NHS
West Suffolk
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 28 July 2017 at 9.15** in the Northgate Room, 2nd Floor, Quince House at West Suffolk Hospital

Roger Quince
Chairman

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**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 30 June 2017	Roger Quince
6.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Roger Quince
7.	**Chief Executive's report (attached)** To accept a report on current issues from the Chief Executive	Steve Dunn
9:35 DELIVER FOR TODAY		
8.	**Quality & Performance reports (attached)** To receive the report	Helen Beck / Rowan Procter
9.	**Finance & Workforce Performance report (attached)** To accept the monthly Finance & Workforce report	Craig Black
10.	**Transformation report - Q2 (attached)** To receive the report	Helen Beck
10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
11.	**Aggregated quality report (attached)** To accept the aggregated analysis including serious incidents, red complaints and PALs enquiries	Rowan Procter / Nick Jenkins
12.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter
13.	**Mandatory training report (to follow)** To receive the report	Jan Bloomfield

14.	**Consultant appointment report (attached)** To accept the report	Jan Bloomfield
15.	**Medical Revalidation annual report (attached)** To receive the report	Nick Jenkins
16.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
10:50 BUILD A JOINED-UP FUTURE		
17.	**e-Care report (attached)** To receive an update report	Craig Black
18.	**Alliance and community services update (attached)** To receive an update report	Helen Beck
11:00 GOVERNANCE		
19.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
20.	**Quality & Risk Committee report (attached)** To receive the report for the meeting held on 30 June 2017	Roger Quince
21.	**Remuneration Committee report (attached)** To receive the report	Neville Hounsome
22.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:15 ITEMS FOR INFORMATION		
23.	**Any other business** To consider any matters which, in the opinion of the Chairman, should be considered as a matter of urgency	Roger Quince
24.	**Date of next meeting** To note that the next meeting will be held on Friday, 29 September 2017 at 9:15 am in the Committee Room.	Roger Quince
RESOLUTION TO MOVE TO CLOSED SESSION		
25.	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

West Suffolk NHS
NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 30 JUNE 2017

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

Action

GENERAL BUSINESS

17/128 APOLOGIES FOR ABSENCE

There were no apologies for absence.

17/129 QUESTIONS FROM THE PUBLIC

- Jo Pajak referred to the Chief Executive's report and discharge summaries. He said that the communication between NEDs and Governors about this issue had been helpful. He asked for assurance that everything possible was in place and that the Trust would be able to make use of e-Care to connect different discharge letters about the same patient who might have been seen by different clinicians.

  Nick Jenkins confirmed that this would eventually be the case and there would interoperability between GP and hospital records which would solve the problems that had recently been experienced. Helen Beck explained that within the next few weeks there would be a medium term solution with a read only link between GP practices and hospitals.

  The Chief Executive explained that this issue had not immediately been apparent for a variety of reasons. WSFT would be communicating with GPs within the next two weeks, but as far as the Trust was aware there had been no patient harm as a result of this.

- June Carpenter referred to the Grenfell Tower fire; she asked for assurance that the hospital was a safe building and what plans were in place to evacuate patients. The Chief Executive explained that the Trust had been required to provide detailed risk submissions to the Department of Health and there was an ongoing programme of fire compartmentation.

Suffolk Fire & Rescue were satisfied with the Trust's approach to risk mitigation around fire, and information had been provided on the cladding on the Education Centre, which was being followed up.

Craig Black explained that Grenfell Tower had relied on compartmentation as a fire fighting strategy; however due to the nature of the cladding this had not been effective. West Suffolk Hospital's evacuation strategy was horizontal evacuation, which had been tested. A detailed inspection of the building had been undertaken four years ago and issues with the fire compartmentation had been identified and were being addressed with an ongoing programme of remediation. However, this was challenging due to capacity and the need to free wards to enable the work to be undertaken.

An annual assessment of fire risk was undertaken and signed off by Suffolk Fire & Rescue. They had again confirmed that West Suffolk hospital was not a high risk building.

- Judy Cory, on behalf of the volunteers, thanked the Board members who had attended the annual volunteers' afternoon tea. This had been greatly appreciated by everyone.

17/130 REVIEW OF AGENDA

The agenda was reviewed and it was noted that item 8, endoscopy, would be discussed in the closed meeting.

17/131 DECLARATION OF INTERESTS

There were no declarations of interest.

17/132 MINUTES OF THE MEETING HELD ON 26 MAY 2017

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

17/133 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and there were no issues.

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

Item 1402 - update on SLT services, including performance against original plan, work with local authority and assurance for future delivery. Steve Turpie asked how this was performing against the original plan. It was agreed that this would be discussed later in the meeting.

Item 1418 – confirm the information on the change in the nature of car parking complaints which was incomplete in the report. The Chairman asked what was being done to address this issue. Rowan Procter explained that Cassia Nice would be meeting with Estates within the next few weeks to discuss the issues raised from complaints. The Chairman requested that an update on this should come back to the Board meeting in September. **R Procter**

Gary Norgate referred to a previous action relating to additional sessions and the need to understand how many were created by failure of equipment, staffing issues etc and the level of inefficiency. Richard Jones explained that extra sessions would be part of the finance report for a future meeting. **C Black**

17/134 CHIEF EXECUTIVE'S REPORT

The Chief Executive commended the Estates team for all the work they had put into the new building. However, he stressed that it was very important that those based in this building did not become segregated from the main hospital, and everyone was very aware of ensuring that this did not happen.

Everyone had been very saddened by the terrorist actions and the Grenfell Tower fire. The executive team had been focussing on issues around this and ensuring that staff knew how to respond to issues or speak up if they had any concerns.

The Trust was close to delivering the A&E target for the quarter and the organisation had been very focussed on this. Over the last week there had been sustained high levels of activity but performance had been maintained and he thanked those involved for all their hard work in managing this.

The issue of oral surgery and orthodontics had been raised by Governors and the media. He said that it was regrettable that this service was ceasing to be provided at WSFT, but it was not able to provide the quality of service it would wish to, nor with a degree of economy. The Trust had given notice to NHS England a year ago (the requirement was six months' notice), but it had taken time for a decision to be made as to how/where to provide this service to patients.

This had highlighted the need to manage this type of issue sensitively and he introduced Tara Rose, the Trust's new Head of Communications

As discussed earlier, the discharge summary issue was being addressed.

Rowan Procter continued to work on establishing a Buurtzog team and there had been a lot of interest from nurses.

Alan Rose asked if the Buurtzog project team would be able to measure the quanttive impact on admissions to the hospital, ie would this reduce admissions and if this could be measured. The Chief Executive explained that there had been a considerable reduction in emergency admissions in Holland as a result of this model. WSFT was looking at securing an evaluation framework for this. The Chairman explained that this would also release capacity for primary care and social workers to care for other patients, therefore there would be a full system benefit.

Alan Rose asked if this model would cover the whole of the Trust's area. The Chief Executive explained that this would be piloted in one area and then they would look at extending across the whole area.

The Chief Executive reported that WSFT had been identified as one of five organisations to take part in a national pilot to assist Sir Thomas Hughes-Hallett in expanding the role of volunteers.

Steve Turpie considered this to be a very good report and echoed the comments on the excellent work of the volunteers and he was very pleased that this was being recognised nationally. He asked about OrderComms and the feedback that had been received. Craig Black explained that this was working and go-live went very well, although there had been some issues. Nick Jenkins agreed that technically this had gone extremely well, although floor walker support had probably been taken away too soon and had therefore been reinstated for a short period. However, there was now focussed training for individuals where necessary. It was generally considered that this was a better way of doing things and this needed to continue to be focussed on.

The Chief Executive reported that he had received fairly positive feedback from staff. Nick Jenkins agreed and considered that people were paying more attention to OrderComms as a result of the issues which had been identified with discharge summaries. Staff were raising any concerns they had, which was a particularly positive outcome.

The Chief Executive stressed that this was as much about changing the way people worked as well as introducing a new system.

Richard Davies asked how sophisticated e-Care was at identifying sepsis. Helen Beck confirmed that this was quite sophisticated and would highlight a concern as a result of a number of patient indicators.

Neville Hounsome asked about the Health Service Safety Investigation Branch (HSSIB) and if this was a new organisation which would replace another organisation. Nick Jenkins explained that this was a new organisation which would look at cross-cutting themes and general/national learning from these.

DELIVER FOR TODAY

17/135 QUALITY & PERFORMANCE REPORT

Rowan Procter explained that falls were being reviewed in line with staffing levels, and different ways of working on wards were being piloted in surgery and medicine. If this was effective the way in which wards were run throughout the organisation would be changed. This should see benefits in both falls and pressure ulcers.

Pressure ulcers were performing well in surgery and a generic action plan had been produced which would be applied in key areas of medicine to begin with.

She explained that the SIRI report which was beyond 60 days was over by one day (61 days) due to a counting error.

Helen Beck reported that A&E performance had been very challenging over the past week and the team had responded very well. As of today performance for the quarter was at 95.08%; yesterday 97.7% had been achieved and if the 95% target for the quarter was achieved this would be an excellent performance. Currently WSFT was one of the top organisations in the region for A&E performance.

The Chief Executive said that this underpinned all the work that had been undertaken around the emergency department, flow and Red2Green. This enabled capacity to be generated for deep cleaning and fire compartmentation work to be undertaken. In addition this helped with staff morale and the Trust's finances.

Helen Beck explained that, as advised by the Intensive Support Team (IST), the Trust was now reporting the actual RTT performance position, which was 79.7% versus the standard of 92%. However, she thought that this was slightly low due to data quality issues.

She referred to the IST's summary which stated that the Trust had an effective understanding of the data quality issues and there was clear evidence of a well-considered and logical approach to data quality. They also identified that the Trust was able to articulate a clear and appropriate onward plan for improving data quality.

The five recommendations from the IST were being worked on or had been completed. Item 4, "review the timeliness of the production of the PLT and determine if weekly production provides suitable operational responsiveness and oversight of elective performance", would be implemented from next week.

One less 52 day breach had been reported for May than anticipated. The current position for June was nine, with a further five potentials. All five had actions that were being followed up and this should come under the trajectory of 15 that had been set.

Gary Norgate noted the good performance on nutrition assessments and monitoring and that the target for this had been achieved for the last three months. He was also very pleased to see that duty of candour was now at zero.

He asked about overdue investigations of incidents and if this was due to resource or attitude/culture. Rowan Procter explained that WSFT appeared to be an outlier because it reported this differently to other organisations; it would not close an investigation until actions had been delivered

Neville Hounsome noted that the WHO checklist in maternity was still not being properly completed for one in ten patients. Nick Jenkins explained that for 93% of patients this had been completed correctly. However, there were three patients for whom the WHO checklist had been used, but every section had not been completed which meant that this was a fail. He had asked surgeons to explain why this had happened, whether or not this was an emergency.

Rowan Procter referred to community children's services and the pathway for looked after children. The requirement for an initial healthcare assessment within 28 days had improved, and work continued with the local authority on this.

The plan to address the backlog in paediatric speech and language therapy had not been delivered due to changes which the local authority wished to introduce. This plan had been created by WSFT, the CCG and the local authority and continued to be worked on.

Steve Turpie asked if there was a timeline for this. Rowan Procter explained that WSFT was doing as much as it could to address this but it could not get agreement on everything from the CCG and local authority. It was very difficult to get bank and agency or locum speech and language therapists and it could not recruit to a full term post without the support of the CCG and local authority.

Steve Turpie requested visibility of future plans to address this, showing the backlog and when it would be reduced and support that was required, both financially and staffing. **R Procter**

Richard Davies referred to the recommended action for Dermatology and the proposal to assist GP learning to refer patients appropriately. He asked if discussions had been had with the CCG on increasing capacity, as well as reducing demand. Helen Beck confirmed that this was being focussed on and they were trying to put speedy communication in place between GPs and WSFT's clinicians to avoid inappropriate referrals.

Richard Davies said that the only way to assess a melanoma was through specialist work. Helen Beck agreed but explained that currently only one cancer was identified out of 120 referrals. The plan was to meet with acute clinicians and GPs to look at this.

Angus Eaton asked about the two referrals to the Ombudsman and if there was anything that the Board should be concerned about. Rowan Procter confirmed that these were historical cases.

17/136 FINANCE AND WORKFORCE REPORT

Craig Black reported that performance was ahead of plan again this month; therefore the Trust remained marginally ahead of plan.

The key issue was the CIP programme and they had been much more aggressive this year in phasing of CIPs evenly across the year. Therefore there was a tougher target for the first part of the year than previously. 75% of these CIPs were recurring compared to 50% last year and the non-recurring items were mainly non-cash.

A more detailed analysis had been undertaken on the workforce (pages 8-10), in particular around the consultant workforce which had increased the most significantly over the last three years. This was mainly in medicine around patient flow and performance in the emergency department, and in surgery in order to increase activity and reduce waiting times.

Cash was reasonably good but the Trust was relying on receiving significant cash sums within the next few months, ie £5m STF funding and £3.3m GDE funding, which was still awaited and most of which had already been spent. The cash position remained a significant focus for the team.

Neville Hounsome said that it was good to see a better phased plan and real CIPs being delivered with the first two months. He understood how the GDE revenue helped cash but could not understand how this would be a CIP. Craig Black explained that they had allowed in the capital programme for all the GDE money to be spent as capital; where the funding came in as revenue this represented an improvement to the I&E position.

Steve Turpie considered this to be a really good start to the year but agreed that accounting adjustments were not cost savings. He asked what Craig Black's impression was about the organisational engagement in CIPs and KPMG's role in this. Craig Black explained that this was discussed at every divisional meeting and engagement was varied but was better this year than in previous years. KPMG were particularly important and had helped with the engagement process. He hoped this would result in more confidence about delivering CIPs this year and a higher proportion of recurring CIPs.

Jan Bloomfield explained that part of KPMG's cultural assessment was about staff engagement in finance and WSFT had scored amber/green for this. As a result of this assessment there was a communication plan and a number of actions. One of the actions was for executive directors to give more briefings to staff about finance, quality and productivity. Craig Black confirmed that the less engaged areas were already being focussed on.

Alan Rose asked if the finance report could include information on future CIPs for 2018/19 and 2019/20. Craig Black confirmed that he would include this. **C Black**

Gary Norgate noted that the biggest line in the CIP was the staffing review. He requested a view of what this should be in order to deliver the plan, ie by staff group, so that it was possible to see what the target should be and how the Trust was performing against this. **C Black**

Rowan Procter stressed that this was not always about removing posts, but about better management of a post or skill mix.

Nick Jenkins said that a continued focus on medical productivity was required, but this was not necessarily about increasing staffing levels. There had been a 100% increase in NHS consultants in the last 20 years, but a 35% reduction in productivity over this time. WSFT would continue to focus on this.

17/137 EMERGENCY PREPAREDNESS

Helen Beck explained that the first remit for the new Head of Emergency Preparedness, Response and Resilience (EPRR) had been to go out into the organisation and undertake a baseline assessment of the Trust and report back on areas of concern. Issues that had been identified were now being addressed and progressed.

She reported that a couple of weeks ago there had been a real security incident and the police had been impressed with how this had been managed.

Steve Turpie asked if the Trust had taken any advice from the police to confirm that it did not need to increase its security measures, ie gates etc. He requested that any advice sought and received should be documented. Helen Beck explained that a considerable amount of work had been done on how the site would be locked down if necessary. **H Beck**

Steve Turpie asked if the new Head of EPRR would be focussing on policies that were not fit for purpose. Helen Beck confirmed that this was the case.

Angus Eaton asked for assurance that all staff were aware of how communication would work if there was an incident. Helen Beck confirmed that this was being looked at and the recent incident had highlighted areas that could be improved.

Tara Rose reported that WSFT was linking with the CCG and Suffolk Resilience forum on looking at guidelines and statements so that everyone in the organisation was aware of how this would be dealt with both internally and externally. She proposed providing the Board with a report on this.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/138 AGGREGATED QUALITY REPORT

Rowan Procter reported that formal complaints remained low, which was very positive. Incidents resulting in major harm were being worked through and lessons that could be learned from these identified.

Steve Turpie referred to discharge incidents and asked about transport problems and if there was any support around this. Helen Beck agreed that WSFT had a problem with this and explained that it was working with the CCG on the specification for a new contract, as the current one did not meet the Trust's needs. WSFT would also be meeting with the CCG to look at a contract variation for the current contract with the aim of improving this before the winter.

Steve Turpie requested commentary on this in the next report. **H Beck**

17/139 GP STREAMING REPORT

Richard Davies asked why this facility would not have access to diagnostics, eg x-ray. Nick Jenkins explained that this was the mandate of NHS England, although he agreed that it was not ideal. He hoped that this could be addressed by considering whether this facility could be morphed into an urgent treatment centre, which would overcome this ruling.

Alan Rose asked who would be funding the operating costs of this. It was confirmed that the CCG would be paying for this and there should be no additional operating costs for the Trust on this.

Neville Hounsome asked if one patient per hour was a mandate. Nick Jenkins explained that this was a contract and it was expected to prevent one patient per hour needing to be admitted to A&E.

Richard Davies suggested that there could be some confusion as there would be three separated GP services running in the same area. Nick Jenkins agreed that there was a serious risk of this happening and they were looking at this could be addressed.

17/140 NURSE STAFFING REPORT

Rowan Procter explained that wards F7 and F8 were areas of concern due to high vacancies. The issue around retention was not due to staff not wanting to work in these areas, but because of internal promotion or people moving areas. Specifically targeted pieces of work were being undertaken on falls and pressure ulcers in these areas.

17/141 CONSULTANT APPOINTMENT REPORT

Jan Bloomfield apologised that this report was not in the correct format for Board reports.

The Board noted the appointment of the following consultants:-

Lucy Truman, Consultant Otolaryngologist

Rachel Furley, Acute Consultant Paediatrician

Dr Alexander Martin, Consultant Oncologist

Nick Jenkins noted that it was particularly good to have appointed an ENT consultant, even if this was a fixed term, part time appointment.

17/142 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that the Rosemary Ward team at Newmarket Hospital and Jo Bayliss, Endoscopy lead pre-assessment nurse had received Putting You First Awards this month.

The Rosemary Ward had been nominated as a result of members of staff going well beyond their duty, from bringing in clothes for patients who had nothing (obtained from charity shops) to pushing boundaries to meet the wishes of patients. The MDT team were all patient centred and their care really stemmed from the needs of the person.

Jo Bayliss is a staff nurse who has worked for the endoscopy unit for four years. She was given the post of endoscopy lead pre-assessment nurse following a period of ill health when it was agreed that she was no longer able to continue to work long days and on-call. This position consists of telephone calls to patients prior to their appointment to take a brief medical history, ensure they understand any eating/drinking or nil by mouth instructions and bowel preparation directions. She has worked extremely hard in the role and made it her own, improving the patient journey and linking with all members of the MDT.

The Board congratulated the Rosemary ward and Jo Bayliss on this award and noted that it demonstrated how staff were engaged in improving services to patients, often beyond the role of their job.

BUILD A JOINED UP FUTURE

17/143 e-CARE REPORT

Craig Black confirmed that sepsis and AKI were now live and working. e-Care identified when certain indications for sepsis were present in a patient and alerted both doctors and nurses as to what should be done, ie administration of antibiotics within an hour.

Angus Eaton asked if this was a self-learning system. It was explained that this was not the case and this was a static system, however this could be looked at in the future.

The Chief Executive referred to the patient portal and suggested that the Trust needed to consider how it could get engagement from the community. He also reported that the new website was now live and encouraged people to look at this.

Helen Beck explained that the patient portal had been purchased as part of the initial Cerner contract and the plan was that this should be deployed. However, those who had seen it were not particularly impressed with it. There were a number of issues but the main one was to create one route into the patient portal. WSFT was keen to implement this but it was currently work in progress.

Alan Rose asked about the ICO and if there was a single person championing IT. It was confirmed that this was the case and WSFT had an individual who was focussing on this with other organisations.

Steve Turpie asked about data quality, apart from RTT, and if the lack of data in other areas was an e-Care issue and if this was being addressed for these areas, ie VTE. Craig Black confirmed that this was being addressed, but the main focus was currently on RTT.

Steve Turpie asked if the Board could be updated on data quality progress, including a timeline and action required for items that were currently unavailable. The Audit Committee was also concerned about this. **C Black**

Angus Eaton referred to the General Data Protection Regulation (GDPR) that was being introduced next year and asked if this was being addressed by the Trust. It was confirmed that this was being looked at and there was an implementation plan.

GOVERNANCE

17/144 TRUST EXECUTIVE GROUP REPORT

It was noted that a report had been received on the recent MHRA inspection which had also been discussed by the Scrutiny Committee. The inspector had recommended moving from weekly to monthly reporting.

A formal response to this report had to be submitted by next week.

17/145 COUNCIL OF GOVERNORS REPORT

Alan Rose reported that Governors had asked why they had not been made aware of the discharge summary issue that appeared in the media.

It was confirmed that Governors received copies of press releases.

The Chairman explained that this was not as a result of a press release but had been picked up on a website. Governors were also communicated with on serious issues, eg never events. He considered that it was a matter of courtesy to inform governors of this type of occurrence. However, for both NEDs and Governors it was about assurance that issues were being focussed on.

Nick Jenkins agreed and explained that in this case it was not considered to be a major issue with regard to the effect on patients. He noted that Governors also received copies of the closed Board minutes once they were approved.

The Chairman proposed reviewing communication to Governors. **J Bloomfield /R Jones**

17/146 AUDIT COMMITTEE REPORT

Steve Turpie reported that Jason Parker and Maurizio Privitelli had attended this meeting and presented their findings. The challenge was to consider how to take this further into the local health economy.

17/147 SELF-CERTIFICATION – General condition 6, continuity of service, FT4 and governor training

The Board approved the six corporate statements and certification for training of Governors.

The Board received in public session the general condition 6 and continuity of services condition 7 certificates.

17/148 USE OF TRUST SEAL

The Board noted the use of the Trust seal.

17/149 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were approved. It was noted that further items would be added as a result of discussions at today's meeting.

ITEMS FOR INFORMATION

17/150 ANY OTHER BUSINESS

There was no further business.

17/151 DATE OF NEXT MEETING

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

RESOLUTION TO MOVE TO CLOSED SESSION

17/152 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 July 2017

AGENDA ITEM:	Item 6
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	21 July 2017
SUBJECT:	Matters arising action sheet
PURPOSE:	Approval

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

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

Actions are RAG rating as follows:

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

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

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1331	Open	30/9/16	Item 9	Provide Board with a stroke services option appraisal and sustainability report	Following discussion in October Board meeting it was agreed that this should consider the provision of care out of hospital. An initial review was considered by the executive team on 16 Nov. Based on this discussion a full option appraisal to be considered by the Board. Agreed at April meeting to discuss with CCG the provision of stroke services in the community as part of community services negotiations. **Subject of 'deep dive' at July Audit Committee.**	HB	28/07/2017	Green
1402	Open	28/4/17	Item 8	Update on SLT services, to include: performance against original plan, work with local authority and assurance for future delivery	At meeting on 30/6 agreed to (a) report timeline to address backlog - confirming the current backlog, when this will be addressed and the resource required to deliver this (b) confirm when the new model of care will be implemented. For both elements need to be clear on any reliance on the Local Authority for delivery. **Work underway to provide required information for September meeting.**	RP	29/09/2017	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1413	Open	26/5/17	Item 7	Review provision of unhealthy options in vending machines	Confirmed that current arrangements are compliance with requirements. Options are being considered to move beyond these requirements.	CB	29/09/2017	Green
1427	Open	30/6/17	Item 7	Review the issue and options for use of the ramp by disabled patients/visitors using car park A		CB	29/09/2017	Green
1430	Open	30/6/17	Item 10	Document recent of advice from police and others regarding for example site lockdown and report to the Emergency Planning Group with learning from recent events (e.g. internal and external communication plans)		HB	29/09/2017	Green
1432	Open	30/6/17	Item 16	Set out the timeline for improvements in data quality and report - detailing for each data item which is currently unavailable when this will be reported and the key action required to enable reporting		CB	29/09/2017	Green

Completed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1395	Open	31/3/17	Item 7	Maternity WHO analysis to include further detail of performance and remedial action	Included in April's Quality Report. Confirmed with maternity lead no pattern of individuals not complying with checklist. **Following discussion at meeting on 30/6 agreed to ask team to reflect on breaches and action to improve compliance. Covered in Quality Report**	NJ	28/07/2017	Complete
1428	Open	30/6/17	Item 9	Include in the finance report a position statement for the future year CIPs (2018/19 and beyond) in terms of the value currently identified.	**Finance report**	CB	28/07/2017	Complete
1429	Open	30/6/17	Item 9	Provide further detail of the staffing review CIP for 2017/18 (as the largest CIP) including forecast and actual performance with appropriate analysis of performance e.g. breakdown by professional group	**Finance report**	CB	28/07/2017	Complete
1431	Open	30/6/17	Item 11	Provide update within the performance report of transport issues and planned improvements	**Included in performance report**	HB	28/07/2017	Complete
1433	Open	30/6/17	Item 18	Put in place a process so that NEDs and Governors are informed of issues which are likely to attract negative media coverage	Press release for issues generated by the Trust are already shared with the NEDs/governors. In respect of negative media enquiries briefing will be provided alongside any press statement.	JB / RJ	29/09/2017	Complete

Item 7

NHS
West Suffolk
NHS Foundation Trust

Protecting and improving your health and wellbeing, together

2017/18

Putting you first

Protecting and improving your health and wellbeing, together

In our five year strategy "Our patients, our hospital, our future, together", West Suffolk NHS Foundation Trust made a clear and substantial commitment to make the prevention of ill health a core part of everything we do.

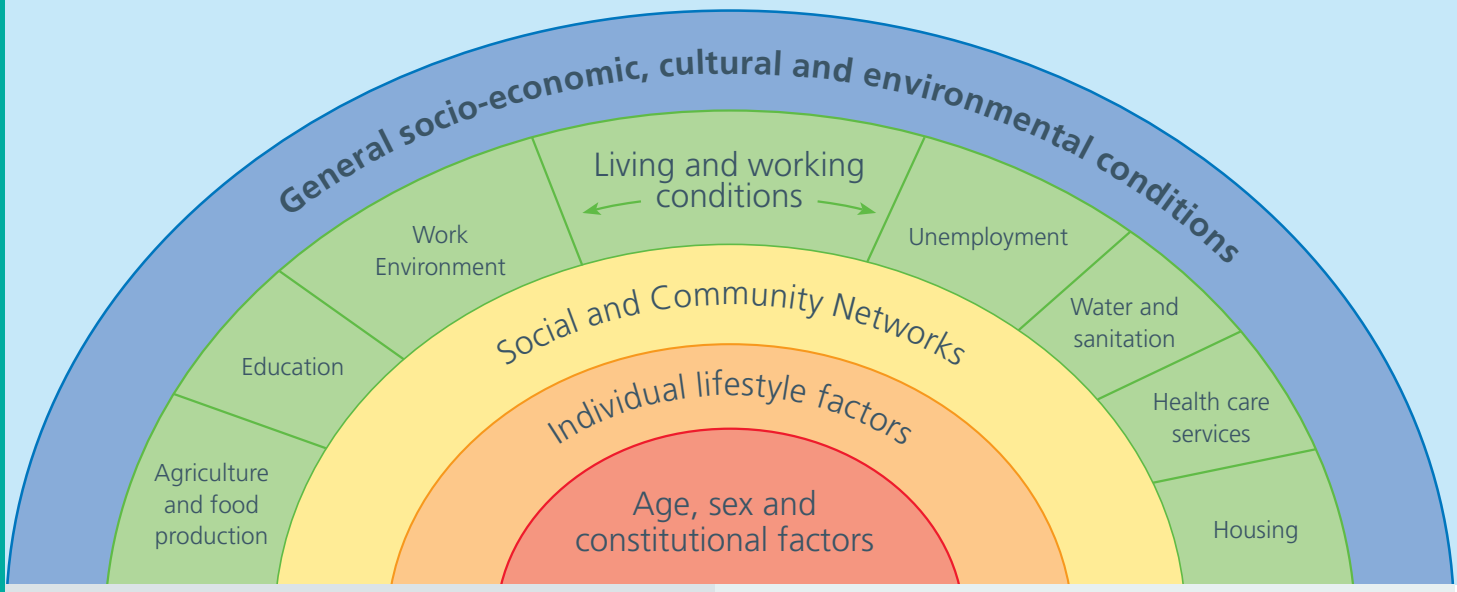
Prof Dr Stephen Dunn

It is our privilege to be here 24 hours a day, ready to look after you in your hour of greatest need. But our interest in your health doesn't begin when you are already sick, there is plenty we can do to help you keep well in the first place. When it comes to your health and wellbeing, we walk beside you all through your life, together with our colleagues throughout the health and care system.

The means by which we can protect and improve health and wellbeing in west Suffolk are many, and we can do so, not only as a healthcare service, but also as a large employer and as an organisation with substantial purchasing power. This document describes just some of the ways we play our part and how we will continue to strive to do more.

Prof Dr Stephen Dunn
Chief executive

1 Protecting and improving your health and wellbeing, together



The wider determinants of health

You know as well as anyone how the circumstances and conditions you live in affect the way you feel. The benefit you get, for example, from a good education, rewarding work, the comfort of your home, your outdoor environment and the friends and family you have around you.

It is also well known how important your lifestyle is for staying in good health: not smoking, sticking to a low alcohol intake, enjoying a good diet and being physically active. These factors are often called **the wider determinants of health**. The rainbow shows how they build up in layers around each of us. West Suffolk NHS Foundation Trust (referred to as WSFT throughout this document) can have a positive influence on several layers, and that is what we have committed to do.

We are your national health service, not just a national illness service

The strength of our commitment to prevention is demonstrated by the fact that four of our seven ambitions are about supporting every member of our community to live well and be healthy.

In his landmark review of inequalities in health in England, Sir Michael Marmot described the way positive and negative effects on health and wellbeing accumulate over the course of a person's life. Reflecting that, we have pledged to provide our care in such a way that helps build up your 'bank' of positives from before birth onwards.

The first two sections of this brochure describe ways in which we will help to improve your wellbeing when you are a patient with us, a relative, a visitor or a member of staff. The second two sections describe ways in which we extend our reach beyond our clinic rooms, wards and grounds, to continue contributing to your health, even when you are out and about in your daily lives, when the hospital and illness are far from your thoughts.

At WSFT we are never content to sit on our laurels. At the end of each section we outline the next steps we will take, 'walking the walk' of the commitment we have made to you in our strategy.

Protecting and improving your health and wellbeing, together

1

Health and wellbeing for our patients

Each year we look after 65,000 people overnight, see 382,000 people in outpatients and treat another 65,000 in our emergency department. We welcome our newest members of the community into the world and we care for people who are nearing the end of their lives.

Your thoughts and motivation about your health are heightened whilst you're with us, so in Ambition Five of ***Our patients, our hospital, our future, together*** we have pledged to give lifestyle advice and help you to change behaviours that are at risk of making you unwell.

Health and wellbeing for our patients 2

Making every contact count

Our nursing assistants and healthcare support workers are trained to make every contact count while they look after patients on the wards and in clinic. Making every contact count means talking to patients, family members and carers about the importance of a healthy lifestyle and giving information and advice about smoking, alcohol, weight, diet and exercise. There are a number of services in west Suffolk which can help you change your lifestyle for the better. Our staff will point you in the right direction.

"Within my role I have learnt the skills to build on my relationships with patients so I can start discussions and signpost them towards information. The training reminds me to focus on the individual and not just a number."

Gareth Reynolds
Assistant practitioner

Holistic approach to care

Our doctors, nurses, therapists and pharmacists know there is much more to illness than the textbook definitions. Many of our services provide innovative, holistic care which recognises all the mental, emotional, social and physical aspects of how you feel when you are unwell.

A good example is the relaxation service which our physiotherapy department offers to people with a range of different health problems.

In one-to-one appointments, the therapists teach a range of relaxation techniques to help people of all ages manage stress or anxiety and the impact it is having on their other conditions and their quality of life.

The techniques are tailored to the person and their condition and might include mindfulness, breathing exercises or keeping a relaxation diary. At the end of the appointment there is a relaxation CD available for everyone to take home, to help them continue to use what they have learnt.

"I really appreciated the time given to help me improve my wellbeing and understanding of my condition."

Anonymous patient feedback

2 Health and wellbeing for our patients

Baby-friendly award

UNICEF has recognised the support the hospital offers parents to give their babies the best start in life by breastfeeding. In 2016 we were awarded stage 2 baby friendly status.

Stage 2 means all our maternity staff are educated to have the right skills and knowledge to help all our new mums and babies get going well with breastfeeding.

"It was hard at the beginning, but once I got past the initial challenges it was one of the most rewarding experiences I've ever had. I was able to provide the absolute healthiest food for my baby."

Breastfeeding mother

Health coaching

WSFT has been leading the way with health coaching since 2014. We have over 190 therapists, nurses and doctors trained to use coaching techniques.

If you have a long-term condition, it is you who is the expert on how it affects your life. There is often far more that you can do yourself to help maintain a good quality of life than our staff can do for you. Health coaching helps us to help you identify the ways you can control your condition and stop it getting the better of you.

"Health coaching can have a big impact… increasing confidence, motivation and self-sufficiency, and improving quality of life."

Trudi Dunn and Nina Finlay
Accredited health coaching trainers

Health and wellbeing for our patients 2

Chaplaincy

Spiritual wellbeing is important to many of our patients and visitors. Our hospital chaplains and volunteers provide emotional and spiritual support to all, regardless of beliefs or faith.

The Chapel of the Good Samaritan in the main hospital building is always open for quiet reflection and prayer. A chaplain is available 24 hours a day and a contact list of ministers for all the world's main religions is maintained. The chapel holds an Anglican Sunday service every week and patients who can't attend the chapel can receive communion at their bedside.

Stop–smoking support

As well as our stop-smoking clinic which patients can attend, we also have nurses and healthcare assistants in every ward and clinic who can help patients quit. They provide information and advice on how to break the habit of smoking and the hospital pharmacy can supply nicotine replacement therapies and other medication which help reduce the cravings.

Using our buildings and spaces to promote wellbeing

Having sight of and access to natural landscapes is good for mental wellbeing. There is even research that shows patients admitted for surgery feel better and are discharged sooner when they are able to see greenery outside their window or enjoy a hospital garden. An imaginative approach to our courtyard gardens has created some lovely green space on our Hardwick Lane site, which patients can enjoy along with staff and visitors. There is even a dedicated therapeutic garden for people who have had a stroke and are being cared for on ward G8.

It's not just our outdoor space that can contribute to wellbeing. Two initiatives make great use of the hospital corridors: the Forget-Me-Not dementia walk and the Paintings in Hospitals art displays.

2 Health and wellbeing for our patients

The Forget-Me-Not walk is a 100-metre memory walk which encourages people living with dementia to reminisce with staff and loved ones about times gone by. It combines popular images of iconic people, events and objects from the 20th century with displays of everyday household items. It was unveiled in 2016 after a two-year fundraising campaign by My WiSH Charity and was only made possible by the generosity of our local community.

"Mum really lit up when she saw the photo of the old cattle market – it really struck a chord with her and we were able to have a lovely chat about her childhood memories of Bury."

Daughter of a patient with dementia

Elsewhere, around 100 pieces of art brighten our main corridors, loaned and curated by the Paintings in Hospitals charity. The pieces are specially selected to make the hospital environment more welcoming, stimulating and comforting. The displays feature works by local, national and international artists and include works selected especially to appeal to children, people with autism and older people.

What's next?

OneLife Suffolk is going to train even more of our staff to Make Every Contact Count by starting good conversations about the importance of a healthy lifestyle. The first groups will be our student nurses, porters and pharmacists. Then we'll build partnerships with other lifestyle services too.

We will also work together to make sure our doctors, nurses and therapists can refer patients directly to OneLife's services.

We will continue to encourage staff to use health coaching techniques. The next step is to make sure that every patient who could benefit from health coaching is able to. We'll support our clinical teams to make it a routine part of the care they provide.

We are going to get our baby-friendly status up to stage 3 - the highest level.

To help achieve all this, we've been approved by the General Medical Council to have a junior doctor work with us who specialises in public health and prevention; only the second hospital in the region to do so.

"There's a saying that prevention is better than the cure. I fundamentally believe that we must make every effort to invest our time and resources in preventing ill health, and that applies equally to physical and mental health.

The litmus test comes not only when we measure how long people are living – which incidentally is on the increase – but people's quality of life as they age. This is the real measure of how successfully we are preventing ill health and it's something to which I, and many others, pay close attention.

Every individual's health matters, and touches the lives of others around them. That's why it's great to see that West Suffolk NHS Foundation Trust is collaborating with wider health and care services not only to focus on making patients well when they are ill, but also on what it can do to improve people's health in general.

Only when we have succeeded in this long-term, collective goal we will enjoy a population that is truly living longer, healthier and happier lives."

Abdul Razaq
Director of Public Health for Suffolk

Health and wellbeing for our patients 2

Health and wellbeing for our staff

The Trust takes its role as an employer of 3,500 people seriously. In a typical community, eight per cent of people will be employed in health care, and 18 per cent will have a family member who is.

Supporting our staff to live well and feel good is a public health action in itself. A happy, healthy workforce is essential if we want to go on delivering the outstanding patient care we are so proud of.

Specialist physiotherapy service

The important work of healthcare is often physically demanding, whether it's our nursing assistants helping to wash and dress patients or our porters moving people and equipment around the hospital. Low back pain, and shoulder and neck injuries are the most common reasons for members of the team needing to have time off work. To look after our staff, many of whom have worked with us for decades, we have a dedicated occupational physiotherapy service.

The service is run with self-referral for ease of access and everyone is seen within two weeks. On average, 35 new people receive help every month.

"My physio was fantastic. It got me back to work and helped to get movement back in my arm. I am very pleased... thank you."

Health and wellbeing for our staff 3

3 Health and wellbeing for our staff

Smoke-free environment

All our buildings and grounds are smoke-free environments. A special stop-smoking clinic runs in the outpatient department every Monday morning, which is open to all staff and patients. Staff can have time off to attend during their working hours because we recognise the huge benefit that giving up smoking brings, not just for the person quitting, but also for the relatives and children they share their life with. Quitting can be four times more successful if it is done with the help of a NHS stop-smoking service.

Care First

Care First is our employee assistance programme, available free of charge to all members of staff. A 24/7 freephone number provides access to trained counsellors and information specialists who provide a listening service, advice and support on a wide range of topics that affect our staff. Everything from problems at home, money worries, health issues and challenges at work can be talked about. Face-to-face counselling can also be arranged and between 8am and midnight there's even an online counsellor available for those who can't or prefer not to speak over the phone. The service is completely confidential. Since its introduction in February 2016, the number of people using the service has increased rapidly as has the number of people recommending it to colleagues.

The counselling and information service is backed up by a website containing information and news on a wide range of health and wellbeing topics. As well as offering advice about maintaining a healthy lifestyle, getting good sleep and dealing with stress, it has articles and webinars for our managers to learn how they can improve the health and wellbeing of members of their team.

Eat Out, Eat Well award

Many of our staff have physically demanding roles and work long or irregular hours. It's important there is fresh, healthy food available to keep them going. In February 2016, the hospital's catering team became the first in the area to receive a gold Eat Out, Eat Well award from St Edmundsbury Borough Council for the food it serves in the Time Out Restaurant and Courtyard Café.

The award celebrates the healthy choices on offer every day, including fresh fruit and vegetables, wholegrain bread and rice, and low fat meat and dairy products. It also recognises our healthier cooking practices, such as limiting the amount of fried food which is served and not cooking with salt.

"We pride ourselves on the quality of food we offer at West Suffolk Hospital, and regularly receive excellent feedback from our patients and visitors. The award shows we make it easier for people to follow a balanced diet when they are not eating at home."

Brodrick Pooley
Catering manager

3 Health and wellbeing for our staff

Putting You First awards

Research has shown that it's important for mental wellbeing to feel valued at work, to be able to voice concerns and to be encouraged to act on ideas about how things could improve. An example of how we put this into action is our Freedom to Improve campaign and the monthly Putting You First awards.

By giving all our staff the freedom to speak up about the patient care they provide and see, and the freedom to try out ideas they think might make that care better, we make the most of the enormous wealth of knowledge, skills and experience we share. Every month staff nominate colleagues who have made a difference to patients through their thoughtfulness, innovation or commitment to going the extra mile. Nominees are recognised with a Putting You First award from the chief executive, which is celebrated at the Trust-wide monthly meeting.

Weight management and NHS health checks

OneLife Suffolk provides lifestyle services throughout our area. They can help you stop smoking, lose weight or increase your physical activity. To make it easier for staff who want to lose weight, OneLife provide a 12-week programme on our Hardwick Lane site.

We're also keen for staff aged between 40 and 74 to have their NHS health check. Everyone is eligible to have a health check every five years to test for the warning signs of diabetes and heart disease. Most people go when they are invited by their GP surgery, but OneLife come to us to offer health checks to our staff who find it more convenient to have them done at work.

Active travel

Our rural environs don't make it easy for everyone to avoid having to use their car, but we're committed to helping all our staff get some exercise on their way to work.

In partnership with Bury Rugby Club we have 150 parking spaces off-site, giving staff the opportunity to walk the last mile of their journey and get their recommended 30 minutes of moderate exercise every day.

For those who would like to cycle, we offer the national Cycle-to-Work scheme. Staff can buy a bike and cycling equipment tax-free. We have shower facilities, clothes storage lockers and secure cycle parking on our Hardwick Lane site.

We also encourage everyone to walk, cycle or take the bus one day a week by asking them to nominate a car-free day.

"Having a OneLife health check at work was really convenient. Not only did it highlight an issue requiring GP consultation, but their advice helped me make healthier lifestyle choices. I have since revived my love of swimming and regularly walk home from work instead of catching the bus. I feel a new spring in my step!"

Sheila Broadfoot
Project Manager

Sports groups and leisure activities

Lots of our staff take part in sports or activities outside work which they would like to share with colleagues. Our communications team shares information on groups and clubs which are being run by staff, and whenever we can we make space available on site for staff to use.

A good example is Steve Monkhouse and Kevin Crowe's tae kwon do classes. Steve and Kevin both work in our estates and facilities directorate. They are also both tae kwon do black belts and they run two classes every week. A mixture of staff, their children and members of the public attend. They use a room in our Education Centre.

Books for mental wellbeing

The Education Centre offers a quiet space for peace and relaxation in the library. We have two collections of books which improve mental wellbeing:

- Mood Boosting Books, which are chosen by the Reading Agency for their uplifting qualities and
- Books on Prescription, which provide self-help techniques for managing a variety of common mental health conditions.

The library team has also introduced colouring materials for mindfulness.

What's next?

As a member of the Suffolk Health and Wellbeing Board we have signed up to the national Workplace Wellbeing Charter and aim to achieve its Excellence award by 2020.

New hot food vending machines will mean staff can get healthy, nutritious meals on site even when the restaurant is closed overnight.

In 2017 we introduced the Neyber financial wellbeing service. Neyber allows people who are in debt to control their monthly repayments and reduce the cost. Financial wellbeing is well recognised as a cause of stress and anxiety and it's one of the things staff have been talking to our CareFirst counsellors about.

OneLife Suffolk will increase the time they spend on site, so more staff can make use of the stop smoking clinic and weight loss programme and have their NHS health check.

"There is compelling research evidence that living healthily in early and middle years has a very strong bearing on health in later life. It is difficult to get enough exercise and to eat well given the demands of work and family, particularly for staff who work shifts. It is marvellous to see the ways in which our staff and managers are helping themselves and others. I encourage everyone to make use of these benefits, as part of a personal plan for looking after their physical and mental wellbeing."

Roger Quince
Chairman, West Suffolk NHS Foundation Trust

Health and wellbeing for the community

WSFT has always been firmly rooted in our community. One of our greatest strengths is the support we enjoy from our fundraisers, Friends, foundation trust members and more. Like all relationships, it works both ways, and the Trust does what it can to give back on a regular basis.

Promoting physical activity with our fundraising

The hospital's own charity, My WiSH charity, organises a number of high profile fundraising events in the community each year. It has made a commitment that all of them will be based on physical activity.

From the annual West Suffolk Spin cycling event to the Toddle for Tots and Teddybears' Picnic, the events are designed so that everyone can participate, to get out in the fresh air and enjoy some fun.

Cardiopulmonary resuscitation training

Cardiopulmonary resuscitation (CPR) is attempted in nearly 30,000 people who suffer out-of-hospital cardiac arrests in England each year. Teaching members of the public how to do CPR and how to use community defibrillators increases the likelihood of survival. It is an incredibly simple life saving treatment which anyone can perform.

For a number of years, staff members from the West Suffolk Hospital Resuscitation Service have provided CPR training to secondary schools, sports clubs and communities. The training includes how to use public access defibrillators.

The training is offered free of charge and the Resuscitation Practitioners deliver it in their own time. The team have arranged a session for our hospital volunteers to attend in May this year.

"The resuscitation practitioners Georgie and Kevin have been brilliant. Through their own initiative and personal commitment they are making such a difference to people's chances of survival. I'm really proud of them."

Julie Head
Resuscitation and outreach clinical service manager

4 Health and wellbeing for the community

Volunteering

We have long recognised the huge benefits that our dedicated army of volunteers brings to the Trust. We enjoy the support of over 400 volunteers who gave 42,000 hours of their time in 2015/16 to help the rest of our staff provide the highest quality care.

Our volunteer service doesn't just benefit patients, relatives and staff though, volunteering is also well known to have a positive impact on the volunteers themselves.

By offering a wide range of roles, looking after our volunteers well and matching them carefully with roles that suit them, we can help members of our community from all ages and backgrounds to keep fit, feel good, make new friends and develop new skills. Volunteering can offer a route into a new career for young people and for people who have been out of work for a period of time. It can also provide rewarding opportunities for people who are unable to work, perhaps because they have a long-term health condition or a learning disability.

We embrace this responsibility by having a dedicated voluntary services management team, who are constantly finding new and stimulating ways for volunteers to make their invaluable contribution to the important work we do.

Volunteer Ron Knight helps staff and supports patients in our Eye Treatment Centre.

Ron was a runner up after being nominated for Volunteer of the Year Award by the staff he helps. He has been volunteering for eight years and says, "My volunteering gives me a great feeling of wellbeing, being useful and wanted and the satisfaction of being part of a team. Patients sometimes say that they are pleased I am there with them and after each session the clinical staff all thank me which makes me feel all the time I give is well worthwhile. I walk regularly, about 12 miles and go to the gym, but volunteering helps me mentally and I don't feel that I am just sitting at home alone with nothing to do, so I always look forward to the next time I come in to the hospital."

Volunteer James White-Miller and his support worker Steve Flack help our health records team by delivering patient notes to medical secretaries and finding stray wheelchairs to bring back to the front entrance for patient use.

James' mother Sandra White-Miller writes: "James takes his role as a volunteer very seriously indeed. He feels he has an important role to play at the hospital and benefits immensely.

"James is very sociable and loves the interaction he has with other volunteers and staff. I understand he brightens many people's day with his chirpy 'I can' attitude and big smile. James' confidence has grown through volunteering and he feels a sense of belonging.

"In the world's eyes James' contribution may be small but it makes him feel valued and all the walking around the hospital ensures he reaches his 10,000 step target, which is an added bonus especially after he has enjoyed his lunch in the hospital's Time Out restaurant."

Student volunteer programme

Our student programme supports 6th form, college and post-graduate students from our local community who are planning a career in healthcare and offers a very valuable experience of shadowing or volunteering alongside staff and helping patients on wards. In addition, a limited number of non-clinical work experience placements may be offered to year 10/11 students and are arranged with schools and the voluntary services team

Taking part means a commitment to volunteering for a minimum of six months for at least two hours a week. This allows time to become an integrated member of the ward team and provides a really rewarding volunteer experience. All our student volunteers acknowledge that this experience is a great help to forming decisions about their future studies.

"Volunteering impacts on my health and wellbeing as it motivates me towards my chosen career within healthcare. I believe even as a volunteer I should be a role model and encourage people to adopt a healthy lifestyle. Within my role as a volunteer it is important to make every contact count."

Ruby Last
Student volunteer

What's next?

We'll offer more and varied volunteer roles. We'll work with other voluntary organisations and other parts of the health system to create new volunteering opportunities closer to people's own homes. We'll also set up a health ambassador programme.

We'll equip and encourage everyone who is connected with WSFT to take healthy living messages into their community.

"Maintaining our health and wellbeing is good for our physical and mental health, but also good for the soul. I am always amazed by the strength of our community and the range of local activities open to everyone. The restorative power of engaging with our community knows no bounds and there is truly something for everyone."

Jo Churchill
Member of Parliament for Bury St Endmunds

The health and wellbeing of your environment

The beautiful rural landscape of west Suffolk has been a source of food, employment, leisure and enjoyment for centuries. The natural environment and its resources are precious to you and therefore they are precious to us too.

The NHS in England has a sustainable development strategy which requires every NHS organisation to recognise the impact it has on the environment and to reduce it. We take this responsibility seriously, because an unprotected environment is bad for human health. Air pollution alone causes nearly 1,500 deaths a year in west Suffolk.

Lots of you are already reducing your environmental footprint by buying local, recycling, leaving the car at home and getting your power from renewable energy. So are many organisations in west Suffolk, including schools, businesses, councils and more. As a hospital we're no different. We're determined to use only what we absolutely need to deliver the care that you deserve. That way, we will help protect your health now and your children's future tomorrow.

The health and wellbeing of your environment 5

5 The health and wellbeing of your environment

Energy from waste facility Great Blakenham

Efficient on-site power and heat generation

We have a combined heat and power plant at Hardwick Lane. We use it to generate our own electricity and capture the heat that is a by-product for use in our buildings. It is much more efficient than using a conventional generator and a separate boiler for heating. We've reduced our consumption of fossil fuels and also reduced our energy bills, saving thousands of pounds which have been reinvested into providing you with outstanding care.

Electric car charging points

The shift away from petrol and diesel to cleaner fuels for driving is a key component of the UK strategy to reduce transport emissions and improve air quality. WSFT has led the way by installing six electric vehicle charging points on site.

Waste

Understandably, the Trust creates a lot a waste. The 'stuff' of healthcare is substantial. Every day we need to dispose of used equipment, packaging, waste gases, waste water, food waste and green waste.

Guidance on applying the Waste Hierarchy

We use the Waste Hierarchy to reduce the amount of waste we generate in the first place. We make sure that what we do create is handled as responsibly as possible. For example, all our general rubbish which can't be recycled is sent to Suffolk's energy from waste facility at Great Blakenham where it is used to generate electricity. This facility produces enough electricity to power 30,000 homes each year.

Fresh, ethical and sustainable food

The food you'll enjoy at WSFT isn't just good for you, it is ethical and sustainable too. In 2016 we were awarded the Soil Association's Food for Life Catering Mark bronze award.

The award shows that our catering team is proud to use fresh ingredients, carefully sourced and prepared on site. All our meat comes from a local butcher and conforms to UK animal welfare standards. Our fish is certified by the Marine Stewardship Council and eggs are always free-range.

The team believes the food tastes better for it and the compliments they get on a regular basis show you do too.

As Brodrick Pooley, catering manager at the hospital says, "The whole department was very pleased and proud to have been recognised with the Food for Life award. It shows that we care about the quality of the products we use and the dishes we serve to our patients, staff and visitors."

"What a great idea! I found just what I was looking for."

Sue Smith

My WiSH charity fundraising manager, who was first in the Trust to use Warp It.

"Warp It"

A new initiative for 2017 is our Warp It re-use network. Warp It is a web resource which is a similar concept to Freecycle. In an organisation of our size, with several sites, re-using large items like furniture, office equipment and clinical equipment is difficult to achieve. With Warp It, though, items which staff don't need anymore can be posted on the website for others to find and use.

Other hospitals around the country who are using Warp It have seen massive benefits from it. Not only does it reduce the amount of bulky waste they have to deal with, they have saved money and reduced their carbon footprint by not having to buy new all the time.

5 The health and wellbeing of your environment

What's next?

Our sustainable development management plan is being refreshed for 2017. We'll set ourselves stricter targets on energy, waste, water, travel and transport.

The catering team are busy making the improvements they need to meet the exacting standards of the Soil Association's gold award. Only seven hospitals in the country currently hold it.

We'll introduce a Liftshare scheme to put staff who travel from the same direction in touch with each other.

Once Warp It is fully established, we'll open it up to external organisations so the charities, community groups and other organisations you're involved in can benefit from what we no longer need.

"Suffolk is a beautiful county. Our natural environment is important in its own right, but the quality of life it provides is also much treasured by people who visit, live and work here. It is also one of the county's key strengths, providing us with enviable natural capital on which to improve health and wellbeing and to grow our economy. Physical and mental health, known to be associated with an attractive and accessible natural environment, are a benefit to business, innovation and entrepreneurship and can reduce pressures on social care and health services."

Matthew Hicks
Cabinet member for environment and public protection

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Putting you first

LB/11595/15032017

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28 July 2017

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

Despite soaring patient numbers and one of the busiest days that the emergency department has ever recorded, the Trust has exceeded the national 95% **four-hour A&E standard** for the first quarter of this year. In the April to June quarter the emergency department saw 17,471 patients, with 95.12% being seen within four hours and exceeding the national emergency access standard (95%). This is despite an increase of 3,476 patients compared to the same period in 2016. I am exceptionally proud of our whole hospital team for this fantastic achievement. It is not just our emergency team who contribute, but the coordination of everyone from across the hospital helps to make this happen. For the same period in 2016 we were achieving 85.9% at this stage of the year, which shows the incredible commitment to quality care and the drive of our staff to deliver the very best for patients under sustained pressure.

During July the **Emergency Care Intensive Support Team** visited our emergency department (ED). The formal report from the visit is pending but feedback from the day was positive about the performance being delivered within the limits of the ED physical environment. To improve patient experience, help us better manage the flow of patients and address some of the issues raised with ECIST we are embarking on a redesign of our ED. Initial development work started on 14 July, with the hope that it will be fully completed by the end of October.

June's **performance pack** shows that we have maintained operational performance for emergency flow reflecting the focus on red2green – achieving 95.53% for Q1. 18 week referral to treatment (RTT) performance in June is 83.36 for patients on an incomplete pathway against a standard of 92%. Whilst this is still below the standard of 92% it is a significant improvement from the previously reported May position of 79.71%. I regret that this month we have reported 15 patients breaching 52 weeks. The majority of theses are within ENT reflecting the significant capacity issues within this specialty, with patient choice being a significant factor in the remaining breaches. We did not achieve the 62 day cancer standard with a performance of 84.76 % against a standard of 85% but recovered our previous performance for the two week wait standard with a performance of 96.59 % against a standard of 93%.

We are continuing to work with our digital partner, Cerner, to implement a medium term solution for identified inaccuracies around information contained within some **discharge summary letters** issued to GPs. At the point the issue was identified we immediately implemented a manual process

to ensure the correct information was being sent to GPs. A medium term solution is being implemented to allow us to further improve the information sent to GPs in the coming weeks.

The **month 3 financial position** reports a deficit of £809k for June which is worse than plan by £74k.The reported cumulative position is therefore £6k better than plan. The 2017-18 budgets include a CIP of £13.3m of which £2,664k has been achieved by the end of June (20%). Delivering the control total will ensure the Trust receives Sustainability and Transformation Funding (S&TF) of £5.2m, resulting in a year end net deficit of £5.9m. We continue to work with KPMG as part of the financial improvement programme (FIP) for 2017/18 and beyond. The focus of FIP is to ensure that robust CIPs are in place to deliver the control total for 2017/18 and a CIP pipeline for future years.

We have an exciting new project for West Suffolk Hospital volunteer service - Helpforce! We are extremely excited to be one of five hospitals in the country to pilot this new initiative. HelpForce will provide the NHS with additional support through greater use of volunteers, volunteer led initiatives and the voluntary sector—integrated with health and social care systems and staff. With Helpforce we will look to:

- support our discharge and early intervention teams by creating new volunteer roles to help patients' discharge home and intervention regarding unnecessary admission to hospital.
- push the boundaries to create new roles to fit volunteers and to develop existing roles too
- support our patients at home and coordinate signposting on for further help.
- promote physical and mental health and wellbeing in volunteers and their value.

We look forward to working in partnership with our community to achieve these aims.

In July I attended Suffolk Health & Wellbeing Board and presented our health and wellbeing strategy - **Protecting and improving your health and wellbeing, together**. In our five year strategy this makes a clear and substantial commitment to make the prevention of ill health a core part of everything we do. A copy of the document is appended to the report. As part of this work the Trust Executive Group (TEG) this month supported a proposal to invest in on-going coordination of staff health and wellbeing initiatives and line manager training for mental wellbeing.

NSHI started publishing monthly data on the numbers of **patient safety incidents reported** to the NRLS in the last 12 months by each NHS trust and foundation trust in England. The data is broken down by month reported and degree of harm, and is refreshed and updated on a monthly basis. The publication provides timely organisational data on reporting to the NRLS, promotes data transparency, encourages more consistency in NRLS reporting patterns, and supports organisations to monitor potential under-reporting of incidents. We will use this data in future Board reports to monitor performance regarding incident reporting.

The Trust has hosted the latest of its **leadership events**, this month opening the session to wider system leaders to support the establishment of the West Suffolk integrated care system. Bringing together our own leaders, as well as representatives from our clinical commissioning groups (CCGs) and GPs. The day focused on digital advancements in the NHS, with a number of expert guest speakers from across the country and was a real success allowing leaders from across the system to share ideas and break down barriers to joint working.

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

DELIVER FOR TODAY

Exceptional stroke care being delivered in Suffolk
The radical turnaround of stroke services across east and west Suffolk has been recognised with a national award. Earlier this month, NHS Ipswich and East Suffolk and NHS West Suffolk clinical commissioning groups (the CCGs) scooped the Healthcare Transformation Award for Innovation in Improving Outcomes and Reducing Variation. Dr Anne Nicolson, stroke services lead at West Suffolk NHS Foundation Trust and Suffolk stroke services, said: "This collaboration continues to improve stroke care for all patients and carers in Suffolk. Working closely with the CCGs and Ipswich Hospital, seven-day-a-week working has become normal practice in the acute hospitals for multiple

disciplines including physiotherapy, occupational therapy and stroke medicine. The early supported discharge service has also been embedded to provide ongoing stroke therapy at home for patients after discharge." Suffolk now has the lowest level of premature stroke mortality compared to similar areas in the country. Please see the Public Health England Healthier Lives website for more information.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

'I am proud to work here' – staff praise hospital in latest survey
Staff have heaped praise on the Trust in the latest Staff Friends and Family Test survey, with more than 95% saying they would recommend it as a place to receive care or treatment. More than 870 people across the Trust responded to the questionnaire, which asked colleagues to think about their experience of the hospital from April to June this year (Q1). Staff reported that the Trust was a "high standard hospital", saying that "staff go the extra mile to care for their patients", and that WSFT is "a caring, professional organisation with patient care its top priority". One colleague simply put: "I am proud to work here." The Staff Friends and Family Test is a national initiative introduced by NHS England to help improve patient experience.

High visibility for infection prevention and control team
Hospital acquired infections are a huge risk to patients' recovery. To raise the profile of the infection prevention and control team, they are now wearing bright red uniforms, so they are more visible than ever for staff and visitors. Anne How, infection prevention control lead, said: "The team are delighted with the new uniforms, and we take a lot of pride in supporting our patients and the clinical teams across our hospitals. By being more visible in clinical areas we hope people will take the opportunity to stop and ask us what we can do to help. We've already seen an increase of questions from staff, so the uniforms are a definite success! This will also help us control an area in times of an outbreak, as it will be clear who we are and where we are for both staff and patients."

BUILD A JOINED-UP FUTURE

Taking strides towards paper-free care
The Trust's Global Digital Exemplar (GDE) journey continues, as it received the first portion of funding from NHS England for digital developments. The hospital was given GDE status last year, after bidding for a share of the central £100million NHS England put forward for the initiative. Awarded to hospitals considered to be the most advanced technologically, the Trust has already begun putting its portion of the funds to good use. Dermot O'Riordan, chief clinical information officer and consultant surgeon, said: "The possibilities as a Global Digital Exemplar are vast and very exciting. Our latest development has been programming our computers with automatic alerts, calculated from a patient's symptoms, for conditions like sepsis and acute kidney injury. These conditions can be life-threatening, and these digital advancements are helping our staff detect these issues as early as possible. Further investment over time will enable us to gain more clinical information out of the system, to identify areas where we can improve the quality of patient care." Earlier this month the Trust received £3.3million of the total £10million it will get from NHS England to make the developments.

NATIONAL NEWS

New ambulance standards
A new way of working for ambulance services is being implemented across the country to make sure patients get the right response, first time. The Ambulance Response Programme follows the largest clinical ambulance trial in the world and will update a decades old system. From now on call handlers will be given more time to assess 999 calls that are not immediately life-threatening, which will enable them to identify patients' needs better and send the most appropriate response.
These changes focus on making sure the best, high quality, most appropriate response is provided for each patient first time.

Guidance for GP Resilience Programme published
NHS England has now published guidance on the 2017/18 allocations under the GP Resilience

Programme, which will see a further £8million go to practices to support them in becoming more sustainable and resilient, better placed to tackle the challenges they face now and into the future. Last year 2,100 practices received support for resilience work as part of the Vulnerable Practices Programme (VPP) (£10 million) and the GP Resilience Programme (GPRP) (£16 million).

Patients to benefit from £325 million investment in NHS transformation projects
Health Secretary Jeremy Hunt and NHS England boss Simon Stevens have announced £325m of capital investment for local projects that will help the NHS to modernise and transform care for patients. This round of funding will support 15 Sustainability and Transformation Partnerships (STPs) across the country; patients will see this investment deliver faster diagnosis for conditions like cancer, easier access to mental health care, expansion of A&Es, shorter waits for operations, and more services in GPs surgeries.

Rebooting health and social care integration: an agenda for more person centred care
This report finds that the future of health and social care integration agenda is dependent on moving away from central policy direction. It states that funding and financial sustainability should be influenced at local level. The authors also believe that health and social care integration can create new value locally, but it must build on greater person centred care. The report makes four strategic recommendations and six policy recommendations to support integration. (Localis, 2017)

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28th July 2017

AGENDA ITEM:	Item 8
PRESENTED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer
DATE PREPARED:	July 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 no C Diff (0 in May). Falls for the month were 50 (52 in May and 20 pressure ulcers (8 in May) - pages 5-6.
- This month's report shows an improvement against 18weeks from point of referral to treatment in aggregate - patients on an incomplete pathway standard; June performance of 83.36% against a standard of 92% (79. 71% May) – page 22-23
- Provisional data for June indicates that the Trust has achieved 2WW performance standard of 96.59% against a standard on93%, but missed the 2WW symptomatic breast standard with a performance of 88.8% against a standard of 93% - page 22
- Provisional data for June also indicates a performance of 84.76% against a standard of 85% for the 62 day referral to treatment cancer standard. – page 22
- The Trust achieve the ED standard for the first quarter with a performance of 95.53% representing a significant achievement as a result of focussed effort within the emergency department and across the Trust. – page 22

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	Apr	May	Jun
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	96	100	100
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	97	98
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	85	100
HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	= 100	100	100	100
HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	81	92	93
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<85	85-99	= 100	100	NA	NA
Total no of MRSA bacteraemia: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	0
Total no of MRSA bacteraemia: Community acquired (Trust level only)	No Target	No Target	No Target	No Target	1	0	0
Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	NA	NA	92
MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	92	93	95
Hand hygiene compliance	= 95%	<85	85-99	= 100	98	97	99
Total no of MSSA bacteraemia: Hospital	No Target	No Target	No Target	No Target	ND	1	0
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	3	0	0
Total no of C. diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	ND	0	2
Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	NA	NA	91
Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	2	0	2
Isolation data (Trust level only)	= 95%	<85	85-94	95-100	90	95	90
Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	NA	NA	91
Quarterly VIP score documentation	= 90%	<80	80-89	90-100	NA	NA	84
PEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	80	100	90
No of patient falls	= 48	>=48	No Target	<48	54	52	50
Falls per 1,000 bed days (Trust and Divisional levels only)	= 5.6	>5.8	5.6-5.8	<5.6	5.1	4.5	ND
No of patient falls resulting in harm	No Target	No Target	No Target	No Target	9	17	20
No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	0	ND
Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	0	0	ND
No of patients with ward acquired pressure ulcers	< 5	>=5	No Target	<5	7	8	20
No of patients with avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target	3	ND	ND
Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	91	87	89
No of SIRIs	No Target	No Target	No Target	No Target	9	5	7
No of medication errors	No Target	No Target	No Target	No Target	64	81	69
Cardiac arrests	No Target	No Target	No Target	No Target	4	6	4
Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	0
Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	75	NA	NA
Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	NA	NA	96
Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	98.53	98.26	98.91
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4	3	1	3
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC	60	66	54
Median NRLS upload 6 month rolling average [NEW]	46days	>46	No Target	0-46	81	87	64

Indicator	Target	Red	Amber	Green	Apr	May	Jun
SIRIs reported > 2 working days from identification as red	0	>1	1	0	0	0	0
SIRI final reports due in month submitted beyond 60 working days	0	>1	1	0	0	1	0
Active risk assessments in date [see 1.13]	100%	<75%	75 – 94%	>=95%	100	100	100
Outstanding actions in date for Red / Amber entries on Datix risk register [see 1.13]	100%	<75%	75 – 94%	>=95%	100	100	100
Total Verbal Duty of Candour outstanding at month-end [NEW]	0	>3	1 - 3	0	3	0	0

Exception reporting for indicators in the Patient Safety Dashboard

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

Data notes:

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

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

Data items Falls per 1000 Beds days and Falls with moderate/severe harm/death per 1000 bed days which had not been previously available from e-Care have been provided as a working estimate for Jan-May17 with an aim to provide final figures for reporting from Q2 2016/17 onwards.

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

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

1.1 HII compliance 2b: Peripheral cannula ongoing

a) Current Position

A score of 98 in June was an improvement on 97 in May and was RAG-rated as amber for the second month in a row.

b) Recommended action

Changes on e-Care have made some improvements to ensure care of peripheral cannulae is documented however, as the insertions are not consistently recorded, some targeted work in ED and Theatres in planned which should improve this indicator further.

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

a) Current Position

A score of 93 in June was an improvement on 92 in May.

b) Recommended action

This indicator consistently flags as Red or Amber and the Infection Prevention team are planning targeted education for wards G4 / G5 as these areas consistently score lower than other wards. These wards will be trialled as areas to focus on initially. This project will then be rolled out to all wards to improve the documentation and care.

1.3 Hand Hygiene

a) Current Position

A score of 99 was above/below the figure for May (97) and was Amber RAG rated for the third month in a row. There was one failure on G4 noted by a rehab assistant.

b) Recommended action

The Hand Hygiene action plan notes that names of staff will be recorded if "support and challenge" approach does not result in compliance.

1.4 Quarterly Antibiotic Audit

a) Current Position

In Q1, the Trust overall achieved 91% compliance against a target of 98%, down from 93% in Q4.

b) Recommended action

The quarterly audit is shared with all clinical areas. Key messages for dissemination included the following:

- Due to global shortage of IV Piperacillin /Tazobactam, the antibiotic guidelines underwent extensive review.
- The e-Care team are working on an improved review date alert, until then the e-Care auto-text *##antibioticreview* is encouraged on ward rounds.
- The Trust has provided support to Cerner in the build of a new antimicrobial stewardship module.
- An alert on e-Care highlighting the significance of the meropenem + sodium valproate interaction is now live. This will appear any time that this combination is prescribed. It provides appropriate guidance and advice regarding managing sodium valproate and who to contact.

1.5 Quarterly VIP score documentation

a) Current Position

VIP score compliance results have improved slightly from 79% in Q4 to 84% in Q1 although perforamcne still remains below target. New changes in e-Care have moved the VIP score to the nurses accountability which has improved compliance with this, however cannula insertions and removals are recorded separately within e-Care providing a disjointed view of the cannula care record.

b) Recommended action

The quarterly audit is shared with all clinical areas. Key messages for dissemination included the following:

- Staff need to ensure cannula insertions and removals are documented. The Audit Team continue to provide ad-hoc training to ward staff on how to complete cannula insertions and document VIP scores on e-Care, and have offered more formal training as required.
- Managers are asked to ensure that all staff are aware when inserting a cannula that it is appropriately documented on e-Care.
- When a patient is transferred to a ward, staff should check that, if they have a cannula in-situ, that the insertion has been recorded and ensure that VIP scores are documented on every shift.

1.6 Nutrition: Assessment and monitoring

a) Current Position

A score of 89 in June was a rise from 87 in May and continues to be amber RAG rated and this will continue to be a major focus for the next few months. The Trust's CQC local Relationship Manager has queried the status of Nutrition in the Board quality report. The narrative below was provided to the CQC.

b) Recommended action

The Heads of Nursing are planning a working group to focus on the assessment and management of nutrition for patients within the WSH. The group will have membership from the Heads of Nursing, Matron

team, Ward staff (a nominated Band6, Band 5 and Band 2 from each clinical inpatient area) and dietetic staff. We are planning to work with the e-Care team in modifying the alerts on the system to ensure that appropriate assessments are conducted within the agreed time frame. We will also look at cascade training from the senior group members in relation to educating staff on meeting the nutrition needs of the various patient groups we encounter. The Trust will be purchasing new vital sign monitoring equipment (hopefully from the end of August) which will directly interface with e-Care and could be set up to include nutritional parameters that would impact upon performance. The Matron team will continue to focus on 'nutrition' and will monitor their individual ward performance and discuss this with the senior ward teams so they are apprised of their current position and in turn can target resources in addressing this area.

1.7 Quarterly VTE: Prophylaxis compliance

a) Current Position

The audit was rated Amber against a Trust target of 100% of high-risk patients receiving the required prophylaxis. There is however an overall Trust improvement from 95% (Q4) to 96% (Q1).

b) Recommended action

The results for the divisions show weaknesses in the areas below and this has been fed back to the relevant divisions:

- Assessing VTE prophylaxis on admission in the medical division (94%)
- Re-assessing VTE prophylaxis risk within 24 hours in the medical division (63%)
- Warfarin or other oral anticoagulants being prescribed if not contraindicated and LMWH (low molecular weight heparin) not prescribed (90%).

1.8 Total no of C. difficile infections: Hospital

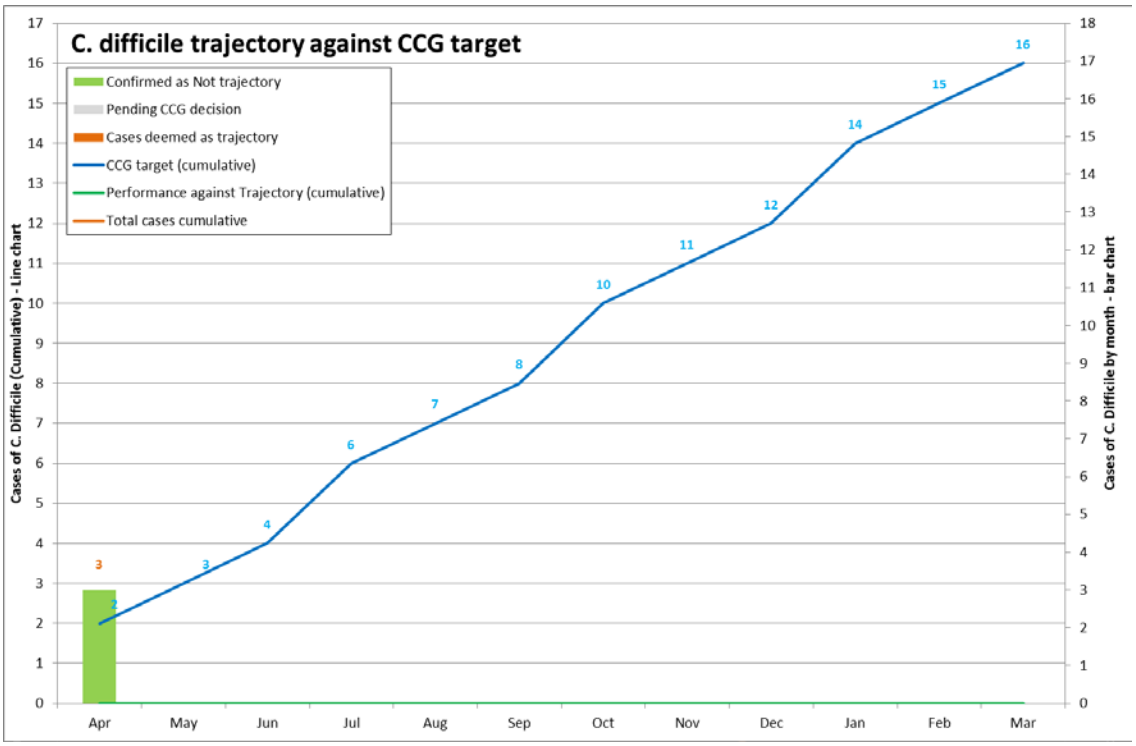
a) Current Position

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

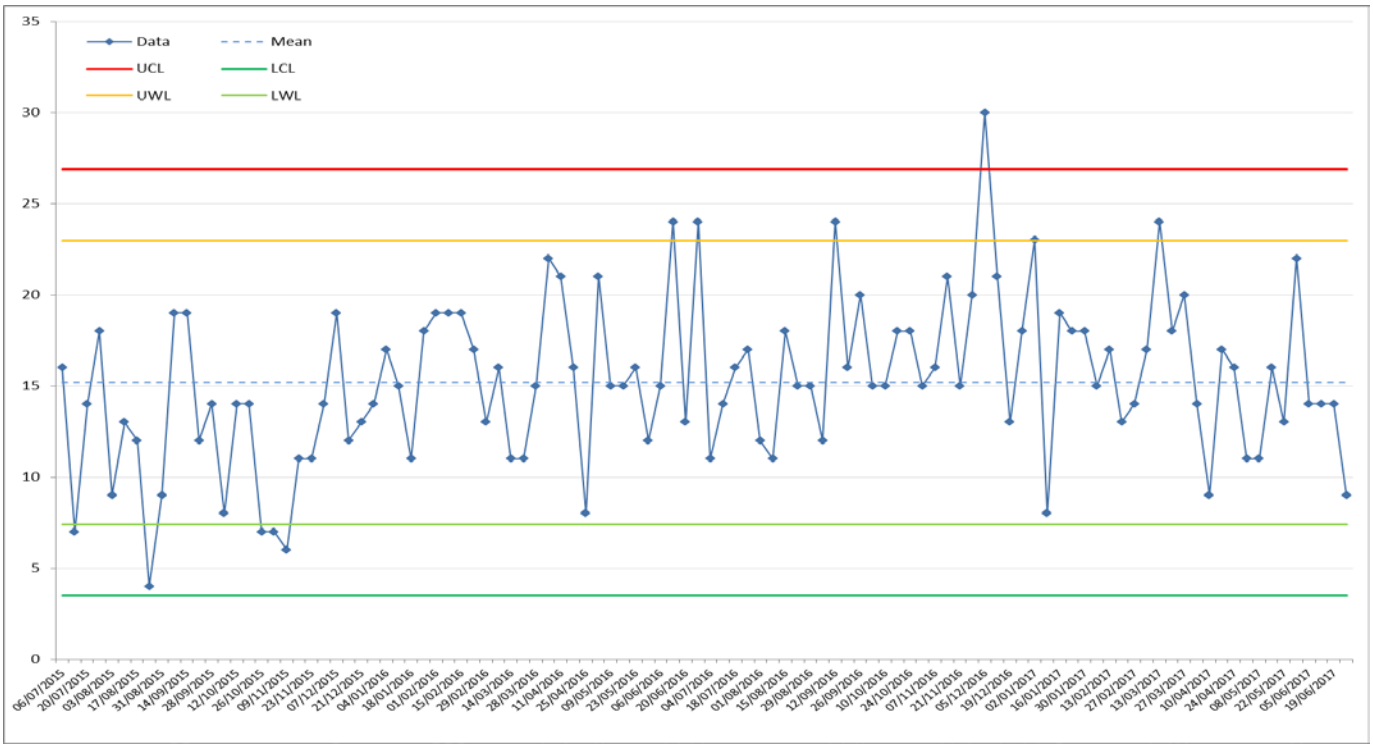
The graph below has been updated to demonstrate the Trust performance against the trajectory target set by the CCG.

b) Recommended Action

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



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



There were 50 falls in June (down from 52 in May), one with moderate harm and one with major harm.

Moderate Harm – Ward G4 / 95 year old lady admitted with ?UTI/LRTI who following an NSTEMI / seizure in the toilet fell, resulting in a fractured humerus. The patient continued to have seizures and failed to recover despite medical intervention. Palliative care team contacted who supported a best supportive care approach and patient passed away.

Major Harm – Ward F7 / 83 year old lady admitted with increasing confusion who fell resulting in a neck of femur fracture. This was surgically repaired but sadly the patient developed a hospital-acquired pneumonia and passed away. This case is currently under investigation by the Executive Chief Nurse and an action plan is being formulated to address the events surrounding the fall and concerns raised by the family.

Two patients fell at Newmarket Hospital (down from four in May), with three patients falling at Glastonbury Court (five in May) – these falls are reported separately.

Two patients were assisted to the floor (nine in May) preventing them from falling.

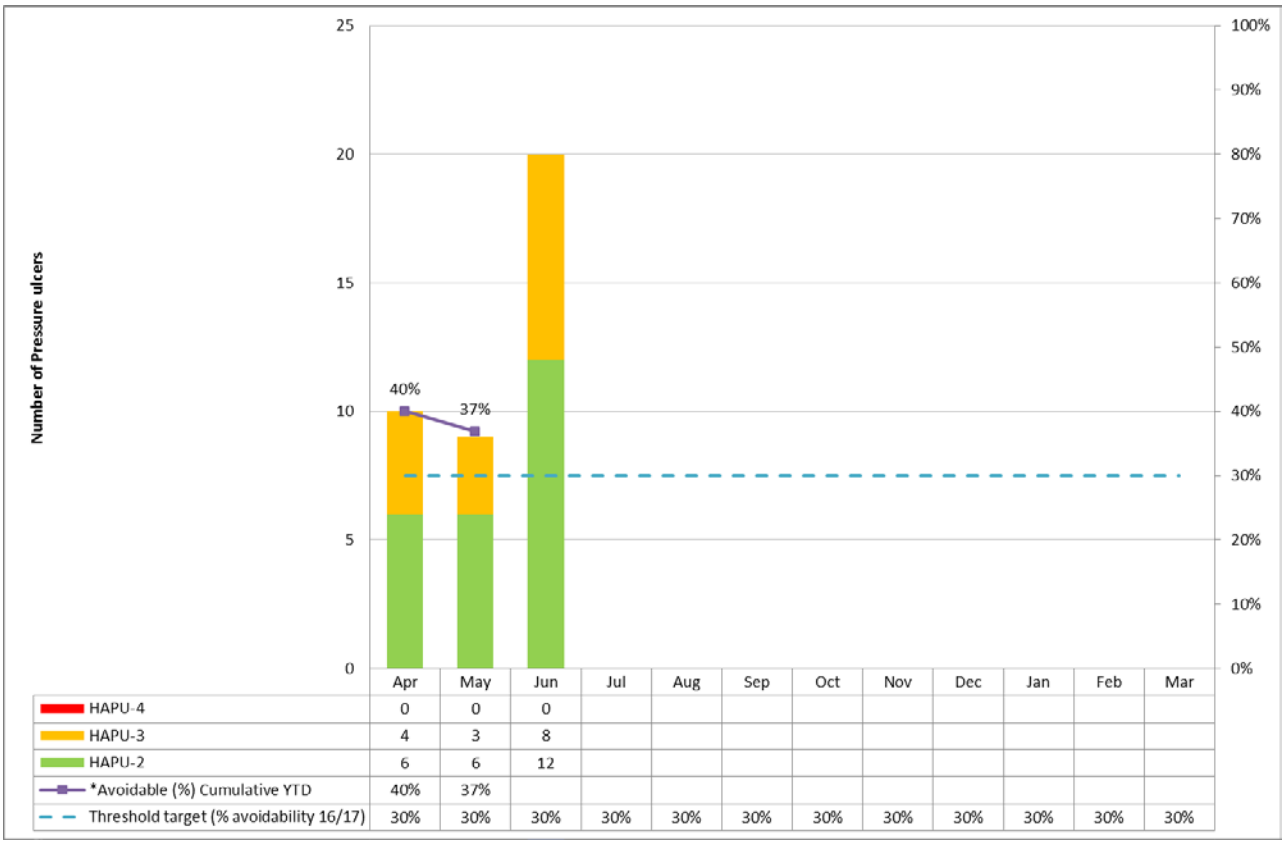
One patient fell more than twice in their inpatient stay this month, (three in May).

The areas of F3 (5 x falls) / G4 (8 x falls) / G8 (8 x falls) were the areas with the highest number of patients falling. Cognitive impairment and staffing levels were a factor in certain cases and as such the Senior Matron team continue to focus on the reduction of falls and the review of staffing resource to meet individual ward acuity.

Going forwards the Matron Team are leading on a Trust wide falls group to address the high number of falls, this will include Ward level involvement at Band 6/5/2 along with the relevant specialist nurses and AHP's whereby the sharing of best practice and learning from previous incidents and outcomes will be supported. The group is planning to commence this approach from September with quarterly meetings thereafter and agreed actions for wards to develop and implement.

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

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



Judged as Avoidable following clinical review by Matron or TVN

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

There were 12 HAPU-2 in June. Two each on G8, F10, G5 and G3 and one each on F7, G1 and Coronary Care.

There were eight HAPU-3 in May. Three each on F9 and F3, one on G5 and one G4 .

There were four DTI reported in June.

There was also one HAPU-2 reported at Glastonbury Court

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.

Ward F5 have not had any pressure ulcers reported since April 2016 and on the 1st September will have achieved 500 days free which will be celebrated with a ward harm free care award.

Avoidable harm

The 2017/18 Trust quality priority target for avoidable pressure ulcers is to improve upon the 2016/17 year end performance of 30%.

At the end of June there had been 39 HAPU 2, 3 or 4 reported. Seven of these have been classified as avoidable and 19 as unavoidable with another 13 pending confirmation of grading as these cases are currently under investigation (HAPU-3 have a 60 working day deadline in line with the Serious incident framework).

Pressure ulcer prevention

There has been an increase in reported grade 2 and grade 3 HAPUs in June despite the continued work of the 'React to Red' programme. It is probable this has been exacerbated by an increased demand for services and a prolonged period of high temperatures in June resulting in an increase in associated risk factors. There has been a heightened focus on ensuring patients remain hydrated in the extreme temperatures.

Early review of the incidents indicates many of those affected by pressure damage were in the last days of life. This increase of reported damage will be continued to be monitored to ensure there is not a continued upward trend.

The 'React to Red' project is currently focussing on preventing heel damage by identifying prevention champions on each ward, 'Heel Heroes'. Staff training is being delivered and there continues to be a strategy of raising awareness amongst the nursing teams, promoting the use of pressure damage prevention strategies and accurate risk assessment. The Tissue Viability team has been restructured and continues to work in conjunction with the Matrons and Ward Managers to maintain the profile of pressure ulcer prevention.

The Heads of Nursing and Matrons are also planning some focussed sessions for the nursing teams on pressure ulcer prevention, falls prevention and maintaining adequate nutrition. These groups will be support joint working with Allied Health Professionals and Specialist Nurses to ensure practice is safe, current and evidence based.

1.11 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.

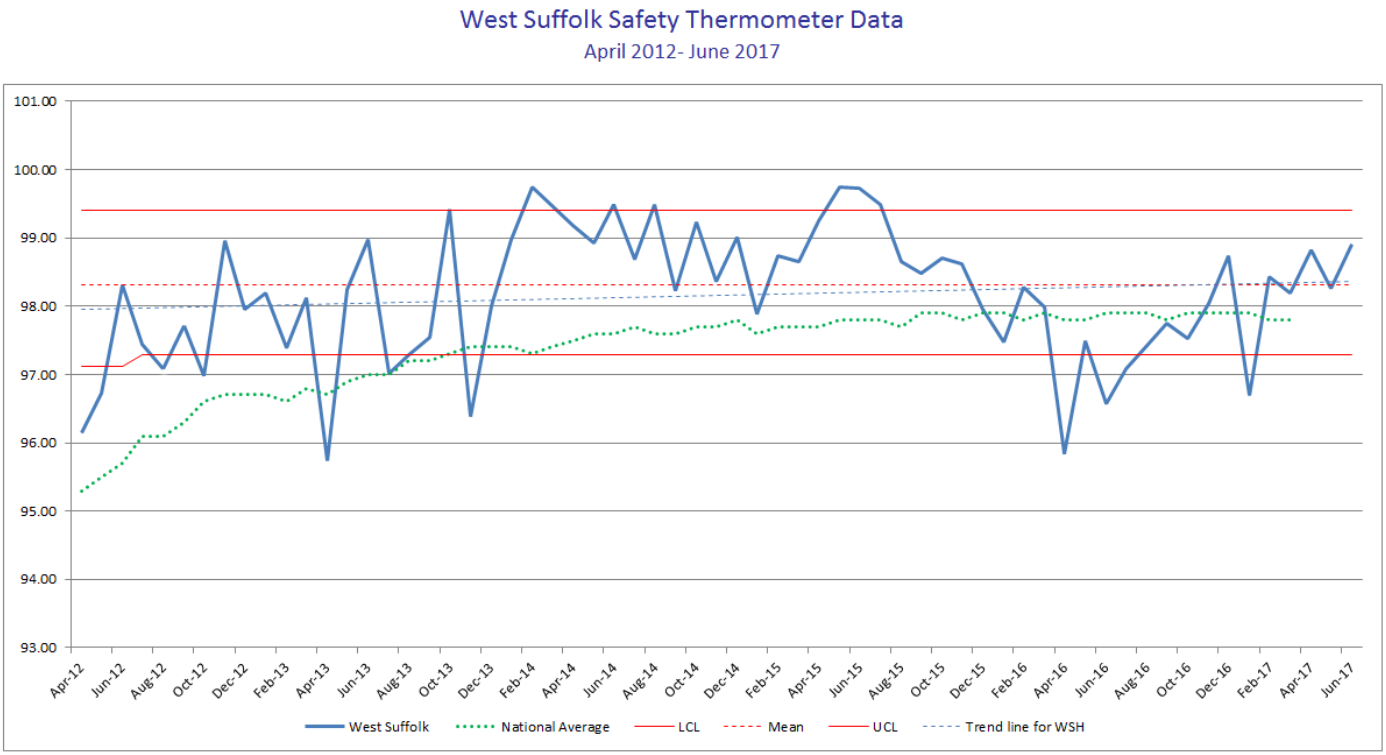
	Jul16	Aug16	Sep16	Oct16	Nov16	Dec16	Jan17	Feb17	Mar17	Apr17	May17	Jun17
Harm Free	92.31	92.25	92.71	92.31	92.61	93.16	91.35	93.72	94.06	94.12	91.30	92.92
Pressure Ulcers – All	5.31	3.88	5.03	5.49	5.67	3.80	5.34	4.71	3.62	5.00	5.22	4.90
Pressure Ulcers - New	1.06	1.29	1.01	1.65	1.23	0.51	1.53	1.05	0.52	0.88	0.87	0.54
Falls with Harm	0.53	0.00	0.75	0.55	0.49	0.76	0.76	0.00	0.00	0.00	0.29	0.00
Catheters & UTIs	2.12	3.62	1.51	2.20	1.23	2.28	2.04	1.31	1.81	1.18	3.48	2.18
Catheters & New UTIs	0.53	0.78	0.50	0.00	0.25	0.00	0.25	0.26	0.78	0.29	0.29	0.27
New VTEs	0.80	0.52	0.00	0.27	0.00	0.00	0.76	0.26	0.52	0.00	0.29	0.54
All Harms	7.69	7.75	7.29	7.69	7.39	6.84	8.65	6.28	5.94	5.88	8.70	7.08
New Harms	2.92	2.58	2.26	2.47	1.97	1.27	3.31	1.57	1.81	1.18	1.74	1.09
Sample	377	387	398	364	406	395	393	382	387	340	345	367
Surveys	18	18	18	17	18	18	18	18	18	18	17	17

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

Currently SCW have not published the National average due to discrepancies with national data-sets and therefore we are unable to report performance against the national data.

The data can be manipulated to just look at "new harm" (harm that occurred within our care) and with this parameter, our Trust score for June 2017 is **1.09 %** therefore, our new harm free care is **98.91%.** The National new harm is not available so the Trust figure has not been RAG rated

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 with April and May's data provided at Trust level only.



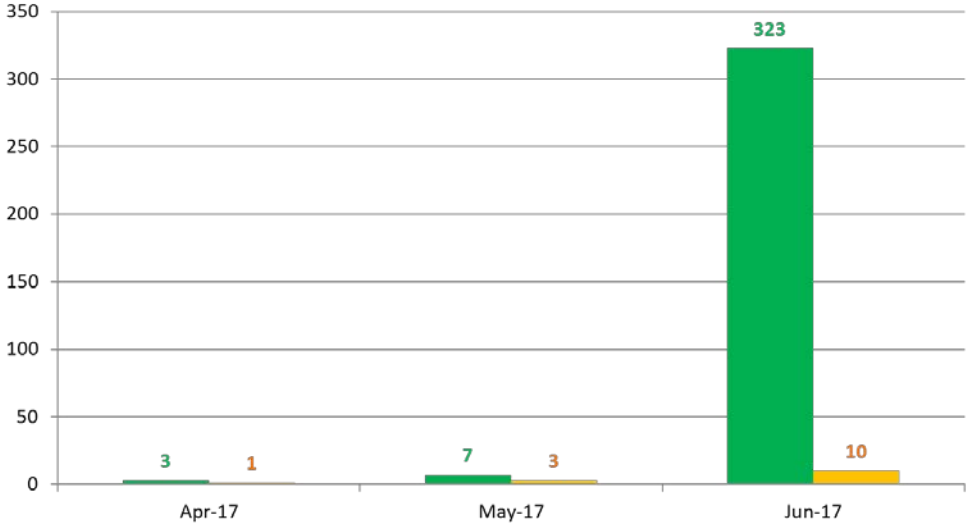
b) Recommended Actions

To continue to monitor actual harm against national benchmarks.

1.12 % of 'Green' PSI incidents investigated / Median NRLS upload 6 month rolling average

a) Current Position

Graph: Green and Amber incidents overdue by month.



The graph above shows the number of green and amber incidents that are still awaiting investigation. There has been an increase in the overall number of overdue incidents and only 54% (221) of the June green incidents had been investigated at the time of this report compared to May (65%).

The timeliness of Trust reporting to the NRLS (national reporting & learning system) has been challenged by the CCG and the Trust is preparing a response. The performance for the period to the end of June has shown a marked improvement and a formal improvement plan is being written.

NHS Improvement is now publishing monthly information reports including timeliness indicators. More details will be provided in next month's report.

1.13 Active risk assessments in date / Outstanding actions in date for Red / Amber entries on Datix risk register

A Risk Officer has now been in post since January 2017 to work alongside the Health, Safety and Risk Manager to ensure there is a robust process in place for managing and monitoring the risk register. Therefore from Q2 the Risk Office will be reporting against two new performance indicators.

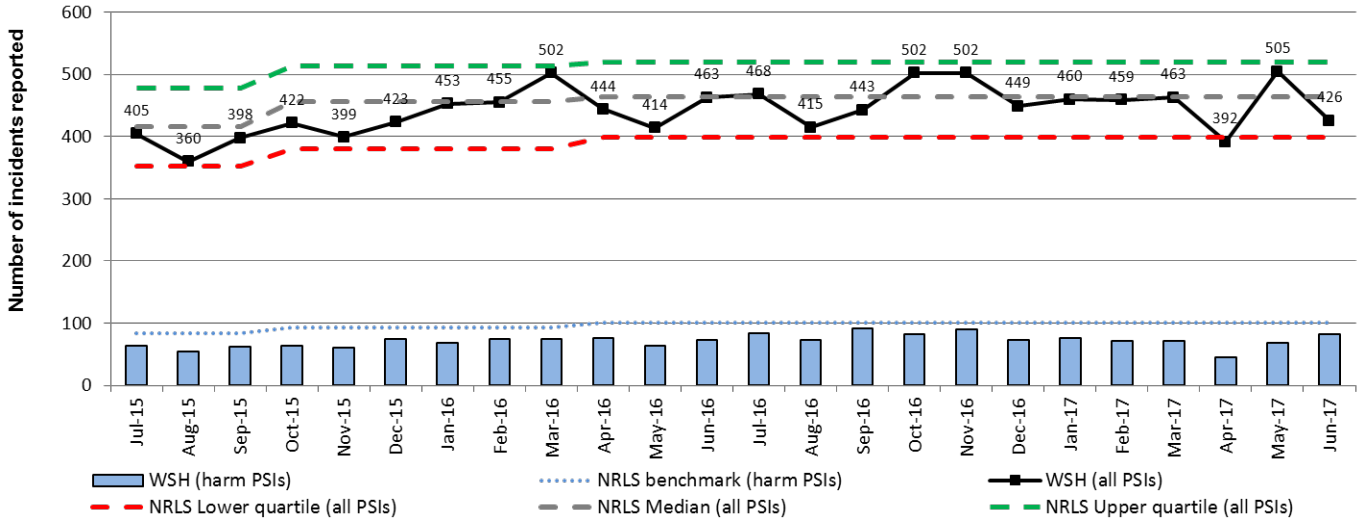
Indicator	Red	Amber	Green
Green, Amber and Red Active and accepted risk assessments in date	>10	5-9	0-4
Datix risk register Red / Amber actions overdue	>10	5-9	0-4

1.14 Patient Safety Incidents reported

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

There were 563 incidents reported in June including 426 patient safety incidents (PSIs). This was lower than May and is explored further in the 'Aggregated' report.

Graph: Patient Safety Incidents reported



1.15 Patient Safety Incidents (Severe harm or death)

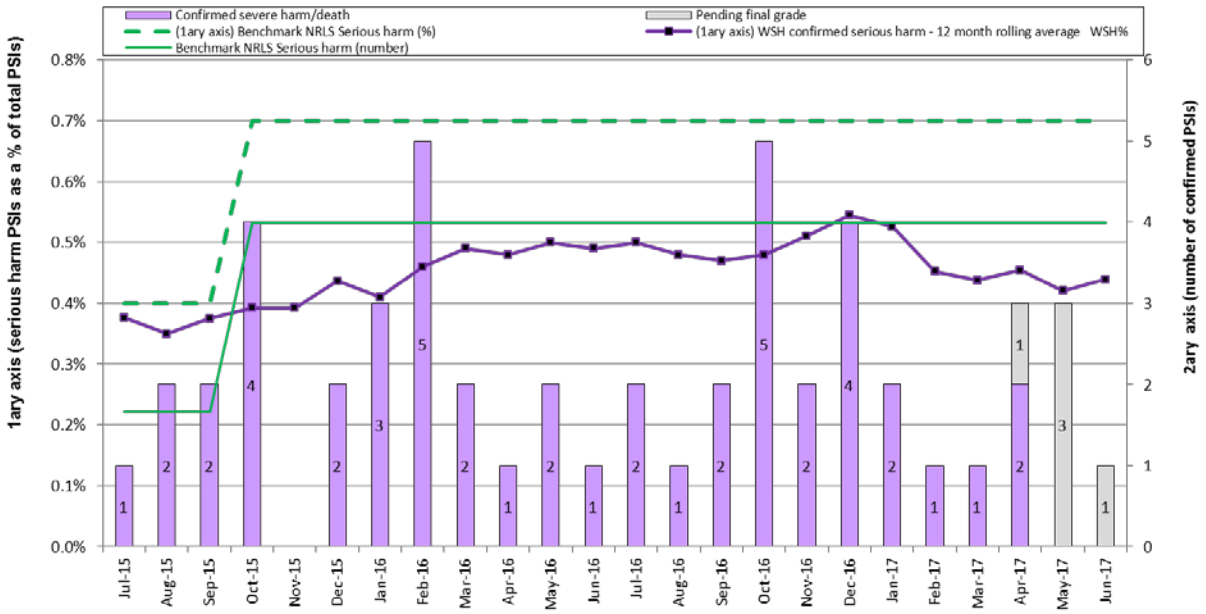
The percentage of PSIs resulting in severe harm or death is a nationally mandated item for inclusion in the Quality Accounts. The NRLS peer group average is from the period Apr – Sept16. The benchmark line applies the peer group percentage serious harm to the peer group median total PSIs to give a comparison 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 June there was one case reported: a fall resulting in fracture which is awaiting RCA to confirm harm grading.

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

- one delay in pathology results,
- one absconder from ED
- one delay in treatment two delay in diagnosis
- one death during transfer to other organisation *(Initial review suggests that this case will be downgraded at the conclusion of the investigation)*

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	Apr	May	Jun
Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	91	94	94
(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	98	96	99
Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	71	72	80
Patient Satisfaction: outpatient overall result	= 85%	<75	75-84	85-100	96	92	88
(Out-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	98	97
Were you informed of any delays in being seen?	= 85%	<75	75-84	85-100	79	73	65
Were you offered the company of a chaperone whilst you were being examined?	= 85%	<75	75-84	85-100	91	70	65
Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	99	99	99
(Short-stay) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	99	98	99
Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	97	98	94
(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	97	96	95
Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	100	100	94
(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	97	96	95
Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	98	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	ND	ND	100
Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	99	99	ND
Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	97	99	99
(F1 Parent & Young Person) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	100	100
Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	94	ND	98
(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	93	ND	95

Additional Patient Experience indicators

Indicator	Target	Red	Amber	Green	Apr	May	Jun
Acknowledged within three working days [NEW]	100%	<75%	75 – 89%	>=90%	ND	90	100
Response within 25 working days or negotiated timescale with complainant	100%	<75%	75 – 89%	>=90%	100	90	75
Number of second letters received	0	>6	2 - 6	0 - 1	3	0	2

Indicator	Target	Red	Amber	Green	Apr	May	Jun
Health Service Referrals accepted by Ombudsman	0	>=2	1	0	0	2	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	0

Exception reporting for indicators in the Patient Experience Dashboard

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

1.16 Inpatient: Noise at night

a) Current Position

The score has improved to 80 from 72 in May, now flagging as amber compared to red in April.

a) Recommended Action

Disturbance from other patients continues to be the most common reason for noise at night. Ward managers have been reminded to continue to offer ear plugs wherever possible and Senior Matrons are prioritising implementing soft closing bins as part of the PLACE inspection action plan.

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

a) Current Position

This score has deteriorated to 65 in June from 73 in May and remains red.

b) Recommended Action

The department continues to increase the number of patient surveys collected which show information about delays was lacking in Colposcopy, Fracture clinic and neurology. This has been fed back to the areas concerned to raise awareness about ensuring outpatient staff are kept informed of delays, and as a consequence patients.

Twenty new patient pagers have been ordered to allow patients to leave the department where there are significant delays – this are due to be delivered at the beginning of August.

1.18 Out-patient: Was there another person with you (other than the doctor) whilst you were being examined?

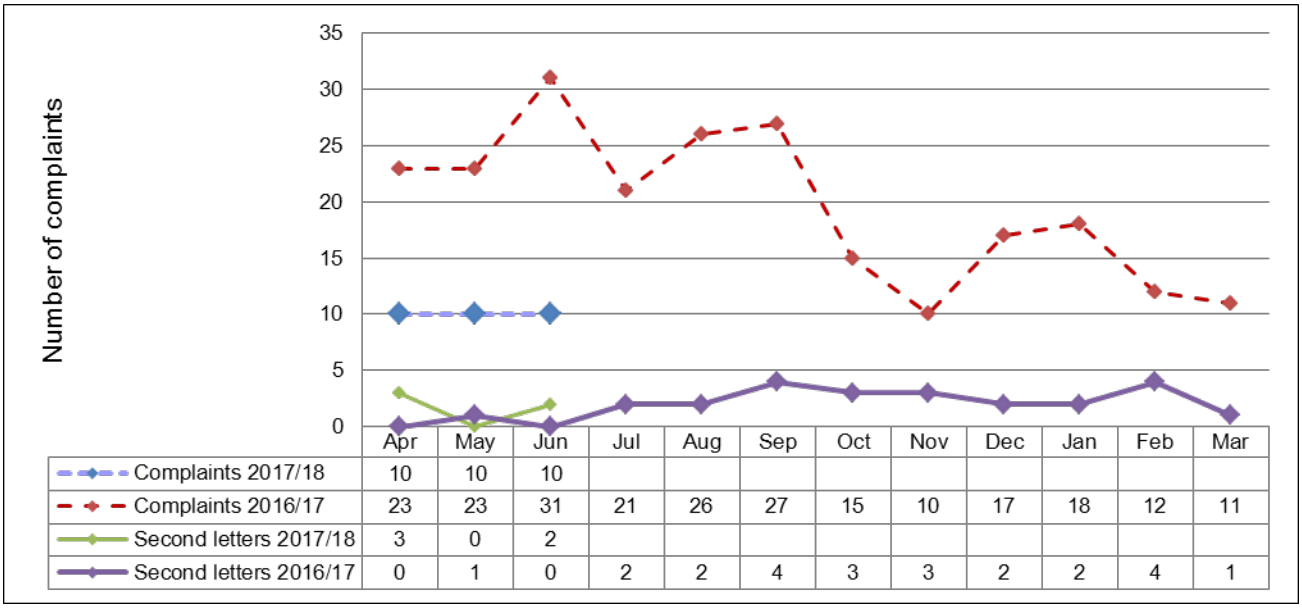
a) Current Position

This score has deteriorated to 65 in June from 70 in May and remains red.

b) Recommended Action

The question still needs to be altered as it doesn't accommodate those patients that didn't want a chaperone – the lowest scoring areas of colposcopy, respiratory and audiology will be the focus for next month.

1.19 Complaints



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

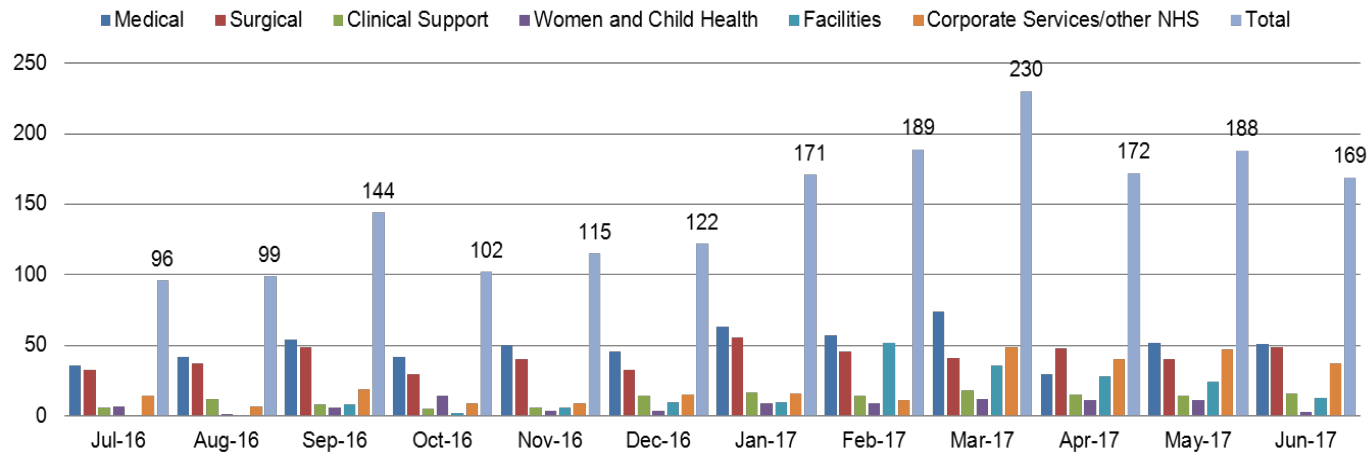
10 complaints were received in June. The breakdown of these complaints is as follows by Primary Division: Medical (5), Surgical (2), Women & Children (3).The top two most common areas are as follows:

Patient Care – including Nutrition / Hydration	4
Clinical Treatment – Clinical Oncology	2

1.20 PALS

In June 2017 there were 169 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 July 16 – June 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 (37)
- Appointments; including delays and cancellations (33)
- Communications (19)

Enquiries about the cessation of the oral and orthodontics services were a theme in June with many patients raising their concerns that they have not yet been informed of where treatment will continue and under which provider.

The Trust has been working closely with NHS England in order to facilitate a smooth transition however unfortunately NHS England have been unable to release details of the newly allocated providers at this time. Understandably patients are finding the lack of information distressing and we have been offering as much information as possible.

Car parking continues to flag as a high area of enquiry, in June the majority of these enquiries related to the cost of parking and issues with the use of pay and display when clinics are delayed.

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	Apr	May	Jun
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	94
Babies admitted to NNU with normal temperature on arrival (term)	100%	<50%	50-80%	>80%	87	66	88
12 month Mortality standardised rate (Dr Foster)	100%	>100	90-100	<90	88.12	88.05	88.05
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	Apr-17	May-17	Jun-17
ACTIVITY – Births						
Total Women Delivered	> 250 or < 2 00	>216 or <208	>208 or <216	213	190	208
Total Number of Babies born at WSH	> 250 or < 2 00	>216 or <208	>208 or <216	215	192	213
Twins	No target	No target	No target	2	2	5
Homebirths	< 1%	2% or less	2.5%	1.4%	3.7%	2.4%
Midwifery Led Birthing Unit (MLBU) Births	<=10%	13% or less	20%	17.8%	17.4%	17.3%
Labour Suite Births	<=64%	69% to 74%	75%	80.8%	78.9%	80.3%
BBAs	No target	No target	No target	1	4	1
Normal Vaginal deliveries	No target	No target	No target	160	123	154
Vaginal Breech deliveries	No target	No target	No target	2	1	1
Non operative vaginal deliveries	No target	No target	No target	0	65.3%	75%
Water births	No target	No target	No target	15	14	12
Total Caesarean Sections	> 22.6%	No target	<22.6%	15%	21.1%	15.9%
Total Elective Caesarean Sections	>=13%	11 - 12%	10%	4.7%	9.5%	4.3%
Total Emergency Caesarean Sections	>=15%	13 - 14%	12%	10.3%	11.6%	11.5%
Second stage caesarean sections	No target	No target	No target	4	8	3
Forceps Deliveries	No target	No target	No target	6.1%	8.9%	6.3%
Ventouse Deliveries	No target	No target	No target	2.8%	4.7%	3.4%
Inductions of Labour	No target	No target	No target	42.7%	41.1%	40.9%
Failed Instrumental Delivery	No target	No target	No target	1.4	1.1%	0
Unsuccessful Trial of Instrumental Delivery	No target	No target	No target	0	2	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%	92%	93%	93%
Total no. of women eligible for Vaginal Birth after Caesarean Section (VBAC)	No target	No target	No target	13	11	23
Number of women presenting in labour for VBAC against number achieved.	No target	No target	No target	6	6	15
ACTIVITY – Bookings						
Number of Bookings (1st visit)	No target	No target	No target	208	262	244
Women booked before 12+6 weeks	<=90%	91 - 94%	95%	95%	95%	97%

	Red	Amber	Green	Apr-17	May-17	Jun-17
CLINICAL OUTCOMES - Maternal						
Postpartum Haemorrhage 1000 - 2000mls	No target	No target	No target	13	15	16
Postpartum Haemorrhage 2,000 - 2,499mls	No target	No target	No target	1	1	1
Postpartum Haemorrhage 2,500mls+	No target	No target	No target	1	0	1
Post-partum Hysterectomies	1	1	0	1	0	0
Women requiring a blood transfusion of 4 units or more	1	1	0	1	0	0
Critical Care Obstetric Admissions	1	1	0	1	0	0
Eclampsia	1	1	0	0	0	0
Shoulders Dystocia	5 or more	3-4	2	2	4	3
3rd and 4th degree tears (All vaginal deliveries)	No target	No target	No target	8	9	6
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)	10	7-9	6	7	5	5
3rd and 4th degree tears (Instrumental Deliveries)				1	4	1
Maternal death	1	No target	No target	0	0	0
Female Genital Mutilation (FGM)	No target	No target	No target	0	0	0
Clinical Outcomes –Neonatal						
Number of babies admitted to Neonatal Unit (>36+6)	No target	No target	No target	15	9	17
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	No target	No target	No target	1	2	3
Number of Babies transferred for therapeutic cooling	1	No target	0	0	0	0
Cases of Meconium aspiration	No target	No target	No target	0	0	0
Cases of hypoxia	No target	No target	No target	0	0	0
Cases of Encephalopathy (grades 2 and 3)	No target	No target	No target	0	0	0
Stillbirths	No target	No target	No target	1	0	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 >	93	110	99
Midwife/birth ratio	>=1:32	No target	1:30	1:30	1:27	1:29
Supervisor to Midwife Ratio	No target	No target	No target			
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	51	62	46
Serious incidents	No target	No target	No target	1	0	0
Never events	No target	No target	No target	0	0	0
Complaints	No target	No target	No target	0	0	1
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	1	0	0
Maternal Postnatal readmissions	No target	No target	No target	ND	ND	ND
Completion of WHO Checklist	80%	90%	100%	84%	93%	84%
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
Number of Women identified as smoking at booking	No target	No target	No target	27	35	37
Number of Women identified as smoking at delivery	No target	No target	No target	20	30	26
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	143	170	174

Exception reporting for red indicators in the Clinical Effectiveness and Maternity Dashboards

1.21 Maternity - Shoulder Dystocia

The two consecutive amber ratings for should dystocia will be discussed at the next Maternity and Gynae Clinical Governance and a plan made whether further monitoring should be undertaken.

1.22 Maternity - Completion of WHO Checklist

The Trust's CQC local Relationship Manager has queried the status of Maternity WHO compliance. The narrative below was provided

The WHO checklist Safer Surgery Audit within Maternity services is a retrospective documentation audit. The audit measures how well the Specialist Obstetric WHO Checklist is completed for every case that requires a procedure in theatres. The results of the audit are reported on the Trust Maternity Dashboard on a monthly basis that is reported to the board internally and externally to the CCG. We now have agreed a strategy to work on improving the results from the audit.

Communication of Results strategy

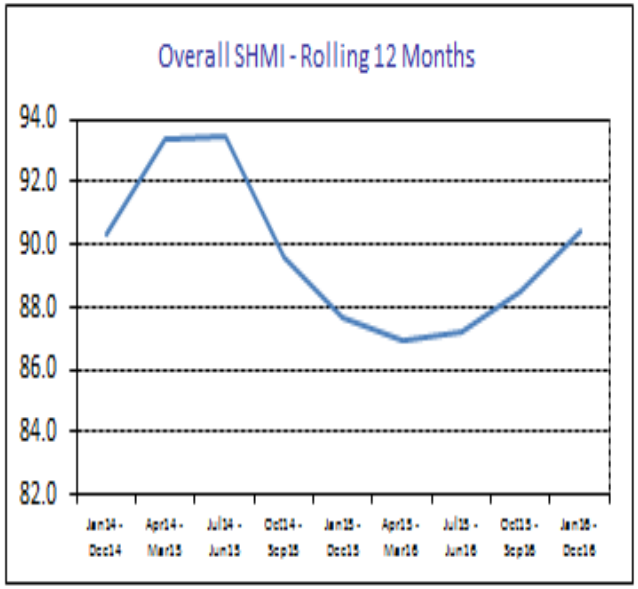
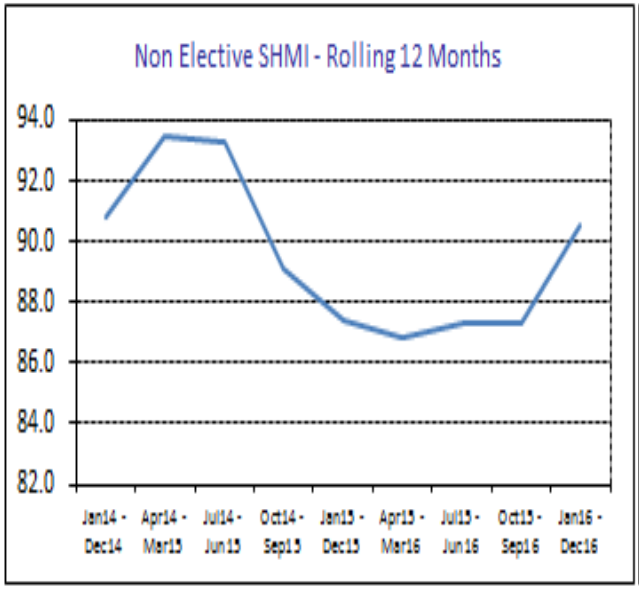
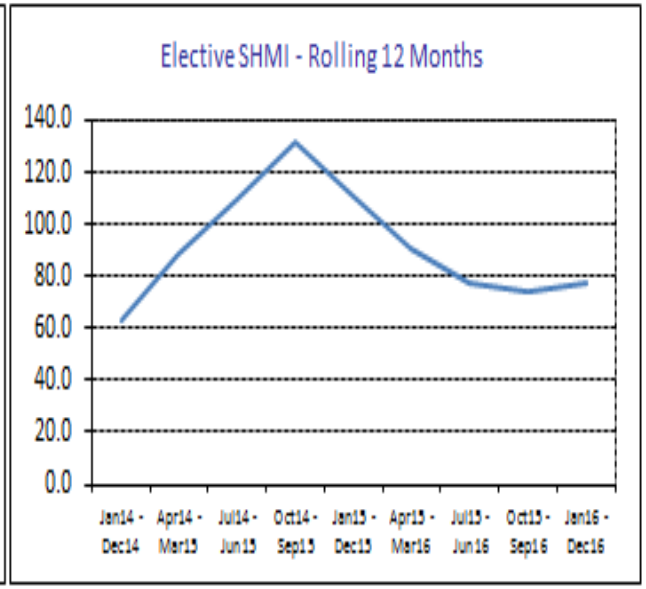
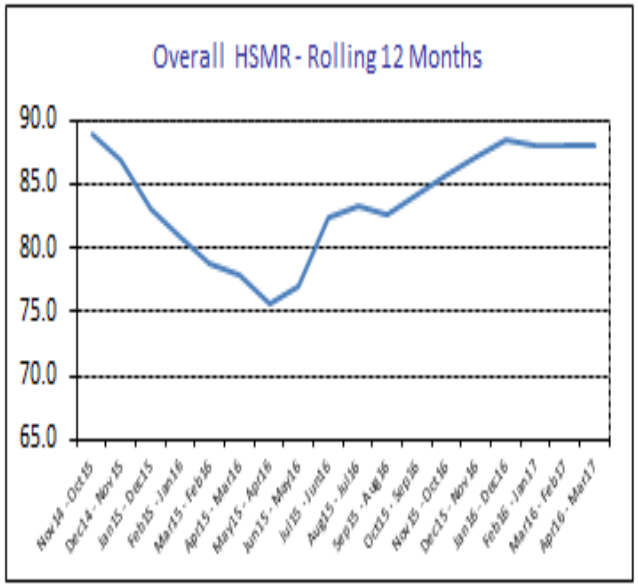
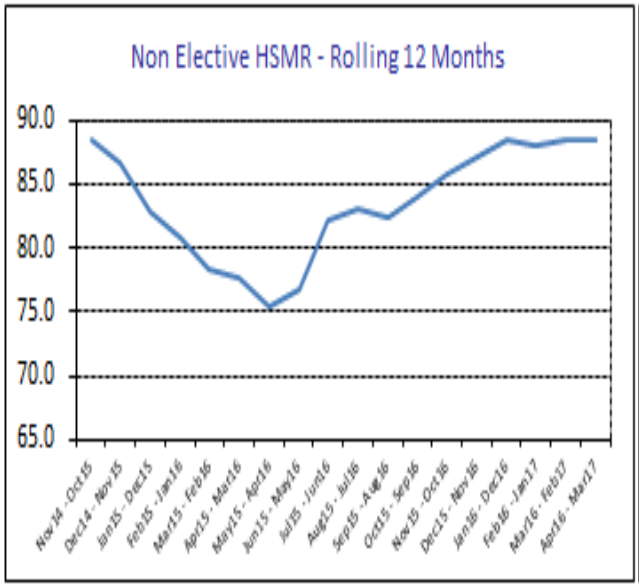
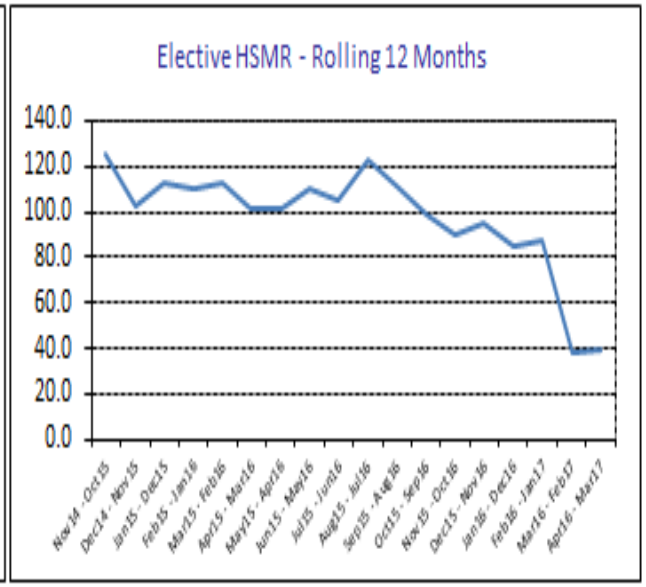
- Continued sharing of the results across the specialty in team meetings
- Communication by email of the results across the specialty
- Displaying of the results within the department.
- Continued reporting and discussion of the results in the Obstetrics and Gynaecology Governance meeting and the Trust Safer Surgery Pathway group.
- Targeted follow up for the Midwives from the Head of Midwifery and follow up for the Medical Staff from the Consultant leads.

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

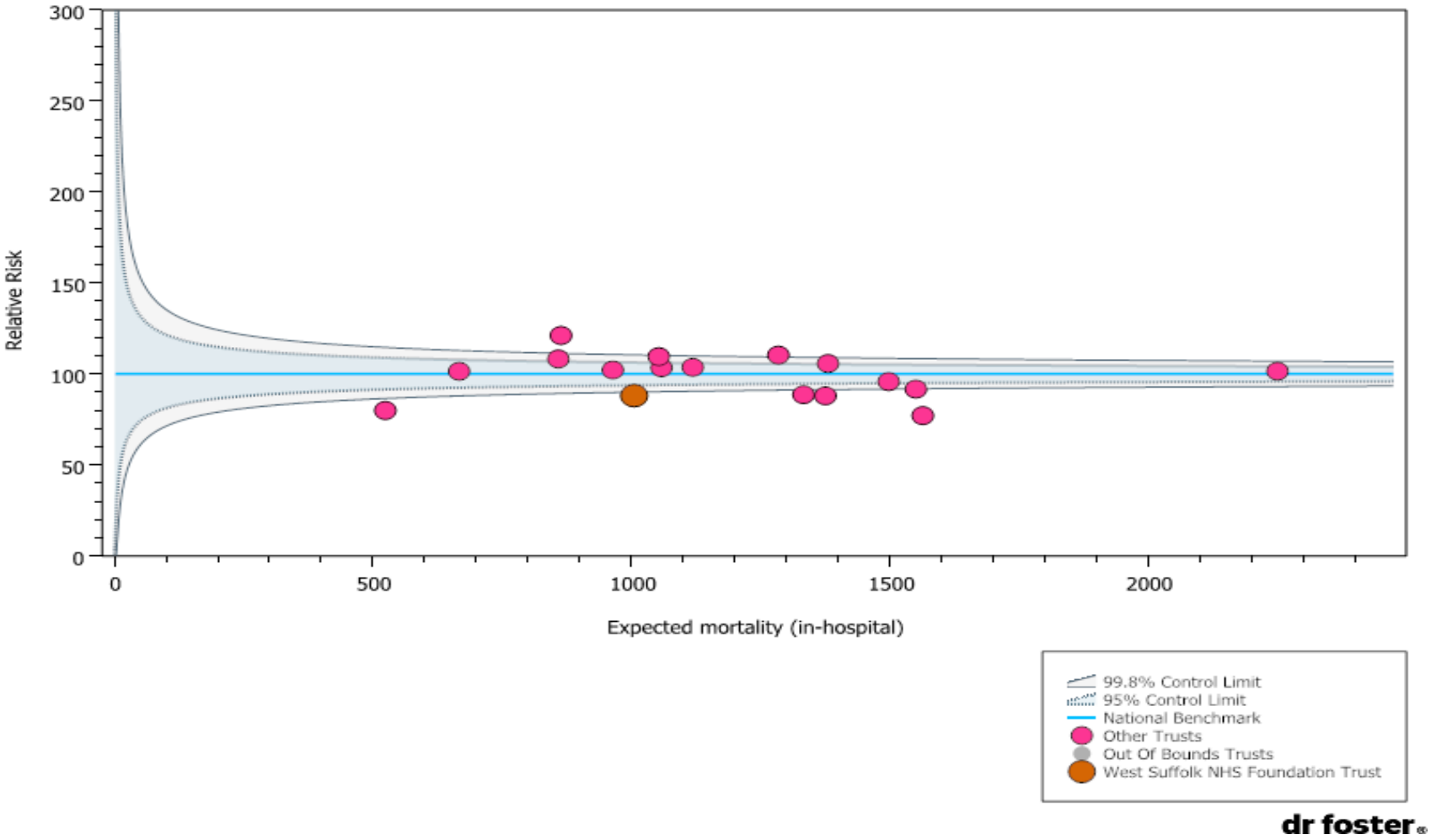
2. MORTALITY HSMR AND SHMI DATA

Mortality (Individual Months)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
No of Deaths	77	55	72	85	78	77	69	80	122	134	105	84
No of Discharges	5,153	5,026	5,072	5,493	4,921	5,298	5,642	5,269	5,313	5,311	4,838	5,360
% Deaths	1.49%	1.09%	1.42%	1.55%	1.59%	1.45%	1.22%	1.52%	2.30%	2.52%	2.17%	1.57%
HSMR*	82.1	71.1	83.4	107.2	106.7	94.9	78.1	94.4	104.9	106.5	108.6	86.7
Mortality (Individual Months)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
No of Deaths	79	73	70	55	70	52	67	73	78	109	91	84
No of Discharges	5,032	5,209	5,273	5,730	5,188	5,483	5,637	5,568	5,402	5,375	5,439	5,725
% 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	5,427	5,691	5,410	5,400	5,674	5,733	5,950	5,401	5,577	5,426	6,444
% Deaths	1.33%	1.60%	1.25%	1.07%	1.37%	1.45%	1.45%	1.65%	1.89%	1.85%	1.82%	1.47%
HSMR*												
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
No of Deaths	72	69	71									
No of Discharges	5,378	5,742	5,661									
% Deaths	1.34%	1.20%	1.25%									
HSMR*												

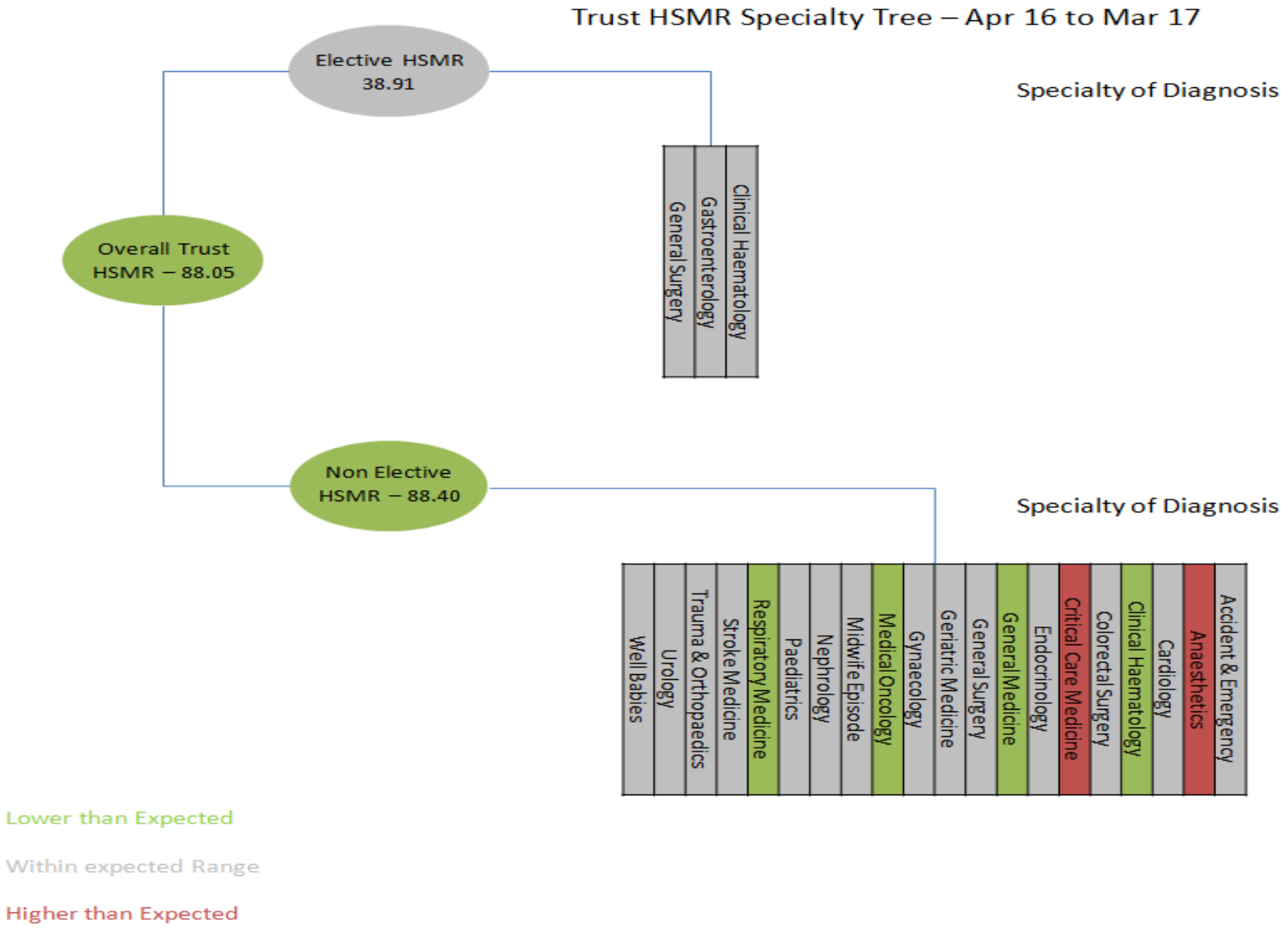
HSMR BENCHMARK IS USING FY 15 -16

	Overall	Non-Elective	Elective
SHMI			
HSMR			

HSMR – Apr 16 - Mar 17



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


Trust HSMR Specialty Tree – Apr 16 to Mar 17
Elective HSMR 38.91
Specialty of Diagnosis
Clinical Haematology
Gastroenterology
General Surgery
Overall Trust HSMR – 88.05
Non Elective HSMR – 88.40
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. NHS IMPROVEMENT'S SINGLE OVERSIGHT FRAMEWORK

NHS Improvement's single oversight framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

NHS Improvement's Single Oversight Framework						April	May	June
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%	83.36%	81.77%	1.0	Helen Beck	82.23%	79.71%	83.36%
Number of RTT Waits over 52 weeks for incomplete pathways	0	15	44	-	Helen Beck	15	14	15
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	95.53%	95.12%	1.0	Helen Beck	95.20%	94.66%	95.53%
All cancers: 62-day wait for first treatment (5) from:Urgent GP referral for suspected cancer - **See Further detail below**	85%	84.76%	85.79%	1.0	Helen Beck	89.47%	83.47%	84.76%
All cancers: 62-day wait for first treatment (5) from: NHS Cancer Screening Service referral	90%	90.00%	97.56%		Helen Beck	100.00%	100.00%	90.00%
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%	100.00%	100.00%	0.5	Helen Beck	100.00%	100.00%	100.00%
Cancer: two week wait from referral to date first seen (8), comprising: all urgent referrals (cancer suspected)	93%	96.59%	94.20%	0.5	Helen Beck	93.90%	92.27%	96.59%
Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)	93%	88.80%	94.50%		Helen Beck	94.02%	99.28%	88.80%
Outcomes:								
Clostridium (C.) difficile - meeting the C.difficile objective - MONTH	2	0		1.0	Rowan Proctor	3	0	0
Clostridium (C.) difficile - meeting the C.difficile objective - QUARTER	4		3		Rowan Proctor			
Clostridium (C.) difficile - meeting the C.difficile objective - ANNUALLY	16		3		Rowan Proctor			
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	-	-	0.5	Rowan Proctor			

West Suffolk NHS Foundation Trust Cancer Waits Performance Report - May 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	9		9	100	93.2
Gynae	2+3x.5		3.5	100	78.1
Haem	1	1x.5	1.5	66.7	78.8
Head & Neck	3	2	5	60	65.4
Lower GI	5	1	6	83.3	68.4
Lung	3+1x.5		3.5	100	72.2
Other	2		2	100	77.3
sarcoma				100	81.2
Skin	7	1	8	85.7	96.1
Upper GI	5		5	100	72.6
Urology	11+1x.5	5+1x.5	17	67.6	75.2
Total	48+5x.5	9+2x.5	60.5	83.47	80.8

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

a) Current Position

83.36% against a threshold 92%

The June position again reflects a true position rather than an estimated position as advised by NHSI IST (Intensive Support Team) following their visit The position has improved from May's performance of

79.71% and the team continue to work through validation and data quality issues, however this is now a business as usual process.
There remains on-going and significant capacity issues within ENT, Vascular, Urology, Dermatology, with patients waiting over 35 weeks for first OPA in ENT, although this is an improved position from a previous 40 weeks. Significant pressure remains in rapid access referrals in Dermatology which is also impacting routine activity in this service.

b) Recommended Action
Detailed action plans for each of the all specialties with RTT and capacity issues have been developed and further validation work of the new PTL continues in all areas. Recruitment is underway for an access manager to cover RTT, cancer and diagnostic performance standards. An initial meeting with the IST has been held from which a plan is being developed to address capacity and demand analysis and also undertake a sustainability assessment addressing organisational capability.

3.2 Number of RTT waits over 52 weeks for incomplete pathways

a) Current Position
15 against a threshold of 0

There were 15 52 week breaches for June 8 of which are linked to patient choice. The breaches include 9 ENT, 2 general surgery, 1 Ophthalmology, 1 T&O, and 2 Urology. Of these 4 will be treated in July, 1 remains subject to further decision making following diagnostic tests, 1 has been transferred to active monitoring, 5 have dates for admission in August and the remaining 4 have dates for admission in September. Patient choice is driving the non ENT related delays

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

3.3 All Cancers: 62 day wait for first treatment (5) from: Urgent GP referral for suspected cancer

a) Current Position
84.76% against a threshold of 85%

6 local breaches to report in June (provisional data) :

Breast - day 78 - surgery treatment delayed as time required to dental abscess, as potential risk of infection following cancer surgery, this was unavoidable medical condition.

Colorectal – day 67 - surgery, as CT broke down on the day of original scan delayed staging investigation to complete for a treatment plan to discuss and agree with the patients. It's was a technical failure difficult to predict and prevent.

Urology - day 193 - surgery, there was significant comorbidity requiring medical work up and there was significant MDT and SMDT review as well at Addenbrookes, surgery took place on 30/06, and RCA is currently with the team including for Clinical Harm review.

Urology – day 114 - Active monitoring, a case of very unlikely prostate ca, and delay in Perineal template biopsy, and patient on active monitoring. RCA with the relevant Clinician and the team including for clinical harm, but is unlikely to have any harm on monitoring patient.

Urology – day 102 - Hormones – patient not available for a period during diagnostic pathway primarily delaying histological confirmation of prostate ca from the Perineal Template biopsy.

Urology – day 78 – hormones, Pathway issues with tissue diagnosis and results.

Shared breaches:

Urology - day 134 - delay in diagnostics in a patient with incidental findings of raised PSA, suspicious MRI and delay in getting tissue diagnosis following transperineal template biopsy. Patient decided to go for Surgery.

H/N - day 106 - delay in diagnosis and April bank holiday also did not help, and referred to Addenbrookes with only metastatic lesion as no primary was found. They treated patients as CUP, and not H/N cancer. RCA for the local part of the pathway is currently with ENT cons and have also asked them to confirm whether delay in referral resulted in any clinical harm.

H/N day 76 - delay internal referrals between ENT and Skin before a decision to refer for MOHs surgery at N&N was made, for the best interest of patient. RCA with the team for review and comment on the part of the local pathway.

Lung – patient referred on time but FDT details awaited from the treating Papworth hospital. A complex case with Royal free also involved in the care pathway. From the Papworth MDT returns, this patient had a chest surgery on 16/06 June, but FDT is yet to be reported.

b) Recommended Action
Urology service to review their turnaround times with a view to reduce waiting times between each events in the pathway and to consider the best time in the pathway for MDT review.
There is a need to enhance Transperineal biopsy capacity urgently.

Breast and colorectal breaches were unavoidable.

3.4 Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)

a) Current Position
88.80% against a threshold of 93%
Unexpected sickness absence of a key member of staff in the early part of the month impacted on limited capacity to see patients and also required cancellation of booked patients.
The Trust is reporting above 94% performance on this standard for the quarter.

b) Recommended Action
The key member of staff is now well and back to work and there is evidence that the service is recovering this performance in July.
Owing to the on-going increase in demand, the service is continuing to run extra clinics every week. There is a plan to increase the Breast Specialist Doctor hours from September.

3.5 104 day Cancer waits

a) Current Position
4 against a threshold of 0
In June there were two Urology patients who were treated past 104 days locally. Currently, Cancer Breach RCA timelines with a request for clinical harm review is with the relevant clinician and they have been asked to confirm this and, if a harm was noted, to follow the Trust Governance process by reporting the incident to DATIX.
There were also 2 Shared patients treated in June – one Urology and one originally referred to H/N but treated for unknown primaries. Cancer breach RCA timelines have gone out to the relevant Clinician and the team to review the part of the local pathway and confirm if the local delay resulted in clinical harm.

b) Recommended Action

We are routinely reporting the status and update on all 104 days or beyond open pathway patients weekly.

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	Apr	May	Jun	Change mth on mth	On Plan To Achieve	Area of Concern	Forecast to Breach
A&E						Apr	May	Jun				
A&E Time to treatment in department (median) for patients arriving by ambulance - CDM	Median time to treatment above 60 minutes	52	43		Helen Beck	35	43	52	↘			
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	10:10	13:57	No medical bed available at point of transfer.	Helen Beck	09:57	13:57	10:10	↗			
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%	30.80%	31.07%		Helen Beck	31.76%	30.69%	30.80%	↘			
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%	91.74%	91.66%		Helen Beck	92.96%	91.10%	91.74%	↗			
A&E - Ambulance Handovers above 30 minutes	0 handovers over 30 minutes - £200 per breach	ND	59		Helen Beck	21	38	ND				
A&E - Ambulance Handovers above 60 minutes	0 handovers over 60 minutes - £1000 per breach	ND	19		Helen Beck	3	16	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%	92.86%	91.31%		Helen Beck	94.12%	86.96%	92.86%	↗			
RTT												
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks	99.00%	94.04%	92.52%		Helen Beck	92.63%	91.04%	94.04%	↗			
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90.00%	70.32%	69.13%		Helen Beck	69.22%	67.84%	70.32%	↗			
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.00%	87.34%	86.81%		Helen Beck	86.15%	86.95%	87.34%	↗			
Stroke												
% of patients scanned within 1 hour of clock start	77% (Contract) 57.5% (Upper Quartile)	72.09%	79.56%		Helen Beck	86.67%	79.59%	72.09%	↘			
% of patients scanned within 12 hours of clock start	96% (Contract) 96% (Upper Quartile)	95.35%	97.08%		Helen Beck	97.78%	97.96%	95.35%	↘			
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75% (Contract) 70% (Upper Quartile)	76.19%	78.68%		Helen Beck	88.89%	71.43%	76.19%	↗			
>80% treated on a stroke unit >90% of their stay	90%	88.10%	91.04%		Helen Beck	97.67%	87.76%	88.10%	↗			
% of patients treated by a stroke skilled early supported discharge team	48% (Contract) 48% (Upper Quartile)	75.00%	56.48%		Helen Beck	50.00%	47.50%	75.00%	↗			
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80% (Contract) 79% (Upper Quartile)	95.35%	91.24%		Helen Beck	93.33%	85.71%	95.35%	↗			
% 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)	90.24%	85.60%	INDICATION ONLY - FINAL SSNAP LEVEL AVAILABLE WHEN RESULTS ARE AVAILABLE FROM SSNAP	Helen Beck	87.18%	80.00%	90.24%	↗			
% of eligible service users given thrombolysis	100% (RCA to be provided for breaches)	100.00%	100.00%		Helen Beck	100.00%	100.00%	100.00%	↔			
All stroke survivors to have a 6 month follow up assessment.	50%	ND	58.00%		Helen Beck		58.00%		-			
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	C	Reports are generated by SSNAP every 4 months - this is as at March 2017, reported for June Board	Helen Beck		C		-			
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	TBC	98.25%	Outstanding report issues with Discharge Summaries which are currently being investigated.	Nick Jenkins	98.13%	98.35%	TBC	-			
Discharge Summaries - Inpatients	95% sent to GP's within 1 day	93.40%	92.91%		Nick Jenkins	91.98%	93.29%	93.40%	↗			
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	1.05%	0.75%		Helen Beck	0.62%	0.56%	1.05%	↘			
Patients offered date within 28 days of cancelled operation	100%	93.10%	93.33%		Helen Beck	93.33%	93.75%	93.10%	↘			
No urgent operation should be cancelled for a second time	0 2nd Urgent Cancellations	0	0		Helen Beck	0	0	0	↔			
Maternity												
Access to Maternity services (VSB06)	90% of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy.	97.54%	95.94%		Rowan Procter	94.71%	95.42%	97.54%	↗			
Maintain maternity 1:30 ratio	1:30	01:29	01:28		Rowan Procter	01:30	01:27	01:29	↘			
Pledge 1.4: 1:1 care in established labour	1:1	100%	100.00%		Rowan Procter	100.00%	100%	100%	↔			
Breastfeeding initiation rates.	80%	87.50%	82.65%		Rowan Procter	79.81%	80.53%	87.50%	↗			
Reduction in the proportion of births that are undertaken as caesarean sections.	22.70%	15.87%	17.18%		Rowan Procter	15.02%	21.05%	15.87%	↗			

Other contract / National targets												
Mixed Sex Accomodation breaches	0 Breaches	0	0		Helen Beck	0	0	0	↔			
Consultant to Consultant referral	Commisioner to audit if concern about levels of consultant referrals	9.72%	9.75%	Revised in line with Finance.	Helen Beck	9.98%	9.59%	9.72%	↘			
MRSA - emergency screening	100% Screened within 24 hours	TBC	TBC	Figures will be available once MRSA report is finalised following Order Comms go-live.	Rowan Procter	TBC	TBC	TBC	-			
MRSA - Elective screening	100% Screened prior to admission		TBC		Rowan Procter	TBC	TBC	TBC	-			
Rapid access - chest pain clinic	100% of patients should have a maximum wait of two weeks	100.00%	99.31%		Helen Beck	100.00%	97.94%	100.00%	↗			
Acute oncology service: 1 hour to needle from diagnosis of neutropenic sepsis	100%	100.00%	91.67%	MacMillan	Helen Beck	66.67%	100.00%	100.00%	↔			
		41.67%	47.06%	ED	Helen Beck	71.43%	40.00%	41.67%	↗			
		63.16%	100.00%	Overall Trust (Inc AMU)	Helen Beck	63.64%	47.06%	63.16%	↗			
New to Follow up	Thresholds set at each speciality - overall Trust Threshold is 1.9	1.97	1.90	Revised in line with Finance.	Helen Beck	1.86	1.87	1.97	↘			
Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test	99%	100.00%	99.91%		Helen Beck	99.86%	99.87%	100.00%	↗			
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 longest stay patient was triaged appropriately within 4 minutes of arrival, with a clinical decision maker seeing the patient by 2 hours, the patient then awaited investigational results and was referred to the medical team by 3 hours. This patient was drowsy and required a CT head prior to awaiting a medical bed, there then was a bed delay. The Trust capacity status was black on both the 12th and the 13th of June, being the admission and transfer day.

b) Recommended Action

See above.

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

a) Current Position

30.80% against a threshold of 27%
Acuity of ED was higher than average due to a heat wave at the end June, therefore patient admissions were very slightly higher than in May.

b) Recommended Action

Acuity of ED was higher than average due to a heat wave at the end June, therefore patient admissions were very slightly higher than in May.
Admission avoidance work continues. High ED user project work in place, focusing on reviewing our Mental Health patients.
GP streaming to go live by October 2017.

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

94.04% against a threshold of 99%.

There are on-going significant capacity issues within the ENT, Vascular, Urology, and Dermatology services. Patients are waiting 35+ weeks for first OPA in ENT, and patients waiting over 30 weeks for Surgery within Urology and 35 weeks for Vascular. There remains significant pressure on rapid access referrals in Dermatology.

b) Recommended Action

Detailed action plans for each of the above specialties are being developed with CCG input where appropriate. Validation work continues to support the data quality of the PTL.

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

a) Current Position
70.32% against a threshold of 90%.

b) Recommended Action
Patients continue to be treated in longest waiting order, validation work continues to identify some patients who have breached 18 weeks and it therefore appears that more patients who have already breached 18 weeks are being treated. New PTL and proactive manual validation continues to provide a clearer picture of the waiting times.

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

a) Current Position
87.34% against a threshold of 95%.
This continues to be predominantly due to excessive waits for first appointment in both ENT and Dermatology.

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

4.6 Stroke: % of patients admitted directly to Stroke Unit within 1 hour of clock start

a) Current Position
72.09% against a threshold of:
77% (Contract)
57.5% (Upper quartile)

b) Recommended Action
Twelve patients breached this standard. Six were themed as arriving out of hours – awareness to be raised at the Emergency Department Operational Group meeting
Six patients were themed as not receiving pre-alerts from EEAST – General Manager will establish any changes in workflows within EEAST

4.7 Stroke: % of patients admitted directly to Stroke Unit within 12 hours of clock start

a) Current Position
95.35% against a threshold of:
96% (Contract)
96% (Upper quartile)

b) Recommended Action
One patient was not thought to be a stroke and one patient was an in-patients stroke – ESOT to promote awareness on in-patient wards.

4.8 Stroke: >80% treated on a Stroke Unit >90% of their stay

a) Current Position
88.10% against a threshold of 90%

b) Recommended Action
A total of five patients beached this standard. One was not thought to be a stroke and two there was a delay to be seen, one awaiting CT & one pending referral to Addenbrookes. Three of the five did not go to the Stroke Unit. The Service Manager will raise awareness at the Emergency Department Operational Group meeting.

4.9 Provider cancelation of Elective Care operation for non-clinical reasons either before or after patient admission

a) Current Position
1.05% against a threshold of 1%

b) Recommended Action
In June there were 47 cancellations for non-clinical reasons which is a slight increase on the previous month's performance. There are a range of recorded reasons including 8 patients who DNA but the prevailing reason for the increase in cancellations was recorded as 'running out of theatre time'. This was not specific to any particular speciality and will be monitored to identify any emerging trends

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4.10 Patients offered date within 28 days of cancelled operation

b) Current Position
93.10% against a threshold of 100%
This represents two ENT patients who were unfortunately cancelled due to running out of theatre time on the day of surgery.

b) Recommended Action
One patient was admitted for surgery on the 10/07/17 and the second patient has been rebooked for the 15/08/17.

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

a) Current Position
Macmillan – 100%
ED - 41.67%
Overall Trust figure of 63.16% against a threshold of 100%

b) Recommended Action
The performance figure for 1 hour to needle from diagnosis of neutropenic sepsis June Data showed that the Macmillan unit and AMU had no breeches during May, but the Emergency Department had 7 neutropenic sepsis patient breeches. The breech cases will be undergoing detailed review. These issues will be escalated to the Emergency Department Clinical and Nursing management to address within the department.

4.12 New to follow up

a) Current Position
1.97 against a threshold of 1.9

c) Recommended Action
There has been a slight increase in the new: follow up ratio this month. This may be due to expediting treatment of long waiting patients as a result of work to manage the RTT position. At this stage this metric will be monitored with no specific action.

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	June	Comments
Workforce			
Sickness absence rate	<3.5%	3.61%	
Turnover	<10%	10.30%	
Reviews	Grievance/Banding reviews	5	Includes 1 employment tribunal
Recruitment Timescales	Average number of weeks to recruit = 7	5	
DBS Checks	To complete 95% of required DBS checks	98.50%	
All Staff to have an appraisal	Both general and consultant staff each have a target of 90% to have had an apprasial within the previous 12 months. Appraisal is a rolling programme	ND	Appraisal figures are currently not available due to HR system issues.

5.1 Sickness Absence Rate

a) Current Position

3.61% against a threshold of <3.5%.

b) Recommended Action

Sickness absence decreased again slightly. HR will continue to monitor and report sickness absence to managers.

5.2 Turnover

a) Current Position

10.30% against a threshold of <10%.

b) Recommended Action

Turnover has remained static. 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

Welcome to the community contract report for June. This month we would like to highlight the following:

- Our FFT for April was 97% from 302 responses. There were 4 ‘unlikely’ to recommend responses, see page 5 of the patient experience report for the detail.

- We received 3 formal complaints in June, 1 for a Community Health Team relating to timely access to treatment and access to supportive equipment, 1 for communication of condition and attitude of a specialist nursing service and post op treatment in the Foot and Ankle service. See page 10 of the patient experience report for more detail.

- The number of patients whose discharge was delayed during June has decreased to 52 from 70 in May.

- The waiting times and numbers waiting for paediatric SLT community clinic service has increased for children waiting over 4 months. The waiting times for the schools service has remained fairly static, although these numbers will increase from now on as schools will close at the end of July, meaning those on the waiting list will not be seen until September at the earliest. The additional locum support will also cease in September.

- Adult SLT had 14 breaches in their ‘seen within 20 days’ category. 12 were seen within 25 days and 2 within 27 days. #

- The Community Equipment Service achieved all of their 8 KPIs.

- The Children in Care Service has made a slight improvement with health assessments offered and seen within 28 days, but continues to experience challenges with receiving notification of children in a timely way, which delays assessments for some children.

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**June 2017**	**June Comments / Queries 2017**	**Apr 2017**	**May 2017**
SCH		**D4-qoc1**	Number and % of service users who rated the service as 'good' or 'better'.	85%	Quarterly report from Provider	98.20%			
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'better'.	85%	Quarterly report from Provider	93.63%			
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'well informed'.	85%	Quarterly report from Provider	95.50%			
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	99.80%		99.93%	99.79%
SCH		**D5-acc8**	18 week referral to treatment for Consultant led services Inpatient rules - Foot and Ankle Outpatient rules - Paediatrics (E&W)	95% patients to be treated within 18 weeks	Monthly report from Provider	99.53%		99.40%	98.32%
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	96.10%		94.81%	95.30%
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	1.60%			
SCH	Safeguarding - children	**c-safe1**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.94%		96.11%	96.41%
SCH	Safeguarding - adults	**c-safe2**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.77%		96.02%	96.24%
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	97.78%		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	0.36		N/A	N/A
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	96.30%	26 out of 27 patients had a management plan agreed with them within 24hours of admission. One patient in Aldeburgh was admitted Saturday 18:15 and had a plan agreed with them on Monday at 12:50.	100.00%	100.00%
IHT		**D2-ltc4**	% of people with COPD who accept a referral to a pulmonary rehabilitation programme who complete the prescribed course and are discharged within 18 weeks of initial referral by a GP/health professional.	95%	Monthly report from Provider	91.89%	3 out of 37 patients breached due to reduced class frequency due to high levels of staff sickness	95.45%	96.30%
IHT	CCC	**D4-int1**	Care coordination centre - % of telephone calls answered within 60 seconds	95% in 60secs	Monthly report from Provider	95.53%	# of calls handled: # of calls answered in 0-60 seconds: **% 0-60 seconds: %** Number of abandoned calls: Abandoned calls %: % Average Wait Time: seconds	96.93%	95.78%

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**June 2017**	**June Comments / Queries 2017**	**Apr 2017**	**May 2017**
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	67 offered		60 offered	72 offered
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses completed	At least 250 courses completed per year	Monthly report from Provider	37 completed		20 completed	27 completed
IHT	COPD	**s-copd5**	Community pulmonary rehabilitation - review offered 6 months after completing the course	95%	Monthly report from Provider	97.30%		100.00%	100.00%
IHT	Comm Continence	**s-cc3**	% of Service Users re-assessed at 6 weeks	98%	Monthly report from Provider	no longer reporting as of November 16		no longer reporting as of November 16	no longer reporting as of November 16
IHT	Comm Continence	**s-cc4**	% of Service Users re-assessed at 12 monthly intervals (previously 6 monthly intervals)	98%	Monthly report from Provider	100.00%		99.65%	100.00%
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 = 100.00%		#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	98.61%			
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%			
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	100.00%			
IHT	MIU	**s-miu5**	Total time spent in A+E department 95% of Service Users waiting less than 4 hours for admitted Service Users and with the same threshold for non-admitted measured over each Quarter rather than monthly (or, where the Quarter does not begin on 1 July, measured over each three-month period beginning on 1 July)	95%	Monthly Secondary Uses Services (SUS) data, A&E Commissioning data set (CDS)	100.00%		100.00%	100.00%
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	98.26% (169/172)		100% (199/199)	99.44% (179/180)
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	99.52% (1042/1047)		98.68% (598/606)	99.14% (921/929)
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	99.55% (2441/2452)		99.74% (1923/1928)	99.82% (2185/2189)
Mede	CES	**c-gen8**	Within 10 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider	99.52% (625/628)		98.37% (423/430)	99.80% (508/509)
Mede	CES	**c-gen9**	Collection times: % of urgent next day collections for deceased Service Users	98% for all standards	Monthly report from Provider	100% (263/263)		99.00% (198/200)	96.37% (239/248)
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	99.61% (513/515)		100.00% (402/402)	99.01% (301/304)
Mede	CES	**c-gen9**	% 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	98.68% (5154/5223)		99.17% (4674/4713)	98.45% (5014/5093)
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%		100.00%	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	N/A
Mede	Wheelchair	**s-wchair1**	Medium Priority	within 12 weeks 100%	monthly report from provider	N/A		N/A	N/A
Mede	Wheelchair	**s-wchair1**	Low Priority	within 18 weeks 100%	monthly report from provider	92.86%	1 out of 14 patients not seen within 18 weeks - Patient cancelled appointment	100.00%	100.00%
NCHC		**D2-ltc2-a**	% of people that have been identified by case finding, (using risk stratification, or other means), and deemed suitable for intervention by the MDT, and referred to SCH, that have a care lead.	95%	Monthly report from Provider	100.00%		100.00%	100.00%

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**June 2017**	**June Comments / Queries 2017**	**Apr 2017**	**May 2017**
NCHC		**D2-ltc2-b**	% of people identified via case finding, that have a care plan (including self-care) that has been shared with the GP practice within two weeks of the patient coming onto the caseload. The GP practice will require a copy of the care plan, and the information will be shared with the MDT, which includes a GP. For clarity, the definition of an MDT is; 'A virtual or real team of health and care practitioners, who could be, or are involved in patient's care. An MDT does not necessarily mean a physical meeting.'	95%	Monthly report from Provider	N/A		N/A	N/A
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	99.42%		98.13%	99.03%
NCHC		**D5-ccc7**	Intermediate - 72 hrs	Intermediate - 95%	Monthly report from Provider	98.28%		98.44%	98.30%
NCHC		**D5-ccc7**	18 weeks	18 weeks - 95%	Monthly report from Provider	99.77%		99.77%	99.67%
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. % of link GP practices and Community Health Team Leads who feel that they have a 'positive working relationship' with each other. A joint action plan is expected to be maintained All link GP Practices and respective CHT leads to be surveyed quarterly, moving to six monthly at an agreed point	80%	Quarterly report from Provider				
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	IDPT	**s-disch1**	Triage and assessment of referrals within 1 Operational Day	98%	Monthly report from Provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
NCHC	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	N/A		100.00%	0.00%
NCHC	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
NCHC	EAU CIS	**eau-cis-IHT**	% of patients seen within 2 hrs. of initial referral. The Senior Nurse (part of the CIS) allocated to the EAU at IHT will begin patient assessment within 2 hrs of consultant referral.	98%	monthly report from provider	N/A		N/A	N/A
NCHC	Verification of expected death training	**c-gen2**	Number of qualified nursing staff trained in Service User areas, community nursing teams and local Healthcare teams (to include all clinical staff from within planned care, urgent care, & intensive case management as the integrated service model is implemented)	90%	Monthly report from provider				
WSH	Adult SALT	**s-salt1**	All new referrals are triaged within 5 Operating Days of receipt of referral;	98%	Monthly report from Provider	100.00%		99.21%	99.37%
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	80.00%	This relates to 14 out of 71 referrals, 12 patients were seen within 25 days and 2 were seen on day 27.	100.00%	85.00%
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%

Host	Service	Technical Reference	Quality Requirement	Threshold	Method of Measurement	June 2017	June Comments/ Queries 2017	Apr 2017	May 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 pledge 2 reporting by Children's Service	98.61%		97.48%	95.83%
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 by Children's Service	99.01%		99.53%	98.92%
WSH	All Paediatric Services	**PaedSLT-4**	All Children to have a Personal Health plan completed where required.	100% Service Users offered a PHP 80% completed a PHP	Monthly report from provider by Children's Service	100.00%		100.00%	100.00%
WSH	All Paediatric Services	**D4-qoc1 D4-qoc2 GP-4**	Quarterly Service User satisfaction surveys based on Suffolk Community Healthcare's processes prior to Effective Start Date. Number and % of service users who rated the service as "good" or better	85%	Quarterly report from provider	Now included in the Patient Experience		Now included in the Patient Experience	Now included in the Patient Experience
WSH	All Paediatric Services	**D4-qoc1 D4-qoc2 GP-4**	Number and % of service users who responded that they felt "supported" and "well informed".	85%	Quarterly report from provider	Now included in the Patient Experience		Now included in the Patient Experience	Now included in the Patient Experience
WSH	All Paediatric Services	**GP-6**	Safeguarding - % eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	monthly report by provider	99.08%		99.53%	100.00%
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		**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	99.59%		98.96%	98.80%
WSH	Newborn Hearing Screening Service (West)	**NBHS-3**	Screening outcomes set within 3 months	≥99%	Monthly Activity Report	99.18%		98.19%	98.72%
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				
WSH	Therapy Focus Suffolk	**TFS-6**	All relevant staff that have been 'Bobath' update trained	100%	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%	Quarterly				
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				
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				
WSH	Access	**cps-a02**	Children/young people in special schools receive speech and language interventions	100%	Systmone	100% 180 contacts		100% 131 contacts	100% 270 contacts
WSH	Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	Systmone	100% 156 contacts		100.00% 91 contacts	100.00% 139 contacts
WSH	Children in Care	**CiC-001c**	Initial Health Assessment appointments that are OFFERED within 28 days of receiving ALL relevant paperwork	100% in 28 days	Monthly report from Provider	85.00%	17 out of 20 children who had an IHA in June were offered their 1st appt within 28 days of the service being made aware of the child. The 3 IHAs offered outside the 28 days were all within 33 days.	47.06%	83.33%
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	80.00%	16 out of 20 children had their IHA completed within 28 days of the service being made aware of the child. Of the 4 appts outside the 28 days: - initial date declined to due child sitting GCSEs - the family carer was attending CiC review - foster carer cannot drive so could only attend appts in Ipswich - would like only like an appt Tuesday or Thursday in Ipswich	35.29%	72.22%
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	25.00%	Of the 16 IHAs completed outside 28days of the child becoming CiC, all 16 were delayed 11 days or more form the child becoming CiC and the service being made aware of the child. 8 referrals were delayed more than 20 days,7 were over 28 days. The longest was a notification delay of 1196 days from the child becoming CiC and the service being notified.	6.25%	0.00%

1 S-apcb6 – Step Up Admission Prevention Beds – All service users have a management plan agreed with them/family/carers within 24hours of arrival

a) Current Position
s-apcb6 – 96.30% against a 98% target

26 out of 27 patients had a management plan agreed with them within 24hours of admission. One patient was admitted Saturday 18:15 and had a plan agreed with them on Monday at 12:50.

b) Recommended Action
- To review the arrangements of out of hour admissions to ensure there is robust process in place 7 days a week.

2 D2-ltc4 – Pulmonary Rehabilitation service – Number of patients who accept a pulmonary rehabilitation course complete the course and are discharged within 18weeks

a) Current Position
D2-ltc4 – 91.89% against a 95% target

34 out of 37 patients completed and were discharged within 18weeks of the remaining 3 patients; all delays were due to reduced class frequency due to staff sickness. The service has been managing with a high level of sickness for many weeks (25-30% sickness with a team of 5.7wte) but this situation has now eased.

b) Recommended Action
- Team lead to implement process for matching staffing capacity with planned courses

3 S-wchair1 – Wheelchair – Low priority referrals to have 1st appt within 18weeks

a) Current Position
s-wchair1 – 92.86% against a 100% target

This relates to 1 out of 14 patients, this patient was seen 18weeks and 1 day after the referral was received by the service this breach was due to patient choice as the patient had cancelled a previous appointment date.

b) Recommended Actions
- To continue to ensure that appointments are offered within the 18 week timeframe

4 s-salt2 –Adult Speech and Language Therapy – Priority 2 referrals to be seen within 20days after triage

a) Current Position
s-salt2 - 80% against a 95% target

This relates to 14 out of 71 referrals, 12 patients were seen within 25 days and 2 were seen on day 27. This service has taken on an extra cohort of patients at the request of the commissioners for a trial 6 month pilot.

b) Recommended Actions
- Monitor the numbers of referrals and activity created by the new cohort of patients
- Explore locum resource to increase capacity temporarily
- Continue to deploy staff flexibly

5 **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-001c – 85.00% against a 100% target
CiC-001b – 80.00% against a 100% target
CiC -001a –25.00% against a 100% target

20 Initial Health Assessments were completed in June. 4 were completed within 28 days of becoming CiC, 16 were completed within 28 days of the service receiving ALL the paperwork and 17 appointments were offered within 28 days. There was a delay of greater than 20 days from the child becoming CiC and the service being notified for 8 of the 20 referrals which directly impacted on the statutory compliance target (7 of the referrals were delayed for greater than 28 days).

b) Recommended Action

- Associate Director has met with Social Care Manager last week. Social Care are working on improving systems to enable timely sharing of their information but this is not fully resolved as yet. Possible business case being considered to support increase in Social Work administrative support but also waiting for implementation of new Social Care information system (Liquid Logic).
  - Shared the Integrated Community Paediatric Services Children in Care Patient Tracking List and information dashboard which was agreed to be of benefit to share with Social Care. Agreed to do this monthly so that Social Care can validate their position.
  - Bi-Monthly meetings established to monitor pathway interface.
  - There are meetings being arranged to review the pathway for Children in Care with the commissioners, Suffolk County Council and the Executive Chief Nurse.

	Units	Target	Red	Amber	Green	Jan	Feb	Mar	Apr	May	Jun
Patient Experience											
Service users who rated the service as 'good' or 'better' (Quarterly)	Nos.	No Target						1195			1528
	%	85%	<80%	80%-85%	>=85%			97.00%			98.20%
Service users who responded that they felt 'better'	Nos.	No Target				141	158	137	132	145	397
	%	85%	<80%	80%-85%	>=85%	96%	96%	93%	94%	93%	93.63%
Service users who felt 'well informed'	Nos.	No Target				182	200	177	198	159	509
	%	85%	<80%	80%-85%	>=85%	96%	91%	94%	96%	94%	95.50%
10% of long term condition patients feel "better supported" to self manage their conditions (Quarterly)	Nos.	No Target									104
	%	No Target									93.69%
Falls (Inpatient Units)											
Total numbers of inpatient falls (includes rolls and slips)	Nos.	No Target				51	33	48	30	47	40
Rolls out of Bed		No Target				2	5	1	1	4	4
Slip out of chair		No Target				8	3	5	0	4	2
Assisted Falls/ near misses		No Target				0	3	6	1	4	1
% of total falls resulting in harm	%	No Target				31%	24%	23%	32%	23%	38%
Numbers of falls resulting in moderate harm	Nos.	No Target				0	0	1	0	0	1
Numbers of falls resulting in severe harm	Nos.	No Target				2	0	1	0	0	0
Numbers of patients who have had repeat falls	Nos.	No Target				11	7	8	6	9	8
% of RCA reports for repeat fallers	%	100%	90%-95%	95%-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	13.9	10.5*	13.8*	8.96	13.96	12.5
Pressure Ulcers											
Pressure Ulcers – In Our Care Community											
Grade 2		100 pa	>110	100-110	<=100	26	31	27	34	32	27
Grade 3		26 pa	>30	27-29	<=26	8	13	10	6	8	7
Grade 4		0 pa	>1	1	0	2	1	2	1	0	1
Pressure Ulcers – In our care In-patient											
Grade 2		13 pa	>17	13-17	<=13	2	3	4	0	3	3
Grade 3		2 pa	>4	02-Apr	<=2	1	1	0	1	0	0
Grade 4		0 pa	>1	1	0	0	0	0	0	0	0
Safeguarding People Who Use Our Services From Abuse											
Number of adult safeguarding referrals made		No Target				4	2	3	2	4	1
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				100%	100%	100%	100%	100%	100%

	Units	Target	Red	Amber	Green	Jan	Feb	Mar	Apr	May	Jun
MRSA											
Bacteraemia – Number of cases		0	>2	>0 to 2	=0	0	0	0	0	0	0
MRSA RCA reports		100%	<95%	95%-100%	=100 %	0	0	0	0	0	0
Clostridium Difficile											
C.Diff number of cases		4 for 6 months	>4 YTD		<=4 YTD	0	0	0	0	0	0
C.Diff associated diseases (CDAD) RCA reports		100%	<95%	95%-100%	=100 %	N/A	N/A	N/A	N/A	N/A	N/A
Infection Control											
Infection control training		100%	<83%	83%-100%	=100 %	89.87%	85.99%	89.70%	86.51%	91.80%	91.80%
Essential Steps Care Bundles Including Hand Hygiene											
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	98.00%	99.00%	98.00%	99.00%	99.00%	99.00%
Isolation room audit		100%	<95%	95%-100%	=100 %	N/A	N/A	100%	100%	100%	100%
Management of Medication -SCH NRLS Reportable Incidents											
Total number of medication incidents in month		No Target				23	18	25	19	17	18
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				23	16	20	15	12	13
(also includes those not attributed to SCH management)	Low harm	No Target				0	2	5	3	5	5
Number of medication incidents involving Controlled Drugs		No Target				0	7	5	1	0	2
Incidents											
NRLS (i.e. patient safety) reportable incidents in month		No Target				217	223	229	199	242	185
Number of Never Events in month		No Target				0	0	0	0	0	0
Number of Serious Incidents (SIs) that occurred in month		No Target				13	15	12	8	8	9
Number of SIs reported to CCG in month *4 STEIS for 2 pts (2 each)		No Target				13	17	17*	7	9	9
Percentage of SI reports submitted to CCG on time in month		No Target				100%	100%	100%	100%	100%	100%
Duty of Candour Applicable Incidents		No Target				13	13	16	8	9	9
Severity of NPSA Reportable Incidents											
None		No Target				140	122	145	131	163	108
Low		No Target				64	87	69	58	70	68
Moderate		No Target				9	13	11	8	9	8
Major		No Target				4	1	4	1	0	1
Catastrophic		No Target				0	0	0	0	0	0
Training Compliance											
Adult Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	97.04%	95.59%	96.74%	96.02%	96.24%	96.77%
Children Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	97.04%	95.86%	96.92%	96.11%	96.41%	96.94%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	94.62%	92.57%	94.34%	94.81%	95.30%	96.10%
WRAP						45.27%	51.73%	67.33%	64.48%	66.82%	69.19%
MCA / DoLs- Training compliance						69.76%	68.46%	67.33%	73.59%	82.33%	83.27%

Compliments/Complaints

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Total compliments	33	19	46	21	38	28	36	27	61	50	46	44	36
Formal complaints (No.)	**6**	**7**	**5**	**1**	**1**	**2**	**2**	**3**	**5**	**1**	**1**	**2**	**3**
Acknowledged within 3 working days (No.)	3	5	4	1	1	1	2	3	5	1	1	1	2
Acknowledged within 3 working days (%)	50%	71%	80%	100%	100%	50%	100%	100%	100%	100%	100%	50%	67%
Responded to within 25 working days (No.)	4	4	2	0	1	1	0	2	0	1	1	2	-
Responded to within 25 working days (%)	67%	57%	40%	0%	100%	50%	0%	67%	0%	100%	100%	100%	-
Responded to outside 25 working days (No.)	2	3	3	1	0	1	2	1	5	0	0	0	-
Responded to outside 25 working days (%)	33%	43%	60%	100%	0%	50%	100%	33%	100%	0%	0%	0%	-
Complaints upheld (No.)	2	4	2	1	-	-	-	1	2	1	1	1	-
Complaints partially upheld (No.)	3	3	2	-	-	-	-	-	3	-	-	-	-
Complaints not upheld (No.)	1	-	1	-	1	2	2	2	-	-	-	1	-
Average response time (days)	29.6	27.6	32.8	31.0	19.0	36.5	38.5	24.0	28.0	7.0	7.0	22.5	-

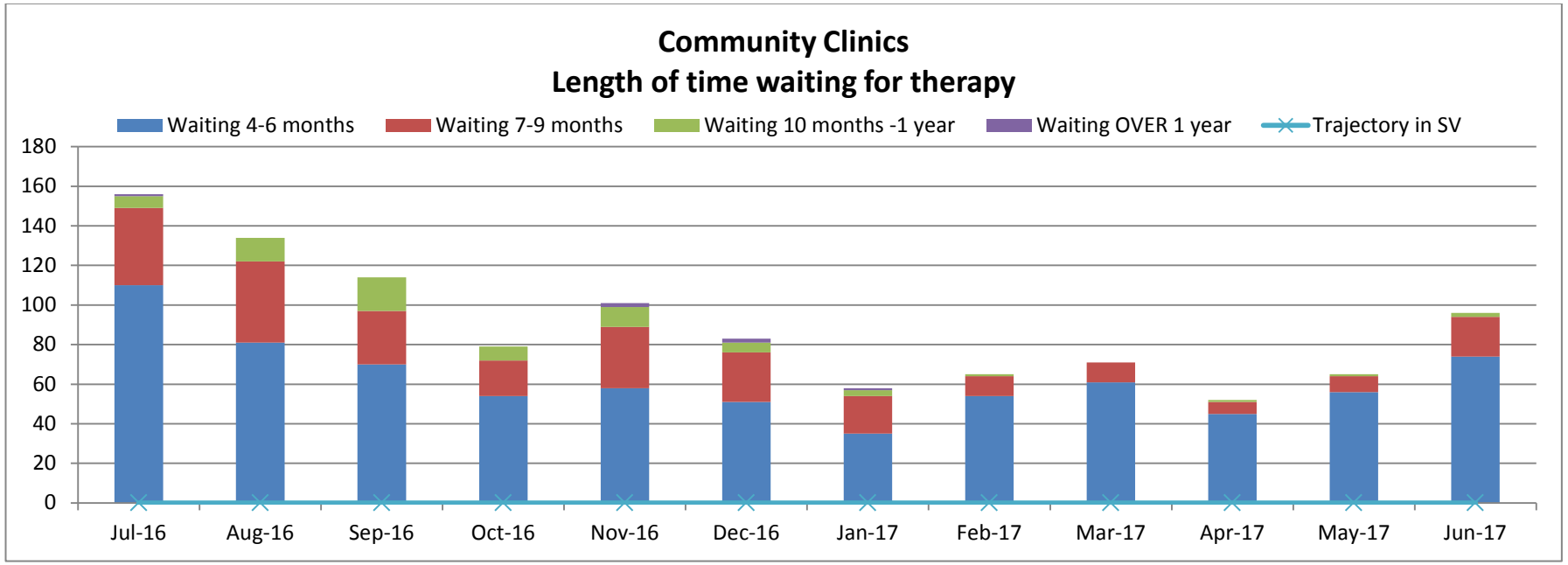
Paediatric Speech and Language Service Waiting times

Community Clinic

Clinic Waiting lists

Reports run 03/7/17

Length of wait Community Clinics *(pre-school caseload)*	No. of children waiting July 2016	No. of children waiting August 2016	No. of children waiting September 2016	No. of children waiting October 2016	No. of children waiting November 2016	No. of children waiting December 2016	No. of children waiting January 2017	No. of children waiting February 2017	No. of children waiting March 2017	No. of children waiting April 2017	No. of children waiting May 2017	No. of children waiting June 2017
Waiting up to 3 months	167	150	156	151	176	158	176	165	162	166	154	156
Waiting 4-6 months	110	81	70	54	58	51	35	54	61	45	56	74
Waiting 7-9 months	39	41	27	18	31	25	19	10	10	6	8	20
Waiting 10 months -1 year	6	12	17	7	10	5	3	1	0	1	1	2
Waiting OVER 1 year	1	0	0	0	2	2	1	0	0	0	0	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**323**	**284**	**270**	**230**	**277**	**241**	**234**	**230**	**233**	**218**	**219**	**252**
Already had PoC	119	97	72	75	67	72	55	60	85	53	51	73
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*	**442**	**381**	**342**	**305**	**344**	**313**	**289**	**290**	**318**	**271**	**270**	**325**

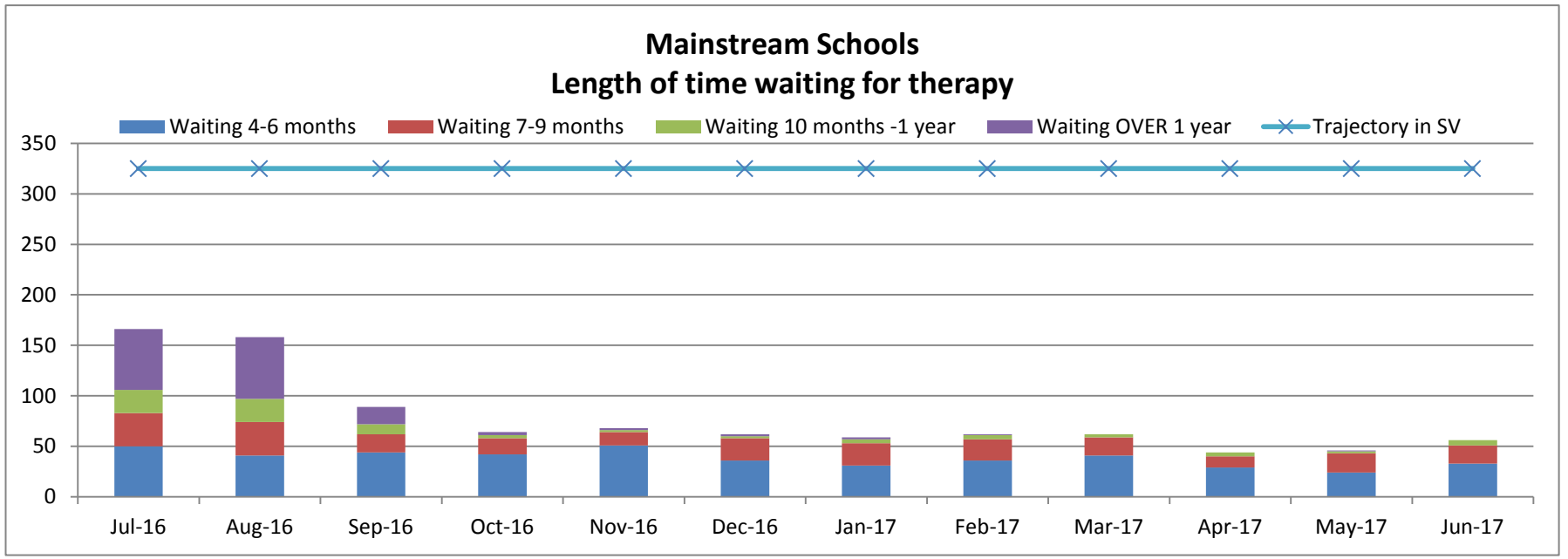


Mainstream Schools

Schools Waiting lists

No waiting data by months prior to May

Length of wait Mainstream Schools *(pre-school caseload)*	**No. of children waiting July 2016**	**No. of children waiting August 2016**	**No. of children waiting September 2016**	**No. of children waiting October 2016**	**No. of children waiting November 2016**	**No. of children waiting December 2016**	**No. of children waiting January 2017**	**No. of children waiting February 2017**	**No. of children waiting March 2017**	**No. of children waiting April 2017**	**No. of children waiting May 2017**	**No. of children waiting June 2017**
Waiting up to 3 months	117	119	88	72	68	59	56	56	73	87	89	84
Waiting 4-6 months	50	41	44	42	51	36	31	36	41	29	24	33
Waiting 7-9 months	33	33	18	16	13	22	22	21	18	11	19	18
Waiting 10 months -1 year	23	23	10	3	2	2	4	4	3	4	2	5
Waiting OVER 1 year	60	61	17	3	2	2	2	1	0	0	1	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**283**	**277**	**177**	**136**	**136**	**121**	**115**	**118**	**135**	**131**	**135**	**140**
Already had PoC	356	396	395	377	392	332	277	266	248	210	194	253
Total waiting ***(Including patients who have already receive 1 POC and are waiting for another)***	**639**	**673**	**572**	**513**	**528**	**453**	**392**	**384**	**383**	**341**	**329**	**393**



Item 8

							Surgery							
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU
Patient Experience: in-patient	QR-PEI-10	Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	90	97	100	98	NA	NA	NA	NA
	QR-PEI-180	(In-patient) How likely is it that you would recommend the service to friends and family?	= 95%	<70	70-89	90-100	97.78	99.56	100	100	NA	NA	NA	NA
	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	99	100	100	NA	NA	NA	NA
	QR-PEI-340	Did you feel you were treated with respect and dignity by staff?	= 85%	<75	75-84	85-100	100	99	100	100	NA	NA	NA	NA
	QR-PEI-330	Were Staff caring and compassionate in their approach?	= 85%	<75	75-84	85-100	99	99	100	100	NA	NA	NA	NA
	QR-PEI-30	Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	22	99	100	100	NA	NA	NA	NA
	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	97	100	100	100	NA	NA	NA	NA
	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	99	99	100	100	NA	NA	NA	NA
	QR-PEI-90	Did staff talk in front of you as if you were not there?	= 85%	<75	75-84	85-100	99	99	100	100	NA	NA	NA	NA
	QR-PEI-350	Were you given enough privacy when discussing your care?	= 85%	<75	75-84	85-100	100	99	100	100	NA	NA	NA	NA
	QR-PEI-100	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	92	0	100	100	NA	NA	NA	NA
		(In-patient) Were you given enough privacy when being examined or treated?	= 85%	<76	75-85	85-101	100	100	100	100	NA	NA	NA	NA
	QR-PEI-150	Timely call bell response	= 85%	<75	75-84	85-100	49	71	100	80	NA	NA	NA	NA
	QR-PEI-290	Same sex accommodation: total patients	= 0	>2	1-2	= 0	0	0	0	0	0	0	0	0
	QR-PEI-300	Complaints	= 0	>2	1-2	= 0	1	0	0	0	0	0	0	0
	QR-PEI-310	Environment and Cleanliness	= 90%	<80	80-89	90-100				88	94		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	100	100	0	98
	QR-PES-60	(Short-stay) How likely is it that you would recommend the service to friends and family?	= 95%	<70	70-89	90-100	100	100	0	97.83
	QR-PES-20	(Short-stay) Were you given enough privacy when being examined and treated?	= 85%	<75	75-84	85-100	100	100	0	100
	QR-PES-30	(Short-stay) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	100	100	0	100
	QR-PES-40	Were you told who to contact if you were worried after leaving hospital?	= 85%	<75	75-84	85-100	100	100	0	92
	QR-PES-50	(Short-stay) Overall how would you rate the care you received in the department?	= 85%	<75	75-84	85-100	98	100	0	96
	QR-PES-70	Number of short stay surveys completed	No Target	No Target	No Target	No Target	134	38	0	46

							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?	= 95%	<70	70-89	90-100	95.29
	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	98
	QR-PEA-120	Did Doctors and Nurses listen to what you had to say?	= 85%	<75	75-84	85-100	99
	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	85
	QR-PEA-140	Number of A&E surveys completed	No Target	No Target	No Target	No Target	837

							Medicine
Group		Indicator	Target	Red	Amber	Green	ED

Patient Experience: A&E (Children questions)	QR-PEAC-70	Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	94
	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?	= 95%	<70	70-89	90-100	95.29
	QR-PEAC-90	Did the Doctor or Nurse listen to what you had to say?	= 85%	<75	75-84	85-100	95
	QR-PEAC-100	Were staff friendly and kind to you and your family?	= 85%	<75	75-84	85-100	100
	QR-PEAC-50	Did we help with your pain?	= 85%	<75	75-84	85-100	88
	QR-PEAC-60	Did staff explain the care you need at home?	= 85%	<75	75-84	85-100	89
	QR-PEAC-130	Number of A&E children surveys completed	No Target	No Target	No Target	No Target	11

							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	89
	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?	= 95%	<70	70-89	90-100	87.5
	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	88
	QR-PEM-135	How likely are you to recommend our antenatal department to friends and family?	= 75%	<70	70-74	75-100	100
	QR-PEM-140	How likely are you to recommend our post-natal care to friends and family?	= 75%	<70	70-74	75-100	84
	QR-PEM-30	(Maternity) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	84
	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	94
	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	94
	QR-PEM-60	(Maternity) Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	94
	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	75
	QR-PEM-80	Were you given adequate help and support to feed your baby whilst in hospital?	= 85%	<75	75-84	85-100	94
	QR-PEM-121	Number of maternity surveys completed	No Target	No Target	No Target	No Target	170

							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?	= 95%	<70	70-89	90-100	100
	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	0
	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	0
	QR-PEBU-60	Did you have confidence and trust in the midwives caring for you during labour?	= 85%	<75	75-84	85-100	0
	QR-PEBU-70	Were your birthing partners made to feel welcome by the midwives on the birthing unit?	= 85%	<75	75-84	85-100	0
	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	0
	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	0
	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	0
	QR-PEBU-110	Number of birthing unit surveys completed	No Target	No Target	No Target	No Target	50

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
	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?	= 95%	<70	70-89	90-100	100
	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

Patient Satisfaction: Young Children	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	na
	QR-PEYC-40	Were you offered age/need appropriate activities?	= 85%	<75	75-84	85-100	na
	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	na
	QR-PEYC-70	Was your experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	na
	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	na
	QR-PEYC-160	Were staff kind and caring towards you?	= 85%	<75	75-84	85-100	na
	QR-PEYC-90	Is the environment child - friendly?	= 85%	<75	75-84	85-100	na
	QR-PEYC-100	Overall, how would you rate your experience in the Paediatric Unit?	= 85%	<75	75-84	85-100	na
	QR-PEYC-130	Number of young children surveys completed	No Target	No Target	No Target	No Target	7

							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	99
	QR-PEF1-110	(F1 Parent) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 95%	<70	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	92
	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	100
	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	100
	QR-PEF1-40	Were there appropriate play activities for your child (such as toys, games and books)?	= 85%	<75	75-84	85-100	100
	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	100
	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	95
	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	100
	QR-PEF1-140	Were staff kind and caring towards your child?	= 85%	<75	75-84	85-100	100
	QR-PEF1-90	Is the environment child-friendly?	= 85%	<75	75-84	85-100	100
	QR-PEF1-100	Overall, how would you rate your experience in the Children's Unit?	= 85%	<75	75-84	85-100	97
	QR-PEF1-160	Number of F1 parent surveys completed	No Target	No Target	No Target	No Target	22

							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	98
	QR-PEST-80	(Stroke) How likely is it that you would recommend the service to friends and family?	= 95%	<80	70-89	90-100	95.24
	QR-PEST-20	In your opinion, how clean was the hospital room or ward you were in?	= 85%	<75	75-84	85-100	98
	QR-PEST-30	Did you feel you were treated with respect and dignity by staff?	= 85%	<75	75-84	85-100	98
		Were staff caring and compassionate in their approach?	= 85%	<76	75-85	85-101	98
		Have you been told you have had a stroke, which lead to your admission to hospital?	= 85%	<77	75-86	85-102	100
		Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<78	75-87	85-103	100
		Were you involved as much as you wanted to be in planning your recovery /rehabilitation?	= 85%	<79	75-88	85-104	93
	QR-PEST-40	Were you given enough privacy when discussing your condition or treatment?	= 85%	<75	75-84	85-100	100
	QR-PEST-50	Were you gicen enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	100
	QR-PEST-60	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	94
	QR-PEST-70	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	97
	QR-PEST-90	Number of stroke surveys completed	No Target	No Target	No Target	No Target	21

Medicine														Women & Children			
ED	CCU	G5	F9	F10	G1	G3	G4	G8	MTU	F12	G9	F7	F8	F1	F11	F14	MLBU
NA	97	91	89	94	94	95	88	NA	NA	94	NA	NA	NA	NA	NA	98	NA
NA	100	100	100	100	100	100	100	NA	NA	100	NA	NA	NA	NA	NA	97.14	NA
NA	100	100	96	96	100	98	98	NA	NA	100	NA	NA	NA	NA	NA	100	NA
NA	100	100	98	100	100	100	100	NA	NA	100	NA	NA	NA	NA	NA	97	NA
NA	100	100	88	100	100	100	100	NA	NA	100	NA	NA	NA	NA	NA	97	NA
NA	78	50	86	80	82	100	50	NA	NA	100	NA	NA	NA	NA	NA	96	NA
NA	100	100	100	100	100	100	93	NA	NA	100	NA	NA	NA	NA	NA	100	NA
NA	98	100	77	100	89	88	87	NA	NA	80	NA	NA	NA	NA	NA	99	NA
NA	100	95	92	88	97	88	87	NA	NA	100	NA	NA	NA	NA	NA	100	NA
NA	95	100	100	96	100	100	100	NA	NA	100	NA	NA	NA	NA	NA	97	NA
NA	100	17	100	100	83	100	63	NA	NA	75	NA	NA	NA	NA	NA	100	NA
NA	100	100	100	96	100	100	100	NA	NA	100	NA	NA	NA	NA	NA	100	NA
NA	85	46	39	77	59	70	53	NA	NA	73	NA	NA	NA	NA	NA	93	NA
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	0	0	1	0	1	0	0	0	0	0	0	1	0	1	0	0	0
91	90	92		94		94							85		96	90	92

item 8

							Surgery								Medicine													Women & Children			
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	G5	F9	F10	G1	G3	G4	G8	MTU	F12	WEW - G9	F7	F8	F1	F11	F14	MLBU
Patient Safety	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	NA	No Data	NA	NA	NA	No Data	NA	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	No Data	100	100	100	100	No Data	No Data	NA	No Data	No Data	No Data	NA	NA	NA	No Data	NA
	QR-PS-30	HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	No Data	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	No Data	100	NA	NA	NA
	QR-PS-40	HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	100	100	100	100	NA	NA	NA	NA	100	88	100	100	100	80	100	100	NA	100	No Data	NA	NA	100	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	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	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	NA	NA
	QR-PS-100	HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	100	NA	NA	No Data	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	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	50	100	100	100	100	77	100	NA	No Data	No Data	NA	NA	NA	NA	100	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	NA	No Data	NA	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	0	0
	QR-PS-400	Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	94	100	100	100	100	No Data	No Data	No Data	No Data	100	79	86	100	94	58	80	85	NA	100	No Data	100	100	No Data	No Data	100	NA
	QR-PS-250	Hand hygiene compliance	= 95%	<85	85-99	= 100	100	100	100	100	100	NA	100	100	No Data	100	100	100	100	100	100	90	100	100	100	No Data	100	100	100	100	100	100
	QR-PS-230	Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-117	Quarterly Standard principle compliance	90%	<80	80-90%	90-100	95	91	97	95	92	No Data	No Data	No Data	95	98	93	98	97	91	87	100	90	NA	100	No Data	96	95	100	88	100	NA
	QR-PS-240	Total no of C. diff infections: Hospital	= 16 per year	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-290	Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	91	100	89	92	NA	NA	NA	NA	NA	78	91	95	86	89	91	86	86	NA	80	No Data	96	100	92	100	No Data	NA
	QR-PS-440	Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	89	91	91	91	93	90	97	91	70	95	97	80	90	92	95	96	91	NA	98	No Data	84	94	100	88	100	NA
	QR-PS-450	Quarterly VIP score documentation	= 90%	<80	80-89	90-100	86	100	100	77	100	No Data	No Data	No Data	67	100	67	67	90	100	88	85	85	NA	86	No Data	79	100	60	100	No Data	NA
	QR-PS-120	No of patient falls	= 48	>=48	No Target	<48	5	3	2	2	0	NA	NA	NA	2	0	3	2	5	2	5	8	8	0	1	0	2	0	NA	0	0	NA
	QR-PS-130	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	3	0	1	1	0	NA	NA	NA	1	0	1	1	4	1	0	5	1	0	0	0	0	0	NA	0	0	NA
	QR-PS-140	No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	0	0	0	0	NA	NA	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	NA	0	0	NA
	QR-PS-470	No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	3	0	0	0	0	NA	NA	NA	NA	1	3	3	2	1	2	0	2	0	0	0	1	0	NA	0	0	NA
	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	NA	NA
	QR-PS-190	Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	100	100	100	100	90	NA	NA	NA	NA	100	88	60	80	90	100	70	90	NA	100	No Data	No Data	No Data	NA	NA	80	NA
	QR-PS-260	No of SIRIs	No Target	No Target	No Target	No Target	1	0	0	0	0	0	0	0	1	0	0	3	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	QR-PS-500	No of medication errors	No Target	No Target	No Target	No Target	4	1	2	4	1	0	0	0	5	1	4	2	6	4	4	1	3	0	1	0	3	6	1	4	1	0
	QR-PS-300	Cardiac arrests	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	1	0	0	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	1	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	0	NA	0	0	0	0	0	0	0	NA
	QR-PS-370	VTE: Completed risk assessment (monthly Unify audit)	> 98%	< 98	No Target	> 98	0.0	0.0	0.0	0.0	0.0	No Data	No Data	0.0	No Data	0.0	No Data	0.0	0.0	0.0	0.0	0.0	0.0	No Data	0.0	No Data	0.0	0.0	No Data	0.0	0.0	0.0
	QR-PS-390	Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	100	100	100	100	100	No Data	No Data	No Data	No Data	100	93.94	100	96	100	100	93.55	100	No Data	100	na	100	No Data	No Data	100	100	No Data
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	0	0

West Suffolk NHS
NHS Foundation Trust

Board of Directors - July 2017

AGENDA ITEM:	9
PRESENTED BY:	Craig Black, Executive Director of Resources
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
DATE PREPARED:	20 July 2017
SUBJECT:	Finance & Workforce Performance Report
PURPOSE:	Review

EXECUTIVE SUMMARY:
The reported I&E for June 2017 is a deficit of £809k (YTD £2,842k), against a planned deficit of £735k (YTD £2,848k) This results in an adverse variance of £74k (YTD £6k favourable).

We are therefore on plan to achieve our control total this year, which will mean we also receive STF funding of £5.2m. Therefore £780k of this funding is included in the June position in line with NHSI guidance.

We continue to work with KPMG as part of the financial improvement programme (FIP) for 2017-18 and beyond. The focus of FIP is to ensure that robust CIPs are in place to deliver the control total for 2017-18 and a CIP pipeline for future years. This Programme has identified further CIP that increases this year's plan to £15.3m. Progress against the 2018-19 CIP target of £18.3m is also included with 63% currently identified, leaving around £6.9m unidentified.

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

West Suffolk NHS
NHS Foundation Trust

FINANCE AND WORKFORCE REPORT

June 2017 (Month 3)

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

Financial Summary

I&E Position YTD	£2.8m	loss
Variance against plan YTD	£0.0m	favourable
Movement in month against plan	£0.1m	adverse
EBITDA position YTD	£0.1m	surplus
EBITDA margin YTD	1.9%	surplus
Cash at bank	£2,689k	

Executive Summary

- The Month 3 YTD position is £6k ahead of plan.

Key Risks

- Delivering the cost improvement programme.
- Containing the increase in demand to that included in the plan (2.5%).
- We are in arbitration with NHSPS regarding property charges for Community Services dating back to October 2015.
- 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

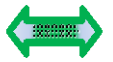
SUMMARY INCOME AND EXPENDITURE ACCOUNT - June 2017	Jun-17 Budget £m	Jun-17 Actual £m	Jun-17 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance £m
NHS Contract Income	19.1	19.1	(0.0)	55.9	55.7	(0.1)	226.2	225.7	(0.4)
Other Income	2.3	2.6	0.2	6.3	6.9	0.6	25.3	26.6	1.3
Total Income	**21.4**	**21.6**	**0.2**	**62.1**	**62.6**	**0.5**	**251.4**	**252.3**	**0.9**
Pay Costs	12.3	12.2	0.1	36.5	36.1	0.4	145.3	145.3	0.0
Non-pay Costs	9.3	9.6	(0.3)	27.7	28.5	(0.8)	108.7	109.6	(0.9)
Operating Expenditure	**21.6**	**21.8**	**(0.2)**	**64.2**	**64.6**	**(0.4)**	**253.9**	**254.8**	**(0.9)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	2.5	2.5	0.0
EBITDA	**(0.2)**	**(0.2)**	**0.0**	**(2.1)**	**(2.0)**	**0.1**	**(5.0)**	**(5.0)**	**(0.0)**
EBITDA margin	(1.3%)	(1.2%)	0.1%	(2.1%)	(1.9%)	0.1%	0.1%	0.1%	(0.0%)
Depreciation	0.3	0.4	(0.0)	1.1	1.2	(0.1)	4.7	4.7	0.0
Finance costs	0.1	0.1	(0.0)	0.4	0.4	0.0	1.4	1.4	0.0
SURPLUS/(DEFICIT) pre S&TF	**(0.6)**	**(0.7)**	**(0.1)**	**(3.6)**	**(3.6)**	**0.0**	**(11.1)**	**(11.1)**	**(0.0)**
S&T funding - Financial Performance	(0.1)	(0.1)	(0.0)	0.5	0.5	0.0	3.6	3.6	0.0
S&T funding - A&E Performance	(0.0)	(0.0)	(0.0)	0.2	0.2	0.0	1.6	1.6	0.0
SURPLUS/(DEFICIT) incl S&TF	**(0.7)**	**(0.8)**	**(0.1)**	**(2.8)**	**(2.8)**	**0.0**	**(5.9)**	**(5.9)**	**(0.0)**

FINANCE AND WORKFORCE REPORT – June 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	

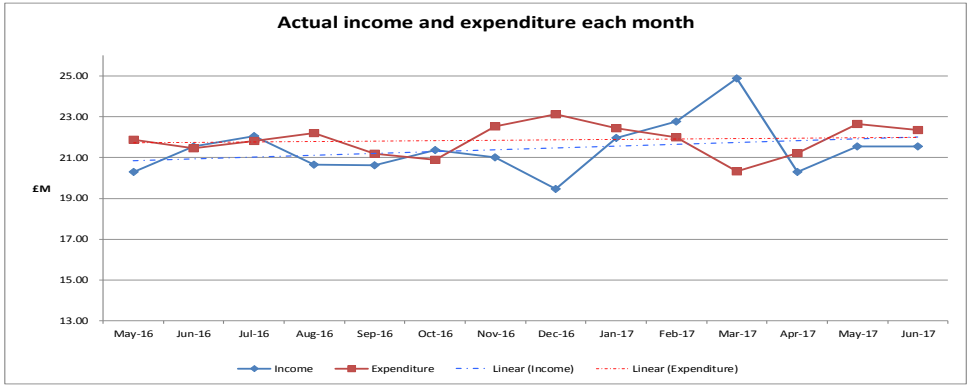
FINANCE AND WORKFORCE REPORT – June 2017

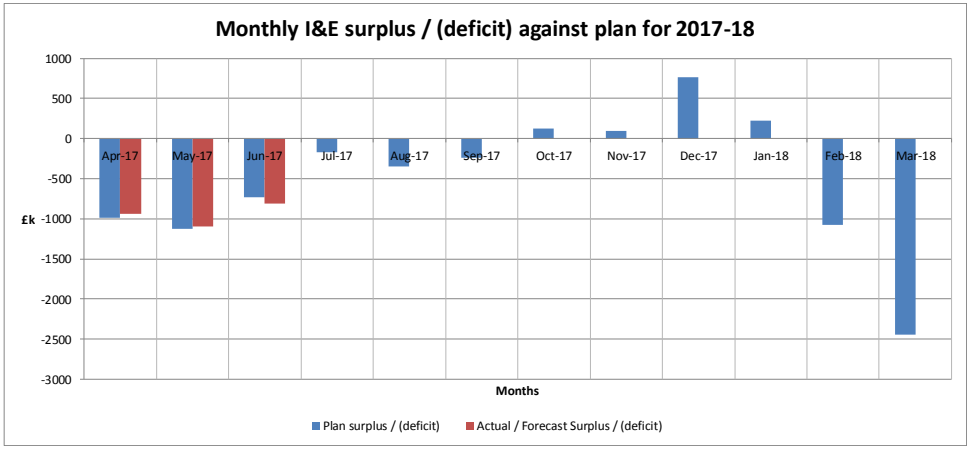
Income and Expenditure summary as at June 2017

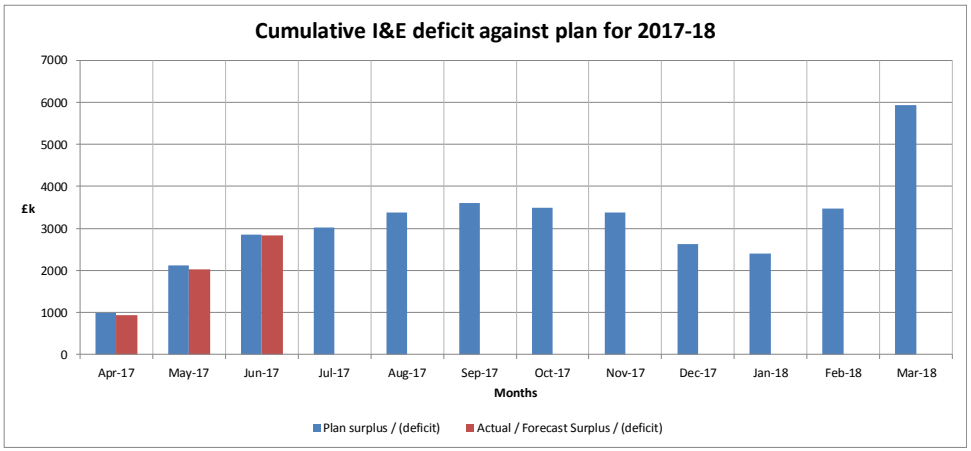
The reported I&E for June 2017 YTD is a deficit of £2,842k, against a planned deficit of £2,848k. This results in a favourable variance of £6k YTD.

Summary of I&E indicators

Income and Expenditure	Plan / target £'000	Actual / forecast £'000	Variance to plan (adv) / fav £'000	Direction of travel (variance)	RAG (report on Red)
In month surplus / (deficit)	(735)	(809)	(74)	↓	Green
YTD surplus / (deficit)	(2,848)	(2,842)	6	↓	Green
Forecast surplus / (deficit)	(5,928)	(5,928)	0	↔	Green
EBITDA YTD	(1,275)	(1,212)	63	↑	Green
EBITDA (%)	(2.0%)	(1.9%)	0.1%	↔	Amber
Use of Resources (UoR) Rating fav / (adv)	3	3	0	↔	Amber
Clinical Income YTD	(55,854)	(55,720)	(134)	↑	Amber
Non-Clinical Income YTD	(7,067)	(7,653)	586	↓	Amber
Pay YTD	36,471	36,089	381	↑	Green
Non-Pay YTD	29,298	30,126	(828)	↓	Green
CIP target YTD	(2,690)	(2,664)	(26)	↓	Green







FINANCE AND WORKFORCE REPORT – June 2017

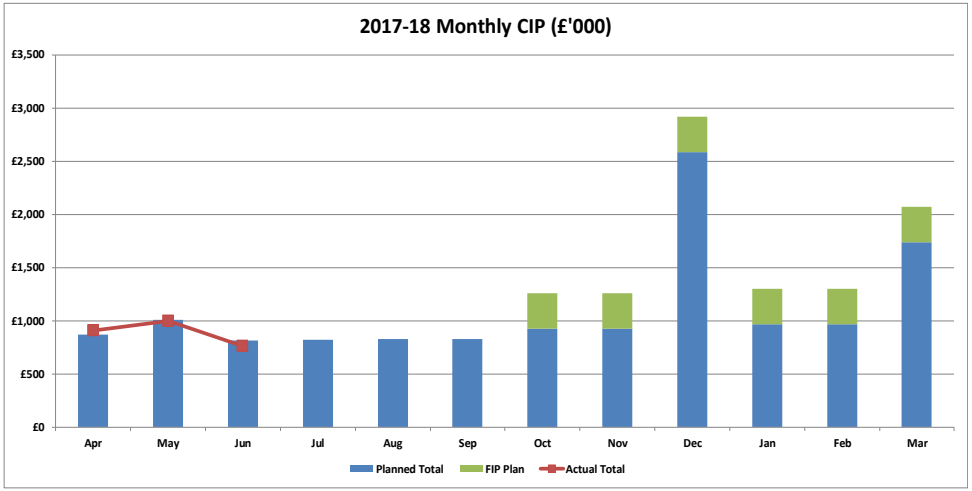
Cost Improvement Programme (CIP)

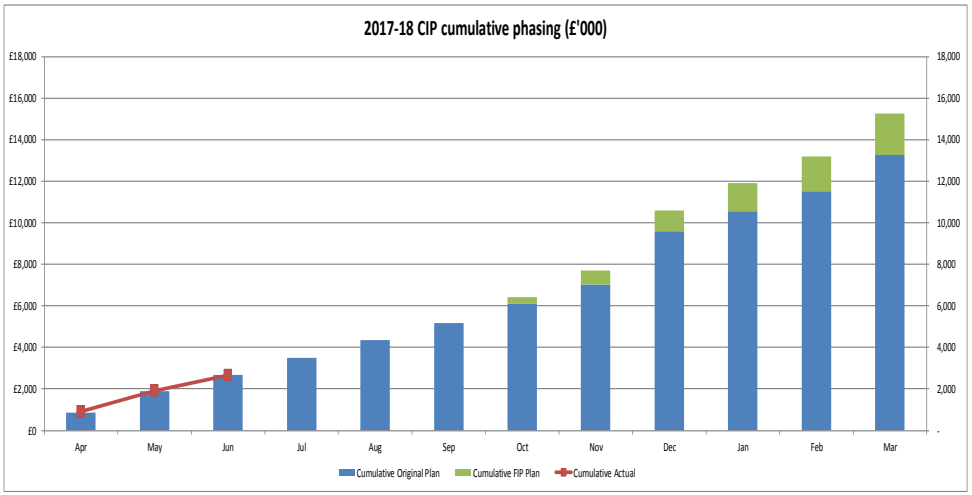
The June position includes a target of £2,690k YTD which represents 20% of the 2017-18 plan. There is currently a shortfall of £26k YTD against this plan.

We continue to work with KPMG as part of the financial improvement programme (FIP) for 2017-18 and beyond. The focus of FIP is to ensure that robust CIPs are in place to deliver the control total for 2017-18 and a CIP pipeline for future years.

This Programme has identified further CIP that increased this year's plan to £15.3m, some of which will be offset by the KPMG fee. This has been phased from October 2017 as below.

2017-18 CIP	£m	£m
Original CIP schemes		13.27
Risk adjustments as per Phase 2		(0.66)
Revised CIP before Phase 3		12.61
Phase 3 CIP schemes		
Patient Flow	0.30	
Outpatients	0.07	
Theatres	0.90	
Endoscopy	0.03	
Nursing productivity	1.10	
Medical productivity	0.10	
Administrative and Clerical	0.60	
Pay Controls	0.56	3.66
Revised CIP plan		**16.27**
less KPMG fee		(1.14)
17-18 phasing risk		(1.00)
Net forecast CIP 17-18		**14.13**





FINANCE AND WORKFORCE REPORT – June 2017

All 2017-18 CIP is summarised below.

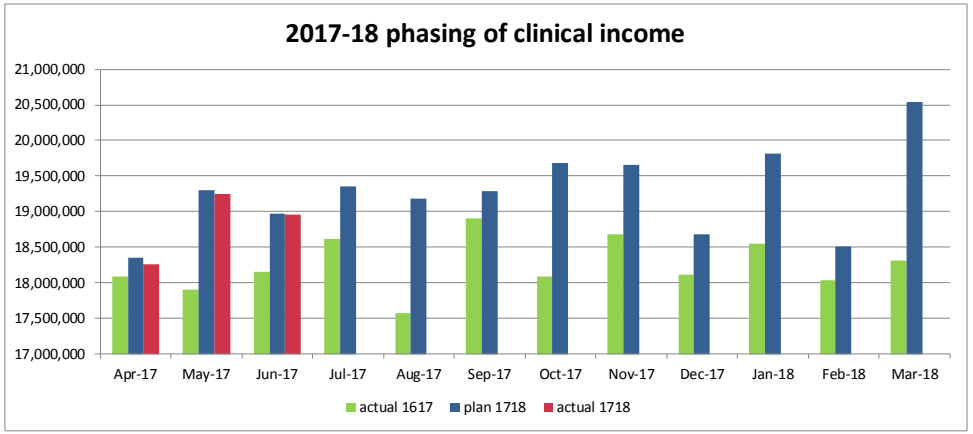
Recurring/Non Recurring	Summary	2017-18 Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Activity growth	297	62	30
	Car Park Income	400	100	100
	Other Income	167	33	46
	Consultant Staffing	326	51	54
	Additional sessions	192	48	18
	Staffing Review	2,722	468	692
	Agency	482	121	67
	Procurement	1,801	350	285
	Community Equipment Service	465	100	48
	Contract review	8	1	3
	Drugs	326	30	95
	Capitalisation	480	120	120
	Other	2,047	544	489
	less Phase 2 Risk adjustment	(660)	-	-
Recurring Total		**9,052**	**2,029**	**2,046**
Non-Recurring	Activity growth	300	300	300
	Other Income	19	5	5
	Additional sessions	10	3	22
	Staffing Review	20	5	-
	Contract review	41	10	10
	Estates and Facilities	389	97	97
	Non-Recurring	396	-	-
	Capitalisation	350	125	150
	Other	383	117	32
	GDE revenue	1,650	-	-
Non-Recurring Total		**3,558**	**662**	**617**
FIP	Patient Flow	300	-	-
	Outpatients	70	-	-
	Theatres	900	-	-
	Endoscopy	30	-	-
	Nursing productivity	1,100	-	-
	Medical productivity	100	-	-
	Administrative and Clerical	600	-	-
	Pay Controls	560	-	-
	less Phasing Risk	(1,000)		
FIP Total		**2,660**	-	-
Grand Total		**15,271**	**2,690**	**2,664**

Progress against the 2018-19 CIP target of £18.3m is also tabled below, with 63% currently identified, leaving around £6.9m unidentified.

2018-19 CIP	**£m**	**£m**
Original CIP target		18.30
17-18 excess CIP (recurring)		(3.00)
Revised CIP target		15.30
Divisional targets at 2%		4.60
Phase 3 CIP schemes FYE		
Patient Flow	0.90	
Outpatients	0.07	
Theatres	0.40	
Endoscopy	0.03	
Nursing productivity	0.75	
Medical productivity	0.10	
Administrative and Clerical	1.50	
Pay Controls	0.10	3.85
Unidentified CIP (at July 17)		**6.85**

Income Analysis

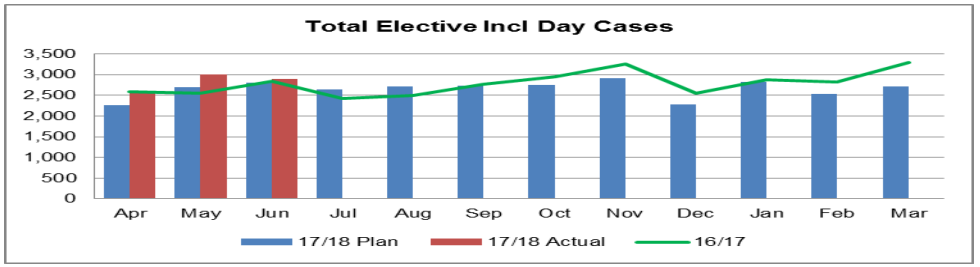
The chart below summarises the phasing of the clinical income plan for 2017-18, including a full year for Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.

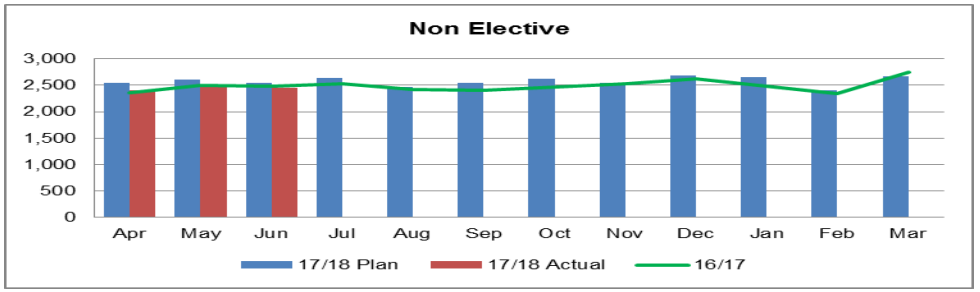


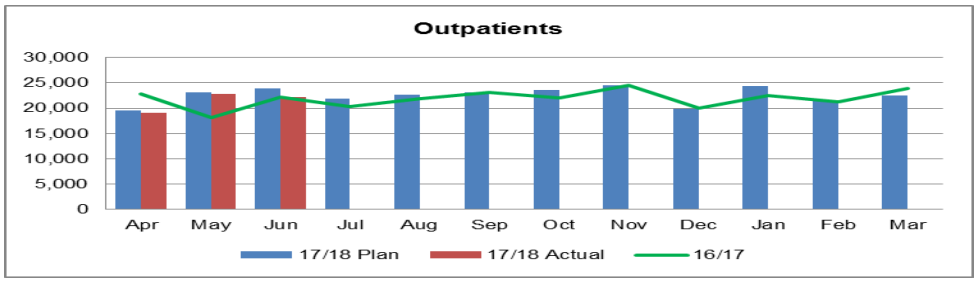
The income position was behind plan in June. The main area of underperformance was seen within the outpatient category during the month.

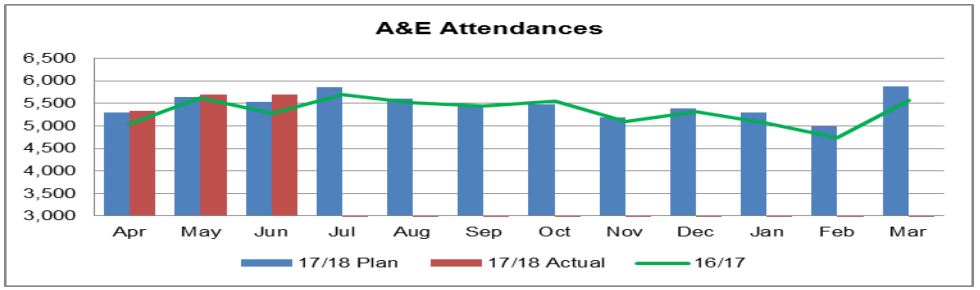
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	687	744	57	2,042	2,096	53
Other Services	2,294	2,156	(138)	7,089	6,699	(390)
CQUIN	307	303	(4)	890	889	(1)
Elective	2,723	2,884	161	7,551	8,235	683
Non Elective	5,067	5,120	53	15,318	15,357	39
Emergency Threshold Adjustment	(284)	(387)	(103)	(861)	(1,099)	(238)
Outpatients	2,865	2,686	(179)	7,987	7,706	(281)
Community	5,379	5,379	0	10,759	10,759	0
Total	**19,038**	**18,885**	**(153)**	**50,776**	**50,641**	**(135)**

Activity, by point of delivery

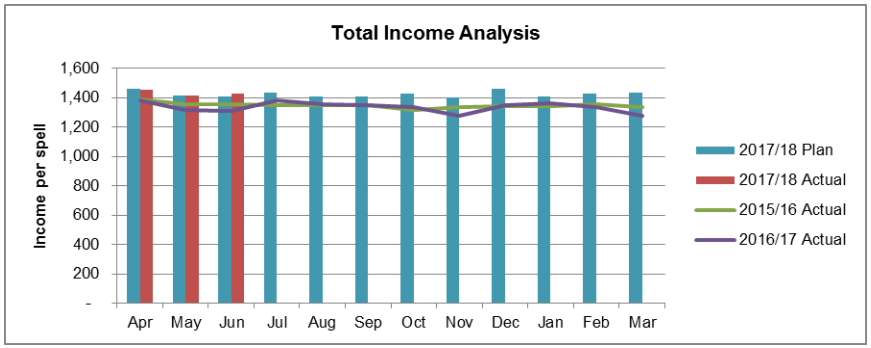


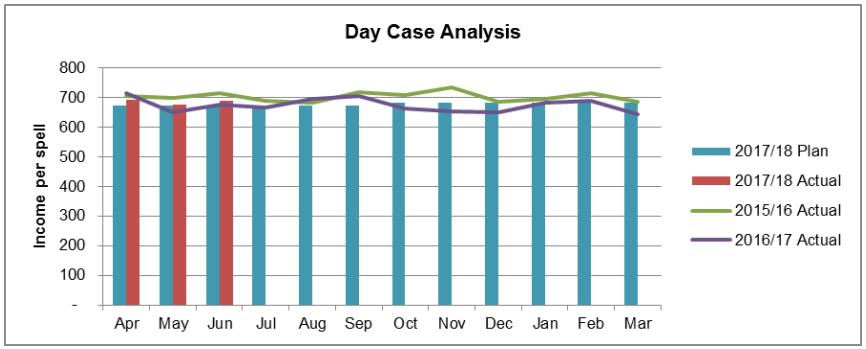


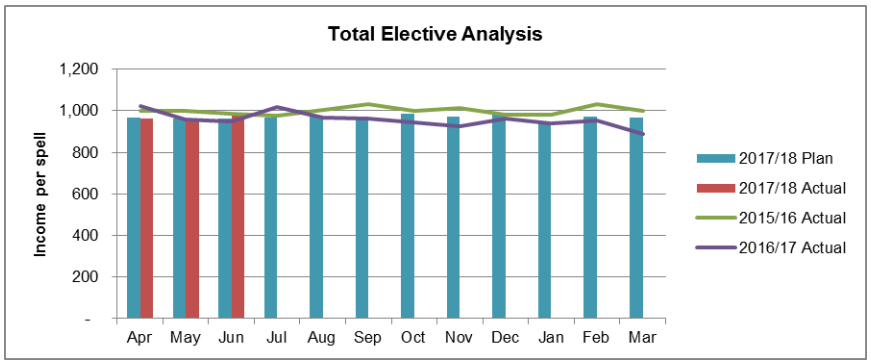


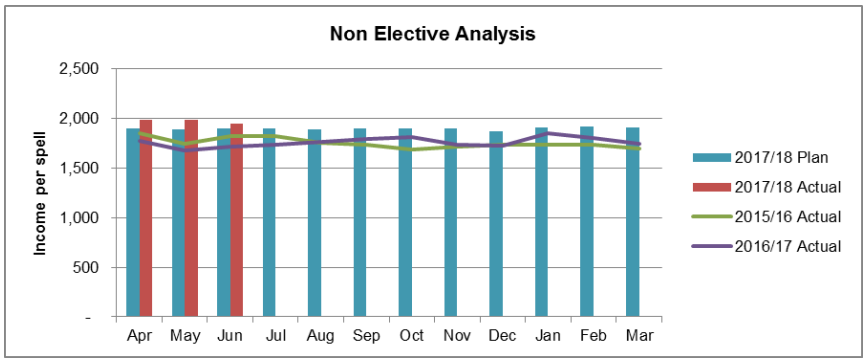


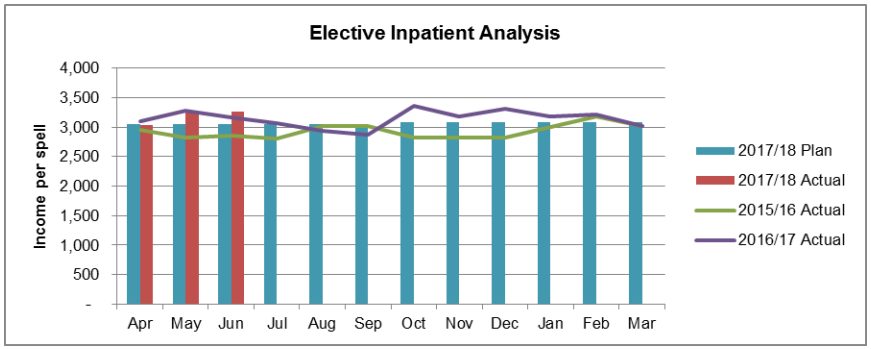
Trends and Analysis

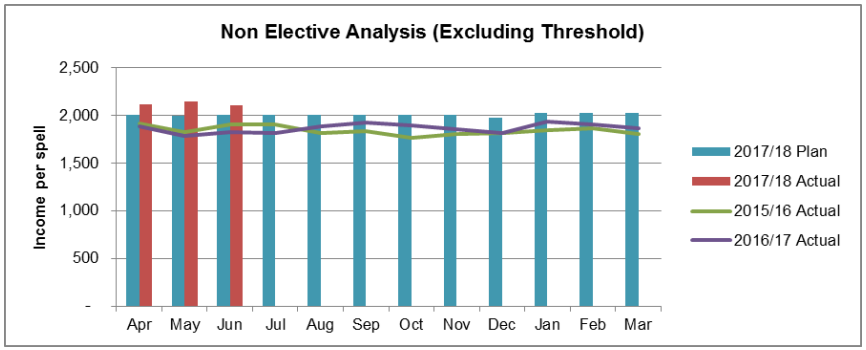












FINANCE AND WORKFORCE REPORT – June 2017

Workforce

Monthly Expenditure Acute services only				
As at June 2017	Jun-17	May-17	Jun-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**11,151**	**10,798**	**10,885**	**33,106**
Substantive Staff	9,935	9,692	9,313	29,169
Medical Agency Staff (includes 'contracted in' staff)	132	136	157	411
Medical Locum Staff	229	231	112	626
Additional Medical sessions	230	263	244	725
Nursing Agency Staff	81	66	182	219
Nursing Bank Staff	162	154	248	545
Other Agency Staff	49	76	367	167
Other Bank Staff	120	133	114	406
Overtime	88	89	63	287
On Call	55	59	41	161
Total temporary expenditure	1,147	1,208	1,528	3,546
Total expenditure on pay	**11,083**	**10,900**	**10,841**	**32,715**
Variance (F/(A))	68	(102)	44	391
Temp Staff costs % of Total Pay	10.4%	11.1%	14.1%	10.8%
Memo : Total agency spend in month	262	278	706	796

Monthly whole time equivalents (WTE) Acute Services only			
As at June 2017	Jun-17	May-17	Jun-16
	WTE	WTE	WTE
Budgeted WTE in month	**2,980.9**	**2,945.0**	**3,037.7**
Employed substantive WTE in month	**2724.3**	**2725.03**	**2,669.5**
Medical Agency Staff (includes 'contracted in' staff)	11.13	14.74	8.8
Medical Locum	16.46	18.06	14.0
Additional Sessions	18.21	21.85	21.2
Nursing Agency	12.5	10.26	23.1
Nursing Bank	52.86	50.16	76.2
Other Agency	16.41	20.29	38.0
Other Bank	57.73	60.75	56.2
Overtime	40.19	40.99	43.2
On call Worked	8.42	11.23	10.4
Total equivalent temporary WTE	**233.9**	**248.3**	**291.1**
Total equivalent employed WTE	**2,958.2**	**2,973.4**	**2,960.6**
Variance (F/(A))	22.7	(28.3)	77.2
Temp Staff WTE % of Total Pay	7.9%	8.4%	9.8%
Memo : Total agency WTE in month	40.0	45.3	69.9
Sickness Rates (May/April)	3.61%	3.62%	3.76%
Mat Leave	1.8%	2.1%	2.1%

Monthly Expenditure Community Service				
As at June 2017	Jun-17	May-17	Jun-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,123**	**1,129**	**1,007**	**3,365**
Substantive Staff	1,056	1,049	949	3,162
Medical Agency Staff (includes 'contracted in' staff)	13	14	0	41
Medical Locum Staff	4	3	10	10
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	0	0	2	2
Nursing Bank Staff	11	16	5	42
Other Agency Staff	15	24	25	73
Other Bank Staff	9	7	7	28
Overtime	4	5	4	13
On Call	1	1	1	4
Total temporary expenditure	57	70	54	212
Total expenditure on pay	**1,114**	**1,120**	**1,003**	**3,374**
Variance (F/(A))	9	9	(6)	(9)
Temp Staff costs % of Total Pay	5.1%	6.3%	5.4%	6.3%
Memo : Total agency spend in month	28	38	27	116

Monthly whole time equivalents (WTE) Community Services			
As at June 2017	Jun-17	May-17	Jun-16
	WTE	WTE	WTE
Budgeted WTE in month	**362.57**	**367.57**	**334.3**
Employed substantive WTE in month	**344.1**	**343.1**	**313.6**
Medical Agency Staff (includes 'contracted in' staff)	1.0	1.5	0.0
Medical Locum	0.4	0.4	0.5
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.0	0.1	0.4
Nursing Bank	3.8	5.1	1.5
Other Agency	5.4	9.9	6.5
Other Bank	2.3	2.2	2.8
Overtime	2.1	2.5	2.2
On call Worked	0.0	0.0	(0.7)
Total equivalent temporary WTE	**14.9**	**21.5**	**13.2**
Total equivalent employed WTE	**359.0**	**364.6**	**326.7**
Variance (F/(A))	3.6	3.0	7.6
Temp Staff WTE % of Total Pay	4.2%	5.9%	4.0%
Memo : Total agency WTE in month	6.4	11.4	6.9
Sickness Rates (May/April)	3.55%	3.80%	3.63%
Mat Leave	1.1%	1.1%	1.4%

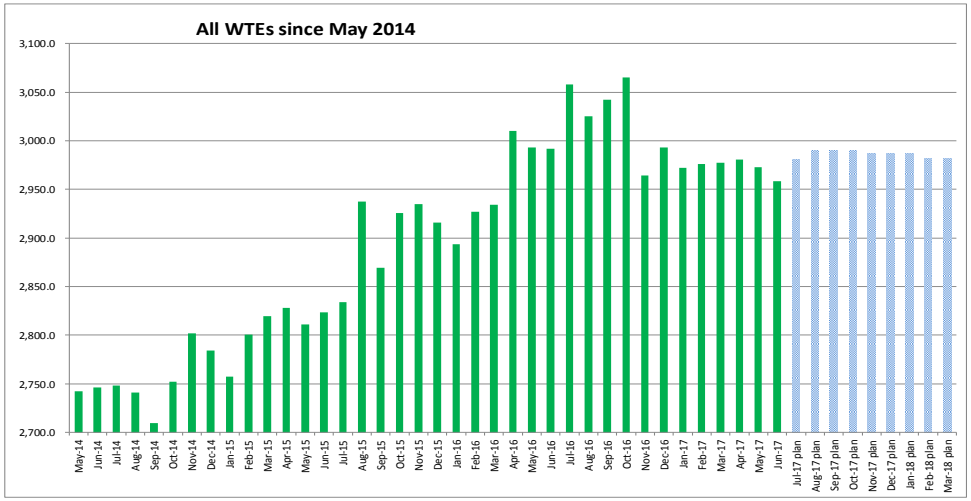
* Note the Acute tables includes Collaborative Procurement Hub staff on WSH Contracts
* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

FINANCE AND WORKFORCE REPORT – June 2017

Staffing levels

The following graphs exclude Community staff but include Capitalised staff.

The planned establishment from July 17 onwards is the level of staffing required to achieve the original CIP, although this needs to be updated to reflect the proposals in FIP. As at June 17 we employed 23 less WTE than planned and 15 WTE fewer than in May 2017.

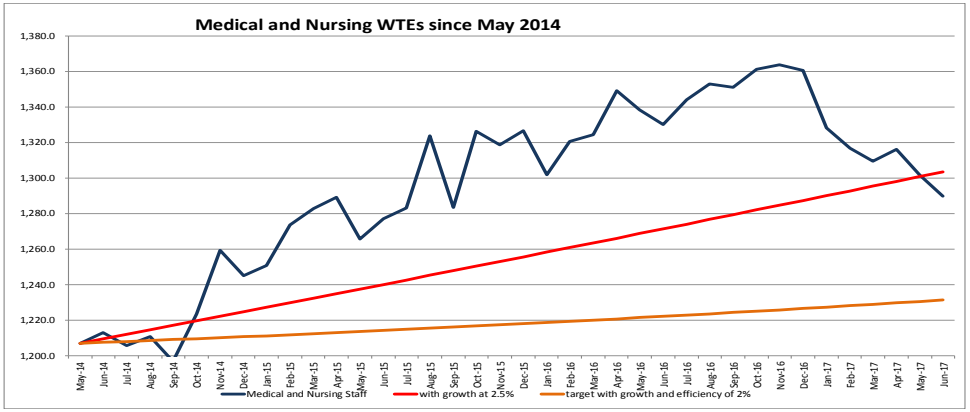


Since May 2014, (excluding Community staff) the Trust has employed 183 more WTEs, an increase of 6.7%. During this same period activity has grown by around 7.5%

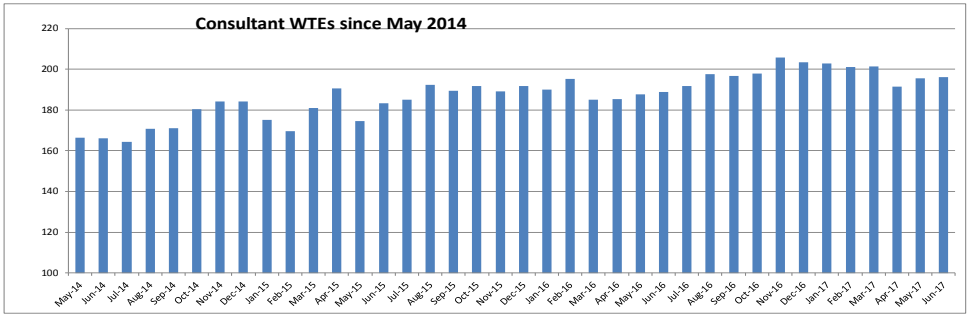
The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 83 WTEs (blue line). This includes around 30 WTE Consultants which are analysed further below.

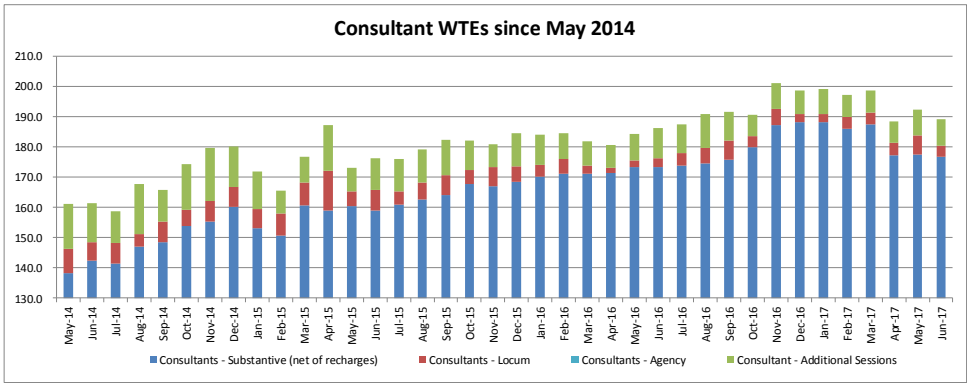
There has been a decrease of 15 WTE during June. Medical staffing have increased by 4.6 WTE since April 2017, largely as the result of increases in medical agency and locum staff.

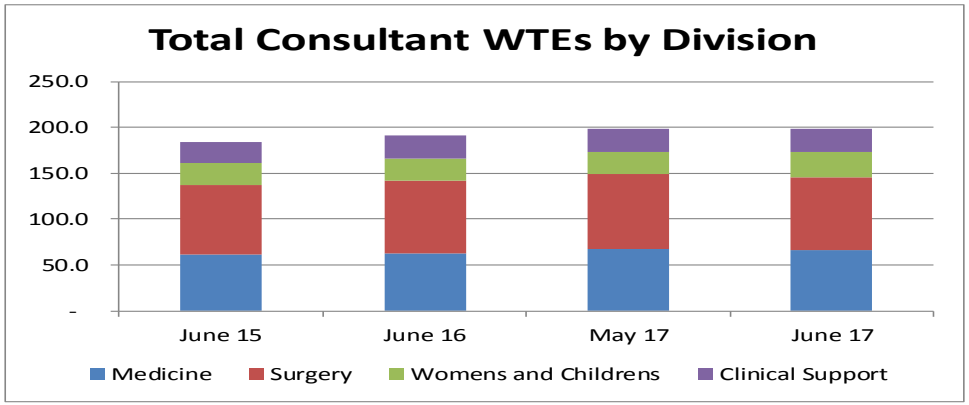
If medical and nursing staffing levels had increased in line with our growth in activity of broadly 2.5% we would currently be employing 14 more WTEs (red line). In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 50 WTE fewer than at June 2017.



The graphs below highlight the increase in Consultant WTEs of 17% over the past 3 years. Substantive staff have increased by 32.9 WTEs whilst temporary staff have dropped by 3.8 WTEs.



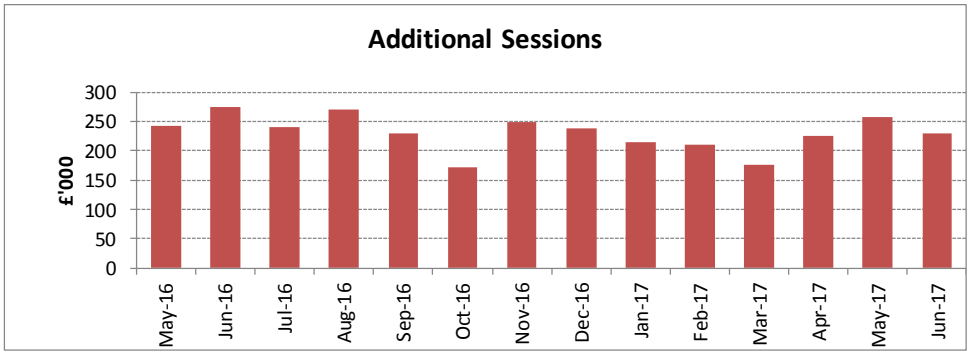


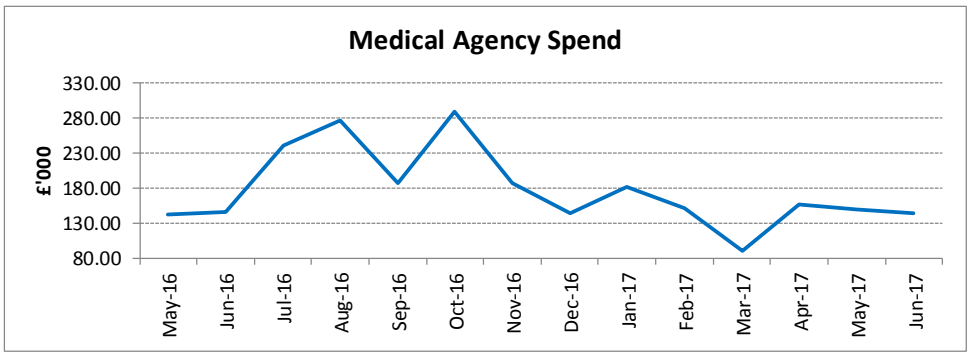


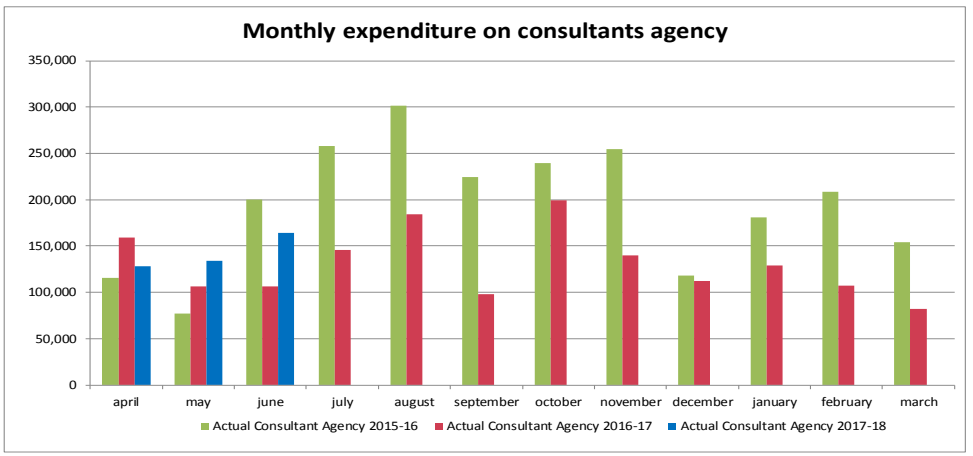
Division	Specialty	Sum of Jun-15	Sum of Jun-16	Sum of May-17	Sum of Jun-17
Medicine	A&E Medical Staff	5.8	6.3	7.9	7.7
	Cardiology	6.2	4.6	5.0	6.6
	Chest Medicine	3.9	4.0	4.1	4.4
	Chronic Pain Service	0.4	0.9	0.7	0.7
	Clinical Haematology	4.1	4.2	4.4	4.4
	Dermatology	4.4	4.4	4.2	4.0
	Diabetes	4.1	4.3	4.4	4.5
	Eau Medical Staff	8.3	7.5	9.4	8.5
	Gastroenterology	5.8	6.8	7.9	7.5
	General Medicine	6.9	7.0	5.9	4.5
	Nephrology	0.5	0.1	0.8	0.6
	Neurology	2.4	2.5	2.6	2.6
	Oncology	3.2	3.1	2.7	2.9
	Palliative Care	- 0.7	0.3	0.3	0.3
	Rheumatology	2.4	2.9	3.9	3.5
	Stroke	3.7	3.4	3.8	3.9
Medicine Total		**61.3**	**62.2**	**68.0**	**66.5**
Surgery	Anaesthetics	30.5	35.0	32.7	32.9
	E.N.T.	3.2	3.5	3.0	3.2
	General Surgery	12.4	10.8	9.8	9.8
	Ophthalmology	6.6	7.6	7.5	7.1
	Oral & Maxofacial Surg	1.0	0.8	1.0	1.0
	Plastic Surgery	3.1	2.5	4.3	4.1
	Trauma & Orthopaedic	13.2	13.4	13.7	13.7
	Urology	5.7	5.2	8.1	6.3
	Vascular Surgery	-	1.4	1.2	1.2
Surgery Total		**75.7**	**80.3**	**81.2**	**79.3**
Women and Childrens	Obstetrics	12.4	12.8	12.8	16.6
	Paediatrics	11.5	11.1	10.9	10.9
Women and Childrens Total		**23.9**	**23.9**	**23.7**	**27.5**
Clinical Support	Chemistry	0.6	0.7	0.7	0.8
	Histopathology	7.2	7.7	8.0	8.3
	Microbiology	3.3	3.3	3.2	3.2
	MRI	0.9	1.0	0.9	1.0
	Xray - Wsh	12.5	12.2	12.4	12.2
Clinical Support Total		**24.5**	**24.8**	**25.3**	**25.4**
Grand Total		**185.4**	**191.2**	**198.1**	**198.7**

Pay Trends and Analysis

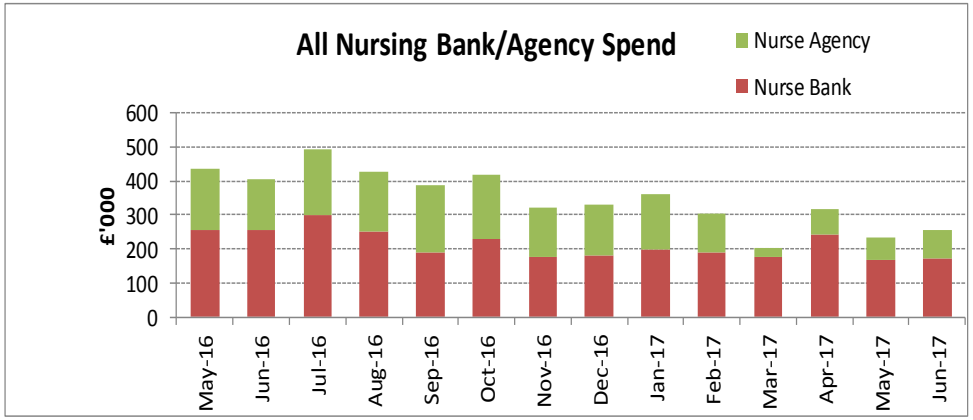
The Trust underspent pay budgets by £78k in June (£381k YTD).

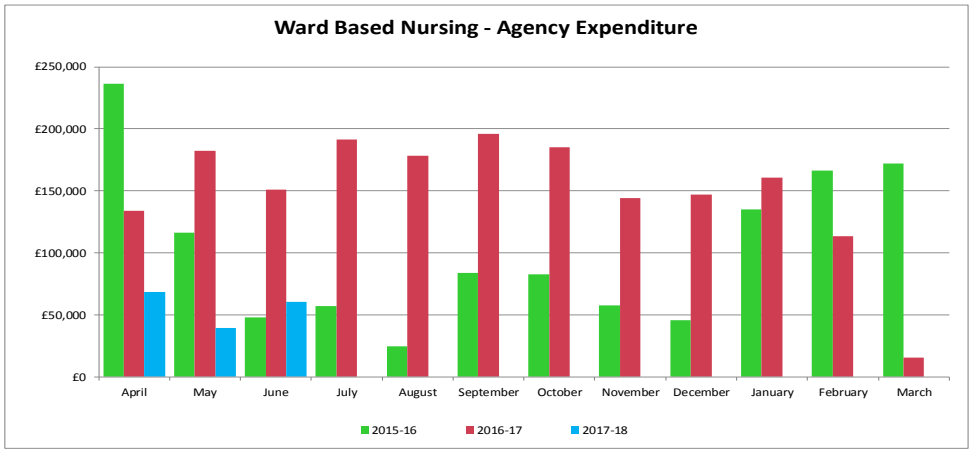


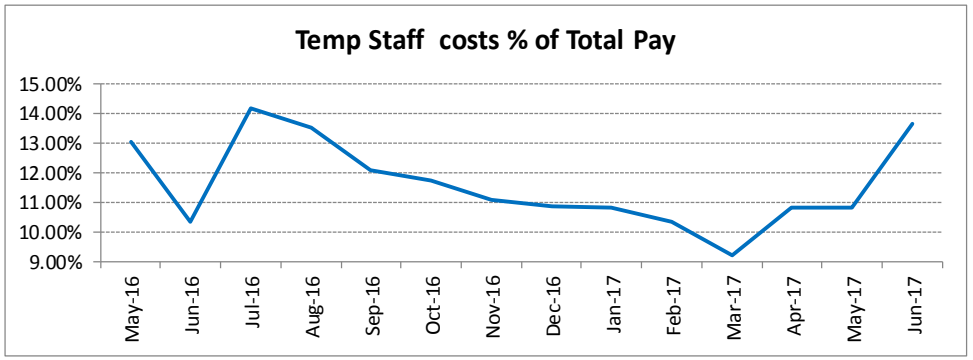




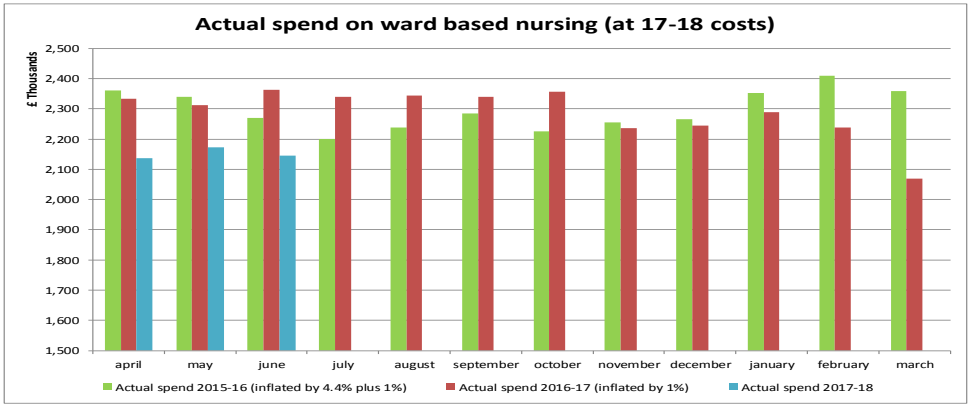
FINANCE AND WORKFORCE REPORT – June 2017

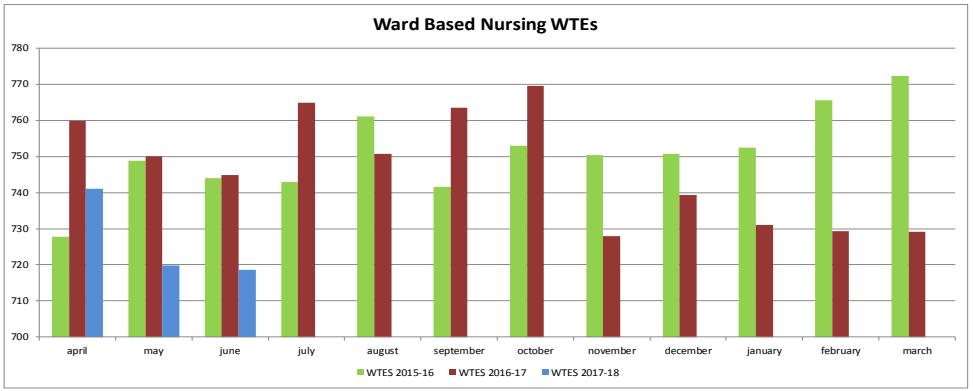


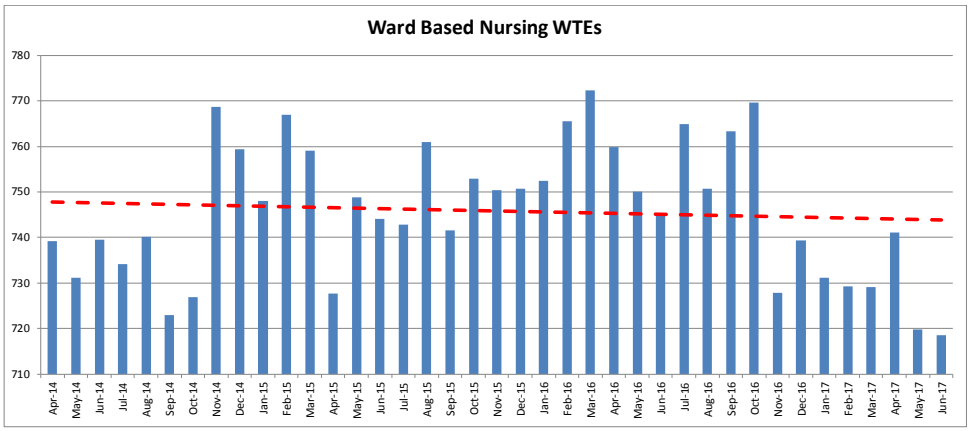




Ward Based Nursing







FINANCE AND WORKFORCE REPORT – June 2017

Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Jun-17 Budget £k	Jun-17 Actual £k	Jun-17 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(5,557)	(5,611)	54	(16,075)	(16,192)	117
Pay Costs	3,380	3,363	18	10,185	10,137	48
Non-pay Costs	1,320	1,333	(12)	4,025	4,094	(69)
Operating Expenditure	**4,700**	**4,695**	**5**	**14,210**	**14,231**	**(21)**
SURPLUS / (DEFICIT)	**856**	**915**	**59**	**1,865**	**1,961**	**96**
SURGERY						
Total Income	(4,892)	(4,888)	(4)	(14,207)	(14,389)	182
Pay Costs	2,982	2,974	7	8,958	9,027	(69)
Non-pay Costs	1,054	1,176	(122)	3,104	3,126	(22)
Operating Expenditure	**4,036**	**4,150**	**(115)**	**12,062**	**12,153**	**(91)**
SURPLUS / (DEFICIT)	**856**	**738**	**(118)**	**2,145**	**2,236**	**91**
WOMENS and CHILDRENS						
Total Income	(1,940)	(1,736)	(205)	(6,015)	(5,631)	(384)
Pay Costs	1,105	1,097	8	3,314	3,319	(5)
Non-pay Costs	126	139	(13)	395	359	36
Operating Expenditure	**1,230**	**1,236**	**(5)**	**3,709**	**3,678**	**31**
SURPLUS / (DEFICIT)	**710**	**500**	**(210)**	**2,306**	**1,952**	**(353)**
CLINICAL SUPPORT						
Total Income	(1,065)	(1,036)	(29)	(2,936)	(2,846)	(90)
Pay Costs	1,765	1,719	46	5,144	5,039	105
Non-pay Costs	1,108	1,026	82	3,108	3,219	(110)
Operating Expenditure	**2,873**	**2,745**	**128**	**8,252**	**8,258**	**(5)**
SURPLUS / (DEFICIT)	**(1,808)**	**(1,709)**	**99**	**(5,316)**	**(5,411)**	**(96)**
COMMUNITY SERVICES						
Total Income	(10,845)	(10,846)	2	(32,491)	(32,546)	55
Pay Costs	1,123	1,113	10	3,365	3,374	(9)
Non-pay Costs	4,197	4,240	(43)	12,559	12,551	8
Operating Expenditure	**5,320**	**5,353**	**(33)**	**15,924**	**15,925**	**(2)**
SURPLUS / (DEFICIT)	**5,525**	**5,494**	**(31)**	**16,567**	**16,621**	**54**
ESTATES and FACILITIES						
Total Income	(371)	(335)	(37)	(1,113)	(1,025)	(88)
Pay Costs	749	734	15	2,246	2,230	16
Non-pay Costs	593	611	(18)	1,745	1,734	10
Operating Expenditure	**1,341**	**1,345**	**(3)**	**3,990**	**3,964**	**26**
SURPLUS / (DEFICIT)	**(970)**	**(1,010)**	**(40)**	**(2,877)**	**(2,939)**	**(62)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	3,227	2,905	322	9,782	9,256	527
Pay Costs	1,171	1,196	(25)	2,861	2,964	(103)
Non-pay Costs (net of contingency and reserves)	1,052	1,093	(41)	3,322	3,412	(90)
Finance & Capital	454	543	(89)	1,574	1,631	(57)
Operating Expenditure	**2,677**	**2,832**	**(155)**	**7,756**	**8,006**	**(250)**
SURPLUS / (DEFICIT)	**(5,904)**	**(5,737)**	**168**	**(17,538)**	**(17,262)**	**276**
TOTAL (including penalties, contingency and reserves)						
Total Income	(21,442)	(21,547)	104	(63,056)	(63,373)	319
Contract Penalties	0	0	0	0	0	0
Pay Costs	12,273	12,196	78	36,072	36,089	(18)
Non-pay Costs	9,450	9,616	(167)	28,258	28,496	(237)
Finance & Capital	454	543	(89)	1,574	1,631	(57)
Operating Expenditure (incl penalties)	**22,177**	**22,355**	**(178)**	**65,904**	**66,216**	**(312)**
SURPLUS / (DEFICIT)	**(735)**	**(809)**	**(74)**	**(2,848)**	**(2,842)**	**6**

Medicine (Annie Campbell)

The Division over performed by £59k in June (£96k YTD)

Contract Income was ahead of plan. ED attendances averaged 197.4 per day in June – a 6.18% increase on the same month the previous year. Acuity also increased in the month and the average income per HRG increased to £130.80 per attendance (May £123.20), this helped improve the position to £57k ahead of plan. The increased level of attendances fed into an increase in non-elective activity (£58k above plan), and elective inpatients (£12k above plan). Poor outpatients performance (£64k behind plan) offset this. The main areas of concern were Dermatology (£23k – vacancies compared to last year), Rheumatology (£9k – consultant on retire and return) and Respiratory Physiology (£15k - vacancy). A specialty by specialty review is to be conducted to identify outstanding issues.

Net expenditure was £12k underspent and £36k under for the year to date. Pressures on ED and non-elective activity meant an increase in nurse agency in AMU and ED, reversing underspends from previous months. Medical staff remain underspent, but those specialties with significant vacancies AND pressures on RTT (Cardiology and Dermatology), used significant agency/locums. Drugs were underspent in the month though there are continued pressures from the prices of antibiotics. Security costs contributed most to the overall non-pay overspend of £12k in the month.

CIPs performance was disappointing, due to the increased agency costs (£72k achieved versus a target of £92k). Year to date the Division is £31k behind its target of £258k. Some schemes have had delayed starts, but this will improve by September, and overall the Division is forecasting to have an overspend of just £30k for the full year. PMO CIP schemes allocated to the Division are performing poorly, particularly agency where the expected 15% price decrease has not materialised. Medical locums are either the same rates as last year or higher (due to IR35 and vacancies in hard to fill specialties), whilst nurse agency prices have reduced by just 7.7%

Surgery (Simon Taylor)

The Division has underperformed by £118k in June (over performed £91k YTD)

Income over achieved against plan by £29k in June. Surgery overachieved in elective surgery but underperformed in non- elective and outpatients. There was also an increase in private patient income,

Pay is under spent by £7k.

Non-pay is overspent by £122k. This is mainly in theatres due to a significant increase in medical and surgical equipment being chargeable as a result of a receipting issue which resulted in underspends in the previous two months.

Surgery CIP's have over achieved by £82k YTD. This is due to some CIPs delivering earlier than planned, as well as higher vacancy management than plan.

Women and Children's (Rose Smith)
In June, the Division reported an under performance of £210k (£353k YTD).

Clinical income reported a £184k behind plan in-month (£366k YTD). Obstetrics and Midwifery Services reported £86k under performance due to a lower number of births although this was an increase against the previous month. Lower births have also had an effect on the number of women receiving post-natal care. Gynaecology Services reported a £73k underperformance with less patients being seen in both admitted patient care and outpatient. This is due to medical staffing sickness and annual leave.

Pay reported an £8k underspend in-month and £5k overspend YTD due to overspends on medical staffing in Paediatrics, offset against vacancies within Maternity Services.

Non pay reported a £13k overspend in-month and a £36k underspend YTD. The main overspend is on MSE non-disposable within Maternity Services. This is a timing difference and is not expected to continue. Also, this month reported an increase in drugs costs across the whole of Paediatric Services offset in part by an underspend in FP10's.

Clinical Support (Rose Smith) The Division over performed by £99k in June (under-performed by £96k YTD).

Clinical income for Clinical Support reported a £38k under performance in June and £69k YTD, mainly due to underperformance in Diagnostic Imaging (£24k), in both outpatient and admitted patient care.

Income was £20k behind plan in-month and £51k YTD. Main variances include Private Physiotherapy Service £14k and EIT Service £10k (although this is offset against a corresponding underspend within Pay).

Pay reported a £46k underspend in-month and £105k YTD due to vacancies, mainly within Integrated Therapies, in particular, EIT (partly offset against an underperformance on income) as well as vacancies within Outpatient Nursing.

Non pay reported a £82k underspend in-month and £110k overspend YTD. This is largely non-recurring and relates to a one off adjustment for outstanding drugs not invoiced following completion of a recent review.

Community Services (Dawn Godbold)
The Division reported a £31k under performance (£54k over performance YTD).

Pay reported a £10k underspend in-month and £9k overspend YTD. There have been vacancies across the service with a number of vacancies in Clinical Governance, Paediatrics and Adult Speech and Language Therapy. These underspends have been offset against overspends within Glastonbury Court (this is expected to continue until July), Rosemary Ward and Community Estates having to employ agency to cover staff sickness, annual leave and vacancies.

Non pay reported an overspend of £43k and an £8k underspend YTD. This month reported overspends for dressings partly offset against income as well as costs for consultants involved in the disaggregation of community services £38k, Catering Invoices £33k, and Continence products £26k.

Use of Resources (UoR) Rating

The Single Oversight Framework (SOF) assesses providers' financial performance via five "Use of Resources (UoR) Metrics.

The key features of the UOR ratings are as follows:

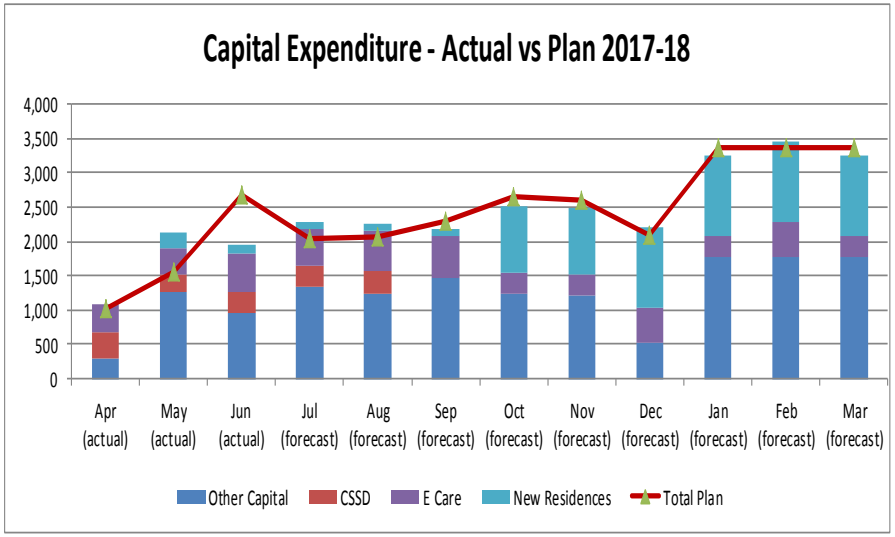
- 1 is the highest score and 4 is the lowest
- The I&E margin ratio is based on a control total basis rather than normalised surplus (deficit).
- The Agency rating measures expenditure on agency staff as a proportion of the ceiling set for agency staff. A positive value indicates an adverse variance above the ceiling.
- The overall metric is calculated by attaching a 20% weighting to each category. The score may then be limited if any of the individual scores are 4, if the control total was not accepted, or is planned / forecast to be overspent or if the trust is in special measures.

Metric	Value	Score
Capital Service Capacity rating	-2.501	4
Liquidity rating	-15.723	4
I&E Margin rating	-4.30%	4
I&E Margin Variance rating	0.40%	1
Agency	-42.50%	1
Use of Resources Rating after Overrides		3

The Trust is scoring an overall UoR of 3 again this month but the liquidity score has decreased from 3 to 4. This is likely to improve in July following the receipt of cash for GDE, STF and Primary Care Streaming.

The I & E margin rating and the Capital Service Capacity rating are closely linked and reflect the Trust is not generating a surplus in revenue to fund capital expenditure.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2017-18 £'000
E Care	415	381	567	533	585	625	305	305	505	305	505	305	5,333
CSSD	384	260	300	322	323	0	0	0	0	0	0	0	1,589
New Residences	0	246	128	97	97	97	974	974	1,174	1,174	1,174	1,174	7,310
Other Schemes	296	1,253	952	1,336	1,248	1,461	1,242	1,220	520	1,782	1,782	1,768	14,858
Total forecast / Forecast	1,096	2,140	1,947	2,288	2,253	2,183	2,520	2,499	2,198	3,260	3,460	3,246	29,090
Total Plan	1,012	1,568	2,673	2,034	2,058	2,283	2,643	2,612	2,103	3,365	3,365	3,363	29,082

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

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

The CSSD build is nearing completion and is forecast to be in line with its budget of £1.6m for the year. The final expenditure for this project (except for retentions) will be paid in August.

Expenditure on e-Care for the year to date is £1,363k and this is in line with the budget for the same period. The E-Care programme budget reflects the increased scope associated with the Global Digital Excellence (GDE) funding. The first tranche of this funding £3.3m was received in July. Initial indications are that the second tranche of funding will be received in December 2017, however past history would indicate that this timing is not guaranteed.

The forecasts for all projects have been reviewed by the relevant project managers. There are no significant financial risks to the budgets reported. Year to date the overall expenditure of £5,182k is slightly below the plan of £5,253k.

Statement of Financial Position at 30th June 2017

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2017 £000	Plan 31 March 2018 £000	Plan YTD 30 June 2017 £000	As at 30 June 2017 £000	Variance YTD 30 June 2017 £000
Intangible assets	15,611	19,711	17,142	16,658	(484)
Property, plant and equipment	74,053	94,189	76,970	76,996	26
Trade and other receivables	0	0	0	0	0
Other financial assets	0	0	0	0	0
Total non-current assets	**89,664**	**113,900**	**94,112**	**93,654**	**(458)**
Inventories	2,693	2,600	2,700	2,678	(22)
Trade and other receivables	18,345	11,700	17,011	19,434	2,423
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	2,500	2,689	189
Total current assets	**22,390**	**15,300**	**22,211**	**24,801**	**2,590**
Trade and other payables	(23,434)	(28,195)	(22,000)	(24,165)	(2,165)
Borrowing repayable within 1 year	(534)	(1,796)	(2,299)	(2,302)	(3)
Current ProvisionsProvisions	(61)	(61)	(84)	(89)	(5)
Other liabilities	(1,325)	(295)	(6,000)	(6,726)	(726)
Total current liabilities	**(25,354)**	**(30,347)**	**(30,383)**	**(33,282)**	**(2,899)**
Total assets less current liabilities	**86,700**	**98,853**	**85,940**	**85,174**	**(766)**
Borrowings	(44,375)	(55,951)	(45,668)	(45,704)	(36)
Provisions	(181)	(158)	(163)	(168)	(5)
Total non-current liabilities	**(44,556)**	**(56,109)**	**(45,831)**	**(45,872)**	**(41)**
Total assets employed	**42,144**	**42,744**	**40,109**	**39,302**	**(807)**
Financed by					
Public dividend capital	59,232	65,732	59,232	59,232	(0)
Revaluation reserve	3,621	3,621	3,621	3,621	(0)
Income and expenditure reserve	(20,709)	(26,609)	(22,744)	(23,551)	(807)
Total taxpayers' and others' equity	**42,144**	**42,744**	**40,109**	**39,302**	**(807)**

Intangible Assets

E-care expenditure in June was less than expected following phase 2 implementation in May.

Trade and Other Receivables

These increased in June due to Sustainability and Transformation Funding (STF) owed from DH increasing, a significant private patient charge and some 2016/17 accounting issues on contract income being resolved which had previously been netted off other liabilities.

Trade and Other Payables

The increase on this balance is mainly due to accruals for amounts owing on the capital programme. In addition there is still a significant backlog of invoices owing. An interface between the pharmacy system and the ledger has been delayed until August which will significantly reduce the volume of input required and therefore help to address the backlog.

Other liabilities

The increase on this balance is due to the accounting issues on 2016/17 contract income being resolved and transferred from this balance to receivables.

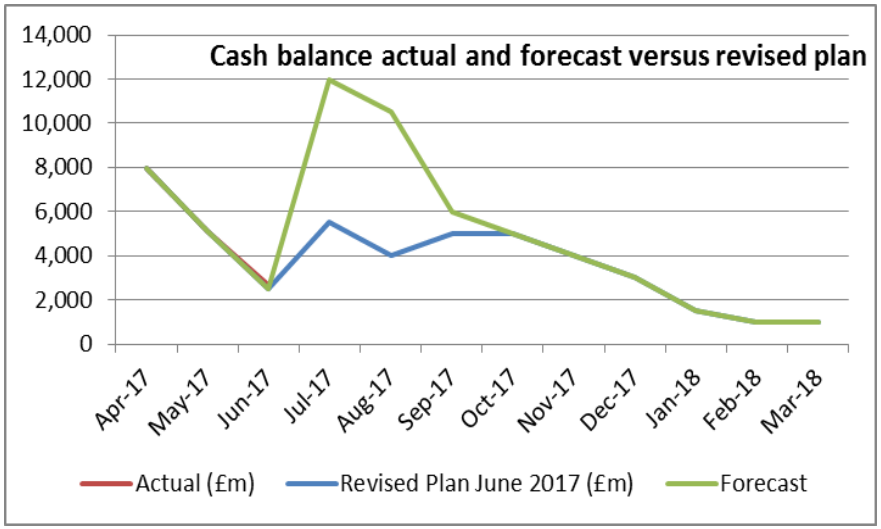
Cash:

Although this report is up to the end of June there is significant movement in July which will be of interest to the Board:

- £3.3m GDE cash has been received
- £1.0m Primary Care Streaming cash has been received
- £4.8m 2016/17 STF funding has been received.

FINANCE AND WORKFORCE REPORT – June 2017

Cash Balance Forecast for the year



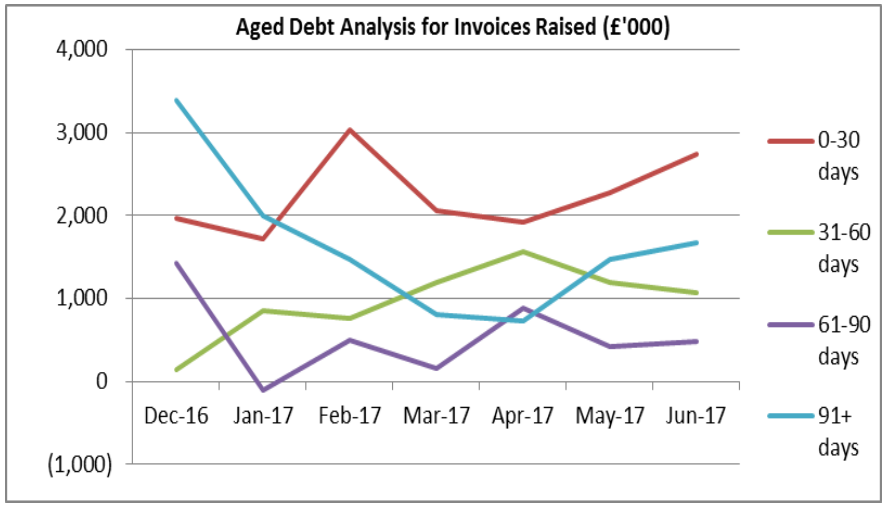
The graph illustrates the cash trajectory year to date, plan and revised forecast. The increase above plan is due to the STF cash being received earlier than was assumed when the plan was revised last month and the primary care streaming being received in July too.

The drawdown of capital loans has been paused until the cash is needed to minimise interest costs.

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.



Invoices have been raised in June following resolution of 2016/17 contract income issues which has caused an increase in the 0-30 days category.

Nearly half of the debt outstanding for over 90 days relates to charges to Suffolk County Council for Community Equipment. Discussions are ongoing to resolve this matter. Of the remainder in this category £656k relates to other NHS bodies and is being actively pursued with issues escalated as appropriate.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28 May 2017

AGENDA ITEM: 10

PRESENTED BY: Helen Beck – Interim Chief Operating Officer

PREPARED BY: Lesley Standring – Transformation Lead & John Connelly – PMO Lead. Sheila Broadfoot CQUIN Lead

DATE PREPARED: 18th July 2017

SUBJECT: Transformation Board Report

PURPOSE: Update

EXECUTIVE SUMMARY:

This report provides an update from the last reporting period and relates to the joint transformation team and the Trusts internal PMO. Financial aspects of CIP identification and delivery are included in the monthly finance and performance report.

Linked Strategic objective
(link to website)

Issue previously considered by:
(e.g. committees or forums)

Risk description:
(including reference Risk Register and BAF if applicable)

Description of assurances:
Summarise any evidence (positive/negative) regarding the reliability of the report

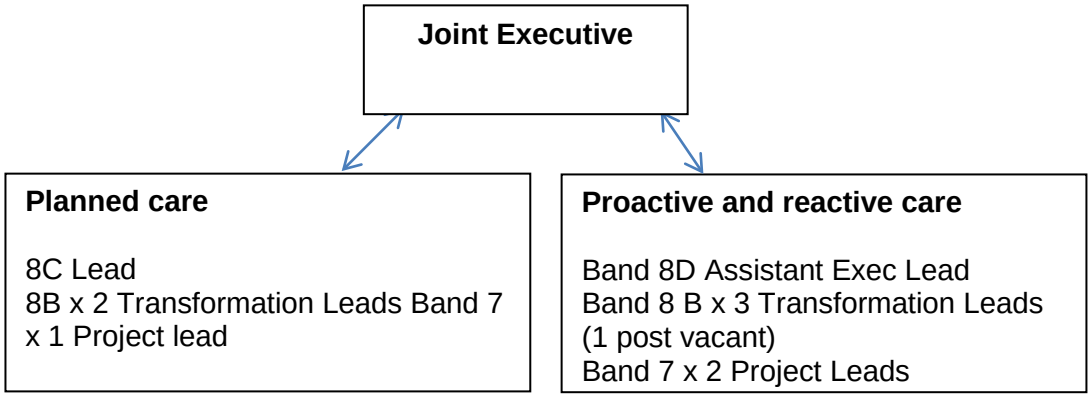
Legislation / Regulatory requirements:

Other key issues:
(e.g. finance, workforce, policy implications, sustainability & communication)

Recommendation:

The Board is asked to note the Transformation Report.

1.0 Update of the WSFT and WSCCG Joint Transformation Team Staffing



Since the last Trust Board update, there has been recruitment to two of the vacant posts within planned care however there is now a band 8B vacancy within the proactive/reactive care team. Consideration is currently being given to the post being downgraded to a band 7 to support the development of the team.

2.0 Integrated Care Programme Project highlights

2.1 Red to Green/SAFER: The Trust hosted a visit from the Head of Improvement Analytics with ECIST which was extremely positive. The team have taken away examples of the data we currently collect and will advise how we show the data to enable a clearer view of progress through the use of SPC charts.
A weekly meeting to review DTOC and stranded patients with colleagues from across the system will be set up by the end of July. WSFT has agreed to work with Dr Jonathan Back from Kings College London to evaluate Red2Green and SAFER.

2.2 Ambulatory Emergency Care: Following implementation and review of the MAT service to pull AEC patients from ED, this has been modified to ensure there is sufficient cover in the unit however the AEC nurse still visits ED, aiming for every two hours to 'pull' patients through the service rather than just rely on the ED push. On Monday 24th July the unit celebrates its third year, and since it has been meeting it's KPI's in the last 6 months the team are celebrating. A press release about the service's success is being created, a video about the service has been made and the team will have a stand at the innovation event. The team continues to plan the new unit AAU (Acute Assessment Unit) which will incorporate Surgical assessment also. The surgical AEC team have secured funding to join the national network and Trisha Stevens (CCG Transformation Manager) will be leading on the new surgical initiative.

2.3 Primary Care Streaming: The project Team led by Lee Taylor (CCG Transformation Lead) continue to progress plans. Estates and Facilities plans are on track, IM&T joint plans with GP Federation are proving more challenging. The team are currently focusing on workflows and the model of support required.

2.4 7 day Services: Data from the March 2017 survey is now available. A paper is being written to summarise outcomes and compliance. A deep dive of where there were cases of non-compliance with Consultant reviews has taken place. NHSI have just circulated a request for a gap analysis with costings and detail to determine Trust's compliance to the four priority standards, this is being completed, to be presented with the paper at TEG on the 7th August, to enable submission by the 9th August deadline. The Autumn 2017 and Spring 2018 survey dates have just been published.

2.5 Discharge to Optimise and Assess (D2OA): A paper outlining the model for the west of Suffolk has been prepared. The full case will be presented to the August Integrated Care Network (ICN) meeting and will include an update on the 5Q's looking at the full scope of all the pathways including CHC.

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

2.7 Mandated High Impact Changes

An action plan has been developed following a system wide self-assessment against the 8 High Impact Changes. Action plans are being developed to address areas requiring additional focus.

These 8 impacts are:

Early Discharge Planning:	In elective care, planning should begin before admission. In emergency /unscheduled care, robust systems need to be in place to develop plans for management and discharge, and allow an expected date of discharge to be set within 48 hours.
System to Monitor Patient Flow:	Robust patient flow models for health and social care, including electronic patient flow systems, enable team to identify and manage problems
Multi-Agency Discharge Teams Including the voluntary and Community Sector:	Co-ordinated discharge planning based on joint assessment processes and Delayed Transfers of Care protocols, on shared and agreed responsibilities promotes effective discharge and good outcomes for patients
Home First/Discharge to Assess:	Providing short-term care and reablement in people's homes or using 'step-down' beds to close the gap between hospital and home which means that people no longer need to wait unnecessarily for assessments in Hospitals. In turn, this reduces delayed discharges and improves patient flow
Seven-Day Services:	Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs
Trusted Assessors:	Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way
Focus on Choice:	Early engagement with patients, families and carers is vital. A robust protocol underpinned by a fair and transparent escalation process is essential so that people can consider their options. The voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care
Enhancing Health in Care Homes:	Offering people joined-up, co-ordinated health and care services can help reduce unnecessary admissions to hospital as well as improving hospital discharges.

3.0 Planned Care Programme

3.1 Integrated Pain Service

Executives Boards at West Suffolk Foundation Trust (WSFT), GP Federation and West Suffolk Clinical Commissioning Group (WSCCG) have agreed to set up an Integrated Pain Management Service (IPMS) as a joint arrangement between West Suffolk Hospital and GP Federation using an 'Alliance contract/Strategic Partnership' model. This service will amalgamate the current hospital and community services and will be a significant transformational change within the West Suffolk system. The IPMS will be a new entity providing a single point of access and an integrated approach to patient care with a greater emphasis on patients self-managing their condition and receiving follow up care closer to where they live.

Executives Boards have agreed that the new Integrated Pain Management model will go live by April 2018 and be managed via a Board consisting of clinicians and managers from partners across the health and care system. Shadow governance arrangements will be in place during the transition period running from now until March 2018 to implement the agreed clinical pathway, finalise the service specification and develop the contractual arrangements and organisational structure for the new service.

4.0 WSFT Programme Management Office

4.1 PMO Highlight Report

Developments in period:

- Inclusive Transformation Steering Group (TSG)Report redesign to support integration: Executive Summaries by CIP Cluster underpinned by detailed CIP Tables with reporting by exception. The redesign also compares CIP performance with divisional actual performance.
- Established TSG Reporting formula with actions to move CIP's from Red to Amber to Green
- Secured shared space on 'O' drive to enhance access for all cluster team members supporting effective meetings
- TSG Terms of Reference updated to include RAG Guidance and Management of Interdependencies process

Key TSG Issue:
Materiality: Exception reporting in divisional TSG CIP Slides to include CIP Values / Top 3 Value CIP's / Outstanding QIA Authorization from August 2017 TSG

Key Risks: (1) Double Counting **(2)** Internal Audit Report

Key Next Steps (including Risk Mitigations):
Two strands of work to be developed in July (1) Interdependencies (2) Double Counts

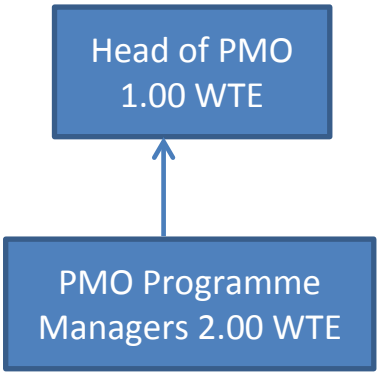
(1) Interdependency Risks will be identified in the cluster meetings based on the TSG CIP Tables. Interdependency risks will be recorded in the project workbook risk log by the project manager and captured at aggregate level by the PMO . Impact assessments will be developed by the project manager with mitigations agreed by parties at Interdependency Review Workshops and CIP Values adjusted accordingly.
(2) Double Counting: The double counting risk will be mitigated by including 'Ledger Transaction' as a Milestone in the Milestone Tracker
including the account code to provide focus on the double counting issue. A spreadsheet will be developed in a joint weekly PMO / KPMG / Finance meeting. The spreadsheet will include Project Name, CIP Value and Account Code to identify savings attributable to each code.

The Interdependency Risks and the Double Count spreadsheet will be reviewed in the cluster meetings and in the weekly Operations Directorate Meeting where the CIP Programme has an agenda slot.

The CIP set up documentation phase needs to be completed with all new and existing CIP's migrated on to the revised workbook format.
This will provide sufficient assurance to the auditors that the processes and governance are improving and doing their jobs and project delivery can then become the singular programme focus based on milestone trackers and action logs to support effective cluster meetings.

4.2. PMO Structure

Governance: Current PMO Reporting Structure (Interim Consultants)



Programme Manager 1: Project Delivery Portfolio: E Rostering, Outpatients, Community CIP's

Programme Manager 2: Project Delivery Portfolio: Nursing and Medical Agency, Medical Products Usage, Renal Dialysis, Joint Pharmacy

Note: PMO resource covers planning, facilitation and administration of WSFT TSG and Cluster Meetings

PMO Transition: Executive discussions and decisions are required regarding the future PMO scope and function

- PMO function needs to be clear. PMO currently has responsibility for the delivery of a sub-section of CIP's and executive reporting. The future PMO model is envisaged to facilitate change and provide effective oversight of all WSFT CIP's. Responsibility for the delivery of projects would therefore rest with the Executive Sponsor and Project Leads with cluster level PMO Managers in place.

4.3 PMO Project Management Update

A review of current portfolio of key PMO delivery projects is as follows:

- The Medical and Nursing Agency CIP is still expected to achieve and may exceed the £264k target in 2017/18 although there is a double counting risk to be reviewed in the next stage of the programme.
- Medicine's Optimisation is also on track at July expecting to realize £170k savings in the current financial year.
- The management of the Medical Products Usage will transfer to Surgery in July 2017 and is still on track at £201k in the financial year.
- E-Rostering is an invest to save project offering significant organizational demand management and reporting benefits to the Trust. The project would be cost neutral over a five-year period and as such has been removed from the WSFT CIP Tracker as the CIP Programme has a short to medium term focus. The procurement process is currently being worked through with the PMO Programme Manager, Head of

procurement and the Executive Sponsor.

- Integrated Pain Management: This project was developed as an Alliance Project by the previous COO and has now transferred to the Planned Care program) for the West Suffolk System.
- Renal Dialysis: The current plan is that management of the Renal Dialysis Unit will transfer to WSFT from CUH in October 2018/19 following the transfer of Nephrology outpatient work.
- Joint Pharmacy Project: This is a project devised as a joint system venture with the CCG and has the potential to achieve significant CIP. The project is being hampered however by the inability to recruit a pharmacy technician to deliver the project. A revised job description at Band 6 level is currently out to advert via NHS Jobs.
- Outpatients: The estimated value of potential savings continues to decrease as the original baseline assumptions are not valid. There is a delivery plan in place to realize approximately £14k savings compared with the original estimates of £350k+

5. CQUIN Projects

National CQUIN projects 2017-8-9

Value £3,428,060 divided between 14 projects NATIONAL	Q1	Q2	Q3	Q4
1a) Staff Health & Wellbeing: Improve the support available to NHS Staff to help promote their health and wellbeing, for them to remain healthy and well. Achieve set targets on 2 of 3 Staff Survey questions. Trusts do not have to pre-select which two. **Year 1** Baselines x 3: 2015 staff survey. **i) General H&W -** Does your organisation take positive action on health & wellbeing? Yes, definitely: 45% or 5% improve. **ii) MSK** – In the last 12m have you experienced MSK as a result of work activities? No: 85% or 5% improve. **iii) Stress** – During the last 12m have you felt unwell as a result of work related stress? No: 75% or 5% improve.	**TARGET %** Progress work	Progress work	Progress work **FULL £**	>5% or set targets: i) 45% ii) 85% iii) 75% Part payments available: Half £ for 3% Three quarters £ for 4% Result unknown until published Feb 2018
Year 2 As above but baseline x 3: 2016 staff survey				Result unknown to Feb 2019
1b) Healthy food for staff, visitors and patients **Year 1** **Part a)** Evidence to show: Health of food offered on premises - Items high in fat, sugar & salt – full ban on: 1) price promotions, 2) advertising & 3) items at checkouts; 4) ensure healthy options available; including for staff working at night. **NEW Part b)** i) 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). Also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). ii) 60% of confectionery and sweets do not exceed 250 kcal. iii) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g. Evidence of a) changes maintained & b) introduced with signed between Trust and food supplier: commitment to keep changes; Improvements reported to a public facing Board.	**TARGET %** Progress work	Progress work	Progress work **FULL £**	Part a) evidence maintained Part b) i) 70% ii) 60% iii) 60% Part payments available: a) 2016-7 maintained = half £ b) 2017-8 changes introduced = half £ Both above for full £ Only risk is with a national Franchise following the rules.
Year 2 As above but part b) targets: i) 80%, ii) 80%, iii) 75%.				Part payments as above.
1c) Frontline clinical staff – flu vaccinations: **Year 1** Achieving an uptake of flu vaccinations by frontline staff of 70% by 28 February 2018. **Risk:** high target. 2015-6 = 53%. 2016-7 = 64.6%. Resource TBC invest (£) as per 2016-7.	**TARGET %** Prep	Progress	Progress **FULL £**	70 Part payments: 50% or less 0 50-59% quarter £ 60-64% half £ 65-70% three quarters £
	N/A	N/A		
Year 2 As above except target increases to 75% for top £.				Part payments as above except pre top is 65-75%
2) Reducing Impact of Serious Infections Timely identification and treatment for sepsis and a reduction of clinically inappropriate antibiotic prescription and consumption.	**TARGET %** **90**	**90**	**90** **FULL £**	**90**

Year 1
2a) SEPSIS: Timely identification in Emergency Departments and Inpatients: Adult and Paediatrics.
Screening: via local protocol.
Q1-4 top £ for 90%. Stepped payment available.

Part payment available: 49.9% or less 0 50-89.9% half £	Part payment available: 49.9% or less 0 50-89.9% half £	Part payment available: 49.9% or less 0 50-89.9% half £	Part payment available: 49.9% or less 0 50-89.9% half £

Year 2 - as above.

2b) SEPSIS: Timely treatment in Emergency Departments and Inpatients: Adult and Paediatrics.

The percentage of patients who were found to have sepsis in sample 2a* and received IV antibiotics within 1 hour of the diagnosis.

*Interpretation: NICE 2016 guidance – specifies those who meet a high risk of sepsis (most Trusts call red-flag) should have IVABx within 1 hr. Query to NHS England – is the target really for 'all' in 2a Sepsis?

Risk: Current 'red-flag' Sepsis status: **65.47%.**
Note: e-Care adding Pathology in June 2017 = aid in ID Sepsis & prompt

TARGET %

90	**90**	**90**	**90**

FULL £

Part payment available: 49.9% or less 0 50-89.9% = £ 5.0% of total	Part payment available: 49.9% or less 0 50-89.9% = £ 5.0% of total	Part payment available: 49.9% or less 0 50-89.9% = £ 5.0% of total	Part payment available: 49.9% or less 0 50-89.9% = £ 5.0% of total

Year 2 – as above.

2c) Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.
% of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours.

Audit of 30 prescriptions per month & submit via Public Health England data portal. / Year 2 presume as above - tbc

TARGET %

25	**50**	**75**	**90**

FULL £

2d) Reduction in antibiotic consumption.
Per 1,000 admissions (Defined Daily Doses) by end Q4:
1% reduction for those trusts with 2016 consumption indicators below 2013/14 median value, **OR**
2% reduction for those trusts with 2016 consumption indicators above 2013/14 median value in:
1. Total antibiotic consumption
2. Total consumption of carbapenem
3. Total consumption of piperacillin-tazobactam

Risk: major challenge to reduce from a low base.
Year 2 tbc

TARGET %

Tbc <1%

FULL £

Submit quarterly data to Public Health England	Submit quarterly data to Public Health England	Submit quarterly data to Public Health England	Each item is worth 33%

4) Improving services: Mental Health needs in ED
Ensuring people presenting at ED with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at ED.

Mental health and acute providers work together with partners (e.g. primary care, police, ambulance, substance misuse, social care, voluntary sector).
Year 1
i) Reduce by 20% the number of attendances to A&E (0% increase) for those within a selected cohort of frequent attenders and establish improved services to ensure this reduction is sustainable. Develop a care plan for each, in collaboration with the patient and providers & make available to ED for use when the patient attends.
ii) Improve data quality, information sharing & robust coding for

TARGET %

i) & ii) ID patients iii) baseline iv) joint working – did cohort present at other UEC system points June ? or 20/7	i) & ii) review coding including audit, iii) joint governance, iv) create care plans & in place. v) ID new frequent attenders & plan in place, vi) share info, vii) plan to sustain reduction. Sept 2017	i) & ii) Review progress on data quality plan & confirm systems in place for Q4 confidence: coding. Dec 2017	<20% Reduction of the frequent attenders March 2018

FULL £ - mental health provider has own £

audit.

Q1)

i) Identify the people who attended each A&E most frequently during 2016/17 (e.g.10-15 times or more).

ii) Review this group and identify the sub-cohort of people for whom mental health and psychosocial interventions led by specialist mental health staff would have the greatest impact. The number of people in the cohort will need to be agreed locally e.g.10-15 people per hospital site or more.

iii) Set the baseline. Report to Unify.

iv) Evidence collaborative working: identify whether identified cohort also presenting frequently at other UEC system touch points.

Q2)

i) Review whether identified cohort were coded appropriately.

ii) Conduct audit of coding. Agree joint data quality improvement plan & arrangements for sharing of data.

iii) Establish Acute & MH Trust – joint governance to review progress.

iv) Create care plans (co-produced with the patient) & put in place.

v) System to ID new frequent attenders & care plans in place quickly.

vi) Share care plans with other partners (patient permission).

vii) Agree development plan to support sustained reduction.

Q3)

i) MH trust, acute trust review progress against data quality improvement plan and all confirm that systems are in place to ensure that coding of MH need via A&E HES data submissions is complete and accurate, to allow confidence in Q4 submissions. Assurances provided to CCGs accordingly.

ii) Agree formally and assure CCG confident that a robust and sustainable system for coding primary and secondary mental health needs is in place.

Q4)

20% reduction in A&E attendances of those within the selected cohort of frequent attenders

i) – iv) Value 10%

i) and ii) Value 10%

iii) Value 0%

iv) Value 10%

v) Value 20%

i) and ii) Value 10%

Part payments available:

Reduction of frequent attenders:

5-9.99% = £ one quarter
10-14.99% = £ half
15-19.99% = £ three quarters

20% & over = £ full payment

Value 40%

Year 2

i) Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions.

ii) Reduce total number of attendances to A&E by 10% (compared to Year 1) all people with primary mental health needs.

iii) Strengthen existing / develop new services to support people with mental health needs better and offer safe and more therapeutic alternatives to A&E where appropriate.

iv) Repeat internal audit of mental health diagnostic coding in A&E to provide assurance of the quality of coding.

Q1

i) Baseline total number of attendances with primary mental health diagnosis in Q4 2017-8, total frequent attenders and submit to Unify.

Baseline (Q4 2017-8)

Unify data submit

Evaluation to ED Board

May

Audit Coding

Dec

Plan for BAU

ii) 0% increase in frequent attenders

iii) 10% reduction in ED attendances

March

FULL £

ii) Evaluation of progress signed off by local ED Board.
Q3
i) Repeat internal audit of ED mental health coding to ensure improvement from year 1 is sustained.
ii) Provide assurance of confidence in robust system for coding.
Q4:
i) Agree plan for 'business as usual' going forward.
ii) 0% increase in number of A&E attendances of frequent attenders
iii) 10% reduction in ED attendances with primary mental health diagnosis, compared to baseline Q4 2017-8.

Year 3

Q1 2019-20

National data submission to NHS England via UNIFY2 for total number of A&E attendances during 2018/19 for those within the selected cohort of frequent attenders in 2017/18 who would benefit from mental health and psychosocial interventions.

Evaluation report of 2 year CQUIN submitted.

0%		10%	ii) 10% iii) 80% Part payments available: Reduction in ED attendances of all people with primary mental health diagnosis: 0-2.49% = £ 20% of value 2.5-4.99% = £ 40% of value 5-9.99% = £ 60% of value

6) Advice and Guidance to GP

Improve GP to access consultant advice prior to referring patients in to secondary care.
Set up and operate A&G service for non-urgent GP referrals
Allowing GP access to Consultant advice before referring.
Either through ERS platform or local solution: telephone, email, online.

Can include: virtual review of test results, supply of plan, direct booking of tests or intervention, advice re: clinic referral.
Review & decided on specialties e.g. Gynae, T&O, ENT, Dermatology, Ophthalmology.

Suggested data:
Average number of GP A&G queries relative to GP referrals.
GP A&G queries which led to referrals.
Data source: Monthly Activity Return or tbc new data standard.
Meet with Commissioners quarterly to review.

Year 1

Q1
• Agree specialties with highest volume of GP referrals for A&G implementation
• Agree trajectory for A&G services to cover a group of specialties responsible for at least 35% of GP referrals by Q4 2017/18
• Agree timetable and implementation plan for introduction of A&G to these specialties during the remainder of 2017/18
• Agree local quality standard for provision of A&G, including that 80% of asynchronous responses are provided within 2 working days
Q2
• A&G services mobilised for first agreed tranche of specialties in line with implementation plan and trajectory
• Local quality standard for provision of A&G finalised
• Baseline data for main indicator provided
Q3
• A&G services operational for first agreed tranche of specialties
• Quality standards for provision of A&G met
• Data for main indicators provided
• Timetable, implementation plan and trajectory agreed for rollout of A&G services to cover a group of specialties responsible for at least 75% of GP referrals by Q4 2018/19
Q4
• A&G services operational for specialties covering at least 35% of total GP referrals by start of Q4 and sustained across the quarter
• Quality standards for provision of A&G met
• Data for main indicator provided

TARGET %

Agree specialties with highest volume of GP ref; trajectory toward Q4; timetable and plan ;	Services mobilised for 1st tranche specialties; baseline data for main & supported indicators	Services operational for 1st tranche; data for main & supported indicators provided; timetable, implementation trajectory agreed toward Q4 2018-9.	Services operational for 35% of total GP referrals by start of Q4 & sustained. Data provided.
Prep local quality standard incl: 80% responses in 2 days	Local quality standard finalised re: 80% responses in 2 days	Quality standards met - 80% responses in 2 days	Quality standards met - 80% responses in 2 days

FULL £

Value 25%	Value 25%	Value 25%	Value 25% Part payments available: 20-24.99% = £ 40% of value 25-29.99%= £ 60% of value 30-34.99% = £ 80% of value

Year 2
Continue project toward the Q4 target:

A&G services in place for a group of specialties responsible for receiving 75% of total GP referrals by start of Q4 and sustained across the quarter.

- Local quality standards met
- Data for main and supported indicators provided

Q1-Q3
- A&G services introduced in line with Q1 trajectory and implementation plan
- Quality standards for provision of A&G met
- Data for main indicator provided

Q4
- A&G services in place for a group of specialties responsible for receiving 75% of total GP referrals by start of Q4 and sustained across the quarter
- Local quality standards met
- Data for main indicator provided

TARGET %			
A&G services introduced in line with plan/ data.	A&G services introduced in line with plan/ data	A&G services introduced in line with plan/ data	75% of total GP referrals by start Q4 & sustain
Quality standard 2 day turnaround	Quality standard 2 day turnaround	Quality standard 2 day turnaround	Quality standard 2 day turnaround
FULL £			
Value 15%	Value 15%	Value 15%	Value 55% Part payments available: 45-54.99% = £ 40% of value 55-64.99% = 60% of value 65-74.99% = 80% of value

7) e-Referrals

All providers to publish ALL of their services and make ALL of their First Outpatient Appointment slots available on eRS by 31 March 2018 following trajectory.

Undertake required work on the Trust's Directory of Services.
Q1
Baseline plan to deliver Q2-Q4 targets, including solutions for gaps.

Q2-4
i) Services are published and receiving referrals through NHS e-Referral service.

ii) Adequate slot polling is taking place to allow patients to book – evidence reduction in 'Appointment Slot issues' to a rate of 4% or less.

Data source:
e-RS System and Providers: i) Q2-4 data from the Directory of Services e-RS extract EBSX05; ii) monthly e-RS Appointment Slot Issues report.
See quarterly requirements opposite.

TARGET %			
i) Submit baseline/plan & trajectory to deliver Q2-4 targets ii) Supply a list of services/ clinics accepting 1st O/P referrals & detail NRS e-RS services mapped to: published.	i) 80% of referrals to 1st O/P Services able to be received through e-RS. ii) Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment **Slot Issues by service reducing to 4% or less** in line with the agreed trajectory set in Q1.	i) 90% of referrals to 1st O/P Services able to be received through e-RS. ii) As per Q2	i) 100% of referrals to 1st O/P Services to be received through e-RS. ii) As per Q2
FULL £			
Value 25%	Value 25% Part payment available: i) 50-60% = £ 50% 61-70% = £ 60% 71-79% = £ 70%	Value 25% Part payment available: i) 61-70% = £ 50% 71-80% = £ 60% 81-89% = £ 70%	Value 25% Part payment available: i) 71-80%= £ 50% 81-90%= £ 60% 91-99%= £ 70%

8)
a & c) Proactive and Safe Discharge – patients aged 65+ (admitted via non-elective route) & discharged within 3-7 days of admission to their usual place of residence.
Baseline: Q3 & Q4 2016-7

b) Emergency Care Data Set (ECDS) upgrade (Cerner).

Note: Parts a) & c) are a separate project to Part b)

Year 1:

TARGET			
Part b) i) Prep or ensure IT / training plans in place collect ECDS data from 1/10	**Part a)** i) Map & streamline discharge pathways in partnership ii) Plan, baseline, trajectories for part b)	Part b) Weekly data; 95% have valid Chief Complaint & diagnosis (values from code set)	**Part c)** Increase discharged to usual place of residence within 7 days of residence by 2.5% points from baseline OR 47.5% patients
FULL £			

Q1 Part b) Type 1 or 2 A&E provider has demonstrable and credible planning in place to make the required preparations (e.g. by upgrading IT systems and training staff) so that the Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017.	Value split: Part b) = 15%	Value split: Part a) 40%	Value split: Part b) 5%	Value split: Part c) 40%
Q2 **Part a)** i) Map and streamline existing discharge pathways across acute, community and NHS-care home providers, and roll-out protocols in partnership across local whole-systems. ii) Develop and agree with commissioner a plan, baseline and trajectories which reflect expected impact of implementation of local initiatives to deliver the *part b** indicator for year 1 and year 2. As part of this agree what proportion of the part b indicator for each year will be delivered by the acute provider and what proportion will be delivered by the community provider. Achievement of part b will require collaboration between acute and community providers. **query part a)*				Part payments available: Less than 1.5% point increase = £0 1.5 to 1.99% point increase = 50% £ 2 to 2.49% = 80% £ **OR** Less than 40% = £0 40-44.9% = 50% £ 45-47.4% = 80%
Q3 Part b) ii) Type 1 or 2 A&E provider is returning data at least weekly AND 95% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 95% of patients have a diagnosis. Chief complaint should be any value from the ECDS Chief Complaint code set (SNOMED CT). Diagnosis should be any value from the ECDS diagnosis code set (SNOMED CT).				
Q4 **Part a / c)** Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17) compared to Q3 and Q4 2017-8 (OR 47.5% of patients). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.				

Year 2:

Part a) Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 7.5% points from 2017/18. Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.

Part b)

Completion and timely submission of data by provider in line with the collection requirements. Where part b is not applicable to a provider this weighting will be applied to part a.

Q1

Type 1 or 2 A&E provider is returning data daily AND 99% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 99% of patients have a diagnosis AND 99% of patients have a measure of acuity recorded. Acuity should be any value from the ECDS acuity set

Q2

Type 1 or 2 A&E provider is returning data daily AND 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis AND 100% of patients have a measure of acuity recorded AND 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number).

Q3

Type 1 or 2 A&E provider is returning data daily AND 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis AND 100% of patients have a measure of acuity recorded AND 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number) AND 100% of patients have the referral source recorded. Referral source should be any value from the EDCS referral source set.

Q4

Type 1 or 2 A&E provider is returning data daily AND 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis AND 100% of patients have a measure of acuity recorded AND 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number) AND 100% of patients have the referral source recorded AND 100% of patients have discharge status recorded. Discharge status should be any value from the EDCS discharge status set.

Part a / c) Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 7.5% points from baseline 2017/18 (OR increase to 50% of patients). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.

Daily data & 99% patients has diagnosis & measure of acuity recorded (ECDS data set)	Daily data & 100% patients has diagnosis & measure of acuity recorded (ECDS data set) & recorded discharge clinician number	Daily data & 100% patients has diagnosis & measure of acuity recorded (ECDS data set) & recorded clinician number & referral source (ECDS)	Daily data & 100% patients has diagnosis & measure of acuity recorded (ECDS data set) & recorded clinician number & referral source (ECDS) & discharge status (ECDS)

			Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 7.5% points from baseline 2017/18 (OR increase to 50% of patients).
Value split: Part b) 5%	Part b) 5%	Part b) 5%	**Part a) 80%** Part payments available: Less than 3% increase = £0 3-6.49% = £ 50% 6.5-7.49% = 80% £ OR Less than 45% = £0 45-47.49% = 50% £ 47.5-49.9% = 80% £

2018-9

9) Preventing ill health by risky behaviours: tobacco & alcohol screen, advice, treat adult inpatients (non-repeat admission during the 2 years). Excluding maternity.
Data to be submitted to Unify (via electronic records: all patients; non-electronic manual audit x 500 per quarter.

Tobacco
9a) Screening – % who are screened (as per NICE) for smoking status AND whose results are recorded.
9**b) Brief Advice**
% of unique patients who smoke (from part a) and are offered very brief advice by healthcare professional & it is recorded in record.
9**c) Referral and medication offer**
% of unique patients from a) who are offered referral to stop smoking services (these could be e.g. Local Authority funded Local Stop Smoking Services or lifestyle service in the community; in-house services in hospital; or within GP practices or pharmacies) and this to be recorded in the patient's record in a clear and consistent way; and offered medication.
Alcohol
9d) Screening
% of unique adult inpatients who are screened for drinking risk levels and whose results are recorded.
9e) Brief Advice or referral
Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral.

Audits:
To include all patients via electronic records (or if cannot search electronically; a random sample).
Submit to Unify.

TARGET %

Information systems audit: i) proposed mechanisms, ii) data capture, iii) approach for case note audits b) Advice – Staff training i) ID & assess staff; ii) who will be trained; iii) training criteria; iv) how effective training; v) training schedule, process in place for new starters c) Baseline data	High target performance or improving performance % Targets tbc for 9a-9e	High target performance or improving performance % Targets tbc for 9a-9e	9a) 90% 9b) 90% 9c) 30% 9d) 50% 9e) 80%

FULL £

Part payments available Q2-4

	% of £ CQUIN scheme available for meeting final indicator value				
Final indicator value	**9a**	**9b**	**9c**	**9d**	**9e**
Target met	**5%**	**20%**	**25%**	**25%**	**25%**
For those achieving below 100% of target / final indicator value					
10% point improvement over last Q performance	**2%**	**10%**	**12%**	**12%**	**12%**
20% point improvement over last Q performance	**4%**	**15%**	**18%**	**18%**	**18%**

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28th July, 2017

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

EXECUTIVE SUMMARY

- This report will be reflective of the data from June 2017
- In June there were 426 Patients Safety Incidents (PSI) reported; a decrease from May (505).
- Level of harm in proportion to overall Patient Safety Incidents reported:
  - 81% (87% May) no harm (Green)
  - 15% (11% May) minor harm (Green)
  - 3% (3% May) moderate harm (Amber)
  - 0.2 % (0.6% May) major harm (Red)
  - 0% (0% May) catastrophic harm (Red)
- In relation to type of incidents reported in June the highest areas of reporting related to Pressure ulcers, Slips Trips & Falls, and Medication.
- 10 Complaints were received in June compared to 10 in May
- 169 PALS contacts were recorded in June compared to 188 in May

Thematic Review of Stillbirths

In the calendar year 2016 there were 13 stillbirths at WSH giving a ratio of 5.0 per 1000 births, higher than the expected figure. As a small unit (delivering approximately 2,500 babies per year) each investigation, whilst detailed and robust is isolated and it is difficult to ensure that any possible themes are identified. Therefore it was agreed that a thematic review of this cohort of stillbirths should be undertaken, to give added assurance to the findings it was felt appropriate to seek a peer review presence at the meeting. Having reviewed all cases it was felt that there was the possibility that the care of three cases could have been influenced had the care pathways discussed been in place; however it was accepted that this was a very difficult assessment to make in retrospect. The key recommendations from the review are set out below and a full action plan is being developed to address the recommendations which will be monitored by TEG and reported to CSEC on 8 September.

Stillbirth review recommendation
1. The development of a Task and Finish group to look at the provision of ultrasound scans, the frequency for high risk groups, in line with the recommendations of Saving Babies Lives and the information gained at scan, i.e. Doppler and PI. Additionally how this information should be recorded, the possible use of "Chitty" charts for some groups of women.
2. Consideration of the introduction of a clinic for women with twin pregnancies, in line with the guidance of NICE. Due to low numbers this might form part of another antenatal clinic.

Stillbirth review recommendation
3. Continue the work currently in process to try to improve urine testing at antenatal appointments.
4. To introduce clear guidance for when women should be referred to Fetal Medicine.
5. To consider the use of Aspirin in cases of previous SGA babies
6. To implement the GAP audit of missed cases of IUGR
7. To introduce checking that women are taking Aspirin and Folic Acid during routine antenatal appointments
8. To continue the already commenced work with women who smoke in pregnancy, including looking at the referral pathway.
9. Establish smoking status at referral, ensure GPs are up to date with this and to encourage early offering of nicotine replacement therapies.

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

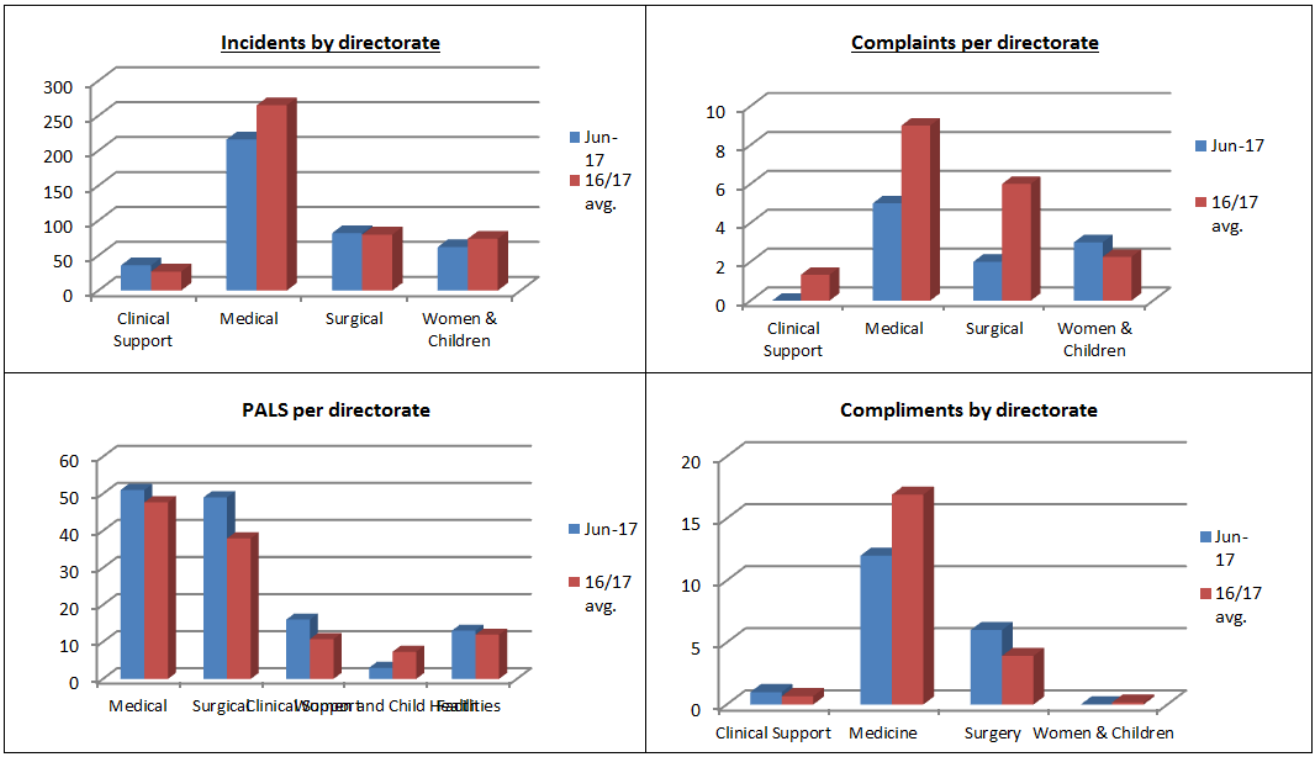


Table 2: PSIs reported by month (24 months)

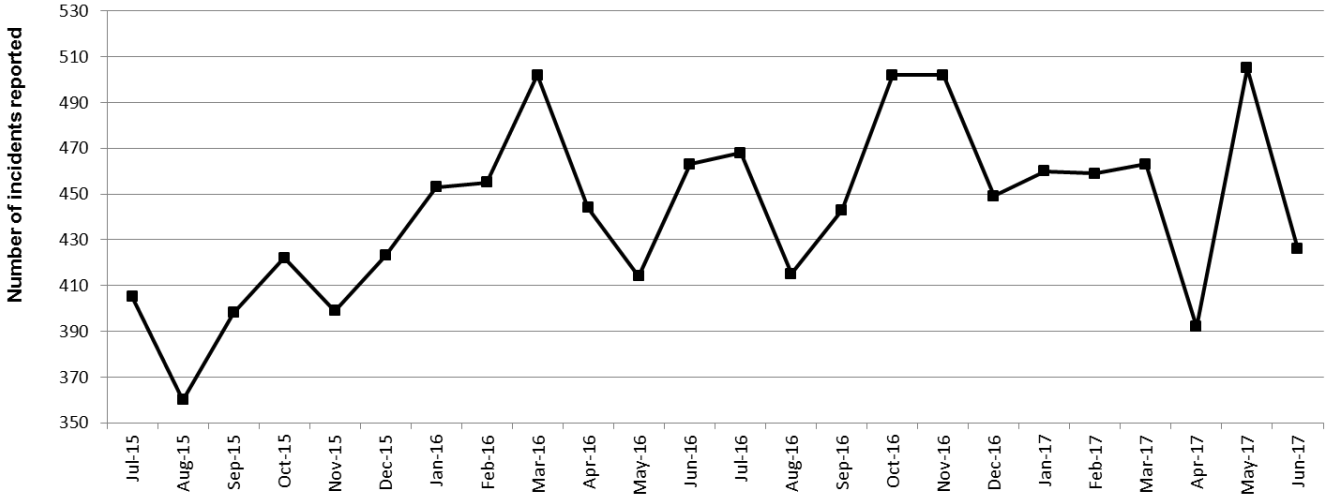
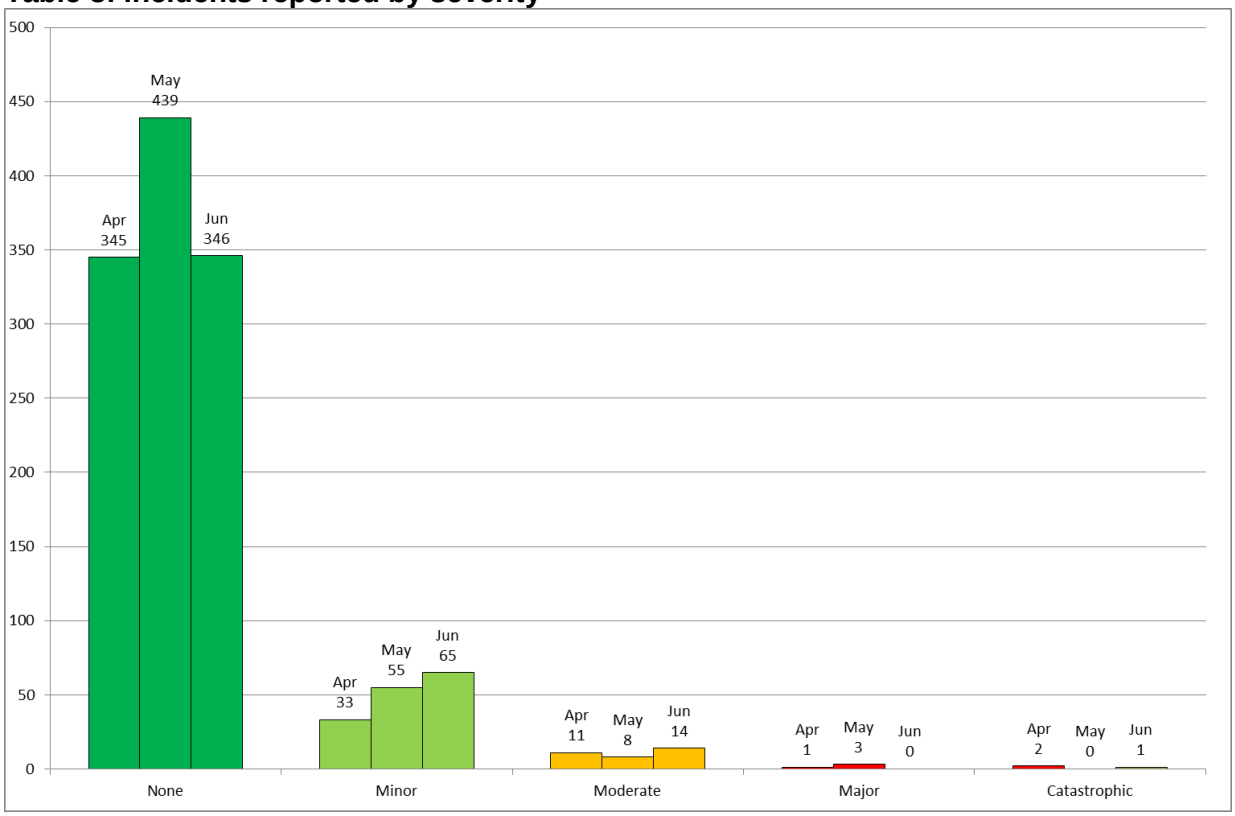


Table 3: Incidents reported by severity



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).

This month has seen a decrease in overall reporting but not to the levels of April. This month's incidents have seen a continuous increase in minor harm incidents reported over the last three months. Moderate incidents have also increased to 14 with Major harm decreasing and catastrophic harm being zero for the second month in a row. A further breakdown of the incidences are below.

The one Catastrophic harm incident is:

- Fall on F7 resulting in neck of femur fracture, patient then became septic and died.

The 14 moderate harm incidents relate to:

Medicine (8)

- Hospital acquired pressure ulcers (4 cases)
- Fall (1 case)
- Delay in psychiatric assessment resulting is patient, family distress
- Delay in identification of illness resulting in further invasive surgical procedures
- Confused patient who was aggressive towards staff, caught leg whilst trying to kick the member of staff.

Surgical (3)

- Hospital acquired pressure ulcers (2 cases)
- Incorrect diagnosis given to patient and referral to specialist centre for chemotherapy, upon review by specialist centre patient was given correct diagnosis not requiring chemotherapy.

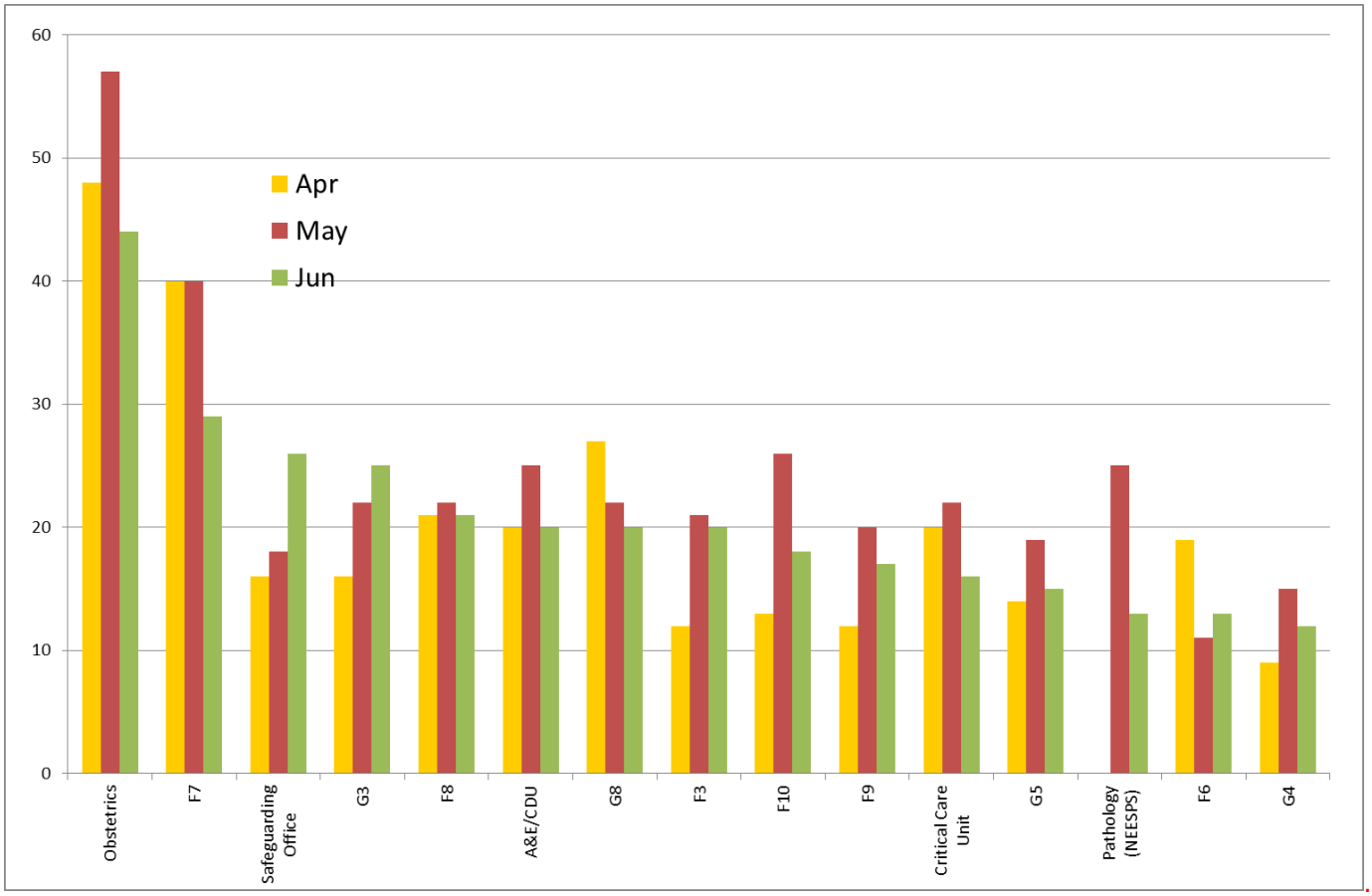
Women & Children (2)

- Hospital acquired pressure ulcer (1 case)
- Incorrect recording of abnormal Glucose tolerance test leading to delay in management

Clinical Support (1)

- Delayed reporting of rapid access CT

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



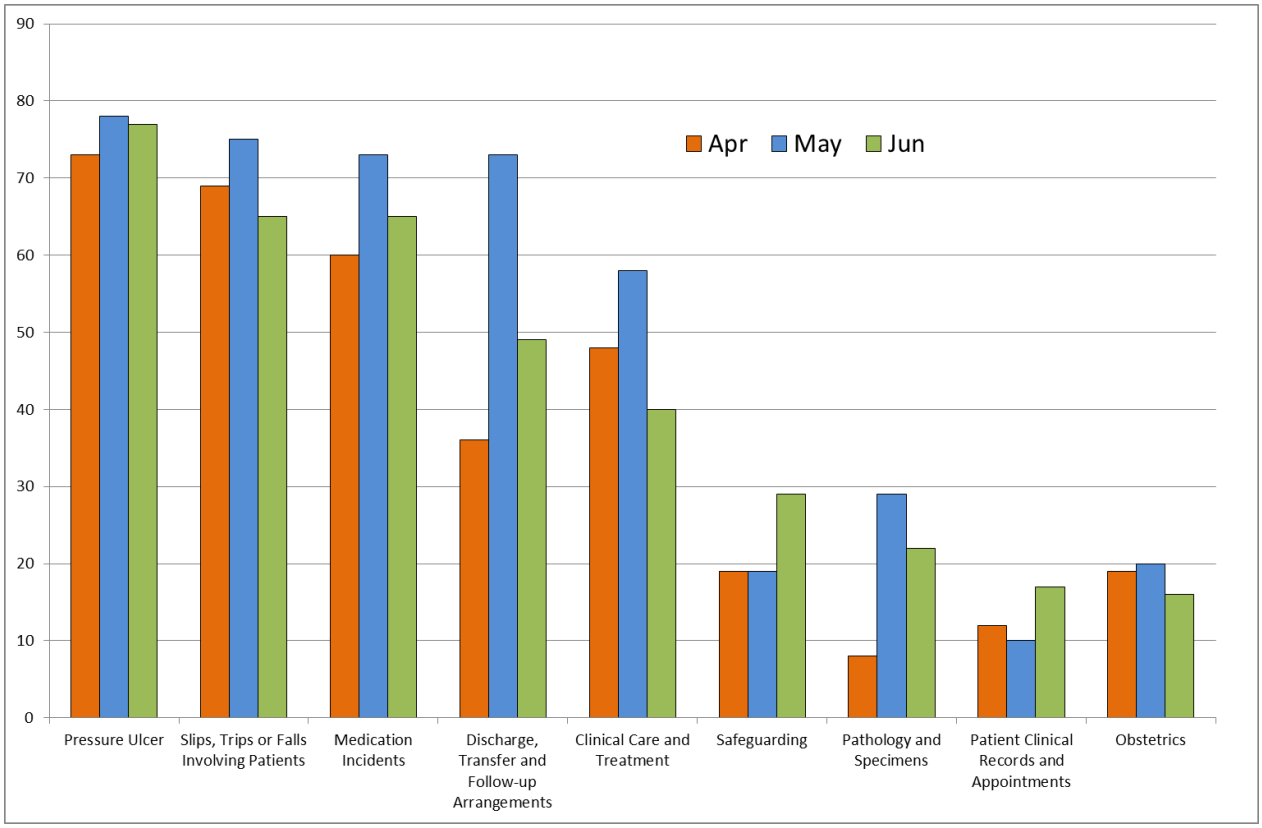
This month has seen a general decrease in incident reporting, however Safeguarding, G3 and F6 have all seen an increase. Safeguarding has seen an increase in both safeguarding referrals and DOLs referrals this month with 4 patients having multiple referrals made.

G3 has seen a small increase in incidents compared to last month however this has been a trend over the past 3 months. There has been an increase this month with multiple incidences affecting 3 patients on G3. With a small increase in Medication incidences, Slips/trips and falls, and Pressure Ulcers.

F10 had seen an increase from 13 incidents to 26 last month; this has decreased this month to around their normal levels.

F6 slight increase this month from 11 to 13 has two patients who have had more than one incident.

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



There has been a general decrease in reporting this month, however the main categories remain the same. It is good to see that medication incidents have reduced this month as there has been an increase month on month over the past four previous months. This was explored in last month's report. The increase in safeguarding has been noted this month and discussed above.

Complaints

10 complaints were received in June. The breakdown of these complaints is as follows by Primary Division: Medical (5), Surgical (2), Women & Children (3).

Patient Experience Themes

Area	Analysis	RAG rating
Car Parking	Car parking continues to flag as a high area of enquiry, in June the majority of these enquiries related to the cost of parking and issues with the use of pay and display when clinics are delayed.	
Oral Surgery and Orthodontics	Enquiries about the cessation of the oral and orthodontics services were a theme in June with many patients raising their concerns that they have not yet been informed of where treatment will continue and under which provider. The Trust has been working closely with NHS England in order to facilitate a smooth transition however unfortunately NHS England have been unable to release details of the newly allocated providers at this time. Understandably patients are finding the lack of information distressing and we have been offering as much information as possible.	

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

West Suffolk NHS
NHS Foundation Trust

Trust Board – 28th July 2017

AGENDA ITEM:	12
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Sinead Collins, Clinical Business Manager
DATE PREPARED:	18th July 2017
SUBJECT:	Quality and Workforce Dashboard – Nursing
PURPOSE:	For Information

EXECUTIVE SUMMARY:

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

For in depth review of areas, please inquire for the Matrons' governance reports that are completed monthly for their divisions.

Included are any updates in regards to the nursing review

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

Recommendation:

Observations in June and progress of nurse staffing review made below

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	5 medication errors	High bank and agency use. High sickness
F7	3 medication errors	High bank and agency use. Management changes. High sickness and vacancy
F8	6 medication errors	Management changes
G1	4 medication errors	High bank use
G3	4 medication errors and 2 pressure ulcers	High bank use
G4	5 falls (with harm) – 3 of the falls was one dementia pt.	High bank use and high sickness
G5	4 medication errors and 3 pressure ulcers	-
G8	3 medication errors	High bank use
F1	-	High bank use
F3	4 medication errors, 2 pressure ulcers and 3 falls (with harm) – 2 were one confused patient	Agency use
F4	-	High bank and agency use. Long term sickness and high annual leave
F5	-	High bank use
F6	4 medication errors	Agency use
F9	3 pressure ulcers	High bank use
F10	6 medication errors, 2 pressure ulcers and 4 falls (with harm) - 2 were the same pt	High sickness
F11	4 medication errors	High bank use
Kings Suite		High bank use & sickness

Vacancies – Current processes are being reviewed due to template used between HR and Finance creating some inappropriate figures in some areas. A&E and F8 are still query areas

Roster effectiveness – Out of 26 areas, 19 are over the Trust standard of 20%. This is a strong increase from May that had only 8 areas over 20%. The reasoning for this have been put down to annual leave allocation and staffing levels following KPMG review

Sickness – Out of 27 areas, 13 are over the Trust Standard of 3.5% (one less than last month)

Update on progress of Nurse Staffing Review

Nurse Specialist review is being supported by KPMG

KPMG have determined that controlling annual leave at a 12% maximum threshold and implementation of stricter regulation on hours owed through e-rostering system are their recommended steps.

Item 12

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Jun-17			Establishment for the Financial Year 2017/18						Data for June 2017												
										Workforce											Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day (June 2017)	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night			Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	81.79	70.47%	29.53%	N/A	1 - 4	1 - 5	110.7%	95.1%	117.3%	96.7%	5.80%	6.10%	4.70	-6.40	9.90%	N/A	28.10%	N/A	5	1
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	84.5%	91.0%	107.2%	94.0%	11.30%	7.70%	-5.40	-5.63	9.30%	7.41	24.30%	1	3	0
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	80.5%	N/A	91.0%	N/A	1.90%	0.30%	1.21	0.31	3.30%	N/A	22.90%	0	6	0
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	91.2%	85.7%	N/A	N/A	2.20%	0.00%	-4.30	0.00	6.80%	23.99	17.20%	0	1	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	116.9%	100.3%	N/A	N/A	1.30%	0.00%	-1.10	-0.40	4.20%	N/A	19.20%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	135.0%	80.6%	54.4%	N/A	3.20%	0.00%	-2.21	0.00	2.80%	N/A	22.20%	0	0	N/A
WSFT	DSU	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward area	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	91.1%	N/A	92.1%	N/A	2.30%	0.00%	-1.90	-1.45	4.10%	N/A	20.50%	0	1	0
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	100.1%	100.0%	67.8%	N/A	0.40%	0.00%	-0.10	-0.70	1.20%	12.89	15.40%	1	1	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	89.3%	96.6%	93.1%	N/A	8.50%	0.00%	-1.00	2.10	5.70%	8.21	26.80%	1	4	1
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	88.9%	95.8%	98.0%	106.2%	10.90%	0.00%	-0.66	-2.90	4.70%	5.07	20.40%	2	4	0
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	92.5%	86.5%	108.1%	110.8%	15.50%	0.20%	-1.08	-3.30	8.00%	6.26	23.30%	0	1	5
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	78.5%	92.5%	111.4%	101.4%	4.90%	0.40%	-0.50	-0.48	2.20%	5.00	15.60%	3	4	1
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	88.6%	97.0%	91.8%	93.1%	10.80%	0.20%	-2.80	-2.40	2.20%	6.68	21.40%	1	3	1
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	93.3%	143.8%	133.8%	N/A	12.20%	0.00%	-1.30	2.50	0.80%	N/A	23.10%	N/A	1	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	89.5%	95.0%	130.1%	95.6%	1.90%	3.50%	-3.00	-2.60	2.90%	5.34	20.00%	2	4	3
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	89.0%	94.2%	103.8%	187.4%	16.70%	5.10%	-1.70	-3.28	5.60%	7.10	24.60%	0	1	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	91.8%	93.3%	91.7%	120.9%	7.00%	0.50%	-2.46	-0.30	2.30%	6.02	20.10%	0	2	1
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	88.3%	97.9%	105.5%	100.1%	1.70%	5.20%	-3.20	-2.10	2.00%	9.26	20.70%	0	4	1
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	100.7%	100.0%	88.9%	98.8%	11.10%	0.00%	-3.90	-1.35	2.90%	12.90	17.30%	3	2	1
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	115.1%	80.8%	85.9%	96.2%	3.60%	0.00%	-0.50	0.80	6.30%	5.74	23.90%	2	6	4
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	120.4%	97.6%	72.5%	60.8%	10.00%	0.00%	-0.98	-0.55	5.40%	N/A	23.20%	0	4	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1												0	0	0
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre recovery area, bereavement suite					1 - 2	1 - 2												0	1	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	85.2%	83.5%	33.9%	100.0%	9.10%	0.00%	-3.60	2.90	3.60%	10.35	21.80%	0	1	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	101.2%	96.7%	N/A	N/A	0.00%	0.00%	-0.70	-0.40	0.60%	N/A	20.80%	0	1	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	9.00	80.00%	20.00%	N/A	5 - 8	N/A	92.7%	N/A	77.3%	N/A	0.00%	0.00%	-0.20	0.00	0.00%	N/A	12.10%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	96.5%	91.1%	26.7%	30.0%	1.30%	0.00%	-1.50	-1.40	1.00%	19.42	21.70%	N/A	1	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	97.1%	96.7%	96.2%	106.7%	5.15%	0.33%	-2.08	-0.40	1.26%	7.10	N/A	0	0	0
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	99.7%	98.8%	98.0%	97.9%	12.90%	0.0%	-0.90	-0.10	7.8%	5.50	24.70%	1	2	2
																-41.16	-27.53	Target - 3.5%		Trust standard is 20%			

Explanations

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

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

Item 13

West Suffolk NHS
NHS Foundation Trust

Board of Directors (Public) – 28th July 2017

PRESENTED BY:	Jan Bloomfield, Executive Director Workforce & Communications
PREPARED BY:	Karen Margetts, Training Improvement Manager
DATE PREPARED:	24th 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 July 2017 Mandatory Training Report, this represents data taken from the system on 10th July 2017. Safeguarding Children Level 2 is now at 91% and Level 1 is at 89% and therefore only 1% from reaching the Trust target. Level 3 at the end of quarter 1 was at 81% and further to the July 2017 report, it has reduced to 75%. This will be followed up with the Subject Matter Expert and an update will be reported in the next report. Information Governance compliance is currently at 89% which is the highest it has been for several months. Compliance for Moving and Handling continues to meet the Trust Target level of 80% for Non-Clinical Load Handler, 81% for Clinical and 82% for e-learning. Conflict Resolution (classroom) is currently at 75% compliance.

There was a 82.23% compliance rate for induction during quarter 1. A number of staff that commenced employment in quarter 1 are booked onto the September 2017 Trust Induction. The Trust Induction for August 2017 was cancelled due to the recent changes in venues, however, the fire and health and safety elements will continue for new starters to ensure we are meeting are legal obligations.

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 Q1 there were 2,754 that required training and the total number trained were 2,622 which equates to 95.21%.

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 93.89% for June 2017 and this is a 0.68% 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 July 2017

Competence Name	Does not meet requirement	Meets Requirement	Grand Total	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
179|LOCAL|Infection Control - Classroom|	61	1429	1490	95%	94%	94%	94%	94%	94%	95%	95%	96%	95%	96%
179|LOCAL|Equality and Diversity|	163	3031	3194	90%	90%	91%	91%	91%	92%	93%	93%	94%	95%	95%
179|LOCAL|Infection Control - eLearning|	124	1386	1510	87%	86%	87%	87%	87%	88%	88%	88%	88%	90%	92%
179|LOCAL|Safeguarding Adults|	263	2931	3194	87%	87%	87%	87%	86%	87%	88%	88%	89%	90%	92%
179|LOCAL|Fire Safety Training - Classroom|	283	2911	3194	88%	88%	88%	89%	89%	89%	89%	90%	90%	90%	91%
179|LOCAL|Safeguarding Children Level 2|	139	1387	1526	86%	86%	85%	86%	86%	87%	87%	87%	88%	90%	91%
179|LOCAL|Health & Safety / Risk Management|	295	2899	3194	86%	86%	86%	87%	86%	87%	88%	88%	89%	89%	91%
179|LOCAL|Security Awareness|	295	2899	3194	87%	86%	87%	87%	87%	87%	88%	88%	89%	90%	91%
179|LOCAL|Information Governance|	346	2848	3194	82%	80%	81%	82%	82%	82%	82%	80%	81%	85%	89%
179|LOCAL|MAJAX|	346	2848	3194	84%	85%	85%	85%	85%	86%	86%	86%	86%	88%	89%
179|LOCAL|Medicine Management (Refresher)|	165	1306	1471	86%	86%	85%	85%	85%	86%	87%	87%	87%	88%	89%
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	364	2830	3194	87%	87%	86%	87%	86%	87%	86%	86%	86%	87%	89%
179|LOCAL|Slips Trips Falls|	253	1811	2064	84%	83%	83%	83%	82%	84%	85%	84%	85%	87%	88%
179|LOCAL|Blood Bourn Viruses/Inoculation Incidents|	235	1570	1805	82%	82%	82%	82%	81%	84%	85%	84%	84%	86%	87%
179|LOCAL|Conflict Resolution - elearning|	97	636	733	76%	76%	77%	76%	77%	81%	83%	81%	83%	85%	87%
179|LOCAL|Fire Safety Training - eLearning|	434	2760	3194	87%	86%	87%	87%	86%	86%	85%	85%	86%	87%	86%
179|LOCAL|Basic Life Support - Adult|	327	1676	2003	76%	78%	78%	81%	81%	80%	81%	83%	85%	85%	84%
179|LOCAL|Moving & Handling - elearning|	158	742	900	75%	76%	77%	77%	77%	79%	79%	81%	81%	81%	82%
179|LOCAL|Blood Products & Transfusion Processes (Refresher)|	271	1205	1476	75%	75%	77%	77%	76%	78%	80%	80%	82%	83%	82%
179|LOCAL|Moving and Handling - Clinical|	322	1339	1661	78%	77%	78%	80%	82%	80%	79%	81%	83%	84%	81%
179|LOCAL|Moving and Handling Non Clinical Load Handler|	77	313	390	69%	71%	75%	86%	87%	84%	83%	81%	81%	83%	80%
179|LOCAL|Conflict Resolution|	310	949	1259	75%	73%	73%	74%	74%	74%	75%	75%	75%	77%	75%
NHS|MAND|Safeguarding Children Level 3 - 1 Year|	79	238	317	81%	80%	83%	81%	81%	79%	78%	85%	83%	81%	75%

Q1 Apr-Jun 2017 New Starters % Compliance – Trust	Total
No	14
Yes	65
Grand Total	79
% Compliance	82.23%

Mandatory Training Action Plan Apr 2017

Appendix B

	Apr 2017 %	Method	Actions	Completion date	Responsibility	Progress
Safeguarding Children level 1	86%	E-learning	To improve Safeguarding Children level 1 compliance to 90%	Oct 2017	Lisa Sarson	At the end of Q1, compliance for Safeguarding Children level 1 is reported at 87% and following the July 2017 report, it has increased to 89% and is therefore only 1% away from reaching the Trust target.
Safeguarding Children level 2	87%	E-learning	To improve Safeguarding Children level 2 compliance to 90%	Complete	Lisa Sarson	At the end of Q1, compliance for Safeguarding Children level 2 is reported at 90%.
Safeguarding Children level 3	85%	Face to face	To improve Safeguarding Children level 3 compliance to 90%	Oct 2017	Lisa Sarson	At the end of Q1, compliance for Safeguarding Children level 3 is reported at 81%. However in July 2017 it has decreased to 75%. This will be reviewed by the SME, however, early indications suggest this could be made up of a combination of changes in staffing, cancellations and the timings of attendance being recorded in ESR/OLM.
Moving & Handling–clinical	81%	Face to face	To improve compliance to 80%	Complete	Neil Herbert	Target now met
Moving & Handling–e-learning	81%	E-learning	Manual Handling Advisor e-mailing mangers encouraging staff to be compliant and complete the eLearning package.	Complete	Neil Herbert	Target now met
Information Governance	80%	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 Q1 compliance is reported at 85%. However in July 2017 it has increased by another 2%. Compliance rise is likely to be slower than others as it's a yearly requirement for all staff.
Conflict Resolution	75%	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 Q1 compliance is reported at 77%. However in July 2017 it has decreased to 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	917	870	94.87%
May	919	874	95.10%
June	918	878	95.64%
Q1.	**2754**	**2622**	**95.21%**
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 June 2017

WSH									
Topic	All			Enabling**	Workforce	Leadership	Operations*	Quality and Governance	Paediatrics
	Compliant	NonCompliant	% Compliancy						
Conflict Resolution	375	25	93.75%	88.89%	N/A	100.00%	97.33%	100.00%	94.47%
Dementia Compliance	389	11	97.25%	96.97%	N/A	100.00%	96.00%	100.00%	97.70%
Equality and Diversity	385	15	96.25%	90.91%	N/A	100.00%	94.67%	100.00%	99.08%
Fire	368	32	92.00%	88.89%	N/A	100.00%	89.33%	100.00%	94.01%
Health & Safety	390	10	97.50%	95.96%	N/A	100.00%	93.33%	100.00%	99.54%
Infection Control	369	31	92.25%	93.94%	N/A	100.00%	92.00%	100.00%	91.24%
Information Governance	389	11	97.25%	96.97%	N/A	100.00%	98.67%	100.00%	96.77%
Learning Disabilities	369	31	92.25%	81.82%	N/A	100.00%	90.67%	100.00%	97.24%
Life Support	187	52	78.24%	N/A	N/A	N/A	77.94%	100.00%	77.98%
Mental Capacity	33	7	82.50%	N/A	N/A	N/A	84.21%	50.00%	N/A
Moving and Handling	356	44	89.00%	97.98%	N/A	100.00%	90.67%	100.00%	83.87%
Safeguarding Adults	392	8	98.00%	94.95%	N/A	100.00%	98.67%	100.00%	99.08%
Safeguarding Children	391	9	97.75%	93.94%	N/A	100.00%	98.67%	100.00%	99.08%
Overall % for all topics	**4393**	**286**	**93.89%**	**92.84%**	**N/A**	**100.00%**	**92.91%**	**98.92%**	**94.48%**
*** Enabling = Facilities, Finance & Informatics*									
*** Operations = Newmarket Hospital, Epilepsy, Neurology, Parkinsons, Adult SLT*									

SCH Induction

New Starters % Compliance	Q1 Apr-Jun 2017
No	0
Yes	17
Grand Total	17
% Compliance	100%

Item 14

Board of Directors – 28th July 2017

PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Medical Staffing, HR and Communications Directorate
DATE PREPARED:	19th July 2017
SUBJECT:	Consultant Appointments
PURPOSE:	To receive report
STRATEGIC OBJECTIVE:	To continue to secure, motivate, educate and develop a committed workforce providing high quality patient focused services.

POST:	Consultant in Plastics
DATE OF INTERVIEW:	13th July 2017
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]

	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	5 2 3

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28 July, 2017

ITEM NO:	15
PRESENTED BY:	Dr Nick Jenkins, Medical Director
PREPARED BY:	Paul Molyneux, Deputy Medical Director/Nick Jenkins, Responsible Officer and Medical Director
DATE PREPARED:	July, 2017
SUBJECT:	Responsible Officer Annual Report 2016-17
PURPOSE:	To update the Board on the status of Medical Revalidation and Appraisal, and approve the annual Board Statement of Compliance
STRATEGIC OBJECTIVE:	Invest in quality, staff and clinical leadership

EXECUTIVE SUMMARY:

Boards have statutory duties in respect of medical appraisal and revalidation, and are required to receive an Annual Report form the appointed Responsible Officer.

Since the last Annual Report in June 2016, the Trust has implemented the changes proposed by the Revalidation Support Team in their report of January 2016.

This Annual Report outlines the Trust position as at 31 March 2017, updates the Board on recent developments in appraisal and revalidation and asks for confirmation that it is satisfied the West Suffolk is compliant with current regulations.

The report highlights areas where progress has been made, and further work that will be required to ensure both timely and appropriate appraisal of all Senior doctors with a prescribed connection to this Trust.

The number of doctors with whom the Trust has a prescribed connection during this period was 303.

Matters resulting from recommendations made in this report	**Present**	**Considered**
Financial Implications	Yes / ~~No~~	Yes / ~~No~~
Workforce Implications	Yes / ~~No~~	Yes / ~~No~~
Impact on Equality and Diversity impact	~~Yes~~ / No	~~Yes /~~ No
Legislation, Regulations and other external directives	Yes / ~~No~~	Yes / ~~No~~
Internal policy or procedural issues	Yes / ~~No~~	Yes /~~ No~~

Risk Implications for West Suffolk Hospital Appraisal and revalidation are key mechanisms by which assurance is gained regarding high-quality medical care and leadership: without satisfactory processes in place poor performance may go unrecognised and unmanaged.	**Mitigating Actions** (Controls): • Regular monitoring of appraisal compliance, satisfactory revalidations and deferral rates • Escalation process for failure to comply with appraisal requirements • Management of conduct / capability issues using *Maintaining High Professional Standards* process
Level of Assurance that can be given to the Board from the report based on the evidence Sufficient	
Recommendations: • The Board are asked to accept the Annual Report, note the contents and approve it for submission to the higher level Responsible Officer • The Board are asked to approve the statement of compliance confirming that the West Suffolk NHS FT is compliant with relevant legislation and regulations	

Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care to patients, improving patient safety and increasing public trust and confidence.

Provider organisations have a statutory duty to support their Responsible Officer in discharging their duties under the Responsible Officer Regulations, and it is expected that provider Boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisation
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback is sought at suitable intervals from patients so that their views can inform the appraisal and revalidation process for their doctor
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Governance Arrangements

Individual doctors are responsible for ensuring they undertake annual appraisal and have a prescribed connection with a designated body. The Responsible Officer is responsible for evaluating the doctor's performance based on evidence provided through appraisal and other mechanisms, and making a recommendation to the General Medical Council (GMC) every five years about their fitness to practice. Boards have a responsibility to ensure the RO is provided with adequate resources to fulfil their statutory function.

Doctors now have a fixed appraisal month and it has been made clear that they should conduct their appraisal at the latest by the end of the fixed appraisal month. In line with other organisations, failure to complete the appraisal process within three months of the fixed month now counts as a formal 'missed appraisal'. Doctors may agree reasons for delay with the Responsible Officer, but this is only approved if there is a genuine reason such as long term sick leave.

The status of every doctor is continually reviewed and updated and doctors are reminded of upcoming appraisal with sufficient notice to complete their e-portfolio and submit their appraisal documentation to their appraiser in good time for the appraisal interview. Any doctor who is non-compliant with appraisal or revalidation processes is identified early and sent escalating reminders and interventions. The General Medical Counsel has now developed a more formal mechanism for dealing with non-engagement through a non-engagement concern letter. If the Responsible Officer notifies the GMC of non-engagement, as set out in their criteria, the GMC will put the doctor under notice. If sufficient progress is not made by the Doctor to engage in appraisal, the GMC may bring forward the revalidation date to allow the Responsible Officer to submit a recommendation of non-engagement. If a recommendation of non-engagement is made, the GMC will begin the process of removing the doctor's license to practice

Appraisal processes have been well-established for many years. Appraisers are trained and receive top-up training at intervals. An electronic system called 'SARD' is used. In addition to providing a monitoring and reporting function it allows creation of an e-portfolio, generation of an appraisal document equivalent to the GMC 'MAG' form, creation of an appraisal output summary and other tools such as multi-source feedback.

The annual appraisal includes:

- Preparation by the doctor which should include reflection on the full scope of their professional activities, not only their West Suffolk clinical work but private practice, voluntary activities, educational supervisor or appraiser roles and any external professional activities. The doctor

must upload a range of suitable supporting evidence applicable to each role. This is captured in the e-portfolio and transferred to an annual appraisal document prior to the appraisal interview

- An assessment by the Appraiser of the whole of the doctor's professional activities, which should be supported by evidence. The appraiser will review among other things scope of work, activity, patient outcomes, complaints and incidents, colleague and patient feedback, health and probity.

- A review of the personal development plan from the previous year, achievements and challenges, and the development of a new PDP to address the learning needs and career development of the doctor.

- Declarations by the Appraiser and Appraisee that the doctor continues to practice in accordance with the obligations of the General Medical Council *Good Medical Practice* Framework

- An appraisal summary which describes how the appraiser has evaluated the doctor against their professional roles, and what topics were discussed. The summary is an opportunity to describe the doctor's fitness for *purpose* compared to their fitness to *practice*. Although the appraisal process is generally confidential between appraiser and appraise, the summary is often requested by other employers or organisations for whom the doctor provides services and is therefore written so it can be shared by the appraisee.

The West Suffolk Hospital has a system in place which ensures that all doctors have suitable pre-employment checks.

The Trust submits quarterly information to NHS England about appraisal activity including whether the Responsible Officer has sufficient resources to undertake the role, and also submits an Annual Organisational Audit.

Responsible Officer

The RO is appointed by the Board and is normally the Medical Director, as at the West Suffolk. As RO, Dr Nick Jenkins has undertaken all the required training and ongoing training required by NHS England to fulfil this role. His own appraisal includes evaluation against this role and includes provision of supporting evidence to the higher level RO, Dr David Levy. The RO makes recommendations to the GMC regarding revalidation, and can either make a positive recommendation, or recommend deferral or non-engagement.

Medical Appraisal Lead

The Medical Appraisal Lead at the West Suffolk is the Deputy Medical Director, Dr Paul Molyneux, who has undertaken Case Investigator training as well as Responsible Officer Training. The SAS doctors have a Lead appraiser, Dr Balendra Kumar, who ensures this group are suitably advised and supported, even if they only work at the West Suffolk for a short period.

Progress in 2016-17

a) Continue to monitor appraisal uptake/rates of completion – appraisal compliance rates rose from despite stricter application of the criteria for missed appraisals. A doctor who is 1 day overdue will count as non-compliant, as will all doctors who are delayed for an accepted reason e.g. sickness or maternity leave. Of the 11 doctors showing as 'non-compliant' 2 had an accepted reason for delay, 9 were less than three months overdue (of which 7 were less than one month overdue). Doctors in this category – providing the West Suffolk have

made every effort to remind and support them – are sent a formal letter which forms part of their revalidation evidence and must be discussed with their appraiser.

b) Quality Assure at least 20% of appraisals. As part of an on-going process of Quality Assurance, a system has now been developed for Quality Assurance of at least 20% of all appraisals. Until recently, the Lead Appraiser and Responsible Officer have carried out this role. However, after reviewing this arrangement, it was felt that it would be beneficial for all the appraisers to Quality Assure at least two appraisals completed by a different appraiser per year, using an electronic appraisal Checklist. The aim is to allow appraisers not only to critically review the work of other appraisals, but also to learn and benefit from areas of good practice. Permission will be sought from the appraisee prior to this independent review, given the need for a different appraiser to have access to the full appraisal record.

c) Continue to recruit and train new appraisers. A total of 5 new appraisers were recruited and trained. Training was provided by either the Deputy Director of Workforce using a model provided by UEA, or an external trainer with more than a decades experience in appraiser training

d) Provide appraisers with enhanced training through annual Appraiser Training Workshop

e) Provide appraisers with feedback using the SARD evaluation

f) MPIT process embedded - this is the formal transfer of information between Responsible Officers when doctors change designated body. This has been aided by a change to *GMC Connect*, the GMC Revalidation Management system, whereby previous and current Designated Bodies and Responsible Officers are now visible to all ROs.

g) NHS England have introduced a new MAG form, however this has not required any changes to our existing SARD form

h) Considerable work has been done on the supporting evidence required for Educational Supervisors to provide as part of their appraisal, including evidence of specific mandatory and other training, and trainee feedback

i) The establishment of a Medical Revalidation Panel. The external monitoring visit of 2016 recommended establishment of a Medical Revalidation Panel, to review all revalidation recommendations. At present, this panel has met only once, in May 2016, because there has been a significant transient drop in the number of doctors coming up for revalidation in the last 6 months. However, this year, there will be a large number of Doctors coming up for revalidation, and the panel will need to convene on at least an alternative monthly basis. The terms of reference and membership of this panel has now been established, to include the Medical Director, representation from Human Resources, a Non-Executive Director, Lead Appraiser and Appraisal Administrator. The recommendations of this panel will assist the Responsible Officer in making a Revalidation decision to the GMC

Medical Appraisal Activity

216 doctors were appraised during this period.

Delayed appraisals are detailed in the table below.

6 over 3 months overdue were agreed by the RO – sick, maternity leave, understanding of SARD system or appraiser not available in time (sick or A/L)

Consultants	Completed in due month	95		
	One month overdue	28		
	Two months overdue	20		
	Three months overdue	5		
	Over three months over due	7		
	Not submitted	10	165	
Staff Grades	Completed in due month	13		
	One month overdue	2		
	Two months overdue	2		
	Three months overdue	0		
	Over three months over due	0		
	Not submitted	0	17	
Fix term & Locum	Completed in due month	11		
	One month overdue	1		
	Two months overdue	0		
	Three months overdue	1		
	Over 3 months overdue	1		
	Not submitted	1	15	
Clinical Fellows & Trust Doctors	Completed in due month	11		
	One month overdue	1		
	Two months overdue	0		
	Three months overdue	2		
	Over 3 months overdue	4		
	Not submitted	0	18	
	Total			215

The total number of trained appraisers at 31st March 2017 was 46. At present we have a sufficient number of appraisers.

Revalidation Activity

The number of recommendations made between April 2015 and March 2016 was 8

Positive recommendations	7
Deferrals	1
Non-engagements	0
Late recommendations	0

It should be noted that due to the revalidation timetable paid out by the GMC, nearly all doctors have been revalidated in the first three years of the first cycle. This means that revalidation numbers will drop off dramatically in 2016 and 2017 followed by a surge at the start of 2018.

Concerns

There are currently no consultants being managed according to Maintaining High Professional Standards by the Responsible Officer. A small number of doctors with prescribed connections have current or previous GMC undertakings, these are all being managed appropriately and do not give rise to active concerns.

Two doctors (one consultant, one foundation level doctor) have been dismissed in 16/17. Both have been referred to the GMC, one by the Trust and one by HEE.. The GMC have made a number of enquiries during the year regarding current or former employees. This is normal and we do not monitor the number of enquiries, however it is almost certainly rising.

Development Plan / Issues for 17-18

1. The Trust does not routinely provide structured information to support appraisal, and is now becoming an outlier in this respect compared to other organisations. During the past year, HR, Governance and the Appraisal Administrator have attempted to ensure all complaints are fed into annual appraisal, however this has turned into a manual process which is very time-consuming and frequently inaccurate due to the way Datix collects the information. The Clinical Directors and Medical Director have produced a list of suitable performance indicators which could be fed into appraisal. However at present there is no easy way of collecting, collating or providing this information by individual doctor. A fundamental issue is the lack of resource within the Governance Dept to take on this work. This risks the quality of appraisal, as it potentially compromises the ability to feed appropriate Supporting Information into the Appraisal. Without a robust system that collates, redacts and embeds relevant performance, complaints and incident information, neither the appraisee or appraiser can reflect on and critically assess these data.
2. As identified last year, appraisers are concerned about the responsibility placed on them in terms of assurance regarding fitness to practice. There is no budget allocated to appraisal for either appraiser training or undertaking appraisals, in comparison to medical educational activities. Appraisers have considered this and do not wish to be remunerated, however, it has been agreed that appraisers will be allocated an extra day study/professional leave in recognition of the substantial amount of work required This has now been written into the Appraisal Guidance.
3. The SARD job planning module is now in use and was embedded by the first half of 2016. This means that we now have the same system for both appraisal and job planning.
4. Administrative support – there is 0.6 WTE support which was originally set up to provide support for appraisal. Since Revalidation the tasks associated with Appraisal and Revalidation have increased significantly and require assimilation of new requirements, associated tasks, creation and submission of reports to NHS England. The Trust has also increased the number of doctors supported by the administrator over the past few years.

For approval

- The Board are asked to accept the Annual Report, note the contents and approve it for submission to the higher level Responsible Officer
- The Board are asked to approve the statement of compliance confirming that the West Suffolk NHS FT is compliant with relevant legislation and regulations

Attachments:

- Annual Organisational Audit 16-17
- Statement of Compliance

West Suffolk NHS
NHS Foundation Trust

Designated Body Statement of Compliance

The board of the West Suffolk Hospital NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been appointed as a responsible officer;

   The Medical Director, Dr Nick Jenkins is the nominated Responsible Officer, and has undertaken suitable training to fulfil this role:

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Confirmed. Maintained on the SARD system and triangulated with GMC Connect

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Confirmed. Adequate appraisers have been recruited in the past year to ensure sufficient numbers are maintained.

4. Medical appraisers participate in on-going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Confirmed Appraisal training has been provided to all new and existing appraisers in 2016-17 that fulfils the criteria.

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Confirmed.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Confirmed

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Confirmed.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Confirmed. We send a Transfer of Information form to the previous Responsible Officer when a new doctor adds us as their designated body, and respond to requests for information from elsewhere promptly.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Confirmed The Responsible Officer has confirmed that all agencies are fully compliant with this requirement

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Confirmed

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Chief executive or chairman

Date: _ _ _ _ _ _ _ _ _ _ _

West Suffolk NHS
NHS Foundation Trust

Trust Board – 28th July 2017

AGENDA ITEM:	17
PRESENTED BY:	Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Sarah Jane Relf, e-Care/GDE Operational Lead
DATE PREPARED:	13 July 2017
SUBJECT:	To receive an update on e-Care/Global Digital Excellence Programme
PURPOSE:	Update on current position

EXECUTIVE SUMMARY:

- e-Care phase 2, drop 1 – OCS (OrderComms) pathology is now live (including Sepsis and AKI).
- e-Care phase 2, drops 2 and 3 re-aligned to one single drop at the end of October.
- Pillar two leadership event held
- New e-mail system and Remote Access update now underway
- New firewall equipment is on site awaiting kick off meeting
- Expect to order new SAN in July

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

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

1	**Purpose**
1.1	This paper provides the trust Board with an update on the current status of the e-Care and Global Digital Excellence (GDE) programmes. The Board is asked to note the report.
2	**Background**
2.1	The organisation has committed to a ten year programme of major transformation around digitising the organisation. The first major part of this programme was the original go live of e-Care in May 2016. This initial go live included a replacement PAS, FirstNet (within emergency department), clinical documents and electronic medicines management. In addition some limited components of OrderComms were introduced. Pathology OrderComms and Sepsis/AKI alerting was successfully implemented in June 2017.
2.2	The organisation now continues with phase 2 of the e-Care programme and delivering GDE commitments with full updates provided below.
3	**Phase 2 e-Care Programme Summary**
3.1	There were three original planned drops for the e-Care phase 2 programme as shown below. At the e-Care Programme Board it was agreed to combine drops 2 and 3 with a go live date of 30th October. This would ensure the least disruption to staff and support the domain strategy. On this basis the revised Phase 2 plan is shown below

Drop	Original dates	Covers
Drop 1	20 May 2017	• OrderComms Pathology • Sepsis and Acute Kidney Infection (AKI) alerting
Drop 2	30 October 2017	• Patient portal • Patient Flow/Capacity management • Diabetic order set • Paediatrics • Dynamic documentation • Suite of nursing care plans • 5 new care pathways

3.2	***Drop 1*** As reported previously we went live with Order Comms pathology on 03 June 2017. Sepsis/AKI went live on Monday 19th June. Both have been successful technically. We continue to support staff in adapting to new workflows.
3.3	***Drop 2***

	We are currently reviewing whether to postpone implementation of patient portal due to its current limited functionality and await the updated Cerner offer. We are also exploring other options on the market. All other projects are progressing and are on target for implementation on 30th October. Engagement and training plans are being finalised.
3.4	In addition to the above planned drops we are also working with Cerner to implement Medical Transcription Management (MTM) module which would improve the current secretarial workflow.
3	**GDE update**
3.1	The Trust had a very successful go live for phase 1 and as such, was one of 26 Trusts asked to bid for national Global Digital Excellence status. In September 2016, it was confirmed that the Trust had been successful in securing £10m funding, as part of an initial tranche of 12 Trusts. The Global Digital Excellence (GDE) programme is a 2-year programme that commenced in November 2016.
3.2	Our GDE programme covers four main pillars: **Pillar 1** — **Digital acute trust** — Completing the internal journey of digitisation **Pillar 2** — **Supporting the ICO** — Creating the digital infrastructure that will support the ambitions of the Sustainability and Transformation Plan **Pillar 3** — **Exemplar digital community** — Building the organisation into a centre of digital excellence and acting as mentor and guide for other developing organisations **Pillar 4** — **Hardware and infrastructure** — Ensuring that we have a robust and compliant infrastructure at the foundation of the programme. To date our main focus has been on pillar four as this is the critical infrastructure that supports delivery of all other components.
4	**Pillar 1 – Digital Acute Trust**
4.1	We are engaging departments with a view to producing outline business cases for all potential GDE opportunities. This will identify benefits, risks and resource implications for each potential project. We will then use an agreed criteria to review each application which in turn will confirm the final content of the GDE pillar 1 programme.
5	**Pillar 2 – Supporting the Integrated Care Organisation**
5.1	• We received a demonstration of the Cerner HealtheIntent population health solution and are currently in the process of organising a further demonstration for system partners and trust clinicians. • The trust hosted a system leadership event on 05 July with dedicated focus on pillar two opportunities. This was well attended with representatives from across the health and social care system.

	• We have now connected 12 EMIS GP practises to Health Information Exchange. This provides the GPs with view only access to the e-Care electronic patient record. This has been well received to date and a full benefits analysis will be undertaken later this year. Early testing of the network links for SystmOne GP Surgeries has now commenced in anticipation of the SystmOne HIE software coming in September.
6	**Pillar 3 – Exemplar Digital Community**
6.1	• We continue to work with Milton Keynes University Hospital NHS Foundation Trust to progress the bid for them to become our fast followers. • We are also considering our requirements from an international partnership. • We are currently organising our first GDE event to showcase our Allied Health Professional (AHP) content. This will be held in September.
7	**Pillar 4 – hardware and infrastructure**
7.1	• Progress continues to be made in 2017 on the Trust technical infrastructure in support of our e-Care and GDE programmes. • Work on the upgrade of the Trust e-mail system is progressing and the new hardware is now on site. The new build should be complete by mid-August (@ 16/08) at which time new mailboxes for meeting room and resource will be created. User mailbox migration will commence w/c 21/08 and will take around 2 months to complete. A more detailed briefing will be provided once the migration plan is complete. • The new firewall has arrived, the kick off has been held; however implementation will not start until 21/08 as key personnel are away at present. It is expected to take around a month to complete the install and a further month to migrate connections from the old to the new. • The remote access upgrade has started with the kick off meeting and a further technical meeting to agree configuration will follow. However after that the project will halt as it is dependent on the proposed SAN upgrade which remains in procurement as options for a managed service are concluded. Once the delivery date for the SAN is confirm the project will restart. • Planning work to migrate EDM (Evolve) and Theatres (Opera) from Windows 2003 to Windows 2008 are well advanced. Business cases for both are expected in September as these migrations facilitate the upgrade of Microsoft AD, which is a key part of the Trust Cyber plan. • New Mobile Device Management software is also being tested as the current "Good" software expires at the end of September. The new product will be deployed on the 300 existing mobile devices (laptops and tablets) providing improved security and better access. In summary the infrastructure work is progressing well and is largely on target for the objectives agree at the start of the project.
8	**Recommendations**
8.1	The Board is asked; • To note the general progress

West Suffolk NHS
NHS Foundation Trust

Trust Board Meeting – 28 July 2017

AGENDA ITEM:	18
PRESENTED BY:	Helen Beck
PREPARED BY:	Dawn Godbold
DATE PREPARED:	19 July 2017
SUBJECT:	Alliance and community services update
PURPOSE:	Information

EXECUTIVE SUMMARY:

1. Purpose

1.1 This paper has been prepared to provide an update on progress towards full mobilisation of the community contract by 1 October 2017, including proposed designated employer arrangements.

1.2 The Board is asked to note progress and approve the recommended employment arrangements relating to West Suffolk NHS Foundation Trust.

2. Background

2.1 The current community services contract ceases on 30th September 2017 and new contractual arrangements need to be in place by then. The commissioners are working through a 'most capable provider' process with two alliances (West and East) formed of the following organisations:

- Suffolk GP Federation
- Suffolk County Council
- Norfolk and Suffolk Mental Health Trust
- West Suffolk Foundation Trust (in the West Alliance)
- Ipswich Hospital Trust (in the East Alliance)

2.2 The alliances have committed to providing services through a collaborative approach, taking opportunities to remove organisational boundaries and barriers wherever possible and are committed to the longer-term strategy of becoming fully integrated care systems. The alliances have established robust working arrangements and programme structures to progress through the most capable provider process and mobilise the community contract by 1st October 2017. The West Suffolk Alliance intends to build on this way of working and use it as a foundation from which to move to an integrated care system (ICS).

2.3 The commissioning process has two main gateways within it. The alliances have successfully progressed through Gateway 1 and submitted all required documentation on 31st May to pass through Gateway 2, which included:

- A 'roadmap' that identifies key stages and milestones for transformation and clinical service delivery, up to and beyond 1st October 2017.
- A mobilisation plan for the safe and smooth transfer of the contract.
- A progress report on the key milestones reached since Gateway 1.
- Clear plans for employment of staff and TUPE arrangements.
- Agreement on both adult and children's services specifications.

2.4 A formal feedback on the Gateway 2 submission is arranged for 20/7/17, the CCGs have not raised any concerns or queries to date. From that feedback session an implementation plan will be developed.

3. Process to Determine Service Disaggregation and Designated Delivery Organisations

3.1 The preparations for contract mobilisation have involved a number of strategic and operational decisions to be taken by the alliance partners that affect the future configuration of services and the employment of staff. These decisions have been reached through a three-step process, namely:

3.2 **Step 1 - Outsourcing:** to review currently-outsourced services and agree whether to continue with outsourced arrangements or to deliver directly from within the alliances; note; it has been agreed to continue to out-source the Community Equipment and Wheelchair Services until 31st March 2018.

3.3 **Step 2 - Disaggregation:** to review all service lines and agree whether they would be best delivered through separate east and west teams (i.e. disaggregated) or on a pan-Suffolk basis. The desire of the West Suffolk Alliance and west wider system, is to develop services on as local basis as possible. Services will be developed and organised around the existing Connect locations and boundaries.

3.4 **Step 3 – Designated Delivery Organisation**: to determine the most appropriate type of organisation (e.g., acute, GP Federation, Local Authority, Mental Health) to be held to account for the delivery of clinical service lines and then to inform the identification of the onward designated employer of staff from 1st October 2017.

3.5 A number of core principles have underpinned the discussions and the decisions made. These include ensuring that service configuration beyond 1st October:

- Is clinically safe, reliable and enables the delivery of service outcomes.
- Wherever possible concentrates on the needs of the local population and clinical pathways rather than on organisational form.
- Optimises patient, public and user engagement opportunities.
- Builds on the locality model of neighbourhood, multidisciplinary, multi-organisational service delivery without organisational boundaries or barriers.
- Brings greater integration opportunities between core and specialist services that traditionally have operated in isolation.
- Maximises collaboration, strengthens trust and builds relationships.
- Creates opportunities for integrated leadership.
- Creates opportunities for integrated delivery across alliance partners.
- Creates benefits to one or more alliance partners or wider system.
- Ensure financial viability and sustainability of high quality services.

3.6 Service leads have been involved throughout the process, especially in the discussions around disaggregation. Service leads completed quality impact assessments (QIAs) that explored and tested the principles set out above on a service line by service line basis.

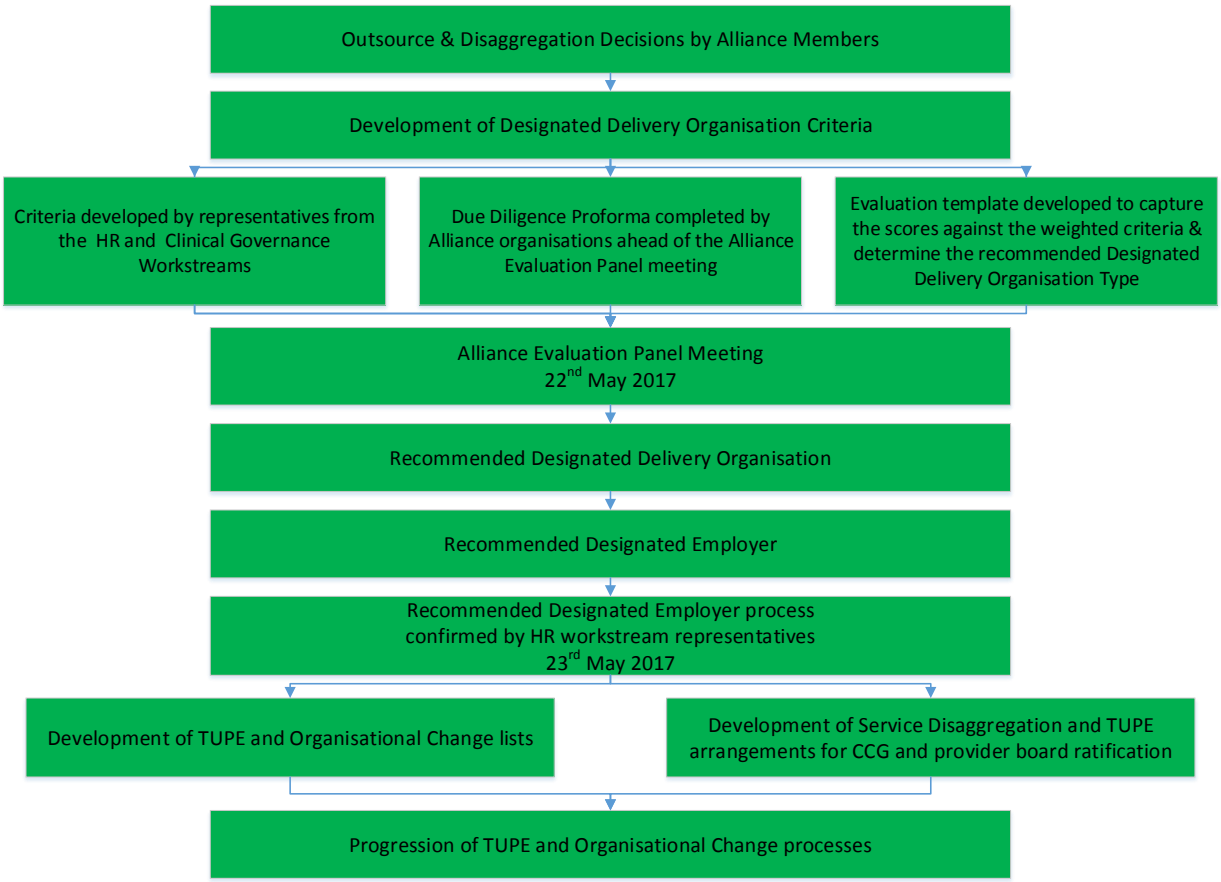
3.7 Following on from Gateway Stage Two, a process for determining the most appropriate type of organisation to take responsibility for delivering each service line was developed. A number of questions were constructed that would evidence and reflect the potential delivery organisations' ability to fulfil the criteria required to assure their suitability to deliver the services being considered for transfer. These questions reflected a requirement to evidence the previous track record of alliance member organisations and the future opportunities to support staff and services to deliver the requirements of the community contract and the wider integration agenda. These questions were then segmented across several key criteria, which could then be evaluated using a weighted scoring approach.

3.8 The segmentation of criteria was agreed to fall into 4 categories:

- Delivery and support to the delivery of services
- Financial governance
- Employment
- Governance and infrastructure

3.9 Once the most appropriate type of delivery organisation had been determined, this, married with the disaggregation recommendations, led to each service being allocated to the most appropriate designated employer.

The flowchart below summarises the process described above:



4. Designated Delivery Organisation and Designated Employer Recommendations

4.1 The table presented summarises the recommendations regarding designated delivery organisation and designated employer that have been proposed by the alliances. As can be seen, there will be a number of transfers in and out of the trust which will require the application of TUPE procedures. The TUPE process will be overseen by the HR work stream of the mobilisation programme, but responsibility for its application will sit with the incumbent and receiving employers.

4.2 For services transferring into the trust, short-term management arrangements will be put in place for 1st October to ensure a smooth and safe transfer. These arrangements will be a 'step change' towards implementing an integrated structure for both community and hospital staff and services. This is in line with the vision and direction of travel that the trust has been working towards for some time.

4.3 The alliances have recommended the disaggregation of specialist services including adult SaLT, cardiac rehab, heart failure, COPD and pulmonary rehab. These services are currently delivered on a pan-Suffolk footprint with staff employed by Ipswich Hospital Trust. Disaggregation of these services will only take place once robust integrated alternative services are available in the West.

4.4 It has become clear that future developments for specialist community children's services within the existing contract must be considered in the context of wider children's services and that this could offer greater opportunities for integration and innovation through alliance working.

4.5 It has been agreed that the existing employment arrangements for specialist children's services will be extended beyond 1st October timeframe to ensure the right solution for children and their families is reached by the alliances. A programme of transformation will continue during this time to ensure that services continue to develop and improve.

4.6 A contract will still need to be in place for 1st October, based on the specification. However, delaying any employment transfers will ensure that staff are not TUPE'd prematurely resulting in additional moves and possible re-organisations once the longer-term arrangements are clear. It is expected that employment transfers for children's services will take place on 1st April 2018.

4.7 The Care Co-ordination Centre will remain county-wide, hosted by Ipswich Hospital Trust, due to a separate procurement of 111 and GP out of hour's services that will affect the Care Co-ordination Centre from 1st June 2018. This avoids unnecessary disruption for the service.

4.8 The Community Equipment and Wheelchair Service contract has been extended with the current provider (Medequip and Bartrams) until 31st March 2018. This is to enable a procurement exercise for the service to take place.

4.9 To ensure that all staff receives consistent information, the communications and HR work streams within the mobilisation programme are working together to co-ordinate the dissemination of key messages across all community teams and across all alliance partners. Generic materials have been produced including slide decks and FAQs and feedback from team meetings will be reviewed and responded to though a weekly joint meeting between the communications and HR work streams.

4.10 There is also material being produced to assist with communication and engagement for key partners outside of the Alliance, public, patient and user groups. Some engagement has already started with Alliance members being invited to attend patient engagement and VCS forums to explain what is happening and what the Alliance hopes to achieve.

5. Impact of Changes

5.1 It has already been previously agreed that the Community Health Teams, Community Hospitals, Admission Prevention Teams, Integrated Discharge Planning Team and Community Matrons will all align east and west as they already work on a locality basis.

5.2 The table below shows the designated employer and the head count of staff in the current clinical services by service line. Where disaggregation has been recommended, some staff will transfer in/out of WSFT. The current WSFT headcount of community staff is 428 out of a total of 1316. The exact resource split between east and west will be determined via the HR work stream and TUPE rules.

Green = it is likely some staff will transfer in. Red = it is likely some staff will transfer out.

Table 1

Service	FTE	Headcount	Remain with WSFT or Transfer In/Out
Bladder and Bowel (Continence)	*10.45*	*12*	*Transfer to GPFed*
Falls & Osteoporosis	1.85	2	Remain IHT
Foot & Ankle Surgery	7.75	11	Remain IHT
Falls/Fracture Liaison	2	3	*Transfer to GPFed*
Pulmonary Rehabilitation	6.73	8	Some Transfer In
Minor Injuries Unit	*14.19*	*19*	*Transfer to GPFed*
Stoma Care	*1.86*	*3*	*Transfer to GPFed*
COPD	10.75	13	Some Transfer In
Care Co-ordination Centre	37.77	39	Remain IHT
Cardiac Rehab & Heart failure	7.94	11	Some Transfer In
Bluebird Lodge CH	39.90	50	Remain IHT
Aldeburgh CH	25.59	34	Remain IHT
Felixstowe CH	26.06	33	Remain IHT
Newmarket CH	42.27	56	Remain WSFT
Area 1 Community Health Team	50	60	Transfer In
Area 2 Community Health Team	90.16	110	Transfer In
Area 3 Community Health Team	*133.5*	*170*	*Transfer to IHT*
Area 4 Community Health Team	*100.7*	*123*	*Transfer to IHT*
Podiatry	*30.66*	*37*	*Transfer to GPFed*
West APS	12.41	15	Transfer In
East APS	*22.11*	*31*	*Transfer to IHT*
Community Epilepsy / Parkinson / Neurology Service	3	4	Remain WSFT
Estates and Facilities	50.75	97	Some Transfer Out

Adult Speech & Language	15.77	18	Some Transfer Out
Paediatric Services	146.1	200	Remain WSFT until at least 30th March 2018

6. Roadmaps for Children's and Adults Services Transformation

6.1 The new contract will commence on 1st October 2017 at which point the alliances will become responsible for the delivery of community services. However, this will be just one step along a transformational journey leading to a fully integrated, pathway-driven, model of community services.

6.2 As part of Gateway 2, service specifications for both children's and adults' services have been agreed. The commissioners understand and accept that parts of the new specifications are aspirational and will not be fully met by 1st October. Therefore, working with the commissioners, the alliances have developed roadmaps setting out the medium-term transformational journey.

6.3 The roadmaps for adult services and children's services are presented in **Appendix A** and **Appendix B** respectively. These give a high-level summary of the actions required leading up to 1st October and through the first year of the new contract to align services against the new specifications.

7. Next Steps

7.1 Formal feedback from the CCGs regarding the Gateway 2 submission will be provided on 20/7/17, although it should be noted that no queries or immediate concerns have been raised by the CCGs to date.

7.2 The 'roadmaps' will be further developed into implementation plans. The transformation work will be conducted via the West Integrated delivery Group which has all Alliance partners plus CCG representation.

7.3 Staff communication and engagement sessions have already begun and will continue through July and August.

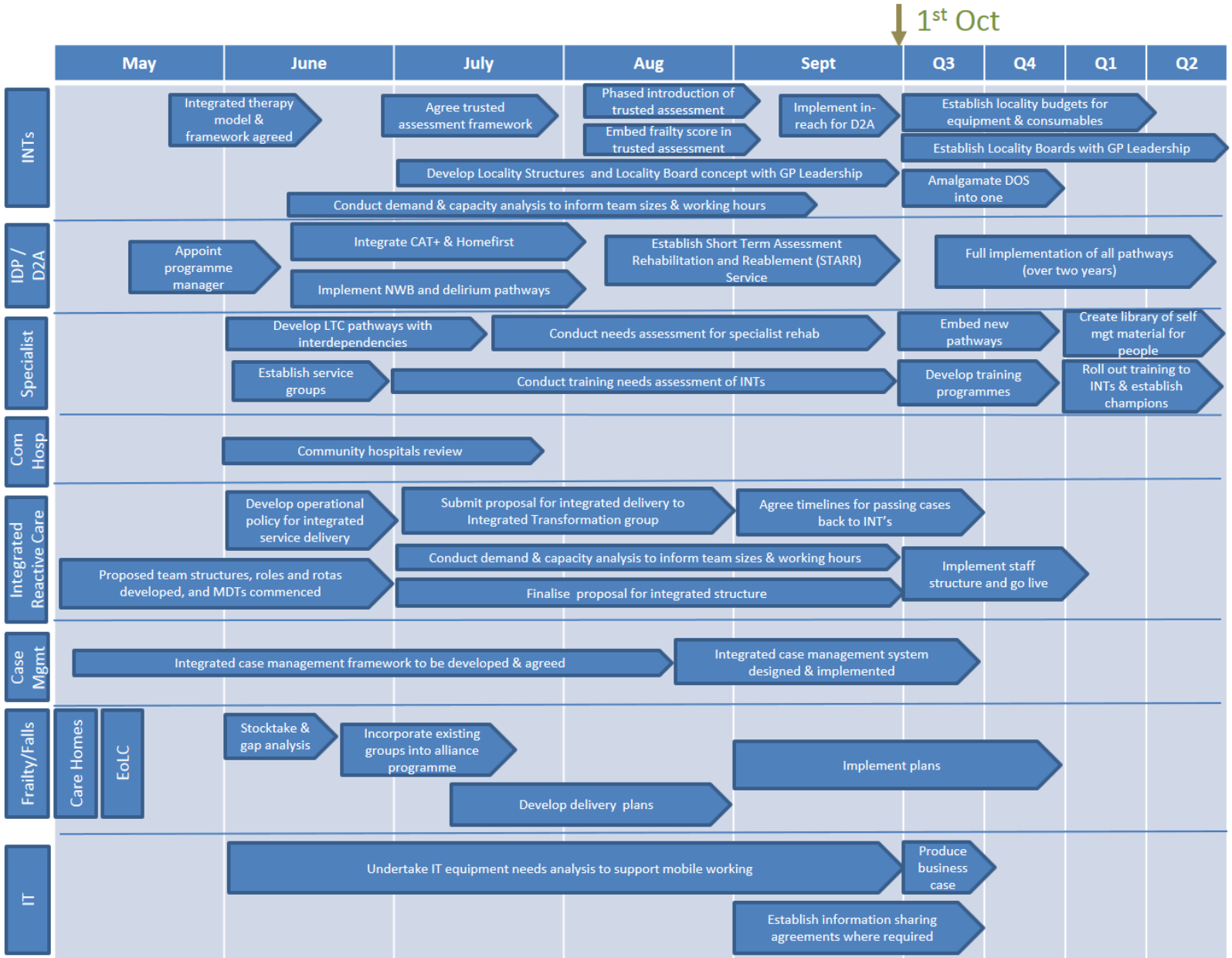
7.3 The board will receive information at the September meeting on: governance arrangements for both the community contract and the Alliance, the interim management structures for 1st October, a timeline for disaggregation and re-design of specialist services, WSFT proportion of finances allocation and final contract model.

Linked Strategic objective (link to website)	Ambition 3 Deliver Joined up Care
Issue previously considered by: (e.g. committees or forums)	Previous Board, council of governors and Executive Director Meetings
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)	

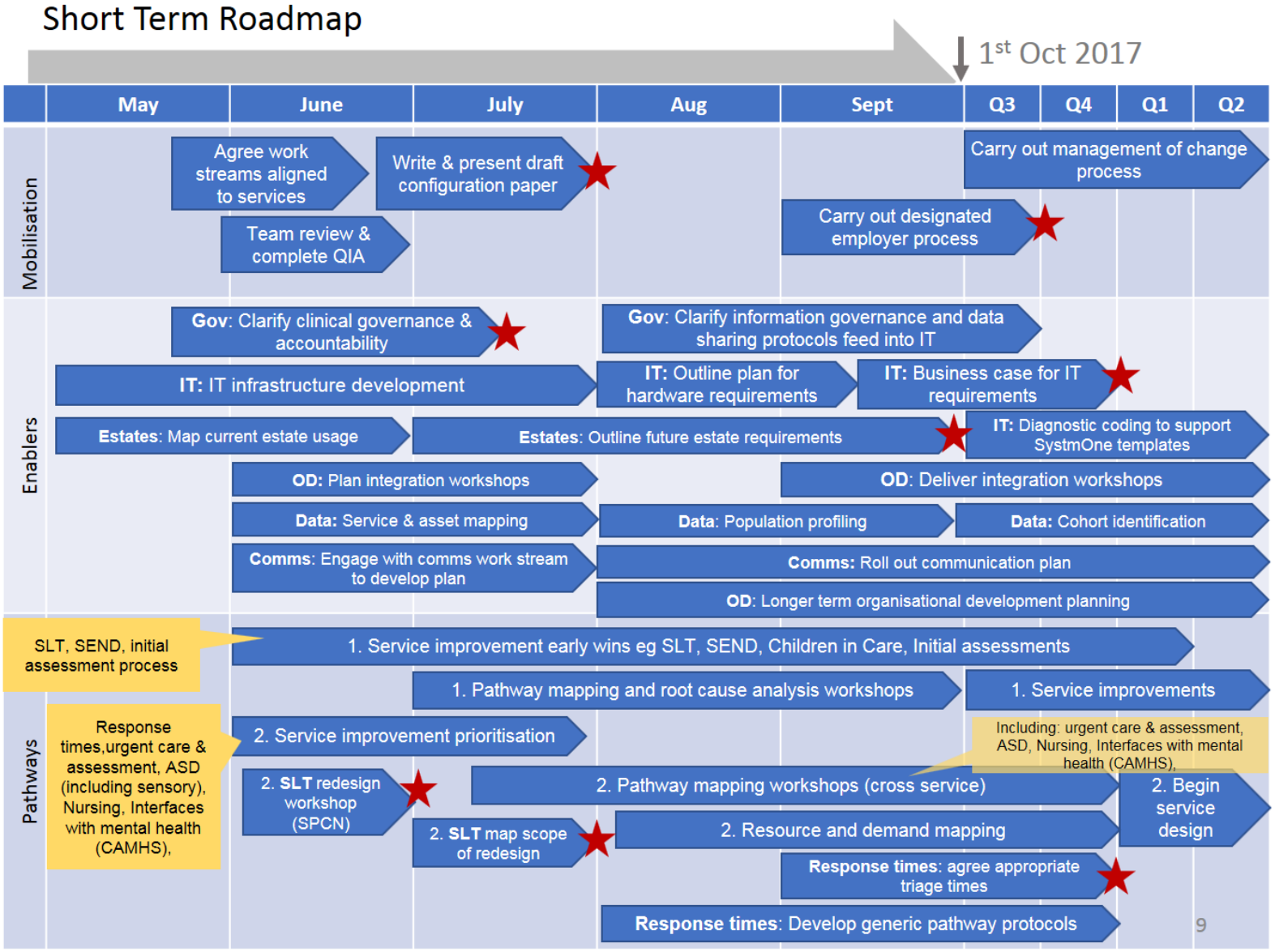
Recommendation:

That the Board note the progress being made to transition the community services contract and the development of the West Suffolk Alliance.

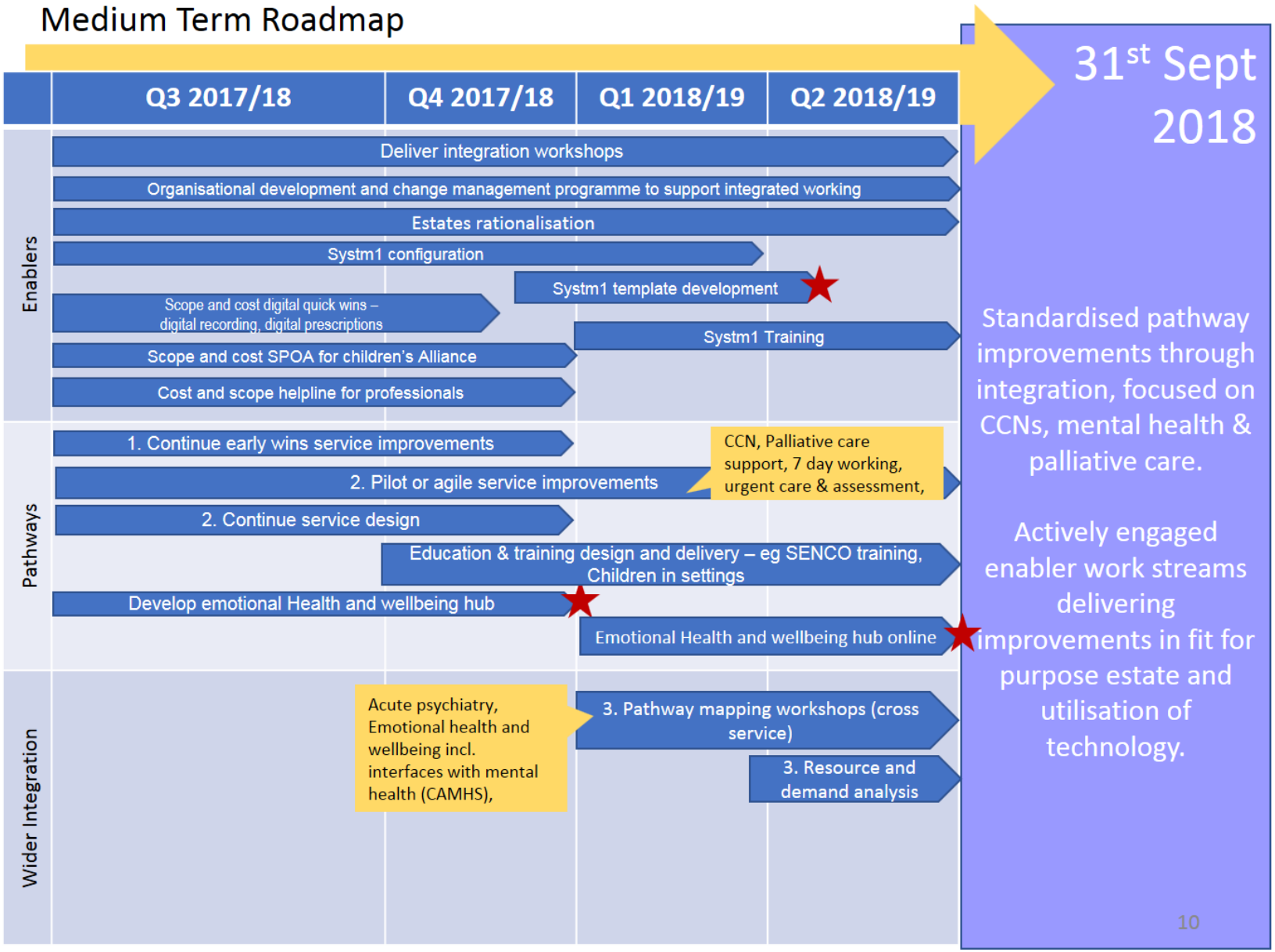
Appendix A: Adult Services Roadmap



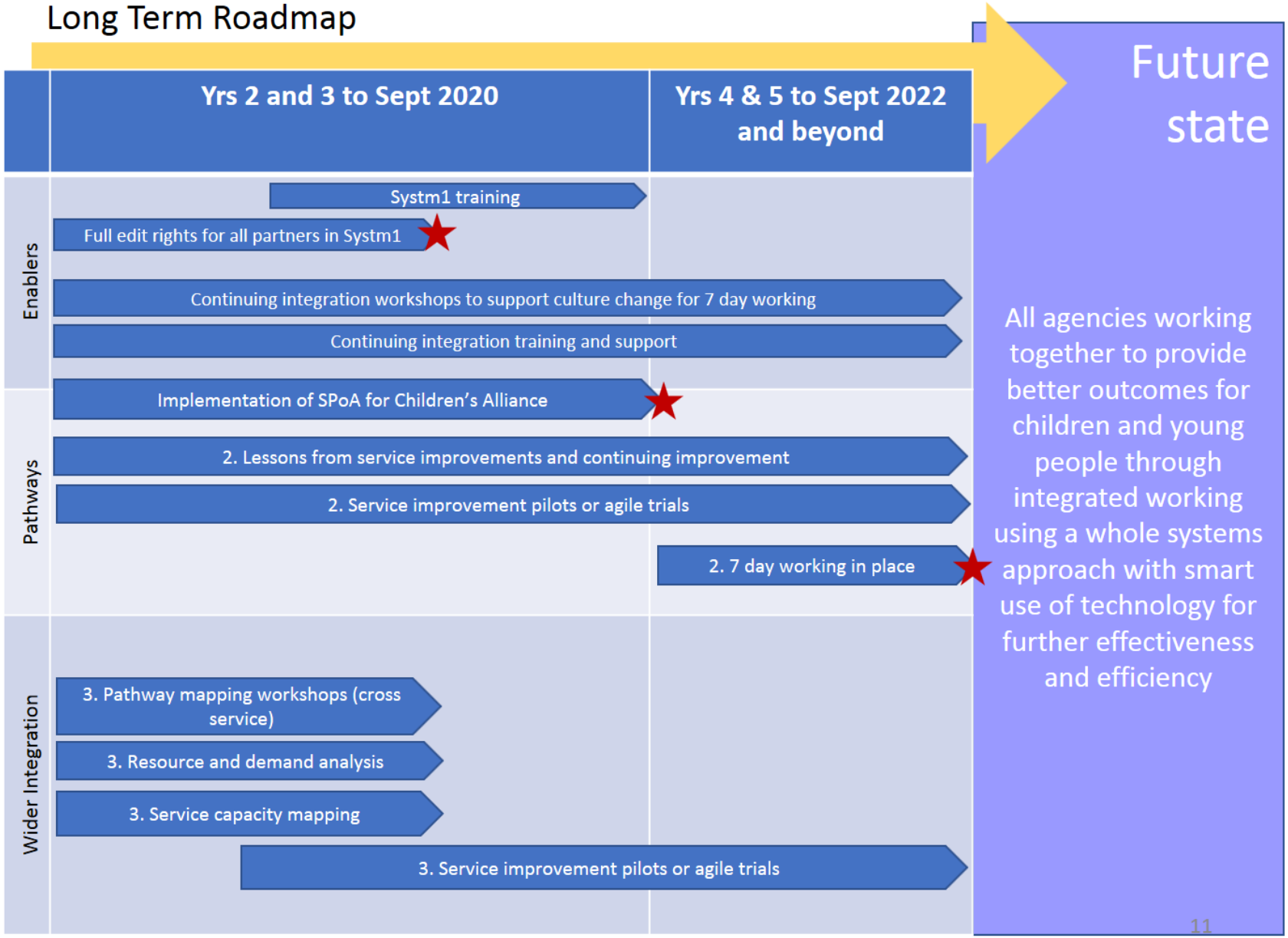
Appendix B: Children's Services Roadmap (short, medium and long-term)



Medium Term Roadmap



Long Term Roadmap



West Suffolk NHS
NHS Foundation Trust

Report Title Quality Assurance Framework
Report for Approval and Information
Report from Rowan Procter, Executive Chief Nurse
Report Author Rebecca Gibson, Compliance Manager

Purpose of the Report

Monitoring of Quality assurance requirements and delivery plans

Background

The CQC published its new assessment framework on the 12th June which highlighted that the first of the 'next phase' NHS Trust inspections likely to take place between September and November 2017 with the new system for NHS Trusts expected to be fully embedded by Spring 2019.

This Proposal is to provide a business as usual quality assurance framework in the organisation that will also deliver for CQC reporting and assessment requirements.

Proposal

It is proposed to set up a monthly Quality Assurance Group (QAG) to implement this programme with a Quarterly assurance reports to the Quality & Risk Committee, which is the trust assurance framework.

Chair –Executive Chief Nurse

Members – Associate Chief Nurse, Head of Quality Improvement, CD Quality (tbd), Heads of Nursing, Head of Governance, Deputy COO, Compliance Manager and Governance Managers.

Operational teams of Clinical Leads, Senior Matron and Service Manager will be members on a rotational basis

Remit – Monitor quality through an assurance framework;

- Quality walkabouts to be undertaken weekly by the Associate Chief Nurse, CEO, Chairman, Governor and an Executive
- Table top review of real time data from eCare undertaken by the Executive Chief Nurse, Associate Chief Nurse and additional members as required.
    - This will be supported by a weekly table-top testing event to undertake real time testing of key indicators with the option to drill down and undertake spot check visits to areas highlighted as a concern.
    - Areas of review will include, but not exclusive to;
        - Deteriorating Patient
        - End of life
        - EPARS
        - DOLS
        - Sepsis
        - VTE
        - AKI
        - Nutrition
        - Falls
        - Pressure Ulcers
        - Datix
        - Mandatory training
        - Complaints and PALs
        - Compliments
        - Infection Control
        - FFT scores and Patient Satisfaction
        - Workforce indicators

- Monthly Divisional Performance provided by
    - Divisional Board minutes
    - Quality Performance presentation
- Quality board report
    - Monthly papers to be reviewed
- 6 monthly provider information request (PIR) completion
    - The CQC PIR template was issued on June 12th and contains a wide range of information requirements both data and free text. Completion of a 'dummy run' would allow confirmation of data availability prior to an official request as well as highlight areas that might demonstrate poor performance.
    - As part of this each division will provide its assessment of CQC compliance (e.g. Outstanding, Good etc). These must be underpinned by self-assessment against the CQC's key lines of enquiry (KLOEs).

NB PIR requires completion on an annual basis with the CQC giving a four week turnaround to compete. Trusts can expect to receive a targeted inspection within 6 months of a PIR request.

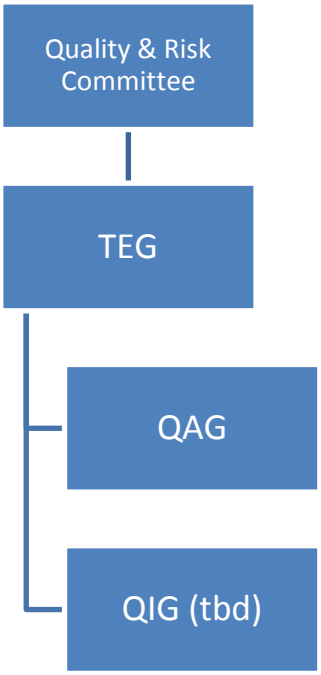
Governance

The QAG will feed into the new CQC Insight methodology which has been developed to support the identification performance across a wide number of quality indicators.

CQC Insight replaces 'Intelligent Monitoring' as the CQC monitoring tool, and is set to become an integral part of relationship management between trusts and their inspection teams, and will inform how they plan regulatory inspection activity.

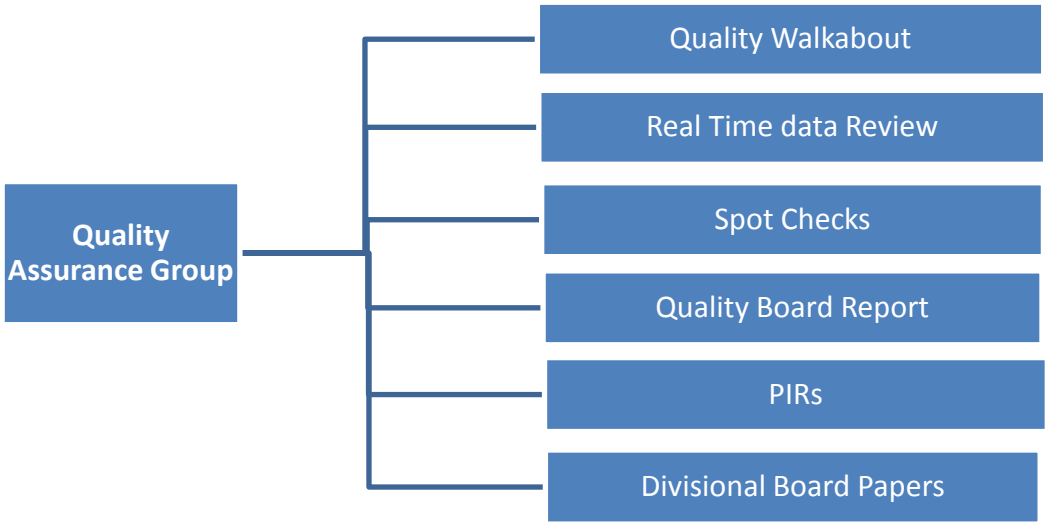
The pathway for receiving and responding to CQC Insight should remain the same as was used for Intelligent Monitoring and the Quality & Risk Profile with reporting to QAG and a quarterly assurance update to the Quality & Risk Committee.

Alongside the QAG there will be a newly formed group, chaired by the Medical Director, to focus on quality improvement, the detail of that group is being worked up and will be presented separately.



Quality Assurance Information Sources

There are 6 streams, as defined above that will feed into the QAG for assurance that quality is being reviewed, improved and managed.



Recommendations

Support the proposed assurance model

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28 July 2017

AGENDA ITEM:	19
PRESENTED BY:	Dr Stephen Dunn, Chief Executive
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	21 July 2017
SUBJECT:	Trust Executive Group (TEG) report
PURPOSE:	Approval

EXECUTIVE SUMMARY:

Steve Dunn provided feedback from the Board meeting reflecting on **operational and financial performance**. This recognised achievement of Q1 A&E 4 hour standard - a huge team achievement which all can be proud of. It was also noted that a helpful presentation had been received regarding the strategy for paediatric services, including the alignment with community services.

It was confirmed that **oral surgery services** are now being commissioned by NHSE in Newmarket. Although they have not yet confirmed who will be delivering the service which is being followed up on a regular basis.

Service level updates were received on **referral to treatment (RTT)** performance and 52 week breaches. This remains a significant focus for improvement both internally and with our regulator.

Detailed discussion took place of the individual schemes within the **Financial Improvement Programme (FIP)** which is being supported by KPMG. TEG remained concerned at level of CIP - 7% but valued the contribution made by KPMG in working-up these schemes. TEG supported the investment to engage KPMG to support delivery of the FIP.

An overview was given of the focus of the **Flow Action Group**. This included drilling down on a ward by ward basis to maintain communication in order to keep staff on track and motivated. A focus was given to ensuring appropriate planned day of discharge (PDD) and clinical criteria for discharge (CCD) as enablers for discharge before 1pm.

An update was provided on the work within the emergency department (ED) to support **primary care streaming**. Plans for the service to go live at the end of October are challenging but remain on track.

An update on **community services** was received against the timeline for the new contract launch on 1 October 2017 - the Alliance was been successful in progressing through gateway 2 review in June.

The **red risk report** was reviewed with discussion and challenge for individual areas. No new red risks were received. TEG noted that following executive review two red risks had been downgraded to amber based on the controls and mitigations implemented – 'Blood transfusion traceability' (Datix risk 2739) and 'Delay of blood issue in an emergency situation' (Datix risk 1837).

A **review of intrauterine deaths** was received and including the recommendations and action considered. TEG welcomed the review which had been commissioned by the service as part of their

governance arrangements. TEG will receive an update on the recommendation and action plan.

An update was received on the **staff health and wellbeing strategy.** A proposal was supported to invest in on-going coordination of staff health and wellbeing initiatives and line manager training for mental wellbeing.

TEG approved a proposal to set up a monthly **Quality Assurance Group (QAG).** As part of the Trust's quality assurance framework QAG will implement a quality assurance programme, providing quarterly reports to TEG and the Quality & Risk Committee. QAG will pull together the findings and learning from existing arrangements, inform the focus for targeted reviews and provide oversight of delivery by the divisional quality boards. A copy of the proposal is attached (Annex A).

A report was received which set of the strategic plan for **theatre efficiency and capacity**. This considered options around the optimal model for structuring the working day to maximise the existing theatre capacity in the context of the medium term plans to reinstate an additional operating theatre. Following considerable discussion it was agreed to bring back a more detailed assessment with a clear recommendation for deliver. KMPG will support this work, bringing their experience from other organisations.

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

Recommendation:

To note the report and approve the establishment of QAG to report into the Quality & Risk Committee.

West Suffolk NHS
NHS Foundation Trust

QUALITY & RISK COMMITTEE
Minutes of the meeting held on Friday 30 June, 2017,
Commencing at 2.00 p.m. in the Northgate Meeting Room, Quince House, WSFT

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**	
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**	
Alan Rose	**(AR)**	Non-Executive Director	**X**	
Angus Eaton	**(AE)**	Non-Executive Director	**X**	
In attendance				
Raman Lakshman	**(RL)**	Clinical Director (Item 4 only)		
Katherine Piccinelli	**(KP)**	Consultant, Paediatrics (Item 4 only)		
Rose Smith	**(RS)**	General Manager, Women & Children & CSS Services (Item 4 only)		
Phil Gadie	**(PG)**	Deputy General Manager, Women & Children & CSS Services (Item 4 only)		
Emma Gaskell	**(EG)**	Assistant Service Manager, Women & Children & CSS Services (Item 4 only)		
Lynne Saunders	**(LS)**	Head of Midwifery (Item 4 only)		
Hannah Pawsey	**(HP)**	Project Manager (Item 4 only)		
Ruth Williamson	**(RW)**	PA to Medical Director (Minutes)		

Action

1. **Apologies for Absence**

No apologies were received.

2. **Minutes of Previous Meeting**

The minutes of the meeting held on 31st March, 2017 were accepted as a true and accurate reflection of the meeting.

3. **Matters Arising Action Sheet**

Completion of matters arising references 30-32 was duly noted.

4. **Children's Services Strategy**

Following the CQC visit, the Paediatric Department have undertaken an overview of their strategic direction. They sought endorsement of the committee for the proposed direction of travel, together with input in to the models proposed, which were in line with requirements of the national contracts.

KP advised that children's and young persons' needs have changed overtime, with the focus on prevention.

SD offered his congratulations to the team, particularly with regard to improvements made in the service in connection with children and young people visiting the Emergency Department.

CYP in ED:
May 2016 – March 2017:
Number CYP triaged within 15 minutes has risen from 21% → 53%
Number CYP seen within 1 hour:25% → 79%
Number CYP seen within 4 hours: 88% → 99%

KP advised that In the last four years, the average Time to First Appointment had been reduced by 7 days, with the average waiting time 30 days. CB stated that was extremely quick, with six weeks deemed as a good performance in most hospitals.

ST stated the increase in activity in the Clinical Assessment Unit was a sign that patients were being directed to the right place and thereby providing a more joined up service. Consideration is being given to the discharge of children from the ED by a paediatrician.

AR asked whether there was a dedicated children's section within the ED. KP advised that work was being undertaken to create this, contained within the GP streaming work. Noted that the GP streaming work would fully address points raised by the CQC.

(RP left the meeting at 2.30 p.m.)

AE asked whether the dashboard outcomes would be used to measure achievement of the strategy. It was confirmed that it would.

AR asked whether there was any joint staffing with the mental health trust. Noted the service was already stretched. AR further enquired whether the department conducted joint appointments with mental health. KP advised that it was dependent on mental health's service capacity, but that joint appointments were conducted with psychologists.

Noted that applications from ST1s in paediatrics had fallen from 800 in 2015 to 580 in 2017. SD asked whether this was considered a risk to the Trust and if so, what action needed to be taken. KP advised that the department was already looking at plugging gaps via permanent staff rather than trainees.

RQ asked how the proposals involving primary care related to efficiency gains. RL responded that the intention was to reduce the disruption to families and provide a better patient experience, ensuring a child was dealt with by the appropriate person, at the right time.

AR asked whether the integration proposals included social care as well as primary. RL advised that health visitors were part of this integration

JB stressed the need for careful workforce planning for this new model, as would have implications not only for the acute paediatrics but for GPs etc.

The Committee agreed that in order to move the matter forward, evaluation of

the model and costs involved should be undertaken.

The Committee thanked the team for their comprehensive presentation. They were impressed with by the attitude and enthusiasm of the team.

The paediatric team left the meeting at 3.25 p.m.

5. **Reports from Sub-Committees**

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

Report accepted.

b. ***Corporate Risk Committee***

Report accepted.

c. ***Patient Experience Committee***

Report accepted.

6. **CQC Report**

RJ advised of the new assessment process, with annual inspection as a core standard and well led review. Further liaison with CQC via attendance at Trust Board Meetings is also being discussed.

Noted the CQC have previously provided a benchmark summary analysis and this is to be re-instigated which will be useful to highlight both positives and areas of focus.

NJ advised that the CQC will not make the Trust re-provide information available from other sources, which was good news. However, this highlighted the importance of accuracy of information provided by the Trust to other sources.

AR stated that the CQC were placing emphasis on leadership, with emphasis on the well led review and suggested a report be provided to the Board detailing the work undertaken in this regard. Agreed JBl and Denise Pora (DP) to action report on Well Led for September Board. **JBl/DP**

7. **Any Other Business**

No other items of business were noted.

8. **Reflection on Meeting and Identify Any Issues for Escalation or Capture/Review on the Risk Register**

a. Timescale for paediatric work – Executive Directors to discuss and confirm. **EDs**
b. JBl to action a report on Well Led for September Board. **JBl**

9. **Date and Time of Next Meeting**

Please note the meeting will start at 14:00 in the Northgate Meeting Room, Quince House, WSFT.

29 September, 2017
1 December, 2017

The meeting closed at 3.40 p.m.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28 July 2017

AGENDA ITEM:	20
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	21 July 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 30 June 2017 (**Annex A**). The Board is asked to note these for information.

As previously agreed 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.

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

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28 July 2017

AGENDA ITEM:	Item 21
PRESENTED BY:	Neville Hounsome, Non-Executive Director
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	20 July 2017
SUBJECT:	Remuneration Committee report – 30 June 2017
PURPOSE:	Information

EXECUTIVE SUMMARY:

The Committee undertook the following:

1. Reviewed the performance and remuneration of the Executive Directors. The committee considered national guidance for very senior managers, benchmarking information for executives' remuneration and agreed relevant remuneration changes

2. Reviewed and approved the schedule for future meetings:

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 Committee meets on a six-monthly basis and provides a report to the Board summarising issues discussed and any issues for escalation.
Risk description: (including reference Risk Register and BAF if applicable)	Failure of the Board to maintain oversight of executive director responsibilities, objectives and performance.
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	The Committee provides assurance to the Board through its activities and escalation arrangements, reported after each meeting.
Legislation / Regulatory requirements:	Monitor's code of governance
Other key issues:	

Recommendation:
The Board notes the report and decisions made.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 28 July 2017

AGENDA ITEM:	Item 22
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	20 July 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 – 29 September 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 - Quality priorities update - Consultant appraisal performance (quarterly)	✓		Written	Matrix	HB/RP
Finance & workforce performance report, include extra session data (links FIP)	✓		Written	Matrix	CB
Red risk report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP					
Aggregated quality report	✓		Written	Matrix	RP
Nurse staffing report	✓		Written	Matrix	RP
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Safe staffing guardian report	✓		Written	Matrix	JB
Stroke option paper		✓	Written	Action point - schedule	HB
Leadership develop programme	✓		Written	Action point	JB
National patient survey report (if available)	✓		Written	Matrix	JB
Annual reports: - Equality annual report - Annual infection control report - Sustainable Carbon Reduction Strategy	✓		Written	Matrix	RP
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
BUILD A JOINED-UP FUTURE					
e-Care report, including when e-Care will report key quality metrics	✓		Written	Action point - schedule	CB
Community service report		✓	Written	Action point - schedule	HB/NJ
Financial improvement programme (FIP) report		✓	Written	Action point - schedule	CB
Procurement hub bid – Category Towers		✓	Written	Action point - schedule	CB
Scrutiny Committee report		✓	Written	Matrix	GN
Strategic update, including Alliance, Integrated Care System (ICS) and STP		✓	Written	Action point - schedule	SD
GOVERNANCE					
Trust Executive Group report	✓		Written	Matrix	SD
Audit Committee report	✓		Written	Matrix	RQ
Board Assurance Framework (BAF), following Audit Committee		✓	Written	Matrix – by exception	RJ
Annual report and accounts, including quality report	✓		Written	Matrix	SD
Confidential staffing matters		✓	Written	Matrix – by exception	JB

Council of Governors report	✓		Written	Matrix	RQ
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Board meeting dates for 2018-19	✓		Written	Matrix	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	RQ