NHS
West Suffolk
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 29 September 2017 at 9.15** in the Northgate Room, 2nd Floor, Quince House at West Suffolk Hospital

Roger Quince
Chairman

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Introductions and apologies for absence** To welcome Catherine Waller on 12-month internship with the Board and 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 28 July 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
10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
10.	**Aggregated quality report (attached)** To accept the aggregated analysis including serious incidents, red complaints and PALs enquiries	Rowan Procter / Nick Jenkins
11.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter
12.	**Learning from death report (attached)** To approve the policy and recommendations	Nick Jenkins

13.	**Leadership develop programme (attached)** To receive the report	Jan Bloomfield
14.	**National patient survey report (attached)** To approve the report recommendations	Rowan Procter
15.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
16.	**Consultant appointment report (attached)** To accept the report	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.	**Annual report and accounts** (available on website via link below) To receive the report in public session http://www.wsh.nhs.uk/Corporate-information/Information-we-publish/Annual-reports.aspx	Steve Dunn
20.	**To receive annual reports for:** a) Equality and diversity (attached) b) Infection prevention and control (attached)	 Jan Bloomfield Rowan Procter
21.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
22.	**Audit Committee report (attached)** To receive the report for the meeting held on 28 July 2017	Roger Quince
23.	**Council of Governors report (attached)** To receive the report for the meeting held on 10 August 2017	Roger Quince
24.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:15 ITEMS FOR INFORMATION		
25.	**Any other business** To consider any matters which, in the opinion of the Chairman, should be considered as a matter of urgency	Roger Quince
26.	**Date of next meeting** a) To note that the next meeting will be held on Friday, 3 November 2017 at 9:15 am in the Committee Room. b) To receive the Board meeting dates for 2018-19 (**attached**)	Roger Quince

RESOLUTION TO MOVE TO CLOSED SESSION		
27.	The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act l960	Roger Quince

DRAFT

West Suffolk NHS
NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 28 JULY 2017

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

Action

GENERAL BUSINESS

17/153 APOLOGIES FOR ABSENCE

Apologies for absence were noted as above.

Steve Turpie chaired the meeting in the absence of the Chairman.

17/154 QUESTIONS FROM THE PUBLIC

- Liz Steele congratulated Tara Rose and her team on the 'marketplace' exhibition in the Education Centre yesterday. She considered this to have been very good but suggested holding it in a larger venue next year.

- Liz Steele referred to the Trust's excellent result in achieving the A&E target for the quarter. As a frequent visitor to the Emergency Department (ED) over the last couple of weeks she had experienced the good turnaround. However, she asked if the Board was assured that this was not resulting in patients returning to ED and if there was any way of monitoring this.

  Nick Jenkins explained that the national standard was that 1%-5% of patients would return to ED. He was not aware of the figure for WSFT but would look into this and confirm at the next meeting. However, he did not think that WSFT could be an outlier as the trust would have been made aware of this. **N Jenkins**

  Helen Beck reported that the Trust had been working with the CCG on looking at re-attenders and what could be done about these patients.

The Chief Executive stressed that staff had put in a huge amount of work in achieving the target for the first quarter and WSFT was one of only two hospitals in the region to do this.

Alan Rose asked if regular attenders to ED were monitored and if any action was taken. Nick Jenkins said that people came to ED because they believed that this was the place they needed to come to. Currently work was being undertaken to look at the top ten most frequent attenders and put a plan in place to try to reduce this. Once this had been completed the next ten would be looked at and this work would continue. He explained that these patients often had a complex set of needs which could not easily be addressed or managed. The Intensive Support Team (IST) had recommended that all EDs looked carefully at trying to reduce frequent attenders.

Steve Turpie referred to the work undertaken previously by Dermot O'Riordan, which looked at 200 patients who had re-attended ED. This has shown that a large number of these patients had mental health needs. He suggested that Nick Jenkins should revisit this work and look at the outcomes.

- Joe Pajak referred to the closure of orthodontics and oral surgery and thanked Helen Beck for the work that had been done to resolve this. He asked if all patients had been communicated to about this. Helen Beck explained that the communications team were currently working to ensure this happened.

- Joe Pajak asked about hand hygiene and for assurance that this was still being focussed on during a period when there was less likelihood of norovirus etc. He noted that there was very little signage about this at the front of the hospital or in other areas.

  Rowan Procter said that she would look into this, particularly at the front of the hospital. She explained that regular hand hygiene audits were undertaken and, as a result of the number of norovirus outbreaks that the Trust had experienced, the director of infection control from regional NHSE had visited to advise if there was anything else that could be done to prevent infections/norovirus. The outcome of this visit had been very positive and she considered that WSFT was doing as much as it could do; out of all the organisations she had visited over the last ten months WSFT was the only one that she had given a green rating to. **R Procter**

17/155 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

17/156 DECLARATION OF INTERESTS

There were no declarations of interest.

17/157 MINUTES OF THE MEETING HELD ON 30 JUNE 2017

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

Page 7, 2nd para, 2nd sentence, to be reworded to say; "There had been a 100% increase in NHS consultants in the last 20 years, and whilst there was some evidence of a 35% decrease in productivity the complexities and changes in quality improvement that had occurred during this time had not been taken into account".

17/158 MATTERS ARISING ACTION SHEET

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

Item 1429 - provide further detail of the staff review CIP for 2017/18, including forecast and actual performance with appropriate analysis of performance. Gary Norgate did not consider that the information in the finance report fully answered the question. It was proposed to discuss this in the finance report and reinstate the action if necessary.

Item 1431 – provide update within the performance report on transport issues and planned improvements. Helen Beck reported that a meeting with the CCG to discuss the contract would be taking place at the end of next week.

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

Item 1331 – provide Board with a stroke services option appraisal and sustainability report. It was explained that this would be discussed at the audit committee meeting this afternoon and would then come back to a future Board meeting.

The Chief Executive reported that stroke services had been the subject for recent discussion at STP and with NHSI.

Neville Hounsome referred to discussions at the closed Board meeting last month that papers should come to the open Board meeting unless they met the requirements to go to the closed meeting. It was confirmed that these requirements were being reviewed to ensure that wherever possible papers went to the open meeting.

17/159 CHIEF EXECUTIVE'S REPORT

The Chief Executive highlighted the following:-

- The first instalment of cash had been received for GDE (global digital exemplar).
- A programme of leadership events had begun and a very good system leadership day had taken place with the CCG where discussions took place on what it would mean to become a GDE community.
- The marketplace innovation day yesterday had been an excellent event and he suggested showcasing this at the annual members meeting (AMM).
- The 5.00 o'clock club was launched yesterday with Roy Lilley who talked about leadership in challenging times. This had been very successful and was attended by 70 people from across the organisation.
- WSFT's 'Protecting and improving your health and wellbeing together' initiative had been presented to the Health and Wellbeing Board a couple of weeks ago and was very well received. It was seen as an exemplar for the STP in terms of how the Trust could engage.
- The challenges around RTT and discharge summaries would be discussed later in the meeting.
- NHSI had approved KPMG moving forward to assist WSFT in achieving its largest ever CIP next near, which would be a huge challenge.
- The new 'Helpforce' pilot, which WSFT's volunteers were only one of five hospitals across the country to be selected to take part in, was a very positive result. The Trust would need to consider how to support volunteers to do this, as this initiative could be a huge benefit in supporting both patients and staff.
- Frankie Dettori had helped WSFT to launch its Every Heart Matters campaign on Monday to raise £500k for additional diagnostic equipment for the new cardiac suite. This had received excellent media coverage.

Neville Hounsome referred to A&E performance and noted that the Chief Executive's report stated that attendances had increased by 20% compared to last year, whereas the finance report referred to this having increased by 2.5%. Craig Black explained that the reason for this was likely to be a reporting issue, as A&E performance was not reported for two weeks immediately after e-Care went live. The finance paper was based on the run rate towards the end of the year. The activity in the financial plan should be more robust than the first quarter of last year was reported as being.

Alan Rose asked Jan Bloomfield who was co-ordinating the 'Helpforce' and if there would be a report on this. He said that this was a very ambitious initiative with regard to training and governance. Jan Bloomfield confirmed that this was being worked on and a paper would be coming to the Board. A community volunteer co-ordinator would be employed to co-ordinate this. **J Bloomfield**

Neville Hounsome agreed with Alan Rose stressed that if appropriate resources were not put into the recruitment, management and training of volunteers this could not be delivered, as they would need to be supported.

Gary Norgate said that he was pleased to see the results of the 'I'm proud to work here' survey, which underpinned the sustainability of the Trust's workforce, eg A&E.

DELIVER FOR TODAY

17/160 QUALITY & PERFORMANCE REPORT

Helen Beck reminded the Board that last month the Trust had started to report actual RTT performance data, which was likely to be slightly low due to data quality issues. This had improved by 5 percentage points for June and was now 83.36% versus a standard of 92%.

Neville Hounsome asked what the figure would be if ENT was removed. Helen Beck explained that this would be 86.1%, which still left a large number of patients in other specialties. Neville Hounsome requested that in future ENT and non-ENT should be shown in the report. Helen Beck confirmed that she would include a breakdown of these figures in future reports until the issue was resolved. **H Beck**

The Chief Executive stressed that a huge amount of work was being undertaken on this, both in terms of access and ensuring that there was no patient harm.

Richard Davies asked if there as a plan in place for tracking this, apart from training GPs better. Helen Beck confirmed that actions were being implemented and an additional ENT consultant was being recruited. Ipswich hospital may have some capacity and discussions were also taking place with Norfolk & Norwich regarding a cohort of patients in south Norfolk. WSFT was working closely on this with the CCG who were being very supportive.

Different models and different ways to provide Dermatology were being looked at. The main issue was the problem with recruiting to this specialty.

She referred to the Intensive Support Team's (IST) 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.

Alan Rose referred to pressure ulcers and expressed concern about the short term trend and recent media coverage that these occurred in the last days of people's life. Rowan Procter explained that patients were given a choice at end of life as to the care they received and some chose not to be moved. She confirmed that these patients would be on a special mattress but nothing else could be done.

Rowan Procter reported that performance had improved in July. The level of hydration in some patients being admitted was not as good as it could have been which had had an impact. She explained that observations were undertaken on all patients who were admitted to assess for signs and risks of pressure ulcers and falls, as well as the requirement for additional hydration, guard rails on beds etc.

Gary Norgate referred to green patient safety incidents (PSI) investigated and the new measure for these. Rowan Procter explained that this was a national reporting requirement and that WSFT uploaded incidents at a different time to other organisations, ie when investigations were closed, which resulted in it showing as an outlier. However, timeframes for processes had been moved forward and it was hoped to get closer to or meet the target for uploading all the information.

Gary Norgate asked why there was such a sudden increase in the numbers. It was explained that this was the way that this was reported and the figures on the graph were total numbers, not closed investigations.

Richard Davies asked about the red and amber ratings for patient satisfaction on G4 and G5, and if there were any problems in these areas in terms of staffing issues. Rowan Procter confirmed that there were no particular issues with staffing and that this was partly due to the type of patients on these wards.

Gary Norgate referred to the two red indicators on the patient experience dashboard and asked if there was a plan to increase these to 85% (green), and when this would be achieved. Rowan Procter explained that "were you offered the company of a chaperone.." was mainly due to the terminology and people not being aware that a chaperone could be a relative or friend.

With regard to "were you informed of any delays in being seen", the outpatients manager had been undertaking training with receptionists, as it was important to manage people's expectations when they arrived at outpatients. Pagers were also being introduced for people who had to wait. It was expected that an improvement should be seen in October.

Gary Norgate noted that completion of the WHO checklist in maternity still looked low. Nick Jenkins agreed that this should be improving and he was trying to understand the problem. He explained that these were small numbers but he could not understand why these were not being fully completed. In each case he had asked the surgeon in charge of the operation to provide him with a reflection as to why this had not been done. Audits showed that different people and different sections were not completing these.

Neville Hounsome asked if this identified a systemic issue of safety in surgery. Nick Jenkins did not consider this to be the case and thought that it was more likely due to lack of attention to detail in the paperwork. He was not concerned about safety.

Neville Hounsome asked if this showed a cultural issue with people thinking that they did not need to do this. Nick Jenkins explained that this was not about the WHO checklist not being completed, but about one or two boxes not having been ticked.

The Chief Executive asked if there was a need to do anything around observation audits and trying to understand where there was an issue. Nick Jenkins explained that this was why he had asked for individual reflections from surgeons in charge of operations; in a sense the WHO checklist was the observation audit. He agreed that it was important to ensure that it was the culture to complete the checklist correctly.

Steve Turpie noted the good performance in A&E and asked if the target was being achieved through people going beyond the call of duty, or if this was due to sustainable activity that had been introduced in order to achieve the target.

The Chief Executive explained that the Trust had invested £500k in additional staff in ED and there had been rigorous focus on Red2Green and improving patient flow throughout the organisation. Glastonbury Court and the early intervention team had also played a significant role in improving performance. However, sustaining this performance would not be easy as attendances were increasing which was putting a lot of pressure on the department. He confirmed that many of the actions suggested by the Emergency Care Intensive Support Team (ECIST) had been completed.

Craig Black explained that the organisation was run and funded in a way which did not provide spare capacity to cope with a peak. When this occurred the Trust relied on staff going the extra mile. He said that the whole of the NHS operated on the basis of ultraism when presented with a peak in demand.

Nick Jenkins agreed with the Chief Executive that this performance was due to the systemic work that had been undertaken throughout the organisation. However delayed transfer of care (DTOC) numbers had recently increased and this needed to be addressed.

Steve Turpie asked if there was anything else that could currently be considered to manage further peaks. Helen Beck explained that work was now being undertaken within the community to on improving flow outside the organisation, ie discharge, 5Qs, reducing DTOCs. The transformation paper gave details of further work that was being undertaken.

Nick Jenkins explained that the refurbishment in ED would also provide more capacity and an increase in ambulatory care. However, he stressed that there was no guarantee that the Trust could sustain the 95% performance in A&E.

Alan Rose agreed that the Trust would always be at the point of capacity and it was important to have a cultural environment to allow ultraism of staff to manage peaks and maintain this performance. This was fundamental to the success of the organisation and needed to transfer to the ICO.

Richard Davies referred to the recommendations relating to urology (3.3b) and asked if there was a plan to increase transperineal biopsy capacity. It was confirmed that this would be followed up. **H Beck**

17/161 FINANCE AND WORKFORCE REPORT

Craig Black reported that I&E at the end of the first quarter was on plan cumulatively, although there had been overspend in month due to non-pay. The finance department was working to understand the trends in non-pay as there had been a considerable increase in month three.

The report provided a lot of information on staffing levels and CIPs. Page 9 addressed some of the issues around forecasting staffing at headline level and work was now

being undertaken to break this down into professional groups.

The original CIP for this year was shown on pages 4-5. The Trust was now working with KPMG and the graphs on page 4 showed the CIP that was additional to the original plan. KPMG would be working with the organisation to deliver this extra CIP, and the plans in place should more than cover their fee for this year as there was no provision in the budget for this.

An indication of the position for 2018/19 was shown on page 5. Part of the work with KPMG was around delivering financial performance for 2018/19. There was still a gap of just under £7m which had not yet been identified and KPMG would assist in identifying further options for next year.

The cash position in July was significantly better than at the end of June. Approximately £9m had been received in cash during the month, ie GDE money, S&T funding in relation to last year's financial performance and the cash to pay for improvements in ED to enable primary care streaming. However, although the position was currently good this would be spent on the capital programme. The consequence of having a deficit was that the Trust did not have the ability to invest in the organisation in the way that it would wish to.

Gary Norgate said that the additional information on staffing levels was very useful. He asked about the breakdown that was being worked on and requested that it should provide details of the mix and reflect KMPG's recommendations. He also asked what the lines on the graph on page 9 were showing. Craig Black explained that these showed the theoretical position since 2014, ie growth at 2.5% and target with growth and efficiency of 2%. In 2014 WSFT was making a surplus; it was now not making a surplus, therefore the plan for the organisation was greater than it needed to be in order to return a surplus. The line showing growth at 2.5% needed to be achieved in order to for the organisation to get back into surplus. **C Black**

Gary Norgate suggested that if this was an ambition of the organisation there should be a plan to achieve this. Craig Black explained that the plan for this year was to have a certain level of staffing that was consistent. This would decrease as the plan moved into next year.

It was confirmed that wte was based on spend, rather than actuals.

Alan Rose asked if the Trust achieved the revised CIP for this year it would slightly beat the control total and improve the cash position. Craig Black confirmed that this would be the case, but it was not yet known if there would be the same mechanism for S&T funding for 2018/19.

Alan Rose asked how the Trust's financial position would be affected if the public sector pay restraint was relaxed for 2018/19. Craig Black explained that the assumption for next year was that there would be a 1% pay award. Therefore, if the pay award increased but funding did not, this would have an adverse effect on finances. However, he would expect the Department of Health to fully fund an additional pay award.

Neville Hounsome noted that there had recently been three months of increased spend on temporary staff costs (page 11). He asked if this was a concern. Craig Black confirmed that this was a concern. Jan Bloomfield explained that part of KPMG's work would be to introduce a tracker so that individual managers could be challenged around this.

Rowan Procter explained that a training session was being arranged on annual leave management which should help to improve the use of temporary staff after the summer holidays.

The Chief Executive reported that the executive team had had a number of discussions about this. Craig Black explained that the information on page 11 referred to nursing staff.

Rowan Procter left the meeting at 10.40am.

Steve Turpie asked about Women & Children. He noted that the largest variance was in this area and if this trend continued there would be a major problem. He asked what the action plan would be if the trend did continue. Nick Jenkins explained that this had been discussed at the divisional performance meeting this week and they did not seem to have a satisfactory explanation. Therefore, Craig Black would be holding a further meeting with this division to try to get a better understanding of this.

Craig Black explained that the ratio of midwives to births was monitored. The target was for one midwife to 31 births per year; currently the ratio was one midwife to 29 births. Therefore the Trust needed to get better at flexing resource, but the ability to do this was limited. There would be an increase in activity in August as the birthing suite at Lakenheath was out of action and WSFT had been asked to help out. It was confirmed that this work could be charged for.

Steve Turpie asked for a commentary on Women & Children to be included in next month's report, including the impact of the additional work for Lakenheath. **C Black**

17/162 TRANSFORMATION REPORT – Q2

Alan Rose asked about additional CQUINs and if this required resource that was not planned for. Helen Beck explained that there was a CQUIN project manager and additional spend on resource would not be required as this would be managed through reprioritisation.

Alan Rose asked if these CQUINs were negotiated. Craig Black explained that some of these were national and some had been discussed and agreed with the CCG.

Rowan Procter re-joined the meeting at 10.46am.

Alan Rose asked what proportion of the block contract was CQUIN based. Craig Black explained that this was 2.5% and there was very little risk to not achieving this.

Richard Davies referred to sepsis data and 'red flag' status and noted that there was no mention of this in the quality report. Helen Beck said that she would follow this up. **H Beck**

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/163 AGGREGATED QUALITY REPORT

Gary Norgate asked about patient experience themes and why car parking was still rated as red. Craig Black explained that the main reason for this was relating to cost. The barriers were improving but there were still occasional problems. The increased capacity at the back of the hospital meant that the situation was improving all the time.

Alan Rose asked if the stillbirth issue had been drawn to the attention of the CQC.

It was confirmed that the CQC had been made aware of the internal investigation that had been undertaken. Rowan Procter explained that the Trust had commissioned a review of processes to ensure that it was not missing anything and any lessons learned were appropriate. The CQC received the Board papers; therefore it had transparency of the issue. Alan Rose said that he was very impressed with the action that the Trust had taken around this.

It was explained that this report was going to the closed session of the Board meeting as it would be possible to identify patients from the information that it contained.

17/164 NURSE STAFFING REPORT

Steve Turpie noted the number of medication errors and asked if there was a high probability of a relationship between the use of bank staff and medication errors. Rowan Procter explained that it was not always the bank and agency staff who made an error, but these tended to occur more in areas where there were bank and agency staff working on the team. In areas where there was not a regular team working together this could have an impact on patient safety indicators. She explained that medication errors included a number of things eg lack of a signature or medication being given later than the prescribed time.

Richard Davies considered that, arguably, the number of medication errors reported was a good thing as this showed that people were being diligent.

Neville Hounsome noted that the labour suite had more permanent staff than budgeted for by 20% and bank usage of 10%. Therefore, although activity was below plan and there were enough permanent staff, this ward was still using bank staff. It was explained that the reason for this was sickness absence and the roster effectiveness. Rowan Procter explained that a number of other things also affected this, ie a community midwife coming in with a patient using the labour suite. She confirmed that she would follow up the reason for the use of 10% bank staff in this area. **R Procter**

Gary Norgate referred to the recent issues with an employee in maternity. He asked if the higher rate of sickness absence in this area was a result of an underlying leadership issue. Rowan Procter said that she would look into this but confirmed that leadership in this area had improved and other indicators were not showing that there was an issue. Jan Bloomfield explained that the HR team were monitoring this and would alert her if they considered that there were issues with leadership resulting in staff dissatisfaction. **R Procter**

Rowan Procter explained that in some areas where there was no psychiatric liaison support, ie F7 and G4, and at least 20% of patients had dementia/delirium. This had a big impact on the number of patients requiring support and careful management, which caused significant pressure on staff. The six monthly staffing review looked at the acuity of patients and the number/mix of staff required in order to maintain the safety and dignity of patients, and the support required for staff working in these extremely difficult situations.

The withdrawal in March, at short notice, of psychiatric liaison support meant that there were now more staff who had not received training in this. The Trust was looking at reinstating this training.

Jan Bloomfield explained that WSFT was second best in the region in terms of sickness absence and it was the only Trust who employed its entire facilities staff on a permanent basis, which could be quite challenging in terms of sickness absence.

Rowan Procter reported that the vacancy factor had improved and another 30 nurses would be starting in September, which meant that there would be no vacancies in paediatrics.

17/165 MANDATORY TRAINING REPORT

Jan Bloomfield reported that there had been a forensic review of safeguarding children and some of the issues for the decrease in level 3.

Rowan Procter explained that an action plan had been produced for this. On the whole this related to A&E staff and was a result of the pressure that this area was under.

17/166 CONSULTANT APPOINTMENT REPORT

The Board noted the appointment of the following consultant:-

Adeshola Adeniran – Consultant in Plastics

17/167 RESPONSIBLE OFFICER ANNUAL REPORT

Steve Turpie asked about the comment that the number of enquiries was "almost certainly rising". Nick Jenkins explained that most of these did not relate to employees working at WSFT, but to locums who had worked at WSFT.

Neville Hounsome referred to the 10 consultants who had not submitted an appraisal and considered this to be an area of concern as they had elected not to follow a mandated process. Nick Jenkins explained that with the exception of one individual, these people were on long term sick or maternity leave. Neville Hounsome asked for a breakdown and reasons for this. **N Jenkins**

Nick Jenkins explained that the GMC suggested a recommendation for non-engagement for people who had not completed an appraisal. This was a five year process and the standard deferment recommendation was for six months.

Jan Bloomfield stressed that the Trust did not wait for the appraisals process and revalidation to identify and address poor performance of doctors.

Richard Davies referred to the development plan and lack of resource and lack of a robust system and asked if there was a plan to address this. Nick Jenkins explained that the Trust was looking at creating additional resource for this.

Gary Norgate expressed concern that there was not an actual plan to address this, considering how important this was. Nick Jenkins said that he was satisfied that there was a plan.

The Board accepted the Annual Report, noted the contents and approved it for submission to the higher level Responsible Officer.

The Board approved the statement of compliance confirming that West Suffolk NHS FT was compliant with relevant legislation and regulations.

17/168 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that Martyn Vaughn, a theatre orderly, had received a Putting You First Award this month.

He was nominated by a patient with a severe muscle wasting condition. She asked him if he could take her down to theatre as he was a familiar face and she was extremely nervous as her condition meant that having an anaesthetic was very dangerous.

Even though her operation was delayed Martyn waited after he had finished work and took her to theatre. He stayed for nearly four hours in order to help calm her down as she was having severe panic attacks.

She had been in and out of hospital throughout her whole life (26 years) and had never known a staff member go out of their way to help her so much.

The Board considered this to be an excellent nomination. It was noted that that it was quite common for staff to behave in this way.

BUILD A JOINED UP FUTURE

17/169 e-CARE REPORT

Steve Turpie asked about GDE funding and how the decision was made on where/how this would be spent. Helen Beck explained that there was a list of options and Craig Black, Mike Bone, the IT team and Cerner were working up the resource requirements for each in terms of cost and staff, to see what was affordable. They were also looking across the organisation at priorities and where things needed to be done. Each option would then be worked through and the benefits looked at. This information would go to TEG in August and the e-Care programme Board in September.

As well as a set of criteria for making decisions on how this money was spent, it also depended on timing, availability and willingness of staff to engage.

H Beck / C Black

Steve Turpie asked for visibility on how and why decisions were made.

He also asked if any constraints had been applied to GDE funding. Helen Beck explained that the expectation was to achieve a certain level of digital maturity across the organisation. The Chief Executive explained that business cases would go through TEG and the e-Care programme Board with a recommendation to the Board at the end of September.

17/170 ALLIANCE AND COMMUNITY SERVICES UPDATE

It was reported that 1:1s had taken place with staff in the community and on the whole they appeared to be reasonably happy.

Jan Bloomfield was currently looking at terms and conditions of employment and how these could be harmonised, and the same was being done around the policies and procedures for work

Alan Rose referred to the designated delivery organisation and designated employer recommendations and the transfers in and out of the Trust. He asked how this would affect users of services and if they would notice anything different. It was considered that there should not be any differences for users and over time it was hoped that some areas/services would improve for patients with ICS etc.

Rowan Procter thought that staff were finding the changes very positive.

GOVERNANCE

17/171 TRUST EXECUTIVE GROUP REPORT

Steve Turpie asked about the proposed Quality Assurance Group (QAG) and if this was going to do anything fundamentally different to the other governance sub-committees, or if any of these would be disbanded. Nick Jenkins reported that this had been discussed by the executive team and they were looking at reviewing and streamlining the other committees to avoid duplication. **R Jones**

Rowan Procter explained that the CQC had commented on the Trust's governance systems and this work was being undertaken to address this.

The Board approved the establishment of QAG to report into the Quality & Risk Committee.

The Chief Executive reported that there had also been detailed conversations at TEG about KPMG's work and the financial challenges moving forward. The Trust needed to ensure that it got value for money and that they provided appropriate support.

17/172 QUALITY & RISK COMMITTEE REPORT

The Board noted the content of this report.

17/173 REMUNERATION COMMITTEE REPORT

The Board noted the content of this report.

17/174 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were approved.

ITEMS FOR INFORMATION

17/175 ANY OTHER BUSINESS

Gary Norgate referred to previous discussions about safety in theatres and that the conclusion was to rely on human factors training as a way in which to advance safety. He asked how many consultants and theatre staff had been through human factors training. Nick Jenkins said that he would provide a report to the next meeting. **N Jenkins**

17/176 DATE OF NEXT MEETING

The next meeting would take place on Friday 29 September 2017 at 9.15am in the Northgate Room.

RESOLUTION TO MOVE TO CLOSED SESSION

17/177 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 – 29 September 2017

AGENDA ITEM:	Item 6
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	22 September 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. **Report delayed until we have further detail of the commissioning intentions re thrombectomy services. Verbal update from Nick Jenkins at Board following CUH and STP discussion.**	HB	29/09/2017 (amended)	Green
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. **Following review of the July performance agreed to bring an update on maternity compliance in September. Nick Jenkins to provide verbal update at Board Meeting.**	NJ	28/07/2017	Red

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1449	Open	28/7/17	Item 2	Provide more visibility of the Helpforce initiative, including the training and governance arrangements	Project plan progress with a full report scheduled for the next Board meeting	JB	03/10/2017	Green
1456	Open	28/7/17	Item 15	Confirm the reason for the 10 consultants with delayed appraisals.	Verbal update to be provided by Nick Jenkins	NJ	29/09/2017	Green
1457	Open	28/7/17	Item 19	Review the functions of the Board committees in the context of establishing the new Quality Group.	Steps being taken to appropriately consolidate scopes of committees. Currently looking to integrate the Patient Safety Implementation Group's responsibilities within the improvement arm of the Quality Group.	RJ	03/11/2017	Green

Completed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1402	Open	28/4/17	Item 8	Update on SLT services, to include: performance against original plan, work with local authority and assurance for future delivery	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. **AGENDA ITEM**	RP	29/09/2017	Complete
1413	Open	26/5/17	Item 7	Review provision of unhealthy options in vending machines	Confirmed that current arrangements are compliant with requirements.	CB	29/09/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
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	The existing ramp maximises the hormonal space available to reduce the gradient. The option of installing a lift was considered to found to be prohibitively expensive. Porters are available to help patients and carers which is communicated through the car parking office.	CB	29/09/2017	Complete
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)	Issue raised have been considered by the Emergency Planning Group and as part of the incident debrief.	HB	29/09/2017	Complete
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	We have now addressed VTE and bed occupancy reporting. Further improvements will be made through 'drop 2' at the end of October	CB	29/09/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1447	Open	28/7/17	Item 2	Confirm the position regarding re-attendance rate for ED against the national standard of between 1-5%. Also agree to provide visibility of the action being taken to mitigate high frequency attendance at ED.	From Oct the Information Team will be able to generate data to monitor this on a routine basis (and include in Board report). Action regarding 'frequent attenders', has been addressed through the Transformation Programme, we held a system-wide meeting looking at high users. Analysis showed the highest 10 users were ALL mental health patients. Action to address this is now being taken forward by the CQUIN for mental health led by the Reactive Care Group.Operationally, the service manager has created a process where they receive a monthly report of ED high attenders and identifies any that are not mental health patients. These are reviewed via the appropriate route, EIT/Paediatrics etc. The service manager is developing a SOP for this process.	NJ	29/09/2017	Complete
1448	Open	28/7/17	Item 2	Review the provision of hand hygiene compliance materials for staff and visitors across the WSH and other sites e.g. main entrance	A review has been undertaken and there is conflicting feedback from other organisations as to wash basins at the entrances to the Trust. Therefore, and due to the review of the courtyard no further action proposed at this time. We have also reviewed increasing our hand hygiene promotional material and at this time, with conflicting materials we hope to achieve target.	RP	29/09/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1450	Open	28/7/17	Item 8	Include breakdown of ENT and non-ENT RTT performance pack. This was in recognition of the need for a longer term solution for ENT capacity.	Detailed within the performance report.	HB	29/09/2017	Complete
1451	Open	28/7/17	Item 8	Confirm plan to urgently address transperineal biopsy capacity	Update provided in quality & performance report.	HB	29/09/2017	Complete
1452	Open	28/7/17	Item 9	Within the staff CIP for 2017/18 provide further details on staffing level 'mix' of grades as well as professional groups (link with KPMG work)	Included within the financial performance report	CB	29/09/2017	Complete
1453	Open	28/7/17	Item 9	Provide further narrative within the pack regarding W&C division performance, including the impact of the USAF maternity	Detailed within the performance report.	HB	29/09/2017	Complete
1454	Open	28/7/17	Item 10	Pull through the sepsis red flag data from the CQUIN report and include within the Quality Report	See 1432 - sepsis reporting will be addressed in Q3. The Sepsis report is now available and used to support local audit. It is still being refined by Cerner as there have been multiple problems before it can be used for national reporting requirements and stop the manual audit process.	CB	29/09/2017	Complete
1455	Open	28/7/17	Item 12	Review the data and action regarding the use of bank and agency within maternity (labour suite) when staffing levels are at the correct level for activity. Also consider link with sickness rate.	Detailed within the nurse staffing report	RP	29/09/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1458	Open	28/7/17	Item 23	Provide an update on progress with the human factors work within the theatre environment e.g. number of staff trained and feedback.	Included in aggregated quality report.	NJ	29/09/2017	Complete

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 29 September 2017

AGENDA ITEM:	7
PRESENTED BY:	Steve Dunn, Chief Executive Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	22 September 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.

It is tough at the moment nationally in terms of A&E and RTT**. National performance** against the four hour treat, admit or discharge target remaining stable during August 2017, despite a 3% increase in the number of patients being admitted as an emergency, compared to this time last year. However, national standards were not met across the board:

- **95% A&E standard not met**, with 90.3% of patients admitted, transferred or discharged within four hours of arrival in all types of A&E departments. This is the same as July 2017 and 91% in August 2016.
- **92% RTT standard not met**, with 89.9% of patients on an incomplete pathway waiting less than 18 weeks to start consultant-led treatment. This compares to 90.3% in June and 91.3% in July 2016. With the exception of February 2016, the standard has not been met since November 2015.

The Trust continues to see high numbers of attendances to the **emergency department**. The unit attendances averaged 188 attendances a day in the first week of August which is higher than our average attendance. For 9 days in August we achieved the 95% target of under 4 hours ED length of stay however the final performance was 90.1% of patients being seen within the four hour national standard (95% target). ED attendance figures were witnessed at over 200 patients a day for 7 days of August, this together with medical staffing deficits resulted in delays to be seen by a clinical decision maker. Mitigation is being planned, but medical staffing recruitment remains an issue. Reviews of the ED RAT process are currently underway, and the ACP roster has been reviewed to enable Sunday and Monday increased staffing levels, as these are our busiest days.

August's performance shows we have marginal improvement in 18 week referral to treatment (RTT) performance with 85.93% for patients on an incomplete pathway against a standard of 92%. This is slightly ahead of our recovery trajectory. Unfortunately we have reported 26 patients breaching 52 weeks. The majority of these are within the ENT service reflecting the significant capacity issues within this specialty. Patient choice continues to be a significant factor with many patients electing to wait longer for their treatment. I am pleased to report that we achieved the 62 day cancer standard with performance of 85.14% against a standard of 85% and the two week wait rapid access standard with performance of 96.02% against a standard of 93%.

The **month 5 financial position** reports a surplus of £5k for August which is better than plan by £15k.The reported cumulative position is therefore £41k worse than plan. The 2017-18 budgets

include a CIP of £13.3m of which £4,936k has been achieved by the end of August (37%). 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.

In preparation for winter and as part of our on-going Red2Green programme, we have signed up to an east-wide 100 day challenge that supports **#EndPJparalysis**. From 14 September 2017 to 22 December 2017, trusts based in the east of England, will spend 100 days capturing the number of patients up, dressed and moving by midday each day. We know that getting our patients up, dressed and moving in their own clothes, rather than wearing hospitals gowns or PJs is really important. It helps them move sooner and retain their level of mobility, and can also help reduce their length of stay in hospital.

To support patient flow the **5Q Care Test (5QCT**), a new 'discharge to assess' model, is currently being rolled locally. 5QCT poses five questions for patients, which will help establish whether their post-discharge needs are primarily health or social care related. This test is used to support decision-making about the level of care a person needs. It can be conducted in hospital, to determine whether a patient's complex needs require an NHS funded community placement.

The way hospital patients are assessed for **NHS Continuing Healthcare** (NHS CHC) has changed. NHS CHC checklists and full assessments will no longer be carried out in hospital for any patients with an NHS Ipswich and East Suffolk or West Suffolk clinical commissioning groups (CCG) GP. NHS CHC is the package of care arranged and funded by the NHS for people with complex ongoing health needs. Until now, a patient's eligibility for NHS CHC funding has been assessed as part of the hospital discharge process. However, this system has led to delays in discharging some patients and patients being subjected to unnecessarily lengthy and intrusive assessments when the majority may not be eligible for funding.

In addition to these initiatives, the work we looking to improve patient experience and flow through the work we are currently undertaking to improve the **physical environment in ED** and our ability to work in a different way running community services.

Plans to develop our emergency department are well underway, with building work ongoing to improve its functionality for staff and patients alike. As part of this, we are pleased to be incorporating front-door 'clinical streaming'. NHS England asked all emergency departments across the country to implement Primary Care Streaming this year, and we bid for funds from NHS England to do so. This will help direct patients to the right clinical care for their needs, and mean our A&E department is free to care for the sickest patients as a priority. We hope this will improve the service we provide for patients, and reduce pressures on our staff, which will be really important ahead of what we anticipate will be another busy winter for the NHS. We're working collectively with GPs, other acute trusts, and the wider health system to support people to see the right person, at the right time, for their health-complaint. We are always looking for ways of working collaboratively with partners to improve our patients' care and experience, and to transform our ways of working.

Our **STP plans** will also drive further integration and collaboration for the longer term that should help us meet future demands. This is exemplified by our focus at the **annual member meeting** on how we can support people to age well and for us to take a more prevention orientated approach to supporting the needs of our population.

Work is continuing to building a new alliance between local health and care organsiations and the delivery of **NHS community services** is centre to this collaborative model. Much work is taking place across health and social care to make services simpler for people and their loved ones. A major part of this is the formation of two new alliances, who will work across organisational boundaries so that patients and carers can navigate services better. The alliances are made up of ourselves (in the west), and Ipswich Hospital NHS Trust (in the east), with Norfolk and Suffolk NHS Foundation Trust (NSFT), Suffolk County Council and the Suffolk GP Federation in both. Decisions have now been taken around which services will be aligned to which of the alliance partners to ensure that they are safe, reliable and bring the greatest opportunities for integration. Managers within community services have shared this information with their teams, and informal drop-in

sessions have also been held to give staff the chance to ask questions. In cases where services are being realigned, a small number of staff may need to transfer to a different employer under TUPE, which offers legal protection for their terms and conditions. Any transfers which do take place follow the proper legal process, which includes a period of formal consultation.

As part of Suffolk and North East Essex STP we have published our delivery guide for '**A healthier long term future**' (attached). Like other STPs, the organisations which are part of the Suffolk and North East Essex Sustainability and Transformation Partnership originally came together in 2016 to develop proposals for local health and care services. In early 2017 a more formalised STP Partnership Board was formed. Key principles for the STP Board are that:

- The STP is not a statutory body. As such each individual partner organisations have the same accountability and responsibility. It's a case of 'both the organisation and our partners', as against 'either/or'
- The STP works according to the local needs of people in Suffolk and North East Essex which will be different to other parts of the country.

Our partnership includes all NHS organisations within the footprint, local government, other health sector bodies, local hospices, ambulance service and other community and voluntary sector organisations. Leadership for the STP is drawn from across these local stakeholders.

Our **annual members meeting** on 12 September was attended by more than 300 people, and it made us exceptionally proud as a service so see so many people there to show their support to our hospital and our staff. The Trust's public health registrar Dr Helena Jopling and our consultant cardiologist Dr Pegah Salahshouri delivered special interest talks about ageing well with a focus on health and wellbeing. We have an important and continuing role to play in helping our community to age and keep well, and will continue to focus on new, innovative ways of doing so.

We also need to prepare for the **Care Quality Commission (CQC)** who notified use that our next visit will take place sometime between mid-October and mid-January. The inspectors will want to hear the good news and the bad news; they want to be told about the good work staff do (especially what you are proud of), as well as any areas we know might need improvement – and the plans in place or being developed to make this happen. We should not be scared of the CQC, and use this visit as part of continuous quality improvement.

Our staff have **continued to praise the trust in the latest staff survey**, with more than 95% saying they would recommend it as a place to receive care or treatment – beating the national average (81%). More than 870 people in the team responded to the questionnaire, which asked colleagues to think about their experience of the hospital from April to June this year (quarter one). Results from the latest Staff Friends and Family Test (FFT), published by NHS England last week (24 August), gave the Trust the 14th best score in England for the question, 'How likely are you to recommend this organisation to friends and family if they needed care or treatment?'

At the end of July we held the launch of our first ever **A-Z of ideas and innovation** in the education centre – designed to showcase the very best ideas from across the Trust. Colleagues from across hospital and community services were invited to profile their home-grown innovations in a marketplace setting, with many of you dropping in to share ideas and knowledge - and to discover some of the inventive developments going on within the hospital. A range of departments came along, including:

- infection prevention, with their innovative wash stations, red aprons and UV light and gel used to educate others on spreading pathogens
- housekeeping and their air mattress request system to help ease pressure sores for patients and audit data for clinicians
- theatre staff with their red hats to identify the lead clinician in surgery
- health coaching discussing how clinicians are learning to help patients with long-term lifestyle and behavioural changes
- dementia twiddle-muffs, the memory walk, and digital 'Dave'

Roy Lilley founder of the Academy of Fabulous NHS Stuff, NHS writer, broadcaster, commentator

and conference speaker was in attendance, and was impressed with the array of ideas on offer commenting: “Twenty six fresh, innovative ideas... department after department showing off! It was stunning. “Was there ever so many good ideas in one place?” Roy also launched our brand new ‘Five O’clock Club’ leadership meeting; designed to bring leaders together each month to listen to a guest speaker from the private or public sector, it aims to inspire and motivate with new ideas and techniques.

We are continuing to work with North East Essex and Suffolk Pathology Services (**NEESPS**) to address the concerns raised by the MHRA regarding transfusion services. Regular progress updates are provided to the MHRA and we are working with Colchester and Ipswich hospitals, our partners in NEESPS, to ensure that effective clinically-led governance arrangements allow effective monitoring of quality and performance with timely escalation of identified concerns. These arrangements are being strengthened by ensuring monthly review from the executive team of operational performance information.

Your hospital, your voice - governor nominations now open. As a Foundation Trust, our hospital has a Council of Governors which ensures that our key stakeholders – patients, members of the public, staff and partner organisations – have a say in shaping their local health service. Our governors play an important role by representing the interests of patients, staff and our community; they are the voice of the people, sharing ideas, concerns, and suggestions on a wider platform; they tell the Board what they think our hospital should offer, and work with them to ensure that community and staff needs are taken into account in the planning of services; they bring valuable perspective and contribution to the Trust’s activities; and they have real influence on the strategic direction and governance of the Trust. It’s a partnership, and it’s one you can be a part of. We have 14 public and five staff vacancies available for you to join our Council of Governors. Help represent the views of your community, and have a say in how our services are run – nominate yourself today. Find out more by visiting the nomination pages on our website.
http://www.wsh.nhs.uk/Corporate-information/How-we-are-run/Your-hospital-your-voice-governor-nominations-now-open.aspx

The **My WiSH Charity’s Every Heart Matters** appeal has been given a £760 kick start thanks to the efforts of I Love Bury St Edmunds website owner James Sheen. The appeal is aiming to raise £500,000 to build a brand new cardiac centre at the hospital in Bury St Edmunds and was officially launched last month by Newmarket jockey Frankie Dettori. The appeal needs to raise the money to support the build of a new cardiac diagnostic unit alongside the cardiac suite to create a fully integrated cardiac centre that will enhance the treatment of all cardiac patients.

Chief Executive blog
http://www.wsh.nhs.uk/News-room/news-posts/Lessons-from-Canterbury-five-reasons-for-hope.aspx

DELIVER FOR TODAY

Patient praise for our diabetes care
As a condition that affects more than three million people in England alone, diabetes is a long-standing item on the NHS radar. We were therefore thrilled to hear that patients here at the Trust are pleased with the care they are receiving from our diabetes unit; according to the 2016 National Diabetes Inpatient Audit (NaDIA) results, 86% of patients were satisfied or very satisfied with the overall care of their diabetes. A further 81% felt they could take control of their diabetes care whilst in our hospital, compared to the average in England of 60%. The NaDIA measures the quality of care provided to people with diabetes who are admitted to hospital. The care patients receive and the help they get in managing their condition really matters, because national research has shown that if their condition is well managed they can live long, fulfilling lives.

Caring for carers
When people think of hospital care, their natural instinct is to think of the unwell patients we look after. But just as important is recognising the crucial role that carers play in looking after their loved ones, and we have a responsibility to care for and recognise them too. We were delighted that local charity, Suffolk Family Carers, recognised our commitment to supporting family carers this month by presenting us with a Family Carer Friendly Hospital Award. We have worked hard to ensure our

practices and policies identify and support family carers alongside the patients themselves. Here, family carers have access to a range of support such as extended visiting times, information packs, including a badge identifying them so that staff know they are the right person to talk to about the patient's care and treatment. One to one support for family carers is also provided by Suffolk Family Carer support and information workers who operate throughout the hospital on the wards and in outpatient departments. We're very proud of the work we do to support family carers, and make their experience easier when their loved one is in our hospital.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Staff nurse's bright idea helps the medicine go down
Sometimes, it's the simple things that can make the biggest difference. A simple idea from Kate Ramsey, one of our staff nurses, has instantly improved patient safety – and it's all started with a cup. Kate came up with the idea of green cups being used to signify a drink that contains soluble medication. This system helps avoid medication being mistaken for water and tipped away, and identifies it as priority for the patient to consume. After Kate submitted her idea in a staff suggestion box, a member of our transformation team got in touch to help make it happen. We have implemented Kate's innovation across all hospital wards, and it goes to show why it's so important we listen to our staff, and how we should all encourage staff on every level to put forward their ideas in a free and open forum.

Involving patients in their care
The Trust has been working with patient representatives to find out how we can make the most of the technology available to us, whilst continuing to have full engagement with our patients and keeping them at the centre of everything we do. Feedback from the representatives was assessed and some 'top tips' have been produced to ensure we keep the focus on our patients:

- Keep eye contact
- Ensure the computer workstation on wheels (WOW) is not a barrier between you and your patient
- Put yourself in your patient's shoes – how would you feel?
- Explain to your patient what you are doing on the computer
- Show them the screen, if appropriate, and if they seem interested.

Medic Bleep pilot
From mid-August, the Trust will be trialling Medic Bleep, a WhatsApp style communication app with tailored healthcare functionality that meets NHS information governance standards. The Trust is keen to use this type of technology to improve communication efficiency within and between teams in the hospital, as well with its primary and community care partners in west Suffolk.

BUILD A JOINED-UP FUTURE

Supporting the national research agenda
We have seen the second biggest percentage increase in clinical studies conducted of all acute trusts in the country, according to the annual National Institute for Health Research (NIHR) Research Activity League Table. Research teams at the Trust increased the number of studies delivered by 58% in the last year alone, offering more opportunities for patients than ever before. We also placed fifth out of all acute trusts in the country for increasing participant recruitment, which is up 243% on the previous year. Taking part in these studies helps us to advance medical knowledge and patient care in the long term, and patients with cancer, diabetes, stroke, arthritis, eye issues, stomach problems, pain, respiratory problems and skin issues have taken part in clinical studies here at the Trust.

NATIONAL NEWS

DELIVER FOR TODAY

Home care: what people told Healthwatch about their experiences
This report analyses the experiences of people who use home care services, their families and front line staff across England. It finds that whilst many people have positive experiences, there is space for improvement in care planning, staff skills, consistency and continuity in services and communication and feedback.

Managing risk in health and care this winter: Update
This report by NHS Providers assesses NHS planning for the upcoming winter season and finds whilst the level of planning and support is more developed than last year, the system still requires emergency funding to ensure patient safety. NHS Providers warns that a failure to make an emergency investment of £200-£350 million will lead to longer patient waiting times and increased patient safety risks.

The bottom line: understanding the NHS deficit and why it won't go away
This briefing assesses the financial health of the NHS provider sector by unpicking the headline figures presented in the official accounts to reveal the true underlying state of the NHS's finances today, and to outline prospects for the next three to four years. The analysis finds that NHS trusts ended last year with an underlying overspend almost £3 billion more than was reported in their official accounts. It warns that even if trusts continue to make savings, underlying deficits will remain until 2020/21.

Managing patient flow and improving efficiencies: The role of technology (The Nuffield Trust)
Technology to track beds, equipment, staff and patients through a hospital has been used in the USA for years, with positive effect, and now there is growing interest in employing it in the NHS. Centrally coordinating patient flow has the potential to create very beneficial results, but they do not come from simply implementing tracking technology. They come from using data to prioritise discharge, bed cleaning and portering efforts; embedding accountability in the system; and monitoring performance to enable continuous improvement. Establishing a control centre that has holistic oversight of the system is a fundamental enabler.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Making effective use of dashboards.
Foster S. *British Journal of Nursing* 2017;26(13):783-783.
The article discusses what the author refers to as the pitfalls that users might face when using performance dashboards to interpret how an organisation's top priority performance results compare to a certain target, and it mentions evidence-based decision making in nursing and the collating and interpreting of data. Employee turnover in nursing is addressed, along with internal and external benchmarking. Nurses in Great Britain are also assessed.
Available with an NHS Open Athens password for eligible users

Do nurse staffing levels affect patient mortality in acute secondary care?
Hill B. *British Journal of Nursing* 2017;26(12):698-704.
This systematic literature review explores and considers whether registered nurse staffing levels affect patient mortality in acute secondary care settings. A discussion makes particular reference to the philosophical foundations of contrasting research approaches used within the literature. Effective management and leadership of acute clinical areas requires appropriate nurse:patient ratios with highly skilled and competent nurses providing best-quality, evidence-based practice.

What characterizes the work culture at a hospital unit that successfully implements change – a correlation study
This study shows that healthcare personnel at a unit with a successful implementation

of change have a working environment with many positive qualities. This indicates that a work environment with a high focus on goal achievement and task orientation can handle the challenges of implementing changes.

BUILD A JOINED-UP FUTURE

Rt Hon Jeremy Hunt MP, Secretary of State for Health, pledged at this month's Health and Care Innovation Expo that **every patient should be able to access their medical records and book appointments with their GP** via an app by 2018. He said: "I do not underestimate the challenge of getting there – but if we do it will be the best possible 70th birthday present from the NHS to its patients." The app has already been piloted in south-east London as patients can already book appointments with their GPs, access NHS 111, receive online consultations with their GPs and order repeat prescriptions using their smartphones. The health secretary said: "People should be able to access their own medical records 24/7, show their full medical history to anyone they choose and book basic services like GP appointments or repeat prescriptions online."

NHS England Chief Executive Simon Stevens has unveiled new plans to **free up funds for the latest world class treatments** by slashing hundreds of millions from the nation's drugs bill, and announced that new and cutting edge treatments will be routinely available for the first time. This will include:

- Revolutionary new treatment for Hepatitis C
- New measures to slash up to another £300 million from the nation's medicines bill
- Trailblazing new treatment to restore sight
- Routine commissioning of the latest technology to help deaf children hear
- An expansion of the Test Bed programme that is testing the treatments and care models of tomorrow.

Investment in the new oral treatments that can cure Hepatitis C more quickly and with fewer side effects has already led to a 10% reduction in the number of deaths and an unprecedented reduction of around 50% in liver transplants for Hepatitis C patients. This is the latest in a series of innovative drug funding arrangements that have been made possible by NHS England working closely with industry to bring prices down, expand treatment options and make new treatments available rapidly – in one case within just four weeks of a treatment receiving its marketing authorisation.

STP progress dashboard
This report outlines baseline data for each STP area in England relating to progress so far on STP plans against nine domains. The nine domains focus on hospital performance, patient-focused change and transformation. West Suffolk NHS Foundation Trust is classified as *'advanced'* from a choice of *'needs most improvement', 'making progress'* and *'outstanding'*.

Market shaping in adult social care
The last five years have seen a reduction in the number of residential and nursing homes operating in England, resulting in 1,400 fewer homes. The long-term trend of increasing numbers of nursing home beds and decreasing numbers of residential home beds has come to a halt. This analysis highlights the fragility of the care home market, although the home care market is equally under pressure. It argues that local authorities must be prepared to be bolder and do things differently in order to shape the market.

Developing accountable care systems: lessons from Canterbury, New Zealand
The health system in Canterbury, New Zealand, has undertaken a significant programme of transformation over the past decade. As a result of the changes, the health system is supporting more people in their homes and communities and has moderated demand for hospital care, particularly among older people. This report outlines lessons for the NHS from the experience of the Canterbury health system. (4 page summary)

People's experience in adult social care services: improving the experience of care for people using adult social care services – NICE consultation

This draft guideline provides evidence-based recommendations with the aim of improving adults' experiences of social care services. It is based on evidence about the views of people who use services on what is important to them in their care and support. NICE is seeking feedback on this draft guideline and the consultation will close on 3 October 2017.

LOCAL PLAN FOR HEALTH AND CARE

A healthier long term future

A Delivery Guide

Suffolk & North East Essex Sustainability & Transformation Partnership

Overview as at July 2017

Foreword

Nick Hulme

Suffolk & North East Essex STP Lead
Chief Executive, Colchester and Ipswich Hospitals

For most of us the health and care support that we and our families need involves services from a broad range of different organisations. However, if like me you have been around for a long time, you will know that our health and care sector doesn't always work that well as a system and has become increasingly difficult for those who need it to understand and to navigate.

Against a backdrop of growing competition and performance management, our health and care organisations have unsurprisingly become increasingly territorial. Sadly sometimes this has led individuals and organisations to put their own priorities ahead of the interests of the wider health and care system that local people rely on.

Sustainability and Transformation Partnerships (STPs) represent an unprecedented opportunity to begin to change all that. In Suffolk and North East Essex, our STP represents the best opportunity that we have had in a generation to come together and address at a local level the inherent design flaws that we know exist in our health and care system.

For the first time, through the STP, colleagues from every organisation in Suffolk and North East Essex are working together in a different way. Working in collaboration rather than in competition, and finding new ways to improve the things that we do and the way that we work as a whole for the benefit of local people.

It is essential that we make a success of this new way of working, because the NHS faces increasingly significant challenges. The model that has worked well since the NHS was established is simply no longer capable of delivering the care that our population needs today and will need in the future. We need to change - and to do this, as health and care leaders we now need to act not only in the interests of our individual organisations but also in the interests of our wider local health and care system. To use a sporting analogy, we all need to play for both "club and country".

For example, if you think about our aspiration that no one should wait any longer than four hours in any of our accident and emergency departments – to achieve this requires our managers and clinicians to think not only about how the whole hospital works, but the whole wider system as well.

We face challenges at every level – from balancing our finances, to ensuring that we have the staff and the professionals that we need now and will need in the future, to working out how we can better use the benefits of new technology. These are not only challenges for us as individual organisations, these are challenges for us as a health and care system as well.

> "It's time for us all to not only think differently. We really do need to act differently too."

We need to recognise that in the future, success will only come if we work together – and what this means is that for unless we put aside our instincts of organisational preservation and personal futures, none of this will work.

It's time for us all to not only think differently. We really do need to act differently too.

Last year, as an STP we made a start by defining the changes that we need to make as a system. Since then we have agreed on some of the outline arrangements that we think will support us to deliver those changes. Initial feedback from NHS England and NHS Improvement is that our STP is in a good position to take forward the work that we need to do. This document provides an early overview of our plans and how as an STP we will work together to deliver change and improvement to the health and care system in Suffolk and North East Essex.

Nick Hulme

Contents

1. Introduction

LOCAL PLAN FOR HEALTH AND CARE

Our partnership

Our patients, carers and partners have told the NHS, social care and other agencies consistently since 2010 that there is a need to change the way the public sector deliver services to make them simpler, safer and reduce waste. Slowly, we are shifting and changing our ways of working.

We were challenged to move faster by the NHS Five Year Forward View (2014) which described how the NHS needs to change, setting out a vision of a better NHS and the steps we should now take to get there. This focused on three areas:

- Improving prevention and public health
- Patients gaining greater control of their own care
- Breaking down the barriers of how care is delivered

The NHS Five Year Forward View committed that local health systems would be supported by the NHS' national leadership to choose radical new care delivery options. These options included:

- Integrating a range of 'Multi-specialty Community Providers' to deliver out-of-hospital health and care
- GP and hospital services combining to form 'Primary and Acute Care Systems'
- Integrating urgent and emergency care services
- Developing primary care, and
- Local innovations.

It meant that planning focused on local services for local populations and tested organisations to work outside of the boundaries formerly set by contracts and finances. In late 2015 NHS England asked local health and care organisations, and local community partners, including patient groups, to develop a shared vision, and create proposals to implement the Forward View. over five years. The Sustainability and Transformation Plans cover all areas of CCG and NHS England commissioned activity, and integration with local authority services, reflecting local agreed health and wellbeing strategies.

To breathe life into these proposals, every area has developed a Sustainability and Transformation Partnership, to bring together GPs, hospitals, mental health services and social care to keep people healthier for longer and join up services around the patients who need it most. The STP is a forum in which leaders can plan services that are safer and more effective by sharing expertise and driving real changes to the way care is delivered. The STP is a vehicle for making the most of each pound of public spending, and engaging with communities and patients in new ways.

Development of Suffolk & North East Essex STP

Like other STPs, the organisations which are part of the Suffolk and North East Essex Sustainability and Transformation Partnership originally came together in 2016 to develop proposals for local health and care services. In early 2017 a more formalised STP Partnership Board was formed. Key principles for the STP Board are that:

- The STP is not a statutory body. As such each individual partner organisations have the same accountability and responsibility. It's a case of 'both the organisation and our partners', as against 'either/or'.
- The STP works according to the local needs of people in Suffolk and North East Essex which will be different to other parts of the country.

Our partnership includes all NHS organisations within the footprint, local government, other health sector bodies, local hospices, ambulance service and other community and voluntary sector organisations. Leadership for the STP is drawn from across these local stakeholders.

See 'Governance' later in this document.

Key roles

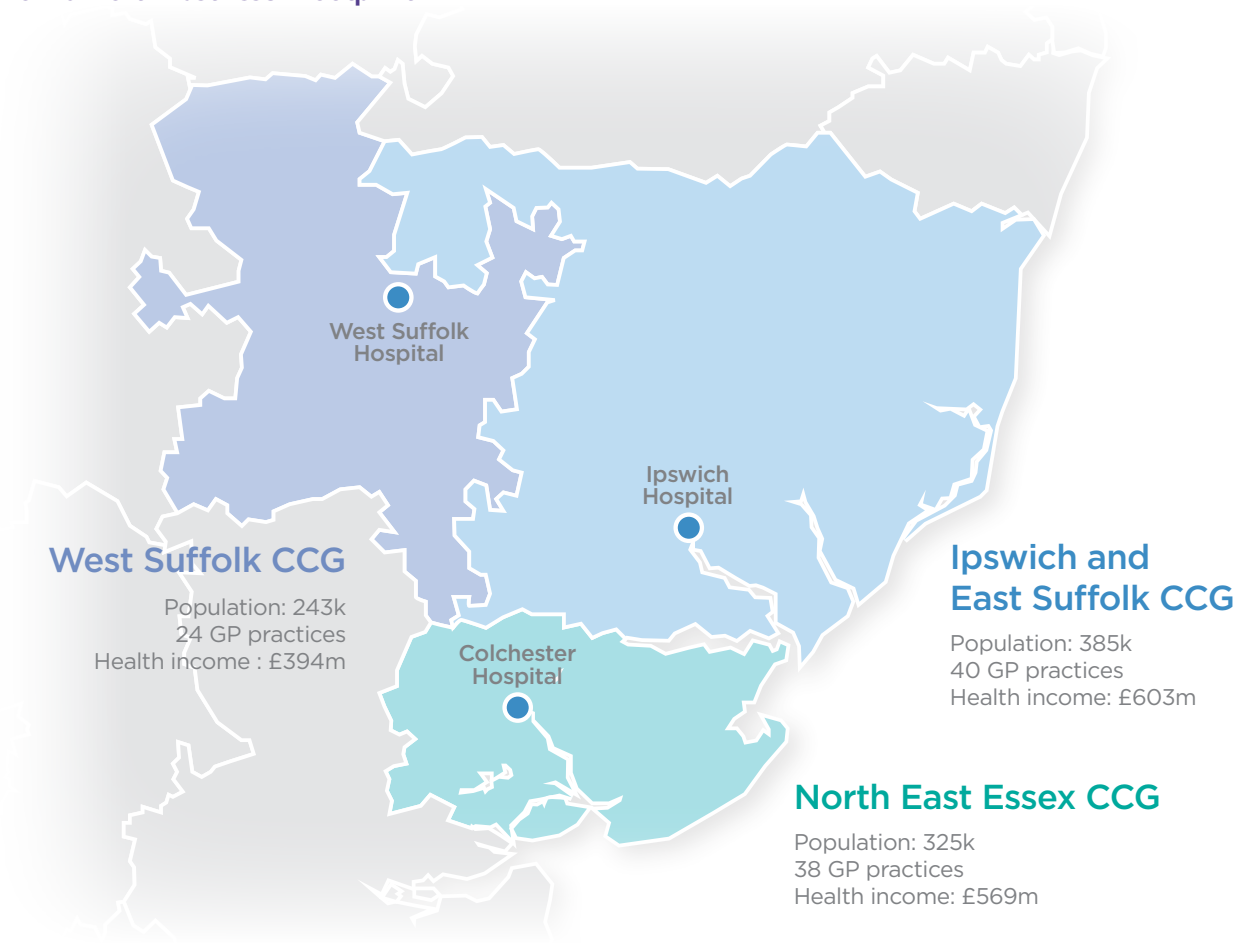
Oversight:

STP Board

Key contact for STP Board:

Susannah Howard, STP Programme Director
susannah.howard2@nhs.net

Suffolk & North East Essex Footprint



Suffolk & North East Essex Sustainability and Transformation Partnership

Local district and borough councils

Local voluntary and community sector

Local pharmacy, dental and optometry networks and committees

Our plan

Our commitment

Over the next five years, health and care organisations in North East Essex and East and West Suffolk will work together better, support you to look after yourself confidently and inspire clinical and community leadership. We want the best for you. So we need to make changes to improve: care for everyone; the quality of services on offer; support for our workforce; and how we spend public money within budgets.

The public, clinicians, the voluntary sector and other partners have told us that they want health and care organisations to join forces to reduce duplication. They want us to do things well without waste and make sure our services are simpler. This is what we will aim to do. By linking up services, you will see GP surgeries, mental health and social care services, acute hospitals and community health professionals all working better together, moving care closer to people's homes and improving their outcomes.

Our vision

Self care & independence

- Working with patients and the public, we will promote ways for people to help themselves, retain their independence and improve quality of life.
- People want to stay in their own homes for as long as possible. We aim to reduce emergency admissions and care home and nursing home placements.
- Working with health, social care and community partners aims to improve community safety and resilience for our population.
- Part of this will require people to take responsibility for their own wellbeing by making healthy lifestyle choices.

Community based care

- We will provide care in community settings to improve patient experience through care closer to home. This will also take pressure off our hospitals.
- GP practices across our footprint will work together to improve patient access, share resources and support each other.
- We will develop local alliances with the public and partners to provide integrated physical and mental health and social care rooted in local communities.
- We will offer patients more treatment and therapy outside of hospital, e.g. minor surgery, joint injections and clinic appointments.
- Work with our mental health providers to align physical and mental health care provision.

Hospital care

- We will enable our hospitals to focus on more complex and specialist care whilst working with other community partners.
- West Suffolk and Ipswich Hospitals are working closely with GPs and community partners to develop new models of urgent care and community services for patients.
- Ipswich & Colchester Hospitals have entered a long term partnership which may include specialisation of sites in different clinical areas to improve safety and quality of care.
- Shift of care from hospital settings to the community.

Care will be more co-ordinated and it will be easier for the public to navigate around the system

Our challenges

Demand on primary care

More people than ever before are going to see their family doctors and nurses. Around 90 percent of patient interaction is with primary care services including GPs, pharmacists, dentists and optometrists. But many GPs are reaching retirement age. Too few new or potential recruits want to come to North East Essex and East and West Suffolk to work. By supporting our workforce, and finding new ways of working between practices, we will strengthen care for patients.

Record numbers of people living with long term health conditions

People with long term conditions, such as diabetes, chronic obstructive pulmonary disease, arthritis and hypertension, account for around 50% of all GP appointments. By 2018, we expect there will be around 45,000 people in North East Essex, West and East Suffolk with three or more long term conditions. We can support people to make changes now to stop them getting ill in the future.

The cost of treatment

In 2016, North East Essex and Suffolk will spend £2.4 billion on health and care. The costs of drugs, treatments and overheads have all gone up, and will do so again. There are some simple ways we can reduce waste and buy services and products together to spend the NHS and care pound well.

The finances

If we continue spending money on health services as we are across the system, we will have an £246 million overspend by 2021. By planning together for the future, we believe we can turn this around.

Things have to be different

Major changes are needed to reduce illness and deteriorating health, to support communities and deliver care closer to people's homes. We want to do more with technology. We want to reduce demand on acute hospitals, and make sure hospitals and primary care can plan together for the future. And it is in everyone's interest that we do this using the money we receive from taxpayers via central Government more efficiently.

A wide range of key organisations have pooled their plans. Numerous pieces of public and voluntary sector engagement have already been carried out in recent years to develop strategies for housing, primary care, end of life, maternity, cancer, hospital care and mental health, including learning disabilities. We still need help from local people to develop parts of the plan and this will happen over the coming months and years.

Our local health and care plan has one central theme at its heart; collaboration, not competition. It focuses on keeping people fitter for longer, improving the quality of health and care and doing so within budget. In it, we set out where we are now and - most importantly - where we need to be.

Our vision

Our vision is that people across East and West Suffolk and North East Essex live healthier, happier lives by having greater control and responsibility for their health and wellbeing.

To achieve this we have three programmes:

- Self care & independence & community based care
- Hospital reconfiguration & transformation
- Working together across the system

A new approach

The fundamental change this plan proposes is that all services, across physical and mental health and social care, will be working together as they have never done before to create a seamless service for the patient. All organisations who are involved are all responsible for making this work. Our STP Lead is Nick Hulme, who is also Chief Executive of Colchester Hospital University NHS Foundation Trust and Ipswich Hospital NHS Trust.

Please remember this is a draft plan and it will change as we will need more input from clinicians, patients, staff and other partners.

You can access the local health and care plan for Suffolk and North East Essex at:

www.healthwatchsuffolk.co.uk/neesuffolkstp

healthwatch Suffolk

What will progress look like?

Welcome to our market place, filled with characters who will help explain more clearly what a good service might look like for people living in Suffolk and North East Essex local health and care system in 2021.

We want to describe what we mean by better services and outcomes. We need to agree how our partnership will measure progress. We know one approach will not work everywhere or for everyone, so we must be able to adapt our ways of working to address local circumstances and individual needs. It will not be perfect, yet having one framework means we can all check our actions against it.

Describing progress: the public vote

People have told us through numerous separate pieces of public and voluntary sector engagement over the last three years to develop strategies for housing, mental health including learning disabilities, urgent care, primary care, end of life, maternity, cancer and hospital plans, that they want:

- To feel in control of their own health using information to make informed choices so that they get support only when they need it.
- To secure the best outcomes possible for them.
- To tell their story once, instead of many times, and for key health and care information to be shared and acted upon across the system.
- Joined up care built around them, not around organisations.
- Support to manage existing conditions and avoid crises.
- Support to maintain health and avoid deteriorating health.

This is EMILY, aged 30. She has a five year old daughter, EVIE, and is planning to have another baby soon. Emily has been given some advice about what to do to prepare her body for the new baby by her nurse, using online appointments and information. She decided to make some healthier choices and got the right advice which means she has given up smoking and is eating a much more balanced diet. After struggling to make these choices in the past she is delighted to have taken control of her own choices. Using the Change4Life app she picks foods with less sugar, salt and calories - and her healthier choices are helping her wider family too.

EVIE has just started school. With support from the school nurse and her teachers, she has settled down well and is enjoying learning and playing. Evie walks a mile a day at her school. In fact, she enjoyed it so much that she is now taking part in her local junior park run, a free 2km run every Sunday morning run by volunteers.

MICHAEL is 76. He has an advanced breathing problem called Chronic Obstructive Pulmonary Disease (COPD). His condition had been managed effectively by his GP working with a specialist community team for the last seven years. However, over the last year he has become increasingly breathless and has needed treatment to control his symptoms. He has had regular visits from a community respiratory nurse and the local hospice outreach team. During the winter he had a number of chest infections which meant he was under the care of hospital clinicians. A multidisciplinary team have been working with him and his family to explain how the disease will progress. He is making some decisions about the care he wants to receive as he nears the end of his life with his family and his care worker. He recently visited the local hospice and met the in-house counsellor and said that he wants to be supported to stay at home until the end of his life. He has a personal budget which has meant he can put in place services to ensure that this can happen, including a tablet computer to help him keep in touch with loved ones and do puzzles. He is comforted that he will be spend his last months in familiar surroundings and that he and his family are being provided with the support that they need.

THEMBI is 48. A few months ago he took up the offer of a health check. He had been feeling tired and knew that he had put on a bit of weight and that he had been drinking more alcohol, so thought it wise to check. He was shocked to be told that his blood pressure was raised and his cholesterol levels were above the ideal levels. It showed him that he was at a greater risk of a number of conditions including diabetes and heart disease. It was a wake up call! He was offered help to make some changes and was referred to a team who supported him. He has a way to go but by improving his diet, increasing his exercise and not drinking every night he has already lost some weight, his blood pressure is coming down and he feels much more energised and in control.

ALI, aged 65, is living with type 2 diabetes. When he was first diagnosed he was referred to a specialist community clinic for advice on diet and exercise. He shaped his own care plan with health professionals which included the provision of medication to help manage his blood pressure. He has also has a support group who have helped him to understand and manage his condition, and share his own experiences with newly diagnosed people. With regular reviews of his medication needs and screening for any worsening of his condition or developing complications, he can work with specialists to tackle potential problems early. His consultant sees him in his community instead of him having to go to hospital. When he has his yearly eye check, this is also done in a mobile van in his community.

SALLY is 55. She first noticed a small lump in her breast three years ago. She ignored it but finally decided to get it checked out during the October breast cancer awareness campaign. At her GP appointment, she was told it might be a cyst, but that it was still worth a referral to a specialist at the breast clinic. She received an appointment within two weeks. After a number of tests she was told that the lump was cancer but that it had been caught very early and so hadn't spread. Sally was introduced to a breast care nurse who talked her through her diagnosis and the treatment options plus the wider support that was available, including a local support group run by the voluntary sector. After successful surgery to remove the lump she had radiotherapy to destroy any cancer cells left behind. Recent tests and scans have shown that the cancer had gone. Sally now receives regular check ups with a community team supported by the specialist team she was treated by and is volunteering with the support group she had attended while under treatment.

This is MAUD. She is 88 years old and lives alone in the home she shared with her husband until he died two years ago. She has a heart condition that she and her GP manage with support from a community outreach specialist team. She is used to being very active but over the last year or so she has found it harder to move around and carry out her every day activities. It made her more socially isolated. People in her community saw this, and a team was contacted to help her out. Maud has had a visit from a lovely firefighter who helped her identify how to reduce the risks of falling. She also gets the support she needs to stay in her own home. She wants to stay there for as long as possible, and her advanced directive plan sets out what she wants to do in the event of a fall or a significant decline in her wellbeing. Her local community has helped her to access community transport and local buses. She is now doing more things, more often which has reduced her loneliness. The local council has made modifications to her home to reduce the risk of falls, including putting up handrails to make it easier for her to get around. She knows who to contact when she feels unwell or needs help and all the services that she comes into contact with have access to same information on her needs. As a result, she is less likely to need emergency care or to be admitted into a care home.

ANDY, aged 23, is fit and healthy. He has a job that he enjoys, plays football regularly and volunteers in the community. In his teens, he had crippling depression; which was a scary time for him and for his family. He had attempted to take his own life. He needed intensive treatment and therapy, which included the skills from a team of people made up of primary care, community, hospital and volunteers. His family also had help. Co-ordinated care helped him learn how best to manage his condition and to get into work. He continues to receive some treatment, knows what warning signs he needs to look out for and who to call on for rapid help. Last month, he sprained his ankle at football which meant he could not exercise. He was able to book his own physiotherapy appointment online and found other exercise options and is now feeling better. He got extra help from the community mental health team for a while too.

Measuring progress

To know that we have succeeded, we also need to be able to demonstrate measurable improvements and benefits.

We want to focus on a small number of key issues that are important to the people living in Suffolk and North East Essex, we can provide tangible evidence of progress.

We will use a small number of measures to help us to track the impact of the changes that we are delivering. These might include measures similar to the following:

Patient **experience** and **satisfaction**

Mortality rate from causes considered preventable

Emergency admissions of those with long term conditions

Cancer diagnosed at stages 1 and 2

Percentage of **people with diabetes** meeting all three targets (HbA1c, blood pressure, cholesterol)

Recovery in **quality of life** for patients with **mental illness**

Injuries due to falls in **people aged 65 and over**

Care home and **nursing home** admissions

Percentage of people who **die in their own home**

Breast feeding prevalence at 6-8 weeks after birth

Child excess weight in 4-5 and 10-11 year olds

Balanced income and expenditure to our health and care system

Public and patient engagement

We will have an ongoing dialogue with our patients, carers and citizens.

Leaders and experts in this field worked together to co-create an overarching pledge during 2016. Based on national best practice, these are:

- Use lived experience and other insights to drive change, putting people at the heart of care, where appropriate.
- We will identify and communicate best practice across the NHS – and also tackle areas of improvement.
- Use a network approach, pooling resources and sharing skills.
- Use social marketing and develop trusted information to support change in behaviours.

There are also some key groups who already support our organisations' communications and engagement work, including strategic partners Healthwatch Essex and Suffolk, and the Health Scrutiny Committees. We will involve our existing networks including:

- CCG lay members, including health forums and community engagement sub-committees.
- Voluntary, community and social enterprise (VCSE) networks.
- Trusts' non-executive directors and governors.
- Community networks, neighbourhood forums, and special interest groups.
- Health and Wellbeing Boards.
- Local councillors and MPs.

Between our organisations, we have tried and tested methods of communicating, engaging, involving and consulting. NHS England has also worked with our STP to offer support and resources from which we are drawing to improve our communications and engagement, and in turn we are able to support NHS England's work. This could include developing case studies to tell the story, participatory events in local areas, listening to local representatives and champions and formal consultation processes. We will want to engage with people who are less frequently heard and who experience the greatest inequalities in health outcomes, so will reach out though local community organisations who work with people with protected characteristics.

Examples of how we will communicate:

- Any organisation will communicate when there is information to share and it will be made clear where this is the system working together.
- We will keep our CCG and Healthwatch websites up to dateand create frequently asked questions documents using any comments or ideas we receive.
- We will speak to those groups we already have connections with and with those we know in the community to take advice on how best to inform and engage in their areas.
- Partners will be organising events about their particular area of work, and we will use our communications networks to share these broadly.

Healthwatch Essex has developed a helpful Five Steps for us to follow to ensure local people have their say:

1. Set out the case for change so people understand the current situation and why things may need to be done differently.
2. Involve people from the start in coming up with potential solutions.
3. Understand who in your community will be affected by your proposals and find out what they think.
4. Give people enough time to consider your plans and provide feedback.
5. Explain how you used people's feedback, the difference it made to the plans and how the impact of the changes will be monitored.

We recognise that some people live outside our STP area but access health and care services within it and may therefore be affected by our proposals, so we will therefore also engage with them where appropriate.

"Being part of this sustainability and transformation partnership means we can both support and influence our health and care system, to improve its ability to speak to and involve the right people, at the right times. Good engagement will mean patients, service users and carers can at the very least be aware of, or indeed be a part of, the changing health and care landscape across Suffolk and North East Essex."

Andy Yacoub, Healthwatch Suffolk, and David Sollis, Healthwatch Essex

Staff engagement

We will engage staff from constituent organisations, working through the internal communication channels available, including with unions.

Transforming the health and care system can only be truly successful if those who deliver the services understand and are committed to the new ways of working, which includes being asked for their views and involvement in developing services wherever practical.

Engagement

Employee engagement can be directly linked to patient satisfaction. High levels of staff engagement can enable staff to have a higher level of trust in their management and greater understanding of their role within it, and therefore achieve organisational change successfully.

We will develop a coordinated communications and engagement plan for STP partners that ensure their staff:

- Have access to information about the issue being discussed.
- Recognises any anxieties staff may have about uncertainty, and the impact of organisational cultures.
- Are clear about the changes that will take place, the consequences for their roles, and our progress.
- Know where they can access further information.
- Know what we want them to do next.

A coordinated approach will allow organisations to ensure the information shared with their staff is consistent across the STP, and to be sensitive to any other changes or events that are happening elsewhere in the system, which may affect the messages being given.

With advice from unions, will also encourage a range of ways to communicate and engage staff to reach as many as possible. Methods might include information and listening events, email and intranet, bulletins and newsletters, team and branch meetings, staff forums, podcasts or other films, workshops and training events and social networking. Some of these may take place within the organisation or across organisations, for example in multi-disciplinary hospital settings. All will be consistent.

Involvement

Involving staff in decision-making makes sure they can influence the decisions that affect their own work and therefore patient care. Good practice in staff involvement includes working in partnership with staff representatives including unions, an effective communications programme, and a proactive cycle of consulting staff, acting on what they say, updating them on that feedback, implementing changes and consulting again.

In some cases where significant changes are proposed within the STP health and care system, we will support a coordinated approach to staff involvement among STP partners, so that their staff have access to all relevant information, and so that they have access to a range of involvement opportunities.

2. Key areas of activity

LOCAL PLAN FOR HEALTH AND CARE

Integrating care

The NHS 'Five Year Forward View'

> The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient."

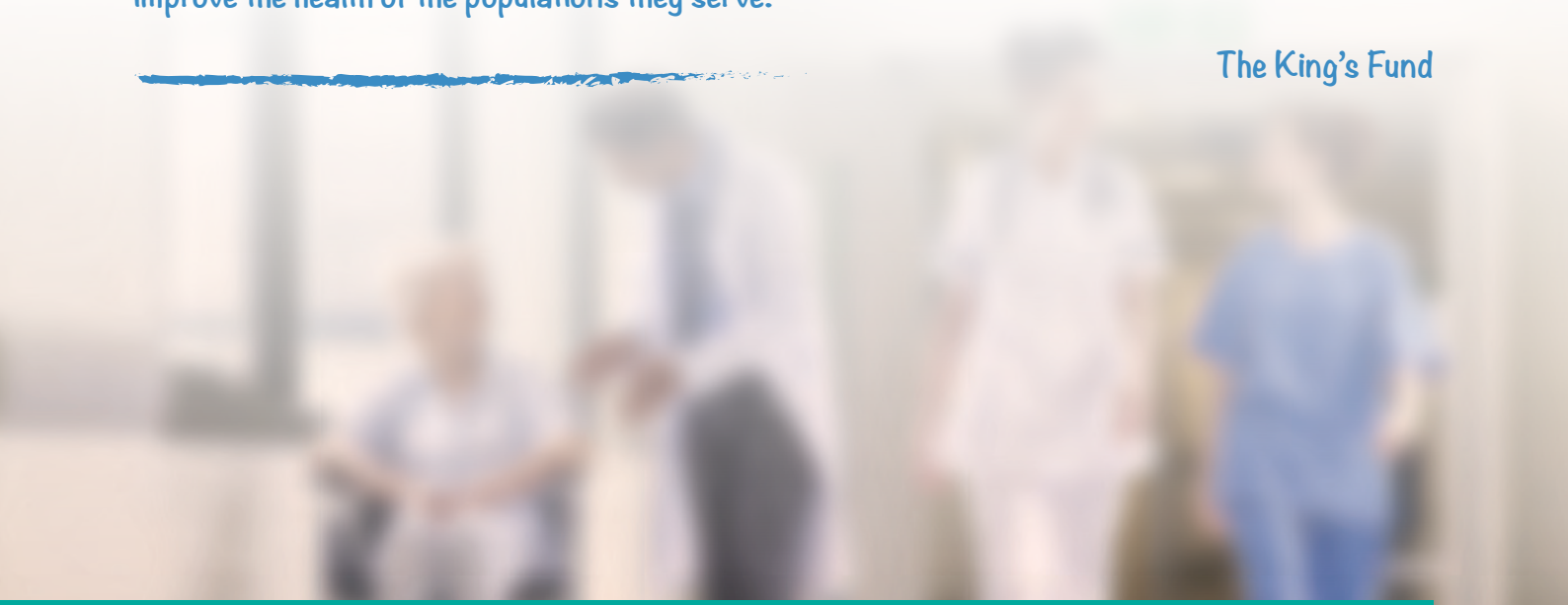
National guidance

In March 2017, the 'Next Steps on the Five Year Forward View' set out a number of criteria for setting up a local accountable care system:

- Agreed accountable performance contract.
- Funding management system for defined population.
- Collective decision-making and governance structure.
- System for horizontal integration between providers.
- System for vertical integrated care.
- Deploy population health management capabilities that improve prevention, enhance patient activation & self-management of long term conditions, manage avoidable demand & reduce unwarranted variation.
- Patients able to exercise choice.

"Organisations need to move away from a 'fortress mentality' whereby they act to secure their own individual interests and future, and instead establish place-based 'systems of care' in which they collaborate with other NHS organisations and services to address the challenges and improve the health of the populations they serve."

The King's Fund



Our local approach in Suffolk

Our vision is that people in Suffolk live healthier, happier lives. We also want to narrow the differences in healthy life expectancy between those living in our most deprived communities and those who are more affluent through greater improvements in more disadvantaged communities.

We have formed two alliances across Ipswich and East Suffolk and West Suffolk, which will integrate local primary, community, mental health and social care services with partners working with each other and with the voluntary sector to take accountability for all health and care outcomes for their local populations. The alliances want people to have a more personalised and co-ordinated health and care service, which helps people to stay well, and supports them back to independence after a period of ill health. Alliance partners believe that by working together we can make the best use of our collective resources and change the health and care system so that it works better for people.

We have agreed the following outcomes for our accountable care system:

- Improved health and care outcomes for patients.
- Focussed on individual needs and empowering and supporting self-care.
- Clinically owned and led models of care that are developed in partnership with service users.
- Services that are built around localities which are seamless across organisational boundaries.

The outcomes must meet national requirements and be affordable.

Our key actions in Suffolk

At the end of June 2017 we have...	✓ Designed, agreed and started our system and governance model.
By the end of September 2017 we will...	✓ Devise a patient and public engagement plan, and begin to report on progress at public meetings. ✓ Review the effectiveness of our governance systems and consolidate reporting systems. ✓ Design a model based on evidence we gather on finance, workforce, resources and activities. The model will incorporate the health needs of our population, integration between providers, best use of space and IT, workforce planning and engagement with staff, and market engagement. ✓ Work together as an alliance to deliver community services contract as part of an integrated health and care system.
By the end of December 2017 we will...	✓ Define the planned outcomes for our system. ✓ Agree and commence new performance reporting. ✓ Confirm our data sharing and governance arrangements.
By the end of March 2018 we will...	✓ Start detailed service redesign.

Integrating care

Our local approach in North East Essex

North East Essex CCG has directly commissioned a contract with community providers, providing care closer to the patient's home, including some consultant led pathways. Patients have their care case managed by, and can access support through, the community hub. Multi-disciplinary teams are wrapped around GP practices and integrated with social care and voluntary sector support to reduce system demand. Care is based around localities and neighbourhoods, rather than around organisations.

The multi-speciality community providers are beginning to achieve the following outcomes:

- Improving health outcomes for patients.
- Shifting care closer to the patients homes.
- Reducing demand on primary and secondary care services.
- Empowering and supporting self- care.
- Training the workforce in behaviour change.
- Services that are built around localities which are seamless across organisational boundaries.
- Planning to shift more pathways of care into the community underway (Phase 2).

This seven year contract includes the outcomes we want to achieve and a performance-related payment system, and is delivered through a lead provider model of delivery.

Our key actions in North East Essex

At the end of June 2017 we have...	✓ Developed our accountable care system (ACS) principles and strategic approach, and engaged with system leaders.
By the end of September 2017 we will...	✓ Devised a detailed short and long list of ACS models including commercial, legal, workforce and financial aspects, evaluated the options and agreed a preferred option. ✓ Develop a plan and timescales for implementation, incorporating funding management systems, a model of care delivery, and patient choice. ✓ Form a model of care group, which will develop a high-level model of care, ensuring the ACS model supports the proposed model of care. ✓ Commence market engagement for potential transformation partner.
By the end of December 2017 we will...	✓ Commence implementation of the ACS. ✓ Agree the principles for a detailed model of care design, delivering care closer to home, rather than in acute hospitals.
By the end of March 2018 we will...	✓ Commence detailed service redesign.

"Integrated care is more than just a buzz word – it's a way of working. It's how the NHS should operate because when you are dealing with people with long-term conditions, multiple long-term conditions, old people with frailty, they cannot afford the service to be disjointed."

Tom Gentry
Head of Health Influencing, Age UK

"We need to heal fractures between services and tear down those administrative, financial, philosophical and practical barriers to the kinds of services our patients want us to deliver."

Sir Bruce Keogh
NHS England Medical Director Professor

"Effective integrated care brings together all the different elements of care that a person needs, providing an improved patient experience and better outcomes. Closer working with local partners is key to addressing the challenges facing the health and social care sector and delivering person-centered coordinated services."

Dr Ed Garratt
Chief Officer, NHS Ipswich and East Suffolk and NHS West Suffolk CCGs

"There are many benefits in having more joined up health and social care services for local people and the communities we serve. Not only does is it make it much easier for people to access services, but it will also mean patients not having to repeat their story over and over again to different professionals."

Ray Hardisty
Chair of the Health Forum Committee in North East Essex

Transforming acute care

Care Quality Commission 'The State of Care in NHS acute hospitals: 2014 to 2016' quoted in 'Next Steps on The NHS Five Year Forward View', 2017

> The model of acute care that worked well when the NHS was established is no longer capable of delivering the care that today's population needs... transformational change is possible, even in the most challenging of circumstances - we have witnessed it, and seen the evidence that it delivers improved care."

National guidance

The NHS 'Five Year Forward View' recognises that in the NHS a one size fits all approach is not appropriate, so supports STPs to debate and develop locally grounded proposals and plans for models that reflect the local population's needs. The focus should be on evolution, not 'big bang' changes, so that we can learn by doing, change can adapt achieve continuous improvement. One way of doing this, highlighted in the "Next Steps in the Five Year Forward View' is to link local hospitals together to 'improve their clinical and financial viability, reducing variation in care and efficiency.'

Our local approach

Our acute transformation programmes comprise projects to transform a range of services in acute care, including in cancer and diabetes. Details of these can be found in later chapters of this guide.

Colchester and Ipswich Hospitals Partnership

A key element of acute care transformation is the exploration of a partnership between The Ipswich Hospital NHS Trust (IHT) and Colchester Hospital University Foundation NHS Trust (CHUFT). The aim of a partnership is that both hospitals will be able to build on their strengths to achieve long term sustainability for healthcare in Ipswich, East Suffolk and North East Essex.

Four objectives have been defined which align with the strategic challenges:

1. Improved quality and patient outcomes.
2. Better value for money.
3. Sustained and improved access to services that meet the needs of the population.
4. A sustainable, skilled workforce.

In May 2016 the boards of both trusts committed to entering into a partnership built on a foundation of collaborative working that has been established between the two Trusts over recent years. At the same time CHUFT appointed IHT's Chief Executive and Chair, who now lead both organisations with the support of NHS Improvement (NHSI). Since then, a number of potential partnership scenarios were developed, and groups of clinicians and managers at the Trusts and in the local health systems met consider to the benefits of each, feeding into a Strategic Outline Case and recommendation to the Trust boards. The next stage of planning will be an Outline Business Case.

February 2017	Publication of the Strategic Outline Case, showing the possible ways the Partnership might progress
March 2017	Launch of the development of a Partnership clinical strategy. A number of specialities with the greatest opportunity for collaboration are identified
July - August 2017	Preparation and publication of an Outline Business Case with a preferred organisational form for the Partnership
August - December 2017	Continued engagement with the public, patients and staff
January - March 2018	Publication of a Full Business Case detailing the organisational form of the Partnership
January - March 2018	Assurance and approval process on the changes proposed within the Full Business Case
April - September 2018	Changes begin to be implemented over a three year period

"It is fantastic to see the collaboration of clinicians and indeed all staff in both hospitals working together to look at how services can be shaped and delivered in the future. There is a strong willingness to change together for the future."

Dr Barbara Buckley,
Managing Director of Colchester Hospital University Foundation NHS Trust

Enabling system working

The NHS 'Five Year Forward View'

> "... nothing in the analysis … suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them."

National guidance

To reduce unwarranted variation in service quality and efficiency, the 'Next Steps on the Five Year Forward View' makes a number of recommendations. Among these are:

- Population health management capabilities that improve prevention, enhance patient activation and supported self-management for long term conditions, manage avoidable demand.
- Managing administration costs efficiently, for example, by sharing buildings or back office functions.
- Developing and implementing a national continuing healthcare framework ensuring that assessments and decisions around care packages are taken with patients and their carers within no longer than 28 days.

Our local approach

Our STP has a number of projects in place to enable support of our aims:

- Developing an efficient support model for STP services at scale.
- An STP-wide population health approach including identifying patients who are at high risk to offer them preventative care.
- Maximising the benefit of the commissioning resources within the STP footprint by shared approaches.
- Implementing a single operating model where it makes sense to release resources to support transformation.

Our key actions

At the end of June 2017 we have...

- ✓ Evaluated existing population health models, and tested our capacity and demand model for population health.
- ✓ Our population health leadership role provided by public health across Suffolk and Essex.
- ✓ Prioritise activity to align commissioning contracting, continuing healthcare and demand management across the STP area.
- ✓ Developed and started implementation of the enablement function transformation plan
- ✓ Developed and started to implement the enablement communication and engagement plan

By the end of September 2017 we will...

- ✓ Agree the accountable care blueprint.

By the end of March 2018 we will...

- ✓ Have a comprehensive plan including timetable and milestones to deliver the accountable care bluepint.
- ✓ Launch a new STP wide population health approach.

"We need to ensure robust management of clinical and financial risk for the STP through aligned system, process and intelligence. The role of the leaders in the system is to make this happen. The enablement workstream looks to promote clinical leadership, a single operating approach to commissioning and where possible maximise the opportunity to release resources through this process to support and deliver transformation."

Sam Hepplewhite - Accountable Officer
North East Essex CCG

3. National priorities

Overview

The NHS 'Five Year Forward View'

> … there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce."

The NHS Five Year Forward View identified:

The health and wellbeing gap: by focusing on prevention and health inequalities

The care and quality gap: by reshaping care delivery, harnessing technology, and driving down variations in quality and safety of care

The funding and efficiency gap: by matching reasonable funding levels with wide-ranging system efficiencies.

The NHS's strategy is driven by the need to close these gaps through transformation in how, where and by whom, care and treatments are delivered.

The 'Next Steps on the Five Year Forward View' highlighted that we face five paradoxes:

1. We're getting healthier, but we're using the NHS more.
2. The quality of NHS care is demonstrably improving, but we're becoming far more transparent about care gaps and mistakes.
3. Staff numbers are up, but staff are under greater pressure.
4. The public are highly satisfied with the NHS, but concerned for its future.
5. There is now an underlying consensus about how care needs to change to 'future proof' the NHS, but the ability to do so risks being overtaken by what CQC has called today's 'burning platform'.

Within the constraints of the requirement to deliver financial balance across the NHS, the main NHS national service improvement priorities in 2017/18 are:

- Improving A&E performance, and upgrading the wider urgent and emergency care system so as to manage demand growth and improve patient flow in partnership with local authority social care services.
- Strengthening access to high quality GP services and primary care, which are by far the largest point of interaction that patients have with the NHS each year.
- Improvements in cancer services and mental health – common conditions which between them will affect most people over the course of their lives.

To achieve this, there will be a focus on local service redesign and on enablers that will achieve change: workforce, safer care, technology and innovation.

Our Suffolk and North East Essex STP plan identifies:

- How we will work together to improve the health and wellbeing of our population.
- How we will combine efforts to improve safety and quality of care in our area.
- How we will value and motivate the staff delivering care across our footprint to make Suffolk and North East Essex an attractive and enjoyable place to work.
- How we will share and align our infrastructure, assets, land and technology to get the best out of them as we use them to deliver high quality care.
- How we will move towards a single system- wide financial control total to make best use of our shared financial resources.

Urgent and emergency care

The NHS 'Five Year Forward View'

> The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care… Over the next five years, the NHS will do far better at organising and simplifying the system."

National guidance

The 'Next Steps on the Five Year Forward View' sets a number of deliverable targets for Urgent and Emergency Care to meet the Government's mandate leading to a return during 2018 to the standard of 95% of patients being treated, admitted or transferred within 4 hours:

- Comprehensive front-door clinical streaming in hospitals, so that A&E departments are free to care for the sickest patients, including older people.
- Good practice by hospitals and local health and social care partners to enable appropriate patient flow, including better and more timely hand-offs between their A&E clinicians and acute physicians, 'discharge to assess', 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven day discharge capabilities.
- Hospitals, primary and community care and local councils work together to ensure people are not stuck in hospital while waiting for delayed community health and social care.
- Specialist mental health care in A&Es provide 24-hour 'core 24' services.
- NHS 111 online will start during 2017, allowing people to enter specific symptoms and receive tailored advice on management.
- An increase to over 30% of 111 calls receiving clinical assessment, so that only patients who genuinely need to attend A&E or use the ambulance service are advised to do this. GP out of hours and 111 services will increasingly be combined. By 2019, NHS 111 will be able to book people into urgent face to face appointments where this is needed.
- Evening and weekend GP appointments available to all patients by March 2019.
- Strengthen support to care homes to ensure they have direct access to clinical advice, including appropriate on-site assessment.
- Standardised new 'Urgent Treatment Centres' open 12 hours a day, seven days a week, integrated with local urgent care services.
- Implementation of the recommendations of the Ambulance Response Programme, ending long waits not covered by response targets.

Our local approach

We will:

- Implement the Ambulance Response Programme.
- Commission a single point of access (SPOA) across Suffolk and North East Essex for urgent healthcare needs.
- Shift a greater proportion of care from acute hospitals to be supported in community based settings with a strong reablement focus.
- Put in place primary care in A&E.
- In Suffolk, implement integrated neighbourhood teams and 24/7 community based urgent care to reduce reliance on acute based care.
- Increase focus on hear and treat and see and treat for urgent and paramedic care.
- Review how community services support the out-of-hospital strategy and national guidance.

"Demand on the emergency healthcare system continues to increase and we need to provide care which meets the patient's needs which is often not in the A&E department. That is why we have put in place our emergency clinical advice and triage centre which can help patients with less urgent conditions over the phone. This means the patient gets quicker advice and treatment first time without the need for a journey to hospital."

East of England Ambulance Service

Our key actions

At the end of June 2017 we have…	✓ 7-day rapid intensive support by Emergency Therapy team in Ipswich Hospital and Early Intervention team in West Suffolk Hospital. ✓ Implemented discharge hub at Colchester Hospital. ✓ Carried out a medical assessment and triage service review to divert ambulatory emergency care (AEC) patients directly to the AEC service. ✓ Developed the geriatrician interface with the Ipswich Hospital A&E to provide early support and enable proactive planning. ✓ Implemented dedicated care home advice lines. ✓ Submitted a capital bid to fund GP streaming on site but separate to Emergency Department in Colchester Hospital. ✓ Updated patient choice policies and ensured staff are trained.
By the end of September 2017 we will…	✓ Implement Discharge to Assess and SAFER clinical review models, continue weekly meetings to reduce delayed discharge, and review our trusted assessor (assessment) model. ✓ Implement the '5Qs' continuing healthcare model across the STP area, and increase the number of assessments in the community. ✓ Continue to implement the shared care and support plan My Care Wishes for people with frail elders, people with long term conditions and people with end of life care needs. ✓ Pilot care home-based rehabilitation for complex patients in West Suffolk. ✓ Commence joint West Suffolk Hospital and Suffolk County Council funded Support to Get Home service. ✓ Have local enhanced service for care homes in place in Ipswich & East Suffolk; a similar service in West Suffolk is being considered. ✓ Have in place an integrated rapid assessment service to divert from admission and facilitate early discharge at Colchester General Hospital. ✓ Comply with 4 clinical standards on consultant assessment and review, and diagnostic facilities 7 days a week. ✓ Implement recommendations for improved ambulance responses. ✓ Procure new model for urgent treatment centres (UTCs) offering appointments through NHS 111 and GP referral.
By the end of December 2017 we will…	✓ Roll out Primary Care Streaming to manage urgent needs and reduce activity in the Emergency Department. ✓ Have a 7-day service at Ipswich Hospital's Frailty Assessment Base.
By the end of March 2018 we will…	✓ Review paediatric activity through Ipswich Hospital A&E and paediatric assessment unit. ✓ Review clinical pathways at Ipswich Hospital to ensure they are safe and effective for biliary & upper GI, falls, and chest pain. ✓ Have five integrated neighbourhood teams to support people in the community. ✓ Work with NHS 11 providers to achieve increase in number of patients transferred to clinician to 40%. ✓ Mobilise the new model for urgent treatment centres offering appointments through NHS 111 and GP referral.
By the end of June 2018 we will…	✓ Align our primary care streaming with the re-commissioning of out of hours and NHS 111.
By the end of September 2018 we will…	✓ Commence 6 month implementation of minor injury service in North East Essex, to be upgraded and classed as a urgent treatment centre pending approval of capital build funds.
By the end of March 2019 we will…	✓ Achieve of 50% of patients to be transferred to clinician by March 2019. ✓ Achieve a psychiatric liaison service 24/7, supported by local transformation opportunities and central funding.
By the end of September 2019 we will…	✓ Review community services provision in Suffolk.
By the end of March 2020 we will…	✓ Continue to improve on performance to achieve 60% of patients transferred to clinician by March 2020.

Primary care

The NHS 'Five Year Forward View'

> The foundation of NHS care will remain list-based primary care. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention."

National guidance

The 'Next Steps on the Five Year Forward View' set a number of targets for primary care:

- More convenient patient access to GP services, to offer same day urgent appointments, while making sure patients with more complex long term conditions have continuity of care. Practice profiles will be published including patient survey results and how easy it is to make an appointment.
- Making available bookable evening and weekend appointments. Not every practice has to be open each evening or weekend, patients will be able to book appointments in a fixed place when they need them; GP practices may develop local networks to achieve this.
- Boosting GP numbers, with an objective of an extra 5000 doctors nationally by 2020. Improve retention of GPs through career schemes, programmes to reduce workloads and free up time to care, and supporting GPs' own wellbeing.
- Expanding multidisciplinary primary care including clinical pharmacists to help free up GP time to focus on those patients who need it most, mental health therapists to support integration of community physical and mental healthcare, physician associates in surgeries, and developing nursing roles.
- Modernising primary care premises.

Our local approach

We aim to provide all services in primary care unless safety determines otherwise. This programme will address some of the variation that exists within primary care, particularly around prescribing. It will support better working between practices as well as integration with community, acute and social care partners. We are designing new models of care that will shift care away from hospitals and into community locations. This will include the creation of neighbourhood or locality hubs that are fully integrated with community and social care.

Our priorities are:

- Integration between primary care community services and social care.
- Primary care at scale/super practices/a single partnership and allied collaborations.
- Improved use of technology in general practice and within the neighbourhood / locality hubs.
- Innovative estates solutions to ensure the primary care estate and infrastructure is fit for purpose.

"Primary care is the foundation of all health services and very important to patients and the system as a whole. It is at the heart of all our plans recognising the key role primary care plays in achieving our aims."

Clinical Leads

Dr Gary Sweeney, Chair of North East Essex CCG

Dr Mark Shenton, Chair of Ipswich and East Suffolk CCG

Dr Christopher Browning, Chair of West Suffolk CCG

Our key actions

At the end of June 2017 we have…	✓Published practice profiles data. ✓Completed the consultation with GP practices on improving access to Primary Care services in the evenings and at the weekends in West Suffolk. ✓Develop proposals for hub based working in to improve access to primary care received from at practices that are working together in bigger groups. ✓Form 2 new legal companies where practices are working together much more closely.
By the end of September 2017 we will…	✓Extend GP+ evening and weekend appointment service to 4 other areas for Ipswich & East Suffolk patients. ✓Open a second GP+ service in Haverhill, offering additional appointments in the evenings and over weekends and bank holidays. ✓Roll out Care Navigation System Software Solution in pilot practices in North East Essex. ✓Achieve 85% take up of extended hours (additional 30mins per 1000 patients).
By the end of March 2018 we will…	✓Continue the roll out of extended access services in West Suffolk with 3 further GP+ Hubs. ✓Introduce GP streaming at the front door of A&E in both West Suffolk and Ipswich Hospital. ✓Complete formal legal Partnerships in North East Essex and develop hub model for access to evening and weekend appointments. ✓Complete all planning processes prior to building new North West Ipswich GP Hub. ✓Agree Masterplan for buildings improvement required in over 20 surgeries in West Suffolk to improve the environment for patients. ✓Complete Connect programme, aligning primary care, social workers and other community health professionals in 13 locations in Suffolk.
By the end of June 2018 we will…	✓Extend access to GP service during evening and weekends available across 100% of Suffolk. ✓Give additional funding to Primary Care for service transformation. ✓Implement new models of care to stream patients 'on the day' within practices and across practice collaborations.
By the end of March 2019 we will…	✓Enable care providers from community services, hospital, mental health, social care and primary care to work together as part of an accountable care system to deliver better joined up care for patients and the public. ✓Extend hub model for access to evening and weekend appointments across 100% of North East Essex. ✓Review community services in North East Essex to optimise use of existing premises within new models of care, and complete feasibility study and options appraisal to improve the quality of other local estates. ✓Have clinical pharmacists, physicians assistants and mental health therapists delivering services in your area as part of the wider Primary Care team.
By the end of September 2019 we will…	✓Implement 'hub & spoke' model for three collaborations providing evening and weekend appointments in North East Essex. ✓Use funding incentives for GP practices to develop extended access. ✓Implement care navigation roles and tools.
By the end of March 2020 we will…	✓Develop business cases and implement rural Estates Technology Transformation Fund (ETTF) schemes.
By the end of September 2020 we will…	✓Confirm plans for two further Ipswich hubs.
By the end of March 2021 we will…	✓Have a minimum of 52 mental health therapists working alongside surgeries.

Cancer

The NHS 'Five Year Forward View'

> One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap. So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas."

National guidance

The 'Next Steps on the Five Year Forward View' set a number of targets for cancer care:

- Expanded screening to improve prevention and early detection of cancer, for example in bowel cancer and cervical screening.
- Faster tests, results and treatment for people with worrying symptoms. Expanding diagnostic capacity, including the latest molecular diagnostics, so that England is meeting all eight of the cancer waiting standards, compared to seven out of eight today. There is specific focus on the cancer 62-day from referral to treatment standard ahead of the introduction of the new standard to give patients a definitive diagnosis within 28 days by 2020. New multi-disciplinary Rapid Diagnostic and Assessment Centres will be in place across England.
- Access to the most modern cancer treatment in all parts of the country, including upgrading radiotherapy machines so that patients will have access to sustainable high- quality, modern radiotherapy treatments wherever they live. Further modern cancer drugs will be available due to the reshaped cancer drugs fund and the new accelerated access approvals process with NICE.
- Transform our approach to people living with and beyond cancer by accelerating the roll out of follow up pathways and the 'recovery package
- Better cancer survival. Within two years, more than 5000 extra people a year will survive cancer compared to now.

Our local approach

We are committed to implementing Achieving World Class Cancer Outcomes (2016) working with the new East of England Cancer Alliance. Our focus is to reduce variation and fragmentation of cancer service practice and improving cancer patient outcomes, by integrating the activities of all partner organisations across primary, secondary, community and social care. The alliance also aims to share and implement learning and best practice, link to new models of care and radical transformation, integrate care pathways across health and social care, focus on prevention and access to services, improve the patient experience, monitor performance and support improvements, and fully involve patients, carers and families.

"Having pushed myself on the bike...my whole being seems alive yet relaxed and refreshed. I do believe that cycling, walking and swimming are helpful because they help to clear the mind, get you out in the air and overall are satisfying and fulfilling."

Active Wellbeing service user with prostate cancer

Our key actions

At the end of June 2017 we have…	✓ In primary care, delivered the strategic commissioning framework and GP Forward View, streamlined referral criteria for GPs and enabled faster access to diagnostic services. ✓ Improved support for self management and wellbeing. ✓ Systems in place to monitor waiting standards, which are a contractual requirement. ✓ Supported providers in changes to NICE medication approvals process. ✓ Cancer STP group in place, and commence development of Cancer Alliance workplan.
By the end of September 2017 we will…	✓ Develop the new model of out-of-hospital care for people following treatment, in line with best practice.
By the end of December 2017 we will…	✓ Build diagnostics capacity by supporting development and investment facilities, based on best practice and level of local demand; and work with local providers to ensure capacity will meet cancer standards. ✓ Roll out training for GPs and other primary care-based clinical staff. ✓ Start a personalised holistic tariff-based recovery package across all specialities, shifting emphasis from clinically led hospital care to self management in the community, and building on Survivorship work at Ipswich Hospital. This includes holistic needs assessments, treatment summaries, care planning and review, and health and wellbeing events. ✓ Extend risk stratification and re-entry pathways. ✓ Identify the role for accountable care partnerships in providing holistic care, rapid response and intermediate care services. ✓ Start phased implementation of electronic records. ✓ Monitor through integrated cancer dashboard and STP locality group. ✓ Further develop prevention by improved information and advice to the public.
By the end of March 2018 we will…	✓ Evaluate and learn from current pilots to inform further service development: (1) Ipswich Hospital as one of the national pilots for the 28 day faster diagnosis standard, (2) vague symptoms pathway and clinic at the Macmillan Ipswich Diagnosis Assessment Service, and (3) unexplained weight loss pathway in West Suffolk. ✓ Further develop model of care following treatment exploring roles such as Cancer Navigator and Community Cancer Nurse. ✓ Explore opportunities to increase screening where uptake is low.
By the end of September 2018 we will…	✓ Deliver the STP component of the Cancer Alliance work on collaboration between radiotherapy providers and other local stakeholders to address any resource challenges.
By the end of March 2019 we will…	✓ Plan for implementation of learning from the unexpected weight loss pilot across the STP area.
By the end of March 2020 we will…	✓ Achieve the 28 day faster diagnosis standard across all specialties.
By the end of March 2021 we will…	✓ Deliver the STP component of the wider Cancer Alliance molecular diagnostics transformation programme ✓ Have electronic records in place across STP area.

Mental health

The NHS 'Five Year Forward View'

> … there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment."

National guidance

The Five Year Forward View for Mental Health, published in February 2016, sets out a clear and unarguable agenda for the reform of mental health care. The strategy is built around the evidence and opinion of the thousands of people who contributed to its development, to increase significantly the availability and quality of care and treatment for people with mental health problems - to improve their outcomes and wellbeing but also to tackle the wider costs of mental ill health to the health service and society as a whole. (Mental Health Five Year Forward View One Year On)

We are committed to the National Mental Health Investment Standard which promoted parity between mental health and physical health, together with investment in early intervention in psychosis and psychiatric liaison services.

The 'Next Steps on the Five Year Forward View' sets a number of targets for mental health. These include:

- A significant increase in psychological (talking) therapies.
- Better mental health care for new and expectant mothers, with an increase in the numbers treated.
- Improved care for children and young people, with an increase in the numbers treated.
- Extra physical health checks.
- Increase in treatments for common mental health conditions, and faster access to digital therapies
- Extra crisis home treatment services to reduce out of area placements.

Our local approach

Our priorities are to:

- Provide co-designed excellent, cost effective and transformational mental health services.
- Promote health, independence, resilience and wellbeing with a stronger focus on improved awareness and identification of people with mental health problems.
- Deliver holistic and integrated mental and physical health responses and support so that needs are considered and treated together.
- Develop a skilled workforce focussed on resilience and recovery approaches.
- Reduce reliance on inpatient provision, increasing home treatment options, treating people in least restrictive setting including delivering our learning disability Transforming Care Plans.
- Development of outcome focussed services

Our approach is to:

- Deliver early identification and early intervention via locality based integrated approaches.
- Establish a joined up, family focussed response to children and young people.
- Deliver care and treatment in the least restrictive environments with emphasis on community approaches and recovery.

"Improving services to include prevention and early intervention will only support those who start to suffer with mental health. This is particularly important for young people, but this covers all ages"

Mental Health Patient

Our key actions

At the end of June 2017 we have…	✓Deliver the 67% dementia diagnosis target in Ipswich & East Suffolk.
By the end of September 2017 we will…	✓Re-commission the Marginalised Vulnerable Adults Service. ✓In Suffolk, submit a bid for NHS England STP Perinatal monies, and progress implementation of a perinatal service in local hospitals. ✓Deliver the 67% dementia diagnosis target in West Suffolk. ✓Implement a community based model in Suffolk to reduce out of area placements for people with learning disabilities. ✓Complete and submit a fully costed Better Births Action Plan to NHS England.
By the end of March 2018 we will…	✓Continue to deliver the Suffolk Children's Emotional Health and Wellbeing Plan including new integrated triage and wellbeing hub, focus on crisis response, and workforce development. ✓Implement new specialist perinatal community services in Suffolk and build links with the new Norwich based Mother & Baby Unit'. ✓Mobilise the Suffolk Wellbeing Service, which provides IAPT services, and explore future bidding opportunities particularly for those with long term conditions. ✓Improve IAPT in North East Essex for people with long term conditions. ✓Deliver the 67% dementia diagnosis target in North East Essex. ✓Explore the options for developing a crisis café in Suffolk. ✓Implement the Essex mental health system preparedness plan. ✓In North East Essex, review inpatient pathways, capacity and flow to identify a holistic approach to reducing out of area patients. ✓Develop a local business case for moving towards 24/7 psychiatric liaison services at West Suffolk and Ipswich Hospital'.
By the end of June 2018 we will…	✓Co-ordinate an integrated approach to the future IAPT provision, integrated between physical and mental health and social care in North East Essex. ✓Implement a newly designed crisis home treatment team in Suffolk alongside access to Norfolk & Suffolk NHS Foundation Trust services.
By the end of September 2018 we will…	✓Implement new specialist perinatal community services across Essex and build links to the new regional Mother and Baby Unit.
By December 2018 we will…	✓Establish our redesigned Early Intervention Psychosis service. ✓Drive an integrated approach to commissioning through the Southend Essex and Thurrock Mental Health Strategy.
By the end of March 2019 we will…	✓Implement the Essex-wide 'Open Up, Reach Out' integrated transformation plan for children and young people. ✓Work with primary care to increase physical health checks for people with severe mental illness.
By the end of March 2020 we will…	✓Achieve 75% of people with learning disability receiving physical health checks, and work with mental health in supporting primary care.

Elective care

The NHS 'Five Year Forward View'

> On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years."

National guidance

The 'Next Steps on the Five Year Forward View' sets out expectations to reduce the demand for elective care by GPs and CCGs tackling clinical practice variation in referrals, trusts tackling variation in clinical quality and productivity, and for CCGs and trusts jointly it will mean redesigning care pathways to promote optimal patient care in line with RightCare. Strategies include:

- Working with higher-referring GP practices and CCGs to measure, monitor and review the clinical appropriateness of hospital referrals.
- Reviewing CCG referral management processes and guidance, where appropriate redesigning patient pathways for example to allow speedier access to physiotherapy for musculoskeletal patients with back pain.
- GP practices and hospitals are moving to universal use of e- referrals, which offers a new specialist 'advice and guidance' option avoiding the need to default to an outpatient referral, and supports demand management through identifying providers with the shortest waiting times.
- 'Getting it Right First Time' will work with consultants on the appropriateness of certain procedures of questionable clinical value such as some spinal surgery procedures.

Our local approach

Over the next four years we will focus on 15 specialty areas in a phased approach. These have been chosen based upon their potential to contribute most to closing the health and wellbeing, finance and quality gaps. We want to benefit from the lived experience from patients to support this work.

Our approach is to identify and quantify potential opportunities to manage demand, particularly for those patients who:

- Could be prevented from needing acute intervention in the first place.
- Could be seen in an alternate (and more cost effective) settings.

We are also exploring how far the following potential models could be used in these services:

- Services transferred whole or in part to community settings to be provided in different ways.
- Networked services with potentially shared rotas across two or three sites.
- Services combined but delivered across multiple sites.
- Services consolidated onto a reduced number of sites.

Diabetes Transformation

We have recently been awarded £955,000 funding by NHS England to improve diabetes care over the next two years. The project aims to improve NICE diabetes treatment targets, and reduce variations in care. We will:

- Increase the number of places and types of diabetes education, promoted through our Big Impact campaign
- Empower people with diabetes by improving their knowledge about the condition and risks
- Support people to access local lifestyle and mental health services
- Provide specialist Mental Health Diabetes Practitioner support to people with severe mental illness
- Support GPs in their role in diabetes care

Our key actions

At the end of June 2017 we have…	✓ In musculo-skeletal and endocrinology, implement revised pathway model with single point of referral, clinical assessments and shift to community services to achieve a reduction in secondary care appointments. ✓ Review referrals where Referral to Treatment standards are not met, and additional capacity sourced as required. ✓ Scope three potential areas in Suffolk and five in North East Essex to develop Right Care proposals to reduce unwarranted variations in services.
By the end of September 2017 we will…	✓ In North East Essex, in gastro, implement a revised model including single point of referral and shift to community services. ✓ In Ear, Nose and Throat in West Suffolk and North East Essex will design and review capacity and redesign clinical pathways. ✓ Deploy CAREIS and Consultant Connect systems to interface between primary and secondary care in North East Essex to support demand management, quality of referrals and admission avoidance. ✓ In diabetes, establish links to local lifestyle services and develop enhanced lifestyle support following completion of education programmes; implement consultant GP visits (Ipswich & East Suffolk and North East Essex) and community nurse visits (West Suffolk); and in Suffolk, commence increasing patients' knowledge of their condition through the Year of Care approach. ✓ In diabetes, increase the number of structured education programmes to improve uptake by prevalent and newly diagnosed patients, with a marketing campaign and communication plan; appoint a joint mental health specialist practitioner to support patients with severe mental illness; implement a GP incentive scheme; and in Suffolk, implement primary care data analysis and reporting systems. [note: text moved from june 17].
By the end of December 2017 we will…	✓ In North East Essex in ophthalmology, respiratory care and CVD, implement a revised model including single point of referral and shift to community services.
By the end of March 2018 we will…	✓ In Ipswich & East Suffolk and West Suffolk, in gastro, implement a revised model including single point of referral and shift to community services.
By the end of June 2018 we will…	✓ Commission an Integrated Pain Management Service via a strategic partnership which is system-wide and functions through a multi-disciplinary approach to improving acute and persistent pain management for the population of West Suffolk. The Integrated Pain Management Service in West Suffolk will go live on 1 April 2018 with transition and shadow governance arrangements in place until 31 March 2018.
By the end of March 2019 we will…	✓ In urology, increase clinical capacity, improve access and ease pressure on acute services. ✓ In maternity and early years services, investigate variation in delivery and devise a system of collaborative working in line with best practice. ✓ In neurology, address variations in care and spend, ensure care is delivered in the right setting and in the right way. ✓ In Ipswich & East Suffolk and West Suffolk, in ophthalmology, respiratory care and CVD, implement a revised model including single point of referral and shift to community services.

"What is most frightening about diabetes is not having specialist support and up to date knowledge when I need it. I hope that this will improve in the future"

Diabetes Patient

Prevention

The NHS 'Five Year Forward View'

> The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health… And as the 'stock' of population health risk gets worse, the 'flow' of costly NHS treatments increases as a consequence... We do not have to accept this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences. Public Health England's new strategy sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals… While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change."

National guidance

The 'Next Steps on the Five Year Forward View' details a range of prevention programmes. These include:

Promoting healthy communities by measures such as:

- Tackling obesity, in particular among children.
- Improving access within the NHS to NHS Health Checks and to screening, advice and referrals for patients who smoke and/or have high alcohol consumption.
- Extending childhood flu vaccinations to Year 4 children.
- Supporting employers to help people with a health condition to stay in work.
- Helping the voluntary sector and local communities to improve wellbeing and self care.
- Improving the identification and support provided to carers.

Supporting people with specific conditions, including:

- Expanding the Diabetes Prevention Programme, helping to reduce risk of Type 2 diabetes.
- Preventing cardiovascular disease.
- Supporting disabled people and those with long-term conditions to manage their own health, care and wellbeing, including through personal health budgets.
- Focusing on diagnosis and support for people with dementia and their carers.

Our local approach

We are developing an STP prevention plan, which will focus on several areas:

- Managing clinical risks, for example working with GPs to help people understand and manage long term conditions such as high blood pressure
- Prevention at scale on lifestyles, addressing the top six risk factors for early death and reduced quality of life: smoking, high blood pressure, being overweight or obese, lack of physical activity, poor diet, and excessive alcohol consumption.
- Healthy hospitals, through helping both staff and patients to be as healthy as possible.
- Personal and community resilience, supporting communities to help themselves to stay healthy.

We will deliver our prevention strategies in a coordinated way and will include a range of communication and engagement activities aimed at behavioural change. Prevention work is often a long term investment, so we recognise the need to support people now to make lifestyle choices that will benefit them and the system in future years. We will better utilise 'place' based prevention as a means of supporting healthy lifestyle choices and provide an environment that enables and sustains good health and wellbeing.

Prevention is a key priority for all STP members, with each organisation doing its part to deliver our prevention vision.

Our key actions

At the end of June 2017 we have…

- ✓Commissioned an new integrated lifestyle service called OneLife Suffolk with a contract that significantly increases the scale of delivery during 2016/17 they delivered over 15,000 interventions and 14,422 users of the website were offered support in changing to a more healthy lifestyle.
- ✓977 individuals completed a weight management programme losing 5337Kg between them
- ✓31,879 individuals had their blood pressure measured through One Life Suffolk or and NHS health checks from GPs, Pharmacies and outreach – 4,500 more than through these routes last year
- ✓940 professionals were trained to deliver brief intervention lifestyle advice (MECC) and if used once a week this would result in 50,000 brief interventions a year.
- ✓Delivered 28,242 NHS Health Checks
- ✓Made significant progress towards adopting a health hospital approach for patients staff and visitors at West Suffolk hospital and progress in Ipswich hospital.
- ✓Additionally work on smoking cessation, falls prevention and hospital alcohol liaison continues.

In Essex activity with benefits expected by 2021 include…

- ✓An extension to the delivery of NHS health checks to deliver Senior Health Checks (Extended upper age limit by 10 years)
- ✓Made a web based brief alcohol intervention tool available and identified the savings for Colchester Hospital from the Alcohol Liaison Nurse service and A&E liaison nurse through economic modelling
- ✓Changing the model for the falls prevention services to deliver similar benefits with less duplication

By December 2017 we will…

- ✓Both Suffolk and Essex will have made progress in ensuring STP level data is available for Public Health commissioned services which is currently available on a county basis.
- ✓Work will show demonstrable progress on the prevention priorities to:
  - Increase the detection of people diagnosed with hypertension by 15% and optimise their management
  - Increase the number of people diagnosed with AF and optimise their treatment
  - Improve detection of pre-diabetes and diabetes; where identified increase referral to intensive lifestyle management
  - Increase alcohol screening and brief interventions for those drinking alcohol levels above the national guidelines
  - Target lifestyle interventions in adults to those in greatest need.

"The prevention agenda is led by Public Health but there must be system wide engagement and action to deliver the required change. The STP is an ideal vehicle to promote the prevention programme."

Dr Amanda Jones,
Assistant Director of Public Health, Suffolk County Council

4. Cross-cutting workstreams

LOCAL PLAN FOR HEALTH AND CARE

Overview

The NHS 'Five Year Forward View'

> … the national leadership of the NHS will need to act coherently together, and provide meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS."

To support the changes needed within the health and care system there are number of workstreams that cut across the key activities we have described.

Robust financial management ensures that we maintain financial balance in the short term, and develop sustainability for the longer term. The 'Next Steps on the Five Year Forward View' recognised that ensuring financial balance will requite 'tough decisions and decisive action'.

NHS estates and facilities must be fit to provide high quality services, and to be able to adapt to the new care models as they develop. The 'Next Steps' document highlighted that as well as spending on improvements, there is scope to cut maintenance and running costs, and to dispose of unused property to benefit the wider community.

Digital innovation and technology must be harnessed and used in an effective way to improve efficiencies and enhance patient experience. The NHS has a phased technology plan that simplifies patient access to care, in the most appropriate location, while supporting people in managing their own health.

Workforce development enables the NHS to have the right numbers and skill mix of staff to meet patients' needs within the new care models. The 'Next Steps' document recognised that despite a growing workforce and improving staff satisfaction at work, NHS staff are under real pressure. They work with ever increasing numbers and complexity of the patient needs, there are challenges in areas that are harder to recruit to, and there is ongoing pay restraint and uncertainty for our international staff.

The following pages summarise our local approach and plans for each of these cross cutting workstreams.

Finance

The NHS 'Five Year Forward View'

> "... nothing in [our] analysis ... suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them."

National guidance

The 'Next Steps on the Five Year Forward View' highlighted that although the NHS has achieved improvements in controlling expenditure, there remain challenges in achieving financial sustainability. These challenges include the continuing pressures on per-person funding levels and areas such as capital investment; hospital pressures;

redesigning services; and the need to make difficult choices on service priorities. The NHS has set a number of service improvement priorities for 2017/18, including improving A&E performance, managing demand and improving flow in urgent and emergency care in partnership with social care, improving access to primary care and mental health services, and improving performance in cancer services. The 'Next Steps' document recognises there are limitations on highlights the need to tackle areas of waste or low value care, and to accelerate service redesign.

Our local approach

Our STP recognised the challenges of financing the local health system, and we predict that if we do nothing, the health system will overspend £246m by 2021, with an estimated additional £114m pressure in social care attributed to the STP footprint.

- Our income (excluding the Sustainability and Transformation Fund) is expected to grow by 12% over the period set out within the STP, with an annual range of between 2.6% - 4.3%. This growth in allocation will not be sufficient to address the cumulative impact that inflation and demand are expected to generate year on year.
- National assumptions on activity and inflation growth suggest that inflation and demand pressures would be expected to create a cumulative growth in the region of 15.9%.

Without change, our financial position by 2020/21 will be unsustainable. Finance leaders across the system are developing existing financial models and using best practice and evidence to evaluate the solutions to closing this gap. We will need balance our income and expenditure, and we can achieve this in several ways.

We can avoid costs by reducing the volume of care provided, for example by commissioning fewer procedures that have low clinical value or poor outcomes or managing demand to reduce the need for people to attend A&E.

We can reduce costs in a range of ways, for example shifting care from high cost hospitals who are structured and resourced to treat the most needy patients to moreappropriate community settings; targeting the direct costs of providing care such as purchasing goods and services more cheaply; reducing 'back office' costs that are not related to direct patient care; innovative use of technology; and organisations collaborating to commission services.

We know that to deliver the vision for the relevant services over the next five years we will incur costs.

We will prioritise and review our assumptions around our investments in service transformation in line with available funding.

Our approach is to:

- Deliver local early identification and early intervention services in an integrated way Establish a joined up, family focussed response to children and young people.
- Deliver care and treatment in the least restrictive environments, with emphasis on community approaches and recovery.

Our solutions

Opportunities to manage costs though service transformations include the following:

Specialist commissioning	Initiatives: including neonatal, spinal, medicines management, renal and chemotherapy.
Mental Health	Dependent on receiving the investments highlighted in the NHS Mental Health Five Year Forward View (MH5YFV).
Inpatient Pathway Changes	Focus on end of life care, minor surgery pathway redesign, reducing variation in elective care, reducing low clinical priority procedures, and musculoskeletal disorders.
GP demand management	Supporting self-care, reducing the need to attend A&E, extended hours through hubs, extended roles in primary care.
A&E & Non-elective	New models of integrated community-based care, reducing delayed transfers of care, new NHS 111/out of hours model, prevention, and risk stratification and proactive management.
Medicines management	Product switches, improved prescribing and reduced item costs, and reducing variation.
Collaborative working	Corporate commissioner efficiencies, improving benchmarked performance on Continuing Health Care and Funded Nursing Care costs, sharing and aligning CCG teams, improved adherence to clinical thresholds and referral management.
2% provider efficiencies	Internal provider efficiency savings, partnership between Ipswich Hospital and Colchester General Hospital, accountable care systems, and cost improvement plans.
Outpatients	Risk stratification, integrate community services, enhanced use of technology, reduce volume and variation, improving referral, triage and review.
Ambulance services	Integration with the wider health service, to send more appropriate resources to patients, treating more patients within the community.

Estates

The NHS 'Five Year Forward View'

> Some commentators have argued that smaller district general hospitals should be merged and/or closed. In fact, England already has one of the more centralised hospital models amongst advanced health systems. It is right that these hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. And some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country …"

National guidance

The 'Next Steps on the Five Year Forward View' highlighted that the NHS needs to protect and improve its estates and facilities. Facilities management has a direct bearing on patient experience, for instance by ensuring that premises are safe, warm and clean, and by preparing high quality and nutritious hospital food. Efficiency savings can be achieved in maintenance and running costs, for example through reducing unwarranted variation in energy costs. The NHS and Department of Health is planning to dispose of surplus estates to create headroom for investment and to free land for new homes. A multi-year programme of capital investment is also in place, with the NHS England's Estates and Technology Transformation Fund (ETTF) enabling GP practices to work with other health and social care services to provide services that people need to access locally. Achieving these efficiencies will mean health services will need to be more responsive and co-operate more closely. Good quality strategic estates planning is vital to making the most of these changes and will allow the NHS to fully rationalise its estate, maximise use of facilities, deliver value for money, and enhance patients' experiences. (Department of Health (2015) Local Estates Strategies: A Framework for Commissioners)

Our local approach

Our STP is working to establish long term sustainable solutions to optimise services across the footprint. Our review of how services are commissioned and provided through new models of care provides us with an opportunity to review utilisation of the estate. In some areas, we may need to increase estate, or invest in the buildings and infrastructure to make them fit for purpose, whilst in other areas we may need to provide solutions where estates no longer meet required standards, are poorly utilised or are no longer economically sustainable. This will be particularly relevant for our primary care transformation strategy which will see hubs supporting 30-50,000 patients in key locations, plus more local services to support care closer to home. A whole system approach will be undertaken encompassing Primary, Community, Planned and Urgent Care services. Members of the STP Estates forum will work with programme teams to consider the most appropriate settings for care delivery and understand the wider impact across the STP footprint. We will work with One Public Estate Boards, Local Estate forums and local authority partners to explore different funding and borrowing opportunities that could support better value for money investments.

The Strategic STP Estates Forum will:

- Work in a whole system approach to improving the utilisation of the existing estate.
- Rationalise estate by using space more efficiently and cheaply, and provide a baseline for future planning and improvements.
- Offer advice around the disposal of surplus estate currently in the system, where it does noyt support the new models of care.
- Reshape the estate to support the wider service redesign programmes emerging from the STP workstreams.
- Escalate risks to delivery of estates programme to the STP Board.

Our key actions

At the end of June 2017 we have…	✓ Continue to empower the STP leadership team to resolve strategic issues related to workstream delivery to ensure that delivery remains aligned to the STP. ✓ Recognise and align our skill set to support the STP delivery workstreams to identify estates requirements and efficiencies. ✓ Agree an Estates framework for capturing details of the existing service delivery infrastructure within the footprint and its efficiency, sustainability, consistency with the STP and fitness for purpose to inform our Estates Strategy.
By the end of September 2017 we will...	✓ Work with partners to establish the estate needed to deliver the STP (primary care, out of hospital/ community, secondary, urgent and emergency care, tertiary, mental health and public health estate). ✓ Identify locally and nationally identified opportunities for estate rationalisation and disposal, (including those identified through the engagement of the Department of Health led Provider Engagement Programme (PEP) leads with relevant providers). ✓ Oversee the progression of Estates projects, including Estates and Technology Transformation Fund (ETTF) and NHS England capital improvement grants.
By the end of December 2017 we will…	✓ Using our Estates Profile establish which sites need to be retained, used more intensively or differently, or divested and what new facilities are required, where and why. ✓ Working closely with the Digital and Workforce STP groups align and agree interdependencies for our Estates group plans. ✓ Agree our KPI's and methods of collating metrics across the STP footprint.
By the end of March 2018 we will...	✓ Have an Estates Strategy including a prioritised and phased plan consolidating across the STP Footprint the high-risk areas that need urgent attention, the identified needs for new or re-purposed accommodation, the opportunities for rationalisation and disposal and the opportunities for improving VFM, efficiency and productivity and generating value from unfit, under-used or redundant assets to create headroom for further infrastructure investment.
By the end of June 2018 we will...	✓ Evaluate the effectiveness of our workplan and the efficiencies delivered. ✓ Produce an end of year report outlining key achievements, challenges, outputs and lessons learnt.

"Estates is a key enabler for ensuring the vision of the STP can be realised. This is an exciting time to be part of a whole system approach to improve patient experience and ensure sustainability of the Health and Social Care services for the future."

Jane Mower,
Estates Development Manager,
North East Essex Clinical Commissioning Group

Digital

The NHS 'Five Year Forward View'

> Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards."

National guidance

The 'Next Steps on the Five Year Forward View' explained the strategy of harnessing technology and innovation will 'simplify patient access to care, in the most appropriate location, while supporting people in managing their own health'. Technological solutions will:

- Make it easier for patients to access urgent care on line.
- Enable 111 to resolve more problems for patients without telling them to go to A&E or their GP.
- Simplify and improve the online appointment booking process for hospitals.
- Make patients' medical information available to the right clinicians wherever they are.
- Increase the use of apps to help people manage their own health.

Our local approach

Our STP Digital Roadmap includes:

- A detailed plan so that we have the mechanisms in place to share high-risk and critical information for people when they need it most, and with their consent.
- A strategic plan to shift the way the NHS and social care operate. It will mean we can implement new ways of working so that people get access to care differently. Staff will need the technology and skills to use them so they can focus on quality of care.
- Ways to connect health and social care workers with the wider public sector, e.g. police, housing and beyond.

Our Digital Roadmap Outcomes are:

- Digital Inclusion – Our patients and citizens are enabled and empowered to interact with health & care services digitally.
- Digital Workforce – We work collaboratively to bring Digital capability to the heart of transformation & services, and ensure our health and care workforce is well supported in new ways of working.
- Information Sharing – Relevant information collated and stored within silo-ed patient and citizen records are available where required, delivering the Shared Care Record, and enabling Paper Free at Point of care.
- iPHWBi3 – Information derived from records is combined, pseudonimised where required, and made available where required to inform decisions enabling improved individual, cohort, and population outcomes.
- Investment and governance - We will ensure activities, investments, standards, resources and benefits are effectively coordinated to best serve our population.

Our approach to date has been one of pan-system collaboration, to ensure the digital agenda acknowledges the complex landscape, with partners fully committed to the vision, and well placed to lead that change. We believe that to truly deliver the local health and care plan's ambitions, digital capability needs to be at the heart of our transformation. We also recognise that opportunities are presented by working across the wider public sector, and as such we will continue to work with partners to align the public sector digital agendas.

Our key actions

At the end of June 2017 we have…	✓ Align Digital Leadership, and Health & Care Services/Workforce empowerment programmes to the Workforce Programme. ✓ Continue to Enable the Workforce, ongoing. ✓ Continue to identify investment cases in line with STP project outputs, ongoing.
By the end of September 2017 we will…	✓ Complete Universal Capabilities standard B (standard A is complete). ✓ Agree scope and approach for Citizen Transaction Service; Co-ordination Information Services; Pan Public Sector WAN; and STP-wide Cyber Security. ✓ Complete Stage 1 of the summary care record with additional information. ✓ Agree approach and identify opportunities for Resource Utilisation/Rationalisation Stage 1. ✓ Governance: agree Standards approach and delivery plan, and initiate Assurance.
By the end of December 2017 we will:	✓ Complete Universal Capabilities standards C and E. ✓ Commence Digital Services/Workforce Collaboration and Transformation Stage 1. ✓ Have identified high priority interoperability requirements for shared care records. ✓ Agree scope and approach for Decision Support, and Population Business Intelligence (Planning). ✓ Agree Benefits Realisation approach and alignment to STP/NHS England/Global Digital Exemplars. ✓ Agree Partnerships approach and identify opportunities. ✓ Governance: agree innovation for Methodologies Stage 1.
By the end of March 2018 we will…	✓ Complete Universal Capabilities standards F-J. ✓ Following a pilot, agree our NHS 111 online deployment approach. ✓ Have in place our Data Quality and Clinical Safety Networks. ✓ Agree scope and approach for Self Service Business Intelligence. ✓ Governance: agree approaches and delivery plans for Portfolio, Programme and Project Offices (P3O); and Shared Care.
By the end of June 2018 we will…	✓ Agree our co-creation approach for Digital Inclusion for children and young people's services – Eastern Academic Health Sciences Network Pioneer. ✓ Agree scope and approach for Business Intelligence (Research).
By the end of December 2018 we will…	✓ Complete Universal Capabilities standard D. ✓ Have in place Global Digital Exemplar in the West Suffolk area, ensuring there are better ways of working across the system. ✓ Have in place Stage 1 of our Connected Networks programme.

"Health, care and the wider public sector are coming together to provide quality care, improve people's health and wellbeing and maintain financial balance. Fundamental to this is building our digital capability so that people have simpler services when they need them, need to tell their story only once, and are supported to lead healthier and happier lives, and so that professionals can use technology to respond to demands and free their time to focus on care."

Kate Walker, Head of Digital Strategy and Transformation

Workforce

The NHS 'Five Year Forward View'

> Health care depends on people — nurses, porters consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important: by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them."

National guidance

The 'Next Steps on the Five Year Forward View' highlighted need to continue to improve productivity and grow the frontline workforce, especially in priority areas such as nursing, mental health, urgent and primary care. This will require more training, more recruitment, better retention and greater return to practice after time out of the workforce. It will also require flexibility as roles and places of work evolve in line with changes to the practice of medicine and the shape of health care:

- For nurses this means developing education and training, retention, return to practice, e-rostering and effective job planning, the new fast track 'Nurse First' programme, and new Advanced Clinical Practice (ACP) nurse roles.
- For the medical workforce there will be increased training places, measures to tackle pressures on doctors in training, and addressing staff shortages in key areas.
- New professional roles are being developed, including Nursing Associates Physician Associates, clinical pharmacists, and mental health therapists in primary care.
- There will be a focus on promoting NHS staff health and wellbeing and the NHS becoming a more inclusive employer.
- Ways of encouraging flexible working and 'de-risking' service change will be developed.
- Leadership and improvement capabilities will be developed across the health and care system.

Our local approach

As part of our system delivery mechanism we have initiated a training and education programme with following overarching themes:

- Health & Wellbeing for staff.
- Developing social care staff skills and competencies.
- Support for new roles.
- Ensuring effective communication with current and future workforce.
- Enabling a cohesive system wide clinical community.

We have formed a Local Workforce Action Board with representation from all organisations within the system and Health Education England, Higher Education Institutions and the voluntary sector. The group has a strategic focus ensuring the workforce agenda is being developed collaboratively, and supporting programme teams in developing the workforce plans required to implement the new ways of working. This will include training and education; alongside strategies to retain workforce supply and ensure cultural and behavioural change are in accordance with the ethos of system working and desired outcomes from the work programmes. To maximise the health and wellbeing of our workforce our organisations will refresh their workplace health strategies.

Our key actions

At the end of June 2017 we have…	✓Promote NHS staff health and wellbeing by engaging in a national CQUIN; and delivering 'resilience' workshops to support staff with new models of care. ✓Engage with health Education England and the National leadership Academy and providers to access a range of leadership provision and develop a systematic approach to develop our people and improve care.
By the end of December 2017 we will…	✓Work with Health Education England to access opportunities to develop Nurse Associates as pilots are extended.
By the end of March 2018 we will…	✓In nursing, develop new relationships with local universities giving our STP providers access to nursing apprenticeships; develop placement capacity that supports the new models of care and allows us to attract students moving onto self-funded pre-registration programmes and masters provision; and increase the number of pre-registration students accessing primary care placements.
By the end of June 2018 we will…	✓Work with Primary Care to develop flexible working arrangements through the primary care hubs. [nb moved from june 2017]. ✓In nursing, upskill and empower our primary care workforce; improve job satisfaction through portfolio careers in primary care; create opportunities for career advancement in ACP and other advanced practitioner roles; use the Apprenticeship Levy to create opportunities for people to access support roles in health and social care with progression to Nursing Apprenticeships; and continue to support return to Practice programmes. ✓In GP medicine, support overseas recruitment; develop portfolio career opportunities; develop a clearer range of career pathways including return to practice; and work with Health Education England and the Deanery to innovate in recruitment and retention. ✓In medicine, improve working conditions for junior doctors in their rotations; and promote our new models of care and innovations to attract staff into rotations in areas of staff shortage. ✓Aid recruitment and retention in medicine, nursing and pharmacy by actively promoting our practices as positive places to work. ✓Work with Health Education England and University of East Anglia to attract Physician Associates into our acute and primary care. ✓Develop an action plan to maximise our inclusive workforce potential.

Note: For information on developing the clinical pharmacy and mental health therapy workforce see page 24, Primary Care

"For us the key to delivering a first class service and achieving the best outcomes for our patients is investing in and developing a workforce which encompasses a wide range of skills across health and social care and then works with the patients to ensure that those skills are used to maximum effect."

Ann Read
Chief Operating Officer, The Colte Partnership

5. Delivery arrangements

STP Governance

Key principles

STPs are not statutory bodies. As such the STP supplements rather than replaces the accountabilities of its individual partner organisations. As stated in Next Steps On The NHS Five Year Forward View, it is a case of 'both the organisation and our partners' as against 'either/or'. The way that the Suffolk and North East Essex STP works will be determined according to the local needs of Suffolk and North East Essex, which will differ from other parts of the country.

STP Board

The STP Board membership includes a single senior representative from STP partner organisations, representatives of other stakeholder groups and the chairs of key STP cross-cutting groups. The STP board meets monthly at locations around the STP footprint.

The purpose of the STP Board is:

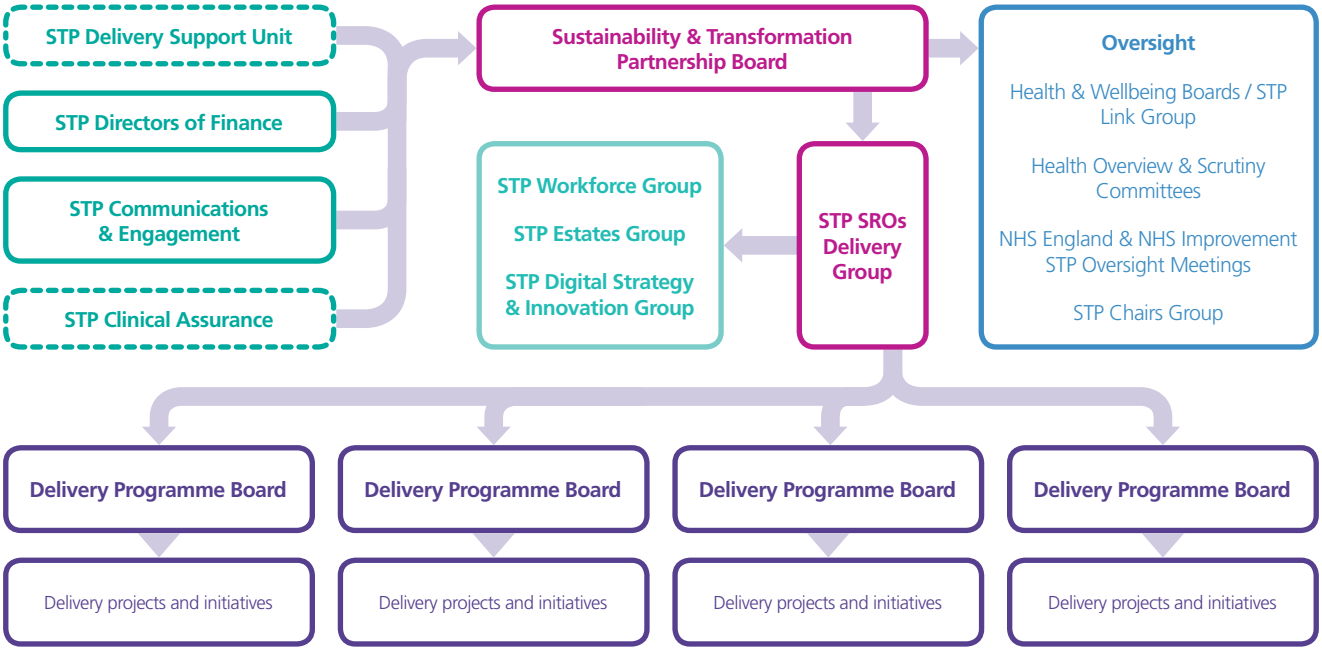
- To bring together GPs, hospitals, mental health services and social care to keep people healthier for longer and to integrate services around the patients who need it most.
- To be a forum in which health leaders can plan services that are safer and more effective because they link together hospitals so that staff and expertise are shared between them.
- To ensure that front-line clinicians in all settings are engaged in driving the real changes to the way care is delivered, that they can see are needed and beneficial.
- To be a vehicle for ensuring efficient public spending.

Where there is a need further appropriate decision-making mechanisms may be established, for example formal CCG Committees in Common.

STP Lead, Nick Hulme pictured with members of the STP Board - June 2017

STP Governance

Suffolk & North East Essex STP – Governance Structure



The Delivery Programme Boards each co-ordinate and oversee a range of projects that will deliver the STP. All projects are subject to a core STP assurance framework to ensure that they:

- Align with STP aims and solutions
- Contribute directly to the delivery the STP plan
- Include details of what will happen and when, performance criteria, and how risks will be managed

The Delivery Programme Boards provide assurance to the STP Board on their projects, and identify any risks or issues that need to be escalated, though the STP SROs Delivery Group.

The cross-cutting workstream groups for Workforce, Estates and Digital support the assurance of the work of the Delivery Programme Boards, and also report to the STP Board through the STP SROs Delivery Group.

Clinical leadership

Many of the plans proposed may include changes to current clinical services, and will certainly require the leadership of our clinicians, by which we mean all those involved with the direct delivery of patient care including doctors, nurses, allied health professionals and technicians with direct patient contact. There are a number of options for types of involvement that can be pursued and models for securing these.

The types of clinical involvement can be differentiated according to the level of responsibility:

Responsibility	Description	Example of clinical involvement
Responsible	People who undertake the work to achieve the task. Others can be delegated to assist in the work required.	A clinical project member or clinical service lead involved in the project, but not accountable for it.
Accountable	The person (people) ultimately answerable for completion of the task. Delegates work to those responsible.	The clinical lead for a service undergoing change, clinical director or medical director.
Consulted	People whose opinions are sought, due to subject matter expertise or overlapping accountability. This is a two-way communication.	Wider members of the clinical team whose work may be affected by the project.
Informed	People kept informed of developments. This is a one-way communication.	Clinicians outside the focus of the project whose patients or clinical pathways may be affected by it.

There are a number of models to secure involvement, which we will draw on as appropriate. These include Clinical Project Members, where clinicians are part of the project team, and Accountable Clinical Leaders, who are appointed through project/programme governance processes.

Other examples of types of involvement are found in the following table.

Model	Description	Contribution
Workshop	Clinicians affected by the project are invited to participate in planning workshops.	Design and implementation ideas Risk management.
Internal reference group	A group of clinicians within the host organisation(s) convened to review the project planning.	Commentary on plans. Communication with peers about the project. Identification of project dependencies and risks.
Internal quality assurance	This may be an existing governance structure in the host organisation(s), such as a Quality Impact Assessment group or one specially convened for the project.	Risk management. Quality Impact Assessment. Equality Impact Assessment. Internal assurance to governing bodies.
External reference group	This may be an existing external organisation asked to review the project planning or one convened specially for the project. This could include Royal Colleges, Universities, Academic Health Science Networks (AHSNs), Clinical Senates or Strategic Clinical Networks (SCNs).	Commentary on plans. Communication with peers about the project. Identification of external project dependencies and risks.
External quality assurance	This may be an existing external body with capability or a statutory requirement to review some types of planning. This might include Clinical Senates and Strategic Clinical Networks.	Formal review of plans. Recommendations for improvement.

We will explore ways to involve clinicians, including resources to allow the release of their time, and how to develop involvement roles further. Clinicians who are not directly involved will always be kept informed of our plans and progress. The STP Board will ensure that its delivery plans are developed with clinical leadership and clinical assurance at all levels.

Oversight

As an STP we engage in a range of forums which ensure that there is appropriate oversight from key stakeholders in the work we are doing.

Health and Wellbeing Boards

Health and Wellbeing Boards (HWB) are formal committees of local authorities charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. They have a statutory duty, with clinical commissioning groups, to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population. Our STP footprint includes two HWBs, one for Suffolk and one for Essex, which the STP attends. There are also further, local HWBs, which the STP attends when requested. In addition, at the request of the HWB chairs, there is a regular link meeting between the STP, HWB Chairs, Adult Social Care Services and Public Health to discuss and update on progress.

NHS England and NHS Improvement STP Oversight

Senior representatives of both NHS England and NHS Improvement meet jointly with STP leaders on a monthly basis to monitor progress and to help us to find solutions to the challenges we face. We also attend regular oversight review meetings with NHS England and NHS Improvement, who monitor our progress and provide advice and support to us to help achieve our plans.

Health Overview and Scrutiny Committee and Joint Health Overview and Scrutiny Committee

In both Essex and Suffolk there is a Health Overview and Scrutiny Committee (HOSC) which scrutinises local NHS and social care activity. Their role is to hold both commissioners and providers to account. It is attended by CCGs, Trusts, and partner services such as the local authority where services are jointly commissioned. The HOSC must also be consulted on any proposed substantial service changes, and here the voices of the local community may also be involved. HOSCs in both Suffolk and Essex are attended by representatives from our area.

A specially convened Essex and Suffolk Joint Health Scrutiny Committee (JHOSC) has also been established to scrutinise and support the implementation of the STP and how it is meeting the needs of the local populations in Suffolk and Essex. Their focus is on those aspects of the work which will impact upon services provided to patients across both counties. The JHOSC also acts as the mandatory joint committee in the event that any of the STP partners are required to consult on a substantial variation or development in service which affects patients across the STP footprint.

STP Chairs' Group

To ensure that there is robust non-executive participation, the non-executive chairs of our partners meet regularly. They provide an invaluable initial sounding board on key issues including STP governance, and how as a system we work together to ensure effective system working across all stakeholders. The STP Chairs' Group also provides a vital link between the STP and other non-executive roles, such as governors, within our partner organisations. From time to time this group also organises larger scale meetings to engage more widely the non-executives and governors within our STP footprint.

STP Delivery Support Unit

To ensure that the STP has the basic 'support chassis' to enable it to work effectively, a small STP Delivery Support Unit has been established. This is led by Susannah Howard, STP Programme Director, who is responsible to Nick Hulme, STP Lead. The role of the STP Delivery Support Unit is to:

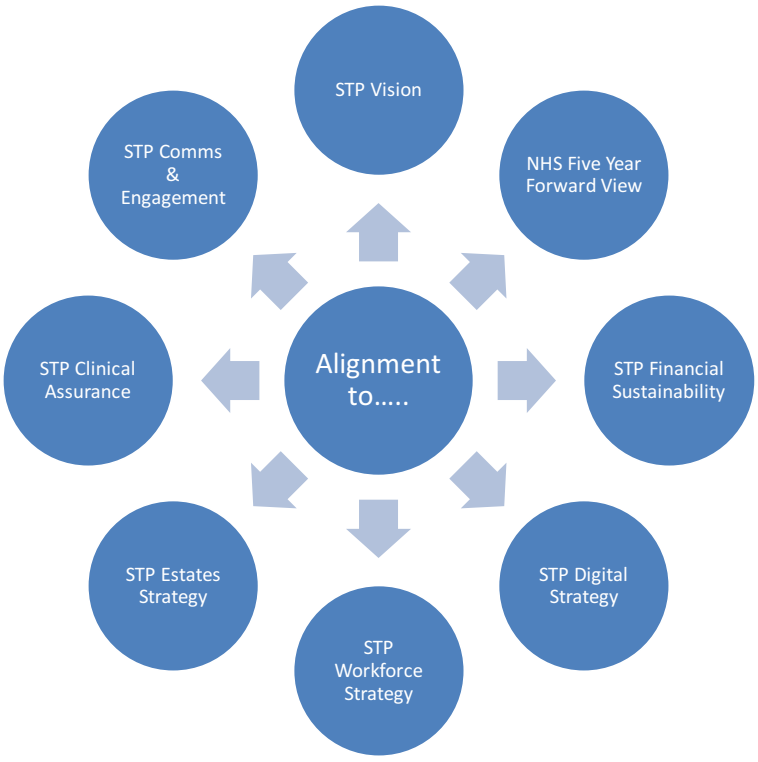
- Realise the underpinning principles for the STP.
- Support STP Governance & facilitates system working
- Provide a central point of contact and operation for the STP
- Collaborate with and facilitate other agencies to support the STP
- Operate an STP PMO & project assurance process
- Ensure that there is a balance of STP level assurance & local delivery
- Focus on developing an STP-wide approach to transformation

There are more than 100 separate transformation initiatives within our STP. Responsibility for the delivery of the transformation projects and initiatives lies with the relevant accountable organisations, which are accountable to the STP through our Delivery Programme Boards.

Assurance is provided at STP level through establishing defined roles, responsibilities and processes within each partner organisation to these programmes.

The STP Delivery Support Unit provides underpinning programme management support for the STP. Each project or initiative has an STP mandate detailing its aims, key actions, details of relevant leads, timescales, and progress including how it will be measured. We track the progress of each delivery programme and are developing a database, which will be accessible to STP Partners.

STP project assurance framework



"Change is hard, and transformational change is harder still. The STP offers new opportunities for us to come together and find new solutions to old problems."

Susannah Howard
Programme Director
Suffolk and North East Essex STP

Glossary

Accountable care system (ACS) – an 'evolved' version of an STP, with NHS organisations (both commissioners and providers), often in partnership with local authorities, taking on collective responsibility for resources and population health. They provide integrated and better coordinated care.

CAREIS – technological tool to support clinical decision-making

Carter Review – review by Lord Carter, which concluded hospitals must standardise procedures, be more transparent and work more closely with neighbouring NHS trusts.

Change: evolution and big bang – evolution involves continuous improvement, adapting and learning by doing. A big bang approach involves sudden major change, which may fail if preparation is not thorough.

Care Quality Commission (CQC) – regulates health and care services in England and ensures these services provide people with safe, effective, compassionate, high-quality care.

Clinical Commissioning Group (CCG) – clinically-led statutory NHS body responsible for the planning and commissioning of health care services for their local area.

Clinical streaming – system to direct patients to the right care or professional for their needs.

Commissioning – the process of planning, agreeing and monitoring services. Commissioning of health services can take place at the local level by CCGs, or at a nation-wide level by NHS England.

Commissioning for Quality and Innovation (CQUIN) – framework to support improvements in the quality of services and the creation of new, improved patterns of care.

Defined population – the number of people living within a specific geographical area (for us this is Ipswich and East Suffolk, West Suffolk and North East Essex).

Elective care – treatment that is scheduled in advance as it does not involve a medical emergency.

Enabler – a person or system that makes something possible. In the NHS enablers are the systems and processes that help achieve change and improvement.

End of life care – support for people who are in the last months or years of their life. End of life care should help people to live as well as possible until they die, and to die with dignity.

Estates and Technology Transformation Fund (ETTF) – NHS England's fund to improve primary care facilities.

Governance – the ways that organisations ensure they run themselves efficiently and effectively, and the ways organisations are open and accountable to the people they serve for the work they do.

Health inequalities – differences in health status between different population groups, or in the personal, social, economic, and environmental factors that influence health status.

Horizontal integration – competing or collaborating organisations, networks or groups in the health system, e.g. grouping outpatient clinics within a network of local providers.

Integrated care – a principle for care delivery that aims to improve patient care through better coordination of services provided

Integration – the combined set of methods, processes and models that bring about integrated care.

Innovation – finding new improved ways of working. Within the NHS this means making changes in practices that ramp up the pace and scale of change, and deliver better outcomes for patients.

Market engagement – gathering information on the level of interest among providers in a new way of delivering services, and feedback from providers on the proposals.

Model of care – the way health services are delivered; the description of best practice care and services for a person, population group or patient group as they progress through the stages of treatment, care and recovery.

Multi-speciality community providers – integration of the various community services in a local area, such as GPs, community nursing, mental health and social care, moving specialist care out of hospitals into the community

Multi-disciplinary teams – a team of professionals from one or more clinical disciplines, which can include social care as well as health, who together make decisions regarding recommended treatment of individual patients. Such teams may be organised for a specific condition, e.g. cancer, or in a specific setting, e.g. a hospital.

Network of care – collaboration, either (1) of care organisations to provide an improved service to the local population, (2) of individual professionals to share, learn from each other and work to improve care, or (3) linking community or other groups such as carers together to share experiences and support each other.

NHS "Five Year Forward View' – NHS document published in 2014 setting out how the NHS needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

NHS England – sets the priorities and direction of the NHS in England, and encourages and informs the national debate to improve health and care. It commissions some NHS services directly, and delegates authority to CCGs to commission other services.

National Institute for Health and Care Excellence (NICE) – provides national guidance and advice to improve health and social care.

Operating model – the way in which an organisation or system is organised. This includes its structure, accountabilities, governance, essential behaviours, and how people, processes and technology will work together to deliver the service.

Pathway of care – decision-making and organisation of care processes for a specific group of patients during a specific period. This includes the care goals; how care is delivered, when and by whom; communication between professionals and with patients and carers; monitoring; and evaluating the outcomes of the care.

Patient activation – the knowledge, skills and confidence a person has in managing their own health and care.

Personalisation – shifting the culture and practice of care so that services are better coordinated and centred around the individual.

Population health management – collection and analysis of data on patients and the public, to help improve planning and management of health and care services in the local system.

Primary and acute care systems – joining up GP, hospital, community and mental health services .

Primary care – primarily GP practices, but also includes community pharmacists, dentists and opticians.

Providers – acute, ambulance, community and mental health services that treat patients and service users in the NHS; social care providers including local authorities, care homes and home care organisations; and community and voluntary organisations.

Reconfiguration – changing the arrangement, structure or model of organisations or services.

RightCare – NHS programme to ensure that the right person has the right care, in the right place, at the right time, making the best use of available resources.

Risk stratification – identifying patients who are at high risk of an adverse event so that they can be offered preventive care today aimed at averting costly, unpleasant health problems tomorrow.

SAFER – a combined set of simple rules for adult inpatient wards for clinical review and discharge planning to improve patient flow and prevent unnecessary waiting for patients.

Secondary care – Either be planned (elective) care such as a cataract operation, or urgent and emergency care such as treatment for a fracture.

Self care or self management – all the actions taken by people to recognise, treat and manage their own health, either independently or in partnership with the healthcare system.

Sustainability – The ability to maintain at a certain level, or to avoid depletion of resources. The NHS is seeking to achieve sustainable position in its finance and systems.

Sustainability and Transformation Partnership – Local partnerships of NHS organisations and local councils to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations. There are 44 STPs in England.

Sustainability and Transformation Plan – five-year plans covering all aspects of NHS spending in a specific local area. They aim to improve patient care and achieve financial sustainability within the five year period.

Trusted assessor – suitably trained professional who carries out an assessment on behalf of the care provider. The provider trusts and relies on the information and assessment to arrange and provide services.

Vertical integration – networks and groups at different stages of care within the supply chain or pathway, e.g. drawing together hospital and local community services.

LOCAL PLAN FOR HEALTH AND CARE

Overview as at July 2017

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 29 September 2017

AGENDA ITEM:	8
PRESENTED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Rowan Procter, Executive Chief Nurse Alex Baldwin, Deputy Chief Operating Officer
DATE PREPARED:	25 September 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 (1 in July). Falls for the month were 68 (66 in July and 13 pressure ulcers (7 in July) - pages 4-7.
- This month's report shows marginal improvement in 18 week RTT performance in aggregate – patients on an incomplete pathway standard: August performance is 85.93% against a target of 92% (85.92% in July). Page 21-23
- The Trust again had a significant number of patients wait over 52 weeks for treatment in August – 26 patients waiting over 52 weeks against a target of 0 (an improvement on the 35 breaches declared in July). Work continues to proactively manage these long waiting patients however there remains a significant number of patients who elect to wait beyond 52 weeks. ENT continues to have the largest number of patients waiting over 52 weeks.
- Provisional data for August indicates that the Trust achieved the 2ww cancer standard with performance of 96.02% against a standard of 93%. The Trust achieved the 2ww symptomatic breast standard with a performance of 100% against a standard of 93%. Page 21.
- Provisional data for August also indicates performance on 85.14% against a standard of 85% for the 62 day referral to treatment cancer standard. Further improvement in this figure is anticipated as reallocations are finalised. Page 22.
- The Trust missed the ED standard for the month of August with performance of 90.09% against a standard of 95%.

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	Jun	Jul	Aug
HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	100	96
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	100	97
HII compliance 2b: Peripheral cannula ongoing	=100%	<85	85-99	= 100	98	93	97
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	95	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	94	88	99
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<85	85-99	= 100	NA	100	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	0	0	1
Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	92	NA	NA
MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	95	95	90
Hand hygiene compliance	= 95%	<85	85-99	= 100	99	100	99
Total no of MSSA bacteraemia: Hospital	No Target	No Target	No Target	No Target	0	0	0
Quarterly Standard principle compliance	90%	<80	80-90%	90-100	95	NA	NA
Total no of C. diff infections: Hospital	= 16 per yr	No Target	No Target	No Target	0	1	0
Total no of C. diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	2	2	0
Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	91	NA	NA
Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	2	2	0
Isolation data (Trust level only)	= 95%	<85	85-94	95-100	90	90	88
Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	91	NA	NA
Quarterly VIP score documentation	= 90%	<80	80-89	90-100	84	NA	NA
PEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	90	100	100
No of patient falls	= 48	>=48	No Target	<48	50	66	68
Falls per 1,000 bed days (Trust and Divisional levels only)	= 5.6	>5.8	5.6-5.8	<5.6	ND	ND	ND
No of patient falls resulting in harm	No Target	No Target	No Target	No Target	20	17	18
No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	0	0
Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	ND	ND	ND
No of patients with ward acquired pressure ulcers	< 5	>=5	No Target	<5	19	7	13
% of patients with avoidable ward acquired pressure ulcers YTD [NEW]	Less than 30%	>30%	No Target	<=30%	29%	ND	ND
Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	89	82	89
No of SIRIs	No Target	No Target	No Target	No Target	7	7	6
No of medication errors	No Target	No Target	No Target	No Target	69	78	70
Cardiac arrests	No Target	No Target	No Target	No Target	4	2	0
Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	1	0	0
Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	NA	61	NA
Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	96	NA	NA
Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	98.91	98.64	98.18
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4	3	4	1
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC	54	53	68
Median NRLS upload 6 month rolling average	46days	>46	No Target	0-46	64	65	58
SIRIs reported > 2 working days from identification as red	0	>1	1	0	0	0	1
SIRI final reports due in month submitted beyond 60 working days	0	>1	1	0	0	0	0
Green, Amber & Red Active / Accepted risk assessments in date	0	>10	5-9	0-4	ND	9	0
Datix risk register Red / Amber actions overdue	0	>10	5-9	0-4	ND	22	0
Total Verbal Duty of Candour outstanding at month-end	0	>3	1 - 3	0	0	0	2

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.

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 but not Jun/Jul with an aim to provide final figures for reporting from Q3 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 97 was achieved for August which was an improvement from 93 in July, though this is still RAG-rated as amber for the fourth month in a row. Failing to document indication for continued insertion lowered the score from the target range.

b) Recommended action

Compliance with documentation following changes to eCare documentation still remains a challenge. The Senior Matron team continue to discuss performance at the Monthly Quality Meeting so as to consider strategies for performance improvement. Senior Matrons continue with regular discussions with Senior Ward Nursing Teams at 1:1's and Ward Team Meetings to highlight and monitor current performance. Individual action plans to be put in place and supported by Senior Matrons and Head of Nursing for areas with persistent poor performance.

High levels of staffing deficits coupled with the continue need for the provision of escalation capacity have impacted upon the accurate and timely completion of assessments and documentation. The Senior Matron and Operational Teams attempt to mitigate the impact of these pressures on compliance through staff re-deployment in line with activity and acuity being experienced.

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

a) Current Position

There has been a significant improvement in compliance in ongoing catheter care from 83% to 99%. This has been achieved by targeted education and monitoring in specific wards which were persistently failing to comply with the expected level of care and documentation. .

b) Recommended action

The Senior Matron team will continue to support and promote compliance in order to sustain and further improve this area of practice. There is positive engagement from the teams with this, which is reassuring despite the backdrop of staff deficits.

1.3 Isolation

a) Current Position

Compliance with Isolation is at 88% this score predominantly reflects three patients on three different wards (F10, F5 and G5) who could not be isolated as the single rooms were occupied with higher risk infection/colonization or suspected infection cases. F12 Adult Isolation ward was also at capacity throughout August.

b) Recommended action

All of the cases were at the low end of the risk assessment for isolation and wards were advised on the measures required to mitigate onward transmission and this is recorded in the embedded document.

1.4 Nutrition: Assessment and monitoring

a) Current Position

The month of August has seen an overall improvement in compliance in weighing patients and completing the nutrition risk assessment and MUST score. The majority of wards have managed, with support and encouragement from Senior Matron team, to improve their performance; however, there remain pockets of poor compliance amongst teams, specifically with weighing patients every 7 days.

It is encouraging that there has been an improvement in weighing patients on admission; however this will continue to be monitored to embed this practice.

b) Recommended action

The Nutrition focus group will commence this month and will support joint working with the Dieticians, specialist nutrition nurse, ward nurses and nursing assistants. The main objective of this group will be to promote the sharing of good practice, raise awareness of the importance of accurate risk assessments and improve the delivery of diet and nutritional support for patients within our care. The objective of the group is to promote ideas by working with the teams, which will generate improved care for our patients.

Overall, the recording of MUST risk assessments is improving, however, it is recognised there continues to be some concerns around accuracy. It is envisaged the introduction of the focus groups will support an improvement with this and promote staff development and improve knowledge.

It is important to also acknowledge that persistent, significant staffing deficits, high acuity, bed capacity pressures and use of escalation beds, particularly during the latter part of July, will have also impacted on the teams' ability to perform and record patient weights consistently. These pressures have been managed alongside a comprehensive decant and deep clean programme placing further strain on depleted nursing teams and their ability to maintain the expected standards of care and performance.

1.5 Total no of C. difficile infections: Hospital

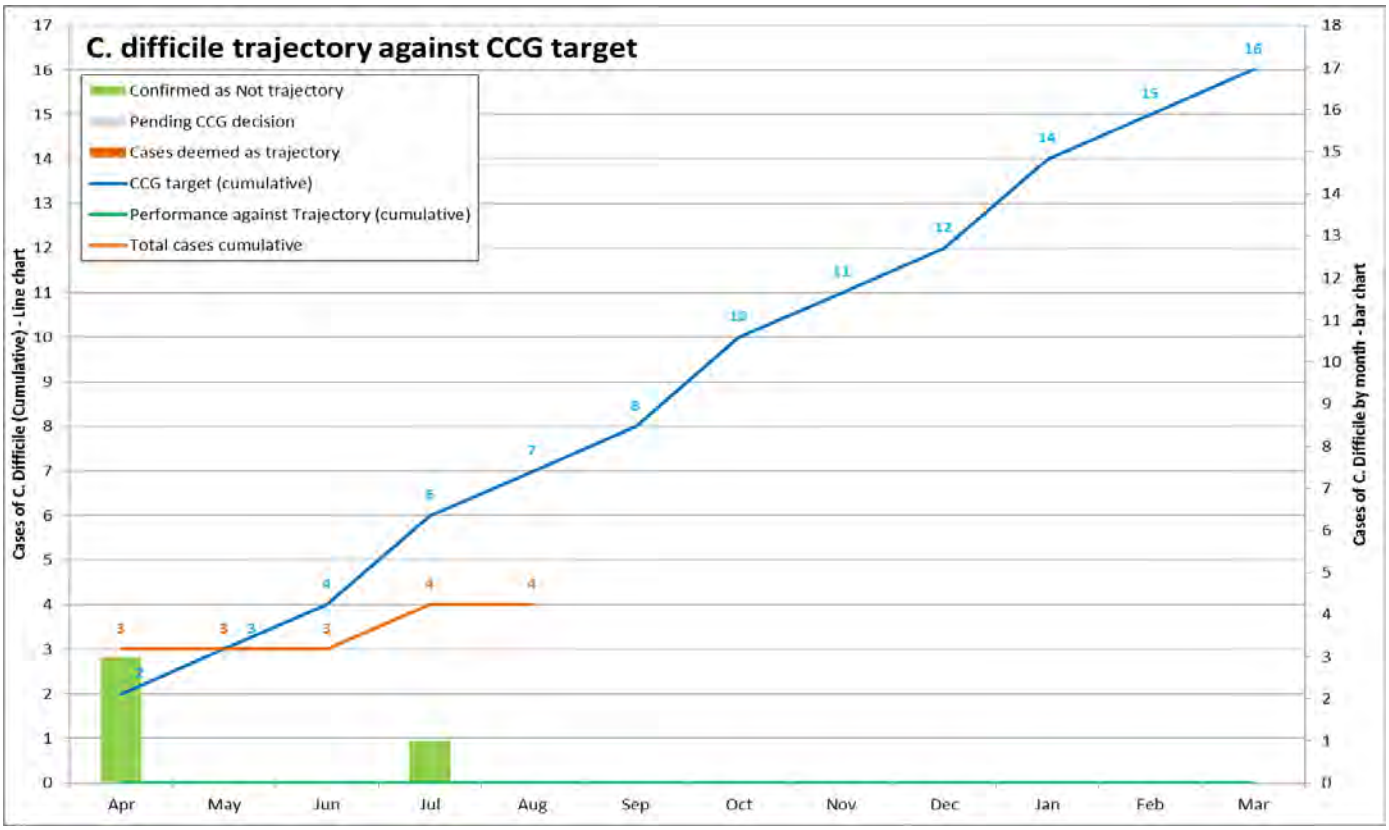
a) Current Position

Performance against trajectory is as follows: There were no cases of hospital attributable CDT in August. To date there have been four 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.

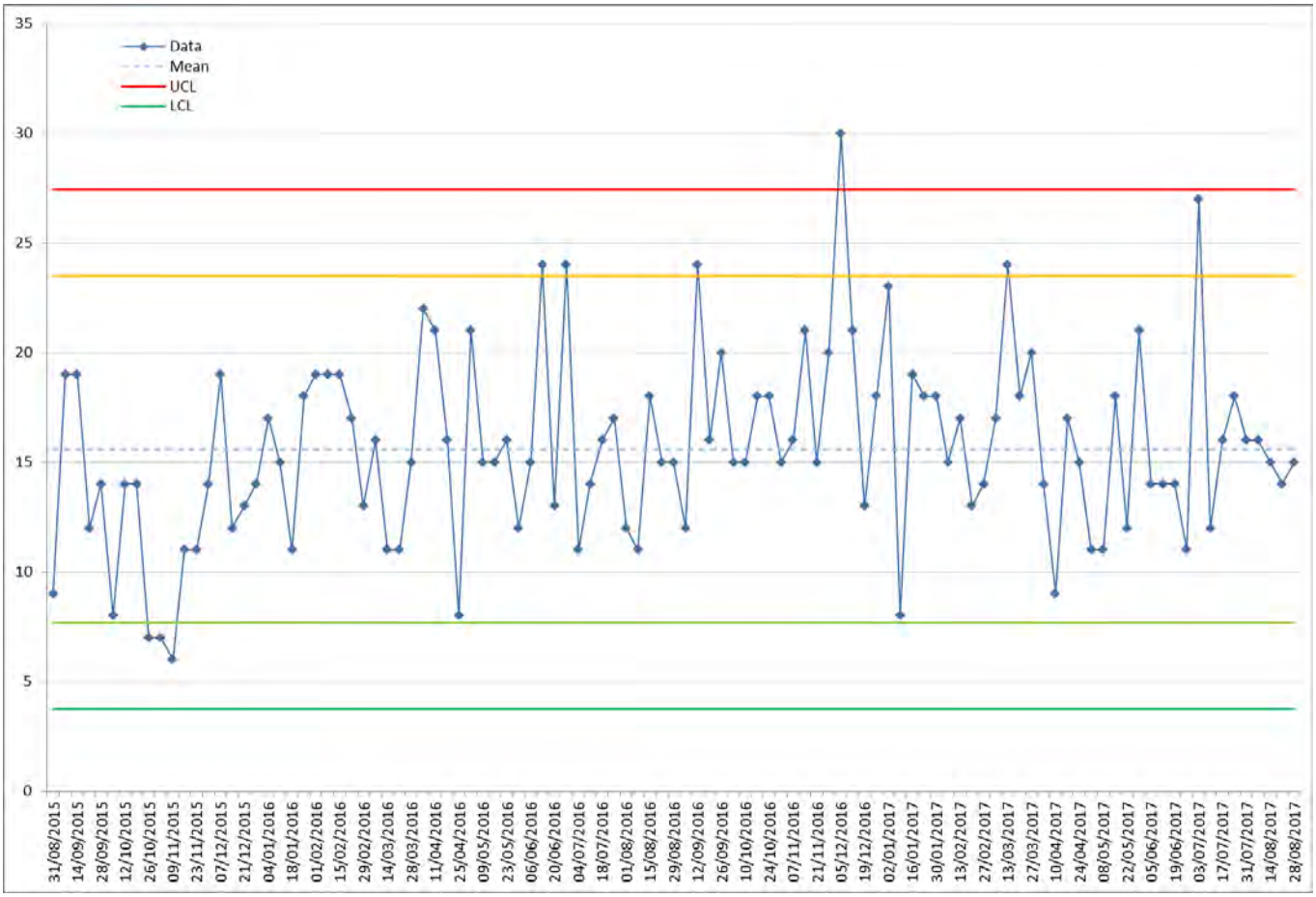
The graph below has been updated to demonstrate the Trust performance against the trajectory target set by the CCG.

b) Recommended Action

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



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



There were 68 falls in August (up from 66 in July), consisting of 1 major harm and 1 with moderate harm reported.

1 x Major Harm – Ward F3

Male patient who had been admitted with osteomyelitis of right great toe potentially requiring amputation, he had been deemed independently mobile by nursing and physiotherapy staff. The patient had bent over and felt a crack which was considered to be a fracture of the greater trochanter which was treated conservatively. The patient then later slipped and fell whilst mobilising resulting in a fracture of the other hip. The hip was surgically repaired; the patient was then transferred to ward G3 due to AKI on CKD and raiser CRP / WCC. The patient suffered a cardiac arrest on the 19th September and passed away. This incident is currently following a red investigation pathway.

1 x Moderate Harm – Ward F7

Male patient with vascular dementia was being nursed in a bed placed against the wall, whilst the nurse left the bay the patient attempted to get out of the bed and fell resulting in a fracture of the right humerus. This was managed with a humeral brace and follow up in 2 weeks by the Orthopaedic Team. The patient was discharged from hospital on the 30th August with follow up arrangements made.

Newmarket Hospital (2 x falls) and Glastonbury Court (1 x fall) – these falls are reported separately.

A total of 4 patients were assisted to floor in August (3 in July) preventing them from falling.

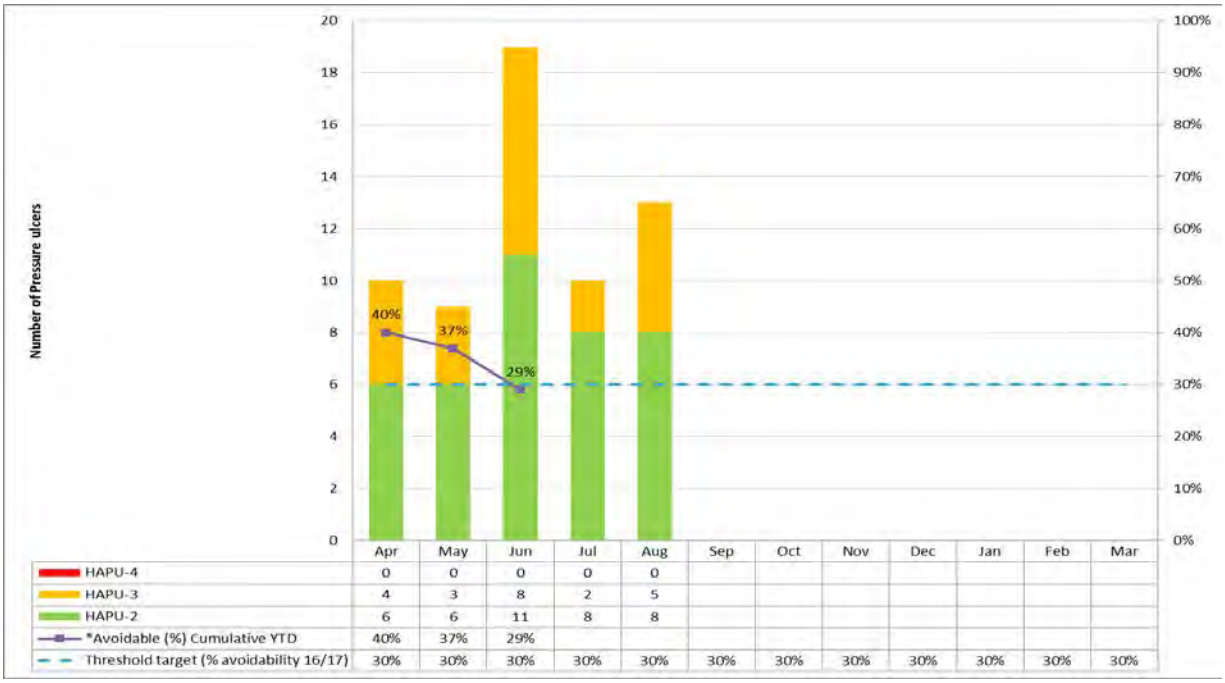
There were 10 patients in total who fell more than twice (5 in July), this figure consisted of 7 patients falling on 2 occasions, 2 patients falling on 3 occasions and 1 patient falling on 4 occasions.

In response to the continued problem of patients falling the initial meeting of the Falls Focus Group took place on the 14th September. The multi-professional group led by the Senior Matron Team will feed in to the Trust Falls group led by Dr Suresh. The group is focusing on the reduction of patient falls through the following approaches:

1) The development of ‘Ward Profiles’ to establish the specifics behind the individual areas factors in relation to patient falls. Data by ward for the last year has already been provided to illustrate the number of falls by ward and the time of day, further data contained within the Datix reports will be supplied to support this process. 2) Establishing ‘Ward Champions’ who along with the Senior Matron and Ward Manager develop a ward specific ‘Fall Reduction Action Plan’ containing strategies that will address the areas current challenges. 3) A review of current eCare processes to ensure that the necessary tasks and care plan are set with the appropriate reminders and actions being triggered. 4) The updating of the incident reporting process (Datix) so that this reflects the current practice and provides the necessary information to be used in improvement of practice and patient safety. 5) The possible reproduction of staff pocket guides to aid in the prevention of patient falls. 6) Review an update of the current ‘Slips, Trips and Falls’ policy so that the information contained is up to date and reflects best practice. 7) Digital Reminiscence Therapy to be considered as a tool in the reduction of patient falls as other Trust have demonstrated some encouraging results following the introduction of this technology.

The Trust has taken part in the National Falls Audit and we anticipate results to be available later in the year. The Trust are at present unable to provide data on Falls per 1000 bed days though the eCare team from Cerner are currently working on rectifying the situation

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
HAPU-4	0	0	0	0	0							
HAPU-3	4	3	8	2	5							
HAPU-2	6	6	11	8	8							
*Avoidable (%) Cumulative YTD	40%	37%	29%									
Threshold target (% avoidability 16/17)	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%

Judged as Avoidable following clinical review by Matron or TVN

Overall, August has seen an increase in hospital acquired pressure ulcers (HAPUs) from the previous month. There were thirteen in total; however, nine of these were reported on two wards, G3 and G5, a significant increase for these specific wards. Early indications are that many of these HAPUs were unavoidable, with the majority of these patients being at the end of life.

The breakdown by ward of the thirteen reported are:

HAPU2 = Eight: G5 and G3 (three each), F7 and Critical Care (one each)

HAPU3 = Four: G3 has two, F3 and G8 (one each)

HAPU4 = One: G5 originally reported as a HAPU3 in August has subsequently been re-classified as a HAPU4 in September following debridement of the wound.

There were also two Deep Tissue injury (DTIs) reported in August.

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%. The line on the dashboard has been updated to report % (ytd) not actual numbers.

Pressure ulcer prevention

At the end of August there had been 61 HAPU 2, 3 or 4 reported including five at Glastonbury Court / Newmarket Hospital. 15 of these have been classified as avoidable and 31 as unavoidable with another 15 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).

It is also important to acknowledge that the month of August has also seen increased staffing pressures, with deficits across all areas, but specifically on these two wards. This has a direct correlation on the ability to provide effective care. These deficits are reviewed and supported daily by the senior nursing team to mitigate the risks to patient safety.

For September, the 'React to Red' project is focussing on preventing heel damage by launching the 'Heel Heroes' campaign. This has involved identifying heel ulcer prevention champions on each ward. 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 restructure of the Tissue Viability team has ensured greater visibility and enabled the team to work in conjunction with the Matrons, Ward Managers and Ward teams to maintain the profile of pressure ulcer prevention. The TV team are actively supporting the improvement of staff knowledge and practice in promoting skin health and integrity.

The Pressure Ulcer Prevention focus group has commenced in September, led by Matron Danni Elliott, with the support of the Tissue Viability Nurse specialists. The aim of this group is to promote the concept of sharing good practice amongst teams and highlight the importance of accurate risk assessment and early preventative measures. Ultimately, the objective with the focus group is to improve knowledge and awareness to eliminate the occurrence of avoidable pressure damage. Coupled with this, is the launch of the compliance report from the patient safety dashboard. The information team are now able to extract data from the dashboard, in order to, monitor compliance with the patient safety assessments related to falls prevention, nutrition risk assessments and pressure ulcer prevention. This report also provides data regarding the timeliness of assessments and initiation of care plans and will be a useful tool for Ward Managers and Matrons to promote compliance and ultimately, improve patient care.

As previously reported, Ward F5 has now achieved over 500 days without HAPU. This significant achievement is being reviewed in order promote the sharing of good practice. One element of good practice identified is the reduction in using the blue procedure sheets as a continence aid. These sheets are not designed for this use and cause moisture damage. This is an area of practice the Senior nursing team are keen to promote in all ward areas. .

1.8 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.

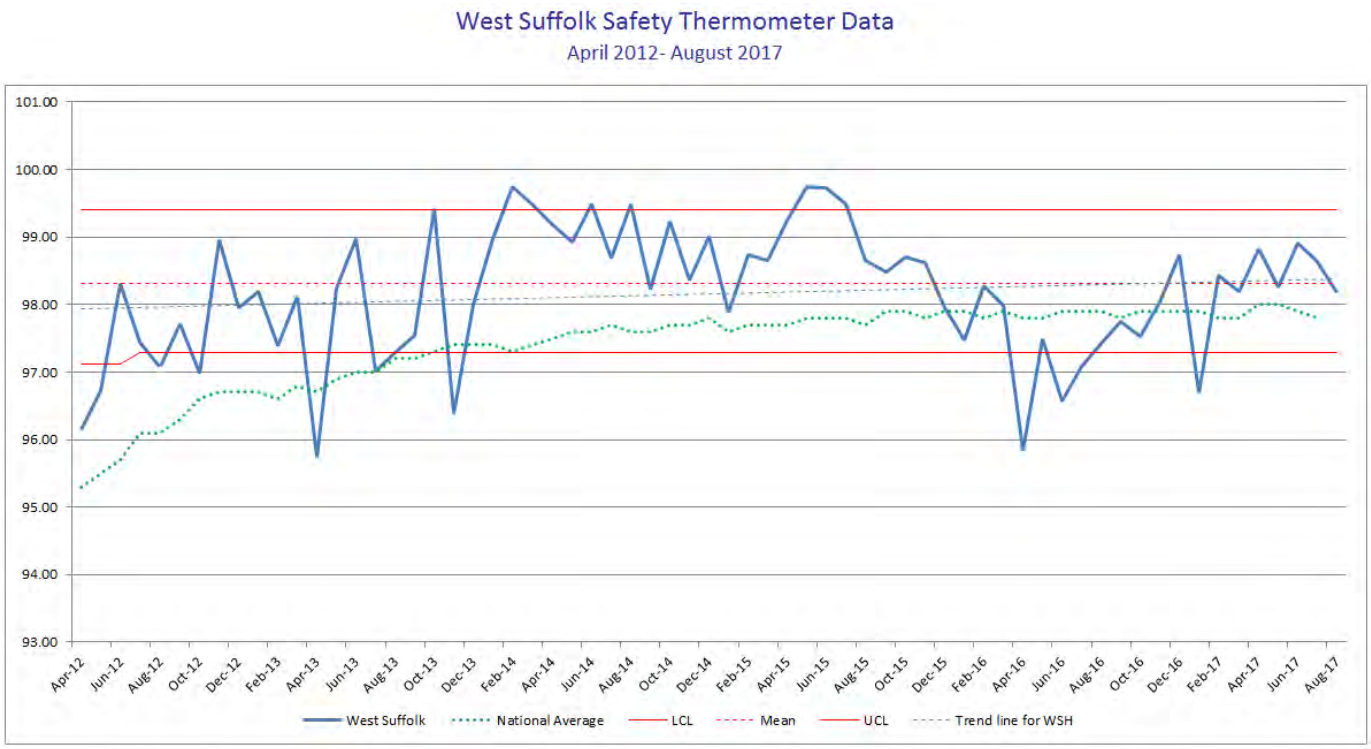
	Sep16	Oct16	Nov16	Dec16	Jan17	Feb17	Mar17	Apr17	May17	Jun17	Jul17	Aug17
Harm Free	92.71	92.31	92.61	93.16	91.35	93.72	94.06	94.12	91.30	92.92	93.21	94.29
Pressure Ulcers – All	5.03	5.49	5.67	3.80	5.34	4.71	3.62	5.00	5.22	4.90	4.08	4.16
Pressure Ulcers - New	1.01	1.65	1.23	0.51	1.53	1.05	0.52	0.88	0.87	0.54	0.82	1.56
Falls with Harm	0.75	0.55	0.49	0.76	0.76	0.00	0.00	0.00	0.29	0.00	0.27	0.26
Catheters & UTIs	1.51	2.20	1.23	2.28	2.04	1.31	1.81	1.18	3.48	2.18	2.17	1.56
Catheters & New UTIs	0.50	0.00	0.25	0.00	0.25	0.26	0.78	0.29	0.29	0.27	0.00	0.00
New VTEs	0.00	0.27	0.00	0.00	0.76	0.26	0.52	0.00	0.29	0.54	0.27	0.00
All Harms	7.29	7.69	7.39	6.84	8.65	6.28	5.94	5.88	8.70	7.08	6.79	5.71
New Harms	2.26	2.47	1.97	1.27	3.31	1.57	1.81	1.18	1.74	1.09	1.36	1.82
Sample	398	364	406	395	393	382	387	340	345	367	368	385
Surveys	18	17	18	18	18	18	18	18	17	17	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.

The national data is now being published and we have data up to July 2017 which show that the Trust has consistently been above the National average since February.

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 August 2017 is **1.82 %** therefore, our new harm free care is **98.18%.** The National new harm is not available for August at this time but if the figure remains the same as the previous month the Trust will be green.

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 August 2017 with August 2017 data provided at Trust level only.



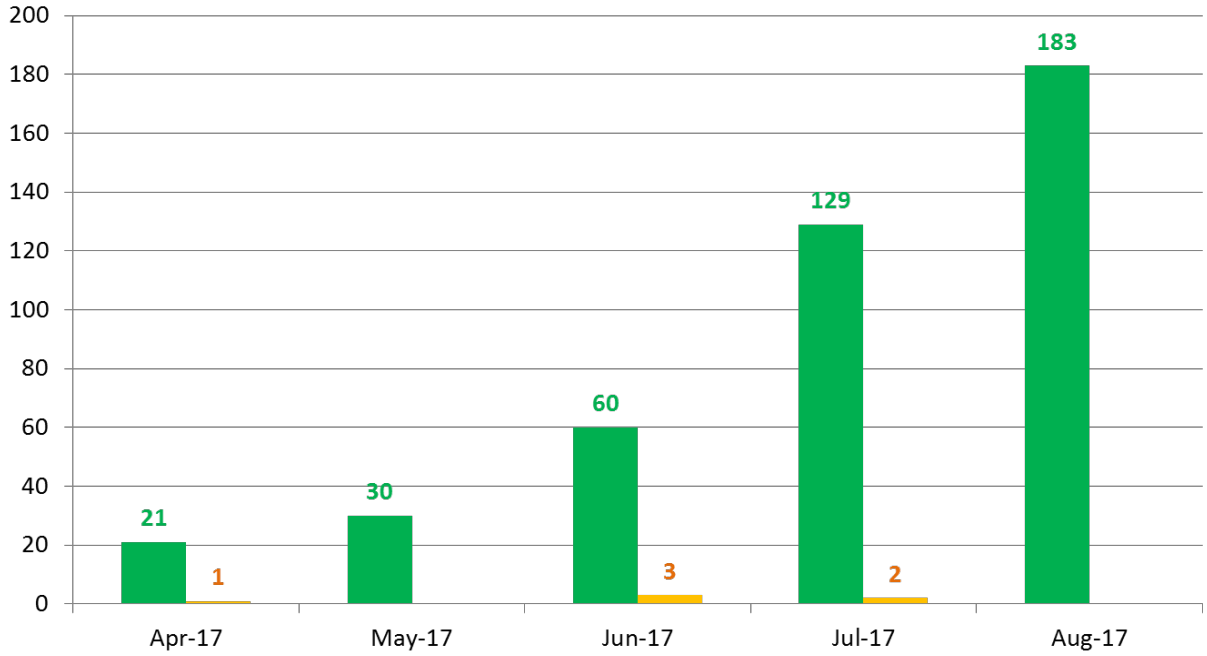
b) Recommended Actions

To continue to monitor actual harm against national benchmarks.

1.9 % 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. 68% (221) of the July green incidents had been investigated at the time of this report compared to June (54%).

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. In the most recent six-month period the median upload was 58 days which continues to improve but has not yet met the local target of 45 days achieved in the last NRLS report (Apr-Sept2016). NHS Improvement is now publishing monthly information reports including timeliness indicators. More details of the NHSI report and the Trust's action plan to improve performance is

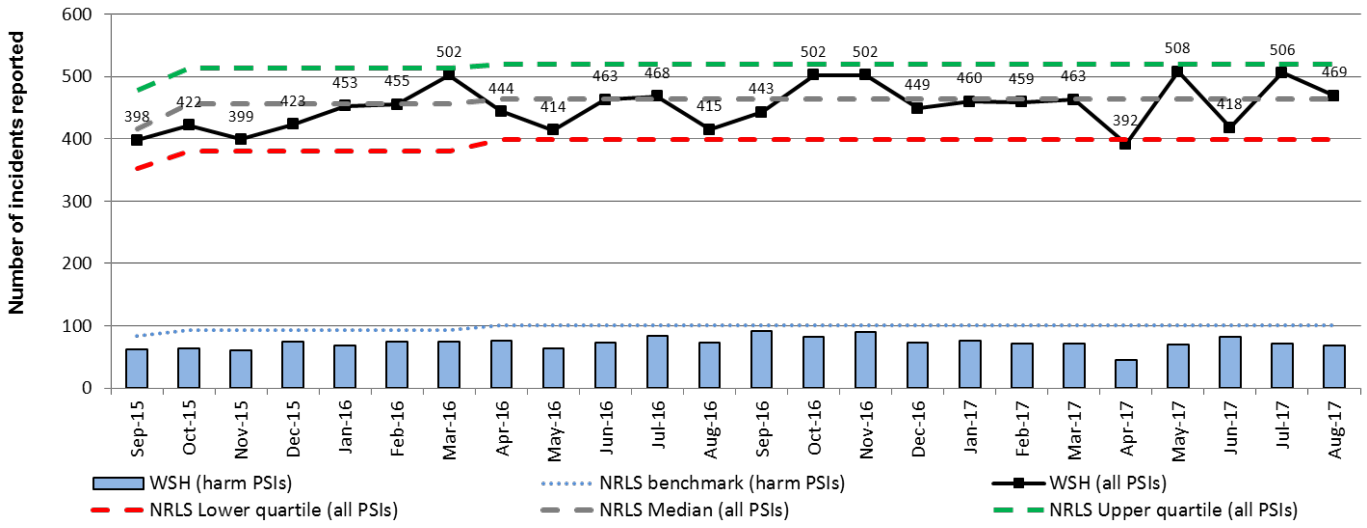
included in the 'aggregated' report this month.

1.10 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 579 incidents reported in July including 469 patient safety incidents (PSIs). This was lower than June but remains high compared to previous months. The number of 'harm' incidents remains low

Graph: Patient Safety Incidents reported



1.11 Patient Safety Incidents (Severe harm or death)

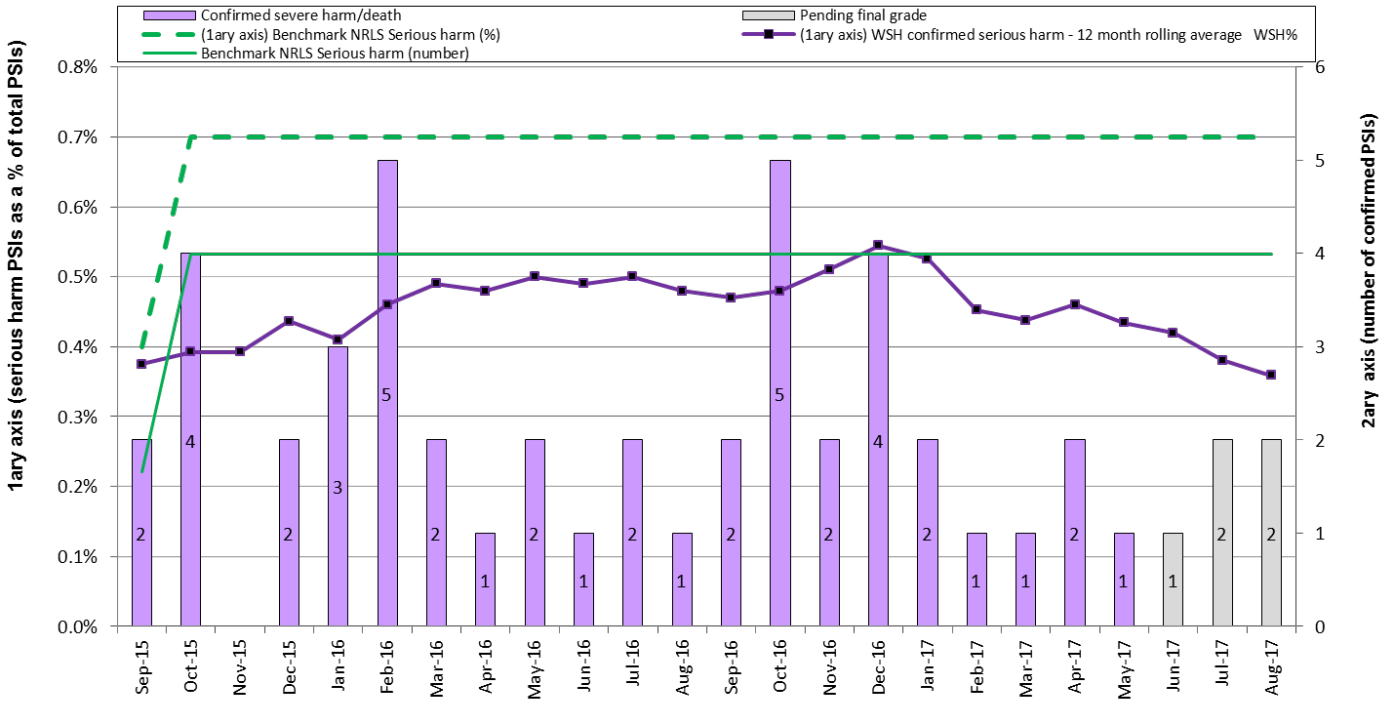
The percentage of PSIs resulting in severe harm or death is a nationally mandated item for inclusion in the Quality Accounts. The NRLS peer group average is from the period Apr – Sept16. The benchmark line applies the peer group percentage serious harm to the peer group median total PSIs to give a comparison 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 August there were two cases reported: one surgical complication and one fall resulting in fracture. Both cases are awaiting RCA to confirm harm grading.

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

- one delay in treatment
- one delay in diagnosis
- one mortality review of a patient with learning difficulties

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	Jun	Jul	Aug
Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	94	94	93
(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	99	98	98
Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	80	78	80
Patient Satisfaction: outpatient overall result	= 85%	<75	75-84	85-100	88	89	91
(Out-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	97	95	95
Were you informed of any delays in being seen?	= 85%	<75	75-84	85-100	65	60	87
Were you offered the company of a chaperone whilst you were being examined?	= 85%	<75	75-84	85-100	65	76	80
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	99	99
Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	94	94	95
(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	95	95	95
Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	94	ND	ND
(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	95	ND	ND
Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	100	100	100
[Maternity] How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	100	ND
How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	ND	ND
Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	ND	ND	ND
(Young children) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	92	ND
Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	99	95	100
(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	92	100
Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	98	99	ND
(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	95	99	ND

Additional Patient Experience indicators

Indicator	Target	Red	Amber	Green	Jun	Jul	Aug
Acknowledged within three working days [NEW]	100%	<75%	75 – 89%	>=90%	100	100	93
Response within 25 working days or negotiated timescale with complainant	100%	<75%	75 – 89%	>=90%	75	100	85
Number of second letters received	0	>6	2 - 6	0 - 1	2	1	1
Health Service Referrals accepted by Ombudsman	0	>=2	1	0	0	1	0
Red complaints actions beyond deadline for completion	0	>=5	1 - 4	0	0	0	0
Number of PALS contacts becoming formal complaints	0	>=10	6 - 9	<=5	0	1	4

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.

1.12 Inpatient: Noise at night

a) Current Position

This indicator continues to flag as an amber area, with a slight improvement to 80 from 78 in July.

a) Recommended Action

A local survey is currently being conducted assessing quality of sleep on the ward and asking patients for feedback about how this might be improved. Results so far highlight other patients as the main cause of noise at night.

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

a) Current Position

There was a vast improvement in the score this month, taking this from a red area (60) to an amber (87).

b) Recommended Action

Results show that the majority of patients did not experience any delays, though of those that did there are still improvements to be made to inform people to expect delays. 20 outpatient pagers are now operational in the department to allow patients to leave the area if there are delays; the uptake for these has been slow but the team are working with Communications to design information alerting patients to this option. Information screens are also being explored with IT.

1.14 Out-patient: Offered the company of a chaperone?

a) Current Position

The score remains amber, improving from 76 in July to 80 in August.

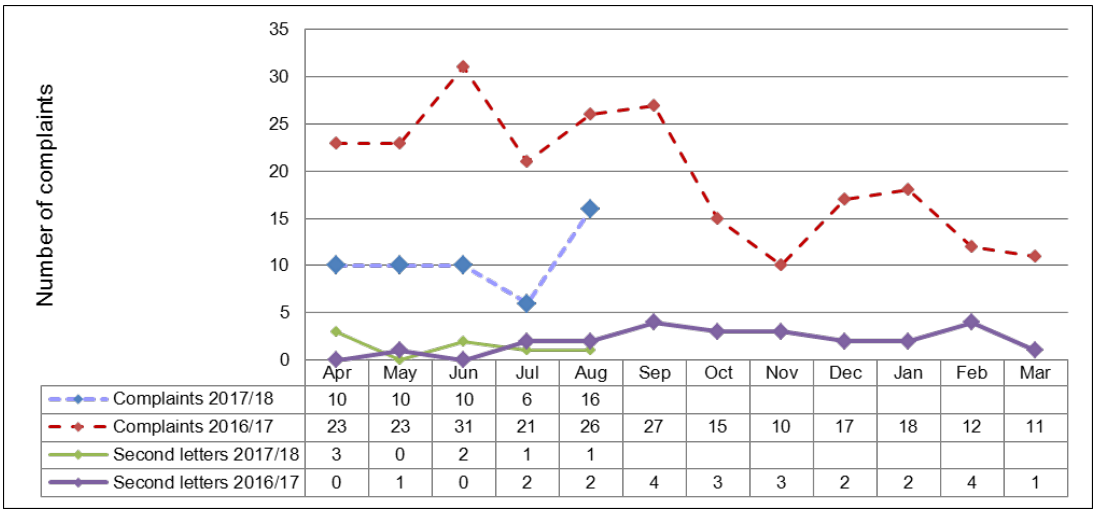
b) Recommended Action

The chaperone policy is currently under review and this question will be altered to reflect the new policy. It should be made clear that having a chaperone present is not always the preference of the patient.

1.15 Complaints

16 complaints were received in August. The breakdown of these complaints is as follows by Primary Division: Medical (9), Surgical (5), Women & Children (2).
Trust-wide the top three most common problem areas are as below:

Clinical Treatment – Surgical group	3
Communications	3
Patient Care – including Nutrition/Hydration	3



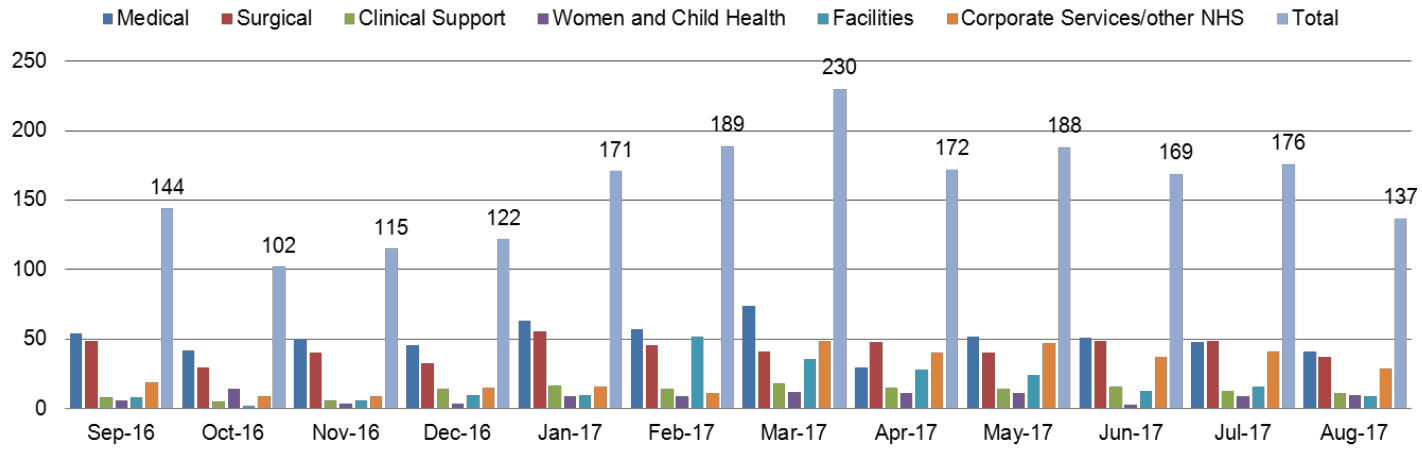
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Complaints 2017/18	10	10	10	6	16							
Complaints 2016/17	23	23	31	21	26	27	15	10	17	18	12	11
Second letters 2017/18	3	0	2	1	1							
Second letters 2016/17	0	1	0	2	2	4	3	3	2	2	4	1

1.16 PALS

In August 2017 there were 137 recorded PALS contacts. This is fewer than previous months due to a vacancy and leave within the team. 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 division from Sep 16 – Aug 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 (39)
- Appointments; including delays and cancellations (27)
- Admissions, discharge and transfers (22)

There have been several enquiries relating to the waiting list for orthopaedic surgery. Car parking queries have decreased compared to previous months, which is the first improvement since the new arrangements were implemented in February.



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	Jun	Jul	Aug
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	99	NA	NA
Trust participation in relevant ongoing National audits (Quarterly)	100%	<75	75 – 89	>=90	94	NA	NA
Babies admitted to NNU with normal temperature on arrival (term)	100%	<50%	50-80%	>80%	88	100	100
12 month Mortality standardised rate (Dr Foster)	100%	>100	90-100	<90	88.05	88.35	84.72
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		Jun-17	Jul-17
ACTIVITY – Births						
Total Women Delivered	> 250 or < 2 00	>216 or <208	>208 or <216	208	213	233
Total Number of Babies born at WSH	> 250 or < 2 00	>216 or <208	>208 or <216	213	215	233
Twins	No target	No target	No target	5	2	0
Homebirths	< 1%	2% or less	2.5%	2.4%	3.3%	2.6%
Midwifery Led Birthing Unit (MLBU) Births	<=10%	13% or less	20%	17.3%	18.8%	15.5%
Labour Suite Births	<=64%	69% to 74%	75%	80.3%	77.9%	82%
BBAs	No target	No target	No target	1	1	4
Normal Vaginal deliveries	No target	No target	No target	154	162	166
Vaginal Breech deliveries	No target	No target	No target	1	0	1
Non operative vaginal deliveries	No target	No target	No target	75%	76.1%	71.1%
Water births	No target	No target	No target	12	20	20 8.6%
Total Caesarean Sections	> 22.6%	No target	<22.6%	15.9%	15.5%	22.3%
Total Elective Caesarean Sections	>=13%	11 - 12%	10%	4.3%	7%	9.4%
Total Emergency Caesarean Sections	>=15%	13 - 14%	12%	11.5%	8.5%	12.9%
Second stage caesarean sections	No target	No target	No target	3	2	5
Forceps Deliveries	No target	No target	No target	6.3%	5.6%	6 2.6%
Ventouse Deliveries	No target	No target	No target	3.4%	2.8%	3.4%
Inductions of Labour	No target	No target	No target	40.9%	36.6%	38.2%
Failed Instrumental Delivery	No target	No target	No target	0	0.9%	0
Unsuccessful Trial of Instrumental Delivery	No target	No target	No target	0	0	2
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%	93%	83%	57%
Total no. of women eligible for Vaginal Birth after Caesarean Section (VBAC)	No target	No target	No target	23	23	25
Number of women presenting in labour for VBAC against number achieved.	No target	No target	No target	15	8	6
ACTIVITY – Bookings						
Number of Bookings (1st visit)	No target	No target	No target	244	272	245
Women booked before 12+6 weeks	<=90%	91 - 94%	95%	97%	95%	99%
CLINICAL OUTCOMES - Maternal						
Postpartum Haemorrhage 1000 - 2000mls	No target	No target	No target	16	16	17
Postpartum Haemorrhage 2,000 - 2,499mls	No target	No target	No target	1	2	1
Postpartum Haemorrhage 2,500mls+	No target	No target	No target	1	3	2
Post-partum Hysterectomies	1	1	0	0	0	0
Women requiring a blood transfusion of 4 units or more	1	1	0	0	0	0
Critical Care Obstetric Admissions	1	1	0	0	0	0
Eclampsia	1	1	0	0	0	0
Shoulders Dystocia	5 or more	3-4	2	3	5	3
3rd and 4th degree tears (All vaginal deliveries)	No target	No target	No target		6	4
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)	10	7-9	6	5	6	4
3rd and 4th degree tears (Instrumental Deliveries)				1	4	0
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	17	0	13
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	No target	No target	No target	3	2	2
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

	Red	Amber	Green		Jun-17	Jul-17
Stillbirths	No target	No target	No target	0	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 >	99	99	96
Midwife/birth ratio	>=1:32	No target	1:30	1:29	1:30	1:33
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	46	64	43
Serious incidents	No target	No target	No target	0	0	0
Never events	No target	No target	No target	0	0	0
Complaints	No target	No target	No target	1	2	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	0	0	0
Maternal Postnatal readmissions	No target	No target	No target	ND	ND	ND
Completion of WHO Checklist	80%	90%	100%	84%	94%	82%
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	37	10+	10+
Number of Women identified as smoking at delivery	No target	No target	No target	26	32	30
UNICEF Baby Friendly Audits	No target	No target	No target	10	30	27
Proportion of parents receiving a Safer Sleeping Suffolk Thermometer.	No target	No target	No target	174	205	155

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

1.17 Maternity - Grade 2 Caesarean Section (Decision to delivery time met)

The maternity service failed to achieve the target of decision to delivery interval of no greater than 75 minutes for Grade 2 caesarean sections in August 2017. Of the 14 cases only 8 achieved this target. All cases have been discussed at the weekly case management meeting and a range of reasons for the delay identified however it was not felt that there was any harm caused and the majority were delayed to ensure appropriate clinical care was provided, i.e. adequate regional anaesthesia.

1.18 Maternity - Shoulder Dystocia

The maternity service reported 3 cases of shoulder dystocia this month, graded amber on the dashboard. Due to the red rated from July 2017 and audit of shoulder dystocia cases is currently in progress due to report to the Womens Clinical Governance meeting in October 2017.

1.19 Maternity - Midwife/birth ratio

The effect of delivering mothers from USAF Lakenheath has had an impact on the midwife to birth ratio this month taking it to 1 to 33, above that which we would normally achieve. The formula used for this calculation however does not allow you to disregard any areas of care not provided, therefore this figure includes the provision of antenatal care to women from Lakenheath , where this was in fact limited. All women who delivered in August 2017 received one to one care in labour, however there was an increased use of the escalation processes.

1.20 Maternity - Completion of WHO Checklist

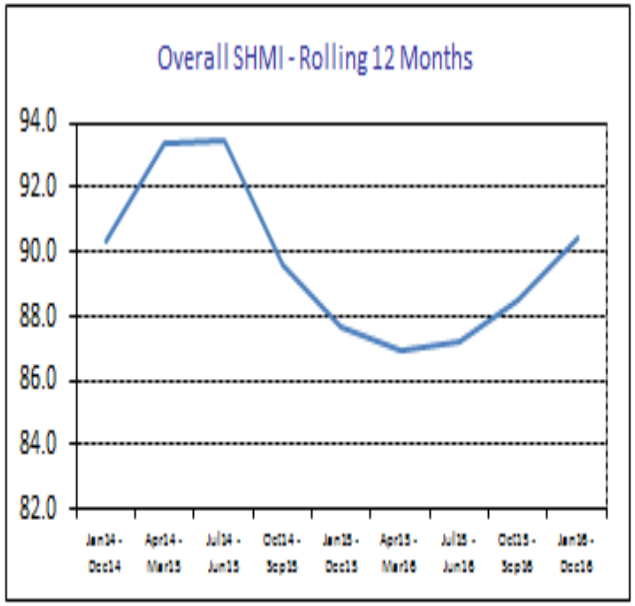
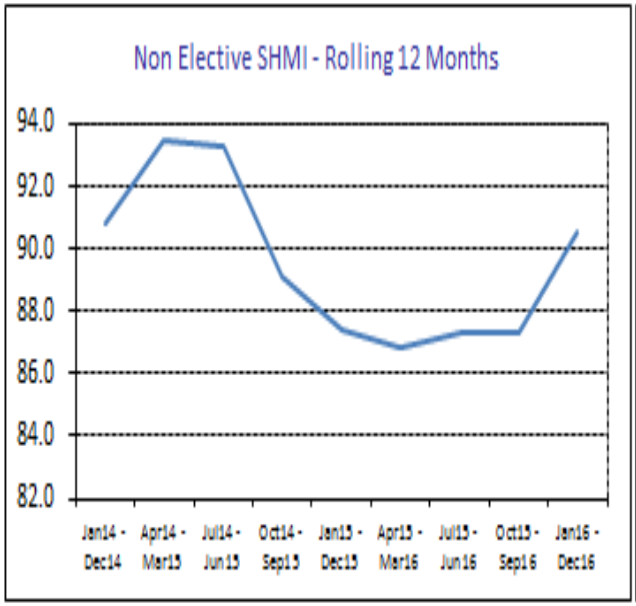
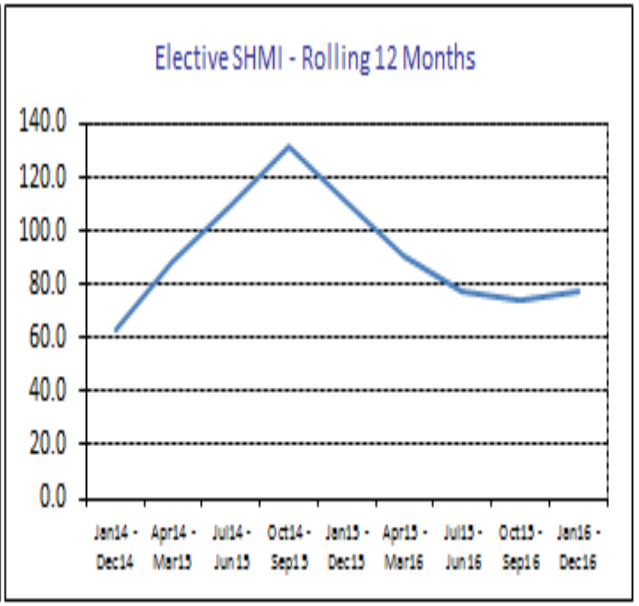
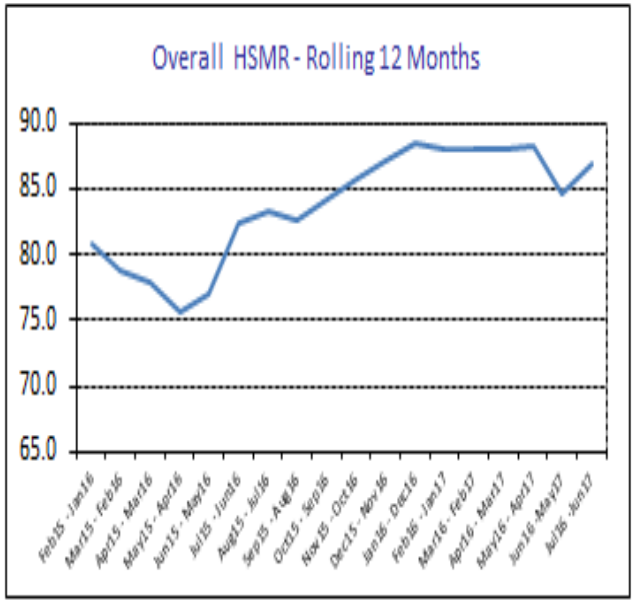
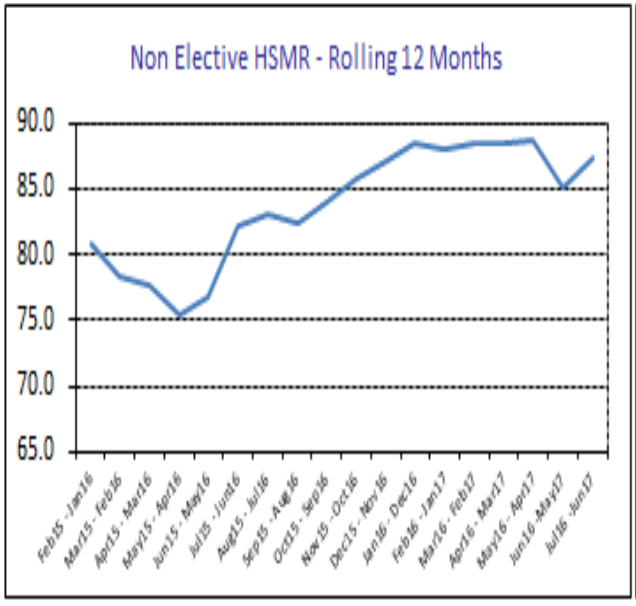
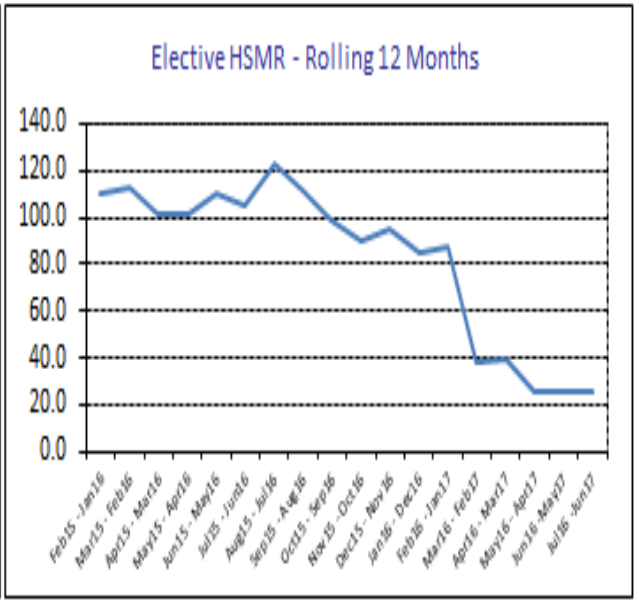
Despite increased follow up of all staff who fail to complete a maternity WHO checklist completely there has been no improvement in the overall figures. It should be noted however that this was affected by the use of locum medical staff during one weekend who was unfortunately unfamiliar with the system (4 of the 10 checklists which failed the audit). The lead consultant continues to address this with individual member of staff, this month doing so as soon as a failure is noted to try to prevent reoccurrence.

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

2. MORTALITY HSMR AND SHMI DATA

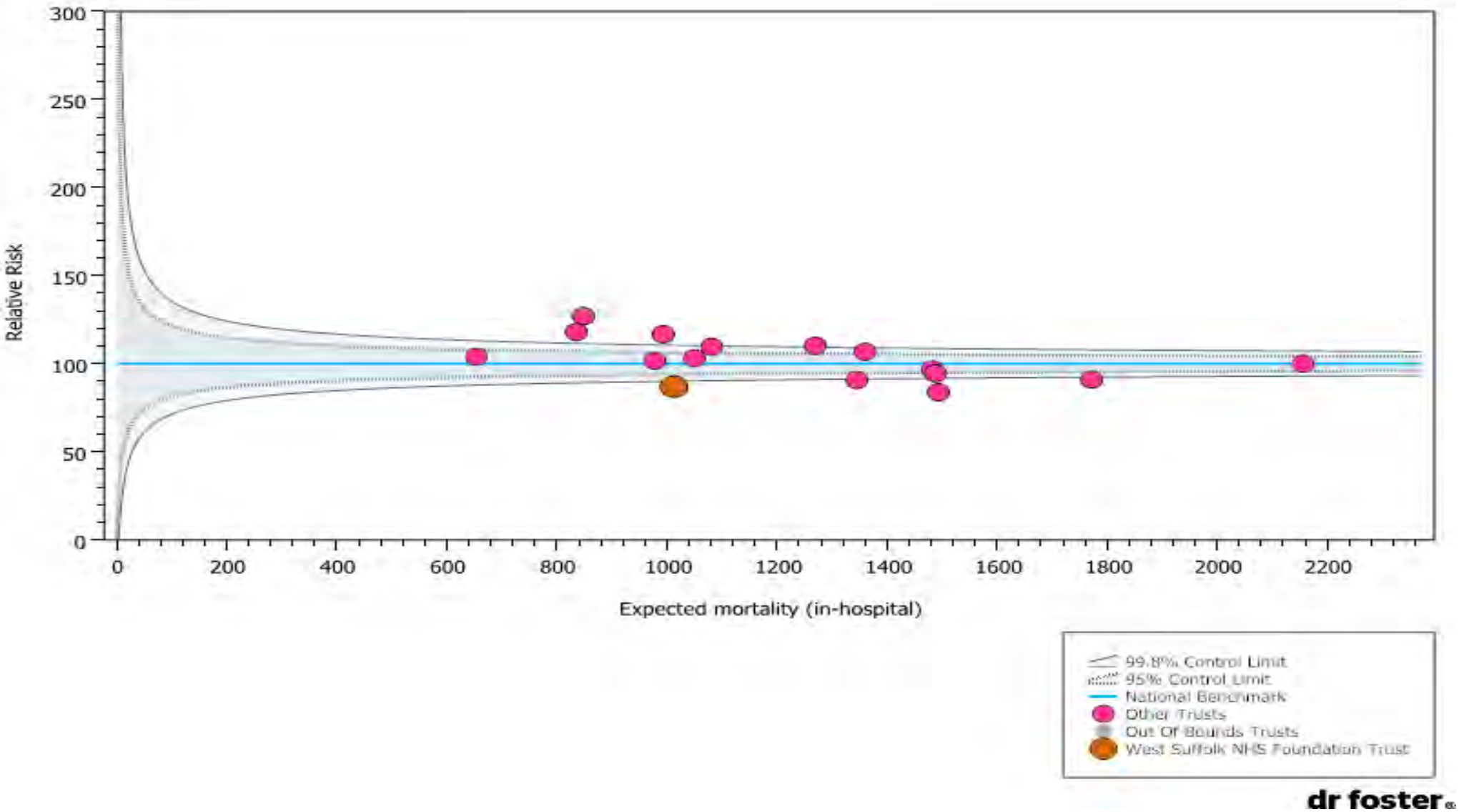
Mortality (Individual Months)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
No of Deaths	77	55	72	85	78	77	69	80	122	134	105	84
No of Discharges	5,153	5,026	5,072	5,493	4,921	5,298	5,642	5,269	5,313	5,311	4,838	5,360
% Deaths	1.49%	1.09%	1.42%	1.55%	1.59%	1.45%	1.22%	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	62	76							
No of Discharges	5,378	5,742	5,661	5531	5592							
% Deaths	1.34%	1.20%	1.25%	1.12%	1.36%							
HSMR*												

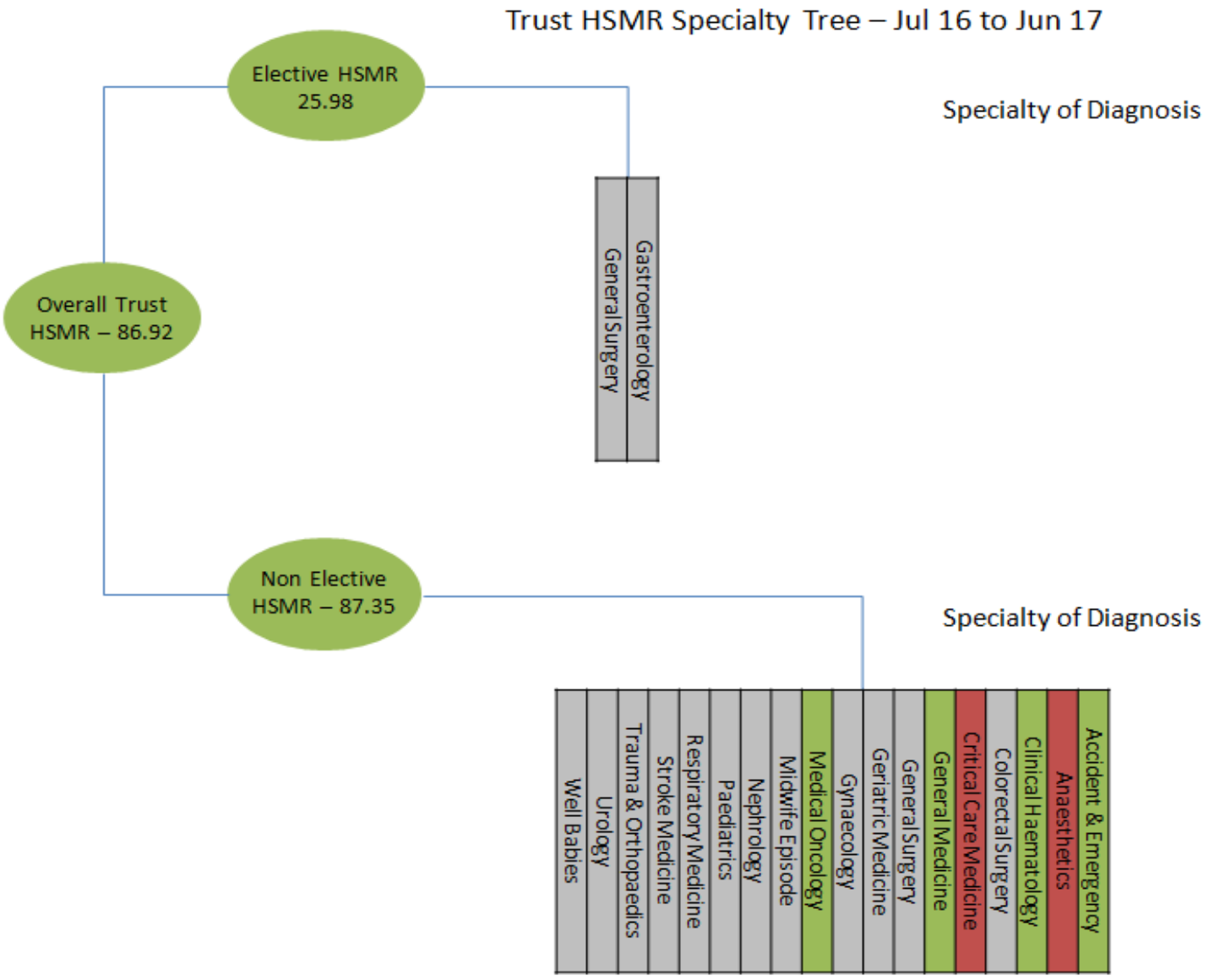
HSMR BENCHMARK IS USING FY 15 -16

	Overall	Non-Elective	Elective
SHMI			
HSMR			

HSMR - Jul 16 - June 17

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




Trust HSMR Specialty Tree – Jul 16 to Jun 17
Elective HSMR 25.98
Overall Trust HSMR – 86.92
Non Elective HSMR – 87.35
Specialty of Diagnosis
Gastroenterology
General Surgery
Specialty of Diagnosis
Accident & Emergency
Anaesthetics
Clinical Haematology
Colorectal Surgery
Critical Care Medicine
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						June	July	August
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%	85.93%	85.93%	1.0	Helen Beck	83.36%	85.92%	85.93%
Number of RTT Waits over 52 weeks for incomplete pathways	0	26	61	-	Helen Beck	15	35	26
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	90.09%	91.61%	1.0	Helen Beck	95.53%	92.47%	90.09%
All cancers: 62-day wait for first treatment (5) from:Urgent GP referral for suspected cancer - **See Further detail below**	85%	85.14%	84.84%	1.0	Helen Beck	85.98%	84.57%	85.14%
All cancers: 62-day wait for first treatment (5) from: NHS Cancer Screening Service referral	90%	100.00%	100.00%		Helen Beck	90.00%	100.00%	100.00%
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%	96.02%	95.23%	0.5	Helen Beck	96.59%	94.51%	96.02%
Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)	93%	100.00%	99.10%		Helen Beck	88.80%	98.06%	100.00%
Outcomes:			1					
Clostridium (C.) difficile - meeting the C.difficile objective - MONTH	2	0		1.0	Rowan Proctor	0	1	0
Clostridium (C.) difficile - meeting the C.difficile objective - QUARTER	4		1		Rowan Proctor			
Clostridium (C.) difficile - meeting the C.difficile objective - ANNUALLY	16		4		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 - July 2017					
GP Suspected Cancer Referral Receipt to Start of 1st Treatment: 62 Days Waiting Times Standard 85%				Performance %	
Cancer Type	<62 days	>62 days	Total	Trust	England~
Breast	17		17	100%	93.7
Gynae	2+1x.5	2x.5	3.5	71.4%	75.1
Haem	4+1x.5	1	5.5	81.8%	80.6
Head & Neck	2x.5	1	2	50%	64.3
Lower GI	8	4+1x.5	12.5	64.0%	70.8
Lung	5+1x.5	1	6.5	84.6%	70
Other				NA	
sarcoma				NA	
Skin	11	1	12	91.7%	96.1
Upper GI	7		7	100%	74
Urology	12	3	15	80%	76.2
Total	66+5x.5	11+3x.5	81	84.6%	81.3

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

a) Current Position

85.93% against a threshold 92%

The August position shows only marginal improvement from July (83.92%) to 85.93% in July. The current waiting list now has a total of 17,346 patients with 2,441 patients breaching 18 weeks (2,629 in July). There remain on-going data quality issues within this number leading to a reported position which we believe is slightly worse than our actual position. There continue to be significant capacity constrains within ENT, Vascular, Urology, and Dermatology services.

b) Recommended Action

Revised detailed action plans for each of the specialties have been developed and reviewed with the CCG. NHSI IST are assisting the trust with demand and capacity modelling to support work around meeting the RTT targets, this is being further supported by colleagues from KPMG. Work continues across all specialities to maximise opportunity for additional capacity and support clinicians in delivering additional activity to reduce waiting times for patients. This is being challenged by high levels of emergency activity but operational teams are working closely with clinical teams to mitigate the impact as far as possible.

Sustained improvement is being demonstrated in the waiting times for first OPA in ENT which has now reduced to a maximum wait of 25 weeks. Although the performance against the aggregate target has plateaued from July to August, the Trust remains on trajectory to recover aggregate RTT performance.

3.2 Number of RTT waits over 52 weeks for incomplete pathways

a) Current Position

26 against a threshold of 0

This has improved on the position from July which saw 35 breaches against this standard. The greatest proportion of patients breaching 52 weeks continues to be in the ENT service which has known capacity issues. In August 15 ENT patients breached 52 weeks compared to 21 in July. The remaining 11 breached patients are shared across Vascular Surgery (4), Audiology (3), T&O (1), Urology (2), and Oral (1).

b) Recommended Action

Long waiting patients and are being actively monitored by the senior team to ensure patients are being booked in turn and proactively managed.

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

a) Current Position

90.09% against a threshold of 95%

b) Recommended Action

August ED performance started off in a difficult position with significant WSH Trust capacity issues. The unit attendances also averaged 188 attendances a day in the first week of August which is higher than our average attendance. For 9 days in August we achieved the 95% target of under 4 hours ED length of stay. ED attendance figures were witnessed at over 200 patients a day for 7 days of August, this together with medical staffing deficits resulted in delays to be seen by a clinical decision maker. Mitigation is being planned, but medical staffing recruitment remains an issue. Reviews of the ED RAT process are currently underway, and the ACP roster has been reviewed to enable Sunday and Monday increased staffing levels, as these are our busiest days.

3.4 104 day Cancer waits

a) Current Position

2 patients treated locally:
Skin – day 130, patient multiple cancellations/DNA and comorbidity
Urology – day 109, diagnostic delay but on hormones

3 Patients treated in shared pathway:
Lung x1 - day 231, very complex pathway, three primaries
Upper GI x1 – day 155, diagnostic delay
Urology x1- day 106, diagnostic delay

b) Recommended Action

All are having clinical harm review by the relevant clinicians.

The following is an update to an issue referenced in the July board report:
Currently only two urology consultants undertake trans perineal template biopsies. These need to be undertaken in main theatres where the equipment is located. Capacity undertakes this work has been limited due to workforce constraints linked to on-going regional and national recruitment problems for urology consultants. This will be further impacted by current difficulties in providing locum cover to the vacant consultant post in urology.

Saturday urology lists are utilised for template biopsy procedures to ensure maximum utilisation of equipment and surgeon time. On-going capacity will be reviewed as part of the future locum arrangements and permanent consultant recruitment plans. However, performance in this area is likely to remain challenged by workforce availability.

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	Jun	Jul	Aug	Change mth on mth	On Plan To Achieve	Area of Concern	Forecast to Breach
A&E												
A&E Time to treatment in department (median) for patients arriving by ambulance - CDM	Median time to treatment above 60 minutes	50	46		Helen Beck	52	52	50	↗			
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	11:46	13:57	Commentary available from Philippa Sharp.	Helen Beck	10:10	13:53	11:46	↗			
A&E Trolley Waits not longer than 12 hours	0 Patients waiting over 12 hours from DTA to Admission	0	0		Helen Beck	0	0	0	↔			
A&E - Threshold for admission via A&E	i) if the monthly ratio is above the corresponding 2012/13 monthly ratio for two month in a six month period ii) if year end is greater than 27%	31.79%	31.14%		Helen Beck	30.80%	30.75%	31.79%	↘			
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%	89.94%	91.37%		Helen Beck	91.74%	90.98%	89.94%	↘			
A&E - Ambulance Handovers above 30 minutes	0 handovers over 30 minutes - £200 per breach	TBC	129		Helen Beck	31	39	TBC				
A&E - Ambulance Handovers above 60 minutes	0 handovers over 60 minutes - £1000 per breach	TBC	35		Helen Beck	9	7	TBC				
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%	TBC	91.31%	Due to eCare updates, report is now showing erroneous figures and will be rebuilt asap.	Helen Beck	92.86%	TBC	TBC	↔			
RTT												
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks	99.00%	94.93%	93.27%		Helen Beck	94.04%	94.31%	94.93%	↗			
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90.00%	69.70%	70.00%		Helen Beck	70.32%	72.92%	69.70%	↘			
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.00%	85.84%	86.78%		Helen Beck	87.34%	87.61%	85.84%	↘			
Stroke												
% of patients scanned within 1 hour of clock start	77% (Contract) 57.5% (Upper Quartile)	79.17%	79.82%		Helen Beck	72.09%	81.58%	79.17%	↘			
% of patients scanned within 12 hours of clock start	96% (Contract) 96% (Upper Quartile)	95.83%	96.41%		Helen Beck	95.35%	94.74%	95.83%	↗			
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75% (Contract) 70% (Upper Quartile)	78.72%	78.54%		Helen Beck	76.19%	77.78%	78.72%	↗			
>80% treated on a stroke unit >90% of their stay	90%	97.87%	93.09%		Helen Beck	88.10%	94.44%	97.87%	↗			
% of patients treated by a stroke skilled early supported discharge team	48% (Contract) 48% (Upper Quartile)	33.33%	49.44%		Helen Beck	75.00%	46.43%	33.33%	↘			
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80% (Contract) 79% (Upper Quartile)	87.50%	90.58%		Helen Beck	95.35%	92.11%	87.50%	↘			
% 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)	89.58%	86.89%	INDICATION ONLY - FINAL SSNAP LEVEL AVAILABLE WHEN RESULTS ARE AVAILABLE FROM SSNAP	Helen Beck	90.24%	87.88%	89.58%	↗			
% 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				-			
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	ND	Reports are generated by SSNAP every 4 months - this is as at March 2017, reported for June Board	Helen Beck				-			
Discharge Summaries												
Discharge Summaries - Outpatients	85% sent to GP's within 3 days	ND	ND	Outstanding report issues with Discharge Summaries which are currently being investigated.	Nick Jenkins	ND	ND	ND	-			
Discharge Summaries - A&E	95% of A&E Discharge Summaries to be sent to GPs within one working day	85.68%	98.25%		Nick Jenkins	87.51%	86.71%	85.68%	↘			
Discharge Summaries - Inpatients	95% sent to GP's within 1 day	TBC	92.91%	Inpatient Discharge Summaries report is currently being built with completion expected in time for next month.	Nick Jenkins	93.40%	TBC	TBC	-			
Choose & Book												
All 2 Week Wait services delivered by the Provider shall be available via Choose & Book (subject to any exclusions approved by NHS East of England)	100%	100.00%	100.00%		Helen Beck	100.00%	100.00%	100.00%	↔			
Cancelled Operations												
Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	i) 1% of all elective procedures		0.81%		Helen Beck	1.05%	1.00%					
Patients offered date within 28 days of cancelled operation	100%		91.86%		Helen Beck	93.10%	88.46%					
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.	99.59%	96.43%		Rowan Procter	97.54%	94.85%	99.59%	↗			
Maintain maternity 1:30 ratio	1:30	01:33	01:29		Rowan Procter	01:29	01:30	01:33	↘			
Pledge 1.4: 1:1 care in established labour	1:1	100%	100.00%		Rowan Procter	100%	100.00%	100%	↗			
Breastfeeding initiation rates.	80%	84.80%	82.04%		Rowan Procter	87.50%	77.30%	84.80%	↗			
Reduction in the proportion of births that are undertaken as caesarean sections.	22.70%	22.32%	17.98%		Rowan Procter	15.87%	15.49%	22.32%	↘			

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	12.88%	10.90%		Helen Beck	9.72%	12.27%	12.88%	↘				
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	97.09%	98.10%		Helen Beck	100.00%	95.45%	97.09%	↗				
Acute oncology service: 1 hour to needle from diagnosis of neutropenic sepsis	100%	92.31%	93.10%	MacMillan	Helen Beck	100.00%	100.00%	92.31%	↘				
		70.00%	68.63%	ED	Helen Beck	41.67%	58.33%	70.00%	↗				
		82.61%	66.28%	Overall Trust (Inc AMU)	Helen Beck	63.16%	68.75%	82.61%	↗				
New to Follow up	Thresholds set at each speciality - overall Trust Threshold is 1.9	2.01	1.91		Helen Beck	1.97	1.96	2.01	↘				
Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test	99%	99.95%	99.92%		Helen Beck	100.00%	99.95%	99.95%	↔				
All relevant Inpatients undergoing a VTE Risk assessment	95%	TBC	88.00%	Issues with new VTE workflow.	Helen Beck	88.77%	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

Patient specific detail:
This patient was referred to ED by 111. He arrived on the 1st of August at 03:45 being triaged 12 minutes later as a category 2 presenting with abdominal pain and D+V, but seen at 06:20 due to a significant wait to be seen by a ED clinician. The patient was referred to surgeons at 07:30 post ED clerking and initial treatment.
At the time of referral to the Surgeons there were no surgical beds available and the Trust was full to capacity.
The patient was seen by surgeons at 12:08 with a potential diagnosis of Gastroenteritis, but the surgical team felt they needed to rule out appendicitis, so plan was still to admit patient to hospital. The patient then continued to await an inpatient Surgical bed being sent to the ward later that afternoon.

ED Unit: Background and Context
The Trust was in a black bed state, with a black ED state when patient booked into the department and for the four hours of his initial ED length of stay. There was a three hour wait to see a doctor, due to medical staffing issues and unit acuity. In addition to this in the early hours a learning disability patient was trying to abscond from the department adding clinical pressures.
There were between 5 and 10 patients waiting for a bed, inclusive of this patient, of the morning of the 1st of August 2017, being the day the patient was admitted.

b) Recommended Action
See above.

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

a) Current Position
31.79% against a threshold of 27%

b) Recommended Action
AECC continues to actively pull acutely medically unwell patients from ED with the emphasis of being discharged the same day.
Red to Green and Stranded Patient reviews now include F7 AMU short stay patients.
The WSH has not joined the next Surgical AECC NHS Elect cohort to enable a local implementation of Surgical Ambulatory Care.
GP streaming commences 31 October in the anticipation of aiding a reduction in ED attendance and admissions.

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
94.93% against a threshold of 99%.
There are on-going significant capacity issues within the ENT, Vascular, Urology, and Dermatology services. Patients are waiting up to 25 weeks for first OPA in ENT, and patients waiting over 30 weeks for surgery within Urology, 40 weeks for Vascular Surgery, and some patients are waiting over 28 week for surgery in Ophthalmology. 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. Targeted work is under way to reduce the back log in challenged specialties including ophthalmology but capacity issues remain in others such as ENT having a consequential effect on aggregate performance.

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

a) Current Position
69.70% against a threshold of 90%.

b) Recommended Action
Patients continue to be treated in longest waiting order, close monitoring and proactive management continues to support RTT position in all specialities.

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

a) Current Position
85.84% against a threshold of 95%.
This continues to be predominantly due to excessive waits for first appointment in both ENT and Dermatology.

b) Recommended Action
On-going work with the CCG and frequent monitoring of the action plans for these specialities.

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

a) Current Position
95.83% against a threshold of:
96% (Contract)
96% (Upper quartile)
Two patients failed this standard - 1 inpatient who had already had a stroke and not detected before 12 hours had elapsed and 1 patient who was intubated and ventilated and subsequently died in ITU who had a massive bleed, therefore too unwell to scan

b) Recommended Action
ESOT to continue to raise awareness on wards of the importance of alerting them as soon as a Stroke is suspected.

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

a) Current Position
33.33% against a threshold of:

48% (Contract
48% (Upper Quartile)

b) Recommended Action
Eligible patient who met the criteria was referred to this service.

4.8 Patients offered date within 28 days of cancelled operation

August performance data is currently unavailable at the time of writing this report.

4.9 Maintain maternity 1:30 ratio

a) Current Position

1:33 against a threshold of 1:30

b) Recommended Action
The effect of delivering mothers from USAF Lakenheath has had an impact on the midwife to birth ratio this month taking it to 1 to 33, above that which we would normally achieve. The formula used for this calculation however does not allow you to disregard any areas of care not provided; therefore this figure includes the provision of antenatal care to women from Lakenheath, where this was in fact limited. All women who delivered in August 2017 received one to one care in labour; however there was an increased use of the escalation processes.

4.10 Rapid Access - chest pain clinic

a) Current Position
97.09% against a threshold of 100%

b) Recommended Action
Due to specialty registrar (SpR) short notice sickness gaps the cardiology SpR had to go home to cover the night gap. This meant the clinic had to be cancelled at short notice. There was no alternative solution at the time.

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

a) Current Position
Macmillan – 92.31%
ED - 70.00%
Overall Trust figure of 82.61% against a threshold of 100%

b) Recommended Action
The performance figure for 1 hour to needle from diagnosis of Neutropenic Sepsis August Data showed that the AMU had no breeches during July, but the Macmillan Unit had one and Emergency Department had 3 Neutropenic Sepsis patient breeches. This was a continued improvement on the past three months data. The breech cases will be undergoing detailed review and any issues will be escalated to the Emergency Department Clinical and Nursing management to address within the departments.

4.12 New to follow up

a) Current Position
2.01 against a threshold of 1.9

c) Recommended Action
Position remains level and the backlog continues to be managed.

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	August	Comments
Workforce			
Sickness absence rate	<3.5%	3.58%	
Turnover	<10%	10.03%	
Reviews	Grievance/Banding reviews	6	Includes 2 employment tribunals
Recruitment Timescales	Average number of weeks to recruit = 7	6.4	
DBS Checks	To complete 95% of required DBS checks	98.40%	
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
3.58% against a threshold of <3.5%.

b) Recommended Action
Figure to be expected at this point in the year. However, we do have a number of staff on long term sick and are at the end of the sickness absence process, so this may affect the figures in a positive way going forward.

5.2 Turnover

a) Current Position
10.03% against a threshold of <10%

b) Recommended Action
This is not a cause for concern; however we are reviewing/refining the exit interview process to ensure that any retention issues are addressed.

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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 August. This month we would like to highlight the following:

- Our FFT for August was 99% from 355 responses.
- We received 1 ‘extremely unlikely to recommend’ response relating to MIU in Felixstowe. The respondent felt the staff member was rude. There were no formal complaints received in August.
- The number of patients whose discharge was delayed in August 49, a reduction from 58 in July. Of these, the number waiting for care packages has reduced.
- The Paediatric SLT service positon has not altered significantly from the July position.
- As requested the report now contains more detail on the activity of the Lymphoedema service.
- The Community Equipment Service narrowly failed 3 out of 7 KPI’s this month.
- The Adult SLT service has had a number of breaches for both priority 1 and priority 2 referrals. The service has 12.01% sickness rate and some outstanding vacancies currently which has contributed to this position.
- The Children in Care service has had 9 breaches for completion of health assessments within 28 days of the child becoming looked after. Of these 9, the delay of the service being notified was an average of 22 days.
- We had 1 case of C Difficile this month at Bluebird Lodge unit. This is the first case this contractual year.

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**August 2017**	**August Comments / Queries 2017**	**June 2017**	**July 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	99.84%		99.80%	98.06%
SCH		**D5-acc8**	18 week referral to treatment for Consultant led services Inpatient rules - Foot and Ankle Outpatient rules - Paediatrics (E&W)	95% patients to be treated within 18 weeks	Monthly report from Provider	98.80%		99.53%	99.58%
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	96.47%		96.10%	96.47%
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	97.06%		96.94%	96.99%
SCH	Safeguarding - adults	**c-safe2**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.20%		96.77%	96.64%
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	98.33%		97.78%	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	100%		N/A	N/A
InPt	Comm Hosp	**s-ip7**	Number of inpatient falls resulting in moderate or significant harm	No more than 1.25 per month (15 per annum) falls/1000bed days	Monthly report from Provider	N/A		0.36	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	96.24%	This relates to one patient out of 21 who had their management plan agreed outside of the 24hour period. This palliative patient was a step-up and was a complex case. The management plan was agreed in 24hours 7 mins	96.30%	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	85.71%	6 out of 7 patients compliant 1 patient breach caused by having to cancel a class due to high levels of staff sickness	91.89%	100.00%
IHT	CCC	**D4-int1**	Care coordination centre - % of telephone calls answered within 60 seconds	95% in 60secs	Monthly report from Provider	95.94%	# of calls handled: 16050 # of calls answered in 0-60 seconds: 15399 **% 0-60 seconds: 95.94%** Number of abandoned calls: 329 Abandoned calls %: 2.01 % Average Wait Time: 14 seconds	95.53%	95.94%

Adult KPI's										
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**August 2017**	**August Comments / Queries 2017**	**June 2017**	**July 2017**
IHT		**D4-ccc6**	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed.	85%	Quarterly			99.03%	
IHT	Card Rehab	**s-card5**	Number of service users successfully discharged from phase 3.	600 per annum	Monthly report from Provider	no longer reporting as of July 16		no longer reporting as of July 16	no longer reporting as of July 16
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses offered	At least 500 courses offered pa	Monthly report from Provider	51 offered		67 offered	62 offered
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses completed	At least 250 courses completed pa	Monthly report from Provider	7 completed		37 completed	19 completed
IHT	COPD	**s-copd5**	Community pulmonary rehabilitation - review offered 6 months after completing the course	95%	Monthly report from Provider	100.00%		97.30%	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%		100.00%	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 = 99.83%		#1 = 100.00%	#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	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	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	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 Service Users	95%	Monthly Secondary Uses Services	99.83%		100.00%	99.84%
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	92.17% (200/217)	This relates to 17 deliveries out of 217. All items were delivered within 7 hours of being ordered.	98.26% (169/172)	100% (148/148)
Mede	CES	**c-gen8**	Same Working day - Urgent equipment	98.00%	Monthly report from Provider				
Mede	CES	**c-gen8**	Next Working day - Urgent equipment	98.00%	Monthly report from Provider	98.90% (898/908)		99.52% (1042/1047	99.22% (893/900)
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	99.50% (2007/2017)		99.55% (2441/2452)	98.91% (2359/2385)
Mede	CES	**c-gen8**	Within 10 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider	97.98% (533/544)	This relates to 11 deliveries out of 544. 9 of these deliveries were made within 11 days of being ordered.	99.52% (625/628)	98.55% (542/550)
Mede	CES	**c-gen9**	Collection times: % of urgent next day collections for deceased Service Users	98% for all standards	Monthly report from Provider	97.66% (167/171)	This relates to 4 collections outside the next day timelimit.	100% (263/263)	99.52% (206/207)
Mede	CES	**c-gen9**	% of urgent collections within 2 working days	98.00%	Monthly report from Provider				
Mede	CES	**c-gen9**	% of urgent collections within 3 working days	98.00%	Monthly report from Provider	100.00% (306/306)		99.61% (513/515)	100.00% (422/422)
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	98.71% (4580/4640)		98.68% (5154/5223)	97.54% (4992/5102)
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	0.00%	This relates to 1 out of 1 high need referrals. Reassessment breach reason - patient was in hospital	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	100.00%		92.86%	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**	**August 2017**	**August Comments / Queries 2017**	**June 2017**	**July 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.	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	N/A		100.00%	100.00%
NCHC		**D5-ccc7**	Urgent 4 hrs	Urgent - 95%	Monthly report from Provider	95.59%		99.42%	98.62%
NCHC		**D5-ccc7**	Intermediate - 72 hrs	Intermediate - 95%	Monthly report from Provider	98.16%		98.28%	98.60%
NCHC		**D5-ccc7**	18 weeks	18 weeks - 95%	Monthly report from Provider	99.21%		99.77%	99.58%
NCHC		**D4-int1**	Community Health Team Leads and/or Local Area Managers to work with GP practices and establish direct working relationships that aid mutual understanding and aim to improve the quality of services to patients. A schedule of face to face meetings is to be agreed and adhered to by both parties and a joint action plan is to be produced that shall be regularly reviewed.	80%	Quarterly report from Provider				
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	66.67%	There were 5 referrals to the service in August: 2 were excluded as awaiting care packages to be arranged. Of the other 3 referrals: 2 patients were discharged within 24hours of referral and 1 patient died in hospital after a delay in the equipment being ordered as awaiting the report from the home visit.	N/A	N/A
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	97.73%	This relates to 3 out of 132 referrals. All referrals were triaged by day 9	100.00%	100.00%
WSH	Adult SALT	**s-salt2**	Service Users seen within the following timescales after triage: Priority 1 within 10 Operating Days	Priority 1 - 100%	Monthly report from Provider	75.00%	This relates to 2 out of 8 referrals, both patients were seen within 17 working days	100.00%	100.00%
WSH	Adult SALT	**s-salt2**	Priority 2 within 20 Operating Days	Priority 2 - 95%	Monthly report from Provider	46.00%	This relates to 49 out of 90 referrals.	80.00%	59.00%
WSH	Adult SALT	**s-salt2**	Priority 3 within 18 weeks	Priority 3 - 95%	Monthly report from Provider	100.00%		100.00%	100.00%
WSH	Medical Appliances	**s-ma1**	% of appointments available within 6 weeks	95%	Monthly report from provider	100.00%		100.00%	100.00%
WSH	Medical Appliances	**s-ma2**	% of urgent cases seen within one working day	100%	Monthly report from provider	No Urgent referrals received		No Urgent referrals received	No Urgent referrals received
WSH	Parkinson's Disease	**s-pd2**	% service users on caseload who have an annual specialist review	95%	Monthly report from provider	100.00%		100.00%	100.00%

Children's Services KPIs									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of Measurement**	**August 2017**	**June Comments/ Queries 2017**	**June 2017**	**July 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	94.74%	28 out of 30 children were seen within 18weeks in the East and 26 out of 27 children were seen within 18weeks in the West	98.61%	98.80%
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	100.00%		99.01%	98.06%
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	99.07%		99.08%	99.07%
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	98.71%		99.59%	98.89%
WSH	Newborn Hearing Screening Service (West)	**NBHS-3**	Screening outcomes set within 3 months	≥99%	Monthly Activity Report	97.84%		99.18%	98.86%
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	100.00% 32 contacts		100% 180 contacts	100.00% 205 contacts
WSH	Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	Systmone	100.00% 109 contacts		100% 156 contacts	100.00% 148 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	90.91%	10 out of 11 children who had an IHA in August were offered their first appt within 28 days of the service being made aware of the child	85.00%	94.74%
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	81.82%	9 out of 11 children had an IHA completed within 28 days of the service being made aware of the child. Of the 2 appts outside the 28 day deadline (39days and 50days) - 1 was due to a delay as the CiC team requested more information before booking the child in - 1 was due to the child moving to the West and the CiC team not being informed.	80.00%	78.95%
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	18.18%	2 out of 11 IHAs were seen within 28days of the child be placed in care. Of the remaining 9 IHAs there was an average delay of 22days from becoming Children in Care to the service being notified. The greatest delay being 76 days and the shortest delay 9 days.	25.00%	10.53%

1 S-apcb6 – Admission Prevention Beds - % Collections within 10 working days

a) Current Position
96.24% against a 98% target
This relates to 1 patient out of 21 in the month. The management plan was agreed within 24hours 7 minutes of the patient being admitted.

b) Recommended Actions
- There is no recommended action as this is an exceptional case. This palliative patient was a step-up and a complex case.

2 D2-ltc4 –COPD rehabilitation programme - % complete a COPD rehabilitation programme within 18weeks of referral

a) Current Position
85.71% against a 95% target
This relates to 1 patient out of 7 who completed in the month. A class had to be cancelled due to high levels of staff sickness

B Recommended Actions
- Review minimum staffing arrangements for classes.
- Future exploration of staffing across acute and community

3 C-gen8 –Community Equipment Service, collections and deliveries

a) Current Position
C-gen8 – delivery within 4 hours – 92.17% against a 98% target
This relates to 17 deliveries out of 217. All items were delivered within 7 hours of being ordered. This was for 8 Service Users and the delay was the office had not issued the jobs to the technicians in an appropriate time to be completed within the target. The main factor in this was due to lack of staff due to absence.

C-gen8 - delivery within 10 working days – 97.98% against a 98% target
This relates to 11 deliveries out of 544. 9 of these deliveries were made within 11 days of being ordered. This was for 9 Service Users. The delay for these orders was due to capacity and route changes. All of the routes have been changed and it took some of the Technicians longer to complete their work than expected so causing a knock-on effect for the following day. This resulted in some work not being completed on the day it was originally booked for.

C-gen9 – collection by next working day – 97.66% against a 98% target
This relates to 4 items out of 171 collections outside the next day time limit. These 4 collections were from a repair replace where the equipment was not collected at the time of the repair. This was due to the equipment still being in use. 4 of these collections were for BED755 where the users were still in the bed. The new mattress was set up and ready for when the patient could be moved. This does happen on occasions where carers are needed to transfer the patient

b) Recommended Actions
- Explore the possibility of joint visits with clinical staff
- Request has been made to review the routes used and time allocated to drivers.

4 **S-Wchair1 – Wheelchair Frist appointments - % of first appointments/contact within 6 weeks of high need user referrals**

a) Current Position
0% against a 100% target
This relates to one high need user out of 1 referral who breached the 6 week target.
The patient was in hospital and so the service was unable to book an appointment.

b) Recommended Actions

- No recommended action as this patient was in hospital

5 **S-disch2 – Urgent discharge within24 hours - % Urgent discharge achieved (<24 hours from referral to the team) for Service Users terminally ill and wishing to die at home**

a) Current Position

66.67% against a 85% target
There were 5 referrals to the service in August:
2 were excluded as awaiting care packages to be arranged.
Of the other 3 referrals:
2 patients were discharged within 24 hours of referral and 1 patient died in hospital 48hours after a delay in the equipment being ordered as awaiting the report from the home visit.

b) Recommended Action

- Continue to monitor to ensure that the delays are not due to our service provision

6 **S-SALT1 & SALT2 – Adult Speech and Language**

a) Current Position

S-salt1 – new referrals triaged within 5 working days – 97.73% against a 98% target
This relates to 3 out of 132 referrals. All referrals were triaged by day 9
S-Salt2 – Priority 1 patients seen within 10 working days – 75% against 100% target
This relates to 2 out of 8 referrals; both patients were seen within 17 working days
S-salt2 – Priority 2 patients seen within 20 working days – 46.00% against 95% target
This relates to 49 out of 90 referrals.

b) Recommended Action

- As the service is due to disaggregate East and West we will review the staffing levels and skill mix to deliver this service
- There are ongoing staff vacancies so looking to implement rotational posts

7 18 week RTT Cons led Paediatric Services – % of patients treated within 18weeks of referral for consultant led Paediatric Service

a) Current Position

94.74% against a 95% target
28 out of 30 children were seen within 18weeks in the East and 26 out of 27 children were seen within 18weeks in the West. Of the 3 breaches 2 were patient choice where a later appointment date was chosen due to holiday or unavailability.

b) Recommended Action

- continue to monitor clinic capacity
- review process of how appointment dates are assigned

8 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 – 90.91% against a 100% target
CiC-001b – 81.82% against a 100% target
CiC -001a –18.18% against a 100% target

11 Initial Health Assessments were completed in August. 2 were completed within 28 days of becoming CiC, and 9 were completed within 28 days of the service receiving ALL the paperwork and 10 appointments were offered within 28 days. Of the 2 appointments outside the 28 day deadline (39 days and 50 days) One was due to a delay as the CiC team requested more

information before booking the child in and the other was due to the child moving to the West and the CiC team not being informed. Overall 2 out the 11 assessments were completed within 28days of the child becoming CiC, there was an average delay of 22 days from the child becoming CiC and the service being notified and the longest delay being 76 days and the shortest delay 9 days.

b) Recommended Action

- Social Care are working on improving their systems to enable timely sharing of their information, there has been recent improvement in the sharing of info but it is not at the required level yet. A regular performance meeting has been set up with the Associate Director and the Social Care manager.
- A meeting has been arranged to review the pathway for Children in Care with the commissioners, Suffolk County Council and the Executive Chief Nurse on 28th September.
- The Associate Director has meet with the CiC service leads responsible for booking the CiC Initial Health Assessments for Waveney and Norfolk to compare processes and share good practice.

Quality Dashboard

	Units	Target	Red	Amber	Green	Feb	Mar	Apr	May	Jun	Jul	Aug
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				158	137	132	145	397	136	74
	%	85%	<80%	80%-85%	>=85%	96%	93%	94%	93%	93.63%	96.00%	100.00%
Service users who felt 'well informed'	Nos.	No Target				200	177	198	159	509	193	121
	%	85%	<80%	80%-85%	>=85%	91%	94%	96%	94%	95.50%	96.00%	98.00%
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				33	48	30	47	40	56	39
Rolls out of Bed		No Target				5	1	1	4	4	1	4
Slip out of chair		No Target				3	5	0	4	2	3	0
Assisted Falls/ near misses		No Target				3	6	1	4	1	5	0
% of total falls resulting in harm	%	No Target				24%	23%	32%	23%	38%	39%	28%
Numbers of falls resulting in moderate harm	Nos.	No Target				0	1	0	0	1	0	0
Numbers of falls resulting in severe harm	Nos.	No Target				0	1	0	0	0	0	0
Numbers of patients who have had repeat falls	Nos.	No Target				7	8	6	9	8	8	4
% of RCA reports for repeat fallers	%	100%	90%-95%	95%-100%	=100%	100%	100%	100%	100%	100%	100%	100%
Numbers of falls per 1000 bed days (* includes Hazel Crt falls)		<1.25/1000 beddays	>1.50	1.25-1.50	<=1.25	10.5*	13.8*	8.96	13.96	12.5	16.47	11.4
Pressure Ulcers												
Pressure Ulcers – In Our Care Community												
Grade 2		100 pa	>110	100-110	<=100	31	27	34	32	27	26	37
Grade 3		26 pa	>30	27-29	<=26	13	10	6	8	7	9	5
Grade 4		0 pa	>1	1	0	1	2	1	0	1	2	1
Pressure Ulcers – In our care In-patient												
Grade 2		13 pa	>17	13-17	<=13	3	4	0	3	3	4	2
Grade 3		2 pa	>4	02-Apr	<=2	1	0	1	0	0	0	1
Grade 4		0 pa	>1	1	0	0	0	0	0	0	0	0
Safeguarding People Who Use Our Services From Abuse												
Number of adult safeguarding referrals made		No Target				2	3	2	4	1	3	3
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				100%	100%	100%	100%	100%	100%	100%

	Units	Target	Red	Amber	Green	Feb	Mar	Apr	May	Jun	Jul	Aug
MRSA												
Bacteraemia – Number of cases		0	>2	>0 to 2	=0	0	0	0	0	0	0	0
MRSA RCA reports		100%	<95%	95%-100%	=100 %	0	0	0	0	0	0	0
Clostridium Difficile												
C.Diff number of cases		4 for 6 months	>4 YTD		<=4 YTD	0	0	0	0	0	0	1
C.Diff associated diseases (CDAD) RCA reports		100%	<95%	95%-100%	=100 %	N/A	N/A	N/A	N/A	N/A	N/A	100%
Infection Control												
Infection control training		100%	<83%	83%-100%	=100 %	85.99%	89.70%	86.51%	91.80%	91.80%	89.10%	87.91%
Essential Steps Care Bundles Including Hand Hygiene												
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	99.00%	98.00%	99.00%	99.00%	99.00%	98.70%	98.00%
Isolation room audit		100%	<95%	95%-100%	=100 %	N/A	100%	100%	100%	100%	100%	100%
Management of Medication -SCH NRLS Reportable Incidents												
Total number of medication incidents in month		No Target				18	25	19	17	18	13	10
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				16	20	15	12	13	13	9
(also includes those not attributed to SCH management)	Low harm	No Target				2	5	3	5	5	0	1
Number of medication incidents involving Controlled Drugs		No Target				7	5	1	0	2	1	1
Incidents												
NRLS (i.e. patient safety) reportable incidents in month		No Target				223	229	199	242	185	211	196
Number of Never Events in month		No Target				0	0	0	0	0	0	0
Number of Serious Incidents (SIs) that occurred in month		No Target				15	12	8	8	9	12	7
Number of SIs reported to CCG in month *4 STEIS for 2 pts (2 each)		No Target				17	17*	7	9	9	9	10
Percentage of SI reports submitted to CCG on time in month		No Target				100%	100%	100%	100%	100%	100%	100%
Duty of Candour Applicable Incidents		No Target				13	16	8	9	9	8	10
Severity of NPSA Reportable Incidents												
None		No Target				122	145	131	163	108	140	124
Low		No Target				87	69	58	70	68	58	65
Moderate		No Target				13	11	8	9	8	11	6
Major		No Target				1	4	1	0	1	2	1
Catastrophic		No Target				0	0	0	0	0	0	0
Training Compliance												
Adult Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	95.59%	96.74%	96.02%	96.24%	96.77%	96.60%	96.20%
Children Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	95.86%	96.92%	96.11%	96.41%	96.94%	96.90%	97.06%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	92.57%	94.34%	94.81%	95.30%	96.10%	96.40%	96.72%
WRAP						51.73%	67.33%	64.48%	66.82%	69.19%	72.20%	73.49%
MCA / DoLs- Training compliance						68.46%	67.33%	73.59%	82.33%	83.27%	84.40%	86.60%

Compliments/Complaints

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun*	Jul	Aug
Total compliments	46	21	38	28	36	27	61	50	46	44	36	56	47
Formal complaints (No.)	5	1	1	2	2	3	5	1	1	2	3	2	0
Acknowledged within 3 working days (No.)	4	1	1	1	2	3	5	1	1	1	2	2	0
Acknowledged within 3 working days (%)	80%	100%	100%	50%	100%	100%	100%	100%	100%	50%	67%	100%	-
Responded to within 25 working days (No.)	2	0	1	1	0	2	0	1	1	2	0	1	-
Responded to within 25 working days (%)	40%	0%	100%	50%	0%	67%	0%	100%	100%	100%	0%	50%	-
Responded to outside 25 working days (No.)	3	1	0	1	2	1	5	0	0	0	3	1	-
Responded to outside 25 working days (%)	60%	100%	0%	50%	100%	33%	100%	0%	0%	0%	100%	50%	-
Complaints upheld (No.)	2	1	-	-	-	1	2	1	1	1	TBC	-	-
Complaints partially upheld (No.)	2	-	-	-	-	-	3	-	-	-	1	1	-
Complaints not upheld (No.)	1	-	1	2	2	2	-	-	-	1	1	1	-
Average response time (days)	32.8	31.0	19.0	36.5	38.5	24.0	28.0	7.0	7.0	22.5	39.0	27.5	-

** 1 complaint from June still pending resolution*

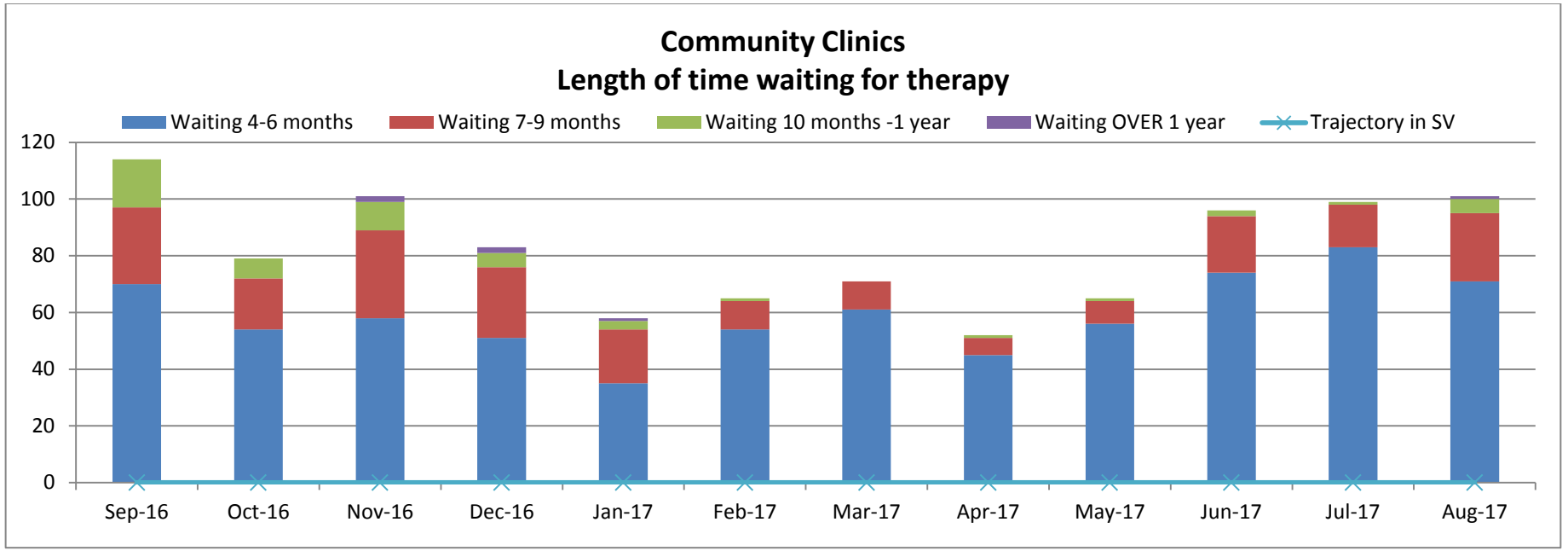
Paediatric Speech and Language Service Waiting times

Community Clinics

Clinic Waiting lists

Reports run 04/9/17

Length of wait Community Clinics *(pre-school caseload)*	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	No. of children waiting July 2017	No. of children waiting August 2017
Waiting up to 3 months	156	151	176	158	176	165	162	166	154	156	150	101
Waiting 4-6 months	70	54	58	51	35	54	61	45	56	74	83	71
Waiting 7-9 months	27	18	31	25	19	10	10	6	8	20	15	24
Waiting 10 months -1 year	17	7	10	5	3	1	0	1	1	2	1	5
Waiting OVER 1 year	0	0	2	2	1	0	0	0	0	0	0	1
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**270**	**230**	**277**	**241**	**234**	**230**	**233**	**218**	**219**	**252**	**249**	**202**
Already had PoC	72	75	67	72	55	60	85	53	51	73	86	67
Total waiting ***(Including patients who have already receive 1 POC and are waiting for another)***	**342**	**305**	**344**	**313**	**289**	**290**	**318**	**271**	**270**	**325**	**335**	**269**

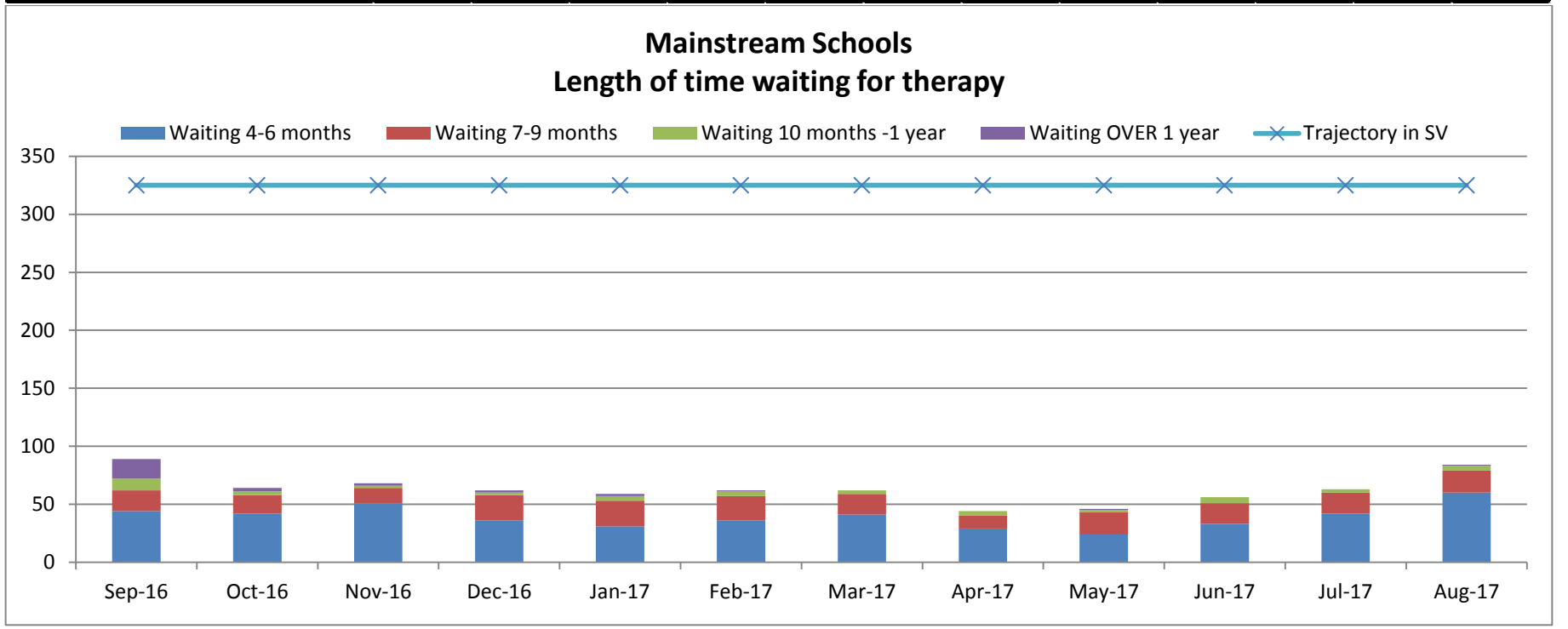


Mainstream Schools

Schools Waiting lists

No waiting data by months prior to May

Length of wait Mainstream Schools *(pre-school caseload)*	No. of children waiting 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	No. of children waiting June 2017	No. of children waiting August 2017
Waiting up to 3 months	88	72	68	59	56	56	73	87	89	84	113	100
Waiting 4-6 months	44	42	51	36	31	36	41	29	24	33	42	60
Waiting 7-9 months	18	16	13	22	22	21	18	11	19	18	18	19
Waiting 10 months -1 year	10	3	2	2	4	4	3	4	2	5	3	4
Waiting OVER 1 year	17	3	2	2	2	1	0	0	1	0	0	1
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**177**	**136**	**136**	**121**	**115**	**118**	**135**	**131**	**135**	**140**	**176**	**184**
Already had PoC	395	377	392	332	277	266	248	210	194	253	759	739
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*	**572**	**513**	**528**	**453**	**392**	**384**	**383**	**341**	**329**	**393**	**935**	**923**



Board of Directors – 29th September 2017

AGENDA ITEM:	9
PRESENTED BY:	Craig Black, Executive Director of Resources
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
DATE PREPARED:	22 September 2017
SUBJECT:	August Board report
PURPOSE:	Review

EXECUTIVE SUMMARY:

The reported I&E for August 2017 is a deficit of £5k (YTD £3,301k), against a planned deficit of £10k (YTD £3,260k) This results in a favourable variance of £15k (YTD £41k adverse).

We are therefore on plan to achieve our control total this year, which will mean we also receive STF funding of £5.2m. Therefore £1,569k of this funding is included in the August 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 forecast to £14.4m.

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

August 2017 (Month 5)

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

Financial Summary

I&E Position YTD	£3.3m	loss
Variance against plan YTD	£0.0m	
Movement in month against plan	£0.0m	
EBITDA position YTD	-£0.2m	deficit
EBITDA margin YTD	-0.7%	deficit
Cash at bank	£3,368k	

Executive Summary

- The Month 5 YTD position is £41k behind plan.

Key Risks

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

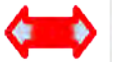
SUMMARY INCOME AND EXPENDITURE ACCOUNT - August 2017	Aug-17 Budget £m	Aug-17 Actual £m	Aug-17 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance £m
NHS Contract Income	18.6	18.7	0.1	92.8	92.8	0.0	223.6	223.3	(0.3)
Other Income	2.6	3.2	0.5	11.1	12.6	1.5	26.2	28.3	2.1
Total Income	**21.3**	**21.9**	**0.6**	**103.8**	**105.3**	**1.5**	**249.8**	**251.6**	**1.8**
Pay Costs	12.0	12.2	(0.1)	60.5	60.2	0.2	144.8	144.8	0.0
Non-pay Costs	9.0	9.5	(0.5)	45.8	47.4	(1.6)	107.4	109.2	(1.8)
Operating Expenditure	**21.1**	**21.7**	**(0.6)**	**106.3**	**107.7**	**(1.4)**	**252.2**	**254.0**	**(1.8)**
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**	**(2.4)**	**(2.3)**	**0.1**	**(5.0)**	**(5.0)**	**0.0**
EBITDA margin	2.1%	2.6%	0.5%	(0.9%)	(0.7%)	0.2%	0.1%	0.1%	0.0%
Depreciation	0.4	0.4	(0.1)	1.6	1.8	(0.2)	4.7	4.7	0.0
Finance costs	0.1	0.2	(0.1)	0.7	0.8	(0.1)	1.4	1.4	0.0
SURPLUS/(DEFICIT) pre S&TF	**(0.3)**	**(0.3)**	**(0.1)**	**(4.7)**	**(4.9)**	**(0.1)**	**(11.1)**	**(11.1)**	**0.0**
S&T funding - Financial Performance	0.2	0.2	0.1	1.0	1.1	0.1	3.6	3.6	0.0
S&T funding - A&E Performance	0.1	0.1	0.0	0.4	0.5	0.0	1.6	1.6	0.0
SURPLUS/(DEFICIT) incl S&TF	**(0.0)**	**0.0**	**0.0**	**(3.3)**	**(3.3)**	**(0.0)**	**(5.9)**	**(5.9)**	**0.0**

FINANCE AND WORKFORCE REPORT – August 2017

Contents:

Key:

Performance better than plan and improved in month	
Performance better than plan but worsened in month	
Performance worse than plan but improved in month	
Performance worse than plan and worsened in month	

Performance better than plan and maintained in month	
Performance worse than plan and maintained in month	
Performance meeting target	✓
Performance failing to meet target	X

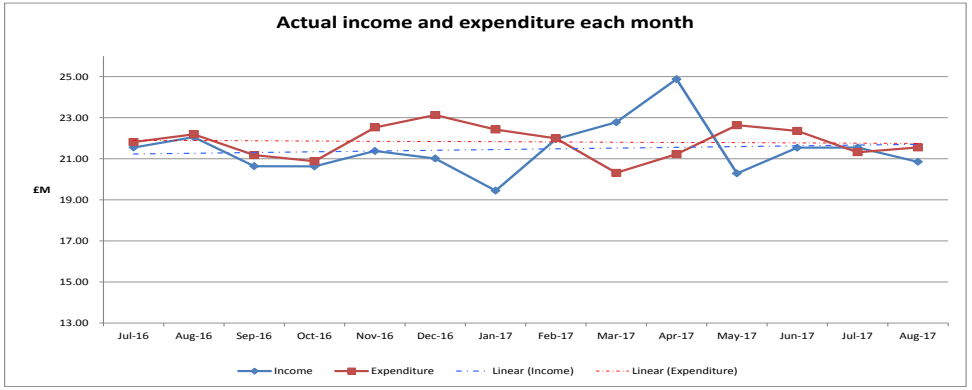
FINANCE AND WORKFORCE REPORT – August 2017

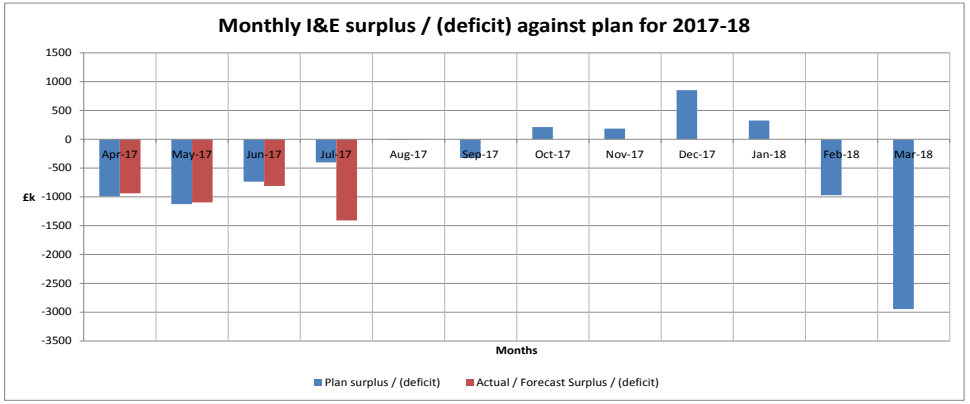
Income and Expenditure summary as at August 2017

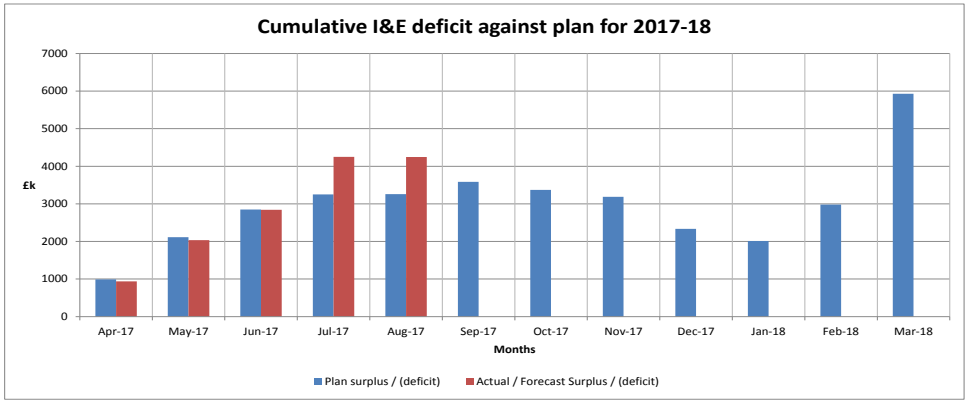
The reported I&E for August 2017 YTD is a deficit of £3,301k, against a planned deficit of £3,260k. This results in an adverse variance of £41k YTD.

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)	(10)	5	15	↑	Green
YTD surplus / (deficit)	(3,260)	(3,301)	(41)	↓	Green
Forecast surplus / (deficit)	(5,928)	(5,928)	0	↔	Green
EBITDA YTD	(965)	(749)	216	↑	Green
EBITDA (%)	(0.9%)	(0.7%)	0.2%	↑	Amber
Use of Resources (UoR) Rating fav / (adv)	3	3	0	↔	Amber
Clinical Income YTD	(92,754)	(92,769)	14	↑	Green
Non-Clinical Income YTD	(12,565)	(14,147)	1,582	↑	Green
Pay YTD	60,447	60,225	221	↓	Green
Non-Pay YTD	48,132	49,991	(1,859)	↑	Amber
CIP target YTD	(4,951)	(4,936)	(15)	↓	Green







FINANCE AND WORKFORCE REPORT – August 2017

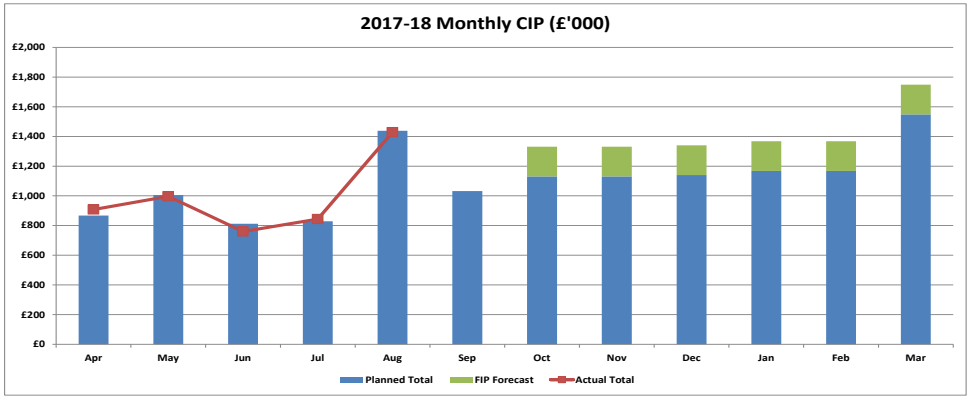
Cost Improvement Programme (CIP)

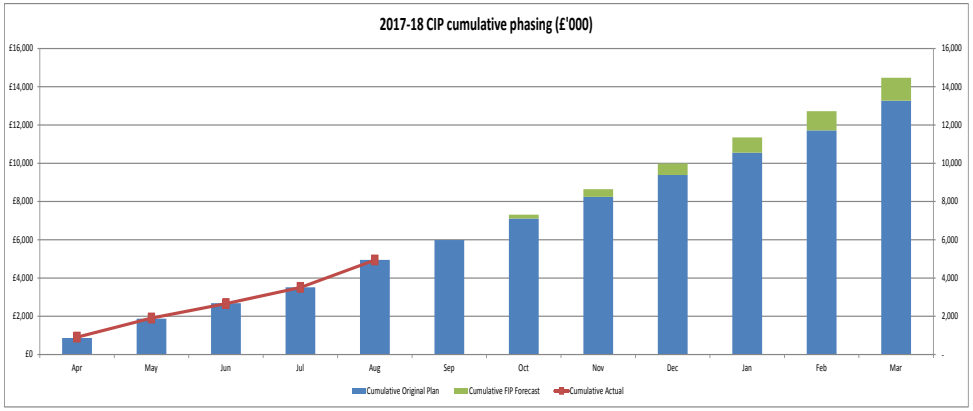
The August position includes a target of £4,951k YTD which represents 37% of he 2017-18 plan. There is currently a shortfall of £15k YTD against this plan.

The plan has been rephased to recognise non-recurring CIP arising in August, as well as phasing the GDE funding from August 2017 to March 2018

Recurring/Non Recurring	Summary	2017-18 Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Activity growth	297	109	57
	Car Park Income	400	167	7
	Other Income	167	63	82
	Consultant Staffing	326	101	92
	Additional sessions	192	80	37
	Staffing Review	2,722	790	1,154
	Agency	482	201	115
	Procurement	1,801	583	405
	Community Equipment Service	465	167	48
	Contract review	8	3	5
	Drugs	326	58	117
	Capitalisation	480	200	110
	Other	2,025	958	979
Recurring Total		**9,690**	**3,480**	**3,207**
Non-Recurring	Activity growth	300	300	300
	Other Income	19	8	10
	Additional sessions	10	4	25
	Staffing Review	20	8	-
	Contract review	41	17	17
	Estates and Facilities	389	162	162
	Non-Recurring	396	396	396
	Capitalisation	350	175	250
	Other	403	195	362
	GDE revenue	1,650	206	206
Non-Recurring Total		**3,579**	**1,472**	**1,729**
Grand Total		**13,269**	**4,951**	**4,936**

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



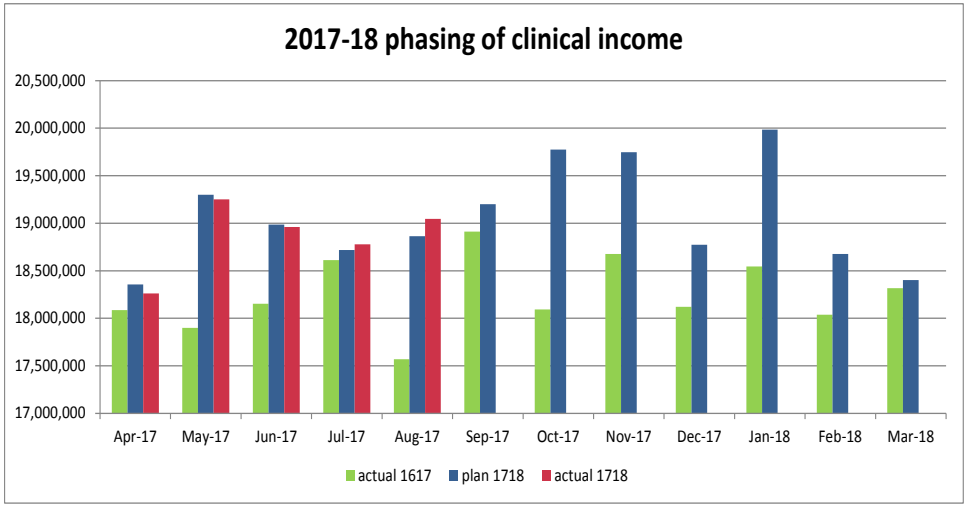


In order to deliver the Trusts pre-STF control total of £7.7m deficit in 2018-19 we need to deliver a CIP of £18.3m (6%). We are working with KPMG to identify and implement schemes to ensure a robust plan is in place. Divisions are being tasked with achieving 2% with 'local schemes' whilst cross-cutting schemes as identified by KPMG (incl FYE of 17-18 schemes) will deliver the balance. More details will be included in the October Board report.

FINANCE AND WORKFORCE REPORT – August 2017

Income Analysis

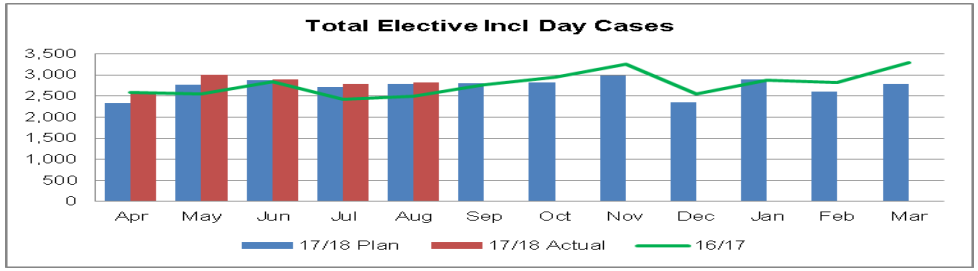
The chart below summarises the phasing of the clinical income plan for 2017-18, including a full year for Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.

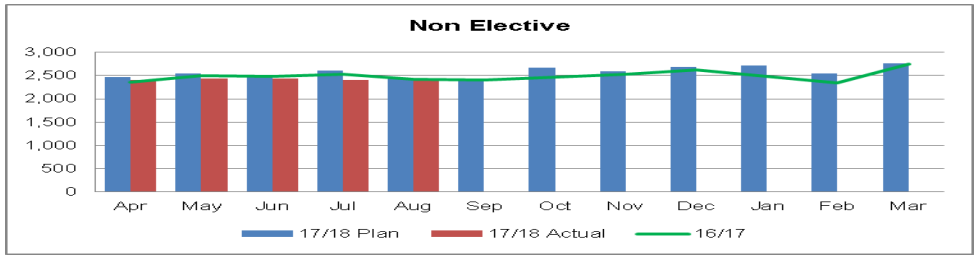


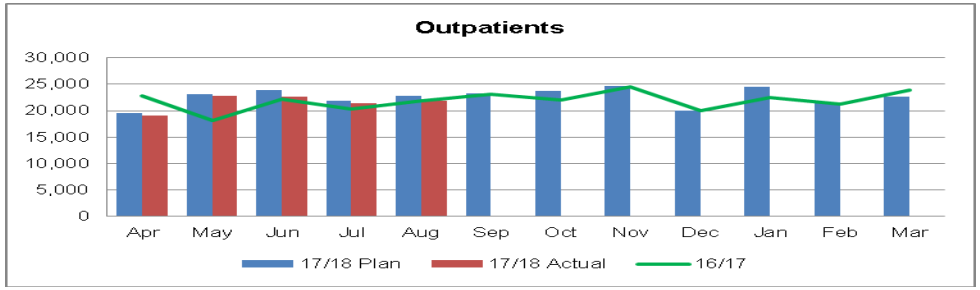
The income position was slightly behind plan in August. The main areas of underperformance were within critical care and maternity bookings, with Non Elective activity increasing in month.

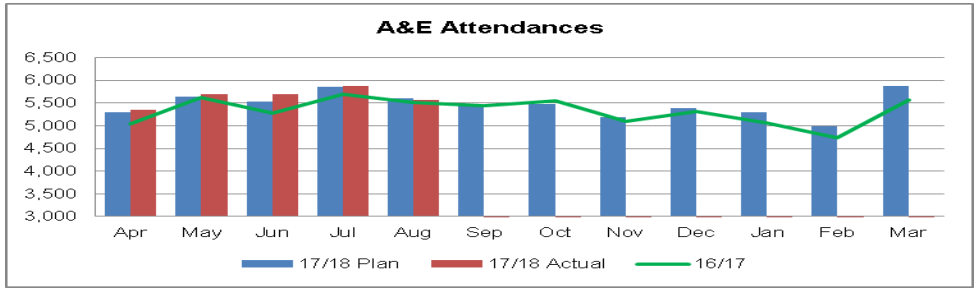
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	694	721	26	3,463	3,590	127
Other Services	2,259	1,848	(411)	12,123	10,970	(1,153)
CQUIN	298	306	9	1,481	1,499	18
Elective	2,686	2,727	42	12,898	13,693	796
Non Elective	4,843	5,537	694	24,989	25,952	964
Emergency Threshold Adjustment	(293)	(431)	(137)	(1,448)	(1,786)	(339)
Outpatients	2,739	2,615	(123)	13,351	12,954	(397)
Community	5,379	5,379	0	26,897	26,897	0
Total	**18,604**	**18,703**	**99**	**93,754**	**93,769**	**14**

Activity, by point of delivery



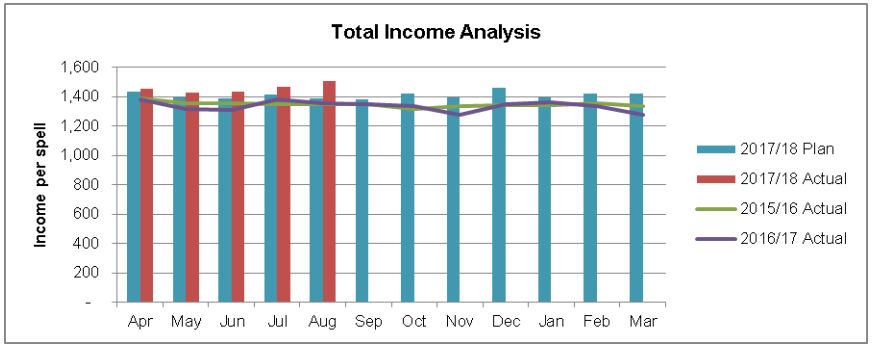


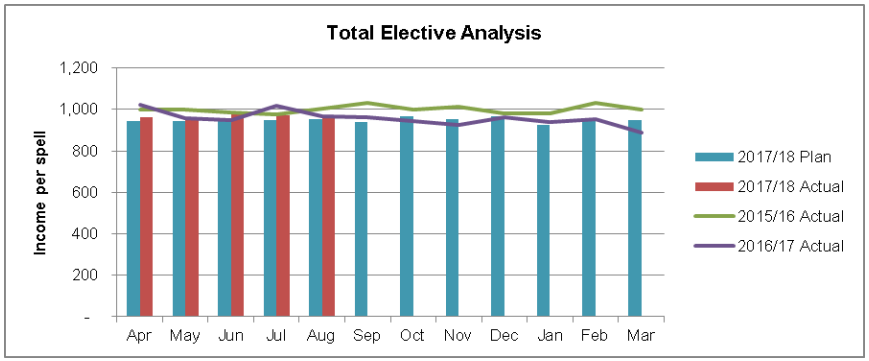


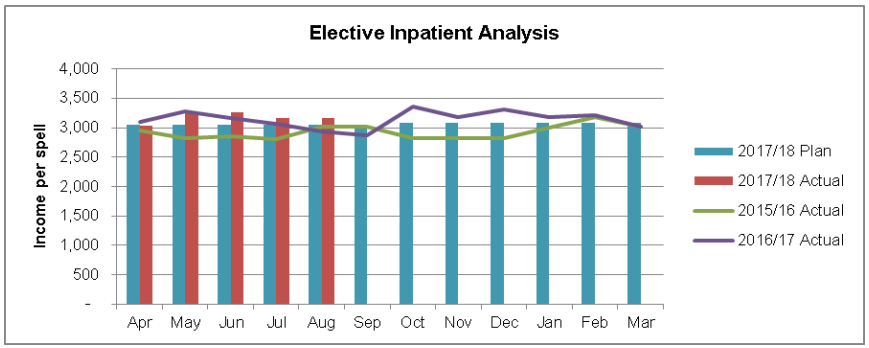


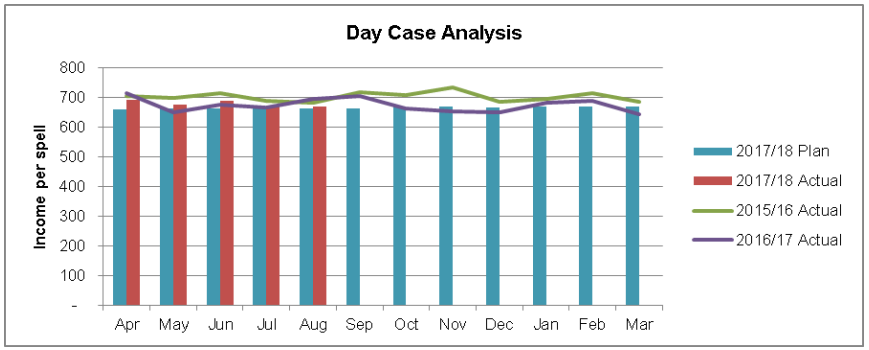
FINANCE AND WORKFORCE REPORT – August 2017

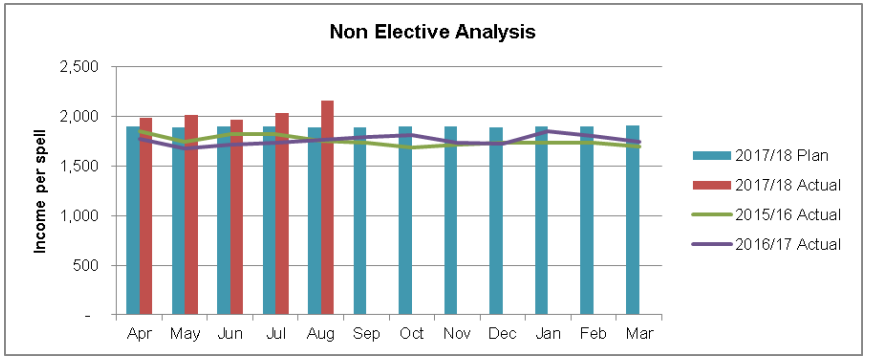
Trends and Analysis

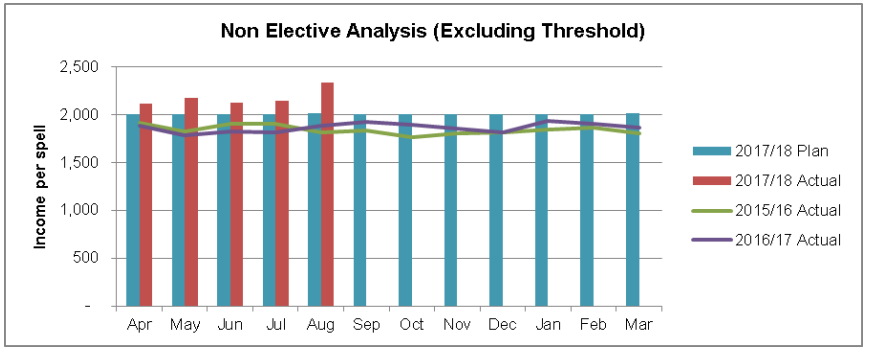












FINANCE AND WORKFORCE REPORT – August 2017

Workforce

Monthly Expenditure Acute services only				
As at August 2017	Aug-17	Jul-17	Aug-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,917**	**10,812**	**10,498**	**54,834**
Substantive Staff	9,798	9,517	9,429	48,484
Medical Agency Staff (includes 'contracted in' staff)	114	130	276	656
Medical Locum Staff	233	251	145	1,110
Additional Medical sessions	373	288	270	1,386
Nursing Agency Staff	(2)	74	175	290
Nursing Bank Staff	178	206	247	929
Other Agency Staff	91	88	188	346
Other Bank Staff	137	166	128	709
Overtime	88	73	83	448
On Call	55	44	59	260
Total temporary expenditure	1,266	1,322	1,570	6,134
Total expenditure on pay	**11,064**	**10,838**	**10,999**	**54,618**
Variance (F/(A))	(148)	(27)	(500)	217
Temp Staff costs % of Total Pay	11.4%	12.2%	14.3%	11.2%
Memo : Total agency spend in month	203	292	639	1,292

Monthly whole time equivalents (WTE) Acute Services only			
As at August 2017	Aug-17	Jul-17	Aug-16
	WTE	WTE	WTE
Budgeted WTE in month	**2,992.9**	**2,999.0**	**3,037.3**
Employed substantive WTE in month	**2751.1**	**2718.5**	**2,679.0**
Medical Agency Staff (includes 'contracted in' staff)	7.9	8.24	19.6
Medical Locum	14.35	18.86	17.6
Additional Sessions	29.37	25.06	21.5
Nursing Agency	4.11	11.47	27.6
Nursing Bank	59.07	67.23	80.1
Other Agency	20.36	16.63	40.5
Other Bank	67.79	79.36	70.8
Overtime	40.52	34.59	42.3
On call Worked	8.87	7.59	10.5
Total equivalent temporary WTE	**252.3**	**269.0**	**330.4**
Total equivalent employed WTE	**3,003.4**	**2,987.5**	**3,009.5**
Variance (F/(A))	(10.5)	11.4	27.8
Temp Staff WTE % of Total Pay	8.4%	9.0%	11.0%
Memo : Total agency WTE in month	32.4	36.3	87.7
Sickness Rates (July/June)	2.54%	2.50%	3.81%
Mat Leave	2.4%	2.0%	2.0%

Monthly Expenditure Community Service				
As at August 2017	Aug-17	Jul-17	Aug-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,125**	**1,123**	**1,014**	**5,612**
Substantive Staff	1,053	1,029	998	5,243
Medical Agency Staff (includes 'contracted in' staff)	14	12	0	66
Medical Locum Staff	3	3	7	16
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	0	0	0	3
Nursing Bank Staff	14	12	1	68
Other Agency Staff	26	32	1	131
Other Bank Staff	10	13	5	51
Overtime	6	4	1	23
On Call	1	1	1	6
Total temporary expenditure	74	78	15	364
Total expenditure on pay	**1,127**	**1,107**	**1,014**	**5,608**
Variance (F/(A))	(3)	17	(6)	4
Temp Staff costs % of Total Pay	6.6%	7.0%	1.5%	6.5%
Memo : Total agency spend in month	40	44	1	200

Monthly whole time equivalents (WTE) Community Services			
As at August 2017	Aug-17	Jul-17	Aug-16
	WTE	WTE	WTE
Budgeted WTE in month	**375.25**	**375.21**	**335.0**
Employed substantive WTE in month	**349.7**	**347.3**	**316.1**
Medical Agency Staff (includes 'contracted in' staff)	0.9	0.9	0.0
Medical Locum	0.4	0.4	0.4
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.1	0.1	0.5
Nursing Bank	4.2	4.0	0.8
Other Agency	7.1	7.7	9.3
Other Bank	3.1	3.5	3.2
Overtime	3.1	2.1	2.8
On call Worked	0.0	0.0	0.0
Total equivalent temporary WTE	**18.7**	**18.8**	**17.1**
Total equivalent employed WTE	**368.4**	**366.0**	**333.2**
Variance (F/(A))	6.9	9.2	1.8
Temp Staff WTE % of Total Pay	5.1%	5.1%	5.1%
Memo : Total agency WTE in month	8.0	8.7	9.9
Sickness Rates (August /July)	3.84%	2.88%	3.82%
Mat Leave	1.3%	1.1%	1.3%

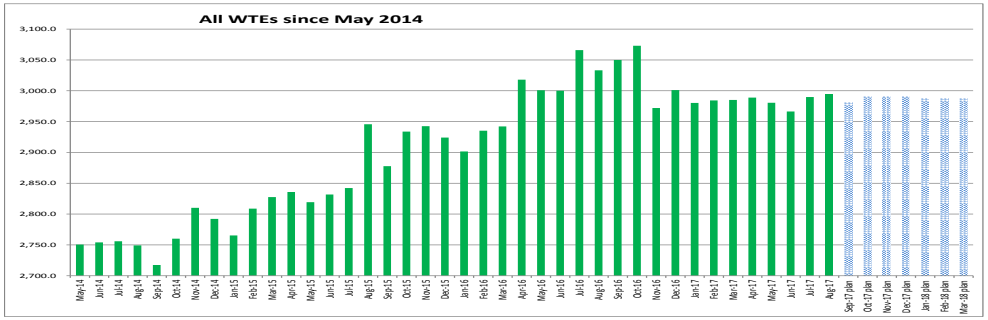
* Note the Acute tables includes Collaborative Procurement Hub staff on WSH Contracts
* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

FINANCE AND WORKFORCE REPORT – August 2017

Staffing levels

The following graphs exclude Community staff but include Capitalised staff. They have been rebased to reflect hours worked by junior doctors before the new junior doctors contractt was implemented.

The planned establishment from September 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 August we employed 10.5 WTE more than planned and 6.1 WTE less than in August 2016.

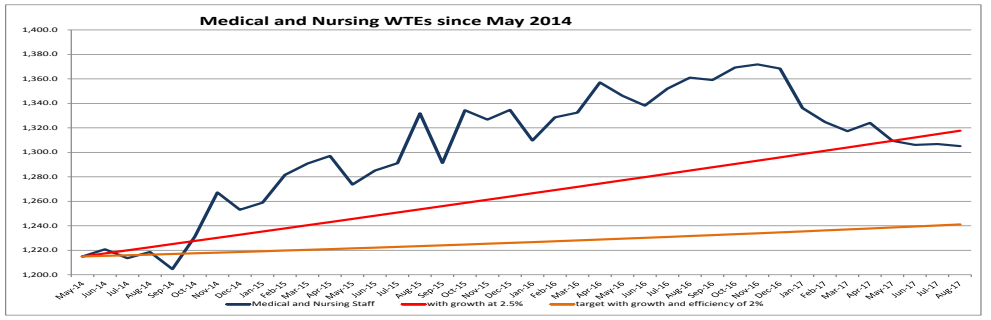


Since May 2014, (excluding Community staff) the Trust has employed 251 more WTEs, an increase of 7.9%. During this same period activity has grown by around 7.5%

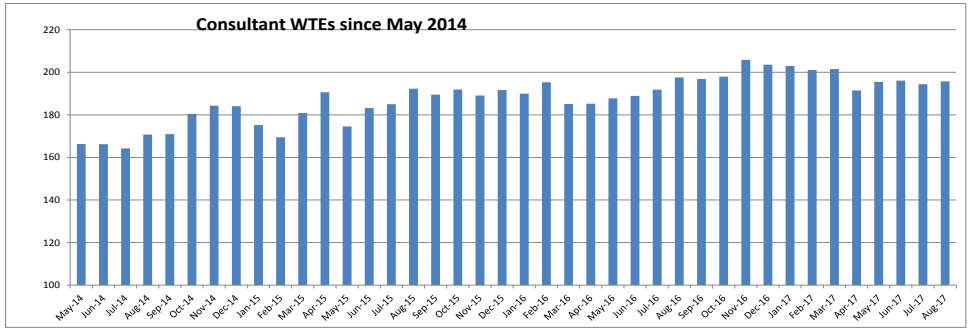
The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 91 WTEs (blue line). This includes around 30 WTE Consultants which are analysed further below.

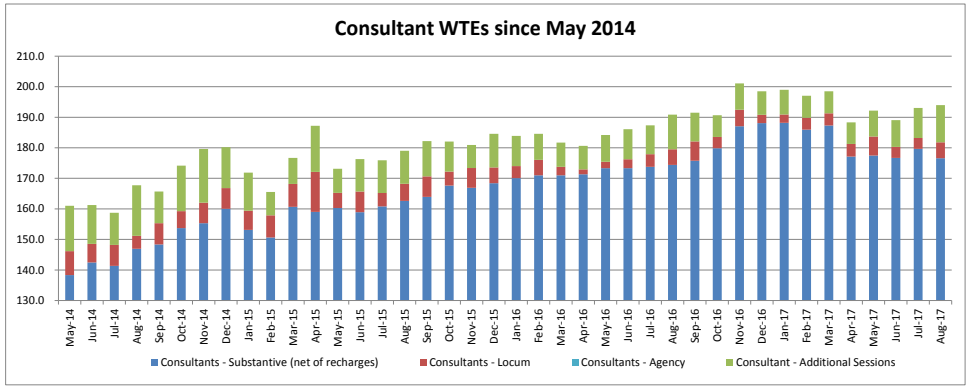
There has been an decrease of 1.7 WTE during August. Medical staffing have increased by 27.1 WTE since April 2017, largely as the result of increases in additional sessions and junior doctors (7 WTE F1 and 7 WTE F2) These increases include replacing locums and reducing additional sessions, but further analysis is being undertaken to ascertain the full benefits of these extra 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 12.0 more WTEs (red line). In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 64 WTE fewer than at August 2017

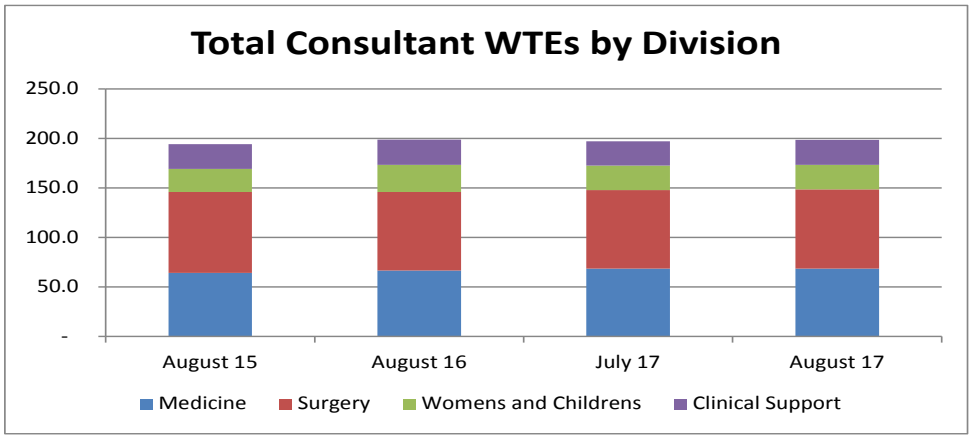


The graphs below highlight the increase in Consultant WTEs of 18% over the past 3 years. Substantive staff have increased by 7.4 WTEs whilst temporary staff have increased by 22.4 WTEs.





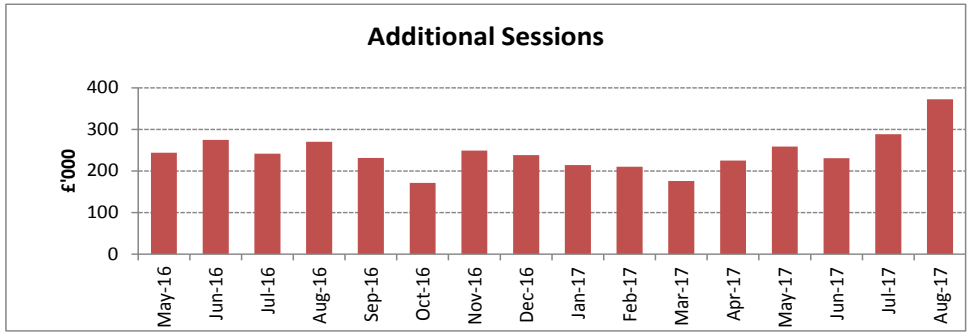
FINANCE AND WORKFORCE REPORT – August 2017

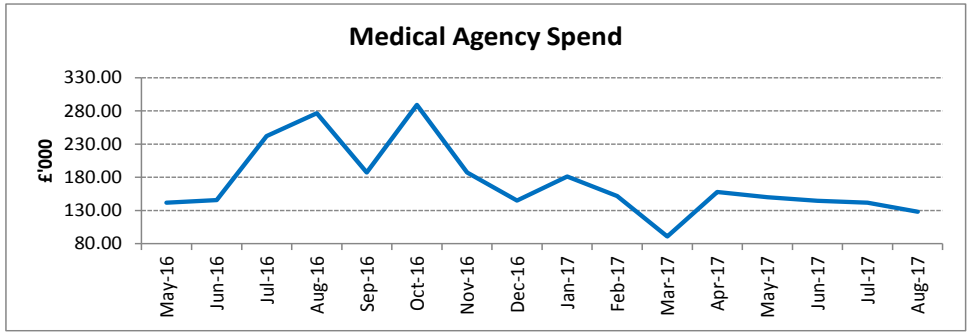


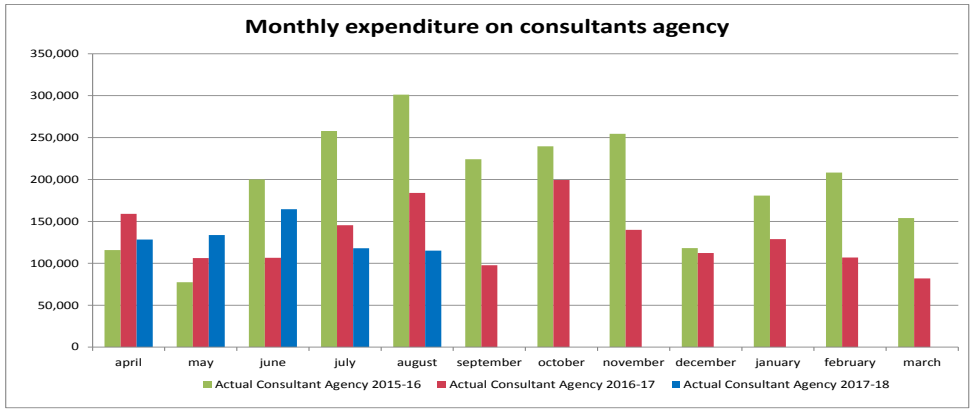
Division	Specialty	Sum of Jul-15	Sum of Jul-16	Sum of Jun-17	Sum of Jul-17	Sum of Aug-17
Medicine	A&E Medical Staff	5.9	6.4	7.7	8.1	8.2
	Cardiology	6.0	6.4	6.6	5.9	6.0
	Chest Medicine	4.0	4.0	4.4	4.0	4.0
	Chronic Pain Service	0.7	0.9	0.7	0.7	0.7
	Clinical Haematology	4.1	4.4	4.4	4.4	4.4
	Dermatology	5.0	4.8	4.0	5.0	3.5
	Diabetes	4.1	4.3	4.5	4.4	4.3
	Eau Medical Staff	8.8	7.4	8.5	7.2	9.6
	Gastroenterology	4.8	6.5	7.5	7.5	7.2
	General Medicine	7.0	6.7	4.5	5.8	4.6
	Nephrology	0.5	0.1	0.6	1.5	1.6
	Neurology	2.4	2.5	2.6	2.6	2.7
	Oncology	3.1	3.2	2.9	3.4	3.4
	Palliative Care	0.3	0.3	0.3	0.3	0.3
	Rheumatology	2.3	3.0	3.5	4.0	3.9
	Stroke	3.7	3.4	3.9	3.5	4.0
Medicine Total		**61.3**	**62.2**	**68.0**	**66.5**	**68.4**
Surgery	Anaesthetics	31.4	34.7	32.9	33.6	34.4
	E.N.T.	3.2	3.8	3.2	3.3	3.3
	General Surgery	12.1	11.1	9.8	9.8	9.8
	Ophthalmology	6.3	8.5	7.1	8.3	7.9
	Oral & Maxofacial Surg	1.1	1.0	1.0	0.0	0.0
	Plastic Surgery	3.1	1.9	4.1	3.0	2.3
	Trauma & Orthopaedic	13.4	13.4	13.7	14.2	14.7
	Urology	4.4	5.9	6.3	6.2	6.5
	Vascular Surgery	-	1.4	1.2	1.1	1.1
Surgery Total		**75.7**	**80.3**	**81.2**	**79.3**	**80.1**
Women and Childrens	Obstetrics	12.1	12.3	16.6	13.3	13.4
	Paediatrics	11.4	11.1	10.9	11.3	11.3
Women and Childrens Total		**23.9**	**23.9**	**23.7**	**27.5**	**24.7**
Clinical Support	Chemistry	0.6	0.7	0.8	-	0.6
	Histopathology	8.2	7.6	8.3	8.5	9.3
	Microbiology	3.3	3.3	3.2	3.2	3.2
	MRI	1.0	0.9	1.0	0.9	0.9
	Xray - Wsh	12.9	12.5	12.2	12.1	12.3
Clinical Support Total		**24.5**	**24.8**	**25.3**	**25.4**	**26.2**
Grand Total		**185.4**	**191.2**	**198.1**	**198.7**	**199.4**

Pay Trends and Analysis

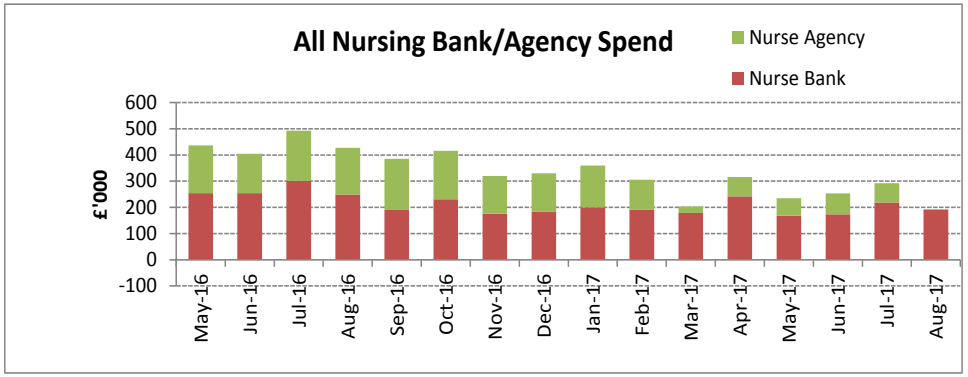
The Trust overspent pay budgets by £150k in August (£221k YTD).



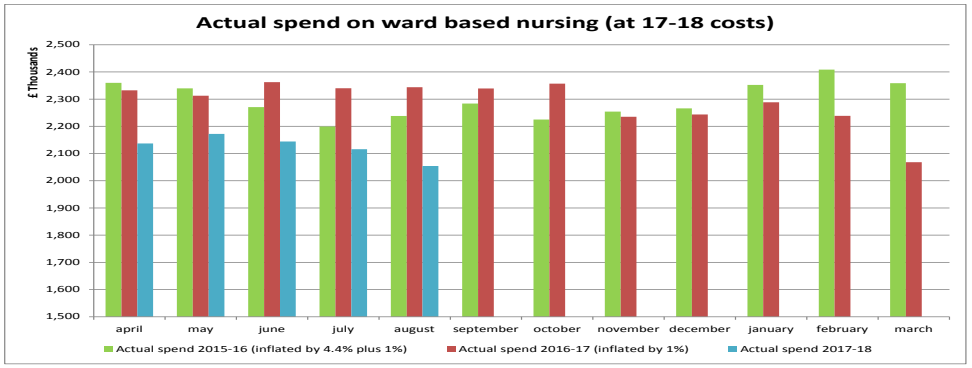


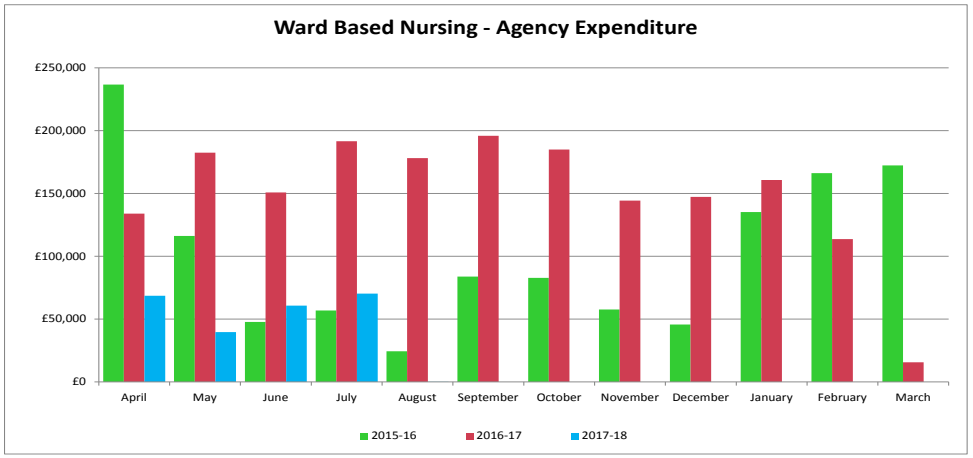


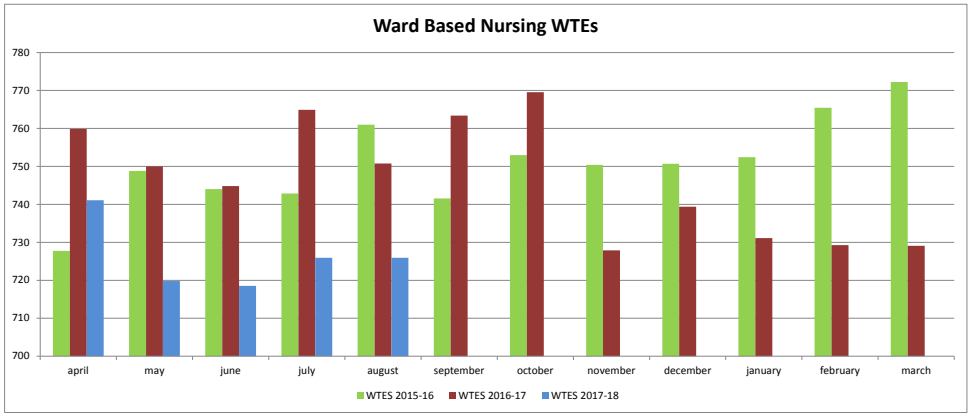
FINANCE AND WORKFORCE REPORT – August 2017

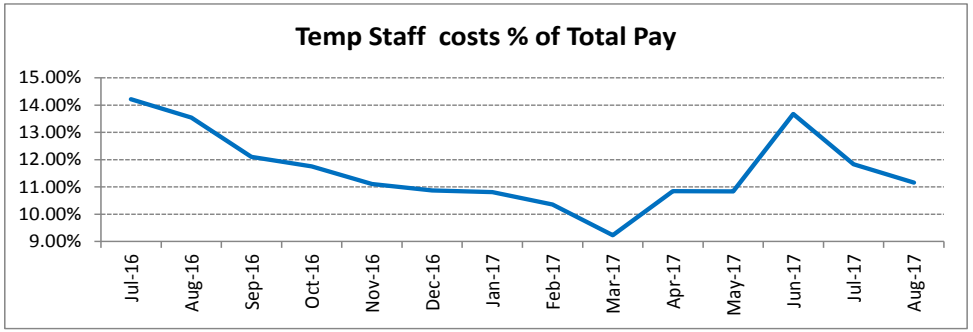


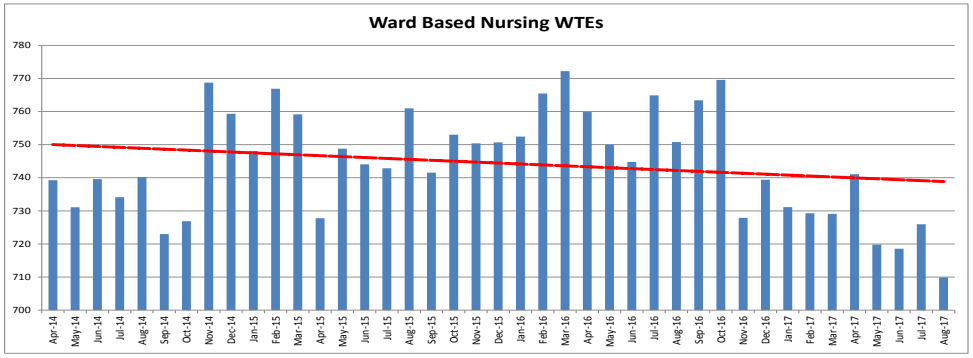
Ward Based Nursing











FINANCE AND WORKFORCE REPORT – August 2017

Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Aug-17 Budget £k	Aug-17 Actual £k	Aug-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	(5,567)	(5,655)	88	(27,177)	(27,470)	293
Pay Costs	3,378	3,392	(13)	16,942	16,905	37
Non-pay Costs	1,301	1,327	(26)	6,447	6,575	(129)
Operating Expenditure	**4,679**	**4,718**	**(39)**	**23,389**	**23,480**	**(91)**
SURPLUS / (DEFICIT)	**888**	**936**	**49**	**3,788**	**3,990**	**202**
SURGERY						
Total Income	(4,755)	(4,994)	238	(23,695)	(24,109)	414
Pay Costs	2,977	2,987	(10)	14,912	15,040	(127)
Non-pay Costs	1,080	1,211	(131)	5,220	5,471	(250)
Operating Expenditure	**4,057**	**4,198**	**(141)**	**20,133**	**20,510**	**(378)**
SURPLUS / (DEFICIT)	**698**	**796**	**98**	**3,563**	**3,599**	**36**
WOMENS and CHILDRENS						
Total Income	(1,941)	(1,973)	31	(10,194)	(9,858)	(335)
Pay Costs	1,105	1,158	(54)	5,523	5,598	(74)
Non-pay Costs	135	167	(32)	679	670	9
Operating Expenditure	**1,239**	**1,325**	**(86)**	**6,202**	**6,268**	**(66)**
SURPLUS / (DEFICIT)	**702**	**647**	**(55)**	**3,992**	**3,590**	**(401)**
CLINICAL SUPPORT						
Total Income	(984)	(907)	(76)	(4,814)	(4,572)	(242)
Pay Costs	1,676	1,737	(61)	8,447	8,365	82
Non-pay Costs	1,113	1,206	(94)	5,307	5,579	(272)
Operating Expenditure	**2,789**	**2,943**	**(154)**	**13,754**	**13,945**	**(190)**
SURPLUS / (DEFICIT)	**(1,805)**	**(2,036)**	**(231)**	**(8,940)**	**(9,373)**	**(433)**
COMMUNITY SERVICES						
Total Income	(10,831)	(10,859)	28	(54,153)	(54,233)	80
Pay Costs	1,125	1,127	(3)	5,612	5,608	4
Non-pay Costs	4,183	4,213	(30)	20,926	20,984	(58)
Operating Expenditure	**5,308**	**5,341**	**(33)**	**26,538**	**26,592**	**(54)**
SURPLUS / (DEFICIT)	**5,523**	**5,519**	**(4)**	**27,615**	**27,641**	**26**
ESTATES and FACILITIES						
Total Income	(371)	(328)	(43)	(1,856)	(1,693)	(162)
Pay Costs	749	731	17	3,743	3,668	74
Non-pay Costs	593	635	(42)	2,930	3,000	(70)
Operating Expenditure	**1,342**	**1,366**	**(25)**	**6,673**	**6,669**	**5**
SURPLUS / (DEFICIT)	**(970)**	**(1,038)**	**(68)**	**(4,818)**	**(4,976)**	**(158)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	2,802	2,470	331	16,165	15,020	1,146
Pay Costs	1,032	1,059	(27)	4,868	5,042	(174)
Non-pay Costs (net of contingency and reserves)	751	724	27	5,131	5,159	(28)
Finance & Capital	461	566	(106)	2,295	2,552	(257)
Operating Expenditure	**2,244**	**2,349**	**(106)**	**12,294**	**12,753**	**(459)**
SURPLUS / (DEFICIT)	**(5,045)**	**(4,819)**	**226**	**(28,459)**	**(27,773)**	**686**
TOTAL (including penalties, contingency and reserves)						
Total Income	(21,648)	(22,246)	598	(105,723)	(106,915)	1,193
Contract Penalties	0	0	0	0	0	0
Pay Costs	12,041	12,191	(150)	60,048	60,225	(178)
Non-pay Costs	9,156	9,484	(328)	46,641	47,439	(798)
Finance & Capital	461	566	(106)	2,295	2,552	(257)
Operating Expenditure (incl penalties)	**21,658**	**22,241**	**(583)**	**108,983**	**110,217**	**(1,233)**
SURPLUS / (DEFICIT)	**(10)**	**5**	**15**	**(3,260)**	**(3,301)**	**(41)**

Medicine (Annie Campbell)

The Division over performed by £49k in August (£202k YTD)

ED attendances continue to perform above plan with a resulting knock on to non-elective inpatient activity.

Outpatients were lower in August, albeit in income terms they are at planned levels for the year to date. It appears the underperformance may be due to the phasing of the plan, though Dermatology were low as they had issues getting locums to fill consultant vacancies. They have now appointed a consultant for three months so the position should improve. Both Cardiology and Dermatology are experiencing difficulties in meeting Referral to Treatment Targets (18 weeks) and are looking at alternatives to address the extra activity required to improve the position. This may increase agency costs, or may result in using private providers.

Expenditure budgets were underspent by £68k in the month. This is partly due to private patient income. Nursing costs were underspent by £46k reflecting an increasing trend of difficulty in recruiting nurses (both qualified and untrained) as well as not being able to attract agency staff whilst the Trust maintains the agency cap. There are also early indications that some Portuguese nurses are starting to look at jobs back home.

Agency costs continue to be well controlled and have underpinned the Divisional CIP performance. Compared to August last year Nursing agency was £10k (2016 - £149k) and Medical agency £60k (2016 - £153k). CIP performance was £1k better than the £105k target.

Non pay costs continue to be a problem – Transport and security costs contributing to a £26k overspend.

Surgery (Simon Taylor)

The Division has over performed by £98k in August (£36k YTD).

Income over achieved against plan by £238k.Whilst ilt has been a very good month for activity this has caused additional costs. There has been significant increase in emergency activity which has contributed to the over achievement. Elective activity has achieved plan with Ophthalmology, ENT & Orthopaedics all significantly over achieving the plan.

Pay is over spent by £10k. The main cost pressure is due to additional sessions to support the additional activity completed.

Non-pay is overspent by £131k. This overspend is mainly in theatres on medical and surgical equipment due to the additional activity.

Surgery CIP's has over achieved by £63k YTD. There was some delivery of CIP's earlier than planned as well as higher vacancy management than plan. Additional activity is having a negative effect on the CIP.

Women and Children's (Rose Smith)
In August, the Division reported a deficit of £55k (£401k YTD).

Clinical income reported £31k ahead of plan in-month and is £335k behind plan YTD. Gynaecology and paediatric outpatient activity was lower than planned which pushed overall outpatient income £43k behind plan in the month. In midwifery services there were fewer intensive and intermediate antenatal patients which contributed to the majority of the £112k adverse variance on cost and volume activity. However, this under performance was mitigated by £163k of private patient income..

Pay reported a £54k over spend in-month and £74k overspend YTD. There have been in-month overspends on obstetric medical staffing and on bank staff within Maternity Services.

Non pay reported a £32k overspend in-month and a £9k underspend YTD. Paediatrics experienced significant pressures on their drugs budget and hospital midwifery experienced broader non pay pressures across most of the non-pay lines.

Clinical Support (Rose Smith)
In August, the Division reported a deficit of £231k (£433k YTD).

Clinical income for Clinical Support reported a £76k under performance in-month and is £242k behind plan YTD. This can be attributed to lower than planned activity for radiology direct access, breast screening and outpatient radiology. Income from Private Physiotherapy Services and the Support to go Home Service also explains £28k of the underperformance in-month.

Pay is £61k overspent in-month and is £82k underspent YTD. The use of locum consultants and additional sessions in Pathology explains £31k of the in-month variance.

Non pay reported a £94k over spend in-month and £272k overspend YTD.

Community Services (Dawn Godbold)
The Division reported a £4k under performance (£26k over performance YTD).

Contract Income reported a £28k over recovery in-month and an over performance of £80k YTD. The main over performances include income from IHT of £14k due to recharges relating to costs of dressings and Attain as well as a recharge of Adult SALT agency relating to inpatient staffing requirements for the service.

Pay reports a £3k overspend in-month and £4k underspend YTD. There have been overspends within Rosemary Ward and Glastonbury Court and Estates offset against vacancies within Paediatrics, Clinical Governance and Information.

Non-pay reported a £30k over spend in-month and a £58k overspend YTD. The main adverse variance in-month relates to dressings £29k and external consultants £53k, both offset in part by income from IHT.

Use of Resources (UoR) Rating

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

The key features of the UOR ratings are as follows:

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

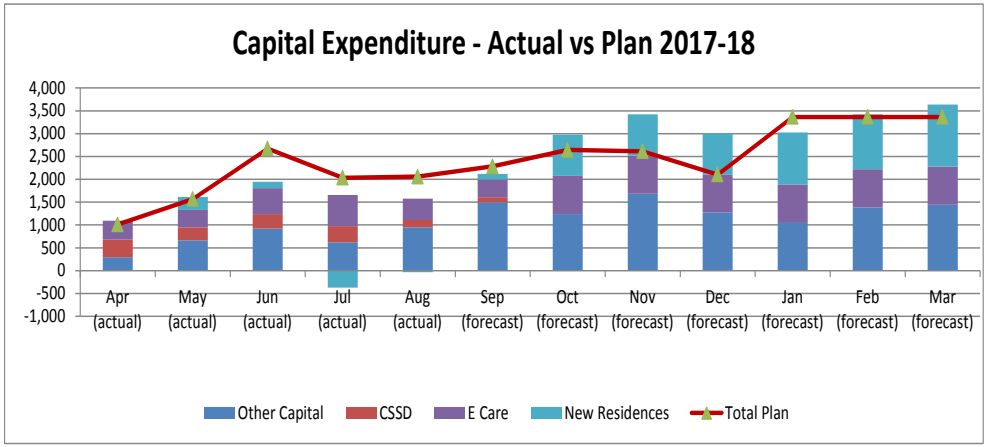
Metric	Value	Score
Capital Service Capacity rating	-0.883	4
Liquidity rating	-12.703	3
I&E Margin rating	-3.04%	4
I&E Margin Variance rating	0.13%	1
Agency	-41.68%	1
Use of Resources Rating after Overrides		3

The Trust is scoring an overall UoR of 3 again this month and there is no change to the individual scores.

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

FINANCE AND WORKFORCE REPORT – August 2017

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'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	683	465	390	839	839	839	839	839	839	7,934
CSSD	384	283	319	352	162	111	0	0	0	0	0	0	1,611
New Residences	0	284	140	-373	-33	123	900	900	900	1,141	1,200	1,356	6,538
Other Schemes	296	665	922	623	948	1,495	1,237	1,683	1,270	1,048	1,382	1,443	13,012
Total forecast / Forecast	1,095	1,613	1,947	1,285	1,542	2,119	2,976	3,422	3,009	3,028	3,421	3,638	29,095
Total Plan	1,012	1,568	2,673	2,034	2,058	2,283	2,643	2,612	2,103	3,365	3,365	3,363	29,082

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

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

The CSSD build is nearing completion and 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 September. The CSSD is planned to be operational in October

Expenditure on e-Care for the year to date is £2,510k 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. The expenditure profiles of these schemes have been rephased. There are no significant financial risks to the budgets reported. Year to date the overall expenditure of £7,482k is below the plan of £9,345k. The current forecasts are in the stages of a major review and initial indications are that there will be some slippage on the Ambulatory Assessment Unit, Main Concourse, Labour Suite, Compartmentation, Staff Residences and Urology Relocation schemes. The review will be completed during early October and at present the slippage cannot be quantified.

Statement of Financial Position at 31st August 2017

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2017 £000	Plan 31 March 2018 £000	Plan YTD 31 August 2017 £000	As at 31 August 2017 £000	Variance YTD 31 August 2017 £000
Intangible assets	15,611	19,711	17,605	17,654	49
Property, plant and equipment	74,053	94,189	79,812	77,694	(2,118)
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**	**97,417**	**95,348**	**(2,069)**
Inventories	2,693	2,600	2,700	2,584	(116)
Trade and other receivables	18,345	11,700	16,470	21,011	4,541
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	4,000	3,368	(632)
Total current assets	**22,390**	**15,300**	**23,170**	**26,963**	**3,793**
Trade and other payables	(23,434)	(28,195)	(23,131)	(21,779)	1,352
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)	(4,500)	(9,153)	(4,653)
Total current liabilities	**(25,354)**	**(30,347)**	**(30,014)**	**(33,323)**	**(3,309)**
Total assets less current liabilities	**86,700**	**98,853**	**90,573**	**88,987**	**(1,586)**
Borrowings	(44,375)	(55,951)	(47,768)	(45,659)	2,109
Provisions	(181)	(158)	(163)	(152)	11
Total non-current liabilities	**(44,556)**	**(56,109)**	**(47,931)**	**(45,811)**	**2,120**
Total assets employed	**42,144**	**42,744**	**42,642**	**43,176**	**534**
Financed by					
Public dividend capital	59,232	65,732	62,565	63,565	1,000
Revaluation reserve	3,621	3,621	3,621	3,621	(0)
Income and expenditure reserve	(20,709)	(26,609)	(23,544)	(24,010)	(466)
Total taxpayers' and others' equity	**42,144**	**42,744**	**42,642**	**43,176**	**534**

Property Plant and Equipment (PPE)
The slippage on PPE is on Residences, Catheterisation Laboratory (Cath Lab) and the Primary Care Streaming project.

The slippage on residences is because the individual tenders for the various components are taking longer than expected and there have been changes to the technical design of the buildings.

The slippage on Cath Lab is because when the original forecast was done it was not clear which elements would be falling within the managed service and which would be loan financed.

Although there is slippage on the Primary Care Streaming project currently the project is expected to be finished November 2017.

The Trust is currently reviewing all the schemes within the capital programme to assess if there will be slippage at the end of the financial year into 2018/19.

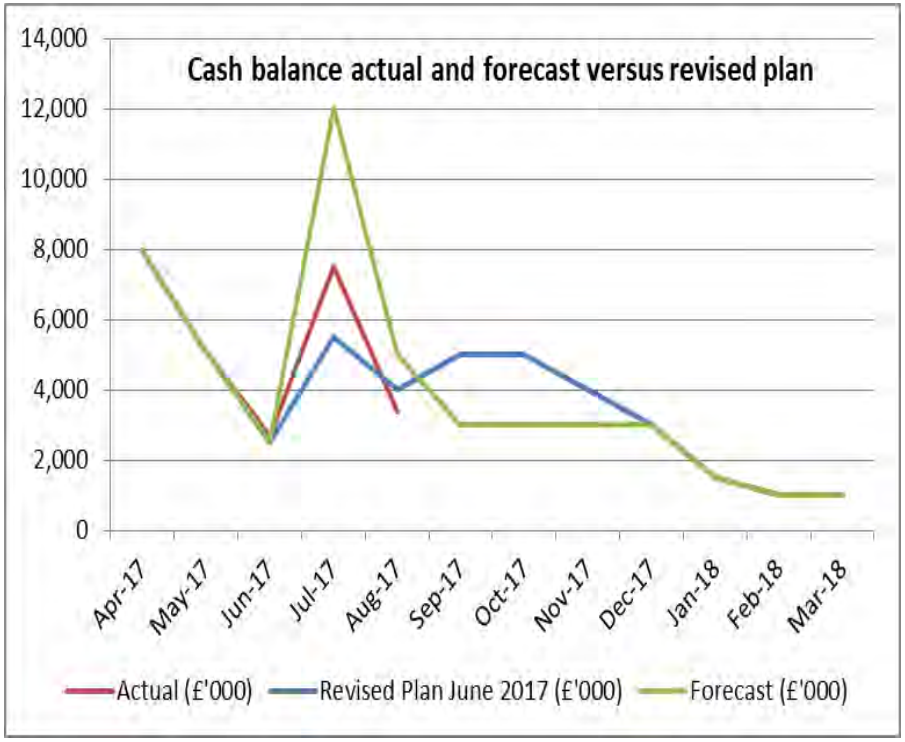
Trade and Other Receivables
These have increased by £3.0m in August. This increase is mainly due to a delay in raising invoices to Health Education England. This has now been addressed in September. In addition we are now recognising 5 months STF income which has not yet been received. We expect quarter 1 to be received in September or October. We are still above plan and the Trust plan assumes the year end receivables position in March 2018 will be £12m compared to £21m at the end of August which is a significant challenge.

Cash
The cash balance has been reduced from £7.2 million at the end of July to £3.4 million at the end of August by postponing the drawdown of agreed loans. The loan drawdown will start again in September.

Trade and Other Payables
The balance on trade and other payables has decreased since July by £1.8 million and is below plan by £1.3 million. In order to manage the Trust's cash position, as slippage on the capital programme reduces the payables balance may increase. The Trust will continue to manage its relationship with suppliers carefully.

Other liabilities
This balance will start to reduce in the second half of the financial year, the payments for the block contract are weighted towards the earlier months in the financial year for cash purposes but the income cannot be recognised until it has been earned in terms of patient care being delivered. The block contract cash payments reduce from September and then again in March 2018.

Cash Balance Forecast for the year



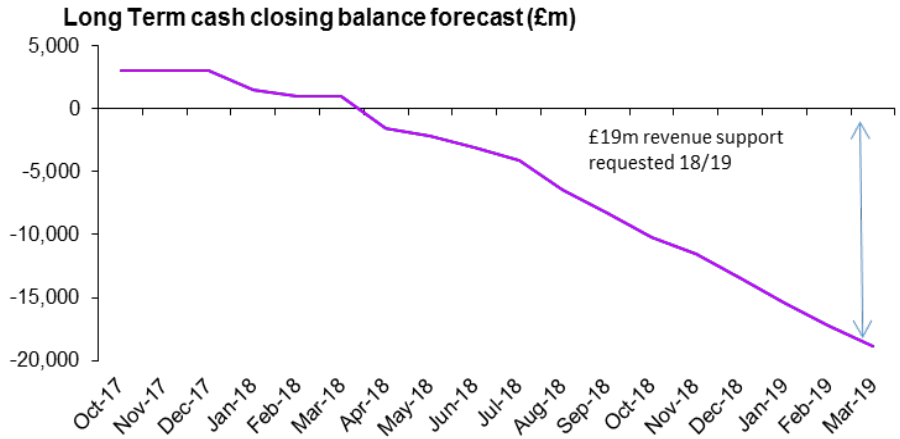
The graph illustrates the cash trajectory year to date, plan and revised forecast.

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

The drawdown of capital loans will start again in September.

Longer Term Cash Forecast

As explained previously, the Trust's revenue and capital plan to March 2019 exceeds the agreed finance available. To date the Trust has relied on slippage on the capital programme to fund this gap but in 2018/19 it is forecast we will need an additional £19 million revenue support in order to maintain the planned capital programme. This has been included in the two year financial plan submitted to NHS Improvement in December 2016 and March 2017 but no formal agreements is in place yet.

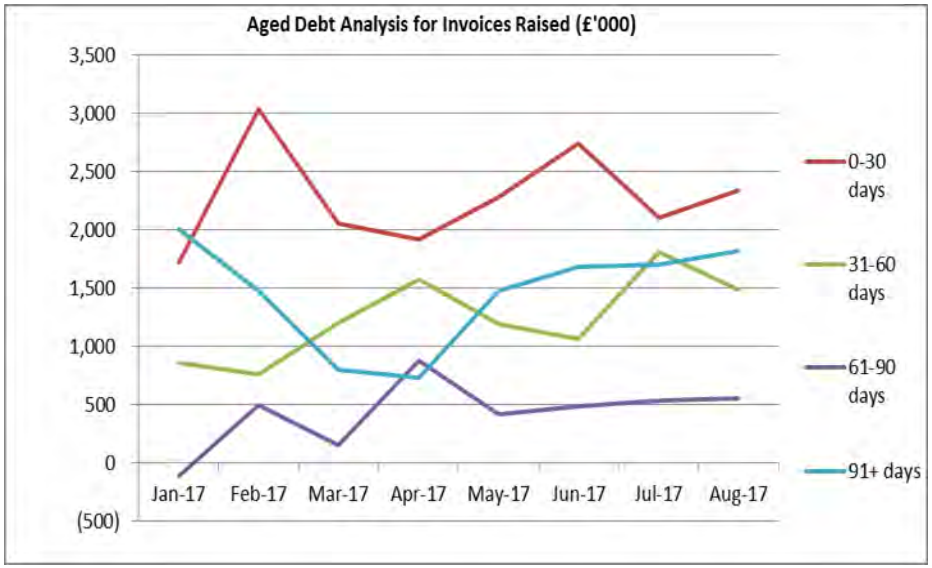


Debt Management

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. In order to manage the Trust's cash position the receivables balance needs to reduce significantly by year end.

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

FINANCE AND WORKFORCE REPORT – August 2017



Some invoices raised following the reconciliation of the 2016/17 contract activity remain unpaid, most notably the invoice to NHS England for £845k which is now in the 61-90 day category. The Trust is liaising closely with NHS England to secure payment as soon as possible.

Over 40% 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 at a senior level. Of the remainder in this category £593k relates to other NHS bodies and is being actively pursued with issues escalated as appropriate.

Board of Directors – 29th September, 2017

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

EXECUTIVE SUMMARY

- This report will be reflective of the data from July and August 2017
- In August there were 469 Patients Safety Incidents (PSI) reported; a decrease from July (508).
- Level of harm in proportion to overall Patient Safety Incidents reported:
  - 86% (86% July) no harm (Green)
  - 11% (12% July) minor harm (Green)
  - 3% (1% July) moderate harm (Amber)
  - 0.2% (0.2% July) major harm (Red)
  - 0.2% (0.2% July) catastrophic harm (Red)
- In relation to type of incidents reported in August the highest areas of reporting related to Slips Trips & Falls, Pressure ulcers, and Medication.
- 6 complaints were received in July and 16 in August.
- 176 PALS contacts were recorded in July and 137 in August

Appendix A provides details of the new NHS Improvement NRLS (national reporting & learning system) report and action being taken by the Trust to improve timely reporting upload. Key messages are:

- Simplification of the Falls and Pressure ulcer investigation pathways will assist staff in timely completion.
- Trusts in the best performing quartile (peer group 'all acute trusts') mostly achieve this through a 'double upload' methodology which the Trust is **NOT** proposing to implement as this would require additional resource whilst not providing any quality benefit to the organisation as the incidents still require an investigation.

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

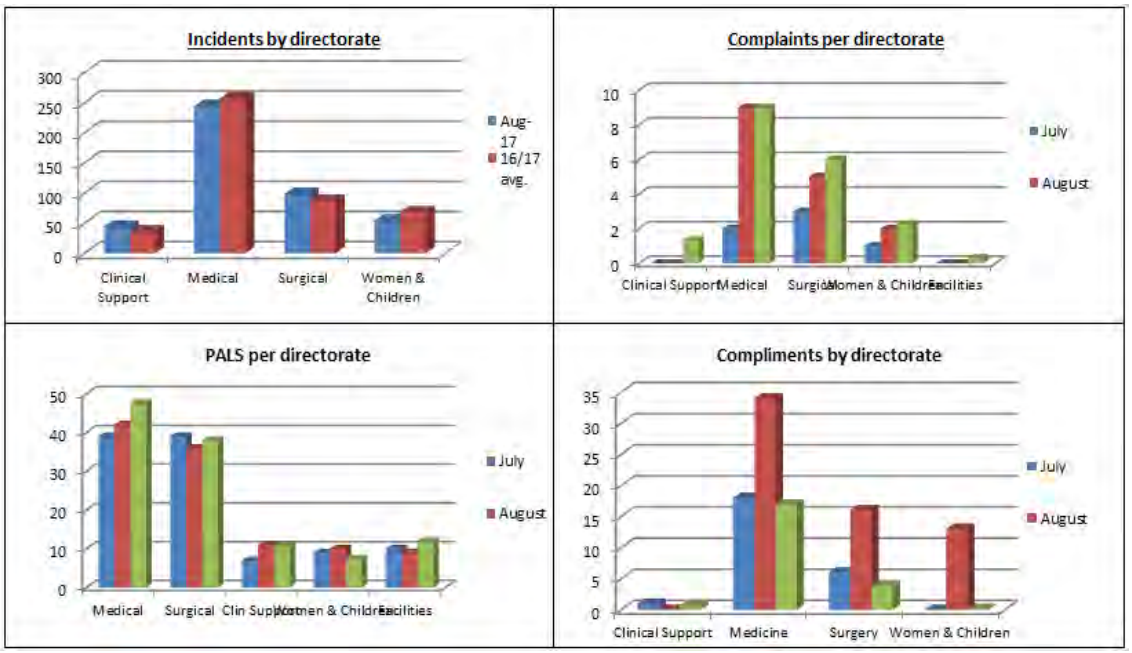


Table 2: PSIs reported by month (24 months)

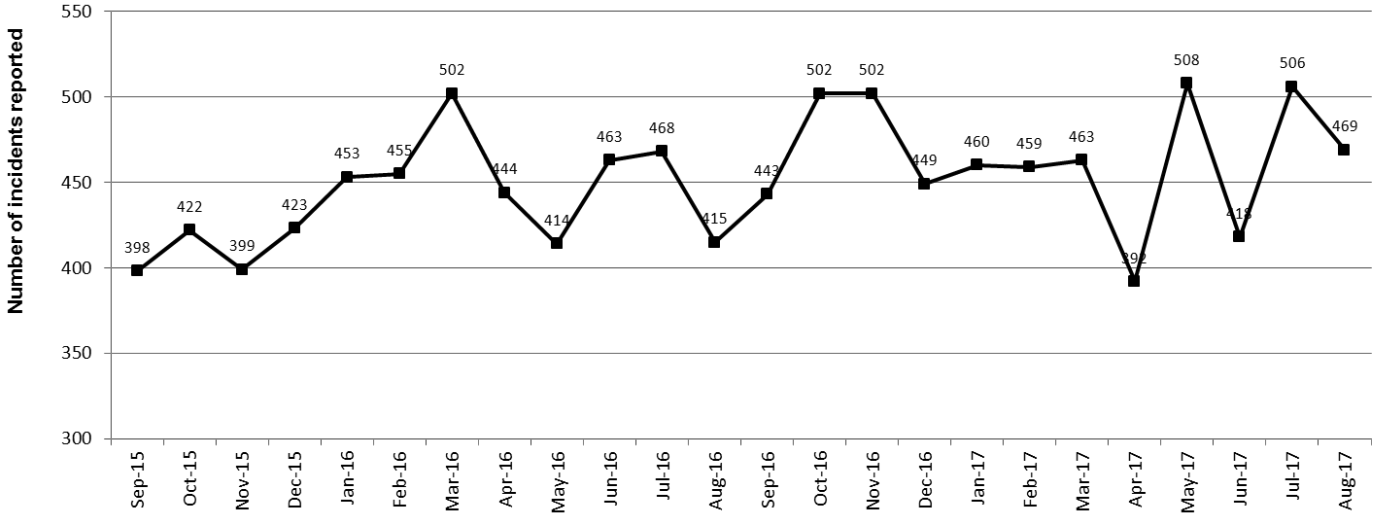
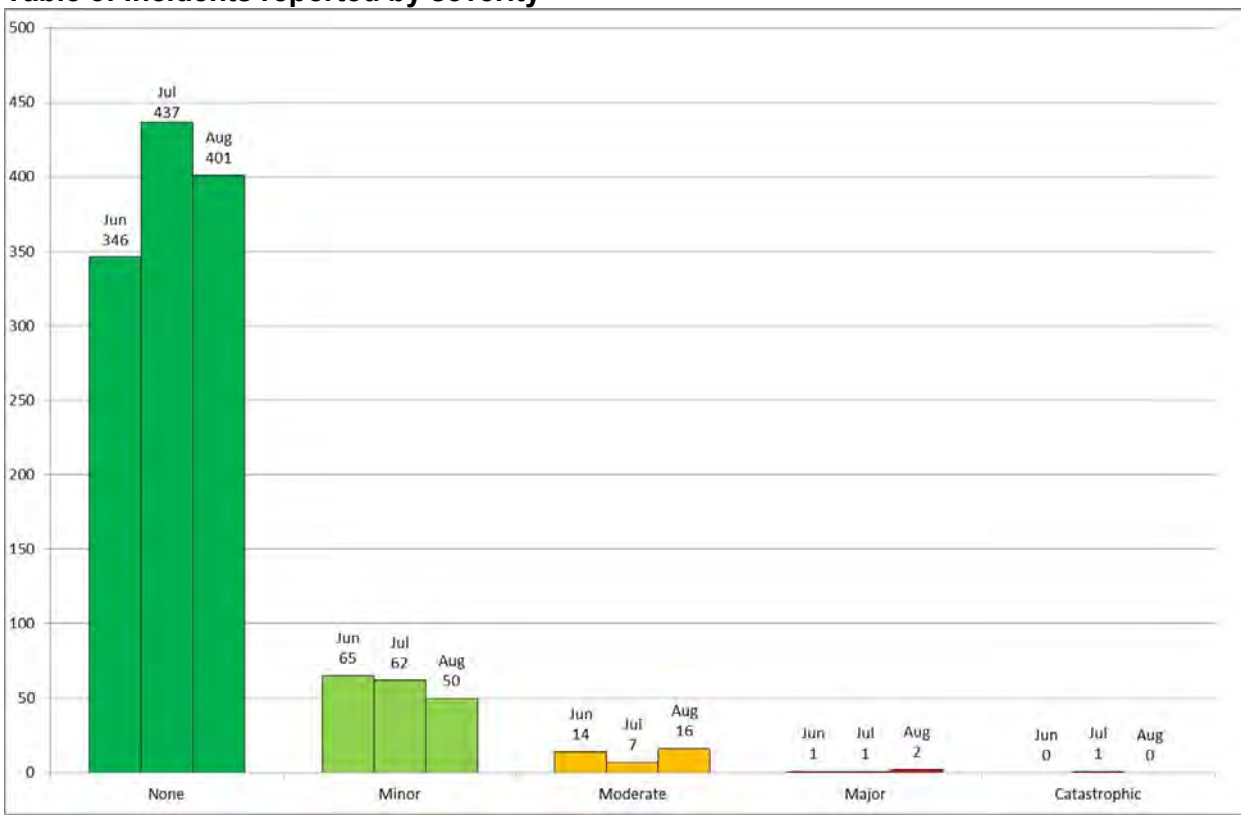


Table 3: Incidents reported by severity



Within Table 3 (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 compared to July but remains high. This month's incidents have seen a reduction in both no harm and minor harm and an increase of 9 incidences of moderate harm. Major harm has seen an increase to two cases and there has been no catastrophic level of harm incidences for August. A further breakdown of the incidents are below.

There are no Catastrophic harm incidents:

The two Major harm incidents are:

- Surgical procedure which resulted in the wrong end of the bowel being used to create a stoma which was detected post-surgery and a second operation was required to correct this. Initial surgery was complex. Investigation is ongoing.
- Fall on F3 resulting in a neck of femur fracture.

The 16 moderate harm incidents relate to:

Medicine (11)

- Hospital acquired pressure ulcers (4 cases)
- Fall (1 case)
- Delay in referral to specialist centre due to unable to perform relevant test at the WSH
- Possible delay on reviewing blood results on an inpatient where there was increasing confusion resulting in falls
- Missed DVT diagnosis
- Missed anti epilepsy medication, patient went onto have a seizure
- MRSA Bacteraemia detected on an inpatient – investigation ongoing
- Inpatient did not receive correct dose of anticoagulation, patient went on to develop DVT

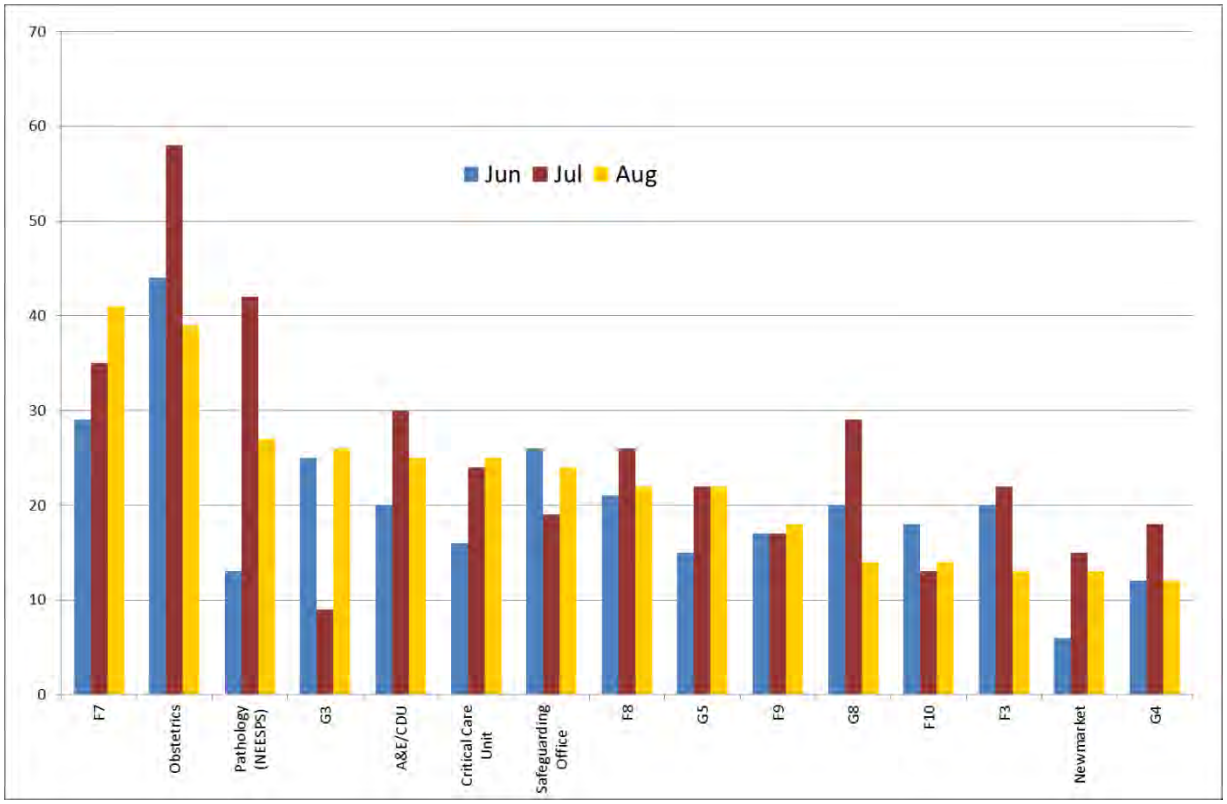
Surgical (2)

- Hospital acquired pressure ulcer (1 case)
- Patient developed DVT following short course of Tinziparin following a ligament injury

Women & Children (3)

- Delay in referral centre seeing new-born with Tongue Tie resulting in bottle feeding
- Patient discharged from another trust for specialist care/dressing before adequate training/plan had been put into place
- Shoulder Dystocia

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



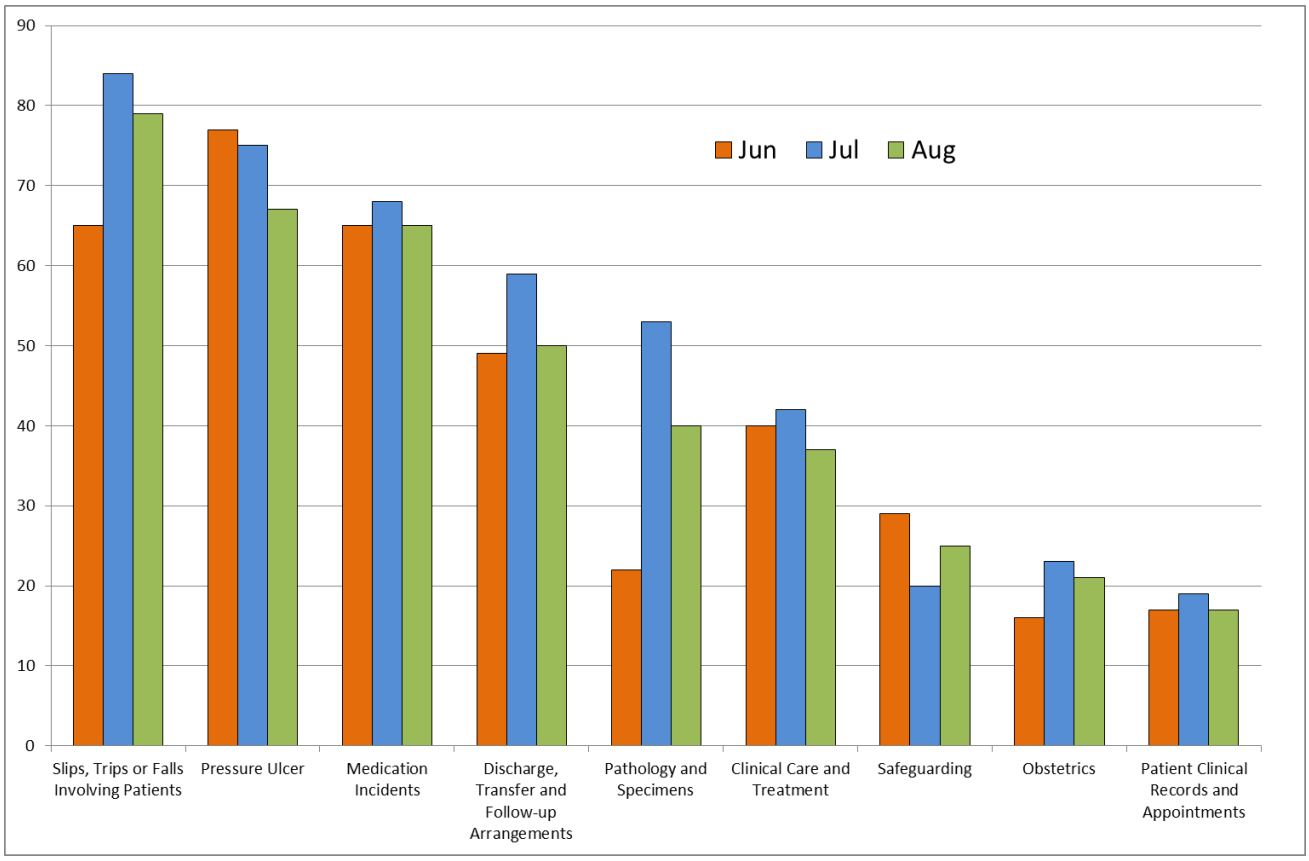
This month has seen an increase in the reporting of incidences in F7, F9, G3. On deeper review of these incidences the following has been seen.

On F7 there has been an increase in reporting and this has been due to an increase in Pressure Ulcers/Slips and Trips and Falls, however there has been a reduction in Medication incidences. One incident for F7 did relate to staffing difficulties which the only incident is relating to staffing. This did not result in harm.

G3 has seen an increase in incidences; these are due to an increase in Slips, Trips and Falls of 10 from 1 to 11. However these incidences do cover multiple falls for the same patients.

F9 saw an increase in medication incidences of one.

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



There has been an increase in safeguarding referrals, these have been appropriate and the Safeguarding lead has been encouraging an increase in reporting, this was covered in greater depth last month. All other areas have seen a decrease.

Complaints

6 complaints were received in July and 16 in August. The combined breakdown of these complaints is as follows by Primary Division: Medical (18), Surgical (10), Women & Children (4).

Patient Experience Themes

Area	Analysis	RAG rating
Orthopaedics	A number of enquiries have been received relating to waiting to undergo orthopaedic surgery which links in with on-going work that is being carried out around improving RTT. Patients have been kept informed about their surgery where possible however unfortunately for many an approximate date cannot be given.	
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 – 29th September 2017

AGENDA ITEM:	11
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Sinead Collins, Clinical Business Manager
DATE PREPARED:	19th September 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 August's and progress of nurse staffing review made below.

Action - 1455
Review the data and action regarding the use of bank and agency within maternity (labour suite) when staffing levels are at the correct level for activity. Also consider link with sickness rate.
Maternity staffing is combined across MLBU, F11 and Labour Suite and staff are moved according to need. This month due to high sickness, they have had the need for more bank staff. No agency staff were used

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	4 medication errors	Bank and agency use. Increase in number of attendances into A&E
F7	6 medication errors	High bank and agency use. High sickness and vacancy
F8	-	High annual leave rate and high bank use
Theatres	-	High sickness
DSU	-	High sickness and annual leave rate
G1	9 medication errors	High bank use and high sickness
G3	4 medication errors and 5 pressure ulcers	Unusually reduced staffing levels and high bank use
G4	-	High bank use
G5	4 pressure ulcers	Reduced staffing levels and high bank use and vacancies in RNs
G8	9 medication errors	High bank use and annual leave rate
F1	-	High bank use
F4	5 medication errors	High bank and agency use.
F5	-	High bank use
F6	-	High bank and agency use. High sickness
F9	-	High bank use & vacancy in RNs
F10	-	High sickness
Maternity	-	High bank use & sickness
F12		High bank use
Kings Suite	-	High bank use & sickness

Vacancies – There has been a significant increase in vacancies of registered staff. This has been highlighted operationally leading into the winter period and HR are aware.

Roster effectiveness – Out of 26 areas, 22 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is an increase in number from July. The reasoning for this have been put down to annual leave allocation, vacancies and staffing levels.

Sickness – Out of 27 areas, 16 are over the Trust Standard of 3.5% (two more than last month) (Day surgery unit & ward are counted as one area).

Update on progress of Nurse Staffing Review

Nurse Specialist review is being supported by KPMG. Results to be shared and discussed with Service Managers of those areas before shared with wider staff groups.

Trust has 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. Separate meetings are happening for this to progress

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Aug-17			Establishment for the Financial Year 2017/18						Data for Aug 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	102.8%	97.0%	132.8%	109.4%	5.80%	3.64%	0.25	-3.40	5.00%	N/A	24.60%	N/A	4	0
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	72.5%	84.1%	98.5%	94.9%	18.75%	3.66%	-5.70	-5.35	8.50%	6.45	31.20%	1	6	0
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	68.9%	N/A	100.3%	N/A	6.26%	0.00%	-0.40	-0.20	4.00%	N/A	30.50%	0	1	1
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	94.1%	89.6%	N/A	N/A	6.04%	0.00%	-4.73	0.00	2.80%	20.21	24.90%	1	3	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	101.3%	102.4%	N/A	N/A	1.52%	0.00%	-2.70	-0.40	7.50%	N/A	24.90%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	130.6%	90.4%	69.1%	N/A	3.47%	0.00%	-2.87	-0.10	2.20%	N/A	21.40%	0	0	N/A
WSFT	Day Surgery Unit	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	60.6%	N/A	68.5%	N/A	2.61%	0.00%	0.00	-1.45	11.90%	N/A	29.60%	0	0	0
	Day Surgery Wards													5.82%	0.00%	-0.60	0.10	9.30%		35.60%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	107.7%	97.6%	69.0%	N/A	3.26%	0.00%	0.00	-0.70	0.70%	11.40	20.80%	0	1	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	85.5%	100.0%	101.1%	N/A	3.05%	0.00%	1.00	2.10	6.80%	7.83	25.60%	0	9	0
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	86.9%	89.6%	88.2%	100.6%	9.37%	0.00%	-2.89	-1.20	4.90%	4.73	20.20%	5	4	3
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	86.0%	74.2%	106.2%	116.6%	17.93%	0.42%	-2.54	-2.90	6.10%	I/D	24.40%	0	2	2
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	73.8%	77.3%	109.5%	106.5%	7.51%	0.92%	-4.50	-0.30	2.90%	4.70	20.90%	4	0	1
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	84.5%	91.4%	91.9%	100.0%	11.62%	0.36%	-3.80	-0.81	6.60%	5.83	23.90%	1	9	0
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	90.5%	152.7%	146.0%	N/A	7.48%	0.00%	-1.40	2.50	1.50%	N/A	22.80%	N/A	2	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	93.3%	95.0%	126.9%	108.4%	6.39%	2.85%	-2.20	-4.30	3.20%	4.73	18.20%	1	0	1
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	86.9%	93.3%	109.8%	218.4%	17.52%	1.92%	-1.70	-3.34	3.80%	5.23	22.50%	0	5	2
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	87.4%	90.3%	101.9%	132.5%	8.28%	0.26%	-3.30	0.70	2.30%	4.83	21.40%	0	2	1
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	92.8%	98.1%	87.9%	96.8%	7.53%	7.67%	-3.43	-1.90	9.90%	6.66	28.80%	0	2	0
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	85.3%	102.3%	86.8%	103.6%	9.47%	0.23%	-5.00	-1.99	2.90%	4.75	18.80%	0	3	3
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	112.5%	76.7%	82.2%	97.9%	1.99%	0.00%	-0.50	-0.10	6.70%	6.03	23.00%	0	2	1
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	116.8%	95.3%	95.9%	56.1%	11.96%	0.00%	-3.30	1.49	11.20%	N/A	27.10%	0	1	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1												0	0	0
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre recovery area, bereavement suite					1 - 2	1 - 2												0	0	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	94.4%	85.6%	26.7%	95.8%	13.14%	0.61%	-1.70	-0.60	4.80%	7.75	26.10%	0	1	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	100.4%	100.0%	N/A	N/A	0.00%	0.00%	-0.70	-0.40	0.00%	N/A	16.90%	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	89.7%	N/A	78.9%	N/A	0.00%	0.00%	-0.20	0.00	1.10%	N/A	17.00%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	98.2%	80.9%	22.6%	58.1%	2.04%	0.00%	-1.98	-1.40	2.60%	I/D	24.40%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	100.3%	96.8%	103.1%	106.5%	7.43%	0.30%	-2.34	-0.85	4.28%	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	96.1%	99.1%	93.7%	98.4%	14.52%	0.0%	0.10	-0.70	6.20%	5.30	24.40%	0	2	0
																-57.13	-25.50	Target - 3.5%		Trust standard is 20%			

Explanations

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

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

Trust Policy and Procedure **Document ref. no: PP(xx) xxx**
Learning from Deaths Policy

For use in:	Trustwide
For use by:	All staff
For use for:	Learning from Deaths
Document owner:	Public Health Registrar
Status:	Draft

Key message

The purpose of this policy document is to describe how West Suffolk NHS Foundation Trust responds to, and learns from, the deaths of people who die under our management and care.

Contents

1. INTRODUCTION

West Suffolk NHS Foundation Trust (WSFT) endeavours to provide outstanding quality care to all our patients, their relatives and carers.

However, international research shows that problems in healthcare arise and that in some cases those problems cause harm. In a very small percentage of cases, the harm caused is unfortunately serious enough that it hastens or precipitates the patient's death.

WSFT has had a system of mortality case record review in place for some time. In March 2017, NHS Improvement and the Care Quality Commission jointly launched the national Learning from Deaths programme, to standardise the way NHS trusts and foundation trusts do this important work.

This policy document lays out how WSFT will update its approach to learning from deaths to meet the recommendations in the new national guidance[1].

2. SCOPE

This policy applies to:

- All staff involved in patient care, quality and governance
- Deaths as defined in paragraph 5.1

3. DEFINITIONS

3.1 Case record review

The application of a case record review to determine whether there were any problems in the care provided to the patient who died, in order to learn from what happened.

3.2 Investigation

An investigation under the Serious Incident Framework[2].

4. RESPONSIBILITIES

The Medical Director is responsible for the learning from deaths agenda within the trust and therefore is responsible for ensuring that this policy is implemented.

The nominated Non-Executive Director is responsible for Board-level oversight of implementation.

The policy author is responsible for ensuring the policy is up to date and complies with national guidelines and legislation. The author will monitor the policy against the key performance indicators and maintain the Equality Impact Assessment. The policy author is responsible for bringing non-compliance issues to the Learning from Deaths group for action. The policy author will ensure the policy is reviewed at the date stated.

[1] National Quality Board. National Guidance on Learning from Deaths. March 2017. Available from https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/ Accessed 10/07/2017

[2] Available at https://improvement.nhs.uk/resources/serious-incident-framework/ Accessed 11/07/2017

5. WSFT PROCESS FOR LEARNING FROM DEATHS

5.1 Deaths in scope

WSFT will review the quality of care given to all patients who die under our care and management. We will define patients under our care and management as comprising:

- all inpatients in West Suffolk NHS Foundation Trust
- all patients attending West Suffolk Hospital emergency department

People who are receiving care as outpatients or on our community services case list will not routinely be considered in scope, pending specific guidance from the National Quality Board on learning from deaths in community trusts. We will, however, willingly conduct a case record review for any patient who has died outside hospital, for whom another care agency, or the patient's relatives or carers, would like us to review the care the patient received from us.

In all cases, deaths which require investigation will be managed by that process and a separate case record review will not be performed.

5.2 Method for mortality case record review

WSFT will use a single-stage version of the Royal College of Physicians' Structured Judgment Review (SJR) method. The method will be introduced during 2017/18.

5.3 Process for mortality case record review

When a death is documented in the electronic patient record it is reported to the bereavement office and the Learning from Deaths coordinator.

Senior clinicians will perform the case record reviews. The post of Medical Reviewer will be introduced in 2017/18 to create protected time and develop the necessary expertise. Medical reviewers will be trained to use the SJR method and data will be collected on an electronic database. The process will be supported by the Learning from Deaths coordinator.

The case record review will be performed promptly after a patient has died. The review will be informed by conversations with the clinical team who looked after the patient, the patient's relatives or carers, and any other agencies who were involved in the patient's care immediately preceding their death.

Medical reviewers will liaise closely with the hospital bereavement service and the patient advice and liaison service to offer relatives and carers the opportunity to give feedback on the quality of care received at a time which suits them. This need not be straightaway.

Medical reviewers will identify any problems in care which they judge to have arisen and inform the clinical team of their judgment. They will also consider whether the problems had a material impact on the time or circumstances of the patient's death and make a judgment about whether, on balance, the death was potentially avoidable.

5.4 Deaths in people in groups under special focus

The following five groups of patients will be subject to special focus for mortality review.

a. People who have a learning disability
Any patient who dies and who has been identified as having a learning disability by themselves, a relative or carer, or any agency involved in their care, will be referred for full review by the national Learning Disabilities Mortality Review Programme (LeDeR). WSFT will cooperate fully with the LeDeR process.

b. People who have severe mental illness
The trust's response to some deaths in people who have severe mental illness is already determined under the Care Quality Commission (Registration) Regulations 2009, the Coroners and Justice Act 2009 and the Serious Incident Framework.

If a patient who dies has been identified as having a severe mental illness by themselves, a relative or carer, or any other agency involved in their care, and the response to their death is not already governed by one of these instruments, the trust will undertake a case record review internally and will also willingly contribute to a multi-agency review with other agencies involved in the patient's care.

We will define severe mental illness as equal to serious mental illness as described by NHS Digital in the NHS Outcomes Framework[3] (indicator 1.5i Excess under 75 mortality rate in adults with serious mental illness). That is, any person who has been in contact with secondary mental health services in the current or last two financial years.

c. Infants and children
The trust will continue to participate in the full multi-agency reviews conducted by the Suffolk Safeguarding Children Board Child Death Overview Panel. A separate case record review will only be undertaken in the case of a young person aged 16-18 who has died after being cared for in one of our adult inpatient wards.

d. Babies who are stillborn
The maternity service will continue to conduct a local review of the care received when a baby is stillborn.

e. Women who die during or after pregnancy or childbirth
The care provided to women who die during or after pregnancy or childbirth will be subject to full review using the SJR method.

5.5 Process for learning

Medical reviewers will provide a copy of their case review report and verbal or written feedback to the responsible clinician in every case. Where problems in care have been identified, the responsible clinician will be required to demonstrate that the case has been discussed and reflected upon at the appropriate ward, departmental or divisional governance meeting. The medical reviewer will be informed of any learning which is identified during the discussion and any actions which have been agreed.

[3] Indicator specification available at https://indicators.hscic.gov.uk/download/Outcomes%20Framework/Specification/NHSOF_Domain_1_S.pdf Accessed 12/07/2017. See page 74.

Medical reviewers will meet regularly to identify themes in learning which have arisen over time.

A multidisciplinary Learning from Deaths group will meet monthly. The group's terms of reference are appended to this policy.

The Learning from Deaths group will receive reports on deaths in the following categories:

- Every death where the Medical Reviewer's judgment is that a problem in care has led to a potentially avoidable death[4]
- Every death in a patient in a group under special focus (paragraph 5.4)

The Learning from Deaths group will also consider:

- learning and actions which have been identified by clinical teams and progress towards their implementation
- themes which the Medical Reviewers have identified as common across multiple cases.

The Learning from Deaths group will identify learning which has relevance to other parts of the trust and will advise the quality team of actions which will require support for implementation. The Learning from Deaths group will also identify learning which should be shared beyond the trust, with partner agencies or with fellow NHS trusts.

The group, through its chair, will be responsible for facilitating shared learning which may include, but not be limited to, a regular newsletter and learning events for staff and the wider system.

The reports, views and decisions of the Learning from Deaths group will be considered alongside other sources of information about care quality by the Quality Group under the trust's Quality Assurance Framework.

5.6 Engagement with families and carers

Families and carers will be offered information on the progress and conclusion of the mortality case record review for each deceased patient. They will be able to receive this in the format of their choice, including by telephone, face to face or in writing. The information, as requested, will be provided in plain English so medical terminology does not act as a barrier to understanding. The trust will not make an assumption that families and carers wish to receive information about the mortality case record review and will respect their privacy following their bereavement.

The conclusion of the case record review will also be communicated in writing to the deceased patient's GP.

Families' and carers' involvement in the learning process and implementation of actions which are identified will be welcomed and encouraged. This will be facilitated by the quality team and the patient advice and liaison team.

[4] Defined as an avoidability of death judgment score of 1, 2 or 3 in the structured judgment review

If families or carers wish to obtain legal advice about the circumstances of the deceased patient's death, the patient advice and liaison team or the legal services team will be able to provide initial guidance. If the trust wishes to obtain legal advice about the risk of legal action concerning possible clinical negligence or professional misconduct, the legal services team or the human resources team respectively will inform the family or carers.

5.7 Data collection and reporting

The Learning from Deaths group will collect and report the results of the case record reviews, including the number of deaths which are judged to be more than 50% likely to be due to a problem in care. This information will be reported to the trust Board in public on a quarterly basis, effective December 2017.

The Learning from Deaths group will also report the ways in which it has acted on its learning from deaths, and how those actions have improved quality of care and patient safety, in the annual Quality Account, effective April 2018.

6. CONSULTATION

This policy has been prepared in consultation with:

- the members of the Learning from Deaths group
- the Learning Disability Liaison Nurse
- the Bereavement Officer
- the Patient Advice and Liaison Service manager
- the Information Governance and Legal Services manager
- a family representative
- the Acting Head of Midwifery
- the Senior Midwife for Risk Management

7. EQUALITY IMPACT ASSESSMENT

An equality impact assessment of this policy has been completed. No unfavourable impact on any group or individual with a protected characteristic has been identified.

8. APPROVAL PROCESS

This policy has been considered and approved by:

- the Trust Executive Group
- the Learning from Deaths group
- the Clinical Safety and Effectiveness Committee
- the Trust Board

9. IMPLEMENTATION & MONITORING

The policy will be implemented and monitored as described in section 5.

10. REVIEW

The policy will be reviewed every three years. An earlier review will be conducted if changes or additions are made to the national Learning from Deaths guidance.

Appendix: EQUALITY/DIVERSITY ASSESSMENT TOOL

Title of Document	Learning from Deaths policy
Date of assessment	05 Aug 2017
Date for review	05 Aug 2020
Division	n/a
Completed by	Dr Helena Jopling, Public Health Registrar
Date	05 Aug 2017

	Yes/No	**Rationale**
Does the document affect one group less or more favourably than another on the basis of:		
• Race	No	All deaths which occur under the care and management of the trust will receive a review.
• Gender	No	
• Sexual orientation	No	
• Age	No	
• Disability	No	
• Marriage and civil partnership	No	
• Pregnancy and maternity	No	
• Culture	No	
Does this document affect an individual's human rights?	No	

Author(s):	Public Health Registrar
Other contributors:	
Approvals and endorsements:	Learning from Deaths group, Trust Executive Group, Clinical Safety and Effectiveness Committee, Trust Board
Consultation:	Learning from Deaths group, Learning Disability Liaison Nurse, Bereavement Officer, Patient Advice and Liaison Service Manager, Information Governance & Legal Services Manager, Family Representative, Acting Head of Midwifery, Senior Midwife for Risk Management.
Issue no:	New policy
File name:	
Supercedes:	
Equality Assessed	Yes - completed
Implementation & Monitoring	The policy will be implemented and monitored as described in section 5.
Other relevant documents/documents & references:	

West Suffolk NHS
NHS Foundation Trust

Learning from Deaths group

Terms of Reference

1. Aim

The Learning from Deaths group exists to ensure that West Suffolk NHS FT learns from, and acts upon, the quality of care provided to people who die under our management and care.

2. Responsibilities

The **Chair** of the committee will convene the group for monthly meetings. The Chair will report the group's outputs to the Clinical Safety & Effectiveness Committee or Patient Experience Committee as appropriate, and to the Trust Board. The Chair will escalate identified risks to quality of care to the Quality Group.

All members will promote and contribute to the identification of problems in care associated with a patient's death, and participate in securing meaningful action to reduce the likelihood of those problems recurring. All members of the group will also promote and advocate for the celebration of good care which is apparent in case record reviews.

All members of the group must adequately prepare for the meeting by reading the papers and provide effective challenge to the issues under discussion. If a member is unable to attend a suitable deputy should attend instead.

3. Core Responsibilities

- To enact the Learning from Deaths policy
- To synthesise the information arising from case record reviews to understand problems in care which have caused or contributed to the time or circumstances of a patient's death
- To ensure that learning from these problems in care occurs and that meaningful actions which will reduce the likelihood of the problems recurring are identified
- To recognise when these actions are likely to need support in order to be implemented, and secure it
- To pay particular attention to the care received by people with learning disabilities or severe mental illness, to make sure it is equitable and matches the standard the Trust aspires to for all its patients
- To advocate for the involvement of families and carers in quality improvement
- To report on a quarterly basis to the Trust Board, information on the number and nature of problems in care which are associated with a patient's death
- To report in the annual Quality Account, how the actions taken in response have improved quality of care

4. Composition

The membership will be as set out below:

- Executive Medical Director (Chair)
- Executive Chief Nurse
- Deputy Medical Director
- Associate Chief Nurse & Head of Patient Safety

- Clinical Directors for all Divisions
- Director of Medical Education
- Public health registrar
- Heads of Nursing
- Medical Reviewers (once appointed)
- Consultant general surgeon
- Consultant in palliative care medicine
- Resuscitation & Outreach Service Manager
- Mortuary manager
- Clinical Coding Manager
- Senior Information Analyst
- Learning Disability Liaison Nurse
- Senior Midwife for Risk Management
- Non-Executive Director
- Family representative

A quorum will be **7** members of the Committee. At least one of the following must be present: the Executive Medical Director, Executive Chief Nurse, Deputy Medical Director or a Head of Nursing/Associate Chief Nurse; plus a Clinical Director.

5. Accountability

- The group is accountable to the Clinical Safety & Effectiveness Committee.
- The group will escalate issues of concern to the Quality Group.

6. Authority

- The group will have authority to establish subgroup.
- The group will have authority to approve relevant policies and procedures.
- The group will escalate risks, it determines as appropriate, to the Quality Group.

7. Review Arrangements

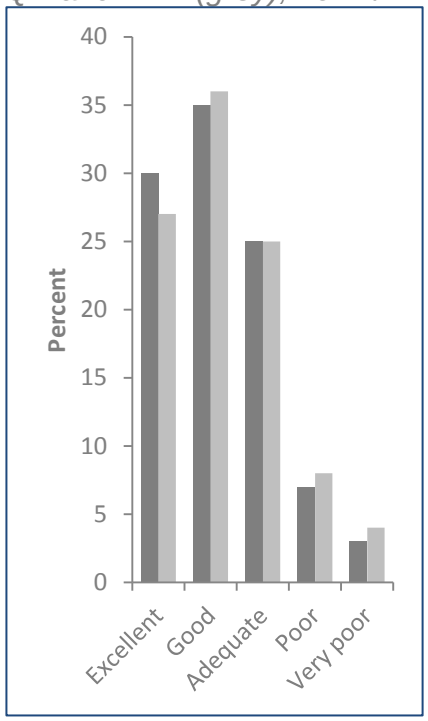
The terms of reference are to be reviewed on an annual basis at the first meeting in the new financial year.

Learning from Deaths dashboard – Quarter 1 2017

Inpatient deaths	Total	Reviews completed
Q1	224	193
Year to date	224	193

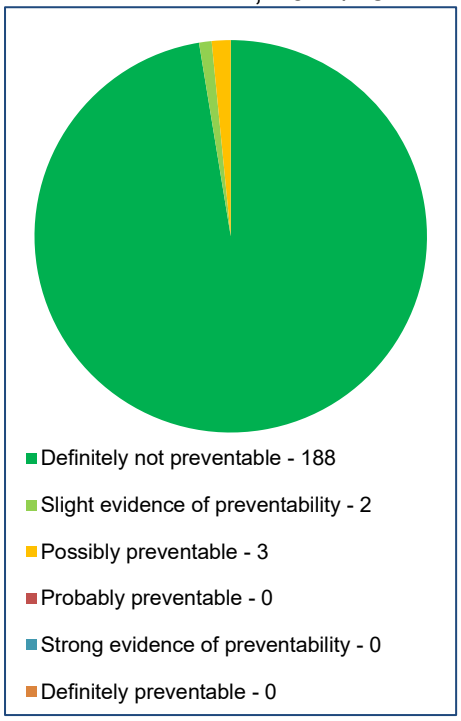
Overall quality of care

QX and YTD (grey), 20XX/XX



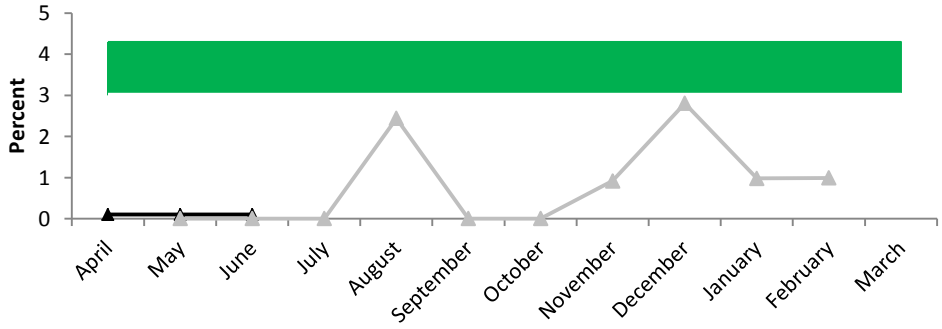
Outcomes of reviews

Year to date, 2017/18



Monthly profile of deaths judged to have had more than 50% likelihood of preventability

Year to date 2017/18 (black) compared to 2016/17 (grey)



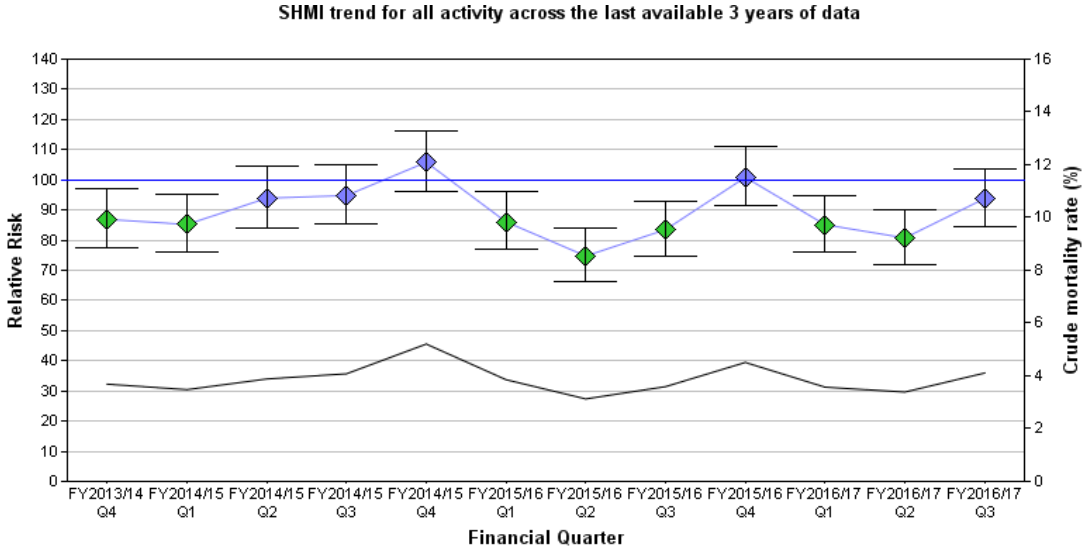
Deaths in people in groups under special focus – Q1, 2017/18 and YTD (in brackets)

Group	Total	Multiagency reviews	Probably, strongly or definitely avoidable
People with learning disabilities	0 (0)	0 (0)	0 (0)
People with severe mental illness	1 (1)	1 (1)	0 (0)
Maternal deaths, child deaths and stillbirths	Not governed through Learning from Deaths in this time period		

Learning themes identified

Contributing to preventable deaths	Not yet available
Not contributing to death	Risk assessment of people with severe mental illness while in the trust needs to be improved

Summary Hospital Mortality Index (SHMI)



West Suffolk NHS
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Trust Board – 29th September 2017

AGENDA ITEM:	12
PRESENTED BY:	Dr Nick Jenkins, Medical Director
PREPARED BY:	Dr Helena Jopling, Public health registrar
DATE PREPARED:	20th September 2017
SUBJECT:	Learning from Deaths policy and dashboard
PURPOSE:	Decision, Performance Monitoring & Information

EXECUTIVE SUMMARY:

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

The Board approved a programme of work which included:

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

The milestones all trusts need to meet are:

- publication of a trust-wide policy by the end of September 2017 (quarter 2)
- publication of information, on a quarterly basis in a public board meeting, describing the number of deaths, the number which have been reviewed and the number in which an element of preventability has been identified, by the end of December 2017 (quarter 3)
- publication of information about how the learning from reviews of deaths has had an impact on the quality of patient care in the 2017/18 annual report.

This paper presents the West Suffolk NHS Foundation Trust's policy on learning from deaths for the Board's consideration and approval.

Accompanying the policy is the first presentation of quarterly data. The Board agreed to receive this on a locally developed dashboard, rather than the nationally suggested one, subject to NHS Improvement's approval. The Medical Director has written to Kathy McLean, medical director at NHS Improvement, to seek this approval. The topic was discussed in a performance review meeting with the NHS Improvement regional team. The information is presented on the locally developed dashboard for the Board's perusal today, with a summary and further information provided below.

Outcomes of reviews of deaths, quarter 1, 2017/18

- In quarter 1 there were 224 inpatient deaths
- 193 have been reviewed
- 188 were judged to be definitely not preventable
- 2 were judged to have slight evidence of preventability
- 3 were judged to be possibly preventable, 50-50 but a close call

Of the 5 with some evidence of preventability, one has been subject to an investigation under the Serious Incident Framework. Four are awaiting peer review by the Learning from Deaths group.

The Learning from Deaths group needs to pay special attention to people in five groups:

- People with a learning disability
- People with severe mental illness
- Infants and children
- Babies who are stillborn
- Women who die during or after pregnancy or childbirth (maternal deaths)

The identification of people with a learning disability and people with severe mental illness is not yet robust, and the Learning from Deaths group has not been overseeing reviews of people in the other three categories during this reporting period. The data quality will improve over the coming months. In quarter 1, one death has been identified as occurring in someone with a severe mental illness.

Quality of care

Once the medical reviewers are recruited and structured judgment review method has been adopted for mortality reviews, the greyed out chart in the dashboard will present the judgments that medical reviewers make about the overall quality of care received by every person who has died and had a review of their care. It can't be populated at the moment. Recruitment of the medical reviewers has begun and we anticipate have the new method fully in use by end of March 2018.

Learning themes identified

The case in a person with a severe mental illness has revealed that in the trust, people who are vulnerable because of mental illness are not assessed well for their risk of self-harm or suicide and the Missing Person's procedure can be difficult to follow. The medical governance manager will lead an exercise to:

- review the Missing Person's procedure, and
- explore whether screening for risk of self-harm and suicide and close observation to reduce that risk should be adopted.

Summary Hospital Mortality Index (SHMI)

The dashboard also presents the most recent published data for the whole-trust SHMI. The SHMI in quarter 3 2016/17 was 93.78, within the expected range.

Linked Strategic objective (link to website)	Priority A: Deliver for today • Improve patients' experiences, safeguard patient safety Priority B: Invest in quality, staff and leadership • Learn lessons and adopt best practice from others
Issue previously considered by: (e.g. committees or forums)	Learning from Deaths group Clinical Safety & Effectiveness Committee

Risk description: (including reference Risk Register and BAF if applicable)	Safety risk if the trust fails to identify problems in care which lead to patient harm and preventable death, and fails to act to reduce them. Reputational risk if the trust fails to report preventable deaths and fails to demonstrate action to reduce them.
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:

To approve the Learning from Deaths policy for adoption and publication
To note the information on the Learning from Deaths dashboard and the narrative in this summary.
To note the learning theme and agree to receive updates on progress in future quarterly reports.

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Board of Directors – 29 September 2017

AGENDA ITEM:	13
PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce & Communications
PREPARED BY:	Denise Pora, Deputy Director of Workforce (Organisation Development)
DATE PREPARED:	21 September 2017
SUBJECT:	**Leadership Development Update**
PURPOSE:	For Information

EXECUTIVE SUMMARY:

This report provides an update on leadership development action planned to support achievement of the Trust's strategic framework *'Our patients, our hospital, our future, together'*. Specifically priority two to '*invest in quality, staff and clinical leadership'* and ambition seven '*support all our staff*'.

It also demonstrates how our leadership development activities address the requirements of the CQC Well Led Criteria and the NHS Improvement and Leadership Development Board's framework 'Developing People – Improving Care', as well as the cultural assessment carried out by KPMG as part of the FIP2 programme.

Three priorities were agreed for leadership development by Executive Directors in March 2017:

1. Development of leadership and improvement skills at all levels of the trust
2. Development of systems leadership in West Suffolk
3. Systematic talent management processes that facilitate a clinically led and managerially supported organisation and feed into NHS talent pipelines

In summary, action has been taken on these priorities as follows:

- **Agreement and initial implementation the Trust's talent management programme**
  - Talent register established to allow for targeting of opportunities and the creation of a talent 'pool' for succession planning
  - Work to develop a talent management framework for senior medical staff
  - Identification of 21 key leaders in roles critical to achieving the Trust's vision who will participate in bespoke programmes of leadership development

- **Development of systems leadership**
  - West Suffolk system leadership summit focusing on GDE as an enabler of the integrated care system in July 2017
  - Contributing to the STP footprint leadership development programme 'Bringing People and Organisations Together' started May 2017

- **Leadership development to support inclusive, compassionate leadership at all levels**
  - 2030 Leaders Programme for middle/senior leaders started in July 2017
  - Coaching skills programme for leaders started in August 2017 and establishment of an internal coaching register
  - Leadership and quality improvement forum the '5 O'clock Club' established in July 2017
  - Development of our leadership routines to provide benchmarks for the expectations of leaders throughout the Trust

More details of the action taken and planned are provided in the attached report along with details of how that action addresses external requirements/frameworks.

Linked Strategic objective (link to website)	• Priority: Invest in quality, staff and clinical leadership • Ambition 7: support all our staff
Issue previously considered by: (e.g. committees or forums)	Executive Directors meeting 22.3.17
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:	• CQC Well Led Framework • Developing People – Improving Care: national framework for action on improvement and leadership development in NHS-funded services • KPMG Cultural Assessment Action Plan June 2017
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	Workforce morale, recruitment and retention, reputation

Recommendation: The Board is invited to receive this report.

Leadership Development Board Update September 2017

Purpose

The purpose of this report is to update Board members on implementation of leadership development action to support achievement of the Trust's strategic framework *'Our patients, our hospital, our future, together'*. Specifically priority two to *invest in quality, staff and clinical leadership* and ambition seven '*support all our staff'.*

It also demonstrates how these activities address the requirements of the CQC Well-Led Criteria and the NHS Improvement and Leadership Development Board's framework 'Developing People – Improving Care', as well as the KPMG cultural assessment action plan resulting from the FIP2 programme.

Priorities for action

In March 2017 Executive Directors agreed three priorities for leadership development:

Priority 1: Development of leadership and improvement skills at all levels of the trust

Priority 2: Development of systems leadership in West Suffolk

Priority 3: Systematic talent management processes that facilitate a clinically led and managerially supported organisation and feed into NHS talent pipelines

Embedding the WSH Leadership behaviours into our culture underpins the action taken to address the priorities. The Leadership Behaviours (see *Appendix A*) were developed from the first Trust Leadership summit in December 2015 and provide a benchmark for the expectations the Trust has of all its leaders.

Links are also being made between our leadership development activity and other elements of the Trust's organisation development agenda i.e. our health and well-being strategy, quality improvement framework and equality and diversity objectives. The 'West Suffolk Leadership and Quality Improvement Faculty' is being developed to reinforce this systematic and connected approach to both leadership and QI.

Addressing our priorities - leadership development activity

The table below summarises action taken and planned to address our agreed leadership development priorities.

Action to address leadership priorities	Summary details	External framework/ requirements met	Trust Priority		
			1	2	3
Talent spotting	Developing management capability to identify and meet development needs and spot talent using the appraisal process (under development)	**CQC Well-Led*:** KLoE 1 & 8			√
***'2030 Leaders'* Programme**	Leadership development programme for 21 middle/senior high potential future leaders, including seven consultant medical staff. Programme includes three West Suffolk CCG participants. Started July 2017 – runs to June 2018. 2030 Leaders curriculum includes Eastern Academic Health Sciences Network (EAHSN) QI bronze and element of silver training and training in coaching skills provided by NHS Elect.	**CQC Well-Led*:** KLoE 1 & 8 **KPMG Action Plan:** Functional Leadership/Enable – "…*programme to improve coaching capabilities*…" **Developing People – Improving Care**:** Conditions 2 and 3	√	√	√
***'Key Leaders'* Programme**	Talent management and development process for 21 leaders in roles that are critical to achieving the Trust's vision. Each participant will have a bespoke programme of development agreed to address their individual needs.	**CQC Well-Led*:** KLoE 1 & 3 **Developing People – Improving Care**:** Conditions 1 and 2	√		√
Senior Medical Staff Talent Management Framework	Framework for tiers of senior medical leadership setting out competencies and development options from the induction of new consultants to the role of medical director. New consultants will undertake	**CQC Well Led*:** KLoE 1, 3, & 8 **Developing People – Improving Care**:** Conditions 1, 2 and 3	√		√

	EAHSN QI bronze training. *See also coaching section*				
Developing a coaching approach to leadership	Coaching skills for leaders workshops being run August 2017 to February 2018. Register of internal coaches and mentors (including NEDs) being established as a resource for trust staff. Pilot programme being established of 1:1 development coaching for all new consultants to facilitate and support them in in developing a personal development plan for their role as an organisational leader. (This is part of the Senior Medical Staff Talent Management Framework.)	**CQC Well-Led*:** KLoE 1 **KPMG Action Plan:** Functional Leadership/Enable – *"…programme to improve coaching capabilities…"* **Developing People – Improving Care**:** Condition 3	√		
Leadership and Quality Improvement Forum: *the '5 O'clock Club'*	The '5 O'clock Club' is open to all in leadership roles in the Trust and representatives from the wider system are also invited. It was launched in July 2017 and a regular programme of events planned including input on leadership from a senior USAF officer from RAF Lakenheath and Dr Mark Britnell, Chairman and Partner of the Global Health Practice at KPMG.	**CQC Well-Led*:** KLoE 1 **KPMG Action Plan:** Trust Leadership/ Improve: *"…time spent in broader staff forums to facilitate two-way discussion…"* **Developing People – Improving Care**:** Condition 3	√	√	
Leadership Summits	Three Leadership summits have been held since December 2015. West Suffolk system leadership summit was held in July 2017 focussing on GDE as an enabler of the ICS. A key outcome of the day was a GDE action plan developed from actions identified	**CQC Well-Led*:** KLoE 1 **Developing People – Improving Care**:** Conditions 1 and 2	√	√	

	by participants during the summit. Next summit will take place in December 2017 will focus on supporting junior/middle level leaders to develop resilience				
'Bringing People and Organisations Together' **Programme**	WSH has contributed to the development of this systems leadership programme covering the STP footprint. WSH therapy team members participating in West Suffolk cohort.	**Developing People – Improving Care**:** Conditions 1 and 2		√	
Establishing leadership routines* across the trust**	Agreement of core leadership routines for the senior executive team, whole trust leadership team and individual leaders to make expectations explicit and allow for standards to be set and monitored (see appendix B)	**KPMG Action Plan:** Trust Leadership/ Align: *"… setting out a structured timetable for leadership routine activities"*	√		
Management Development for leaders	Skills Plus Programme. Management Development modules for junior/middle level leaders Management development for senior leaders covering QI, operational, change, financial and strategic management **(in development)** Management Apprenticeships – level 3+ using the National Apprenticeship Levy	**Developing People – Improving Care**:** Condition 3	√		

***CQC Well-Led KLoE**

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
3. Is there a culture of high quality, sustainable care?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

***Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services** - the five conditions of the framework are:

1. Leaders equipped to develop high quality local health and care systems in partnership
2. Compassionate, inclusive and effective leaders at all levels
3. Knowledge of improvement methods and how to use them at all levels
4. Support systems for learning at local, regional and national levels
5. Enabling, supportive and aligned regulation and oversight

***KPMG Cultural Assessment FIP2 Programme June 2017 “Leadership Routines …a blend of principles, behaviours, skills and tasks.” Appendix B gives details of agreed Trust Leadership routines.

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APPENDIX A

Trust Leadership Behaviours

The Trust is a system of interdependent parts; the success of one part often relies on another. The glue that binds these together is a clear sense of shared values which is essential to success. These are the standards of behaviour expected of all those in a leadership role in the Trust.

1. **Demonstrate shared values**
   Demonstrating our leadership values will allow the organisation to achieve our Trust core values. Leaders should work collectively to lead a connected organisation.

2. **Be positive**
   Be positive and encourage others. There is no place for cynicism in a leader.

3. **Build bridges**
   Commit to working across silos and breaking down barriers. Patients need seamless care, not silos.

4. **Support new ideas**
   Support people to pursue innovations. But be clear about the difference between taking risks, which may sometimes fail, and incompetence.

5. **Communicate well**
   Communicate to staff, patients and stakeholders with clarity, simplicity and honesty.

6. **Say sorry and thank you**
   The most important words in the language of leadership. Acknowledge when you should use them and show appreciation for a job well done.

7. **Build an effective team**
   Develop a real insight into your weaknesses. Construct a team that compensates for any weaknesses and challenges you where required.

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Appendix B

Leadership Routines

Establishing a structured timetable for core leadership routines* helps ensure visible leaders who consistently communicate organisational priorities and are role models for the behaviour expected of trust leaders. Agreement of core leadership routines for the senior executive team, whole trust leadership team and individual leaders makes expectations explicit and allows for standards to be set and monitored.

Leadership routine	Frequency	Who it applies to
Act as a role model for the trust leadership behaviours	Daily	All leaders
Attend and contribute to core brief or TEG	Monthly	All leaders
Hold or actively participate in regular team meetings, including feeding back core brief messages	At least monthly	All leaders
Participate in the 5 o'clock club	Every 6 – 8 weeks	All leaders
Actively identify and recognise activities that improve quality and patient care, including nominating staff for awards and schemes that celebrate success e.g. putting you first, shining lights	Daily	All leaders
Agree clear objectives and provide opportunities for two-way feedback through regular appraisal	At least annually	All leaders who manage staff
Participate in Trust Leadership Summits	Twice annually	Executive Directors and other trust leaders as invited
Be available to all staff to discuss any issue for 1 hour a week (8 – 9 Wednesday mornings)	Weekly	Executive Directors
Participate in Quality Walkabouts	Weekly Tuesday am	Executive and Non- Executive Directors
Undertake a 'back to the floor' shift	At least annually	Executive and Non-Executive Directors
Attend Board Rounds	Daily/ weekly	Executive Directors
Board of Directors Development Sessions on ad hoc matters	Quarterly	Executive and Non-Executive Directors and other invited senior leaders as appropriate
Attend the 'Shining Lights' ceremony	Annually	Executive and Non-Executive Directors, Clinical Directors, General Managers, Heads of Nursing
Meet all new consultant staff and ED direct reports at induction	Ad hoc	Executive Directors

Meet new staff at Trust Induction	Monthly	Chief Executive and Executive Directors on rotation
Meet all consultants for a review of their first year with the Trust	Ad hoc	Medical Director

*Leadership routines are “a blend of principles, behaviours, skills and tasks” KPMG Cultural Assessment FIP2 programme June 2017

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Board of Directors – 29th September 2017

AGENDA ITEM:	14
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Cassia Nice, Patient Experience Manager
DATE PREPARED:	12th September 2017
SUBJECT:	National Inpatient Survey 2016
PURPOSE:	To provide an overview of the results of the National Inpatient Survey (2016).

EXECUTIVE SUMMARY:

The survey was sent to 1250 patients from each trust who were inpatients throughout July 2016, counting back from the last day of July until 1250 patients had been selected for the sample. Fieldwork took place between September 2016 and January 2017. Patients were eligible for the survey if they were aged 16 years or over, had at least one overnight stay and were not admitted to maternity or psychiatric units. The trust scored significantly better than other trusts in two questions and significantly worse than other trusts in one question.

The report has highlighted a number of areas where we have performed significantly worse compared to the 2015 Inpatient Survey. An action plan will follow to address these areas. The Patient Experience Manager will work in conjunction with Heads of Nursing to deliver solutions to these points and progress will be monitored by the Patient Experience Committee on a quarterly basis.

- **How do you feel about the length of time you were on the waiting list?**
- **From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?**
- **Did you get enough help from staff to eat your meals?**
- **In your opinion, were there enough nurses on duty to care for you in hospital?**
- **Discharge delayed due to wait for medicines/to see doctor/for ambulance - how long was the delay?**
- **Were you given any written or printed information about what you should or should not do after leaving hospital?**
- **Did a member of staff explain the purpose of the medicines you were to take home in a way you could understand?**
- **Were you told how to take your medication in a way you could understand?**
- **During your hospital stay, were you ever asked to give your views on the quality of your care?**

Linked Strategic objective (link to website)	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)	None

Risk description: (includingreference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	All trusts are required to participate in the survey following national criteria and centralised analysis.
Legislation / Regulatory requirements:	Results are available to the public on the CQC website and will be used by the CCQ as part of their Intelligence Monitoring processes
Other key issues: (e.g. finance, workforce, policy implications, sustainability&communication)	
Recommendation: Trust Board are asked to receive the report and note poor scoring areas.	

Board of Directors – 29th September 2017

ITEM	16
PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Medical Staffing, HR and Communications Directorate
DATE PREPARED:	21st September 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 Anaesthetics
DATE OF INTERVIEW:	31st August 2017
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]

	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	2 1 1

POST:	Consultant in Care of Elderly
DATE OF INTERVIEW:	10th August 2017
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]

	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	1 1 1

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 29 September, 2017

AGENDA ITEM:	17
PRESENTED BY:	Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Michael Bone, Chief Information Officer
DATE PREPARED:	23 September 2017
SUBJECT:	To receive an update on e-Care/Global Digital Excellence Programme
PURPOSE:	Update on current position

EXECUTIVE SUMMARY:

- In final count down for Phase 2 Drop 3 that is due to go live at the end of October delivering:
- New dynamic documents for clerking, progress notes and frailty
- New dynamic documents and outcomes measures for AHPs (assessments and forms)
- Paediatrics department go live in e-Care
- Twelve new nursing care plans
- Three enhanced recovery pathways (knee, hip and colorectal)
- Two new admission pathways (acute abdominal pain and shortness of breath)
- New diabetes care plan and insulin prescribing.
- New admission, transfer and discharge workflows
- Medicines enhancements – including changes to TTO prescribing process, alert for duplicate paracetamol prescribing, retrospective documentation following arrest/resuscitation, and new pharmacy care organiser.
- Patient Flow for Porters and House Keeping

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	At this time we are in the final stages of preparation for drop 3 with a go live date of 30th October. As noted in the executive summary this will deliver • Dynamic documentation • Paediatrics within e-Care • Suite of nursing care plans • 5 new care pathways (3 Recovery and 2 Admission) • New Diabetic Care Plan • New ADT Workflows • Medicines enhancements • Patient Flow/Capacity management
3.1	***Drop 2*** The patient portal has been delayed due to a mix of technical and staffing issues and will now commence after 30th October. Also of note is that not all of the original Medicines Enhancements have been completed and so the Medicines project will continue into Phase 3.

3.3	After very a considerable level of review the Secretariat have decided not to proceed with the Cerner Medical Transcription Module and so the work to enhance the secretarial workflow is now concluded.
4	**GDE update**
4.1	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.
4.2	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.

Initially the main focus was on pillar four as this is the critical infrastructure that supports delivery of all other components. More recently work has focussed on Pillar 1 to build a proposal for Programme and Trust Board approval.

4	**Pillar 1 – Digital Acute Trust**
4.1	Ahead of the proposal for Pillar 1 work has been underway to build a series of business cases for the areas of the Trust that would benefit from new software available as part of the Cerner EPR. Unfortunately the provision of cost Information from Cerner has been very much delayed and whilst originally proposal was agreed in outline in July final figures have only very recently been provided. As a result a great deal of work has / is being undertaken to calculate the cost of each module option and compare this with the proposed budget to assure VFM and affordability. Sadly it has not been possible to fully complete this work in time for the September Board.
5	**Pillar 2 – Supporting the Integrated Care Organisation**
5.1	• Following the original demonstration of the Cerner population health solution a further demonstration was held in late August for system partners. This was well received and stimulated much debate. It has been agreed that a further demonstration would be appropriate in the fall. • The Trust was a key presenter at the Norfolk EPR day on 20th September with our CCIO and CIO providing a mixed clinical and operation audience with

	valuable insight into the work we have undertaken. • We have now connected 14 out of 16 EMIS GP practises to Health Information Exchange (HIE) and are now busy preparing for rollout to the SystmOne GP sites. At this time view only access remains one way (GP's have access to e-Care) and so the Trust remains frustrated by the lack of progress on the CRV which will permit two way view only access. The latest position is it should be ready in late October. • In parallel work continues on the HIE link to Cambridge (CUH). In test mode the CUH link is up and running, however testing continues as fine adjustments to the clinical content is made. Work also continues to finalise governance and security settings.
6	**Pillar 3 – Exemplar Digital Community**
6.1	• We continue to work with Milton Keynes University Hospital NHS Foundation Trust who are now officially our NHS GDE "Fast Follower". We have regular monthly meetings by video conference and will meet F2F in December. As part of the partnership technical blueprints and some staff assets are now being shared. • We continue to deliver our requirements from an international partnership and have been in discussion with both Advocate and Banner, with former being preferred. • The Trust held a highly successful first GDE event to showcase our Allied Health Professional (AHP) content in September. This was well received by all who attended and we have been asked to Blueprint what we have done.
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. • The new Firewall is now installed and working, so the digital communications team are busy consolidating and migrating existing firewall rules as we look to centralise control and decommission some seven obsolete units. • The first of two planned upgrades of our e-mail system (from 2003 to 2010) is now complete. New location mailboxes are now being created as the Trust prepares to centralise management of all meeting room and enable the meeting room display panels in Quince House and the Directorate Offices. • The VoIP Telephone system is now fully up and running in Quince House with new telephone extension being provided as part of the GP Streaming Project and the new building work on G6, F12 and the Cath Lab. • Skype 4 Business video conferencing is now up and running for some 30 staff and will shortly be available in several of the Trust meeting rooms. In parallel Webex and Audio Conferencing services are also being built to further extend our ability to work collaboratively.

8	Recommendations
8.1	The Board is asked; • To note the general progress

West Suffolk NHS
NHS Foundation Trust

Trust Board – 29th September 2017

AGENDA ITEM:	18
PRESENTED BY:	Nick Jenkins
PREPARED BY:	Dawn Godbold
DATE PREPARED:	20th September 2017
SUBJECT:	Community contract and services update
PURPOSE:	Information and approval

EXECUTIVE SUMMARY:

1. Purpose

1.1 This paper has been prepared to provide an update on the progress of full mobilisation of the community contract on 1 October 2017, including: designated employer arrangements, TUPE arrangements, mobilisation actions, and finance and governance arrangements.

1.2 The Board is asked to note progress and approve the actions and monitoring 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 1st October 2017. We have successfully undertaken a 'most capable provider' process to be awarded the community services contract for a minimum of 7 years with the option to extend for a further 3 years. Two alliances (West and East) to deliver the contract have been 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 plan for and mobilise the contract on the 1st October. The West Suffolk Alliance intends to build on this way of working, and use it as the foundation to move to an integrated care system (ICS). The early framework for how this will be structured is included as Appendix A.

3.0 Key Points

The Board is asked to note the key stages and programme of work shown below that has been completed to transition and mobilise the community services contract:

- 2 assurance gateways with commissioning colleagues
- Service outsourcing decisions
- Service disaggregation process
- Designated delivery organisation process
- Designated employer process
- TUPE process/consultation
- Mobilisation arrangements for the new contract
- Clinical and corporate governance arrangements
- Financial and contractual arrangements
- 'Go live' plan 1st October
- Future service transformation plans
- Future integration plans

4.0 Recommendation

4.1 The Board is asked to note the process followed to secure the community services contract and to note and approve the arrangements for managing and monitoring the contract from 1st October 2017.

4.2 The Board is asked to give its continued support and involvement in the development of the West Suffolk System Alliance and the transition to a fully Integrated Health and Care System.

Linked Strategic objective (link to website)	Ambition 3 Deliver Joined up Care
Issue previously considered by: (e.g. committees or forums)	Previous Boards and Board workshops, Council of Governors, Scrutiny Committee 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 / Regulatory requirements:	
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.

West Suffolk NHS Foundation Trust

Community Contract Mobilisation – Board Update Report

September 2017

1.0 Introduction

1.1 The board has previously received regular updates on the changes affecting the community services contract. Namely:

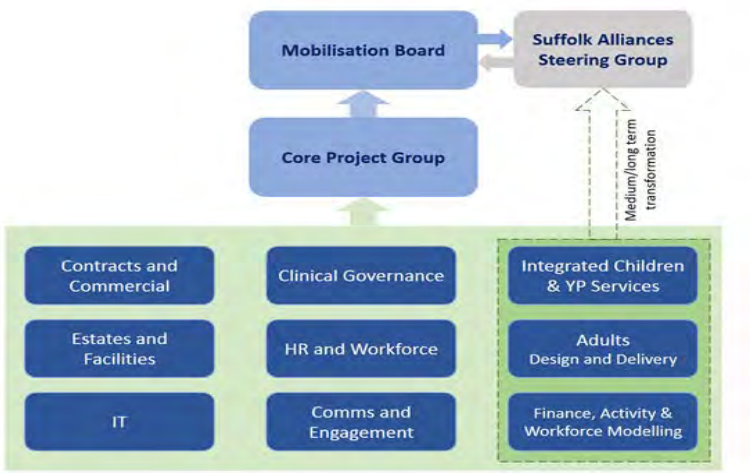
- The 'most capable provider' process that has been followed
- The dis-aggregation east and west of some services
- The process used to determine designated employer
- The project governance and work stream processes followed
- The early development ideas to form the West Suffolk Alliance
- The early stage thinking of future system shape and structures
- The context of the STP and its connection to the local changes planned

1.2 The new community services contract will commence on 1st October 2017, this paper provides an update on the project, our state of readiness and describes the future arrangements and further changes that will develop and evolve over the next 10 years. The changes we are making to the community services contract and delivery models from the 1st October are the first steps to wider whole system change.

2.0 Project Structure

2.1 The programme to transition the services and contract has been operating with a number of work streams, one each for clinical governance, finance/activity modelling, estates and FM, information technology, human resources, communication and engagement, contracting and commercials, integrated children and young people's services and adult's services operational delivery and transformation.

The programmes structure used is shown below:



3.0 Designated Delivery Organisation and Designated Employer Outcomes

3.1 The cessation of the current contract and the ceasing of the arrangement with Norfolk Community Health and Care (NCHC) means that some services needed to be aligned to new employers and some current county wide services needed to be aligned on an east/west basis.

3.2 The process followed to determine where services would align and how employer decisions would be reached has been shared with the Board previously, and is summarised in the chart in Appendix A.

3.3 Having completed this process the table below shows where services will be aligned from the 1st October 2017:

Services remaining / transferring to WSFT	Services remaining / transferring to IHT	Services transferring to GP Fed	Posts transferring to the Central Education Hub (hosted by IHT)
Community Services Communication Officer	Care Co-ordination Centre	Clinic Clerks, Receptionists and Line Manager	District Nurse Development Lead
Informatics	Falls & Osteoporosis (East only)	Stoma Service	Practice Development Facilitators
Paediatrics	Integrated Discharge Planning	Falls Fracture Liaison (West only)	Tissue Viability Nurses
Lymphoedema Service	SystmOne Manager & Trainers	Minor Injuries Unit (Felixstowe)	Clinical Educator
Glastonbury Court	Payroll Administrator	Podiatry, including Line Manager	Corporate Business Support
Neurology Service, including Parkinson's & Epilepsy	Foot & Ankle Service	Bladder & Bowel Service, including procurement	Safeguarding Lead
Admission Prevention Service	Admission Prevention Service		
Adult Speech & Language Therapy	Adult Speech & Language Therapy		
Community Health Teams, including Local Area Managers, Team Admin & Business Support	Community Health Teams, including Local Area Managers, Team Admin & Business Support		
Community Matrons	Community Matrons		
Community Hospitals	Community Hospitals		
COPD Service	COPD Service		
Pulmonary Rehabilitation	Pulmonary Rehabilitation		
Cardiac Rehabilitation	Cardiac Rehabilitation		
Heart Failure	Heart Failure		
Facilities Management	Facilities Management		
Workforce Team	Workforce Team		
Community Equipment Service (outsourced)			
Wheelchair Service (outsourced)			

3.4 For some services listed there will be a TUPE transfer in and out of some staff. These transfers will result in an increase of 133 staff headcount for the trust. For staff leaving the trust there is a farewell lunch organised for 26th October.

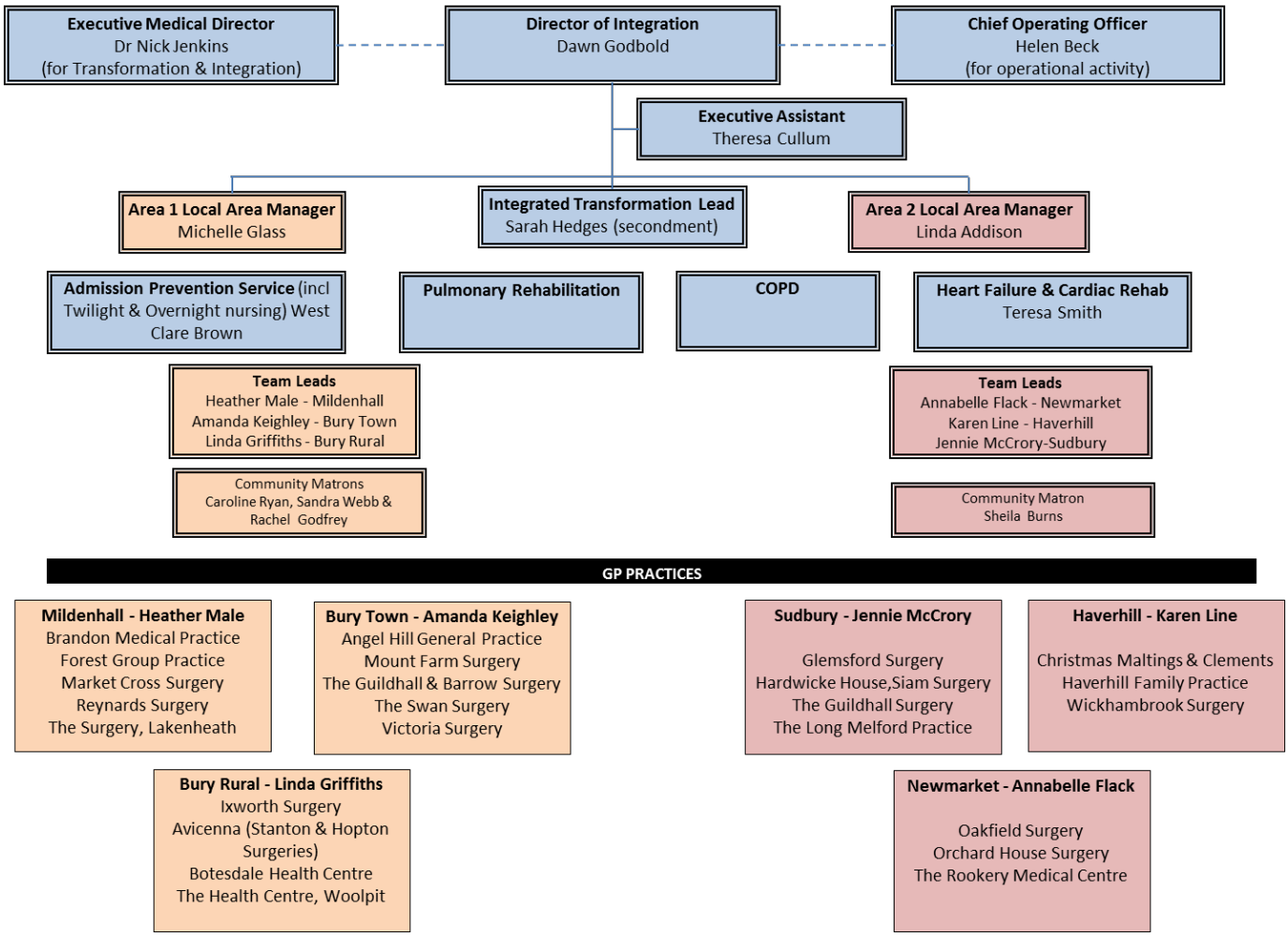
Provider	Current Headcount	Proposed Headcount	Net Headcount Change	New total headcount as proportion of contract	Comments
NCHC	**575**	**0**	Decrease of 575	**0%**	Reflects loss of sub-contract
IHT – Adult Services	**212**	**563**	Increase of 351	**48%**	
IHT – Care Coordination Centre	**39**	**39**	Nil		Will be subject to procurement at later date
WSFT – Adult Services	**197**	**330**	Increase of 133	**45%**	
WSFT – Specialist children's services	**243**	**243**	Nil		Specialist children's staff subject to change in 6+ months
Suffolk GP Fed	**0**	**91**	Increase of 91	**7%**	

4.0 Operational Arrangements for Community Services joining WSFT from 1st October

4.1 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 and to allow for a 'settling in period'. 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.

4.2 For the community services that are already at the trust, the current management structures will remain 'as is' to avoid unnecessary disruption. The interim management structure for the community teams joining the trust is shown in the chart below:

West Suffolk Community Services Structure



4.3 To ensure we maximise the opportunity that combining and joining up traditional community and acute services present, it is proposed that we approach these integration discussion and arrangements in a staged way:

Stage 1: 1st October – 31st December – interim arrangements/settling in period.

Stage 2: 1st September–31st December - scope integration opportunities/vision for both community and acute services.

Stage 3: 1st January – 31st March 2018 plan for integration engagement/consultation with key stakeholders and staff.

Stage 4: April 2018 - implementation of integrated structures and operational arrangements

4.4 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 take place on 1st November for adult SaLT, and mid -December for the reminder. This is ensure that a robust 'west only' service model can be put in place

4.5 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.

4.6 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. The transformational roadmap for children's services in presented in appendix D.

4.7 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 any changes for children's services will take place on 1st April 2018.

4.8 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.

4.9 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 which is currently underway.

4.10 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.

4.11 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.

5.0 Governance arrangements

5.1 The joining of acute and community services requires new mechanisms to be in place to optimise sharing and learning, whist recognising the distinct differences of providing safe services in contrasting locations.

6.0 Clinical Governance

6.1 The clinical governance work stream has completed a piece of work, which reviewed the central functions, examined the options for those functions and has recommended the following arrangements:

- To transfer all current centralised governance functions to the new employing organisations
- The current central function will cease on the 31st September 2017
- The governance arrangements for each provider will then be explicit to ensure CQC compliance, and clarity of accountability
- Implement mechanisms to understand the risks, learning and best practice across both alliances to develop a more integrated way of working
- Ensure any new arrangements keep disruption to business as usual to a minimum

6.2 The clinical governance work stream has reviewed all governance functions currently provided in the community contract. A due diligence exercise has been completed to identify ensure the organisations receiving staff have the capacity and functions available to ensure the community governance functions can be incorporated. The full list of governance functions is presented in appendix B. The appendix outlines the current status of the work undertaken to ensure that all functions are ready for 1st October.

6.3 This work has also identified if there are any differences or gaps in the functions and if any additional work is required to ensure the needs of the community services can be met. West Suffolk Foundation Trust and the other alliance partners have current governance arrangements that will need to continue without disruption.

6.4 There will be a central education hub that will operate county wide for all community services. The functions that will be within this hub are: mandatory training (up to end Dec 2017), tissue viability services, safeguarding services, District Nurse training, professional development and education. This will help to ensure consistency across all teams and make best use of this small resource.

7.0 Corporate Governance

7.1 The trust has been hosting some community services since October 2015. During that time the community information, monitoring of services and overview of provision has been reported slightly separately to the acute information. Now that this contract is to be awarded for a longer time period we have the opportunity to fully integrate both sets of information and monitoring arrangements. This will require changes to the way we currently operate some of the board sub-committees and memberships.

7.2 The community services managers will attend a performance review meeting with Executive Directors from November onwards; this will be consistent with the other divisions in the trust.

7.3 The community services will still need to produce a separate quality and contract report for the CCG; however information contained in the report will also be routed through the relevant trust forum/sub-committee.

7.4 The corporate governance arrangements for the new contract will be key to ensure learning from incidents, sharing of best practice and innovation is approached in an integrated way across the whole care pathway.

7.5 There are already many similarities in the way we carry out governance functions as we have to comply with the same regulatory bodies. The access to policies and clinical protocols will continue to exist for all community staff via the community intranet to avoid confusion.

8.0 Contracting Mechanism

8.1 Developing an alliance approach to the contract requires specific commitments and behaviours from all parties. It is a significant step change to the way we have traditionally

worked and organised ourselves. With this in mind the alliance partners have agreed to work to the following contracting principles:

- Collaborate and co-operate with integrity and respect. Commit to no disputes;
- Be accountable to each other. Take on, manage and account to each other for performance of respective roles, responsibilities and for the delivery of their service elements;
- Ensure open and transparent communication, discussing major concerns or issues openly, exhibiting clarity where conflicts of interest arise, and working together to realise opportunities relating to any joint undertakings;
- Deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the agreed responsibilities;
- Act in a timely manner, recognising the time-critical nature of joint activity and respond accordingly to requests for support;
- Make 'best for service' decisions. Work collaboratively to deliver person centred, sustainable, high quality care and service outcomes with services that are responsive to local needs;
- Operate open book accounting within the Alliance to deliver best value and financial sustainability, agreeing priorities for development based on system return;
- Adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, competition law, data protection and freedom of information legislation;
- Manage stakeholders effectively.

8.2 At the Alliance Steering Group on 20/07/17 the following recommendations for the preferred contracting model were agreed:

- Initially adopt a prime provider contract model;
- Initially issue two prime contracts - one to WSFT for West Suffolk services and one to IHT for East Suffolk services;
- Minimise the number of sub-contracts in place wherever possible, so that sub-contractors are assigned to one prime provider and any sub-contracted services are themselves shared between the prime providers by inter-prime sharing agreements or sub-contracts;
- The initial contracts between the alliance provider partners are "place holders" and enablers for transition to an alliance form of contract on a timetable to be agreed;
- The alliance partners will work towards transition to an Alliance model of contracting within a period of two years;
- The initial prime contract term should extend over the full expected service delivery term (10 years) notwithstanding the planned transition of the contract model
- The partners would explore ways to manage the contracts in an alliance environment.

9.0 Contract Management Options

9.1 The following contract management options were explored by the contracting and commercials work stream and presented to Alliance Steering Group members on 14/09/17.

9.2 **Option A – Do nothing - keep the existing arrangements**

9.2.1 This is not a viable option. The current contract is managed by a Joint Venture which will be discontinued on 30th September 2017. The management arrangements for the JV would not support the proposed contracting arrangements with effect from 1st October 2017.

9.3 **Options B1 & B2 – Traditional contract management**

9.3.1 Traditionally, contracts are managed on a party by party basis by a series of escalating meetings between the Commissioner and the Provider. This usually requires separate meetings between the contracted parties and, where sub-contracted services are involved, additional separate meetings between the prime provider and the sub-contractor. These arrangements can result in splintered discussions and agreements regarding inter-dependent services and to mis-alignment of those services. The multi-level nature of such management leads to extra meetings and consequently a need for a higher level of resources than would be necessary if the management arrangements could be merged.

9.4 **Option C Alliance Contracting – Contracted Providers Only - Merged Management**

9.4.1 This option develops the traditional management arrangements and moves towards an alliance style of working. In this option the West and East contract management meetings would be held on a merged basis with the GP Fed as a material sub-contractor also in attendance. Matters arising from all the related contracts would be discussed at each relevant meeting in an integrated manner with all parties contributing.

9.4.2 Joint Sub-group meetings would be expected to manage the initial detailed review of clinical and operational governance. These meetings would expect to be operated on an open book basis by all parties to enable visibility of quality, performance and early warning triggers.

9.4.3 Joint Contract meetings would review KPIs, proposed contract variations and proposed escalations of clinical and operational governance to the Lead Directors' Meeting.

9.5 Options D1 & D2 – Alliance contracting – All Partners

9.5.1 Options D1 & D2 are a development of Option C and moves the management to a full alliance structure where all the Alliance Partners are involved in management of the contracts i.e. NSFT and SCC are now involved.

9.5.2 Option D1 provides for the management to be undertaken on a West / East split basis. Option B2 provided for as pan Suffolk model where all the Partners manage the Suffolk wide contracts.

9.5.3 Neither of these options align with the contract model which the parties have agreed for the commencement of services on 1st October 2017. It is suggested that these options (D1 & D2) should be fully considered when the Partners undertake the transition of the contract model, which is proposed during the two year period post contract commencement.

9.5.4 On 14/09/17 the Alliance Steering Group approved the contract and commercial work stream's recommendation to adopt option C as the preferred initial model for managing the contracts, with a standing invitation to all alliance partners to attend contract management meetings.

10. Finances

10.1 Financial model development has been undertaken through the finance, activity and workforce modelling work stream utilising elements of previously developed and tested

financial models, aligned with the mechanics of the Monitor developed Long Term Financial Model (LTFM).

10.2 The model takes into consideration a range of variables and assumptions including growth in activity, funded and unfunded cost inflation, cost pressures (e.g. relating to NHS Property Services estate) and investments required (e.g. for IT).

10.3 Finance is the subject of a separate paper to the closed Board.

11.0 Preparedness

11.1 In addition to work streams a number of events and forums have taken place to ensure readiness for the 1st October. Fortnightly staff reference group calls, fortnightly meetings with the trade unions and monthly meetings/workshops with the senior community staff and relevant alliance partners have all taken place in addition to the Mobilisation Board (monthly), the project core group (fortnightly) and the Alliance Steering Group (monthly).

11.2 The trust has developed a 'welcome pack' for all new joiners. The pack is a comprehensive set of information about the trust, processes and structures that new staff will need. It has been developed with the input of existing managers, staff, trade unions and 'lesson learnt' from previous transitions. The pack has already been shared with staff and training on new finance systems, mileage claims etc is already underway during September.

11.3 Colleagues from both acute and community services have made informal contact with one another and workshops have been held to share information and familiarise colleagues with each other's areas of responsibility. Executive Directors have also committed to visiting community teams during September.

11.4 A 'meet and greet' session for senior managers of the trust and community is arranged for 2nd October.

12.0 Risks

12.1 A risk log for the programme has been developed and continuously developed to monitor and mitigate risks as they occur. Each transition work stream has its own risk log which is reviewed at each meeting. The individual work stream risks are then populated into the overarching programme risk log. This is reviewed at the project group and the Mobilisation Board and shared with all stakeholders as part of the weekly highlight reports. A copy of the current risk log can be found in appendix E.

12.2 The programme structure and work streams will continue beyond 1st October, to ensure any implementation/transition issues can be resolved.

12.3 The alliances will review the current arrangements for alliance working once this contract has transitioned. In the West we will move to a more formal West Alliance structure to allow for local decision making. The West Alliance will continue to develop over the coming months in parallel with the changes we will make in the trust to ensure acute and community services are truly integrated.

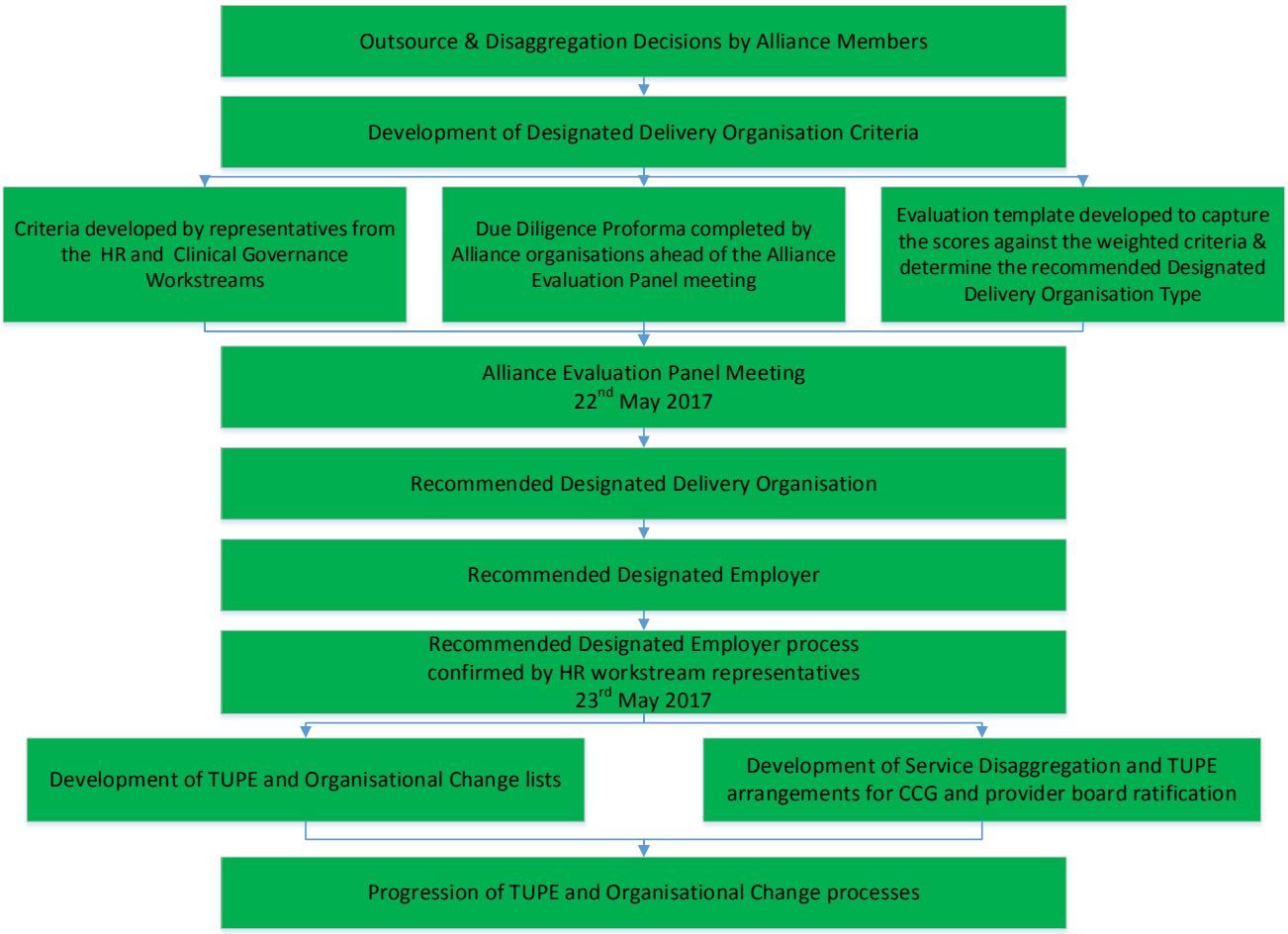
13.0 Next Steps

13.1 The TUPE transfer of adult community services staff will take place on 1st October and the new interim operational management structure will come into effect at that point.

13.2 Specialist children's community services will be delivered under the contract from 1st October, although existing employment arrangements will continue for an interim period of up to six months. This is to allow for further transformational work to ensure that the right solution for children and their families is reached by the alliances. A detailed programme of activity has been developed and will be presented to the Alliances Steering Group on 12/10/17.

13.4 Work continues to scope the integration opportunities and vision for both community and acute services. It is expected that engagement and consultation on plans for integration will commence in January with key stakeholders and staff, with new integrated structures and operational arrangements in place for 1st April 2018.

Appendix A: **Designated Delivery Organisation and Designated Employer Decision Process**



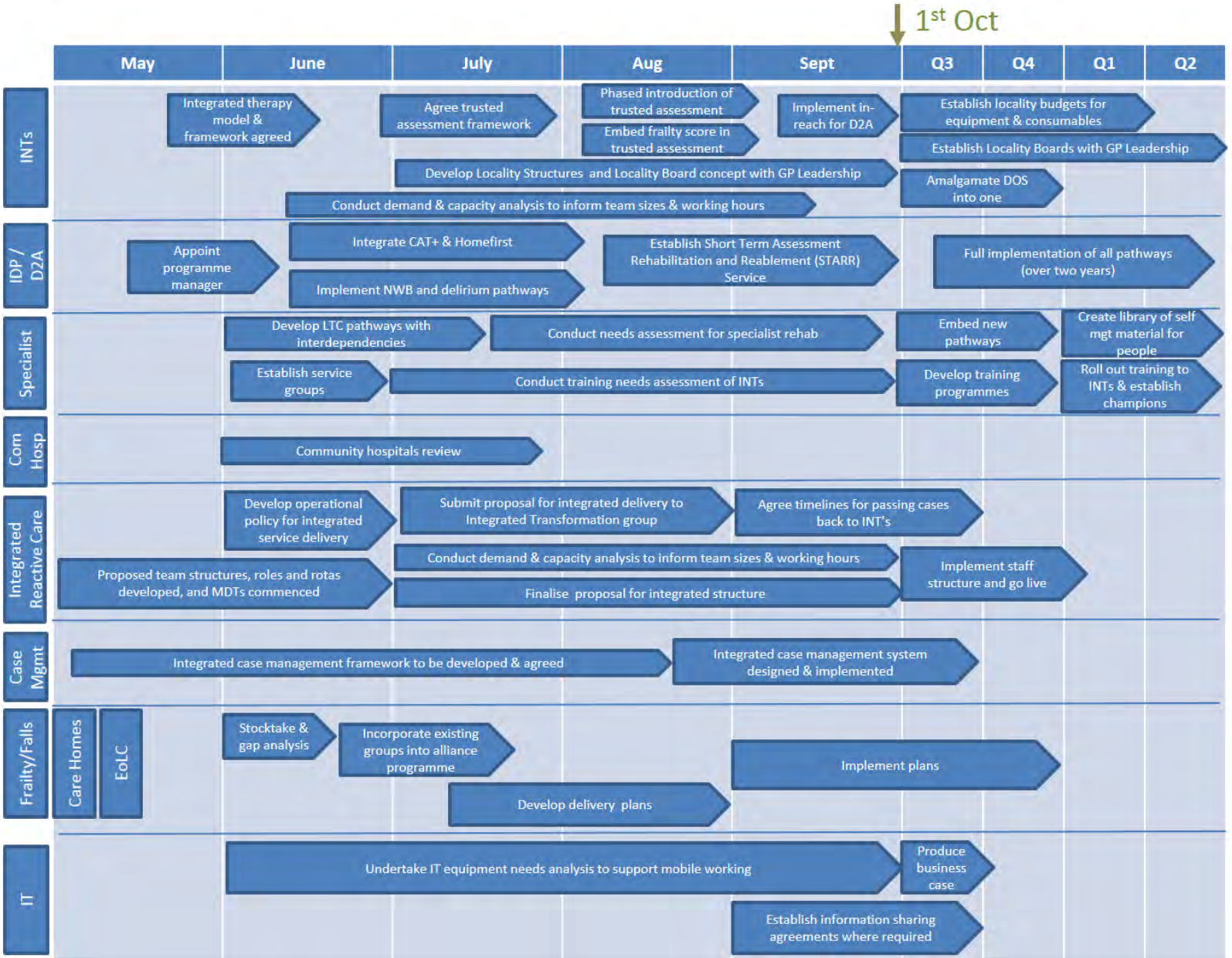
Appendix B: **Governance functions and current status**

Function	Overview	Additional considerations
Health and safety-	The current Health and Safety currently covered by the current host organisation and will need to continue.	
Local Security Management Specialist (LSMS)	This function is currently with hosts organisations.	Within the new providers the GP Fed does not have this function, work is underway to identify if this will be a requirement going forward with the additional staff they are employing as they providing services on behalf of the NHS.
EPRR	Provision needs to continue with Host organisations.	
Incident management	A sub group has been set up to explore the incident reporting systems in the new hosts and if they meet the needs of the community services. Norfolk Community Health and Care (NCH&C) are also involved to support this work. The GP Fed currently does not use Datix but is in the progress of having it installed within their organisation which will be ready for the 1st October. The groups of staff who are Datix incident reviewers have been provided to each organisation so they can be uploaded on their systems. Work is underway to ensure the subject matter experts are correctly linked. Staff access and identifying what training is required is on the current action plan to be completed. Duty of Candour compliance is managed within the Datix system and will continue to do so.	Discussion on how access to incident data post 1st Oct from NCHC. This will be required for patient complaints, CQC queries, and litigation queries. **Three options;** 1. Extract on excel by NCHC team, type etc, which will not include attachments. 2. Pay for an extract from Datix onto a standalone data base for all 3 providers to access. 3. Contact NCHC if there are queries for them to provide the required information. Options to go to clinical governance work stream.
Management of Serious Incidents (SIs)	Currently SI's are managed within the current Datix owners and the SCH risk team and subject matter experts link into this. We have a central process for managing the action plans and ensuring reports are completed and submitted to hosts for uploading on STEIS and the forwarding o the CCG. This process will be entirely within the 3 employing organisations going forward, information will need to be sent to staff to understand who is responsible for submitting Sis RCAs and action plans.	
CQC registration	All new organisations have current registration with the CQC, are in the process of reviewing their locations and registered activity and statement of purpose. The Clinical governance workstream is undertaking a due diligence process to ensure CQC registration is appropriate.	Positive return required from all providers
CQC preparedness	Currently there is a programme where by all services in SCH received a 'mock' CQC audit by the current governance team and senior managers. A report and actions are provided to the services and they attend a Quality Assurance Panel to sign off the actions in due course. This process is recognised as best practice in ensuring staff have a working understanding of the CQC regulations and are able to articulate and demonstrate their compliance.	It is requested this is consider to continue in the new contract which could be incorporated within the new organisations own CQC preparedness.
Accountable	This function is currently with the host	

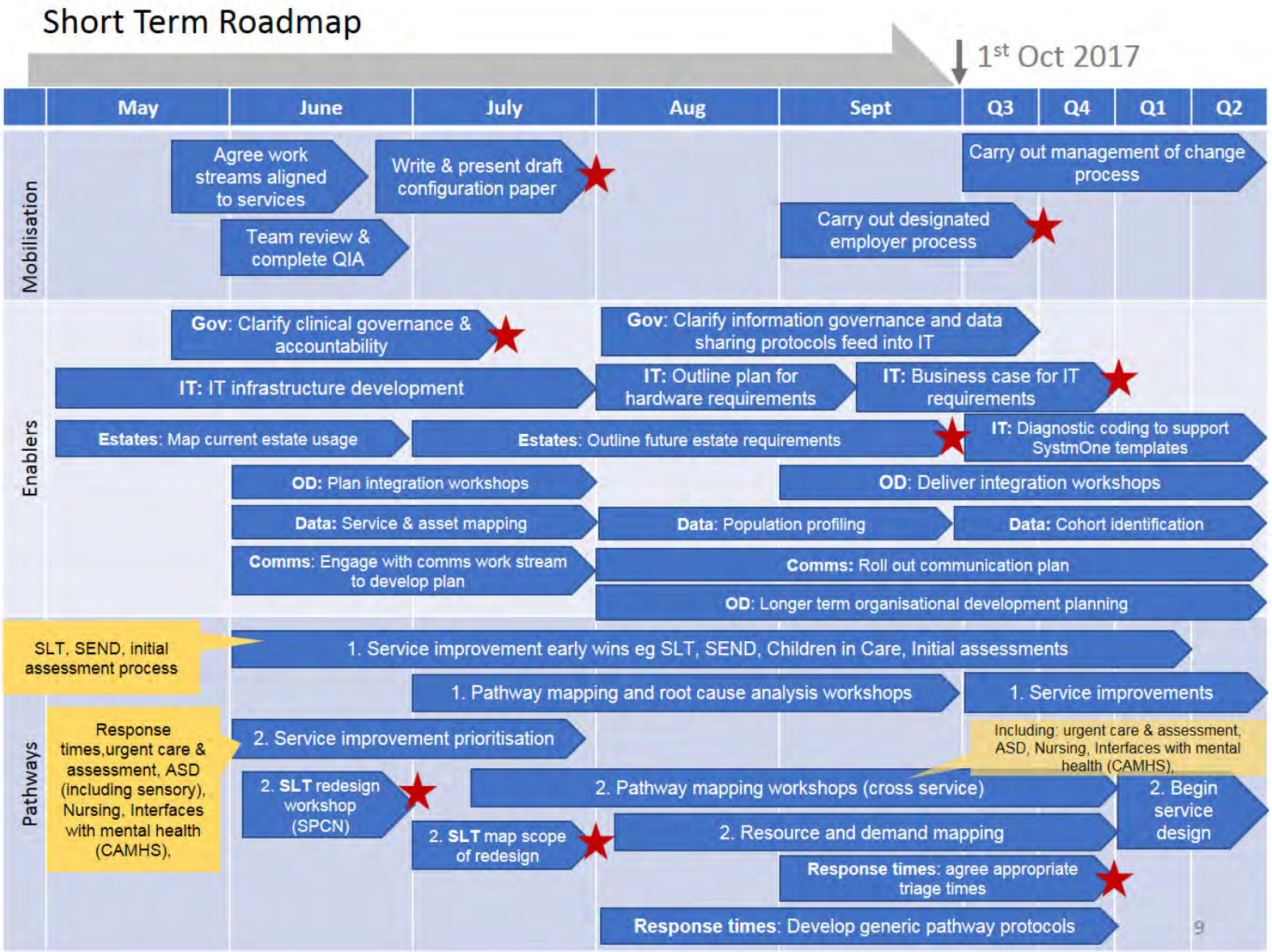
Officer	organisations and will remain with the new providers. The management of controlled drugs is already supported by both IHT and WSNHSFT Chief Pharmacists so processes within the inpatient units will be aligned in full. The GP Fed has an accountable officer function that will cover the new services. The provision of the quarterly AO report will need to include community services.	
CAS/ MRHA notices	The distribution and management of action plans currently sits within the hosts organisations supported by the central governance team. In order for the new providers to take this in-house entirely , a process will need to be set up to ensure the new community services are included within all distribution lists and key contacts are mad e to ensure services receive any alerts relevant to them.	
Coroners case	There are currently 5 coroner's cases which relate to inpatient units or the community Healthcare teams. Any outstanding cases at the end of September will be handed over to the relevant provider organisation and the coroner informed of the organisational change.	
Legal requests	There are currently 10 Legal requests/cases in SCH. 3 of which are legacy which are being dealt with via the SERCO Legal team. Upon transfer the organisations whom the case is brought against will remain the owners of the case.	Access to SCH notes for both staff and patents will need to be available to enable any additional information to be submitted and support staff in the event of them appearing at a hearing
GP log	The GP log is the mechanism that the GPs in Suffolk raise their concerns via the CCG regarding SCH services. The log has approximately 1-2 complaints per month and is monitored by the CCG. The Pals Team in the CCG will need to be informed where services are going so they can direct the query to the appropriate provider.	Consideration need to be given with the CCG as to whether the log is still required with the development of a more integrated serviced.
Risk registers	Each current provider has a risk register for our services. The top risks are amalgamated to the SCH Risk Report each month. The risks on each register will need to be transferred where appropriate, to the new providers and allocation of the risk owner reviewed. NCH&C will provide a down load of the risks at the end of the current contract. Provision or reports hosts	
SCH Intranet	This will remain in place on transfer of services to ensure all staff has access to policies, procedures and the information they need to undertake their work safely. A GP Fed page will be developed in advance of the change and revealed on the 1st October.	
Adult safe guarding Lead	This post is transferring to the Educational Hub under a SLA which will enable cross organisational working. Work will need to be undertaken by the SG Lead to understand the different policies and reporting for each provider so her advice is in line with trust policy.	
Policy	All clinical policies have been sent to the new providers to either ratify as is or amalgamate with their policy. All policies will be listed under the new providers on the intranet on the 1st October.	
Infection control (IC)	Infection control is with the current host IC leads as is the Director of Infection Prevention and Control (DIPC) role.	Infection control training is currently paid for on bank; additional resource will be required for each provider to

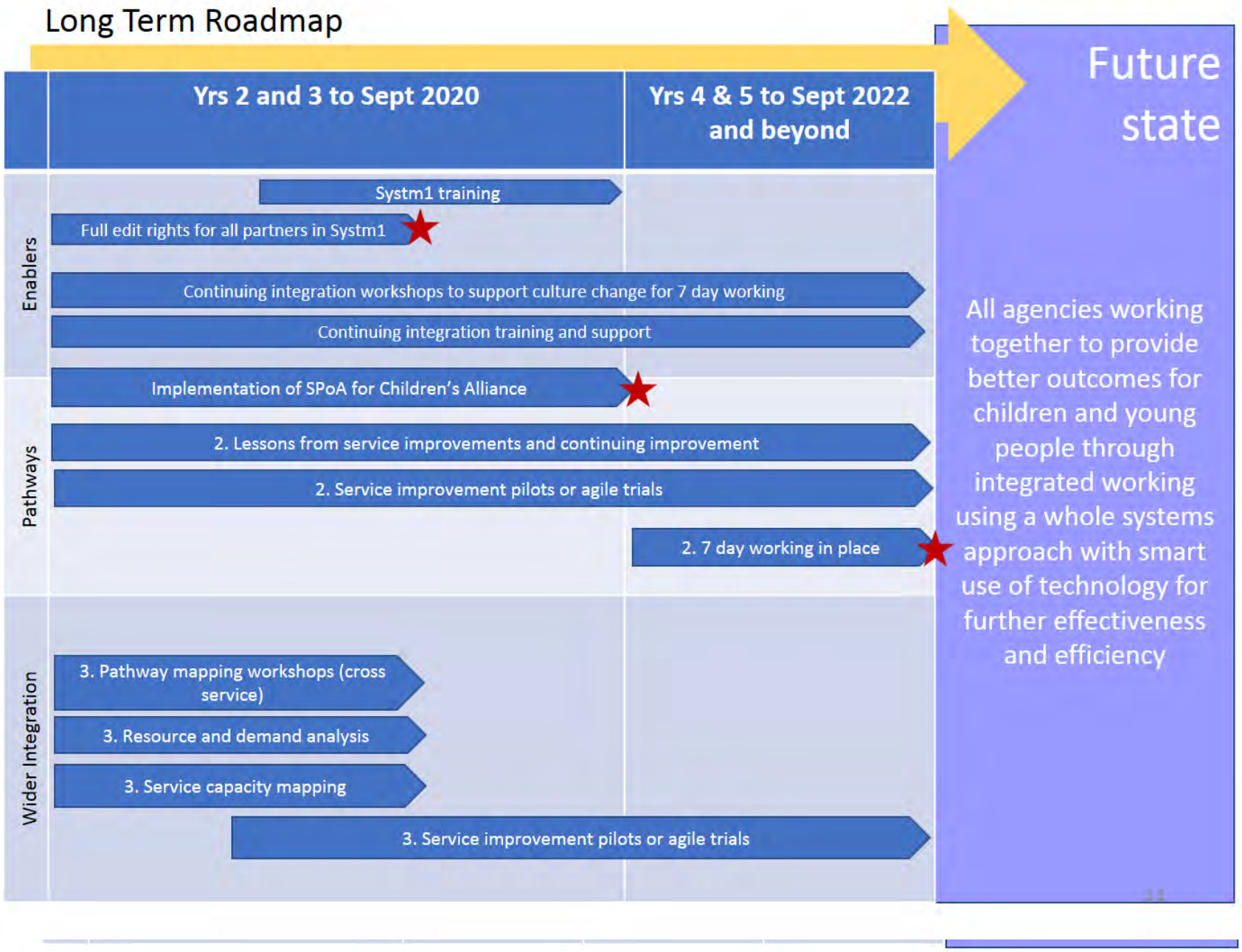
		undertake this.
Patient Experience	The current Patient experience surveys are distributed by post and hand out in paper form. They are then sent to the CCC for collating via pre-paid envelopes. The Patient Experience lead and admin then collate the results.	Agreement on how surveys will be managed in the new providers needs to be made in order to prevent a gap in patient feedback. Work commenced to undertake this with host colleagues
Meds management	All medicine management support or sign off of PGDs, policies, operational advice is provided by the current host organisations. The new providers will take on this role within their current provision. PGDs and SOPs are with IHT and WSNHSFT for ratifying in preparation for the 1st Oct. GP Fed will use the IHT ones.	
Information Governance	Currently provided by IHT and WSNHSFT. The SCH IG toolkit will be obsolete and will be the responsibility of the new providers to review their own tool kit submission to ensure their new services are covered.	
Clinical Audit	Initial meeting planned to review how to align the audit calendar to the new providers and understand how the completed audits will be managed.	Safety thermometer service registration will need to be changed on transfer.
Children's safeguarding-	Post subject to review, within Children's Services. Seeking clarification for WSNHSFT regarding the function that will be provided across the current SCH services due to the differing timeframe for children's services.	Confirmation required as to who will be covering adult community services with Children's Safeguarding queries as this is currently covered by the SCH Children's SG Lead.
PALS	PALs are currently provided by the CCG with a wish for it to transfer to provider organisations. IHT and WSNHSFT have their own PALS functions and the GP Fed use the CCG. All new providers have their own complaints department to manage the investigations and responses.	Review use of CCG PALs function for the GP Fed.
Professional leads	Roles to be confirmed for both Nursing and AHP in both East and West Alliances. The scope and remit and remit of roles to be reviewed and confirmed.	
Educational Hub	The Hub will contain the practice development team, TVN and Adult safeguarding roles. SLAs will be required for all 3 areas and meetings are booked with providers and the current teams to draft an SLA ready for the Alliance board.	Agreement required as to where the AHP Practice Development Educator will receive her professional Leadership. Agreement needs to be confirmed on the continuation of the AHP Practice Development Educator and PEBLES facilitator as they both on fixed term contracts ending March 2018 and both have expressed a wish to remain in their posts.

Appendix C: **Adult Services Roadmap**



Appendix D:
Children's Services Roadmap (short, medium and long-term)




Long Term Roadmap
Yrs 2 and 3 to Sept 2020
Yrs 4 & 5 to Sept 2022 and beyond
Future state
Enablers
Systm1 training
Full edit rights for all partners in Systm1
Continuing integration workshops to support culture change for 7 day working
Continuing integration training and support
Pathways
Implementation of SPoA for Children's Alliance
2. Lessons from service improvements and continuing improvement
2. Service improvement pilots or agile trials
2. 7 day working in place
Wider Integration
3. Pathway mapping workshops (cross service)
3. Resource and demand analysis
3. Service capacity mapping
3. Service improvement pilots or agile trials
All agencies working together to provide better outcomes for children and young people through integrated working using a whole systems approach with smart use of technology for further effectiveness and efficiency

Appendix E: **Risk Log**

RISK LOG - Suffolk Community Contract Mobilisation

Project Title	Suffolk Community Contract Mobilisation
Last updated by	Jon Hayes
Date	20/09/2017
Version	19

#	Work Stream	Risk Description details of the possible event with description of the perceived impact)	Existing Controls (mitigating actions / contingency plans / rational for acceptance	Date Added	Owner	Current Impact 1-5	Current Likelihood 1-5	Initial score 12-25	Mitigating Actions / Rationale for Acceptance	Mitigated Impact 1-5	Mitigated Likelihood 1-5	Mitigated risk score 1-25	Status	Escalation Level	Date Closed	Closure Comment
2	All	Business as usual commitments for senior alliance leaders and work stream leads may impact on programme delivery.	Additional project management resource in place from Attain. PMO rigour and rhythm will be established to support reporting and communication to minimise the need for face to face meetings.	27.02.17	Jon Hayes	3	4	12	Currently engagement and attendance is good. Will continue to monitor meeting attendance and engagement, providing support from the PMO team wherever possible.	2	2	4	Open	Steering group		
8	All	Diasggregation of some services may have a negative imact on services and functions instead of achieving the improvement hoped for.	Service leads have been involved in the review of services and disaggregtaion options. In addition impact assessments have been undertaken to inform decision making and pick up on issues or risks relating to quality and safety.	22.03.17	Sarah Warmington	5	3	15	QIAs have been carried out for adult services, and will be carried out for childrens services. Decision making will be based on the perceived impact on quality and safety as well as financial and workforce implications	4	3	12	Open	Steering group		31-8-17 - Mobilisation Board recommends the CYP workstream reflect & review this risk.
9	HR	HR process may not be followed perfectly in relation to the designated employer, creating variation in staff experience throughout process.	Greater HR involovement based on how and where staff are transferred. There is an agreed management of change policy across the alliance organisations that will be adhered to.	22.03.17	Sarah Warmington	4	3	12	Steering group need to ensure that there is sign off and sign up to all HR processes to protect the alliances in delivering new services.	4	3	12	Open	HR work stream		31-8-17 - Mobilisation Board recommends HR workstream review re Children's
10	HR	Multiple formats of HR files, not aligned to the format of receiving organisation may result in information being lost and lack of continuity and consistency in staff maangement.	HR work stream standardising files where possible when planning for transfers. ESR will be used wherever possible to ensure smooth transfer of records.	22.03.17	Sarah Warmington	4	3	12	The process of standardising files will be labour intensive, need to maintain close scrutiny of progress and use ESR wherever possible.	4	3	12	Open	HR work stream		
11	HR	Open disciplinary cases may not be transferred appropriately to new employer. Query over management of those against new, not existing processes, policies and procedures.	Effective transfer of records will be required (linking to risk #10).	22.03.17	Sarah Warmington	4	4	16	Cases to be closed, where possible, ahead of transfer.	4	3	12	Open	HR work stream		
12	HR	Capacity could be affected if bank staff are not transferred as part of disaggregation.	Work stream to develop and put in place clear bank process to help manage capacity through transition.	22.03.17	Sarah Warmington	4	3	12	Work stream to develop and put in place clear bank process to help manage capacity through transition.	4	3	12	Open	HR work stream		* Being discussed after the Core group meeting Sarah to update
15	IT	No WIFI at core sites, restricting operational effectiveness, and may mean staff cannot work remotely once the new service goes live.	Plan from IT work stream to identify where there are gaps in provision, to work closely with Estates workstream and identify whether there is opportunity to provide standardised infrastructure, based on requirements at sites.	22.03.17	Paul Berriman	4	3	12	IT strategy developed and approved by steering board	4	3	12	Open	Core Team		
16	Communication	Lack of awareness of programme in wider workforce, especially acute members of staff may result in lack of co-operation and/or not achieve the full benefits of integration.	Communications work stream to develop plan for all stakeholders, including messages and channels.	23.03.17	Jan Ingle	3	3	9	Some communication and engagement activities in train. Full plan in development. HR & CG WS/S's to support removal of blockages	3	3	9	Open	Core Team		
18	Contracting	CCG may receive challenge to the approach taken to developing 'most qualified provider' contract, which may delay all progress and voids plans, putting contract at risk	Continued conversation with CCG, invited to Joint Advisory Group and Community Contract Mobilisation Steering Group.	29.03.17	Jon Hayes	3	2	6	Work with commissioners to agree/ensure evidence for most capable provider contract.	3	2	6	Open	Core Team		
20	Finance	No detailed financial running costs have been modelled, including investment, double running etc	To be tested through the modelling work stream, and agreed with work stream leads.	29.03.17	Jon Hayes	4	5	20	Work stream leads to develop clear plans including requirement for need to review Education Hub Jamie Drake to review and update	3	3	9	Open	Core Team		
21	Communication	Lack of engagement with community groups could adversely affect the programme (delay), and reputation of the alliances.	There are groups in place to work with our communtiy groups, these will be used to communicate around the alliances.	28.3.17	Jan Ingle	3	2	6	Stakeholder analysis will pick up the level of communication and messaging required as well as level of engagement.	2	2	4	Open	Communications & Engagement work stream, and HR work stream		
24	All	Ability to maintain "business as usual" from the services provided by NCHC.	Items on the agenda for the contracting meeting to be raised by Dawn Godbold and Nicola Brunning.	4.4.17	Dawn Godbold	4	4	16	Fortnightly meetings in place	4	3	12	Open	Steering group		
26	Estates	Potential increase in rental costs after 30/09/17 due to end of current contract date	Option to renegotiate or hand back contracts, continue to monitor options negotiated wider with NHSE	13.4.17	Paul Fenton	4	3	12	Option to renegotiate or hand back contracts, continue to monitor options negotiated wider with NHSE. Being picked up through baseline exercise.	3	3	9	Open	Steering group		
27	Clinical Governance	Risk that policies in the designated employer organisations are not suitable to support the staff and services transferring into the organisation	Clinical Governance Workstream to oversee the mapping and review of all policies in the identified designated employer organsiations, with onward revision of policies, as required, to ensure suitability to support staff and services transferring into the organisation	26.4.17	Fiona Whitfield	4	4	16	Policies in designated employer organisations will be suitable to support the staff and services tranferring into them Policy work from CG W/S	2	2	4	Open	Steering group		

29	**Estates**	Leases not completed by 01/10/17 with a residual lack of clarity regarding responsibility associated with assets. Likely points of contention:- Market rents - not relative to the condition of estate i.e. too high - NHSPS require a full repairing and insuring obligation on the tenant for their leases - Consortium estate representatives have advised NHSPS they will not recommend leases with this clause to be signed as the Consortium will not take responsibility for properties that have lacked investment - Standard NHSPS lease terms exclude a security of tenure provisions under section 2 of the Landlord and Tenant Act 1954 - the risk to the Consortium is once the lease term has expired the landlord is under no obligation to renew the lease (this approach is not recommended by the DH)	Compliance and estate issues are monitored on a monthly basis by the Consortium, with issues escalated as they arise Internal meeting scheduled for 01/06/17, first meeting with NHSPS set for 22/06/16 NHSPS have commissioned Montague Evans to prepare draft heads of terms, CAD drawings with demise marked and proposed market rents identified - these have been received by the Consortium and are being reviewed on 01/06/17 Also NHSPS are going through a re-organisation and to date have failed to meet any agreed timescales A further complication is that the Consortium and NHSPS use the same legal advisors, and whilst NHSPS initially felt this would not be an issue, they have since reconsidered their position and are seeking an alternative provider	24/05/17	Paul Fenton	4	4	16	Meeting with NHSPS on 16.06 to plan mitigating actions	4	4	16	Open	Steering group		
30	**Contracting**	The parties may be unable to agree the model and form of the contract	Discussion paper to be shared with the Steering Group	24/05/17	Alan Page	4	3	12	Contract model agreed by steering group members.	4	3	12	Open	Steering group		
31	**Estates**	Termination notice for Sandy Hill Lane, up in August, decision needed re Oct timeframe	Decision to be made regarding future use of the building with consideration of CCC.	07/06/17	Paul Fenton	4	4	16	Option to renew exercised. Await feedback from landlords agent (has been changed on 4 occasions)	4	4	16	Open	Steering group		
33	**SystmOne**	Current support officers are at full capacity, if there is an intention to increase the use of SystmOne, there will be increased demand on an already stretched resource.	Explore impact of disaggregation on shared resource and cross-skilling existing teams	21.06.17	Paul Berriman	4	4	16	Full review to be carried out following disaggregation decision, prepare business case if necessary. Transformation work.	2	2	4	Open	Steering group		
38	**Finance & Contracting**	Risk of additional costs relating to procurement inc continenece products and need to understand how this risk is shared across the alliance	Curerntly receive First Dressing Initiative from CCG and procurement of continence products is being reviewed. Need to consider how this type od cost pressure is managed and then resolved across the alliance	24.08.17	Craig Black	4	4	16	Alliance members to discuss risk share following Steering Group on 14th September	4	4	16	Open	Steering group		
41	**Finance & contracting**	Risk that stock levels run low at point of contract mobilisation impacting upon patient care	Staff encouraged to order stock as per usual and to ensure suffient levels at point of transfer.	30/08/17	Dawn Godbold	4	3	12	Order codes from NHS supplies are being aligned to ensure ease of ordering post-transfer.	4	3	12	Open	Mobilisation Board		
42	**Finance & contracting**	Risk that staff carry forward large amounts of time-owing upon contract mobilisation	Due diligence enquiry across all out-going employers around discharge of liabilities ahead of treansfer inc time owing.	30/08/17	Dawn Godbold	4	4	16	Scale of risk to be assess and mitigation agreed in response	4	4	16	Open	Mobilisation Board		
43	**Finance & Contracting**	Unresolved value and ownership of assets transferring with community contract mobilisation	Asset register in existance but needs decision regarding disaggregation.	30/08/17	Nick Macdonald	4	3	12	Raise through contract negotiations.	4	3	12	Open	Steering group		

NHS
West Suffolk
NHS Foundation Trust

Equality and diversity

Report to the Board September 2017

Putting you first

Introduction

Equality and diversity are at the heart of our continued ambition to become the employer of choice and our vision to deliver the best quality and safest care for our community. We are also fully committed to complying with the 2010 Equality Act and our public sector equality duty (PSED).

This report provides:

- **A snapshot of the Trust's equality and diversity profile as of 31 March 2017**

  Where it is possible to collect the data we have analysed how we stand against the nine characteristics protected by the 2010 Equality Act:

  - Age
  - Disability
  - Gender reassignment
  - Marriage and civil partnership
  - Pregnancy and maternity
  - Race
  - Religion and belief
  - Sex
  - Sexual orientation

  Other comparators (i.e. pay and working patterns) have also been used to highlight trends.

- **Our Equality and Diversity objectives and action plan**

  A single comprehensive action plan has been developed for the trust covering the Workforce Race Equality Standard (WRES), the Equality Delivery Scheme 2 (EDS2), equality and diversity issues arising from the national staff survey 2016 and the Social Partnership Forum collective call to action on tackling bullying in the NHS.

  Six equality and diversity objectives have been identified. Staff and the local community have been consulted on these and their associated actions. The objectives are:

  - Improve the patient experience and care of older age patients (including those with dementia)
  - Promote and support inclusive leadership at all levels of the trust
  - Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours
  - Embed equality and diversity in mainstream business processes
  - Improve information and data collected, in respect of protected characteristics
  - Ensure that the recruitment interview process is bias free

Equality Delivery System 2 (EDS2)
Implementation of the EDS2 is a requirement on both NHS commissioners and NHS providers. At the heart of the EDS2 is a set of 18 outcomes grouped into 4 goals. These focus on the issues of most concern to patients, carers, communities, NHS staff and Boards of Directors.

The four goals are:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

Workforce Race Equality Standard (WRES)
The Workforce Race Equality Standard (WRES) is included in the NHS standard contract and its main purpose is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators.
- Produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff and
- To improve BME representation at the Board level of the organisation.

West Suffolk NHSFT equality and diversity profile 31 March 2017

The Trust workforce appears more diverse than immediate local areas, and less diverse than the whole of England with the exception of Asian groups. Ethnic groups account for approximately 10.9% of total workforce and 8% of total staff survey of respondents, a slight increase on last year.

The Staff Survey 2016 results have shown that the trust has maintained a score in line with the average for staff not experiencing discrimination at work. Further references to the 2016 Staff Survey are made within the text of the report.

Whilst the White British group make up around 84% of the workforce, this is not necessarily reflected across all staff groups:

- Nursing & Midwifery has a greater proportion of white groups overall, followed closely by Admin & Clerical.
- Medical & Dental has the smallest proportion of white groups and the highest proportion of minority groups, showing greater overall diversity within this group.

The number of appointments split between white groups and minority groups roughly reflects the Trusts ethnicity split. The proportion of minority group applicants has increased by approx. 3% since last year however there has been an approx. 3% decrease in shortlisted staff from minority groups being appointed. There has been an approx. 3% decrease in applicants and those shortlisted from White groups, but an overall increase in appointments.

81% of the Trust's workforce is female, with the majority of these working in Nursing, Admin and Healthcare Support posts. Male staff members represent 19% of the workforce with a slight majority in medical roles.

Female staff members work almost equally part-time and full-time, whilst most male staff members work full-time. Overall, 56% of Trust staff work full-time, with 44% working part-time.

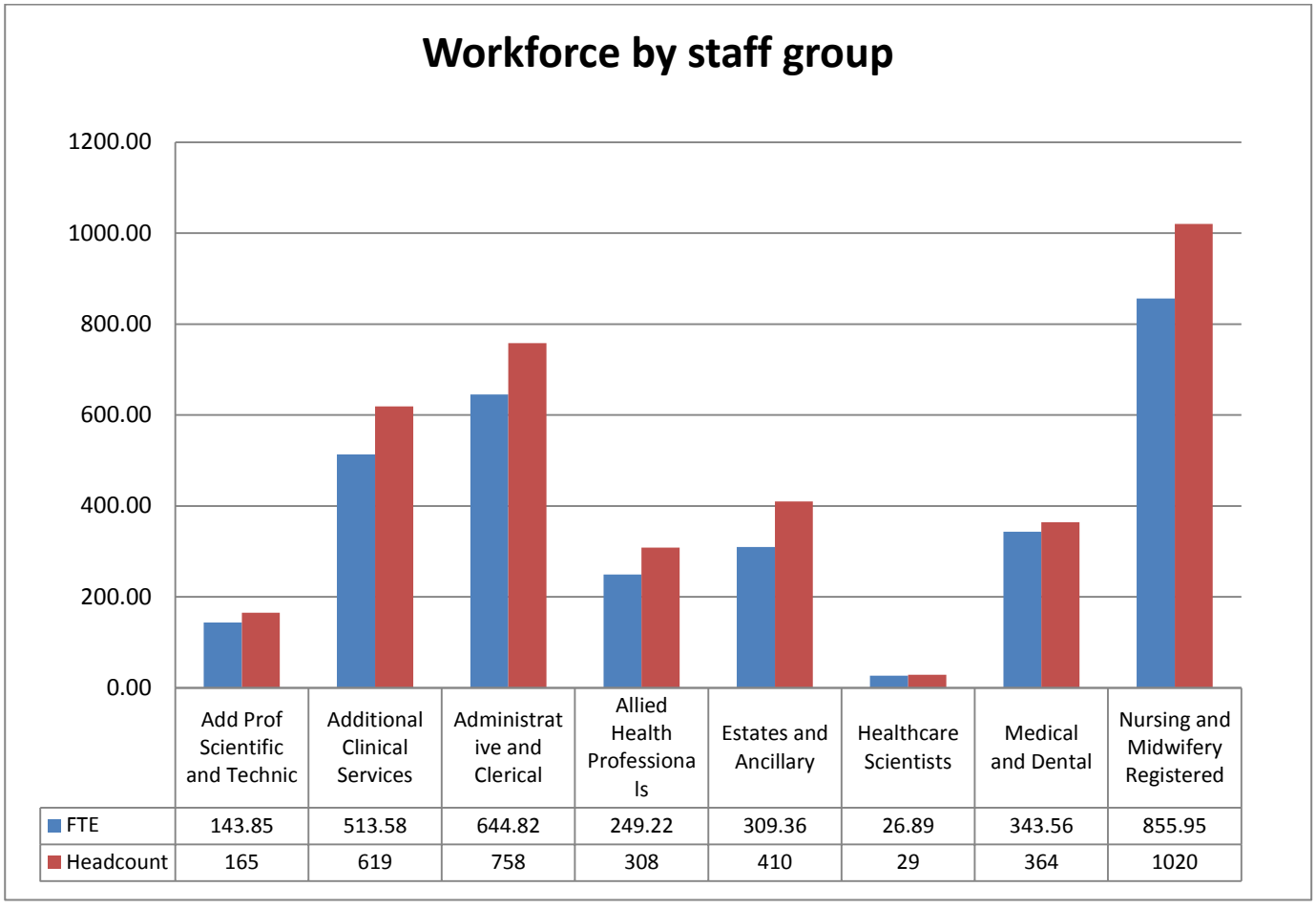
Pay by gender split roughly reflects the male/female ratio of the Trust with the exception of bands 8 and above, where there is a larger proportion of male staff at senior level. There are no disclosed minority groups in Bands 8c, 8d and 9.

The majority of staff members are between the ages of 40-60, with a large number of staff having been with the trust between 5-10 years.

- Approximately 51% of the workforce falls within the 36 – 55 age bracket.
- There are 253 employees over 60 seven of these are over the age of 71.
- The majority of staff have a length of service between 1-15 years.

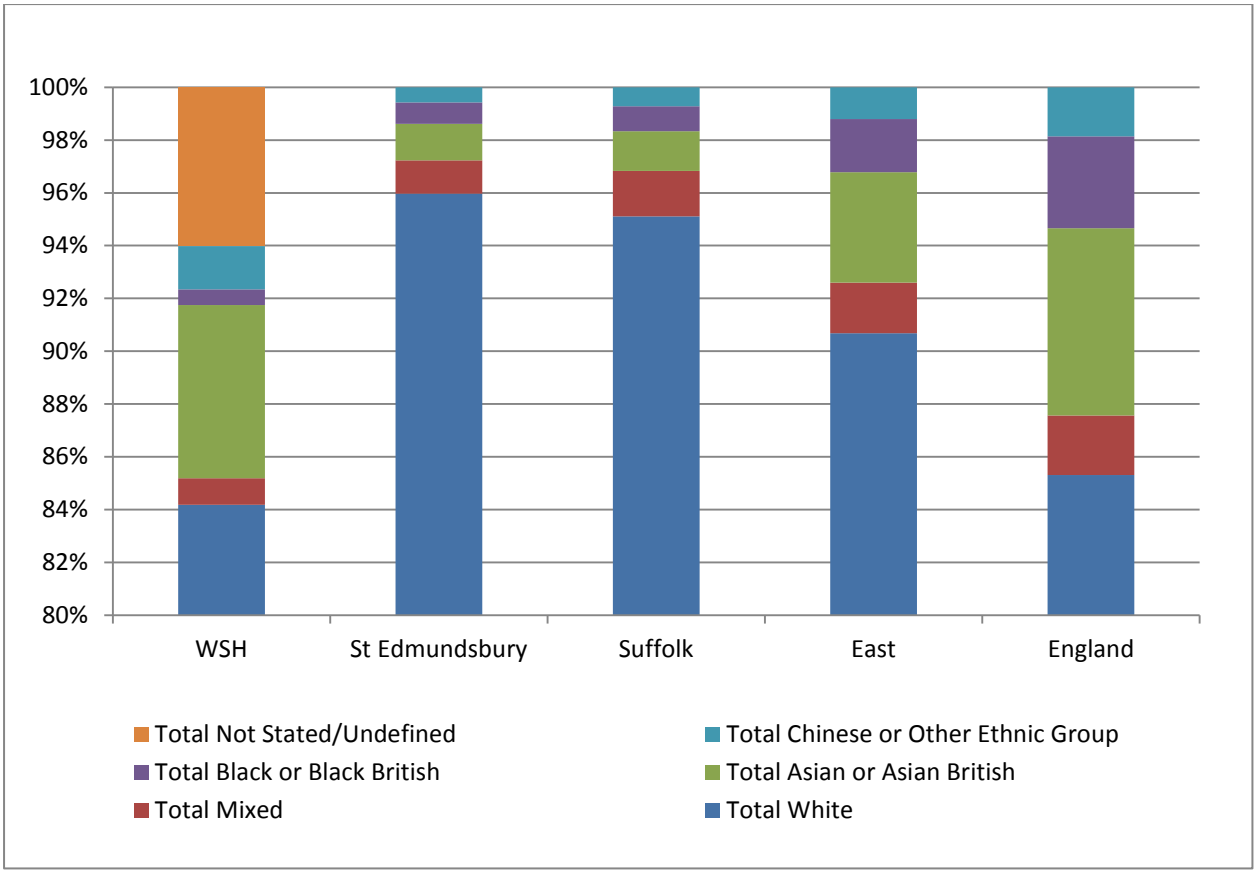
Workforce by staff group

The Trust's total headcount as of 31 March 2017 was approximately 3673. Nurses and midwives continue to be the largest single staff group, accounting for almost 30% of total staff in the Trust, followed closely by administrative and clerical and additional clinical services.



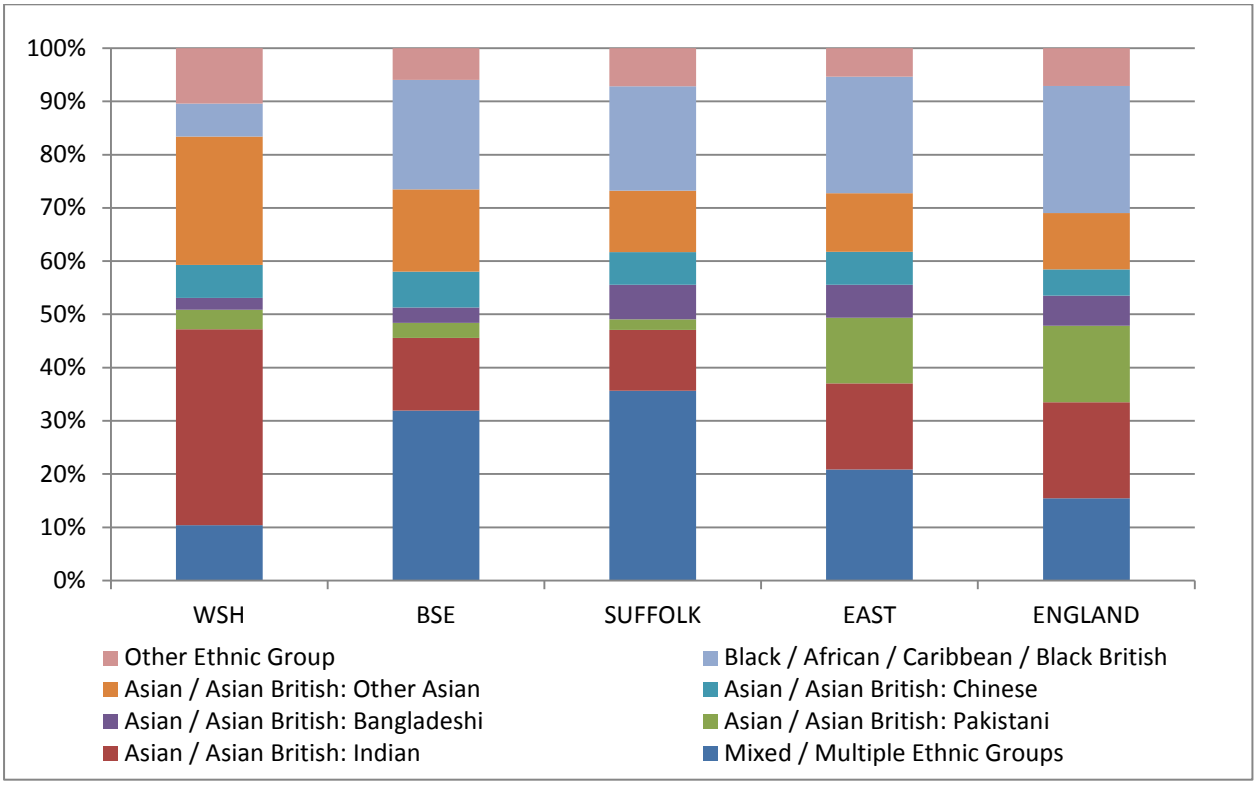
	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
FTE	143.85	513.58	644.82	249.22	309.36	26.89	343.56	855.95
Headcount	165	619	758	308	410	29	364	1020

Population ethnicity



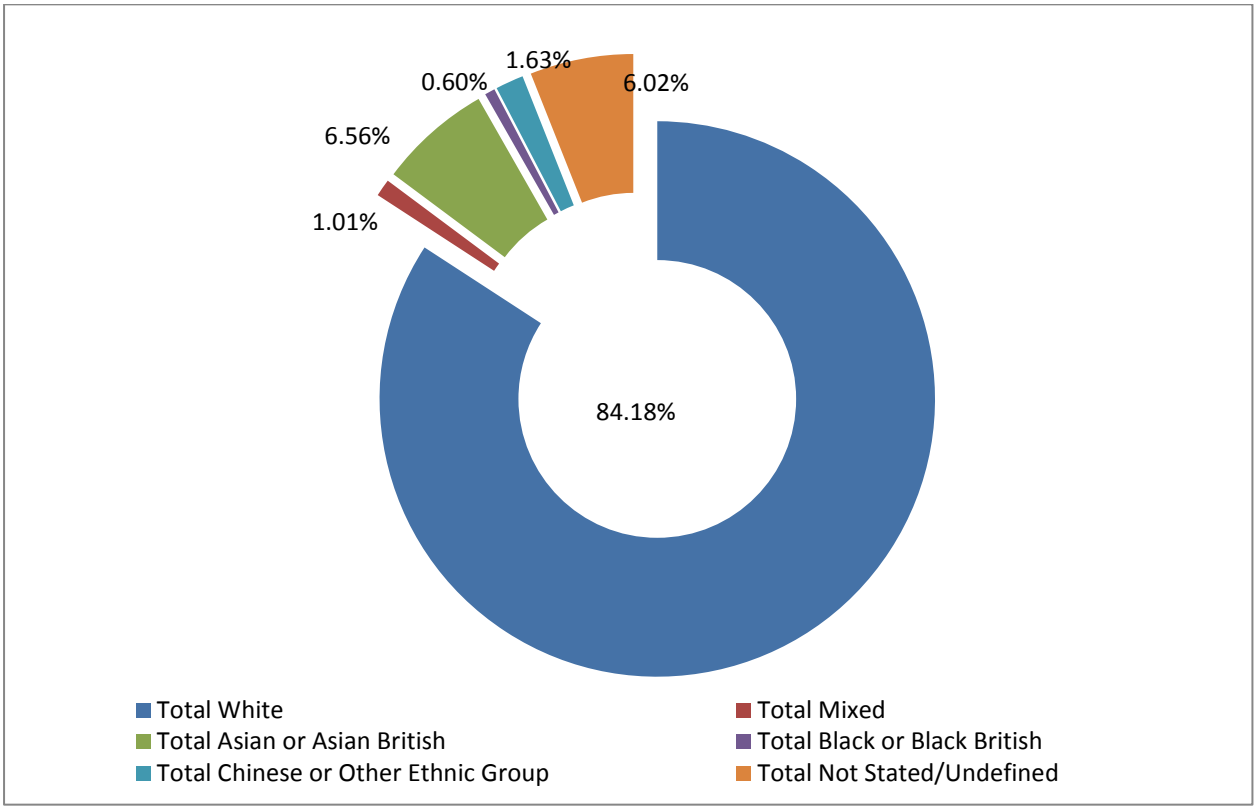
The chart above compares the overall ethnic profiles for the Trust, St Edmundsbury, Suffolk, East of England and England as a whole. The Trust appears more diverse than the immediate local areas, however slightly less diverse when compared with England as a whole, with the exception of the Asian groups.

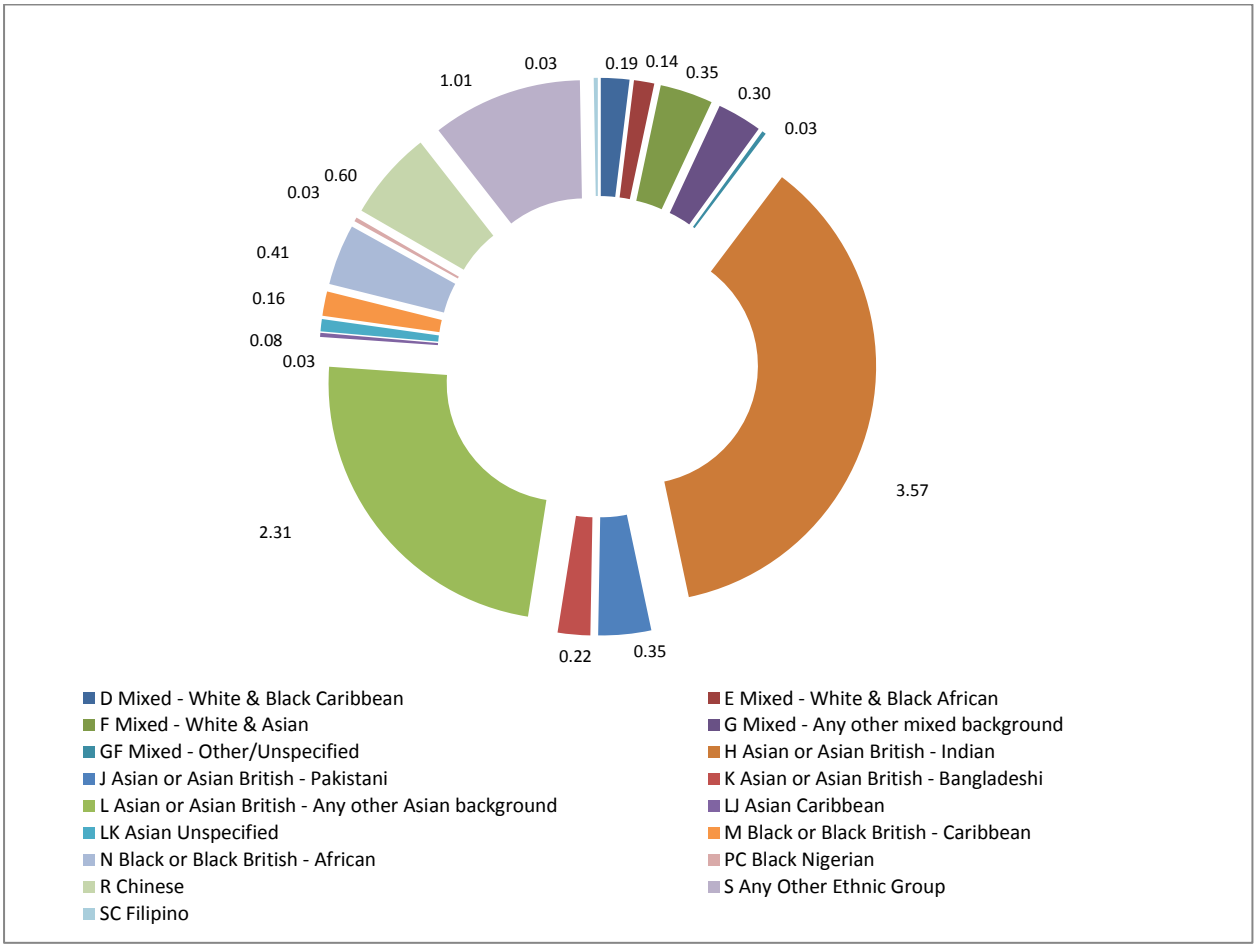
Minority group distribution



Workforce ethnicity breakdown

Overall, 9% of those staff choosing to disclose their ethnicity stated they were from a minority ethnic group. Currently 93% of the workforce has chosen to disclose their ethnicity.

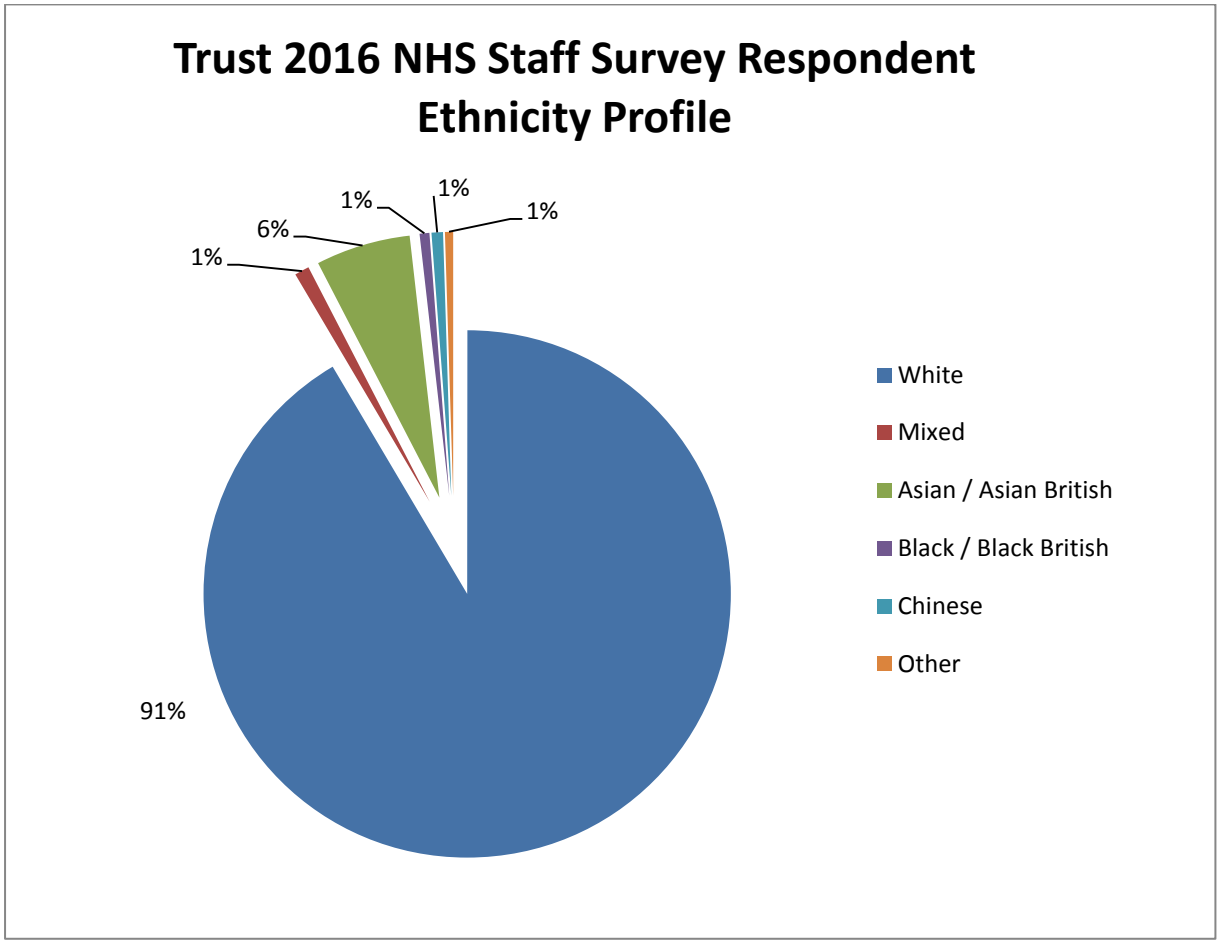




Staff Survey sample – ethnicity

Out of the 1243 eligible staff surveyed, 624 employees responded to the Staff Survey in 2016, giving a total response rate of 50.2% - well above the Picker Institute average for Acute Trusts, which was 39.9%

The chart below shows how our staff respondents described their ethnic background when completing the survey. In total 91% were recorded as white groups and 9% as minority groups - a slightly more diverse return compared to the previous year.

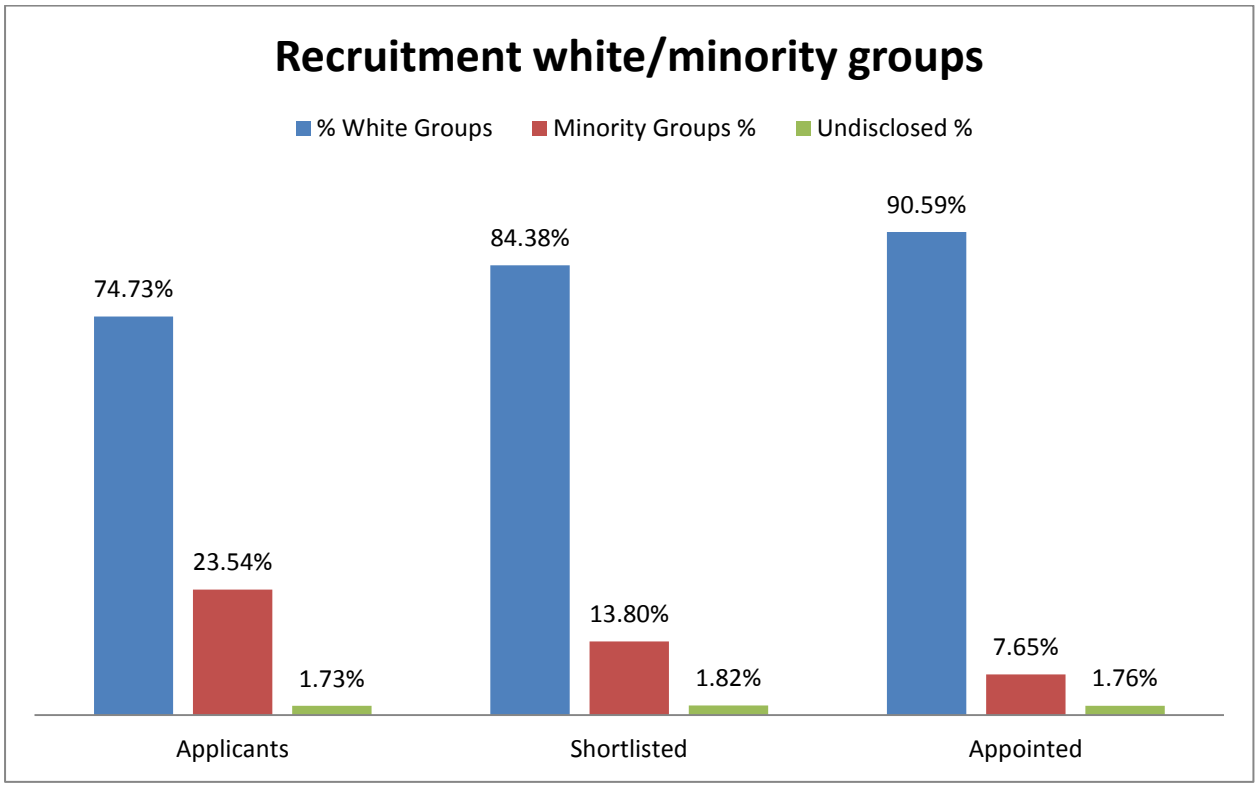


Recruitment

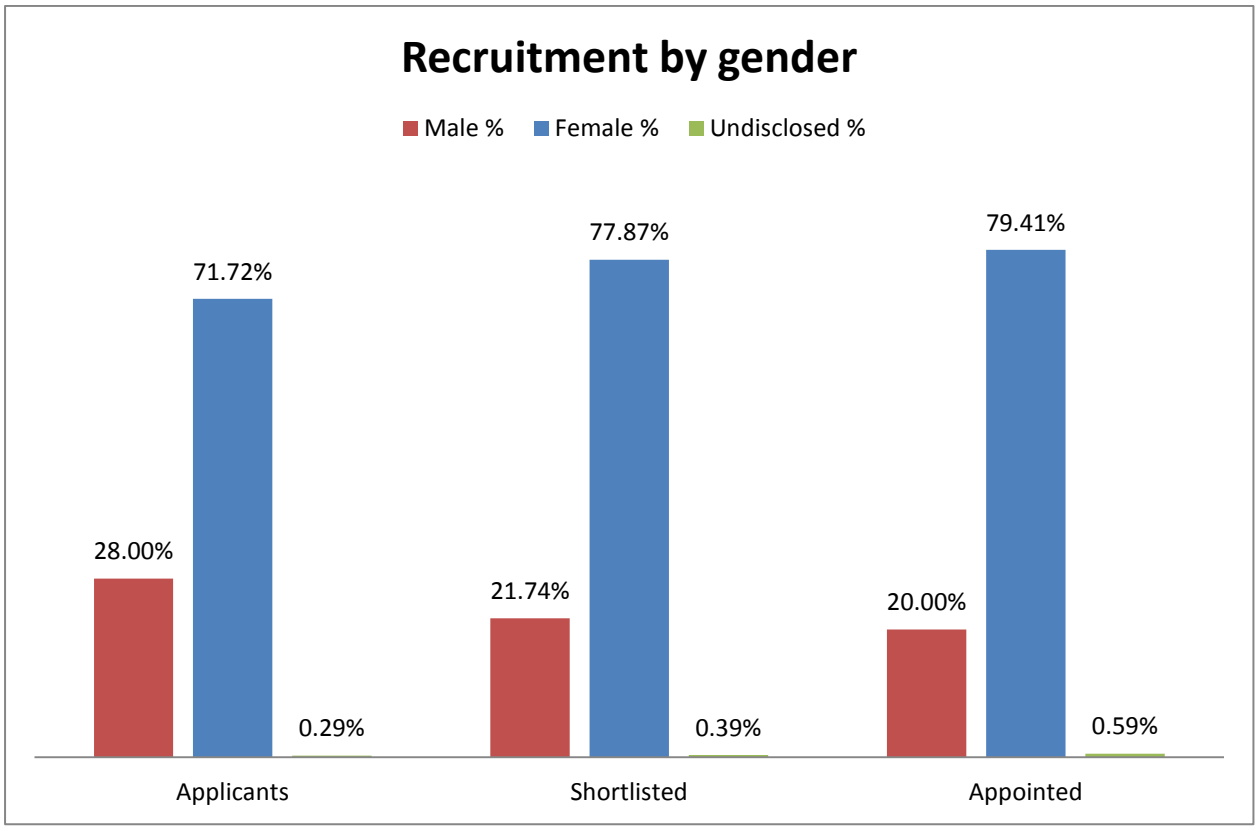
Sample data from NHS Jobs the shows a similar distribution to previous years in the numbers of White and ethnic groups throughout the recruitment process, but with a 3% increase in the number of applicants from Ethnic groups, but 3% decrease in those who are finally appointed.

This was also highlighted in our WRES data this year which highlighted that white candidates are 1.94 times more likely to be appointed from shortlisting than BME staff. Based on 2016 national WRES data (the most current available) this places WSH in the bottom third of trusts.

This is of concern and will be addressed by Equality and Diversity objective six “Ensure the recruitment interview process is bias free”.

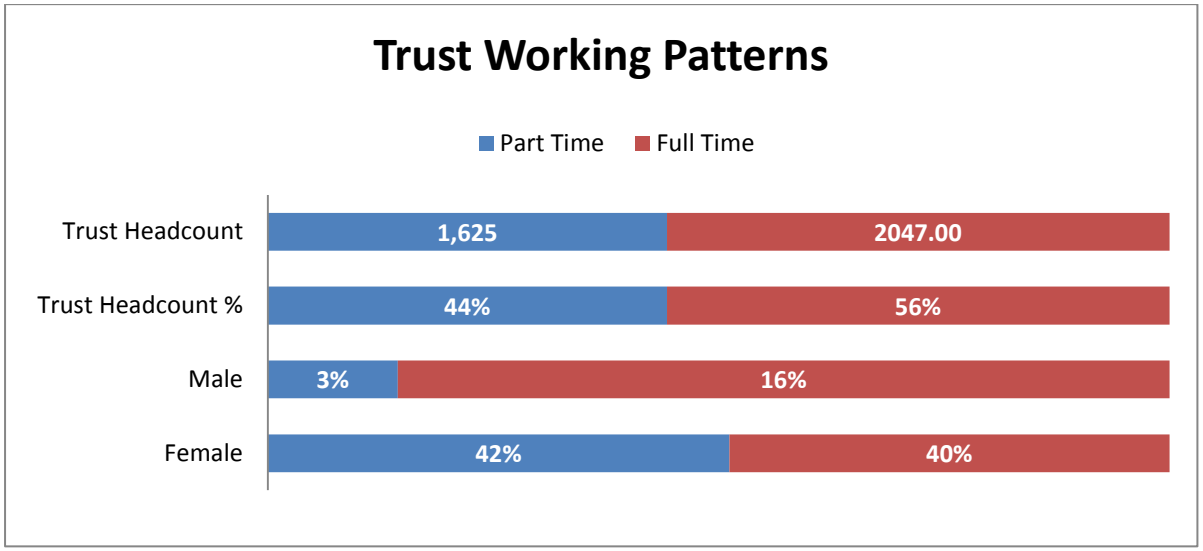


The gender profile of those applicants, shortlisted and appointed staff reflects the Trusts current gender split, showing a large female majority.



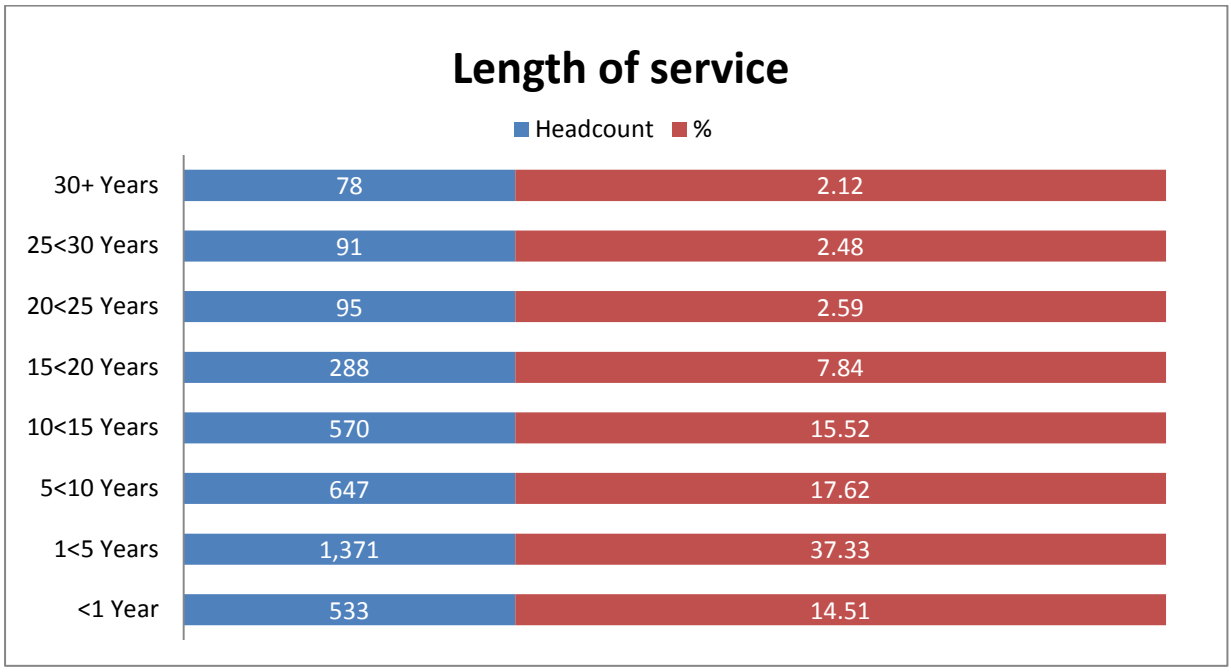
Working patterns

Current working patterns within the Trust show a consistent distribution in full-time and part-time working. Slightly more staff are working part-time compared to the previous year. The number of male staff working full-time has increased by 1%. Female staff working patterns have remained the same.



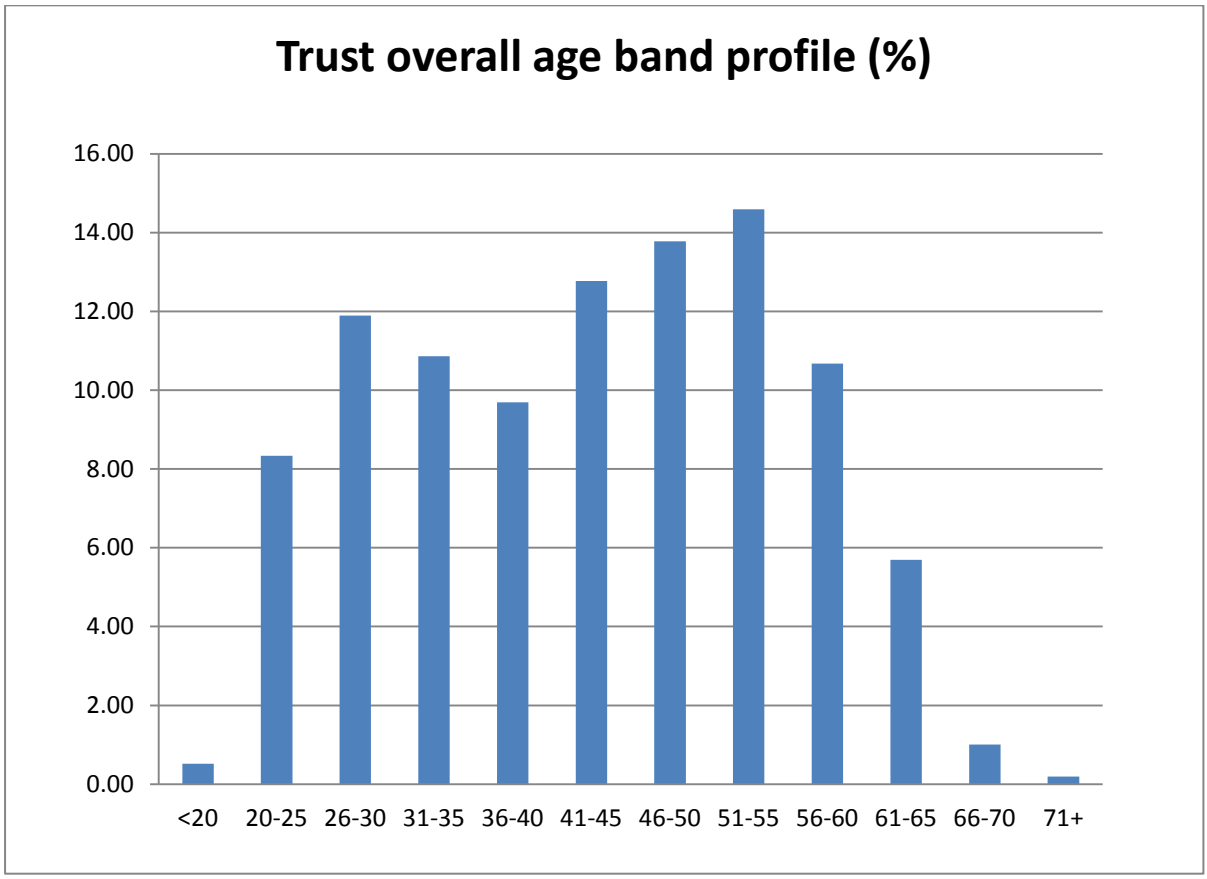
Length of service

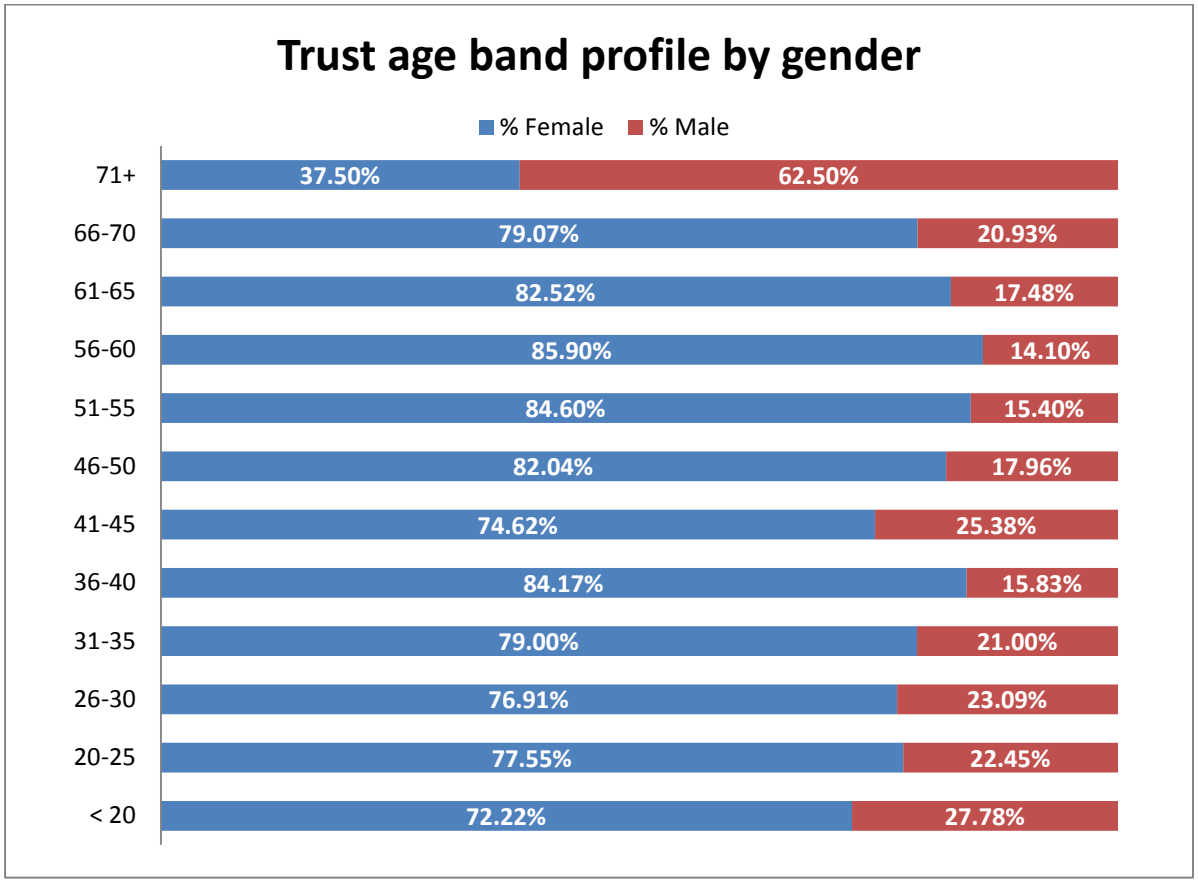
The table below shows the length of service by headcount and the percentage of total staff with that current length of service at the Trust. Most staff have a length of service between 1-15 years.



Age

Monitoring of information by age shows that the Trust has a diverse workforce comprising a variety of age groups, with the highest proportion of staff members aged between 36-55 years old.

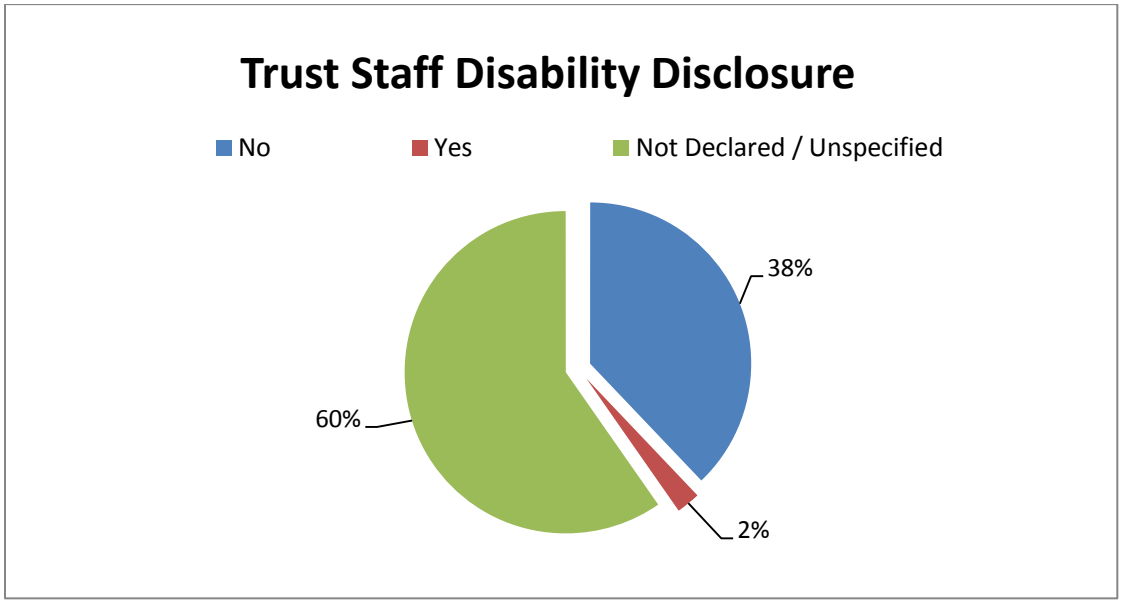




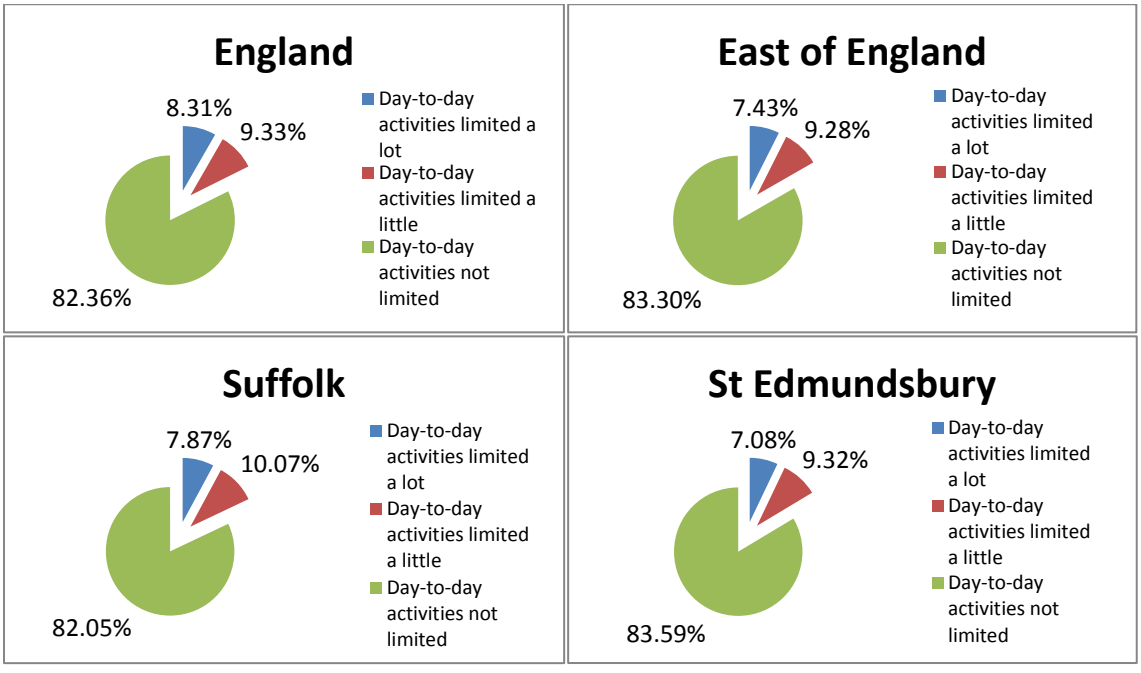
The average age for staff within the Trust is 43 years old. For female staff it is 44 and for male staff, 42.

Disability

Trust disability data shows that over a third of all staff have stated no disability. This has increased by 4% from last year. The number of staff whose disability status is not declared/undisclosed has fallen by another 4% indicating an improvement in data quality.

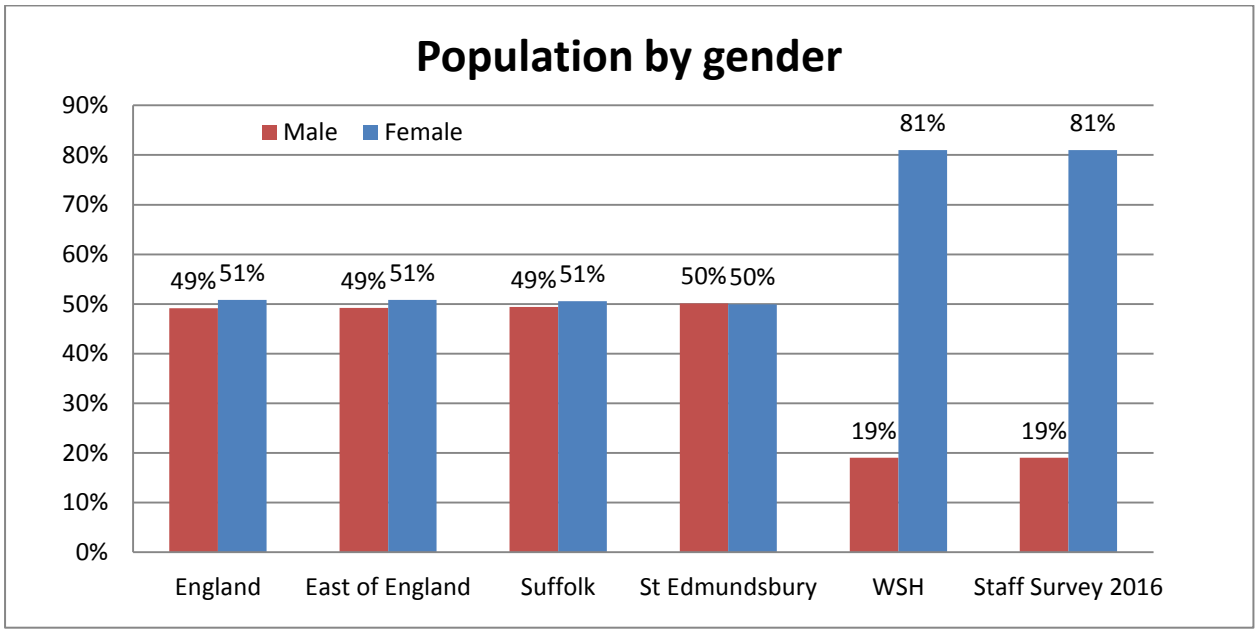


The data below shows the comparison between the locality, region and country as a whole in terms of the number of people who have either no disability/limitation with day-to-day activities, limited or more limited activity.

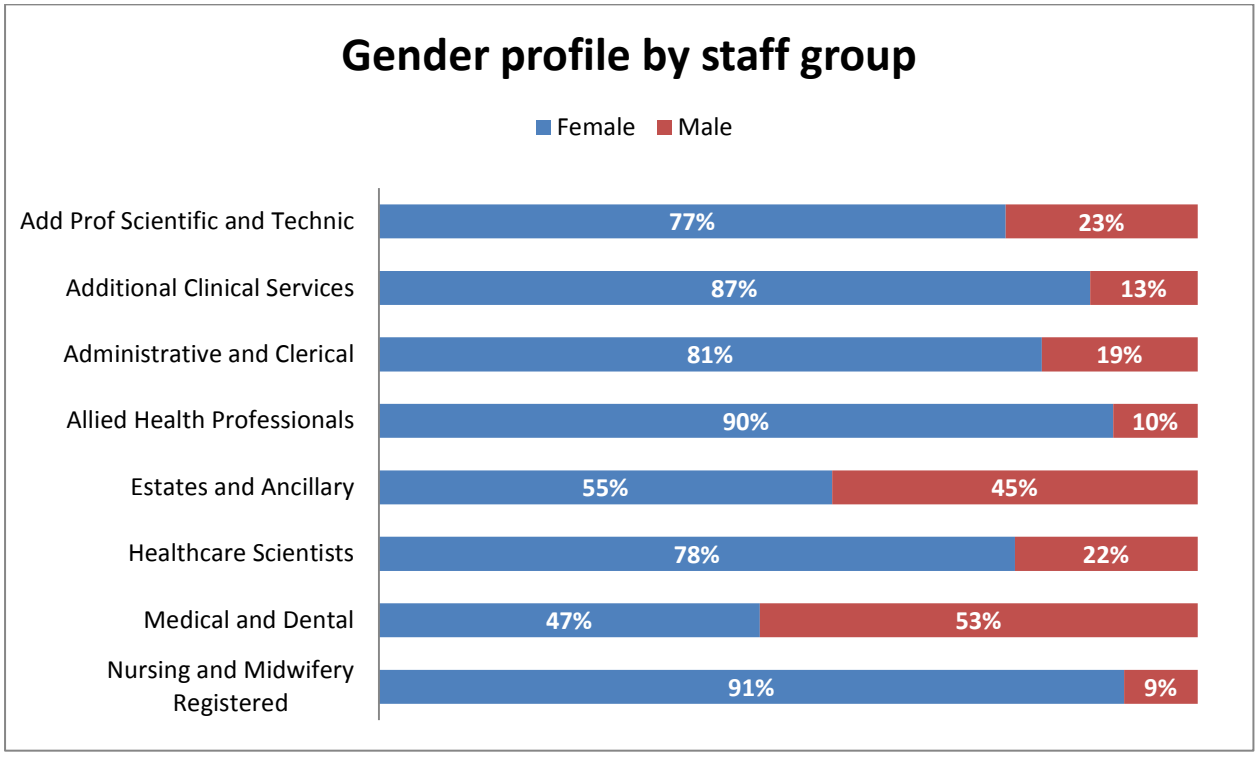


Gender

The gender split of the workforce remains reasonably constant; it comprises 81% female staff and 19% male staff. A similar distribution was seen in amongst the respondents to the Staff Survey 2016.

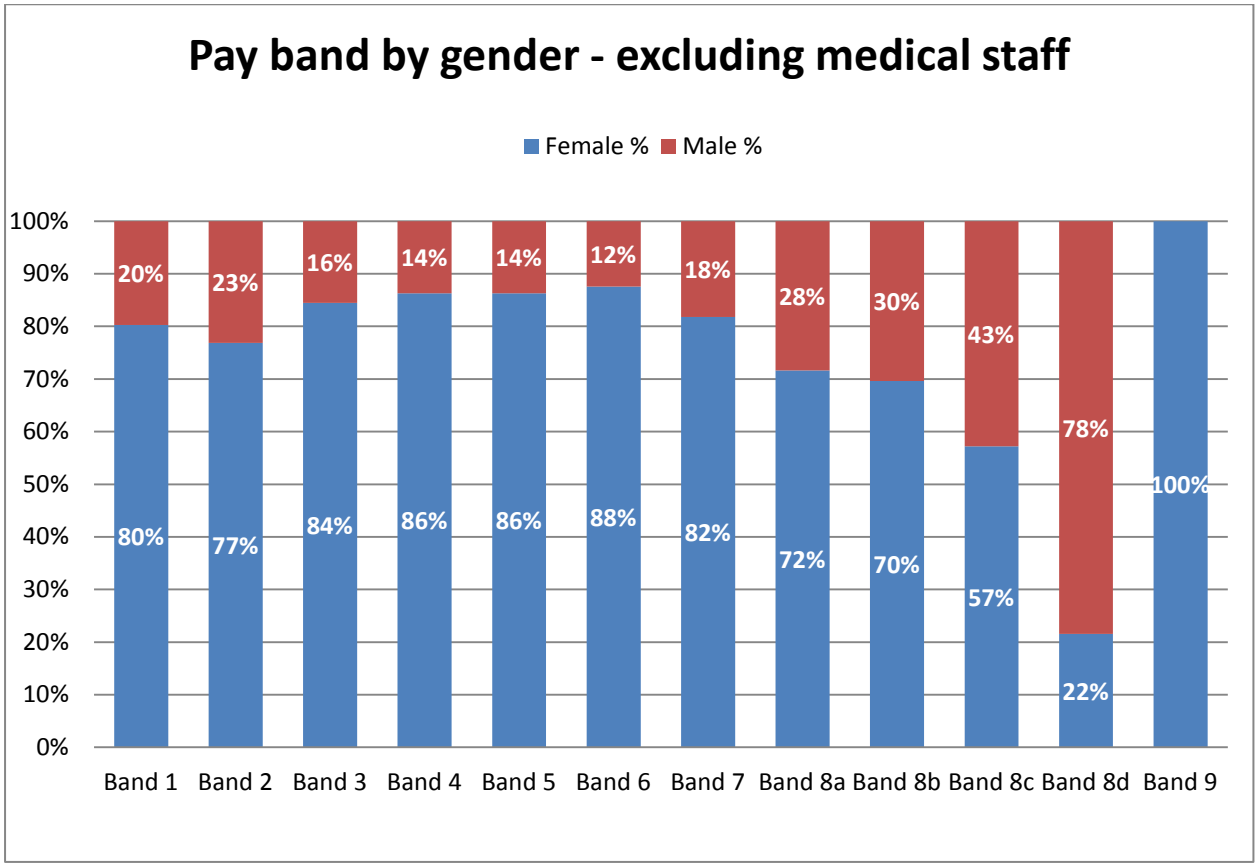


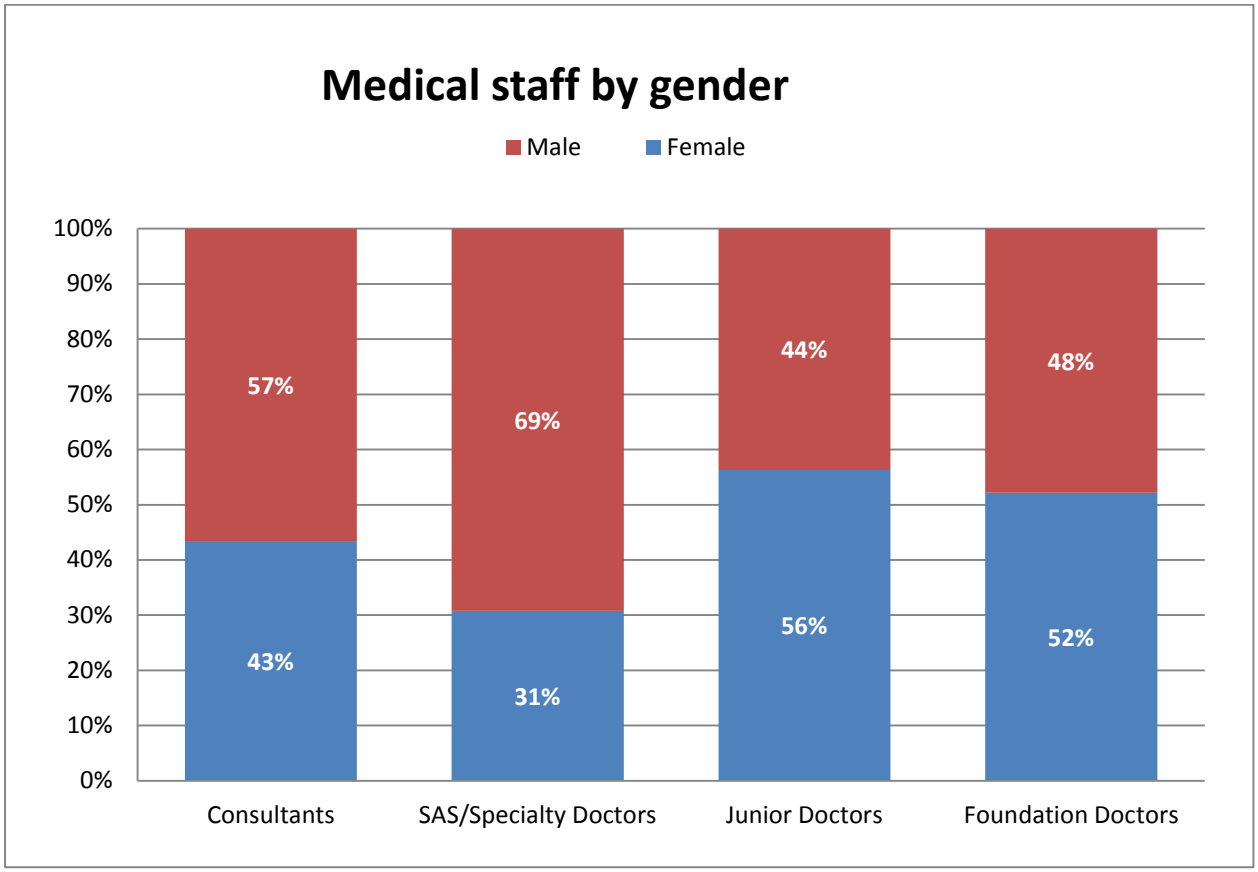
The chart above shows that England and the locality has an approximate a 50:50 gender split, however the Trust has a consistently higher proportion of female staff compared to male staff with the exception of the medical and dental and estate and ancillary staff groups.



Pay

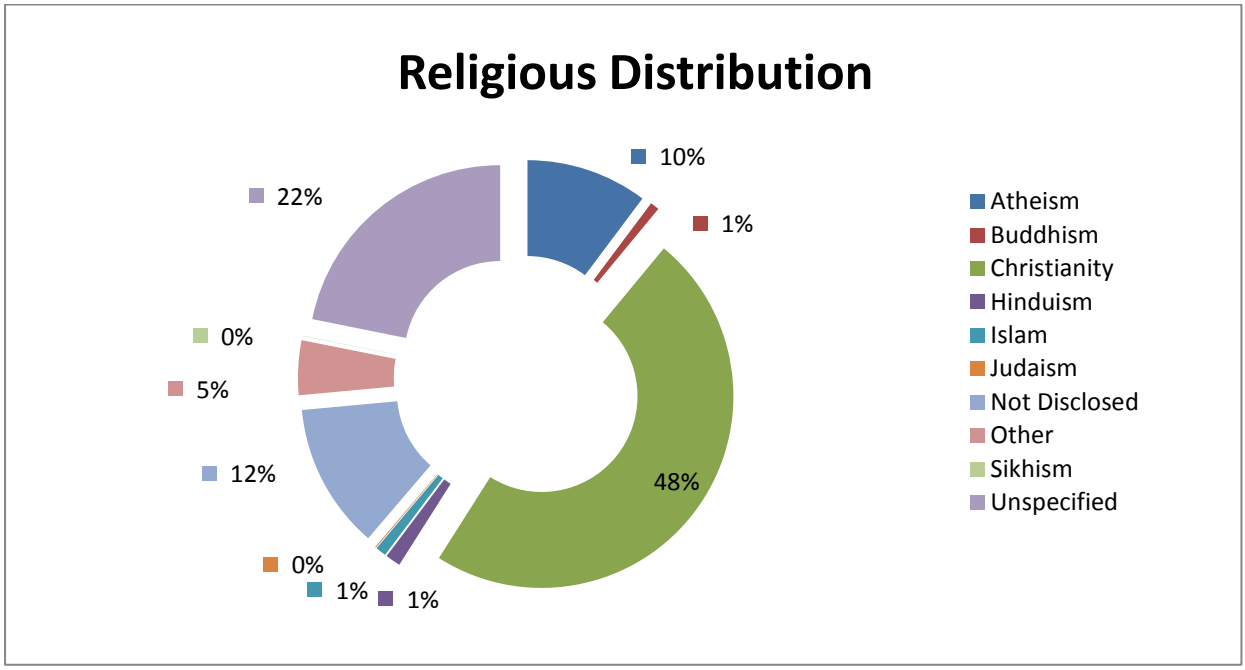
Pay band data by gender displays an approximate reflection of the Trust's 80/20 gender split. At band 8 and above the distribution of male/female staff at higher bands starts to change and we see an increase in the number of male senior staff



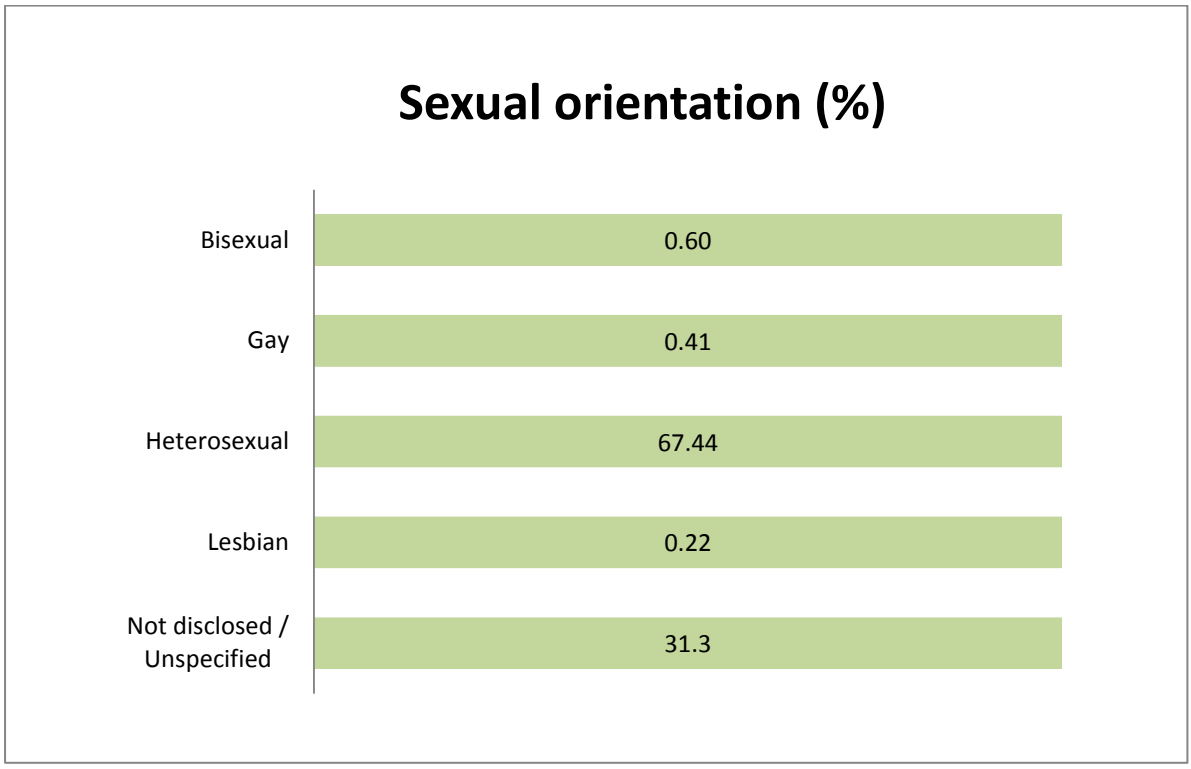


Religion and belief and sexual orientation

There is no current benchmark for religion and sexual orientation however as part of the Public Sector Equality Duty (PSED) the Trust has an obligation to eliminate unlawful discrimination, harassment and victimisation. The Trust currently shows a diverse range of faiths, with over a quarter of staff choosing not to disclose their religion.

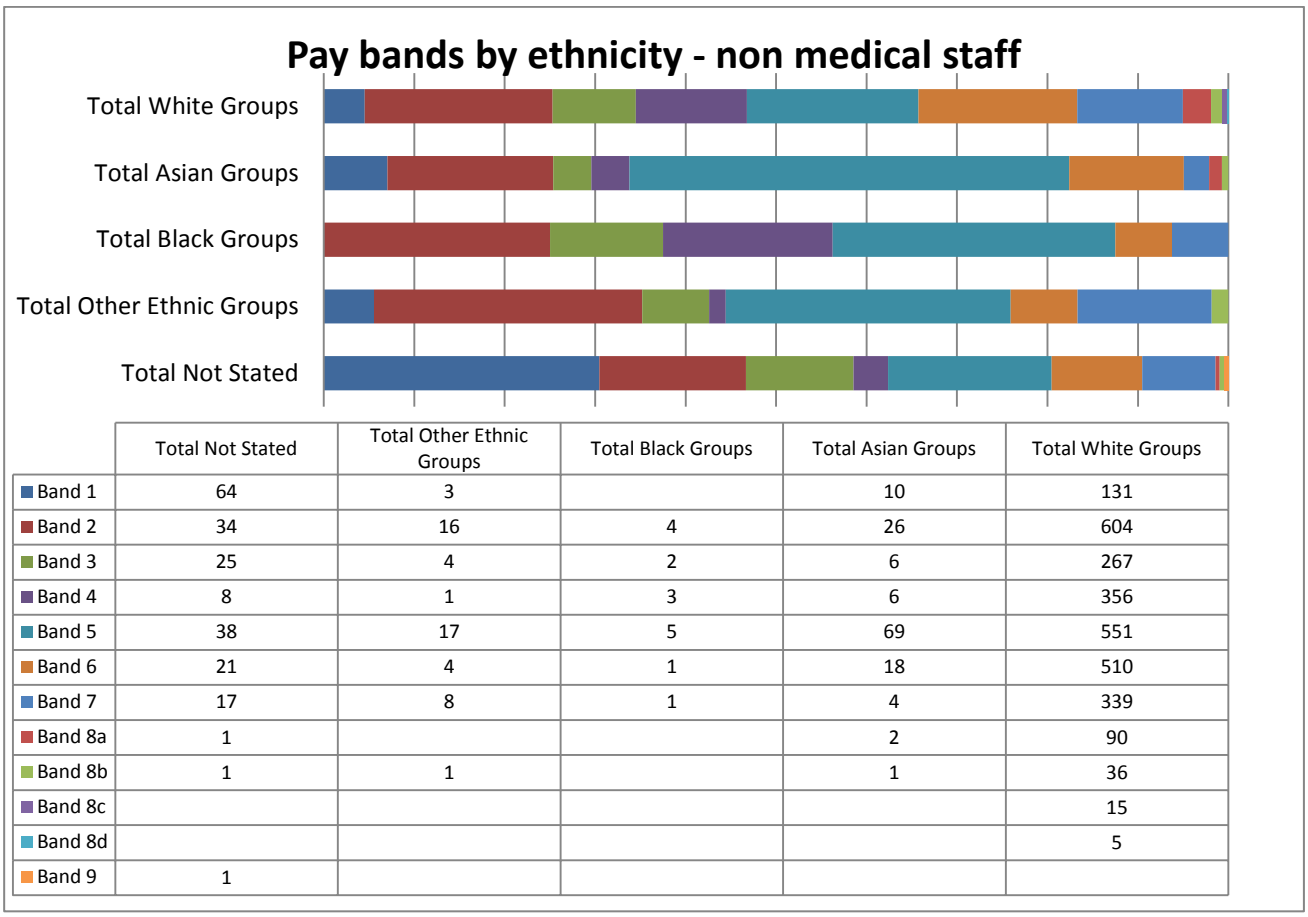


More staff have chosen disclose their sexual orientation since last year. The number of staff choosing not to disclose their sexual orientation has fallen by 3.5%

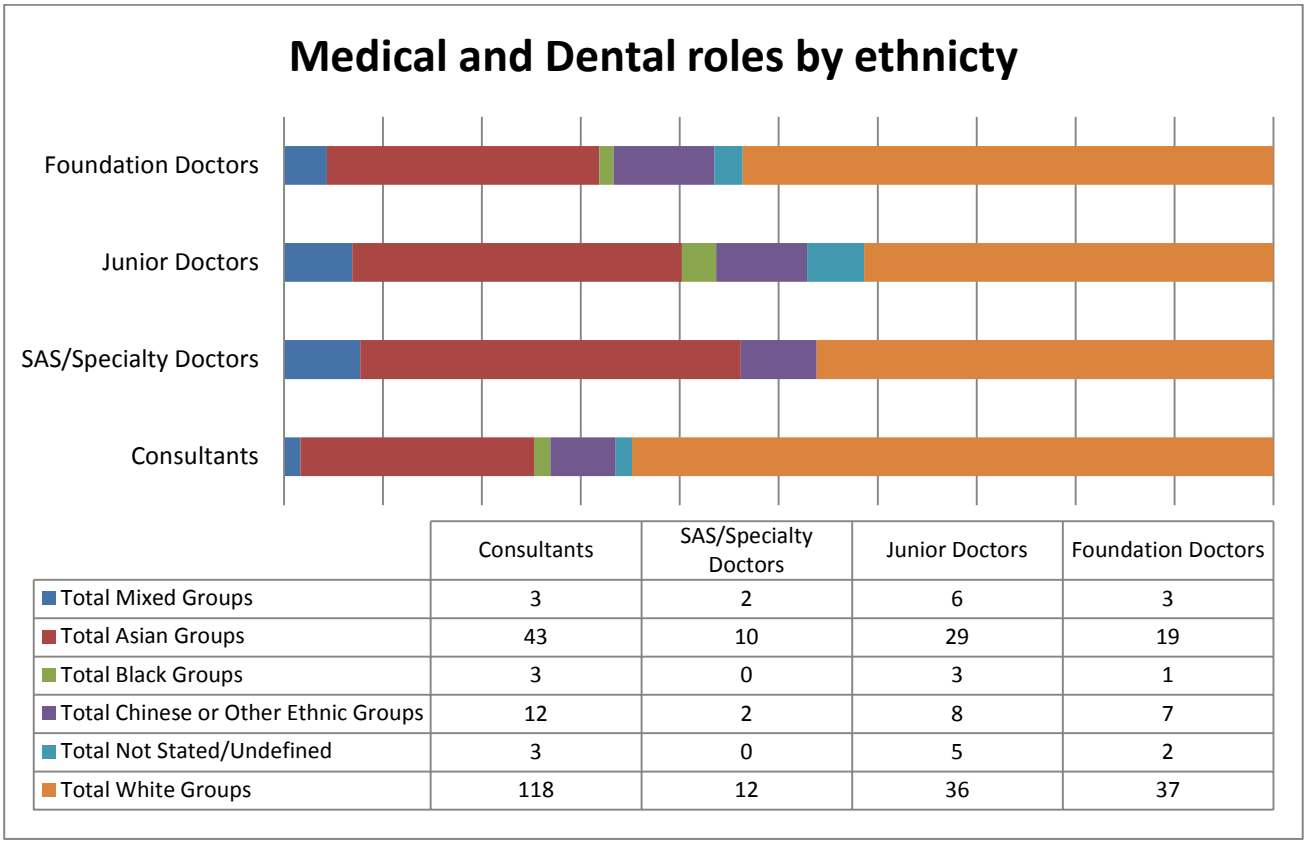


Pay band by ethnicity

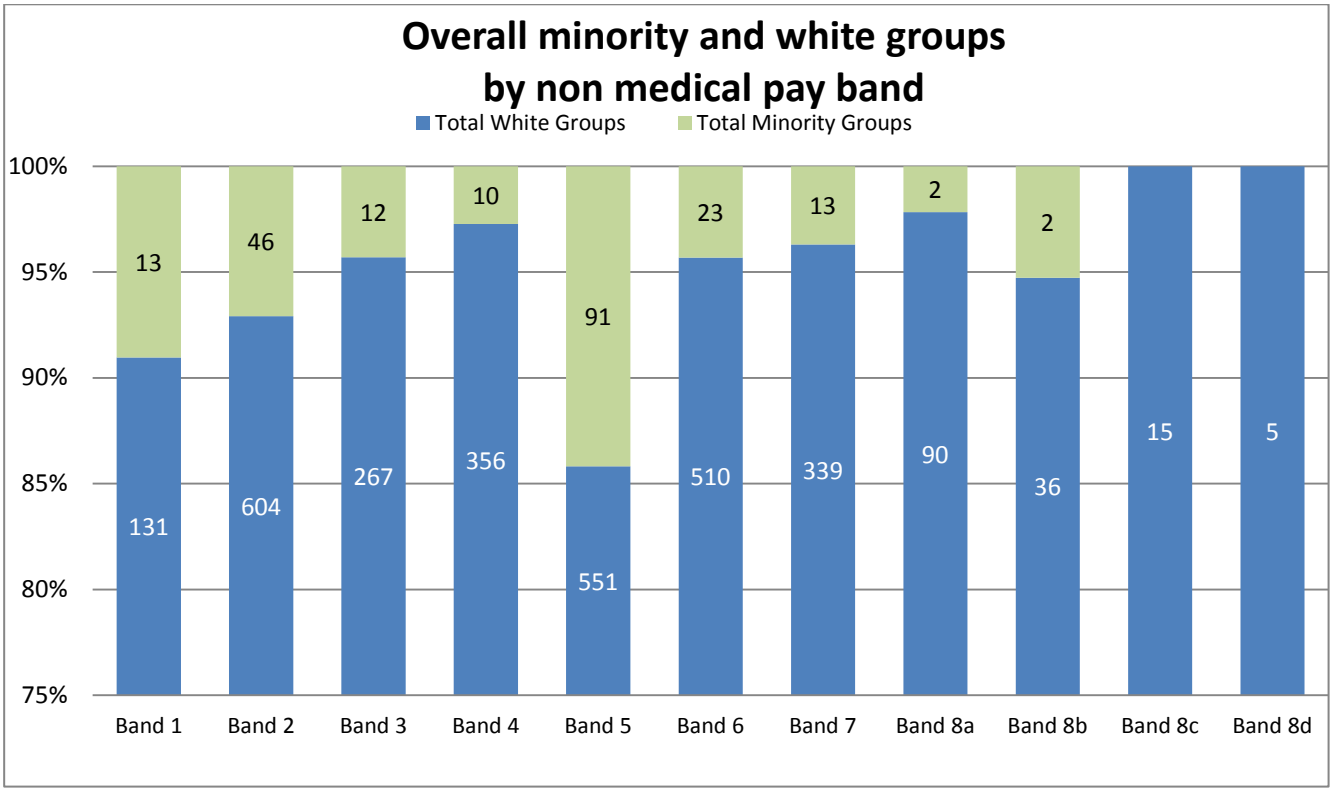
Bands 2 - 6 show the largest distribution of Minority groups. There are few disclosed Minority groups in pay bands 8 and above.



	Total Not Stated	Total Other Ethnic Groups	Total Black Groups	Total Asian Groups	Total White Groups
Band 1	64	3		10	131
Band 2	34	16	4	26	604
Band 3	25	4	2	6	267
Band 4	8	1	3	6	356
Band 5	38	17	5	69	551
Band 6	21	4	1	18	510
Band 7	17	8	1	4	339
Band 8a	1			2	90
Band 8b	1	1		1	36
Band 8c					15
Band 8d					5
Band 9	1				



	Consultants	SAS/Specialty Doctors	Junior Doctors	Foundation Doctors
Total Mixed Groups	3	2	6	3
Total Asian Groups	43	10	29	19
Total Black Groups	3	0	3	1
Total Chinese or Other Ethnic Groups	12	2	8	7
Total Not Stated/Undefined	3	0	5	2
Total White Groups	118	12	36	37



EDS evidence showed that all staff, and therefore all protected groups, have nationally determined and locally agreed equal pay and related terms and conditions. The Trust is fully engaged with staff and unions and any potential or perceived unfairness in relation to pay and conditions are fully investigated with subsequent feedback to those concerned.

Performance management
As part of the Trust's processes for equality monitoring the Workforce and Communications Directorate record all formal investigations for disciplinary, capability, grievance, bullying, harassment and recruitment complaints.

The factors being monitored are age, ethnicity, gender and disability to identify any trends that may indicate discrimination. Sickness absence is monitored separately.

In 2016/17 the Trust conducted a total of 37 formal investigations split into the categories listed in the table below.

	2016/17	2015/16	2014/15
Disciplinary	22	24	19
Capability	11	14	4
Grievance	3	7	3
Bullying & Harassment	1	6	2
Recruitment Discrimination	0	0	0
TOTAL	37	51	28

Our analysis shows that 33 of the cases listed above involved White British or White European/White Other staff, and 4 cases were staff from ethnic minorities. None of the cases involved members of staff with a disability and the age range was from 19 - 61 years old. No significant trends have been identified during the analysis.

Disciplinary Cases - 22
The proportion of cases between male and female staff is 5 male cases and 17 female cases. Two cases involved staff from ethnic minorities and the rest were White British or White European/White Other. Six cases went to dismissal and two cases for potential dismissal resigned before the hearing. One dismissal was an employee from an ethnic minority.

Capability Cases - 11
We had eleven cases, six male and five female. None of the cases involved an employee with a disability and their ages ranged from 30 – 64 years old. One case involved an employee from an ethnic minority.

Grievance Cases - 3
We had three grievances raised and all three were lodged by male employees. Two employees were White British and one was from an ethnic minority. None of the employee had a disability.

Bullying & Harassment - 1
We had one case involving a female employee who was White British.
On the basis of the data collected for 2016/17 we have not identified any trends or individual cases that indicate discrimination.

Mediation
Mediation is being used increasingly as a means of resolving disputes. It is too early to identify trends but our expectation is that this will have an impact on formal grievances being raised and thus reduce senior management involvement in what can be a time-consuming process.

Data sources for this report
Electronic staff record (ESR) / Oracle BI
Standard workforce figures for staff groups as at 31-March-2017
Trust diversity statistics as at 31-March-2017, for protected characteristics

Office for National Statistics (ONS)
Census information 2011
Population ethnicity profile 2011

NHS Jobs
Data sample of equal opportunities employment progress April 2016 – March 2017.

Equality and Diversity Action Plan 2017 to 2019

Equality and Diversity Objective	Action – by 31/8/19	Lead	Supports
Improve the patient experience and care of older age patients (including those with dementia).	• Cognitive screening – review dementia screening within eCare; process to include single question and request for review/referral for memory assessment services via GP	Lead Nurse Dementia & Frail Elderly	• EDS Goals: better health outcomes, improved patient access and experience • Strategic Framework Ambitions: 1,6
	• Add delirium screening to eCare	Lead Nurse Dementia & Frail Elderly Consultant in Elderly Medicine	
	• Frailty screening for all patients over 65		
	• Train volunteers to become 'Ward Companions' to offer comfort, compassion and company for patients at the ends of their lives and their families	Voluntary Services Manager	
	• Install orientation calendar clocks in all ward bays and clinical areas	Estates Manager	
	• Seek and act on feedback from carers, specific carer feedback forms within WSH carer packs. Provide quarterly reports of carer feedback	Lead Nurse Dementia and Frail Elderly	
	• Participate in Suffolk Family Carers Carer Friendly Hospital Award	Lead Nurse Dementia and Frail Elderly	

Promote and support inclusive leadership at all levels of the Trust.	• Include cultural competence in 2030 Leaders Programme and evaluate the impact. • Improve the understanding and recognition of managers and leaders of hidden and unconscious bias and its potential impact on patient care. • Increase target for compliance with mandatory Equality and Diversity training from 80% to 90% by 1.4.18 and review with a view to increasing to 95% by 1.1.19	Deputy Director of Workforce (Organisation Development) Deputy Director of Workforce (Organisation Development) Deputy Director of Workforce (Organisation Development)	• EDS Goal: inclusive leadership • Strategic Framework Ambition: 7
Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.	• Promote 'Freedom to Speak Up, Freedom to Improve' campaign to all staff. • Support and develop the roles of Freedom to Speak-Up Guardian and Guardian of Safe Working.	Executive Director of Workforce and Communications	• EDS Goal: representative and supported workforce • Strategic Framework Ambition: 7 • Social Partnership Forum: Tackling Bullying in the NHS – A collective call to action
Embed equality and diversity in mainstream business processes	• Explore the potential of recruiting and training cultural ambassadors to support mediation processes • Include equality impact assessment as part of the standard business planning template • Ensure impact on equality is considered appropriately in all reports put before the Trust Board and Trust Executive Group	Deputy Director of Workforce (Organisation Development)	• EDS Goal: inclusive leadership • Strategic Framework Ambition: 1 • Public Sector Equality Duty

Improve information and data collected, in respect of protected characteristics, to ensure that the right services are delivered, and in order to improve patient experience and staff satisfaction.	• Review how we analyse and use complaints data relating to protected characteristics • Work towards 100% workforce sample for the NHS staff survey with particular concerted focus on BME staff who are generally less likely to complete the exercise • Review results of gender pay gap reporting and identify action • Identify potential for additional patient data collection on protected characteristics via e-Care • Roll out ESR self-service giving all staff access to update their personal details (including protected characteristics) and promote to staff. Campaign will focus on BME staff and those with a disability.	Deputy Director of Workforce (Organisation Development) Deputy Director of HR (Workforce) Deputy Director of Workforce (Organisation Development) Deputy Director of Workforce (Organisation Development) Deputy Director of HR (Workforce)	• EDS Goals: representative and supported workforce and improved patient access and experience • Workforce Race Equality Scheme • Strategic Framework Ambition 1
Ensure that the recruitment interview process is bias free	• Internal audit of recruitment interview process to seek to identify reason(s) for the reduced likelihood of shortlisted BME candidates being appointed by comparison to shortlisted white candidates. Identify action as appropriate. • Explore the potential of recruiting and training cultural ambassadors to support the selection process.	Deputy Director of Workforce (Organisation Development)	• Workforce Race Equality Scheme • Public Sector Equality Duty • EDS Goal: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

Board of Directors – 29 September 2017

AGENDA ITEM:	20 a
PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce & Communications
PREPARED BY:	Denise Pora, Deputy Director of Workforce (Organisation Development) and Ian Beck, Workforce Information Analyst
DATE PREPARED:	14 September 2017
SUBJECT:	**Equality & Diversity**
PURPOSE:	For Information

EXECUTIVE SUMMARY:

The annual Trust Equality & Diversity Report is attached. This report updates the Board by providing:

- A snapshot of the Trust's equality and diversity profile as of 31.3.17. Where it is possible to collect data an analysis has been made of how the Trust stands against the characteristics protected by the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation).

- Details of the assessments made of equality and diversity priorities for the Trust based on the equality and diversity profile, the NHS equality delivery system (EDS) and the Workforce Race Equality Standard and the CQC Well Led framework.

- Assurance that the Trust is aware of its duties, and is monitoring HR practice through the NHS jobs system and ESR.

Equality and Diversity objectives and an action plan have been developed to address the Trust's priorities. These were consulted upon with representatives of both the local community and staff.

Linked Strategic objective (link to website)	Ambitions 1, 4, 5, 6 and 7
Issue previously considered by: (e.g. committees or forums)	Trust Board – annual report to board July 2016
Risk description: (including reference Risk Register and BAF if applicable)	Public sector duty requires the Trust to abide by the law (see below).
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Equality monitoring processes within Workforce & Communications.
Legislation / Regulatory requirements:	**2010 Equality Act** – Public Sector Equality Duty the trust is required to *"Have due regard for the need to eliminate unlawful discrimination, harassment and victimization; to advance equality of opportunity; and to foster good relations between people who share a protected characteristic and those who do not"* **Equality Delivery System 2** implementation is a requirement on NHS providers

	Workforce Race Equality Standard is included in the NHS standard contract **CQC Well Led Framework** **NHS Constitution**
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	Workforce morale, recruitment and retention, reputation
Recommendation: To receive this report, the EDS template, the WRES template and approve the Trust Equality and Diversity objectives and action plan.	

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 29 September 2017

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Item 20b

West Suffolk Hospital NHS Foundation Trust Infection Prevention and Control Team

Director of Infection Prevention and Control
Annual Report April 2016 - March 2017

Executive Summary

The Health and Social Care Act (2008) Code of Practice on the Prevention and Control of Infections and Related Guidance requires the Director of Infection Prevention and Control (DIPC) to produce an annual report on the Trust's performance in respect of healthcare associated infections (HCAIs). This report covers the period April 2016-March 2017 and provides information on the progress being made to reduce HCAIs.
The format of this annual report has been revised so that it is aligned with the criteria in the Code of Practice; this format was recommended by Dr Debra Adams, Senior Infection Prevention and Control Adviser, Midlands and East (NHS Improvement).
Since October 2015 the Trust has been responsible for community beds in King's Suite at Glastonbury Court, and at Newmarket Community Hospital. This includes provision of Infection Prevention advice and support.

Introduction

The strategic and operational aim of the Infection Prevention and Control service is to increase organisational focus and collaborative working to maintain standards and support compliance the ten criteria identified in the Health and Social Care Act 2008 (amended in 2015). The objective is to engage staff at all levels and to ensure effective leadership, in order to develop and embed a culture that supports effective Infection Prevention and Control within the Trust.
The Infection Prevention and Control Team (IPT) have worked in collaboration with operational leads and members of the Nursing and Quality teams to maintain an effective service that has delivered a broad programme of work.
The programme of work has been supported and monitored by the Infection Prevention and Control Committee, which is chaired by the Chief Executive Officer. The Committee provides assurance to the Board through the Clinical Safety and Effectiveness Committee.

The following section of the report describes the annual programme of work in terms of compliance with the ten criteria of the Code of Practice. Compliance with the Code of Practice is assessed by the Care Quality Commission.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection to other people. (That all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection).
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Criterion 1
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment or other users may pose to them.
The Trust Board is committed to fulfilling their responsibility to minimise the risk of preventable infection.

The Infection Prevention and Control Arrangements

- The Chief Executive accepts on behalf of the Board responsibility for all aspects of Infection Prevention and Control within the Trust. This responsibility is delegated to the DIPC (who is also the Executive Chief Nurse). The DIPC works with the Infection Prevention Team.
- The Infection Control Doctor provides expert microbiological and IPC advice and supports the DIPC and the IPT in the production of policies and procedures.
- The Lead Infection Prevention Nurse has operational responsibility for management of the Infection Prevention Nurses and for ensuring that IP&C is embedded within the Trust. The Lead Nurse is a source of expert advice and is responsible for on-going development and evaluation of communication strategies at Trust and divisional levels aimed at promoting IPC policies, guidelines and procedures. The Lead IPN is line managed by the Executive Chief Nurse who is also the DIPC.
- The IPN team comprises:
    - **Lead IPN WTE 0.8, Band 8a**
    - **Two Infection Prevention nurses 1 WTE Band 6 & 1 0.6 WTE Band 6**

  Limited clerical support is provided by the Pathology Admin and Clerical staff
- **The Infection Prevention and Antibiotic audit nurses work closely with the IPNs. They are professionally accountable to the lead IPN, although they are managed within the Pharmacy Department, Clinical Support Services Division.**
    - **Band 7 WTE 0.8**
    - **Band 6 WTE 0.8**
- **The Infection Prevention Doctor is a Consultant Microbiologist; a payment of 0.5 programmed activities is paid in respect of this role, although it is acknowledged that significantly more time is required that this to fulfil the role. Another Consultant Microbiologist acts ad Deputy IPD, without specific additional remuneration.**

All members of the team undertake Continuous Professional Development as required by their respective registration bodies, and annual appraisal as required by the Trust. All of the IPN nursing team have been revalidated in the last year and are compliant with NMC requirements.

The Lead IPN is a member of the Suffolk Community Healthcare Infection Control Group.

Assurance Framework
The Trust Board receives reports from the IPC via CSEC, as described above. Additional reports are provided by other departments, which inform the Board in respect of compliance with the 10 criteria. These include:

ANNUAL PLAN
In addition to the regular activities described in subsequent sections, progress was made against the 2016-17 Annual Plan in the following areas:

- Chlorhexidine-impregnated dressings for central venous catheters have been introduced for patients at high risk of infection. The relevant care bundles and pathways have been revised accordingly and will be reviewed again in 2017 with the publication of the revised High Impact Interventions
- Specialist manufacturer Bioquell undertook a survey to see if it would be possible for their 'pop-up' isolation facilities (which allow a ward bed to function as an isolation facility for that patient) to be used in the Trust. Unfortunately it was found that because of the lack of standard size requirements then bespoke solutions would be required for each ward area. The cost of this would be prohibitive, so this option will not be pursued.
- The use of hypochlorite-containing cleaning products as the Trust standard was reviewed because of concerns about frequent exposure of staff, and of damage to some surfaces. A number of products were assessed but a decision was made to continue to use hypochlorite in line with national guidelines.
- Using ward G9 as a decant facility allowed deep cleaning of 9 wards to take place.
- The Trust Antibiotic Treatment guidelines were revised and re-issued.
- The Anti-Microbial Management Team worked with other Trust staff with a view to meeting the requirements of National CQUIN target (see below).
- The IPT has been involved in planning for all major estates projects including the Cardiac Unit.

Criterion 2
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection
Inspections and audits not undertaken by the IPT are presented to Trust Board by the Hotel Services Manager. They include:

- Dashboard
- Monitoring Officer audits (See attached flow chart)
- Patient Environment Action Group (PEAG) audits
- Annual Patient Lead Assessments of the Care Environment (PLACE)

The Trust Water Safety Group, at which the IPT are represented, considers matters relating to the supply and quality of water and water systems within the Trust. It reports to the IPCC.
The programme of testing for pseudomonas in augmented care areas continues. Significant remedial work has been undertaken (removal of redundant pipework, replacement and resupply of taps and showers; however some outlets continue to test positive. These are being managed with the use of filters.

Regular testing for Legionella is also undertaken. Positive results in two of the residences required interruption of the supply for hyperchlorination to be performed; since then the results have been satisfactory.
The IPT participated in an external Water Safety Audit undertaken by the Trust's specialist adviser in January 2017.

Criterion 3
Provide suitable accurate information to service users and their visitors
The IPT reports cases of *Clostridium difficile,* and *Staphylococcus aureus* bacteraemia (both meticillin-sensitive and meticillin-resistant) to the mandatory National Surveillance Scheme. Mandatory surveillance of E coli bacteraemia commenced in June 2011 and going forward in 2017/18 will be assigned using PHE criteria to 'community onset' or 'Hospital onset' as part of the quality premium to reduce Gram negative bloodstream infections.

1. *C. difficile infection (CDI)*

A total of 23 cases of hospital-attributable (by timeframe) CDI were reported for the financial year. Of these 18 were deemed by the CCG to be non-trajectory as there had been no lapses in care. The nationally set objective for 2016-17 was 16. The Post Infection Review meetings with the CCG are a valuable forum where notable practice is acknowledged as well as any lapses of care discussed and appropriate actions identified.
The principle issue making cases trajectory is that of failure to isolate patients in whom infectious diarrhoea is suspected, and a sample is sent.

2. Meticillin-resistant *Staph aureus* bacteraemia

Two cases were identified which following review by the CCG and then by NHSI Eastern region) were deemed to be 'third party' i.e. not attributable to either the Trust or community. To illustrate this, one of the cases deemed 'Third party' is a patient with a dermatological condition and extensive excoriations colonized with MRSA. Despite repeated decolonization regimens and specialist dermatology support including on-going use of Octenisan, the patient remained heavily colonized. The patient was poorly compliant with interventions due to her advanced dementia.
One case was Trust-attributable by time-frame but it was agreed that the isolate was a contaminant; actions and learning were agreed with the CCG such that blood cultures may now be taken only be appropriate clinical staff. This forms part of an internal remedial action plan overseen by the IPCC
The nationally-set objective for these cases remains zero.

3. Meticillin-sensitive *Staph aureus* bacteraemia

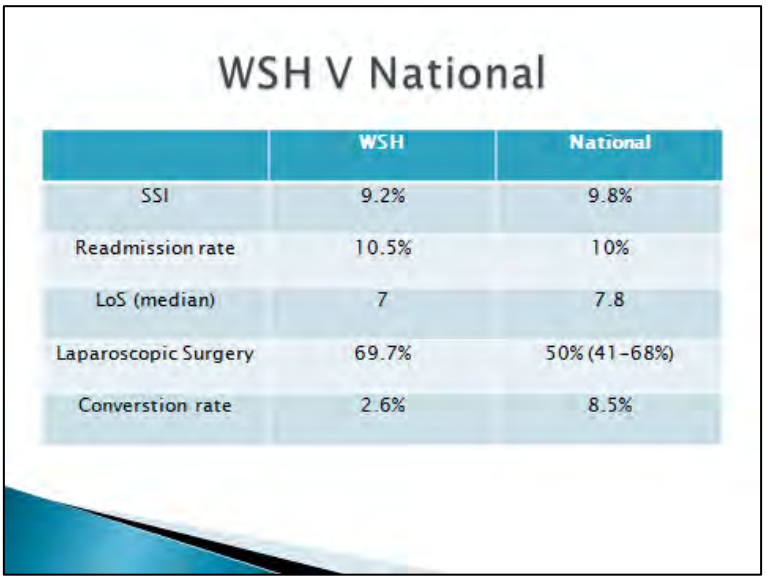
Six cases were identified; all were deemed to be unavoidable by Post Infection Review meeting process, and therefore downgraded to Green as the severity category. There were no common themes.
The presence and of a senior clinician at these meetings is very helpful in understanding the course of events, and the support of clinical colleagues is gratefully acknowledged.

4. *Escherichia coli* bacteraemia.

There were a total of 182 cases across community and Trust, of which 15 were attributable to the Trust by time-frame. It was noted that many of the patients had significant comorbidities, including 5 with cancer. A Root Cause Analysis tool is being developed for investigation of these cases and we are advised that this will be required in due course and will be reviewed by Public Health England. This will form part of their national initiative to reduce Gram negative Bloodstream infections. These surveillance results are in the public domain, on the Health Protection Unit website.

5. Surgical Site Infection Surveillance.

Surveillance of elective Large Bowel Surgery was undertaken between October 2016 and March 2017, the first time that this module has been undertaken. Comparative results for WSFT against the national results are shown below.



WSH V National

	WSH	National
SSI	9.2%	9.8%
Readmission rate	10.5%	10%
LoS (median)	7	7.8
Laparoscopic Surgery	69.7%	50% (41-68%)
Converstion rate	2.6%	8.5%

Surveillance of orthopaedic surgery was undertaken for three procedures: fractured neck of femur, total hip replacement and total knee replacement.

Surveillance data is collected for all patients having the procedure during the surveillance period. This is undertaken by review of the clinical records for their admission and at the six week post-operative consultation, looking for evidence of infection. Some Trusts also use a patient questionnaire (PQ in the tables below) to collect information about infections that were managed elsewhere; this is extremely time-consuming and is not feasible for WSFT at the present time.

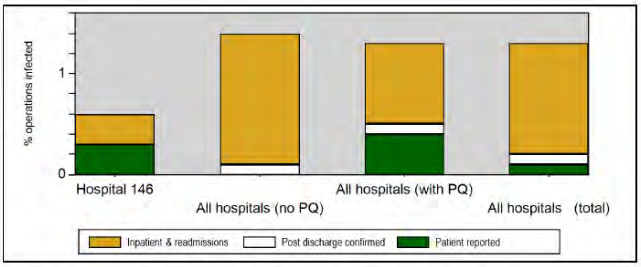
NOF

Public Health England

Surgical Site Infection Surveillance Service

Rate of SSI

Category	Repair of neck of femur
Data between	Apr-2016 and Mar-2017
Hospital	West Suffolk Hospital [146]



All hospitals* for the previous 5 years available (Apr-Jun 2012 to Jan-Mar 2017).

	No. operations	Patient questionnaire		Surgical Site Infection: Inpatient & readmissions		Post discharge confirmed		Patient reported		All SSI	
		No. given	% complete	No.	%	No.	%	No.	%	No.	%
Hospital 146	331	300	85.5	1	0.3	0	0.0	1	0.3	2	0.6
All hospitals (no PQ)	63251	No data	No data	801	1.3	50	0.1	No data	No data	858	1.4
All hospitals (with PQ)	32368	32368	77.2	273	0.8	39	0.1	127	0.4	439	1.4
All hospitals (total)	95619	32368	0.0	1074	1.1	89	0.1	134	0.1	1297	1.4

*Please refer to 2.4 Definition of Terms at the back of the Summary report for an explanation of data included in the benchmark.

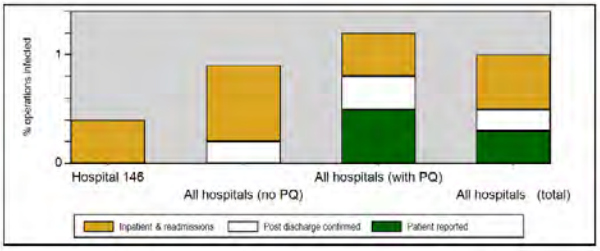
THR

Public Health England

Surgical Site Infection Surveillance Service

Rate of SSI

Category	Hip replacement
Data between	Apr-2016 and Mar-2017
Hospital	West Suffolk Hospital [146]

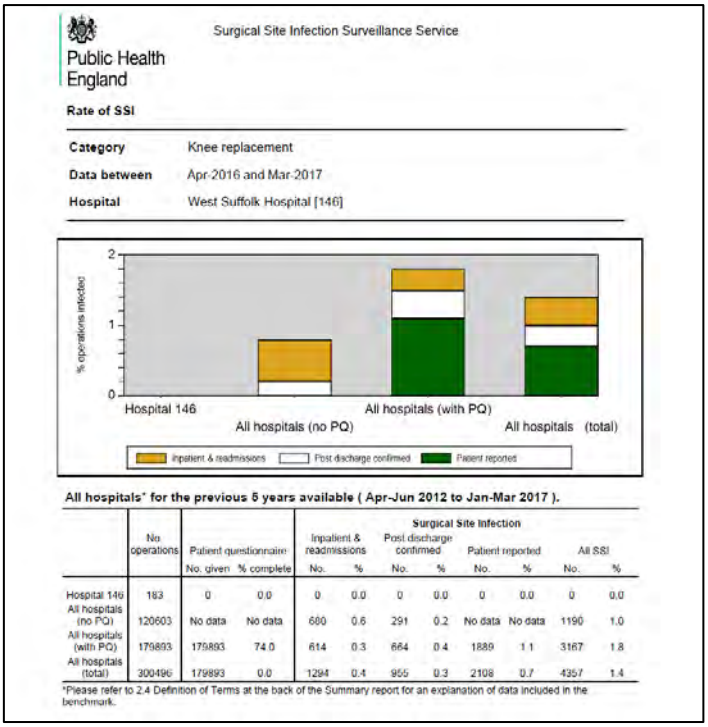


All hospitals* for the previous 5 years available (Apr-Jun 2012 to Jan-Mar 2017).

	No. operations	Patient questionnaire		Surgical Site Infection: Inpatient & readmissions		Post discharge confirmed		Patient reported		All SSI	
		No. given	% complete	No.	%	No.	%	No.	%	No.	%
Hospital 146	241	26	10.8	1	0.4	0	0.0	0	0.0	1	0.4
All hospitals (no PQ)	116165	No data	No data	833	0.7	185	0.2	No data	No data	1096	0.9
All hospitals (with PQ)	167593	167593	75.7	586	0.4	430	0.3	868	0.5	1686	1.1
All hospitals (total)	283758	167593	0.0	1421	0.5	615	0.2	946	0.3	2982	1.1

*Please refer to 2.4 Definition of Terms at the back of the Summary report for an explanation of data included in the benchmark.

TKR



Public Health England

Surgical Site Infection Surveillance Service

Rate of SSI

Category	Knee replacement
Data between	Apr-2016 and Mar-2017
Hospital	West Suffolk Hospital [146]

All hospitals* for the previous 5 years available (Apr-Jun 2012 to Jan-Mar 2017).

	No operations	Patient questionnaire		Surgical Site Infection							
				Inpatient & readmissions		Post discharge confirmed		Patient reported		All SSI	
		No. given	% complete	No.	%	No.	%	No.	%	No.	%
Hospital 146	183	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
All hospitals (no PQ)	120603	No data	No data	680	0.6	291	0.2	No data	No data	1190	1.0
All hospitals (with PQ)	179893	179893	74.0	614	0.3	664	0.4	1889	1.1	3167	1.8
All hospitals (total)	300496	179893	0.0	1294	0.4	955	0.3	2108	0.7	4357	1.4

*Please refer to 2.4 Definition of Terms at the back of the Summary report for an explanation of data included in the benchmark.

Criterion 4
Provide suitable accurate information on infection to any person concerned with providing further support of nursing/medical care in a timely fashion

Infection Prevention advice is available 24 hours a day with from the IPNs or the duty consultant microbiologist.
To ensure that everyone is aware of their responsibilities the managers are responsible for ensuring that the suite of infection prevention & control posters is available for their staff and that there are leaflets or information available for their patients and visitors. The IPCT is responsible for ensuring that information is available for staff via the intranet site and for visitors/carers on the Trust website, this includes the latest Annual Report and Strategy.
The information available on the Trust Internet site has been reviewed by the Team as part of the overall website review.

Criterion 5
Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people

The IPT strategy has been developed based on the key principles of successful prevention and control techniques, which include:

- Assessment and proactive response to the risk of infection
- Ensuring effective working practices that avoid the risk of transmission

- Universal application of applying fundamental infection prevention and control techniques and practices
- Managing specific infectious agents in line with best practice

The key objectives for 2016-2017 to:

- Work effectively with the wider health and social care economies to reduce the incidence of health care associated infections and communicable diseases. With particular reference to the correct use of personal protective equipment. To work with colleagues across the whole health economy in respect of the quality premium to reduce gram negative bloodstream infections.
- Continue to build a culture where staff are prepared to challenge and be challenged on clinical practice including hand hygiene and the use of personal protective clothing.
- Ensure, through a system of audit and observation, that our services provide a clean safe environment conducive to good infection prevention and control practice.
- Work effectively with operational services and the training teams to strengthen and promote IPC education and training.
- Ensure effective risk assessment and risk management strategies are employed whenever and wherever a risk is identified.

These objectives will be supported by an annual development plan to strengthen the Trust's compliance with the Health and Social Care Act (2008) Code of Practice. The work plan will be agreed and scrutinised by the Strategic Infection Control Committee, with a biannual report being presented to the Clinical Safety & Effectiveness Committee.

Updates on the progress of the work plan are presented to the Infection Prevention and Control Committee. The Executive Team and the Board also receive monthly reports on the commissioner's infection control targets that include a year on year reduction in *Clostridium difficile* and zero tolerance of MRSA bacteraemia. Information regarding audit results and training compliance is also presented.

(A point prevalence survey undertaken in June 2016 identified 10 patients who would have required isolation and screening for CPE).

Criterion 6
Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

All WSFT receive mandatory training at induction and regularly thereafter; the frequency is determined by their role:

- Non-clinical staff undertake e-learning every three years (88% are up to date against a Trust target of 80%).
- Frontline Clinical staff (predominantly but not exclusively Nursing staff) receive annual classroom training
- Consultants undertake annual e-learning. 95% are compliant (target 80%)

IP is a core element in Trust mandatory training.
All new staff job descriptions include the statement that 'it is the personal responsibility of the post holder to adhere to the West Suffolk NHS Foundation Trust policies and procedures outlined in the Infection Control Manual and any other Infection Control policies, procedures and practices which may be required from time to time'.

As part of IPC audit, if poor practice is noted than it is escalated to the area manager for resolution; part of this may be incorporated into appraisals.

Most clinical areas have an IP Link Practitioner who acts as a source of information and advice regarding appropriate practice. The Link Practitioners are supported by the IPT and there are four training days a year, each focussing on a different topic. The most recent meetings have covered:

- Carbapenemase resistant Enterobacteriacae
- Risk assessment
- Asepsis and patient safety

Criterion 7
Provide or secure adequate isolation facilities
The Trust has an acknowledged risk noted on the Trust Risk register describing the low number of single rooms (circa 10% of available beds are single rooms) which is recognised as being the lowest in the region. The Trust increased the number of single rooms in 2014 by opening an all single roomed adult isolation ward (F12), which increased the single room capacity by an additional 8 rooms. The Trust continues to support this initiative; ensuring patients urgently requiring isolation can be accommodated. The Trust aims to have a ring fenced bed available on F12 to ensure timely isolation can be achieved. The IPT attend as a minimum (and more frequently as required) the Midday patient flow meeting to ensure staff managing this key function can access accurate information on available isolation facilities.
The IPN's visit the acute wards daily in order to assess patients requiring isolation and those for whom monitoring is required to ensure all measures to reduce onward transmission are in place.

Our commissioners have set a target of 95% compliance with Isolation and this is reported on a monthly basis via the Infection Prevention Dashboard. The Trust achieved 95% in April 2016 thereafter the monthly totals range from 89% to 94% compliance.

Criterion 8
Secure adequate access to laboratory support as appropriate
Microbiology services are provided by Public Health England as a subcontractor of North East Essex and Suffolk Pathology Services (which replaced the Pathology Partnership in May 2017). The Microbiology laboratory is still on-site, as there have been significant delays in the transformation process that is intended to move the laboratory service to Ipswich.
There are on-going difficulties with extracting data from the Laboratory information Management System (Clinisys WinPath Enterprise) in order to provide lists of in-patients with 'alert organisms' that are of particular concern from an IP point of view. In addition it has not yet been possible to replicate the searches for MRSA screens linked to in-patients to allow reporting of the percentage of patients who are screened. Work continues in these areas.
On a positive note, with the award to the Trust of 'Global digital excellence' status, the Trust is actively seeking to implement the e-Care Infection Prevention module. Meetings and discussions are on-going to ensure that this will provide the necessary functionality.

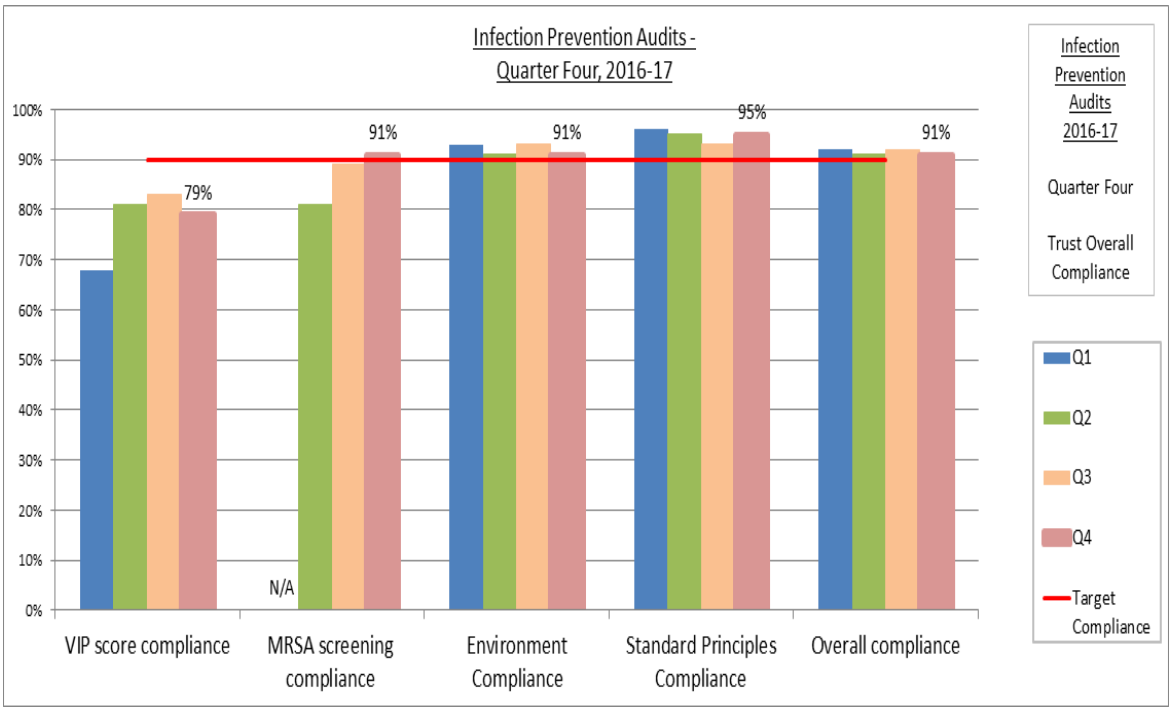
Criterion 9
Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Compliance with elements of the policies is assessed in the programme of Trust audits (High Impact Interventions and Hand Hygiene) and Infection Prevention audits. There is also a rolling programme of audits of compliance with Trust antibiotic treatment policies.

HIIs and Hand Hygiene Audits

Indicator	Target	Red	Amber	Green	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	100	na	100	100	100	100	100	100	100	100	100	100
HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	95.65	na	100	94.44	96.30	100	100	86.36	100	100	94.74	100
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	na	97.56	100	100	100	100	100.00	100	97.62	98	98
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	96.83	na	94.12	88.80	93.22	98.06	93.33	95.92	99.01	92.52	98.11	94.83
HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	100	na	100	100	100	100	100	100	95	100	100	100
HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	75	na	100	100	100	100	100	87	100	100	100	100
HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	100	na	100	100	100	100	100	100	100	100	100	100
HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	96.30	na	87.32	88.24	97.40	95.50	90.48	85.25	93.44	95.45	95.24	82.19
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<80	80-99	= 100	100	na	100	na	na	na	na	na	na	na	na	na
Hand hygiene compliance	= 95%	<85	85-99	= 100	99	99	99	100	99	100	98	99	100	99	99	100

Additional Infection Prevention Audits



Compliance with Visual Infusion Phlebitis scores has been below target since the launch of e-Care in May 2016. Both ad-hoc and formal training on how and why to complete this has been offered to wards and key groups of staff, and changes to e-Care have been made to request documentation of the care of the IV cannula in the nurse accountability that is completed each shift.

MRSA screening also fell below target following the launch of e-Care, however a return to more than 90% was seen by Quarter Four. Again, ad-hoc and formal training was provided by the Infection Prevention Audit team and changes were made within e-Care to support the screening of patients.

Following the audit, areas of non-compliance/poor performance are reported to the Ward manager and Matron and the findings discussed. If there are on-going issues identified in previous audits a formal meeting is held with the Ward Manager and Matron. Audit results and issues identified during the audits are discussed at the IPT/DIPC meeting.

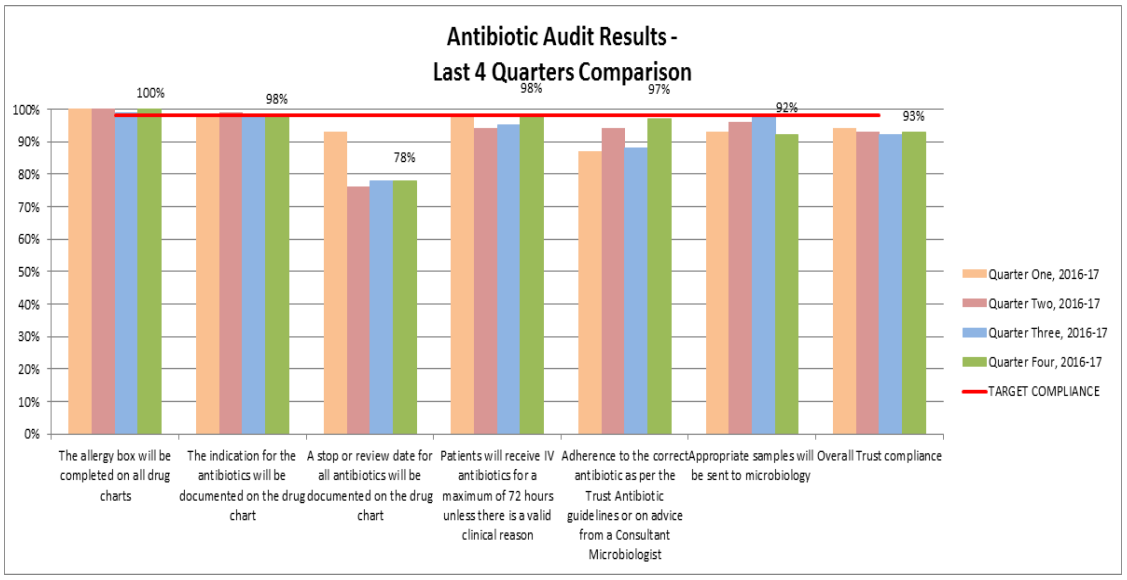
The results of the audits are formally reviewed by the Lead IPN and Audit Nurse. If there are concerns then additional review of practice on the ward is undertaken and support given as necessary to improve practice. This process has continued in 2016/17, allowing any themes to be identified and appropriate actions taken.

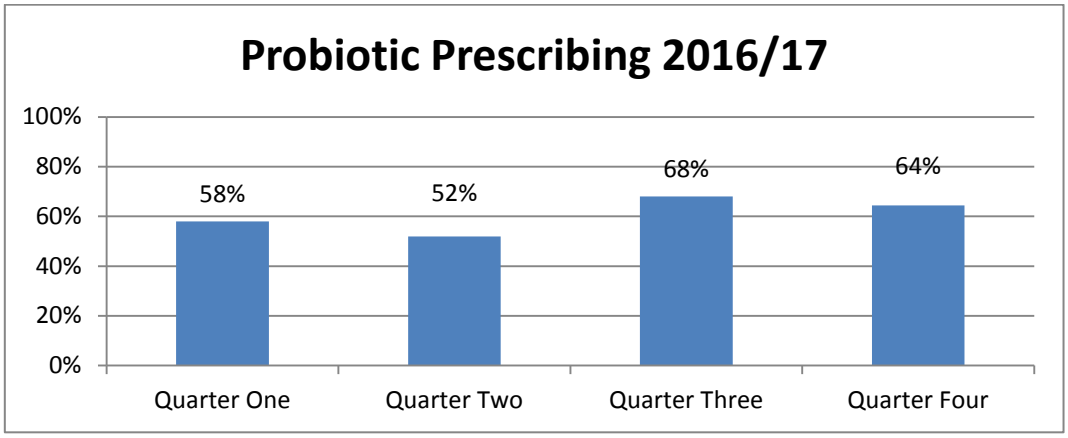
Aseptic Non Touch Technique (ANTT)

It is now 7 years since the ANTT training and assessment programme was introduced. At the end of 2016/17 the Trust compliance with ANTT assessments stands at 66.29%, with the standard being that all relevant staff are assessed every 3 years. Ward Managers are being provided with quarterly compliance reports and we have since seen an increase in completed assessments.
Medical staff are also emailed on a quarterly basis to advise them of compliance with these competency and assessments offered where required. Completion of all elements of mandatory training is a requirement for completion of their annual appraisal.

ANTIMICROBIAL STEWARDSHIP

The rolling programme of audit has continued. Compliance with prescribing of probiotics was included as an additional audit from October 2013.





Overall results

The Trust was contractually required to achieve 98% compliance in 2016-17; however the Trust failed to achieve this in all quarters, with 94% compliance achieved in Quarter One, 93% compliance in Quarters Two and Four, and 92% in Quarter Two.

Individual ward results are emailed to the Ward Manager, Senior Matron, Ward Consultants and Service Manager. Results are discussed at Antimicrobial Management Group, Infection Prevention & Control Committee, Matron Performance meetings and Divisional Governance meetings where required.

Dr Younis Dahar continued in the role of Antibiotic lead.

Antimicrobial Stewardship Initiatives

- The nurse mandatory session has been updated to include more information relating to antimicrobial stewardship.
-

- 14th – 18th November 2016 was the first World Antibiotic Awareness Week:

    1. The Antimicrobial Management Team visited all wards to promote best practice antimicrobial use.
    2. The use of the 'Microguide' app was also promoted to all doctors, nurses and pharmacists.
    3. 18th November was European Antibiotic Awareness Day & the team held an information display in Time Out.
    4. Information was also displayed at the front entrance to the hospital and in the Pharmacy waiting room for patients and visitors.

- The weekly Microbiology ward round continues on F7.
- The Antimicrobial Management Team has provided support to Cerner in the build of a new antimicrobial stewardship module.
- Since January, a daily report is produced and distributed to the wards via the ward pharmacists identifying the prescriptions that require a 72 hour review to further support medical staff to review prescriptions within 72 hours. The Antimicrobial Management Team has been working with the e-Care Medicines Management teams to develop a more functional review alert.
- In January one of the antibiotic audit nurses presented at a national nursing summit to promote the role of nurses within antimicrobial stewardship, with an invitation to present again in November.

2016/17 AMR CQUIN

- CQUIN No 3a): Reduction in antibiotic consumption per 1,000 admissions
    - There were three parts to this indicator.
      1. Total antibiotic consumption per 1,000 admissions
      2. Total consumption of carbapenems per 1,000 admissions
      3. Total consumption of piperacillin-tazobactam per 1,000 admissions

      Baseline: 2013-4. Target: <1% Q4.

      4. An additional 25% to be paid for submission of consumption data to PHE for years: 2014/15 to 2016/17
    - The above targets 1-3 were not met, which was predicted as unachievable at the start of the CQUIN year. Part 4 was achieved.

- CQUIN No 3b): Empiric review of antibiotic prescriptions
    - This CQUIN was met for all quarters this year.

Surgical prophylaxis audit

The Trust guidelines for Surgical Prophylaxis are currently under review, the next audit will be conducted following this.

Criterion 10

Ensure, so far as is reasonably practical, that care workers are free of infection and are protected from exposure to infection that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Please see criterion 6 with respect to staff training.
The importance of vaccinating staff against influenza is acknowledged by this having been made one of the national CQUIN targets for 2016-17. The Trust achieved a vaccination rate of 64.9% against a target of 65%. The IPT are involved with Occupational health in planning the 2017-18 vaccination programme. Two of the team will again be working as peer vaccinators.

INCIDENTS – Norovirus

Ward affected	Patients with symptoms	Reported Staff with Symptoms	Ward/ Bay closed	Ward / Bay opened	Days affected	Confirmed Norovirus	Comments
G4	20	2	06/11/2016	14/11/2016	8 Days	2	Additional sampling for suspected Norovirus identified two of the symptomatic patients to have CDT not Norovirus. Ribotyping demonstrated no link (different strains). SIRI completed
F5	12	4	03/01/2017	09/01/2017	6 Days	2	
G4	13	5	03/01/2017	10/01/2017	7 Days	2	

The outbreaks were reported as Serious Incidents Requiring Investigation and RCAs undertaken (organised by the Governance Department). The Trust was noted to be an outlier with regard to Norovirus during the winter of 2016, in light of which NHS Improvement were invited to visit the Trust. In addition the CCG were asked to review our policies and procedures; the only suggestion was to circulate a top tips to all wards which was completed. Action plans were agreed with the CCG. The CCG commented on the robustness of the investigations into these incidents and the Trust will continue to implement control measures within the limitation of our estate. This is noted on the Trust risk register.

DECONTAMINATION INCIDENT
In November 2016 it was found that one of the instrument washers had not been properly dosing detergent. The incident was reviewed and risk assessed by Estates and the IPT with support from the external Authorised Engineer. All instruments were recalled. Specialist checks on instruments showed that cleaning had been sufficient and that there was therefore no concern about inadequate instrument decontamination. No further action was required.

COMMUNITY CONTRACT
The Infection Prevention lead post for Community has remained vacant, the responsibility being shared between Ipswich Hospital, WSFT and Norfolk Community Healthcare NHS Trust. This will change in October 2017 when WSFT becomes the preferred provider for Western Suffolk.

The WSFT IPT have had significant input into Newmarket Hospital, including the introduction of appropriate audit tools and provision of support for day to day issues and during outbreaks. Since February Michelle Smith has taken on extra hours specifically for Infection Prevention support for Newmarket and King's Suite, Glastonbury Court. This has allowed for valuable proactive work in these areas.

SUMMARY

Infection Prevention remains a high priority for the Trust. Significant monitoring and audit of a variety of measures is undertaken and reported.

The IPT have established an excellent working relationship with the CCG Infection Prevention Nurse Adviser, who has provided support and advice in SIRI and PIR meetings.

The main challenge remains the inadequacy of single room provision, both the number and the lack of rooms with en-suite toilets. A likely increase in the number of patients requiring isolation when CPE screening is introduced will exacerbate this problem.

Board of Directors – 29 September 2017

AGENDA ITEM:	20b
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Infection Prevention and Control Team
DATE PREPARED:	September 2017
SUBJECT:	**Infection Prevention and Control Annual Report**
PURPOSE:	For Information

EXECUTIVE SUMMARY:

The Health and Social Care Act (2008) Code of Practice on the Prevention and Control of Infections and Related Guidance requires the Director of Infection Prevention and Control (DIPC) to produce an annual report on the Trust's performance in respect of healthcare associated infections (HCAIs). This report covers the period April 2016-March 2017 and provides information on the progress being made to reduce HCAIs.

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)	

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 29 September 2017

AGENDA ITEM:	21
PRESENTED BY:	Dr Stephen Dunn, Chief Executive
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	22 September 2017
SUBJECT:	Trust Executive Group (TEG) report
PURPOSE:	Approval

EXECUTIVE SUMMARY:

4 September 2017

Nick Jenkins provided an introduction to the meeting, including an update on **operational and financial performance**. It was noted that the CQC had notified the Trust of a planned inspection and as part of this submission of the provider information request (PIR) was due on 8 September. The terms of reference of TEG were reviewed and membership updated to include heads of nursing, chief clinical information officer (CCIO) and public health registrar.

A detail review took place of the **RTT position**. It was noted that we remain ahead of the agreed recovery trajectory. July saw an increase in patients waiting over 52 weeks, due to various reasons, including those patients wanting to have treatment after their summer holidays and losing some key clinics due to staff sickness.

In response to the DH toolkit approval was given for the implementation of selective screening of patients for colonisation with **Carbapenemase Producing Enterobacteriacae (CPE)**.

The report from the **Flow Action Group (FLAG)** highlighted that analysis of the board rounds continued with a focus on removing any blockages to patient flow. It was noted that KPMG had acknowledged that F3 was seen as an exemplar ward for the best red to green rounds at the Trust and within the NHS

A report on **seven day services (7DS)** provided clarity on the interpretation of standards 2 (time to consultant review) and 8 (on-going review). This national clarification has informed the Trust's gap analysis. The synergy between these ambitions and our work to improve patient flow was recognised.

An update was received on transition of **community services** and support for staff throughout this process. It was noted that the TEG meeting in October will be used to engage with the new community senior managers joining the Trust. Clarification was sought and received regarding the contractual position and it was subsequently confirmed that there would be an annual inflationary uplift for the contract.

Relevant **policy documents** were reviewed and approved - risk management strategy (attached for Board ratification) and interventional procedures policy.

18 September 2017

Steve Dunn provided an introduction to the meeting including an update on **operational and financial performance**. The submission to the CQC was noted and divisions thanked for their contribution to the self-assessment process.

ED performance over the last two weeks was reviewed with focus on action to improve after what has been a very challenging period. It was noted that a £15m bid had been submitted for development of the **ED department** with the outcome expected by the end of October. As part of this work it was highlighted that a clinical review is ongoing to development the service model for AMU, this will inform the plans for the building design.

A detailed discussion took place on **preparation for winter**. This included the flu immunisation programme for staff and options for delivery as well as the operational arrangements within the Trust and the wider healthcare system.

An update was received on **RTT performance** and plans to deliver the improvement trajectory. Feedback was received from the recent intensive support team (IST) visit using the sustainability model. The visit highligted three key elements which form the basis of the action plan – access, data quality and capacity/demand. The capacity planning model, which is being developed with KPMG, will support this work. The terms of reference for a clinical harm review for long waiting patients was approved.

The **red risk report** was reviewed with discussion and challenge for individual areas. A new red risk was received approved regarding pathology sample labelling.

In the context of national focus on **flu immunisation** the plans were reviewed in detail. These include the use of peer vaccinators to support administration of vaccination at a time and location convenient for staff. Discussion took place regarding the wider system preparation for winter such as access to relevant equipment and business continuity.

A report from the first meeting of the **Quality Group** was received, summarising the work of the group focused on quality assurance and quality improvement. CQC preparedness was reviewed including: the timetable for the CQC visit; table top quality assurance schedule; and areas for intensive review.

Relevant **policy documents** were reviewed and approved - standards of business conduct policy and use of mobile devices policy.

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 updated risk management strategy (attached)

NHS
West Suffolk
NHS Foundation Trust

Document ref. no: PP(17)093

Strategy and Policy for Risk Management

For use in:	All areas of WSHT
For use by:	All trust staff
For use for:	Management of all areas of risk to the Trust
Document owner:	Head of Governance
Status:	Revised

Summary

This document provides guidance on the Trust's risk management responsibilities and procedures to ensure risks are effectively identified, monitored and managed (controlled). Staff must ensure that risks are appropriately reported to managers. Managers must ensure that risks are properly assessed and as necessary escalated.

Risks are captured on the risk register as 'Operational' (risks local to an area or service), 'Corporate' (risks with a wide organisational impact) or 'Strategic' (risks to delivery of strategic objectives). Risks are rated as Red (high), Amber (medium) and Green (low) based on an assessment of the likelihood and consequence (harm) of a risk materialising. This risk rating informs the escalation requirements. Monitoring arrangements are in place to ensure that risks are appropriately reviewed and agreed action taken.

These arrangements ensure that staff, patients and others (others include visitors and contractors) are protected through the delivery of high quality and safe services.

Contents

1. Introduction

The Trust is committed to ensuring the safety of staff, patients and others through an integrated approach to managing risk, regardless of whether the risk relates to the delivery of patient care or achievement of business objectives. Good arrangements for risk management underpin the Trust's ability to identify and manage its risks in a robust manner.

Healthcare is a hazardous environment; it brings together sick and vulnerable patients with medical services often using complex technology and requires the effective coordination of many people. Complex systems in any industry are prone to human error. No matter how committed, skilled and hard working the staff, the complexity of modern NHS care and the nature of human behaviour means that incidents do happen and errors are made. Very few errors are due to a lack of care or commitment from healthcare professionals or from a desire to deliberately harm patients.

Therefore, the Trust operates effective risk management systems and a positive learning environment that supports improvements in patient care and safety which will reduce the level of risk. The Trust's objective is to manage risk as part of normal line management responsibilities which are monitored by the Trust's committee structure with risk escalated in an appropriate and timely fashion. Funding must be appropriately prioritised to mitigate/address 'risk' as part of the management and business planning processes. To support this the Trust has appropriate policies and procedures in place to eliminate or minimise risk and these should be followed by staff who will be provided with the necessary training. The Trust uses a Risk Register to log and effectively manage the information from risk assessments to enable the prioritising and monitoring of actions.

Definitions

Risk management is the identification, assessment, and prioritisation of risks followed by coordinated and economical application of resources to eliminate, minimise, monitor, and control the probability and/or impact of incidents. Risks can come from uncertainty in financial markets, project failures, equipment failure, infrastructure limitations, accidents, natural causes and disasters as well political climate changes to name but a few.

The purpose of risk assessment is designed to identify hazards and to evaluate if enough protective measures are in place, or if more should be done to prevent harm to staff, patients and others.

A **hazard** is something that has the potential to cause injury, illness, harm or damage e.g. electricity, working from height, a piece of sharp equipment etc.

Risk is comprised of two elements: the likelihood that a hazard will actually cause injury, illness, harm or damage and the severity of the consequence of that harm. The hazard may be the same but the risk is different depending upon the circumstances / environment. For example, used needles left on work surfaces represent a serious risk, however, needles correctly placed in sharps containers are normally of low risk.

Risks fall broadly into three categories as defined in the Datix Risk Register:

- **Operational**: risks identified within a specific area e.g. ward or department
- **Corporate:** risks found to apply in a number of areas across the Trust and therefore being assessed and managed at a wider, organisational, level. Examples include trust wide management of patient safety priorities (e.g. falls) or compliance with health & safety legislation.
- **Strategic**: risks to the delivery and success of the Trust's strategic objectives

Within each of these categories, risks can be identified which relate to a range of topics, such as patient care, health, safety and welfare, environmental, information governance, business continuity and finance.

2. Background

Effective risk management is vital to the provision of high quality services and ensuing the success and sustainability of the Trust. Therefore identification, control and management of risk is fundamental. To achieve effective risk management the Trust requires a systematic approach to clinical and non-clinical risk management by maintaining and improving the quality of staff and patient care and ensuring that other types of risk are identified and managed appropriately.

Under the Health and Safety at Work etc. Act 1974 and the Management of Health and Safety at Work Regulations 1999 the Trust has a legal duty to identify risks to health, safety and welfare and ensure so far as is reasonably practicable that these are eliminated, mitigated and managed appropriately to safeguard the health, safety and welfare of staff, patients, and others on Trust premises who could be affected by its undertakings. Health, safety and welfare risks will largely fall into the category of 'operational risk' but may also be considered in some cases be a risk to a Trust strategic objective.

NHS organisations also need to take into account the standards and requirements issued by the Department of Health and other regulatory bodies (such as NHSI and the Care Quality Commission (CQC)).

3. Aims

- To support the delivery of high quality services and protect staff, patients and others through an integrated approach to risk management (whether the risk relates to patient care, health, safety and welfare, environmental, information governance, business continuity and finance)
- To support achievement of the Trust's strategic objectives as set out in the assurance framework.
- To clearly define roles and responsibilities for the management of risk.
- To ensure that risk management methodologies are clearly understood and systematically applied throughout the Trust.
- To ensure that risks are identified, evaluated and prioritised for action.
- To establish clear and effective communication that enables information sharing.
- To foster an open culture that supports organisational risk identification and learning, including incident reporting.

4. Objectives and implementation

All Trust policies and procedures (including Health, Safety and Welfare, Nursing, Financial and Personnel) are relevant to risk management. Following appropriate standards, national and statutory guidance and best practice identified in policies and procedures will so far as is reasonably practicable minimise risk.

The implementation of the risk management strategy will be achieved through:

1. Developing robust arrangements in all divisions for managing and as appropriate escalate risk.
2. Undertaking effective monitoring of these risk management arrangements.
3. Providing training and support to managers to enable them to manage risk as part of normal line management responsibilities.
4. Undertaking suitable and sufficient risk assessments systematically in all divisions to identify hazards, and through effective controls eliminate or minimise risk.
5. Capturing risks on the Trust's Datix Risk Register. Ensuring that any decision to accept risk is taken appropriately and that prioritisation of funding, where required to manage identified risks, takes place as part of the management process and business planning arrangements.
6. Through business continuity arrangements ensure that procedures exist for establishing contingency plans.
7. Ensure that all staff groups within the Trust systematically report incidents on Datix.

8. Use information from risk assessments, incidents, complaints, audit (clinical and non-clinical), claims and other relevant internal and external sources to improve safety and facilitate Trust learning.
9. Use root cause analysis techniques to investigate certain incidents and claims. Ensuring learning takes place and is shared across the Trust and more widely.
10. Ensuring that there are appropriate policies and procedures in place that are communicated to and followed by staff to identify, eliminate or mitigate risk.
11. Improve compliance with risk management assessment frameworks and benchmark performance with other organisations:
    a) Supporting registration with the Care Quality Commission for the delivery of healthcare
    b) Supporting licensing by NHSI for the delivery of healthcare
12. Foster cross-organisational learning through appropriate information sharing and representation on local forums.
13. Mitigate the adverse financial consequence of a risk through the appropriate use of "insurance" arrangements.
14. Utilise internal and external audit, and other external regulatory and assessment bodies to provide assurance of the implementation and effectiveness of controls to eliminate or minimise risk.

Organisational key performance indicators

Safety Indicator	Target	Red	Amber	Green
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC
Median NRLS upload 6 month rolling average	46days	>46	No Target	0-46
SIRIs reported > 2 working days from identification as red	0	>1	1	0
SIRI final reports due in month submitted beyond 60 working days	0	>1	1	0
Green, Amber & Red Active / Accepted risk assessments in date	0	>10	5-9	0-4
Datix risk register Red / Amber actions overdue	0	>10	5-9	0-4
Total Verbal Duty of Candour outstanding at month-end	0	>3	1 - 3	0

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

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

5. Risk Management procedures

5.1 Risk identification

Risks can be identified from many different sources. Effective risk management allows these various sources to drive a single co-ordinated approach to the identification, assessment, elimination or the reduction of risk. Some of the potential sources are described below.

- Risk assessments for operational (local), corporate (trust-wide) and strategic risks
- Clinical and non-clinical incident reporting (including near misses), accidents, fire and security
- Concerns identified through complaints, litigation, inquests and internal whistle-blowing
- Feedback from patients and stakeholders, including patient and staff surveys
- Clinical audit findings
- Workplace inspections and health & safety compliance self-assessments, undertaken as part of the H&S monitoring programme
- National recommendations and guidance, including confidential enquiry recommendations safety alerts and NICE guidance
- Benchmarking, clinical indicators and performance assessments
- External and strategic risks through PEST and SWOT analysis of the annual plan
- External and Internal Audit reports
- Assessment against Care Quality Commission's standards
- Care Quality Commission inspections, improvement review reports and benchmark analysis (Insight)
- Compliance with perfromance targets and regulatory requirements of: the Department of Health, NHSI and the CQC.
- Results of information governance assessments (e.g. data confidentiality, quality and security).
- Information from disciplinary procedures, grievances and harassment cases
- External regulatory and assessment body inspections and reviews, including Royal Colleges, Post Graduate dean reports; accreditation inspections and Health and Safety Executive (HSE) reports

Aggregated data from each of these sources informs operational, corporate and strategic risk management priorities. For example aggregated information from incidents, complaints and claims would inform a programme to undertake/review risk assessment activities for an area.

5.2 Management options

Risk transfer

Where the level of risk is unacceptably high and the Trust cannot, for whatever reason, put adequate control measures in place to eliminate or reduce the risk the Board will consider whether the activity should continue in the Trust. An example of such a risk avoidance measure would be the decision that patients requiring certain high-risk surgical procedures for which the required level of surgical expertise or equipment is not available in the Trust will be referred to a tertiary centre for their treatment. In this case a balance of risk must be considered – the risk from transferring the patient must be less than the risk of operating in the Trust environment.

Risk reduction

Where a risk is identified that cannot be eliminated or avoided the Trust must consider whether there are suitable and sufficient control measures in place. If there are not, then the Trust must consider how better control measures may be applied in order to reduce the risk. Making and carrying out risk reduction action plans is the responsibility of the line manager.

Risk acceptance

When all reasonable control mechanisms have been put in place, some residual risk will inevitably remain in many Trust processes. This level of risk must be accepted. Risk acceptance by the Trust will be systematic, explicit and transparent. The financial consequences of risk acceptance will be managed through participation in NHS Litigation Authority insurance schemes.

5.3 Risk assessment

The Trust has an agreed Risk Assessment Policy and Procedure (PP132), which sets out:

- how all risks are assessed
- how risk assessments are conducted consistently
- authority levels for managing different levels of risk within the organisation
- how risks are escalated through the organisation
- how the organisation monitors compliance with all of the above

All risk assessments must be captured and maintained on the Trust's electronic Risk Register (Datix). For clarity this includes operational, corporate and strategic risks.

Risk Rating:

To assist in prioritising risks the following formula is used:-
Likelihood x Consequence (severity) = **Risk Rating (RR)** - as seen in the matrix below:

Scoring Matrix

Likelihood of harm	Consequence of harm				
	Negligible	Minor	Moderate	Major	Catastrophic
20-Yearly	Green	Green	Green	Green	Green
5-Yearly	Green	Green	Green	Amber	Amber
Annually	Green	Green	Amber	Amber	Red
Quarterly	Green	Green	Amber	Red	Red
Weekly	Green	Green	Amber	Red	Red

Action required to reduce risk rating

Green (low)	Escalate to **ward/department manager or equivalent** to: • Implement additional controls whenever possible to reduce reduce/eliminate (through routine procedures). Funded by Division or escalated if required. • Review progress of "active" risk assessment as appropriate, including the implementation of additional controls (minimum every 12 months) • Accept risk if mitigated as far as reasonable practical. "Accepted" risk assessment to be reviewed as appropriate* (minimum every 12 months)
Amber (medium)	Escalate to **Service Manager, Head of Department or equivalent** to: • Implement additional controls whenever possible to reduce/eliminate risk (as soon as reasonably practicable). Funded by Division or escalated if required. • Review progress of "active" risk assessment as appropriate, including the implementation of additional controls (minimum every six months) • Accept risk if mitigated as far as reasonable practical. "Accepted" risk assessment to be reviewed as appropriate* (minimum every 12 months)
Red (high)	Escalate to **Director, General Manager or equivalent** to: • Implement additional controls whenever possible to reduce/eliminate risk (as soon as reasonably practicable). Funded by Division or escalated if required. • Review progress of "active" risk assessment as appropriate, including the implementation of additional controls (minimum every three months). • **Escalate to Board** to "Accept" risk if mitigated as far as reasonable practical. "Accepted" risk assessment to be reviewed as appropriate* (minimum every 12 months)

After management action at a divisional level, issues that continue to pose a significant risk to the Trust (risk rating of Red (high) following the implementation of all identified controls) will be escalated to the Trust Executive Group (TEG) for deliberation and recommendation.

Appendix B sets out the escalation framework ensuring timely escalation of risks from wards, divisions or specialist committees. Red risks must be escalated to TEG as soon as identfied through the relevant General Manager or Clinical Director (for divisions) or Directors (for specialist committees).

If TEG concludes that the risk cannot be controlled the matter will be escalated to the Board for consideration or **acceptance**. This consideration will also agree appropriate monitoring arrangements. Red (high) risks considered by TEG will be reported to the Board as part of the Red risk report.

5.4 Risk Register and Assurance Framework

All risk assessments must be captured and maintained on the Trust's electronic Risk Register (Datix). For clarity this includes operational, corporate and strategic risks.

The risk register will be used and reviewed at all levels, including: the Board, Trust Executive Group, Divisions and Departments/Wards. As such, the risk register allows risks to be systematically recorded, managed and escalated. This intelligence is incorporated into the Trust's strategic and business planning processes at division and corporate levels.

Reporting from the risk register ensures appropriate escalation of risk according to the risk rating as set out in section 5.3. As well as reports to TEG, this will include reports to Division Governance Steering Groups and exception reporting to Division Quality & Performance Meetings if risk reduction action plans are not implemented or if risk assessments are not reviewed in accordance with agreed timeframes.

In addition to the escalation of individual risk assessments a quarterly review of the risk register is presented by the Health, Safety and Risk Manager to the Corporate Risk Committee to identifying trends, as well as review performance in risk identification, escalation and mitigation.

The Risk Register is monitored as follows:

- Trust Executive Group: All high (red) risks (monthly)
- Corporate Risk Committee: All high (red) risks (quarterly)
All medium (amber) "corporate" risks (quarterly)
- Quality & Risk Committee: All "red" risks (operational and corporate)
- Board of Directors: All risks scoring high (red)

New risks scoring high (red) are highlighted in TEG's report to the Board..

Risks to the Trust's strategic objectives are managed through the **Board Assurance Framework (BAF)**. The Board and its committees review the progress in controlling risks to strategic objectives and plans to mitigate the impact on the Trust should the risks materialise.

The Audit Committee receives assurances that these reporting arrangements are effectively capturing, managing and escalating risks.

5.5 Assurance

As part of the process for managing risk, consideration must be given to the level of independent assurance for the effectiveness of identified controls. The level of assurance expected will be influenced by the nature of the risk e.g. risks at the strategic or corporate level will require greater assurance.

The Trust will seek assurance that hazards are being appropriately identified and managed through the following:

- Receipt by relevant committees of reports for activities detailed in the Risk Management Strategy (section 5.1).
- Receipt by the Quality & Risk Committee of the minutes of the sub-committees, including where appropriate reports from specialist committees (see section 6.1).
- Quarterly review of the the Trust's Quality Memorandum by the Quality & Risk Committee. This document describes the Trust's framework to monitor and assure quality.
- Findings of Internal and External Audit reviews informing the Audit Committee, priorities for these reviews informed by the assurance framework and risk register.
- The annual Annual Governance Statement (AGS), supported by Quality & Risk Committee, External and Internal Audit work programmes.
- Compliance with regulatory requirements, including Care Quality Commission and NHSI.
- Findings of external reviews and reports regarding the Trust's practices and procedures.
- Achievement of the Trust's strategic objectives as set out in the assurance framework.
- Review of the Risk Register and Assurance Framework demonstrating progress with additional controls to eliminate or minimise risk.

6. Roles and responsibilities

The Trust's governance structure for managing risk is outlined in the chart at Appendix A. The following section outlines key roles and responsibilities of individuals and committees to ensure the systematic implementation of the processes for the management of risk at all levels of the organisation. Critial to any governance system is the ability to identfy and escalate and manage risk in a timely and effective way. Appendix B sets out the framework for this within the Trust.

6.1 Corporate responsibilities

Chief Executive, Executive Director of Resources, Finance & Information and Executive Chief Nurse

The overall responsibility for effective risk management in the Trust, meeting all statutory requirements and adhering to guidance issued in respect of risk lies with the Chief Executive. At an operational level, the Executive Chief Nurse is the Director designated with responsibility for governance and risk management. Accountability for management of financial (business) risk including the correct application of Standing Financial Instructions and Standing Orders lies with the Executive Director of Resources.

The Executive Chief Nurse will liaise with the Executive Medical Director for medical issues relating to clinical risk management, patient safety and staff concerns regarding service delivery.

Trust Board
The Board is collectively responsible for promoting the success of the Trust by directing and supervising the organisations affairs. This responsibility is achieved through:

- providing active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed.
- setting the organisation's strategic aims, ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance
- setting the organisation's values and standards and ensuring that its obligations to patients, the local community and the Secretary of State are understood and met.

The Board has delegated some of its powers to formally constituted committees. These committees have a remit and decision making powers defined by the Board and report back to it at agreed intervals. The Board remains responsible for considering and accepting high (red) risks escalated through the risk management procedures.

Audit Committee
The committee will provide an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations.

Quality & Risk Committee
The committee will monitor and review the Trust's quality performance indicators relating to patient safety, clinical outcome & effectiveness, and patient experience. This includes infection control and the review feedback to the Trust on the experience, including patient and staff surveys and complaints.

Scrutiny Committee
Oversees a work programme, determined by the Board of Directors, to support the delivery of the Trust's strategic objectives. This includes scrutinisong and providing strategic advise/steer on these projects.

Remuneration Committee
Sets remuneration for Executive Directors and considers organisational remuneration issues.

Charitable Funds Committee
Ensure appropriate management and control of charitable funds in accordance with the requirements of Charitable Commission guidance.

The following committees are subcommittees of the Quality & Risk Committee, and provide assurance on their performance through submission of their minutes and reports. Non-Executive Directors who are members of the Quality & Risk Committee and Audit Committee are also members of these subcommittees.

- **Clinical Safety & Effectiveness Committee (CESC)**
  To ensure that the Trust's clinical procedures and practices are effective in protecting staff, patients and others by ensuring that they comply with national requirements, promote best practice and are effective in the identification and elimination or reduction of hazards.

- **Corporate Risk Committee (CRC)**
  To ensure that the Trust's risk management, financial and workforce procedures are effective in promoting good business standards, protect the organisation,staff,patients and others, and comply with national standards and guidance.

- **Patient Experience Committee (PEC)**
  To ensure first rate customer and patient experience through the implementation of patient experience and Patient's First initiatives.

Executive committees

Trust Executive Group (TEG)
Consisting of the senior management team of the Trust, TEG is corporately responsible for delivery of service quality and sustainability through the formulation, implementation and delivery of the Trust's strategy, service aims and objectives as approved by the Board. This includes performance managing and reviewing specific quality issues highlighted by and through Divisions, setting the direction, vision & scope for the transformation programme, performance managing at a corporate level the Cost Improvement Plans (CIPs) and acting as the forum for agreeing and planning future cost reduction and efficiency activities.

Risks are escalated for consideration by TEG via the subcommittees of Quality & Risk Committee, Audit Committee, Divisions, specialist committees and other Executive Committees according to the criteria set out in section 5.4. Action available to be taken by TEG includes:

- Escalating a high (red) risk that cannot be eliminated or reduced to the Board for consideration or acceptance
- Agreement of funding to implement additional controls to eliminate or mitigate the risk
- Amending risk ratings (after an informed discussion has taken place) to ensure that risks are rated appropriately.

TEG will also review summary reports of risks being managed at strategic and operational levels. This will include "top risks" for divisions and wards.

Transformation Deliver Group
The combined CCG/WSFT transformation programme comprises workstream/portfolio including transformation/re-design plans, CIP/QUIP schemes, benefits realisations from e-Care and recommendations from the Carter review. The programme aims are:

- Delivery of financial plans
- Development of future financial sustainability including demand management plans
- Support for sustainable delivery of mandated performance targets
- Service re-design for quality
- Support to STP and West Suffolk ACO programme.

Specialist advisory committees
The Trust has established a number of specialist committees/groups. Each committee provides a forum for discussing quality, risk and other issues where expert opinion can be sought. Issues that individual committees are unable to resolve can be escalated to the responsible committee. The specialist committees are summarised in Appendix A (some of the committees shown have delegated responsibility to groups/committees below the level shown)..

Health and Safety Committee
The function of this committee is to maintain effective joint consultation across the Trust, monitoring (with the aid of the incident reporting system) the health, safety, welfare and environment within the workplace for staff, patients and others to the site in line with statute legislation. The accountability for the committee is to the Corporate Risk Committee.

Quality Assurance Group (QAG)
Implements a monthly quality assurance programme through six streams that feed into QAG for assurance that quality is being reviewed, improved and managed: quality walkabout; real time data review; spot checks; quality board report; cqc provider infoirmation requests; divisional quality board papers. Quarterly assurance reports are provided to the Quality & Risk Committee.

Patient Safety Implementation Group
The function of this committee is to support the implementation of best practice in delivery of the Trust's patient safety priorities. This will include leading on the Trust's participation in the local and national patient safety initiatives, both ensuring delivery of the identified priorities and planning for future implementation.

6.2 Divisional responsibilities

Directors
Directors are responsible for ensuring that risk is managed appropriately in their area of responsibility. These responsibilities will in the main be discharged through the implementation of good clinical governance practices to identify and manage risk (see section 5.1 for sources of risk identification).

High (red) risk issues are to be escalated to Trust Executive Group and/or the Board.

General Managers/Deputy Directors and Clinical Directors
General Managers/Deputy Directors and Clinical Directors are responsible for ensuring that hazards are controlled appropriately in their area of responsibility. These responsibilities will in the main be discharged through the implementation through good clinical governance practices to identify hazards and manage risk (see section 5.1 for sources of risk identification). These approaches will be implemented in the services, departments and specialities in their management responsibility.

Key responsibilities include:

- Taking action on hazards identified within their area that cannot be eliminated by the Lead Clinician, Head of Department, Service Manager or Matron. This includes the development of continuity plans for key business risks (see Business Continuity Policy PP256).
- Investigate and manage serious incidents (graded as red) using the Trust's approved Incident reporting and management procedure. Ensuring that lessons are learnt and changes in practice implemented, including appropriately sharing across the Trust.
- Coordinate inquest preparation relevant to their area of responsibility.
- Review compliance with NICE and other national guidelines or standards.
- Consider and addressed issues identified through clinical benchmarking indicators and performance assessments.
- Act on risk issues escalated by Lead Clinicians, Heads of Department, Service Managers and Matrons

Escalating any significant concerns to the appropriate Director and reporting via Division Quality & Performance Meetings to Trust Executive Group and/or Board.

Lead Clinicians, Heads of Department, Service Managers and Matrons
Lead Clinicians*, Heads of Department, Service Managers and Matrons are responsible for ensuring that risk is managed appropriately in their area(s) of responsibility.

Key responsibilities include:

- Reviewing risk assessments
- Reviewing incidents, complaints and claims within their area and identifying lessons learnt
- Identifying lessons and changes in practice arising from incidents, complaints and claims that should be shared across the Trust
- Acting on the results of audit reports and their recommendations
- Reviewing training provision and uptake (including: induction (Trust and local), mandatory training, competencies, skills and equipment)

Escalating any significant concerns to the appropriate General Manager and/or Clinical Director.

* For specialities in which a Lead Clinical has not been identified responsibilities remain with the Clinical Director.

Managers (including Ward Managers and Area Managers)
All managers are responsible for:

- Managing hazards and associated risks in their areas of responsibility. This includes for example, incident investigation, workplace inspection and undertaking risk assessment.
- In support of this responsibility for health and safety the Trust has recognised and introduced the roles of 'Health and Safety Representatives' from recognised unions, and has trained key individuals to become 'Health and Safety Link Persons' with functions similar to those of Health and Safety Representatives. Managers should ensure that they nominate someone to act in this role for their areas of responsibility. The responsibilities of the 'Health and Safety Representative/Health and Safety Link Person' are detailed in the Health, Safety and Welfare Policy PP018, and should only be undertaken by those who have received the appropriate health and safety training. **N.B the manager's accountability for health and safety cannot be delegated.**
- Undertaking risk assessments using the Trust's agreed policy and procedure within their areas to identify and assess hazards and escalate risks rated medium (amber) or more to their immediate manager.
- Must take immediate action to eliminate or reduce risks rated as high (red) or more.
- Recommend, implement and monitor the effectiveness of those appropriate control measures to eliminate or minimise the risks within their areas of responsibility.
- Ensuring that all staff and others in their areas affected by the organisations operations are made aware of all the hazards within their working environment and of their personal responsibilities, and that they receive appropriate information, instruction, training and supervision to enable them to work safely.
- Ensuring that staff within their area are aware of the Trust's strategy for managing risk, and their individual responsibilities in delivering this strategy.
- Ensuring that staff within their area are appropriately trained (see section 7).
- Escalating any significant concerns to their Head of Department, Service Manager or Matron.

All staff
All staff are expected to:

- Report incidents and near misses using the Trust's incident reporting system (Datix) and in accordance with the Trust's Incident reporting and management policy and procedure PP105

- Support safe clinical practice in diagnosis and treatment.
- Take reasonable care for the health and safety of themselves and of others who may be affected by what they do while at work
- Be familiar with the Trust's risk management strategy and departmental risk issues.
- Adhere to all relevant Trust policy and procedures.
- Be aware of emergency procedures relevant to their area of work.
- Attend mandatory training or seek additional training to carry out the duties of their role.

Divisional Executive Performance Meetings
Responsible for reviewing quality, finance, service performance and human resources within the Division. This includes:

- Receiving performance reports for the key areas, including defined metrics and KPIs
- Receiving Divisional reports detailing areas of good practice and concerns with appropriate remedial action plans
- Escalating areas of concern as appropriate to TEG and/or Board.

Divisional Governance Steering Groups
Have responsibility to consider quality and risk management issues within the Division. This includes:

- Monitor and when necessary take action to improve performance against agreed Trust and division quality priorities in relation to safety, effectiveness and patient experience
- Provide a systematic approach to encourage learning and promote improvements in practice based on individual and aggregated analysis of incidents, complaints and claims, through:
    - Monthly review of incidents, complaints and PALS enquiries, including monitoring of action plans for amber incidents.
    - Regular analysis of incident and complaint data
- Reviewing identified hazards and associated risks within the division, including review of the Risk Register and remedial action taken/planned.
- Ensure effective implementation of best practice locally through audit, clinical benchmark analysis (e.g. Dr Foster) and implementation of national best practice (e.g. NICE and Royal College reports).
- Monitor and review governance arrangements within components of the division (specialties, wards or departments).
- Escalating any significant concerns to General Manager/ Deputy Directors (or equivalent)/Clinical Director to consider reescalation to the Divisional Quality & Performance Meeting or TEG.

The Women & Children Division has a specific Risk Management Policy (PP137) that sets out the arrangements for managing risk within the division.

Ward/Department Governance Groups
Have responsibility to consider quality and risk management issues within the ward/department. This includes:

- Monitor and when necessary take action to improve performance against agreed ward/department quality priorities in relation to safety, effectiveness and patient experience
- Provide a systematic approach to encourage learning and promote improvements in practice based on individual and aggregated analysis of incidents, complaints and claims, through:
    - Monthly review of incidents, complaints and PALS enquiries, including monitoring of action plans for amber incidents.
    - Regular analysis of incident and complaint data
- Reviewing identified hazards and associated risks within the area, including review of the Risk Register and remedial action taken/planned.

- Ensure effective implementation of best practice locally through audit, clinical benchmark analysis (e.g. Dr Foster) and implementation of national best practice (e.g. NICE and Royal College reports).
- Escalating any significant concerns to Service Manager/Matron and/or the Divisional Governance Steering Group.

6.3 Governance Department

Within the Governance Department, the following key posts support the management of quality and risk in the Trust: Trust Secrertary & Head of Governance, Head of Patient Safety and Clinical Effectiveness, Health, Safety and Risk Manager, Complaints Manager, Information Governance and Legal Services Manager, Divisional Governance Managers, Compliance Manager and Datix Administrator. Together these posts are responsible for:

- Communicating and co-ordinating the process of risk management throughout the Trust.
- Supporting Division Governance Steering Groups to identify and manage risks at a local level.
- Acting as a central reference point for all risk management issues and co-ordinating the management of risk activities throughout the Trust.
- Managing the Trust's system (Datix) for reporting incidents and near misses and encouraging prompt reporting of all incidents.
- Liaising with statutory and other official bodies, for example the Health and Safety Executive, Care Quality Commission, Audit Commission, NHS England and the NHS Litigation Authority.
- Supporting the review of incident trends and feeding back information and learning to relevant committees, i.e. Clinical Safety & Effectiveness Committee and Division Governance Steering Groups.
- Co-ordinating the investigation of serious incidents in line with the Trust's Incident Reporting and Management Policy PP105, where appropriate facilitating a root cause analysis.
- Reporting of Serious Incidents Requiring Investigation (SIRIs) to the Clinical Commissioning Group (CCG) and providing progress reports regarding investigation and learning.
- Managing claims (clinical negligence, employers and public liability, property losses) quickly, economically and effectively to minimise the financial and other potential negative consequences e.g. distress to the claimant and negative publicity etc.
- Supporting the clinical audit process by promoting, supporting and facilitating this across the Trust so that that all patient care wherever possible should be evidence based.
- Ensuring that appropriate audit processes are in place and that results and recommendations coming from clinical audit are incorporated into the clinical governance agenda of divisions and are their implementation monitored.
- Co-ordinating the implementation of NICE guidance, National Service frameworks (NSFs) and Confidential Enquiries.
- Ensuring that the Trust has appropriate and adequate 'insurance' arrangements with the NHSLA Risk Management scheme in respect of clinical negligence and third party and professional liability and where appropriate commercial insurers.
- Acting as a central source of information on risk and statutory safety issues, distributing this information as necessary using the Trust's risk register and assurance framework.
- Ensuring that the Trust has appropriate policies and procedures relating to risk/health and safety issues to comply with statutory requirements and Approved Code Of Practices.
- Ensuring effective liaison with other organisations with whom there is a shared responsibility for risk management such as the CCG

6.4 Other specialist support

Specialist support and advice is also available from Occupational Health, Estates Compliance Officer, Local Security Specialist, Infection Control Team (including the Director of Infection Prevention and Control), Named Nurse for Safeguarding Children, Blood Transfusion Team and Clinical skills trainers.

7. Education and training

7.1 Board members and senior managers

The Board of Directors and Senior Managers will receive specific risk management training on an annual basis. This will be arranged by the company secretary and reflect specific learning needs of board members and issues included within the annual risk management plan.(details Appendix C) and quality improvement plan. This training will be considered mandatory and where individuals miss training alternative opportunities will be arranged.

It is essential for senior staff to have a high level of awareness of the duties placed upon them by the Health and Safety at Work etc Act 1974 and other relevant legislation.

All managers within The Trust are required to attend a managerial health, safety and risk awareness induction and to undertake the three yearly cycle of e-learning refresher training. Any change in policy / practice / legislation etc. will be addressed through targeted update training to all relevant staff.

Anyone undertaking risk assessment or who is involved with the management of risk should attend risk assessment training which will provide the necessary skills to undertake risk assessments, manage risks appropriately and to understand the Trust's processes for risk management. This training is provided by the Health, Safety and Risk Manager who can be contacted for course information and details by ringing ext: 3944. A register of training will be maintained by HR to allow reporting and monitoring.

7.2 All staff groups (including volunteers)

The policy and procedure for delivery of mandatory training to all other staff groups is set out in trust policy PP244 mandatory training.

8. Monitoring

- Annual review of the Executive Committees' terms of reference to ensure they have fulfilled their responsibilities.
- The Board receives information on key performance indicators as part of the Quality & Performance dashboard
- The Trust rolling programme of workplace assessments will identify whether appropriate risk management processes are in place at local level (e.g. local risk assessments).
- The Trust Executive Group will receive information on its high (red) risks.
- Quarterly Risk register reports to Corporate Risk Committee includes thematic analysis of the risk register
- Corporate Risk Committee review of progress with priorities set out in the risk management development plan (Appendix C).

9. Development of strategy and policy

9.1 Other relevant documents

Incident reporting and management PP105; Handling of Clinical Negligence and Personal Injury Claims PP061; Health, Safety and Welfare Policy PP018; Inquest policy and procedure PP135; Local resolution of complaints PP002; Maternity, Obstetric and Gynaecological Risk Management Strategy PP137; Occupational Health Policies PP046; Staff Concerns about Patient Care PP056; Risk assessment policy and procedure PP132, PP244 Mandatory training; Business Continuity Policy PP256, NICE policy PP218, Responding to nationally issued best clinical practice publications PP205

9.2 Changes compared to previous document

This document replaced the Trust's previous Risk Management Strategy (PP(13)093). Changes to the document include:

- Minor changes to wording to bring up to date and improve readability
- Updated details of specialist committees
- Updated KPIs within document consistent with those reviewed by Board on monthly basis
- Updated the risk matrix (section 5.3)

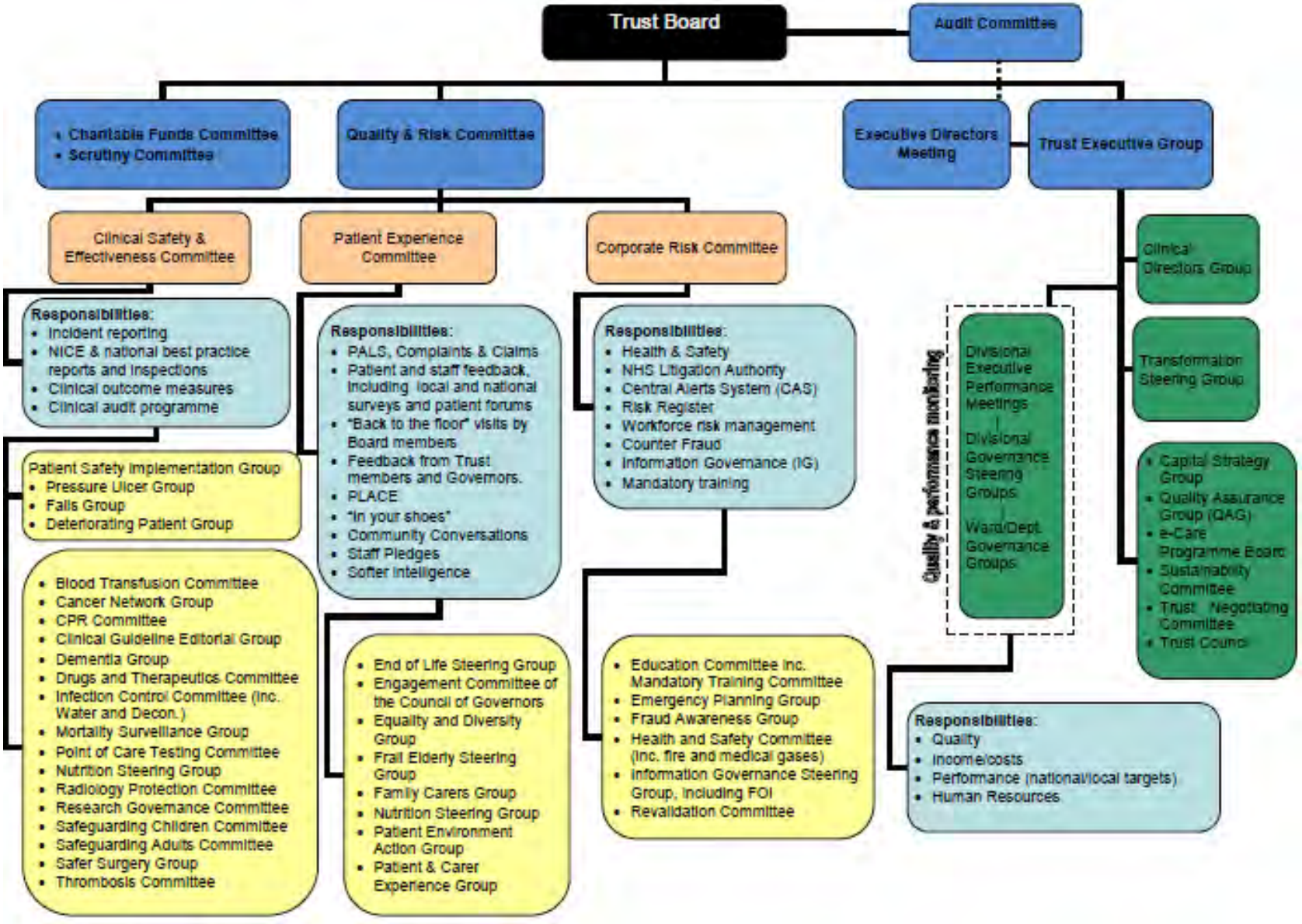
9.3 References

Health and Safety at Work etc Act 1974).
Building the assurance framework: a practical guide for NHS boards (Department of Health 2003).
NHS Litigation Authority Risk Management standards (April 2008)

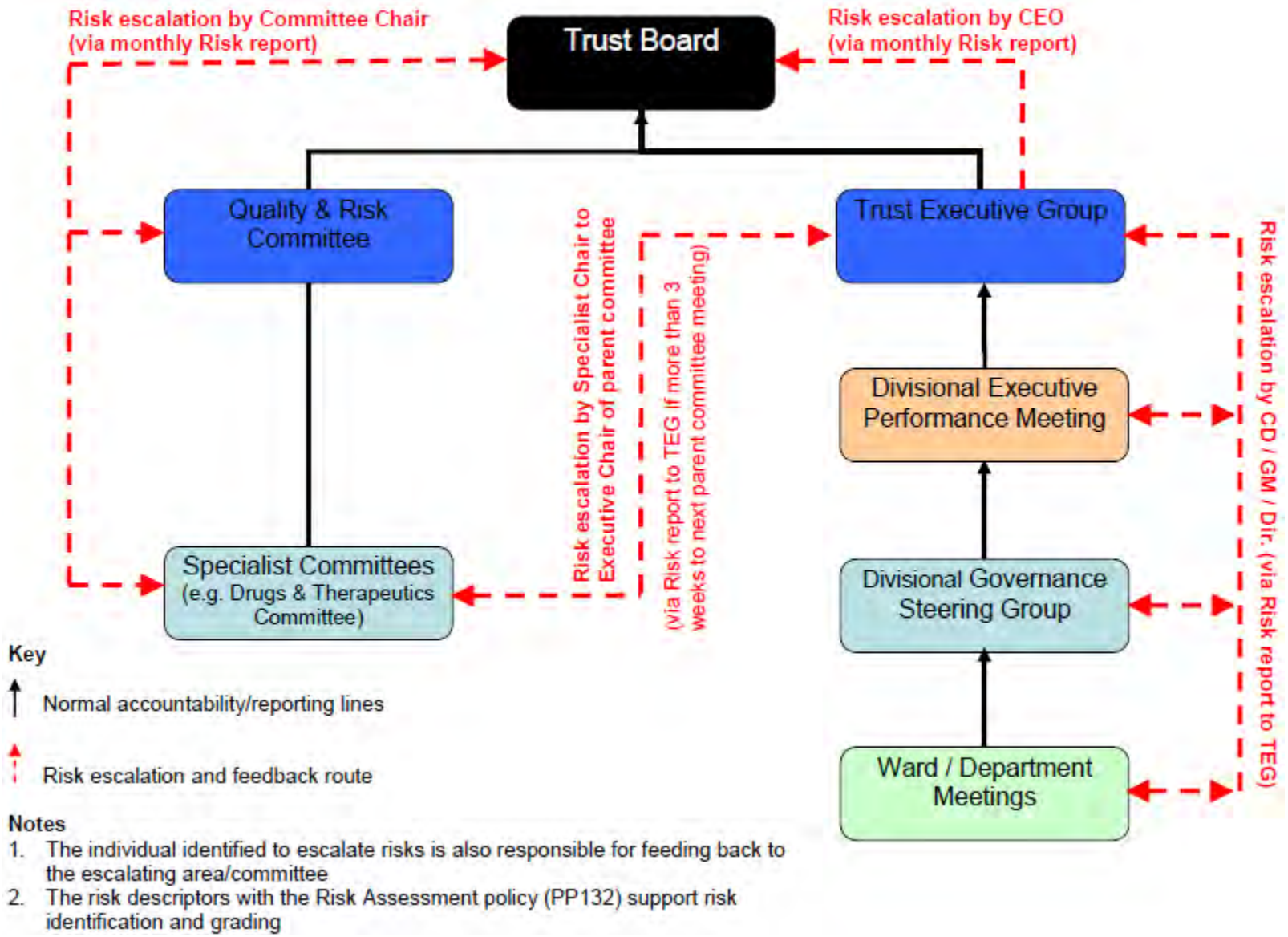
Document configuration information

Author(s):	Trust Secretary & Head of Governance
Other contributors:	Health, Safety and Risk Manager, Executive Chief Nurse
Approvals and endorsements:	Trust Executive Group and Trust Board
Consultation:	
Issue no:	12
File name:	S:\Governance strategies and policies\PP(17)093 Risk Management Policy and Strategy.docx
Supercedes:	PP(15)093
Equality Assessed	Yes
Implementation	This document will be widely circulated within the Trust, including all heads of department and ward managers and will be made availability on the Trust's Intranet and Internet sites. Relevant changes will be brought to the attention of staff during circulation. Comprehensive training programmes exist including mandatory training and relevant modules as detailed in the Trust's training prospectus. Specialist training will also be targeted at those with responsibility for managing hazards with a high risk rating.
Monitoring:	See section 8. The Corporate Risk Committee has the responsibility for monitoring compliance to this policy and strategy. The committee also has the responsibility for monitoring the development plan and providing assurance to the Quality & Risk Committee on its ongoing progress.
Other relevant policies/documents & references:	See section 9.1 and 9.3

Appendix A: Governance structure for managing risk



Appendix B: Risk escalation and Feedback Framework



Notes

1. The individual identified to escalate risks is also responsible for feeding back to the escalating area/committee
2. The risk descriptors with the Risk Assessment policy (PP132) support risk identification and grading

Appendix C: Risk Management development priorities

Issue	Action
Understanding of roles and responsibilities of Managers	Develop and implement a programme of risk management training for directors, governors, senior staff and managers.
	Consider options rollout RSPH Level 3 Award in Health and Safety
Clear identification and escalation of non-compliance with Health and Safety legislation	Review the self-assessment and audit programme to provide independent assurance of compliance with relevant Health and Safety regulations, this needs to include the Community
Fully integrate community health, safety and risk management arrangements within WSFT	(a) Community Health and Safety and Risk Management Policies and Procedures to be updated to ensure they are harmonised with WSFT (b) Health and Safety Link Person Training, workplace inspections, COSHH including Sypol access and Datix all to be rolled out across the Community
Health and safety accreditation standards	Review and consider timescales and the process required for achieving a health and Safety accreditation or standard e.g. the British Safety Council International Safety Award, RoSPA, ISO 45001
Staff health and wellbeing	Committee to receive progress on the work plan to improve staff including for example stress, musculoskeletal injuries etc.
Records have not been retained to demonstrate which staff members have received risk management training.	The level of risk management training to be received will be defined by type of staff. For example: • All staff - basic training, • Managers and approvers – intermediate training, • Senior Managers and Executives advanced training) Once established, compliance with training requirements will be reported to, retained and monitored by the Corporate Risk Committee.
Assurances, gaps in assurance, provider of assurance and frequency of assurance have not been activated within the Datix Risk Module and therefore not captured.	1) Review best practice in the capture of operational risk assurances 2) Develop and test approaches to capturing these assurances within WSFT, including the use of the deep dive risk register audits and workplace inspections 3) Based on the findings of this work make recommendations for future arrangements within WSFT
The Generic risk assessment document captures 21 risks assessments which may be applicable to the majority of wards, or departments however the average number of risks documented per locality is 11.The Common Risk Assessment document does not record the assurance mechanisms in place for the key controls identified against each risk and has not been disseminated to all wards and departments.	1) The generic risk assessment documents will be disseminated to all wards and departments requesting that their risk registers are updated to include the risks relevant to their area.
	2) Using the generic risk assessment documents as a starting point, current assurance activities will be mapped to the generic operational risks identified.
	3) Once mapped these will be documented against the respective risks within Datix detailing who will provide the outcomes of these assurances and how often each ward can expect to receive them.

<table>
<tr><th>Issue</th><th>Action</th></tr>
<tr><td>Our review identified four outstanding risk actions however reporting to Corporate Risk Committee indicated no outstanding actions</td><td>All actions relating to active risks which are overdue will be reported to the Corporate Risk Committee to ensure oversight is achieved.</td></tr>
<tr><td>Explicit evidence of risk discussion was not present within Ward/Department meetings notes.
Assurances are not presently captured and therefore risk discussions cannot be prioritised by assurance outcome.</td><td>1) Department or Ward meetings will be required to include a review of the following as part of their standing agenda:
New risks
Increasing/decreasing risks
Risk requiring escalation
2) This will include review of best practice and recommended approach to the reporting, discussion and communication of assurance through the ward/departmental meetings.</td></tr>
<tr><td rowspan="2">Review of Divisional minutes identified limited evidence of discussion regarding risk other than noting the top ten risks.

The risk report presented to the divisions does not include new or increasing risks, controls and the actions to address control gaps or weaknesses, accepted risks or assurances</td><td>The risk register report to Divisions will be updated to include the following:
New risks and risks increasing in score will be reported within the risk register report to Divisions.
Risk register reporting will the full risk assessment for new red and amber risks.
Newly accepted amber and red risks will be included within the risk report.</td></tr>
<tr><td>Once assurances are established, these will be included within the risk report alongside the timeliness and outcomes of the assurances</td></tr>
<tr><td>Few Community risks have been captured within the Datix risk module and the deadline for collating these is recognised as unrealistic by the Health, Safety and Risk Manager.</td><td>A detailed schedule will be created demonstrating the timescale for capturing community risks for each of the Community properties and presented to the next Corporate Risk Committee meeting.</td></tr>
<tr><td>Planned internal Audit work that will provide assurance to the Corporate Risk Committee</td><td>Relevant IA plan for 2017/18, including:

<table><tr><th>Assignment area</th></tr><tr><td>Business Continuity and Disaster Recovery (in progress)</td></tr><tr><td>Information Governance including Changes to Date Protection Act (phase 1 Sept)</td></tr></table></td></tr>
</table>

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 29th September 2017

ITEM NO:	22
PRESENTED BY:	Steve Turpie, Non-Executive Director
PREPARED BY:	Kathryn McMahon, PA
DATE PREPARED:	September 2017
SUBJECT:	Audit Committee report
PURPOSE:	To approve recommendations from meeting held on 28th July 2017.
STRATEGIC OBJECTIVE:	To demonstrate first class corporate, financial and clinical governance, underpinned by effective business support systems

EXECUTIVE SUMMARY:
The draft minutes of the meetings of the Audit Committee on 28th April and 26th May 2017 are attached. **Please note these have yet to be approved.** The key issues and actions discussed were:-

28th July 2017

- **Board Assurance Framework 'deep dive'-** The Stroke Team, headed by Anne Nicholson, gave a presentation on the current Stroke pathway and of current challenges the specialty faced and future developments within the specialty.
- **Governance and Assurance** – Clinical Audit was discussed together with assurance being received that clinical audit of community, during the disaggregation transition period, would still go ahead.
- **Internal Audit and Counter Fraud** – the Internal Audit Progress Report was discussed together with Benchmarking Report and Progress Report April to July 18.
- **External Audit** – the Annual Audit Letter was discussed and the Value Added Services for Contract was also discussed with a full report to come to the next Audit Committee in November.
- **Financial Reporting** – Review of waivers was discussed together with Losses & Special Payments with a discussion around the Flue vaccination costs and ordering process.
- **Reporting, Accountability, Monitoring and Review of Effectiveness** – The Audit Committee Annual report was discussed together with the slightly amended TOR.

Matters resulting from recommendations in this report	**Present**	**Considered**
Financial Implications	N/A	N/A
Workforce Implications	N/A	N/A
Impact on Equality and Diversity impact	N/A	N/A
Legislation, Regulations and other external directives	N/A	N/A
Internal policy or procedural issues	Yes	Yes
Risk Implications for West Suffolk Hospital (including any clinical and financial consequences): N/A	**Mitigating Actions** N/A	
Level of Assurance that can be given to the Committee from the report based on the evidence [significant, sufficient, limited, none]: Significant		
Recommendation to the Committee: The Trust Board is asked to consider the report of the Audit Committee		

AUDIT COMMITTEE
MINUTES OF THE MEETING HELD ON FRIDAY 28th July 2017,
COMMENCING AT 08:00 IN THE NORTHGATE MEETING ROOM, WEST SUFFOLK HOSPITAL

COMMI7TTEE MEMBERS			**Attendance**	**Apologies**
Steve Turpie	**(ST)**	Non-Executive Director (Chair)	√	
Alan Rose	**(AR)**	Non-Executive Director	√	
Richard Davies	**(RD)**	Non-Executive Director	√	
Gary Norgate	**(GN)**	Non-Executive Director	√	
Neville Hounsome	**(NH)**	Non-Executive Director	√	
Angus Eaton	**(AE)**	Non-Executive Director		√
IN ATTENDANCE:				
Stephen Dunn	**(SD)**	Chief Executive Officer	√	
Liana Nicholson	**(LN)**	Manager, Public Sector, BDO (Maternity Leave)		√
Lisa Clampin	**(LC)**	Lead Partner, BDO	√	
Asam Hussain	**(AH)**	Senior Manager, RSM	√	
Andrew Barnes	**(AB)**	Senior Manager, RSM		
Dan Harris	**(DH)**	Partner, RSM	√	
Mark Kidd	**(MK)**	Counter Fraud, RSM	√	
Richard Jones	**(RJ)**	Head of Governance & Trust Secretary		√
Craig Black	**(CB)**	Executive Director of Resources		√
Roger Quince	**(RQ)**	Chairman	√	
Dr Nick Jenkins	**(NJ)**	Medical Director	√	
Helen Beck	**(HB)**	Acting Chief Operating Officer	√	
Louise Wishart	**(LW)**	Assistant Director of Finance (Acting)	√	
Jan Bloomfield	**(JBl)**	Executive Director Workforce & Communications	√	
Rowan Procter	**(RP)**	Executive Chief Nurse	√	
Nick MacDonald	**(NM)**	Deputy Director of Finance		
Kathryn McMahon	**(KM)**	PA to Executive Director of Resources (Minutes)	√	

		Action
1.	**Apologies**	
	Apologies received as detailed above. ST welcomed the inturns who were shadowing Lisa Clampin to the audit committee.	
2.	**Minutes of 28th April 2017 and 26th May 2017**	
	28th April 2017 Minutes	
	Item 7.2 Lisa Clampin noted that it should have read 'external audit plan for 16/17' (not 17/18). On page 11 there was a highlighted word, INE – which Nick MacDonald clarified was I&E and asked that this be amended. Asam noted an error on item 7.2 and asked that 'she noted he advised' be	

	amended to reflect 'she noted, she advised'.	
	26th May 2017 Minutes These were agreed as an accurate reflection on the meeting.	
3.	**Matters Arising Action Sheet**	
	There were no comments on the matters arising section.	
4.	***Board Assurance Framework 'deep dive'***	
4.1	STP Service Review Stroke	
	Dr Nicholson was in attendance to present her business case. NJ asked all of the committee to introduce themselves to her. He explained the presentation was an example of the challenges the Hospital experienced in smaller specialties. He commented there was a dilemma that related to the extent in which we try to solve some of the challenges on our own, some on STP or other footprints which don't coincide with STP. HB noted another speciality with similar issues would be ENT, with sustainable recruitment being a major challenge in this area. There was a discussion around what would be a sensible geographical footprint for the hospital and for patients. Dr Nicholson explained her presentation, explaining Stroke, TIA, Mimics, Research and took the committee through her slide pack.	
4.2	Reflections and Discussion	
	SD asked around the community discussion. Dr Nicholson advised that the Trust did need to improve on community but for how long? She noted patients currently had a 7 – 14 day average length of stay. She noted that ESD was currently 4 weeks but should be 6. Whilst there was a need to improve community services, extending this timeframe for patient support, wouldn't necessarily make patients any better than they could be. Dr Nicholson noted that once a patient has had a stroke then they are more at risk of other medical problems and patients are unlikely to be normal again, unless they had a very small stroke. NJ added to this, that patients have a desperately difficult time coming to terms with chronic disease and a stoke can be very devastating, with all important recovery happening early on but with permanent deficit and there comes a point in their recovery when those deficits can't be improved. NJ noted a challenge which had rarely been taken up with commissioners, was that the demand on community services for ongoing support, was not a realistic demand as the additional support won't always deliver benefit to the patient. SD noted that they had been previously exploring a considerable benefit in community services. ST noted his thoughts and that it seemed that the first three months was the most important in regard to recovery. However, he commented, it could be more around people adapting to their situation and that he felt a lot of demand could be around this adaption support. AR asked around investment in regard to preventative measures for patients at risk of strokes. Dr Nicholson advised that a lot had been done in this respect.	

	HB noted there could be a facility in e-Care to run an algarythum to flag such issues on atrilfibulation. GN noted his thoughts around vitals and e-Care. NJ noted that you would physically need to feel someone's pulse to see if it was irregular. Dr Nicholson gave some additional facts. NJ advised that this service couldn't be fully automated. RD noted this was a primary care problem and that GP's need to and were having better training in primary care, Dr Nicholson noted these tests could also be carried out by district nurse/nurses also (in addition to GP's). RD commented, in terms of secondary prevention, that continual care to check hypertension/tablets was being taken with a lot of investment having been made in GP training. Dr Nicholson noted that she felt medical secondary prevention could be better. RP asked if patients came to Stroke Services, would the Trust be more sustainable, Dr Nicholson noted the issue would still be a requirement for more staff to meet any increase in demand on the service. RP asked why would we not want to go for stroke hub – Dr Nicholson commented that the aim would be to retain thrombolysis, this being important. AR asked where the Trust would propose market share on this, Dr Nicholson noted with Addenbrookes. Dr Nicholson noted some dialogue she had with a clinician at Addenbrookes. She commented around the requirement of 4 higher dependency beds and a dedicated angiogram suite for stroke being the requirement for Addenbrokes. Dr Nicholson discussed the Bedford and Harlow situation with the committee members. SD noted his thoughts on the presentation. He noted it seemed to him a big question/issue was between a 'hub and spoke' or 'drip and shift' service. There was a question for SD and NJ to discuss around the regional footprint on the engaging model. Another key thing would be the fragility of the workforce issues and that currently they were working a 5 or 6 day service in key areas but this would need to be a 7 day services and 1 in 4 rota. Dr Nicholson advised they would need to a 24/7 service moving forward. SD asked if 'drip and shift' worked for the locality, then the question was, on the back of this model, what would be the medical workforce required to provide and support that model and was there any realistic possibility the Trust could fill it? Dr Nicholson noted this was a reasonable question. Dr Nicholson explained the model she felt would work and possible problems this could pose. HB asked around length of stay being 2 days above national average, Dr Nicholson noted a lot of this was due to quick turnarounds and explained what that meant. Dr Nicholson gave her closing comments, noting that the Trust needed to make a decision as October 2018 was the deadline for any decision. ST commented that he presumed something would come to the board which summarised where the Trust needed to go by 2018. SD noted that this was captured in an outstanding board action. AR advised that he felt it was clear that the trust needed a joint strategy with Addenbrookes around this. GN agreed with SD comments and noted that the presentation was a real life example of where the Trust needed to get integrated care working and why it really matters and the challenges faced. NJ noted this was why they had used this particular service as an example. NJ commented around some possible issues with the East of Anglia Ambulance Service in regard to the new services. HB noted her thoughts. ST asked NJ if there was a plan for the plan, to which NJ advised there was at the Trust due to STP footprint and that the plan for the plan was for Dr Nicholson to corral her team to come to a team view/decision. SD noted he and NJ should get clarity where Addenbrookes would be likely to end and what	**SD/NJ**

	their clinicians were advocating for and if it would warrant looking further than STP. RP asked why clinicians were not on the same page? NJ explained the possible reasons. ST asked NJ and SD to bring back a summary of this to the Trust Board.	**NJ/SD**
5	***Governance and Assurance***	
5.1	Clinical Audit	
	ST asked questions around the national clinical audits that were delayed and asked what was the impact on patient safety in light of the delays and also asked about the chart around drug usage, in particular around asthma where the Trust was over on clinic follow up over two days, he asked if the Trust was over medicating? RD and NJ explained the graph noting it showed the trust was in fact under national average. RP noted she would ask Paul Morris in regard to any other questions raised. RD commented that the report and results made him wonder about the realistic standard for national audit in light of the results shown, in particular around consultant sign off. NJ explained his thoughts. ST commented around sepsis – noting the Trust was below standard and national average for most things, ST asked around the processes in place. NJ commented on the sepsis alert which was now on e-Care and that he and HB and RP were speaking to matrons / ops teams around how to get sepsis patients out of emergency to G1. ST asked where the outcomes of these audit went and RP explained the process, she advised that Emergency Dept Governance Meeting covered all the audits and their results. ST noted he just wanted assurance that all these things were reviewed at certain meetings/forums etc. NJ reiterated that all three were reviewed at Governance Meetings which in turn would attend to any problems. AR noted his thoughts around the plan on clinical audit on community and in light of the change in contract, he needed assurance this would still go on through the transition. RP noted yes there was still a community lead to work through the transition disaggregation aspect of the transition. RP added that they were currently going through decisions in terms of responsibilities.	
5.2	Quality and Risk Committee Report	
	ST noted that the report had been covered at the board meeting that morning.	
6	***Internal Audit and Counter Fraud***	
6.1	Internal Audit Progress Report & Recommendations	
	AB referred to pages 4 and 5 of the document provided and advised that the three final reports from 16/17 plan were included for completeness. Also, he noted, that they had finalised two 17/18 reports both with positive opinions. He advised there were three further reviews in progress, with one of those being around the CIP Programme work, he noted at the November meeting, they would have 6 further completed reports. AB noted he was happy to take any	

	questions in regard to changes in the plan i.e. timing being one and a request having been received to replace one of the audits. AB referred to page 15, which was the summary of progress that had been made in implementing previously agreed actions, he noted that 29 of 30 actions were now fully implemented, which he felt was a great result. He commented that the 1 action which had not been implemented would be picked up in Q2 work. AB referred to the 5 executive summaries, which all had positive opinions. ST noted the report was very positive. ST asked around the audit timing and based on the field work the team had previously done, would they flag as a risk/concern, or too early? AB noted this was more of a timing issue and they had agreed to come back and re test in August in order to report back to the next meeting in November. In regard to the reasonable assurance rating, NJ asked what the Trust would need to do in order to make sure they were outstanding? AB advised that aside from saying do as advised, (he referred to an example page 25, around mandatory training review) commented that the way the reporting was designed showed perhaps a higher level of non-compliance than is felt was actually in place. He commented that work was required around the structure of the management information. AB referred to other actions agreed, which all would have quick lead times, in order to report back to the November meeting that these had been successfully completed (in order to possibly upgrade the rating). ST noted his thoughts on TOR. He noted he didn't think a result had been published which hadn't been prior agreed. AB noted that happens and the dialogue and challenge was there, however there was an odd instance when a result was disagreed. ST noted the process of audit in regard to NJ's question. AR noted his thoughts around risk register also countering into this. CIP review, AR asked for clarity on this. AH noted it was around process and governance, were they quality impact assessed, were they fully assessed and managed through to reporting of the numbers.	
6.2	Counter Fraud – Progress Report	
	Benchmarking Report MK introduced the item. He noted that he had seen an increase in referrals in regard to declarations of interest and had also seen an increase around referrals of procurement. He noted that LW was providing data to carry out testing. ***Progress Report*** MK noted that the report detailed work over the period from April to July, he commented they had just started a piece of work around Procurement SFI's. ST asked how did the Trust compare in regard to other Trusts. MK noted this was an aspect he could look at. ST asked on average, per 1000 members of staff, how did the Trust sit. MK advised the Trust sat on par, however he could update on this, at next meeting on this. AR asked around community services, had MK had any fraud experience in that. MK noted they had the Fraud Action Group and he had been given some contact details for a point person for community who dealt with training and he would also contact each site. He noted that the risks in community would be different to those in the trust. i.e. could be mileage claims, not working when they say they had. He commented that they could also make managers aware of what to look out for as part of their induction process. He noted that no	**MK**

	referrals had yet been made. SD noted this would be happening from October. Following discussion, an action was agreed for MK to find out likely sources of community fraud NJ asked around the overseas visitors issues, which MK explained in detail. NJ asked if the Trust had any. JB noted the issue was mainly with getting payment back from overseas visitors, following their treatment. **NOTED THAT NJ and RP left audit committee at 3:31pm** **NOTED THAT RP & NJ returned 3:42pm** GN asked around the borderline between cyber fraud and traditional fraud and asked whether the Trust had got the appropriate skills to keep up with the vast array of cyber fraud. MK advised most common problem of this type of fraud was due to staff clicking on attachments of emails, however staff training/awareness is key in helping combat this. MK went on to discuss some new referrals he hadn't seen before, medical staffing being one of these.	**MK**
7	***External Audit***	
7.1	External Audit Progress Report	
	LC referred to the previous report provided.	
7.2	Annual Audit Letter	
	LC referred to the letter and took the committee through the key points. She noted this was a public facing document giving a summary of all external work which had been previously reported to the audit committee, which would go to COG. LC focused on the exec summary on page 1. She referred to the audit conclusions and that these were materially accurate. She referred to 'except for use of resources', this was the part that hadn't been quite finalised at the last committee, however after the committee LC had several conversations with CB and ST and NHSI and the ultimate outcome was that they issued a qualified 'except for use of resources' conclusion, the 'except for' was around the Trust's financial resilience. LC referred to page 9 and the detail on pages 9,10,11, this being the summary of the whole outcome. She commented that essentially they judged that the scale of the challenge, despite good work and commitment and strategy, was quite transformational in terms of financial challenge and also the Trust working with KPMG, but the opinion was retrospective and around outcomes and the situation the Trust was currently in. LC referred to pages 10 and 11 which touched on e-Care and how the Trust couldn't make informed decisions and also around the pathology partnership issues, it also looked at the action taken during the year which was satisfactory for both issues. LC commented on the Quality Report, in regard to the exec summary, and noted that the committee had received the full detailed report at last meeting. She noted this did qualify limited assurance, due to RTT issues. AR asked if the Trust could suffer for the 'except for use of resources' recommendation. LC noted it was uncommon for the financial part to be a clean sweep for any trust, therefore she felt no, the Trust wouldn't suffer under this recommendation.	

7.3	Value Added Services for Contract	
	LC noted David Eagles couldn't attend that meeting as he was on leave but this was part of a new commitment, which formed part of the new contract. Verbally LC noted an outline plan had been prepared and discussed with CB and had been shown to ST. ST advised his thoughts, that this needed to be turned into a formal paper for discussion at the next committee meeting in November. LC noted she would get David to do this ahead of the next meeting. LC explained the TBC aspects of the document. LC commented that they could do something more bespoke for the Trust which ST agreed too.	**LC/David Eagles**
8	***Financial Reporting***	
8.1	Review of Waivers	
	NM took the committee through the waivers. ST noted that at closed board, they had made discussed that any consultancy over £50k needed approval from NHSI and commented around one consultant for e-Care which appeared on the spreadsheet and asked whether NHSI approval had been sought for this (it was commented that this had been the second time this person had been used, this being due to that person having a specific set of skills) ST asked what was being done in terms of knowledge transfer of skills, to try and reduce the need to repeat the work? NM noted this was something that Mike Bone was looking at however, he was unsure of the exact details around this particular person. HB noted this was around a specific GDE piece of work and the individual was embedded in various teams for knowledge transference/coaching and confirmed that mentoring was also taking place. NM noted that both CB and SD had approved this and asked SD if he recalled it, SD noted he wasn't sure around NHSI approval. It was agreed that an action would be for NM to send SD, ST and CB a noted ref the requirement for NHSI approval. NH asked around a £91k spend and asked what was the reason for the urgency of spend of this – GN noted this was due to the cyber threat and the need for the Trust to urgently upgrade the email system. SD noted it was not unreasonable to ask for a more detailed explanation in regard to the reasons behind this spend and ST noted the main question was around whether the Trust paid a fair price and had the Trust checked value for money.	**NMAC/ LW**
8.2	Losses and Special Payments	
	NM noted a small spike in relation to pharmacy drugs, specifically on flue vaccines. He noted that this sometimes happened but may be due to the Trusting having over ordered. ST asked whether the trust could order in stages, NJ advised, no it couldn't. JB noted also, the Trust had to put a bid in early and had to guess amounts required. She went on to mention that the flue jab target was now down to 70% not 75% so this may assist in a reduction in cost. There was a discussion around giving free vaccine to the public, which RP noted couldn't be done due to various issues, with governance and health and safety issues being main reasons why not. JB noted one area they could use any additional vaccines left over, which was occupational health, as the department could contact their local business contacts and ask whether their staff want to have flue jabs. ST noted around the capital towers piece of work and as a new process, the Trust could suggest putting a different system in place for ordering flue vaccines.	

9	***Reporting, Accountability, Monitoring & Review of Effectiveness***	
9.1	Audit Committee Annual Report	
	ST introduced the item. He commented that this was to go to the Council of Governors meeting in August.	
9.2	Terms of Reference Review	
	ST introduced the TOR and noted a change (which was on back page of the report) around hospitality, which meant the committee would have oversight of that. It was noted that this was a good change. Asam noted NHS resolution change of name on Item 8.1.5.	**NMac/LW**
10	***Planned Agenda for Audit Committee***	
	There were no questions or comments on this.	
11	***AOB***	
11.3	Report to the Council of Governors – External Audit Performance	
	External Auditors left the meeting at 4:05pm. NM advised the report was a governance requirement that which would be submitted to the Council of Governors. AR asked if the auditors presented directly to governors which NM confirmed they did. NH asked how long the contract was for, NM advised three years and additionally commented they were happy with the auditors.	
12	***Reflection on Meeting***	
	GN noted that it had been a brilliant presentation by Dr Nicholson. ST commented he felt this was a little complicated for a non-clinician. AR asked why the presentation hadn't been done at the Board Meeting? ST advised there was a time challenge for the board meeting so it had instead come to Audit Committee. In addition, the agreement from Board was for the Audit committee to look at items on the BAF register and look at each item in order, based on risk and to then do a deep dive for each item.	
13	***Dates of Future Meetings***	
	2.00 p.m. – 4.30 p.m. – Committee Room	
	3 November 2017	

Board of Directors – 29 September 2017

AGENDA ITEM:	23
PRESENTED BY:	Roger Quince, Chair
PREPARED BY:	Georgina Holmes, Foundation Trust Office Manager
SUBJECT:	Council of Governors Report – 10 August 2017
PURPOSE:	Information

EXECUTIVE SUMMARY:

This report provides a summary of the business considered at the Council of Governors meeting held on 10 August 2017. The report is presented to the Board of Directors for information to provide insight into these activities. Key points from the meeting were:

- It was noted that Ian Collyer had resigned as a public Governor and confirmed that he would not be replaced prior to the elections.
- The Chairman informed the Council of Governors that Alan Rose had been appointed as Senior Independent Director.
- The Chief Executive's report provided an update on the challenges facing the Trust and recent achievements. Governors were asked to support the 'Every Heart Matters' appeal to raise money for the new cardiology suite.
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge.
- Richard Davies gave a short presentation on his background, experience and how he thought he could contribute to WSFT as a Non-Executive Director.
- A report was received on Pathology Services including the governance structure.
- An update was given on e-Care, including progress with reporting and an update on phase 2.
- The annual report and accounts for 2016/17 were received.
- The Annual Audit Letter & Quality Report limited assurance review were presented by Lisa Clampin from BDO.
- The Council of Governors approved the recommendation that BDO should remain in appointment as the Trust's external auditors until their current contract ended.
- The Equality & Diversity report and action plan was received.
- The Council of Governors approved the appointment of Liz Steele as Deputy Lead Governor.
- Reports from the Lead Governor and Staff Governors were received.
- Dates for meetings for 2018 were noted.

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)	Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.
Risk description:	Failure of Directors and Governors to work together effectively.
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Representation of Directors at Council of Governor meeting and vice versa. Joint workshop and development sessions. Workshop in September to consider future working between NEDs and Governors.
Legislation / Regulatory requirements:	Health & Social Care Act 2012. Monitor's Code of Governance.
Other key issues:	

Recommendation:

The Board is asked to

(a) receive the report for information

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 29 September 2017

AGENDA ITEM:	Item 24
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	22 September 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 – 3 November 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
Quality & performance report, including mandatory training	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Transformation report – Q2	✓		Written	Matrix	HB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP					
Aggregated quality report	✓		Written	Matrix	RP
Nurse staffing report	✓		Written	Matrix	RP
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Safe staffing guardian report	✓		Written	Matrix	NJ
Freedom to speak up guardian report	✓		Written	Matrix	JB
Helpforce initiative	✓		Written	Action point - schedule	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
BUILD A JOINED-UP FUTURE					
e-Care report	✓		Written	Action point - schedule	CB
Sustainable Carbon Reduction Strategy	✓		Written	Matrix	JB
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
Quality & Risk Committee report	✓		Written	Matrix	RQ
Confidential staffing matters		✓	Written	Matrix – by exception	JB
Operational plan 2018/19		✓	Written	Matrix	RJ
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Well-led review		✓	Written	Action point - schedule	SD
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	RQ

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Board of Directors – 29 September 2017

AGENDA ITEM:	26
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	25th September 2017
SUBJECT:	Trust Board Meeting dates for 2018
PURPOSE:	Approval

EXECUTIVE SUMMARY:

The attached details proposed dates for the Board and its subcommittees for 2016/17. The Board meeting dates are scheduled for the last Friday of the month with the following exceptions:

- March 2018 – Meeting scheduled for 23rd March to avoid Easter holidays
- August 2018 – no meeting scheduled (relevant reports will be circulated)
- December 2018 – to be confirmed

The will be no Board meeting in December 2018 however it is proposed that the Quality & Performance and Finance reports will be circulated and reviewed at Scrutiny Committee meeting on 10th January 2018.

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)	None
Risk description:	Failure to adequately plan for meeting schedule
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Effective arrangements for previous years.
Legislation / Regulatory requirements:	Health & Social Care Act 2012
Other key issues:	

Recommendation:
The Board approves the proposed meeting dates and arrangements.

West Suffolk NHS
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TRUST BOARD MEETING DATES

LOCATION: NORTHGATE MEETING ROOM

2018

Open (Public) Session commences 9.15am – 11.15am
Closed (Private) Session commences 11.30am – 1.00pm

2018

Friday, 26 January 2018

Friday, 23 February 2018

***Friday, 23 March 2018**

Friday, 27 April 2018

Friday, 25 May 2018

Friday, 29 June 2018

Friday, 27 July 2018

Friday, 28 September 2018

AGM Meeting 11th September 2018

***Friday 2nd November 2018**

Friday, 30 November 2018

- To avoid Bank holidays & half term