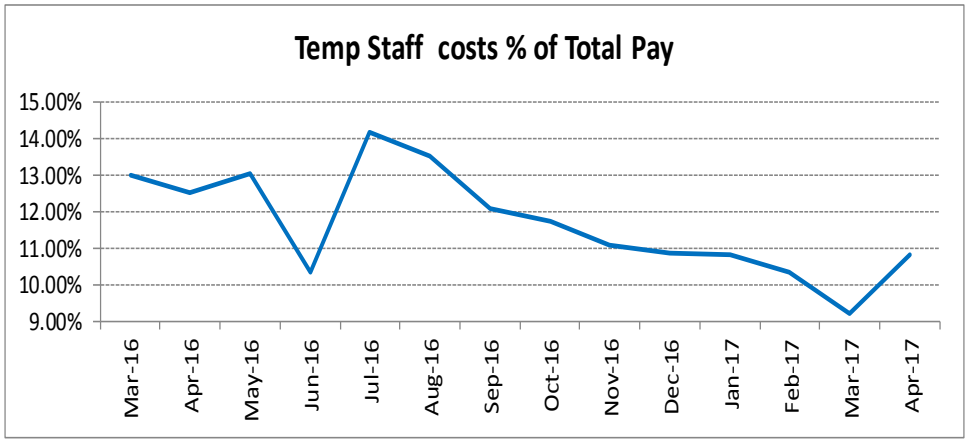


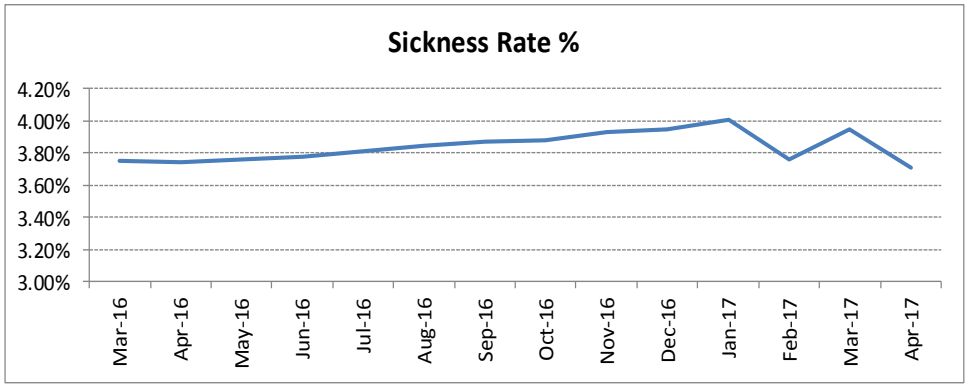


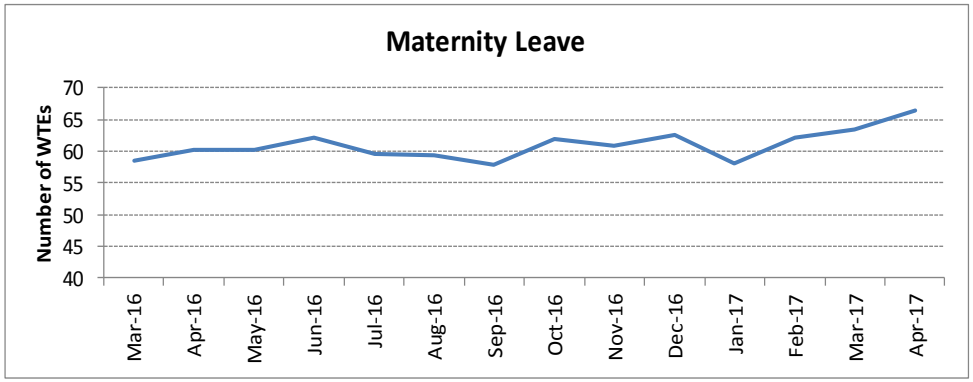




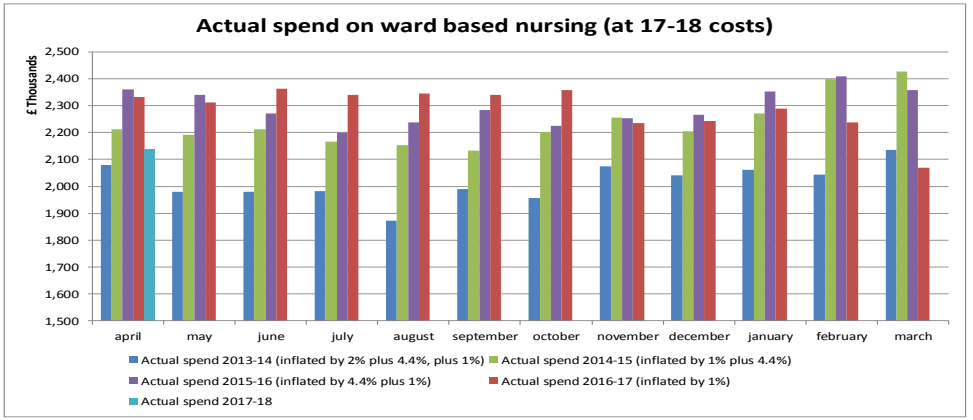
FINANCE AND WORKFORCE REPORT – April 2017

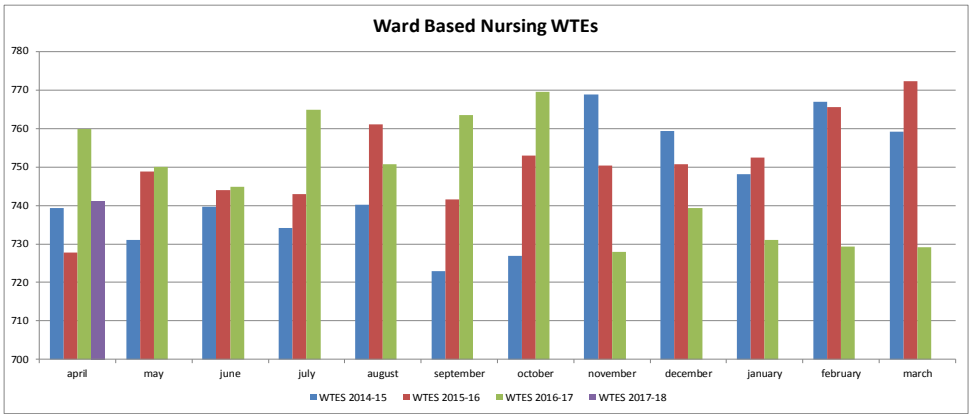


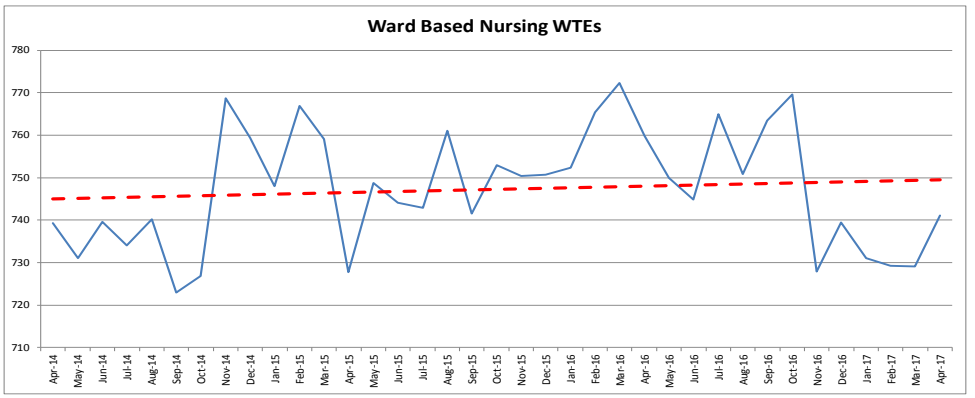




Ward Based Nursing







Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Apr-17 Budget £k	Apr-17 Actual £k	Apr-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	(4,980)	(4,948)	(32)	(4,980)	(4,948)	(32)
Pay Costs	3,338	3,340	(3)	3,338	3,340	(3)
Non-pay Costs	1,275	1,294	(19)	1,275	1,294	(19)
Operating Expenditure	**4,612**	**4,634**	**(22)**	**4,612**	**4,634**	**(22)**
SURPLUS / (DEFICIT)	**367**	**313**	**(54)**	**367**	**313**	**(54)**
SURGERY						
Total Income	(4,540)	(4,597)	57	(4,540)	(4,597)	57
Pay Costs	2,948	2,947	1	2,948	2,947	1
Non-pay Costs	1,014	920	94	1,014	920	94
Operating Expenditure	**3,962**	**3,868**	**94**	**3,962**	**3,868**	**94**
SURPLUS / (DEFICIT)	**578**	**729**	**152**	**578**	**729**	**152**
WOMENS and CHILDRENS						
Total Income	(1,786)	(1,723)	(63)	(1,786)	(1,723)	(63)
Pay Costs	1,094	1,099	(5)	1,094	1,099	(5)
Non-pay Costs	132	95	37	132	95	37
Operating Expenditure	**1,225**	**1,194**	**31**	**1,225**	**1,194**	**31**
SURPLUS / (DEFICIT)	**561**	**529**	**(32)**	**561**	**529**	**(32)**
CLINICAL SUPPORT						
Total Income	(898)	(862)	(36)	(898)	(862)	(36)
Pay Costs	1,673	1,638	35	1,673	1,638	35
Non-pay Costs	923	1,030	(107)	923	1,030	(107)
Operating Expenditure	**2,596**	**2,669**	**(73)**	**2,596**	**2,669**	**(73)**
SURPLUS / (DEFICIT)	**(1,698)**	**(1,807)**	**(109)**	**(1,698)**	**(1,807)**	**(109)**
COMMUNITY SERVICES						
Total Income	(10,822)	(10,832)	10	(10,822)	(10,832)	10
Pay Costs	1,113	1,142	(28)	1,113	1,142	(28)
Non-pay Costs	4,178	4,061	117	4,178	4,061	117
Operating Expenditure	**5,291**	**5,203**	**88**	**5,291**	**5,203**	**88**
SURPLUS / (DEFICIT)	**5,531**	**5,629**	**98**	**5,531**	**5,629**	**98**
ESTATES and FACILITIES						
Total Income	0	0	0	0	0	0
Pay Costs	(371)	(322)	(49)	(371)	(322)	(49)
Non-pay Costs	752	734	18	752	734	18
Operating Expenditure	**380**	**412**	**(31)**	**380**	**412**	**(31)**
SURPLUS / (DEFICIT)	**(380)**	**(412)**	**(31)**	**(380)**	**(412)**	**(31)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	4,654	4,491	163	4,654	4,491	164
Pay Costs	(525)	(536)	11	(525)	(536)	11
Non-pay Costs (net of contingency and reserves)	988	973	15	988	973	15
Finance & Capital	832	992	(161)	832	992	(161)
Operating Expenditure	**1,294**	**1,429**	**(135)**	**1,294**	**1,429**	**(135)**
SURPLUS / (DEFICIT)	**(5,949)**	**(5,920)**	**29**	**(5,949)**	**(5,920)**	**29**
TOTAL (including penalties, contingency and reserves)						
Total Income	(18,372)	(18,470)	98	(18,372)	(18,470)	99
Contract Penalties	0	0	0	0	0	0
Pay Costs	9,270	9,308	(39)	9,270	9,308	(39)
Non-pay Costs	9,260	9,107	153	9,260	9,107	153
Finance & Capital	832	992	(161)	832	992	(161)
Operating Expenditure (incl penalties)	**19,362**	**19,408**	**(46)**	**19,362**	**19,408**	**(46)**
SURPLUS / (DEFICIT)	**(990)**	**(938)**	**52**	**(990)**	**(938)**	**52**

Medicine (Annie Campbell)

The Division under performed by £54k in April.

Contract income was below plan for the month, primarily in ED and Emergency/Non-elective. This continued a trend from the end of March, where activity reduced, and the ED Department improved upon their 95% 4 hour performance. This meant that the Division announced the closure of the escalation ward mid-month, with the intention to save on agency nursing. Unfortunately, an outbreak of norovirus a few days afterwards reversed some of the savings.

Elective work was £7k behind plan – the inpatient element was ahead of plan, but this was pulled back by outpatients. Anticoagulation activity was missing due to delays in processing, which would have improved the position, but outpatients were generally behind plan due to the Easter holidays.

Expenditure was £24k underspent in April. Income from Tri-care patients (USAF personnel) has improved due to actions taken within the Division and in conjunction with the Private Patients Officer. All referrals should now come direct to the Trust and the patients specifically identified.

Pay was overspent by £3k in the month. The escalation ward was closed in the month and nurse agency costs were within budget, as well as substituting overtime for agency. There were agency and additional session pressures on Medical Staff in Dermatology and Cardiology to solve the RTT 18 week pathway issues. Dermatology, in particular, has suffered from a loss of staff, and unsurprisingly RTT performance was at 85.9% (NHSE, March 2017), against the 92% target.

Non pay was overspent due to security costs to manage patients who are a danger to themselves and others, as well as the implementation delay in some CIPs.

Surgery (Simon Taylor)

The Division has over performed by £152k in April

Income, over achieved against plan by £57k. This was mainly due to elective surgery, which will aid the RTT position. Outpatients are still behind plan. Ophthalmology private activity has contributed more than originally planned.

Pay is underspent by £1k. Surgery's cost centres are generally underspent. The three biggest overspends are all due to temporary medical staffing. Due to on-

going staffing gaps it is likely that in at least one speciality (urology) the agency will be needed for the medium to longer term. This is being looked into to see if there is an alternative and more cost efficient way to provide the service.

Non-pay is underspent by £94k. Much of the underspend is in theatres prosthesis. However, the reasons behind this are being reviewed as it is not reflected by the activity profile for the month.

Surgery CIP's have over achieved by £101k. There was some delivery of CIP's earlier than planned and also surgery achieved a higher than planned vacancy management return. Further to this private patient income over achieved as did non-pay reductions.

The CIP RAG rating and forecast are revised on a monthly basis to ensure full opportunity is taken to maximise CIP potential form the existing schemes.

Women and Children's (Rose Smith)

In April the Division reported an under performance of 32k.

Clinical income reported £67k behind plan in April. There have been underperformances in Gynaecology (in both elective inpatients and outpatient procedures), Maternity Services (underperformance in both antenatal and post natal) and Obstetrics (non-elective admitted patients).

Other Income reported a £3k over performance across both Paediatric and Maternity Services.

Pay reported £5k overspend due to medical staffing in Paediatrics, and bank usage within the Neonatal Unit.

Non pay reported a £37k underspend of which £20k relates to a one off saving against rent, and other minor variances.

Clinical Support (Rose Smith)

In April the Division has underperformed by £109k.

Clinical income for Clinical Support reported an £18k under performance due to Diagnostic Imaging in both breast screening and direct access activity.

Other Income was £18k behind plan, mainly due to the Private Physiotherapy Service (£16k), EIT (£10k) linked to unfilled new posts, and a decrease in both private inpatient and outpatient income for radiology of (£15k). These adverse variances have been offset against an increase in pharmacy income for family planning drugs.
Pay reported a £35k underspend due to vacancies. These were mainly in EIT and are partly offset against an underperformance in income.

Non pay reported £107k overspend. This is due primarily to a contract variation in Diagnostics (£35k), Pharmacy Overhead (£25k), Drugs expenditure for family planning (£17k, offset against income) Consumables and use of InHealth for outsourced Endoscopy cases (offset against vacancies).

Community Services (Dawn Godbold)

Community Services reported a £98k over performance in April.

Contract Income reported a £10k over recovery in-month mainly due to increased income to cover agency usage within Paediatric SALT; this is offset against agency costs within Pay.

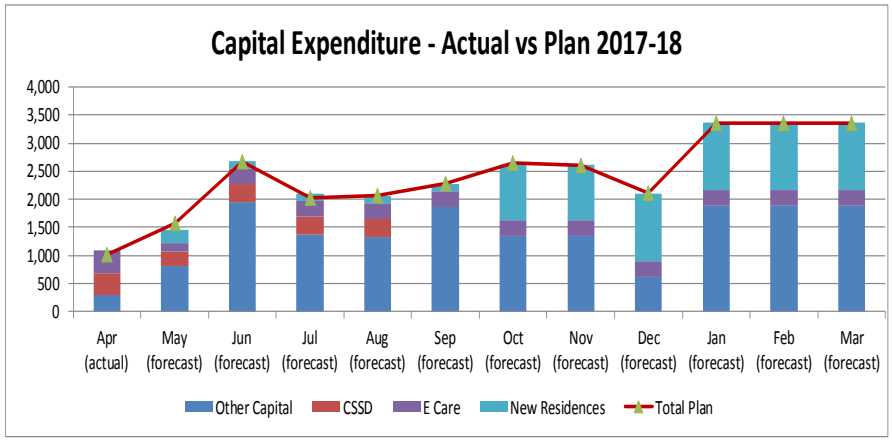
Pay reported £28k overspend. There have been overspends within Glastonbury Court (£14k) relating to a delay in implementing a new rota. This is not expected to improve until July, when the first change in rota will be implemented. Rosemary Ward has also overspent by £8k due to bank.

Non pay reported £117k underspend primarily on Community Equipment Services (£66k) which is over and above the CIP target applied against the service. This favourable variance is due to a reduction in the value of the equipment delivered in the month and also an increase in collection credits following the recycling amnesty.

Community IHT reported an adverse variance of £26k on continence products. Following the retender of products contracts and implementation of an action plan looking at a number of key areas including Nursing home assessments it is expected that expenditure will reduce.

FINANCE AND WORKFORCE REPORT – April 2017

Capital Progress Report



	Apr Actual £'000	May Forecast £'000	Jun Forecast £'000	Jul Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2017-18 £'000
E Care	415	141	278	278	278	278	278	278	278	278	278	278	3,333
CSSD	384	260	322	322	323	0	0	0	0	0	0	0	1,611
New Residences	0	246	123	123	123	123	1,000	1,000	1,200	1,200	1,200	1,200	7,538
Other Schemes	296	816	1,950	1,372	1,334	1,872	1,341	1,340	626	1,888	1,888	1,886	16,607
Total forecast / Forecast	1,095	1,462	2,673	2,094	2,058	2,273	2,618	2,617	2,103	3,365	3,365	3,363	29,089
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 CSSD build is nearing completion and is forecast to be in line with its budget of £1.6m for the year. The final expenditure for this project (except for retentions) will be paid in August.

Expenditure on e-Care for the year to date is £415k and this is in line with the budget for the same period. The E-Care programme budget reflects the increased scope associated with the Global Digital Excellence (GDE) funding.

The forecasts for all projects have been reviewed by the relevant project managers. There are no significant risks to the budgets reported.

FINANCE AND WORKFORCE REPORT – April 2017

Statement of Financial Position at 30th April 2017

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2017 £000	Plan April 2017 £000	Plan YTD 30 April 2017 £000	As at 30 April 2017 £000	Variance YTD 31 Mar 2017 £000
Intangible assets	15,611	17,977	17,977	15,622	(2,355)
Property, plant and equipment	74,053	74,912	74,912	74,683	(229)
Trade and other receivables	0	0	0	0	0
Other financial assets	0	4,909	4,909	0	(4,909)
Total non-current assets	**89,664**	**97,798**	**97,798**	**90,305**	**(7,493)**
Inventories	2,693	2,850	2,850	2,679	(171)
Trade and other receivables	18,123	11,849	11,849	12,593	744
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	1,000	7,956	6,956
Total current assets	**22,168**	**15,699**	**15,699**	**23,227**	**7,528**
Trade and other payables	(23,434)	(24,985)	(24,985)	(24,058)	927
Borrowing repayable within 1 year	(534)	(7,500)	(7,500)	(7,500)	0
Current ProvisionsProvisions	(61)	(84)	(84)	(84)	0
Other liabilities	(545)	(295)	(295)	(954)	(659)
Total current liabilities	**(24,574)**	**(32,864)**	**(32,864)**	**(32,596)**	**268**
Total assets less current liabilities	**87,258**	**80,633**	**80,633**	**80,936**	**303**
Trade and other payables - Non current	0	(1,180)	(1,180)	0	1,180
Borrowings	(44,375)	(39,008)	(39,008)	(39,009)	(1)
Provisions	(181)	(203)	(203)	(163)	40
Total non-current liabilities	**(44,556)**	**(40,391)**	**(40,391)**	**(39,172)**	**1,219**
Total assets employed	**42,702**	**40,242**	**40,242**	**41,764**	**1,522**
Financed by					
Public dividend capital	59,232	59,232	59,232	59,232	0
Revaluation reserve	3,621	2,151	2,151	3,621	1,470
Income and expenditure reserve	(20,151)	(21,141)	(21,141)	(21,089)	52
Total taxpayers' and others' equity	**42,702**	**40,242**	**40,242**	**41,764**	**1,522**

Intangible Assets and Property Plant and Equipment:
There has been some slippage on the capital plan partly caused by the uncertainty due to the cash for GDE still not being received.

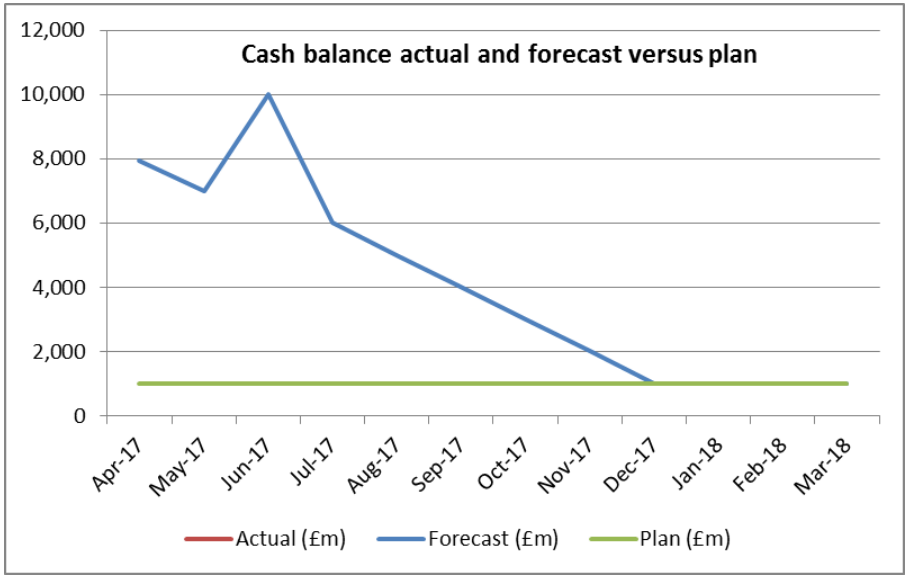
Other financial assets:
The financial asset related to tPP and was impaired at the end of 2016/17 to £0 due to uncertainties about future performance.

Cash:
The cash balance is higher than expected. This is partly due to no invoice being received from NCHC for the April contract payment

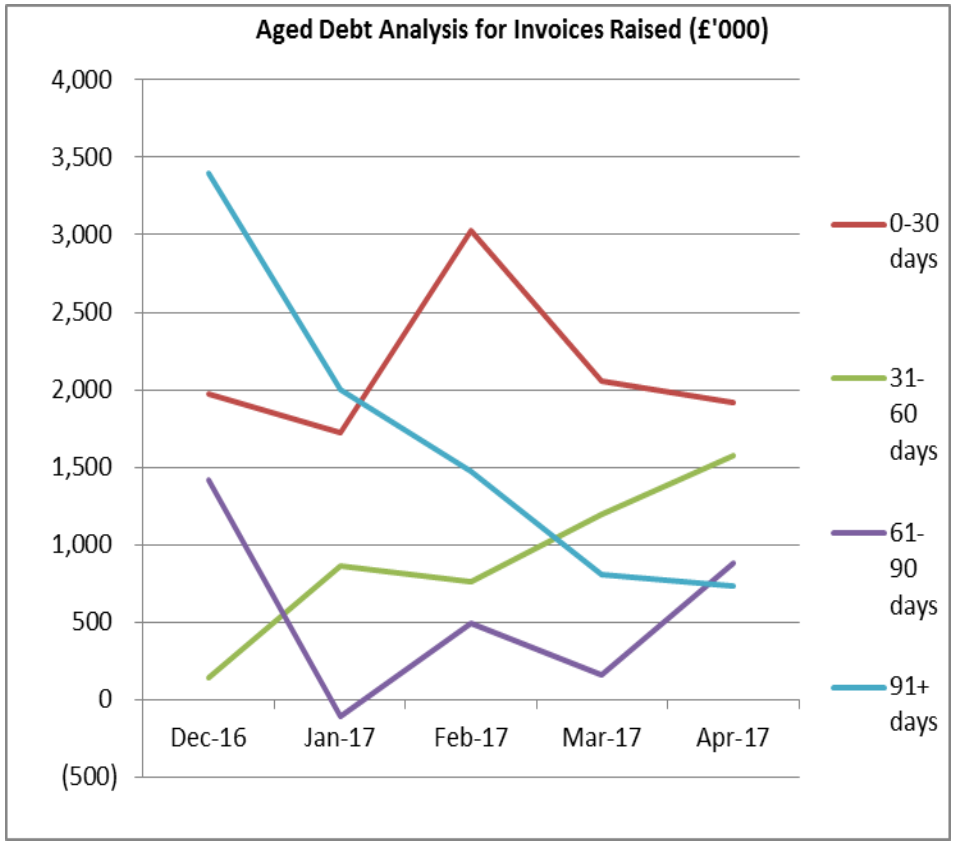
The Trust has still not received the anticipated £3.3m GDE cash which was expected by the end of January and there are ongoing conversations with DH to determine when this is likely to be received. In response to the uncertainty Trust accelerated the drawdown of the capital loan by £3.3m in March.

Revaluation Reserve:
This is higher than planned due to the revaluation at year end.

Cash Balance Forecast for the year



The graph illustrates the cash trajectory year to date, plan and revised forecast. It assumes receipt of STF funding June 2017 and repayment of 2017/18 distress funding in July 2017. Cash is higher than planned in April because invoice payments were lower than planned.



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.

Board of Directors – 26 May 2017

AGENDA ITEM:	10
PRESENTED BY:	Helen Beck – Interim Chief Operating Officer
PREPARED BY:	Lesley Standring – Transformation lead & John Connelly – PMO Lead
DATE PREPARED:	19th May 2017
SUBJECT:	Transformation Board Report
PURPOSE:	Update

EXECUTIVE SUMMARY:

This report outlines the organisational changes which have taken place since the last reporting period, relating to the formation of the WSFT and WSCCG joint transformation team and the organisation and governance arrangements for the Trusts internal PMO. Financial aspects of CIP identification and delivery are included in the monthly finance and performance report.

Details of the end of year position for 16/17 CQUINS and an outline of 17/18 schemes is also included.

Linked Strategic objective (link to website)	
Issue previously considered by: (e.g. committees or forums)	
Risk description: (including reference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatory requirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	

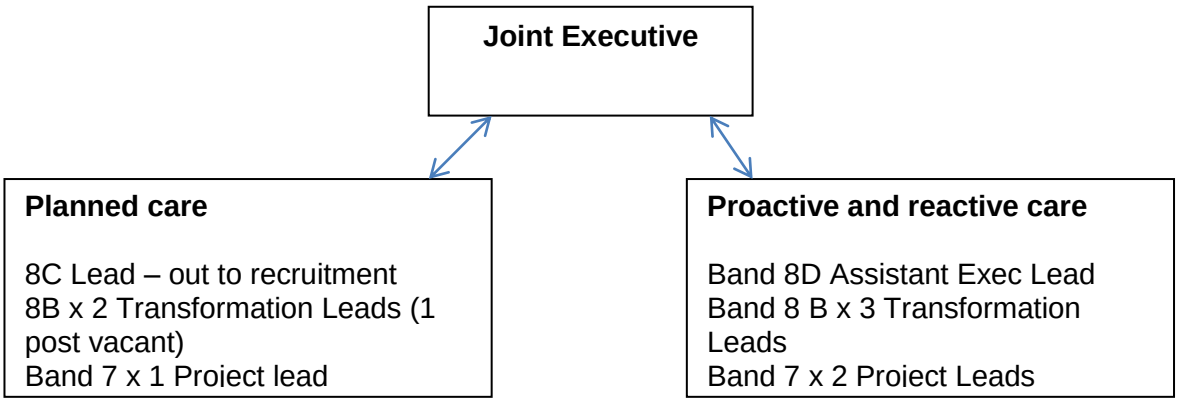
Recommendation:
The Board is asked to note the Transformation Report.

1.0 Establishment of the WSFT and WSCCG Joint Transformation Team

Since the last Trust Board update, there has been significant work undertaken to more formally align the transformation teams from the hospital and the CCG under the joint executive leadership of the WSFT ICOO Helen Beck and the IE&WSCCG Chief Redesign Officer Richard Watson.

This Service Transformation Programme is a joint activity between the WSCCG and WSFT and comprises projects which will deliver benefits across the West Suffolk health system. Acting as “one organisation” with a joint Executive, this programme manages projects which deliver benefits across Primary Care, Acute and Community settings.

The newly formed transformation team consists of the following:

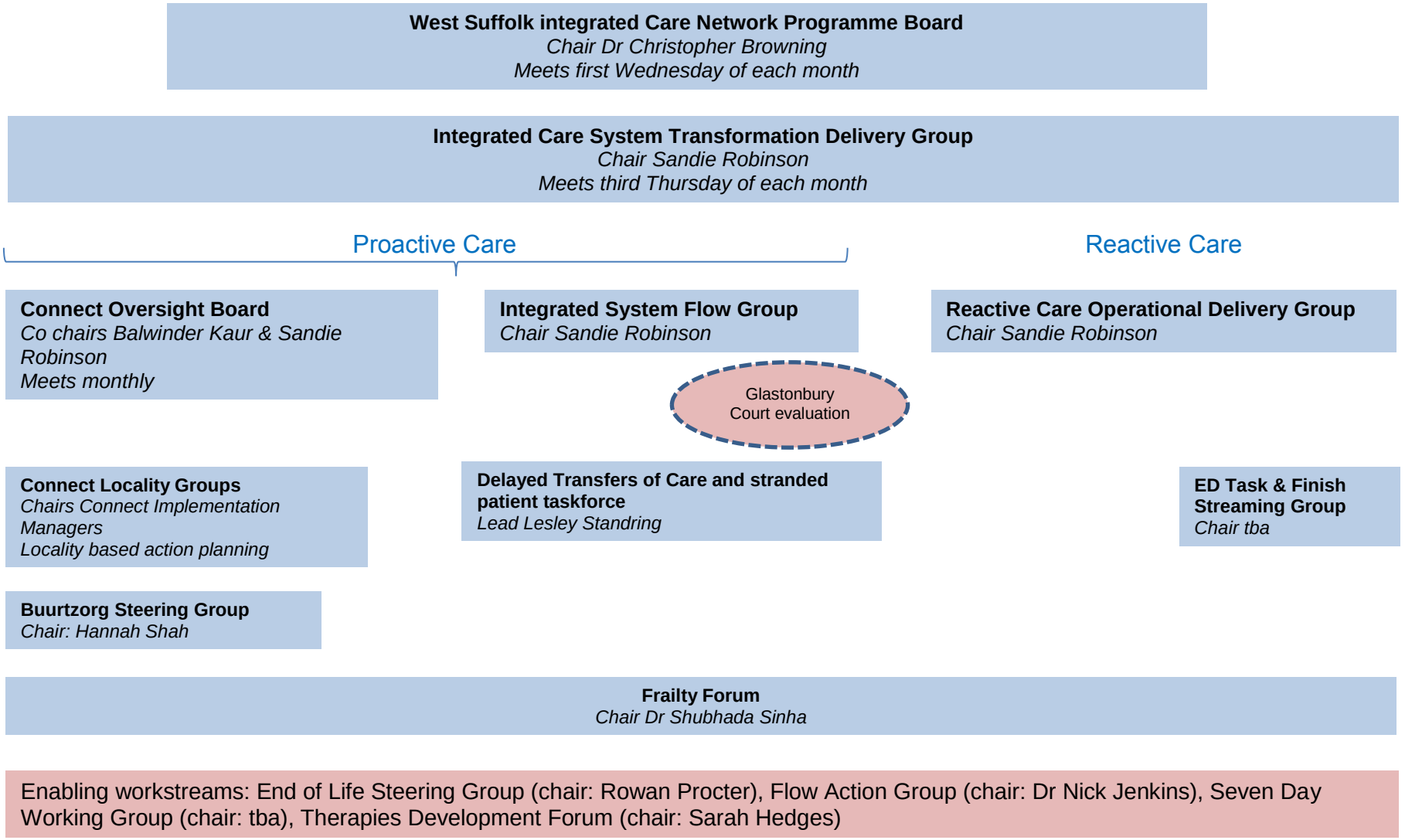


2.0 WSFT and WSCCG Joint Integrated Care Programme

This joint programme of work will focus on urgent and emergency activity with reactive and proactive schemes of work, which will be managed through the Integrated Care System Transformation Delivery Group.

WSFT and WSCCG Joint Integrated Care Programme

2.1 West Suffolk Integrated Care Programme Governance Structure



2.2 West Suffolk Integrated Care Programme 17/18

Integrated Care Programme agreed for 2017/18 – signed off by system-wide partners in Feb '17 through the A&E Delivery Board. The Integrated Care Network will hold the accountability for delivery.
Key Programme KPIs are: A&E attendances held to 3.3%, emergency admissions held to 1.6% and delayed transfers of care held at 3.5% (ambition for 2.5% or lower)

Executive Leads: Richard Watson, Chief Redesign Officer & Dr Nick Jenkins Medical Director **Programme Lead:** Sandie Robinson, Associate Director of Redesign

Scheme	Description	Scheme	Description
Reactive Programme		**Proactive Programme**	
Urgent and Emergency Care Demand Management	a. Addressing high volume/complex users b. Development of new primary care led 'front door' c. Development of 3-4 primary care hubs starting in Bury St Edmunds moving to Haverhill and Newmarket and then Sudbury and Mildenhall	**Connect 5 Integrated Neighbourhood Teams**	Roll out the INT teams across the 5 localities. Also to take responsibility for embedding Frailty, LTC management, End of Life, My Care Wishes within the locality teams Implementation of Buurtzorg test site
24/7 admissions avoidance service	a. Early Intervention Team (EIT) - amalgamate other community services further, remove duplication and address capacity constraints to stretch the trajectory for community based referrals b. Implement acute frailty pathway from A&E c. Implement seven day service provision (links to proactive and seven day discharge) d. Ambulatory Care and Flow e. Open admission prevention pathways to EEAST to avoid A&E/NEL	**Effective Discharge**	Further developments and support on patient flow i.e. DTOC work to achieve 2.5% and onto no DToCs including: •Proactive pull based discharge approach •Discharge to Optimise and Assess (D2OA) development and delivery include trusted assessor arrangements Implementation of SAFER patient flow bundle and red to green days
Integrated Urgent Care Service (IUCS) (111, GP Out of Hours and CCC) Programme *(Pan STP)*		**Community Hospitals Review *(Pan Suffolk)***	
Procurement and mobilisation of the new service model to create a 24/7 integrated IUCS for Suffolk and NE Essex.		Comprehensive review of community hospitals across Suffolk and their future role within the Suffolk integrated care model. The review will commence more formerly in late Spring.	
Care Homes Programme *(Pan Suffolk)*			
Comprehensive programme of support to care homes across Suffolk with particular focus on the top admitting care homes. A Vanguard bid is in development following the national announcement of a Wave 2 Care Homes Vanguard Programme later this year.			

2.3 West Suffolk Integrated Care Programme 17/18 – Reactive Care Metrics

		Activity	Start	Detail	Monitoring	Plan Reference
NEL	CDU/EIT/Coding	343	Q1	Change of coding in CDU based on current of 403 admissions per year for EIT, with reduction of 5 per month for EIT moving more into community	Over 75's admissions total	Coding development
	EIT stretch/balance	208	Q1	Additional avoided admissions for EIT	Over 75's admissions total	Access to EIT Interface with Proactive Care model
	Greater than 65% of all EIT admission avoidance referrals and contacts to be from community sources	65%	Q1	YTD activity 59%	Systmone and SUS	Access to EIT Interface with Proactive Care model
	Total	**551**				
A&E	Over 75's to A&E - all referral sources	260	Q1	Stretch for EIT of 5 additional admissions avoided per week. Assumption this directly translates to a reduction in A&E attendances	Over 75's A&E attends total	Access to EIT Interface with Proactive Care model
	Minor adults (19-74)	166	Q2	Combined impact from reduction in ambulance conversion rate, 111 transfers to ED to achieve 6% KPI and a reduction on high volume ED attenders.	19-74 years A&E attends coded as HRG's VB09Z and VB11Z	NHS mandated area for 111
	Total A&E Attendances - Adult	839	Q3	A&E streaming and co-located primary care facility with ED to enable shift of activity traditionally seen within ED.	MAR	NHSE mandated streaming developments
	Total	**1265**				
KPIs	Reduction of 111 transfers to ED to achieve 6% (to include high volume ED attenders)	<6%	Q1	YTD 8%	KPI monitoring (total across adults and children)	
	Percentage of green ambulance calls diverted against a total of green ambulance calls triggered to a more appropriate service, to be in line with contract KPI trajectory	34%	Q1	YTD 30%	111 KPI (pending 17/18 negotiations)	
	EEAST Percentage KPI to deliver increase in Hear and Treat and See and Treat	10%	Q1	CQUIN to deliver by March 2018 (Q4). YTD delivery 8%	KPI monitoring	
	A&E 4 hour access target – 95%			WSFT sitrep	95%	

2.4 West Suffolk Integrated Care Programme 17/18 – Proactive Care Metrics

	Source	Target	Start	Detail	Monitoring	Plan Reference
Delayed Transfers of Care	WSFT	3.5% (ambition to 2.5%)	Q1	Zero tolerance YTD 4.9%	Monthly sitrep	DTOCs
	Community beds	tba	Q1	Zero tolerance Target YTD 50%	Monthly sitrep	DTOCs
Number of patients who die in their preferred place of death	Primary Care Mortality Database	60%	Q1	YTD delivery 48%	Monthly	My Care Wishes, Advance Care Planning and EOL Guidance
Reduction in numbers of stranded patients	WSFT	Tba ?5%	Q1	Patients who stay in hospital for 7 days or more YTD delivery increase year on year 7.4%	SUS	Discharge to Optimise and Assess DTOCs
Reduction in average length of stay	Community beds	tba	Q1	Baseline being assessed	Community systmone data set	Discharge to Optimise and Assess DTOCs
Reduction in readmissions for over 75s within 30 days	WSFT	18%	Q1	YTD delivery 18.8%	SUS	

3.0 Integrated Care Programme Project highlights

3.1 Red to Green/SAFER: The recent ECIST visit went well and Pete Gordon was very complimentary about the progress made in a short time frame. Board rounds are in place on all medical and surgical wards moving to business as usual. Data dashboards are available on each ward with plans to include review of the information as part of ward governance meetings looking at; the top 3 constraints, Length of Stay, time discharge, number of 'red and 'green' patients, number of patients with a CCD and PDD. A plan to embed R2G and SAFER has been developed as part of the FLAG working group.

3.2 Ambulatory Emergency Care: The AEC teams have started a service of 'MAT' Medical Assessment and triage within the ED Department in order to maximize the AEC cohort and fully utilise this service to avoid admissions, this service involves a member of AEC staff reviewing the patients in ED every 2 hours. AEC is currently meeting the KPI of 30% of medical take and 10% or less conversion to admission

3.3 Primary Care Streaming: The Trust was successful in the first stage of the bid for £1 million to fund primary care streaming at the front of the ED Department. The required business case has been created. The service has to be in place in October 2017.

3.4 7 Day Services: The latest data collection is complete and will be authorised by Nick Jenkins to meet the national deadline on Monday 22nd May. Data will be published and benchmarked, a summary paper will be written to inform executives of WSFT national status.

3.5 Discharge to Optimise and Assess (D2OA): A paper is being prepared for the June Integrated Care Network Board (ICN) to outline the model for the west of Suffolk. Full case will be presented to the July ICN and will include Trusted Assessor and Pull based discharge initiatives.

3.6 Early Intervention Team: A paper is being prepared for the June ICN which will contain recommendations for system leaders to support EIT going forward.

4.0 Proposed Planned Care and Demand Management Functions

West Suffolk	
Planned Care	**Demand Management**
MSK New Pathway **- single point of referral** **- skill mix**	Clinical Thresholds Service Team Management (2 member of staff)
Ophthalmology New Referral Refinement Platform **- direct listing** **- new pathways to community care**	Prior approval processes established by Planned Care Team for agreed specialties e.g. agreed pathways and referral guidance as a short term arrangement in advance of new national ERS (E-referral) functionality and handed over to be coordinated once BAU likely through the Threshold Team
Gastro Redesign **- Direct access diagnostics** **- New direct access Gall Bladder Pathway**	Reducing Clinical Variation - Supporting the COO teams to encourage take up of e-referral and in reducing clinical variation between GP Practices using the PISP packs, Map of Medicine and locality meetings
Right Care Delivery (county/STP wide) **- Circulation** **- Neurological Problems** **- Respiratory system (QP)**	Map of Medicine further development, roll out and ongoing administration with further pre-referral guidance and pathways for conditions/specialities developed by the Planned Care Team
Dermatology **- Rapid diagnosis screening clinics**	Coordinate roll out of new ERS (E-referral) functionality at WSH in conjunction with the COO and IT Clinical Support teams
ENT/Audiology Redesign **- Demand and capacity review** **- Redesign pathway (specifically community audiology)**	Support development of IT solutions for management of outpatient activity with WSH
Urology Demand Management **- New virtual clinics** **- Top tips (advice and guidance)**	Support clinical audit programme as required linked to the planned care programme
Pain Management **- Integrated community and acute model**	

4.1 The Planned Care Programme will further develop a number of specialty level service redesign aimed at demand management, reduction in variations in care and improved patient access to the most appropriate service. Further updates will be provided in future board reports as this team is established and the work develops.

5. WSFT Programme Management Office

5.1 PMO Organisational Change In the period since the last board report The PMO has undertaken an inclusive Change Management process at the Trust to align the Divisions, Finance Department, Transformation Team and PMO to develop an integrated, quality assured WSFT CIP Delivery Model. All of the Trust CIP programmes have been grouped into clusters to facilitate monitoring and delivery.
The revised governance and process model has been reviewed and approved at TPG subject to KPMG validation.

The Key Products include:

- A comprehensive Terms of Reference including:
    - Revised CIP Governance Process
    - Revised CIP Reporting Process
    - Revised CIP Project Management Workbook
    - Integrated BRAG Rated CIP Finance report including CIP Lists from all 5 Clusters and Summary
- An auditable documentation maintenance monitoring report

The Terms of Reference have been socialized in introductory meetings at cluster level.

5.2 Next Steps:

The key objective over the next month is for the PMO to establish joint working with KPMG to:

- Review the existing PMO and Divisional Projects
- Allocate risk assessed values to the existing CIP Projects
- Allocate live CIP Projects to the CIP Cluster Lists
- Establish the CIP Clusters
- Develop Integrated CIP Reporting
- Identify the organizational CIP Gap
- Identify future CIP opportunities to bridge the CIP Gap (Chunky Projects Time!)
- Agree the resourcing of CIP Projects

5.3 PMO Transition: A review of the current WSFT PMO will be undertaken jointly between the PMO, KPMG and the WSFT Executive Group in June 2017 with a planned transition to a substantive WSFT Team by October 2017.

6. CQUIN Projects

6.1 CQUIN 2016/17

2016-7 – Total Value £3,443,256 for 8 projects	Q1	Q2	Q3	Q4
NATIONAL				
1a) Staff Health & Wellbeing:	**FULL £344,326**			
Activity, Stress, MSK. Introduce a full range of health & wellbeing initiatives covering: physical activity, mental health and improving access to physiotherapy for MSK issues.	£68,865: for Action Plan	£ N/A – continue delivery	£ N/A – continue delivery	£275,461: Deliver plan
1b) Healthy food for staff, visitors and patients	**FULL £344,326**			
Part a: Health of food offered on premises: Items high in fat, sugar & salt, ban on: **1)** price promotions, 2) advertising & 3) items at checkouts; **4)** healthy options available incl. at night. **Issues resolved: 1)** W H Smith; **4)** vending: staff at night	£ N/A – prep.	£ N/A – progress	£ N/A – progress	£68,865 per each complete = £275,461
Part b: Submit national data collection returns Q1 based on existing contracts with food and drink suppliers.	£68,865	N/A		
1c) Frontline staff – flu vaccinations:	**TARGET %**			
Achieving an uptake of flu vaccinations by frontline staff of 75% by 31/12/2016. Data monthly over 4 months (Sept-Dec). **Risk was:** very high target noting **2015-6 = 53%** to Feb. Resource invested (£12.7k). **Achieved = 64.6%.**	Prep	Progress	**75**	N/A
	FULL £344,326			
	N/A	N/A	55%-64% = £120,514 **Achieved 64%-74% = £172,163** 75% = £344,326	
2a) ED - Sepsis	**TARGET %**			
Screening: via local protocol. Note new NICE guide July. Q1-4 top £ for 90%. Stepped payment available. Red Flag Sepsis: anti-biotic in 1 hour of presenting & anti-biotic review within 3 days. Locally agreed target Q2-4. **Issue:** Q2-Q4: e-Care delay on Sepsis ID may affect %. **Risks:** CCG Treat target of 55% Q4. Request step payment.	**90** Screen % Treat	**90** Screen 50 Treat	**90** Screen 51 Treat	**90** Screen 55 Treat
	FULL £172,163			
	Screen: £17,216	Screen: £17,216	Screen: £17,216	Screen: £17,216
	Treat: £25,825	Treat: £25,825	Treat: £25,825	Treat: £25,824
2b) Inpatients - Sepsis	**TARGET %**			
Screening: via local protocol. Note new NICE guide July. Red Flag Sepsis: i) New patient - anti-biotic in 1 hour of ID & anti-biotic review within 3 days. ii) Existing patient – anti-biotic in 90 minutes of ID & anti-biotic review within 3 days. **Issue:** Q2-Q4: e-Care delay on Sepsis ID may affect %. **Risks:** Q4 National Treat target of 90%. One third payment available for 50%-89.99%.	Baselines x 3	90 Screen 65 Treat	90 Screen 75 Treat	**90** Screen **90** Treat
	FULL £172,163			
	Screen £17,216	Screen £17,216	Screen £17,216	Screen £17,216
	Treat £25,825	Treat £25,825	Treat £25,825	Treat £25,824 £8608 likely
3a) 1% reduction (from 2013-4) in antibiotic consumption per 1,000 admissions (Defined Daily Doses) by end Q4: 1. Total antibiotic consumption 2. Total consumption of carbapenem 3. Total consumption of piperacillin-tazobactam **Risk:** major challenge to reduce from a low base. 4. Supply consumption data 2014-5 & 2015-6.	**TARGET %**			
	Prep	Progress	Progress	**<1%**
	FULL £275,460			
	£ N/A 4. Target met.	£ N/A	£ N/A	£68,865 met. Of the total £275,460.
3b) Empiric review of antibiotic prescriptions. % of antibiotic prescriptions reviewed within 72 hours. Audit 50 prescriptions per month. **Risk:** Jan: 86%, Feb 98%	**TARGET %**			
	25	**50**	**75**	**90**
	FULL £68,865			
	£17,216	£17,216	£17,216	£17,216
LOCAL	**FULL £1,721,628**			
4) Frailty. Multi-organisational. Action Plan, system vision, data dashboard. Quarterly report to monthly SWF Group. Q4 overview report of the year to March or April meeting.	Q1 rolled over to Q2	£430,407 Q1 £430,407	£430,407	£430,407

2017-8 – NHS England national x 5 new & all 2016-7 continue with additions. In progress.

6.2 CQUIN projects 2017-18-19 – Outline - £TBC

NATIONAL	Project & Status	Years
1a – Staff Health & Wellbeing – via Staff Questionnaire: i) activities provided/ awareness of them; ii) reduce staff say suffered MSK due to work; iii) reduce staff say stressed due to work. Q4 % targets. Challenge: no direct influence on individual staff answers or their own interpretation.	Increase awareness & highlight prevention	2
1b – Food & drinks sold on WSFT site: make further changes and adhere to rules & Q4 % targets.	Review/ change/ embed	2
1c – Staff Flu vaccination uptake - Q4 % targets	Increase campaign	2
2a – Sepsis Screening ED & Inpatient - Q1-4 % targets – clinical audit	Education/ e-Care alerts	2
2b – Sepsis Treatment ED & Inpatient (antibiotic 1 hour of diagnosis) Q1-4 % targets – clinical audit. Challenge: antibiotic within the time.	Review delays, education /e-Care alerts	2
2c – Sepsis antibiotic prescriptions review - between 24 & 72 hours – Q1-4 % targets - clinical audit	Monitor	1
2d – Reduction in antibiotic consumption: all & carbapenem & piperacillin-tazobactam. 2017-8 % targets against previous years.	Review, educate	1
4 – Mental Health in ED – Reductions in re-attendance - including evidence of collaborative working with multi-partners. Coding review & audits: Data Quality Improvement Plan. Challenge: project activity = result in reduction % in Q4.	Reviews, plans, actions, data.	2
6 – GP Advice from Consultant pre referral – formalise access & recording via Choose & Book: % targets. Challenge: 2 day turnaround.	Formalise, educate	1
7 – e-Referrals – all services & first outpatient slots available on eRS by 31/2/18. Challenge: % Reduce Appointment Slot Issues.	Review/ change/ embed	1
8 a) Proactive & Safe Discharge – aged 65 & over: increasing discharged to usual place of residence in 3-7 days; including collaborative working & plans. % targets. Links to Discharge to Assess, SAFER, red to green, HOME (transport). Challenge: project activity = result in increase % in Q4	Plans, actions, data	2
8 b) ECDS (emergency care data set) revised - requiring Cerner e-Care updates to system, coding, education – data start 1/10/17	Amend e-Care, educate, data	2
2018-9 **9) Preventing Ill Health – inpatient – a) smoking and b) alcohol** Improvement in i) screen; ii) advice; iii) treat or refer. e-Care updates to record 2017 ready for data start 1/4/18. Educate users.	Review, amend e-Care, educate, data	1
LOCAL – 2017-8		
STP Support – commitment to delivering STP plan as seen by evidence of attendance at STP Board and agreement to ToR.	Document meetings	

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 25th May, 2017

AGENDA ITEM:	Item 11
PRESENTED BY:	Rowan Procter , Executive Chief Nurse
	Paul Morris, Associate Chief Nurse, Head of Patient Safety
PREPARED BY:	Rebecca Gibson, Compliance Manager
	Cassia Nice, Patient Experience Manager
DATE PREPARED:	May 2017
SUBJECT:	Aggregated Quality Report
PURPOSE:	Information

EXECUTIVE SUMMARY

- This report will be reflective of the data from April 2017
- In April there were 392 Patients Safety Incidents (PSI) reported; a considerable reduction from March (462).
- Level of harm in proportion to overall Patient Safety Incidents reported:
  - 88% (83% March) no harm (Green)
  - 8% (11% March) minor harm (Green)
  - 3% (4% March) moderate harm (Amber)
  - 0.3% (0.6% March) major harm (Red)
  - 0.5% (0.4% March) catastrophic harm (Red)
- In relation to type of incidents reported in April the highest areas of reporting related to Pressure ulcers, Slips Trips & Falls, and Medication.
- 10 Complaints were received in April compared to 11 in March
- 172 PALS contacts were recorded in April compared to 230 in March.

Appendix A provides the six monthly NRLS benchmarking report for April to September 2016.

Linked Strategic objective (link to website)	To demonstrate first class corporate, financial and clinical governance to maintain a financially sound business
Issue previously considered by: (e.g. committees or forums)	Clinical Safety & Effectiveness Committee Clinical Governance Steering Groups
Risk description: (including reference Risk Register and BAF if applicable)	Failure to effectively triangulate internal and external intelligence on quality themes or areas of poor performance
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Monthly quality reporting to the Board strengthened aggregated analysis. Quality walkabouts and feedback from staff, patients and visitors.
Legislation / Regulatory requirements:	NHS Improvement Quality Governance requirements. CQC Registration and Key Lines of Enquiry (KLOE)
Other key issues:	

Recommendation: To note the report

Table 1: Aggregated Patient Experience Report

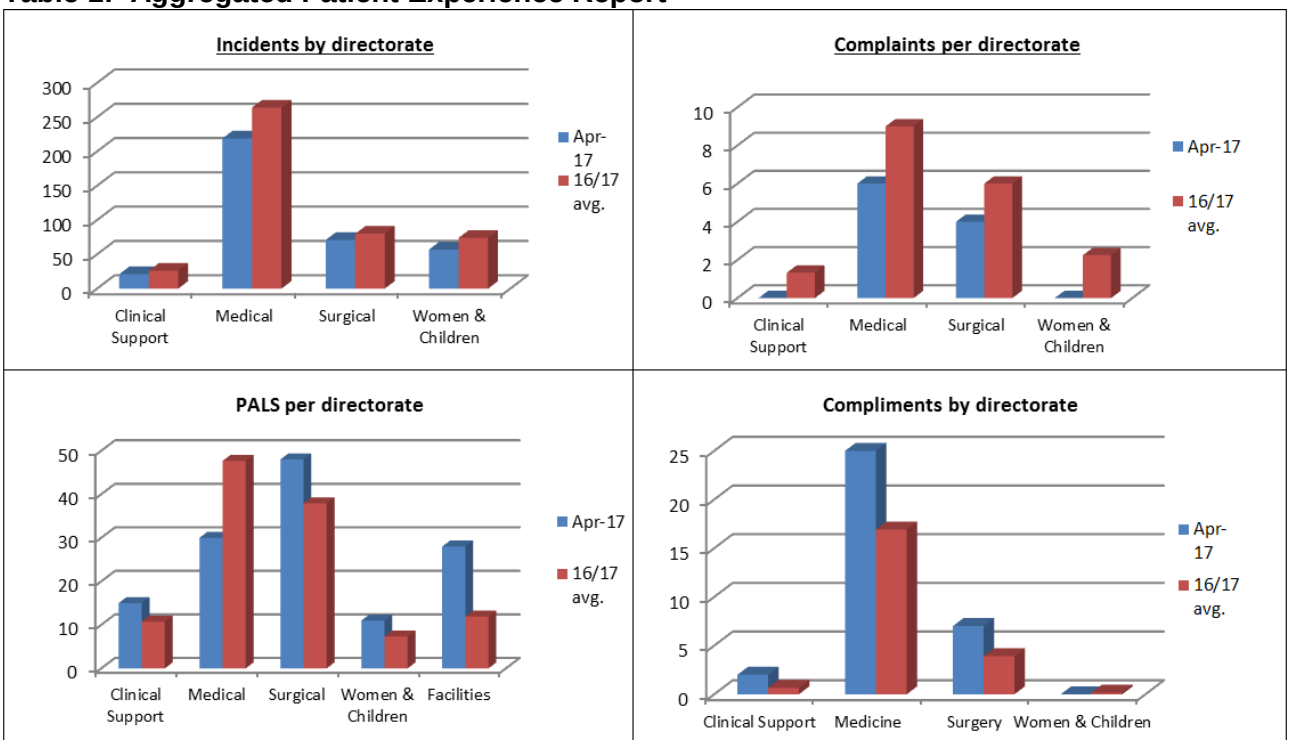


Table 2: PSIs reported by month (24 months)

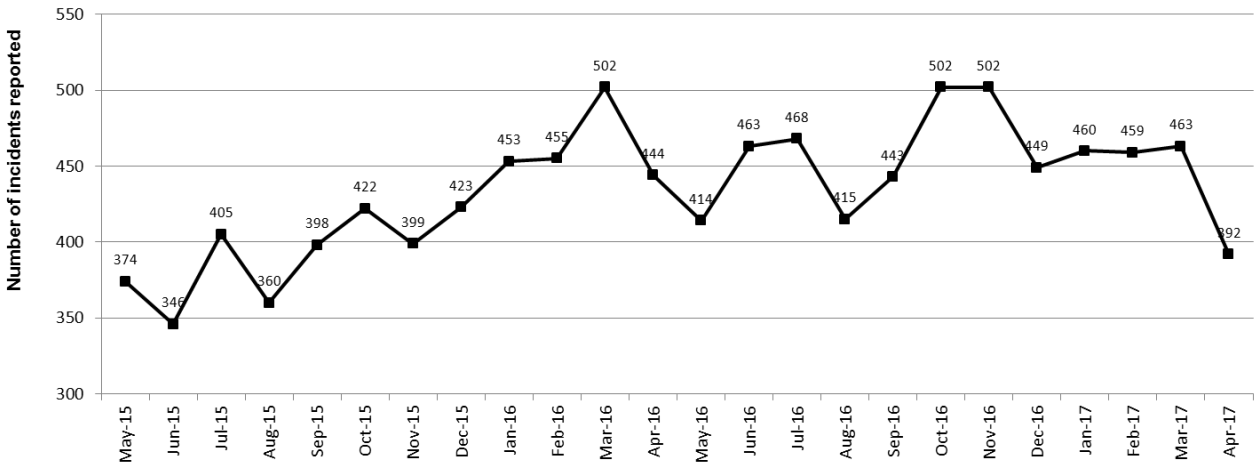
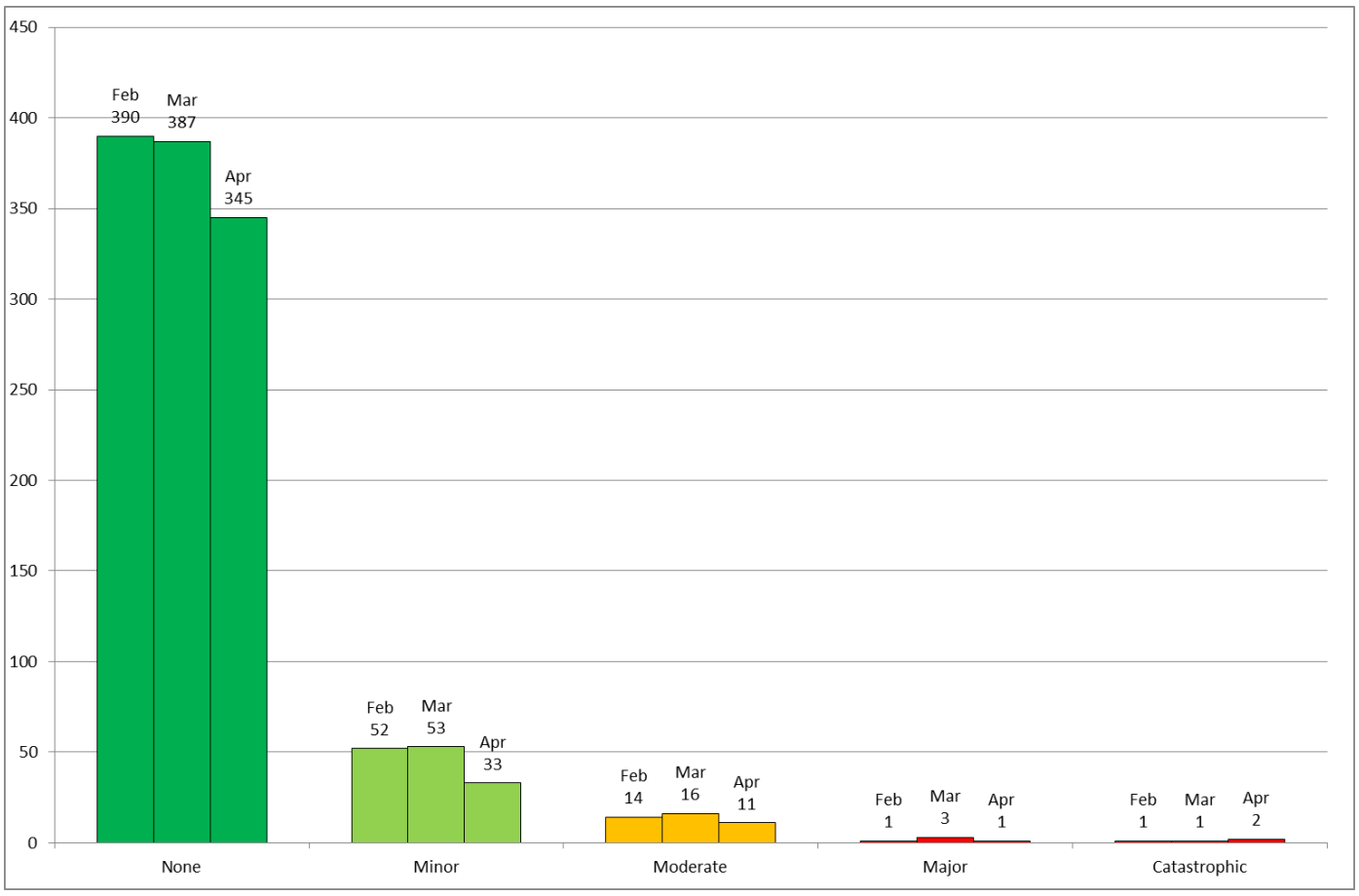


Table 3: Incidents reported by severity



Within Table 2 (above) the chart reflects incidents in relation to harm grading colour coded by grade (for example the dark green columns reflect incidents which resulted in no harm over the last 3 months).

In the month of April there were considerably less incidents reported than previous months. We have looked into this and have been unable to identify the reasons for this drop in reporting. It is not in a part of the year we have seen a drop in reporting before. We are monitoring this going forward and trying to look for themes that could attribute to a decrease in reporting. We have not changed any of our reporting structures or processes. This has been reflected in a reduction in all incident categories with the exception of catastrophic harm, which has seen an increase from one to two incidents reported.

The three Catastrophic / Major harm (red) incidents are as follows:

- IUD
- Delayed BCG
- E-Care Discharge letters

The 11 moderate harm incidents relate to:

Medicine (6)

- Hospital acquired pressure ulcers (4 cases)
- Patient with C. difficile (2 cases)

Surgical (2)

- Patient with C. difficile
- Complicated Hip replacement requiring return to theatre

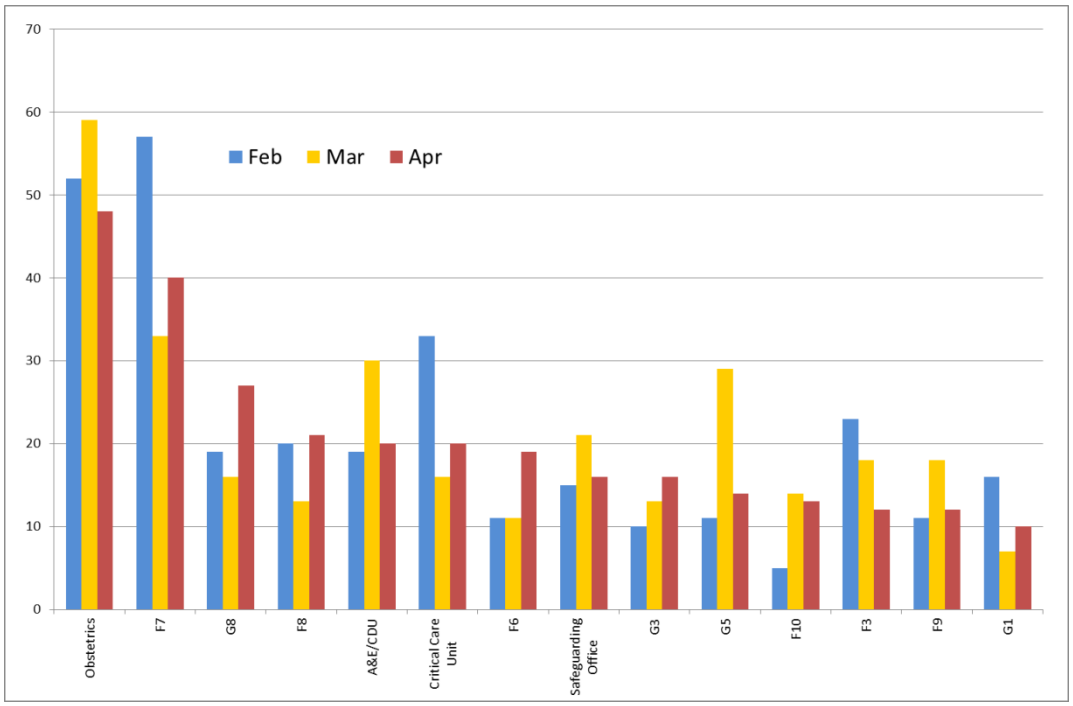
Clinical Support (2)

- Alleged theft from patients home address by staff
- Alleged delay in reporting of MRI which resulted in delay in referral to specialist centre

Women & Children (1)

- Hysterectomy following post-partum haemorrhage

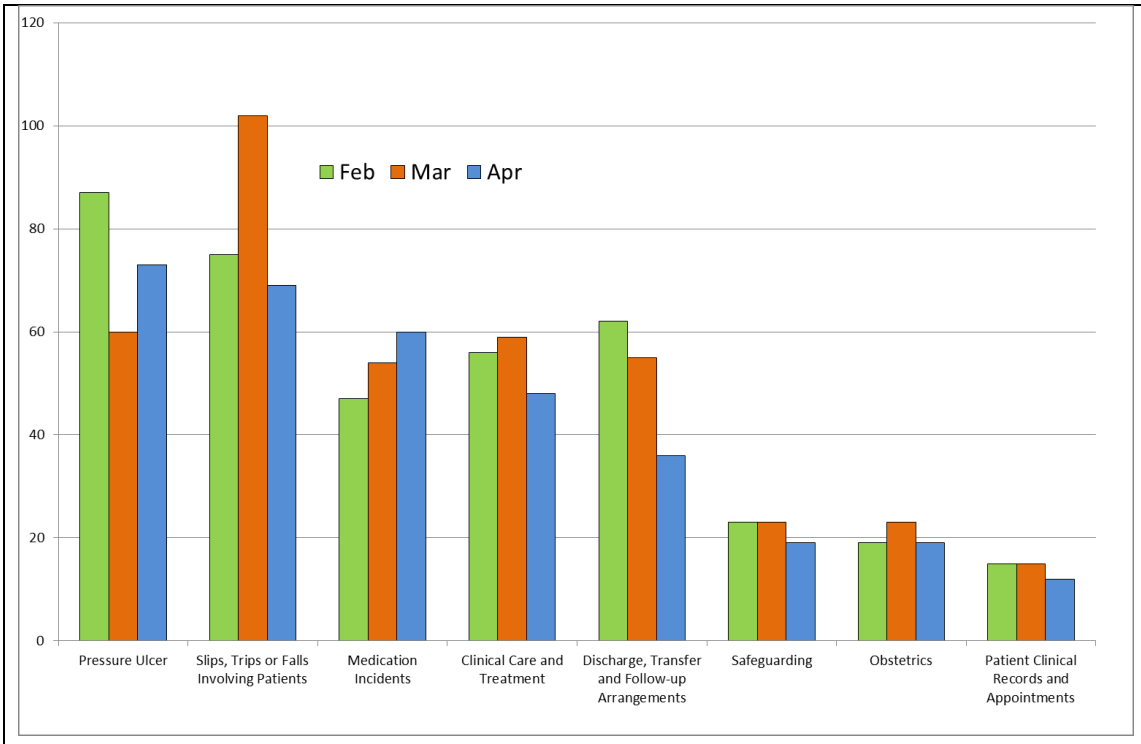
Table 4: High reporting areas (n >10 incidents per month)



April has seen a general decrease in reporting in both ED, Obstetrics however F7 saw a slight increase. All of the F7 incidences resulted in no harm with the majority of these being Community Acquired Pressure Ulcers. G8 also saw an increase in incidences, with 1 incident resulting in harm. The majority of cases in G8 were due to falls.

However there has been an increase in medication incidences in general across the trust.

Table 5: High reporting incident types (n >10 incidents per month)



Pressure ulcers, Slips, Trips & Falls, and Medication incidents account for the highest number of incidents reported. Medication incidences have continued to increase month on month over the past 3 months.

The Drugs and Therapies Group (D&T) have been trying to promote an increase in reporting of near misses and minor incidents. The medication incidents are reviewed on a monthly basis, at the D&T meeting and then a medication safety bulletin is published to try to highlight any recurring themes.

In discussion with pharmacy e-Care is now making more incidents and issues visible and therefore we are gaining more learning as to what is or can be going wrong. This has resulted in increased reporting, however we are not seeing an increase in harm incidents being reported. There are a number of incidents/near misses being reported that could be associated with staff working under pressure, however these also have not resulted in harm

We have been working with some of the clinical areas to identify reporting triggers to support staff to know what should be reported in relation to both operational and quality of care issues. This work commenced within the Day Surgery Unit, Critical Care, Emergency Department and is now commencing with Main Theatres. The Emergency Department Triggers are;

- Ambulance stacking and patients remain in vehicle
- CDU used for expected patients
- Escalation area activated
- Exit block due to bed availability
- Inappropriate admission to CDU
- Patients in CDU greater than 24 hours

Critical Care Services Triggers are;

- Delayed admission
- Escalation plan activated
- Non clinical transfer
- Out of hours
- Discharge
- Reduced recovery capacity

- Surgical delay/cancellation

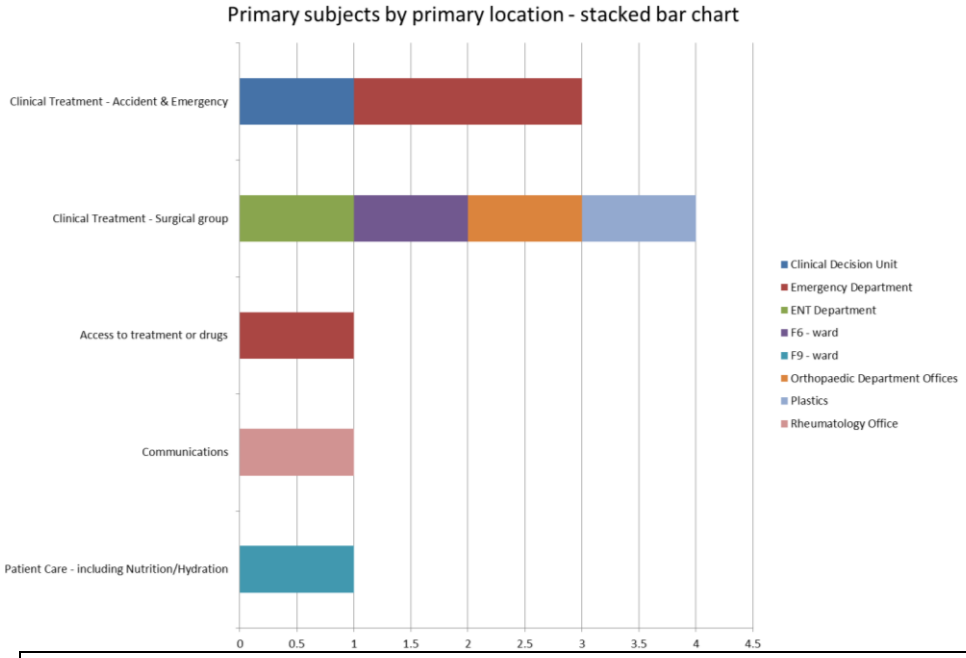
Day Surgery Unit Triggers;

- DSU patient requiring unforeseen transfer to main hospital after day case procedure.

Complaints

10 complaints received in April. The breakdown of these complaints is as follows by Primary Division: Medical (6), Surgical (4), Clinical Support (0) and Women & Children's Health (0).

Table 6: Complaints by type



Patient Experience Themes

Area	*Analysis*	*RAG rating*
Car Parking	*Patients and visitors continue to raise concerns about parking at the hospital. These appear to have shifted from complaints about charges to*	
Orthopaedics	*There were a higher than usual number of enquiries from patients enquiring about when their orthopaedic surgery would be taking place or in relation to delays in appointments being allocated.*	

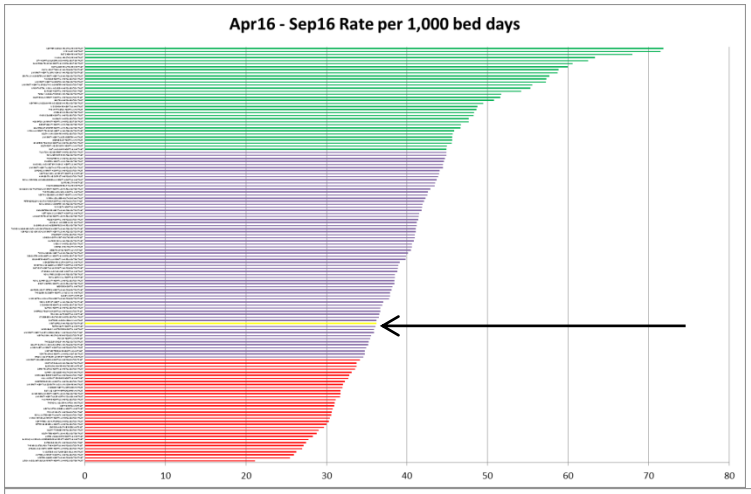
Green	*Problem area for only one month in the quarter*
Amber	*Problem area for two consecutive months*
Red	*Problem area for three consecutive months*

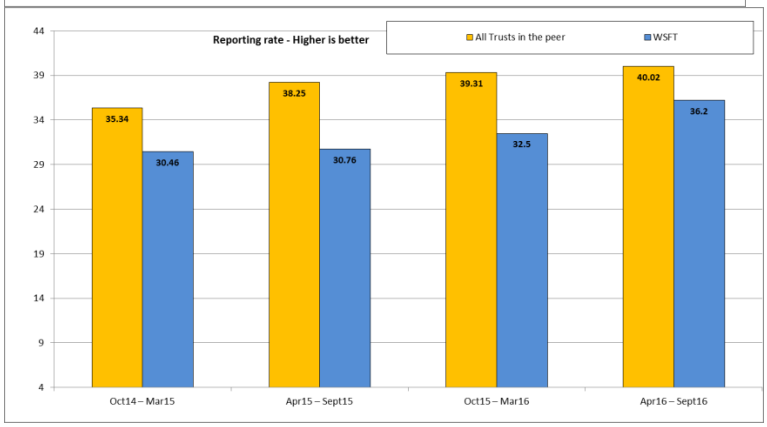
Red rating = area for concern for >=3 months
Amber rating = area for concern for 2 months
Green rating = new area for concern

Appendix A: NRLS Organisation Patient Safety Incident Report Apr-Sept 2016

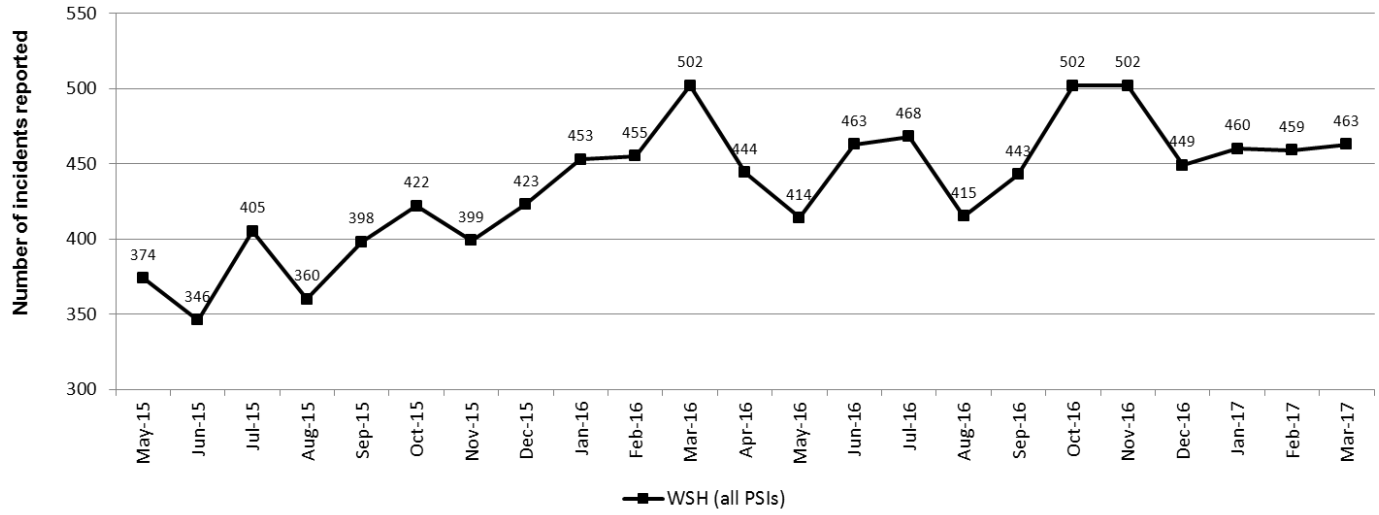
Are you actively encouraging reporting of incidents?

WSFT's reporting rate 36.2 incidents per 1,000 bed days (previous period 32.5). The median reporting rate for this cluster is 40.02 incidents per 1,000 bed days. This puts WSFT above the threshold for the lower quartile and is an increase compared to the last report. The Trust performance has improved over the period more than the peer and therefore the trust's performance against the peer has improved as well.



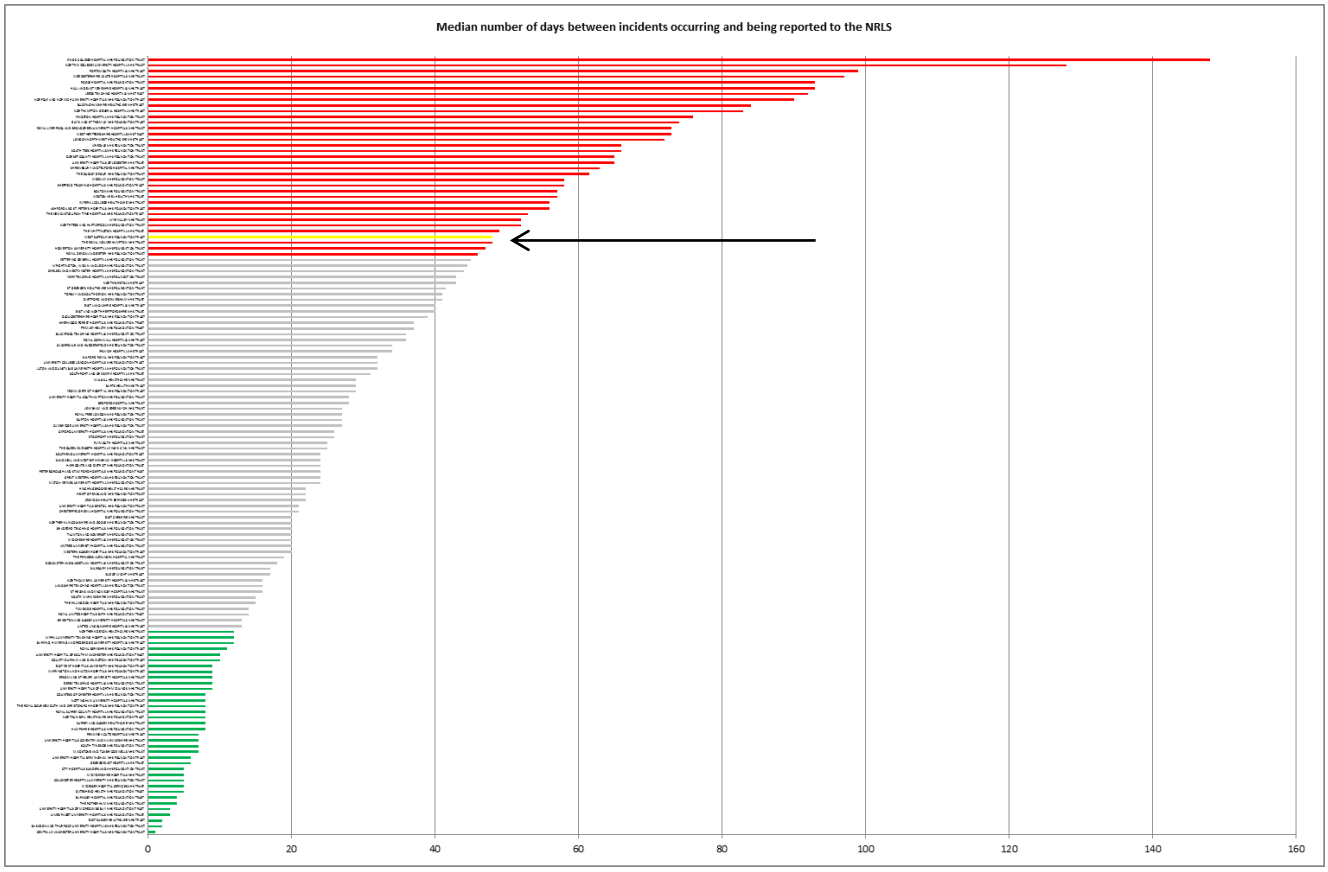


It is envisaged that the Trust's performance will remain similar or possibly slightly improve in the next period (Oct-Mar) as the total reporting rate has fluctuated but remained comparable over the full period (see graph below) however we are unable to predict performance against the peer benchmark until the actual data set is released (estimated September 2017).



How regularly do you report?

WSFT's reporting timeliness in the reporting period (48 days to upload 50% of all incidents) is a considerable improvement on the previous period (91 days) although it remains in the lower quartile.



Actions that have led to this improvement are detailed below and a new monthly 'timeliness of 50% upload" KPI is being reported in the Board Quality report to monitor the effectiveness of these measures.

a. Simplified Green incident investigation pathway is so that the handler can complete and finally approve the investigation at the same time.

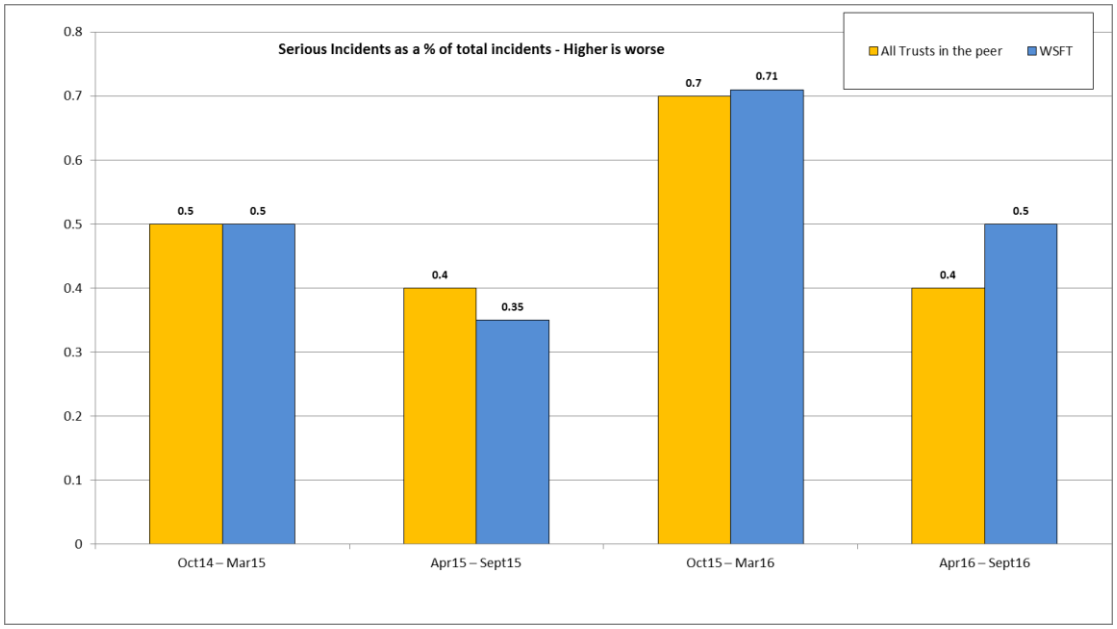
b. A dedicated admin resource for NRLS data quality checks and overdue incident follow up.

The importance of the admin resource has been demonstrated by a fall in performance over the more recent period (Oct16-Mar17) when the bank cover that had been in place was absent for a period of time. The performance has been estimated at 62 days for Oct16-Mar17 although the official figure will not be issued until September 2017.

The resource has now been substantiated into the Governance administrator role for two days a week and it is anticipated that performance will start to improve again with a view to aiming for a target of 25 days (median for peer group) by the end of 2017/18.

Analysis of the reported degree of harm

WSFT percentage of cases graded as serious harm (red incidents) shows a decrease in the most recent report. This matches a comparable reduction in the peer group. Numbers are very small however and will be affected by an increased reporting rate. WSFT's percentage is slightly higher than the peer.


Serious Incidents as a % of total incidents - Higher is worse
All Trusts in the peer
WSFT
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
0.5
0.5
0.4
0.35
0.7
0.71
0.4
0.5
Oct14 – Mar15
Apr15 – Sept15
Oct15 – Mar16
Apr16 – Sept16

Item 12

Trust Board – 26th May 2017

PRESENTED BY:	Nick Jenkins
PREPARED BY:	Helena Jopling
DATE PREPARED:	22nd May 2017
SUBJECT:	Learning from Deaths
PURPOSE:	• To receive information on the new national Learning from Deaths requirements • To consider a new reporting format and schedule for inpatient mortality data
STRATEGIC OBJECTIVE:	Priority A: Deliver for today • Improve patients' experiences, safeguard patient safety Priority B: Invest in quality, staff and leadership • Learn lessons and adopt best practice from others • Develop a Service Quality Improvement Framework, so we can measure intended improvements and show impact

EXECUTIVE SUMMARY:

This paper presents information on the new national Learning from Deaths programme launched by NHS Improvement and the Care Quality Commission (CQC) on 21st March 2017, and its implications for West Suffolk NHS Foundation Trust (WSFT).

Background

Following the systematic failures of care identified in trusts including Mid Staffordshire, Southern Health & Morecambe Bay in recent years, and the CQC's subsequent report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*, the National Quality Board has issued national guidance on how NHS trusts and foundation trusts should identify, report, investigate and learn from deaths in their care.

WSFT has structures and processes in place to learn from deaths which occur in the trust, and before the new guidance was published a small number of improvements had already been identified by the Learning from Deaths (LfD) group (formerly the Mortality Surveillance Group) and agreed on. Nevertheless there are several ways in which WSFT's approach needs to be adapted to meet the new requirements. This paper provides details. It also presents a new reporting style for the Board to consider and relates the Learning from Deaths programme to the trust's strategic objective to develop a Service Quality Improvement Framework.

The salient objectives of the programme are:
a) to raise the profile of learning from deaths in NHS trusts and FTs
b) to standardise methods of learning and governance
c) to ensure board-level leadership and oversight
d) to increase the involvement and improve the experience of families and carers following a bereavement
e) to improve safety
f) and ultimately to reduce the number of preventable deaths in healthcare settings.

Content

The main document provides an overview of the requirements of the national guidance and benchmarks WSFT's current practice against them. It describes the actions which the trust needs to

take to implement the guidance in full.

The national programme mandates a timescale which includes:

- preparation and publication of a trust-wide policy on Learning from Deaths by end of September 2017
- reporting of detailed information to the Board on the prevalence of preventable deaths by end of December 2017
- reporting of detailed information in the annual Quality Account about the actions which have resulted and the impact they have had by end of June 2018.

The main changes proposed to the way we conduct mortality reviews from our current processes are:

- more involvement of families and carers in the learning process
- creating the post of Medical Examiner to provide independent review of every death which occurs in the hospital
- more systematic learning, sharing of learning and implementation of actions in response to problems in care
- measurement of the impact of that learning on patient safety and the rate of preventable deaths.

It is estimated, based on published research and experience in other trusts, that between 10 and 45 preventable deaths occur each year in WSFT as a result of problems in care. Up to 150 people who die will experience a problem with their care, whether it led to or hastened their death or not.

The guidance requires the trust to publish its progress towards identifying the avoidable deaths that these problems in care may contribute to. The **Board is asked to agree** to receive this information on a locally developed dashboard.

The Board currently receives mortality statistics on a monthly basis; the guidance requires reporting at a minimum of quarterly. The **Board is therefore asked to agree** to reduce the reporting frequency to quarterly.

The appendices present the ward-to-board governance arrangements which have been devised to support the Learning from Deaths programme. Please note in appendix 1 the grey box containing the “Division or department quality improvement programmes” which are the vehicle by which generalizable learning will be implemented across the trust. The box is greyed out because in order to harness the full benefit of the learning which the new rigorous process will generate, the trust needs to build on its existing capacity and capability to implement organisation-wide improvements systematically and at scale. The strategic framework *Our patients, Our hospital, Our future, together* includes an objective to develop a Service Quality Improvement Framework. The Learning from Deaths programme is a good case study for how more support for, and robust measurement of, quality improvement activity on a pan-organisation or even multiagency level would allow us to build further on our clinical effectiveness, safety and patient experience record. A proposal for the design and implementation of a Service Quality Improvement Framework is suggested to be brought to the Board in the coming months.

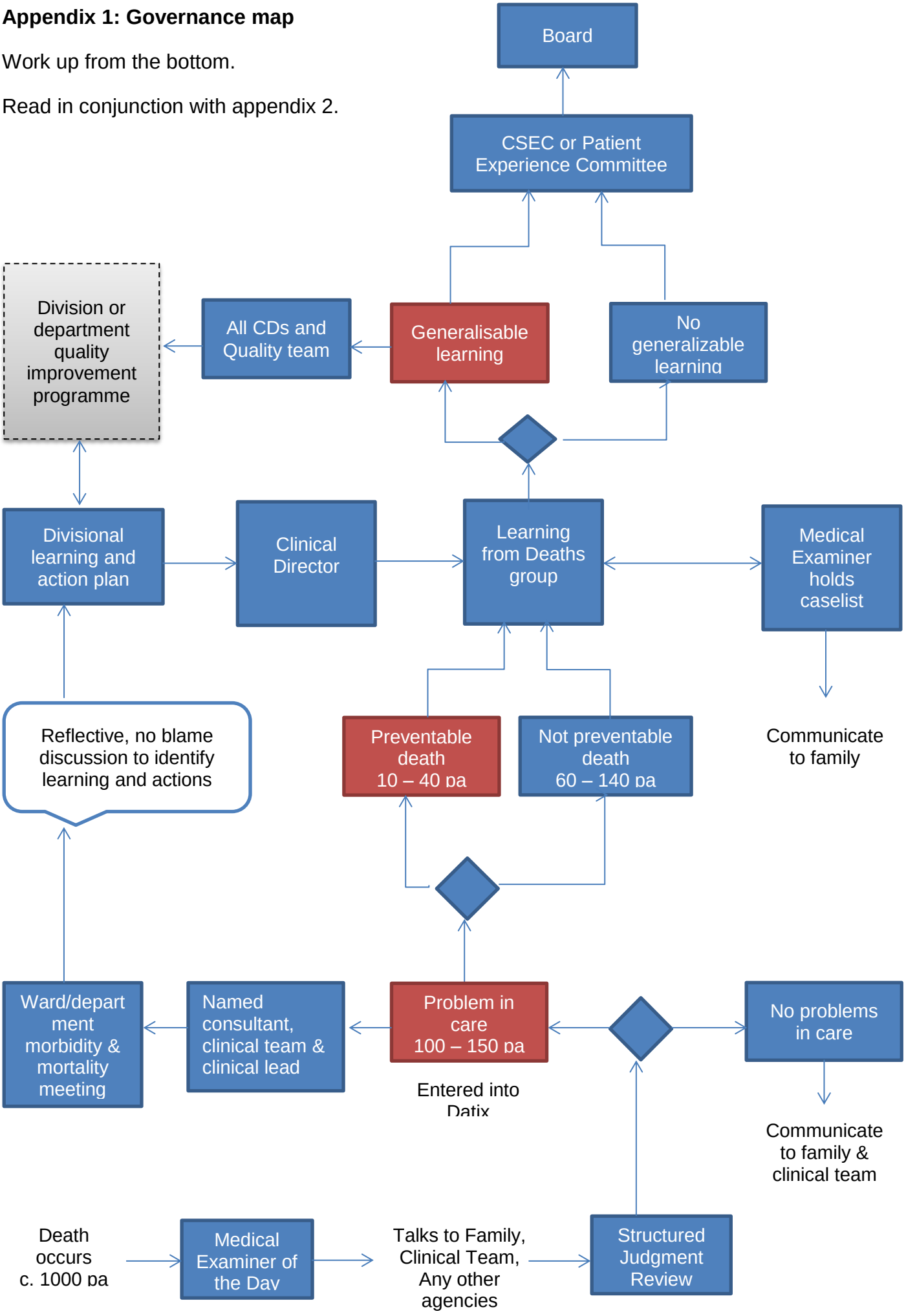
Matters resulting from recommendations made in this report	**Present**	**Considered**

Financial Implications	**Yes** / No	Yes / No
Workforce Implications	**Yes** / No	Yes / No
Impact on Equality and Diversity impact	Yes / **No**	**Yes** / No
Legislation, Regulations and other external directives	**Yes** / No	Yes / No
Internal policy or procedural issues	**Yes** / No	Yes / No
Risk Implications for West Suffolk Hospital (including any clinical and financial consequences): 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.	**Mitigating Actions** (Controls): The processes and governance described in the paper are expected to fully mitigate the risks from not identifying problems in care. The independence of the medical examiner in reviewing case records is particularly important. The introduction of a Service Quality Improvement Framework and robust methods to share learning without and beyond the trust will mitigate the risks from not acting on the learning generated.	
Level of Assurance that can be given to the Committee from the report based on the evidence [significant, sufficient, limited, none]: Sufficient		
Recommendation to the Committee: To approve the actions described in the paper which will allow the trust to implement the national Learning from Deaths programme. To agree to receive information on Learning from Deaths in public, on a locally developed dashboard, on a quarterly basis. To agree to receive a proposal for a Service Quality Improvement Framework in the coming months.		

Appendix 1: Governance map

Work up from the bottom.

Read in conjunction with appendix 2.



Appendix 2: Roles and accountabilities in Learning from Deaths governance

Group/person	Role and accountability
Board	Accountable for demonstrating reduction in % preventable deaths
Clinical Safety and Effectiveness Committee	Test and assure actions which are described in action plans Accountable to Quality and Safety Committee
Patient Experience Committee	Take learning from deaths into consideration in its organisation-wide workplan Accountable to Quality and Safety Committee
Medical Director	Represent LfD group at committees and board Accountable to Chief Executive
Learning from Deaths group	Hear cases with problem in care +/- preventability Identify themes or trends which are emerging Refer generalizable learning to all divisions via CDs and to quality team via associate chief nurse Report learning and actions to CSEC or Patient Experience Committee as appropriate Accountable to CSEC
Clinical Directors	Identify themes or trends which are emerging Refer cases with generalizable learning to LfD Present action plans and report progress against them to LfD Take generalizable learning from LfD back to divisional governance meetings as appropriate Accountable to Medical Director
Clinical Lead	Support named consultant and clinical team to reflect and identify learning and actions and implement them List case for ward/departmental M&M and support M&M to identify/take ownership of learning and actions Produce/oversee production of action plan and deliver to CD Identify learning which is generalizable to other departments and refer to clinical director Support team and oversee implementation of actions as relevant Accountable to clinical director
Named consultant	Share reflections with the medical examiner about care preceding death Where a problem with care is identified, reflect with team, present to ward/departmental M&M and identify learning and actions Identify learning which is generalizable and refer to clinical lead +/- clinical director Implement actions if they are team-specific Accountable to clinical lead
Medical examiners	Perform the case record review, including feedback from the family or carers, clinical team and any other agencies involved in care Record their judgments, including giving a score of preventability Make recommendations for action if they wish to and make a judgment on whether the learning is generalizable if they wish to Report findings to family when there are no problems with care Refer problems with care +/- recommended actions to:

	• Clinical team • Clinical lead Enter details on to Datix. Report cases with problems with care and preventable deaths to LfD group, including any themes or trends which are emerging. Hold a case list until they are satisfied learning and actions have resulted. Communicate with the family when a problem in care is found, including learning, actions and impact that result Accountable to Medical Director
Administrators	Receive death notifications and assign to Medical Examiner of the Day Support administration of mortality reviews and maintenance of case lists Administer written communication with families and other agencies Monitor and record progress of cases with problems in care through the governance cycle Coordinate Learning from Deaths group meetings Coordinate trust-wide learning events and interagency meetings Coordinate reporting schedule and papers to assurance committees

Learning from Deaths

Meeting the new requirements of the National Quality Board, effective 01 April 2017

Trust Board

26th May 2017

Introduction

Following the systematic failures of care identified in trusts including Mid Staffordshire, Southern Health & Morecambe Bay in recent years, and the subsequent Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*, the National Quality Board has issued national guidance on how NHS trusts and foundation trusts (FTs) should identify, report, investigate and learn from deaths in their care.

The key findings of the CQC report that the guidance aims to address are:

1. learning from deaths was not being given sufficient priority in some organisations
2. valuable opportunities for improvements were being missed
3. there is more we can do to engage families and carers and learn from their insights

The National Quality Board is a national oversight body with membership from CQC, NHS England, NHS Improvement, Public Health England (PHE), National Centre for Health and Care Excellence (NICE) and Health Education England (HEE) and Department of Health (DH).

NHS Improvement and CQC jointly hosted a conference on 21st March 2017 to introduce the new national programme to non-executive directors and medical directors. Roger Quince and Nick Jenkins attended for WSFT.

The salient objectives of the programme are:
a) to raise the profile of learning from deaths in NHS trusts and FTs
b) to standardise methods of learning and governance
c) to ensure board-level leadership and oversight
d) to increase the involvement and improve the experience of families and carers following a bereavement
e) to improve safety
f) and ultimately to reduce the number of preventable deaths in healthcare settings.

West Suffolk NHS Foundation Trust (WSFT) has structures and processes in place to learn from deaths which occur in the trust, and before the new guidance was published a small number of improvements had already been identified by the Learning from Deaths (LfD) group (formerly the Mortality Surveillance Group) and agreed on. Nevertheless there are several ways in which WSFT's approach needs to be adapted to meet the new requirements. This paper provides details. It also presents a new reporting style for the Board to consider and relates the Learning from Deaths programme to the trust's strategic objective to develop a Service Quality Improvement Framework.

Actions for implementation

Over the next few pages the 'shoulds' from the national guidance are presented in tables, with the current WSFT position, any extra relevant information, and an explanation of how WSFT will improve its process to meet the new requirements. More detail is presented in subsequent pages and in the appendices for the Board's information.

The subject matter is dense. The national guidance is extensive, prescriptive and detailed.

In summary, the proposed actions are:

With respect to the process for mortality review:

1. Agree and publish a trust-wide policy on our approach to reviewing deaths and what we are aiming to achieve by doing so

2. Continue to review all deaths which occur in the trust

3. Change the method we use to review deaths by adopting a variation on the nationally recommended Structured Judgment Review method developed by the Royal College of Physicians (see pages 5 and 9)

4. Replace the current system of two-stage review and overcome capacity problems for individual consultants with high numbers of deaths by implementing a "medical examiner" model. Condense case record reviews and peer reviews into a single stage process (see pages 5 and 9)

5. Create or source an information management and technology system suitable for collecting, reporting and monitoring learning

With respect to acting on the learning and reporting it as required:

6. Ensure there is adequate support to the named Executive Director and Non-Executive Director for Learning from Deaths

7. Report to the Board with a Learning from Deaths dashboard on a quarterly basis (see pages 6 and 10-12)

8. Enhance the clinical governance of Learning from Deaths and actions that result (see page 6 and appendices 1 and 2)

9. Proceed with developing an organisation-wide Service Quality Improvement Framework to ensure that there is the necessary machinery, enough capacity, and suitable recording mechanisms in place, to be able to capture and implement quality and safety improvements which are triggered by Learning from Deaths, and the benefits they create for patient safety.

With respect to supporting and involving families and carers better:

10. Routinely collect family and carer feedback on care during their loved one's hospital admission to inform the mortality case record review

11. Co-produce how to share learning with families and carers following a review, and how to give assurance that it has had an impact

12. Add a family or lay member to the LfD group

13. Benchmark WSFT's bereavement service against the national guidance and make any improvements identified

With respect to sharing the learning with partner organisations across the health and care system:

14. Put mechanisms in place identify all deaths in people with learning disabilities and refer them to the NHS England Learning Disabilities Mortality Review programme

15. Resolutely promote a culture of learning, as espoused by the Berwick review into patient safety (2013), and put structures in place to spread learning from deaths

16. Agree an approach to joint working with responsible directors and quality teams of all local partners, including primary care and social care (note all acute, community and mental health trusts are required to meet these new national requirements)

National guidance "Shoulds" – Items on how we review deaths			
"Should"	**WSFT currently**	**Of note**	**Actions required**
Hold and make public a policy on how the trust responds to, and learns from, deaths of patients who die under its management and care	No existing policy; LfD group terms of reference do not contain enough information to act as a policy	Required to be agreed at a public board meeting by 30th September 2017	Agree a policy and publish it
Conduct case record reviews, using an evidence-based method, of deaths selected according to criteria defined in the Learning from Deaths policy Ensure that staff have the necessary skills, through specialist training, and protected time under their contracted hours to review and investigate deaths to a high standard Increase objectivity by having reviews conducted by clinicians who were not directly involved in the deceased's care	All deaths are meant to be subject to case record review. Some clinicians in high mortality specialties are hampered by lack of capacity so coverage is not complete and reviews are not always timely Evidence base for current method unknown; training has not been provided LfD group reports occasional difficulty in applying the review method Consultant time is not protected. Peer reviews place high demands on clinical director time. LfD group had previously decided to distribute peer review workload amongst morbidity and mortality meetings to address this	Minimum criteria for selection for case record review are laid out The guidance recommends (but does not mandate) the Royal College of Physicians' (RCP) structured judgment review (SJR) method for case record review. See page 9 Training in the RCP SJR method is being rolled out nationally. First training in East of England is 29th and 30th June 2017. Other sources of specialist training are not apparent Some trusts have adopted dedicated "medical examiner" roles to create the necessary capacity to do reviews quickly and well.	Continue with expectation that all deaths are reviewed Adopt a variation on the RCP SJR method Implement a medical examiner model Condense case record reviews and peer reviews into a single task

Continued… Items on oversight and reporting of the results of death reviews			
"Should"	**WSFT currently**	**Of note**	**Actions required**
Have an executive director who takes responsibility for learning from deaths and a non-executive director who takes responsibly for oversight of progress	Nick Jenkins, medical director, is the responsible executive director Richard Davies is the responsible non-executive director		Name the responsible directors in the trust's LfD policy Ensure adequate support to both ED and NED to fulfil their roles
Collect and publish, at public board meetings on a quarterly basis, data on inpatient deaths, reviews and learning points which have resulted	WSFT uses a bespoke mortality database to collect data; this will need to be adapted or replaced to facilitate the SJR method The LfD group, Clinical Safety and Effectiveness Committee and the board all review mortality statistics at the moment. These groups only receive HSMR and SHMI data, with no information on learning.	Data needs to be reported covering time series from 01 April 2017 onwards. Reporting to public board needs to start by 31st December 2017 The current mortality database collects enough data to report in the interim LfD guidance includes a suggested dashboard (see pages 10-12)	Continue to collect data through the current methods and concurrently adapt or replace the mortality database to support the new review method Agree a dashboard and reporting frequency (see pages 10-12)
Collect and publish, in the annual quality account, evidence of learning and action and an assessment of the impact of actions that have been taken	Annual quality account presents HSMR and SHMI and number of deaths and reviews completed. Learning and actions not systematically reported at the moment, in mortality database or elsewhere Impact of actions not systematically collated	Reporting needs to start in 2017/18 quality account (published by 30th June 2018) Enabling quality/safety improvement governance would be needed.	Proceed with developing an organisation-wide Service Quality Improvement Framework to ensure learning from deaths can be systematically implemented, evidenced, reported and scrutinised Enhance the clinical governance for Learning from Deaths (see appendices 1&2)

Continued… Items on support to and involvement of families and carers			
"Should"	**WSFT currently**	**Of note**	**Actions required**
Meaningfully and compassionately engage bereaved families and carers A detailed list of principles is provided in the guidance (on page 15), extracted for reference below	Bereavement service provided A letter to bereaved families and carers recently agreed by LfD group		Medical examiner to collect family and carer feedback at time of case record review Co-produce how to share learning following a review, and how to provide assurance that it has had an impact Add a family or lay member to the LfD group Benchmark the bereavement service against the national guidance and make any improvements identified

BEREAVED FAMILIES AND CARERS - KEY PRINCIPLES:

- bereaved families and carers should be treated as **equal partners** following a bereavement;
- bereaved families and carers must always **receive a clear, honest, compassionate and sensitive response** in a sympathetic environment;
- bereaved families and carers should receive a **high standard of bereavement care** which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;
- bereaved families and carers should be informed of their **right to raise concerns about the quality of care** provided to their loved one;
- bereaved families' and carers' views should **help to inform decisions about whether a review or investigation is needed**;
- bereaved families and carers should receive **timely, responsive contact and support in all aspects of an investigation process**, with a single point of contact and liaison;
- bereaved families and carers should be **partners in an investigation** to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations;
- bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in **delivering training for staff in supporting family and carer involvement** where they want to.

Continued… Items on sharing learning across the trust and with other agencies			
"Should"	**WSFT currently**	**Of note**	**Actions required**
Refer all deaths in people with learning disabilities to the regional NHS England lead for the Learning Disabilities Mortality Review (LeDeR) programme and cooperate with its review	People admitted who have a learning disability are identified and notified to the LD liaison nurse Regional arrangements for LeDeR programme are still in development	LeDeR can replace the internal case record review but doesn't have to	Write this into the LfD policy and make sure information streams exist to act on it once the regional programme is fully running
Cooperate with external, independent investigations and reviews as appropriate, such as Child Death Overview Panel, coroner investigations, suicide reviews, maternal deaths	All requests for information or participation met		-
Share relevant learning across the organisation and with other services where the insight gained could be useful Consider whether they can routinely arrange joint case record reviews with partners	LfD group facilitates some learning being shared across the organisation Sharing with external organisations is only on adhoc basis	All acute, community and mental health NHS trusts need to comply with the new guidance. Other interested partners mightinclude primary care and social care Other areas use a number of methods to spread learning, including mortality conferences, bulletins, peer review by neighbouring trusts The Berwick review emphasises the importance of a no-blame culture	Resolutely promote a culture of learning and put internal and cross-agency structures in place to spread learning Agree approach to joint working with responsible directors and quality teams of all local partners including primary care and social care

Further information - The RCP structured judgment review method and medical examiner model

The Royal College of Physicians began a 3-year project in 2016, in partnership with the Yorkshire and Humber Academic Health Science Network and Datix, to facilitate the adoption of a validated, standardised method for reviewing deaths in hospital to identify problems in care which may have hastened or caused the person's death. The method, called a structured judgment review (SJR), was developed and tested in 2013 by a research team led at the University of Sheffield, led by Professor Allen Hutchinson.

The method requires reviewers to make explicit judgments about the quality of care which has been received throughout the inpatient admission, so that an inexpert reader can know whether care has been good enough or not. It uses a two-stage process to first identify any problems in care, and then to establish whether those problems in care had a material impact on the time, circumstances or cause of death. In doing so, it enables trusts to understand whether and how systematic problems in care are putting patients at risk of major harm.

The project's pilot findings suggest problems in care are likely to be found in 10 – 15% of cases.
Published research has shown that in 3.0 – 4.3% of cases, the problems in care are more than 50% likely to have caused or hastened death, although some trusts which have already implemented the RCP method anecdotally report a lower rate than this.

In WSFT this would indicate 100 – 150 deaths per year where the person's care has fallen below the expected standard and 30 – 45 deaths per year which might have been preventable. The Learning from Deaths group only identifies a fraction of this number at the moment.

The time required to use the SJR method is an average of one hour per case record. In WSFT this would necessitate 1000 hours of senior clinician time per annum. Some clinicians in high mortality specialities, such as geriatric medicine and respiratory medicine, already struggle to perform the reviews for their high caseload. In addition, the SJR method requires objectivity. We have considered different models for creating the time required for senior clinicians to be able to perform reviews to a high quality. The preferred option is to:

1. adopt the medical examiner model which other trusts are using, with a small number of highly skilled reviewers performing all case record reviews
2. move to using the SJR method to benefit from the explicit judgments and objectivity that it introduces, but condense the two-stage process into a single stage.

Further information - Reporting on learning

The national guidance states that trust boards must receive information on a quarterly basis on the number of deaths in hospital, the number which have been reviewed and the number which have been identified as having a degree of preventability.

The percentage of preventable deaths in the trust will become a key summary statistic.

The National Quality Board have published a suggested dashboard for trusts to use, but it is not mandated. A mock version is provided overleaf on page 11. The Learning from Deaths group feels the dashboard relies heavily on quantitative data, which is in conflict with the spirit of the national programme which is very much about moving to a qualitative understanding of the nature of problems in care and preventable deaths. The LfD group also feels it presents too much data in an un-interpreted format. An alternative dashboard is therefore proposed, with the intention of providing the Board with accessible information which it can assess with meaning. A mock version of this local dashboard is shown on page 12.

Frequency of reporting
The national guidance requires boards to receive information at a minimum of a quarterly basis. WSFT board currently receives mortality statistics every month. Given the low frequency of preventable deaths (somewhere between 1% and 4% predicted, i.e. 1 to 4 cases per month), it would be appropriate to consolidate the information into quarterly reports.

The Board is therefore asked to approve:
1. receiving information on the locally developed dashboard rather than the nationally provided version
2. reducing the reporting frequency on Learning from Deaths to quarterly.

In-depth information on the outcomes of actions taken and the measureable impact they have had on patient safety will be published in the annual quality report. The content and format will be worked up over time as we establish the new approach and the systems required to support it.

Nationally produced dashboard – mock version for illustration

NHS Anytown Foundation Trust: Learning from Deaths Dashboard - September 2017-18

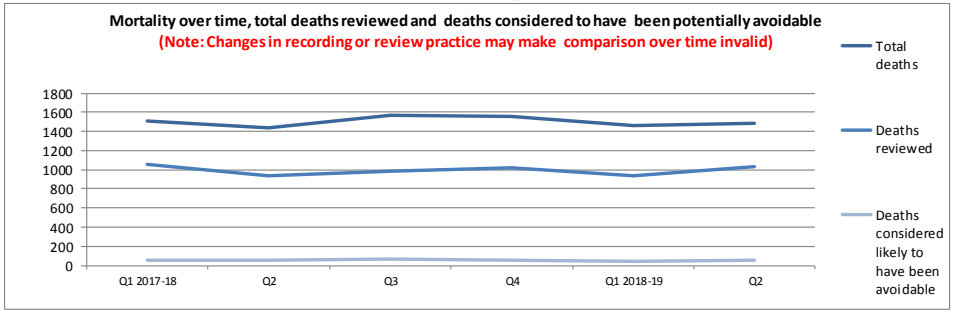
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
454	523	339	298	14	20
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1436	1509	939	1053	50	54
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
6069	0	3991	0	227	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

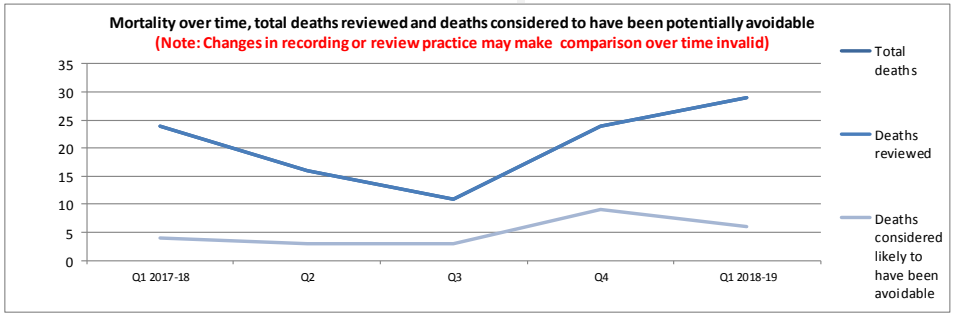
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	4	1.2%	This Month	10	2.9%	This Month	33	9.7%	This Month	65	19.2%	This Month	227	67.0%
This Quarter (QTD)	5	0.5%	This Quarter (QTD)	14	1.5%	This Quarter (QTD)	31	3.3%	This Quarter (QTD)	90	9.6%	This Quarter (QTD)	178	19.0%	This Quarter (QTD	621	66.1%
This Year (YTD)	30	0.8%	This Year (YTD)	65	1.6%	This Year (YTD)	132	3.3%	This Year (YTD)	378	9.5%	This Year (YTD)	754	18.9%	This Year (YTD)	2632	65.9%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
10	2	10	2	2	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
16	24	16	24	3	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
75	0	75	0	19	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1

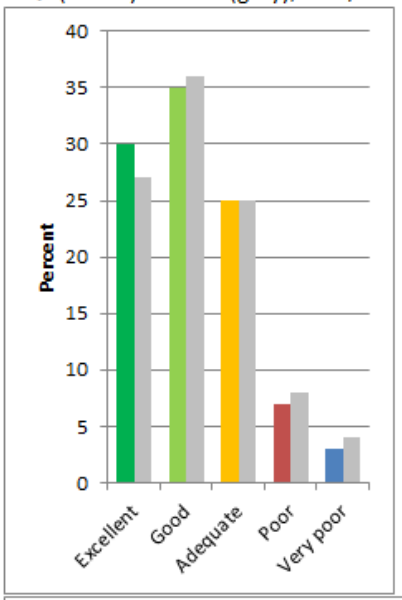


Preferred, locally developed board report dashboard – mock version for illustration

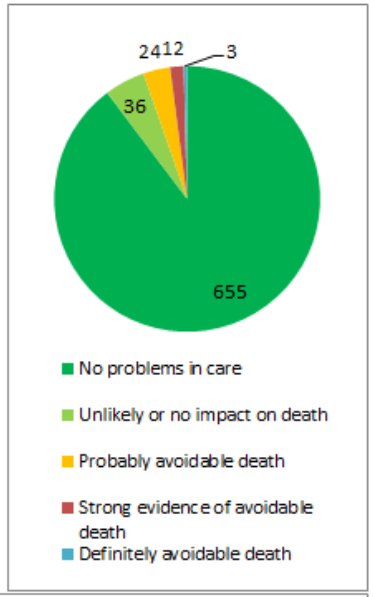
Learning from Deaths dashboard

Inpatient deaths	Total	Reviews completed
Q3, 2017/18	250	245
Year to date	750	730

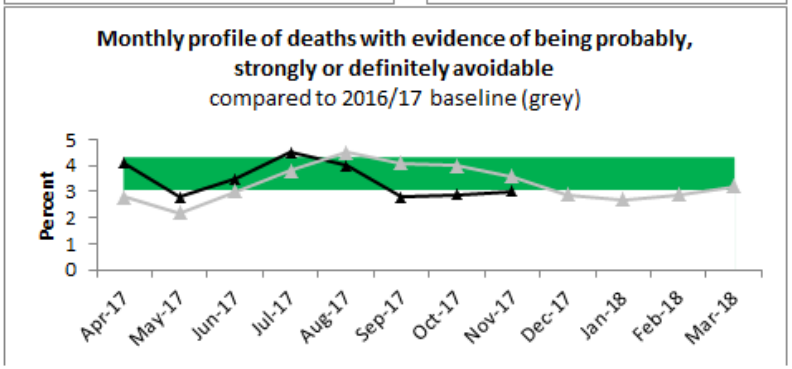
Overall quality of care
Q3 (colour) and YTD (grey), 2017/18



Outcomes of reviews
Year to date, 2017/18



Monthly profile of deaths with evidence of being probably, strongly or definitely avoidable
compared to 2016/17 baseline (grey)



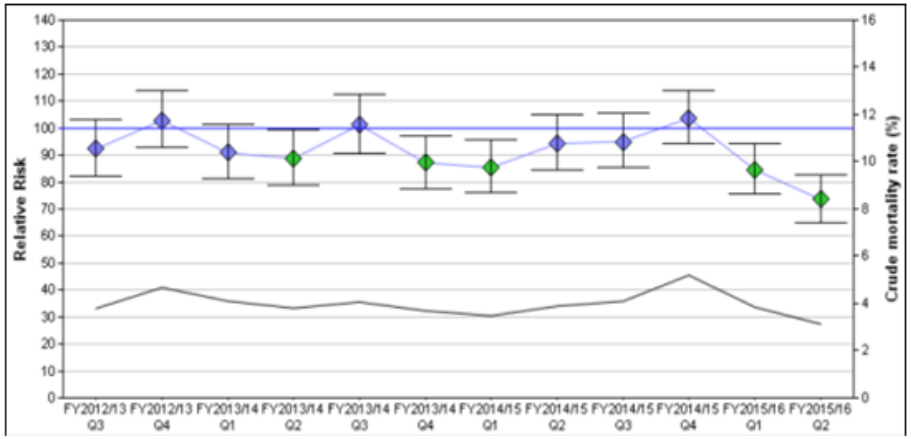
Deaths in people in groups under special focus – Q3, 2017/18 and YTD (brackets)

Group	Total	Number reviewed by multiagency	Probably, strongly or definitely avoidable
People with learning disabilities	3 (9)	3 (8)	1 (4)
People with severe mental illness	2 (5)	2 (5)	1 (2)
Recipient of care from another organisation	15 (50)	12 (38)	2 (5)

Learning themes identified

Contributing to avoidable deaths	Avoidable fall Stroke after stopping anticoagulation for atrial fibrillation Inadequate fluid management Gastrointestinal bleed which could not be treated at WSFT
Not contributing to death	Over-treatment at end of life Insufficient community-based end-of-life support to allow people to die at home Noise on wards

Summary Hospital Mortality Index



West Suffolk NHS
NHS Foundation Trust

Trust Board – 26th May 2017

AGENDA ITEM:	13
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Sinead Collins, Clinical Business Manager
DATE PREPARED:	19th May 2017
SUBJECT:	Quality and Workforce Dashboard – Nursing
PURPOSE:	For Information

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

Linked Strategic objective (link to website)	1. To be the healthcare provider of first choice by providing excellent quality, safe, effective and caring services;
Issue previously considered by: (e.g. committees or forums)	-
Risk description: (including reference Risk Register and BAF if applicable)	-
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	-
Legislation / Regulatoryrequirements:	-
Other key issues: (e.g. finance, workforce, policy implications, sustainability&communication)	-

Recommendation:

Observations in April and progress of nurse staffing review made below

Observations

April

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
F7	10 medication errors	High agency and bank use
G1	7 medication errors	High roster effectiveness
G8	5 medication errors and 2 falls (with harm)	High bank use
G9	4 medication errors	High staff turn around due to uncertainty of ward closure
G4	-	High bank use
F1	-	Low RN day fill rate and high bank use – due to two long term sickness and two staff on mat leave not covered
F9	-	High bank use
F12	-	High bank use
Kings Suite	-	Low RN fill rate and high bank use

Vacancies – Current processes being reviewed due to template used between HR and Finance have created some inappropriate figures in some areas. This means areas will not be highlighted for concern this month. Staff are escalating when required. It should be stated from this month forward, that if a figure has a '–' before then this is a vacancy, and if the figure has a '+' before then it is over established compared to budget. This has been changed due to confusion

Roster effectiveness – Out of 27 areas, 22 are over the Trust standard of 20% (Four more than March). As mentioned in the dashboard, roster effectiveness is a sum of sickness, annual leave and study leave. HR sends a KPI report to corporate managers, which highlights when these areas are over trust average.

Sickness – Out of 27 areas, 16 are over the Trust Standard of 3.5% (six less than last month)

Update on progress of Nurse Staffing Review

Outstanding review of the Nurse Specialist roles in Surgery, Paediatrics and Clinical Support Services.

SCNT review was completed and reviewed by General Managers. Attached alongside this document for oversight

Paediatrics review has been postponed due to the General Manager's other duties. No date has been agreed

KPMG are currently reviewing the WSFT nursing process, in view to help us improve in standard

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Apr-17			Establishment for the Financial Year 2016/17						Data for April 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 (Apr 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	122.7%	100.0%	131.3%	131.2%	3.80%	6.40%	8.30	4.30	8.70%	N/A	26.90%	N/A	2	0
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	87.5%	93.5%	103.7%	93.6%	7.80%	9.30%	N/A	N/A	4.30%	8.92	21.30%	0	10	0
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	85.8%	N/A	86.1%	N/A	2.90%	0.00%	N/A	N/A	1.30%	N/A	25.20%	0	1	0
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	80.7%	70.5%	N/A	N/A	4.20%	0.00%	-0.34	-0.10	2.30%	25.65	24.00%	0	2	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	111.0%	100.1%	N/A	N/A	0.40%	0.00%	-11.50	8.20	6.00%	N/A	22.60%	0	1	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	130.0%	93.1%	77.8%	N/A	0.00%	0.00%	-2.09	0.00	2.20%	N/A	21.90%	0	1	N/A
WSFT	DSU	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward area	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	86.3%	N/A	114.0%	N/A	3.20%	0.00%	1.20	-0.59	9.90%	N/A	29.50%	0	1	0
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	100.7%	94.8%	50.2%	N/A	0.90%	0.00%	0.90	0.40	6.30%	12.18	23.00%	0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	95.1%	100.3%	96.5%	N/A	4.80%	0.00%	-1.36	1.00	3.60%	8.76	27.50%	0	7	1
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	98.4%	98.9%	97.0%	97.2%	8.90%	0.00%	-3.81	0.50	5.90%	5.55	19.30%	0	3	1
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	100.4%	96.7%	106.6%	102.2%	15.70%	0.70%	-3.53	-1.15	2.70%	5.92	23.10%	1	0	0
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	89.7%	98.0%	100.6%	97.8%	4.90%	0.50%	-5.00	-0.88	4.30%	5.22	20.70%	0	1	1
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	83.7%	92.8%	94.4%	90.9%	8.50%	1.90%	-3.50	-2.70	7.20%	6.26	22.40%	1	5	2
WSFT	G9	Winter Escalation	30	Included within winter escalation budget	Included within winter escalation budget	Included within winter escalation budget	N/A	6	10	Closed on 20th April	Closed on 20th April	Closed on 20th April	Closed on 20th April	24.60%	15.40%	0.00	2.70	1.70%	N/A	21.90%	1	4	0
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	78.9%	147.3%	120.0%	N/A	15.70%	0.00%	-3.16	0.60	5.40%	N/A	27.30%	N/A	1	N/A
WSFT	F3	Trauma and Orthopaedics	33	40.47	59.07%	40.93%	48.48	7	11	94.8%	98.3%	123.2%	102.1%	1.90%	7.00%	-5.00	2.00	3.80%	4.93	22.50%	1	2	0
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	96.2%	95.0%	99.3%	129.4%	7.80%	3.40%	-1.10	-2.28	3.60%	8.03	25.70%	0	0	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	94.1%	100.0%	101.6%	116.3%	3.10%	0.00%	-1.60	-0.50	2.50%	5.35	18.40%	0	1	0
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	85.7%	96.7%	110.6%	109.4%	2.40%	2.70%	-4.42	-2.10	0.90%	7.71	13.00%	1	2	1
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	106.7%	103.2%	91.0%	105.6%	11.40%	0.20%	-4.40	-1.49	7.60%	5.45	17.60%	0	3	1
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	110.4%	90.0%	87.0%	93.3%	8.00%	0.30%	-1.10	-0.70	1.80%	6.40	22.00%	1	3	0
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	126.3%	95.8%	91.3%	70.1%	7.70%	0.00%	-0.36	-2.20	5.90%	N/A	20.20%	0	3	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1												N/A	1	N/A
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre recovery area, bereavement suite					1 - 2	1 - 2												1	1	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	89.6%	80.1%	39.6%	126.7%	13.60%	0.00%	-3.90	2.70	3.60%	9.01	22.00%	0	1	1
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	98.3%	95.0%	N/A	N/A	1.10%	0.00%	-0.70	-0.40	0.70%	N/A	20.50%	0	1	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	9.00	80.00%	20.00%	N/A	5 - 8	N/A	83.2%	N/A	57.5%	N/A	0.00%	0.00%	-0.20	0.30	0.50%	N/A	23.70%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	100.8%	93.8%	33.1%	46.7%	1.50%	0.00%	-1.02	-2.70	1.60%	N/A	13.20%	N/A	1	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	99.3%	100.0%	99.2%	100.0%	4.20%	0.00%	-2.33	0.00	0.07%	7.10	N/A	0	0	0
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	69.7%	98.1%	104.6%	96.7%	17.20%	0.4%	9.70	11.30	9.5%	5.50	25.10%	0	1	0
																-40.32	16.21	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)
Theatres and DSU establishment includes ODPs and non-nursing professionals and thus fill rate is not included
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

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

West Suffolk NHS
NHS Foundation Trust

Trust Board – 26th May 2017

AGENDA ITEM:	15
PRESENTED BY:	Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Sarah Jane Relf
DATE PREPARED:	22 May 2017
SUBJECT:	To receive an update on e-Care/Global Digital Excellence Programme
PURPOSE:	Information

EXECUTIVE SUMMARY:

- Drop One - OrderComms go live delayed – revised date to be communicated at Board
- This may also impact on our ability to hit the July deadline for drop two.
- Good progress with all other workstreams including significant work around infrastructure
- Future State Validation events concluded for drop three.
- Workshops planned to agree plan and milestones for Global Digital Excellence work around supporting the Integrated Care Organisation and STP ambitions.
- Work continues to resolve discharge summary and reporting issues – separate full reports to the Board on these issues.

Linked Strategic objective (link to website)	1. To be the healthcare provider of first choice by providing excellent quality, safe, effective and caring services; 2. To work with partners to develop integrated healthcare services to ensure that patients receive the right care, at the right time, and in the right place; 3. To be the provider of urgent and emergency care services for the local population; 4. To continuously improve service quality and effectiveness through innovation, productivity and promoting wellbeing in patients and staff; 5. To continue to secure, motivate, skill and develop an engaged workforce which will be able to provide high quality patient focused services **6.** To provide value for money for the taxpayer and to maintain a financially sound organisation
Issue previously considered by: (e.g. committees or forums)	e-Care Programme Board and Programme Group. Design Authority.
Risk description: (including reference Risk Register and BAF if applicable)	e-Care programme has a dedicated risk register and all key risks are included in the BAF.
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Scrutiny committee receives updates, audit reviews.
Legislation / Regulatoryrequirements:	Not relevant

Other key issues: (e.g. finance, workforce, policy implications, sustainability&communication)	Not relevant
Recommendation: The board is asked to note progress with e-Care and Global Digital Excellence programmes.	

1.	**Purpose**
1.1	This paper provides the trust Board with an update on current status of e-Care programme. The Board is asked to note the report.
2.	**Background**
2.1	The organisation has committed to a ten year programme of major transformation around digitising the organisation. The first major part of this programme was the original go live of e-Care in May 2016. This initial go live included a replacement PAS, FirstNet (within emergency department), clinical documents and electronic medicines management. In addition some limited components of OrderComms were introduced. OrderComms pathology was uncoupled from this initial go live.
2.2	The trust had a very successful go live and as such was one of 26 trusts asked to bid for national global digital excellence status. In September 2016 it was confirmed that the trust had been successful in securing £10m funding as part of an initial tranche of 12 trusts. The Global Digital Excellence (GDE) programme is a 2 year programme that commenced in November 2016.
2.3	The GDE programme covers four main pillars:

Pillar one	**Digital acute trust**	Completing the internal journey of digitisation
Pillar two	**Supporting the ICO**	Creating the digital infrastructure that will support the ambitions of the Sustainability and Transformation Plan
Pillar three	**Exemplar digital community**	Building the organisation into a centre of digital excellence and acting as mentor and guide for other developing organisations
Pillar four	**Hardware and infrastructure**	Ensuring that we have a robust and compliant infrastructure at the foundation of the programme.

2.4	The trust continues the ten year programme using GDE funds to increase the scope and speed up the original programme. The remainder of this report provides the Board with an update on progress.
3.	**Pillar one – digital acute trust**

3.1	**Drop 1 – planned for May 2017 – covering OrderComms, Sepsis and AKI** We had originally planned to go live with drop 1 on the weekend of 20/21 May. Unfortunately we had to make the decision to delay on 21 May. This is a very complex project with interfaces and dependencies between multiple partners. Unfortunately the recent cyber attack issues meant that some of our partners had to take down their test environments while patches were applied. This meant that we had a delay to OrderComms testing and despite best efforts to catch up it was agreed that insufficient testing had been completed to ensure a safe go live. On this basis we stood down the go live at 10.00 on Sunday 21st May. A verbal update will be provided to the Board on the revised go live date.
3.2	**Drop 2 – planned for July 2017 – covering Patient Portal, Patient Flow and PowerChart Touch** The delay to OrderComms go live may impact on our ability to deliver the above modules for the original July date. The current domain plan will need to be reviewed in light of the delay to OrderComms go live. This may in turn affect our ability to deliver drop 2 to the original July date. On this basis we are reviewing whether to push drop 2 into the October 2017 go live. A verbal update will be provided to the Board.
3.3	**Drop 3 – planned for October 2017 – covering Complex Meds, ClinDocs and Paediatrics** Good progress is being made in all three components. The scope of complex medicines has been reduced in light of capacity of pharmacists currently to support a large scale programme. A future state validation event was held during w/c 15th May with good representation in the majority of events (full programme at Appendix A). At this stage we remain on target to hit the go live for October 2017.
4.	**Pillar two – supporting the Integrated Care Organisation**
4.1	This workstream is in very early days of scoping. It is intended that this will cover initiatives such as Health Information Exchange, Patient Portal and population health. A workshop is being held on 24 May to agree overall approach and milestones so a verbal update will be provided to the board.
4.2	In the meantime good progress is already being made around Health Information Exchange for EMIS practises. The configuration work to enable a direct bi-directional connection to and from each surgery has been completed by Cerner and by EMIS. However as part of our due diligence work, we agreed to test the flow of patient data prior to any go-live switch on. Yet in light of the planned Pathology OCS go-live, all of testing resources at WSH has been focussed on OCS and so the HIE programme is now behind schedule. This will remain so, as the Pathology OCS go-live has only been postponed which means that the interface and testing resource will remain focussed on OCS for at least a further 2-3 weeks.
4.3	Despite this testing with our designated GP partner (Hardwick House) has continued which has allowed us to migrate the (5 surgery locations) away from the MIG connection (charged on a per transaction basis) to one which is direct (no charges). In parallel the WSH team has continued the discussions with Cerner regarding the

	availability of the CRV solution which once in placed will allow two way viewing (read only) of GP and Millennium patient data.
5.	**Pillar 3 – exemplar digital community**
5.1	We continue to work with Milton Keynes University Hospital NHS Foundation Trust to progress the bid for them to become our fast followers. A formal submission meeting with NHS Digital is planned for 23 June 2017.
5.2	We are holding a workshop on 25 May to consider what our GDE offer is to other organisations i.e. what is our area of most significant expertise for blue printing etc. A verbal update will be provided to Board. In the meantime the Trust continues to support visits and provide support to other organisations.
6.	**Pillar 4 – hardware and infrastructure**
6.1	Considerable progress has been made in 2017 on the Trust technical infrastructure in support of our e-Care programme. This commenced with detailed planning in January leading to the creation of a three year roadmap. As part of the early work IT have been replacing local network connectors (called switches) which will provide faster connectivity and improved resilience as the programme develops. At the heart of the network, our two main network switches are also being upgraded and we are adding further high speed switches in both computer rooms to again improve performance and increase reliability.
6.2	Recently the Trust has approved three major business cases. The first for a new firewall which will help protect the trust against the type of Cyber Attack suffered in May. The second is a new Remote Access solution which will expand our ability to offer remote working across the trust, most notably at community sites and for staff working away from the trust. We are also investing in a new e-mail system that offer improved performance, better mailbox management and support far greater integration across mobile devices. In parallel work is underway to replace our current GOOD mobile device management platform which again will assure the security of mobile working.
6.3	As part of the commissioning of Quince House the Trust is investing in a new modern digital telephone system which will offer alternative ways of working many of which will have benefits in clinical areas. This is being run as a pilot for staff in Quince House and will quickly be followed by G6 and F12 as part of the new build work already underway. Over the next three years all existing telephones will be migrated onto the new system with many locations being able to adopt the range of new features offered by it.
6.4	Over the summer of 2017 a survey is being undertaken across the West Suffolk hospital campus ahead of planned upgrade of the wireless network. The aspiration is to provide campus wide wireless network coverage at WSH and in parallel to provide basic building wireless into locations such as Newmarket, Sudbury, Thetford and Stowmarket. As part of this WSH is working with STP partners seeking to adopt a solution that will allow Trust staff to gain secure access to the wireless network from any location owned and/or operated by any STP partner (Suffolk and NE Essex wide).

6.5	Finally work continues on a daily basis to ensure that Endpoint technology (desktop, laptop, tablet, phone et al) are of the right specification to support all Trust operations. This includes upgrades and replacement as equipment reaches end of life or where additional equipment is needed to support the next phases of both the e-Care and GDE programmes. In terms of printing the Trust will continue the migration towards centralised Multi-Function Devices (scan, fax, copy & print) as we seek to reduce the number of local printers that whilst cheaper to buy are far more expensive to run.
7	**GDE general**
7.1	The Trust is required to submit a revised Statement of Benefits for the GDE programme by the end of May. This will be brought back to the Board at the June meeting once it has been through e-Care governance.
7.2	We are working closely with the other Cerner and the other GDE sites that use the Cerner solution to agree and co-ordinate the programme of work across the 7 sites. This includes progressing the preferential GDE offer from Cerner.
7.3	At the time of writing this report GDE funding had still not been received.
8.	**On-going issues**
8.1	**Discharge summaries** The team continue to support improvements around discharge summaries and a full separate paper has been provided to Board with the most current update.
9.	**Recommendations**
9.1	The Board is asked to: • Note the general progress • Note the delayed go live for OrderComms

22 May 2017
Sarah Jane Relf

APPENDIX A: e-Care Future State Validation Programme

Staff are invited to attend the validation events for the new paediatric and clinical documentation that will be available as part of Phase 2 of e-Care.
The clinical documentation and paediatric e-Care team have held design sessions for each of the topics below over the last few months, and have built the new content and functionality with our Cerner colleagues. We now need our e-Care users to view the new elements we plan to add to e-Care in the autumn.

Monday 15th May		
9.00am – 12.00pm Ed Centre, 19B	Enhanced recovery – major bowel pathway	New pathway for colorectal enhanced recovery patients. Suitable for surgeons, junior doctors, specialist nurses, F5/F6 ward nurses, therapists, pharmacists.
1.00pm – 4.00pm Ed Centre, 19B	Enhanced recovery – major joint pathway	New pathway for joint replacement enhanced recovery patients. Suitable for orthopaedic surgeons, junior doctors, specialist nurses, F3/4 ward nurses, therapists, pharmacists.
9.00am – 12.00pm Therapy Training Room (opp G3)	Paediatric – full patient pathway, full day	Includes all aspects of clinical documentation and medication management for paediatric patients. Suitable for all staff who see paediatric patients. This is repeated on Tuesday – no need to attend both.
1.00pm – 4.00pm Therapy Training Room (opp G3)		

Tuesday 16th May		
9.00am – 12.00pm Ed Centre, 19B	Frail elderly	New functionality for identifying and managing frail elderly patients. Suitable for all ward staff who treat frail elderly patients, specialist nurses, therapists, medical and geriatric consultants, and junior doctors working on medical/admission wards.
1.00pm – 4.00pm Ed Centre, 19B	Shortness of breath pathway	Pathway designed to assist route to diagnosis for patients admitted with shortness of breath. Suitable for all admitting and on call consultants and junior doctors, specialist nurses and AMU staff, therapists, pharmacists.
9.00am – 12.00pm G6 IT training bay	Paediatric – full patient pathway, full day	Includes all aspects of clinical documentation and medication management for paediatric patients. Suitable for all staff who see paediatric patients. This is a repeat of Monday's sessions – no need to attend both.
1.00pm – 4.00pm G6 IT training bay		

Wednesday 17th May		
9.00am –	Nursing care plans	Additional care plans for inpatient nurses.

12.00pm Ed Centre, 19B	• Constipation • Diarrhoea • Bladder management • Catheter • Pain • Moving and handling • Hygiene • Communication	Suitable for all ward nurses, specialist nurses and teams, ward managers, matrons, therapists.
1.00pm – 4.00pm Ed Centre, 19B	Nursing care plans • Cognition (1pm) • Stoma (2pm) • Nutrition & Feeding (3pm)	Additional care plans for inpatient nurses. Suitable for all ward nurses, specialist nurses and teams, ward managers, matrons, therapists.

Thursday 18th May		
9.00am – 12.00pm Ed Centre, 19B	AHP outcome measures, assessments and new documentation pages	New functionality and content for therapists. Suitable for inpatient and outpatient therapists (AHPs).
1.00pm – 2.30pm Ed Centre, 19B	Acute abdominal pain pathway	Pathway designed to assist route to diagnosis for patients admitted with acute abdominal pain. Suitable for all consultants and junior doctors, specialist nurses, surgical and gynae ward staff, therapists, pharmacists.
3.00pm – 4.30pm Ed Centre, 19B	Nursing care plan – last days of life	Care plan specifically for last days of life. Suitable for ward nurses, specialist nurses, palliative care, matrons.

Friday 19th May		
9.00am – 12.00pm Ed Centre, 19B	New documentation pages for all doctors and specialists nurses	New 'workflow' pages for clerking, progress noting and outpatient documentation, and new 'dynamic documentation' for creating notes. Essential for all junior doctors and consultants.

For more information on any of the sessions shown above please contact sarah.judge@wsh.nhs.uk or ian.coe@wsh.nhs.uk in the first instance.

West Suffolk NHS
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Board of Directors – 26 May 2017

AGENDA ITEM:	Item 16
PRESENTED BY:	Dr Stephen Dunn, Chief Executive
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	19 May 2017
SUBJECT:	Trust Executive Group (TEG) report
PURPOSE:	Information

EXECUTIVE SUMMARY:

15 May 2017

Craig Black chaired the meeting. An update was given on the **cyber-attack** and the work undertaken over the weekend as well as the situation in other trusts. A large amount of work has been done over the weekend and all commended the IT team's response.

An update was received on **operational performance**. It was noted that the performance against the 4 hour target had improved but remained fragile. The position for speciality performance against the 52 week wait target was reviewed in detail. Action is being taken to address capacity issues in ENT and vascular services.

A detailed report was received on the proposed **learning from deaths strategy**. Based on the national programme the proposed arrangements scale-up the way we currently learn from deaths in a more transparent and rigorous way. Details of the proposal will be presented to the Board in May.

The majority of the meeting was dedicated to a **KPMG workshop**. The session set out the background to the appointment of KPMG as part of the national financial improvement programme (FIP) commissioned by NHSI. The programme will critically challenge our existing cost improvement and efficiency programmes, identify additional opportunities from a range of other initiatives and support delivery at pace. Through this approach the programme will support delivery of our control total in-year and establish a programme to ensure long term sustainability.

Linked Strategic objective (link to website)	To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by:	N/A
Risk description:	N/A
Description of assurances:	N/A
Legislation / Regulatory requirements:	N/A
Other key issues:	None
Recommendation: To note the report	

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Board of Directors – 26 May 2017

AGENDA ITEM:	17
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	19 May 2017
SUBJECT:	Appointment of Senior Independent Director
PURPOSE:	Approval

1. Purpose

To approve the nomination of the Senior Independent Director (SID), following consultation with the Council of Governors. The position of SID became vacant in April 2017.

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.

3. Proposal

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.

4. Recommendation

Based on discussions with the Non-Executive Directors and at the Board meeting on 28 April the nomination of Alan Rose was considered and supported at the Council of Governors meeting held on 11 May 2017.

Linked Strategic objective (link to website)	6. To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	New item
Risk description: (including reference Risk Register and BAF if applicable)	Failure to comply with Regulator's Code of Governance and Trust Constitution .
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Legal review of constitution to ensure compliance with Health & Social Care Act 2012
Legislation / Regulatory requirements:	Health & Social Care Act 2012, Regulator's Code of Governance and Trust Constitution
Other key issues:	

Recommendation:

Approve the appointment of Alan Rose as the senior independent director (SID) for the remainder of NED term.

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Board of Directors – 26 May 2017

AGENDA ITEM:	18
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	19 May 2017
SUBJECT:	Annual Governance Review
PURPOSE:	To demonstrate first class corporate, financial and clinical governance to maintain a financially sound business.

EXECUTIVE SUMMARY:

The Board undertakes an annual review of its governance structure in order to ensure that it is adequately discharging its responsibilities and managing risks to quality, performance and finance.

All Board members were asked to undertake a self-assessment based on the consultation document from the CQC and NHS Improvement for the new well-led assessment framework. This is structured around eight key lines of enquiry (KLOE) for leadership and governance and will be used by the CQC as the basis for annual review of trusts' compliance:

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
2. Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people who use services, and robust plans to deliver?
3. Is there a culture of high quality, sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is robust and appropriate information being effectively processed and challenged?
7. Are the people who services, the public, staff and external partners engaged and involved to support high quality sustainable services?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

The results of the self-assessment were considered in detail at the Quality & Risk Committee meeting in March 2017. Based on the summary assessments and recommendations against each KLOEs the following were identified as key areas for development:

(a) Performance management, including the use of management information
(b) Quality improvement methodology
(c) Staff and leadership support and development

The Trust is due to commission its independent well-led review but given a number of factors this has been discussed with NHSI and they support the deferral of this piece of work until later in 2017/18. These factors include:

- the pending release of the final guidance for NHSI and CQC for the well-led framework

- the current work being undertaken by KPMG as part of the financial improvement programme (FIP) which includes a piece of work to review and improvement of the culture of change within the organisation.

The findings of the annual governance review have been shared with KPMG to inform and align with their work.

Linked Strategic objective (link to website)	To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	Annual governance review previously reported to the Board. The new CQC and NHSI well led framework structure was reported to the Board in January 2017.
Risk description: (including reference Risk Register and BAF if applicable)	Failure to comply with NHSI's single oversight framework or code of governance and quality governance framework and failure to comply with the CQC's well led framework.
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Previous governance reviews by the Board. Engagement of independent as part of the well led assessment process during 2017.
Legislation / Regulatory requirements:	Monitor's code of governance, risk assessment framework and quality governance framework
Other key issues: (e.g. finance, workforce, policy implications, sustainability& communication)	N/A

Recommendation:

It is proposed that:

(a) The Board note NHSI's support for deferring the well-led review until later in 2017/18
(b) The Board note that we are aligning the KPMG work to review and improvement the culture of change to build on the annual governance review and reflect the NHSI/CQC KLOEs
(c) The Board receives a further report in September which uses the findings of the KPMG work and the final well-led framework guidance to inform the scope of the independent well-led review

West Suffolk NHS
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Board of Directors – 26 May 2017

AGENDA ITEM:	Item 19
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	19 May 2017
SUBJECT:	Items for next meeting
PURPOSE:	Approval

EXECUTIVE SUMMARY:

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.

Linked Strategic objective (link to website)	6. To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	The Board received a monthly report of planned agenda items.
Risk description: (including reference Risk Register and BAF if applicable)	Failure effectively manage the Board agenda or consider matters pertinent to the Board. .
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.
Legislation / Regulatory requirements:	
Other key issues:	

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 30 June 2017

DESCRIPTION	OPEN	CLOSED	TYPE	SOURCE	DIRECTOR
Declaration of interests	✓	✓	Verbal	Matrix	All
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
DELIVERY FOR TODAY					
Quality & performance report	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Red risk 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
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
National patient survey report (if available)	✓		Written	Matrix	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
BUILD A JOINED-UP FUTURE					
e-Care report	✓		Written	Action point - schedule	CB
Financial improvement programme (FIP) report		✓	Written	Action point - schedule	CB
Estates strategy (following Scrutiny Committee)		✓	Written	Matrix	CB
Stroke option paper		✓	Written	Action point - schedule	HB
Scrutiny Committee report		✓	Written	Matrix	GN
Strategic update, including STP, ICO and TPP		✓	Written	Action point - schedule	SD
Community services – key decision point		✓	Written	Action point - schedule	NJ
GOVERNANCE					
Self- certification – general condition 6, continuity of service, FT4 and governor training	✓		Written	Matrix	SD
Trust Executive Group report	✓		Written	Matrix	SD
Council of Governors	✓		Written	Matrix	RQ
Audit Committee report	✓		Written	Matrix	ST
Confidential staffing matters		✓	Written	Matrix – by exception	JB
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

West Suffolk NHS
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Board of Directors – 26 May 2017

AGENDA ITEM:	19
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Ruth Williamson, PA, Trust Office
DATE PREPARED:	18 May 2017
SUBJECT:	Use of Trust Seal
PURPOSE:	Note

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. 119

  Deed of Variation – Cambridge University Hospital Trust, Colchester Hospital University NHS Foundation Trust, East & North Hertfordshire NHS Trust, North West Anglia NHS Foundation Trust, The Ipswich Hospital NHS Trust, West Suffolk NHS Foundation Trust – Joint venture for provision of community pathology services and acute pathology services in the East of England.

Linked Strategic objective (link to website)	To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by:	N/A
Risk description:	N/A
Description of assurances:	N/A
Legislation / Regulatory requirements:	N/A
Other key issues:	None

Recommendation:

The Trust Board notes the use of the Trust Seal for the items set out above.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 26 May 2017

AGENDA ITEM:	Item 20
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	19 May 2017
SUBJECT:	Items for next meeting
PURPOSE:	Approval

EXECUTIVE SUMMARY:

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.

Linked Strategic objective (link to website)	6. To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	The Board received a monthly report of planned agenda items.
Risk description: (including reference Risk Register and BAF if applicable)	Failure effectively manage the Board agenda or consider matters pertinent to the Board. .
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.
Legislation / Regulatory requirements:	
Other key issues:	

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 30 June 2017

DESCRIPTION	OPEN	CLOSED	TYPE	SOURCE	DIRECTOR
Declaration of interests	✓	✓	Verbal	Matrix	All
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
DELIVERY FOR TODAY					
Quality & performance report	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Red risk 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
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
National patient survey report (if available)	✓		Written	Matrix	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
BUILD A JOINED-UP FUTURE					
e-Care report	✓		Written	Action point - schedule	CB
Financial improvement programme (FIP) report		✓	Written	Action point - schedule	CB
Estates strategy (following Scrutiny Committee)		✓	Written	Matrix	CB
Stroke option paper		✓	Written	Action point - schedule	HB
Scrutiny Committee report		✓	Written	Matrix	GN
Strategic update, including STP, ICO and TPP		✓	Written	Action point - schedule	SD
Community services – key decision point		✓	Written	Action point - schedule	NJ
GOVERNANCE					
Self- certification – general condition 6, continuity of service, FT4 and governor training	✓		Written	Matrix	SD
Trust Executive Group report	✓		Written	Matrix	SD
Council of Governors	✓		Written	Matrix	RQ
Audit Committee report	✓		Written	Matrix	ST
Confidential staffing matters		✓	Written	Matrix – by exception	JB
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