West Suffolk NHS
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 28 April 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 –	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 31 March 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** To accept the monthly Finance & Workforce report	Craig Black
10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
10.	**Aggregated quality report (attached)** To accept the aggregated analysis including serious incidents, red complaints and PALs enquiries	Rowan Procter / Nick Jenkins
11.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter
12.	**Mandatory training report (attached)** To approve report	Jan Bloomfield
13.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield

14.	**Nursing strategy update (attached)** To approve report	Rowan Procter
15.	**Guardian report (attached)** To receive the report *(Sarah Gull to attend at 11:00)*	Nick Jenkins / Sarah Gull
11:10 BUILD A JOINED-UP FUTURE		
16.	**e-Care report (verbal)** To receive an update report	Craig Black
11:20 GOVERNANCE		
17.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
18.	**Quality & Risk Committee report (attached)** To receive the report	Roger Quince
19.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:20 ITEMS FOR INFORMATION		
20.	**Any other business** To consider any matters which, in the opinion of the Chairman, should be considered as a matter of urgency	Roger Quince
21.	**Date of next meeting** To note that the next meeting will be held on Friday, 26 May 2017 at 9:15 am in the Committee Room.	Roger Quince
RESOLUTION TO MOVE TO CLOSED SESSION		
22.	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
Item 5

West Suffolk NHS
NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 31 MARCH 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	•	
Jon Green	Executive Chief Operating Officer		•
Neville Hounsome	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Gary Norgate	Non Executive Director	•	
Rowan Procter	Executive Chief Nurse	•	
Steven Turpie	Non Executive Director		•
Rosie Varley	Non Executive Director	•	
In attendance			
Ali Bailey	Head of Communications		
Georgina Holmes	FT Office Manager *(minutes)*		
Richard Jones	Trust Secretary		

Action

GENERAL BUSINESS

17/53 APOLOGIES FOR ABSENCE

Apologies for absence were noted above.

The Chairman welcomed Helen Beck to her first Board meeting as Interim Chief Operating Officer. He also welcomed Georgie Goodman, Head of Workforce of Queen Elizabeth Hospital, Kings Lynn, Governors and members of the public.

17/54 QUESTIONS FROM THE PUBLIC

- Joe Pajak noted that orthodontic and oral surgery referrals were no longer being accepted at WSFT. He asked about the implication of this for patients and where information about this service could be found, as there was concern in the community. Helen Beck confirmed that these services would no longer be delivered at WSFT, but explained that patients already in the system would be treated at and cover would be provided until September. The Trust was currently working with NHS England on alternative pathways for patients.

  Nick Jenkins explained that he had spoken to the Medical Director at Papworth, which took referrals from a large number of places who did not provide this service in-house. It was hoped to find a community dental provider who could visit the hospital occasionally, if not patients might have to go to Addenbrooke's prior to going to Papworth, however this was unlikely to happen more than two or three times a year.

  Craig Black explained that this was a very unsatisfactory service that had been delivered at WSFT. Orthodontics did not need to be delivered in an acute hospital and WSFT was not willing to continue to provide a service that could not be

delivered to the quality standard expected.

- June Carpenter asked about the current situation with norovirus in the hospital. It was explained that this would be discussed later in the meeting.

- Liz Steele reported that she had attended the STP event on Wednesday. She asked for assurance that all NEDs were up to speed on this, as they needed to be aware of representation on Boards, panels etc. The Chairman explained that he sat on the STP Chairs' group and Executive Directors represented the member organisations on panels etc. The STP had no statutory rights and was meant to be a planning body. Unless those who had to implement ideas were in agreement this could not happen.

  R Jones / R Quince

  The Chief Executive proposed that there should be a joint Board/CoG workshop on the STP.

- Joe Pajak referred to the NHS England list of 32 high risk systems relating to delayed transfers of care (DTOCs). He understood that WSFT was on this list and asked about the implications and how this was being managed. Craig Black explained that the system was under significant pressure to do something around DTOCs; WSFT's performance was 4.9% versus a target of 3%. The County Council had just received £10.4m in the budget and it was expected that this money would be used to reduce the numbers of DTOCs in acute systems across the country.

  The establishment of Glastonbury Court meant that these patients were not counted as DTOCs; therefore WSFT's position was worse than shown.

  The Chief Executive explained that the Trust was looking at implementing the five 'Q's, an initiative from Kings Lynn, to assist with speedy discharge and reduce DTOCs.

17/55 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

17/56 DECLARATION OF INTERESTS

There were no declarations of interest.

17/57 MINUTES OF THE MEETING HELD ON 3 MARCH 2017

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

Rowan Procter referred to Item 17/31 (page 53), Ref 1369, and explained that she had written a letter to the Director of Children's Services and was working with them to address.

Rosie Varley referred to Item 17/36, (page 9 & 10), and was concerned that the actions around these were not being fully addressed. (Referred to under ongoing action point 1331).

17/58 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 – Rosie Varley asked for assurance that this referred to all the issues raised in the minute of the meeting from 3 March 2017, Item 17/36 (page 9 and 10).

She stressed the need to have a proper look at support provided to patients in the community after the initial six weeks following discharge from hospital. She referred to the final paragraph on page 9 and requested that the Chief Executive should write to the CCG about this. She also referred to the first paragraph on page 10 and requested that consultants should take some responsibility to ensure that patients would receive sufficient and ongoing support following discharge.

The Chief Executive confirmed that this would be followed up. **H Beck / Nick Jenkins**

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

Ref 1387 – update the CQC action plan to reflect the position re wardable patients and RTT performance. The Chairman requested that this item should remain open as the actions were ongoing. **R Jones**

17/59 CHIEF EXECUTIVE'S REPORT

The Chief Executive highlighted the following:-

- Regrettably there had been a further never event. This would be discussed in further detail in the closed session of the Board meeting,

- The Trust had been under a lot of pressure during February but staff had worked very hard to and performance had improved.

- The Trust would achieve its control total through non-recurrent means, although it would have been preferable to achieve this through recurrent means. He commended Craig Black and his team for all their work on this.

- The national stroke audit had shown WSFT to be the sixth best in the country.

- The results of the Staff Survey had shown WSFT to be best in the country for staff engagement and best in the region for the place to work. There had also been significant process on bullying and harassment.

- The MHRA had undertaken a re-inspection and there were still ongoing serious and significant issues with the blood transfusion service. The Trust was having regular conversations with MHRA and Rowan Procter had been focussing on this. A great deal of work was being done to resolve the issues.

  Gary Norgate commended Rowan Procter for this work. He asked what governance had been put in place to ensure that this type of situation did not occur again. Craig Black explained that the weakness had been the separation of clinical leadership from the lab. The new governance structure was heavily focussed on clinical leadership and the three Medical Directors would sit on the Clinical Board and there would be clinical speciality leads with a role across the three organisations. They were also trying to join up all sectors of staff.

  Rowan Procter explained that they were now using WSFT's clinical incident reporting system so that the Trust had full view of any issues occurring in the lab.

Neville Hounsome asked if 'go green' was being used across all the Trust's locations. It was confirmed that it was being used across the whole Trust, including Glastonbury Court and Newmarket.

Richard Davies noted that 'flow' was already showing benefits; he said that it was important that this was fed back to consultants and other relevant staff. The Chief Executive assured him that information was fed back through the Green Sheet and other medium.

Nick Jenkins referred to the recent never event. He understood that there had been NED involvement in previous review processes and said that he would like this to be ongoing, so that there would be NED involvement whenever there was a never event. Richard Davies volunteered to be the NED representative for the current review. **R Procter**

Rosie Varley asked how WSFT benchmarked against other organisations of the same size for never events. The Chairman said that this would require a considerable amount of data as these were fairly rare. He stressed that never events should not occur regardless of how the Trust benchmarked against other organisations.

Nick Jenkins considered that some assurance could be gained from the fact that the same issues were not recurring with never events.

DELIVER FOR TODAY

17/60 QUALITY & PERFORMANCE REPORT

It was noted that some areas of performance had dipped in February but quality remained good and there were no major issues.

The Chairman asked Rowan Procter if there were any areas or issues that she was concerned about. She explained that norovirus had been a significant issue since November. Nationally this only had to be reported when a whole ward was closed. However WSFT had to close a ward more quickly than other hospitals as it did not have doors on bays. If a ward was closed it could no longer take admissions and could not discharge patients to residential or nursing homes, but patients could go back to their own home.

When a ward was closed due to norovirus it had to remain closed for 72 hours after the last symptom. It then had to be deep cleaned prior to reopening to admissions. Last week there had been 20 empty beds on G4. Currently there was one bay closed on G3 and one on F7; all other wards were open. The Trust had been working with the CCG who had looked at this but could not come up with anything. Dr Debra Adams, Head of Infection Prevention and Control, Midlands and East NHSI, was coming in in May to look around and see if she had any suggestions. WSFT was not an outlier compared to other hospitals who had also had wards closed due to norovirus.

Nick Jenkins explained that this was the worst strain of norovirus and was particularly virile, with a 50% attack rate. It was very infectious and despite all efforts would spread. He stressed that norovirus was not necessarily about staff carelessness. Rowan Procter explained that in one instance it had been brought into one of the wards by a relative who was visiting and this had then spread.

A presentation had been given to Corporate Managers on Monday and an email had been sent out reminding staff about dress code, eg bare below the elbows etc. Colour coding of aprons had also been introduced to try to restrict cross-contamination.

The Chief Executive asked about the effectiveness of nursing staff and doctors wearing masks. Helen Beck said that this might help slightly but they very quickly became no longer effective. Nick Jenkins agreed and said that if it was considered that these

worked Public Health England would have advised organisations to use them.

With regard to looked after children, a by patient breakdown was now being sent to the local authority on the lack of information and also on attendance at initial health assessments. As part of the new way of working there was now a specific work stream for looked after children and this would be the first project to show how integration could work.

Neville Hounsome referred to 1.5, Hand Hygiene Compliance, and asked for assurance that was the first offence for this individual. It was confirmed that this was the case and it had not happened again.

Rowan Procter reported that monthly spot checks were being undertaken for VTE and the latest audit was 90% versus a target of 98%, therefore there was further work to be done around this.

A task and finish group had been set up on documentation and templates on e-Care. She explained that nutrition could be recorded in a number of different ways which could have an impact on scoring. This was going to be looked at in a different way and would be helped by the new observation measures that were being introduced and would mean that everything would be recorded in the same way.

Rosie Varley said that she was concerned that nutrition assessment figures were still not improving. Rowan Procter explained that a recent audit had shown an improvement but how this was recorded on e-Care did not show this. One of the issues was that some patients could not be weighed due to scales being broken and this was being rectified.

Helen Beck reported that A&E performance for the current month was at 92.82%, and this week it was at 90.31%. Recently F7 had been affected by norovirus, which had impacted on through flow. She considered that this was a good performance, as there had been a number of closed wards and also a high number of admissions.

Nick Jenkins reported that yesterday 100% of non-admissions went home within four hours of arrival. However, not all patients got to the beds they were being admitted to within four hours of arrival.

Gary Norgate referred to duty of candour and noted that there were still four patients. Rowan Procter confirmed that these were different patients to last month and that this was being progressed and an improvement should be seen next month.

Neville Hounsome referred to maternity completion of the WHO checklist and asked if the expectation was for 100% compliance, in which case 87% was very poor. Rowan Procter confirmed that this was the case; this was being looked into and further detail of performance and remedial action which would be provided.

The Chief Executive noted that it was a significant step forward for the Board to receive this level of detail. Neville Hounsome also noted the improved narrative on falls and pressure ulcers.

Jan Bloomfield referred to the sickness absence rate which had increased this month. However, she was reassured that the team was monitoring all staff with a Bradford factor over 100. The next staff survey would ask questions about return to work interviews.

Since August last year 19 staff had voluntarily resigned as a result of more focus on sickness absence; eight had taken ill health retirement; two had been dismissed following a final attendance hearing and another six had left before their final hearing. She explained that this might account for some of the staff turnover and also highlighted the focus on sickness absence.

17/61 FINANCE AND WORKFORCE REPORT

It was noted that this was reporting the month 11 position and February which had improved compared to previous months. The report reflects the Trust achieving the stretch CIP through non-recurring means and therefore forecasting to achieve the control total and receive the majority of the Sustainability and Transformation funding. This was being done through non-recurrent adjustments for the cost of equipment in the community and would give a one off benefit that would allow it to hit its control total. The reason for this was to bring extra cash into the Trust and health economy.

The cash position remained a real concern and the Trust was struggling to pay its suppliers. The key focus of cash management was to pay salaries, which meant that there was not enough cash to pay suppliers as quickly as it would like. This was a national issue and a team of people were spending their time on the telephone to suppliers who were chasing for payment.

The Trust had been having discussions with NHSI about its control total for next year. The Board would need to decide whether to accept the revised control total, which was £3.4m less than previously. This would result in the organisation returning a deficit of £5.9m, after receiving £5.2m in S&T funding.

The report recommended accepting the control total which would require a CIP of £13.3m. This was 5.1% of turnover which was more than the organisation had ever delivered before. Currently £11.3m CIPs had been identified; therefore there was still a gap of £2m.

This year the Trust had incurred costs of £2m for Glastonbury Court, as it was considered that this was the right thing to do and provided WSFT with a significant amount of resilience. Discussions were currently taking place with the CCG around the funding of Glastonbury Court and these may also encompass the County Council, as Glastonbury Court helped to reduce the number of DTOCs.

However, the organisation needed to be striving to recurrently deliver £13.3m of CIPs, whether or not it received funding for Glastonbury Court. There was a rolling programme of CIP development and the Trust would continue to look for schemes to achieve or exceed to the control total.

Neville Hounsome referred to the £11.3m of CIPs that had been identified to date and asked the executive team how confident they were of delivering these at this stage. Rowan Procter said that she considered that these should be achievable, when she had looked at the quality impact.

Helen Beck said that from an operational point of view the General Managers were fairly confident about what had been identified so far. She was currently having conversations with them about the gap and how this could be delivered. She was also working with the Head of PMO to align the divisional and corporate schemes to ensure there was no double counting or no opportunities were being missed. She considered that there was a risk around the gap but she was fairly confident about the £11.3m.

Jan Bloomfield said that this was about making sure that time was set aside for focussed bandwidth in order to deliver these. Craig Black said that there was strong focus within the organisation and a Head of Performance was being brought in and support was being provided by NHSI as part of WSFT's application to be a member of the Financial Improvement Programme.

Nick Jenkins agreed with Rowan Procter and Jan Bloomfield; the schemes looked achievable but the challenge was around bandwidth. However, there was a slight concern around phasing and progressing these quickly enough. Craig Black explained that only half of the full year effect was included in the report.

The Chief Executive agreed that 5.1% CIPs would be a significant challenge for the organisation. He said that the focus must be on maintaining a sustainable hospital and an improvement in efficiency. Changes being made in the organisation should enable greater focus on this.

Craig Black explained that the capital plan (page 14) reflected what the Board had seen previously and was a five year programme. The earlier years were more reliable and the schemes for later years had not yet been identified. However, the fundamental issue was around affordability as the cash position funded the capital programme.

Gary Norgate referred to the significant improvement in agency expenditure since October and asked how this had been achieved whilst maintaining quality. Craig Black explained that there had been a national focus on reducing agency costs. WSFT had been playing its part in this and the approval process that this had to go through. Rates were reducing nationally due to the cap, and compliance with this was steadily increasing. This performance was being replicated across the country which highlighted that when the NHS decided to work in a unified way benefits would be seen.

Jan Bloomfield referred to medicine, which had not performed as well as it had not been possible to hold the cap. Of more concern was that it was not always possible to employ agency staff, which could be a risk around safety. She explained that from 1 April 2017, the intention was that staff with a substantive contract could not work for an agency in another organisation. However, the Royal College of Nursing was challenging this as it was not enforceable.

Gary Norgate asked about additional sessions and the efficiency of these. Craig Black explained that this was detailed on page 8, however it was hoped to provide more information following the appointment of the Director of Performance, as more work would be done around this. Nick Jenkins explained that further work had already started and he and Helen Beck were working on this. It was hoped that further information would be available in the June Board papers (May performance).

The Board agreed the financial plan including the associated cash flow and borrowing requirements. The final amount of borrowing would reduce if the control total and associated Sustainability and Transformation Funding was achieved. The arrangements for borrowing remained as previously agreed with authority to draw down loan finance being delegated to one of the following:-

Craig Black, Director of Resources
Stephen Dunn, Chief Executive Officer
Jon Green, Director of Operations

The administration of the loan drawdowns would be completed by the Assistant Director of Finance and the Board accepted the need to comply with Terms and Conditions imposed by the Department of Health for this borrowing.

The Board approved the budget, CIP and control total for 2017/18. It also approved the Capital Plan for 2017/18.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/62 AGGREGATED QUALITY REPORT

The Chief Executive noted that car parking continued to be an issue with patient experience. Jan Bloomfield explained that an annual report on car parking would be produced. Recently positive feedback had been received from staff on being able to find a parking space easily.

Gary Norgate noted that there had been eight medication errors due to high vacancies and asked if there was plan to address this. Rowan Procter explained that 50% of these errors involved agency staff and these individuals would not be working in the Trust again.

17/63 NURSE STAFFING REPORT

The Chairman noted the high sickness rates on wards. Rowan Procter explained that this was likely to be due to ongoing pressures and staff being affected by norovirus. This was being closely monitored and ward managers were being supported. Everything possible was being done to fill the vacancy factor; however it was noted that the fill rate was well over 80%, which was positive. It was sometimes easier to have a vacancy and use internal staff rather than fill with agency staff. A form was completed at the 3 o'clock bed meeting which showed staff being moved around the organisation and what could be approved at night. This information was emailed to Rowan Procter each day.

An area of concern around medication errors had been F3, but this was improving and vacancies were slowly being filled.

The Chairman asked if there was a mechanism for restricting the number of hours a nurse could work within a week across all sources of employment. Rowan Procter explained that it was only possible to restrict what was known about. If a member of staff went off sick they were not able to do bank work at WSFT for a period after they returned to work. However, they could do bank or agency work for another organisation. If there was a concern about the number of hours an individual was working their manager would discuss this with them.

Jan Bloomfield stressed that the most important issue was monitoring an individual's performance and ensuring they were healthy and well.

The Chief Executive proposed that the executive team should look at the additional hours nurses worked on bank and agency. Rowan Procter stressed that with the majority of staff this was not an issue and cautioned against overreacting to this and upsetting staff.

Richard Davies asked about WSFT's sickness rates compared with other Trusts. Rowan Procter said that the Trust's sickness rates were low compared to other Trusts and the average nurse sickness rate in the East of England was 14%.

It was confirmed that there were clear guidelines from Occupational Health on when nursing staff should not come to work.

17/64 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that Denise Combe, Education & Outreach Sister, Critical Care and Georgie and Kevin Brown, Resuscitation Team had received Putting Your First Awards this month. They had all been nominated by the Resuscitation Committee

Denise Combe was nominated for her hard work and dedication to the sepsis cause. Educating and updating staff on sepsis criteria, treatment and the timely recognition of sepsis. She has promoted the importance and relevance of sepsis trollies and shown motivation and fresh ideas, including coordination of World Sepsis Day last October,

Georgie and Kevin Brown were nominated for teaching school children which had been a key driver within the Resuscitation Council's agenda. They had worked tirelessly and with great passion to get this message and cardiopulmonary resuscitation training into the community, including visiting local schools in their own time to deliver lifesaving skills.

The Board congratulated Denise, Kevin and Georgie on their commitment and dedication to educating staff and children, which would benefit patients and the community.

17/65 EDUCATION REPORT

Rosie Varley asked about human factors training. She considered this to be very important; taking into account discussions around never events, and asked if any consideration had been given to human factors training across the Trust. The Chief Executive assured her that they would continue to look at every opportunity for improving quality across the organisation.

It was explained that the human factors programme was still work in progress and they were looking at what had been done at Colchester hospital and how this could be transferred and implemented at WSFT. The human factors programme needed to be evaluated and it also linked to leadership development.

Rowan Procter explained that the Nurse Associate role was being taken forward. A review band 4s was being undertaken, looking at where they would be best placed to work within the organisation and utilising them to their full potential. WSFT was looking at the University of Suffolk to start a training programme for this. WSFT had been unsuccessful in its bid to be a pilot and there were a very limited number of places in the country. Cambridge and Peterborough had been successful and had shared their business case and learning with WSFT.

Rowan Procter explained that with regard to Continued Professional Development funding (CPD) she had been through the list and presented it to the Charitable Funds Committee to ascertain if any funding was available. Funding from different budgets was also being looked at, ie if a nursing role was taking the place of a junior doctor,

using the junior doctor budget.

Jan Bloomfield explained that there would still be CPD money available but this would be STP managed rather than held by local Trusts.

Richard Davies reported that the Government had announced an increase in placements for medical students in the UK. There would be an additional 1500 places and the first 500 of these allocated to medical schools across the country.

Cambridge had been allocated another 21 medical students to join a course in 2018 and it was considered that it would be a good idea to allocate these students to the graduate course, which would benefit WSFT. Craig Black explained that they key issue was accommodation but the plan was for the residences to be opened in August 2018, which would be in time for the students starting in September.

The Chief Executive said that WSFT was extremely pleased about this and considered it to be major coup.

17/66 CONSULTANT APPOINTMENT REPORT

The Board noted the appointment of the following Dr Nadim Sheikh, Consultant in Gastroenterology.

Jan Bloomfield reported that this was considered to have been a very good interview and an excellent candidate.

17/67 NHS STAFF SURVEY

It was agreed that this was a very positive result, with WSFT being the top acute Trust in the country for engagement

Jan Bloomfield said that this continued to be an excellent marker for the CQC and future employees. The Trust's performance had improved for KF1, 'staff recommendation as a place to work or received treatment', and it was the best Trust in the East of England.

Although the report showed the WSFT's bottom five ranking scores as red, these should be amber or green, as the scores had improved, in particular KF22 'experiencing violence from patients'.

KF27, '% reporting most recent experience of harassment, bullying or abuse' had improved as a result of the launch of the Freedom to Speak Up campaign and working with mangers and staff. There had also been a number of high profile dismissals which it was hoped had given staff the confidence to come forward and report harassment or bullying.

The Chief Executive commended Jan Bloomfield for the Trust's performance, particularly KF27. It was agreed that this was a very good performance from the HR team and also managers across the organisation.

Rosie Varley asked about KF29 '% reporting errors, near misses or incidents witnessed in the last month' as this related to human factors and never events. Jan Bloomfield considered that staff had the confidence to report this and she did not know why this had deteriorated. The Chief Executive proposed focussing on this over the next twelve months, in a similar way that the focus had previously been on KF27. It was noted that

the national average for KF29 was 90% and WSFT was also 90%, however it should strive to be better than average.

BUILD A JOINED UP FUTURE

17/68 e-CARE REPORT

Craig Black explained that currently the focus on e-Care was Ordercomms go-live on 20/21 May.
A huge effort was required to co-ordinate this internally, as well as with Clinisys and TPP. A solution for the secretarial system was being worked on and it was hoped that this might also go-live 20/21 May.

There was an issue around no cash having being received by any of the GDE exemplars this year. Jeremy Hunt had said that he was in discussion with the Treasury and this was a matter of time. WSFT had formally committed its intention to partner Milton Keynes as a fast follower site.

Craig Black explained that the finance department was making an assumption that this money was accrued for the year, as WSFT had already spent the money it was due to receive.

Gary Norgate referred to the secretarial work around and confirmed that the Trust was not compromising on the future plan for e-Care moving responsibility for secretarial roles to the end user.

GOVERNANCE

17/69 TRUST EXECUTIVE GROUP REPORT

The Chief Executive reported that a great deal of work was being undertaken around RTT. There was also a focus on efficiency, with a forensic focus on performance, productivity and finance.

17/70 REMUNERATION COMMITTEE

The Board noted the content of this report.

17/71 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were approved.

ITEMS FOR INFORMATION

17/72 ANY OTHER BUSINESS

The Chairman explained that this was Rosie Varley's last Board meeting. He thanked her for everything she had done for the Trust in her role as a NED and said that she had been a great Board colleague and had been appreciated by NEDs, Executive Directors and Governors.

She had been the NED lead on the Patient Experience Committee and also played a leading role in safer surgery. In each case she had taken up the cause and been a very effective agent for change. As a Board member she had been a real champion for patients.

He wished her the best for the future and thanked her for everything that she had done.

Rosie Varley said that she had been associated with the hospital since 1984. Her family had been regular users of the hospital and were very grateful for all the care they had received. She had tried to use her experiences in a strategic way to improve services. She was particularly pleased to have spent the last six years of her working life in the NHS with WSFT.

She thanked her Board colleagues and wished everyone at the Trust all the best.

17/73 DATE OF NEXT MEETING

The next meeting would take place on Friday 28 April 2017 at 9.15am in the Committee Room.

RESOLUTION TO MOVE TO CLOSED SESSION

17/74 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 – 28 April 2017

AGENDA ITEM:	Item 6
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	21 April 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 in Mar '17 (revised). **Agreed at April meeting to discuss with CCG the provision of stroke services in the community as part of community services negotiations.**	HB	26/05/2017	Green
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. **Report scheduled for May meeting.**	NJ	26/05/2017	Green
1370	Open	27/1/17	Item 8	Confirm with new clinical director whether a trust paediatric strategy group is still required	The new clinical director is delighted to have NED support and will be in touch shortly with dates. **Email exchange to arrangement planning meeting.**	HB	03/03/2017	Green

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 and will be reported to the Board in May with the proposed arrangements for future CQC compliance monitoring and assurance	RP	26/05/2017	Green
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	Green
1393	Open	31/3/17	Item 2	Consider timing for an STP workshop with Board and Governors	Reviewing possible dates - provisionally 18 May.	RJ	26/05/2017	Green

Completed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1367	Open	27/1/17	Item 5	Terms of reference for Q&RC to be reviewed at its next meeting sand submitted to the Board	Scheduled for review in April. Provisional meeting dates for 2017 - 30 Jun, 29 Sept and 1 Dec. **AGENDA ITEM**	RJ	28/04/2017	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 Quality Report	NJ	28/04/2017	Complete

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28 April 2017

AGENDA ITEM:	Item 7
PRESENTED BY:	Steve Dunn, Chief Executive Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	21 April 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.

The **Red2Green campaign** continues at pace across the Trust with the team urging all board rounds to focus on the following five areas:

1. **Red reasons** – these are live on the whiteboard therefore each patient that is marked as red should have at least one reason ticked to explain why. This will help identify constraints for each ward, division and the Trust.
2. **Huddle** – the afternoon catch ups have really reduced. This is an opportunity for wards to evaluate where they are with the plans set out that morning. We are asking all wards to ensure they are carried out.
3. **Planned date of discharge (PDD)** – these are completed on e-Care, and are determined by what the patient presents to hospital with. If, following diagnosis, the treatment changes, this will be acknowledged.
4. **Clinical criteria for discharge (CCD)** – wards are on the whole completing a CCD. We must now concentrate on the quality of the criteria. A good simple example – repeat bloods, ECG and lying standing BP. If all OK home.
5. **Medically optimised** – tick on the whiteboard and the date the patient is expected to be medically optimised – can be done in advance and the date added.

The board rounds are driven by a multidisciplinary team which includes: the consultant – to lead; ward manager or nurse in charge; therapist; pharmacist; and social worker.

March's **performance pack** reflects improved operational performance for emergency flow - the Red2Green campaign has helped contribute to March performance which shows an improvement to 92.88%, compared to 83.9% in February. This position has been sustained and further improved in April allowing us to close the escalation ward (G9) earlier than initially planned. The draft 62 day cancer performance for February shows just below target at 83.56% however indications are that we will achieve the target of 85% due to reallocations to other trusts.

As I have previously indicated the launch of e-Care in May 2016 while very successful in terms of go-live had an expected impact on our ability to report performance against a number of quality standards. This included the **referral to treatment (18 week) standard**. During 2016/17 reporting against this standard has been based on estimates as we have been unable to accurately track activity at the patient level. We now have a functional patient tracking list (PTL) within e-Care and work is underway both manually and via automated scripts to address underlying data quality

issues. Working with our digital partner, Cerner, we have made significant progress to improve reporting and plan to have all aspects in operation by June 2017. The estimated incomplete referral to treatment (RTT) performance has been impacted by capacity issues in several services and it is extremely disappointing that a number of patients have waited over 52 weeks for treatment. With an effective PTL now in place we have put in place procedures to actively manage treatment plans to ensure these are expedited for patients with excessive waits.

The **month 12 financial position** reports a deficit of £4.3m for 2016-17 which is better than plan by £0.7m against our control total of £5.0m. The improvement in our financial position reflects the Trust achieving the stretch CIP through non-recurring means and therefore receiving the majority of the Sustainability and Transformation Funding (£5.7m for 2016-17) as well as financial incentive funding of £0.6m. The 2017-18 budgets include a CIP of £13.3m in order to deliver a control total of £11.1m deficit which has been agreed with NHSI. Delivering the control total will ensure the Trust receives Sustainability and Transformation Funding (S&TF) of £5.2m, resulting in a net deficit of £5.9m in 2017-18.

I am delighted that **national recognition has been given to our staff by the Secretary of State** for Health, Jeremy Hunt, for the Trust's exceptional performance. In the NHS staff survey results for 2016, WSFT emerged as the acute trust with the best performance engagement score throughout the whole of England. Rt Hon Jeremy Hunt MP said: "From visiting organisations throughout the country, I know the immense amount of day to day hard work that will have been behind this outcome cannot be underestimated. It is greatly appreciated, not just by me, but by all your patients that will be benefiting as a result … Please pass on my personal congratulations and thanks to everyone who has made this happen." A copy of the letter is attached.

Well done to all our staff on receiving this recognition. They make our hospital a great place to work and deliver outstanding outcomes for our patients. We are not perfect. We don't always get it right. It sometimes is tough. But our staff do go the extra mile and do deliver, as Jeremy Hunt acknowledges, exceptional performance. This is down to the commitment of all our staff, Doctors, Nurses, Allied Health Professionals, Porters, Estates, Housekeeping, IT, Finance, HR, as well as volunteers who help make our hospital an outstanding place to work. It is a privilege to work with such great people. We must not become complacent, however, because there are areas where we know we can do better, but what a great achievement. I have encouraged staff to keep on contributing their ideas about how we can improve and we need to build on this foundation.

I am pleased to confirm that **e-Care OrderComms** will go live over the weekend of 20/21 May 2017. From this point we will order pathology from e-Care. We had originally hoped to go live at the beginning of April but have had some testing issues to resolve which are now in hand. Over the next few weeks we will give detailed information on how we will run the go-live weekend. We will have floorwalker support across all areas during the first few days of go-live and we are not anticipating any significant disruption to services. A key focus in the coming weeks is to make sure that staff are trained for OrderComms launch.

During April the executive team had a further meeting with the **Medicine Healthcare Regulatory Authority (MHRA)** following unannounced inspection of the blood transfusion service operated within the hospital by the pathology partnership (tPP). The inspection team were keen to see how much progress had been made since their last visit. Progress and future plans to mitigate concerns were reviewed in a contracture meeting.

The plans to restructure **the pathology partnership (tPP),** formally announced in late February, continue. Based on several months of work to develop the new approach a new model for the partnership has been agreed which means that from May services in the east of the partnership (West Suffolk, Colchester and Ipswich Hospitals) will be managed locally as a stand-alone network, with the hub laboratory remaining at Ipswich Hospital and Colchester Hospital University NHS Foundation Trust acting as host. The East Pathology Services will be clinically led by four specialty clinical leads in each of the four service areas: Cellular Pathology; Chemistry; Haematology & Blood Transfusion' and Microbiology.

The Department of Health has published the Government's **mandate to NHS England for 2017-18**. This mandate to NHS England sets out the government's objectives for NHS England, as well as its

budget. It sets out plans to ensure that NHS England delivers the best care and support to NHS patients, but also continues to deliver the reform and renewal needed to sustain the NHS for the future. The seven objectives set out in the mandate are:

1. Through better commissioning, improve local and national health outcomes, and reduce health inequalities
2. To help create the safest, highest quality health and care service
3. To balance the NHS budget and improve efficiency and productivity
4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.
5. To maintain and improve performance against core standards
6. To improve out-of-hospital care
7. To support research, innovation and growth

Chief Executive blog
http://staff.wsha.local/Blog/Sisforsupportingourstaff.aspx

DELIVER FOR TODAY

High performing stroke services at West Suffolk Hospital
Stroke services at West Suffolk NHS Foundation Trust continue to improve according to the latest Sentinel Stroke National Audit Programme (SSNAP) scores, with the Trust rated joint 6th nationally out of 144 trusts routinely admitting stroke patients in England and Wales. This story was well received and featured across BBC Radio Suffolk news bulletins and in local print media.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Nursing agency ban
The EADT ran a story about nationwide plans to restrict nurses on substantive NHS contracts from taking agency work that were put "on pause", following a backlash in the profession. NHS Improvement's proposals were intended to reduce the millions of pounds spent by hospitals on agency fees at a time of financial pressures; however, nurses said it would leave them struggling to make ends meet. West Suffolk Hospital said it would consult with staff emphasising that as a trust we want to spend our money wisely and try to ensure we have permanent nursing staff to fill posts, avoiding the use of costly agency staff where possible. However, patient care is our priority and if agency staff are needed to ensure a high quality service we will use them. It is important that all staff are consulted on plans such as those proposed by NHS Improvement and we would have had an extensive consultation process before implementing any changes to our workforce.

Shining Lights staff awards
The deadline for entries is now closed for our annual staff awards, Shining Lights. We received 229 nominations, and 51 individuals/teams have been shortlisted. The awards event will be held on 11 May 2017. This year the awards have been adapted with a range of new categories.

Facelift for Newmarket restaurant
The restaurant at Newmarket Community Hospital will be closed for refurbishment from Wednesday 26 April, reopening as a café on Wednesday 3 May. During this time staff will be able to order food by phone from the catering department. We look forward to welcoming you to the new White Lodge Café.

BUILD A JOINED-UP FUTURE

Suffolk people return vital NHS and social care equipment
The Return Recycle Reuse campaign aimed at encouraging people in Suffolk to hand back items of community equipment they no longer require has been a huge success. The month-long amnesty led to the return of more than 8,500 items, ranging from crutches and commodes to adjustable wheeled frames and air mattresses. It proved so successful that the waste-busting work is now being extended in the hope of retrieving even more discarded equipment. The campaign, which was

launched on March 1, triggered a 10 per cent increase in the number of items returned to local NHS services compared to the previous month. It unearthed a small mountain of items with an estimated value of more than £800,000 and everything collected will either be sterilised and re-used or recycled if it's beyond repair. Alongside Medequip sites, Suffolk County Council can now take collection of community equipment items at three of its household waste recycling centres at Bury, Foxhall and Lowestoft.

Ageing well in Suffolk
The Trust was included in an EADT feature about health in older age in Suffolk – which highlighted concerns about the risks posed by this stage of life being so great that doctors actively target people approaching retirement to advise them on "Ageing Well". Our teams are redesigning services for people with multiple long-term conditions with our community services are leading the way in developing early intervention services that identify and support patients who are at risk of coming into hospital. We work with mental health professionals, social workers, therapists and hospital consultants to manage treatments in the home wherever possible. Studies showing that ten days in hospital is the equivalent of ten years' worth of ageing for over 80s show the importance in the coming decades of changing the way we view and support our ageing population to ensure that people in Suffolk, as the saying goes, add life to their years as well as years to their life. GP, CCG and Suffolk County Council services are also included in this work.

NATIONAL NEWS

DELIVER FOR TODAY

All emergency departments must have GP led triage by October
Every hospital in England must have a "comprehensive" GP led triage system in emergency departments by October 2017 in a bid to avoid a repeat of the winter crisis that gripped the service this year. (BMJ Current, March 2017)

Patients first: improving patients' food and drink experience through a better understanding of their priorities
This report covers a large-scale, independent survey of patients' preferences and experiences of hospital meals. Food providers should work to satisfy the top three patient priorities for meal experience, namely Taste, Choice andTemperature and to fulfil the needs and priorities of groups of patients who are currently less satisfied.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Latest data on reported patient safety incidents
The data shows a further increase in reported numbers of incidents as the NHS continues to foster a greater culture of openness and transparency. Better reporting helps to identify safety concerns and supports organisations to improve safety.

Do hospitals respond to rivals' quality and efficiency? a spatial econometrics approach
Do hospitals in the NHS increase their quality (mortality, emergency readmissions, patient reported outcome, and patient satisfaction) or efficiency (bed occupancy rate, cancelled operations, and cost indicators) in response to an increase in quality or efficiency of neighbouring hospitals? This study concludes that hospitals generally do not respond to neighbours' quality and efficiency. This suggests the absence of spillovers across hospitals in quality and efficiency dimensions and has policy implications, for example, in relation to allowing hospital mergers.

A year of plenty? An analysis of NHS finances and consultant productivity
This report finds that the NHS used almost half of the £2bn real terms increase in funding it received in 2015-16 to commission care form non-NHS organisations and to support the social care system. The report also highlights that the focus on meeting rising demands for emergency care means that NHS hospitals are receiving lower financial returns which is making it increasingly difficult for NHS trusts to break even. (The Health Foundation, March 2017)

Mobility Communication Charts
How do you provide the multi-disciplinary team a clear, at-a-glance guide to see the mobility status of the patient at all times? Susan Walters, Senior Specialist Physiotherapist at South Tees Hospitals NHS Foundation Trust looked at the usefulness of having a permanent, documented, easy to view/read method of communication positioned at the patient's bedside. This could be viewed at any time of the day by any member of the ward team, family and visitors, which would communicate, up to date current levels of achievement regarding their mobility status from the patient's last physiotherapy treatment session. It would show the walking aid used, the distance mobilised and the staff assistance required for the patient to mobilise safely. The type of walking aid required is colour-coded so this is clear from a distance as a member of staff walks towards the patient. (Patients Association)

How WiFi in hospitals can help improve health of the elderly
Gavin Wheeldon, chief executive of Purple, reveals how The Queen Elizabeth Hospital in King's Lynn has seen impressive results from implementing WiFi. (Building Better Healthcare, March 2017)

CCGs launch innovative online services for elderly patients
Under the initiative which is called the 'Making Technology Enabled Care Services (TECS) a Reality in Elderly Care' scheme, selected GP practices and nursing and residential homes in the region will use portable tablets loaded with audio visual programmes, the CCGs' Florence telehealth system, health management apps and video consultation technology, linking them with an extended network of primary care, mental health and palliative care staff, community pharmacists and geriatricians. Dr Anil Sonnathi, GP and clinical lead for the project, added: "This initiative will allow bedside-based and 'at-the-point-of-care' consultations with remote clinicians and extended care teams to take place. "Implementation will allow for the establishment of 'virtual wards' under the care of geriatricians working closely with the GP, saving valuable clinic time and improving health outcomes for patients."

NHS women on boards: 50:50 by 2020
This report examines the steps the NHS needs to take to reach the target of equal gender representation on boards by 2020. It summarises demographic data from 452 organisations, including arms-length bodies, NHS trusts and clinical commissioning groups. It has been published in conjunction with NHS Employers and NHS Improvement. (NHS Employers, March 2017)

Integration and the development of the workforce
This working paper reveals how integration of the fields of health and social care will require organisations to break down traditional barriers in how care is provided. It details how workforce development plays a crucial role in successful integration. (Skills for Health, March 2017)

Integrated health and social care apprenticeship
Working with social care partners, Norfolk and Norwich University Hospitals NHS Foundation Trust developed an integrated apprenticeship designed to provide a broad understanding of the different roles and responsibilities that exist in both health and social care. (NHS Employers, March 2017)

BUILD A JOINED-UP FUTURE

The social care funding gap: implications for local health care reform
This briefing analyses information from STPs on the position of social care funding and estimates that the size of the funding gap will be at least £2bn in 2017/18. It draws on interviews from a range of STP leaders and argues that the social care funding gap has significant implications for STPs. (The Health Foundation, March 2017)

Social work: essential to integration
Explains the contribution social workers make and how to support local and regional health and social care integration initiatives. (DH, March 2017)

Community engagement: improving health and wellbeing
This quality standard covers community engagement approaches to improve health and wellbeing and reduce health inequalities, and initiatives to change behaviours that harm people's health. This includes building on the strengths and capabilities of communities, helping them to identify their

needs and working with them to design and deliver initiatives and improve equity. NICE Quality Standard [QS148] March 2017

Understanding NHS financial pressures: how are they affecting patient care?
This report finds that access to and quality of, care are both being affected in different ways across the NHS. While public attention tends to focus on high-profile examples of rationing such as restricting access to some types of treatment, the report warns that financial and other pressures are also affecting patient care in ways that go unseen. (The King's Fund, March 2017)

How should the NHS be funded?
With the NHS under huge financial pressure, questions are being raised about the sustainability of its funding model. The King's Fund pulls together a range of content around the NHS funding debate, including an explanation of the main ways that health care is funded around the world, analysis of some of the main claims made about the NHS, and essential facts and figures. (The King's Fund, March 2017)

Back-office efficiencies could save over £400m a year
Improving the efficiency of NHS corporate services costs could save the health service over £400m in the next three years if all trusts performed as well as the average, NHS Improvement (NHSI) has claimed. By looking into corporate support activities, which are responsible for services like finance, information management and technology (IMT), and legal and HR within the NHS, the organisation was able to see that crucial savings could be delivered if these services were run more smoothly. (NHS Executive, March 2017)

NHS Efficiency Map
The HFMA and NHS Improvement have worked in partnership to update and revise the NHS efficiency map. The map is a tool that promotes best practice in identifying, delivering and monitoring cost improvement programmes in the NHS. The map contains links to a range of tools and guidance to help NHS bodies improve their efficiency. Healthcare Financial Management Association [HFMA], updated March 2017)

Attachment – copy of letter from Jeremy Hunt, Secretary of State for Health

Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

020 7210 4850

RECEIVED
30 MAR 2017

Dr Stephen Dunn, Chief Executive Officer
Roger Quince, Chairman
West Suffolk NHS Foundation Trust
Hardwick Lane,
Bury
Saint Edmunds
IP33 2QZ

24 MAR 2017

Dear Stephen and Roger,

I am writing to congratulate you and your team on the exceptional performance at West Suffolk NHS Foundation Trust that has come together to mean that you were the Acute Trust with the best performance in the NHS Staff Survey Engagement Score across the whole of England during 2016.

From visiting organisations throughout the country, I know that the immense amount of day to day hard work that will have been behind this outcome cannot be underestimated. It is greatly appreciated, not just by me, but by all your patients that will be benefitting as a result.

It should be particularly pleasing to you to have achieved a score of 3.98 with more colleagues, collectively, recommending your organisation as a place to work and be cared for, motivated and contributing to making things even better.

Please pass on my personal congratulations and thanks to everyone who has made this happen.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28th April 2017

AGENDA ITEM:	Item 8
PRESENTED BY:	ROWAN PROCTER, EXECUTIVE CHIEF NURSE
PREPARED BY:	ROWAN PROCTER, EXECUTIVE CHIEF NURSE
DATE PREPARED:	21 APRIL 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 1 C Diff (0 in February). Falls for the month were 71 (55 in February and 4 pressure ulcers (10 in February) - pages 6-7.
- RCA actions overdue are 8 - page 10
- Overdue Duty of Candour are six – page 10
- ED performance continues to improve with a March performance of 92.88% against the 95% target - page 23
- Stroke failed only two measures this month - page 27
- Looked after children performance: 11 out of 12 initial health appointments were offered within 28 days of being notified with eight being accepted - page 35

This month's performance pack reflects RTT issues which have been identified with the new PTL from e-Care. This PTL contains a significant caveat due to data quality issues which are being worked through both manually and via a series of automated scripts. As a result of the previous PTL issues we have now identified a number of 52-week breaches which are being proactively managed and will be treated as quickly as possible.

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	Jan	Feb	Mar
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	100	95	100
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	98	99	98
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	93	98	95
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 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	95	82
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<85	85-99	= 100	NA	NA	100
Total no of MRSA bacteraemias: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	0
Total no of MRSA bacteraemias: Community acquired (Trust level only)	No Target	No Target	No Target	No Target	0	0	ND
Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	NA	NA	91
MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	93	90	ND
MRSA Elective screening (Trust level only)	= 100%	<80	80-99	= 100	ND	ND	ND
MRSA Emergency screening (Trust level only)	= 100%	<80	80-99	= 100	ND	ND	ND
Hand hygiene compliance	= 95%	<85	85-99	= 100	99	99	100
Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	1	0	ND
Quarterly Standard principle compliance	90%	<80	80-90%	90-100	NA	NA	95
Total no of C. diff infections: Hospital	= 16 per yr	No Target	No Target	No Target	0	0	1
Total no of C.diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	3	0	ND
Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	NA	NA	93
Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	19	9	ND
Isolation data (Trust level only)	= 95%	<85	85-94	95-100	90	90	ND
Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	NA	NA	91
Quarterly VIP score documentation	= 90%	<80	80-89	90-100	NA	NA	79
MEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	ND	ND	ND
PEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	100	100	100
No of patient falls	= 48	>=48	No Target	<48	61	55	71
Falls per 1,000 bed days (Trust and Divisional levels only)	= 5.6	>5.8	5.6-5.8	<5.6	ND	ND	ND
No of patient falls resulting in harm	No Target	No Target	No Target	No Target	11	14	16
No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	ND	ND
Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	ND	ND	ND
No of patients with ward acquired pressure ulcers	< 5	>=5	No Target	<5	22	10	4
No of patients with avoidable ward acquired pressure ulcers	= 0	>0	No Target	= 0	3	3	0
Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	83.85	83.11	90
No of SIRIs	No Target	No Target	No Target	No Target	16	7	8
No of medication errors	No Target	No Target	No Target	No Target	51	54	60
Cardiac arrests	No Target	No Target	No Target	No Target	3	8	13
Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	1	1	0
Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	68	NA	NA
VTE: Completed risk assessment (monthly Unify audit)	> 98%	< 98	No Target	> 98	ND	ND	ND
Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	NA	NA	95
Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	96.69	98.43	98.19
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4	9	9	8
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC	69	64	60
Median NRLS upload	26days	>48	27-47	0-26	50	64	53
SIRIs reported > 2 working days from identification as red	0	>1	1	0	0	0	2
SIRI final reports due in month submitted beyond 60 working days	0	>1	1	0	0	0	0
Number of SIRI reports open on STEIS more than 60 days after initial notification – Total	No Target	No Target	No Target	No Target	0	0	3
Number of SIRI reports open on STEIS more than 60 days after initial notification– Sitting with WSFT (excludes 'stop the clock')	0	>6	4-6	0-3	0	0	3

Indicator	Target	Red	Amber	Green	Jan	Feb	Mar
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
Non-compliance with Duty of Candour requirements	0	>3	1 - 3	0	0	2	4

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:

Please note March's audit data for *MEWS* is incomplete.

In addition data items *Falls per 1000 Beds days Falls with moderate/severe harm/death per 1000 bed days*, *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 tPP 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 2a: Peripheral cannula insertion

a) Current Position

A score of 98 in March was the same as 98 in February and was amber RAG rated for the third month in a row. This was based on one episode of non-compliance where Critical Care failed to document and insertion.

b) Recommended action

Clinical lead to remind medical staff to complete documentation following every insertion

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1.2 HII compliance 2b: Peripheral cannula ongoing

a) Current Position

A score of 95 in March was lower than 99 in February and was amber RAG rated for the 10th month in a row. This was based on 6 episodes of non-compliance where documentation of checks were incomplete

b) Recommended action

Support from ward manager and matron to ensure that all staff are aware of requirement for cannula ongoing care.

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

a) Current Position

A score of 82 in March was lower than 95 in February and was RAG-rated as red. This was based on 12 episodes of non-compliance. There were 11 episodes where catheter care was note recorded and 1 episode where the catheter bag was poorly positioned.

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.

1.4 Quarterly MRSA (including admission and length of stay screens)

a) Current Position

This quarter compliance has fallen slightly from 93% (Q3) to 91% (Q4).

b) Recommended action

The quarterly audit results are sent out to all clinical areas and disseminated to ensure staff are aware of this & change practice to improve compliance.

1.5 Quarterly Antibiotic Audit

a) Current Position

This quarter compliance has risen slightly from 92% (Q3) to 93% (Q4)..

b) Recommended action

The quarterly audit results are sent out to all clinical areas and disseminated to ensure staff are aware of this & change practice to improve compliance.

1.6 Quarterly VIP score documentation

a) Current Position

Fallen from 83% (Q3) to 79% (Q4).

b) Recommended action

The quarterly audit results are sent out to all clinical areas and disseminated to ensure staff are aware of this & change practice to improve compliance.

1.7 Nutrition: Assessment and monitoring

a) Current Position

A score of 90 in March was higher than 83.11 in February and has improved from red to amber RAG rated. The matrons' focus for March was Nutrition 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.

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.

1.8 Quarterly VTE: Prophylaxis compliance

a) Current Position

A score of 95% in Q4 is an improvement on 87% in Q3. There is an overall Trust improvement of 8% in high-risk patients receiving the required prophylaxis. The results for the divisions show weaknesses in the areas of; re-assessing VTE prophylaxis within 24 hours in the medical division (52%) high risk patients receiving appropriate prophylaxis in the surgical division (88%).

b) Recommended action

The results of the audit are shared with the divisions.

1.9 Total no of C. difficile infections: Hospital

a) Current Position

Performance against trajectory is as follows:

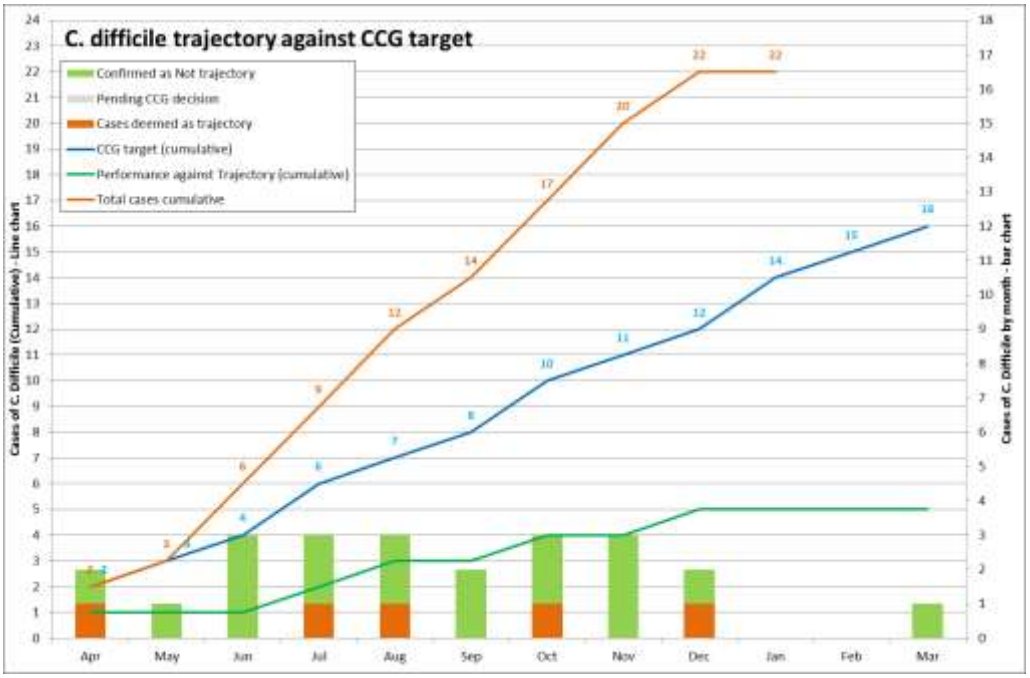
There was one case of hospital attributable CDT in March. At the end of March the Trust had reported a total of 23 reported cases against a final total of no more than 16 trajectory cases for 2016-2017.

Of the 23 cases; 18 have been deemed non trajectory by our commissioners (no lapses of care) whereby they will not accrue a penalty, there are five trajectory cases and none are pending.

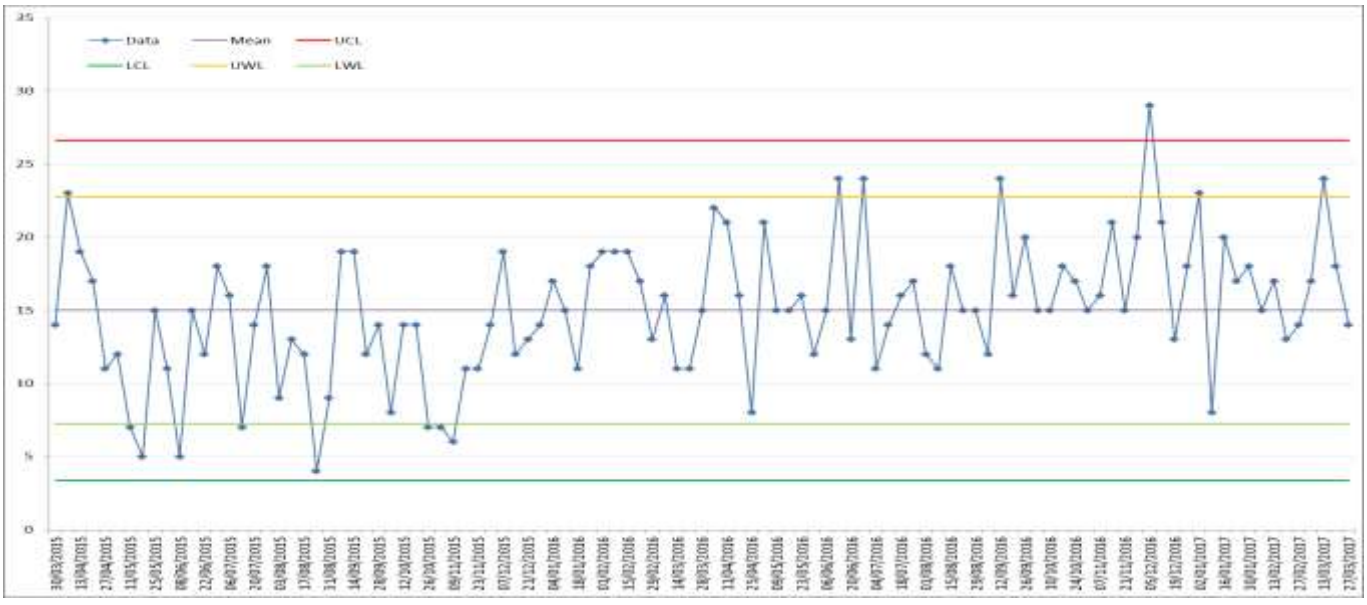
The graph below has been updated to demonstrate the Trust performance against the trajectory target set by the CCG.

b) Recommended Action

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



1.10 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. This related to 29 incidents and included one patient who fell four times and one who fell three times in that week.

There were 71 falls in March (55 in February), two with major harm both on G5, one fractured neck of femur and one head injury, no moderate harm

Two patients fell at Newmarket Hospital (4 in February). 6 patients fell at Glastonbury Court (none in February), these falls are reported separately.

Four patients were assisted to the floor (9 in February) preventing them from falling, three at Newmarket and one at Glastonbury Court.

G5 experienced 15 falls, of those one patient fell three time and one patient fell twice, two patients sustained major harm, one has since died.

Nine falls occurred between the 4th and the 16th of the month, six falls occurred in between the 24th and the 28th of the month, further analysis is underway to identify any themes or issues

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

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.

Data items: Falls per 1000 beds days and falls with moderate/severe harm/death per 1000 bed days 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 in the future.

No. of avoidable serious injuries or deaths resulting from falls. There is no data currently available for February as these cases are currently under investigation and these have a 60 working day deadline in line with the Serious incident framework.

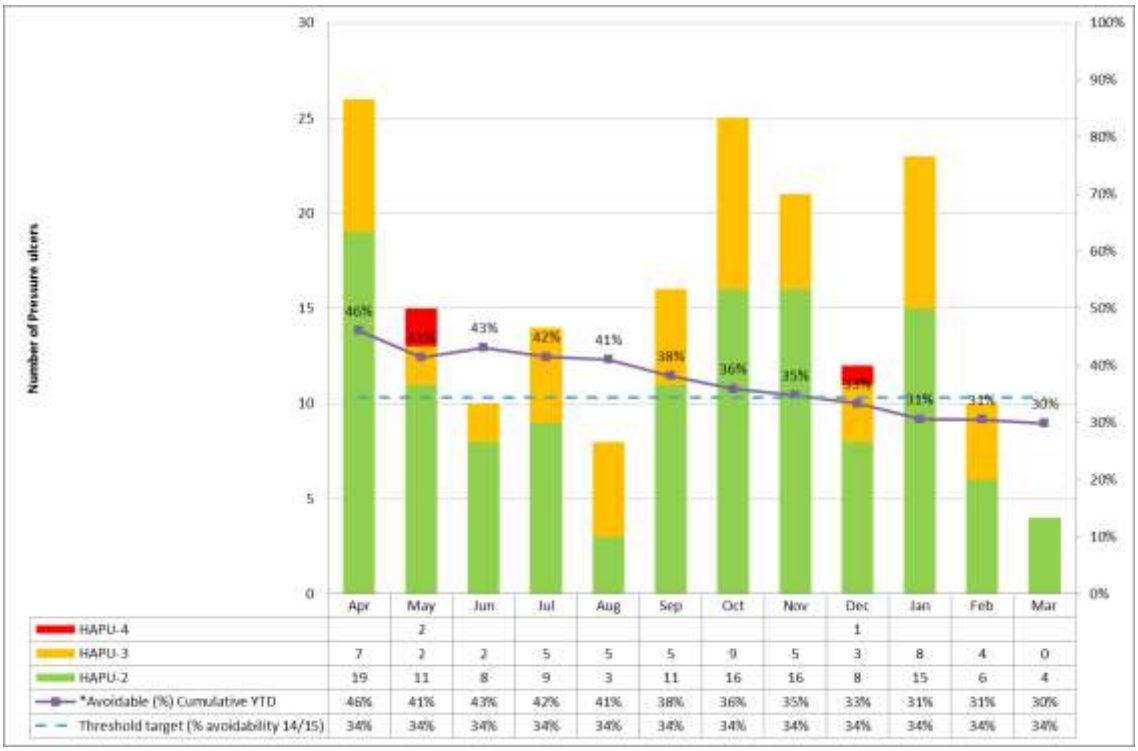
In April we reported 64 falls which was 5.06 falls per 1000 beds day, if we are to assume similar numbers of bed days this month our overall number of falls per thousand bed days will have reduced.

Over the past six months inpatient falls have averaged at approx. 62 per month. Oct recorded the highest number at 66, and Feb the lowest at 55.

Falls prevention continues to concentrate on bay working and close patient observation especially at night. Lying and standing Blood pressure recording continues to be an issue and education into this has been and continues to be provided at ward level. One problem appears to be that on admission patient's condition could make standing impossible and by the time they can safely stand the staff are not remembering to do it; the Trust is looking into how e-Care can help.

The Trust is taking part in the National Falls Audit next month, once the results are published in the summer we will see how we fair against other trusts. We have now have confirmation from Ipswich Hospital that they will work with us to share quality data such as falls and share innovations and good practice.

1.11 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		2							1			
HAPU-3	7	2	2	5	5	5	9	5	3	8	4	0
HAPU-2	19	11	8	9	3	11	16	16	8	15	6	4
*Avoidable (%) Cumulative YTD	46%	41%	43%	42%	41%	38%	36%	35%	33%	31%	31%	30%
Threshold target (% avoidability 14/15)	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%

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 March. F9, F10, G4 and G9 had one ulcer each.

There were no HAPU-3 in March.

There were two DTI reported in March.

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 target for avoidable pressure ulcers is defined in the quality priority *Maintain the incidence of avoidable pressure ulcers, avoidable inpatient falls and hospital acquired VTE below the baseline for 2014/15.* The target is therefore to ensure the percentage of total pressure ulcers deemed avoidable does not exceed the 2014/15 level (34%) by the end of March 2017.

At the end of March there had been 184 HAPU 2, 3 or 4 reported. 55 (30%) of these have been classified as avoidable and 129 (70%) as unavoidable. This means that the Trust has met the quality priority target of being below the 2014/15 threshold (34%).

Benchmarking

The Trust had agreed to provide data on numbers and avoidability to another trust who were coordinating an informal benchmarking exercise following a notable rise in the number of reported pressure ulcers at their trust however this has not resulted in any feedback and therefore we have approached Ipswich Hospital with a view to local benchmarking and sharing of lessons learned and good practice and a meeting has been agreed.

Pressure ulcer prevention

Lead nurse for Tissue Viability and Senior Matron have been working on developments within the Trust since June 2016, with the aim of making the reporting of pressure ulcers more user-friendly and robust for staff. The emphasis of the campaign has been on the importance of early skin assessment, prevention and identification of patients at high risk. As part of this Action plan (detailed in the Pressure ulcer project plan) training sessions available to all staff have been set up, the focus has been on e-Care assessments such as the Waterlow and skin assessment. Weekly ward walks are being undertaken by Matron Lead for PU and the Tissue Viability Lead to educate and support staff in area of high incidence.

Short competency packs have been rolled out a ward at a time, targeting high incidence areas first. These focus on the identification of patients who are at risk, clear assessments and preventative methods give staff the skills to grade and treat pressure ulcers appropriately. The tissue viability team will be leading on the completion of the competencies.

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

a) Current Position

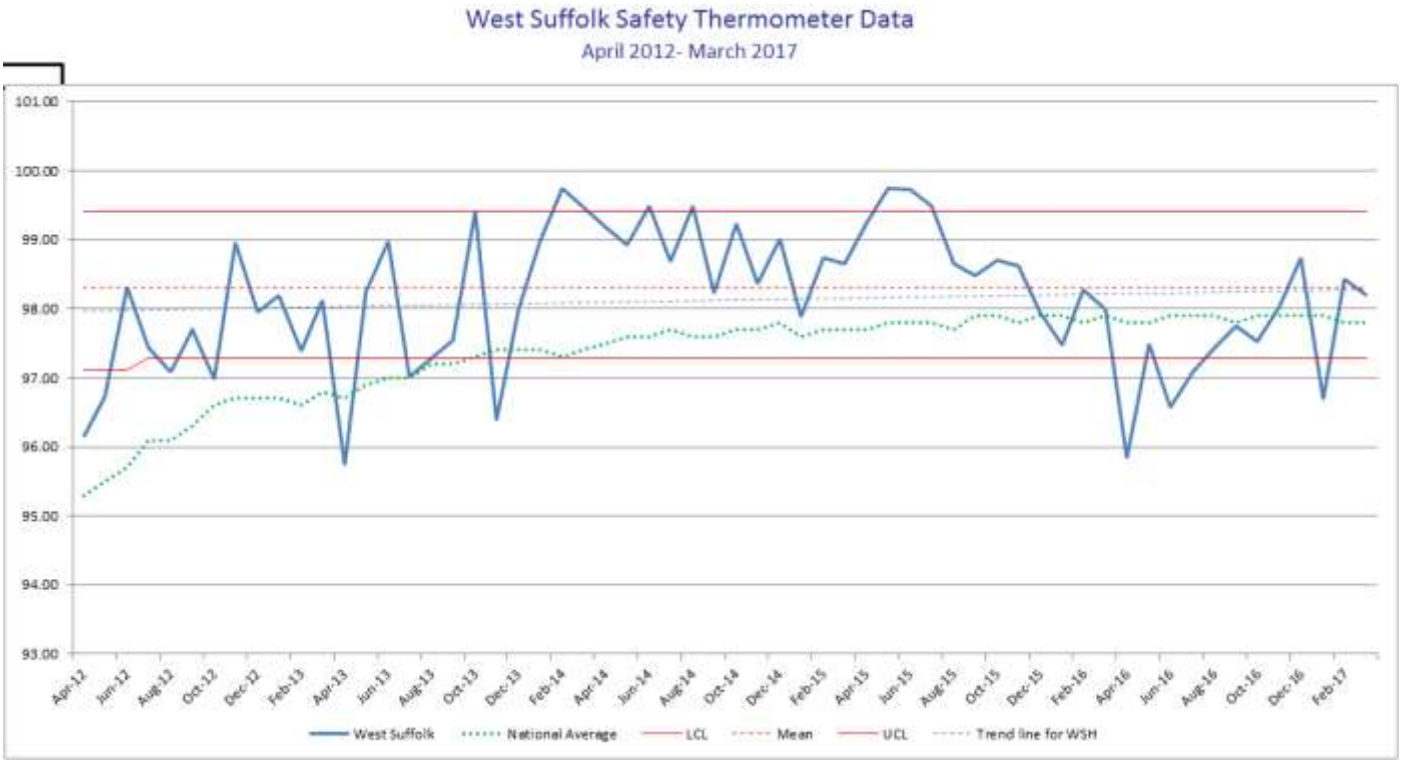
The National 'harm free' care composite measure is defined as the proportion of patients without a pressure ulcer (ANY origin, category II-IV), harm from a fall in the last 72 hours, a urinary tract infection (in patients with a urethral urinary catheter) or new VTE treatment.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec - 16	Jan-17	Feb-17	Mar-17
Harm Free	91.43	94.97	93.63	92.31	92.25	92.71	92.31	92.61	93.16	91.35	93.72	94.06
Pressure Ulcers – All	4.68	3.27	3.43	5.31	3.88	5.03	5.49	5.67	3.80	5.34	4.71	3.62
Pressure Ulcers - New	2.34	1.26	1.47	1.06	1.29	1.01	1.65	1.23	0.51	1.53	1.05	0.52
Falls with Harm	1.30	0.50	0.49	0.53	0.00	0.75	0.55	0.49	0.76	0.76	0.00	0.00
Catheters & UTIs	2.86	1.26	1.96	2.12	3.62	1.51	2.20	1.23	2.28	2.04	1.31	1.81
Catheters & New UTIs	0.78	0.50	0.98	0.53	0.78	0.50	0.00	0.25	0.00	0.25	0.26	0.78
New VTEs	0.00	0.25	0.49	0.80	0.52	0.00	0.27	0.00	0.00	0.76	0.26	0.52
All Harms	8.57	5.03	6.37	7.69	7.75	7.29	7.69	7.39	6.84	8.65	6.28	5.94
New Harms	4.16	2.51	3.43	2.92	2.58	2.26	2.47	1.97	1.27	3.31	1.57	1.81
Sample	3.85	398	408	377	387	398	364	406	395	393	382	387
Surveys	18	18	18	18	18	18	17	18	18	18	18	18

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 March 2017 is **1.81 %** therefore, our new harm free care is **98.19%** The National new harm for March 2017 is **2.2%** or (**97.8**%).

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 March 2017. The Trust figures have remained above the National Average for March.



b) Recommended Actions

To continue to monitor actual harm against national benchmarks

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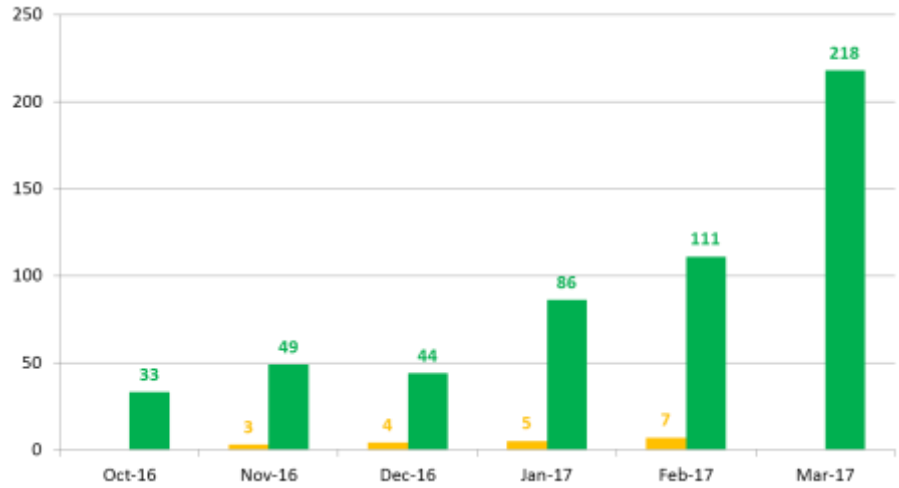
1.13 Incidents with investigation overdue

a) Current Position

Graph: Green and Amber incidents overdue* by month.



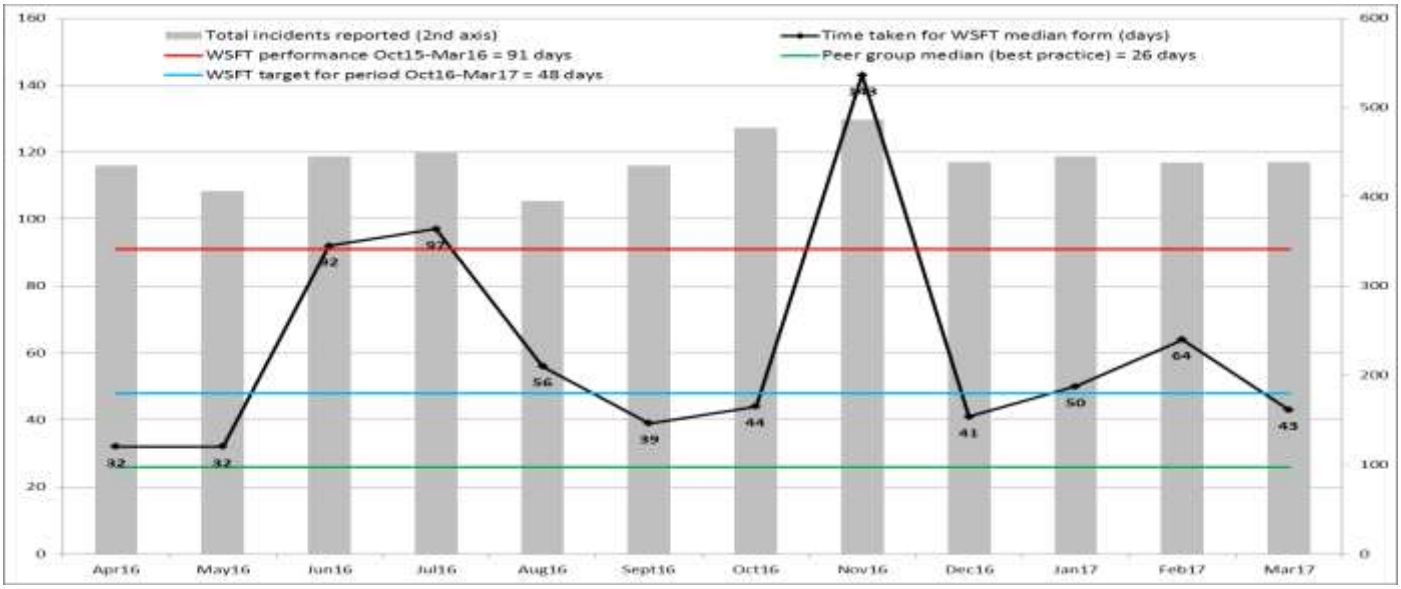
*Overdue - Amber incidents for current reporting month are still within 30 day deadline so are not included on the graph

The graph above shows the number of green and amber incidents that are still awaiting investigation. NB: All green incidents up to September 2016 were closed off as part of the six monthly NRLS submission deadline.

325 (60%) of the March green incidents had been investigated at the time of this report compared to (64%) last month.

The indicator 50% of patient safety incidents uploaded to the NRLS has been added as a new KPI with 26 days (peer group median) as a best practice (green) and <48 days (threshold for the lower quartile in the most recent NRLS benchmark) as an in-year target (blue). The red line (91 days) is the last published WSFT data for the period Oct-Mar 2016.

Initial data for the period Apr-Sept 2016 indicates a considerable improvement in the Trust position and the May Trust Board will receive a full outline within the 'Aggregated' report.



1.14 SIRIs reported > 2 working days from identification as red

a) Current Position

There were two incidents reported to STEIS outside the two working day deadline. One, a fall where the patient subsequently was noted to have a sub-dural bleed, was reported after three days just missing the target. The other case, the MHRA visit to Blood transfusion in January was reported on behalf of the Pathology Partnership at the request of the CCG having not originally been considered as SI reportable for the Trust.

b) Recommended Action

The Trust continues to maintain a high rate of compliance against the two working day deadline.

1.15 RCA Actions beyond deadline for completion

a) Current Position

There are currently eight RCA actions showing as overdue on Datix. Two of these have a due date prior to March 2016.

b) Recommended Action

The individual staff members have been contacted to get a position update on each action and an estimated completion date.

1.16 Duty of Candour

c) Current Position

There are currently six cases requiring verbal Duty of Candour which are reported as overdue.

d) Recommended Action

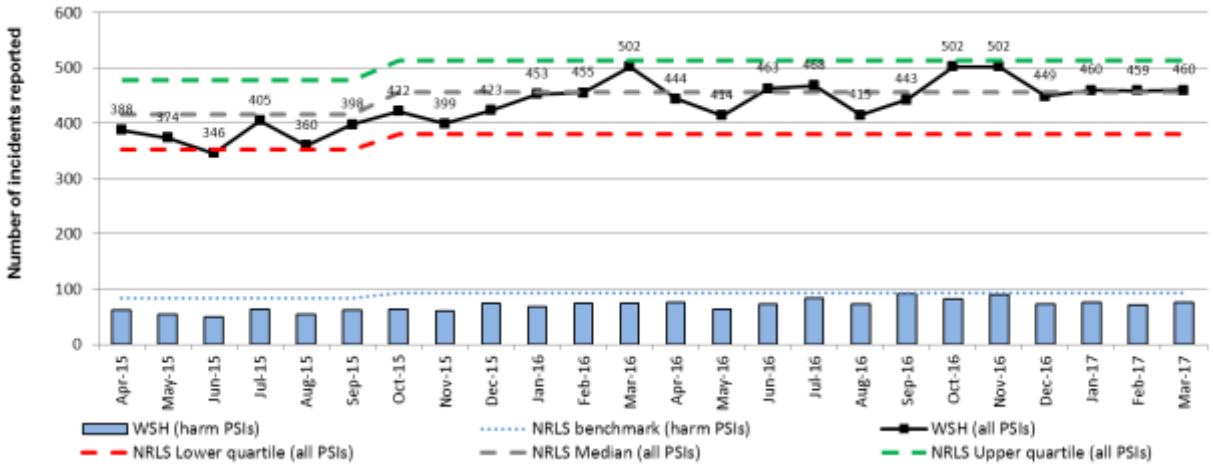
The individuals responsible for providing Duty of Candour have been contacted; non-compliance with Duty of Candour is escalated to the Clinical Directors.

1.17 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 will be updated to reflect the new parameters in next month's Board report.

There were 579 incidents reported in March including 460 patient safety incidents (PSIs). This was similar to previous months and is just below the median threshold for the peer group. Community incidents are now being captured through Datix e-reporting as of the 1st August 2016.

Graph: Patient Safety Incidents reported



1.18 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 will be updated to reflect the new parameters in next month's Board report. 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.

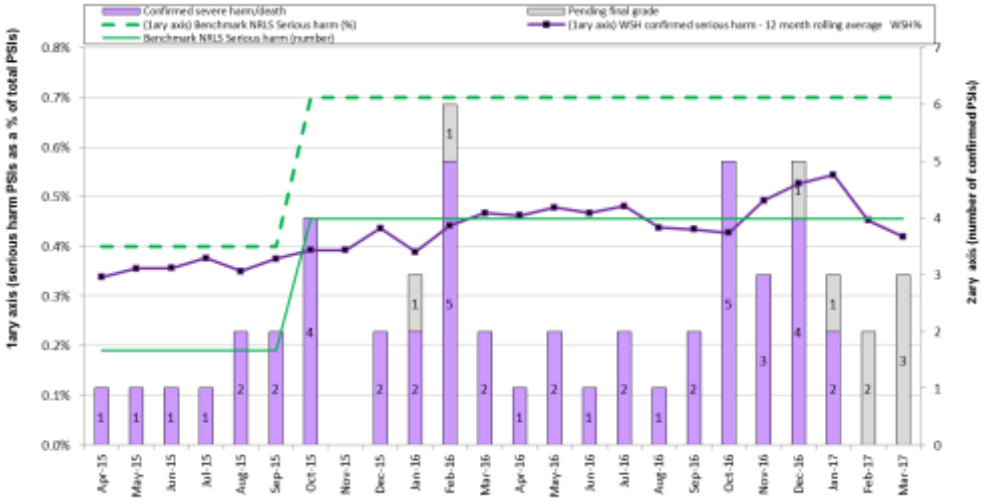
The Trust percentage sits below the NRLS average. The number of serious PSIs (confirmed and unconfirmed) is plotted as a column on the secondary axis.

In March there were three cases reported: two falls and one unexpected death all of which are awaiting RCA to confirm harm grading.

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

- two delay in diagnosis
- one unexpected death
- two mortality reviews
- one intrauterine death

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	Jan	Feb	Mar
Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	94	93	94
(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	99	98	99
Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	70	73	73
Patient Satisfaction: outpatient overall result	= 85%	<75	75-84	85-100	92	92	91
(Out-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	97	97	93
Were you informed of any delays in being seen?	= 85%	<75	75-84	85-100	63	69	65
Were you offered the company of a chaperone whilst you were being examined?	= 85%	<75	75-84	85-100	65	72	74
Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	99	99	98
(Short-stay) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	99	99
Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	96	93	94
(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	95	96	96
Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	ND	98	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	ND	98	96
Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	94	96	100
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	91	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	ND
How likely are you to recommend our antenatal department to friends and family?	= 90%	<80	70-89	90-100	99	100	95
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	100	ND
Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	ND	95	ND
Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	ND	99	97
(F1 Parent) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	ND	100	100
Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	94	95	95
(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	100	100

Additional Patient Experience indicators

Indicator	Target	Red	Amber	Green	Jan	Feb	Mar
Response within 25 working days or negotiated timescale with complainant	100%	<75%	75 – 89%	>=90%	86	86	100
Number of second letters received	0	>6	2 - 6	0 - 1	2	2	1
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	0	1

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.

1.19 Inpatient: Noise at night

a) Current Position

With the same score as February of 73 in March, this area continues to flag as red.

a) Recommended Action

A further deep-dive will be conducted to understand the effects of noise at night and to audit whether earplugs are consistently being offered.

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

a) Current Position

This score has deteriorated from 69 to 65 in March.

b) Recommended Action

Further outpatient area observations with patient representatives are being planned across the Trust, reviewing information about delays specifically. Ways of communicating delays in patients in the Main Outpatient Department are also being reviewed.

1.21 Out-patient: Offered the company of a chaperone whilst being examined?

a) Current Position

The score improved from 72 to 74 this month, bordering on an amber grading.

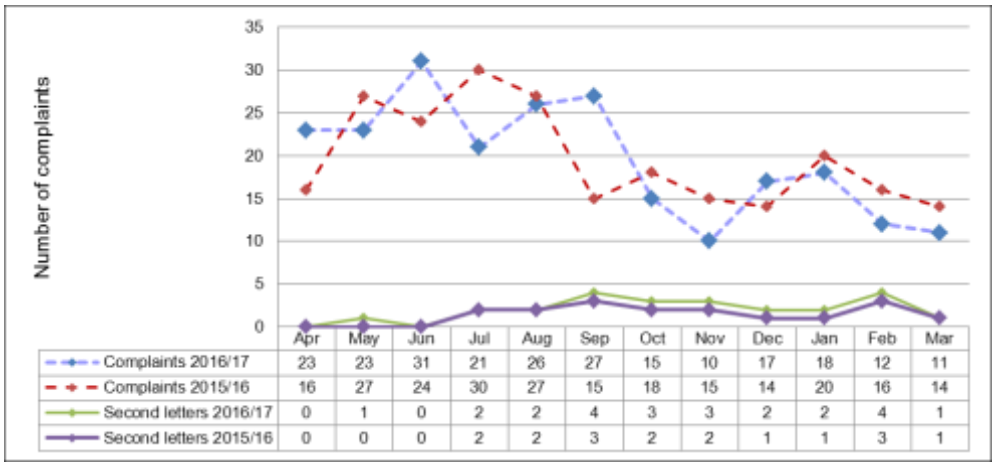
b) Recommended Action

Staff will continue to chaperone patients in appointments. This question is being changed in the new financial year which will eradicate any confusion caused by the wording, giving us a clearer understanding of whether this is an issue.

1.22 Complaints

11 complaints received in March compared with 12 in February. The breakdown of these complaints is as follows by Primary Division: Medical (5), Surgical (3), Clinical Support (2), Women & Children's Health (1). Trust-wide the top 2 most common problem areas are as below:

Communications	4
Waiting times	3



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Complaints 2016/17	23	23	31	21	26	27	15	10	17	18	12	11
Complaints 2015/16	16	27	24	30	27	15	18	15	14	20	16	14
Second letters 2016/17	0	1	0	2	2	4	3	3	2	2	4	1
Second letters 2015/16	0	0	0	2	2	3	2	2	1	1	3	1

1.23 PALS

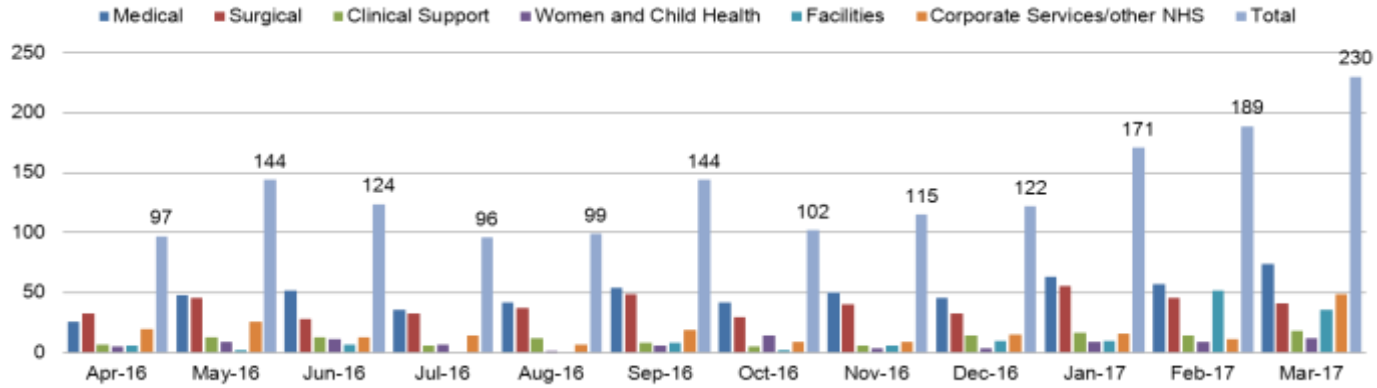
In March 2017 there were 230 recorded PALS contacts. This number denotes initial contacts and not the number of actual communications between the patient/visitor which can, in some particular cases, be multiple.

A breakdown of contacts by Directorate from Apr 16 – Mar 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 (47)
- Facilities (38)
- Appointments; including delays and cancellations (26)

The category of 'Queries, advice & request information" appeared as the top issues in March, 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 ramp access to the hospital, and pay and display due to not knowing how long a patient is going to be at the hospital. Facilities Manager to review. Gynaecology flagged up due to patients having a long wait to be listed for surgery and having outpatient appointments cancelled.



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	Jan	Feb	Mar
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	NA	99
Trust participation in relevant ongoing National audits (Quarterly)	100%	<75	75 – 89	>=90	NA	NA	95
Gynaecology (F14) 30 day readmissions	No target	No target	No target	No target	ND	ND	ND

Indicator	Target	Red	Amber	Green	Jan	Feb	Mar
Babies admitted to NNU with normal temperature on arrival (term)	100%	<50%	50-80%	>80%	100	100	100
12 month Mortality standardised rate (Dr Foster)	100%	>100	90-100	<90	85.85	87.2	88.38
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	Jan-17	Feb-17	Mar-17
ACTIVITY – Births						
Total Women Delivered	> 250 or < 2 00	>216 or <208	>208 or <216	195	197	234
Total Number of Babies born at WSH	> 250 or < 2 00	>216 or <208	>208 or <216	198	197	238
Twins	No target	No target	No target	3	0	4
Homebirths	< 1%	2% or less	2.5%	2.0%	3%	2.1%
Midwifery Led Birthing Unit (MLBU) Births	<=10%	13% or less	20%	24.1%	19.3%	15.8%
Labour Suite Births	<=64%	69% to 74%	75%	73.8%	77.7%	82.1%
BBAs	No target	No target	No target	1	1	2
Normal Vaginal deliveries	No target	No target	No target	145	151	160
Vaginal Breech deliveries	No target	No target	No target	0	1	0
Non operative vaginal deliveries	No target	No target	No target	145	152	
Water births	No target	No target	No target	20	16	16
Total Caesarean Sections	> 22.6%	No target	<22.6%	16.4%	13.2%	19.2%
Total Elective Caesarean Sections	>=13%	11 - 12%	10%	8.2%	4.6%	6.5%
Total Emergency Caesarean Sections	>=15%	13 - 14%	12%	8.2%	8.6%	12.4%
Second stage caesarean sections	No target	No target	No target	1	5	2
Forceps Deliveries	No target	No target	No target	5.6%	5.1%	6%
Ventouse Deliveries	No target	No target	No target	3.6%	4.6%	6.4%
Inductions of Labour	No target	No target	No target	33.8%	36%	37.2%
Failed Instrumental Delivery	No target	No target	No target	1	3	1
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%	71%	70%	89%
Total no. of women eligible for Vaginal Birth after Caesarean Section (VBAC)	No target	No target	No target	11	18	24
Number of women presenting in labour for VBAC against number achieved.	No target	No target	No target	8	9	8
ACTIVITY – Bookings						
Number of Bookings (1st visit)	No target	No target	No target	262	247	275
Women booked before 12+6 weeks	<=90%	91 - 94%	95%	93%	95%	96.3%
CLINICAL OUTCOMES - Maternal						
Postpartum Haemorrhage 1000 - 2000mls	No target	No target	No target	10	11	22
Postpartum Haemorrhage 2,000 - 2,499mls	No target	No target	No target	0	1	0
Postpartum Haemorrhage 2,500mls+	No target	No target	No target	5	0	0
Post-partum Hysterectomies	1	1	0	0	0	0
Women requiring a blood transfusion of 4 units or more	1	1	0	ND	0	ND
Critical Care Obstetric Admissions	1	1	0	0	0	1
Eclampsia	1	1	0	0	0	0
Shoulders Dystocia	5 or more	3-4	2	3	2	8
3rd and 4th degree tears (All vaginal deliveries)	No target	No target	No target	5	4	7
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)	10	7-9	6	5	2	6
3rd and 4th degree tears (Instrumental Deliveries)				0	2	1
Maternal Sepsis	No target	No target	No target	ND	ND	1
Maternal death	No target	No target	No target	0	0	1
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	8	0

	Red	Amber	Green	Jan-17	Feb-17	Mar-17
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	No target	No target	No target	0	1	3
Number of Babies transferred for therapeutic cooling	1	No target	0	1	1	1
Cases of Meconium aspiration	No target	No target	No target	0	0	1
Cases of hypoxia	No target	No target	No target	0	1	0
Cases of Encephalopathy (grades 2 and 3)	No target	No target	No target	1	1	2
Stillbirths	No target	No target	No target	0	1	0
Postnatal activity						
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 >	63	81	60
Midwife/birth ratio	>=1:32	No target	1:30	1:28	1:28	1:33
Supervisor to Midwife Ratio	No target	No target	No target	1:19	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	54	49	64
Serious incidents	No target	No target	No target	0	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	ND
Maternal Postnatal readmissions	No target	No target	No target	ND	ND	ND
Completion of WHO Checklist	80%	90%	100%	93%	87%	89%
Babies assessed as needing BCG vaccine	No target	No target	No target	ND	ND	ND
Babies who receive BCG vaccine following assessment	No target	No target	No target	ND	ND	ND
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	156	157	165

Exception reporting for red indicators in the Clinical Effectiveness Dashboard

1.24 Maternity - Total Women Delivered and Number of Babies born at WSH

The total number of deliveries and babies born at WSH varies from month to month. The maternity service delivered more babies in March 2017 than would be expected, reducing the midwife to birth ratio to 1:33. It is not planned to take any action on this.

1.25 Critical Care Obstetric Admission / Maternal death

Reported as an SI – see Closed Board paper for case details

1.26 Maternity - Number of Babies transferred for therapeutic cooling

In March 2017 one baby was transferred out to a tertiary centre for therapeutic cooling. An amber investigation is currently being undertaken at present. From 1st April 2017 it is planned to report these cases as red incidents and externally report, in line with the recommendations of national reports and initiatives.

1.27 Maternity - Completion of WHO Checklist

In March 2017 there was a slight improvement for the maternity service compliance with completion of the WHO checklist rising from 87% to 89%, identified in a continuous documentation audit. All clinicians involved in the completion of a checklist which are non-compliant with the audit are individually notified of their omission and given an opportunity to review the health records for the case. This applies to substantive Trust staff only, and the use of locum staff does affect compliance. The audit results are discussed and disseminated in a number of local forum. There are no reports of any clinical incidents stemming from this lack of documentation.

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

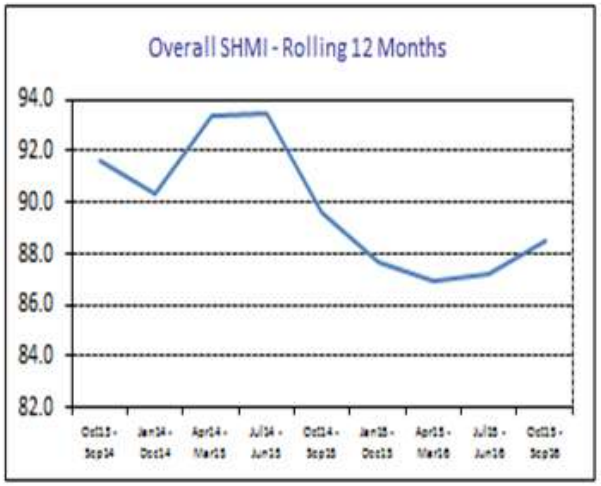
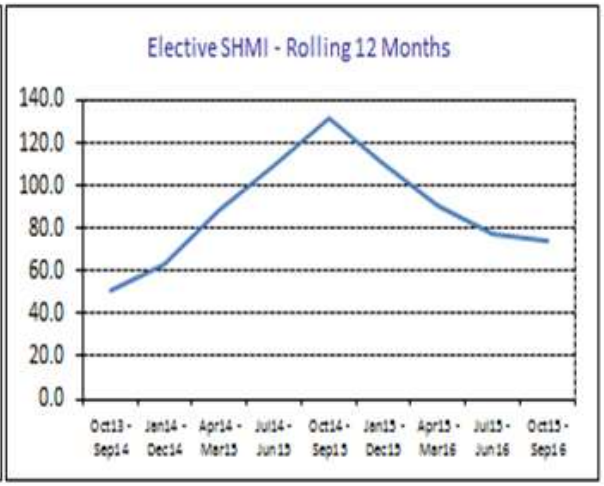
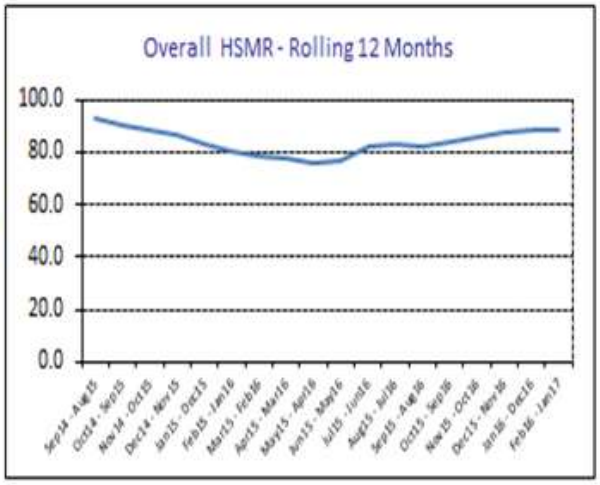
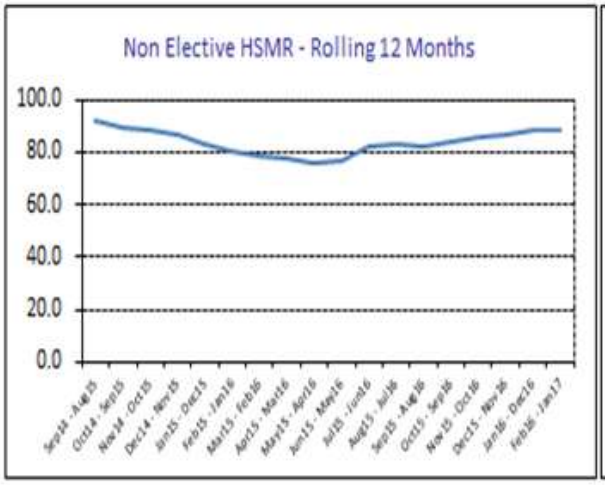
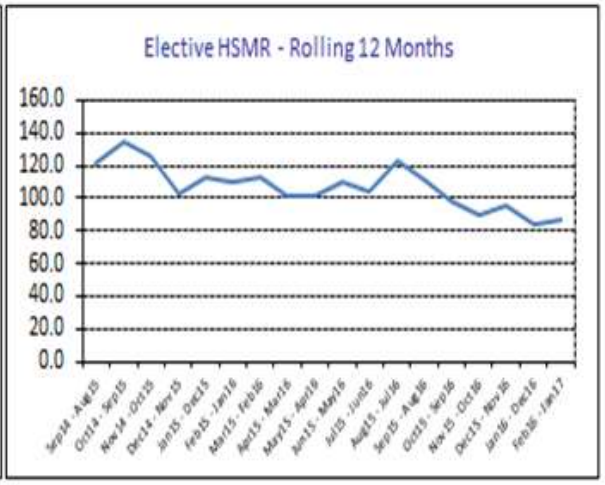
2. MORTALITY DATA

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
	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*												

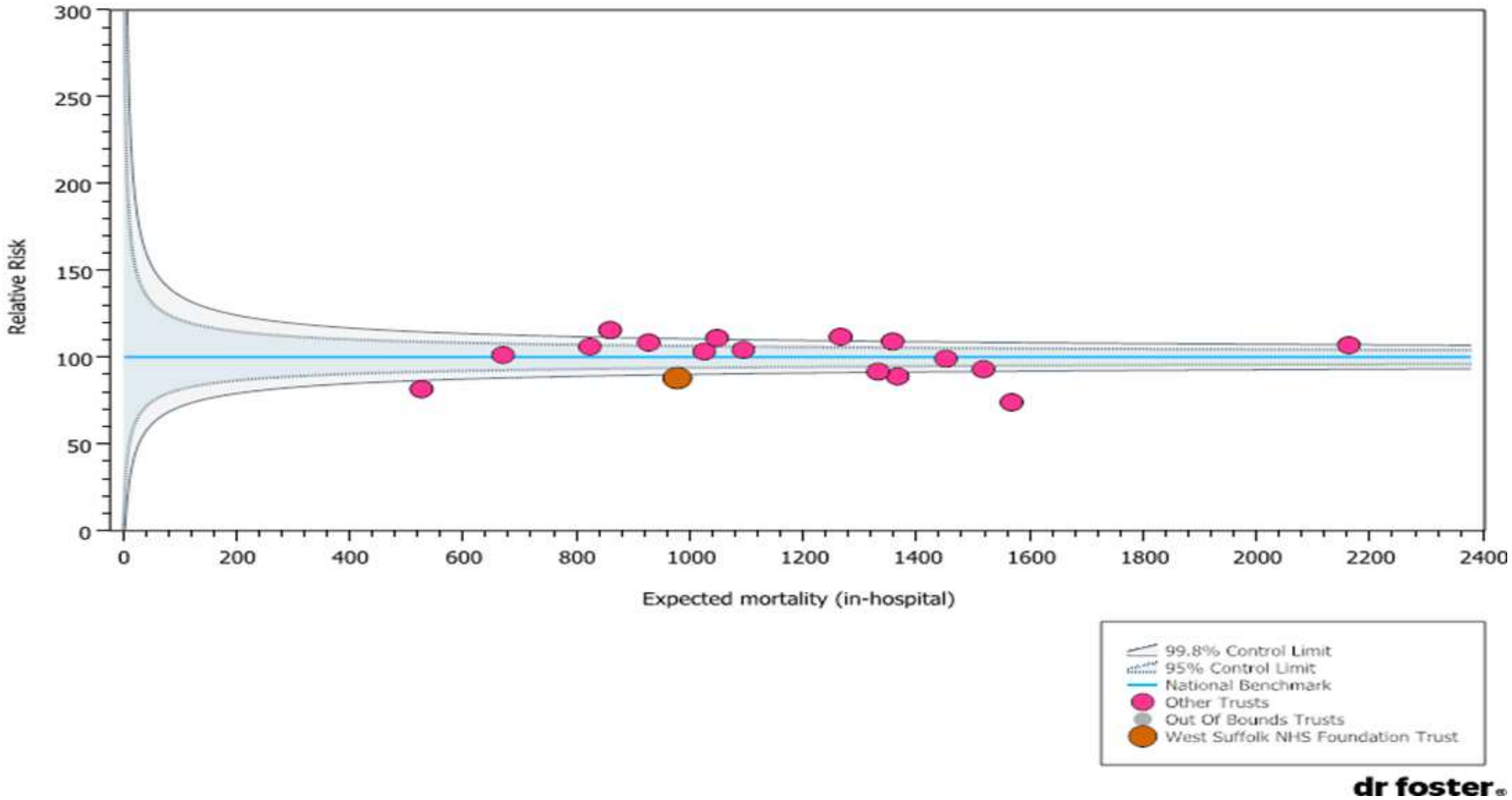
HSMR BENCHMARK IS USING FY 15 -16

SHMI - Rolling 12 Months (Quarterly)	Apr12 - Mar13	Jul12 - Jun13	Oct12 - Sep13	Jan13 - Dec13	Apr13 - Mar14	Jul13 - Jun14	Oct13 - Sep14	Jan14 - Dec14	Apr14 - Mar15	Jul14 - Jun15	Oct14 - Sep15	Jan15 - Dec15
Overall Observed Deaths	1254	1275	1328	1349	1281	1264	1292	1316	1439	1461	1401	1361
Overall Expected Deaths	1403	1420	1424	1418	1396	1392	1410	1456	1541	1562	1563	1553
Overall SHMI	89.4	89.8	93.2	95.1	91.8	90.8	91.6	90.3	93.4	93.5	89.6	87.7
Non Elective SHMI	89.8	90.2	93.9	95.4	92.1	91.1	92.2	90.8	93.4	93.3	89.1	87.4
Elective SHMI	67.2	63.4	49.2	71.7	68.8	71.5	50.8	63.2	88.4	109.7	131.5	110.9
	Apr15 - Mar16	Jul15 - Jun16	Oct15 - Sep16	Jan16 - Dec16	Apr16 - Mar17	Jul16 - Jun17	Oct16 - Sep17	Jan17 - Dec17	Apr17 - Mar18	Jul17 - Jun18	Oct17 - Sep18	Jan18 - Dec18
Overall Observed Deaths	1334	1337	1370									
Overall Expected Deaths	1535	1533	1547									
Overall SHMI	86.9	87.2	88.5									
Non Elective SHMI	86.9	87.3	87.3									
Elective SHMI	90.1	77.2	74.5									

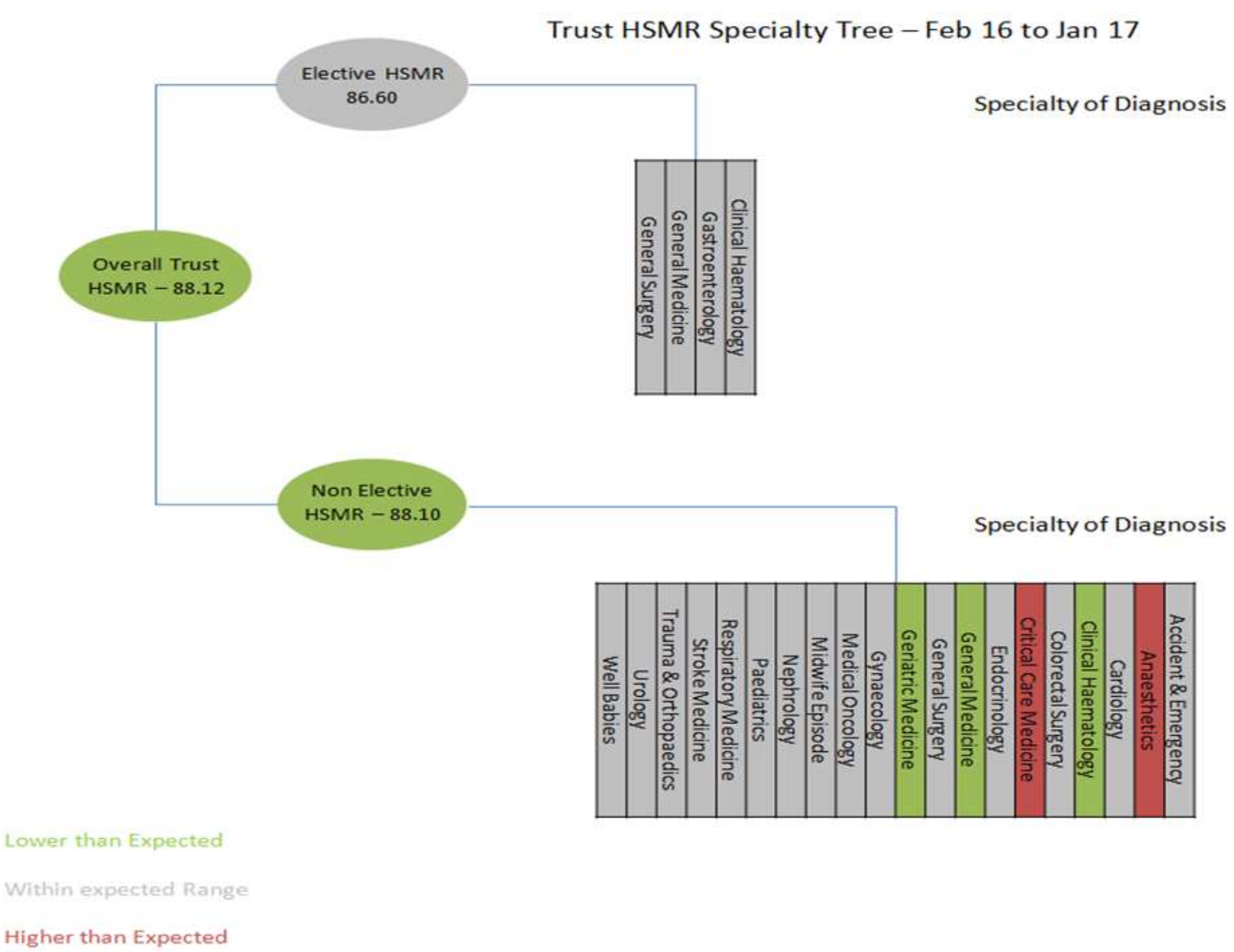
HSMR - Rolling 12 Months	Jun13 - May14	Jul13 - Jun14	Aug13 - Jul14	Sep13 - Aug14	Oct13 - Sep14	Nov13 - Oct14	Dec13 - Nov14	Jan14 - Dec14	Feb14 - Jan15	Mar14 - Feb15	Apr14 - Mar15	May14 - Apr15
Overall Observed Deaths	755	758	779	798	804	792	803	842	902	934	938	946
Overall Expected Deaths	883	894	902	898	913	916	926	910	971	985	992	958
Overall HSMR	85.4	84.7	86.3	88.8	88.0	86.4	86.7	92.5	92.8	94.8	94.5	98.7
Non Elective HSMR	85.6	84.9	86.6	89.2	88.5	86.7	86.3	92.6	94.0	95.8	94.5	98.6
Elective HSMR	65.7	66.8	56.7	55.4	42.0	60.4	75.2	77.6	82.1	102.1	103.8	112.2
	Jun14 - May15	Jul14 - Jun15	Aug14 - Jul15	Sep14 - Aug15	Oct14 - Sep15	Nov14 - Oct15	Dec14 - Nov15	Jan15 - Dec15	Feb15 - Jan16	Mar15 - Feb16	Apr15 - Mar16	May15 - Apr16
Overall Observed Deaths	954	956	925	913	892	886	876	836	812	784	785	766
Overall Expected Deaths	968	974	980	984	991	996	1009	1005	1004	996	1006	1011
Overall HSMR	98.5	98.1	94.4	92.8	90.0	88.9	86.8	83.2	80.8	78.7	78.0	75.8
Non Elective HSMR	98.4	97.9	94.2	92.5	89.5	88.5	86.8	82.9	80.8	78.4	77.8	75.5
Elective HSMR	107.4	117.4	110.6	122.1	134.6	125.6	102.9	112.9	109.5	112.5	100.8	100.9
	Jun15 - May16	Jul15 - Jun16	Aug15 - Jul16	Sep15 - Aug16	Oct15 - Sep16	Nov15 - Oct16	Dec15 - Nov16	Jan16 - Dec16	Feb16 - Jan17	Mar16 - Feb17	Apr16 - Mar17	May16 - Apr17
Overall Observed Deaths	786	781	791	793	812	832	850	869	865			
Overall Expected Deaths	1020	948	949	960	965	916	975	983.3	981.6			
Overall HSMR	77.1	82.4	83.3	82.6	84.1	85.9	87.2	88.4	88.1			
Non Elective HSMR	76.8	82.2	83.0	82.4	84.0	85.8	87.2	88.4	88.1			
Elective HSMR	109.8	104.4	122.4	111.3	99.2	89.8	95.3	84.5	86.9			

	Overall	Non-Elective	Elective
SHMI			
HSMR			

HSMR – Feb 16 - Jan 17



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


Trust HSMR Specialty Tree – Feb 16 to Jan 17
Elective HSMR 86.60
Specialty of Diagnosis
Clinical Haematology
Gastroenterology
General Medicine
General Surgery
Overall Trust HSMR – 88.12
Non Elective HSMR – 88.10
Specialty of Diagnosis
Accident & Emergency
Anaesthetics
Cardiology
Clinical Haematology
Colorectal Surgery
Critical Care Medicine
Endocrinology
General Medicine
General Surgery
Geriatric Medicine
Gynaecology
Medical Oncology
Midwife Episode
Nephrology
Paediatrics
Respiratory Medicine
Stroke Medicine
Trauma & Orthopaedics
Urology
Well Babies
Lower than Expected
Within expected Range
Higher than Expected

3. MONITOR ASSURANCE FRAMEWORK

The Governance Rating table shows no failures of the governance rating against Monitor's Risk Assessment Framework.

Monitor Compliance Framework						January	February	March
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%		90.09%	1.0	Helen Beck	90.30%	89.89%	
Number of RTT Waits over 52 weeks for incomplete pathways	0		14	-	Helen Beck	7	7	
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	92.88%	88.26%	1.0	Helen Beck	87.28%	83.92%	92.88%
All cancers: 62-day wait for first treatment (5) from:Urgent GP referral for suspected cancer - **See Further detail below**	85%	83.56%	84.58%	1.0	Helen Beck	84.21%	85.96%	83.56%
All cancers: 62-day wait for first treatment (5) from: NHS Cancer Screening Service referral	90%	96.77%	95.22%		Helen Beck	100.00%	88.89%	96.77%
All cancers: 31-day wait for second or subsequent treatment, comprising: Surgery	94%	100.00%	100.00%	1.0	Helen Beck	100.00%	100.00%	100.00%
All cancers: 31-day wait for second or subsequent treatment, comprising: anti-cancer drug treatments	98%	100.00%	100.00%		Helen Beck	100.00%	100.00%	100.00%
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%	99.24%	99.75%	0.5	Helen Beck	100.00%	100.00%	99.24%
Cancer: two week wait from referral to date first seen (8), comprising: all urgent referrals (cancer suspected)	93%	97.66%	95.35%	0.5	Helen Beck	90.06%	98.33%	97.66%
Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)	93%	93.41%	92.66%		Helen Beck	88.29%	96.27%	93.41%
Outcomes:								
Clostridium (C.) difficile - meeting the C.difficile objective - MONTH	2	1		1.0	Rowan Proctor	0	0	1
Clostridium (C.) difficile - meeting the C.difficile objective - QUARTER	4		1		Rowan Proctor			
Clostridium (C.) difficile - meeting the C.difficile objective - ANNUALLY	16		22		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	3.0

West Suffolk NHS Foundation Trust Cancer Waits Performance Report - February 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	10		10	100	95.9
Gynae			0	na	78.4
Haem	2	1x.5	2.5	80	81.3
Head & Neck				na	
Lower GI	5	2	7	71.4	67.8
Lung	5+1x.5		5.5	100	71.3
Other	1		1	100	57.2
Skin	9	3	12	75	96.2
Upper GI	4+1x.5	1	5.5	81.8	71.9
Urology	11+2x.5	1+1x.5	13.5	88.9	71.5
Total	47+4x.5	7+2x.5	57	86	79.6

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

TBC against a threshold of 92%

Due to significant capacity issues within ENT, Vascular, Urology, Dermatology, patients are waiting 30+ weeks for first OPA in ENT, and patients waiting over 28 weeks for Surgery within Vascular and Urology. 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 have been developed with CCG input where appropriate. Work in is on-going to develop a dermatology action plan. Validation of new PTL continues.

3.2 Number of RTT waits over 52 weeks for incomplete pathways

a) Current Position

8 against a threshold of 0 - TBC

There are 5 ENT patients over 52 weeks due to reporting and capacity issues and 1 Vascular patient, who has been delayed due to capacity. Patient needs GA surgery and is for Mr Boyle only to do. I gynaecology patient and one general surgery patient.

b) Recommended Action

New PTL now highlighting long waiting patients. All over 35 week waits now manually validated and actively monitored by senior team.

3.3 A&E: Maximum waiting time of four hours from admission/transfer/discharge

a) Current Position

92.88% against a threshold of 95%

ED continues to experience high levels of demand.

b) Recommended Action

Actions in place include:

- The Flow Action Group continues to work towards tackling challenges and constraints to patient flow and discharge. Red to Green (R2G) initiative continues to be a significant focus across the organisation with new dashboards developed to monitor performance at ward and consultant level.
- The AECC (Ambulatory Emergency Care Centre) have recently (19/04/17) implemented phase one of Medical Assessment and Triage process (MAT). The aim is to ensure medically referred & GP expected patients are assessed and filtered more effectively to the right area. This will improve ED flow, reduce base bed usage and reduce length of stay.
- The unit is developing criteria based discharge standard operating procedures (SOP's) for AMU short stay perspective , with a view to enable patients to be discharged earlier, planning for at least one/two patients a day to be discharged by 10am
- Primary Care Streaming in ED – The Trust has recently submitted a capital bid to NHSE to fund the implementation of the recognised Luton & Dunstable GP streaming model. The overarching view is that there is a recognition of increased attendance and overcrowding of cohorts of patients attending A&E instead of their GP centres. Working alongside the CCG, GP Federation & CARE UK, we are developing a business case ahead of the outcome of our bid submission.

3.4 All cancers: 62-day wait for first treatment (5) from Urgent GP referral for suspected cancer

a) Current Position

The most up to date figures in Somerset so far for February - dependent on reallocation - is 83.56% pre-validation against a threshold of 85%.

b) Recommended Action

Further information regarding shared breaches and reallocations is showing 85.5%.

3.5 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	Jan	Feb	Mar	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	53	63		Helen Beck	50	48	53	↘			
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	22:32	22:32	Legitimately validated by ED - wait due to patient awaiting psychiatric assessment	Helen Beck	13:19	12:25	22:32	↘			
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%	32.04%	31.92%		Helen Beck	34.91%	33.61%	32.04%	↗			
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%	88.27%	84.89%		Helen Beck	90.16%	83.61%	88.27%	↗			
A&E - Ambulance Handovers above 30 minutes	0 handovers over 30 minutes - £200 per breach	ND	333	**Unvalidated data until March; validated thereafter.**	Helen Beck	39	52	ND				
A&E - Ambulance Handovers above 60 minutes	0 handovers over 60 minutes - £1000 per breach	ND	109		Helen Beck	21	35	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%	100.00%	82.73%		Helen Beck	80.00%	89.47%	100.00%	↗			
RTT												
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks	99.00%		98.14%		Helen Beck	96.07%	95.56%					
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90.00%		73.62%		Helen Beck	67.88%	68.84%					
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.00%		91.65%		Helen Beck	87.51%	84.73%					
Stroke												
% of patients scanned within 1 hour of clock start	77% (Contract) 57.5% (Upper Quartile)	87.50%	75.70%		Helen Beck	76.32%	68.75%	87.50%	↗			
% of patients scanned within 12 hours of clock start	96% (Contract) 96% (Upper Quartile)	100.00%	97.25%		Helen Beck	100.00%	90.63%	100.00%	↗			
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75% (Contract) 70% (Upper Quartile)	75.00%	74.10%		Helen Beck	81.78%	62.50%	75.00%	↗			
>80% treated on a stroke unit >90% of their stay	90%	87.50%	88.39%		Helen Beck	91.89%	90.63%	87.50%	↘			
% of patients treated by a stroke skilled early supported discharge team	48% (Contract) 48% (Upper Quartile)	34.48%	45.17%		Helen Beck	46.67%	42.31%	34.48%	↘			
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80% (Contract) 79% (Upper Quartile)	93.75%	85.61%		Helen Beck	81.58%	84.38%	93.75%	↗			
% 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)	72.41%	77.87%	INDICATION ONLY - FINAL SSNAP LEVEL AVAILABLE WHEN RESULTS ARE AVAILABLE FROM SSNAP	Helen Beck	77.14%	80.00%	72.41%	↘			
% of eligible service users given thrombolysis	100% (RCA to be provided for breaches)	100.00%	84.89%		Helen Beck	100.00%	100.00%	100.00%	↔			
All stroke survivors to have a 6 month follow up assessment.	50%	ND	57.59%		Helen Beck	50.00%			-			
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	Reports are generated by SSNAP every 4 months - this is as at November 2016, reported for February Board	Helen Beck	B			-			
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	97.29%	97.69%		Nick Jenkins	98.08%	97.73%	97.29%	↘			
Discharge Summaries - Inpatients	95% sent to GP's within 1 day	92.23%	92.21%	Due to data quality issues this will be reported on next month	Nick Jenkins	94.33%	92.80%	92.21%	↘			
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	0.93%	0.89%		Helen Beck	1.35%	0.49%	0.93%	↘			
Patients offered date within 28 days of cancelled operation	100%	96.55%	94.64%		Helen Beck	100.00%	92.31%	96.55%	↗			
No urgent operation should be cancelled for a second time	i) 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.	96.36%	95.61%		Rowan Proctor	93.13%	95.14%	96.36%	↗			
Maintain maternity 1:30 ratio	1:30	01:33	01:29		Rowan Proctor	01:28	01:28	01:33	↘			
Pledge 1.4: 1:1 care in established labour	1:1	100.00%	99.96%		Rowan Proctor	100.00%	100.00%	100.00%	↔			
Breastfeeding initiation rates.	80%	76.37%	77.74%		Rowan Proctor	73.98%	80.21%	76.37%	↘			
Reduction in the proportion of births that are undertaken as caesarean sections.	22.70%	18.99%	18.48%		Rowan Proctor	16.33%	13.47%	18.99%	↘			

Other contract / National targets												
Mixed Sex Accomodation breaches	0 Breaches	0	7		Helen Beck	0	2	0	↗			
Consultant to Consultant referral	Commissioner to audit if concern about levels of consultant referrals	ND	ND	Due to data quality issues with eCare we are unable to report on referrals at this time	Helen Beck	ND	ND	ND	-			
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%	91.82%		Helen Beck	51.58%	100.00%	100.00%	↔			
Acute oncology service: 1 hour to needle from diagnosis of neutropenic sepsis	100%	100.00%	99.36%	MacMillan	Helen Beck	100.00%	100.00%	100.00%	↔			
		72.73%	77.51%	ED	Helen Beck	54.55%	90.91%	72.73%	↘			
		80.00%	85.13%	Overall Trust (Inc AMU)	Helen Beck	72.22%	94.12%	80.00%	↘			
New to Follow up	Thresholds set at each speciality - overall Trust Threshold is 1.9	2.07	2.01		Helen Beck	2.11	2.12	2.07	↘			
Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test	99%	99.89%	96.31%	Cardiology excluded due to Cardiology system issues	Helen Beck	96.04%	99.42%	99.89%	↗			
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.

The breach that exceeded the standard wait was a complex psychiatric adolescent patient. The Psychiatric team assessed the patient and recommended transfer to an adolescent specialist unit. Unfortunately, due to the complexities of the case the bed was difficult to source. The patient was not suitable to admit to ward F1 whilst awaiting placement. Therefore, the A&E was deemed the best place of safety for the child..

b) Recommended Action

Actions in place include: Work with NSFT to explore alternative solutions if this situation were to presented itself again.

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

a) Current Position

32.04% against a threshold of 27%

b) Recommended Action

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

TBC against a threshold of 99%.

Due to 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. 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
TBC against a threshold of 90%.

b) Recommended Action
Patients are being treated in longest waiting order, due to some patients being missing from the report previously this has seen more breaches appear and therefore more patients who have already breached 18 weeks being treated. New PTL and proactive manual validation underway.

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

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

b) Recommended Action
Action plan being developed in conjunction with the CCG.

4.6 Stroke - >80% treated on a stroke unit >90% of their stay

a) Current Position
87.50% against a threshold of 90%
4 patients breached – 2 required specialist treatment on other areas eg. NIPPI, and 2 were short stay patients staying one night when there were no male stroke beds available.

b) Recommended Action
2 could not be avoided as clinically they needed to be elsewhere. Two – trust capacity issues all male stroke beds full.

4.7 Stroke - % of patients treated by a stroke skilled early supported discharge team

a) Current Position
34.48% against a threshold of:
48% (Contract)
48% (Upper quartile)
All patients meeting criteria were referred

b) Recommended Action
This target is currently under review with the CCG, it may be removed – awaiting confirmation.

4.8 Discharge Summaries – Inpatients

a) Current Position
92.23% against a threshold of 95%.

4.9 Patients offered date within 28 days of cancelled operation

a) Current Position
96.55% against a threshold of 100%

This represents one patient was unable to be booked within their 28 days as it was then decided they needed to have their Orthopaedic operation before their Urology procedure, so it was not possible to bring them back in within 28 days.

b) Recommended Action
There were seven patients cancelled during March who were not re-booked within 28 days. Four patients (1 ENT and 3 T&O) were unable to be re-booked due to capacity issues within the services, all now have dates before the 05/05/17. The T&O patients were cancelled to accommodate trauma admissions and were unable to be re-booked within 28 days due to surgeon annual leave and surgeon specific cases. Three patients (1 MOS, 1 urology, and ENT) missed potential opportunities to be booked within 28 days of cancelation and action is being taken by the team leader within appointments to address this with the booking teams.

4.10 Maintain maternity 1:30 ratio

a) Current Position
1:33 against a threshold of 1:30

b) Recommended Action
The total number of deliveries and babies born at WSH varies from month to month. The maternity service delivered more babies in March 2017 than would be expected, reducing the midwife to birth ratio to 1:33. It is not planned to take any action on this.

4.11 Breastfeeding initiation rates

a) Current Position
76.37% against a threshold of 80%

b) Recommended Action
Breastfeeding initiation rate in March 2017 was 76.37%, below the target of 80%. 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. The maternity service is also continuing to address the gap in service created by the recent withdrawal of the Suffolk County Council funded peer support system at very short notice.

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

a) Current Position
Macmillan - 8/8 - 100%
ED - 7/12 - 66.66%
Overall Trust figure of 80% against a threshold of 100%

b) Recommended Action
The performance figure for 1 hour to needle from diagnosis of Neutropenic Sepsis March Data included, the Emergency Department that had four breaches. These breaches are undergoing a more detailed review.

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	March	YTD	Comments
Workforce				
Sickness absence rate	<3.5%	3.95%		
Turnover	<10%	10.43%		
Reviews	Grievance/Banding reviews		4	
Recruitment Timescales	Average number of weeks to recruit = 7	6		
DBS Checks	To complete 95% of required DBS checks	99.00%		
All Staff to have an appraisal	Both general and consultant staff each have a target of 90% to have had an apprasial within the previous 12 months. Appraisal is a rolling programme		92.00%	Workforce Information are awaiting guidance on appraisal reporting - figure fixed since November 2016.

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.

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 February's performance, the second section provides the detail of the contractual KPI position.

- Our patient experience survey continues to be very positive with an overall FFT for March of 97%, from 377 responses. We had 4 "Unlikely to recommend" responses in the month. The services are: Adult Speech and Language, Community Health Team, Cardiac Rehabilitation and Podiatry.

- We received 1 complaint in the month regarding access to the Phlebotomy clinic at Mildenhall due to staff shortages .

- Delayed Transfers of Care in March had an increase in numbers from 52 patients in February to 63 in March, this equates to 635 bed days lost in March compared to 619 bed days in February. Glastonbury Court has the highest number of Delayed Transfer of Care at 21 patients for March. Overall the % of Delayed Transfer of Care in community beds is 18.29%.

- There has been an improvement in the number of breaches of the 18 week RTT targets in consultant paediatric service, 3 patients (2 in the East and 1 in the West) breached 18 week in March out of 109 clock stops (97.25%). This is above the national target of 95%.

- The Children in Care performance of completing Initial Health Assessments within 28 days of notification continues to be good. 11 out of 12 Initial Health Appointments were offered within 28 days of being notified. Eight of these 1st appointment dates were accepted and attended (66.67%). There continues to be a delay of notification to the service of children being placed in care.

- There has been a further increase in the number of re-admissions, 29 in February to 31 in March, back to the acute units from our community beds. Readmission rate for March was 21.53%. Community clinical leads are investigating with acute colleagues to understand the reasons.

- There has been a further increase in the number of Datix notifications related to staffing/capacity challenges and wound care product availability within Community Health teams. This is being addressed by the Norfolk Community contract meeting and the Provider Management Group have requested a report.

c									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**Mar 2017**	**March Comments / Queries 2017**	**Jan 2017**	**Feb 2017**
SCH		**D4-qoc1**	Number and % of service users who rated the service as 'good' or 'better'.	85%	Quarterly report from Provider	97.71%	Quarterly Report		
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'better'.	85%	Quarterly report from Provider	94.78%	Quarterly Report		
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'well informed'.	85%	Quarterly report from Provider	93.46%	Quarterly Report		
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	99.62%		99.93%	100.00%
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	98.69%		93.89%	96.57%
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	94.34%	The IT upgrade continues to impact compliance	94.62%	92.57%
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	1.58%	Quarterly Report		
SCH	Safeguarding - children	**c-safe1**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.74%		97.04%	95.86%
SCH	Safeguarding - adults	**c-safe2**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.92%		97.04%	95.59%
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	97.56%		100.00%	100.00%
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	0.54		0.55	N/A
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
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%		100.00%	95.83%

Host	Service	Technical Reference	Quality Requirement	Threshold	Method of measurement	Mar 2017	March Comments / Queries 2017	Jan 2017	Feb 2017
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	100.00%		N/A	88.89%
IHT	CCC	**D4-int1**	Care coordination centre - % of telephone calls answered within 60 seconds	95% in 60secs	Monthly report from Provider	96.01%	# of calls handled: 17,482 # of calls answered in 0-60 seconds: 16,785 % 0-60 seconds: 96.01% Number of abandoned calls: 349 Abandoned calls %: 1.96% Average Wait Time: 13 seconds	96.00%	95.84%
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	98.05%			
IHT	Card Rehab	**s-card5**	Number of service users successfully discharged from phase 3.	600 per annum: (trajectory of 50 Service Users in total per month)	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	82 offered	Over 500 courses have been offered in 16/17	65 offered	67 offered
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses completed	At least 250 courses completed per year	Monthly report from Provider	32 completed	Over 250 courses have been completed in 16/17	0 completed	18 completed
IHT	COPD	**s-copd5**	Community pulmonary rehabilitation - review offered 6 months after completing the course	95%	Monthly report from Provider	100.00%		N/A	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	99.86%		100.00%	99.62%
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	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	98.46%	Quarterly Report		
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	100.00%	Quarterly Report		
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	94.44%	Quarterly Report		
IHT	MIU	**s-miu5**	Total time spent in A+E department 95% of Service Users waiting less than 4 hours for admitted Service Users	95%	Monthly	100.00%		100.00%	100.00%
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	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%		50.00%	N/A
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	97.03% (229/236)	7 deliveries to 3 different patients. 2 patients had their 4 items of equipment delivered within 5 hours of ordering and 1 patient had their 3 items of equipment delivered within 6.5 hours	98.82% (168/170)	100.00% (194/194)
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	99.77% (859/861)		99.42% (861/866)	99.24% (783/789)
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	99.75% (2386/2392)		99.48% (2090/2101)	99.28% (2060/2075)
Mede	CES	**c-gen8**	Within 10 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider	99.31% (579/583)		99.82% (549/550)	98.68% (524/531)

Host	Service	Technical Reference	Quality Requirement	Threshold	Method of measurement	Mar 2017	March Comments / Queries 2017	Jan 2017	Feb 2017
Mede	CES	**c-gen9**	Collection times: % of urgent next day collections for deceased Service Users	98% for all standards	Monthly report from Provider	96.42% (269/279)	This relates to 10 collections from 8 different patients	98.38% (182/185)	98.64% (217/220)
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	99.38% (480/483)		98.47% (580/589)	99.37% (471/474)
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	98.90% (5946/6012)		99.05% (4884/4931)	98.32% (4850/4933)
Mede	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%
Mede	Ass Tech	**s-at4**	Delivery of equipment within agreed time frames	95%	Monthly report from provider	100.00%		c	100.00%
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		N/A	100.00%
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%		90.00%	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%
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	100.00%		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	100.00%		98.76%	99.46%
NCHC		**D5-ccc7**	Intermediate - 72 hrs	Intermediate - 95%	Monthly report from Provider	98.18%		97.36%	97.87%
NCHC		**D5-ccc7**	18 weeks	18 weeks - 95%	Monthly report from Provider	99.54%		99.28%	99.10%
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
WSH	Adult SALT	**s-salt1**	All new referrals are triaged within 5 Operating Days of receipt of referral;	98%	Monthly report from Provider	98.79%		95.65%	100.00%
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	98.00%		98.81%	99.00%
WSH	Adult SALT	**s-salt2**	Priority 3 within 18 weeks	Priority 3 - 95%	Monthly report from Provider	100.00%		100.00%	100.00%
WSH	Medical Appliances	**s-ma1**	% of appointments available within 6 weeks	95%	Monthly report from provider	100.00%		100.00%	100.00%
WSH	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
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%

Children's Services KPIs									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of Measurement**	**Mar 2017**	**Mar Comments / Queries 2017**	**Jan 2017**	**Feb 2017**
WSH	All Paediatric Services	**GP-1**	18 week RTT for Consultant led services	95% of consultant led Service Users to be treated within 18 weeks	Monthly RTT reporting	97.25%		86.59%	93.51%
WSH	All Paediatric Services	**GP-1**	18 week RTT for non-Consultant led services	95% of non-consultant led Service Users to be treated within 18 weeks	Monthly pledge 2 reporting	98.01%		99.55%	100.00%
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 reported within SCH KPIs		
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 reported within SCH KPIs		
WSH	All Paediatric Services	**GP-6**	Safeguarding - % eligible staff who have completed level 1 training	98%	monthly report by provider	99.54%		100.00%	99.53%
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 (all discharge letters whether electronic/non electronic to clearly state date dictated, date signed and date sent)	95%	Monthly	100.00%		100.00%	100.00%
WSH	All Paed Services	**PaedSLT-5**	Personalised Care Planning - Percentage of Transition (to adults) Care Plans completed	Q3 2012/13 establish baseline	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	100.00%		98.40%	98.37%
WSH	Newborn Hearing Screening Service (West)	**NBHS-3**	Screening outcomes set within 3 months	≥99%	Monthly Activity Report	100.00%		98.56%	99.16%
WSH	Community Children's Nursing	**CCN-14** **cps-ip02**	% of children identified as having high level needs being actively case managed.	Q3 2012/13 establish baseline Q4 2012/13 onwards >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		Now reported within SCH KPIs		
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		Now reported within SCH KPIs		
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		Now reported within SCH KPIs		
WSH	Access	**cps-a02**	Children/young people in special schools receive speech and language interventions	100%	Systmone	100% 284 contacts		100.00% 241 contacts	100.00% 167 contacts
WSH	Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	Systmone	100.00% 166 contacts		100.00% 221 contacts	100.00% 141 contacts
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. All initial health assessments and SMART care plans are shared with appropriate parties.	100% in 28 days	Monthly report from Provider	91.67%	11 out 12 children were offered an IHA within 28 days of the service being notified of the child (irrespective of whether they accepted the date)	0.00%	6.67%
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	66.67%	8 out these children had their IHA within 28 days of the service being notified of the child	71.43%	86.67%
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	25.00%	3 children had their IHA within 28 days of becoming CiC. 8 children's referrals were delayed > 14 days from becoming CiC and the service being notified	92.86%	93.33%

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

a) Current Position
Currently 94.34% against 95% target.
The IT upgrade continues to impact compliance. An IT upgrade at e-learning for health has resulted in difficulties for staff in accessing the module on laptops.

b) Recommended Action
- There is a system wide approach being taken to upgrade the Internet Explorer to all clinical laptops.
- Non-compliant staff are being targeted.
- Reasons for non-attendance at booked sessions are being interrogated by the Lead Nurse.

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2 Community Equipment Service - C-gen8 &9

a) Current Position
C-gen8 – 4hour delivery - Currently 97.03% against a 98% target
This relates to 7 deliveries to 3 different patients.
2 patients had their 4 items of equipment delivered within 5 hours of ordering and 1 patient had their 3 items of equipment delivered within 6.5 hours

C-gen9 – Urgent next day collections – Currently 96.42% against a 98% target
This relates to 10 collections from 8 different patients

b) Recommended Action
- More information has been requested from the service provider.
- A detailed report has been commissioned by Provider Management Group to understand the drivers behind increasing demand and costs.

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3 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 – 91.67% against a 100% target
CiC-001b – 66.67% against a 100% target
CiC -001c – 25.00% against a 100% target

12 Initial Health Assessments were completed in March. 3 were completed within 28 days of becoming CiC, 8 were completed within 28 days of the service receiving ALL the paperwork and 11 appointments were offered within 28days. There was a delay of greater than 14 days from the child becoming CiC and the service being notified for 4 referrals which directly impacted on the statutory compliance target.

b) Recommended Action
- Following the escalation of delays in notification of children in care with complete paperwork. A meeting with the County Council has been held to investigate 20 cases. Agreement has been made to trial a new process which will improve timely transfer of revised paperwork. A review meeting of the impact will be conducted in 6 weeks.

	Units	Target	Red	Amber	Green	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Patient Experience												
Service users who rated the service as 'good' or 'better' (Quarterly)	Nos.	No Target				1557						
	%	85%	<80%	80%-85%	>=85%	98.23%						
Service users who responded that they felt 'better'	Nos.	No Target				106	159	179	115	141	158	137
	%	85%	<80%	80%-85%	>=85%	98%	94%	94%	94%	96%	96%	93%
Service users who felt 'well informed'	Nos.	No Target				133	187	190	144	182	200	177
	%	85%	<80%	80%-85%	>=85%	94%	93%	90%	96%	96%	91%	94%
10% of long term condition patients feel "better supported" to self manage their conditions (Quarterly)	Nos.	No Target				119						
	%	No Target				100%						
Falls (Inpatient Units)												
Total numbers of inpatient falls (includes rolls and slips)	Nos.	No Target				47	26	59	60	51	33	48
Rolls out of Bed		No Target				1	1	1	5	2	5	1
Slip out of chair		No Target				2	0	3	3	8	3	5
Assisted Falls/ near misses		No Target				5	4	0	1	0	3	6
% of total falls resulting in harm	%	No Target				19%	15%	29%	22%	31%	24%	23%
Numbers of falls resulting in moderate harm	Nos.	No Target				1	0	0	0	0	0	1
Numbers of falls resulting in severe harm	Nos.	No Target				0	0	0	2	2	0	1
Numbers of patients who have had repeat falls	Nos.	No Target				8	6	10	13	11	7	8
% 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	13.3	7.6	17.3	17.4	13.9	10.5*	13.8*
Pressure Ulcers												
Pressure Ulcers – In Our Care Community												
Grade 2		100 pa	>110	100-110	<=100	13	18	13	23	26	31	27
Grade 3		26 pa	>30	27-29	<=26	5	10	10	6	8	13	10
Grade 4		0 pa	>1	1	0	0	0	0	1	2	1	2
Pressure Ulcers – In our care In-patient												
Grade 2		13 pa	>17	13-17	<=13	2	2	4	5	2	3	4
Grade 3		2 pa	>4	02-Apr	<=2	0	1	2	0	1	1	0
Grade 4		0 pa	>1	1	0	0	0	0	1	0	0	0
Safeguarding People Who Use Our Services From Abuse												
Number of adult safeguarding referrals made		No Target				1	5	3	5	4	2	3
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				100%	100%	100%	100%	100%	100%	100%

	Units	Target	Red	Amber	Green	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	1	0	0	0	0	0	0
C.Diff associated diseases (CDAD) RCA reports		100%	<95%	95%-100%	=100 %	100%	N/A	N/A	N/A	N/A	N/A	N/A
Infection Control												
Infection control training		100%	<83%	83%-100%	=100 %	88.82%	88.39%	90.17%	91.00%	89.87%	85.99%	89.70%
Essential Steps Care Bundles Including Hand Hygiene												
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	99.00%	99.00%	98.00%	99.00%	98.00%	99.00%	98.00%
Isolation room audit		100%	<95%	95%-100%	=100 %	100%	100%	100%	100%	N/A	N/A	100%
Management of Medication -SCH NRLS Reportable Incidents												
Total number of medication incidents in month		No Target				8	4	9	16	23	18	25
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				5	4	8	15	23	16	20
(also includes those not attributed to SCH management)	Low harm	No Target				3	0	1	1	0	2	5
Number of medication incidents involving Controlled Drugs		No Target				1	1	1	0	0	7	5

Incidents												
NRLS (i.e. patient safety) reportable incidents in month		No Target				165	160	191	178	217	223	229
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				0	11	12	9	13	15	12
Number of SIs reported to CCG in month *4 STEIS for 2 pts (2 each)		No Target				0	11	10	9	13	17	17*
Percentage of SI reports submitted to CCG on time in month		No Target				N/A	0%	100%	100%	100%	100%	100%
Duty of Candour Applicable Incidents		No Target				7	11	9	10	13	13	16

Severity of NPSA Reportable Incidents												
None		No Target				115	117	125	119	140	122	145
Low		No Target				43	32	54	50	64	87	69
Moderate		No Target				7	11	12	6	9	13	11
Major		No Target				0	0	0	3	4	1	4
Catastrophic		No Target				0	0	0	0	0	0	0

Training Compliance												
Adult Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	92.96%	96.45%	97.25%	96.94%	97.04%	95.59%	96.74%
Children Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	94.28%	96.81%	97.52%	97.12%	97.04%	95.86%	96.92%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	95.60%	96.30%	94.62%	94.10%	94.62%	92.57%	94.34%
WRAP							35.50%	44.48%	44.47%	45.27%	51.73%	67.33%
MCA / DoLs- Training compliance							64.80%	71.46%	70.97%	69.76%	68.46%	67.33%

Compliments/Complaints

	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Compliments	52	21	33	19	46	21	38	28	36	27	61	50	36
Total SCH Complaints	3	4	2	6	7	5	1	1	2	2	3	5	1
Acknowledged within 3 days	100%	60%	100%	50%	83%	100%	100%	50%	50%	100%	100%	100%	100%
% of Responses within 25 days	66%	25%	50%	33%	71%	TBC	0%	100%	50%	50%	67%	TBC	100%
Responded to within 25 days	2	1	1	2	5	TBC	0	1	1	2	2	TBC	1
Responded to after 25 days	1	3	1	4	2	TBC	1	0	1	0	1	TBC	0
Average response time (days)	29	31	33	30	24	TBC	31	19	37	39	24	TBC	7

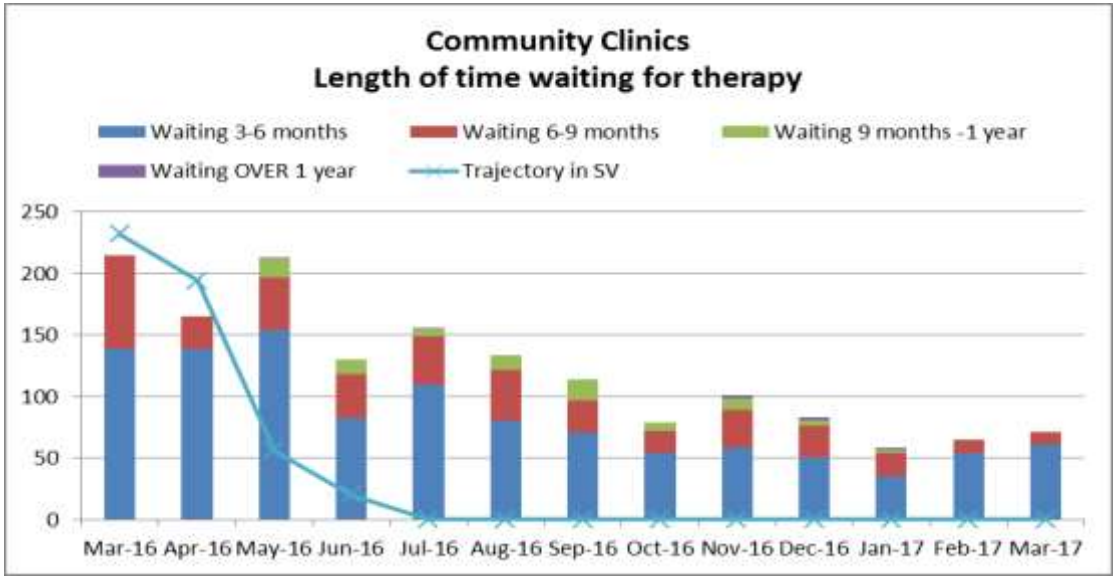
Paediatric Speech and Language Service Waiting times

Community Clinic

Clinic Waiting lists

Reports run 03/04/2017

Length of wait Community Clinics *(pre-school caseload)*	No. of children waiting July 2015	No. of children waiting March 2016	No. of children waiting April 2016	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
Waiting up to 3 months	139	193	206	135	191	167	150	156	151	176	158	176	165	162
Waiting 3-6 months	139	139	139	154	82	110	81	70	54	58	51	35	54	61
Waiting 6-9 months	151	76	26	43	36	39	41	27	18	31	25	19	10	10
Waiting 9 months -1 year	106	0	0	15	12	6	12	17	7	10	5	3	1	0
Waiting OVER 1 year	0	0	0	1	0	1	0	0	0	2	2	1	0	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**535**	**408**	**371**	**348**	**321**	**323**	**284**	**270**	**230**	**277**	**241**	**234**	**230**	**233**
Already had PoC		62	78	70	66	119	97	72	75	67	72	55	60	85
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*		**470**	**449**	**418**	**387**	**442**	**381**	**342**	**305**	**344**	**313**	**289**	**290**	**318**

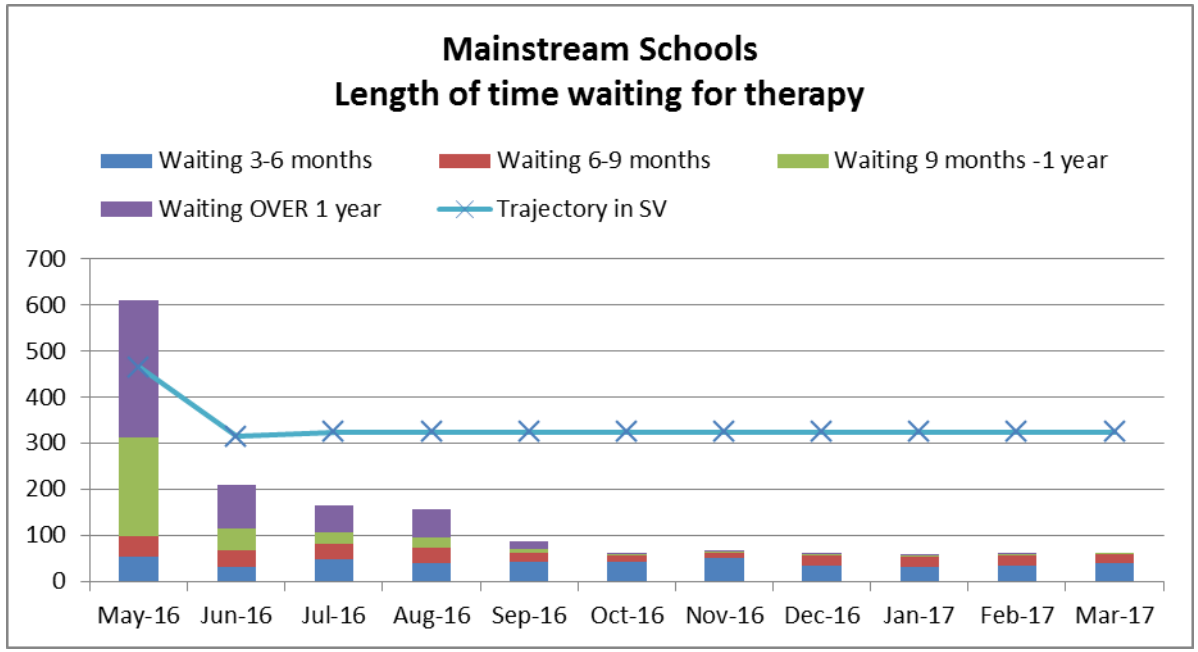


Mainstream Schools

Schools Waiting lists

No waiting data by months prior to May

Length of wait Mainstream Schools *(pre-school caseload)*	No. of children waiting July 2015	No. of children waiting March 2016	No. of children waiting April 2016	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
Waiting up to 3 months				142	126	117	119	88	72	68	59	56	56	73
Waiting 3-6 months				54	32	50	41	44	42	51	36	31	36	41
Waiting 6-9 months				46	36	33	33	18	16	13	22	22	21	18
Waiting 9 months -1 year				212	48	23	23	10	3	2	2	4	4	3
Waiting OVER 1 year				298	95	60	61	17	3	2	2	2	1	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**
Already had PoC				*unavailable*	264	356	396	395	377	392	332	277	266	248
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**



Appendix B – Provider Management Group Report

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

1. Contract Performance KPI Summary

The group received an update on the highlights of the contract performance and quality report.

- FFT 99% for February.
- 5 complaints received for February, 1 each for Community Health Team, COPD, Continence, Admission Prevention Service and Paediatrics.
- There has been a slight decrease in the numbers of Delayed Transfers of Care to 52 but this number is still high. Numbers of patients waiting for domiciliary care have also reduced.
- There has been a slight rise for children waiting for SaLT for 3-6 months due to interim locum resources being reduced.
- The Care Co-ordination Centre has achieved the Speed of Answer KPI.
- There has been a reduction in Paediatric 18 week Referral to Treatment breaches.
- Medequip has achieved all their KPI's for February.
- Children in Care improvements – there are still problems with notifications of children being taken into care from Suffolk County Council, but improvements are being seeing in the time it takes for paperwork to be received once notified.
- Readmission rates from the community beds back to acute units is currently 25.22% - service leads are conducting analysis into this to determine any correlation between that and patient cohorts. A report will be received at the next PMG meeting.
- The number of falls within inpatient units has reduced from January.

There has also been an increase in the level of incidents being recorded on Datix, from Norfolk hosted staff for dressing's availability and staffing capacity. Laura Clear confirmed that there have been more incidents recorded in relation to wound care products, stock availability and staffing levels; however she is assured that no detrimental impact on patient care had been experienced as a result.

2. Provider Updates

West Suffolk Foundation Trust

- Paediatric 18 week waiting times – slightly better for February, however, waits will continue to increase until vacancy is filled. A permanent locum has been sought to fill this vacancy.
- Adult Speech and Language Therapy pilot to include dementia / nursing home referrals has commenced. Evaluation from the pilot will be in June

Ipswich Hospital Trust

- The Care Co-ordination Centre has started receiving Paediatric referrals as from 3/4/17 – there has been no negative impact on speed of answer experienced to date.

Norfolk Community Health & Care

- A phone line requires re-siting at Haverhill due to it being a trip hazard. Difficulties have been encountered in arranging for this work to be done, subsequently there has now been an accident, resulting in a member of staff having tripped and is now absent from work.
- There are issues with SIM cards in laptops due to the laptop build.

Medequip

- All KPI's have been met for February 2017

- February deliveries and collections activity is down from January figures – however a lot of activity has been seen throughout March re: returns of equipment – 0.5% increase seen for March, this equates to a value of an extra £100,000
- Equipment labels and delivery notes detail how to return equipment when this is no longer required and states the equipment is issued “on loan”.
- The number of outstanding service and maintenance plans has reduced by another 300 from January to February and another 300 from Feb to March. There are 1372 still outstanding, from an original figure of over 7,000.
- Net equipment cost is still over budget – more expensive equipment is being issued to patients, but activity hasn’t increased.
- Single site solution: The building next door to the existing CES store in Ipswich has come up for lease within the last two weeks. This, along with the existing site would be the ideal size.

3. Risk report

- PMG received an updated risk report. It was confirmed that the current governance groups are still meeting across the contract, and that planning for contract transition is part of the governance work stream.

4. CIP/SIP Update report

Minor Injuries Unit (Felixstowe) review

- There is a current cost of approx. £100,00pa for GPs to attend MIU. There is no clear specification for what they should provide.
- Need to review the opening hours, majority of patients attending after 6pm are for routine wound care which could happen during the day. X-ray facility – the current equipment is obsolete, however, there is the opportunity for the FCH League of Friends to fund this. PMG were in agreement that the project should proceed.

Heart Failure Service

- CCG and providers are keen to review this service, it is currently experiencing demand challenges and there are opportunities to re-design some of the admission prevention pathways. It was agreed to include this in the transformation plan for the Alliances.

Item 8

							Surgery												
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	F9	F10	G1
Patient Experience: in-patient	QR-PEI-10	Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	89	99	96	98	NA	NA	NA	NA	NA	96	87	96	100
	QR-PEI-180	(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	97.22	100	100	100	NA	NA	NA	NA	NA	100	100	100	100
	QR-PEI-20	In your opinion, how clean was the hospital room or ward that you are in?	= 85%	<75	75-84	85-100	99	100	98	100	NA	NA	NA	NA	NA	100	100	99	100
	QR-PEI-340	Did you feel you were treated with respect and dignity by staff?	= 85%	<75	75-84	85-100	100	100	100	100	NA	NA	NA	NA	NA	98	96	100	100
	QR-PEI-330	Were Staff caring and compassionate in their approach?	= 85%	<75	75-84	85-100	100	100	100	100	NA	NA	NA	NA	NA	98	94	100	100
	QR-PEI-30	Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	28	98	78	83	NA	NA	NA	NA	NA	78	47	65	100
	QR-PEI-70	(In-patient) Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<75	75-84	85-100	90	100	97	99	NA	NA	NA	NA	NA	98	94	94	100
	QR-PEI-80	Were you involved as much as you wanted to be in decisions about your condition and treatment?	= 85%	<75	75-84	85-100	93	100	95	100	NA	NA	NA	NA	NA	98	94	100	100
	QR-PEI-90	Were you given enough privacy when discussing your care?	= 85%	<75	75-84	85-100	100	100	99	100	NA	NA	NA	NA	NA	100	100	100	100
	QR-PEI-350	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	96	100	100	100	NA	NA	NA	NA	NA	96	100	100	100
	QR-PEI-100	(In-patient) Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	100	100	98	100	NA	NA	NA	NA	NA	100	100	100	100
	QR-PEI-150	Timely call bell response	= 85%	<75	75-84	85-100	87	95	94	100	NA	NA	NA	NA	NA	95	47	100	100
	QR-PEI-290	Same sex accommodation: total patients	= 0	>2	1-2	= 0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PEI-300	Complaints	= 0	>2	1-2	= 0	0	0	0	0	0	0	0	0	1	0	1	0	0
	QR-PEI-310	Environment and Cleanliness	= 90%	<80	80-89	90-100	88	90	88	89	90	93	97	94	89	89	84	89	95

							Surgery		Medicine	
Group		Indicator	Target	Red	Amber	Green	F4	DSU	F7	F8
Patient Experience: short-stay	QR-PES-10	Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	99	100	100	0
	QR-PES-60	(Short-stay) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	100	100	0
	QR-PES-20	(Short-stay) Were you given enough privacy when being examined and treated?	= 85%	<75	75-84	85-100	100	100	100	0
	QR-PES-30	(Short-stay) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	100	100	100	0
	QR-PES-40	Were you told who to contact if you were worried after leaving hospital?	= 85%	<75	75-84	85-100	100	100	100	0
	QR-PES-50	(Short-stay) Overall how would you rate the care you received in the department?	= 85%	<75	75-84	85-100	98	99	100	0
	QR-PES-70	Number of short stay surveys completed	No Target	No Target	No Target	No Target	159	35	5	0

							Medicine
Group		Indicator	Target	Red	Amber	Green	ED
Patient Experience: A&E	QR-PEA-10	Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	94
	QR-PEA-100	(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	96.09
	QR-PEA-30	Were A&E staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	98
	QR-PEA-110	Were you given enough privacy when discussing your condition at reception?	= 85%	<75	75-84	85-100	92
	QR-PEA-120	Did Doctors and Nurses listen to what you had to say?	= 85%	<75	75-84	85-100	97
	QR-PEA-130	Did staff tell you who to contact if you were worried about your condition after leaving A&E?	= 85%	<75	75-84	85-100	91
	QR-PEA-80	Did a member of staff tell you what danger signs to watch for when going home?	= 85%	<75	75-84	85-100	90
	QR-PEA-140	Number of A&E surveys completed	No Target	No Target	No Target	No Target	598

							Surgery	Medicine	Women & Children
Group		Indicator	Target	Red	Amber	Green			
Patient Experience: A&E (Children questions)	QR-PEAC-70	Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	Currently no data for this		
	QR-PEAC-80	(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			
	QR-PEAC-30	Did the Doctor or Nurse listen to what you had to say?	= 85%	<75	75-84	85-100			
	QR-PEAC-100	Were staff friendly and kind to you and your family?	= 85%	<75	75-84	85-100			
	QR-PEAC-50	Did we help with your pain?	= 85%	<75	75-84	85-100			
	QR-PEAC-60	Did staff explain the care you need at home?	= 85%	<75	75-84	85-100			
	QR-PEAC-130	Number of A&E children surveys completed	No Target	No Target	No Target	No Target			

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F11
Patient Experience: Maternity	QR-PEM-10	Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	100
	QR-PEM-120	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
	QR-PEM-130	How likely are you to recommend our labour suite to friends and family if they needed similar care or treatment?	= 75%	<70	70-74	75-100	NA
	QR-PEM-135	How likely are you to recommend our antenatal department to friends and family?	= 75%	<70	70-74	75-100	95.4
	QR-PEM-140	How likely are you to recommend our post-natal care to friends and family?	= 75%	<70	70-74	75-100	100
	QR-PEM-30	(Maternity) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	100
	QR-PEM-40	(Maternity) Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<75	75-84	85-100	100
	QR-PEM-50	Were you involved as much as you wanted to be in decisions about your care and treatment?	= 85%	<75	75-84	85-100	100
	QR-PEM-60	(Maternity) Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	100
	QR-PEM-70	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	75-84	85-100	100
	QR-PEM-80	Were you given adequate help and support to feed your baby whilst in hospital?	= 85%	<75	75-84	85-100	100
	QR-PEM-90	How many minutes after you used the call button did it usually take before you got the help you needed?	= 85%	<75	75-84	85-100	94
	QR-PEM-100	Has a member of staff told you about medication side effects to watch for when you go home?	= 85%	<75	75-84	85-100	100
	QR-PEM-110	Have hospital staff told you who to contact if you are worried about your condition after you leave hospital?	= 85%	<75	75-84	85-100	100
	QR-PEM-20	In your opinion, how clean was the hospital room or ward that you were in?	= 85%	<75	75-84	85-100	100
	QR-PEM-125	Number of maternity surveys completed	No Target	No Target	No Target	No Target	128

							Women & Children
Group		Indicator	Target	Red	Amber	Green	MLBU
Patient Experience: Birthing Unit	QR-PEBU-10	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	NA
	QR-PEBU-20	Did you feel that your community midwife gave you sufficient information about the birthing unit prior to you being referred?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-40	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	75-84	85-100	NA
	QR-PEBU-50	Do you feel that the 'home from home' environment had a positive effect on your birthing experience?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-60	Did you have confidence and trust in the midwives caring for you during labour?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-70	Were your birthing partners made to feel welcome by the midwives on the birthing unit?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-80	Were you at any time left alone by your midwife at a time when you felt worried?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-90	Thinking about your care during labour and birth, were you involved in the decisions about your care?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-100	Overall how would you rate the care you received on the MLBU during your labour and birth?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-110	Number of birthing unit surveys completed	No Target	No Target	No Target	No Target	NA

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
Patient Satisfaction: Young Children	QR-PEYC-120	Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	NA
	QR-PEYC-110	(Young children) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	NA
	QR-PEYC-20	Did you understand the information given to you regarding your treatment and care?	= 85%	<75	75-84	85-100	NA
	QR-PEYC-10	Were you as involved as you wanted to be in decisions about your care and treatment?	= 85%	<75	75-84	85-100	NA
	QR-PEYC-140	Did the Doctor or Nurses explain what they were doing in a way that you could understand?	= 85%	<75	75-84	85-100	97
	QR-PEYC-40	Were you offered age/need appropriate activities?	= 85%	<75	75-84	85-100	100
	QR-PEYC-60	Was your experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	75-84	85-100	100
	QR-PEYC-70	Was your experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	100
	QR-PEYC-150	If you were in pain, did the Doctor or Nurse do everything they could to help with the pain?	= 85%	<75	75-84	85-100	88
	QR-PEYC-160	Were staff kind and caring towards you?	= 85%	<75	75-84	85-100	100
	QR-PEYC-90	Is the environment child - friendly?	= 85%	<75	75-84	85-100	100
	QR-PEYC-100	Overall, how would you rate your experience in the Paediatric Unit?	= 85%	<75	75-84	85-100	100
	QR-PEYC-130	Number of young children surveys completed	No Target	No Target	No Target	No Target	86

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
F1 Parent	QR-PEF1-120	Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	100
	QR-PEF1-110	(F1 Parent) 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
	QR-PEF1-20	Did you understand the information given to you regarding your child's treatment and care?	= 85%	<75	75-84	85-100	93
	QR-PEF1-10	Were you and your child as involved as you wanted to be in decisions about care and treatment?	= 85%	<75	75-84	85-100	10
	QR-PEF1-130	Did the Doctor or Nurses explain what they were doing in a way that your child could understand?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-40	Were there appropriate play activities for your child (such as toys, games and books)?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-60	Was your child's experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-70	Was your child's experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-150	If your child was in pain, did the doctor or nurse do everything they could to help with the pain?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-140	Were staff kind and caring towards your child?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-90	Is the environment child-friendly?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-100	Overall, how would you rate your experience in the Children's Unit?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-160	Number of F1 parent surveys completed	No Target	No Target	No Target	No Target	NA

							Medicine
Group		Indicator	Target	Red	Amber	Green	G8
Patient Experience: Stroke	QR-PEST-10	Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	95
	QR-PEST-80	(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100
	QR-PEST-20	Have you been told you have had a stroke, which lead to your admission to hospital?	= 85%	<75	75-84	85-100	100
	QR-PEST-30	Have you been involved in planning your recovery / rehabilitation?	= 85%	<75	75-84	85-100	88
	QR-PEST-40	While you were in the Stroke Department how much information about your condition or treatment was given to you?	= 85%	<75	75-84	85-100	95
	QR-PEST-50	Have you received the help you require while eating?	= 85%	<75	75-84	85-100	86
	QR-PEST-60	Do you feel cared for?	= 85%	<75	75-84	85-100	93
	QR-PEST-70	Were you given enough privacy when being examined or treated or when your care was discussed with you?	= 85%	<75	75-84	85-100	100
	QR-PEST-90	Number of stroke surveys completed	No Target	No Target	No Target	No Target	21

Medicine									Women & Children			
G3	G4	G8	MTU	F12	G5 - Ward (OLD G9)	WEW – G9	F7	F8	F1	F11	F14	MLBU
94	83	NA	NA	94	97	92	88	92	NA	NA	96	NA
96.43	100	NA	NA	94.44	100	100	100	100	NA	NA	94.74	NA
99	89	NA	NA	96	98	99	95	98	NA	NA	100	NA
100	94	NA	NA	97	97	99	99	100	NA	NA	97	NA
100	94	NA	NA	97	97	98	98	100	NA	NA	97	NA
64	61	NA	NA	83	83	67	46	75	NA	NA	89	NA
92	65	NA	NA	96	97	92	87	67	NA	NA	93	NA
93	75	NA	NA	94	97	98	94	93	NA	NA	95	NA
96	97	NA	NA	100	100	96	98	96	NA	NA	95	NA
100	75	NA	NA	100	100	96	97	96	NA	NA	96	NA
100	100	NA	NA	97	100	99	99	98	NA	NA	96	NA
100	62	NA	NA	87	96	78	69	90	NA	NA	100	NA
0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	1	0	1	0	0	0	0
85	No Data	91	99	95	86	95	85	90	92	94	93	95

Item 8

							Surgery								Medicine													Women &
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	F9	F10	G1	G3	G4	G8	MTU	F12	G5 - Ward (OLD G9)	WEW – G9	F7	F8	F1	F11
Patient Safety	QR-PS-10	HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA
	QR-PS-20	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	100	100	100	100	No Data	No Data	NA	100	No Data	No Data	No Data	NA	NA	NA
	QR-PS-30	HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	88	No Data	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA	No Data	100	NA
	QR-PS-40	HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	100	100	100	90	NA	NA	NA	NA	100	80	100	100	80	100	100	NA	100	80	100	NA	NA	100	NA
	QR-PS-50	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
	QR-PS-60	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
	QR-PS-90	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
	QR-PS-100	HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	100	NA	NA	100	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA
	QR-PS-110	HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	100	100	100	100	NA	NA	NA	NA	NA	100	20	100	100	75	80	80	NA	100	50	100	NA	NA	NA	NA
	QR-PS-111	HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<80	80-99	= 100	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
	QR-PS-220	Total no of MRSA bacteraemias: Hospital	= 0 per yr	> 0	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
	QR-PS-400	Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	95	100	100	98	95	No Data	No Data	No Data	No Data	100	56	82	83	83	94	85	NA	100	100	No Data	100	86	No Data	No Data
	QR-PS-250	Hand hygiene compliance	= 95%	<85	85-99	= 100	100	100	100	100	100	NA	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	QR-PS-230	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
	QR-PS-117	Quarterly Standard principle compliance	90%	<80	80-90%	90-100	84	96	93	96	98	No Data	No Data	No Data	91	98	89	94	100	95	90	95	NA	97	92	No Data	100	98	100	97
	QR-PS-240	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
	QR-PS-290	Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	93	100	88	94	NA	NA	NA	NA	NA	100	98	91	100	93	89	89	NA	100	92	No Data	99	97	87	No Data
	QR-PS-440	Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	92	93	92	95	85	85	98	90	81	96	87	89	90	89	95	93	NA	99	81	No Data	91	95	100	97
	QR-PS-450	Quarterly VIP score documentation	= 90%	<80	80-89	90-100	53	100	53	71	100	No Data	No Data	No Data	29	100	78	96	100	86	85	89	NA	100	77	No Data	69	100	100	100
	QR-PS-120	No of patient falls	= 48	>=48	No Target	<48	5	1	2	4	0	NA	NA	NA	5	0	7	5	2	1	4	6	0	2	16	5	6	0	NA	0
	QR-PS-121	Falls per 1,000 bed days (Trust and Divisional levels only)	= 5.6	>5.8	5.6-5.8	<5.6	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA
	QR-PS-130	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	0	0	1	0	0	NA	NA	NA	2	0	1	0	0	1	2	2	0	1	6	0	0	0	NA	0
	QR-PS-140	No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-141	Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-470	No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	0	0	0	0	0	NA	NA	NA	NA	0	1	1	0	0	1	0	0	0	0	1	0	0	NA	0
	QR-PS-480	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
	QR-PS-190	Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	100	100	100	100	100	NA	NA	NA	NA	100	80	90	50	100	67	90	NA	100	80	90	No Data	No Data	NA	NA
	QR-PS-260	No of SIRIs	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	0	0	0	2	0	0	0	0	0
	QR-PS-500	No of medication errors	No Target	No Target	No Target	No Target	3	0	2	2	3	0	0	0	6	0	5	1	4	3	2	2	0	0	2	2	8	1	2	3
	QR-PS-300	Cardiac arrests	No Target	No Target	No Target	No Target	1	0	0	1	0	0	1	0	5	0	0	1	0	0	0	1	0	1	0	1	1	0	0	0
	QR-PS-490	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
	QR-PS-340	Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	0	0	0	0	NA	NA	NA	NA	NA	NA	0	0	0	0	0	0	NA	0	0	NA	0	0	0	0
	QR-PS-370	VTE: Completed risk assessment (monthly Unify audit)	> 98%	< 98	No Target	> 98	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na
	QR-PS-380	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
	QR-PS-390	Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	100	100	96.15	100	88.89	No Data	No Data	No Data	No Data	85.71	93.94	100	100	100	96.88	96.55	No Data	100	100	100	100	No Data	No Data	100
Patient Experience: in-patient	QR-PEI-290	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

Children	
F14	MLBU
NA	NA
No Data	NA
NA	NA
100	NA
NA	NA
NA	NA
NA	NA
NA	NA
100	NA
NA	NA
0	0
100	NA
100	100
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na	na
NA	NA
100	No Data
0	0

West Suffolk NHS
NHS Foundation Trust

Board of Directors - March 2017

AGENDA ITEM:	Item 9
PRESENTED BY:	Craig Black, Executive Director of Resources
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
DATE PREPARED:	21 April 2017
SUBJECT:	March Board report
PURPOSE:	Review

EXECUTIVE SUMMARY:
The year-end position reports a loss of £4.3m, against a planned loss of £5.0m.

Due to exceeding our pre-STF control total this position includes Financial Incentive Funding of £0.6m which accounts for the majority of this over performance. We have also anticipated total STF funding of £5.7m for the year.

Our annual accounts will also include an impairment on our TPP investment which results in a £5.0m 'below the line' deterioration in our final position. Therefore our annual accounts (pre-audit) will report a total deficit of £9.3m.

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

Item 9 FINANCE AND WORKFORCE REPORT

March 2017 (Month 12)

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

Financial Summary

I&E Position YTD	£4.3m	loss
Variance against plan YTD	£0.7m	favourable
Movement in month against plan	£5.7m	favourable
EBITDA position YTD	£1.3m	loss
EBITDA margin YTD	0.51%	loss
Cash at bank	£1,352k	
Use of Resources Rating (UoR)	3	

Executive Summary

- The Month 12 YTD position is ahead of plan by £0.7m.
- The Use of Resources Rating (UoR) (previously Financial Sustainability Risk Rating), is 3 YTD, in line with plan.

Key Risks for 2017-18

- 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 - March 2017	Mar-17 Budget £m	Mar-17 Actual £m	Mar-17 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m
NHS Contract Income	19.0	18.3	(0.7)	219.7	219.0	(0.7)
Other Income	0.1	0.3	0.2	29.3	28.7	(0.6)
Total Income	**19.1**	**18.6**	**(0.5)**	**249.0**	**247.7**	**(1.3)**
Pay Costs	12.9	11.7	1.2	142.3	142.3	(0.0)
Non-pay Costs	9.2	7.2	2.0	109.9	110.1	(0.2)
Operating Expenditure	**22.2**	**18.9**	**3.3**	**252.2**	**252.4**	**(0.2)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**(3.0)**	**(0.3)**	**2.8**	**(3.2)**	**(4.7)**	**(1.5)**
EBITDA margin	(15.9%)	(1.5%)	14.3%	(1.3%)	(1.9%)	(0.6%)
Depreciation	(0.7)	(0.7)	0.0	6.2	5.1	1.1
Finance costs	(0.8)	(0.8)	0.0	1.7	0.8	0.9
SURPLUS/(DEFICIT) pre S&TF	**(1.6)**	**1.2**	**2.8**	**(11.1)**	**(10.5)**	**0.6**
Sustainability and Transformation funding	0.5	3.4	2.9	6.1	6.3	0.2
SURPLUS/(DEFICIT) incl S&TF	**(1.1)**	**4.6**	**5.7**	**(5.0)**	**(4.3)**	**0.7**

FINANCE AND WORKFORCE REPORT – March 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 – March 2017

Income and Expenditure summary as at March 2017

The reported I&E for March 2017 is a surplus of £1.2m, against a planned deficit of £1.6m. This results in a favourable variance of £2.8m which is predominantly due to the Trust accounting for non-recurring credits which includes deposits for community equipment.

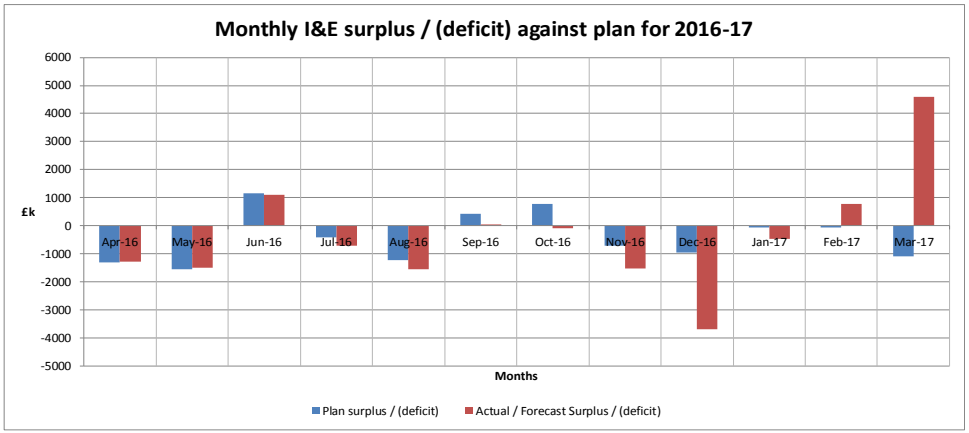
Our year end position is a loss of £10.5m which is ahead of our pre-STF financial control total. We therefore expect to receive further Sustainability and Transformation funding for Q3 and Q4 of £2.8m as well as financial incentive funding of £0.6m.

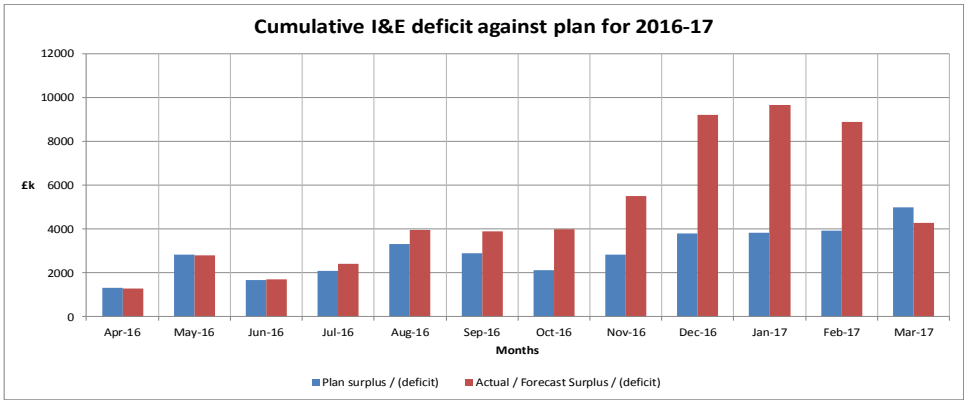
This means our reported year end position (before tPP impairment) is a loss of £4.3m against a planned loss of £5.0m

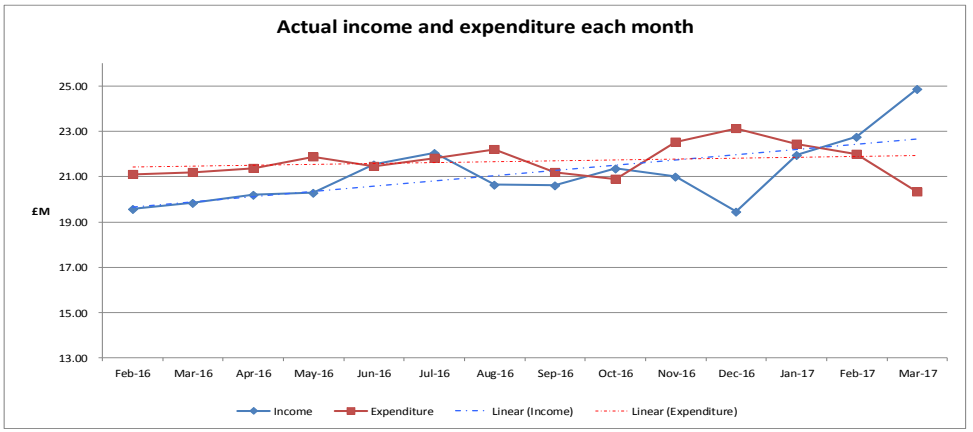
However, once the £5.0m tPP impairment is included our 2016-17 reported loss (pre-audit) will be £9.3m. This impairment is not included when determining our performance against the control total agreed with NHSI.

Summary of I&E indicators (before tPP impairment)

Income and Expenditure	Plan / target £'000	Actual / forecast £'000	Variance to plan (adv) / fav £'000	Direction of travel (variance)	RAG (report on Red)
In month surplus / (deficit)	(1,090)	4,600	5,690	↑	Green
YTD surplus / (deficit)	(5,000)	(4,277)	723	↑	Green
Forecast surplus / (deficit)	(5,000)	(4,277)	723	↑	Green
EBITDA YTD	2,907	(1,283)	(4,190)	↓	Red
EBITDA (%)	1.1%	(0.5%)	(1.7%)	↓	Red
Use of Resources (UoR) Rating fav / (adv)	3	3	0	↑	Amber
Clinical Income YTD	(219,681)	(219,017)	(664)	↑	Amber
Non-Clinical Income YTD	(35,437)	(34,967)	(470)	↓	Amber
Pay YTD	141,286	142,324	(1,038)	↓	Amber
Non-Pay YTD	118,833	115,937	2,896	↑	Amber
CIP target YTD	(12,500)	(12,500)	0	↔	Green

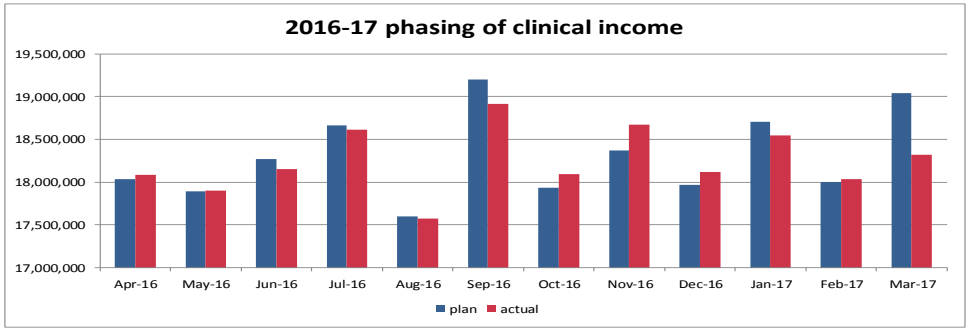






Income Analysis

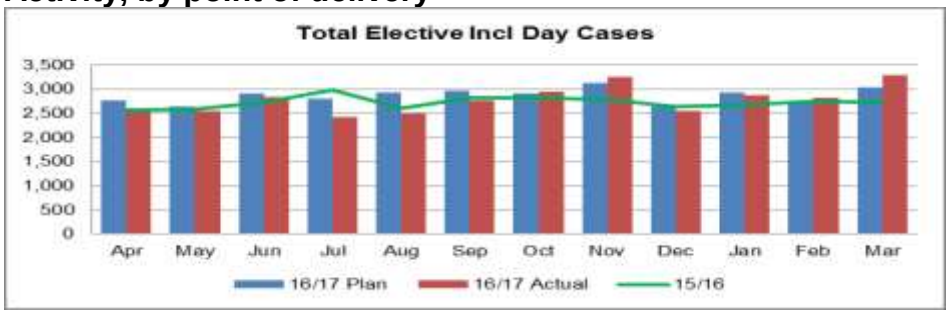
The chart below summarises the phasing of the clinical income plan for 2016-17, including Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.

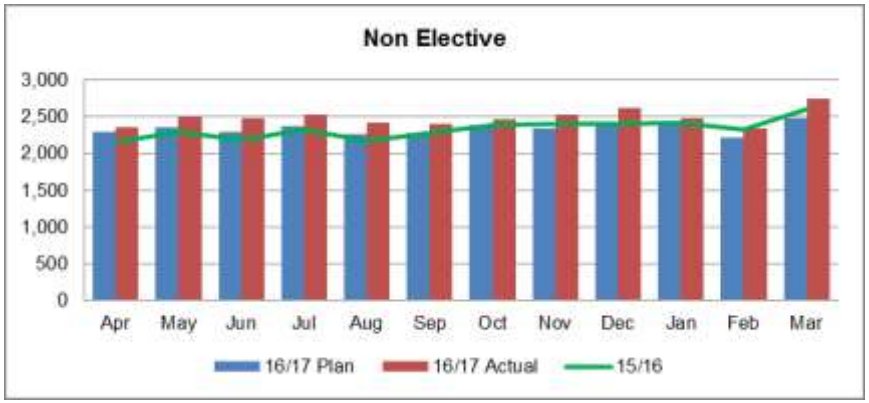


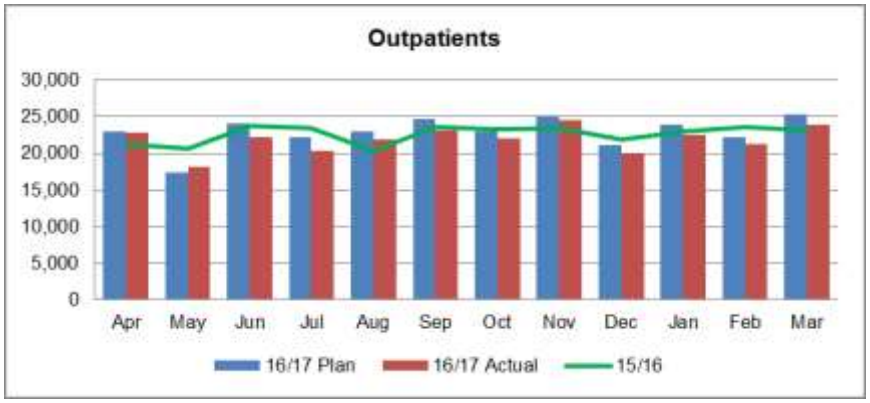
The income position was behind plan in March. Outpatient and Elective activity were the main area behind plan within the month and they have been consistently throughout the year.

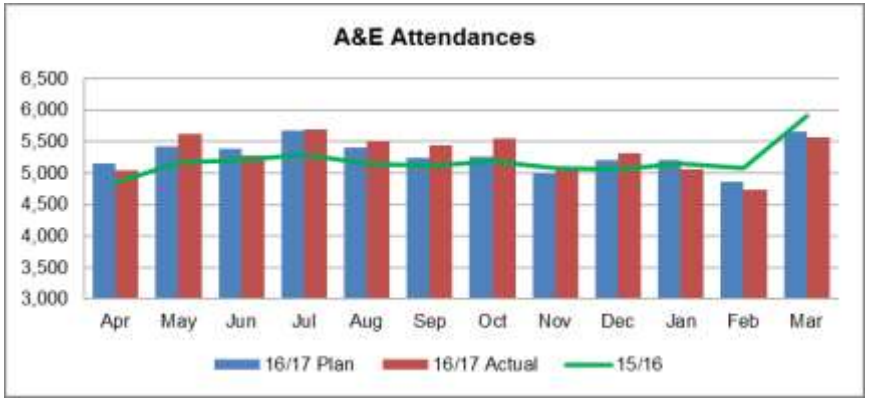
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	660	626	(34)	7,410	7,215	(195)
Other Services	2,128	1,512	(616)	26,074	29,662	3,588
CQUIN	327	327	1	3,674	3,564	(110)
Elective	3,091	2,991	(100)	35,048	32,275	(2,773)
Non Elective	4,872	5,136	264	55,350	56,856	1,505
Emergency Threshold Adjustment	(238)	(332)	(94)	(2,792)	(3,142)	(350)
Outpatients	3,256	3,114	(142)	35,616	33,287	(2,328)
Community	4,942	4,942	0	59,300	59,300	0
Total	**19,038**	**18,317**	**(721)**	**219,681**	**219,017**	**(664)**

Activity, by point of delivery

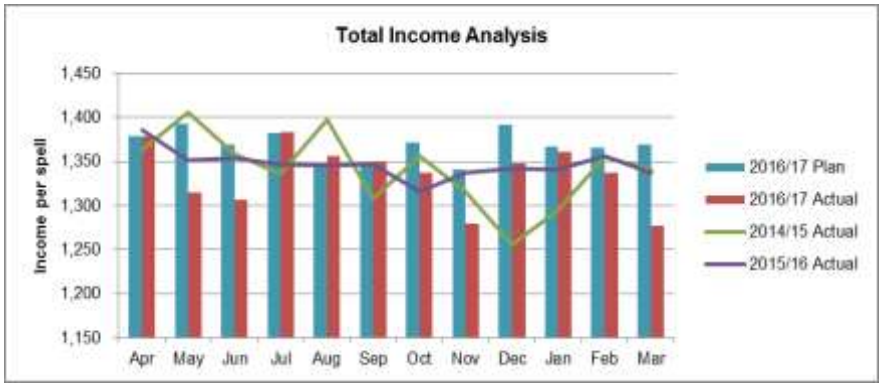


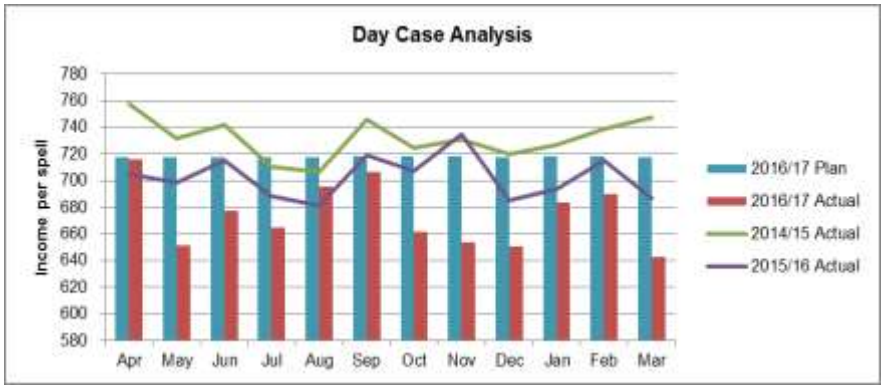


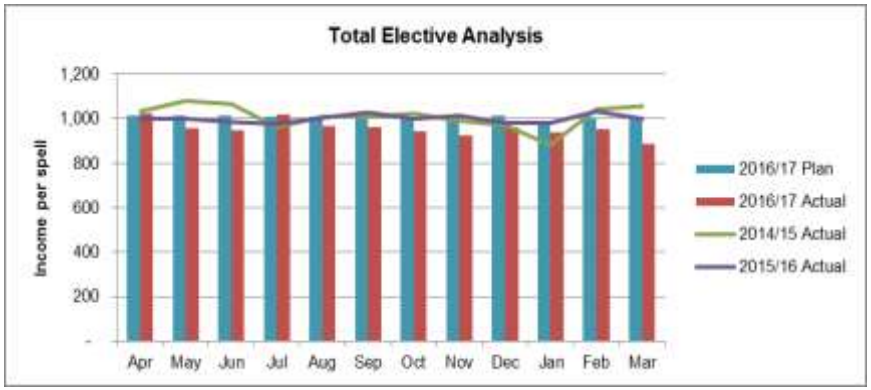


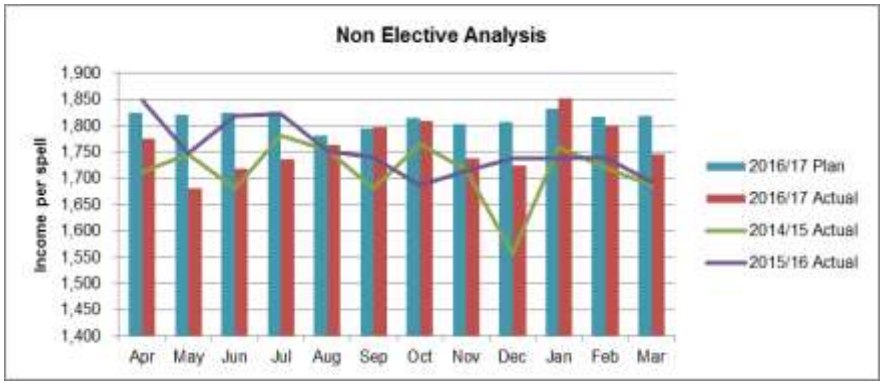


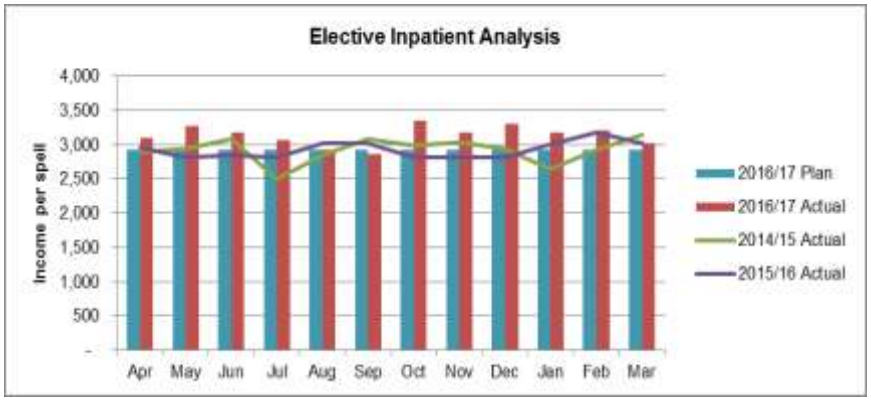
Trends and Analysis

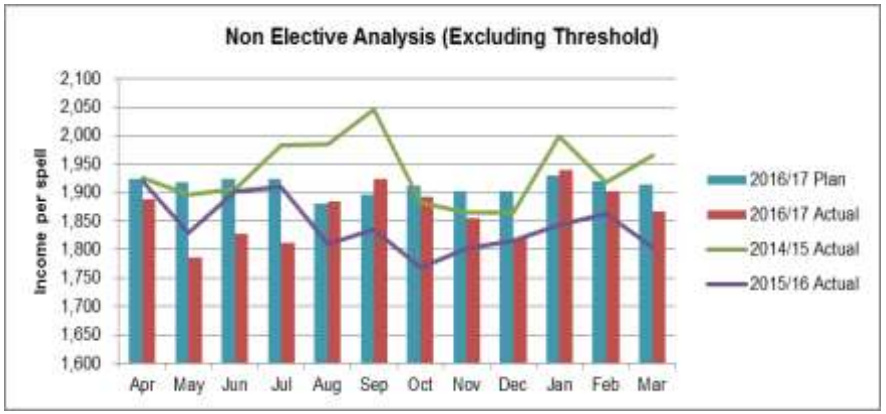












FINANCE AND WORKFORCE REPORT – March 2017

Workforce

Monthly Expenditure Acute services only				
As at March 2017	Mar-17	Feb-17	Mar-16	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,839**	**10,595**	**10,120**	**128,794**
Substantive Staff	9,570	9,627	9,063	113,818
Medical Agency Staff (includes 'contracted in' staff)	81	152	215	2,277
Medical Locum Staff	153	173	156	1,800
Additional Medical sessions	176	210	280	2,747
Nursing Agency Staff	23	112	170	1,771
Nursing Bank Staff	171	180	261	2,636
Other Agency Staff	130	62	115	1,340
Other Bank Staff	113	127	109	1,583
Overtime	92	101	78	975
On Call	41	58	42	602
Total temporary expenditure	980	1,175	1,425	15,732
Total expenditure on pay	**10,550**	**10,803**	**10,487**	**129,550**
Variance (F/(A))	289	(208)	(368)	(756)
Temp Staff costs % of Total Pay	9.3%	10.9%	13.6%	12.1%
Memo : Total agency spend in month	234	326	499	5,388

Monthly Expenditure Community Service				
As at March 2017	Mar-17	Feb-17	Mar-16	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,078**	**1,084**	**960**	**12,492**
Substantive Staff	1,074	1,179	976	11,964
Medical Agency Staff (includes 'contracted in' staff)	10	0	11	(5)
Medical Locum Staff	3	3	6	49
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	1	2	3	36
Nursing Bank Staff	8	11	5	81
Other Agency Staff	43	26	59	431
Other Bank Staff	9	13	6	145
Overtime	5	5	3	56
On Call	2	2	1	17
Total temporary expenditure	81	62	94	810
Total expenditure on pay	**1,155**	**1,241**	**1,070**	**12,774**
Variance (F/(A))	(78)	(157)	(6)	(283)
Temp Staff costs % of Total Pay	7.0%	5.0%	8.8%	6.3%
Memo : Total agency spend in month	54	28	73	462

Monthly whole time equivalents (WTE) Acute Services only			
As at March 2017	Mar-17	Feb-17	Mar-16
	WTE	WTE	WTE
Budgeted WTE in month	**3,019.2**	**3,019.2**	**2,931.5**
Employed substantive WTE in month	**2732.49**	**2719.82**	**2,685.3**
Medical Agency Staff (includes 'contracted in' staff)	7.65	11.75	14.3
Medical Locum	13.86	14.17	10.2
Additional Sessions	18.42	19.65	19.1
Nursing Agency	11.49	17.38	27.3
Nursing Bank	65.77	59.91	85.0
Other Agency	28.27	14.74	32.4
Other Bank	57.44	63.16	55.7
Overtime	44.75	46.57	39.2
On call Worked	6.83	9.99	7.5
Total equivalent temporary WTE	**254.5**	**257.3**	**290.6**
Total equivalent employed WTE	**2,987.0**	**2,977.1**	**2,975.9**
Variance (F/(A))	32.3	42.1	(44.4)
Temp Staff WTE % of Total Pay	8.5%	8.6%	9.8%
Memo : Total agency WTE in month	47.4	43.9	73.9
Sickness Rates (February/January)	3.66%	4.01%	4.2%
Mat Leave	2.2%	2.0%	2.0%

Monthly whole time equivalents (WTE) Community Services			
As at March 2017	Mar-17	Feb-17	Mar-16
	WTE	WTE	WTE
Budgeted WTE in month	**359.2**	**359.2**	**327.6**
Employed substantive WTE in month	**342.7**	**337.6**	**312.3**
Medical Agency Staff (includes 'contracted in' staff)	1.1	0.0	1.2
Medical Locum	0.4	0.4	0.8
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.2	0.3	0.7
Nursing Bank	2.9	3.5	1.8
Other Agency	13.0	15.9	13.9
Other Bank	2.6	3.6	1.9
Overtime	2.5	2.9	1.5
On call Worked	0.1	0.1	0.0
Total equivalent temporary WTE	**22.6**	**26.5**	**21.7**
Total equivalent employed WTE	**365.3**	**364.1**	**334.0**
Variance (F/(A))	(6.1)	(4.9)	(0.9)
Temp Staff WTE % of Total Pay	6.2%	7.3%	6.5%
Memo : Total agency WTE in month	14.3	16.1	15.8
Sickness Rates (February/ January)	4.59%	4.08%	
Mat Leave	0.8%	1.4%	

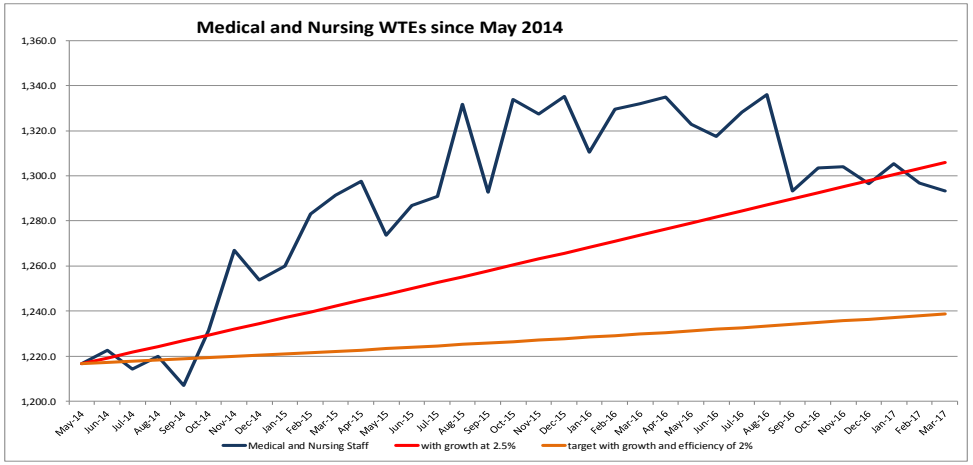
* Note the Acute tables includes Collaborative Procurement Hub staff on WSH Contracts
* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

FINANCE AND WORKFORCE REPORT – March 2017

Staffing levels

The Trust underspent pay budgets by £211k in March (£1,038k overspent YTD), with an underspend of £335k within Nursing (£99k overspent YTD).

The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 77 WTEs (blue line). There has been a decrease of 3 WTE during March.



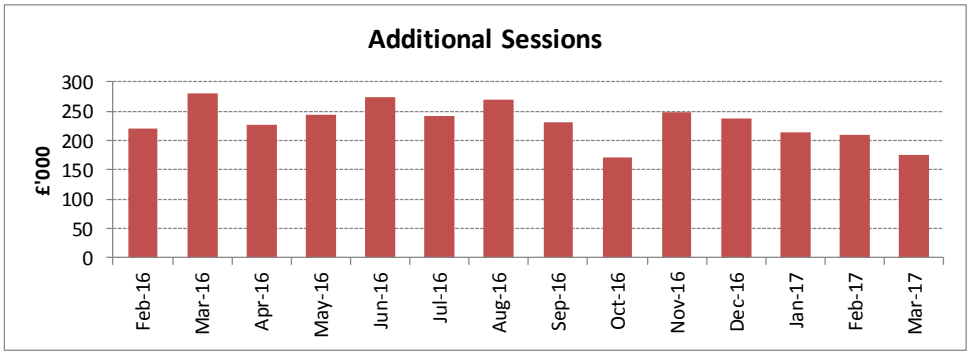
Medical staffing has increased by 11 WTE since April 2016, largely as the result of increases in medical agency staff.

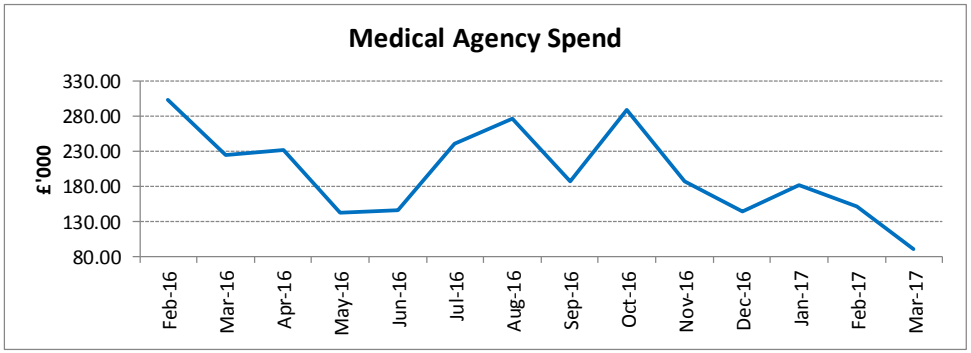
If our medical and nursing staffing levels had increased in line with our growth in activity of broadly 2.5% we would currently be employing 13 more staff (red line).

In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 55 WTE fewer than we were at March 2017.

Pay Trends and Analysis

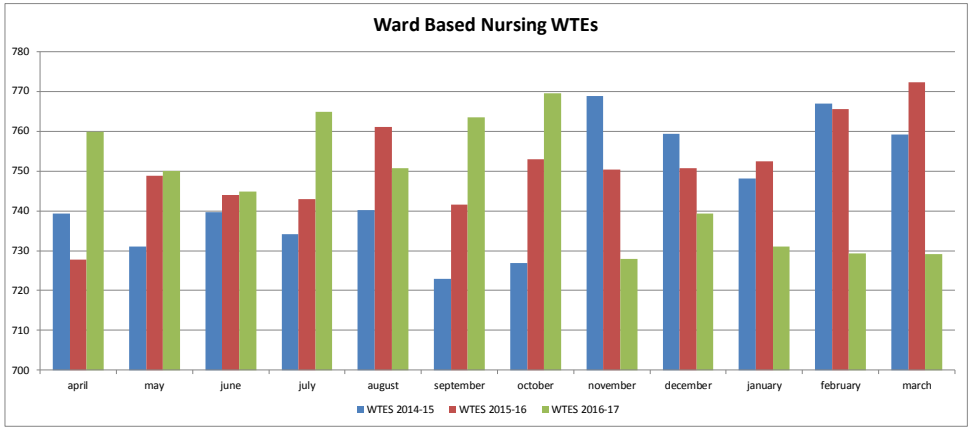
The monthly cost of additional sessions decreased by £34k to £176k. These costs are for both Medical and Non-Medical staff. However, Medical Agency staffing costs decreased by £71k, being £81k in March (£152k in February).



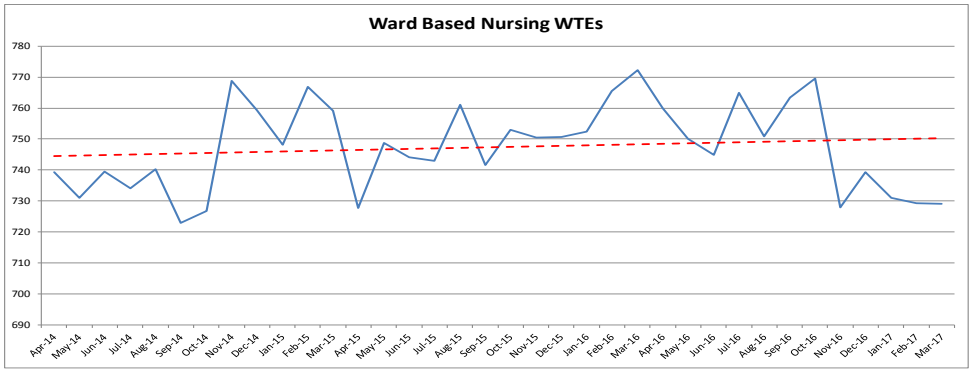


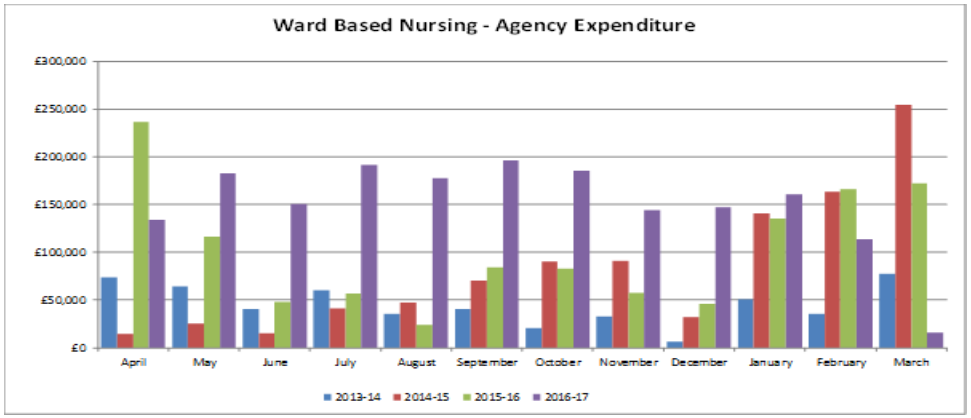
Ward Based Nursing

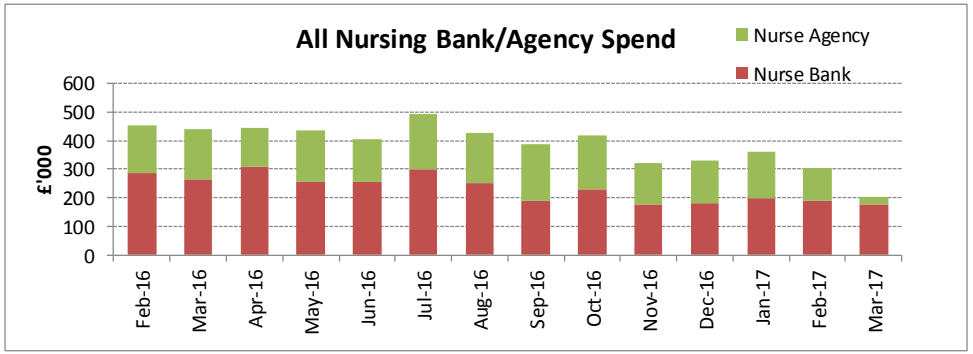
Ward based nursing costs decreased by £170k to £2.05m in March



FINANCE AND WORKFORCE REPORT – March 2017





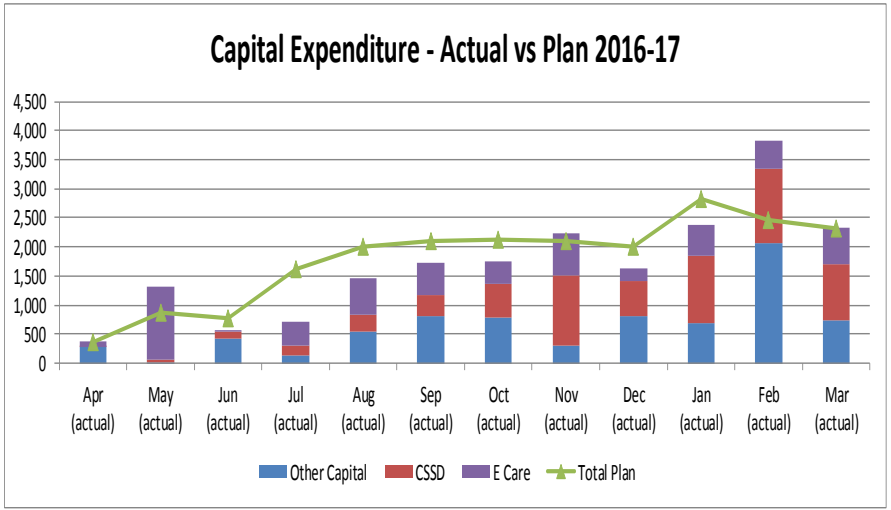


Sickness rates reported for February (the latest month available) are 3.76%, the lowest level since May 2016.

However, there are 63 wte staff on maternity leave, being the highest all year.

FINANCE AND WORKFORCE REPORT – March 2017

Capital Progress Report



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	2016-17
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
E Care	94	1,262	19	412	625	561	378	705	198	545	505	628	5,932
CSSD	11	37	130	176	281	365	580	1,221	603	1,156	1,264	974	6,798
Other Schemes	270	15	426	124	548	806	793	299	819	685	2,068	738	7,590
Total Actual / Forecast	375	1,313	574	713	1,454	1,732	1,751	2,225	1,620	2,385	3,838	2,341	20,320
Total Plan	359	864	770	1,628	2,012	2,104	2,124	2,101	2,009	2,834	2,459	2,327	21,590

The capital programme for the year is shown in the graph above. The CSSD and E-Care schemes are shown separately.

Overall the slippage on the 2016-17 Capital Programme is £1.3m. This is mainly due to re-phasing of larger projects such as the CSSD building and the Cath Lab.

The CSSD build has commenced and will incorporate two additional floors to facilitate future clinical development in the hospital core. Expenditure is £0.6m above plan in March and £1.3m behind plan for the year.

Slippage on the Cath Lab in 2016-17 is £2.9m which largely relates to 6 months slippage whilst looking at wider project that included F6 and F7. Enabling works have now started and building commenced mid-March.

Phase 1 E-Care went live at the beginning of May and the Capital Programme assumes Phase 2 of the original business case will be completed within this financial year. Expenditure on e-Care is £5.9m at the end of March, (against a total plan for 2016-17 of £3.4m)

The E-Care programme budget has been revised to take account of the increased scope associated with the Global Digital Excellence (GDE) funding, although this is still subject to formal Treasury sign-off.

Use of Resources (UoR) Rating

Following implementation of the Single Oversight Framework (SOF), providers' financial performance will now be formally assessed via five "Use of Resources (UoR) Metrics.

The key features of the UOR ratings are as follows:

- The scoring has reversed (compared with the FSRR ratings) so that 1 is now the highest score and 4 is now the lowest
- The liquidity ratio and the capital servicing capacity ratios are identical (except for the scoring) to those that were included within the FSRR
- The I&E margin ratio and the distance from plan ratio is similar to those used in the FSRR except that the calculation is based on a control total basis rather than normalised surplus (deficit). Note that these are not applied to plan data as control totals were not in use prior to 2016/17.
- A new metric has been introduced to measure expenditure on agency staff as a proportion of the ceiling for agency staff. A positive value indicates an adverse variance above the ceiling.
- The overall metric is calculated by attaching a 20% weighting to each category. The score may then be limited if any of the individual scores are 4, if the control total was not accepted, or is planned / forecast to be overspent or if the trust is in special measures.

Area	Metric	2016/17 Q4 Score (forecast)
Financial Sustainability	Capital Service Capacity rating	**4**
	Liquidity rating	**4**
Financial Efficiency	I&E Margin rating	**2**
Financial Controls	I&E Margin Variance rating	**1**
	Agency	**2**
Overall Scoring		**3**

The Trust's UoR score is estimated to improve to 3 at year end, in line with the plan, due to the improved I & E outturn.

FINANCE AND WORKFORCE REPORT – March 2017

Statement of Financial Position at 31st March 2017

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2016 £000	Plan 31 March 2017 £000	Plan YTD 31 Mar 2017 £000	As at 31 Mar 2017 £000	Variance YTD 31 Mar 2017 £000
Intangible assets	10,876	13,487	13,487	15,611	2,123
Property, plant and equipment	61,923	74,893	74,893	74,053	(840)
Trade and other receivables	273	340	340	0	(340)
Other financial assets	1,688	2,409	2,409	0	(2,409)
Total non-current assets	**74,760**	**91,129**	**91,129**	**89,664**	**(1,466)**
Inventories	2,825	2,850	2,850	2,693	(157)
Trade and other receivables	11,191	9,230	9,230	17,214	7,984
Non-current assets for sale	1,400	0	0	0	0
Cash and cash equivalents	2,601	3,007	3,007	1,352	(1,654)
Total current assets	**18,017**	**15,087**	**15,087**	**21,260**	**6,173**
Trade and other payables	(21,692)	(20,686)	(20,686)	(23,478)	(2,792)
Borrowings	(130)	(130)	(130)	(507)	(377)
Provisions	(84)	(84)	(84)	(61)	23
Other liabilities	(1,892)	(295)	(295)	(545)	(250)
Total current liabilities	**(23,798)**	**(21,195)**	**(21,195)**	**(24,591)**	**(3,396)**
Total assets less current liabilities	**68,979**	**85,021**	**85,021**	**86,332**	**1,311**
Trade and other payables - Non current	(912)	(1,083)	(1,083)	0	1,083
Borrowings	(18,205)	(39,075)	(39,075)	(44,303)	(5,228)
Provisions	(202)	(203)	(203)	(181)	22
Total non-current liabilities	**(19,319)**	**(40,361)**	**(40,361)**	**(44,484)**	**(4,123)**
Total assets employed	**49,660**	**44,660**	**44,660**	**41,848**	**(2,812)**
Financed by					
Public dividend capital	59,232	59,232	59,232	59,232	(0)
Revaluation reserve	2,151	2,151	2,151	3,621	1,470
Income and expenditure reserve	(11,723)	(16,723)	(16,723)	(21,005)	(4,282)
Total taxpayers' and others' equity	**49,660**	**44,660**	**44,660**	**41,848**	**(2,812)**

Intangible Assets and Property Plant and Equipment:
In 2016/17 there was slippage against the capital plan of £1.3 million but the useful economic lives of the intangible assets and property, plant and equipment have been reviewed with the Trust's Valuer which has resulted in a reduction to depreciation. This has meant that overall the closing balance on these assets is higher than planned.

Other financial assets:
This investment relates to The Pathology Partnership (TPP). The investment increased from £1.7m at the beginning of the year to £5.3m by the end of the financial year. However an impairment review has concluded that the asset should no longer be held in the balance sheet so it has been impaired to £0.

Trade and other receivables:
These have increased significantly in March because the Trust has recognised the value of recoverable deposits paid on community equipment.

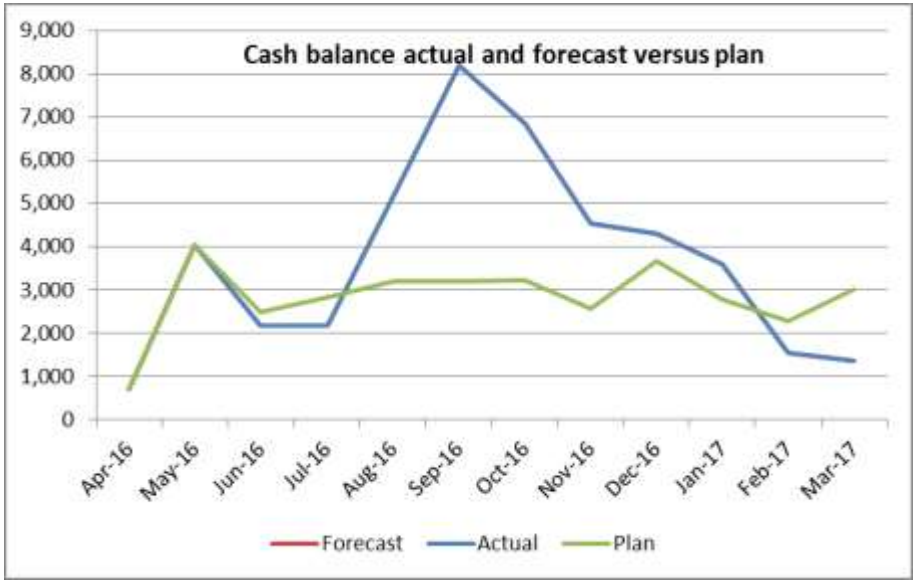
Cash:
The cash balance has been maintained above the £1m minimum balance required.
The Trust has still not received the anticipated £3.3m GDE cash which was expected by the end of January and there are ongoing conversations with DH to determine when this is likely to be received. In response the Trust accelerated the drawdown of the capital loan by £3.3m in March. A further £5m drawdown of the Trust working capital finance facility was made in March as previously reported to the Board.

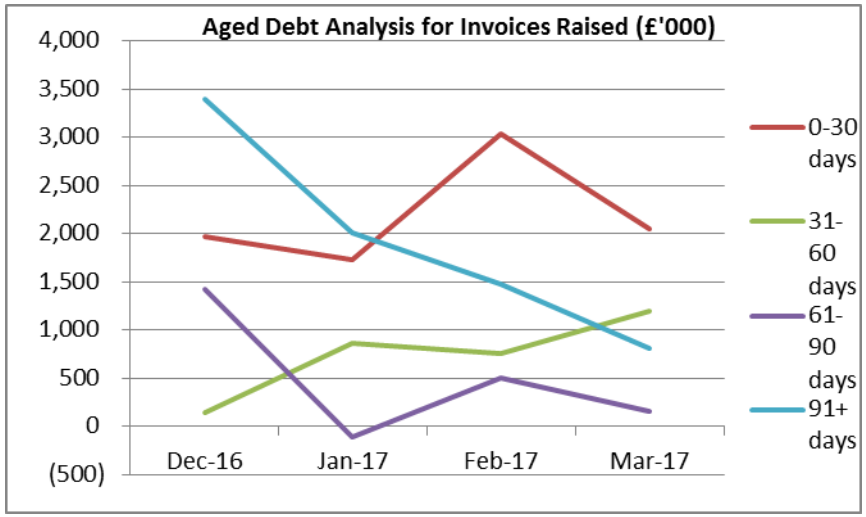
Trade and other payables:
Trade and other payables has reduced by £6m in March which is partly due to a n increased effort to clear the backlog on invoices but also due to a rigorous review of accruals at year end.

Borrowing:
Borrowing is above plan because of the additional £2.5m borrowed in relation to TPP and also the accelerated drawdown of the capital loan in lieu of GDE not being received.

Income and Expenditure Reserve:
The I & E Reserve is lower than planned because of the impairment of the TPP investment which does not count against the Trust's control total.

Cash Balance 2016/17





The graph illustrates the cash balances against original plan for 2016/17.

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.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28th April, 2017

AGENDA ITEM:	Item 10
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:	April 2017
SUBJECT:	Aggregated Quality Report
PURPOSE:	Information

EXECUTIVE SUMMARY

- This report will be reflective of the data from March 2017
- In March there were 462 Patients Safety Incidents (PSI) reported, similar to February (458).
- Level of harm in proportion to overall Patient Safety Incidents reported:
  - 83% (85% February) no harm (Green)
  - 11% (11% February) minor harm (Green)
  - 4% (3% February) moderate harm (Amber)
  - 0.6% (0.2% February) major harm (Red)
  - 0.4% (0.2% February) catastrophic harm (Red)
- In relation to type of incidents reported in March the highest areas of reporting related to Slips Trips & Falls, Pressure ulcers and Clinical Care & Treatment.
- 11 Complaints were received in March compared to 12 in February
- 230 PALS contacts were recorded in March compared to 189 in February.

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

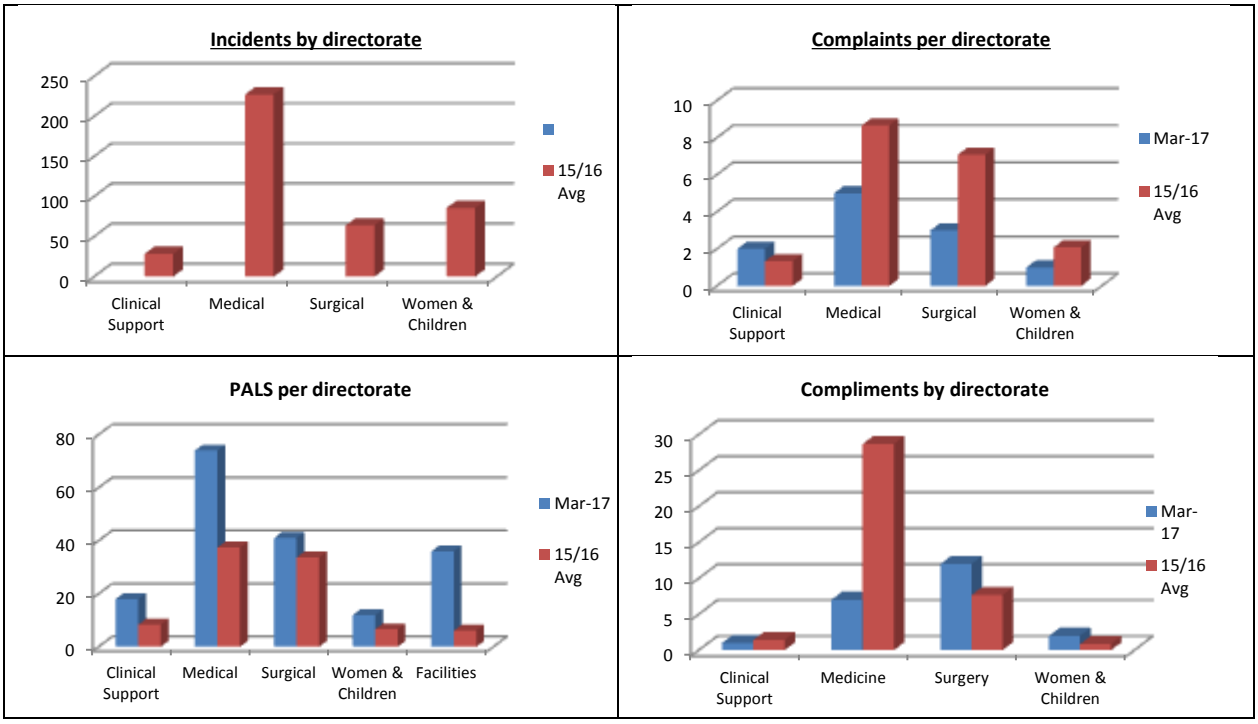


Table 2: PSIs reported by month (24 months)

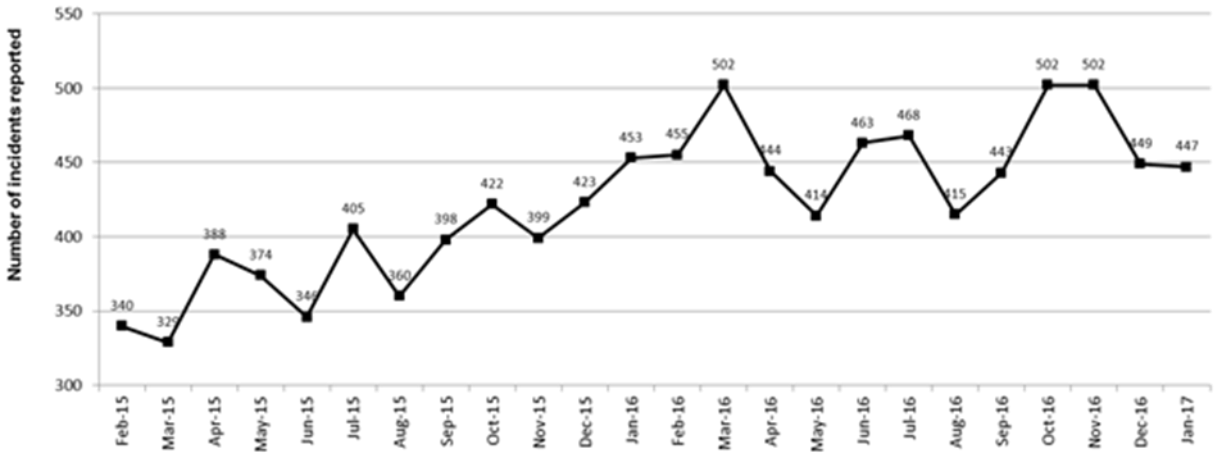
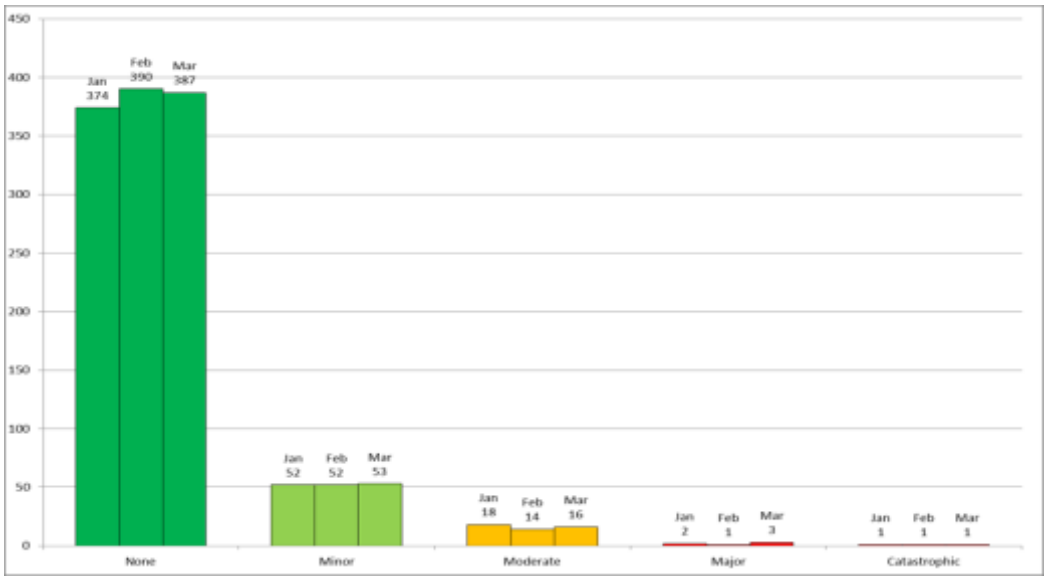


Table 3: Incidents reported by severity



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 March there were similar numbers of incidences, however there has been an increase in both Moderate and major harm cases. February saw 14 moderate,1 Major and 1 Catastrophic. March saw 16 moderate,3 Major and 1 Catastrophic.

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

- Unexpected transfer post child delivery to Papworth following complications. Patient died whilst at Papworth
- Two unwittnessed falls resulting in harm (one fractured neck of femur, one possible infarct following seizure/fall
- Dislocation of hip whilst on transport home

The 16 moderate harm incidents relate to:

Medicine (4)

- Discharge of a patient resulting in readmission within 2 hrs of discharge
- Weight loss whilst being an in patient
- Training of family carers prior to discharge
- Patient with mental health issues, families concern at patient being allowed to self-discharge

Surgical (4)

- Delay in treatment due to no intravenous access
- Clostridium Difficile detected in stool specimen
- Patient under the care of WSH outsourced to another provider, where the patient had a complication requiring surgery at WSH
- Delay in escalation of deteriorating patient

From last report an incident graded as an amber awaiting post-mortem report to allow consideration of whether any element of WSH care contributed to the death has been reviewed. Following the Day 5 review this incident was downgraded to green.

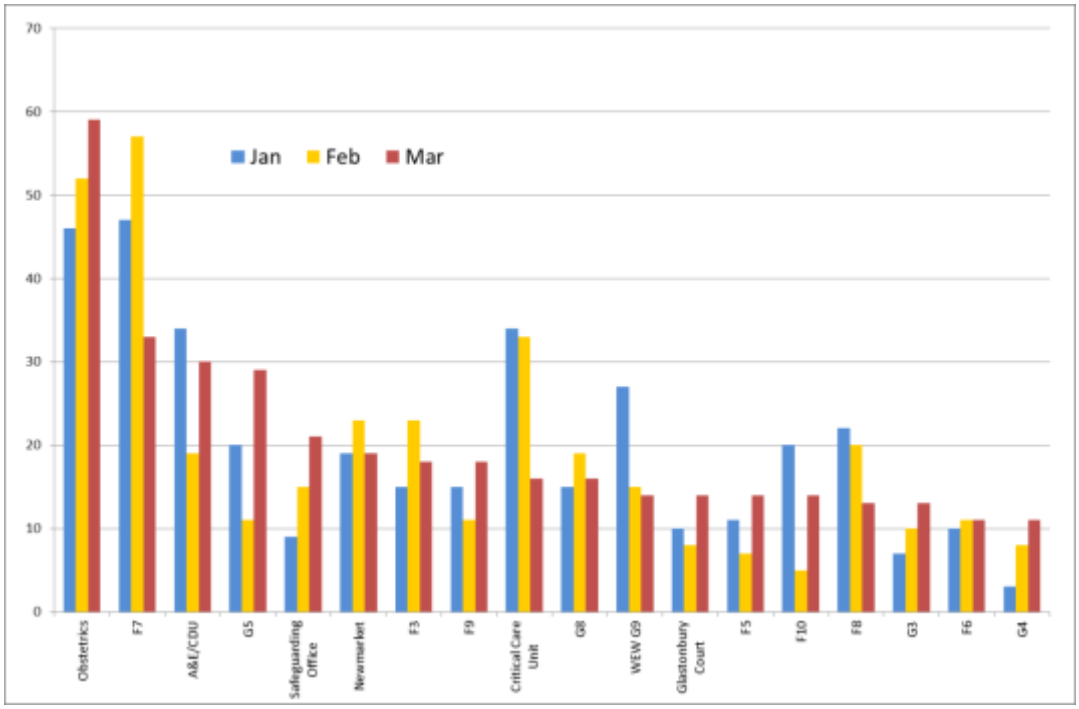
Clinical Support (2)

- Attitude of transport staff towards WSH staff
- Delay in appointment due to the incorrect scanning of referral letter. In the process of review and may be downgraded to Green

Women & Children (6)

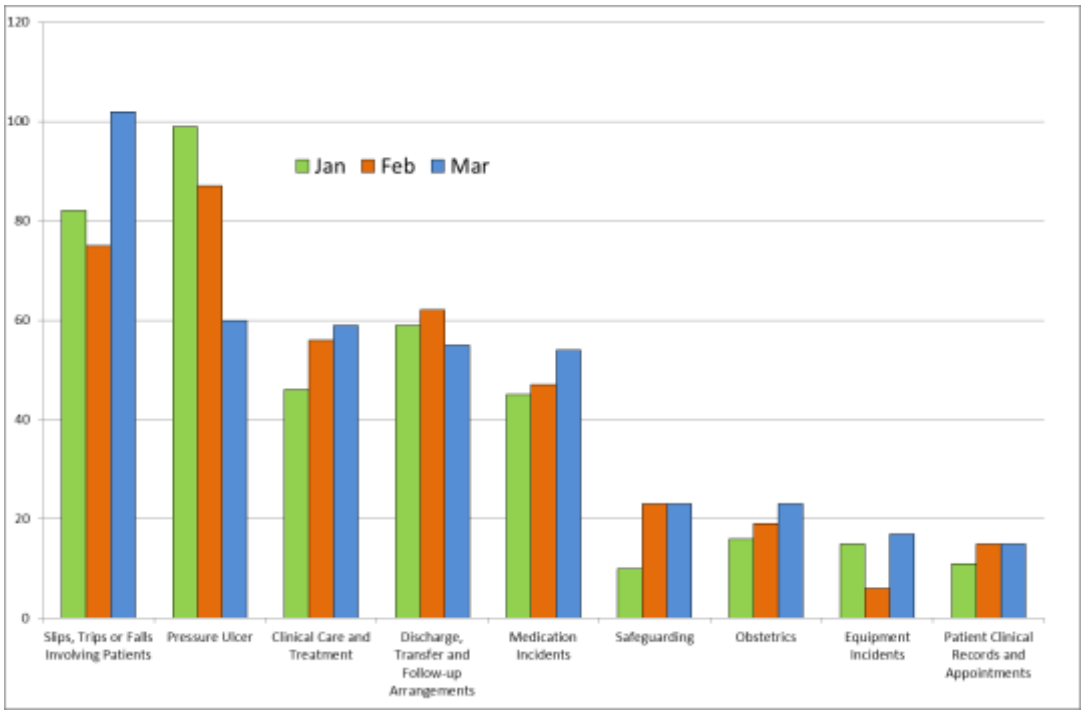
- New born admitted following delivery in theatre with fracture to humerus
- Two transfers to other care providers
- Brachial plexus palsy following delivery
- Concealed pregnancy and spontaneous delivery at 20 weeks gestation
- Bilateral PEs three days post delivery

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



March has seen an increase in Obstetrics reporting with unexpected transfer being a common theme. The Emergency Department themes are around medication incidents and delay in providing treatment, however none of these resulted in harm. F7 high reporting remains consistent in the reporting of community acquired pressure ulcers being they main type of incident being reported. March has seen an improvement in the levels of reporting from Critical Care Services (CCS) however delays in discharges from CCS remains to be the main theme (9/16). G5 16 of the 28 incidences where related to falls, of which two incidences resulted in major harm and are under investigation. , There has been an increase in reporting incidences following the previous month of February, where there was a reduction in Falls four out of eleven incidences. However in January saw 10 falls reported out of 20 incidences. The remaining incidences resulted in no harm.

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



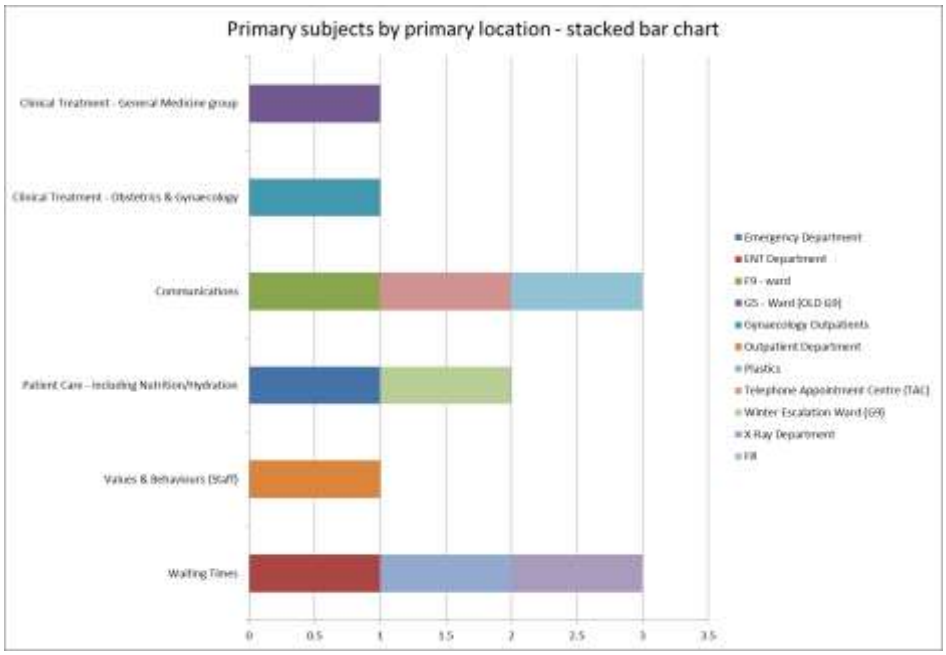
Pressure ulcers, Slips, Trips & Falls, and Discharge, Transfer & Follow up incidents account for the highest number of incidents reported. There has been a continued decrease in the number of Hospital acquired pressure ulcers in March (4 compared to 10 in Feburary) which is a continual improvement month on month for the past .

We have been working with some of the clinical area 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 is being finalised within the Day Surgery Unit, Critical Care and Main Theatres and further detail will be provided in the May report.

Complaints

11 complaints received in March. The breakdown of these complaints is as follows by Primary Division: Medical (5), Surgical (3), Clinical Support (2) and Women & Children's Health (1).

Table 6: Complaints by type



Patient Experience Themes

Area	*Analysis*	*RAG rating*
Car Parking	*Although parking concerns have decreased slightly from February, the general subject of the enquiries has changed. In February we saw many patients and relatives complaining of the new charges however now that this has defused we are receiving a high number of concerns about access to the hospital from Car Park A.* *Blue badge holders and carers are experiencing difficulties transporting wheelchair users from the new spaces in Car Park A up the ramp; many of the people accompanying patients to appointments are finding the ramp very steep.*	
Gynaecology	*Several patients are concerned by delays in receiving dates for procedures and also about cancellations. There is a longer wait currently due to a consultant vacancy.*	

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

Item 11

West Suffolk NHS
NHS Foundation Trust

Trust Board – 28th April 2017

AGENDA ITEM:	Item 11
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Sinead Collins, Clinical Business Manager
DATE PREPARED:	21st April 2017
SUBJECT:	Nurse Staffing Report
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 March and progress of nurse staffing review made below

Observations

March

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
ED	6 medication errors	High pressure environment and high agency use
F7	8 medication errors	High vacancies and high agency and bank use
G1	4 medication errors	No trends seen
G5	6 falls (with harm)	Had Norovirus outbreak
F9	4 medication errors	High sickness

High Vacancies – F7, AMU, G8, Theatres

Roster effectiveness – Out of 27 areas, 18 are over the Trust standard of 20% (same as Feb.)

Sickness – Out of 27 areas, 22 are over the Trust Standard of 22% (one higher than last month)

- Trust wide nursing vacancy figures have significantly reduced from previous month
- No apparent trend on areas of concern, as previous months, as other wards were identified
- Ward G9 fill rate has seen a reduction in % but still high and this is just due to RNs being moved during the night to help other wards

Update on progress of Nurse Staffing Review

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

SCNT data of wards has been added to dashboard and the report is part of this Appendix. There have not been any significant changes other than Ward F7 involvement this time round and MTU, Rosemary Ward and Kings Suite excluded due to need to fill in via paper form. There is also a need for activity/deeper review of areas.

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

QUALITY AND WORKFORCE DASHBOARD

Item 11 Month Reporting	Mar-17			Establishment for the Financial Year 2016/17						Data for March 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 (Mar 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	65.24	77.64%	22.36%	N/A	1 - 4	1 - 5	116.7%	97.3%	133.7%	98.8%	5.50%	8.10%	-7.30	-3.30	6.90%	N/A	26.30%	N/A	6	2
WSFT	F7	Short Stay Ward	34	78.04	53.99%	46.01%	42.65	6	9	86.3%	97.2%	96.0%	86.9%	8.70%	10.70%	24.91	12.75	3.60%	7.27	19.80%	0	8	0
WSFT	AMU	Acute Medical Unit	12 beds, 10 trollies and 4 chairs				I/D	6	N/A					2.70%	0.00%			4.10%	N/A	22.90%	0	2	0
WSFT	CCS	Critical Care Services	9	48.69	96.14%	3.86%	N/A	1 -2	1 -2	95.1%	86.4%	N/A	N/A	2.00%	0.00%	-2.37	0.10	1.80%	15.59	17.80%	0	3	0
WSFT	Theatres	Theatres	8 theatres	87.84	74.00%	26.00%	N/A	1/3	(1/3)	109.2%	100.1%	N/A	N/A	0.70%	0.00%	12.50	-7.60	6.60%	N/A	21.70%	N/A	1	N/A
WSFT	Recovery	Theatres	11 spaces	22.56	96.00%	4.00%	N/A	1 -2	1 -2	133.8%	111.3%	87.5%	N/A	0.00%	0.00%	-0.55	0.00	4.80%	N/A	22.40%	N/A	0	N/A
WSFT	DSU	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward area	51.15	78.00%	22.00%	N/A	1 - 1.5	N/A	90.6%	N/A	127.7%	N/A	1.70%	0.00%	-2.20	-0.33	8.90%	N/A	19.70%	N/A	0	N/A
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	99.0%	96.8%	58.8%	N/A	0.40%	0.00%	-1.10	-0.40	4.90%	11.66	21.30%	0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	91.3%	99.9%	98.4%	N/A	0.90%	0.00%	-0.97	-1.50	5.00%	7.61	22.40%	0	4	0
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	90.2%	94.7%	78.4%	83.7%	13.20%	0.00%	1.86	0.40	5.00%	5.31	19.40%	0	3	1
WSFT	G4	Elderly Medicine	32	48.04	50.06%	49.94%	44.78	6	10	98.3%	91.9%	88.4%	71.7%	16.30%	0.40%	2.51	1.81	5.00%	5.60	24.50%	1	2	2
WSFT	G5	Elderly Medicine	33	Waiting on Finance	Waiting on Finance	Waiting on Finance	50.52	6	11	85.9%	94.8%	92.7%	89.2%	4.10%	0.20%	2.72	-0.39	3.90%	4.96	18.90%	0	2	6
WSFT	G8	Stroke	32	48.42	54.31%	45.69%	42.26	5	8	78.1%	87.1%	101.0%	91.2%	9.80%	2.00%	5.20	2.60	5.20%	6.56	21.90%	0	2	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	87.0%	164.0%	87.2%	82.8%	25.00%	20.00%	-9.20	-9.30	3.60%	N/A	25.80%	1	2	0
WSFT	F1	Paediatrics	15 - 20	29.85	68.64%	31.36%	N/A	6	9	95.2%	146.6%	109.7%	N/A	13.70%	0.00%	0.74	-0.60	3.00%	N/A	24.60%	N/A	2	N/A
WSFT	F3	Trauma and Orthopaedics	33	37.89	59.07%	40.93%	48.48	7	11	87.8%	94.3%	122.9%	100.0%	1.50%	1.30%	4.00	-3.30	1.30%	4.78	15.00%	0	3	0
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	93.1%	85.4%	72.0%	161.3%	14.20%	4.40%	2.10	0.07	11.10%	7.78	21.70%	0	0	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	93.8%	98.9%	97.9%	116.4%	3.50%	0.50%	-0.01	0.50	1.50%	4.44	16.70%	0	2	1
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	86.3%	94.2%	115.9%	98.2%	2.30%	6.40%	3.24	2.10	1.80%	7.50	17.60%	0	2	0
WSFT	F9	Gastroenterology	33	43.77	52.34%	47.66%	48.16	7	11	105.6%	97.4%	82.4%	102.4%	11.00%	0.20%	3.40	-0.64	11.50%	4.75	22.90%	1	5	1
WSFT	F10	Respiratory	25	40.76	56.58%	43.42%	40.62	6	6	105.9%	78.4%	97.4%	87.1%	10.10%	0.20%	2.10	1.70	4.00%	5.64	25.80%	1	1	0
WSFT	F11	Maternity	29	54.71	72.14%	27.86%	N/A	7.25	14.5	115.6%	101.9%	91.5%	65.7%	13.60%	0.00%	-0.39	1.40	5.80%	N/A	22.50%	0	3	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1												N/A	0	N/A
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre recovery area, bereavement suite					1 - 2	1 - 2												N/A	0	N/A
WSFT	F12	Infection Control	8	16.43	68.59%	31.41%	9.61	4	4	95.3%	95.3%	93.5%	93.5%	18.40%	2.30%	3.90	-1.80	4.00%	8.23	24.40%	0	0	1
WSFT	F14	Gynaecology	8	11.58	96.55%	3.45%	I/D	4	4	99.9%	100.0%	N/A	N/A	0.00%	0.00%	0.70	0.40	0.00%	N/A	16.20%	0	0	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	8.73	82.47%	17.53%	N/A	5 - 8	N/A	96.7%	N/A	56.7%	N/A	0.00%	0.00%	0.20	-0.30	6.80%	N/A	22.80%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.69	85.14%	14.86%	N/A	2 - 4	2 - 4	112.0%	88.9%	19.4%	61.4%	3.90%	0.00%	-2.18	1.70	5.60%	N/A	23.60%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	98.8%	96.8%	98.0%	105.8%	7.75%	0.00%	1.35	2.19	3.79%	7.10	N/A	0	0	1
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	77.1%	99.9%	87.1%	96.6%	9.70%	0.7%	-12.39	-10.30	5.1%	5.30	12.40%	0	0	1
																32.77	-12.04	Target - 3.5%		Trust standard is 20%			

Key findings

WSFT have some significant environmental layout challenges and additional activity that are not reflected in the SNCT(F14/G1/G8/F12/CCU/NCH)
SNCT review to be repeated (Feb 2017)
Theatres and DSU establishment includes ODPs and non-nursing professionals and thus fill rate is not included
Theatres have had an increase in capacity recently
Some units do not use electronic rostering therefore there is no data for those units
G9 - changed just after beginning of November so can not get true figures for vacancies, etc

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

West Suffolk NHS
NHS Foundation Trust

Item 12 Board of Directors (Public) – 21st April 2017

PRESENTED BY:	Jan Bloomfield, Executive Director Workforce & Communications
PREPARED BY:	Karen Margetts, Training Improvement Manager
DATE PREPARED:	19th April 2017
SUBJECT:	Mandatory Training
PURPOSE:	For information and update
STRATEGIC OBJECTIVE:	To continue to secure, motivate, educate and develop a committed workforce providing high quality patient focused services

EXECUTIVE SUMMARY:

Appendix A is the April 2017 Mandatory Training Report, this represents data taken from the system on 18th April 2017. Following the previous quarter it was noted that compliance for Safeguarding Children (Levels 1, 2 and 3), Information Governance and Manual Handling remained lower than we had hoped and the Subject Matter leads were asked to complete recovery plans. Compliance for Manual Handling has reached the Trust Target level of 80%. Conflict Resolution is currently at 75% compliance. There was 78% compliance for induction in this quarter.

Appendix B outlines the actions currently in place to improve take up of mandatory training across the Trust in those areas below 80% compliance, 90% for Safeguarding Children and 95% for Information Governance.

Appendix C provides a risk assessment for those areas below the relevant target, compiled by the subject matter experts for each area.

Appendix D The National CQUIN 2015-6 target for **Dementia** staff training states that the Trust should include quarterly reports to Provider Boards of:
• Numbers of staff who have completed the training;
• Overall percentage of staff training within each provider'.
During Q4 there were 2,774 that required training and the total number trained were 2,596 which equates to 93.58%.

Appendix E shows mandatory training and induction figures for SCH Community staff. SCH Community currently records training in a system called Staff Pathways. The overall compliance level for all mandatory topics is 93.21% for March 2017 and this is a 0.79% increase from the previous quarter. There was 100% compliance for induction in this quarter.

Matters resulting from recommendations in this report	**Present**	**Considered**
Financial Implications	yes	no
Workforce Implications	yes	yes
Impact on Equality and Diversity	yes	yes
Legislation, Regulations and other external directives	yes	yes

Internal policy or procedural issues	yes	yes
Risk Implications for West Suffolk Hospital (including any clinical and financial consequences): Risk to patient safety due to untrained staff.	**Mitigating Actions** Mandatory Training action plan (attached) and risk assessment	
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 Board of Directors: Acceptance of the action plan to further improve compliance		

Appendix A

Subject Matter - High Level Mandatory Training Analysis April 2017

Competence Name	Trust Target	Does not meet requirement	Meets Requirement	Grand Total	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
179|LOCAL|Infection Control - Classroom|	80%	74	1424	1498	94%	95%	95%	95%	94%	94%	94%	94%	94%	95%	95%
179|LOCAL|Equality and Diversity|	80%	234	2968	3202	90%	91%	90%	90%	90%	91%	91%	91%	92%	93%	93%
179|LOCAL|Fire Safety Training - Classroom|	80%	323	2879	3202	88%	89%	87%	88%	88%	88%	89%	89%	89%	89%	90%
179|LOCAL|Security Awareness|	80%	371	2831	3202	90%	90%	87%	87%	86%	87%	87%	87%	87%	88%	88%
179|LOCAL|Infection Control - eLearning|	80%	184	1325	1509	91%	91%	88%	87%	86%	87%	87%	87%	88%	88%	88%
179|LOCAL|Health & Safety / Risk Management|	80%	397	2805	3202	89%	89%	88%	86%	86%	86%	87%	86%	87%	88%	88%
179|LOCAL|Safeguarding Adults|	80%	400	2802	3202	90%	91%	89%	87%	87%	87%	87%	86%	87%	88%	88%
179|LOCAL|Safeguarding Children Level 2|	90%	198	1338	1536	90%	90%	87%	86%	86%	85%	86%	86%	87%	87%	87%
179|LOCAL|Medicine Management (Refresher)|	80%	196	1281	1477	89%	90%	86%	86%	86%	85%	85%	85%	86%	87%	87%
179|LOCAL|MAJAX|	80%	460	2742	3202	86%	87%	85%	84%	85%	85%	85%	85%	86%	86%	86%
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	90%	461	2741	3202	90%	90%	88%	87%	87%	86%	87%	86%	87%	86%	86%
179|LOCAL|Fire Safety Training - eLearning|	80%	470	2732	3202	89%	90%	88%	87%	86%	87%	87%	86%	86%	85%	85%
NHS|MAND|Safeguarding Children Level 3 - 1 Year|	90%	48	277	325	80%	84%	86%	81%	80%	83%	81%	81%	79%	78%	85%
179|LOCAL|Blood Bourn Viruses/Inoculation Incidents|	80%	285	1520	1805	85%	85%	83%	82%	82%	82%	82%	81%	84%	85%	84%
179|LOCAL|Slips Trips Falls|	80%	341	1734	2075	86%	86%	84%	84%	83%	83%	83%	82%	84%	85%	84%
179|LOCAL|Basic Life Support - Adult|	80%	347	1645	1992	75%	77%	76%	76%	78%	78%	81%	81%	80%	81%	83%
179|LOCAL|Moving & Handling - elearning|	80%	171	736	907	80%	80%	74%	75%	76%	77%	77%	77%	79%	79%	81%
179|LOCAL|Conflict Resolution - elearning|	80%	139	596	735	80%	82%	74%	76%	76%	77%	76%	77%	81%	83%	81%
179|LOCAL|Moving and Handling Non Clinical Load Handler|	80%	76	318	394	67%	70%	66%	69%	71%	75%	86%	87%	84%	83%	81%
179|LOCAL|Moving and Handling - Clinical|	80%	322	1346	1668	75%	77%	78%	78%	77%	78%	80%	82%	80%	79%	81%
179|LOCAL|Information Governance|	95%	645	2557	3202	85%	85%	84%	82%	80%	81%	82%	82%	82%	82%	80%
179|LOCAL|Blood Products & Transfusion Processes (Refresher)|	80%	300	1179	1479	76%	77%	74%	75%	75%	77%	77%	76%	78%	80%	80%
179|LOCAL|Conflict Resolution|	80%	312	918	1230	76%	75%	75%	75%	73%	73%	74%	74%	74%	75%	75%

Q4 Jan-Mar 2017 New Starters % Compliance – Trust	Total
No	16
Yes	56
Grand Total	72
% Compliance	78%

Mandatory Training Action Plan Apr 2016

Appendix B

	Apr %	Method	Actions	Completion date	Responsibility	Progress
National requirements		E-learning	The region has signed up to a Streamlining project which includes statutory and mandatory training, recruitment, medical staffing and occupational health. The project should see a reduction in duplication of paperwork and training for staff and reduce the hire time and cost for Trusts.	Complete	Rebecca Rutterford	West Suffolk aligned their training to the 11 subjects within the Core Skills Training Framework (CSTF). The Streamlining project – phase one completed at the end of March 2017. We are awaiting information on phase 2
e-Care			Consider the implication of e-Care training on existing education programmes.	Complete	MTSG	The impact on mandatory training compliance due to e-Care training was being monitored – appendix A. The cancellation of all training, including mandatory training for a 4 week period over e-Care go live was likely to have an impact on compliance. The Education Team booked two additional dates to support staff in remaining compliant. These dates are 30th September 2016 and 4th November 2016. Induction was not affected and continued as normal.
Conflict Resolution e-learning	82.03%	E-learning	Emails to mangers encouraging staff to be compliant and complete the eLearning package.	Complete	Darren Cooksey	Targeted emails to staff reminding them to complete training. 3.22% Increase seen since the last Board report and now compliance is over 80%
Safeguarding Children level 3	83.71%	Face to face	To improve Safeguarding Children level 3 compliance to 90%	Jul 2016	Lisa Sarson	At the end of Q4, compliance for Safeguarding Children level 3 is reported at 78%. However in April 2017 it has increased to 85%.
Moving & Handling–e-learning	80.43%	E-learning	Manual Handling Advisor e-mailing mangers encouraging staff to be compliant and complete the eLearning package.	Complete	Neil Herbert	Target now met
Basic Life Support	80.97%	Face to face	Reliance on bank and reduced staffing due to sickness has had an impact on figures.	Complete	Julie Head	Target now met

	Apr %	Method	Actions	Completion date	Responsibility	Progress
Information Governance	85.09%	E-learning	Staff who are out of date with IG training are being targeted directly with the training slides and compliance test.	Jul 2016	Sara Ames	Will continue to offer one off training sessions to departments that require it. At the end of Q4 compliance is reported at 82%. Compliance rise is likely to be slower than others as it's a yearly requirement for all staff.
Conflict Resolution	75.32%	Face to Face	Training sessions have been fully booked due to bank staff being encouraged to book onto courses.	Oct 2016	Darren Cooksey	At the end of Q4 compliance is reported at 75%.

Risk Assessments

Appendix C

Subject	Issues	Risks	Description of Action	Lead	Status *
179|LOCAL| Moving and Handling –e-learning	• Poor uptake	• Potential staff injury • Financial implication such as sick pay, staff cover, court costs, compensation.	• Reminders to be sent to those who are non-compliant	Moving and Handling Advisor	Low
179|LOCAL| Conflict Resolution|	• Staffing levels and the Ward/ Departments ability to backfill will affect the numbers attending • Release of staff on clinical areas.	• Failure to recognise body language indications of possible aggression. • Failure to recognise warning signs when an aggressor is agitated or distressed. • Failure to recognise danger signs which may indicate imminent attack. • Failure to employ applicable communication skills • Litigation consequences • Potential staff injuries resulting in RIDDOR absenteeism. • Poor staff morale	• Training compacted to four hours to enable staff attendance. • LSMS and Portering can be called to via 2222 to assist staff in managing difficult situations • Police assistance can be summoned. • Restrictive Physical Intervention team may be employed when managing clinically confused patients. • Refresher sessions for staff who have expired, lasting 2 hours. • Discussion taking place to incorporate conflict resolution, dementia awareness and break away training into one package	Portering and Security manager	Low
179|LOCAL| Conflict Resolution – elearning|	•	• Failure to recognise body language indications of possible aggression. • Failure to recognise warning signs when an aggressor is agitated or distressed. • Failure to recognise danger signs which may indicate imminent attack. • Failure to employ applicable communication skills • Litigation consequences • Potential staff injuries resulting in RIDDOR absenteeism. • Poor staff morale	• Communication has gone out to all staff to advertise the new training package. • Targeted communication has been sent to specific staff groups and managers that require the new training package. • LSMS to enlist support from security management director and non-executive member of the board responsible for security.	Portering and Security manager	Low
179|LOCAL|Information Governance|	• Annual training replaced 3 yearly training in 2014 • 95% compliance target explicit in 2015/16 IG toolkit	• Increased risk of IG breaches and vulnerability to ICO fine if staff awareness of IG is poor. • IG toolkit compliance will be unsatisfactory (level 1 only) if we cannot demonstrate achievement of 95% target.	• Outstanding staff are contacted on a monthly basis to update training. • Training materials and test attached to email to facilitate a quick and convenient way to carry out training.	IG Manager	Medium

Subject	Issues	Risks	Description of Action	Lead	Status *
NHS|MAND| Safeguarding Children Level 3 - 1 Year|	• Poor uptake • Specialised face to face learning • Annual dates for departmental sessions scheduled past staff expiry dates	• Failure to recognise signs & symptoms of abuse in a child • Failure to recognise parental factors that predispose a child to significant harm • Failure to understand how to report concerns for child • Failure to recognise and act upon more specialised areas of child protection	• Paediatric, neonatal and midwifery level 3 training offered over a number of dates throughout the year. • Extra training sessions advertised • Three sessions per year open to all Trust employees and partner agencies presenting a range of topics • Unit managers for areas with high contact with children and young people also receive lists of non-compliant staff. • Emails of those non-compliant sent to managers and risk assessments requested.	Named Nurse Safeguarding children	Medium

Appendix D – Dementia Training Figures

Month	Number require training	Total number trained	% Compliance
April	1023	877	85.75%
May	1079	917	84.99%
June	1065	918	86.20%
Q1.	**3167**	**2712**	**85.63%**
July	1053	906	86.04%
Aug	1033	908	87.90%
Sep	1064	956	89.85%
Q2.	**3150**	**2770**	**87.94%**
Oct	1041	944	90.68%
Nov	1020	935	91.67%
Dec	1018	940	92.34%
Q3.	**3079**	**2819**	**91.56%**
Jan	928	858	92.46%
Feb	924	864	93.51%
March	922	874	94.79%
Q4.	**2774**	**2596**	**93.58%**

Appendix E – SCH Community

Mandatory Training – as at March 2017

WSH									
Topic	All			Enabling**	Workforce	Leadership	Operations*	Quality and Governance	Paediatrics
	Compliant	NonCompliant	% Compliancy						
Conflict Resolution	348	40	89.69%	79.35%	N/A	100.00%	94.37%	100.00%	92.13%
Dementia Compliance	374	14	96.39%	96.74%	N/A	100.00%	95.77%	100.00%	96.30%
Equality and Diversity	379	9	97.68%	94.57%	N/A	100.00%	95.77%	100.00%	99.54%
Fire	344	44	88.66%	83.70%	N/A	100.00%	80.28%	87.50%	93.52%
Health & Safety	382	6	98.45%	97.83%	N/A	100.00%	95.77%	100.00%	99.54%
Infection Control	336	52	86.60%	85.87%	N/A	100.00%	91.55%	100.00%	84.72%
Information Governance	373	15	96.13%	97.83%	N/A	100.00%	92.96%	100.00%	96.30%
Learning Disabilities	355	33	91.49%	83.70%	N/A	100.00%	87.32%	100.00%	95.83%
Life Support	204	30	87.18%	N/A	N/A	N/A	76.19%	75.00%	91.62%
Mental Capacity	29	8	78.38%	N/A	N/A	N/A	77.78%	100.00%	N/A
Moving and Handling	347	41	89.43%	97.83%	N/A	100.00%	87.32%	100.00%	86.11%
Safeguarding Adults	381	7	98.20%	94.57%	N/A	100.00%	98.59%	100.00%	99.54%
Safeguarding Children	379	9	97.68%	92.39%	N/A	100.00%	98.59%	100.00%	99.54%
Overall % for all topics	**4231**	**308**	**93.21%**	**91.30%**	**N/A**	**100.00%**	**90.80%**	**97.85%**	**94.61%**
*** Enabling = Facilities, Finance & Informatics*									
*** Operations = Newmarket Hospital, Epilepsy, Neurology, Parkinsons, Adult SLT*									

SCH Induction

New Starters % Compliance	Q4 Jan-Mar 2017
No	0
Yes	10
Grand Total	10
% Compliance	100%

West Suffolk NHS
NHS Foundation Trust

Trust Board – 28th April 2017

AGENDA ITEM:	14
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Sinead Collins, Clinical Business Manager
DATE PREPARED:	21st April 2017
SUBJECT:	Nursing & Midwifery Strategy 2016-2021 : Update
PURPOSE:	For Information

EXECUTIVE SUMMARY:

Led by the Executive Chief Nurse, the nursing and midwifery strategy was developed by April 2016 in collaboration with the relevant team members setting out the ambitions and priorities over the coming years, which is now just finished its first year.

It reflects and supports the national framework 'Leading Change, Adding Value: A framework for nursing, midwifery and care staff' was released in May 2016 and it closely aligns with the 'Five Year Forward View' as set out by Simon Stevens, Chief Executive, NHS England.

The strategy aligned with the national nursing/midwifery and wider healthcare strategies to ensure nursing and midwifery continues to forge ahead, delivering the best care to patients, advancing and learning in tandem with national agendas whilst being sufficiently cognisant of local population needs.

This paper outlines the progress to date from April 2016 – March 2017 against the local nursing strategy and provides further detail in relation to the national direction.

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:

Description of update in detail given below.

The nursing strategy continues to drive improvements in care delivery and workforce redesign. The nursing & midwifery team will continue to work alongside strategy in 2017 which will ensure steps towards continually improving care, putting patients at the heart of what we do whilst ensuring our workforce are developed and valued for their contribution.

1. Purpose

The Nursing and Midwifery Strategy (2016-2021) was developed by April 2016 in collaboration with the relevant team members setting out the ambitions and priorities over the coming years, which is now just finished its first year. This strategy is under-pinned by our 'Putting you first' values and the ambitions set out in the Trust's vision, 'Our patients, Our hospital, Our future, together'

It reflects and supports the national framework for nursing midwifery and care staff 'Leading Change, Adding Value', which pledges to close the gaps between health and social care by targeting health and wellbeing, care and quality and funding and efficiency. We are committed to delivering the ten commitments of this national framework.

2. Progress

2.1. West and East Community split and move

As of October 2017, the community will be split into east and west hubs that include Ipswich & Colchester and West Suffolk Hospital, respectively, to allow for more integrated work and to help improve patient's experience.

2.2. SAFER Patient Flow Bundle - Red2Green

As of the 3rd January 2017, the hospital has been part of the SAFER Campaign to improve patient flow. The nurses have been actively involved in the Red2Green Board Round in the mornings, to help effectively plan each patient's day and increase the chance of a patient being discharged safely to place of residence earlier.

2.3. React2Red

"React to red" has been designed to raise awareness of the steps which staff can take to minimise the chance of their patients developing the painful sores. Its aim is to reduce the number of avoidable pressure ulcers and this was initiated in September 2016 and is continually being driven by nursing teams.

2.4. Education – Budget cuts

In March 2016, Health Education England reduced funding for "workforce development" by around 50% for each of its 13 local education and training boards across the country. Cuts to funding for continuing professional development has led to on-going training for nurses being reduced and opportunities to develop via attending courses lessened considerably. However we are working with UCS to develop courses to help with training.

2.5. Staff levels and skills mix

This is constantly being reviewed at bed meetings in the trust, as well as, the Trust from June 2016 preforms a biannual review of staff requirements using various calculation methods suggested by '*Hurst, K. (2003) Selecting and Applying Methods for Estimating the Size and Mix of Nursing Teams - A Systematic Review*' to allow staff to use appropriate instruments and data to help them plan and implement efficient and effective nursing teams.

2.6. Nursing & midwifery newsletter

This has not been progressed due to the various other methods of communication currently used by the trust. Normally via Core Brief email (sent on a Monday) or Greensheet (sent on a Friday) each week.

2.7. Patient experience in top 10% for N&M questions

In the Overall Patient Experience Scores: 2015 / 2016 Adult Inpatient Survey we achieved performance in top 20% for safe, high quality and coordinated care. This was released on early June 2016.

2.8. Nursing – related complaint reduction

There has been no reduction in complaints; however there is also not obvious pattern either occurring in when we receive complaints. In general, in comparison to other hospitals, out complaint levels are fairly low.

2.9. Reduction in HCAI

Reducing hospital-associated infections continues to be one of the main priorities for our patients and the public. In addition, it remains a key priority for the NHS as a whole and for our commissioners. Within the Trust we continue to strive for further improvement, with a focus on the timely identification and management of patients with infections and at risk of infection. Further quality improvement is focused on:

- Installation of doors to bays in some clinical areas to improve the ability to isolate patients
- Improvement in antibiotic policy compliance, including identifying clinically appropriate 'non-compliance' with the policy, for example, extending an existing antibiotic regime for a further 24 hours
- Provision of a decant ward to facilitate rolling programme of 'deep cleaning'
- Consideration of use of bespoke isolation provision where space allows.

2.10. Side rooms on F12 and whole of G5 made dementia friendly

Due to significant capacity challenges throughout the year and no decant ward being available to allow deep cleaning, G5 and F12 have not been able to have a redecoration

2.11. Access to a leadership development and competency assessment AND Develop talent management programme to support the future workforce

A leadership development and talent management action plan was approved by Executive Directors in March. The priorities of the plan are to deliver systematic, transparent, talent management, the development of leadership and improvement skills at all levels of the Trust and contribute to the development of systems leadership in West Suffolk.

The plan builds on existing programmes and resources, and includes: the Key Leaders programme for 20 senior leaders across the organisation; the 2030 Leadership Programme for aspiring future senior leaders; co-ordinated participation in regional and national leadership development programmes; support for the further development of effective developmental coaching and mentoring at all levels of the Trust; and a series of leadership seminars.

2.12. Buddy system of nurses who require extra support

This has been commenced on a bespoke level, with ED being one of these areas.

2.13. Professional accountability flow diagram has changed

Please refer to Appendix A for altered flow diagram

2.14. Band 5 & 6 development in house programmes

Band 5's on each ward have a checklist that they have to go through when initially starting. Band 6's however are expected to attend Expect Navy Courses and attending Resilience Training run by an Ipswich Hospital colleague

2.15. Ward Checklist has changed

Please refer to Appendix B for Altered Ward Checklist

3. Next Steps

A fair amount of progress has been made in this year, but there are still improvements to be made. As well as continuing to develop areas where required, the Nursing Directorate will look to progress:

- Annual nursing conference and nursing achievement wards
- Ward accreditation scheme
- Increase rate of submission for nursing awards
- Side rooms on F12 and whole of G5 made dementia friendly

4. Embedding the strategy

As previously mentioned, the Nursing & Midwifery Strategy was developed by Nurses and Midwives working at all levels within the Trust and therefore "belongs" to everyone. It is not a document written to sit on a shelf it is fundamental to the day-to-day delivery of our services. Therefore, the Divisional Heads of Nursing/Midwifery are continually with their teams agreeing areas to focus on and issues and/or areas of development are bought to the monthly Nursing & Midwifery Council.

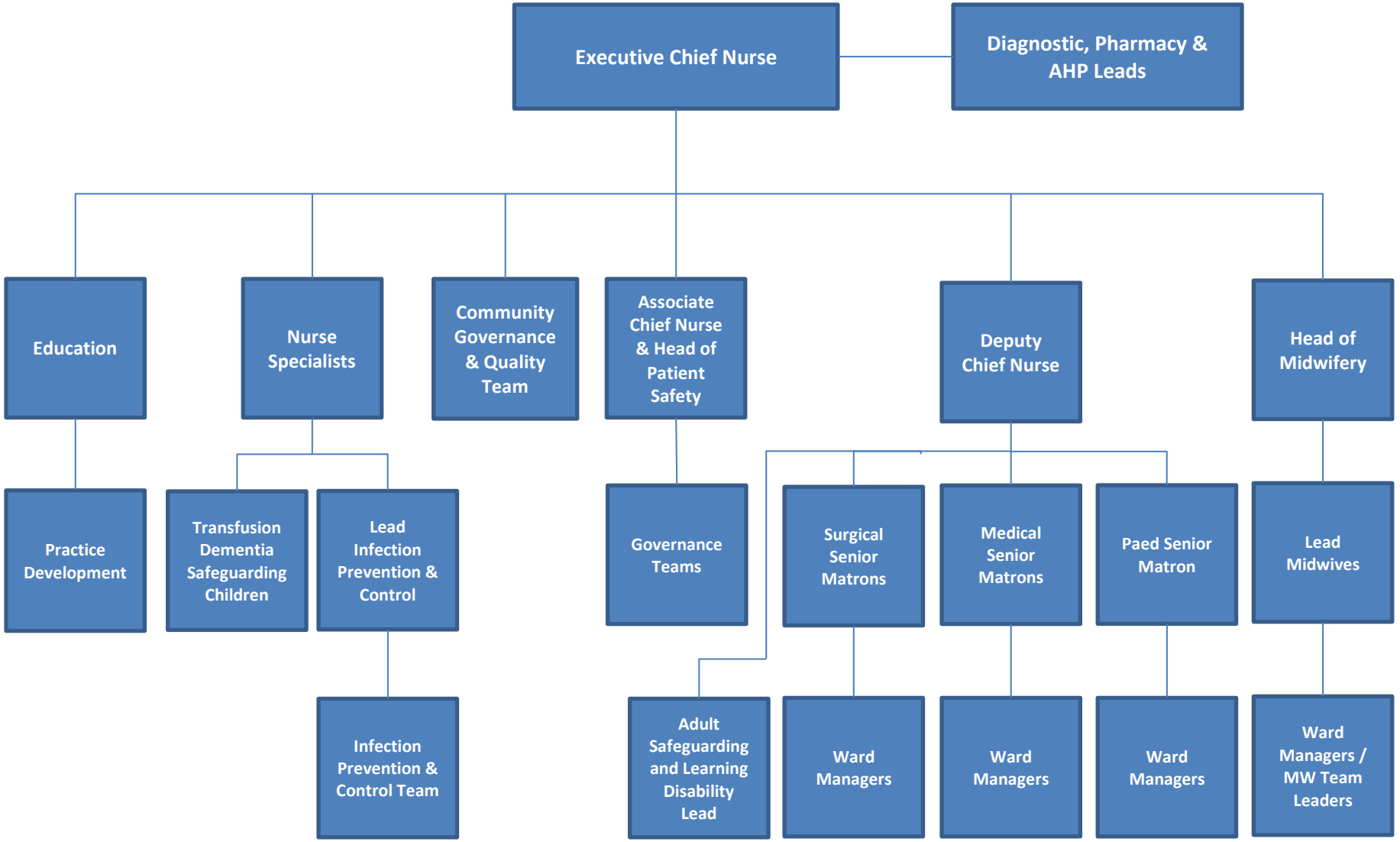
5. Conclusion

The nursing strategy continues to drive improvements in care delivery and workforce redesign. The nursing & midwifery teams will continue to work alongside strategy in 2017 which will ensure steps towards continually improving care, putting patients at the heart of what we do whilst ensuring our workforce are developed and valued for their contribution.

The Board are asked to note:

- The clear commitment amongst Trust staff to progress the principles within the Strategy, the central focus of which is on developing and maintaining a workforce that keeps the patient truly central to all care delivery.
- Many of the principles can only be achieved through collaborative working with colleagues working in Higher Education and CCGs, evidenced within the progress made to date.
- The challenge now is to maintain the focus on making further progress on the Strategy whilst working towards the integration of acute services with community services in October 2017.
- The Strategy should provide staff with a point of focus and help with decision making for the key priorities that need to be progressed

Appendix A – Professional Accountability at WSFT



Appendix B – Ward Checklist

Matron Round

Ward: **Date:**

First 15 Steps Comments…….

SAFE	✓ OR × OR N/A	**EFFECTIVE**	✓ OR × OR N/A
Drug keys with RN		Resuscitation trolley checked for 7 consecutive days	
CD keys with nurse in charge		Safety crosses up to date	
Drug room locked		Oxygen and suction checked	
CDs checked for 7 consecutive days		Oxygen cylinders stored correctly	
Drug cupboards and fridge locked		Management plans up to date	
No drugs unlocked		High MEWS escalated over 7 days	
Fridge temp recorded daily (min and max)		Pts adequately hydrated	
Drug trolleys locked and secured		Bristol stool chart completed where appropriate	
IV Fluids locked		Lying and Standing BP (5)	
IV Fluids stored off floor		VIPS recorded (5)	
Spot check IV fluids in date		**RESPONSIVE**	✓ OR × OR N/A
Medications not left on bedside tables in bays		Patient data managed confidentially	
Nurse staffing levels displayed		User's not leaving WOWs logged on	
Sharps bins labelled, closed		**CARING**	✓ OR × OR N/A
Hand gels on beds		EPARS fully completed	
Appropriate hand hygiene		MCA & DOLS forms filled in	
WELL LED	✓ OR × OR N/A	EOLC rounding tool done on EOLC pts	
Boards above bed complete		Pain Score	
Datix issues mainly raised (3)		Call bell to hand	
Ward performance awareness (3)		Toilets and bathrooms clean	
Ward tidy, clutter free		Sluice tidy	
Bay tidy, clutter free		Commodes clean and labelled	
Bay boards completed		Call bells answered promptly	
Appropriate uniform			

Overall Ward / Area Rating	
Good	
Needs some improvement	
Poor	

Comments:

Patient / relative feedback:

Item 15

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING (SAMPLE TEMPLATE)

6th December 2016 – 6th March 2017

Executive summary

Introduction

This is the first quarterly report produced since the introduction of the 2016 Terms and Conditions of Service (TCS) for Doctor and Dentists in Training by NHS Employers. Full details of this contract are to be found here: http://www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-2016-contract

The report is compiled by the Guardian of Safe Working Hours, a new role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A new system of Exception Reporting has been introduced, which replaces monitoring of working hours. This is done using Allocate software, a system already in place at West Suffolk, but extended for this purpose.

Another initiative introduced is a monthly Junior Doctors' Forum. This is attended by Junior Doctors, including the mess president, chief resident and BMA representatives, the Director of Education and members of HR.

So far 30 doctors (Foundation Year One trainees) have joined the TCS since December 2016. This will increase through 2017 so that all new trainees taking up appointments will be on the 2016 TCS by October 2017.

Summary data

Number of doctors / dentists in training (total):	149
Number of doctors / dentists in training on 2016 TCS (total):	30
Amount of time available in job plan for guardian to do the role:	1 PAs / 4 hours per week
Admin support provided to the guardian (if any):	0 WTE [1]
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee[2]
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[2]

a) Exception reports (with regard to working hours)

The purpose of exception reporting is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained. If there are consistent problems a work schedule review should be carried out . A process is in place on Allocate for the Junior Doctors to fill in the report, which at present requires permission from a consultant and a narrative of the situation

which led to exceeding the contractual obligation. Details are sent to the Guardian and Clinical Supervisor
It is expected that patterns may emerge which may prompt reflection on working practice within the department at a service or educational level.

b) Exception reports (with regard to working hours)

Summaries of ERs have been discussed at each JD Forum. It is generally agreed that ER reporting should be encouraged, but there may be individuals reluctant to complete an ER, and therefore it is likely this provides an incomplete picture at present. Ways of overcoming this are being considered.

During the quarter there were 30 ERs raised, which were evenly divided between Surgical and Medical specialties.

For those doctors still on the 2002 contract the system of monitoring still holds. This is currently underway and results will be available for the next board report.

Exception Reports by Department				
Specialty	No. exceptions carried over from before Dec 2016	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	0	14	9	5
Medicine	0	16	13	3
Woman & Child	0	0	0	0
Clinical Support	0	0	0	0
Total	0	30	22	8

Exception reports by Rota				
Specialty	No. exceptions	No. exceptions	No. exceptions	No. exceptions

	carried over from before Dec 2016	raised	closed	outstanding
General Surgery F1's	0	14	9	5
General Medicine F1's	0	14	12	2
ITU F1's	0	0	0	0
A&E F1's	0	2	1	1
Paediatrics ST4+'s	0	0	0	0
Total	0	30	22	8

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	30	22	8
ST4+	0	0	0	0
Total	0	30	22	8

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	9	9	4	8
ST3-8	0	0	0	0
Total	9	9	4	8

c) Work schedule reviews

Work schedule reviews for individuals may be requested by either the doctor, or the education/clinical supervisor, service manager or guardian in writing. To date none have been carried out.
Any future reviews will be presented thus:

Work schedule reviews by grade	
F1	0
ST3+	0

Work schedule reviews by department	
Surgical	0
Medical	0
Woman & Child	0
Clinical Support	N/A

Locum Bookings & Locums carried out by trainees

It is recommended by NHS Employers that Trusts also report on data concerning the use of locums in order to identify any impact on safe working hours. This may occur where there are gaps in a rota caused by vacancies or where there are frequent unplanned absences requiring locum cover.

Over the next quarter the Trust will develop a range of reports that specifically focus on providing data that quantifies the level of locum cover requested by department and grade. It will also split the data by agency locum and in-house banks cover in order provide assurance of safe working by our own junior doctors who are registered on the bank.

d) Vacancies

HR have provided details of current vacancies:

Vacancies by month						
Specialty	Grade	Dec 16	Jan 17	Feb 18	Total gaps (average)	Number of Shift to cover
Anaesthetics	CT	0	0	1	0.33%	Information not available.
ENT	GP	0	0	1	0.33%	
General Surgery	F1	1	1	0	0.66%	
Medicine	F2	1	1	1	1	
Medicine	CT	0	0	1	0.33%	
Medicine	ST3+	1	1	2	1.33%	
Ophthal'	ST3+	1	1	1	1	
Paediatrics	GP	1	1	0	0.66%	
Paediatrics	ST3+	0	1	1	0.66%	
Total		5	6	8	6.3%	

e) **Fines**

There is a system of financial penalty now in place where exception reporting demonstrates the following:
-a breach of the 48-hour average working week across the reference period agreed for that placement in the work schedule

-a breach in the maximum 72-hour limit in any seven days
- the mimimum 11 hours rest requirement between shifts has been reduced to fewer than 8 hours.

So far, exception reporting has not generated any fines. This is being calculated on an individual basis as so far Allocate is unable to provide that information.

Any future fines will be reported in this way:

Fines by department		
Department	Number of fines levied	Value of fines levied
Acute medicine		
Cardiology		
Total		

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter

Matters arising

As this has been a new process it is early days to draw any conclusions from the data presented. The new contract was introduced under difficult circumstances, as there was disagreement between government recommendations and the BMA. This led to Industrial Action in 2016. The contract was finally agreed after ACAS arbitration in May 2016 and signed off in July, despite members of the BMA voting against it. Further industrial action was announced, but then cancelled. It is therefore not surprising that there is uncertainty about the implications at present.

Various issues have arisen, partly about the process itself, and partly identified through reporting. There is still a clear place for sorting matters out "on the ground" as they arise, and preferably before an ER report is required. The Junior Doctors Forum has also offered an opportunity to discuss things with a view to finding solutions.

- Rota Gaps There was a persistent rota gap in General Surgery due to difficulties in a Visa Application. This led to considerable discontent amongst the junior doctors, leading to an extraordinary meeting, chaired by the Clinical Director for Surgery on 24th January. The large majority of junior doctors agreed that F1s and F2s should be ward based for surgical patients. It was agreed a small working group would work with HR on this for the future. This is still under discussion.
- Locum rates. At the meeting on the 24th January it was agreed that predictable rota gaps should be advertised via agency first but also advertised internally by text with a minimum of 2 weeks notice at the standard negotiated locum rate. If there was an unforeseen gap due to acute illness/absence this should be covered internally with remuneration at the standard negotiated locum rate.
- Training and Support. The Guardian attended 2 one-day conferences in London run by NHS Employers in July 2016 and March 2017. The Eastern Deanery has also set up a regional Guardian group, attended by the Director of Education in March. Common issues have

emerged around administrative support for the Guardian Role and HR. Administrative support is required for booking and taking minutes for the JD Forum, and ensuring completion of ERs with the Clinical Supervisor. Different Trusts are making their own arrangements up to 1 x WTE. This has now been identified as a cost pressure for the coming year.

- The role of clinical and educational supervisors has changed as they are now part of the ER process. This has led to delays in completion of reports, not always due to lack of engagement, but also practical issues, such as annual leave.
- Other ways of working: Use of non-medical staff, such as Clinical Skill Practitioners and Physician Assistants is generally welcomed, and there may be ways of streamlining work processes (such as TTOs) which could reduce the workload on Junior Doctors safely

Summary

This document is designed to provide an introduction to the Trust Board around how we are working towards Safe Working. It is early days to make recommendations, particularly around locum usage and vacancies, with current lack of data. It is hoped that future reports will be able to address this. It is also too easy when highlighting problems not to recognize how much is actually going well. There is much work that could be done around improving the culture for working, which often comes down to a personal level as well as an organizational one.

This report is likely to expand as data becomes more forthcoming and the numbers of doctors within the new contract will have increased substantially after August 2017.

Appendices

1. Identified as a cost pressure for next year.
2. HEEoE require that 0.25 PA is paid per trainee in a numbered post for Educational Supervision and also to Named Clinical Supervisors. This is a requirement on all trusts in the region with trainees and was set as a requirement in the Trust's Action Plan following our Quality and Performance Review visit last June.

Sarah Gull

Guardian of Safe Working Hours

March 28th 2018

Board of Directors – 28 April 2017

AGENDA ITEM:	Item 17
PRESENTED BY:	Dr Stephen Dunn, Chief Executive
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	21 April 2017
SUBJECT:	Trust Executive Group (TEG) report
PURPOSE:	Information

EXECUTIVE SUMMARY:

3 April 2017

Steve Dunn provided feedback from the Board meeting reflecting on **operational and financial performance**. The positive impact of red2green was discussed and the importance of feeding information back to consultants. The positive **staff survey** results were highlighted along with the Trust excellent performance in the recent national **stroke audit**.

The achievement of the **financial target** through non-recurrent cost improvement was discussed and the downside that the non-recurrent nature of the savings makes the job harder for next year. It was noted that KPMG would be undertaking work for the Trust as part of the national Financial Improvement Programme (FIP). The cost of the work being met by NHSI.

A report was received from the **Flow Action Group (FLAG).** Emphasis remained on Red to Green Board Rounds. Nick Jenkins reflected on experience and priorities going forward and how this is being communicated to drive continued improvement. The planned pilot of a new mobile application to support communication was discussed and pilot users identified.

The **red risk report** was reviewed with discussion and challenge for individual areas. A new red risk was received regarding failure to meet MHRA legal requirement and a potential breach of blood safety regulations.

A presentation was received on **Cyber Security** from Paul Maskall, Cyber Security Advisor, Norfolk & Suffolk Constabularies

An evaluation report for **Glastonbury Court** was received which set out an early assessment of the commissioned beds from September 2016. This early evaluation suggests evidence of good practice, with potential to extend the impact much further through a more integrated system approach for 'Discharge to Optimise and Assess' and pull based discharge principles. Further review will be undertaken, including linking with teams in south Warwickshire to learn from their experience.

An overview of the national direction of **7 day services** (7DS) was received. This included the outcomes of the recent audit and details of the revisions in the four priority 7DS standards made in December 2016. It was stressed that this issue was about more than just the monies and represented a recruitment challenge.

The **Sustainable Development Management Plan** was received and approved.	
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: (including reference Risk Register and BAF if applicable)	N/A
Description of assurances:	N/A
Legislation / Regulatory requirements:	N/A
Other key issues:	None
Recommendation: To note the report	

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28 April 2017

AGENDA ITEM:	18
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	21 April 2017
SUBJECT:	Quality & Risk Committee (QRC) report
PURPOSE:	Approval
STRATEGIC OBJECTIVE:	To deliver and demonstrate rigorous and transparent corporate and quality governance

EXECUTIVE SUMMARY:

Attached are the minutes of the QRC meeting held on 31 March 2017 (**Annex A**). The Board is asked to note these for information. The outcome of the annual governance review will be used to inform the scope of the mandated external 'well led' review. A report is scheduled for the Board on this proposal in May '17.

The format of the meeting was amended to provide greater emphasis on quality improvement developments at a strategic, corporate and divisional level as well as the 'business as usual' through reports and escalation from the subcommittees.

To reflect this change of emphasis the terms of reference of the committee have been updated for approval by the Board (**Annex B**). Approved changes will be incorporated into the Scheme of reservation and delegation.

Previously considered by:	This is a regular report to the Board since the inspection took place
Risk description:	Failure to appropriately respond to concerns raised could lead to a cease and desist order being made by MHRA
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	WSFT management oversight of TPP action and regular discussion with MHRA
Legislation / Regulatory requirements:	European Blood Safety Directives / Blood Safety and Quality Regulations (BSQR)
Other key issues:	None

Recommendation:
1. To note the report and issues identified
2. Approve the updated terms of reference

West Suffolk NHS
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Annex 18A

QUALITY & RISK COMMITTEE
Minutes of the meeting held on Friday 31 March, 2017,
Commencing at 2.00 p.m. in the Committee Room

COMMITTEE MEMBER			Attendance	Apologies
Roger Quince	**(RQ)**	Chairman (Chair)	**X**	
Stephen Dunn	**(SD)**	Chief Executive	**X**	
Craig Black	**(CB)**	Director of Resources	**X**	
Nick Jenkins	**(NJ)**	Medical Director	**X**	
Helen Beck	**(HB)**	Interim Chief Operating Officer	**X**	
Jan Bloomfield	**(JBl)**	Director of Workforce & Communications	**X**	
Rowan Procter	**(RP)**	Chief Nurse		**X**
Jon Green	**(JG)**	Chief Operating Officer		**X**
Gary Norgate	**(GN)**	Non-Executive Director	**X**	
Steve Turpie	**(ST)**	Non-Executive Director		**X**
Neville Hounsome	**(NH)**	Non-Executive Director	**X**	
Richard Davies	**(RD)**	Non-Executive Director	**X**	
Richard Jones	**(RJ)**	Trust Secretary & Head of Governance	**X**	
In attendance				
Kaushik Bhowmick	**(KB)**	Consultant, Anaesthetics (Item 2 only)		
Mike Gill	**(MG)**	Director, Consulting Services, RSM (Item 4 only)		
Denise Pora	(**DP**)	Workforce Development Manager (Item 4 only)		
Ruth Williamson	**(RW)**	PA to Medical Director (Minutes)		

Action

1. **Apologies for Absence**

As detailed above.

2. **Simulation Training**

The Committee received a presentation from Dr. Kaushik Bhaumick on simulation training.

CB asked whether it was an improvement in technique that was reducing errors. It was believed to be the case, together with a focus on team work. NJ advised that the majority of errors made were not as a result of the complexity of the task, but as a result of human error.

GN also asked whether this training was borne from KB's passion or from planned Trust developments? KB advised that having worked on simulation previously, he had met with James Whatling, Simulation Lead and Peter Harris, PGME Director. Whilst there was a lead in situ, there had not been a Group and KB had requested to take the matter forward. Recruitment of further faculty was under way. He confirmed that this work had been supported as the planned direction of travel by the Trust.

NH asked how this training would coincide with human factors. KB stated that human factors was about behaviour and the nature of communication. Simulation related to the behaviour of each person, giving the individual an opportunity to speak out and help change the climate.

RD said that some of the barriers had been identified, i.e. in respect of equipment, cost and time. He asked if there were any in respect of culture, did staff buy-in to the concept. KB advised that culture change was not easy and simulation was not just for junior staff.

SD reported that development of a trust-wide quality improvement framework had been discussed at the Board. However, there was no systematic approach for quality improvement at present. Simulation was one component of this framework required for systematic quality improvement. (RP left at 2:55 pm).

The Committee thanked KB for his efforts in this regard. (KB left at 2:56 pm).

3. **Reports from Sub-Committees**

a. ***Clinical Safety & Effectiveness Committee***

Reports were duly accepted.

b. ***Corporate Risk Committee***

Reports were duly accepted.

RJ advised that in respect of issues highlighted potential future escalation to this committee, i.e. NHS Property Services response to issues raised; and health and safety audit programme. It was noted that if adequate progress has not been made at the next meeting (30 June) these items will appear on board agenda. **RJ**

c. ***Patient Experience Committee***

Reports accepted.

NH observed that for all of the above meetings, the only executive in attendance was the one acting as Chair. SD, RQ and RJ to meet regarding meeting attendance and reinvigoration of same. **SD/RQ/ RJ**

RV departed at 3.00 pm. MG joined at 3.00 pm, together with Denise Pora.

4. **Well-Led Assessment**

MG gave a presentation on the Well-Led Assessment and revisions to same.

The meeting broke in to groups to consider the following (from 3.20 p.m. - 3.45 p.m.):

1. Based on the self-assessment results are there additional areas that the Trust should focus on for the independent well-led review?
2. Based on the above focus and any further areas you determine what does good look like, i.e. what is the perceived gap?
3. As a board what do you wish to see that will assure you that the gaps are being sufficiently addressed?

RJ advised that his group had looked at KLOE 3 and 4 in particular – consistency of culture and addressing behaviour and clarity over responsibilities and had come to the view that of the three questions, they had moved quality improvement methodology to the top with sub-bullet points

regarding staff, education, support and how to take the positives of the West Suffolk way and ensure a consistent and systematic method of delivery.

MG advised that the other group had looked at division of responsibilities and clarity of role and this was a consistent theme across the groups. A potential contentious issue was around quality improvement. If we know we have a deficit, do we need to have an external body investigate.

RJ believed the Trust wished to obtain a consensus on areas for improvement rather than focus for an external assessment. GN believed the perceived gap to be one of informality and whether the Trust had a formal policy/framework. MG said it was a question of how to corral.

RQ stated it was a matter of leadership development and information flow available down the organisation. What the Board received was management information, which management could use as time passed. The Trust needed to think how to deal with this and how to engage with people within the organisation to develop staff, i.e. talent spotting and development; how to get teams to work more effectively.

HB suggested ward to board, linking in to continuous improvement and closing the gap, with the Trust's objectives to ensure each service and individual is aware of the part they play; creating a structure.

Committee to consider whether any areas identified in objectives were to form part of external assessors review, or focus elsewhere. Delivery timeline to be brought back to this committee at meeting on 30th June. **RJ**

MG, CB and DP departed at 3.55 pm.

5. **Any Other Business**

No further business was noted.

Date and Time of Next Meeting

Please note the meeting will start at 14:00 in the Committee Room.

30 June, 2017
29 September, 2017
1 December, 2017

The meeting closed at 4.05 p.m.

West Suffolk NHS
NHS Foundation Trust

Quality & Risk Committee

Terms of Reference

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Quality & Risk Committee (the Committee). The Committee is a sub-committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Programme Board. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary

1.3 The Committee will, when required and appropriate, establish subcommittees and delegate certain responsibilities and decisions to subcommittees

1.4 The Committee has the authority to approve relevant strategies, policies and procedures

1.5 The Committee will work closely with the Audit Committee, avoiding duplication

1.6 Significant risks reported to or identified by the Committee will be reviewed to consider the implementation of additional controls. Where these additional controls cannot be implemented in a timely manner the matter will be referred to the Trust Executive Group (TEG) for consideration of resource implication. At the Chair's discretion the Committee may refer significant risks directly to the Trust Board

1.7 The emphasis in formatting the agenda of the committee will be to review and share quality improvement methodologies use externally and internally, promoting a systematic quality improvement methodology across the Trust. *This includes the use of presentations previously received at the open Board meetings.*

2. Membership

2.1 Membership will comprise executive and non-executive directors as set out below. The roles of Chairman and Vice Chairman will be reserved to non-executive directors

- Chairman of the Board of Directors (Chair)
- Three Non-Executive Directors (also members of the Audit Committee)
- Chief Executive
- Executive Director of Resources
- Executive Chief Operating Officer
- Executive Director of Human Resources and Communications
- Executive Chief Nurse
- Executive Medical Director

2.2. Attendees will be key individuals as set out below

- Chair of the Audit Committee
- Deputy Medical Director with responsibility for Patient Safety
- Clinical Directors

- Assistant Director of Finance
- Deputy Chief Nurse
- Trust Secretary & Head of Governance
- Governors by invitation to attend presentations relating to quality improvement developments and initiatives

2.3 Attendees are only required to attend the meeting for specific items relevant to them, but can attend for the whole meeting should they wish

2.4 A quorum will be four members which must include a non-executive director) and an executive director.

3. Attendance at Meetings

3.1 With the exception of the Chief Executive, members should have an identified deputy who will attend in their place when they are unable to. Details of members, attendees and where appropriate nominated deputies are detailed in Annex A

3.2 The Committee will have the over-riding authority to request or restrict attendance under specific circumstances.

4. Frequency of Meetings

4.1 Meetings will normally be held no less often than four times in a year.

4.2 Special meetings may be convened by the Board of Directors or the Chairman of the Committee in accordance with the standing orders of the Trust.

5. Duties and Responsibilities

5.1 General

5.1.1 The Quality & Risk Committee shall:

- Monitor and review the risk, control and governance processes delegated to the committee by the Board
- Annually review and approve the Trust's quality and risk improvement plans to support their delivery. These plans relate to clinical effectiveness, patient safety, including infection control and review feedback to the Trust on the experience, including patient and staff surveys and complaints. This will include organisational and directorate performance reports for quality and risk
- Review and approve annually the work plans of the reporting committees detailed within this section and Annex B, monitor their activities and consider issues escalated by them and to receive an annual report from them on their performance and outcomes
- Monitor and review directorate quality on a quarterly basis. This will include quality walkabouts and other feedback.
- To consider risks escalated by the directorates and its subcommittees. The Committee will escalate risks, it determines as appropriate, directly to the Board.

5.2 Quality

5.2.1 To advise the Board of Directors on the Trust's quality improvement framework, including the appropriate quality and safety performance indicators for inclusion in the Trust's Quality Accounts

5.2.1 Review and monitor:

- Compliance with CQC registration standards
- Quality improvement developments and initiatives at strategic, corporate and divisional levels
- Any other relevant performance indicators relating to clinical effectiveness, patient safety and experience as the committee may from time to time agree.

5.3 Clinical Safety & Effectiveness

5.3.1 Agree an annual work plan with and receive an annual report from the Clinical Safety & Effectiveness Committee

5.3.2 Review and monitor:

- The activities of the Clinical Safety & Effectiveness Committee, including progress against the Trust's patient safety priorities and Serious Incidents Requiring Investigation (SIRIs) reported and actions being taken
- The outcomes of clinical area reviews and the actions being taken (this includes patient safety walkabouts and the planned programme of structured reviews)
- Key patient safety indicators

5.3.2 Promote learning and sharing, both from within and outside of the Trust.

5.4 Patient Experience

5.4.1 Agree an annual work plan with and receive an annual report from the Patient Experience Committee

5.4.2 Review and monitor:

- The activities of the Patient Experience Committee
- The outcomes of Patient-Led Assessments of the Care Environment (PLACE) reports and the actions being taken
- Key patient experience indicators
- Patient and staff survey results and actions being taken.

5.5 Corporate Risk

5.5.1 Agree an annual work plan with and receive an annual report from the Corporate Risk Committee

5.5.2 Review and monitor:

- The activities of the Corporate Risk Committee
- Key corporate risk indicators
- Any serious breaches of health and safety where an enforcement notice has or may have resulted and actions being taken.

5.6 Other key activities

5.6.1 Promote learning and sharing for all areas of activity, both from within and outside of the Trust

5.6.2 To review the adequacy of systems to ensure that the Trust meets, and where possible exceeds relevant statutory and regulatory obligations including the duty of quality set out in the NHS Act 2006

5.6.3 To monitor and make recommendations on the adequacy and effectiveness of any aspects of the Trust's performance as the Board may request

5.6.4 To oversee Trust's registration with the Care Quality Commission and its ongoing compliance

5.6.5 To oversee the process for the Trust acting on reports received from external accreditation bodies, where applicable consider any main findings arising from them and management actions being taken

5.6.6 To address any serious and sustained failure to meet minimum standards where this cannot be resolved through line management or professional self-regulation

5.6.7 To contribute to the Trust's Annual Governance Statement (AGS) and Internal Audit programme.

6. Reporting, Accountability and Review of Effectiveness

6.1 The minutes of Committee meetings shall be formally recorded and submitted to the Board

6.2 The Committee shall review its terms of reference annually

6.3 The Committee will agree on an annual basis a reporting framework for all areas of it terms of reference (Annex C). This determines standing items for the agenda and items for regular reporting.

6.4 The Committee shall carry out a self assessment in relation to its own performance no less than once every two years

6.5 An annual report of the activities of the Committee shall be presented to the Board of Directors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

Annex A

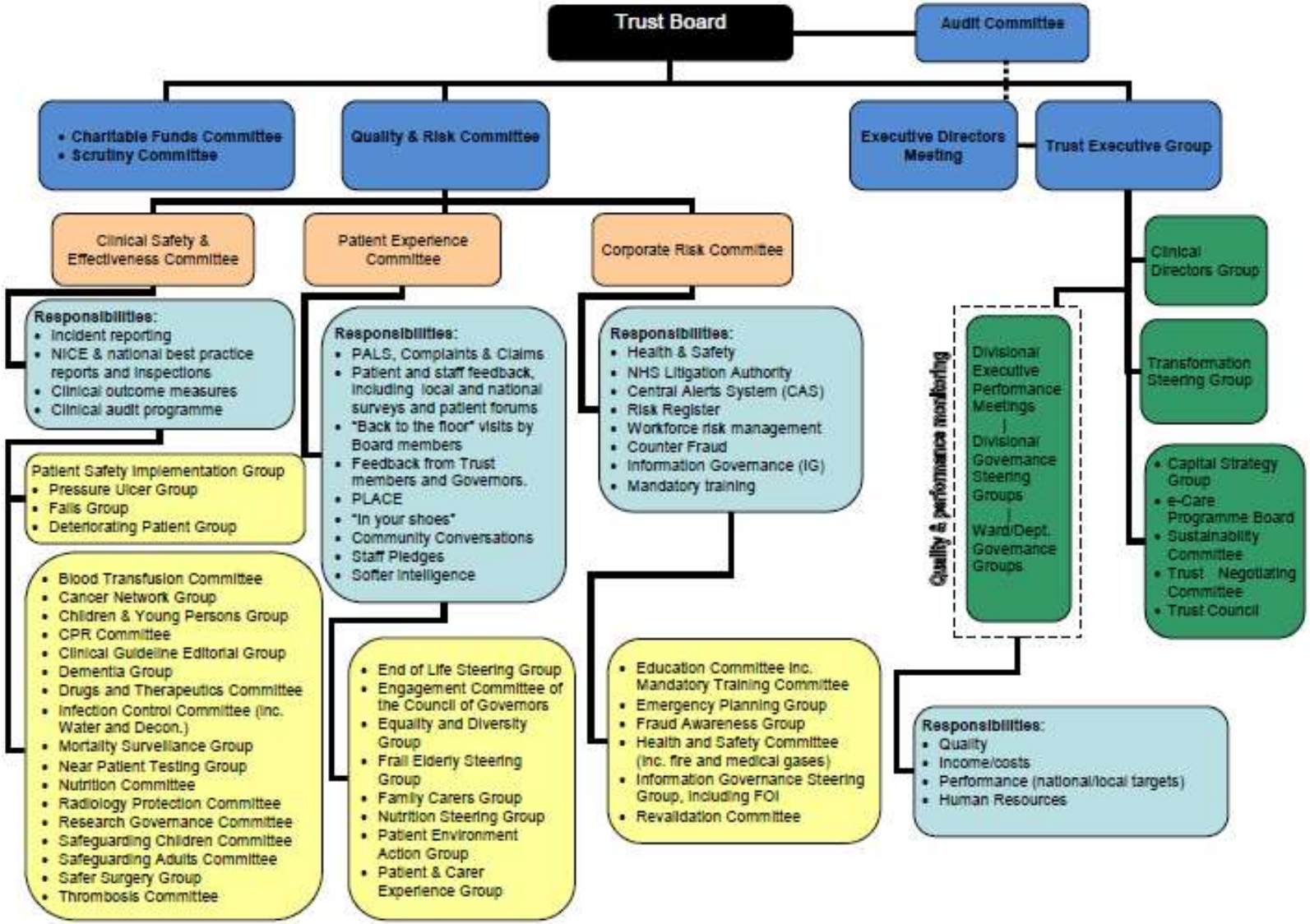
Current Membership

Four Non-Executive Directors	Mr Roger Quince (Chairman) Mr Alan Rose Mr Neville Hounsome Dr Richard Davies
Chief Executive	Dr Stephen Dunn
Executive Chief Operating Officer	Mrs Helen Beck
Executive Chief Nurse	Mrs Rowan Procter
Executive Medical Director	Dr Nick Jenkins
Executive Director of Workforce and Communications	Mrs Jan Bloomfield

Attendees

Chair of the Audit Committee	Mr Steve Turpie
Deputy Medical Director with responsibility for Patient Safety	Dr Paul Molyneux
Clinical Directors (as requested)	Ravi Ayyamuthu Rachel Darrah Sue Deakin Raman Lakshman Margaret Moody Patricia Mills Vivek Rajogopal
Assistant Director of Finance	Mrs Louise Wishart
Deputy Chief Nurse	Mrs Tracey Oats
Head Patient Safety & Effectiveness	Mr Paul Morris
Trust Secretary & Head of Governance	Mr Richard Jones

Annex B: Committees and reporting framework



Annex C: Quality & Risk Committee reporting schedule

Topic	Lead	Frequency
Review agreed external quality indicators	Rowan Procter	Quarterly
Quality improvement methodology (review prior to Board)	Rowan Procter / Nick Jenkins	Annual - June
Quality improvement plan	P Chrispin / Rowan Procter	Quarterly
Agree annual work plans of reporting committees	Roger Quince	Annual - March
CQC self-assessment and benchmarking	Nick Jenkins / Rowan Procter	Quarterly
Annual Governance Statement	Steve Dunn	Annual - March
Clinical Safety & Effectiveness Committee report	Helen Beck	Quarterly
Patient Experience Committee report	Rowan Procter	Quarterly
Corporate Risk Committee report	Nick Jenkins	Quarterly
Annual reports		
Quality & Risk Committee	Roger Quince	Annual – March
Subcommittees (CRC, CSEC & PEC)	Chairs	Annual – March
Health & Safety	Rowan Procter	Annual – June
Fire Annual report	Helen Beck	Annual – June
Infection Control	Rowan Procter	Annual – June
Safeguarding children	Rowan Procter	Annual - June
Reflection and issues for escalation to Board	Roger Quince	Quarterly

The following documents will be reserve for approval by the Board:

- Risk management strategy
- Quality improvement strategy

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28 April 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:	21 April 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 – 26 May 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, including: staff recommender scores, mandatory training analysis, consultant appraisal	✓		Written	Matrix	HB/RP
Revised mortality reporting	✓		Written	Action point	NJ
Finance & workforce performance report	✓		Written	Matrix	CB
Transformation report (quarterly)	✓		Written	Matrix	HB
Red risk report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP					
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
Appointment of senior independent director	✓		Written	Action point	RQ
Annual complaints report	✓		Written	Matrix	RP
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
BUILD A JOINED-UP FUTURE					
e-Care report	✓		Written	Action point - schedule	CB
Stroke option paper		✓	Written	Action point - schedule	HB
Scrutiny Committee report		✓	Written	Matrix	GN
Clinical Excellence Awards Scheme assessment criteria		✓	Written	Action point - RemCom	JB
Strategic update, including STP, ICO and TPP		✓	Written	Action point - schedule	SD
Annual report and accounts		✓	Written	Matrix	CB/RJ
GOVERNANCE					
Trust Executive Group report	✓		Written	Matrix	SD
Audit Committee report	✓		Written	Matrix	RQ
External 'well led' review proposal	✓		Written	Matrix	SD
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