NHS
West Suffolk
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 30 June 2017 at 9.15** in the Committee Room, at West Suffolk Hospital

Roger Quince
Chairman

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Apologies for absence** To note any apologies for the meeting	Roger Quince
2.	**Questions from the Public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Roger Quince
3.	**Review of agenda** To agree any alterations to the timing of the agenda	Roger Quince
4.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Roger Quince
5.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 26 May 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.	**Emergency preparedness (attached)** To approve report	Helen Beck
10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
11.	**Aggregated quality report (attached)** To accept the aggregated analysis including serious incidents, red complaints and PALs enquiries	Rowan Procter / Nick Jenkins
12.	**GP streaming report (attached)** To accept the report	Nick Jenkins
13.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter

14.	**Consultant appointment report (attached)** To accept the report	Jan Bloomfield
15.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
10:50 BUILD A JOINED-UP FUTURE		
16.	**e-Care report (attached)** To receive an update report	Craig Black
11:00 GOVERNANCE		
17.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
18.	**Council of Governors report (attached)** To receive the report	Roger Quince
19.	**Audit Committee report (attached)** To receive the report for meetings held on 28 April and 26 May 2017	Steve Turpie
20.	**Self- certification – general condition 6, continuity of service, FT4 and governor training (attached)** To approve the report recommendations	Richard Jones
21.	**Use of Trust seal (attached)** To receive the report	Richard Jones
22.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:15 ITEMS FOR INFORMATION		
23.	**Any other business** To consider any matters which, in the opinion of the Chairman, should be considered as a matter of urgency	Roger Quince
24.	**Date of next meeting** To note that the next meeting will be held on Friday, 28 July 2017 at 9:15 am in the Committee Room.	Roger Quince
RESOLUTION TO MOVE TO CLOSED SESSION		
25.	The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act l960	Roger Quince

Item 5

DRAFT

West Suffolk NHS
NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 26 MAY 2017

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

Action

GENERAL BUSINESS

17/106 APOLOGIES FOR ABSENCE

Apologies for absence were noted above.

The Chairman welcomed everyone to the meeting and introduced Paul Morris, Associate Chief Nurse & Head of Patient Safety, who was deputising for Rowan Procter.

17/107 QUESTIONS FROM THE PUBLIC

- Jo Pajak referred to the Chief Executive's report (page 2) and the transfer from the Pathology Partnership (TPP) to North East Essex and Suffolk Pathology Services (NEESPS). He asked if it was possible to provide any headlines in terms of assurance about the governance arrangements that had been put in place. The Chief Executive explained that discussions had previously taken place in the closed Board meetings and that there was a new laboratory manager and partnership manager. This meant that there was stronger leadership in place in the laboratories and the Medical Directors also had greater oversight.

  The action plan relating to issues identified by the Medicines and Healthcare products Regulatory Agency (MHRA) continued to be worked through and they would be making a further inspection in June.

  In order to provide assurance that it was operating effectively, NEESPS would be required to deliver on plans in place and staff would need to achieve what they had been asked to do.

Nick Jenkins said that he did not yet have all the assurance required, but currently the system was working well. There should be more assurance as a result of there being more involvement from the Medical Directors.

The Chairman explained that from a governance perspective arrangements looked a lot more effective than previously and there was much more clinical involvement. He proposed that there should be a short paper on this at a future meeting. **C Black**

Alan Rose stressed that Governors needed to be aware that NEESPS would lose money for a period. He proposed that the paper should also include information on finance.

- Liz Steele referred to Dementia Awareness Week and the 'digital Dave' initiative. She noted that at times people were admitted to areas of the hospital that did not specialise in dementia and asked for assurance that staff across the organisation were trained in the different forms of dementia. Paul Morris explained that mandatory training for staff included dementia awareness training. Dementia patients would be treated appropriately whatever area of the hospital they were in.

  The Chief Executive said that in addition to there being dementia awareness across all wards, the Trust was trying to make all wards dementia friendly from an environmental point of view, eg colour coding etc.

- June Carpenter reported that at the joint CoG/NED meeting last night it had been agreed that it was helpful if executive directors attended CoG meetings. At the last CoG meeting there had been no executive directors present. The Chairman explained that some of the executive directors had planned to be there, but some last minute problems had intervened.

- June Carpenter referred to the recent cyber-attack and asked for assurance that everything was in place and if there was a Majax the Trust's plans were robust enough to manage both. The Chairman explained that a letter had been received from NHS England a few days ago about being fully prepared for a major attack, ie emergency preparedness and ensuring there was enough blood etc in stock.

  Helen Beck explained that she was the responsible officer for this and confirmed that policies were in place and had been reviewed for major incidents and business continuity. The Trust had responded to the letter from NHS England accordingly. Communications to staff had also gone out about awareness and how they should respond.

  The Chief Executive confirmed that processes were in place to manage situations as well as possible. He explained that the Trust had managed fairly well with regard to the cyber-attack and Rowan Procter and Craig Black had been present in the organisation over the weekend. There had been a tremendous response from the IT team to ensure that patches were in place to deal with the attack. There were already plans to put these patches in place, but this was brought forward.

  Craig Black explained that there were a number of protections already in place, such as a firewall, and the Trust subscribed to services designed to alert organisations about threats. Admin rights had also been deliberately restricted on computers across the organisation in order to protect it. This had enabled it to respond very quickly on this occasion. However, he stressed that WSFT had been lucky, as its policy had been to update patches every two months so that 'glitches' they caused had already been highlighted elsewhere.

WSFT was now considering whether to shorten this timeframe as it was still very vulnerable and approximately 2500 computers and 307 servers had to be patched. He warned that there would be a point when WSFT was hit by a cyber-attack and it was now reviewing current procedures.

- Judy Cory referred to Liz Steele's question about dementia training and asked if it was feasible for volunteers to receive training on dementia. Helen Beck said that she would follow this up with Rowan Procter. **R Procter**

17/108 REVIEW OF AGENDA

The agenda was reviewed and it was noted that sufficient time needed to be allowed for item 12, Revised mortality reporting.

17/109 DECLARATION OF INTERESTS

There were no declarations of interest.

17/110 MINUTES OF THE MEETING HELD ON 28 APRIL 2017

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

Item 17/91 (page 5, third para) – final sentence to be amended to "Also an update on discussions with Community Services on who would be funding the provision of SALT in special schools."

17/111 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and there were no issues.

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

Ref 1395 – maternity WHO analysis to include further detail on performance and remedial action. Neville Hounsome noted that at the previous Board meeting he had asked whether it was the same people who made more than one mistake or if this was a systemic issue. Richard Jones reported that he had spoken to the team about whether it was the same people and they were very clear that this was not the case.

Neville Hounsome said that in which case this must be a systemic issue. Nick Jenkins agreed and explained that a new lead for Obs and Gynae, Jac Reeve, had been appointed and one of their first jobs would be to look at this and ensure completion of the WHO checklist every time, even in an emergency. The Board would see details of compliance with the checklist in the quality report. The Chief Executive confirmed that this issue had been raised by the executive team in the divisional quality and performance meetings.

Ref 1402 – update on SLT services to include performance against original plan, work with local authority and assurance for future delivery. Helen Beck explained that this action point should remain open. A paper should have been coming to the Board today, but following discussions around funding this was pulled. Rowan Procter was following this up and further information would come back to the next Board meeting. **R Procter**

17/112 CHIEF EXECUTIVE'S REPORT

The Chairman referred to the JAG accreditation for endoscopy and said that this was a very positive result. On behalf of the Board he congratulated the team, particularly considering the issues they faced with accommodation etc.

The Chief Executive reported that feedback from the inspection team had been exceptional. There were still a couple of issues to be addressed but these were being worked through.

The Chief Executive highlighted the following:-

- A&E performance in February was 83.9%; this increased to 92.8% in March and 95.2% in April, and performance in May had remained strong. This was as a result of the benefits being seen from the focus on flow and Red2Green. He confirmed that this was being fed back to consultants.

- There was a major issue with referral to treatment (RTT) and this was reported in the Board papers. The Intensive Support team had come into the Trust to validate its approach to reporting and resolving the data quality issues it had.

- NHSI had closed its investigation into the Trust's compliance with its licence. However, it still faced significant challenges and KPMG were supporting the Trust in addressing these.

- He referred to Ransomware and commended Steve Turpie and the audit committee for the focus on preparing for a cyber-attack, which had helped the Trust manage the recent attack. Craig Black explained that the Trust had appointed an individual to look after cyber-security as a result of discussions that had been had by this committee.

Steve Turpie referred to the visit from NHS England and their comments on vending machines within the Trust, ie chocolate vending machine at the back of the hospital, opposite Rainbow ward. He asked what WSFT's approach to this was. The Chairman referred to the directive that chocolate available should be no more than 250g and the Trust was complying with this. He proposed that this should be revisited. **C Black**

Neville Hounsome asked about the Buurtzorg nursing pilot and if there would be an update in six months. The Chief Executive explained that they were still in the process of recruiting new nurses and NHS England had asked that this was properly evaluated. He considered that this was a very positive initiative and a report would come back to a future Board meeting. **H Beck**

Angus Eaton referred to the cyber-attack and asked if the Trust was doing enough from a cultural perspective, as there was a greater risk through people than through a cyber-attack. Craig Black explained that this was why admin rights had been removed and there was also mandatory training around information governance to reinforce the message on the need to be vigilant. However, cyber-attacks were becoming more and more sophisticated and very difficult for people to identify.

Steve Turpie agreed that this was a behavioural issue and proposed using this as an opportunity to remind people of the risks. Craig Black said that people had become very aware of the risks and impact of a cyber-attack as a result of how other hospitals had been affected, ie Mid Essex.

DELIVER FOR TODAY

17/113 QUALITY & PERFORMANCE REPORT

The Chairman considered this to be a good report but said the focus needed to be on referral to treatment (RTT).

Helen Beck reported that there had been a significant drop in reported performance. This continued to be estimated, but it was now realised that previous estimates were inaccurate and a revised and more accurate position, although still an estimate, had been reported this month. There had been a visit from the Intensive Support Team, at the request of NHSI, to look at the methodology for estimating and the governance arrangements around this. The Trust was still waiting for their report but they had said that WSFT had a good grip on the issues and the mitigation approach was correct. This had provided reassurance that the issues were around data and the system, rather than around processes.

Feedback from this report would be provided at the next Board meeting. **H Beck**

Significant changes would be made next week as to how this would be managed internally and she was confident that the position would improve rapidly over the next few months. However, there would still be issues where there were capacity problems in some specialties.

Helen Beck explained that she had planned for accurate reporting from July, but the Intensive Support Team would be recommending that from June the Trust reported the actual figures on the patient tracking list (PTL), notwithstanding the known data quality issues. She informed the Board that this would result in a worse position being reported.

Gary Norgate asked about data inaccuracy and lack of capacity and if there was an operational problem with meeting RTT. Helen Beck explained that in some specialties, ie ENT, vascular surgery, there were operational capacity issues which were being addressed. However, these were not sufficient for the Trust to fail to meet the target overall once the issues within the majority of specialties had been addressed.

Gary Norgate asked how long the worst cases had to wait. Helen Beck explained that this was 52 weeks or longer, which varied by specialty. However, as a result of patient choice some patients were waiting 70 weeks.

He asked if there was any evidence that this was causing patient harm. Helen Beck explained that each of these patients had a clinical review; this would also be looked at across the patient pathway and issues could be identified early. To date no patient harm had been identified as a result of this.

The Chairman asked if the fact that it was not known what was going on masked the fact that there were long waiting times in some specialties. Helen Beck explained that this was not the case as this was always known about and individual specialties had action plans to address this.

Alan Rose asked about the four specialties with capacity problems and if, in the medium term, they would continue to be delivered by WSFT.

Helen Beck explained that the Trust had been working with the CCG on ENT and moving some cases into the community. Vascular surgery was already part of a network with Addenbrooke's but some work needed to stay at WSFT. The Trust was looking at urology and ophthalmology and what could be done in the community and in other settings. The Intensive Support Team had a sophisticated modelling system and would help work through the capacity issues going forward.

Dermatology was a supply and demand issue. A very positive meeting had taken place last week with the CCG and analysis showed an increase in demand, but because of workforce issues supply had decreased.

The Chief Executive explained that some ENT consultants were also on a network with Addenbrooke's. Challenges with ENT and dermatology were also replicated in other hospitals.

Nick Jenkins said that this was very much WSFT's work as no one else would do it, ie GPs or other hospitals. It ought to be possible to do this in other places but all these specialties related to an ageing population; therefore demand was unlikely to reduce. He stressed that WSFT would need to continue to provide these services. He explained that vascular was being provided at WSFT by another organisation. Although the Trust did not provide this service itself, it still needed to be delivered at WSFT.

Angus Eaton referred to demand and asked if patients coming into A&E were sicker and if this was consistent with the assumption around demand. Nick Jenkins explained that the Trust did not have a very good way of measuring the sickness of patients within the emergency department. It did measure 'majors' or 'minors' but this did not provide this type of information.

Helen Beck considered that more work could be done on this to enable they type of patient to be understood better.

Nick Jenkins explained that he had had discussions with GPs about frailty scores to try to characterise particular patient groups that were considered to be high risk, but this was not yet finalised.

The Chairman asked Nick Jenkins about having a GP in A&E and the funding to enable this to happen. He noted that NHSI had intimated that if WSFT had a different way of doing this they could do it and asked what was going to happen in October, which was when this had to be implemented by.

Nick Jenkins explained that the Trust was still aiming to do what it had originally planned to do. However, the CCG were not planning to commission the full range of hours that was originally mandated as they could not afford to do so, but they were also planning to host some of their services alongside this, ie GP plus. Currently they were planning to operate this service from 11.00am-9.00pm.

A meeting took place yesterday evening to discuss the operational model which was still being developed. The Chief Executive explained that this was still contingent on recruitment, which would be overseen by the CCG.

Nick Jenkins reported that he had visited the USA last week to try to recruit physician associates. The aim had been to recruit three, but they had managed to recruit ten. Two of these would be suitable for the GP role at the front of the hospital, however he stressed that this was the CCG's service to commission.

Gary Norgate noted the need to continue to focus on nutrition assessment and monitoring. He also expressed concern at the constant failure to meet duty of candour metrics and asked why this was the case. Paul Morris confirmed that two of the three outstanding had now been completed. He had discussed a proposal for escalating this with Nick Jenkins and the process was being updated to address this.

Neville Hounsome referred to the patient experience dashboard and asked what the reasons were for the improvement in four of the indicators. It was explained that there had been a greater focus on these areas which had resulted in the improvement. This was particularly the case with patients being informed of any delays in being seen. It was considered that it should be possible for all of these to move from amber to green.

Steve Turpie noted that the target for looked after children had been missed for over a year, and suggested that a different approach was required. He asked if the Trust could learn from other organisations who were successful in managing this. He requested that a plan to address this differently should come back to the Board next month. **R Procter**

Nick Jenkins referred to the three cases of *c.difficile* in the last month. He reminded the Board that at the last meeting he had reported on the antibiotic supply problem which could result in an increase in *c.difficile*, and explained this could be the reason. This was being carefully monitored but the Tazocin supply problem could still not be addressed.

Helen Beck referred to 104 day cancer waits and explained that this was a new metric that would be reported on. The Trust had a process and each patient had a clinical review. She and Nick Jenkins were looking at this to provide assurance that this was robust. In April there were no patients who had exceeded 104 days against the 62 days standard.

17/114 FINANCE AND WORKFORCE REPORT

Craig Black reported that an Audit Committee meeting had taken place this morning and the accounts had been signed off. It was noted that the Audit Committee had agreed that sign off for the position on "use of resources" would be delegated.

The Trust's position in month one was positive and ahead of plan. The positive trend that was seen towards the end of last year in terms of a reduction in agency, bank and locum staff was continuing.

The details of the cost improvement plan (CIP) would be reviewed with KPMG in the closed Board meeting. He explained that KPMG were more comfortable with the CIP than expected and that they compared favourably with the CIPs of other organisations.

The cash position was set to improve in June when the sustainability and transformation (S&T) funding, as a result of the Trust's performance last year, would be received. However, until this was received the cash position would remain tight.

Gary Norgate noted the income analysis (page 5) did not take into account block payment. However, it was expected that there would be higher clinical income every month this year than there was last year. He asked where this income would come from, if not the block payment. Craig Black explained that the block payment assumed an increase in activity, which was paid in equal amounts each month. However the report looked at phasing of income, as if the block contract did not exist.

Gary Norgate also referred to activity and noted that non-elective, outpatients and A&E were lower than planned this month, but elective was above plan. He asked if this trend continued the Trust would be worse off under a block contract than it would have been on a PbR contract. Craig Black explained that the value associated with non-elective work was greater than the average for inpatients and day cases. Therefore under performance in non-elective was worth more than an over performance in elective and day cases. Therefore, if this level of performance continued the Trust would be slightly better off under block contract.

The Chief Executive referred to funding and asked about the accuracy of the graph. Craig Black explained that the phasing was based on the average of three years activity; however there would be differences.

Neville Hounsome asked about the variances in clinical support (page 11) and if this was beginning to show areas that there ought to be concern about. Craig Black said that he was not concerned about this as the numbers were relatively small and he considered this variance to be a one-off. However, this division would need more scrutiny than other areas next month.

Neville Hounsome commented on the reduction in nurse agency spend and bank and locum staff.

Gary Norgate agreed with that this was a positive trend on nurse agency spend, but noted that medical agency spend and overtime had increased in the month, even though volumes were below plan. He asked if this should be the case. Craig Black explained that overtime related to pharmacy and housekeeping. Pharmacy was due to the number of vacancies and the challenge to maintain services, and housekeeping was due to the deep cleaning programme, ie G9. A significant part of medical agency spend was in the emergency department, which was about generating flow. He confirmed that this would continue to be monitored.

Gary Norgate asked if future reports could include a graph showing the number of wte versus the number that would be required in order to meet the efficiency target. **C Black**

The Chief Executive confirmed that KPMG were looking at how the workforce was managed and the use of staff rostering etc.

Jan Bloomfield explained that norovirus had also impacted on junior doctors and resulted in short term absences that could not be filled.

Steve Turpie asked for commentary on 60-90 day debtor performance. **C Black**

Alan Rose asked if £1m was sustainable liquidity. Craig Black explained that this was the 'floor' that the Trust was allowed to operate within, ie if the level of cash was forecast to fall below £1m it would be required to borrow to bring the cash level back to the floor. The long term solution would be the implementation of the KPMG plan.

17/115 TRANSFORMATION REPORT

The Chairman asked for clarification as to how the integration was progressing and if the changes were going well and if there were any problems.

Helen Beck explained that this report showed the changes, and currently no major issues were being experienced. There were a few minor difficulties that were being worked through. The planned care programme was still being recruited to but no real problems were being experienced and good progress was being made.

A significant amount of work had been undertaken in order to put stronger governance in place around the PMO and this had been validated by KPMG.

Alan Rose referred to the Integrated Care Network Programme Board and asked if it was commensurate strategically with all the work going on and consistent with the STP Programme Board, and if this work was aligned.

Helen Beck considered that this was the case and the Chief Executive agreed that these were aligned. STP discussions had moved on and there was now greater alignment and the governance was much clearer.

Helen Beck said the work was absolutely sited on the objectives of the STP and ICO.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/116 AGGREGATED QUALITY REPORT

Paul Morris highlighted the reduction in the level of reporting, which was the lowest since November 2015. This had been looked at and there were no obvious reasons, but it would continue to be monitored.

He referred to medication incidents which had continued to increase over the last three months. He had met with Simon Whitworth to discuss this and explained that e-Care enabled errors to be identified a lot more easily.

Gary Norgate referred to lack of reporting on cases of sepsis and asked for assurance that the protocol was being followed for this. Paul Morris explained that there had been a sepsis audit but there had been problems with reporting this due to a change in personnel. This should improve next month.

Neville Hounsome noted that information on the shift in complaints about car parking had been omitted (page 6). This would be followed up. **J Bloomfield**

Jan Bloomfield reported that issues around car parking appeared to have calmed down.

17/117 REVISED MORTALITY REPORTING

The Chairman explained that this was a new system for reporting and investigating mortality. He introduced Dr Helena Jopling, Public Health Registrar, who was working with Nick Jenkins on this issue.

Helena Jopling explained that there was a new national Learning from Deaths programme and the background and objectives were outlined in the paper. This required Trusts to enhance the way they learnt from deaths that occurred in inpatient episodes. National research suggested that some deaths could have been prevented or should not have occurred when they did.

WSFT already had a group set up to look at this (Learning from Deaths group). However, it was important to note that most deaths in hospital were expected and timely and appropriate. Most of the feedback about care at end of life by WSFT was very good.

The Chairman noted that at the launch event there was a wide variation of systems that organisations were using and methods for estimating the number of excess deaths. He asked if Trusts would be following a similar methodology. Helen Jopling explained that a certain amount of this was left up to individual Trusts, although the Royal College of Physicians had published a method for doing this. It was considered that WSFT should follow this as far as possible and she thought that most Trusts would adopt this method.

The definition of excess deaths was laid out in this method; therefore if all organisations adopted this it would be scored against the same benchmark.

If WSFT did not have the number of preventable deaths that research suggested this would be very difficult to interpret. It was considered that although it had been stated that a league table would not be produced, it was likely that this would happen.

Nick Jenkins thought that the CQC would look at how organisations would be implementing this process and how they would be reporting the numbers. The methods Trusts used would be carefully scrutinised by the CQC.

Angus Eaton referred to roles and accountabilities and asked how WSFT would be measuring the reduction in the number of deaths. Helena Jopling explained that at present the Trust was using an alternative dashboard so that it could provide more qualitative information than just the numbers. She would initially expect to see an increase in identification of deaths that could prevented as they would be looking carefully for these. However, over time she would hope to see a gradual reduction.

Nick Jenkins explained that they had created this dashboard as he felt this would be a more useful way of providing the Board with the assurance they would wish to see.

Alan Rose asked about a middle grade doctor being the "medical examiner". Nick Jenkins explained that there would be a series of senior doctors (approximately seven) sharing this role.

Alan Rose asked if this would be a cost increase to the organisation and suggested that it would incur considerable time and money. However, he felt that this was very important. Nick Jenkins explained that the excess cost would be approximately £30k, however part of the role of the medical examiners would be to complete the paperwork for the crematorium. Therefore this would now become Trust income, rather than being paid direct to the individual.

The Chief Executive referred to the dashboard and the overall quality of care and asked what the grading system referred to. Helena Jopling explained that the medical examiner would be required to look at five phases of care from admission, and grade each of these.

The Board agreed with the proposed format of this report and that this should be reviewed quarterly as a separate agenda item. However, Nick Jenkins should escalate any variations or issues that arose in the meantime.

Nick Jenkins agreed that this would be reviewed quarterly as a separate agenda item to enable discussion. He explained that this should be fully implemented by the end of quarter three, but he would bring back a progress report at the start of quarter three. **N Jenkins**

Alan Rose asked if this referred only to inpatient deaths. Helena Jopling confirmed that currently this was the case but it might eventually be extended to deaths within 30 days of discharge.

The Chief Executive proposed discussing WSFT's approach to this with NHSI at one of their regular meetings.

It was noted that Richard Davies would be the named Non Executive Director for learning from deaths.

17/118 NURSE STAFFING REPORT

The Board received this report and noted its contents.

17/119 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that Solange Gaspar, a Sister on ward F6 and Josh Wigley, IT support, had received a Putting You First Award this month.

Solange Gaspar was nominated for taking time out of a busy day to take a patient outside, as it was his final wish to spend some time in the fresh air before he was transferred to the hospice. She stayed with him so he was able to spend some time with his family, breathing in the fresh air. Despite working on a fast paced, acute ward, Solange made time for this gentleman and his family in the last days of his life and fulfilled his dying wish. Both the patient and family were very touched by this gesture.

Josh Wigley was nominated for his dedication and the excellent work he has undertaken on the catering till system replacement. He came in at short notice when he was meant to be on annual leave in order to see the job through and ensure everything was operational.

The Board commended Solange and Josh for their dedication and agreed that they fully deserved this award.

BUILD A JOINED UP FUTURE

17/120 e-CARE REPORT

Craig Black noted that issues around the cyber-attack had been discussed earlier in the meeting.

The plan to interface the pathology system with Millennium was due to go live last weekend. However the decision was made to delay this as testing had become limited due, in particular, to the issues that Colchester was experiencing as a result of the cyber-attack. He explained that going live in a safe way was largely governed by the amount of testing that the team was able to do; therefore it had been delayed and was now planned for the weekend of 3/4 June.

The team had managed to do a lot of testing this week and further testing was planned for next week, but the new date assumed that the results of testing were successful. To date they were still on track for this.

One of the consequences of not going live last weekend was the planned resources to provide support, ie floor walkers etc. Instead these individuals were utilised to enhance the way in which people were using the system and had gone into outpatients and other areas and worked with clinicians on this.

GOVERNANCE

17/121 TRUST EXECUTIVE GROUP REPORT

The Board noted the content of this report.

17/122 APPOINTMENT OF SENIOR INDEPENDENT DIRECTOR

Jan Bloomfield noted that the Senior Independent Director (SID) was also the named director for whistleblowing and the Board's contact for the Freedom to Speak Up guardian.

Richard Jones confirmed that these changes would be reflected in the terms of reference for this role. **R Jones**

The Board approved the appointment of Alan Rose as Senior Independent Director.

Jan Bloomfield reported that Nick Finch had been appointed as the Trust's Freedom to Speak Up guardian.

17/123 EXTERNAL "WELL LED" REVIEW PROPOSAL

Richard Jones reported that NHSI was very supportive of the recommendations in this report.

The Board noted NHSI's support for deferring the well-led review until later in 2017/18. It also noted that the Trust was aligning the KPMG work to review and improvement the culture of change to build on the annual governance review and reflect the NHSI/CQC KLOEs.

The Board approved the proposal to receive a further report in September which would use the findings of the KPMG work and the final well-led framework guidance to inform the scope of the independent well-led review **R Jones**

17/124 USE OF TRUST SEAL

The Board noted the use of the Trust seal.

17/125 AGENDA ITEMS FOR NEXT MEETING

Helen Beck reported that she did not think that the stroke report would come back to the Board in June. It was proposed that the target for this should be July as the momentum needed to be maintained.

The scheduled agenda items for the next meeting were approved.

ITEMS FOR INFORMATION

17/126 ANY OTHER BUSINESS

There was no further business.

17/127 DATE OF NEXT MEETING

The next meeting would take place on Friday 30 June 2017 at 9.15am in the Committee Room.

RESOLUTION TO MOVE TO CLOSED SESSION

17/128 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 – 30 June 2017

AGENDA ITEM:	Item 6
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	22 June 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. Agree at meeting on 26/5/17 to move to July meeting.	HB	28/07/2017	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. **At meeting on 26/5/17 agree that need to see plan to improve performance. Update through Quality & Performance report.**	NJ	30/06/2017	Green
1413	Open	26/5/17	Item 7	Review provision of unhealthy options in vending machines	Confirmed that current arrangements are compliance with requirements. Options are being consdered to move beyond these requirments.	CB	30/07/2017	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	Report from HB received at meeting on 26/5/17. At meeting on 26/5 also requested: (a) Update to be provided on changes to the funding arrangements from the local authority (RP); and (b) indication of what we will do re paed SLT performance **Update provided in qualiy and perfromance report**	RP	30/06/2017	Complete
1411	Open	26/5/17	Item 2	Provide a paper to the Board setting out the governance arrangements for the new pathology services along with the financial position and plans	**Agenda item**	CB	30/07/2017	Complete
1412	Open	26/5/17	Item 2	Review the provision of dementia training for volunteers	Part of induction training for volunteers. Looking at options for enhancing training through structures talks and simulation sessions.	RP	30/07/2017	Complete
1414	Open	26/5/17	Item 7	Confirm timing for the Board to receive an evaluation report on the Buurtzorg pilot	Following successful recruitment evaluation is scheduled for May 2018.	RP	30/06/2017	Complete
1415	Open	26/5/17	Item 8	Provide feedback from the Intensive Support Team (IST) visit regarding RTT performance	**Included in Quality & Performance report**	HB	30/06/2017	Complete
1416	Open	26/5/17	Item 9	Requested to reinstate chart in finance report which sets out 'WTE and staff needed'	**Part of finance report**	CB	30/06/2017	Complete
1417	Open	26/5/17	Item 9	Provide commentary on the 60-90 day debtors performance	**Part of finance report**	CB	30/06/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1418	Open	26/5/17	Item 11	Confirm the information on changes to the changed nature of car parking complaints which was incomplete in the report.	Issues are being raised re accessibility of the newly designated blue badge spaces and ramp from the front car park. Patients and visitors report experiencing difficulties transporting wheelchair users on the ramp - options to address this options are being considered.	RP	30/06/2017	Complete
1419	Open	26/5/17	Item 12	Schedule quarterly reporting for learning from deaths from the end of Q3 with an update on progress to the Board in October.	Included in forward plan (october) and regular reporting schedule (January 2018 for Q3 results)	RJ	30/06/2017	Complete
1420	Open	26/5/17	Item 17	Update the role summary for the senior independent director to include whistleblowing and link with the freedom to speak up guardian	The following has been included in the role specification: "To undertake other duties relevant to the role, including: - Acting as the NED lead for whistleblowing - Acting as the link NED for the Trust's freedom to speak up and safe working guardians"	RJ	30/06/2017	Complete
1421	Open	26/5/17	Item 18	Schedule report to the Board on proposed arrangement and scope for the independent 'well led' review	Scheduled for October meeting	RJ	30/06/2017	Complete

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30 June 2017

AGENDA ITEM:	Item 7
PRESENTED BY:	Steve Dunn, Chief Executive Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	23 June 2017
SUBJECT:	Chief Executive's Report
PURPOSE:	Information

I am saddened to have to reflect so soon about a further act of terrorism in our country. The shocking attack in London was another reminder of the responsibility we have to care for our community, and the challenges the NHS faces, when major incidents occur. Again, I am proud to be part of the NHS, the fast and effective response to those affected was exemplary. The UK threat level remains at severe, and we are on standby to support any major incident should we be called upon.

The Grenfell Tower fire has been a further shocking event which has shaken all of us and my deepest sympathy goes to all of those affected. We are responding with Suffolk Fire and Rescue Service as part of a nationally assessment of fire prevention and risk assessment.

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.

May's **performance pack** shows that we have maintained operational performance for emergency flow reflecting the focus on red2green – achieving 95.33 for Q1. However the referral to treatment (RTT) performance is 79.71% for patients on an incomplete pathway against a standard of 92%. I regret that this month we have reported 14 patients breaching 52 weeks. Nine of these are within ENT reflecting the significant capacity issues within this specialty. We did not achieve the 62 day cancer standard with a performance of 83.96% against a standard of 85% and the two week wait standard with a performance of 92.27% against a standard of 93%.

We have recently been visited by the **intensive support team (IST)** regarding RTT procedures. In summary the IST found that the Trust has an effective understanding of the data quality issues and there is 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. There are areas for improvement and the report is considered in more detail within the Quality & Performance report.

We have recently identified inaccuracies around information contained within some **discharge summary** letters issued to GPs. This is due to a combination of technical issues within the automated distribution processes and workflows. At the point the issue was identified we immediately implemented a manual process to ensure the correct information was being sent to GPs. The investigation into this incident is ongoing and currently has not identified any patient harm. We are working with our digital partner, Cerner, to implement a long term solution.

The **MHRA** visited the Trust during June. The inspector recognised improvements made but we remain non-compliant. The visit included new areas of assessment and identified two major concerns (staffing and fridge validation) and four other areas for improvement. Based on the improvements seen the inspector recommended moving from weekly to monthly monitoring updates.

The **month 2 financial position** reports a deficit of £1,096k for May which is better than plan by £28k.The reported cumulative position is therefore £80k better than plan. The 2017-18 budgets include a cost improvement plan (CIP) of £13.3m of which £1,906k has been achieved by the end of May (14.4%). 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 primary focus is to ensure that robust CIPs are in place to deliver the control total for 2017/18 and a CIP pipeline is available to deliver financial sustainability going forward. A culture survey for the Trust has also been undertaken which evidenced strong performance from an engaged organisation. Areas for development will be incorporated into engagement and communication plans.

We went live with **OrderComms** on 3 June 2017, a slight delay from the original go live date. Overall the technical implementation has been very successful with minimal issues identified. We continue to support users in understanding and adhering to the new workflows with floorwalker support continuing until 30 June. This includes supporting juniors and consultants with the new endorsing workflows. Sepsis/Acute Kidney Injury (AKI) live reporting was launched on Monday 19 June and has been a success to date. These changes will allow us to start to delivery patient safety improvements through our benefits realisation plans.

I understand the concerns raised regarding the closure of our **orthodontics and oral surgery** service. This is not a decision that we have taken lightly; growing demand for these services, which were being run two-days-a-week, was resulting in patients waiting longer than we would like for treatment. This, combined with the need to replace significant amounts of equipment, meant that we weren't providing the quality of service that we or our patients expect. In total, 235 patients were using the oral surgery service. Surgery has been undertaken for all but 10 patients, and they will receive their surgery here at WSFT as part of the service closure process. Going forward, we hope patients requiring oral surgery will be able to receive care from a dedicated service. Those patients needing follow-up appointments for oral surgery have been asked to contact their general dental practitioner or general practitioner, who will be able to make arrangements for any on-going care that they may require. The majority of patients that require orthodontic treatment can be cared for in dental practices, without the need for acute care, and any patients needing orthodontic appointments will be referred to an appropriate provider in due course. NHS England, which is commissioning the new service, is working with us and making arrangements for patients' on-going care whilst longer-term plans are put in place. Those patients affected have been very understanding, and we're grateful for their ongoing patience. We will continue to keep them informed, and ensure their care is transferred to the new provider as soon as possible.

We are recruiting to our first **Buurtzorg team** to test a Dutch model of integrated health and personal care delivered by small teams of self-managed nurses working in the community. Buurtzorg, which in English means 'neighbourhood care', advocates the use of highly qualified nurses to deliver dedicated personal and health care to patients in a neighbourhood area. The nurses work in small self-managed teams to deliver holistic care, working closely alongside their formal and informal networks to allow individuals to stay in their homes and communities for as long as possible. WSFT, NHS West Suffolk Clinical Commissioning Group, Suffolk County Council and West Suffolk councils, with the support of the East of England Local Government Association, are seeking enthusiastic nurses and nursing assistants with community experience to join west Suffolk's first Buurtzorg team to test this new community model of care at home. This is a really exciting opportunity for community nursing in west Suffolk. The Buurtzorg model has the potential to help us meet our ambition to keep people healthy and living independently for longer. We know many people would prefer to remain in their own familiar environment when unwell or managing a health condition and through this model we can help coach individuals and families to maintain their health and wellbeing.

In light of recent tragic events we maintain our focus on **Prevent** as part of the Government counter-terrorism strategy. It is designed to tackle the problem of terrorism at its roots, preventing people from supporting terrorism or becoming terrorists themselves. Prevent operates in the 'pre-criminal space'. It is about supporting individuals who are at risk of radicalisation away from becoming terrorists, or supporting terrorism. It is not about any particular ideology - it covers all forms of extremism. Prevent is about:

- **Noticing -** vulnerability to radicalisation, changes in behaviour, ideology, and other signs of extremist exploitation.
- **Checking -** your concerns out with your line manager and the Southern Health Corporate Safeguarding Team to offer support and help determine a proportionate response.
- **Sharing -** your concerns, where appropriate, with partner agencies and as far as possible being open and honest with the individual around your duty to share concerns.

Staff concerned that someone they know is at risk of radicalisation can contact the WSFT Safeguarding Team. The Trust Lead for Prevent is Anthony Green, Named Professional for Safeguarding Adults.

The CQC has published the outcome of the consultation it ran recently on forthcoming changes to **CQC regulatory regime**. There will be:

- two CQC assessment frameworks - one for healthcare and one for adult social care. In terms of timing, NHS trusts are expected to implement the new assessment frameworks from this month, whilst adult social care providers and GPs will have until November 2017 and independent sector providers until 2018/19 to implement the new frameworks.
- a new monitoring, inspection and ratings regime for NHS trusts, also coming into effect from this month, meaning that all trusts can expect each year to have a well-led assessment and at least one core service inspection.

Following the first Queen's Speech of the new parliament legislation and commitments of relevance to the health and care sector include the 'Patient safety bill' to establish the **Health Service Safety Investigation Branch (HSSIB)** in statute, granting it the authority to conduct independent and impartial investigations into patient safety risks in the NHS in England.

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

DELIVER FOR TODAY

New cardiology lab
The Trust's planning application for a new single-storey cardiac catheterisation and pacing suite continues. Dr Pegah Salahshouri, lead consultant cardiologist at the West Suffolk NHS Foundation Trust, explained: "The proposed build will allow cardiology services to be developed at the Trust, allowing more complex procedures to take place. For example, we will be able to fit pacemakers and expand the current coronary catheterisation. Patients who currently have to be transferred elsewhere for these procedures will be able to have all of their care here at West Suffolk."

New mothers mental health clinic
A new perinatal service is being launched this summer to treat pregnant women and new mothers suffering from mental health problems, with patients able to get appointments at West Suffolk NHS Foundation Trust and Ipswich Hospital NHS Trust. The clinic has been created by Norfolk and Suffolk NHS Foundation Trust (NSFT), with funding from West Suffolk and Ipswich and East Suffolk NHS Clinical Commissioning Groups (CCG). The NSFT team will work closely with midwifery staff at both trusts, as well as health visitors and social services, in order to provide women with joined-up care when they are at their most vulnerable. The service will offer around 750 appointments each year.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Record-breaking volunteers
This year over 400 volunteers were celebrated at the annual volunteers' tea party, with a record-breaking total of 47,358 hours of time given to the hospital last year. 49 long service awards were handed out by Trust chairman Roger Quince, to volunteers who, between them, have given 530 years of service, and around 30 students completed the Trust's six month student volunteer programme last year.

New freedom to speak up guardian
The Trust has appointed Nick Finch who works in the purchasing department and is also a staff governor as its freedom to speak up guardian. The appointment of a national guardian for speaking up freely and safely, and freedom to speak up guardians in NHS trusts were recommended by Sir Robert Francis, following his review and subsequent report into the failings in Mid Staffordshire.

Quince House – next set of tenants
All executive directors, their 'direct report'* managers, and the Trust office administration team moved into their new offices in Quince House. They join the estates and facilities team who have already moved over to the new building. Remember, it's an open door building and during office hours you can enter Quince House to access the Trust office and HR, the latter will be moving over to the building in the next phase. With the teams moving to the new building, we will be able to create a new, and vital clinical acute assessment unit (AAU) which will have six functions:

- An acute assessment unit
- Same-day ambulatory emergency care
- Rapid assessment triage
- Short-stay clinical unit
- Surgical assessment
- Discharge area

As AAU will vacate its current location, this will also free up space which can be used for patients when work is undertaken in other wards. For example, with space to move patients around, more work can be done to the wards that need roof repairs and asbestos removal, work which will increase the lifespan of our wards by 20+ years.

BUILD A JOINED-UP FUTURE

Sharing patient records pilot scheme
A pilot project in Sudbury enabling GPs and hospital clinicians to securely view each other's patient records is to be rolled out across west Suffolk. The information-sharing scheme has been road-tested by patient volunteers at a surgery in Sudbury for the past 12 months, proving so effective it will be introduced at ten other practices in the west of the county. It increases efficiency and improves healthcare by speeding up treatment times and significantly reducing the number of wasted or cancelled appointments. Dr Dermot O'Riordan, chief clinical information officer, said the scheme would benefit patients hugely: "The scheme enables GPs and hospital clinicians to access the most up-to-date data held on an individual. This information is only used for direct patient care. If a confused patient is admitted to hospital overnight we can access their GP records to see what medication they're on and what allergies they might have. We can also check if they have underlying chronic health problems."

Fast follower nominated
The Trust announced that as a global digital exemplar it had nominated Milton Keynes University Hospital NHS Foundation Trust for the fast follower scheme, intended to provide evidence that the blueprinting process is suitable for the other sites across the NHS. This is another step on the ten-year digitisation programme, which begun with the e-Care go live in May 2016.

NATIONAL NEWS

Up to six million people set to benefit from more clinical pharmacists in GP surgeries
Patients across England are set to benefit from more convenient trips to the GP with the announcement by NHS England of new, surgery-based clinical pharmacists to help with routine medication and treatment. Norwich is one area that is already benefiting from the programme

The Long-term Sustainability of the NHS and Adult Social Care
Service transformation is at the heart of securing the long-term future of the health and care systems. It is dependent on long-term planning, broad consultation, appropriate systems of governance and local accountability. This report identifies what is needed & how it could be achieved. (House of Lords, Select Committee on the Long-term Sustainability of the NHS)

Integrating health and social care
This report investigates the Better Care Fund and concludes that it has missed its objectives to reducing emergency admissions and delayed transfers of care. The report strongly criticises the implementation of the Better Care Fund and argues that the focus on integration should be shifted towards the STP process. ((House of Commons, Committee of Public Accounts)

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

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30th June 2017

AGENDA ITEM:	Item 8
PRESENTED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer
DATE PREPARED:	June 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 (3 in April). Falls for the month were 52 (54 in April and 8 pressure ulcers (7 in April) - pages 6-7.
- This month's report shows an actual position for RTT performance of 79.71% in aggregate for patients on an incomplete pathway against a standard of 92%. The move to reporting an actual figure rather than previous estimated figures is in line with recommendations from the recent Intensive Support Team Visit. Given the remaining data quality issues within the PTL this figure is likely to reflect a worse position than is actually the case. Pages 20-21
- The full IST report is included as an appendix to this paper, which highlighted comments and recommendations included on page 21 of this report.
- This month we have reported 14 x 52 week breaches against a target of 0. 9 of these are within ENT reflecting the significant capacity issues within this specialty with the remaining 5 spread across vascular, gynaecology , urology and T&O – page 22
- This month's report shows a failure of the 62 day cancer standard with a performance of 83.96% against a standard of 85% and the 2 WW standard with a performance of 92.27% against a standard of 93% - Page 22
- Ed performance has been strong within the month achieving a performance of 94.66% for the month and 95.33% for the quarter.

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	Mar	Apr	May
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	96	100
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	98	100	100
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	95	100	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	100	85
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	82	81	92
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<85	85-99	= 100	100	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	ND	1	0
Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	91	NA	NA
MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	90	92	93
Hand hygiene compliance	= 95%	<85	85-99	= 100	100	98	97
Total no of MSSA bacteraemia: Hospital	No Target	No Target	No Target	No Target	1	ND	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	1	3	0
Total no of C. diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	3	ND	0
Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	93	NA	NA
Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	9	2	0
Isolation data (Trust level only)	= 95%	<85	85-94	95-100	89	90	95
Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	91	NA	NA
Quarterly VIP score documentation	= 90%	<80	80-89	90-100	79	NA	NA
PEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	100	80	100
No of patient falls	= 48	>=48	No Target	<48	71	54	52
Falls per 1,000 bed days (Trust and Divisional levels only)	= 5.6	>5.8	5.6-5.8	<5.6	5.35	ND	ND
No of patient falls resulting in harm	No Target	No Target	No Target	No Target	16	9	17
No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	ND	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	0.15	ND	ND
No of patients with ward acquired pressure ulcers	< 5	>=5	No Target	<5	4	7	8
No of patients with avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target	0	3	ND
Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	90	91	87
No of SIRIs	No Target	No Target	No Target	No Target	8	9	5
No of medication errors	No Target	No Target	No Target	No Target	60	64	81
Cardiac arrests	No Target	No Target	No Target	No Target	13	0	0
Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	0
Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	NA	75	NA
Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	95	NA	NA
Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	98.19	98.53	98.26
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4	8	3	1
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC	60	60	66
Median NRLS upload 6 month rolling average [NEW]	46days	>46	No Target	0-46	51	ND	ND
SIRIs reported > 2 working days from identification as red	0	>1	1	0	2	0	0
SIRI final reports due in month submitted beyond 60 working days	0	>1	1	0	0	0	1
Active risk assessments in date	100%	<75%	75 – 94%	>=95%	100	100	100

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

Exception reporting for indicators in the Patient Safety Dashboard

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

Data notes:

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

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

Data items Falls per 1000 Beds days and Falls with moderate/severe harm/death per 1000 bed days which had not been previously available from e-Care have been provided as a working estimate for Jan-Mar17 with an aim to provide final figures for reporting from Q2 2016/17 onwards.

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

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

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

a) Current Position

A score of 92 in June was an improvement on 81 in April March and was RAG-rated as amber. This was based on 5 episodes of non-compliance where documentation of care was missing.

b) Recommended action

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

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

a) Current Position

The Trust achieved 93% compliance in May (92 in April). Within the reported figure are patients who receive more than one day of decolonisation to ensure a robust process is reported. There were seven eligible patients for decolonisation this month and no patients less than one day.

b) Recommended action

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

1.3 Nutrition: Assessment and monitoring

a) Current Position

A score of 87 in May was a drop from 91 in April and continues to be amber RAG rated and this will continue to be a major focus for the next few months. There were 9 omissions of weight on admission, 11 omissions of nutritional assessment on admission, 6 patients were not reweighed after 7 days and 4 patients did not get a re assessment after 7 days, the wards involved were: G1, G5, G4, G1, F3, F7, F9, F12 and F14.

b) Recommended action

Weights and nutritional assessment will be checked by nurse in charge on a weekly basis for the remainder of June overseen by the matrons.

1.4 Total no of C. difficile infections: Hospital

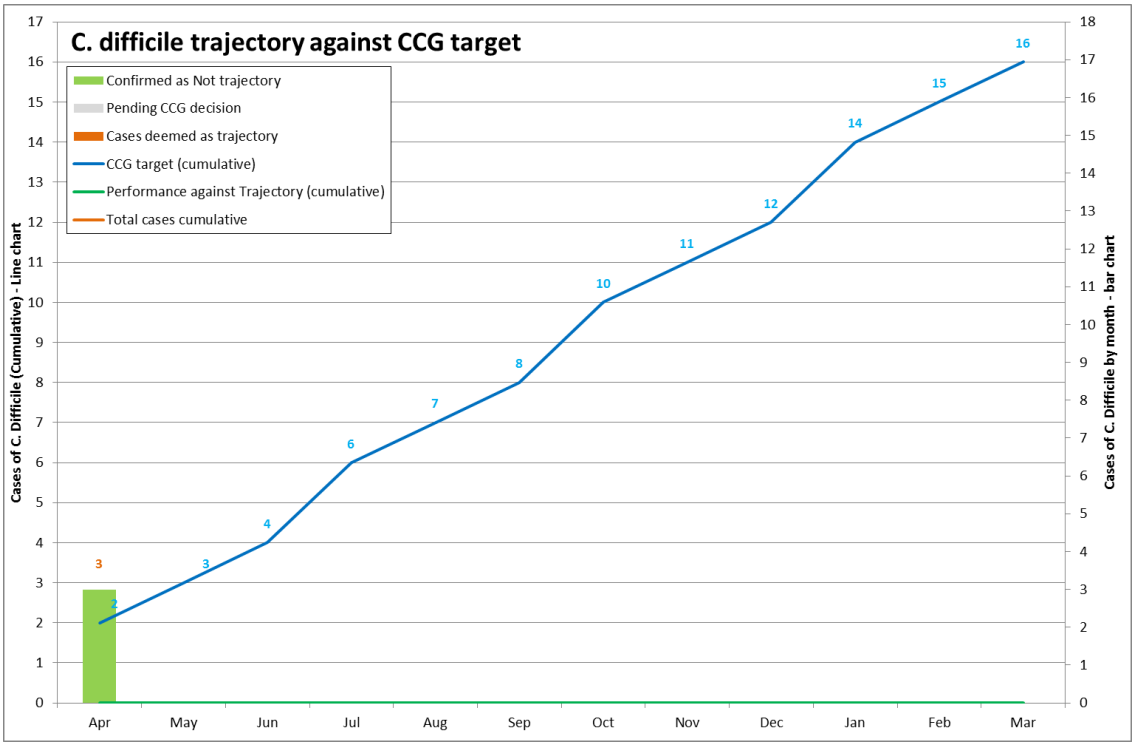
a) Current Position

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

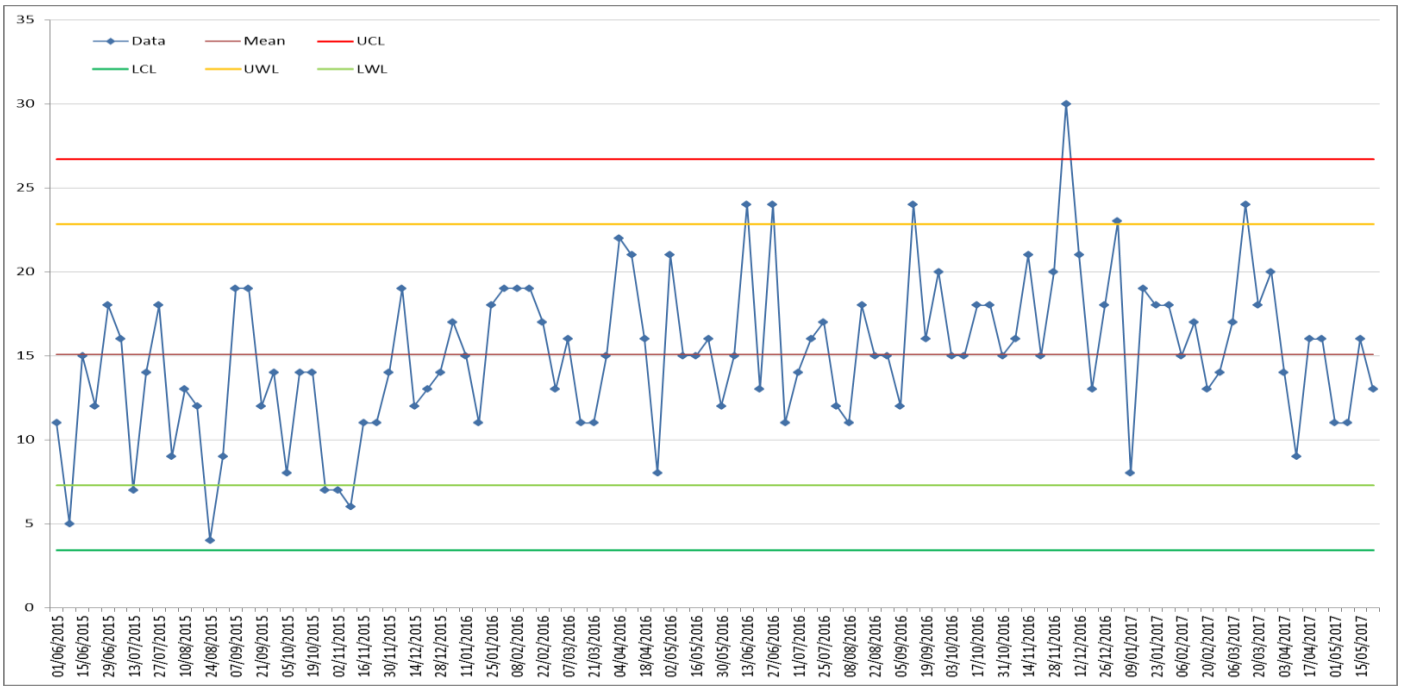
The graph below has been updated to demonstrate the Trust performance against the trajectory target set by the CCG.

b) Recommended Action

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



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



There were 52 falls in May (53 in April), one with moderate harm, none with major harm

Four patients fell at Newmarket Hospital (two in April). Five patients fell at Glastonbury Court (four in April), these falls are reported separately.

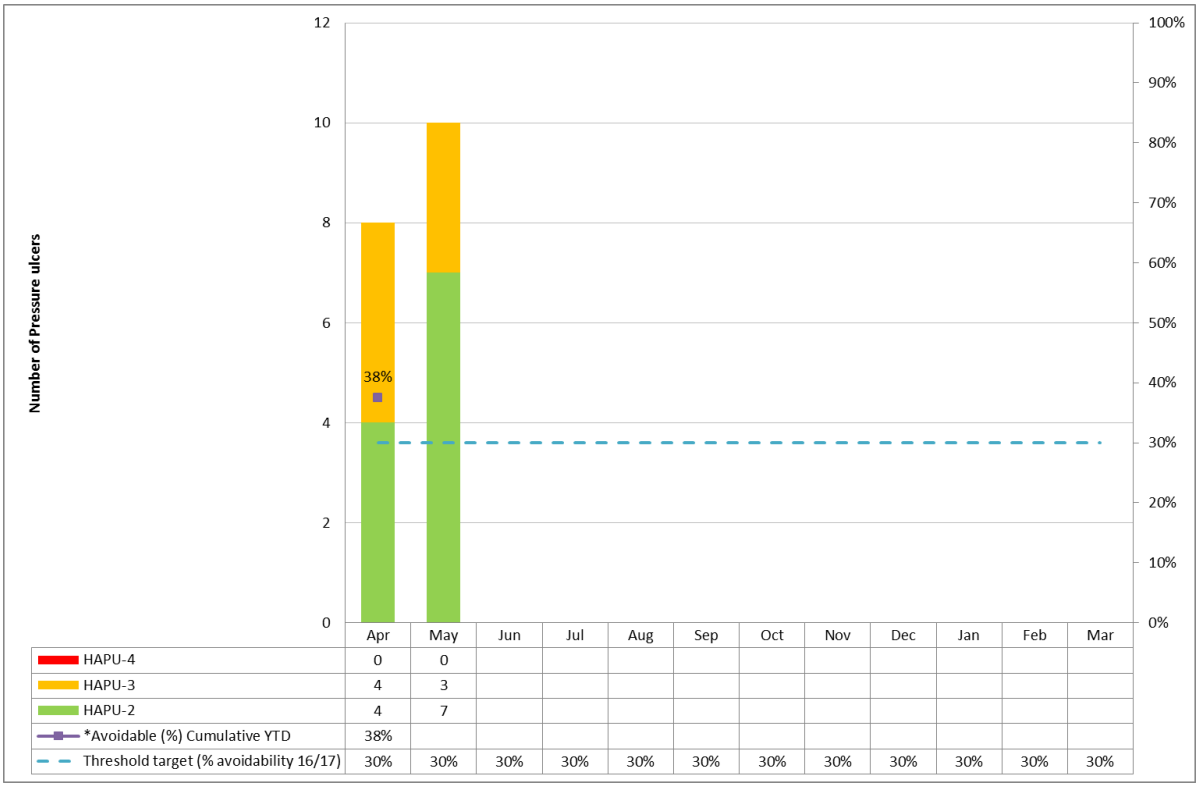
9 patients were assisted to the floor (two in April) preventing them from falling.

G8 experienced 10 falls this month, (13 in April) one patient fell three times, one patients fell twice.

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

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

1.6 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										
HAPU-3	4	3										
HAPU-2	4	7										
*Avoidable (%) Cumulative YTD	38%											
Threshold target (% avoidability 16/17)	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%

Judged as Avoidable following clinical review by Matron or TVN

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

There were five HAPU-2 in May. Two on G5 and one each on G1, G3, and G8

There were three HAPU-3 in May. One each on F3, G3 and G8

There were two DTI reported in May.

There also one HAPU-2 in May in Kings Suite Glastonbury Court.

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

Avoidable harm

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

At the end of May there had been 17 HAPU 2, 3 or 4 reported. Four of these have been classified as avoidable and six as unavoidable with another seven pending confirmation of grading as these cases are currently under investigation (HAPU-3 have a 60 working day deadline in line with the Serious incident framework).

Pressure ulcer prevention

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

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

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

1.7 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.

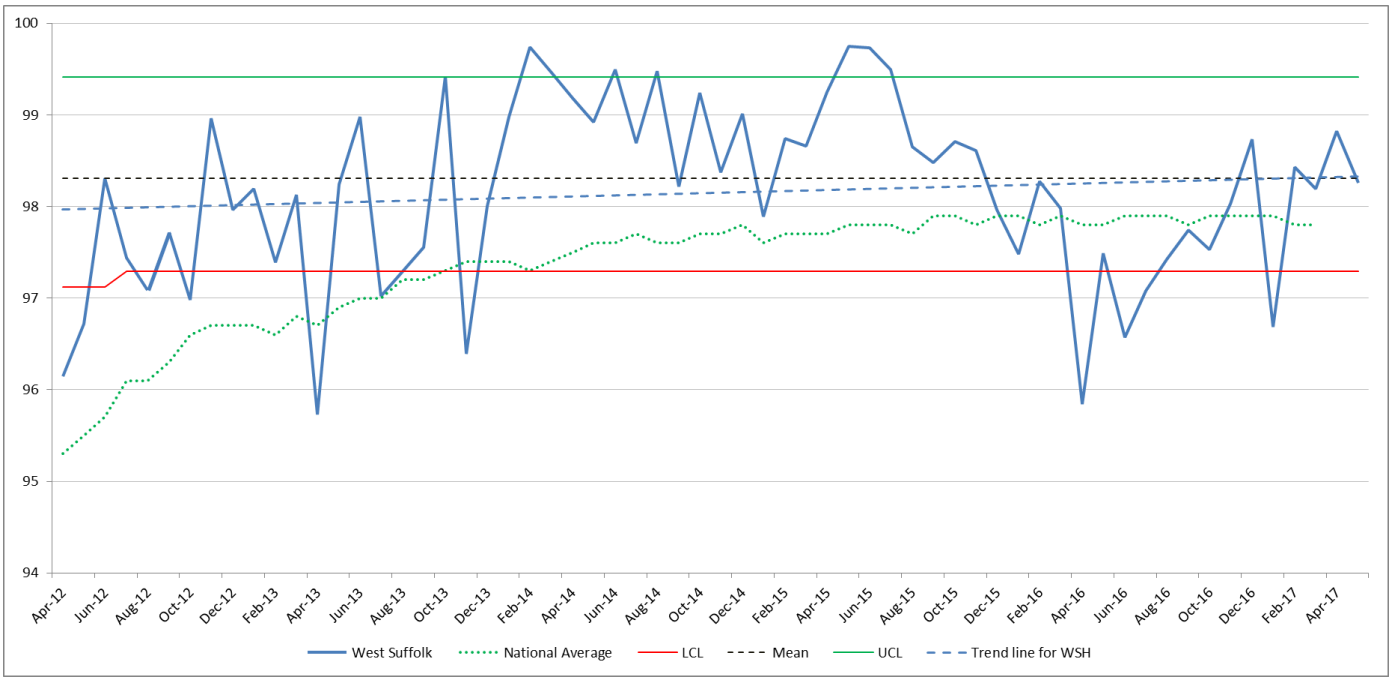
	Jun16	Jul16	Aug16	Sep16	Oct16	Nov16	Dec16	Jan17	Feb17	Mar17	Apr17	May17
Harm Free	93.63	92.31	92.25	92.71	92.31	92.61	93.16	91.35	93.72	94.06	94.12	91.30
Pressure Ulcers – All	3.43	5.31	3.88	5.03	5.49	5.67	3.80	5.34	4.71	3.62	5.00	5.22
Pressure Ulcers - New	1.47	1.06	1.29	1.01	1.65	1.23	0.51	1.53	1.05	0.52	0.88	0.87
Falls with Harm	0.49	0.53	0.00	0.75	0.55	0.49	0.76	0.76	0.00	0.00	0.00	0.29
Catheters & UTIs	1.96	2.12	3.62	1.51	2.20	1.23	2.28	2.04	1.31	1.81	1.18	3.48
Catheters & New UTIs	0.98	0.53	0.78	0.50	0.00	0.25	0.00	0.25	0.26	0.78	0.29	0.29
New VTEs	0.49	0.80	0.52	0.00	0.27	0.00	0.00	0.76	0.26	0.52	0.00	0.29
All Harms	6.37	7.69	7.75	7.29	7.69	7.39	6.84	8.65	6.28	5.94	5.88	8.70
New Harms	3.43	2.92	2.58	2.26	2.47	1.97	1.27	3.31	1.57	1.81	1.18	1.74
Sample	408	377	387	398	364	406	395	393	382	387	340	345
Surveys	18	18	18	18	17	18	18	18	18	18	18	17

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

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

The data can be manipulated to just look at “new harm” (harm that occurred within our care) and with this parameter, our Trust score for May 2017 is **1.74 %** therefore, our new harm free care is **98.26%.** The National new harm is not available so the Trust figure has not been RAG rated

It should be noted that the Safety Thermometer is a spot audit and data is collected on a specific day each month. The SPC chart below shows the Trust Harm free care compared to the national benchmark for the period April 2012 to March 2017 with April and May’s data provided at Trust level only.



b) Recommended Actions

To continue to monitor actual harm against national benchmarks

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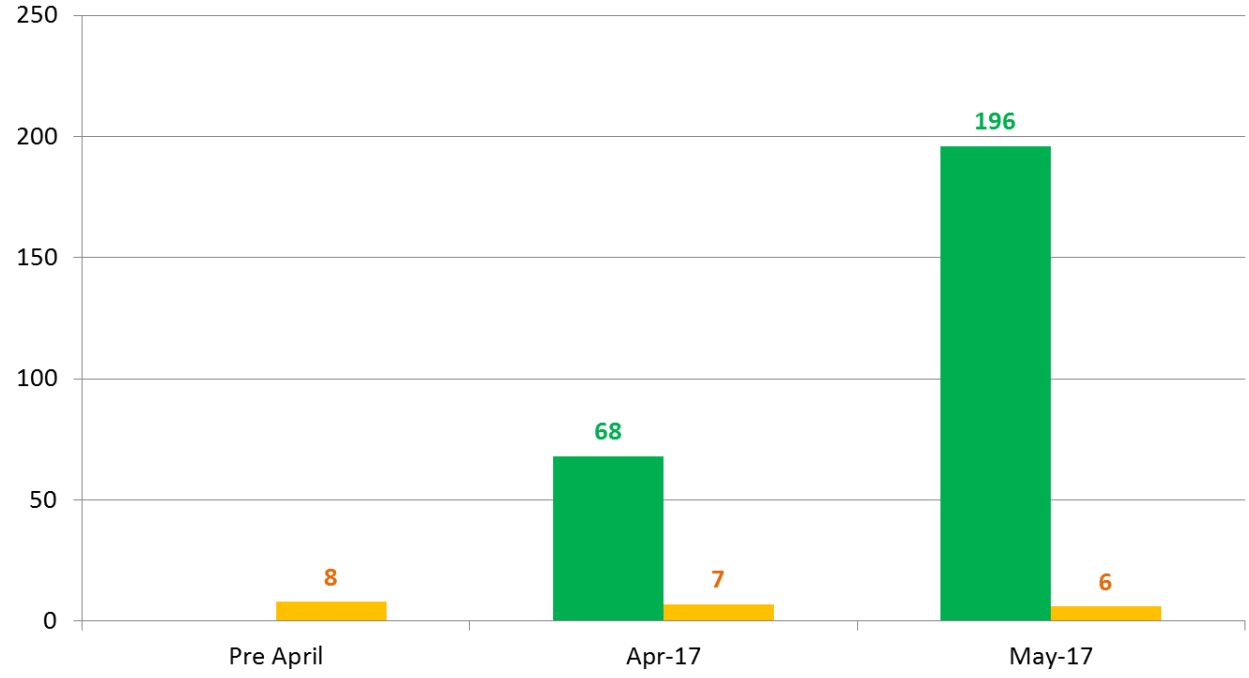
1.8 Incidents with investigation overdue

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.

NB: All green incidents up to 31st March have been closed in order to meet the six monthly NRLS submission deadline of the 25th May. This followed a period of intensive follow up to reduce the number

outstanding. Cases that remained uninvestigated were then closed using the initial 'immediate action' narrative which is often sufficient to provide a learning summary for the national reporting system. Amber and Green incident which were incomplete were uploaded with a holding narrative and then re-opening in Datix to allow completion of the investigation pathway.

313 (65%) of the May green incidents had been investigated at the time of this report compared to (60%) last month.

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. More details will be provided in the aggregated report next month.

1.9 SIRI final reports due in month submitted beyond 60 working days

a) Current Position

One report in May was submitted a day over the due date due to an administrative oversight.

b) Recommended Action

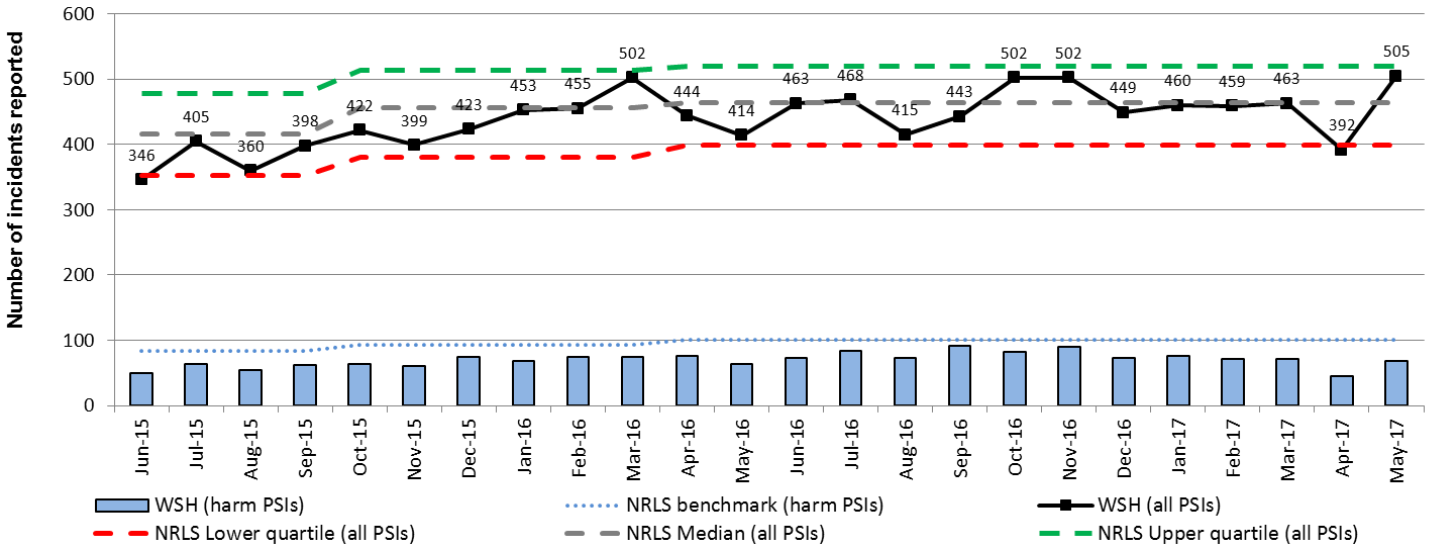
The Trust maintains a high compliance with timely provision of reports.

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 591 incidents reported in May including 505 patient safety incidents (PSIs). The unexpected drop in April was a one-off anomaly and the reporting rate May was the highest since the implementation of Datix as is just below the upper quartile threshold for the peer group. This is explored further in the Aggregated report.

Graph: Patient Safety Incidents reported



1.11 Patient Safety Incidents (Severe harm or death)

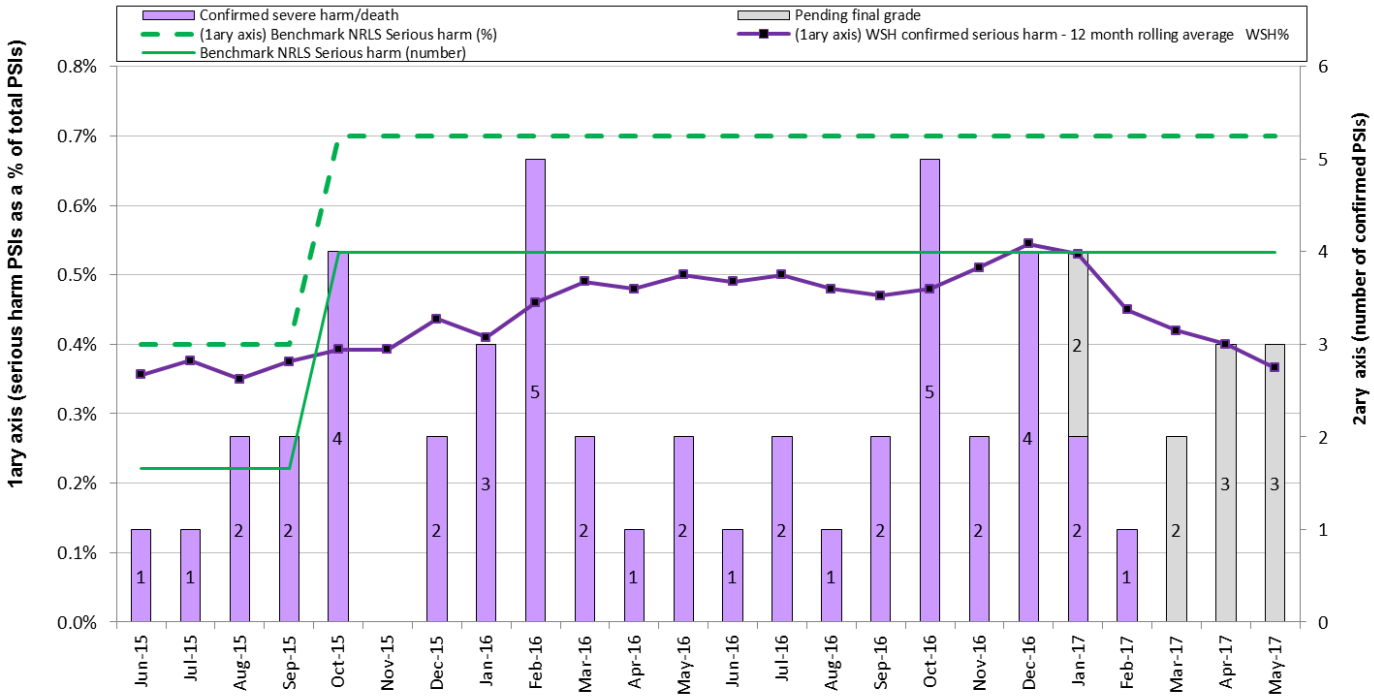
The percentage of PSIs resulting in severe harm or death is a nationally mandated item for inclusion in the Quality Accounts. The NRLS peer group average is from the period Apr – Sept16. The benchmark line applies the peer group percentage serious harm to the peer group median total PSIs to give a comparison 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 May there were three cases reported: one delay in pathology results, one absconder from ED and one delay in treatment all of which are awaiting RCA to confirm harm grading.

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

- two delay in diagnosis
- one Intrauterine death
- one mortality review
- one maternal death *(following case review at the Day 45 meeting this case will be downgraded on completion of the final report)*
- one fall with fracture
- one death during transfer to other organisation *(Initial review suggests that this case will be downgraded at the conclusion of the investigation)*

Graph: Patient Safety Incidents (Severe harm or death)



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

Patient Experience Dashboard

In line with national reporting (on NHS choices via UNIFY) the scoring for the Friends and Family test changed from April 2015. It is now scored & reported as a % of patients recommending the service i.e. answering extremely likely or likely to the question "How likely is it that you would recommend the service to friends and family?". A target of 90% of patients recommending the service has been set.

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

Indicator	Target	Red	Amber	Green	Mar	Apr	May
Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	100	98	100
How likely is it that you would recommend the post-natal ward to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	100	100
How likely are you to recommend our labour suite to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	ND	100	100
How likely are you to recommend our antenatal community care to friends and family?	= 90%	<80	70-89	90-100	95	97	98
How likely are you to recommend our post-natal community care to friends and family?	= 90%	<80	70-89	90-100	100	100	98
How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	ND	ND	ND
Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	ND	99	99
Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	97	97	99
(F1 Parent & Young Person) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	100	100
Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	95	94	ND
(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	93	ND

Additional Patient Experience indicators

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

Exception reporting for indicators in the Patient Experience Dashboard

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

1.12 Inpatient: Noise at night

a) Current Position

The score has slightly improved to 72 from 71 in April, though continuing to flag as a red area.

a) Recommended Action

May 2017 saw updates in patient satisfaction questionnaires asking patients to tell us what kind of noise they experienced, allowing us to target the issues more specifically. Themes included agitated patients (the most common reason for noise at night), snoring and a few mentions of staff. Many patients highlighted that ear plugs aided their sleep. Ward managers have been reminded to continue to offer ear plugs wherever possible. Senior Matrons are prioritising implementing soft closing bins as part of the PLACE inspection action plan.

Comments about noisy patients demonstrated an understanding of the factors of confusion and dementia.

Ward	Comment
F14	No noise that was caused by staff.
F14	Noise from other patients in the room only.
F14	Patient next bed constantly on the phone even after being spoken to by staff
F14	1st night disturbance from another patient - could not be helped.
F6	Patient next door very ill kept me awake most nights
F7	Talking
F7	Dementia patients (Cure: sleeping pills) Dropping bed sides - redesign.
F9	Other people
F9	There was a patient who was not mentally aware that disturbed me.
F9	Other patients
F9	Some patients can't help it & it's not a hotel with spare rooms.
F9	Elderly lady crying out.
F9	Patients with conditions that they had no understanding of what they are doing made most of noise but the staff worked very hard to try to minimise the disturbance.
F9	On previous ward g8 there was aggression from patients at night that wanted to leave the ward.
G3	a patient constantly calling for help

G3	a noisy patient in the opposite bed 1/4
G3	Noisy patients- mostly elderly men with problems so must be accepted.
G3	a distressed patient
G3	one patient, the toilet flushing
G3	shouting from another patient
G4	The patient next to me was very noisy at night times.
G4	Heard bad language from one patient in night.
G5	Noise from dementia patients but that. Wasn't their fault. Noise was from dementia patients but they couldn't help it.
G5	Patient singing all night.
F14	Lady in bed opposite talking loudly on her phone. Very inconsiderate.

Other comments included

Theme	Ward	Comment
positive comments no noise issues listed	CCU	Care is excellent to all staff.
	F5	Everyone friendly first name terms could not be more helpful all in all good service
	G1	staff are brilliant and very nice and caring.
	G4	staff did their best to keep noise down.
	G9	given ear plugs. Best you can ask for in a hospital.
Alarms	F5	Alarms talking banging
	F7	Alarms from machines in my room they weren't being used!
Bins	CCU	the Bins made a noise opening and closing which kept me awake
Doors	F5	cabinet doors being shut noisily in corridor
	F6	shutting toilet doors
Multiple / Generic	F5	People constantly in and out doors slamming people talking trollies making a noise
	F5	clattering equipment ,loud chattering voices
	F3	Sometimes

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

a) Current Position

This score has deteriorated in May from to 79 (amber) to 73 (red).

b) Recommended Action

The department continues to increase the number of patient surveys collected which show information about delays was lacking in haematology and ENT clinics in May. This has been fed back to the lead consultant to raise awareness about ensuring outpatient staff are kept informed of delays, and as a consequence patients.

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

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

a) Current Position

This score has deteriorated in May from to 91 (green) to 70 (red).

b) Recommended Action

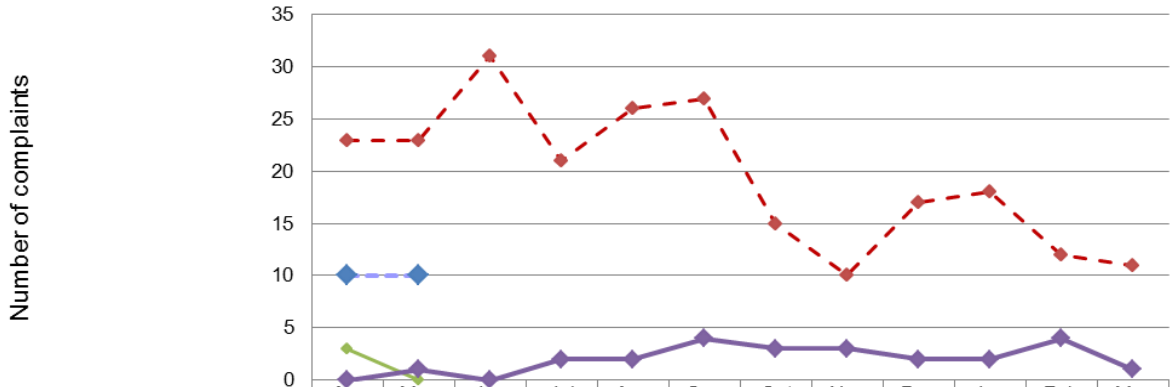
An area observation is due to be conducted including engagement with patients to understand whether they were asked if they required a chaperone during intimate examinations (if relevant). The question was reworded this month however this will require altering slightly as it does not currently reflect those patients that did not want a chaperone.

1.15 Health Service Referrals accepted by Ombudsman

One PHSO case dates back to November 2016 from the daughter of a patient who queries the medication dosage given to her mother. Another related to the outcome of ophthalmology surgery which was

undertaken in 2014, an independent review was sought in 2016 and found the complaint not to be upheld.

1.16 Complaints



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

10 complaints were received in May. The breakdown of these complaints is as follows by Primary Division: Medical (5), Surgical (3), Women & Children (1), Clinical Support (1). The top two most common areas are as follows:

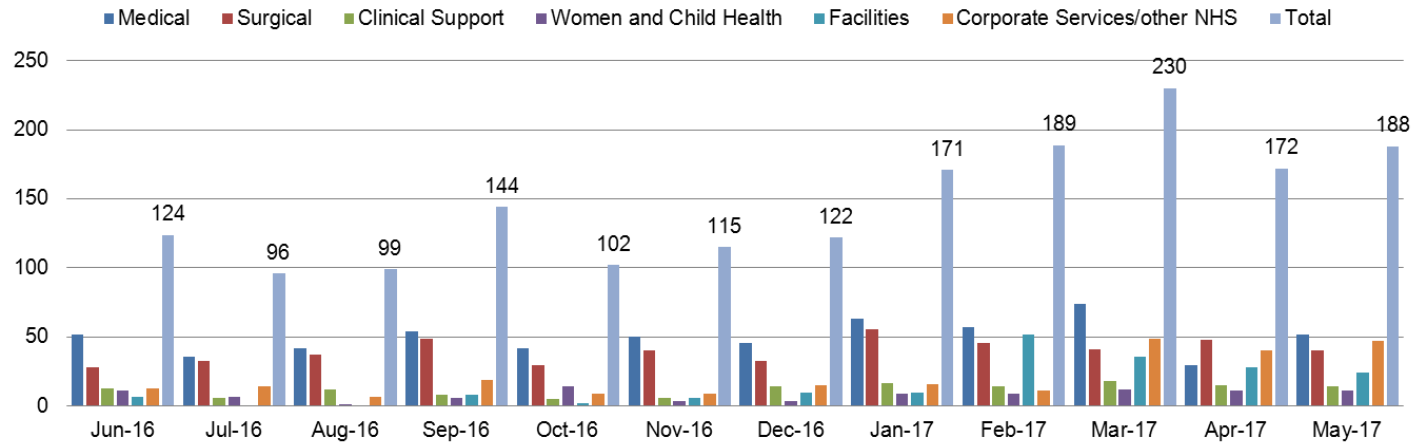
Communications	3
Clinical Treatment – Accident & Emergency	2
Clinical Treatment – General Medicine group	2

1.17 PALS

In May 2017 there were 188 recorded PALS contacts. This number denotes initial contacts and not the number of actual communications between the patient/visitor which can, in some particular cases, be multiple.

A breakdown of contacts by Directorate from June 16 – May 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 (56)
- Facilities (26)
- Appointments; including delays and cancellations (23)

The category of 'Queries, advice & request information" appeared as the top issues in May, the main theme in this data was signposting to other organisations. Facilities: the main theme was the pay machine at the side of the hospital not working. Facilities Manager has ordered a new machine and a note has been placed on machine to direct patients to another pay machine with 20 free minutes parking.

Two contacts throughout May were felt to be highly complex. Six contacts were of complex nature and Fourteen contacts were non-routine, the remainder being classed as routine enquiries.

Clinical Effectiveness Dashboard

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

Indicator	Target	Red	Amber	Green	Mar	Apr	May
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	95	NA	NA
Babies admitted to NNU with normal temperature on arrival (term)	100%	<50%	50-80%	>80%	100	87	66
12 month Mortality standardised rate (Dr Foster)	100%	>100	90-100	<90	88.38	88.12	88.05
CAS (central alerting system) alerts overdue	0	>=1	No target	0	0	0	0

1.18 Babies admitted to NNU with normal temperature on arrival (term)

a) Current Position

There were nine admissions of term babies to NNU in May 2017; three of these had a temperature below 36.5OC therefore 66% had a normal temperature on admission. This is a fall two months in a row as April was 87%.

b) Recommended action

This is a marked deterioration in the standard and will be followed up by the Inpatient Services Manager.

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	Mar-17	Apr-17	May-17

	Red	Amber	Green	Mar-17	Apr-17	May-17
ACTIVITY – Births						
Total Women Delivered	> 250 or < 200	>216 or <208	>208 or <216	234	213	190
Total Number of Babies born at WSH	> 250 or < 200	>216 or <208	>208 or <216	238	215	192
Twins	No target	No target	No target	4	2	2
Homebirths	< 1%	2% or less	2.5%	2.1%	1.4%	3.7%
Midwifery Led Birthing Unit (MLBU) Births	<=10%	13% or less	20%	15.8%	17.8%	17.4%
Labour Suite Births	<=64%	69% to 74%	75%	82.1%	80.8%	78.9%
BBAs	No target	No target	No target	2	1	4
Normal Vaginal deliveries	No target	No target	No target	160	160	123
Vaginal Breech deliveries	No target	No target	No target	0	2	1
Non operative vaginal deliveries	No target	No target	No target	ND	0	65.3%
Water births	No target	No target	No target	16	15	14
Total Caesarean Sections	> 22.6%	No target	<22.6%	19.2%	15%	21.1%
Total Elective Caesarean Sections	>=13%	11 - 12%	10%	6.5%	4.7%	9.5%
Total Emergency Caesarean Sections	>=15%	13 - 14%	12%	12.4%	10.3%	11.6%
Second stage caesarean sections	No target	No target	No target	2	4	8
Forceps Deliveries	No target	No target	No target	6%	6.1%	8.9%
Ventouse Deliveries	No target	No target	No target	6.4%	2.8%	4.7%
Inductions of Labour	No target	No target	No target	37.2%	42.7%	41.1%
Failed Instrumental Delivery	No target	No target	No target	1	1.4	1.1%
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%	89%	92%	93%
Total no. of women eligible for Vaginal Birth after Caesarean Section (VBAC)	No target	No target	No target	24	13	11
Number of women presenting in labour for VBAC against number achieved.	No target	No target	No target	8	6	6
ACTIVITY – Bookings						
Number of Bookings (1st visit)	No target	No target	No target	275	208	262
Women booked before 12+6 weeks	<=90%	91 - 94%	95%	96.3%	95%	95%
CLINICAL OUTCOMES - Maternal						
Postpartum Haemorrhage 1000 - 2000mls	No target	No target	No target	22	13	15
Postpartum Haemorrhage 2,000 - 2,499mls	No target	No target	No target	0	1	1
Postpartum Haemorrhage 2,500mls+	No target	No target	No target	0	1	0
Post-partum Hysterectomies	1	1	0	0	1	0
Women requiring a blood transfusion of 4 units or more	1	1	0	ND	1	0
Critical Care Obstetric Admissions	1	1	0	1	1	0
Eclampsia	1	1	0	0	0	0
Shoulders Dystocia	5 or more	3-4	2	8	2	4
3rd and 4th degree tears (All vaginal deliveries)	No target	No target	No target	7	8	9
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)	10	7-9	6	6	7	5
3rd and 4th degree tears (Instrumental Deliveries)				1	1	4
Maternal death	1	No target	No target	1	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	0	15	9
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	No target	No target	No target	3	1	2
Number of Babies transferred for therapeutic cooling	1	No target	0	1	0	0
Cases of Meconium aspiration	No target	No target	No target	1	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	2	0	0
Stillbirths	No target	No target	No target	0	1	0
Postnatal activity						
Return of women with perineal problems, up to 6 weeks postnatally	No target	No target	No target	ND	ND	ND
Workforce						
Weekly hours of dedicated consultant cover on Labour Suite	<=55 hrs	56-59	60hrs or >	60	93	110
Midwife/birth ratio	>=1:32	No target	1:30	1:33	1:30	1:27
Supervisor to Midwife Ratio	No target	No target	No target	1:19		
Consultant Anaesthetists sessions on Labour Suite	< 8 sessions	8-9 sessions	10 sessions	10	10	10
ODP cover for Theatre 2	80%	90%	100%	100%	100%	100%

	Red	Amber	Green	Mar-17	Apr-17	May-17
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	64	51	62
Serious incidents	No target	No target	No target	1	1	0
Never events	No target	No target	No target	0	0	0
Complaints	No target	No target	No target	0	0	0
1 to 1 Care in Labour	<=95%	96 - 99%	100%	100%	100	100%
Unit closures	No target	No target	No target	0	0	0
Massive Obstetric Haemorrhage protocol	No target	No target	No target	ND	1	0
Maternal Postnatal readmissions	No target	No target	No target	ND	ND	ND
Completion of WHO Checklist	80%	90%	100%		84%	93%
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	ND	27	35
Number of Women identified as smoking at delivery	No target	No target	No target	ND	20	30
UNICEF Baby Friendly Audits	No target	No target	No target	10	10	10
Proportion of parents receiving a Safer Sleeping Suffolk Thermometer.	No target	No target	No target	165	143	170

Exception reporting for red indicators in the Clinical Effectiveness Dashboard

1.19 Maternity - No of Deliveries and Babies delivered

The maternity service delivered less babies than planned in May 2017, there is no obvious reason for this, no planned action at this time other than to observe.

1.20 Maternity - 3rd and 4th degree tears

The number of third and fourth degree tears identified in both April and May of this year is slightly above the expected rate based on available national benchmarking data. This clinical indicator is subject to regular audit and these results will be reviewed as part of the audit cycle.

1.21 Maternity - Completion of WHO Checklist

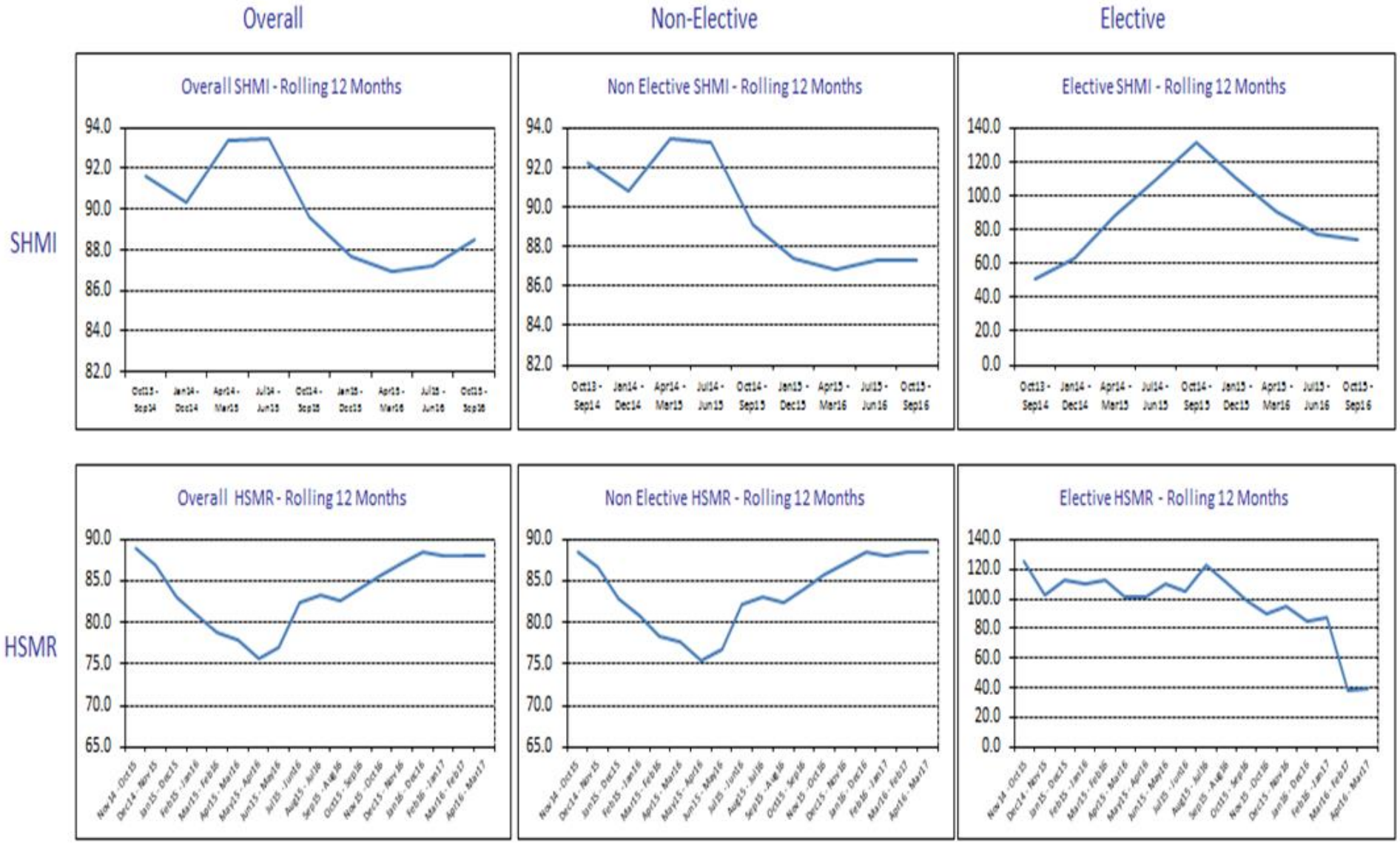
Compliance with completion of the WHO maternity adapted surgical safety checklist remains below the target of 100% compliance. There was however a marked improvement in May 2017 with 93% being fully completed. A more robust follow up of checklists failing the audit with the clinician involved is planned to commence to try to improve the completion rates even further.

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

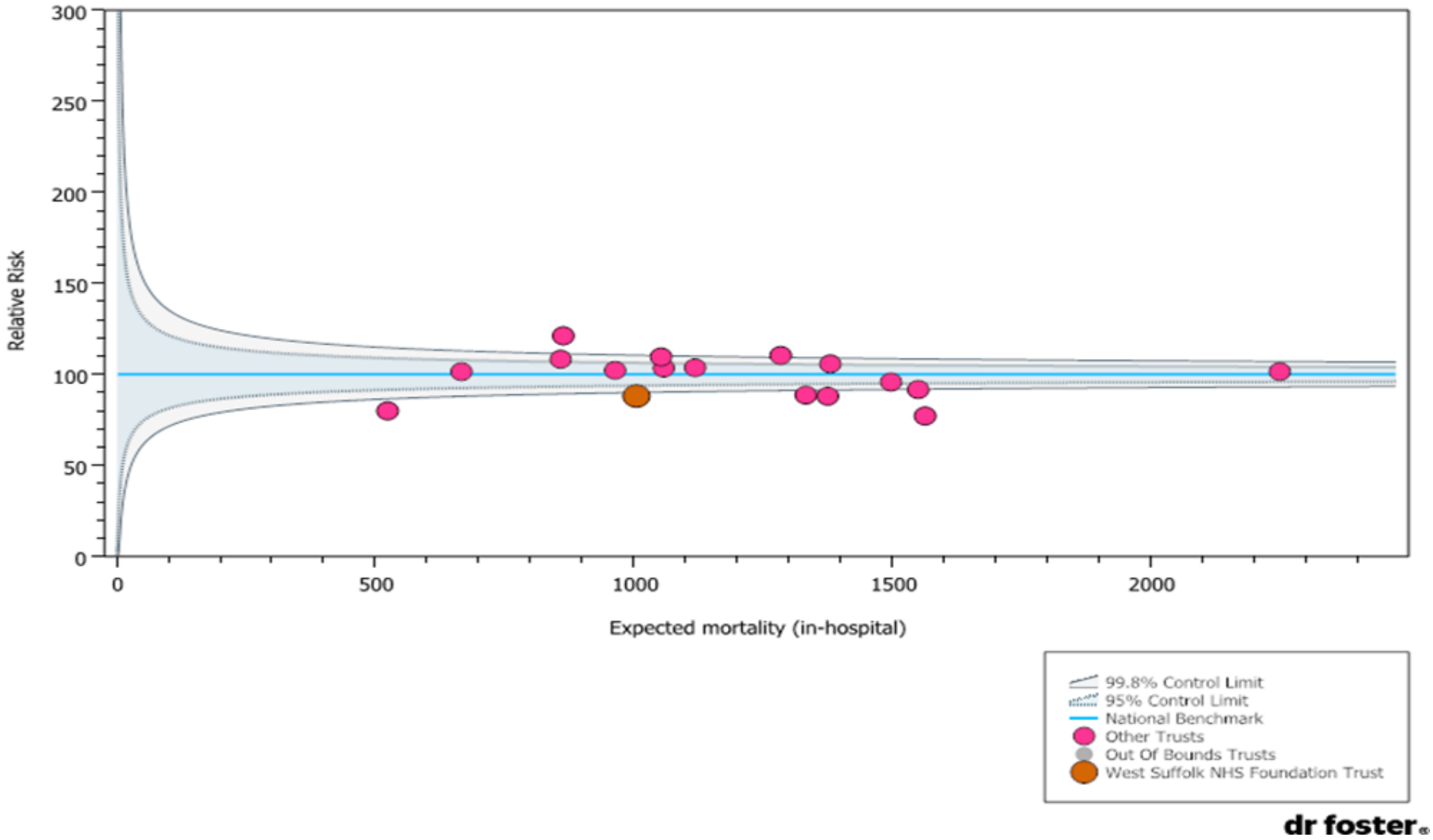
2. MORTALITY DATA

Mortality (Individual Months)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
No of Deaths	77	55	72	85	78	77	69	80	122	134	105	84
No of Discharges	5,153	5,026	5,072	5,493	4,921	5,298	5,642	5,269	5,313	5,311	4,838	5,360
% Deaths	1.49%	1.09%	1.42%	1.55%	1.59%	1.45%	1.22%	1.52%	2.30%	2.52%	2.17%	1.57%
HSMR*	82.1	71.1	83.4	107.2	106.7	94.9	78.1	94.4	104.9	106.5	108.6	86.7
Mortality (Individual Months)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
No of Deaths	79	73	70	55	70	52	67	73	78	109	91	84
No of Discharges	5,032	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										
No of Discharges	5,378	5,742										
% Deaths	1.34%	1.20%										
HSMR*												

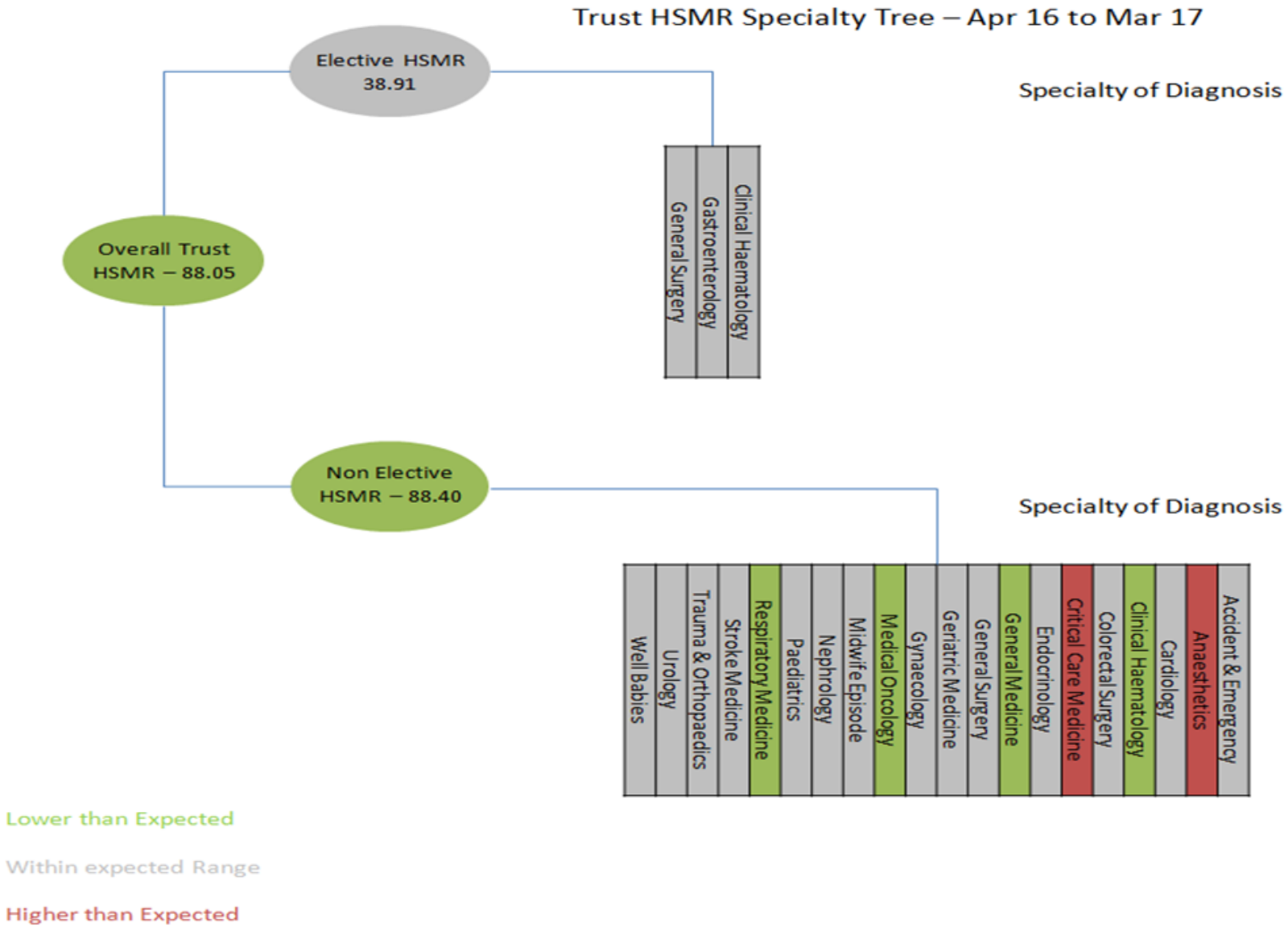
HSMR BENCHMARK IS USING FY 15 -16


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

HSMR – Apr 16 - Mar 17



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


Trust HSMR Specialty Tree – Apr 16 to Mar 17
Elective HSMR 38.91
Specialty of Diagnosis
Clinical Haematology
Gastroenterology
General Surgery
Overall Trust HSMR – 88.05
Non Elective HSMR – 88.40
Specialty of Diagnosis
Accident & Emergency
Anaesthetics
Cardiology
Clinical Haematology
Colorectal Surgery
Critical Care Medicine
Endocrinology
General Medicine
General Surgery
Geriatric Medicine
Gynaecology
Medical Oncology
Midwife Episode
Nephrology
Paediatrics
Respiratory Medicine
Stroke Medicine
Trauma & Orthopaedics
Urology
Well Babies
Lower than Expected
Within expected Range
Higher than Expected

3. MONITOR ASSURANCE FRAMEWORK

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

Monitor Compliance Framework						March	April	May
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%	79.71%	80.97%	1.0	Helen Beck	89.88%	82.23%	79.71%
Number of RTT Waits over 52 weeks for incomplete pathways	0	14	29	-	Helen Beck	8	15	14
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	94.66%	95.35%	1.0	Helen Beck	92.88%	95.20%	94.66%
All cancers: 62-day wait for first treatment (5) from:Urgent GP referral for suspected cancer - **See Further detail below**	85%	83.96%	86.82%	1.0	Helen Beck	83.03%	89.47%	83.96%
All cancers: 62-day wait for first treatment (5) from: NHS Cancer Screening Service referral	90%	100.00%	100.00%		Helen Beck	96.77%	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	99.33%	100.00%	100.00%
Cancer: two week wait from referral to date first seen (8), comprising: all urgent referrals (cancer suspected)	93%	92.27%	93.01%	0.5	Helen Beck	97.67%	93.90%	92.27%
Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)	93%	99.29%	96.89%		Helen Beck	93.45%	94.02%	99.29%
Outcomes:								
Clostridium (C.) difficile - meeting the C.difficile objective - MONTH	2	0		1.0	Rowan Proctor	1	3	0
Clostridium (C.) difficile - meeting the C.difficile objective - QUARTER	4		3		Rowan Proctor			
Clostridium (C.) difficile - meeting the C.difficile objective - ANNUALLY	16		3		Rowan Proctor			
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	-	-	0.5	Rowan Proctor			

Governance Rating	3.5

West Suffolk NHS Foundation Trust Cancer Waits Performance Report - April 2017					
GP Suspected Cancer, Cancer Screening Referral Receipt to Start of 1st Treatment: 62 Days Waiting Times Standard 85%				Performance %	
Cancer Type	<62 days	>62 days	Total	Trust	England~
Breast	11	2	13	84.6	94.6
Gynae	6+1x.5		6.5	100	82.1
Haem	1		1	100	77.5
Head & Neck	1+1x.5		1.5	100	71.3
Lower GI	8	1	9	88.9	72.6
Lung	2		2	100	75.3
Sarcoma	1		1	100	66.3
Skin	7	2	9	77.8	96.3
Upper GI	1		1	100	76.1
Urology	12	1	13	92.3	77.3
Total	50+2x.5	6	57	89.5	82.7

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

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

a) Current Position

79.71% against a threshold 92%

The May position reflects a true position rather than an estimated position as advised by NHSI IST (Intensive Support Team) following their visit in June. The current waiting list now has a total of 22144 patients with 4492 patients breaching 18 weeks; however there is still a significant amount of data quality

issues within this number leading to a reported position which we believe is slightly worse than our actual position.
There remains on-going and significant capacity issues within ENT, Vascular, Urology, Dermatology, with patients waiting over 35 weeks for first OPA in ENT, and patients waiting over 30 weeks for Surgery within Urology and 35 weeks for Vascular . There remains significant pressure on rapid access referrals in Dermatology.

b) Recommended Action

Detailed action plans for each of the all specialties with RTT and capacity issues have been developed with CCG input where appropriate and further validation work of the new PTL continues in all areas. A revised access meeting timetable has been established with weekly divisional PTL meetings implemented to support the monitoring and progression of actions within specialities. Referral guidance has had a positive effect in ENT and further updates are waited on the impact that this has had on the wait to first outpatient appointment within the service. One part time ENT consultant has been recruited and has started clinics in June and interviews are in place for a second consultant on the 29th June, where there are 4 applicants. Recruitment is pending for an ENT RTT pathway co-ordinator. Work to support deman management in dermatology is underway with the CCG; however it is too soon to assess the impact of this.

The NHSI IST visited the trust to review the RTT information position after a sustained period of estimating the 18 week RTT aggregate position following the implantation of eCare. The estimation of the reported position was based upon previous advice from NHSI, however the recommendation of the IST is that we now cease estimating and report an actual position, notwithstanding the remaining known data quality issues.

The attached report from the IST is based on a two hour meeting with representatives from operational and information teams, information taken from the trust's data supplied to the IST, and the IST's own observations.

In summary the IST found that the trust has an effective understanding of the data quality issues and there is clear evidence of a well-considered and logical approach to data quality. They also identified that the trust was able to articulate a clear and appropriate onward plan for improving data quality.

The IST did not identify any concerns with the trust's handling of RTT data and that this appears to be in line with good practice. The IST indicated that they no longer supported the estimation of its national RTT return and they recommended that this practice should cease and actual position should be reported. This recommendation has already been implemented.

The report identifies five key areas for trust action:

1. To discontinue estimating the national RTT return. (COMPLETE)
2. Undertake validation of the c.3000 pathways that are considered genuine RTT waiters. (ALREADY UNDERWAY)
3. Develop a robust Planned PTL to ensure oversight of planned patients approaching their admit date.
4. Review the timeliness if the production of the PTL and determine if weekly production provides suitable operational responsiveness and oversight of elective performance.
5. Review the usage of a data quality dashboard and identify a range of KPI's that could be targeted for improvement over the coming months.

These recommendations are being developed into an action plan to monitor progress against the report. The IST found that further support regarding the trust's information/data quality position was not required based on the recommendations that they made to the trust but that any potential support regarding operation sustainability should be scoped separately between the IST, the trust and the NHSI Regional Team.

3.2 Number of RTT waits over 52 weeks for incomplete pathways

a) Current Position
14 against a threshold of 0

There are 9 ENT patients over 52 weeks due to capacity issues, 5 of which have TCI's for June, 1 has a TCI for July, 2 have appointments in June. There are two vascular surgery patients one of whom has now had their procedure but remains reportable for May, and the second patient has been delayed due to personal circumstances but is booked for a procedure in July. There is one gynaecology patient, one T&O patient (patient choice to wait until August) and one urology patient (patient choice to wait until June).

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

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

a) Current Position
94.66% against a threshold of 95%

b) Recommended Action
The 95% 4 hour ED LOS target was met on 19 out of 31 days in May, this is comparable to 21 days out of 30 in April. This was due to Norovirus on G4 at the start of May and a linked black bed state.
Various activities are taking place to further improve our 95% compliance such as 1st and 2nd triage embedding, Service Manager action log linked to breach themes, review of medical rosters and maximising the use of ACPs within the department, resuscitation nurse allocation considerations so that other areas, such as triage, aren't hampered when ED experiences multiple resuscitation cases coming in at any one given time, medical staffing linked to unprecedented demand is also being reviewed.

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

a) Current Position
83.96% against a threshold of 85%

- Urology: unusually high numbers of suspected prostate cancer - five patients required to go through various investigations and finally the template biopsy resulting in a long wait for tissue diagnosis/result clinic appointment and start of treatment including hormones.
- Colorectal: medical comorbidity and colorectal surgery capacity.
- H/N – low suspicion of ca on initial assessment and inadequate capacity to bring both TCIs earlier
- Skin - patient comorbidity as they needed hospital admission for another ailment.

b) Recommended Action
All RCAS reviewed by the clinicians and the team.
Other actions are to further improve on prostate pathways to reduce diagnostic waiting times, including advanced and pre-emptive booking of tests and to enhance perineal template biopsy capacity and also to bring result clinic appointment on the day or very close to treatment planning MDT. Capacity will also be improved in Colorectal Surgery.

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

a) Current Position
92.27% against a threshold of 93%
A background of on-going increases in 2 week wait suspected cancer, referrals in general and very high numbers in dermatology requiring unprecedented numbers of two week wait patients to be seen in the month of May, are the primary factors responsible for this drop in performance.
There was a technical failure in the CT resulting in two of the breaches.

b) Recommended Action

Following successive discussions, there is an action plan currently being agreed with the CCG to bring in some improvements in managing the demand and also to assist GP learning to refer patients appropriately.

Locum Dermatology consultant posts have been advertised which will help with clinic capacity once recruited.

3.6 104 day Cancer waits

a) Current Position

1 against a threshold of 0

This refers to one patient who was treated at Addenbrookes on day 135 (Radiotherapy) with potential delays in reporting biopsy.

In addition to the weekly cancer PTL review of the patients, the current status of all 104 days or more waiting times patients in the NHSE UNIFY weekly returns is reviewed and updated and reported weekly as per the NHSI proforma requirements.

b) Recommended Action

All treatment breaches in the Trust, including these long waits, have their breach RCAs produced for review by the Clinician/MDTs and services concerned including any clinical harm review and to follow the Trust Clinical Governance arrangements. There is a plan to report this to the CSEC quarterly meetings.

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	Mar	Apr	May	Change mth on mth	On Plan To Achieve	Area of Concern	Forecast to Breach
A&E						Mar	Apr	May				
A&E Time to treatment in department (median) for patients arriving by ambulance - CDM	Median time to treatment above 60 minutes	43	39		Helen Beck	53	35	43	↘			
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	13:57	13:57	This was a clinical breach and due to the acuity and outcome of the patient this case has gone through the red incident process and has been reported as an SI.	Helen Beck	22:32	09:57	13:57	↘			
A&E Trolley Waits not longer than 12 hours	0 Patients waiting over 12 hours from DTA to Admission	0	0		Helen Beck	0	0	0	↔			
A&E - Threshold for admission via A&E	i) if the monthly ratio is above the corresponding 2012/13 monthly ratio for two month in a six month period ii) if year end is greater than 27%	30.69%	31.21%		Helen Beck	32.04%	31.76%	30.69%	↗			
A&E - Service User Impact Indicators	To satisfy at least one of the following Service User Impact Indicators: 1. Unplanned Reattendances within 7 days below 5% (Reattendances for the same condition) 2. Time to treatment in department (median) for all Service Users arriving by ambulance.	ONE MET	ONE MET		Helen Beck	ONE MET	ONE MET	ONE MET	↔			
A&E & AMU - Ambulance submit button complete	80%	91.10%	92.19%		Helen Beck	88.27%	92.96%	91.10%	↘			
A&E - Ambulance Handovers above 30 minutes	0 handovers over 30 minutes - £200 per breach	ND	21		Helen Beck	48	21	ND				
A&E - Ambulance Handovers above 60 minutes	0 handovers over 60 minutes - £1000 per breach	ND	3		Helen Beck	18	3	ND				
Percentage of patients presenting at type 1 and 2 (major) A & E sites in certain high risk categories who are reviewed by an emergency medicine consultant before being discharged	14.00%	86.96%	90.54%		Helen Beck	100.00%	94.12%	86.96%	↘			
RTT												
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks	99.00%	91.04%	91.83%		Helen Beck	95.55%	92.63%	91.04%	↘			
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90.00%	67.84%	68.53%		Helen Beck	68.87%	69.22%	67.84%	↘			
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.00%	86.95%	86.55%		Helen Beck	84.75%	86.15%	86.95%	↗			
Stroke												
% of patients scanned within 1 hour of clock start	77% (Contract) 57.5% (Upper Quartile)	79.59%	82.98%		Helen Beck	87.50%	86.67%	79.59%	↘			
% of patients scanned within 12 hours of clock start	96% (Contract) 96% (Upper Quartile)	97.96%	97.87%		Helen Beck	100.00%	97.78%	97.96%	↗			
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75% (Contract) 70% (Upper Quartile)	71.43%	79.79%		Helen Beck	75.00%	88.89%	71.43%	↘			
>80% treated on a stroke unit >90% of their stay	90%	87.76%	92.39%		Helen Beck	87.50%	97.67%	87.76%	↘			
% of patients treated by a stroke skilled early supported discharge team	48% (Contract) 48% (Upper Quartile)	47.50%	48.68%		Helen Beck	34.48%	50.00%	47.50%	↘			
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80% (Contract) 79% (Upper Quartile)	85.71%	89.36%		Helen Beck	93.75%	93.33%	85.71%	↘			
% 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)	80.00%	83.33%	INDICATION ONLY - FINAL SSNAP LEVEL AVAILABLE WHEN RESULTS ARE AVAILABLE FROM SSNAP	Helen Beck	72.41%	87.18%	80.00%	↘			
% 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%	58.00%	58.00%		Helen Beck			58.00%	-			
Provider rating to remain between A-C in each of the 9 domains covered in SSNAP where the Provider is at this level. For the one domain (SaLT) where the Provider is at level E, this will be improved to level to C by March 2017.	To remain at or above: National average or current performance (A-C) Improve performance to level C by end of the year (SaLT)	C	C	Reports are generated by SSNAP every 4 months - this is as at March 2017, reported for June Board	Helen Beck			C	-			
Discharge Summaries												
Discharge Summaries - Outpatients	85% sent to GP's within 3 days	ND	ND		Nick Jenkins	ND	ND	ND	-			
Discharge Summaries - A&E	95% of A&E Discharge Summaries to be sent to GPs within one working day	98.35%	98.25%		Nick Jenkins	97.29%	98.13%	98.35%	↗			
Discharge Summaries - Inpatients	95% sent to GP's within 1 day	93.29%	92.66%		Nick Jenkins	92.23%	91.98%	93.29%	↗			
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	0.56%	0.59%		Helen Beck	0.93%	0.62%	0.56%	↗			
Patients offered date within 28 days of cancelled operation	100%	93.75%	93.55%		Helen Beck	96.55%	93.33%	93.75%	↗			
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.	95.42%	95.11%		Rowan Procter	96.36%	94.71%	95.42%	↗			
Maintain maternity 1:30 ratio	1:30	01:27	01:28		Rowan Procter	01:33	01:30	01:27	↗			
Pledge 1.4: 1:1 care in established labour	1:1	100%	100.00%		Rowan Procter	100.00%	100.00%	100%	↗			
Breastfeeding initiation rates.	80%	80.53%	80.15%		Rowan Procter	76.37%	79.81%	80.53%	↗			
Reduction in the proportion of births that are undertaken as caesarean sections.	22.70%	21.05%	17.87%		Rowan Procter	18.99%	15.02%	21.05%	↘			

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	TBC	13.51%		Helen Beck	ND	13.51%	TBC	-				
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	97.94%	98.97%		Helen Beck	100.00%	100.00%	97.94%	↘				
Acute oncology service: 1 hour to needle from diagnosis of neutropenic sepsis	100%	100.00%	80.00%	MacMillan	Helen Beck	100.00%	66.67%	100.00%	↗				
		40.00%	50.00%	ED	Helen Beck	72.73%	71.43%	40.00%	↘				
		47.06%	100.00%	Overall Trust (Inc AMU)	Helen Beck	80.00%	63.64%	47.06%	↘				
New to Follow up	Thresholds set at each speciality - overall Trust Threshold is 1.9	TBC	2.00		Helen Beck	2.07	2.00	TBC	-				
Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test	99%	99.87%	99.86%		Helen Beck	99.89%	99.86%	99.87%	↗				
All relevant inpatients undergoing a VTE Risk assessment	95%	TBC	TBC		Helen Beck	TBC	TBC	TBC	-				

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

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

a) Current Position

This was a clinical breach and due to the acuity and outcome of the patient this case has gone through the red incident process and has been reported as an SI.

b) Recommended Action

See above.

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

a) Current Position

30.69% against a threshold of 27%

b) Recommended Action

Admission avoidance work continues, including a new focus on high frequency ED attenders (specifically Mental Health patients). Multiagency work is in progress to reduce these types of ED attendances. GP streaming to be live by Oct 2017.

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

a) Current Position

91.04% against a threshold of 99%.

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

b) Recommended Action

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

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

a) Current Position

67.84% against a threshold of 90%.

b) Recommended Action

Patients continue to be treated in longest waiting order, validation work continues to identify some patients

who have breached 18 weeks and it therefore appears that more patients who have already breached 18 weeks are being treated. New PTL and proactive manual validation continues to provide a clearer picture of the waiting times.

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

a) Current Position
86.95% against a threshold of 95%.
This continues to be predominantly due to excessive waits for first appointment in both ENT and Dermatology.

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

4.6 Stroke: % of patients admitted directly to Stroke Unit within 4 hours of clock start

a) Current Position
71.43% against a threshold of:
75% (Contract)
70% (Upper quartile)

b) Recommended Action
The stroke unit relocated to ward G9 in order for essential works to be carried out on the stroke unit. Unfortunately this impacted on stroke capacity, albeit only two beds were lost. This was coupled with not having access to right sex beds which culminated the nine breaches, one breach was not initially identified as a stroke, two patients were internal breaches so were already on base wards and one patients assessment in ED was delayed.

Actions in place include:
The stroke unit has relocated back to G8, thereby increasing flexibility to move patients within the unit to create appropriate space.

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

a) Current Position
87.76% against a threshold of 90%

b) Recommended Action
A total of six patients beached this standard. Four were unavailability of SU beds, one was not thought to be a stroke and there was a delay in diagnosing one patient.

Actions in place include:
As per the four hour action.

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

a) Current Position
47.5% against a threshold
48% (Contract)
48% (Upper quartile)

b) Recommended Action

The breach was less than 1% of patients treated by this service.
No remedial actions to note.

Patients offered date within 28 days of cancelled operation

a) Current Position
93.75% against a threshold of 100%
This was one patient that we were unable to re-date within 28 days for general surgery, they were cancelled on the day due to running out of operative time. There were a joint operation between 2 consultants and it was not possible to reschedule within their 28 day target

b) Recommended Action
This patient had their procedure on the 16th June.

4.11 Rapid Access - chest pain clinic

a) Current Position
97.94% against a threshold of 100% of patients should have a maximum wait of two weeks

b) Recommended Action
The two patients who breached this target were as a result of a consultants leave request which was not processed in a timely & accurate fashion.

Action in place include
Staff alerted to the deficit in the leave request process and to improve their performance relating to the this, thereby avoiding this in the future.

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

a) Current Position
Macmillan – 100%
ED - 40%
Overall Trust figure of 47.06% against a threshold of 100%

b) Recommended Action
The performance figure for 1 hour to needle from diagnosis of Neutropenic sepsis May Data showed that the Macmillan unit and AMU had no breeches during May, but the Emergency Department had 9 Neutropenic sepsis patient breeches. The breech cases were reviewed and found that 1 case was not Neutropenic and the reason for the 8 other cases were; delays in triage, nurses did not use the PGD available, agency nurse triaged the patient but was not confident in actioning the PGD, doctor requested the patient be medically reviewed prior to prescribing antibiotics. These issues will be escalated to the Emergency Department Clinical and Nursing management to address within the department.

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	May	Comments
Workforce			
Sickness absence rate	<3.5%	3.62%	
Turnover	<10%	10.32%	
Reviews	Grievance/Banding reviews	5	12 months rolling
Recruitment Timescales	Average number of weeks to recruit = 7	6	
DBS Checks	To complete 95% of required DBS checks	98.50%	
All Staff to have an appraisal	Both general and consultant staff each have a target of 90% to have had an apprasial within the previous 12 months. Appraisal is a rolling programme	ND	Appraisal figures are currently not available due to HR system issues.

5.1 Sickness Absence Rate

a) Current Position
3.62% against a threshold of <3.5%.

b) Recommended Action
Sickness absence decreased by 0.33%. HR will continue to monitor and report sickness absence to managers.

5.2 Turnover

a) Current Position
10.32% against a threshold of <10%.

b) Recommended Action
Turnover has reduced this month by .11%. The Workforce team will continue to investigate turnover to identify any trends.

6. RECOMMENDATION

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

Appendix A – Community Data

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

- Our FFT for April was 98% from 477 responses. There was 1 ‘extremely unlikely’ to recommend and 2 ‘unlikely’ to recommend. See page 5 of the patient experience report for the detail.

- We received 2 formal complaints in May, 1 for a Community Health Team relating to insulin injections, and 1 for Children Services, relating to access to appropriate services. See page 10 of the patient experience report for more detail.

- The number of patients whose discharge was delayed during May has increased again to 70, from 60 in April. The data is showing this as the first month that NHS delays (23 patients and 303 days in the month) were higher than Social Care delays (32 patients and 282 days in the month) compared to 18 patients for 276 days for NHS and 38 patients for 503 days for Social Care. This change is mainly attributable to changes in the way the data is categorised, mainly, any delay for patients who are self-funders is now attributed to health.

- The CCC have continued to achieve their speed of Answer KPI (95.78%), May was the first complete month that all Paediatric referrals went through the CCC.

- The pack now includes data for the Lymphoedema service for the first time

- The Community Equipment Service achieved 7 out of 8 of their KPIs. The next working day collection KPI had 9 items that missed the target out of 248. Further details are on page 31.

- At the request of CCG colleagues, the pack now contains detailed information on the handover times for children’s wheelchairs/modifications, in preparation for the new 18 week reporting requirements for March 2018.

- The Children in Care Service continues to experience challenges with receiving notification of children in a timely way, which delays assessments for some children.

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**May 2017**	**May Comments / Queries 2017**	**Mar 2017**	**Apr 2017**
SCH		**D4-qoc1**	Number and % of service users who rated the service as 'good' or 'better'.	85%	Quarterly report from Provider			97.71%	
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'better'.	85%	Quarterly report from Provider			94.78%	
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'well informed'.	85%	Quarterly report from Provider			93.46%	
SCH		**D5-acc4**	18 week referral to treatment for non-Consultant led services 15 services: Paed OT, PT, SALT, Adult, Wheelchairs, Podiatry, Biomechanics, Stoma nurses, Neuro nurses, Parkinson's, SCARC, Environmental, H Failure, Hand Therapy & Continence	95% patients to be treated within 18 weeks	Monthly report from Provider	99.79%		99.62%	99.93%
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	98.32%		98.69%	99.40%
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	95.30%		94.34%	94.81%
SCH	Canc by Prov	**c-gen7**	% of clinics cancelled by the Provider Q3 2012-13 establish baseline. Where benchmarking of community services shows a DNA rate worse then the best quartile. Q4 2012-13 agree an appropriate reduction on baseline. Pcanc-01 ONLY - Q1 2013/14 establish baseline. Where benchmarking of community services shows a DNA rate worse than the best quartile: Q2 reduction of 2.5% on baseline, Q4 reduction of 10% on baseline		Quarterly report from Provider			1.58%	
SCH	Safeguarding - children	**c-safe1**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.41%		96.74%	96.11%
SCH	Safeguarding - adults	**c-safe2**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.24%		96.92%	96.02%
SCH	Disch summ	**dis summ-CQUIN**	% of discharge summaries from the following services; Community Hospital, Adult SaLT, Community Intervention & Leg ulcer service, that are provided to GP practices within 3 days of discharge from the service (previously within 1 day of discharge).	95%	Monthly report from provider	100.00%		97.56%	100.00%
InPt		**D3-str3**	% of patients requiring a joint community rehabilitation Care Plan have one in place ahead of discharge from acute hospital.	75%	Monthly report from Provider	100.00%		100.00%	100.00%
InPt		**D3-str4**	% of appropriate stroke survivors whose community rehabilitation treatment programme started within 7 days of leaving acute hospital, or ESD, where agreed as part of the care plan (SSNAP). The definition of 'Appropriate Patients' is - all patients requiring continued therapy input.	75%	Monthly report from Provider	100.00%		100.00%	100.00%
InPt	MRSA	**c-inf1**	Number of cases	No cases	Monthly report from Provider	0		0	0
InPt	MRSA	**c-inf2**	Completed RCAs on all community cases of MRSA	100%	Monthly report from Provider	N/A		N/A	N/A
InPt	C-Diff	**c-inf4**	Completed RCAs on all community hospital outbreaks of C difficile	100%	Monthly report from Provider	N/A		N/A	N/A
InPt	Comm Hosp	**s-ip7**	Number of inpatient falls resulting in moderate or significant harm	No more than 1.25 per month (15 per annum) falls/1000bed days	Monthly report from Provider	N/A		0.54	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	100.00%		100.00%	100.00%
IHT		**D2-ltc4**	% of people with COPD who accept a referral to a pulmonary rehabilitation programme who complete the prescribed course and are discharged within 18 weeks of initial referral by a GP/health professional.	95%	Monthly report from Provider	96.30%		100.00%	95.45%
IHT	CCC	**D4-int1**	Care coordination centre - % of telephone calls answered within 60 seconds	95% in 60secs	Monthly report from Provider	95.78%	# of calls handled: 16,864 # of calls answered in 0-60 seconds: 16,153 **% 0-60 seconds: 95.78%** Number of abandoned calls: 359 Abandoned calls %: 2.08% Average Wait Time: 13 seconds	96.01%	96.93%
IHT		**D4-ccc6**	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed.	85%	Monthly questionnaires for the first Quarter of operation and quarterly thereafter			98.05%	
IHT	Card Rehab	**s-card5**	Number of service users successfully discharged from phase 3.	600 per annum: (trajectory of 50 Service Users in total per month)	Monthly report from Provider	no longer reporting as of July 16		no longer reporting as of July 16	no longer reporting as of July 16

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**May 2017**	**May Comments / Queries 2017**	**Mar 2017**	**Apr 2017**
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses offered	At least 500 courses offered per year	Monthly report from Provider	72 offered		82 offered	60 offered
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses completed	At least 250 courses completed per year	Monthly report from Provider	27 completed		32 completed	20 completed
IHT	COPD	**s-copd5**	Community pulmonary rehabilitation - review offered 6 months after completing the course	95%	Monthly report from Provider	100.00%		100.00%	100.00%
IHT	Comm Continence	**s-cc3**	% of Service Users re-assessed at 6 weeks	98%	Monthly report from Provider	no longer reporting as of November 16		no longer reporting as of November 16	no longer reporting as of November 16
IHT	Comm Continence	**s-cc4**	% of Service Users re-assessed at 12 monthly intervals (previously 6 monthly intervals)	98%	Monthly report from Provider	100.00%		99.86%	99.65%
IHT	H Failure	**s-hf4**	% of Service Users seen within 14 days of receipt of referral	85% within 14 days referral	Monthly report from Provider	no longer reporting as of July 16		no longer reporting as of July 16	no longer reporting as of July 16
IHT	MIU	**s-miu3**	Timeliness Indicators: 1) Total time spent in A& E department 2) Time to initial assessment (95th percentile) 3) Time to treatment in department (median) 1) 95% of Service Users waiting less than 4 hours 2) 95th percentile time to assessment above 15 minutes 3) median time to treatment above 60 minutes		Monthly Secondary Uses Services (SUS) data, A&E Commissioning data set (CDS)	#1 = 100%		#1 = 100%	#1 = 100%
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who rated the service as "good" or better	85%	Quarterly report from provider			98.46%	
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "supported".	85%	Quarterly report from provider			100.00%	
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "well informed".	85%	Quarterly report from provider			94.44%	
IHT	MIU	**s-miu5**	Total time spent in A+E department 95% of Service Users waiting less than 4 hours for admitted Service Users and with the same threshold for non-admitted measured over each Quarter rather than monthly (or, where the Quarter does not begin on 1 July, measured over each three-month period beginning on 1 July)	95%	Monthly Secondary Uses Services (SUS) data, A&E Commissioning data set (CDS)	100.00%		100.00%	100.00%
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	99.44% (179/180)		97.03% (229/236)	100% (199/199)
Mede	CES	**c-gen8**	Same Working day - Urgent equipment	98.00%	Monthly report from Provider				
Mede	CES	**c-gen8**	Next Working day - Urgent equipment	98.00%	Monthly report from Provider	99.14% (921/929)		99.77% (859/861)	98.68% (598/606)
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	99.82% (2185/2189)		99.75% (2386/2392)	99.74% (1923/1928)
Mede	CES	**c-gen8**	Within 10 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider	99.80% (508/509)		99.31% (579/583)	98.37% (423/430)
Mede	CES	**c-gen9**	Collection times: % of urgent next day collections for deceased Service Users	98% for all standards	Monthly report from Provider	96.37% (239/248)	9 out of 248 items were collected outside of the next working day time bracket. 8 of these collections were for mattresses , the 9th was a hoist	96.42% (269/279)	99.00% (198/200)
Mede	CES	**c-gen9**	% of urgent collections within 2 working days	98.00%	Monthly report from Provider				
Mede	CES	**c-gen9**	% of urgent collections within 3 working days	98.00%	Monthly report from Provider	99.01% (301/304)		99.38% (480/483)	100.00% (402/402)
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	98.45% (5014/5093)		98.90% (5946/6012)	99.17% (4674/4713)
Mede	Ass Tech	**s-at2**	All long term service users to have a minimum annual review	100%	Monthly report from provider	100.00%		100.00%	100.00%
Mede	Ass Tech	**s-at4**	Delivery of equipment within agreed time frames	95%	Monthly report from provider	100.00%		100.00%	100.00%
Mede	Wheelchair	**s-wchair1**	All Service Users have a first appointment/contact seen after initial response time according to priority / need: High Priority	within 6 weeks 100%	monthly report from provider	N/A		N/A	N/A
Mede	Wheelchair	**s-wchair1**	Medium Priority	within 12 weeks 100%	monthly report from provider	N/A		N/A	N/A
Mede	Wheelchair	**s-wchair1**	Low Priority	within 18 weeks 100%	monthly report from provider	100.00%		100.00%	100.00%
NCHC		**D2-ltc2-a**	% of people that have been identified by case finding, (using risk stratification, or other means), and deemed suitable for intervention by the MDT, and referred to SCH, that have a care lead.	95%	Monthly report from Provider	100.00%		100.00%	100.00%

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**May 2017**	**May Comments / Queries 2017**	**Mar 2017**	**Apr 2017**
NCHC		**D2-ltc2-b**	% of people identified via case finding, that have a care plan (including self-care) that has been shared with the GP practice within two weeks of the patient coming onto the caseload. The GP practice will require a copy of the care plan, and the information will be shared with the MDT, which includes a GP. For clarity, the definition of an MDT is; 'A virtual or real team of health and care practitioners, who could be, or are involved in patient's care. An MDT does not necessarily mean a physical meeting.'	95%	Monthly report from Provider	N/A		100.00%	N/A
NCHC		**D5-ccc7**	% of referrals seen following triage; Emergency - 2 hrs	Emergency - 100%	Monthly report from Provider	100.00%		100.00%	100.00%
NCHC		**D5-ccc7**	Urgent 4 hrs	Urgent - 95%	Monthly report from Provider	99.03%		100.00%	98.13%
NCHC		**D5-ccc7**	Intermediate - 72 hrs	Intermediate - 95%	Monthly report from Provider	98.30%		98.18%	98.44%
NCHC		**D5-ccc7**	18 weeks	18 weeks - 95%	Monthly report from Provider	99.67%		99.54%	99.77%
NCHC		**D4-int1**	Community Health Team Leads and/or Local Area Managers to work with GP practices and establish direct working relationships that aid mutual understanding and aim to improve the quality of services to patients. A schedule of face to face meetings is to be agreed and adhered to by both parties and a joint action plan is to be produced that shall be regularly reviewed. % of link GP practices and Community Health Team Leads who feel that they have a 'positive working relationship' with each other. A joint action plan is expected to be maintained All link GP Practices and respective CHT leads to be surveyed quarterly, moving to six monthly at an agreed point	80%	Quarterly report from Provider				
NCHC	PHP	**c-php1**	Number of Service Users with the following Long term conditions with a Personal Health plan (Parkinson's Disease, Multiple sclerosis, Muscular Dystrophy, Chronic Obstructive Pulmonary Disease, all other chronic respiratory diseases, Coronary Heart Disease, Heart Failure).	80% completed	Monthly	100.00%		100.00%	100.00%
NCHC	IDPT	**s-disch1**	Triage and assessment of referrals within 1 Operational Day	98%	Monthly report from Provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
NCHC	IDPT	**s-disch2**	Urgent discharge achieved (<24 hours from referral to the team) for Service Users terminally ill and wishing to die at home	85%	Monthly report from Provider	0.00%	There were 3 referrals to the service in May. 1 referral was excluded as the family had to clear the room before the patient could be discharged. The remaining 2 patients were discharged within 32 hours and 51 hours, this was due to reasons outside of the control of the service	100.00%	100.00%
NCHC	IDPT	**s-disch4**	Transfer from acute hospital to community based provision from receipt of referral within a timescale not exceeding 48 hours providing the Service User is medically and physically fit for discharge	80% of Service Users medically and physically fit for discharge	Monthly report from provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
NCHC	EAU CIS	**eau-cis-IHT**	% of patients seen within 2 hrs. of initial referral. The Senior Nurse (part of the CIS) allocated to the EAU at IHT will begin patient assessment within 2 hrs of consultant referral.	98%	monthly report from provider	N/A		N/A	N/A
NCHC	Verification of expected death training	**c-gen2**	Number of qualified nursing staff trained in Service User areas, community nursing teams and local Healthcare teams (to include all clinical staff from within planned care, urgent care, & intensive case management as the integrated service model is implemented)	90%	Monthly report from provider				
WSH	Adult SALT	**s-salt1**	All new referrals are triaged within 5 Operating Days of receipt of referral;	98%	Monthly report from Provider	99.37%		98.79%	99.21%
WSH	Adult SALT	**s-salt2**	Service Users seen within the following timescales after triage: Priority 1 within 10 Operating Days	Priority 1 - 100%	Monthly report from Provider	100.00%		100.00%	100.00%
WSH	Adult SALT	**s-salt2**	Priority 2 within 20 Operating Days	Priority 2 - 95%	Monthly report from Provider	85.00%	This relates to 11 out of 75 referrals, 9 patients were seen within 23 days and 2 were seen on days 25 and 27.	98.00%	100.00%
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									
Service	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of Measurement**	**May 2017**	**May Comments/ Queries 2017**	**Mar 2017**	**Apr 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	95.83%		97.25%	97.48%
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	98.92%		98.01%	99.53%
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
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
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	100.00%		99.54%	99.53%
WSH	All Paediatric Services	**GP-9** **PDL-01**	Discharge Letters - to be sent within 24 hours of discharge from a community hospital and 72 hours of discharge from all other caseloads (all discharge letters whether electronic/non electronic to clearly state date dictated, date signed and date sent)	95%	Monthly	100.00%		100.00%	100.00%
WSH		**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	98.80%		100.00%	98.96%
WSH	Newborn Hearing Screening Service (West)	**NBHS-3**	Screening outcomes set within 3 months	≥99%	Monthly Activity Report	98.72%		100.00%	98.19%
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% 270 contacts		100% 295 contacts	100% 131 contacts
WSH	Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	Systmone	100.00% 139 contacts		100.00% 169 contacts	100.00% 91 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	83.33%	15 out of 18 children who had an IHA in May were offerd their first appt within 28 days of the service being made aware of the child. The 3 appts offered outside the 28 days were all within 31 days.	91.67%	47.06%
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	72.22%	13 out of 18 children had an IHA completed within 28 days of the service being made aware of the child. Of the 5 appts outside the 28 day deadline (31 days, 31 days, 38 days, 44 days and 65 days): - initial appt date offered was declined - initial appt date was DNA'ed - one initial appt date was delayed due to cancellation by service	66.67%	35.29%
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	0.00%	Of the 18 children with an IHA completed outside of 28days of becoming CiC, 13 referrals were delayed by 20 days or more (11 were over 28days). The greatest delays being 437 and 294 days. The shortest delay was 8 days from the child becoming CiC to the referral being made.	25.00%	6.25%

1 C-gen9 – CES – Next working day collection

a) Current Position
C-gen9 – 96.37% against a 98% target

9 out of 248 items were collected outside of the next working day time bracket, 8 of these collections were for mattresses, the 9th was a hoist.

b) Recommended Action
- Continue to monitor performance via monthly contract meetings
- Support Medequip to implement move to single site solution which will support greater efficiencies

2 s-disch2 – Integrated Discharge Planning Team - Urgent discharge from IHT for service users terminally ill and wishing to die at home

a) Current Position
s-disch2 – 0% against a 85% target

There were 3 referrals to the service in May. 1 referral was excluded as the family had to clear the room before the patient could be discharged. The remaining 2 patients are discharged within 32 hours and 51 hours. In both cases the service responded in a timely manner but the discharge was after 24hours. This delay could be due to transport issues or similar, which is out of control of the service.

b) Recommended Action
- continue to investigate failed discharges with colleagues and offer support and assistance with improving their compliance with this target

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

a) Current Position
s-salt2 - 85% against a 95% target

This relates to 11 out of 75 referrals, 9 patients were seen within 23 days and 2 were seen on days 25 and 27. This was due to staff sickness.

b) Recommended Actions
- review staffing rotas to identify any mitigating actions that could have been taken
- monitor impact that current pilot is having on overall capacity

4 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 – 83.33% against a 100% target
CiC-001b – 72.22% against a 100% target
CiC -001a – 0.00% against a 100% target

18 Initial Health Assessments were completed in May. 0 were completed within 28 days of becoming CiC, 13 were completed within 28 days of the service receiving ALL the paperwork and 15 appointments were offered within 28 days. There was a delay of greater than 20 days from the child becoming CiC and the service being notified for 13 of the 18 referrals which directly impacted on the statutory compliance target (11 of the referrals were delayed for greater than 28.

b) Recommended Action

- The revised paperwork and proposed new process of sharing the Placement Assessment Form had not been implemented by social care following meeting in April. The Associate Director has met with the SCC Admin Hub and Service Manager who has confirmed that they have just been trained to extract this information directly from Care First 6 so this should enable timely sharing of information on receipt of notification that child has entered care. This will continue to be monitored.
- The Social Care manager and Associate Director are liaising to improve communications between services.

	Units	Target	Red	Amber	Green	Dec	Jan	Feb	Mar	Apr	May
Patient Experience											
Service users who rated the service as 'good' or 'better' (Quarterly)	Nos.	No Target									
	%	85%	<80%	80%-85%	>=85%						
Service users who responded that they felt 'better'	Nos.	No Target				115	141	158	137	132	145
	%	85%	<80%	80%-85%	>=85%	94%	96%	96%	93%	94%	93%
Service users who felt 'well informed'	Nos.	No Target				144	182	200	177	198	159
	%	85%	<80%	80%-85%	>=85%	96%	96%	91%	94%	96%	94%
10% of long term condition patients feel "better supported" to self manage their conditions (Quarterly)	Nos.	No Target									
	%	No Target									
Falls (Inpatient Units)											
Total numbers of inpatient falls (includes rolls and slips)	Nos.	No Target				60	51	33	48	30	47
Rolls out of Bed		No Target				5	2	5	1	1	4
Slip out of chair		No Target				3	8	3	5	0	4
Assisted Falls/ near misses		No Target				1	0	3	6	1	4
% of total falls resulting in harm	%	No Target				22%	31%	24%	23%	32%	23%
Numbers of falls resulting in moderate harm	Nos.	No Target				0	0	0	1	0	0
Numbers of falls resulting in severe harm	Nos.	No Target				2	2	0	1	0	0
Numbers of patients who have had repeat falls	Nos.	No Target				13	11	7	8	6	9
% of RCA reports for repeat fallers	%	100%	90%-95%	95%-100%	=100%	100%	100%	100%	100%	100%	100%
Numbers of falls per 1000 bed days (* includes Hazel Crt falls)		<1.25/1000 beddays	>1.50	1.25-1.50	<=1.25	17.4	13.9	10.5*	13.8*	8.96	13.96
Pressure Ulcers											
Pressure Ulcers – In Our Care Community											
Grade 2		100 pa	>110	100-110	<=100	23	26	31	27	34	33
Grade 3		26 pa	>30	27-29	<=26	6	8	13	10	6	8
Grade 4		0 pa	>1	1	0	1	2	1	2	1	0
Pressure Ulcers – In our care In-patient											
Grade 2		13 pa	>17	13-17	<=13	5	2	3	4	0	3
Grade 3		2 pa	>4	02-Apr	<=2	0	1	1	0	1	0
Grade 4		0 pa	>1	1	0	1	0	0	0	0	0
Safeguarding People Who Use Our Services From Abuse											
Number of adult safeguarding referrals made		No Target				5	4	2	3	2	4
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				100%	100%	100%	100%	100%	100%

	Units	Target	Red	Amber	Green	Dec	Jan	Feb	Mar	Apr	May
MRSA											
Bacteraemia – Number of cases		0	>2	>0 to 2	=0	0	0	0	0	0	0
MRSA RCA reports		100%	<95%	95%-100%	=100 %	0	0	0	0	0	0
Clostridium Difficile											
C.Diff number of cases		4 for 6 months	>4 YTD		<=4 YTD	0	0	0	0	0	0
C.Diff associated diseases (CDAD) RCA reports		100%	<95%	95%-100%	=100 %	N/A	N/A	N/A	N/A	N/A	N/A
Infection Control											
Infection control training		100%	<83%	83%-100%	=100 %	91.00%	89.87%	85.99%	89.70%	86.51%	91.80%
Essential Steps Care Bundles Including Hand Hygiene											
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	99.00%	98.00%	99.00%	98.00%	99.00%	99.00%
Isolation room audit		100%	<95%	95%-100%	=100 %	100%	N/A	N/A	100%	100%	100%
Management of Medication -SCH NRLS Reportable Incidents											
Total number of medication incidents in month		No Target				16	23	18	25	19	17
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				15	23	16	20	15	12
(also includes those not attributed to SCH management)	Low harm	No Target				1	0	2	5	3	5
Number of medication incidents involving Controlled Drugs		No Target				0	0	7	5	1	0

Incidents											
NRLS (i.e. patient safety) reportable incidents in month		No Target				178	217	223	229	197	236
Number of Never Events in month		No Target				0	0	0	0	0	0
Number of Serious Incidents (SIs) that occurred in month		No Target				9	13	15	12	8	8
Number of SIs reported to CCG in month *4 STEIS for 2 pts (2 each)		No Target				9	13	17	17*	7	9
Percentage of SI reports submitted to CCG on time in month		No Target				100%	100%	100%	100%	100%	100%
Duty of Candour Applicable Incidents		No Target				10	13	13	16	8	9

Severity of NPSA Reportable Incidents											
None		No Target				119	140	122	145	130	157
Low		No Target				50	64	87	69	58	70
Moderate		No Target				6	9	13	11	8	9
Major		No Target				3	4	1	4	1	0
Catastrophic		No Target				0	0	0	0	0	0

Training Compliance											
Adult Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	96.94%	97.04%	95.59%	96.74%	96.02%	96.24%
Children Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	97.12%	97.04%	95.86%	96.92%	96.11%	96.41%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	94.10%	94.62%	92.57%	94.34%	94.81%	95.30%
WRAP						44.47%	45.27%	51.73%	67.33%	64.48%	66.82%
MCA / DoLs- Training compliance						70.97%	69.76%	68.46%	67.33%	73.59%	82.33%

Compliments/Complaints

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Total compliments	21	33	19	46	21	38	28	36	27	61	50	46	44
Formal complaints (No.)	**2**	**6**	**7**	**5**	**1**	**1**	**2**	**2**	**3**	**5**	**1**	**1**	**2**
Acknowledged within 3 working days (No.)	2	3	5	4	1	1	1	2	3	5	1	1	1
Acknowledged within 3 working days (%)	100%	50%	71%	80%	100%	100%	50%	100%	100%	100%	100%	100%	50%
Responded to within 25 working days (No.)	1	4	4	2	0	1	1	0	2	0	1	1	-
Responded to within 25 working days (%)	50%	67%	57%	40%	0%	100%	50%	0%	67%	0%	100%	100%	-
Responded to outside 25 working days (No.)	1	2	3	3	1	0	1	2	1	5	0	0	-
Responded to outside 25 working days (%)	50%	33%	43%	60%	100%	0%	50%	100%	33%	100%	0%	0%	-
Complaints upheld (No.)	1	2	4	2	1	-	-	-	1	2	1	1	-
Complaints partially upheld (No.)	-	3	3	2	-	-	-	-	-	3	-	-	-
Complaints not upheld (No.)	1	1	-	1	-	1	2	2	2	-	-	-	-
Average response time (days)	33.0	29.6	27.6	32.8	31.0	19.0	36.5	38.5	24.0	28.0	7.0	7.0	-

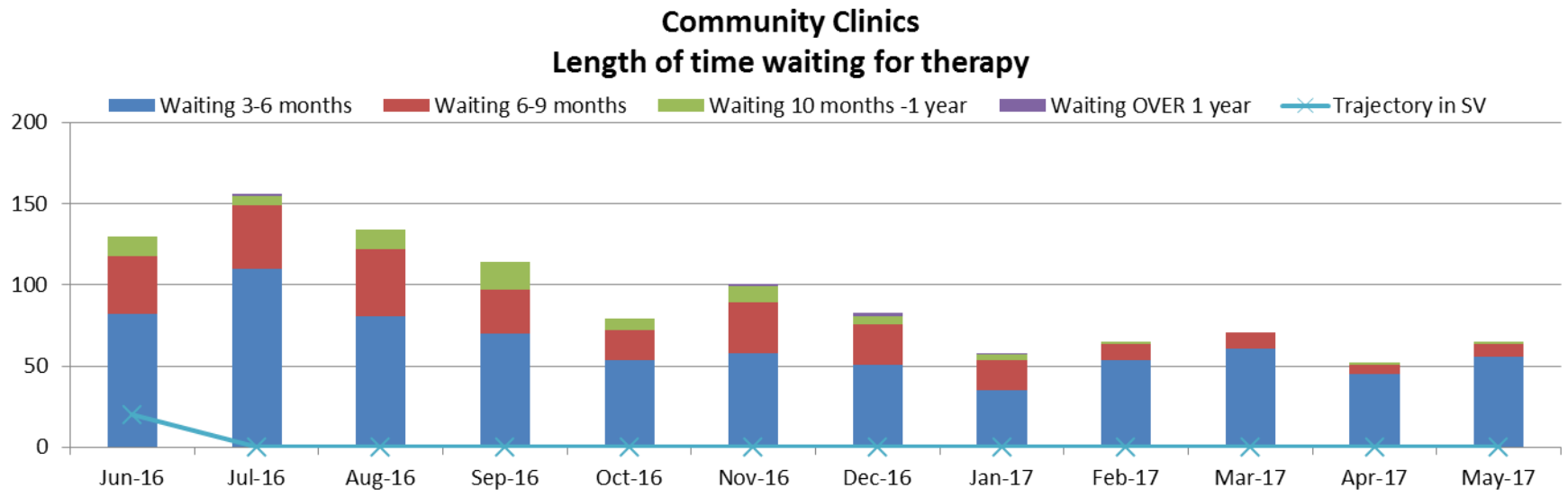
Paediatric Speech and Language Service Waiting times

Community Clinic

Clinic Waiting lists

Reports run 02/06/2017

Length of wait Community Clinics *(pre-school caseload)*	No. of children waiting June 2016	No. of children waiting July 2016	No. of children waiting August 2016	No. of children waiting September 2016	No. of children waiting October 2016	No. of children waiting November 2016	No. of children waiting December 2016	No. of children waiting January 2017	No. of children waiting February 2017	No. of children waiting March 2017	No. of children waiting April 2017	No. of children waiting May 2017
Waiting up to 3 months	191	167	150	156	151	176	158	176	165	162	166	154
Waiting 3-6 months	82	110	81	70	54	58	51	35	54	61	45	56
Waiting 6-9 months	36	39	41	27	18	31	25	19	10	10	6	8
Waiting 10 months -1 year	12	6	12	17	7	10	5	3	1	0	1	1
Waiting OVER 1 year	0	1	0	0	0	2	2	1	0	0	0	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**321**	**323**	**284**	**270**	**230**	**277**	**241**	**234**	**230**	**233**	**218**	**219**
Already had PoC	66	119	97	72	75	67	72	55	60	85	53	51
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*	**387**	**442**	**381**	**342**	**305**	**344**	**313**	**289**	**290**	**318**	**271**	**270**

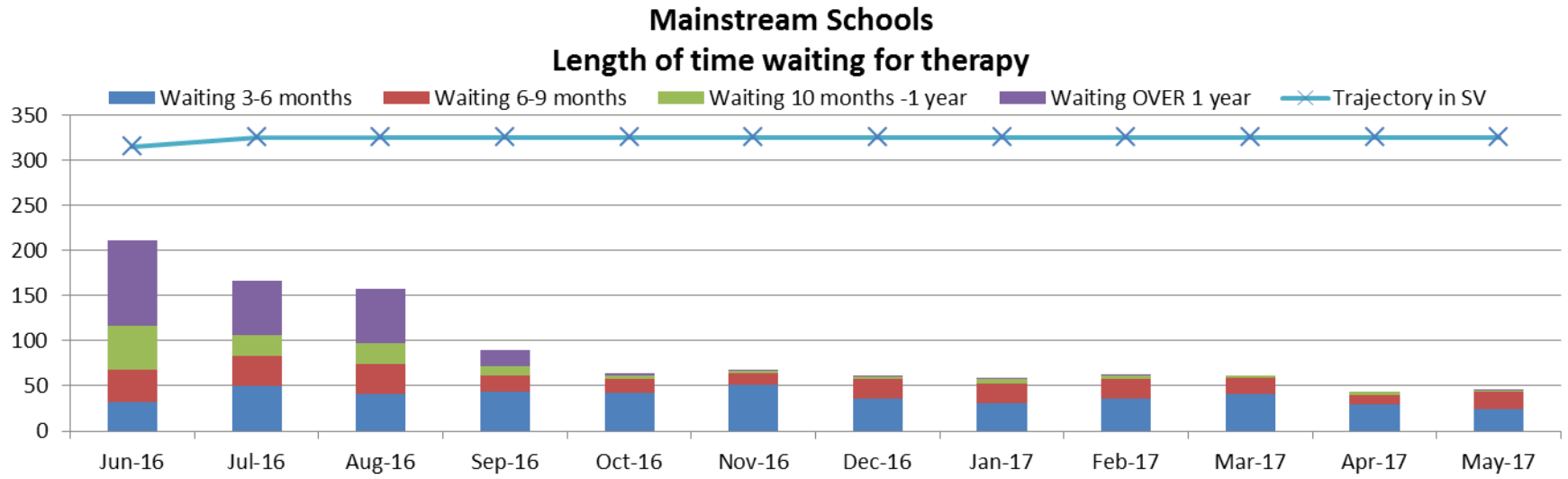


Mainstream Schools

Schools Waiting lists

No waiting data by months prior to May

Length of wait Mainstream Schools *(pre-school caseload)*	No. of children waiting June 2016	No. of children waiting July 2016	No. of children waiting August 2016	No. of children waiting September 2016	No. of children waiting October 2016	No. of children waiting November 2016	No. of children waiting December 2016	No. of children waiting January 2017	No. of children waiting February 2017	No. of children waiting March 2017	No. of children waiting April 2017	No. of children waiting May 2017
Waiting up to 3 months	126	117	119	88	72	68	59	56	56	73	87	89
Waiting 3-6 months	32	50	41	44	42	51	36	31	36	41	29	24
Waiting 6-9 months	36	33	33	18	16	13	22	22	21	18	11	19
Waiting 10 months -1 year	48	23	23	10	3	2	2	4	4	3	4	2
Waiting OVER 1 year	95	60	61	17	3	2	2	2	1	0	0	1
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**337**	**283**	**277**	**177**	**136**	**136**	**121**	**115**	**118**	**135**	**131**	**135**
Already had PoC	264	356	396	395	377	392	332	277	266	248	210	194
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*	**601**	**639**	**673**	**572**	**513**	**528**	**453**	**392**	**384**	**383**	**341**	**329**



Item 8

							Surgery											
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	G5	F9
Patient Experience: In-patient	QR-PEI-10	Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	90	97	96	97	NA	NA	NA	NA	NA	96	86	84
	QR-PEI-180	(In-patient) How likely is it that you would recommend the service to friends and family?	= 95%	<70	70-89	90-100	97.06	100	96.92	100	NA	NA	NA	NA	NA	100	100	76.32
	QR-PEI-20	In your opinion, how clean was the hospital room or ward that you are in?	= 85%	<75	75-84	85-100	97	99	100	100	NA	NA	NA	NA	NA	100	100	92
	QR-PEI-340	Did you feel you were treated with respect and dignity by staff?	= 85%	<75	75-84	85-100	99	99	99	100	NA	NA	NA	NA	NA	100	100	96
	QR-PEI-330	Were Staff caring and compassionate in their approach?	= 85%	<75	75-84	85-100	99	100	99	100	NA	NA	NA	NA	NA	100	100	92
	QR-PEI-30	Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	39	98	71	83	NA	NA	NA	NA	NA	75	50	47
	QR-PEI-70	(In-patient) Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<75	75-84	85-100	100	99	100	100	NA	NA	NA	NA	NA	100	100	97
	QR-PEI-80	Were you involved as much as you wanted to be in decisions about your condition and treatment?	= 85%	<75	75-84	85-100	93	100	95	100	NA	NA	NA	NA	NA	96	96	82
	QR-PEI-90	Did staff talk in front of you as if you were not there?	= 85%	<75	75-84	85-100	100	100	99	100	NA	NA	NA	NA	NA	100	92	87
	QR-PEI-350	Were you given enough privacy when discussing your care?	= 85%	<75	75-84	85-100	100	100	100	100	NA	NA	NA	NA	NA	92	100	95
	QR-PEI-100	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	93	20	100	100	NA	NA	NA	NA	NA	100	42	95
		(In-patient) Were you given enough privacy when being examined or treated?	= 85%	<76	75-85	85-101	100	100	100	100	NA	NA	NA	NA	NA	100	100	97
	QR-PEI-150	Timely call bell response	= 85%	<75	75-84	85-100	68	72	91	83	NA	NA	NA	NA	NA	92	47	37
	QR-PEI-290	Same sex accommodation: total patients	= 0	>2	1-2	= 0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PEI-300	Complaints	= 0	>2	1-2	= 0	0	0	0	1	0	0	0	0	2	0	1	1
	QR-PEI-310	Environment and Cleanliness	= 90%	<80	80-89	90-100	89	91	91	90	94	90	97		93	89	80	87

							Surgery		Medicine	
Group		Indicator	Target	Red	Amber	Green	F4	DSU	F7	F8
Patient Experience: short-stay	QR-PES-10	Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	100	0	100	96
	QR-PES-60	(Short-stay) How likely is it that you would recommend the service to friends and family?	= 95%	<70	70-89	90-100	98.44	0	100	95.74
	QR-PES-20	(Short-stay) Were you given enough privacy when being examined and treated?	= 85%	<75	75-84	85-100	100	0	100	99
	QR-PES-30	(Short-stay) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	100	0	100	98
	QR-PES-40	Were you told who to contact if you were worried after leaving hospital?	= 85%	<75	75-84	85-100	100	0	100	93
	QR-PES-50	(Short-stay) Overall how would you rate the care you received in the department?	= 85%	<75	75-84	85-100	99	0	100	95
	QR-PES-70	Number of short stay surveys completed	No Target	No Target	No Target	No Target	128	0	5	47

							Medicine
Group		Indicator	Target	Red	Amber	Green	ED
Patient Experience: A&E	QR-PEA-10	Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	96
	QR-PEA-100	(A&E) How likely is it that you would recommend the service to friends and family?	= 95%	<70	70-89	90-100	96.01
	QR-PEA-30	Were A&E staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	99
	QR-PEA-110	Were you given enough privacy when discussing your condition at reception?	= 85%	<75	75-84	85-100	98
	QR-PEA-120	Did Doctors and Nurses listen to what you had to say?	= 85%	<75	75-84	85-100	98
	QR-PEA-130	Did staff tell you who to contact if you were worried about your condition after leaving A&E?	= 85%	<75	75-84	85-100	94
	QR-PEA-80	Did a member of staff tell you what danger signs to watch for when going home?	= 85%	<75	75-84	85-100	92
	QR-PEA-140	Number of A&E surveys completed	No Target	No Target	No Target	No Target	823

							Medicine
Group		Indicator	Target	Red	Amber	Green	ED
Patient Experience: A&E (Children questions)	QR-PEAC-70	Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	100
	QR-PEAC-80	(A&E Children) How likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	96.01
	QR-PEAC-90	Did the Doctor or Nurse listen to what you had to say?	= 85%	<75	75-84	85-100	100
	QR-PEAC-100	Were staff friendly and kind to you and your family?	= 85%	<75	75-84	85-100	100
	QR-PEAC-50	Did we help with your pain?	= 85%	<75	75-84	85-100	100
	QR-PEAC-60	Did staff explain the care you need at home?	= 85%	<75	75-84	85-100	100
	QR-PEAC-130	Number of A&E children surveys completed	No Target	No Target	No Target	No Target	5

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F11
Patient Experience: Maternity	QR-PEM-10	Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	96
	QR-PEM-120	How likely is it that you would recommend the post-natal ward to friends and family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	100
	QR-PEM-130	How likely are you to recommend our labour suite to friends and family if they needed similar care or treatment?	= 75%	<70	70-74	75-100	100
	QR-PEM-135	How likely are you to recommend our antenatal department to friends and family?	= 75%	<70	70-74	75-100	100
	QR-PEM-140	How likely are you to recommend our post-natal care to friends and family?	= 75%	<70	70-74	75-100	75
	QR-PEM-30	(Maternity) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	100
	QR-PEM-40	(Maternity) Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<75	75-84	85-100	100
	QR-PEM-50	Were you involved as much as you wanted to be in decisions about your care and treatment?	= 85%	<75	75-84	85-100	100
	QR-PEM-60	(Maternity) Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	100
	QR-PEM-70	Did you hold your baby in skin to skin contact after the birth (baby naked apart from the nappy and a hat, lying on your chest)?	= 85%	<75	75-84	85-100	100
	QR-PEM-80	Were you given adequate help and support to feed your baby whilst in hospital?	= 85%	<75	75-84	85-100	100
	QR-PEM-121	Number of maternity surveys completed	No Target	No Target	No Target	No Target	169

							Women & Children
Group		Indicator	Target	Red	Amber	Green	MLBU
Patient Experience: Birthing Unit	QR-PEBU-10	How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	NA
	QR-PEBU-20	Did you feel that your community midwife gave you sufficient information about the birthing unit prior to you being referred?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-40	If you phoned for advice prior to admission to the birthing unit did you feel that the advice given to you was useful and appropriate?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-50	Do you feel that the 'home from home' environment had a positive effect on your birthing experience?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-60	Did you have confidence and trust in the midwives caring for you during labour?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-70	Were your birthing partners made to feel welcome by the midwives on the birthing unit?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-80	Were you at any time left alone by your midwife at a time when you felt worried?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-90	Thinking about your care during labour and birth, were you involved in the decisions about your care?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-100	Overall how would you rate the care you received on the MLBU during your labour and birth?	= 85%	<75	75-84	85-100	NA
	QR-PEBU-110	Number of birthing unit surveys completed	No Target	No Target	No Target	No Target	NA

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
Patient Satisfaction: Young Children	QR-PEYC-120	Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	na
	QR-PEYC-110	(Young children) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	100
	QR-PEYC-20	Did you understand the information given to you regarding your treatment and care?	= 85%	<75	75-84	85-100	na
	QR-PEYC-10	Were you as involved as you wanted to be in decisions about your care and treatment?	= 85%	<75	75-84	85-100	na
	QR-PEYC-140	Did the Doctor or Nurses explain what they were doing in a way that you could understand?	= 85%	<75	75-84	85-100	na
	QR-PEYC-40	Were you offered age/need appropriate activities?	= 85%	<75	75-84	85-100	na
	QR-PEYC-60	Was your experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	75-84	85-100	na
	QR-PEYC-70	Was your experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	na
	QR-PEYC-150	If you were in pain, did the Doctor or Nurse do everything they could to help with the pain?	= 85%	<75	75-84	85-100	na
	QR-PEYC-160	Were staff kind and caring towards you?	= 85%	<75	75-84	85-100	na
	QR-PEYC-90	Is the environment child - friendly?	= 85%	<75	75-84	85-100	na
	QR-PEYC-100	Overall, how would you rate your experience in the Paediatric Unit?	= 85%	<75	75-84	85-100	na
	QR-PEYC-130	Number of young children surveys completed	No Target	No Target	No Target	No Target	13

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
	QR-PEF1-120	Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	99
	QR-PEF1-110	(F1 Parent) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	100
	QR-PEF1-20	Did you understand the information given to you regarding your child's treatment and care?	= 85%	<75	75-84	85-100	97
	QR-PEF1-10	Were you and your child as involved as you wanted to be in decisions about care and treatment?	= 85%	<75	75-84	85-100	100

F1 Parent	QR-PEF1-130	Did the Doctor or Nurses explain what they were doing in a way that your child could understand?	= 85%	<75	75-84	85-100	100
	QR-PEF1-40	Were there appropriate play activities for your child (such as toys, games and books)?	= 85%	<75	75-84	85-100	98
	QR-PEF1-60	Was your child's experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	75-84	85-100	100
	QR-PEF1-70	Was your child's experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	97
	QR-PEF1-150	If your child was in pain, did the doctor or nurse do everything they could to help with the pain?	= 85%	<75	75-84	85-100	100
	QR-PEF1-140	Were staff kind and caring towards your child?	= 85%	<75	75-84	85-100	100
	QR-PEF1-90	Is the environment child-friendly?	= 85%	<75	75-84	85-100	100
	QR-PEF1-100	Overall, how would you rate your experience in the Children's Unit?	= 85%	<75	75-84	85-100	99
	QR-PEF1-160	Number of F1 parent surveys completed	No Target	No Target	No Target	No Target	32

							Medicine
Group		Indicator	Target	Red	Amber	Green	G8
Patient Experience: Stroke	QR-PEST-10	Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	NA
	QR-PEST-80	(Stroke) How likely is it that you would recommend the service to friends and family?	= 95%	<80	70-89	90-100	NA
	QR-PEST-20	In your opinion, how clean was the hospital room or ward you were in?	= 85%	<75	75-84	85-100	NA
	QR-PEST-30	Did you feel you were treated with respect and dignity by staff?	= 85%	<75	75-84	85-100	NA
		Were staff caring and compassionate in their approach?	= 85%	<76	75-85	85-101	NA
		Have you been told you have had a stroke, which lead to your admission to hospital?	= 85%	<77	75-86	85-102	NA
		Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<78	75-87	85-103	NA
		Were you involved as much as you wanted to be in planning your recovery /rehabilitation?	= 85%	<79	75-88	85-104	NA
	QR-PEST-40	Were you given enough privacy when discussing your condition or treatment?	= 85%	<75	75-84	85-100	NA
	QR-PEST-50	Were you gicen enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	NA
	QR-PEST-60	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	NA
	QR-PEST-70	While you were in the Stroke Department, how much information about your condition or treatment was given to you?	= 85%	<75	75-84	85-100	NA
	QR-PEST-90	Number of stroke surveys completed	No Target	No Target	No Target	No Target	NA

Medicine										Women & Children			
F10	G1	G3	G4	G8	MTU	F12	G9	F7	F8	F1	F11	F14	MLBU
95	92	90	88	NA	NA	92	93	91	NA	NA	NA	94	NA
100	95.24	96.3	95.83	NA	NA	100	100	97.87	NA	NA	NA	94.59	NA
98	95	96	97	NA	NA	100	100	97	NA	NA	NA	98	NA
100	98	92	98	NA	NA	100	100	100	NA	NA	NA	98	NA
100	98	100	94	NA	NA	100	100	99	NA	NA	NA	98	NA
66	62	62	44	NA	NA	78	70	55	NA	NA	NA	69	NA
100	94	92	100	NA	NA	100	100	97	NA	NA	NA	92	NA
100	93	90	94	NA	NA	83	90	95	NA	NA	NA	95	NA
95	100	92	92	NA	NA	89	100	95	NA	NA	NA	97	NA
100	100	92	100	NA	NA	100	100	100	NA	NA	NA	100	NA
100	100	100	83	NA	NA	100	100	100	NA	NA	NA	80	NA
100	100	100	100	NA	NA	100	100	100	NA	NA	NA	100	NA
87	77	74	56	NA	NA	67	0	53	NA	NA	NA	88	NA
0	0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	1	0	0	0	0	0
89	92	94	87		96	94	95	88	88	96	95	93	94

Item 8

							Surgery								Medicine														Women & Children			
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	G5	F9	F10	G1	G3	G4	G8	MTU	F12	WEW - G9	F7	F8	F1	F11	F14	MLBU
Patient Safety	QR-PS-10	HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-20	HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	No Data	100	No Data	100	NA	NA	NA	NA	No Data	No Data	100	100	100	100	No Data	No Data	NA	No Data	No Data	No Data	NA	NA	NA	No Data	NA
	QR-PS-30	HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	No Data	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	No Data	100	NA	NA	NA
	QR-PS-40	HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	100	100	100	100	NA	NA	NA	NA	100	100	100	100	100	80	90	80	NA	100	No Data	NA	NA	100	NA	100	NA
	QR-PS-50	HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	NA	100	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-60	HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	NA	70	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-90	HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-100	HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	100	NA	NA	100	NA	NA	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA
	QR-PS-110	HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	100	100	100	100	NA	NA	NA	NA	NA	100	62	100	100	100	100	100	100	NA	100	No Data	NA	NA	NA	NA	60	NA
	QR-PS-111	HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<80	80-99	= 100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-220	Total no of MRSA bacteraemias: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-250	Hand hygiene compliance	= 95%	<85	85-99	= 100	100	100	100	100	100	NA	100	100	NA	100	NA	100	100	No Data	100	NA	100	100	100	NA	No Data	100	100	100	100	NA
	QR-PS-230	Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-240	Total no of C. diff infections: Hospital	= 16 per year	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-120	No of patient falls	= 48	>=48	No Target	<48	4	0	4	3	0	NA	NA	NA	0	1	2	6	8	2	3	8	10	0	0	0	1	0	NA	0	0	NA
	QR-PS-130	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	1	0	0	3	0	NA	NA	NA	0	0	0	3	1	1	2	3	3	0	0	0	0	0	NA	0	0	NA
	QR-PS-140	No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	0	0	0	0	NA	NA	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	NA	0	0	NA
	QR-PS-470	No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	1	0	0	0	0	NA	NA	NA	NA	0	2	0	0	1	2	0	2	0	0	0	0	0	NA	0	0	NA
	QR-PS-480	No of avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PS-190	Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	90	100	100	100	100	NA	NA	NA	NA	100	60	70	100	77	100	77	100	NA	85	No Data	No Data	No Data	NA	NA	60	NA
	QR-PS-260	No of SIRIs	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	2	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-500	No of medication errors	No Target	No Target	No Target	No Target	6	1	2	1	4	0	1	0	1	1	6	8	7	0	4	0	3	0	0	0	11	8	2	2	0	1
	QR-PS-300	Cardiac arrests	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0
	QR-PS-490	Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-390	Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	96.88	100	100	100	100	No Data	No Data	No Data	No Data	100	No Data	100	96	100	93.1	96.55	100	No Data	100	na	100	No Data	No Data	100	100	No Data
Patient Experience: in-patient	QR-PEI-290	Same sex accommodation: total patients	= 0	>2	1-2	= 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

West Suffolk NHS
NHS Foundation Trust

FINANCE AND WORKFORCE REPORT

May 2017 (Month 2)

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

Financial Summary

I&E Position YTD	£2.0m	loss
Variance against plan YTD	£0.1m	favourable
Movement in month against plan	£0.0m	favourable
EBITDA position YTD	£0.0m	surplus
EBITDA margin YTD	0.00%	surplus
Cash at bank	£5,093k	

Executive Summary

- The Month 2 YTD position is £80k ahead of plan.

Key Risks

- Delivering the cost improvement programme
- Containing the increase in demand to that included in the plan (2.5%).
- We are in arbitration with NHSPS regarding property charges for Community Services dating back to October 2015.
- Receiving Sustainability and Transformation Funding – dependent on Financial and Operational performance
- Working across the system to minimise delays in discharge and requirement for escalation beds

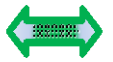
SUMMARY INCOME AND EXPENDITURE ACCOUNT - May 2017	May-17 Budget £m	May-17 Actual £m	May-17 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance £m
NHS Contract Income	18.9	18.8	(0.1)	36.8	36.7	(0.1)	226.1	225.7	(0.4)
Other Income	2.0	2.3	0.2	4.0	4.3	0.3	21.7	22.8	1.0
Total Income	**21.0**	**21.1**	**0.1**	**40.7**	**41.0**	**0.2**	**247.8**	**248.4**	**0.6**
Pay Costs	12.3	12.0	0.3	24.2	23.9	0.3	145.1	145.1	0.0
Non-pay Costs	9.5	10.1	(0.6)	18.4	18.9	(0.5)	105.2	105.8	(0.6)
Operating Expenditure	**21.8**	**22.1**	**(0.3)**	**42.6**	**42.8**	**(0.2)**	**250.3**	**250.9**	**(0.6)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	2.5	2.5	0.0
EBITDA	**(0.8)**	**(1.0)**	**(0.2)**	**(1.9)**	**(1.8)**	**0.0**	**(5.0)**	**(5.0)**	**0.0**
EBITDA margin	(3.8%)	(4.6%)	(0.8%)	(4.6%)	(4.4%)	0.1%	(2.0%)	(2.0%)	0.0%
Depreciation	0.5	0.4	0.1	0.8	0.8	(0.0)	4.7	4.7	0.0
Finance costs	0.2	0.2	0.0	0.3	0.3	0.0	1.4	1.4	0.0
SURPLUS/(DEFICIT) pre S&TF	**(1.5)**	**(1.5)**	**0.0**	**(3.0)**	**(2.9)**	**0.1**	**(11.1)**	**(11.1)**	**0.0**
S&T funding - Financial Performance	0.3	0.3	0.0	0.6	0.6	0.0	3.6	3.6	0.0
S&T funding - A&E Performance	0.1	0.1	0.0	0.3	0.3	0.0	1.6	1.6	0.0
SURPLUS/(DEFICIT) incl S&TF	**(1.1)**	**(1.1)**	**0.0**	**(2.1)**	**(2.0)**	**0.1**	**(5.9)**	**(5.9)**	**0.0**

FINANCE AND WORKFORCE REPORT – May 2017

Contents:

Key:

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

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

FINANCE AND WORKFORCE REPORT – May 2017

Income and Expenditure summary as at May 2017

The reported I&E for April 2017 is a deficit of £1,096k, against a planned deficit of £1,125k. This results in a favourable variance of £29k.

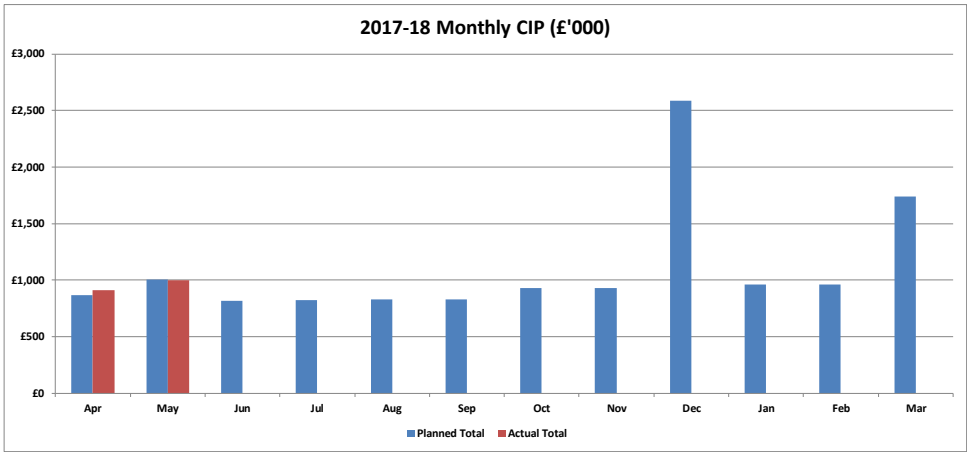
Cost Improvement Programme (CIP)

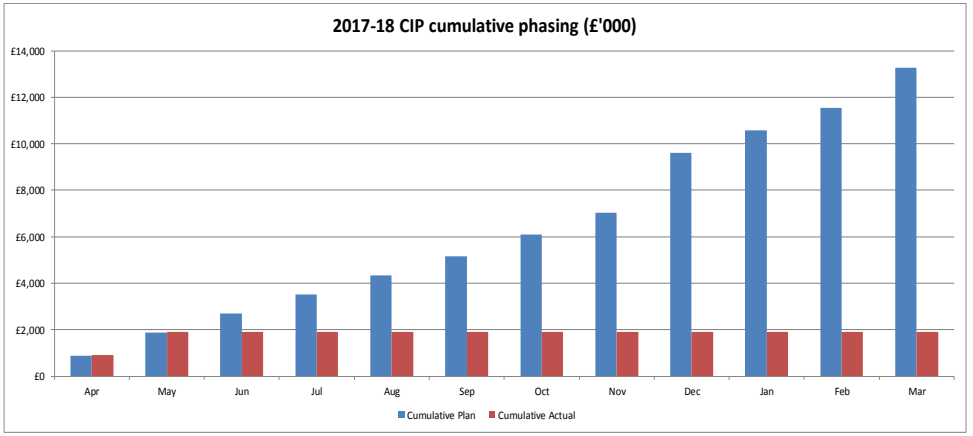
The May position includes a target of £1,906k YTD which represents 14% of the 2017-18 plan. This has been exceeded by £30k YTD.

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

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

Recurring/Non Recurring	Summary	2017-18 Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Activity growth	297	41	23
	Car Park Income	400	67	67
	Other Income	167	22	19
	Consultant Staffing	326	33	32
	Additional sessions	192	32	14
	Staffing Review	2,722	312	432
	Agency	482	80	61
	Procurement	1,801	233	231
	Community Equipment Service	465	67	45
	Contract review	8	-	2
	Drugs	326	20	63
	Capitalisation	480	80	80
	Other	2,047	331	328
Recurring Total		**9,712**	**1,319**	**1,397**
Non-Recurring	Activity growth	300	300	300
	Other Income	19	3	3
	Additional sessions	10	2	14
	Staffing Review	20	3	-
	Contract review	41	7	7
	Estates and Facilities	389	65	65
	Non-Recurring	396	-	-
	Capitalisation	350	100	100
	Other	383	78	21
	GDE revenue	1,650	-	-
Non-Recurring Total		**3,558**	**558**	**510**
Grand Total		**13,271**	**1,876**	**1,906**

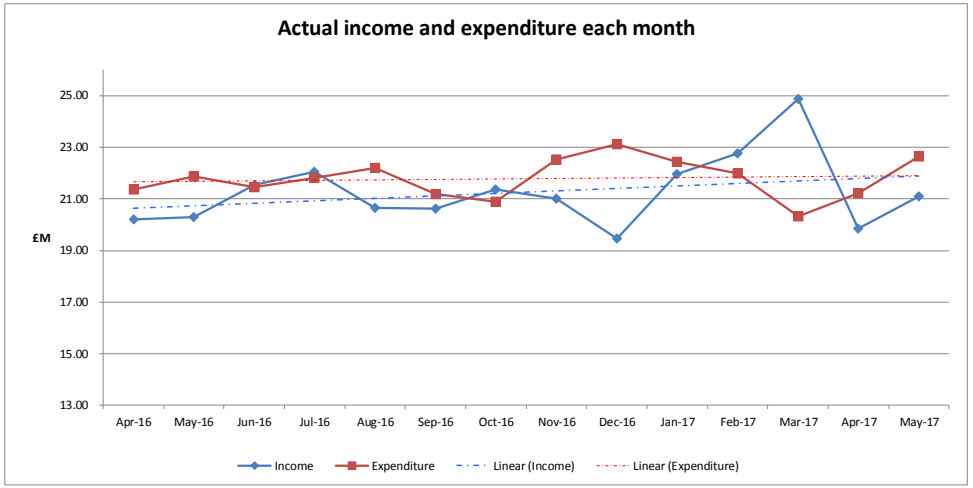


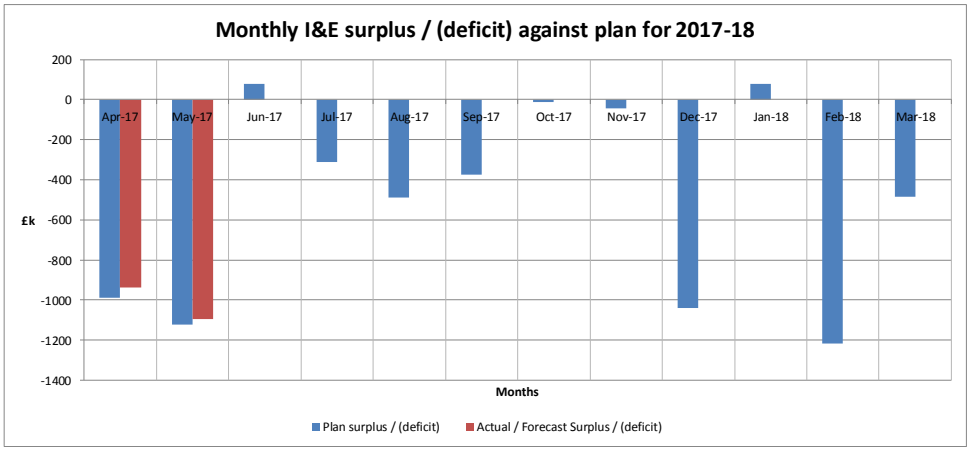


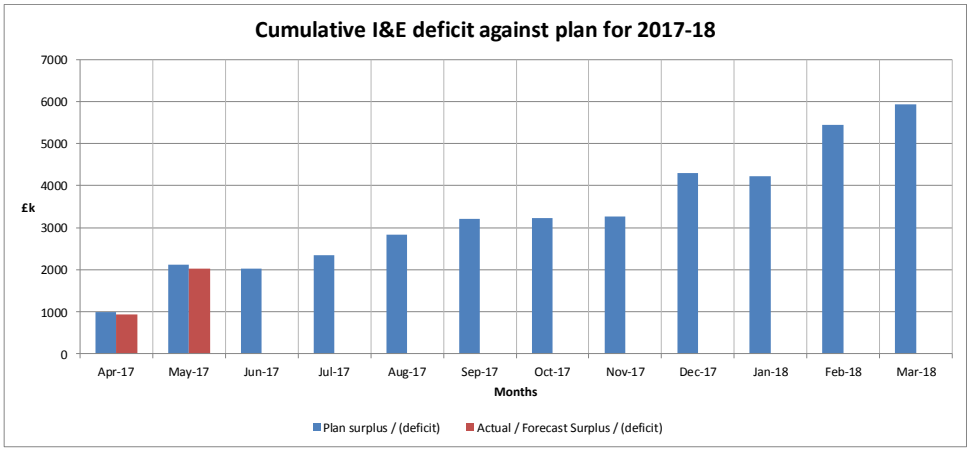
FINANCE AND WORKFORCE REPORT – May 2017

Summary of I&E indicators

Income and Expenditure	Plan / target £'000	Actual / forecast £'000	Variance to plan (adv) / fav £'000	Direction of travel (variance)	RAG (report on Red)
In month surplus / (deficit)	(1,125)	(1,096)	28	↓	Green
YTD surplus / (deficit)	(2,113)	(2,034)	80	↑	Green
Forecast surplus / (deficit)	(5,928)	(5,928)	0	↑	Green
EBITDA YTD	(994)	(946)	48	↓	Green
EBITDA (%)	(0.0%)	(0.0%)	0.0%	↔	Amber
Use of Resources (UoR) Rating fav / (adv)	3	3	0	↔	Amber
Clinical Income YTD	(36,791)	(36,661)	(130)	↑	Amber
Non-Clinical Income YTD	(4,822)	(5,166)	344	↑	Amber
Pay YTD	24,197	23,894	304	↑	Green
Non-Pay YTD	19,529	19,967	(438)	↑	Green
CIP target YTD	(1,876)	(1,906)	30	↓	Green



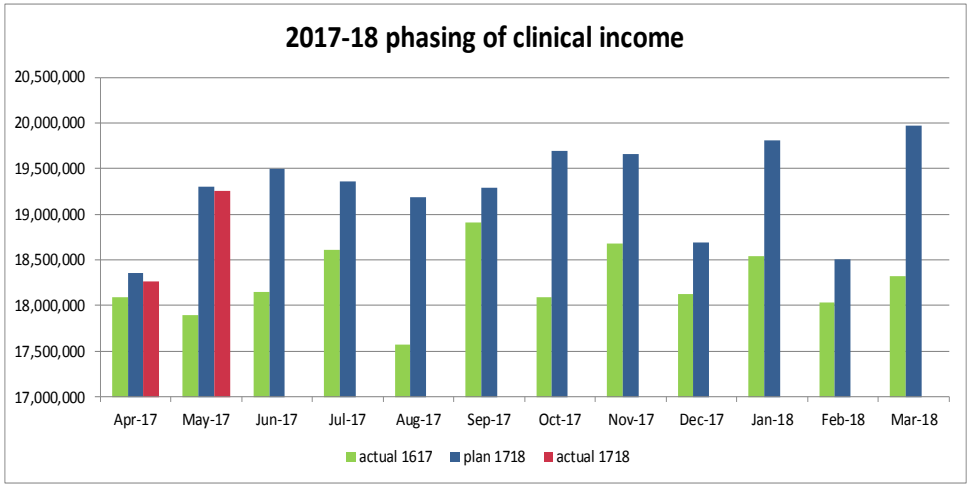




FINANCE AND WORKFORCE REPORT – May 2017

Income Analysis

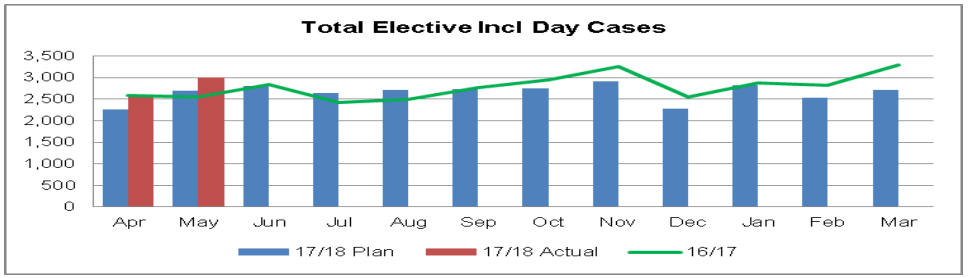
The chart below summarises the phasing of the clinical income plan for 2017-18, including a full year for Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.

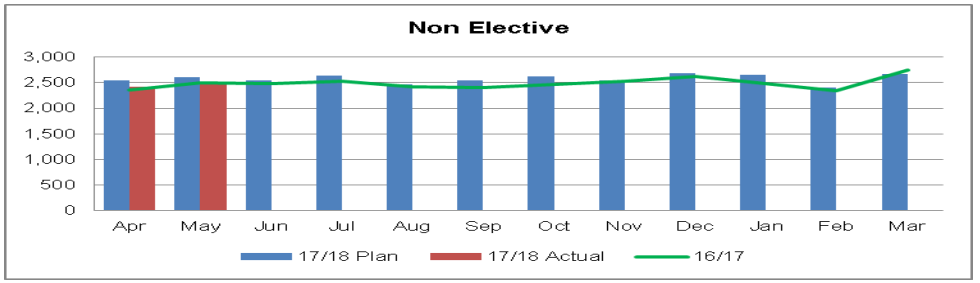


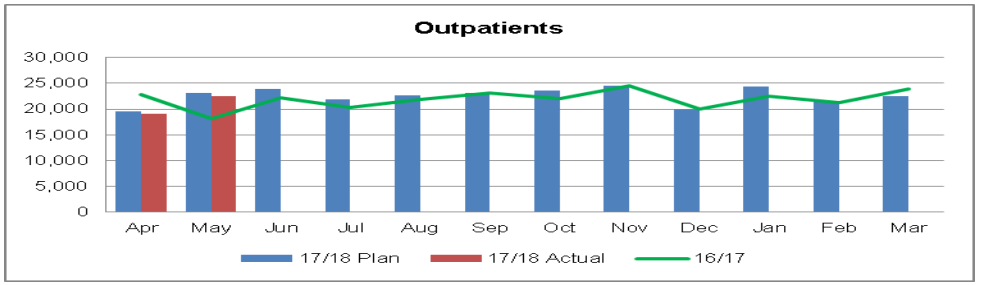
The income position was slightly ahead of plan for May. The main area of over performance was within elective activity.

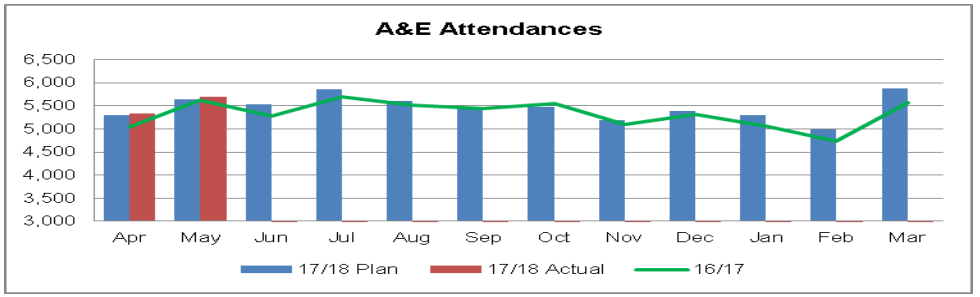
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	700	703	3	1,356	1,353	(3)
Other Services	2,286	2,016	(270)	4,470	4,056	(414)
CQUIN	304	306	2	583	587	4
Elective	2,617	2,878	261	4,828	5,375	547
Non Elective	5,168	5,206	38	10,251	10,223	(28)
Emergency Threshold Adjustment	(293)	(395)	(102)	(577)	(707)	(130)
Outpatients	2,769	2,727	(43)	5,122	5,015	(107)
Community	5,379	5,379	0	10,759	10,759	0
Total	**18,931**	**18,821**	**(110)**	**36,791**	**36,661**	**(130)**

Activity, by point of delivery

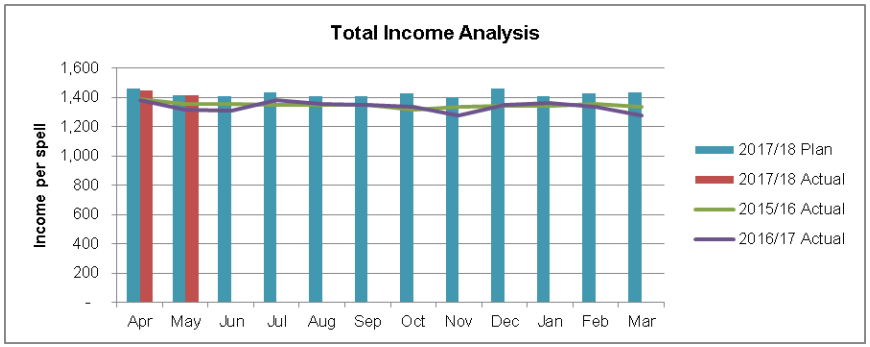


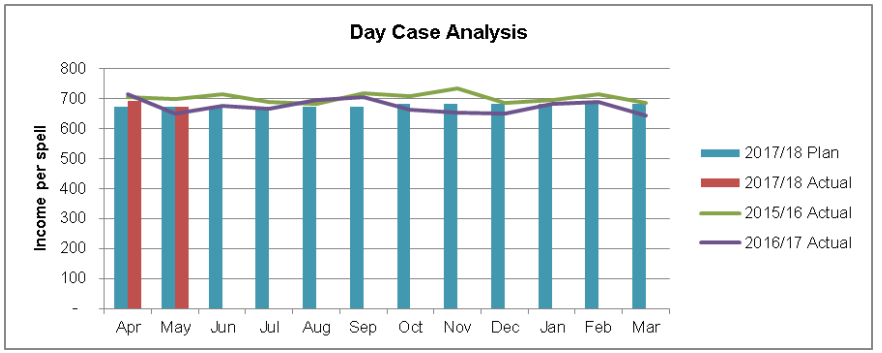


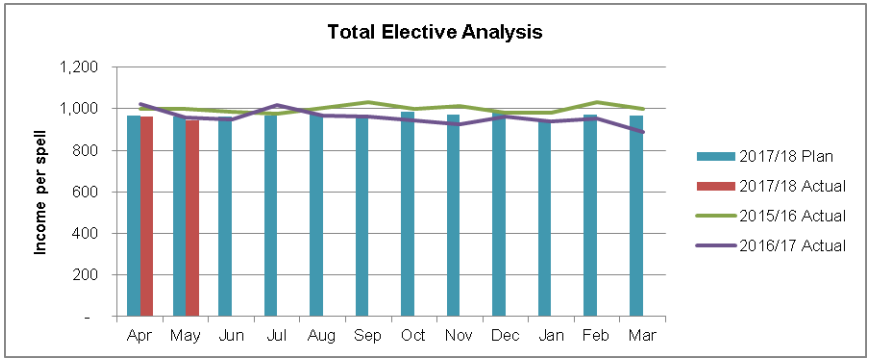


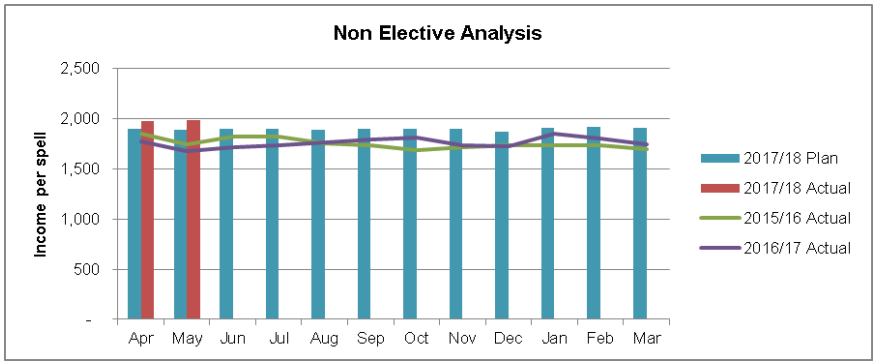


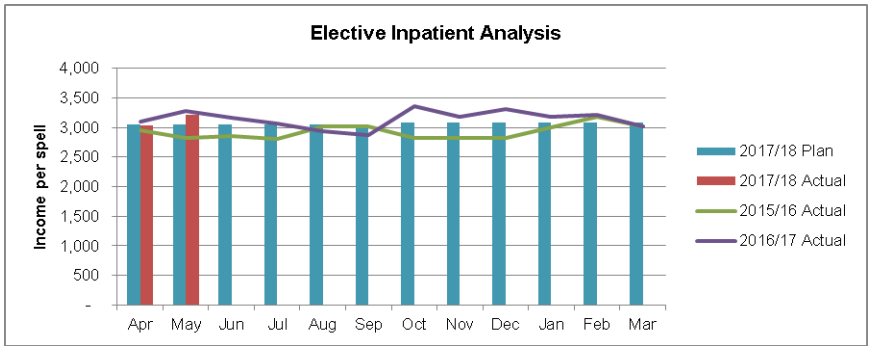
Trends and Analysis

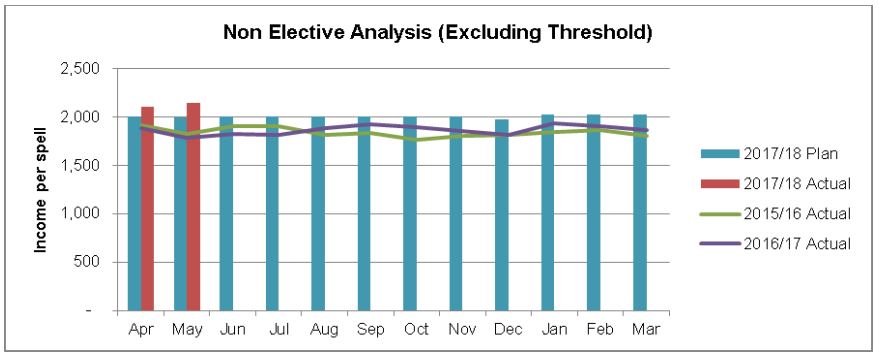












FINANCE AND WORKFORCE REPORT – May 2017

Workforce

Monthly Expenditure Acute services only				
As at May 2017	May-17	Apr-17	May-16	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	**11,163**	**10,798**	**10,885**	**21,955**
Substantive Staff	9,695	9,553	9,313	19,237
Medical Agency Staff (includes 'contracted in' staff)	136	143	157	280
Medical Locum Staff	231	166	112	397
Additional Medical sessions	263	223	244	494
Nursing Agency Staff	66	72	182	138
Nursing Bank Staff	154	228	248	383
Other Agency Staff	76	45	367	117
Other Bank Staff	133	152	114	286
Overtime	89	109	63	198
On Call	59	44	41	106
Total temporary expenditure	1,208	1,181	1,528	2,398
Total expenditure on pay	**10,903**	**10,734**	**10,841**	**21,635**
Variance (F/(A))	260	64	44	320
Temp Staff costs % of Total Pay	11.1%	11.0%	14.1%	11.1%
Memo : Total agency spend in month	278	260	706	535

Monthly whole time equivalents (WTE) Acute Services only			
As at May 2017	May-17	Apr-17	May-16
	WTE	WTE	WTE
Budgeted WTE in month	**3,095.0**	**3,095.6**	**3,036.5**
Employed substantive WTE in month	**2725.03**	**2737.36**	**2,673.7**
Medical Agency Staff (includes 'contracted in' staff)	14.74	8.52	8.7
Medical Locum	18.06	12.32	12.5
Additional Sessions	21.85	22.15	21.7
Nursing Agency	10.26	11.47	28.1
Nursing Bank	50.16	73.21	80.9
Other Agency	20.29	12.73	40.0
Other Bank	60.75	75.33	55.1
Overtime	40.99	50.88	29.7
On call Worked	11.23	8.51	7.7
Total equivalent temporary WTE	**248.3**	**275.1**	**284.4**
Total equivalent employed WTE	**2,973.4**	**3,012.5**	**2,958.1**
Variance (F/(A))	121.7	83.1	78.5
Temp Staff WTE % of Total Pay	8.4%	9.1%	9.6%
Memo : Total agency WTE in month	45.3	32.7	76.7
Sickness Rates (April/March)	3.62%	2.31%	3.75%
Mat Leave	2.1%	2.3%	2.1%

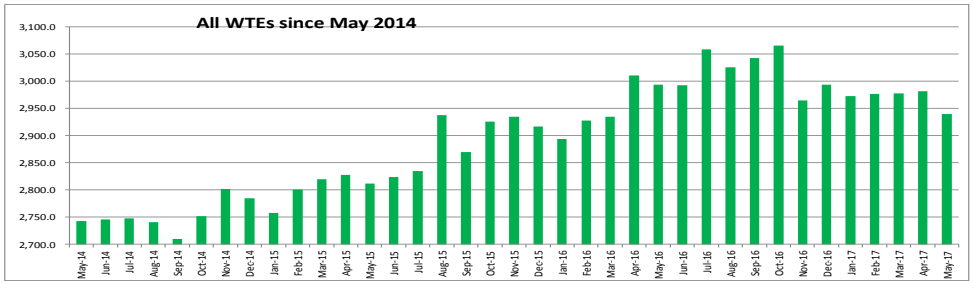
Monthly Expenditure Community Service				
As at May 2017	May-17	Apr-17	May-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,129**	**1,106**	**1,013**	**2,242**
Substantive Staff	1,049	1,053	934	2,105
Medical Agency Staff (includes 'contracted in' staff)	14	14	(15)	28
Medical Locum Staff	3	3	7	6
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	0	2	1	3
Nursing Bank Staff	16	15	6	31
Other Agency Staff	24	34	(3)	58
Other Bank Staff	7	12	8	19
Overtime	5	4	5	9
On Call	1	2	0	3
Total temporary expenditure	70	86	8	156
Total expenditure on pay	**1,120**	**1,139**	**943**	**2,261**
Variance (F/(A))	9	(33)	(6)	(19)
Temp Staff costs % of Total Pay	6.3%	7.5%	0.9%	6.9%
Memo : Total agency spend in month	38	50	(17)	89

Monthly whole time equivalents (WTE) Community Services			
As at May 2017	May-17	Apr-17	May-16
	WTE	WTE	WTE
Budgeted WTE in month	**380.57**	**380.57**	**333.4**
Employed substantive WTE in month	**343.1**	**344.5**	**312.9**
Medical Agency Staff (includes 'contracted in' staff)	1.5	1.5	0.0
Medical Locum	0.4	0.4	0.8
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.1	0.4	0.1
Nursing Bank	5.1	4.6	1.8
Other Agency	9.9	9.2	4.1
Other Bank	2.2	3.3	2.8
Overtime	2.5	2.3	2.4
On call Worked	0.0	0.0	(0.9)
Total equivalent temporary WTE	**21.5**	**21.6**	**11.0**
Total equivalent employed WTE	**364.6**	**366.2**	**323.8**
Variance (F/(A))	16.0	14.4	9.6
Temp Staff WTE % of Total Pay	5.9%	5.9%	3.4%
Memo : Total agency WTE in month	11.4	11.1	4.2
Sickness Rates (April/March)	3.80%	3.80%	3.80%
Mat Leave	1.1%	1.2%	1.2%

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

Staffing levels

The following graphs exclude Community staff but include Capitalised staff.

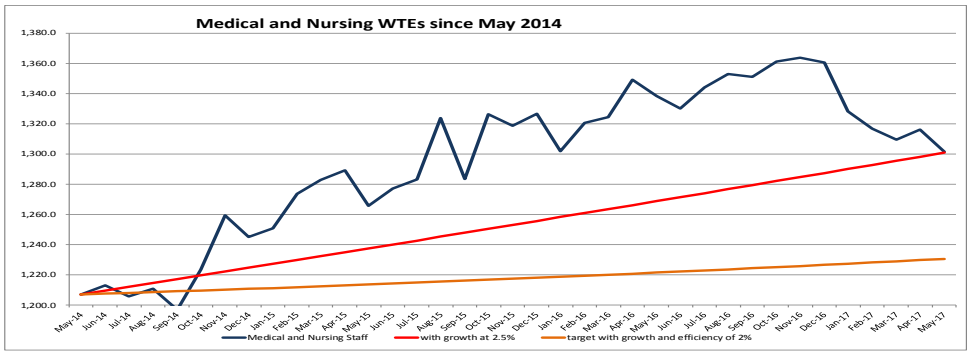


Since May 2014, (excluding Community staff) the Trust has employed 197 more WTEs, an increase of 7.2%. During this same period activity has grown by around 7.5%

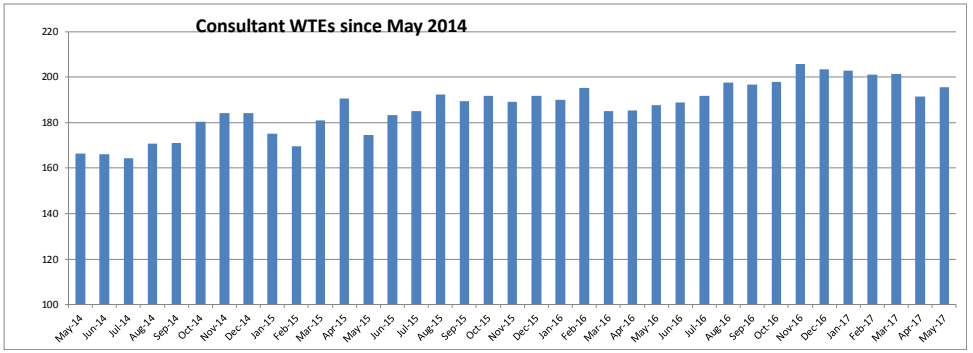
The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 95 WTEs (blue line). This includes around 29 WTE Consultants which are analysed further below.

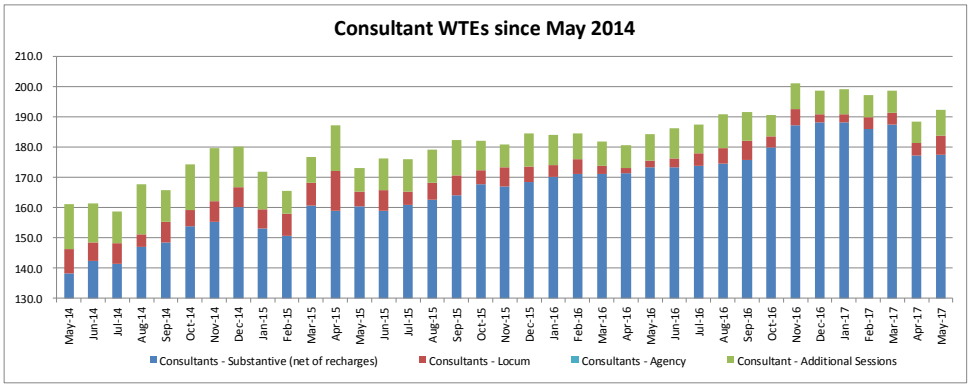
There has been a decrease of 41 WTE during May. Medical staffing have increased by 4 WTE since April 2017, largely as the result of increases in medical agency and locum staff.

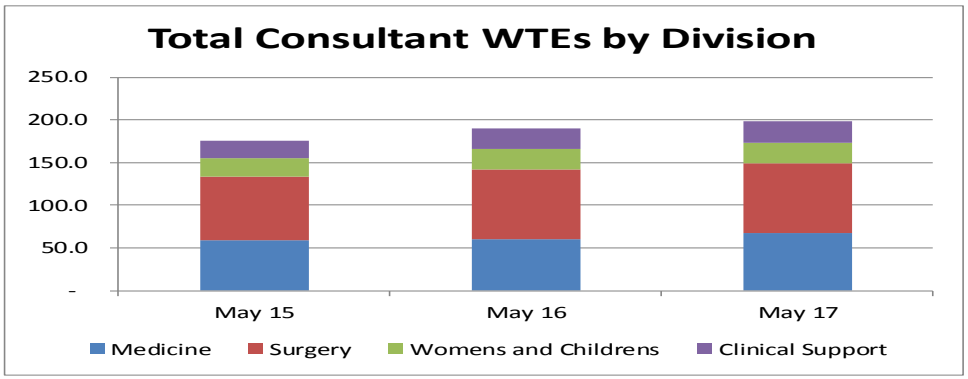
If medical and nursing staffing levels had increased in line with our growth in activity of broadly 2.5% we would currently be employing 1 less member of staff (red line). In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 71 WTE fewer than at May 2017.



The graphs below highlight the increase in Consultant WTEs of 20% over the past 3 years. Substantive staff have increased by 29% whilst temporary staff have dropped by only 10%.

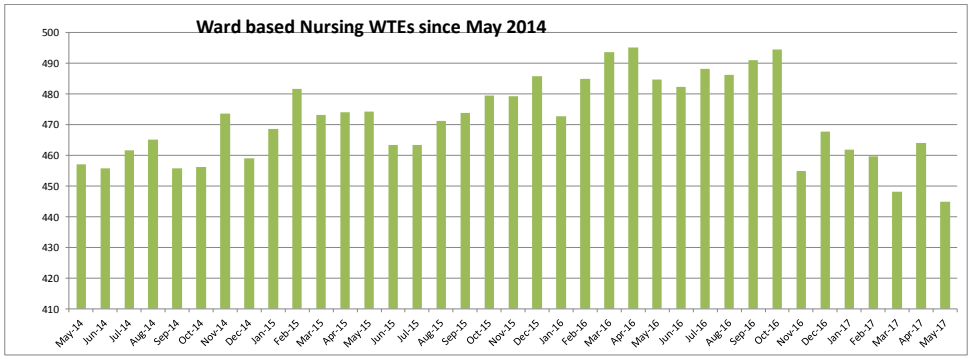






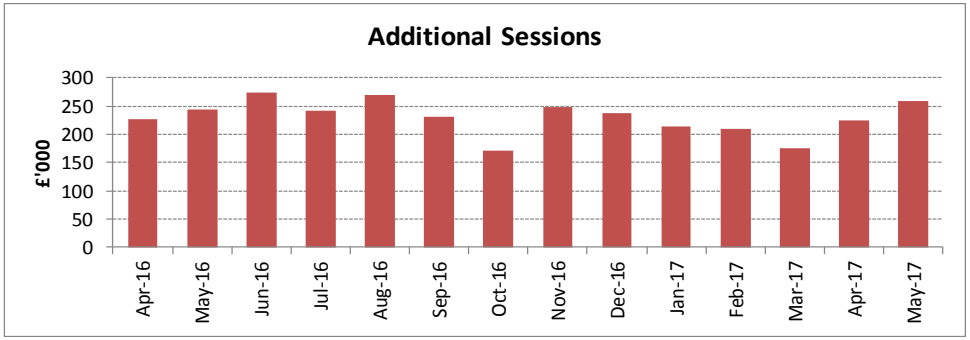
FINANCE AND WORKFORCE REPORT – May 2017

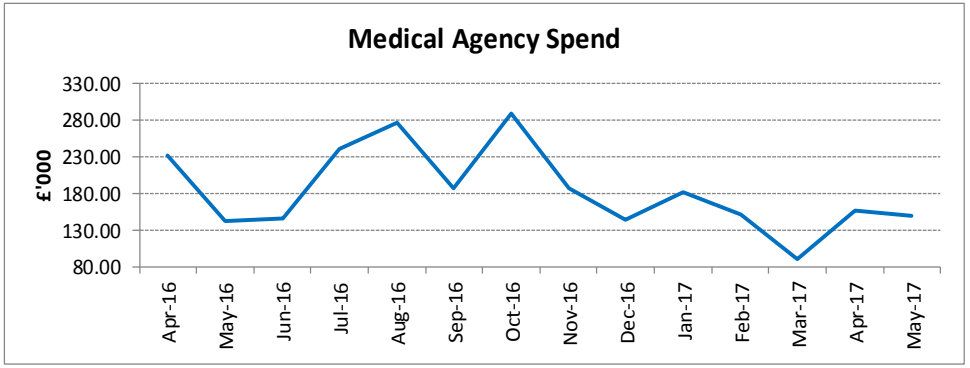
Division	Specialty	Sum of May-15	Sum of May-16	Sum of May-17
Medicine	A&E Medical Staff	5.8	5.2	7.9
	Cardiology	4.8	4.0	5.0
	Chest Medicine	4.0	4.0	4.1
	Chronic Pain Service	0.7	1.3	0.7
	Clinical Haematology	4.1	4.1	4.4
	Dermatology	4.4	5.4	4.2
	Diabetes	4.1	4.3	4.4
	Eau Medical Staff	6.8	7.4	9.4
	Gastroenterology	4.7	6.0	7.9
	General Medicine	6.3	7.2	5.9
	Nephrology	0.5	0.1	0.8
	Neurology	2.4	2.2	2.6
	Oncology	3.1	3.2	2.7
	Palliative Care	0.4	0.1	0.3
	Rheumatology	3.3	2.9	3.9
	Stroke	3.5	3.4	3.8
Medicine Total		**58.8**	**60.8**	**68.0**
Surgery	Anaesthetics	30.5	34.5	32.7
	E.N.T.	3.1	3.2	3.0
	General Surgery	11.5	10.9	9.8
	Ophthalmology	6.7	7.7	7.5
	Oral & Maxofacial Surg	1.1	1.0	1.0
	Plastic Surgery	2.7	2.9	4.3
	Trauma & Orthopaedic	13.2	13.8	13.7
	Urology	4.4	5.5	8.1
	Vascular Surgery	1.0	1.3	1.2
Surgery Total		**74.2**	**80.8**	**81.2**
Women and Childrens	Obstetrics	10.8	12.6	12.8
	Paediatrics	11.3	11.3	10.9
Women and Childrens Total		**22.1**	**23.9**	**23.7**
Clinical Support	Chemistry	0.4	0.7	0.7
	Histopathology	7.2	7.5	8.0
	Microbiology	3.3	3.3	3.2
	MRI	0.9	0.9	0.9
	Xray - Wsh	10.0	12.3	12.4
Clinical Support Total		**21.8**	**24.7**	**25.3**
Grand Total		**176.8**	**190.1**	**198.1**

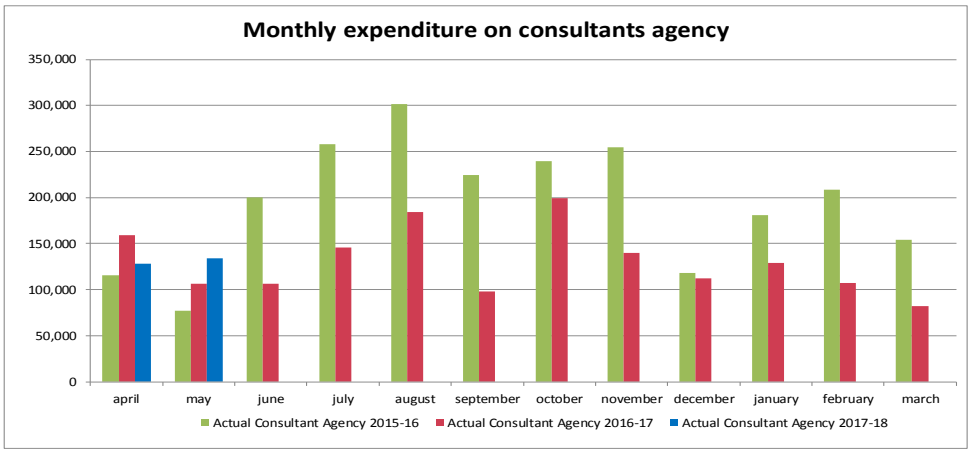


Pay Trends and Analysis

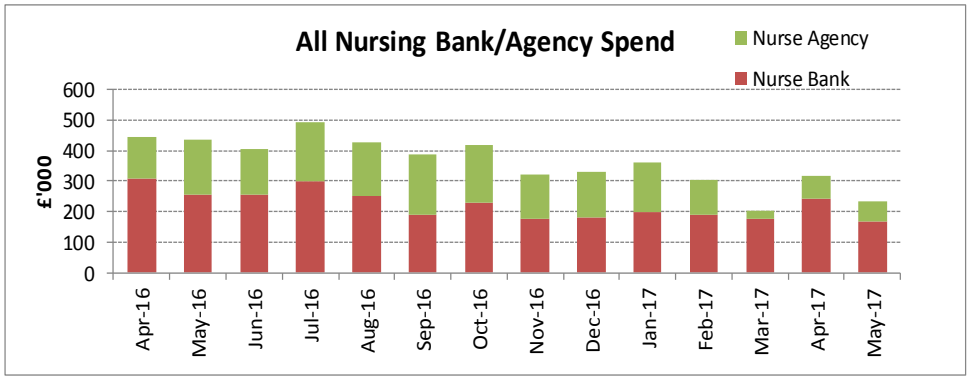
The Trust underspent pay budgets by £272k in May (£304k YTD).

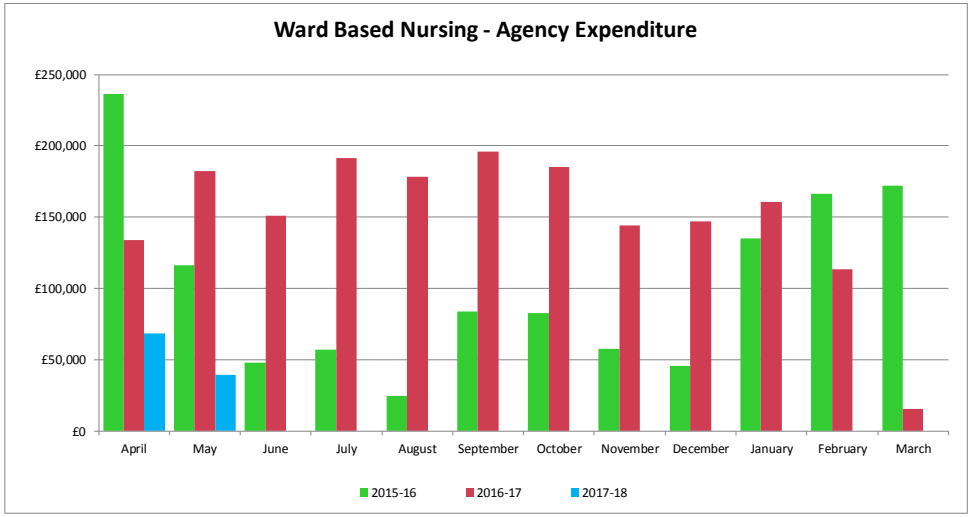


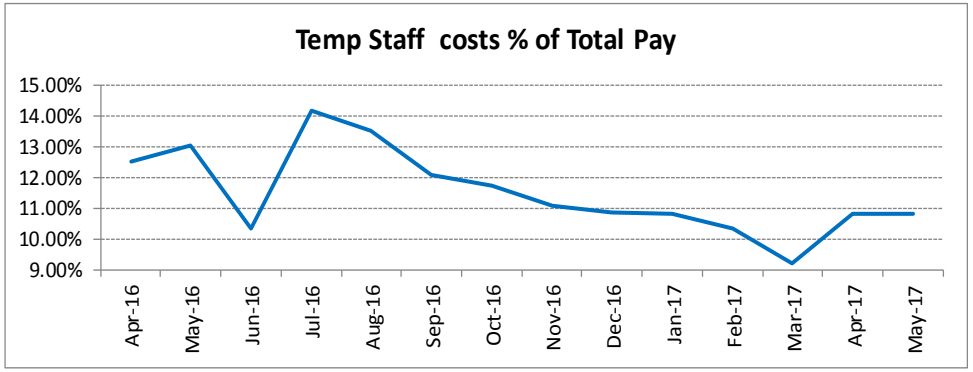




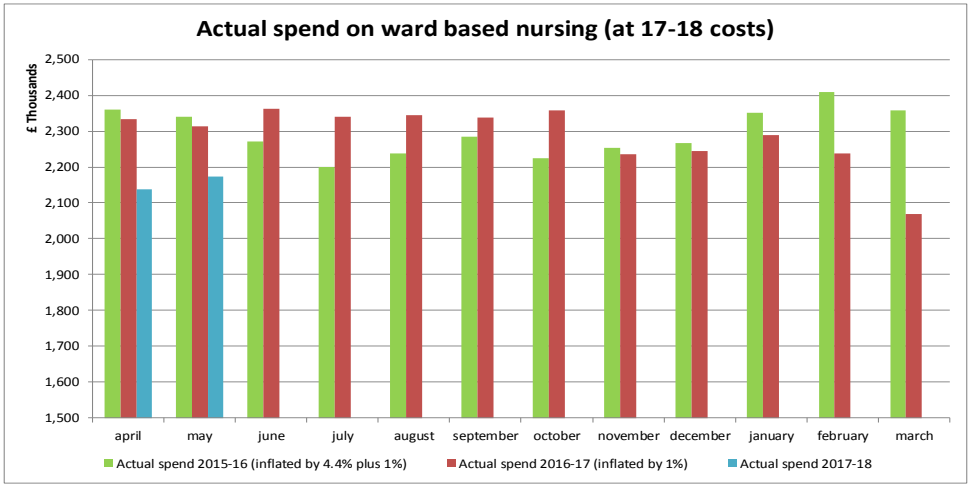
FINANCE AND WORKFORCE REPORT – May 2017

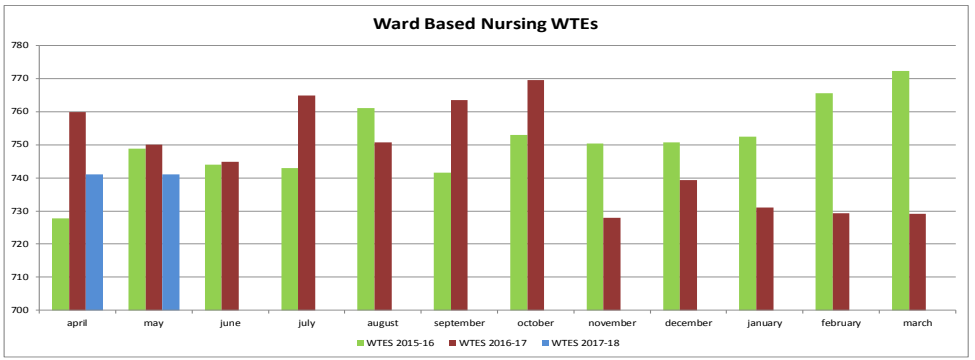


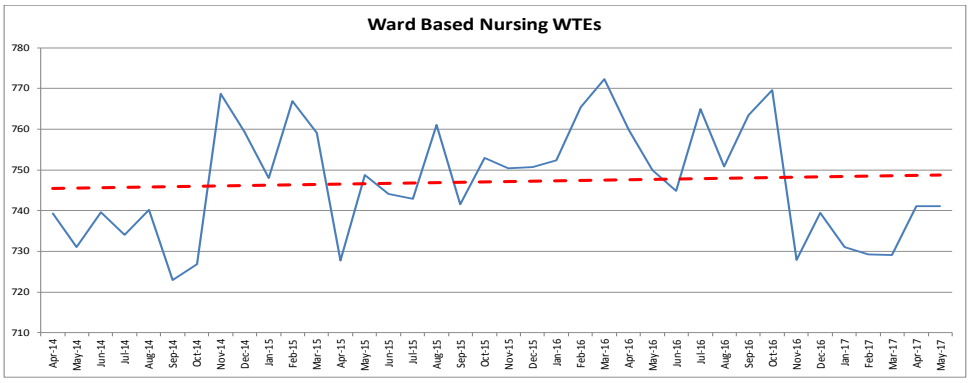




Ward Based Nursing







FINANCE AND WORKFORCE REPORT – May 2017

Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	May-17 Budget £k	May-17 Actual £k	May-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	(5,538)	(5,634)	95	(10,518)	(10,581)	63
Pay Costs	3,467	3,434	33	6,805	6,775	30
Non-pay Costs	1,429	1,467	(38)	2,704	2,761	(57)
Operating Expenditure	**4,897**	**4,901**	**(5)**	**9,509**	**9,536**	**(26)**
SURPLUS / (DEFICIT)	**642**	**732**	**91**	**1,009**	**1,046**	**37**
SURGERY						
Total Income	(4,776)	(4,904)	128	(9,315)	(9,501)	186
Pay Costs	3,028	3,105	(77)	5,976	6,052	(76)
Non-pay Costs	1,037	1,031	6	2,051	1,951	100
Operating Expenditure	**4,065**	**4,135**	**(71)**	**8,027**	**8,003**	**24**
SURPLUS / (DEFICIT)	**711**	**769**	**58**	**1,289**	**1,498**	**209**
WOMENS and CHILDRENS						
Total Income	(2,288)	(2,172)	(116)	(4,074)	(3,895)	(180)
Pay Costs	1,116	1,123	(8)	2,209	2,222	(13)
Non-pay Costs	138	125	13	270	220	49
Operating Expenditure	**1,253**	**1,248**	**5**	**2,479**	**2,443**	**36**
SURPLUS / (DEFICIT)	**1,034**	**923**	**(111)**	**1,596**	**1,452**	**(143)**
CLINICAL SUPPORT						
Total Income	(973)	(948)	(25)	(1,871)	(1,810)	(61)
Pay Costs	1,706	1,681	25	3,379	3,320	59
Non-pay Costs	1,077	1,163	(85)	2,000	2,193	(193)
Operating Expenditure	**2,783**	**2,844**	**(61)**	**5,379**	**5,513**	**(133)**
SURPLUS / (DEFICIT)	**(1,810)**	**(1,896)**	**(86)**	**(3,508)**	**(3,703)**	**(195)**
COMMUNITY SERVICES						
Total Income	(10,824)	(10,868)	44	(21,646)	(21,700)	54
Pay Costs	1,129	1,120	9	2,242	2,261	(19)
Non-pay Costs	4,184	4,250	(66)	8,362	8,311	51
Operating Expenditure	**5,313**	**5,370**	**(57)**	**10,604**	**10,573**	**31**
SURPLUS / (DEFICIT)	**5,511**	**5,498**	**(13)**	**11,042**	**11,127**	**85**
ESTATES and FACILITIES						
Total Income	(371)	(368)	(3)	(742)	(691)	(52)
Pay Costs	746	762	(16)	1,497	1,496	1
Non-pay Costs	593	583	10	1,152	1,124	28
Operating Expenditure	**1,338**	**1,344**	**(6)**	**2,649**	**2,619**	**30**
SURPLUS / (DEFICIT)	**(967)**	**(976)**	**(9)**	**(1,907)**	**(1,929)**	**(22)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	3,429	3,353	76	6,554	6,350	205
Pay Costs	843	795	48	1,690	1,768	(78)
Non-pay Costs (net of contingency and reserves)	1,267	1,438	(171)	2,270	2,319	(49)
Finance & Capital	706	560	146	1,119	1,087	32
Operating Expenditure	**2,816**	**2,793**	**23**	**5,079**	**5,174**	**(95)**
SURPLUS / (DEFICIT)	**(6,245)**	**(6,147)**	**99**	**(11,634)**	**(11,525)**	**109**
TOTAL (including penalties, contingency and reserves)						
Total Income	(21,341)	(21,540)	199	(41,613)	(41,826)	214
Contract Penalties	0	0	0	0	0	0
Pay Costs	12,034	12,020	14	23,798	23,894	(95)
Non-pay Costs	9,726	10,057	(331)	18,809	18,879	(71)
Finance & Capital	706	560	146	1,119	1,087	32
Operating Expenditure (incl penalties)	**22,465**	**22,636**	**(171)**	**43,726**	**43,860**	**(134)**
SURPLUS / (DEFICIT)	**(1,125)**	**(1,096)**	**28**	**(2,113)**	**(2,034)**	**80**

Medicine (Annie Campbell)

The Division over performed by £91k in May (£37k YTD)

Contract Income was £91k above plan for the month, and £10k behind plan for the year to date. This was due to a combination of good performance and a review of the income plan for Medicine. The biggest improvement from April was outpatients – mainly in Rheumatology, Diabetes and Cardiology.

The review of the contract income plan improved ED attendance income and addressed the loss of Glastonbury Court/G9 activity.

Non-contract income was ahead of budget and this will improve in June/July with income from two USAF patients, who were in G8 and F9.

Pay underspent by £33k in the month. This was driven by the reduction of agency costs in the Division. Nurse Agency was less than a third of the value from the same period last year, with the biggest savings seen in ED, AMU and the Escalation Ward - the latter was closed earlier this year by the Division. Medical agency costs were also a third of the amount recorded last year. ED and AMU also improved, bolstered by the impact of clinicians moving to locum/payroll positions due to the imposition of IR35 by HMRC.

Non-pay costs were generally well controlled, the exception being drugs. The world-wide supply issue with the antibiotic Tazocin mostly affects Medicine. This was exacerbated in May by other producers taking their products off-contract and there was a considerable increase in prices. This resulted in a £54k overspend and is unlikely to be resolved soon.

There was an over performance on CIPs in the month (led by agency), and the current forecast is that the Division will meet or even exceed its targets. The fact that its expenditure budget has been underspent for the first two months provides some assurance together with improvements later in the year and a pipeline with further CIPs being developed.

Surgery (Simon Taylor)

The Division has over performed by £58k in May (£209k YTD)

Income over achieved against plan by £128k. This was mainly due to Elective activity which will aid the RTT position. Outpatient activity was behind plan for the month.

Pay was overspent by £77k, with the overspend relating to redundancy costs as well as using an agency urology consultant to support the on call rota. This pressure from the urology consultant will continue for the short to medium term.

Non-pay was underspent by £6k with much of the underspend in theatres. There has been an overspend on hearing aids due to increased dispensing levels as a result of greater availability of audiologists to deliver the activity.

Surgery CIP's have over achieved by £74k YTD due to favourable variance on several CIP's. Some CIP's have delivered earlier than planned and the division also achieved higher vacancy management than planned.

Whilst the division has plans that would deliver the full CIP target, some of these plans are currently still high risk and require more analysis and work. RAG ratings and forecasts are reviewed each month and the division has been reviewing further CIP's to support any shortfall.

Women and Children's (Rose Smith)

In May, the Division, reported an under performance of £111k (£143k YTD).

Clinical income reported a £116k adverse variance in month (£183k YTD). The underperformance is in both Obstetrics and Midwifery Services due to a lower number of births compared to plan (£86k in-month). There also appears to be a shift in casemix of women on the antenatal pathway, with more women being categorised as standard as opposed to intermediate (21 women) and intensive (18 women) which both attract higher tariffs. This has resulted in £30k less income being received in-month. Gynaecology saw fewer outpatients causing an under-recovery of income of £21k. This underperformance was offset against increases in admitted patient care income of £18k.

Pay reported £8k overspend in-month and £13k YTD due to adverse variances on medical staffing in Paediatrics.

Non pay reported a £13k underspend in-month and £49k YTD, due to an underspend in drugs across the division and a further reduction in spend on FP10's within Paediatrics over and above the CIP scheme value.

Clinical Support (Rose Smith)

The Division has underperformed by £86k in-month and £195k YTD.

Clinical income for Clinical Support reported an £11k under performance in-month and £38k YTD, mainly due to an underperformance in Diagnostic Imaging in both breast screening and direct access activity (£30k). This was offset by over activity in admitted patient care income for Interventional Radiology (£25k).

Other Income was £14k behind plan in-month and £32k YTD. This includes Private Physiotherapy Service (£12k) although this is an improvement from April and EIT Service (£10k) linked to unfilled new posts.

Pay reported a £25k underspend in-month and £60k YTD due to vacancies mainly in EIT partly offset against an underperformance in income (£29k), and Nursing vacancies within Outpatients (£8k). These underspends have been offset against Pharmacy overtime £6k and Diagnostic pay overspends of £6k, due to additional sessions and temporary staffing to cover vacancies.

Non pay reported £85k overspend in-month and £192k YTD. Overspends within Diagnostics (£57k) are due to a contract variation in Radiology £35k, Consumables overspend within Chrystal £8k, and use of In-Health for outsourced Endoscopy cases and Pathology (£15k) to address backlogs and increase in blood product usage.

Community Services (Dawn Godbold)

The Division reported a £13k under performance (£85k over performance YTD).

Contract Income reported a £44k over recovery in-month mainly due to CCG income for both Lymphoedema Service and additional income to cover the cost of agency within Paediatric SALT. This is offset by agency costs within Pay.

Pay reported an £9k underspend in-month and £19k overspend YTD. There have been vacancies within Clinical Governance, Change and Informatics, Paediatrics, Lymphoedema and Adult Speech and Language Therapy. These underspends have been offset against overspends within Glastonbury Court, (£12k) due to a delay in implementing a new rota. This is not expected to improve until July, when the first change in rota will be implemented

Non pay reported a £66k overspend in-month and a £51k underspend YTD. There have been in-month underspends offset against a one off cost relating to Systmone licences of £150k. Continence products are expected to reduce following a new contract award.

There remains risk around income assumed from Suffolk County Council for CES services (since October 2015), and the disputed payments to NHSPS for property rental (since October 2015 - the expenditure position assumes only the amount we have agreed to pay).

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:

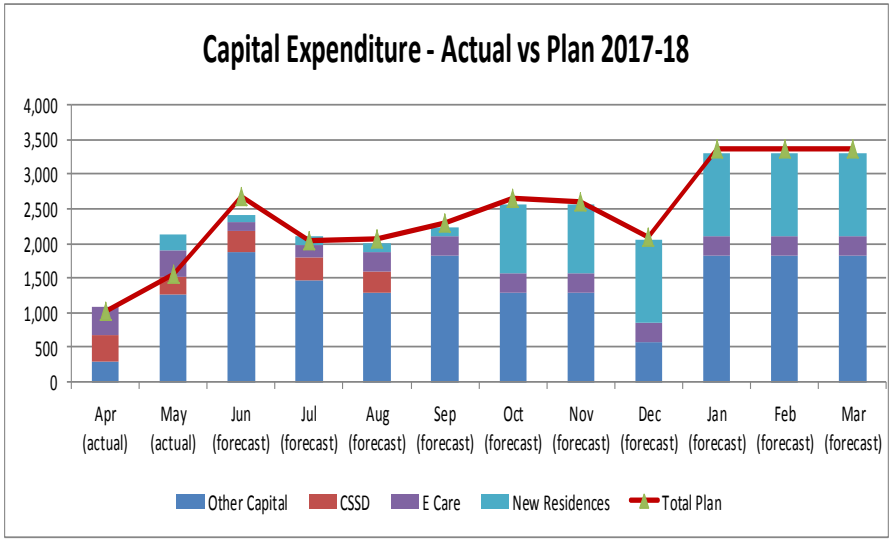
- 1 is the highest score and 4 is the lowest
- The I&E margin ratio is based on a control total basis rather than normalised surplus (deficit).
- The Agency rating measures expenditure on agency staff as a proportion of the ceiling set for agency staff. A positive value indicates an adverse variance 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	-3.189	4
Liquidity rating	-12.151	3
I&E Margin rating	-4.90%	4
I&E Margin Variance rating	1.60%	1
Agency	-41.20%	1
Use of Resources Rating after Overrides		**3**

The Trust is scoring an overall UoR of **3**.

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

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Forecast £'000	Jul Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2017-18 £'000
E Care	415	364	144	171	278	278	278	278	278	278	278	278	3,316
CSSD	384	260	299	322	323	0	0	0	0	0	0	0	1,588
New Residences	0	246	85	123	123	123	1,000	1,000	1,200	1,200	1,200	1,200	7,500
Other Schemes	296	1,271	1,876	1,480	1,280	1,833	1,294	1,286	572	1,834	1,834	1,832	16,686
Total forecast / Forecast	1,096	2,140	2,403	2,095	2,004	2,234	2,571	2,563	2,049	3,311	3,311	3,309	29,089
Total Plan	1,012	1,568	2,673	2,034	2,058	2,283	2,643	2,612	2,103	3,365	3,365	3,363	29,082

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

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

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

Expenditure on e-Care for the year to date is £779k and this is in line with the budget for the same period. The E-Care programme budget reflects the increased scope associated with the Global Digital Excellence (GDE) funding.

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

FINANCE AND WORKFORCE REPORT – May 2017

Statement of Financial Position at 31st May 2017

A plan was submitted to NHS Improvement in March 2017. There have been significant changes since then so a revised plan has been developed for internal monitoring to reflect the revised 2016-17 final position and known changes in this year. A summary of the changes is shown below and the detailed monthly plan is shown in Appendix A.

STATEMENT OF FINANCIAL POSITION- revised internal plan

	Plan 1 April 2017 £000	Plan 31 March 2018 £000	Actual 1 April 2017 £000	Revised (Internal) Plan 31 March 2018 £000	Comments
Intangible assets	17,912	22,025	15,611	19,711	in line with capital programme
Property, plant and equipment	73,801	92,130	74,053	94,189	in line with capital programme
Trade and other receivables	340	0	0	0	
Other financial assets	4,909	4,909	0	0	tPP investment written off
Total non-current assets	**96,962**	**119,064**	**89,664**	**113,900**	
Inventories	2,850	2,950	2,693	2,600	
Trade and other receivables	11,959	11,700	18,345	11,700	
Other financial assets	0		0		
Non-current assets for sale	0	0	0	0	
Cash and cash equivalents	1,000	1,000	1,352	1,000	
Total current assets	**15,809**	**15,650**	**22,390**	**15,300**	
Trade and other payables	(21,538)	(26,474)	(23,434)	(28,195)	reflects profile of capital programme
Borrowing repayable within 1 year	(7,500)	(7,500)	(534)	(1,796)	reclassfication of working capital financing facility
Current Provisions	(84)	(84)	(61)	(61)	
Other liabilities	(295)	(295)	(1,325)	(295)	
Total current liabilities	**(29,417)**	**(34,353)**	**(25,354)**	**(30,347)**	
Total assets less current liabilities	**83,354**	**100,361**	**86,700**	**98,853**	
Trade and other payables	(1,083)	(3,160)	0	0	all payables expected to be current
Borrowings	(37,408)	(53,122)	(44,375)	(55,951)	reclassification of working capital financing facility
Provisions	(203)	(203)	(181)	(158)	
Total non-current liabilities	**(38,694)**	**(56,485)**	**(44,556)**	**(56,109)**	
Total assets employed	**44,660**	**43,876**	**42,144**	**42,744**	
Financed by					
Public dividend capital	59,232	64,215	59,232	65,732	Emergency Department Primary Care Streaming
Revaluation reserve	2,151	2,300	3,621	3,621	2016/17 revaluation
Income and expenditure reserve	(16,723)	(22,639)	(20,709)	(26,609)	2016/17 tPP write off
Total taxpayers' and others' equity	**44,660**	**43,876**	**42,144**	**42,744**	

Our performance against the revised plan is reported in the following table.

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2017 £000	Plan 31 March 2018 £000	Plan YTD 31 May 2017 £000	As at 31 May 2017 £000	Variance YTD 31 May 2017 £000
Intangible assets	15,611	19,711	16,201	16,202	1
Property, plant and equipment	74,053	94,189	75,903	75,903	0
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**	**92,104**	**92,105**	**1**
Inventories	2,693	2,600	2,666	2,666	0
Trade and other receivables	18,345	11,700	17,764	17,765	1
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	5,093	5,093	(0)
Total current assets	**22,390**	**15,300**	**25,523**	**25,523**	**0**
Trade and other payables	(23,434)	(28,195)	(23,298)	(23,299)	(1)
Borrowing repayable within 1 year	(534)	(1,796)	(2,302)	(2,302)	0
Current ProvisionsProvisions	(61)	(61)	(89)	(89)	0
Other liabilities	(1,325)	(295)	(5,962)	(5,962)	(0)
Total current liabilities	**(25,354)**	**(30,347)**	**(31,651)**	**(31,652)**	**(1)**
Total assets less current liabilities	**86,700**	**98,853**	**85,976**	**85,976**	**0**
Borrowings	(44,375)	(55,951)	(45,704)	(45,704)	0
Provisions	(181)	(158)	(163)	(163)	(0)
Total non-current liabilities	**(44,556)**	**(56,109)**	**(45,867)**	**(45,867)**	**0**
Total assets employed	**42,144**	**42,744**	**40,109**	**40,109**	**0**
Financed by					
Public dividend capital	59,232	65,732	59,232	59,232	(0)
Revaluation reserve	3,621	3,621	3,621	3,621	(0)
Income and expenditure reserve	(20,709)	(26,609)	(22,744)	(22,744)	0
Total taxpayers' and others' equity	**42,144**	**42,744**	**40,109**	**40,109**	**(0)**

As the plan has been revised there are currently no variances against plan to report.

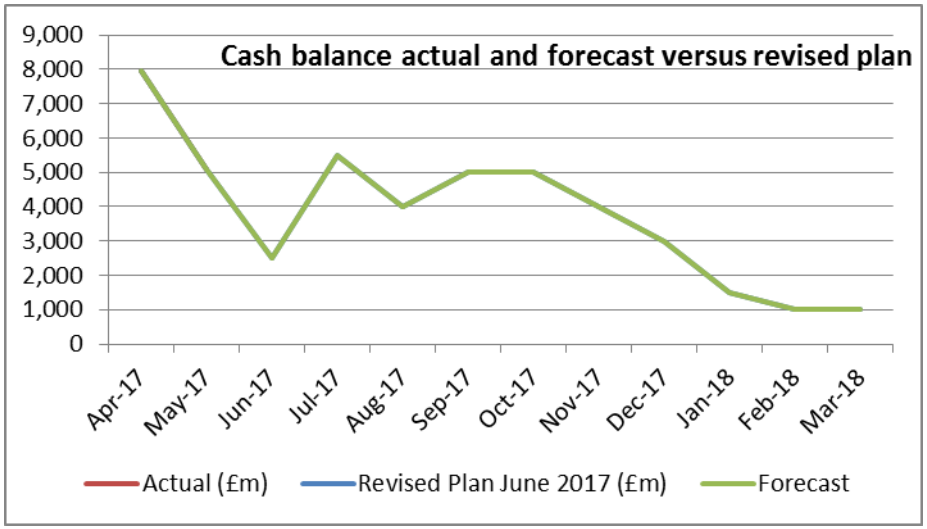
Cash:

The Trust has still not received the anticipated £3.3m GDE cash but he process to draw the money down has now been communicated and is in progress. In response to the uncertainty and delay the Trust accelerated the drawdown of the capital loan by £3.3m in March.

The Trust had planned for the £4.8 million 2016/17 Sustainability and Transformation Funding to be paid in June but we have just been informed we will receive the cash late August at the earliest. As a result the assumption is it will be received in September and therefore the repayment of the revenue support loan will be delayed until September too.

FINANCE AND WORKFORCE REPORT – May 2017

Cash Balance Forecast for the year

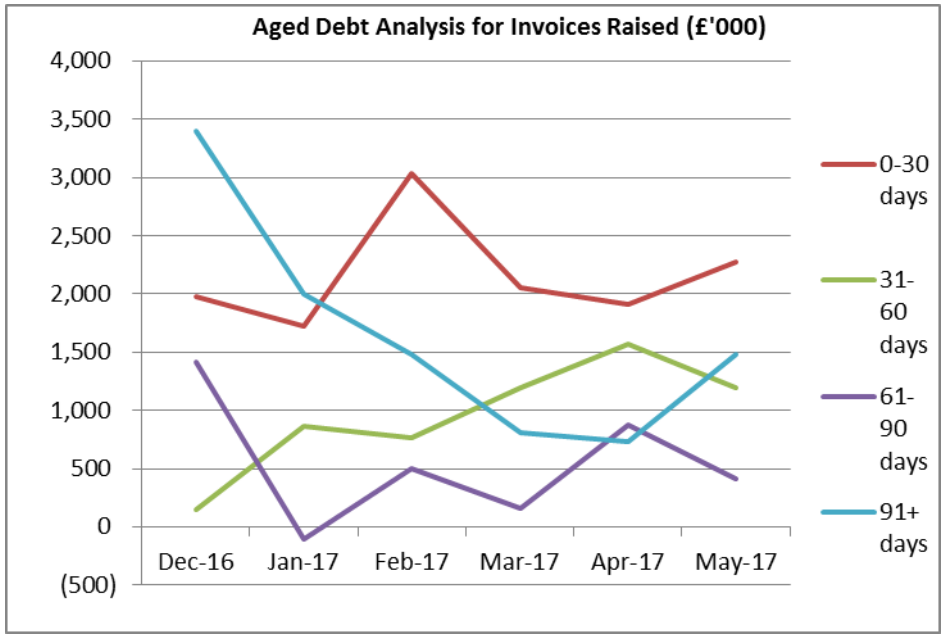


The graph illustrates the cash trajectory year to date, plan and revised forecast. As the plan has been revised this month there is no variance to report. It assumes receipt of STF funding and repayment of 2017/18 distress funding in September 2017.

Debt Management

It is important that the Trust raises invoices promptly for money owed and that the cash is collected as quickly as possible to minimise the amount of money the Trust needs to borrow.

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



Debt outstanding for over 90 days has increased because £683k of charges to Suffolk County Council for Community Equipment is now in that category.

The increase in debt 0-30 days is mainly caused by an unusually high private patient invoice raised in May.

FINANCE AND WORKFORCE REPORT – May 2017

Appendix A

STATEMENT OF FINANCIAL POSITION- revised internal plan

	Actual 1 April 2017	Revised Plan May 2017	June 2017	July 2017	Aug 2017	Sept 2017	October 2017	November 2017	December 2017	Jan 2018	Feb 2018	March 2018
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Intangible assets	15,611	16,201	17,142	17,370	17,605	18,180	18,435	18,690	18,945	19,200	19,455	19,711
Property, plant and equipment	74,053	75,903	76,970	78,440	79,812	81,074	82,993	84,904	86,301	88,959	91,618	94,189
Total non-current assets	**89,664**	**92,104**	**94,112**	**95,810**	**97,417**	**99,254**	**101,428**	**103,594**	**105,246**	**108,159**	**111,073**	**113,900**
Inventories	2,693	2,666	2,700	2,700	2,700	2,700	2,700	2,700	2,700	2,700	2,700	2,600
Trade and other receivables	18,345	17,764	17,011	16,675	16,470	15,000	14,921	14,500	15,796	15,631	13,668	11,700
Cash and cash equivalents	1,352	5,093	2,500	5,500	4,000	5,000	5,000	4,000	3,000	1,500	1,000	1,000
Total current assets	**22,390**	**25,523**	**22,211**	**24,875**	**23,170**	**22,700**	**22,621**	**21,200**	**21,496**	**19,831**	**17,368**	**15,300**
Trade and other payables	(23,434)	(23,298)	(22,000)	(23,039)	(23,131)	(26,067)	(25,908)	(25,727)	(25,419)	(25,619)	(27,120)	(28,195)
Borrowing repayable within 1 year	(534)	(2,302)	(2,299)	(2,299)	(2,299)	(2,048)	(2,048)	(2,048)	(2,049)	(2,049)	(2,049)	(1,796)
Current Provisions	(61)	(89)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(61)
Other liabilities	(1,325)	(5,962)	(6,000)	(6,000)	(4,500)	(4,000)	(3,500)	(3,000)	(2,500)	(2,000)	(1,000)	(295)
Total current liabilities	**(25,354)**	**(31,651)**	**(30,383)**	**(31,422)**	**(30,014)**	**(32,199)**	**(31,540)**	**(30,859)**	**(30,052)**	**(29,752)**	**(30,253)**	**(30,347)**
Total assets less current liabilities	**86,700**	**85,976**	**85,940**	**89,263**	**90,573**	**89,755**	**92,509**	**93,935**	**96,690**	**98,238**	**98,188**	**98,853**
Borrowings	(44,375)	(45,704)	(45,668)	(45,968)	(47,768)	(47,326)	(49,094)	(50,562)	(52,189)	(53,657)	(54,824)	(55,951)
Provisions	(181)	(163)	(163)	(163)	(163)	(163)	(163)	(163)	(163)	(163)	(163)	(158)
Total non-current liabilities	**(44,556)**	**(45,867)**	**(45,831)**	**(46,131)**	**(47,931)**	**(47,489)**	**(49,257)**	**(50,725)**	**(52,352)**	**(53,820)**	**(54,987)**	**(56,109)**
Total assets employed	**42,144**	**40,109**	**40,109**	**43,132**	**42,642**	**42,266**	**43,252**	**43,210**	**44,338**	**44,418**	**43,201**	**42,744**
Public dividend capital	59,232	59,232	59,232	62,565	62,565	62,565	63,565	63,565	65,732	65,732	65,732	65,732
Revaluation reserve	3,621	3,621	3,621	3,621	3,621	3,621	3,621	3,621	3,621	3,621	3,621	3,621
Income and expenditure reserve	(20,709)	(22,744)	(22,744)	(23,054)	(23,544)	(23,920)	(23,934)	(23,976)	(25,015)	(24,935)	(26,152)	(26,609)
Total taxpayers' and others' equity	**42,144**	**40,109**	**40,109**	**43,132**	**42,642**	**42,266**	**43,252**	**43,210**	**44,338**	**44,418**	**43,201**	**42,744**

West Suffolk NHS
NHS Foundation Trust

PHE | NHSE | DoH | Cabinet Office | MoJ | ISO | BS

Policies, legislation, direction and guidance, National frameworks, ISO/BS, good practice

Strategy

WSFT Strategy for EPRR

Business Continuity Incident

Critical Incident

Major Incident (Majax)

Increase in scale, severity, longevity, impact

Escalation

Policies

Loss of Service

Denial of Access/ Security issue

Vital Resource Deficiency

Bespoke Plans

Facility/ Service Specific

Facility/ Service Specific

Facility/ Service Specific

Supporting Activity

Process Flow Charts

Business Impact Assessments

Action Cards

Risk Assessment

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30th June 2017

AGENDA ITEM:	10
PRESENTED BY:	Helen Beck – Interim ECOO
PREPARED BY:	Phil Gadie – Head EPRR
DATE PREPARED:	26/06/17
SUBJECT:	Emergency Preparedness at WSFT
PURPOSE:	To highlight status of the Trust

EXECUTIVE SUMMARY:

- **An audit of Emergency Preparedness, Response and Resilience (EPRR) has been conducted by the incoming Head of EPRR over the last 6 months and has identified areas for refinement.**
- **A strategy for EPRR in WSFT is in circulation with the Emergency Preparedness Team and Site Management Team.**
- **The WSFT Major Incident Policy is being revised.**
- **A series of training interventions have followed a training needs analysis which identified perceived gaps in individual training.**
- **A series of Controlled Area Desk Tops Exercises will be followed by a Major Incident Exercise.**
- **Lessons have been identified following a real security incident at WSH.**
- **Security and Emergency Preparedness remain under constant review given the current national context.**
- **A new Head of EPRR takes up post at the start of July 2017.**

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)	

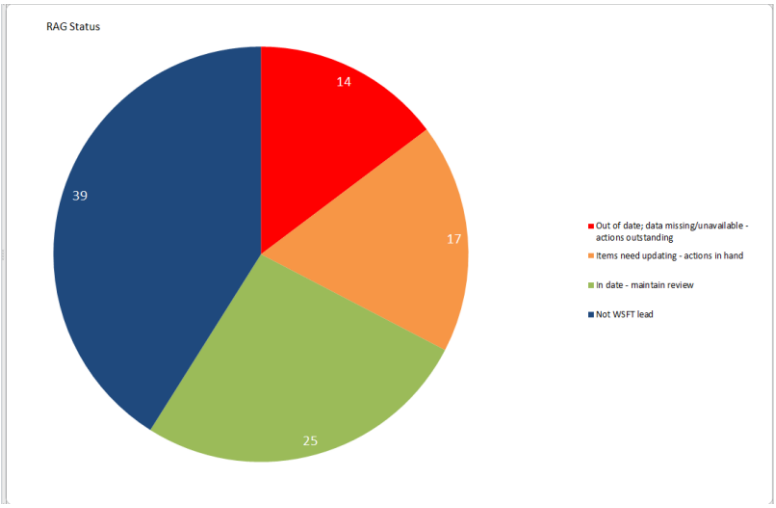
Recommendation:

The Board accept that:

- Review and refinement of EPRR is an on-going process.
- With an audit now completed by the outgoing Head of EPRR and a Strategy crafted to underpin activity, the new Head of EPRR can take the process of refinement forward at some pace.
- Despite some of the refinement activity identified, it is anticipated that the mandated self-assessment report against the EPRR Core Standards will not show any regression from last year's audit.

Policies. Emergency Preparedness, Response and Resilience (EPRR) at WSFT was audited by the incoming Head of EPRR on appointment on 1 Dec 16. All policies have been reviewed over the last 6 months. Some were fit for purpose but 32% needed some sort of remedial actions as represented in Figure 1. In establishing that remedial action would be required it was clear that, without an overarching EPRR strategy, there was nothing that gave the Departments and Divisions within WSH the necessary underpinning guidance. Across the Trust there was therefore considerable variation in format and detail of business continuity policies and plans but many of these remain fit for purpose for the time being.

Figure 1: Overview of the post-audit status of EPRR Policies and Plans



Process. The process of EPRR management has been modified over the last six months and now includes a process of regular review and training opportunity.

- **Emergency Preparedness Team (EPT).** The EPT meets monthly with a standing agenda and key personnel from across the Trust. It reviews all emergency preparedness over the last month and looks forward to upcoming opportunities. Action notes are taken and its terms of Reference (ToR) include providing input to draft strategy, policy and plans and agreement to progress them to the SMM.
- **Site Management Meeting (SMM).** The SMM also meets monthly and is drawn from the Silver Management structure across the organisation. Its standing agenda includes an EPRR update and training opportunity. The SMM will approve draft strategy, policy and plans and agreement to progress them to the TEG.

Strategy. As a start point therefore a new draft strategy for EPRR has been written and this is going through an auditable acceptance process. The strategy articulates responses for the three areas of Emergency Preparedness, Response and Resilience that NHS England proposes need planning consideration. It also articulates a continuum of response that covers business continuity at one end of the scale, escalating through critical incidents to major incidents at the opposite end of the band and is summarised in Enclosure 1.

Major incident.

- The Major Incident Policy and Plan was one of those identified that would benefit revision. This had been conducted in a systematic manner across the Trust well before the terrorist attacks in London and Manchester.
- WSH sent three representatives to Ex VITAL SIGN on 21st March 2017. The regional Mass Casualty Exercise objectives were:

    - To explore the newly expected national Mass Casualties Framework.
    - To explore the operational & strategic capabilities of the Critical Care & Trauma Networks in the Midlands & East regions to manage a mass casualty incident.
    - To promote an understanding of engagement between the NHS and their multi-agency partners of the wider implications of mass casualty events.
    - To explore the implications for mutual aid within the region and the wider Critical Care &Trauma Networks.
    - To test the Command, Control, Communication and Coordination procedures in conjunction with Trust Major Incident & Surge Plans.

- To test the decision making and recording process.
- To identify any learning for future development and improvements to inform the production of a Network Mass Casualty distribution plan.

The WSH representatives assessed the plan for WSH would benefit from some review and refinement but was fit for purpose. Many areas of learning were already in hand (e.g. the move of SSD to co-locate at WSH site).

- Testing and training continues to be reviewed and refined. Clinical debriefs from Manchester have been reviewed and training interventions are programmed as a consequence. WSFT remains well connected and is optimising its network (e.g. USAF) to ensure that training and preparations are optimised.

Training Needs Analysis (TNA). A TNA has been conducted as a self-assessment exercise against the mandate Skills for Justice command and control skills and knowledge framework. Thereafter a series of training interventions have been designed, developed and continue to be delivered to enhance command and control capability for individuals charged with delivering the emergency response. It has been well received and continues to be iteratively reviewed and refined to ensure it remains optimised.

Live incident. The WSFT response to a live incident was reported as proportionate and well executed by attending police officers.

External intelligence review. WSFT LSMS and Head of EPRR continue to review and refine WSH contingency planning in the light of the current security landscape. In the coming weeks and months WSH will be undertaking a series of exercises designed to ensure that readiness is optimised and will seek to include as many personnel as possible commensurate with continuing to deliver '*the best quality and safest care for our community*'.

New Head EPRR. The appointment of a new Head EPRR with similar skill sets as the current role holder should ensure that the momentum created in the last six months can be maintained.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30th June, 2017

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

EXECUTIVE SUMMARY

- This report will be reflective of the data from May 2017
- In May there were 505 Patients Safety Incidents (PSI) reported; a considerable increase from April (392).
- Level of harm in proportion to overall Patient Safety Incidents reported:
  - 87% (88% April) no harm (Green)
  - 11% (8% April) minor harm (Green)
  - 3% (3% April) moderate harm (Amber)
  - 0.6x% (0.3% April) major harm (Red)
  - 0% (0.5% April) catastrophic harm (Red)
- In relation to type of incidents reported in May the highest areas of reporting related to Pressure ulcers, Slips Trips & Falls, and Medication.
- 10 Complaints were received in May the same as April
- 188 PALS contacts were recorded in May compared to 172 in April

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

Table 1: Aggregated Patient Experience Report

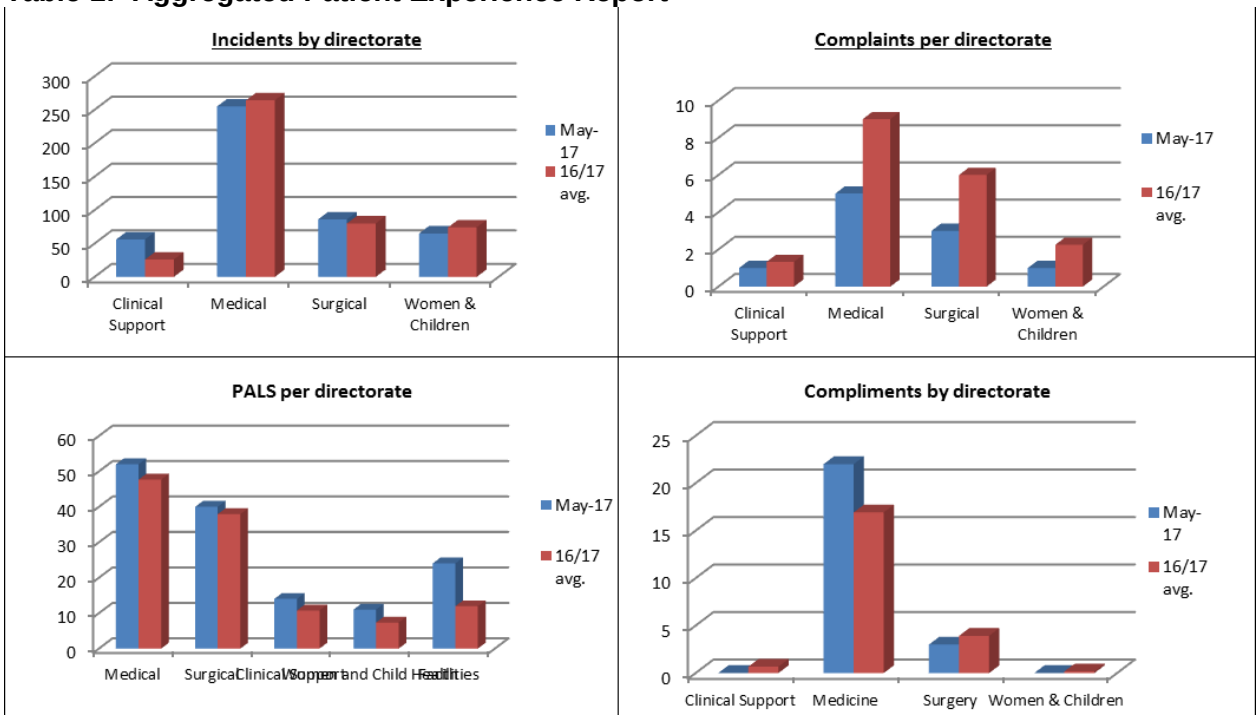


Table 2: PSIs reported by month (24 months)

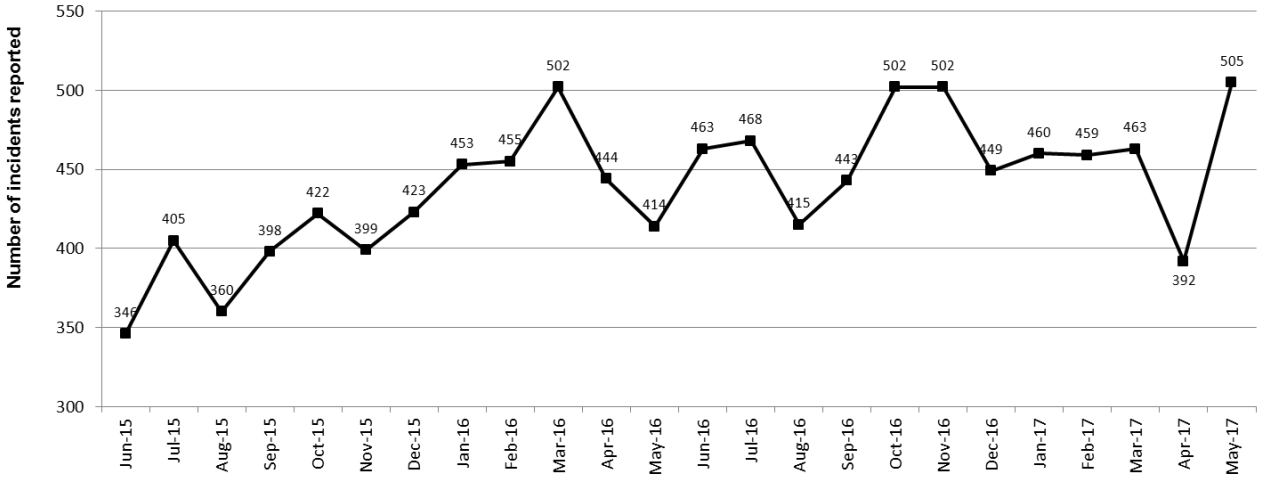
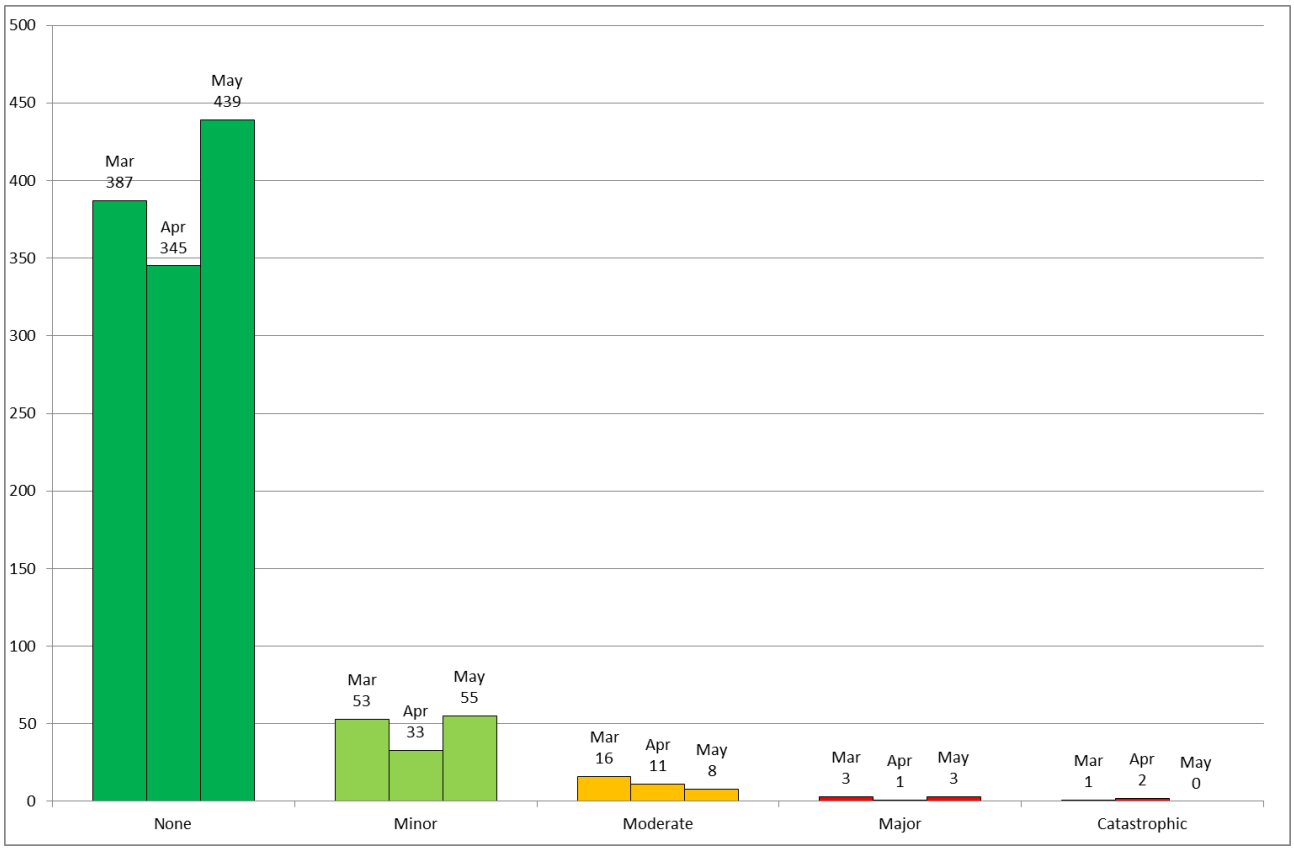


Table 3: Incidents reported by severity



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

In the month of May we have seen an overall improvement in reporting, following our drop in reporting last month. We have seen a drop in moderate incidents and catastrophic incidents, however an increase in major harm incidents. Further detail is provided on these incidents below.

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

- WSH-IR-30747 (Emergency Department overdose and deterioration following self discharge)
- WSH-IR-30763 (Paracetamol levels, delay in receiving results)
- WSH-IR-31388 (Chest pain and admission via ED, investigation around escalation pre arrest)

The eight moderate harm incidents relate to:

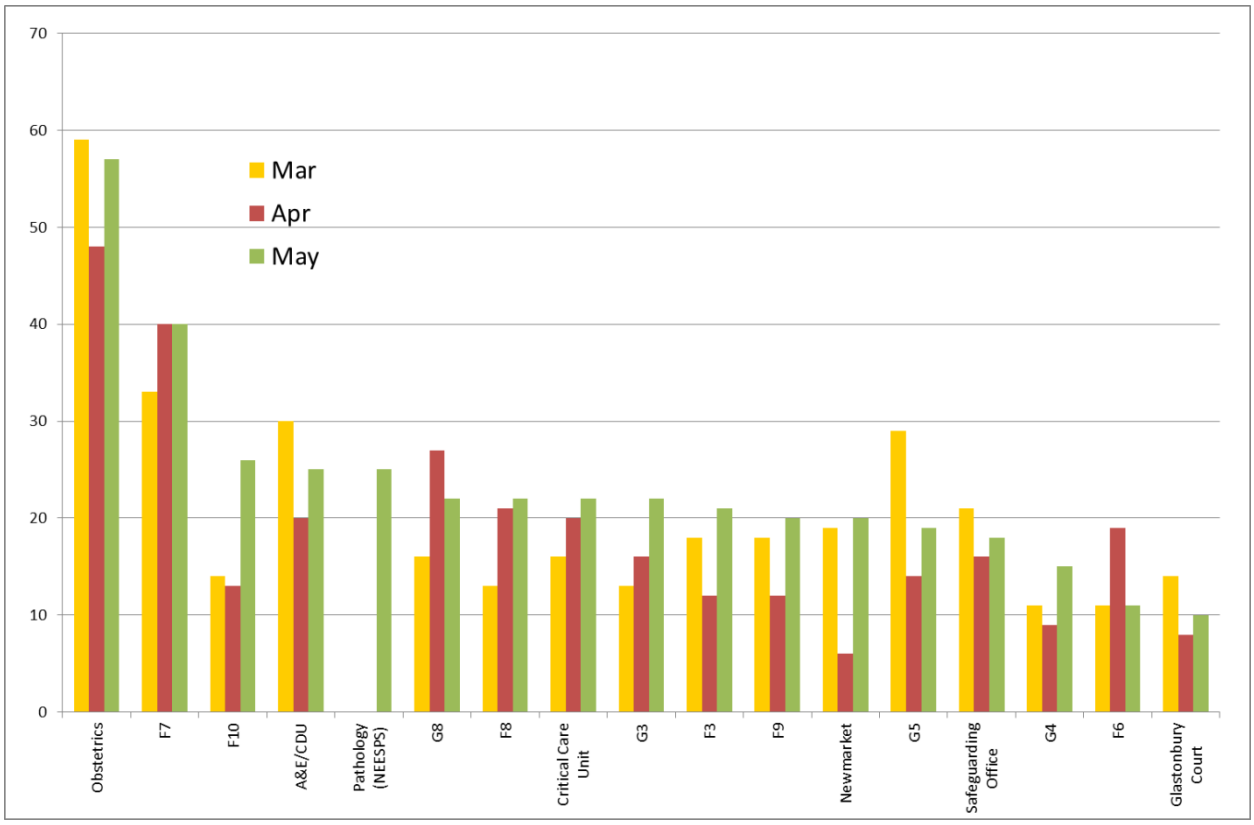
Medicine (5)

- Hospital acquired pressure ulcers (2 cases)
- Fall (1 case)
- WSH-IR-31145 – This case is under review and is likely to be a non-WSH case, this will result in Amber incidents reducing by one
- WSH-IR-31150 – delay in results of post-delivery lady following admission via ED

Surgical (3)

- Hospital acquired pressure ulcers (1 case)
- Fall (1 case)
- MSSA bacteraemia (1 case)

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

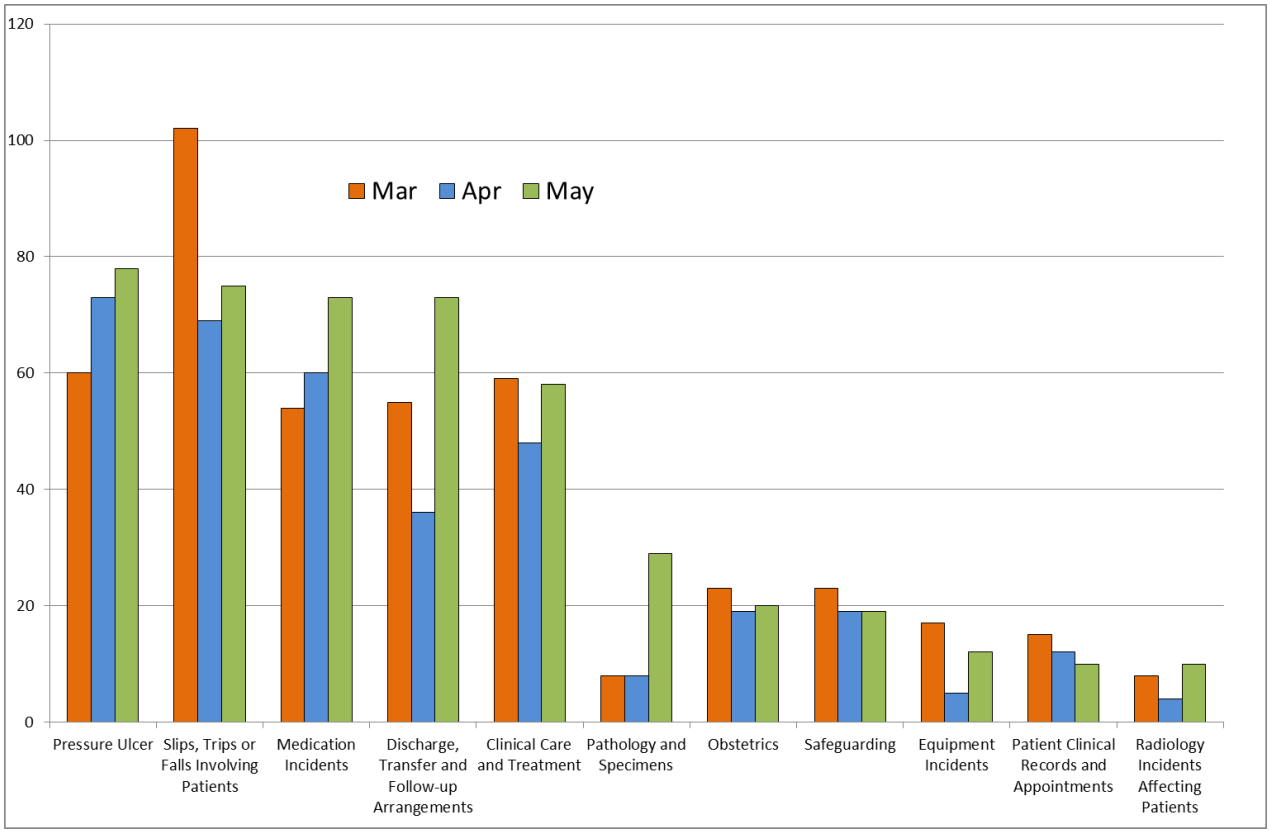


Pathology has now appeared in the numbers for the first time following NEESPS reporting going live on Datix.

This is the first month we have been able to see this data in relation to the whole trust and will be monitoring for trends. Obstetrics main themes remain around transfers of care from Midwife led birthing unit to the labour suite, and Discharge/transfers/follow up care.

F10 has seen an increase from 13 incidents to 26. Upon review of these incidents there are multiple incidents involving the same patient, i.e. the same patient has fallen three times. This however will require further monitoring to ensure a response to any thematic issues identified.

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



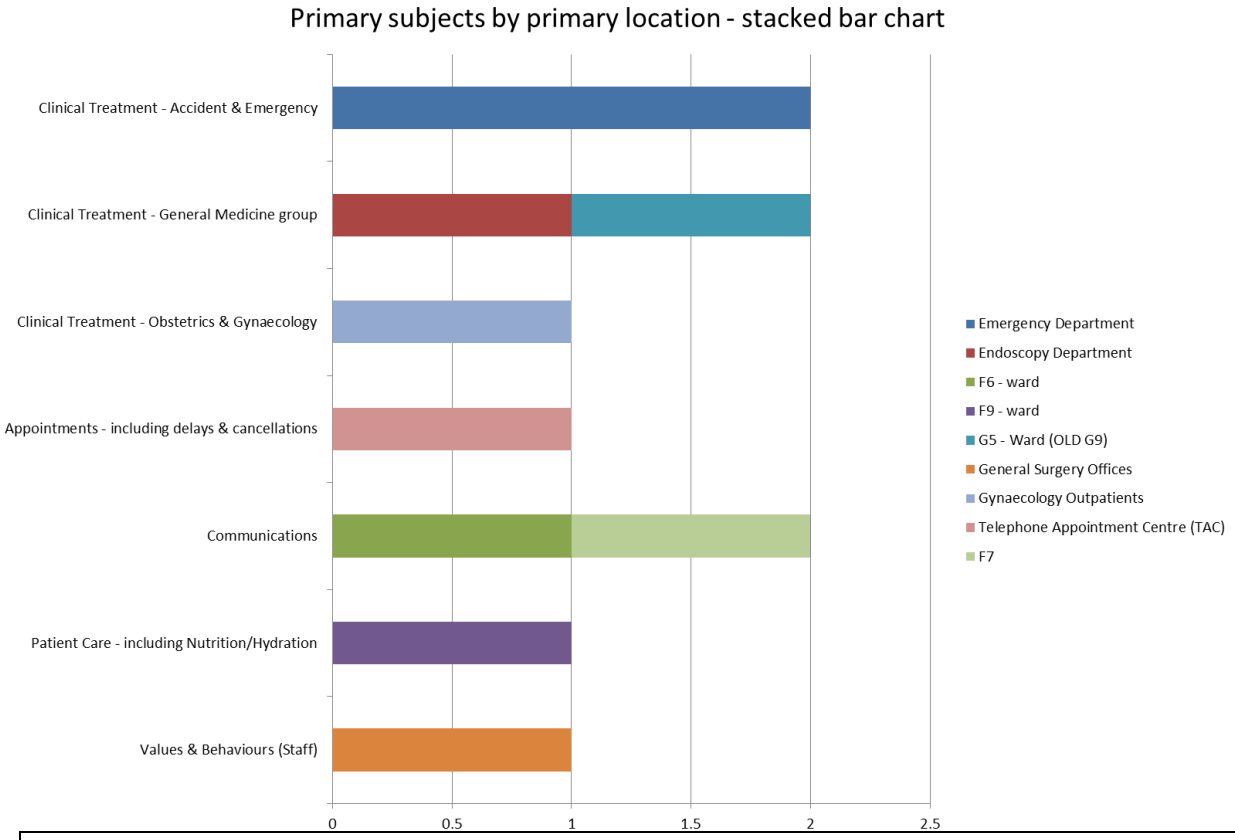
This is the first month Pathology & Specimens category has appeared in the numbers for the first time. Following NEESPS “go live” in reporting all incidents via Datix.

Pressure ulcers, Slips, Trips & Falls, and Medication incidents account for the highest number of incidents reported. However there has been an increase in reported incidents in Discharge, Transfer and follow-up Medication incidences have continued to increase month on month over the past 3 months.

Discharge, Transfer and follow-up has seen an increase with May being the highest reporting month over the last three. Critical care unit incidences are mainly due to delays in being able to discharge from the unit to the ward environment. The main increase is as a result of problems with transport both in discharging patients and also in patient transport for clinic/dialysis appointments.

Complaints

10 complaints were received in May. The breakdown of these complaints is as follows by Primary Division: Medical (5), Surgical (3), Women & Children (1), Clinical Support (1).



Patient Experience Themes

Area	Analysis	RAG rating
Car Parking	Issues with parking are on-going. The main issues arising are the pay and display spaces situated at the front and side of the hospital, which are proving difficult in cases where clinics are running behind resulting in the requirement for blue badge holders to top their payments up, particularly those that are parking at the side of the hospital where the pay machine has been out of action for some time resulting in further to walk. Patients are also dissatisfied with the lack of spaces and there have been several reports of concerns about the gradient of the ramp access from Car Park A, which is causing difficulties for people accompanying wheelchair users, some of which are not entirely mobile themselves. Patient Experience Manager is meeting with Facilities Managers at the end of June to review a plan.	

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 of Directors – 30 June 2017

AGENDA ITEM:	12
PRESENTED BY:	Nick Jenkins, Medical Director, West Suffolk Hospital NHS Foundation Trust
PREPARED BY:	Lee Taylor, Transformation Lead, Joint Transformation Team West Suffolk Clinical Commissioning Group/West Suffolk Hospital NHS Foundation Trust
DATE PREPARED:	23 June 2017
SUBJECT:	Primary Care Streaming
PURPOSE:	Information

EXECUTIVE SUMMARY:
This report provides an update on the background and implementation of primary care streaming for Board Members' information.

Linked Strategic objective (link to website)	
Issue previously considered by: (e.g. committees or forums)	West Suffolk Integrated Care Network
Risk description: (including reference Risk Register and BAF if applicable)	A risk register has been developed and embedded with the overarching project plan.
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	A detailed business case was developed and approved by the project executive sponsors before being submitted to NHS England.
Legislation / Regulatory requirements:	The primary care streaming service is mandated by NHS England for implementation by 31 October 2017.
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	The development of this service is being conducted under challenging timeframes. This includes a complex department building redesign and implementation of a west Suffolk system model of care that will support both ED demand and the extended care provided for primary care.

Recommendation: To note the contents of this report.

Primary Care Streaming Report for Trust Board Members 30 June 2017

Background

NHS England mandated that a primary care streaming service be established within every emergency department by 1 October 2017 with all building redevelopments completed by 31 October 2017.

The aim is to free up Emergency Department (ED) resources to concentrate on major trauma and life threatening conditions. There was clear guidance on what the model should deliver, and is based upon the service provided within Luton and Dunstable University Hospital NHS Foundation Trust, including:

- Urgent primary care service to address people who walk in ED with minor illness conditions (called primary care see and treat in this document)
- Patients streamed by an ENP/Band 7 nurse to establish if they are appropriate for ED or primary care see and treat
- 0800 – 2300hrs hours of work, seven days per week
- There will be no access to diagnostics in the primary care area, and it will be a self-contained area
- A GP practice or consortia could provide the capacity to deliver the service
- It must be co-located with the ED, although within a self-contained/separate area
- There can be no redirection "away" or off-site
- Primary care can return a patient to ED if clinically required
- 2222 cover must be provided by ED
- Primary care to provide patient education regarding where their needs could have been met
- £80 per hour cap for GP time
- Shared clinical governance forums to manage the service, risks, delivery and performance
- All activity will contribute to the 4 hour target

Developments

West Suffolk Hospital NHS Foundation Trust (WSFT) and West Suffolk Clinical Commissioning Group (WSCCG) worked collaboratively with the west Suffolk health and care system to develop a business case to meet the expected requirements of NHS England.

Although the NHS England guideline stated 0800hrs – 2300hrs as operating hours for the streaming service, modelling was completed and the option considered as best meeting the expected demand based on historic data. Although the modelling is not able to fully forecast future hourly and seasonal impact, the agreed hours of operation for this service are:

- Monday to Friday – 1100-2100hrs
- Saturday, Sunday and Bank Holidays – 0900-2100hrs

To ensure alignment of services, the Suffolk GP Federation's GP+ service, which currently operates from the Swan Surgery in Bury St Edmunds, will co-locate to the primary setting in ED enabling the service to run alongside the streaming and walk-in service for the hours of Monday to Friday 1830-2100hrs and Saturday, Sunday and Bank Holiday's 0900-2100hrs.

The current Out of Hours service will continue without change and operate from the corridor behind ED at WSFT. This service will continue to offer to see one patient per hour from ED.

Estates developments

To support the strategic intent to introduce primary care streaming in every ED across England, NHS England made £100m of capital funding available for acute trusts to access funding to support the necessary changes to host this new service.

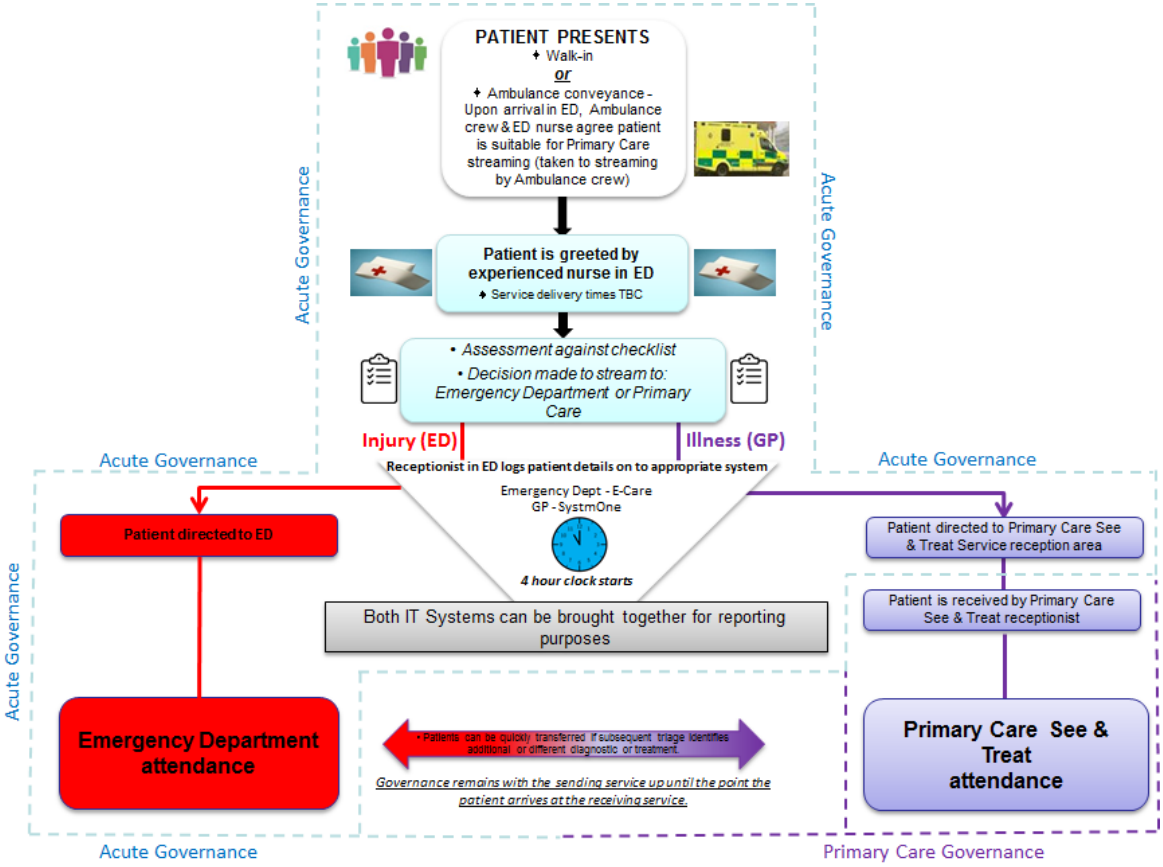
NHS England approved £1,000,000 to support redevelopments at WSFT to host the primary care streaming service with a further £477k funded by WSFT to complete the pre-planned paediatric improvements in ED.

The current footprint of the ED is limited with a lack of space affecting flow and working patterns within the department, so the redevelopment of the current ED will create a new reception, 4 consulting rooms, a sub-waiting area and toilet facilities, whilst relocating displaced teams to another area within the hospital. This aligns with the Carter review by making the best use of the NHS estate and the proposed floorplan is attached as Appendix A.

Currently, the ED can operate at capacity with patients who can be seen, treated and discharged or who are suitable for other services. When pressures persist, escalation areas are opened to enable ambulances to offload. When the ED is full and resource is being used for minor cases, it makes adherence to the 4 hour target more challenging.

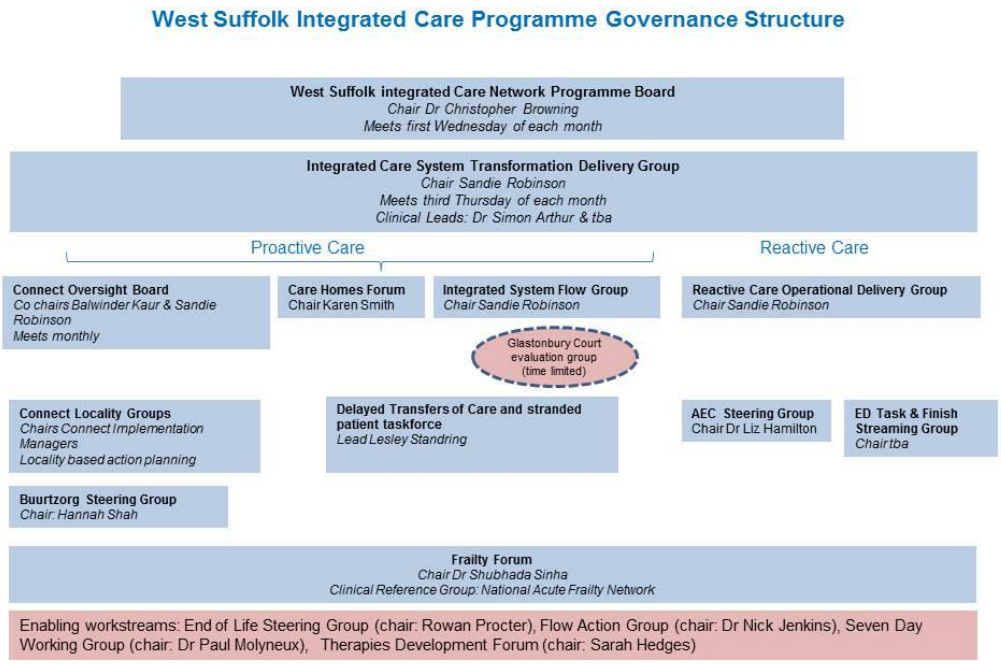
Pathway developments

As per the national guidance, an ENP or Band 7 nurse will stream all patients that walk into the Emergency Department. The streaming will consist of a short visual assessment of the individual to establish whether they have a minor illness and are suitable to move into the primary care service, or whether they have more serious needs or trauma and needs to be seen within the Emergency Department.



Project Governance

To ensure that the strategic direction for the project is clear across the integrated system, it will be essential to have a clear governance structure in place to support this project. The project will report into Integrated Care Network within the West Suffolk health and care system through the Reactive Care Operational Delivery Group.



West Suffolk Integrated Care Programme Governance Structure

To support an integrated approach to the project, the joint executive sponsors for the project will be Helen Beck, Chief Operating Officer (Interim) WSFT and Richard Watson, Chief Transformation Officer, WSCCG. The executive sponsors will be the overarching leads for the project providing guidance and steer as required in the strategic and operational aspects of the project.

The overarching support and management of the project will be completed by the joint WSFT/WSCCG Transformation Team led by Sandie Robinson.

To support the development of this service within a challenging timeframe, an ED task and finish group has commenced with a wider range of system stakeholders. In addition, the following workstreams have been established to work through the detail and support implementation:

- Estates development – Jacqui Grimwood (WSFT)
- Governance, clinical and operational – Paul Morris (WSFT)
- Operational developments – Paul Morris (WSFT)
- Communications and Engagement – Isabel Cockayne (WSCCG)
- IMT and Information Sharing – Guy Hooper (WSFT)

Project timelines

The areas of work being conducted to develop and implement this service will fall within the following timelines:

- ED redesign development commences – 14Jul17
- Clinical and governance arrangements agreed and functional – 8Sep17
- Monitoring and evaluation framework in place – 8Sep17
- Operational developments completed – 7Oct17
- ED redesign work complete – 27Oct17
- Service operational – 31Oct17
- Full service evaluation post launch – Jan18

Appendix A – Proposed ED redesign floorplan

West Suffolk NHS
NHS Foundation Trust

Trust Board – 30th June 2017

AGENDA ITEM:	13
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Sinead Collins, Clinical Business Manager
DATE PREPARED:	23rd June 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 May and progress of nurse staffing review made below

Observations

April

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
F7	11 medication errors	Management changes
F8	8 medication errors	High bank and agency use. Management changes
G3	-	High bank use
G4	3 falls (with harm)	High bank use
G5	6 medication errors	High bank use
G8	3 falls (with harm)	High bank use, change of ward for deep clean
F1	-	High bank use
F3	5 medication errors	Agency use
F4		High bank use
F6	3 falls (with harm)	Agency use
F9	8 medication errors and 3 falls (with harm)	High bank use
F10	7 medication errors	-
Kings Suite	-	Low RN fill rate in day and high bank use

Vacancies – Current processes are being reviewed due to template used between HR and Finance creating some inappropriate figures in some areas. This explains why there has been a shift in NA figures from positive to negative. There are still a couple areas under review and will be informed when complete. Staff are escalating to seniors when required.

N.B. It should be stated from this month forward, that if a figure has a '–' before then this is a vacancy, and if the figure has a '+' before then it is over established compared to budget. This has been changed due to confusion

Roster effectiveness – Out of 27 areas, 8 are over the Trust standard of 20%. This is a drastic decrease from April that had 22 areas over 20%. The reasoning for this is currently being reviewed by KPMG

N.B. As mentioned in the dashboard, roster effectiveness is a sum of sickness, annual leave and study leave. HR sends a KPI report to corporate managers, which highlights when these areas are over trust average.

Sickness – Out of 27 areas, 14 are over the Trust Standard of 3.5% (two less than last month)

Update on progress of Nurse Staffing Review

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

KPMG are currently reviewing the WSFT nursing process, in view to help us improve in standard. Due to this the biannual nursing review is not being done this summer, as it will be covered by KPMG.

The SafeCare tool on Healthroster, as of 23/06/2017, is not going to be used daily, until the Live version or suitable alternate solution comes into place. This is due to the data can only be given retrospectively back to staff and currently only useful for the biannual nursing review.

QUALITY AND WORKFORCE DASHBOARD

Item 13

Month Reporting	May-17			Establishment for the Financial Year 2016/17						Data for May 2017												
										Workforce											Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day (Apr 2017)	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night			Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	81.79	70.47%	29.53%	N/A	1 - 4	1 - 5	120.4%	99.8%	151.4%	143.7%	7.80%	2.40%	-6.28	-2.36	7.70%	N/A	19.90%	N/A	1	0
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	83.0%	90.7%	100.1%	96.6%	0.40%	0.00%	-5.40	-4.80	2.50%	7.25	13.70%	0	11	0
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	72.5%	N/A	80.1%	N/A	7.50%	8.40%	0.36	0.58	5.00%	N/A	14.40%	0	8	0
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	88.1%	83.9%	N/A	N/A	1.60%	0.00%	-3.65	-1.00	2.80%	26.14	16.10%	0	3	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	115.2%	100.2%	N/A	N/A	0.20%	0.00%	-8.70	8.20	7.00%	N/A	21.30%	0	1	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	124.1%	92.7%	63.4%	N/A	0.30%	0.00%	-2.19	0.00	3.20%	N/A	20.80%	0	1	N/A
WSFT	DSU	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward area	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	87.5%	N/A	102.2%	N/A	1.50%	0.00%	-1.10	-0.50	9.90%	N/A	21.60%	0	1	0
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	105.9%	94.6%	64.2%	N/A	2.10%	0.00%	-0.10	-0.70	3.40%	11.91	16.50%	0	1	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	93.9%	101.6%	104.3%	N/A	3.50%	0.00%	-0.80	2.10	4.30%	8.42	20.60%	1	0	1
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	97.4%	91.7%	98.7%	100.4%	10.50%	0.00%	-0.73	-2.40	5.00%	5.35	13.80%	2	4	2
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	95.4%	92.6%	109.1%	105.1%	16.70%	0.00%	-1.28	-3.30	3.20%	6.18	15.40%	0	0	3
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	86.0%	95.2%	115.4%	104.5%	7.80%	0.00%	0.17	-1.24	4.30%	5.12	14.50%	2	6	0
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	85.6%	94.2%	94.3%	99.8%	9.90%	1.20%	-2.80	-2.40	6.70%	I/D	20.10%	2	3	3
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	87.0%	155.7%	151.6%	N/A	11.00%	0.00%	-1.60	2.50	1.30%	N/A	17.30%	N/A	2	N/A
WSFT	F3	Trauma and Orthopaedics	33	40.47	59.07%	40.93%	48.48	7	11	87.9%	98.4%	131.3%	103.2%	3.00%	3.20%	-3.00	-2.60	3.60%	5.04	17.50%	1	5	1
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	82.6%	95.2%	90.0%	171.6%	9.40%	0.80%	-1.10	-2.34	4.90%	7.40	15.20%	0	1	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	93.5%	95.7%	99.2%	124.2%	3.30%	0.00%	-2.22	-0.30	1.50%	5.93	16.90%	0	2	0
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	83.4%	110.9%	99.6%	99.0%	1.50%	4.90%	-4.85	-2.10	1.40%	8.48	11.10%	0	1	3
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	93.4%	94.7%	86.7%	104.0%	13.40%	0.70%	-3.90	-1.67	6.00%	5.08	17.90%	0	8	3
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	115.7%	86.3%	92.9%	98.9%	2.10%	0.00%	-0.50	-0.20	2.70%	6.33	13.00%	0	7	1
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	116.8%	96.6%	85.8%	65.5%	5.20%	0.00%	-2.14	-0.30	6.40%	N/A	20.20%	0	2	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1												N/A	1	N/A
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre recovery area, bereavement suite					1 - 2	1 - 2												0	2	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	71.7%	85.5%	43.9%	122.4%	6.90%	0.00%	-3.60	2.90	1.90%	9.28	14.30%	0	0	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	100.0%	100.0%	N/A	N/A	1.70%	0.00%	-0.70	-0.40	0.00%	N/A	19.30%	0	0	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	9.00	80.00%	20.00%	N/A	5 - 8	N/A	84.5%	N/A	71.7%	N/A	0.00%	0.00%	0.00	0.00	0.50%	N/A	21.30%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	95.7%	97.9%	31.2%	29.0%	0.70%	0.00%	-2.14	-2.00	2.10%	N/A	15.50%	N/A	1	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	96.6%	98.4%	102.5%	116.1%	5.58%	0.00%	-1.41	0.00	4.23%	7.50	N/A	0	2	2
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	70.3%	96.6%	94.9%	96.8%	17.60%	0.0%	-0.90	-0.10	9.7%	5.30	21.50%	2	0	1
																-60.56	-14.43	Target - 3.5%		Trust standard is 20%			

Explanations

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

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

GP Update – 20th May – 21st June

FIXED TERM

Name: [redacted]

Job Title: Consultant Otolaryngologist

From/to dates: 5th June 2017 for 6 months

Last two roles: [redacted]

Email: [redacted]

Contact number: N/A

FIXED TERM

Name: [redacted]

Job Title: Acute Consultant Paediatrician

From/to dates: 25th May 2017 – 24th May 2018

Last two roles: [redacted]

Email: [redacted]

Contact number: [redacted]

SUBSTANTIVE **(You should already have the full report for this Gentleman)**

Name: [redacted]

Job Title: Consultant Oncologist

Last two roles: [redacted]

Email: [redacted]

Bleep: [redacted]

West Suffolk NHS
NHS Foundation Trust

Trust Board – 30th June 2017

AGENDA ITEM:	16
PRESENTED BY:	Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Sarah Jane Relf, e-Care/GDE Operational Lead
DATE PREPARED:	22nd June 2017
SUBJECT:	To receive an update on e-Care/Global Digital Excellence Programme
PURPOSE:	Update on current position

EXECUTIVE SUMMARY:

- e-Care phase 2, drop 1 – OCS (OrderComms) pathology is now live (including Sepsis and AKI).
- e-Care phase 2, drops 2 and 3 are currently being re-planned to align both drops to one single drop at the end of October.
- Future State Validation events are now concluded for drop 3.
- Good progress on infrastructure

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	Not relevant

&communication)	

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. OrderComms pathology was uncoupled from this initial go live.
2.2	The organisation now continues with phase 2 of the e-Care programme and delivering GDE commitments with full updates provided below.
3	**Phase 2 e-Care Programme Summary**
3.1	There were three original planned drops for the e-Care phase 2 programme as shown below:

Drop	Original dates	Covers
Drop 1	20 May 2017	• OrderComms Pathology • Sepsis and Acute Kidney Infection (AKI) alerting
Drop 2	July 2017	• Patient portal • Capacity management
Drop 3	October 2017	• Complex meds • Paediatrics • Clindocs

3.2	***Drop 1*** We went live with OrderComms pathology on 03 June 2017. This was a slight delay from the original go live date. Overall the technical implementation has been very successful with minimal issues identified. We continue to support users in understanding and adhering to the new workflows with floorwalker support continuing until 30 June. This includes supporting juniors and consultants with the new endorsing workflows. Sepsis/AKI went live on Monday 19th June and has been a success to date.
3.3	***Drop 2*** Both projects are progressing to plan (patient portal and capacity management).

<table>
<tr><td></td><td>Kick off meetings have been held for both projects with future state review events agreed and invites distributed. e-Care phase 2, drops 2 and 3 are currently being re-planned to align both drops to one single drop at the end of October. This will reduce the impact on the organisation.</td></tr>
<tr><td>3.4</td><td>Drop 3
Drop 3 is currently reporting as Amber due to knock on impact of delays around drop 1 go live and ongoing and known risks around availability of pharmacy resource to support the medicine components. However at this stage we still remain on plan to deliver against the original timelines.</td></tr>
<tr><td>3.5</td><td>In addition to the above planned drops we are also working with Cerner to implement Medical Transcription Management (MTM) module which would improve the current secretarial workflow.</td></tr>
<tr><td>3</td><td>GDE update</td></tr>
<tr><td>3.1</td><td>The Trust had a very successful go live for phase 1 and as such, was one of 26 Trusts asked to bid for national Global Digital Excellence status. In September 2016, it was confirmed that the Trust had been successful in securing £10m funding, as part of an initial tranche of 12 Trusts. The Global Digital Excellence (GDE) programme is a 2-year programme that commenced in November 2016.</td></tr>
<tr><td>3.2</td><td>Our GDE programme covers four main pillars:

<table>
<tr><td>Pillar 1</td><td>Digital acute trust</td><td>Completing the internal journey of digitisation</td></tr>
<tr><td>Pillar 2</td><td>Supporting the ICO</td><td>Creating the digital infrastructure that will support the ambitions of the Sustainability and Transformation Plan</td></tr>
<tr><td>Pillar 3</td><td>Exemplar digital community</td><td>Building the organisation into a centre of digital excellence and acting as mentor and guide for other developing organisations</td></tr>
<tr><td>Pillar 4</td><td>Hardware and infrastructure</td><td>Ensuring that we have a robust and compliant infrastructure at the foundation of the programme.</td></tr>
</table>

To date our main focus has been on pillar four as this is the critical infrastructure that supports delivery of all other components.</td></tr>
<tr><td>4</td><td>Pillar 1 – Digital Acute Trust</td></tr>
<tr><td>4.1</td><td>The GDE programme and funding will enable us to expand the scope and pace of delivery for additional e-Care components. We are still working closely with Cerner to agree the exact scope of pillar 1 with the potential to include the following:

• Infection control and antimicrobial stewardship
• Bedside medical device integration
• Infusion management
• Vital Links</td></tr>
</table>

	• Ophthalmology • Anaesthesia • Theatres • New PAS • Maternity • Critical Care • Endoscopy • Closed loop medication • Dynamic documentation • Speech recognition • Additional care plans • Kiosk upgrade The final list of projects will be agreed in forthcoming weeks along with timings and milestones. A more detailed plan will be provided to a future Board meeting.
5	**Pillar 2 – Supporting the Integrated Care Organisation**
5.1	This work stream is in the very early days of scoping. It is intended that this will cover initiatives such as; Health Information Exchange, Patient Portal and Population Health. A leadership event is being held on 5th July 2017 to engage system partners in the initiatives.
6	**Pillar 3 – Exemplar Digital Community**
6.1	We continue to work with Milton Keynes University Hospital NHS Foundation Trust to progress the bid for them to become our fast followers. A formal submission meeting with NHS Digital is planned for Friday 23rd June 2017. We are also considering our requirements from an international partnership.
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 work undertaken to replace local network connectors (called switches) that will provide faster connectivity and improved resilience is now complete. However at the heart of the network are two main network switches, which are also being upgraded and this work remains work in progress whilst we await delivery of two new line cards. This will increase our overall capacity and so facilitate many of the other infrastructure projects. Planning has commenced on a programme to upgrade our fibre optic connections across the hospital site which once done, will improve network performance for both wired and wireless services.
7.2	The new firewall, which will help protect the trust against the type of Cyber Attack suffered in May 2017 has now been delivered and the initial kick off meeting to plan installation has now been held. The transfer of services from old to new is complex and so this is not expected to go live until at least late September.
7.3	In parallel the upgrade of the e-mail system has also commenced with work to install the new server hardware starting this month. Once built the new 2010 version of the software will be installed and end to end connectivity checked and

	tested. This will include our primary e-mail connection via the NHS N3 network and access for mobile users via the 'GOOD' mobile device management platform. The new system is expected to be fully built by the end of July at which time IT will commence the migration of user mailboxes for the old system to the new. As part of the migration integration with the new telephone system will commence and the new room booking system will be commissioned
7.4	Running on a slightly later timeline IT is also deploying a new Remote Access solution which will expand our ability to offer remote working away from the base location. The new solution will support Virtual Private Network (VPN) access which will allow users with laptops to connect as if they are in the main network which maintaining the current remote desktop solution which is ideal for remote clinical users as the data remains in the data centre. This is a key enabler not only for trust staff but also for those who work in the Community.
7.5	A business case for a new central data storage solution (called a SAN) is nearing completion. When this approved the Trust will move to a more robust and better performing solution for core data storage that will offer greatly increase data management and faster recovery of data files if/when this is required.
7.6	The new digital telephone system has now been installed and is currently being built for users based in Quince House. Once fully installed and configured this will offer alternative ways of working, many of which, in time, have benefits in clinical areas. Planning continues to rollout the new system to G6 and F12, as part of the new build work already underway. Over the next 3-years all existing telephones will be migrated onto the new system, with many locations being able to adopt the range of new features offered by it.
7.7	Supplier quotations are now being received for a survey to be undertaken across the West Suffolk Hospital campus, ahead of planned upgrade of the Trust wireless network. The aspiration is to provide campus wide wireless network coverage at WSH and in parallel, to provide basic building wireless into locations such as Newmarket, Sudbury, Thetford and Stowmarket. Initial work with Sustainability and Transformation Plan (STP) partners is now underway to facilitate a solution (called GOVROAM) that will allow Trust staff to gain secure access to the wireless network from any location owned and/or operated by any STP partner (Suffolk and NE Essex wide). It is hoped to launch a pilot in the Autumn to test this roaming service.
7.8	Finally, work continues on a daily basis to ensure that Endpoint technology (desktop, laptop, tablet, phone et al.) are of the right specification to support all Trust operations. This includes upgrades and replacement as equipment reaches end of life, or where additional equipment is needed to support the next phases of both the e-Care and GDE programmes. In terms of printing, the Trust will continue the migration towards centralised Multi-Function Devices (scan, fax, copy & print)

	as we seek to reduce the number of local printers, which are cheaper to buy, but far more expensive to run.
8	**Recommendations**
8.1	The e-Care Programme Board is asked; • To note the general progress • To note the implementation of OrderComms (including AKI and Sepsis)

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30 June 2017

AGENDA ITEM:	Item 16
PRESENTED BY:	Dr Stephen Dunn, Chief Executive
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	22 June 2017
SUBJECT:	Trust Executive Group (TEG) report
PURPOSE:	Information

EXECUTIVE SUMMARY:

5 June 2017

Steve Dunn reflected on his horror following the terror attacks over the last couple of weeks. The group reflected on the events and the Trust's preparation to respond.

It was noted that OrderComms had gone live over the weekend and to date not significant concerns had arisen. Steve Dunn provided feedback from the Board meeting reflecting on **operational and financial performance**. It was noted that we had achieved the 4 hour wait performance standard for Q1.

Detailed decision took place regarding the **referral to treatment (RTT)** performance and 52 week breaches. This included reviews and mitigating action at service level. Feedback was received from a visit by the intensive support team (IST) regarding RTT procedures. The formal report is pending but despite the current performance feedback was positive with some areas for improvement.

Jason Parker & Maurizio Privitelli from KPMG joined the meeting to provide an update on the project and initial finding of the **Financial Improvement Programme**

An overview was given of the focus of the **Flow Action Group**. This included drilling down on a ward by ward basis to maintain communication in order to keep staff on track and motivated.

An update was received on the **Medical Staff Rostering** project and it was agreed that the clinical staff undertake a site visit prior to recommendation to assess the systems in practice.

All documentation has been submitted for gateway 2 in the **community services contract**:
Feedback expected mid-June to allow communication with system leaders on 28 June.

19 June 2017

Steve Dunn welcomed all to the meeting for the first time in **Quince House**. This facility will ultimately allow our acute medical unit to be relocated but in the interim is allow enabling work for G6/7 and the catheter lab. Steve recognised the effort of all in delivery of the improved **4 hour performance**. This was very positive for our patients meant that the regulator had reduced the level of monitoring. Progress in securing ED investment and GDE funding was also recognised.

Sadly once again the meeting reflected on tragic events of recent days. Assurance was given that as part of a national process assessment of all facilities for fire risk was being undertaken.

Feedback from the recent **MHRA visit** was received which recognised improvements made but we remain non-compliant. The visit included new areas of assessment and identified two major concerns (staffing and fridge validation) and four other areas for improvement. Based on the improvements seen the inspector recommended moving from weekly to monthly monitoring updates.

The **red risk report** was reviewed with discussion and challenge for individual areas. A new red risk was received approved regarding the management and usage of all nearside testing equipment. Progress with agreed mitigations will be reviewed by TEG in August.

Discussion took place on the **e-Care** go live and the impact of the delay on future updates or 'drops'. The need to ensure appropriate training for the new intake of junior doctors in August was highlighted. It was confirmed that this is being addressed.

A progress report with **consultant job planning** was received which demonstrated that 96% of plans were complete – Steve Dunn welcomed this excellent performance. It was noted that leads are now starting the process for next year's job planning.

The meeting agreed to maintain the current allocation of time to support **educational supervisors** in their role. This was in the context of positive assessment of the Trust's performance in this area.

An interactive session was held to review the current CIPs being developed with KPMG as part of the **financial improvement programme (FIP)** for 2017/18 and beyond. It was noted that the gap in the risk assessed CIP for 2017/18 has now been closed. Discussion took place on specific schemes which will be subject to further review prior to submission to the Board at the end of June. Review also took place of the culture survey for the Trust which evidenced strong performance from an engaged organisation. Areas for development will be incorporated into engagement and communication plans.

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	

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30 June 2017

AGENDA ITEM:	19
PRESENTED BY:	Roger Quince, Chair
PREPARED BY:	Georgina Holmes, Foundation Trust Office Manager
SUBJECT:	Council of Governors Report – 11 May 2017
PURPOSE:	Information

EXECUTIVE SUMMARY:

This report provides a summary of the business considered at the Council of Governors meeting held on 11 May 2017. The report is presented to the Board of Directors for information to provide insight into these activities. Key points from the meeting were:

- The Chairman welcomed and introduced Richard Davies and Alan Rose.
- It was reported that the closed session of this meeting had supported the nomination of Alan Rose as the Trust's Senior Independent Director.
- The Chairman gave a verbal report on a visit from NHS England to WSFT which included a question and answer session with staff.
- The Chief Executive's report provided an update on the challenges facing the Trust and recent achievements.
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge. Governors were updated on the MHRA audit of the TPP laboratory and they expressed concern at the seriousness of this issue.
- A presentation was given by Dr Helena Jopling on 'Ageing Well'.
- Alan Rose gave a short presentation on his background, experience and how he thought he could contribute to WSFT as a non-executive director.
- The commentary from the Governors for inclusion in the Annual Quality Report was approved.
- The process for the annual appraisal of the Chairman and NEDs was noted. Seven Governors volunteered to act appraisers.
- The process for the appointment of a deputy Lead Governor was approved.
- Reports from the Engagement Committee and the Lead Governor were received.

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

West Suffolk NHS
NHS Foundation Trust

AUDIT COMMITTEE

MINUTES OF THE MEETING HELD ON FRIDAY 26th May, 2017, COMMENCING AT 08:00 IN THE COMMITTEE 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	√	
Lisa Clampin	**(LC)**	Lead Partner, BDO	√	
Liana Nicholson	**(LN)**	Manager, Public Sector, BDO		√
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		√
Kathryn McMahon	**(KM)**	PA to Executive Director of Resources (Minutes)	√	

		Action
1.	**Apologies**	
	Apologies received as detailed above.	
2.	**Annual Report**	
	RJ made reference to the narrative for the quality report, he advised that the draft narrative for the full annual report had gone to the Scrutiny committee earlier in the month. He noted this was the update to both of those documents which reflects changes via the external auditors and subsequent details which had come in. He highlighted some slight changes to the narrative – commenting that there was an additional paragraph to the remuneration report on page 64. He also noted they had updated the staff costs and the number of employees to ensure they were consistent with the statement in the accounts (tables on page 69/70). He also made reference to page 75 and the national figures in the staff survey results to ensure consistency. RJ advised that this was the current version they intended to submit. SD referred to a comment one of the governors had raised around Quality and STP. RJ commented he thought this was more a comment aimed around the	

	operational plan not the annual report. On page 62 – acknowledgement of the discharge IT issues, RJ explained that they wanted to highlight the issue with e-Care reporting, around 18 week performance. CB noted the reason was that this affected external reporting and could impact on the Trusts reputation with regulators. However, he commented, whilst he could see why they had chosen this, clinically there was more of a risk around discharge summaries, he felt this should be added in. There was a group discussion and this was agreed. RJ asked if they wanted discharge summaries in just the AGS (or added where e-Care issues were mentioned throughout the documents). It was agreed to add only in exec summary of AGS. ST asked that RQ and SD to check they were happy with their respective summaries, which they agreed they were.	**RJ**
3.	**2016/17 Annual accounts and report**	
	CB introduced the item, confirming that the Trust was reporting a deficit of £8.1m. He referred to LC's report and that he would talk through some of the issues/differences in the accounts.	
3.1	***Annual Report***	
3.2	***Annual Account***	
3.3	***2016/17 Report to those charged with governance (including the Letter of Representation)***	
	LC apologised for late circulation of the report. She referred the committee to page 3 where the overall executive summary started. She noted that the audit was substantially complete she advised they had some outstanding work which she would explain but this was not of significance. LC noted that LN had started her maternity leave earlier than planned and this had set some of the work back a little. Audit Risk – LC advised they had reported a set of significant risks to the committee in the Audit Plan and since receiving the audit plan they had since received the draft financial statements. Following this, one issue highlighted was that the Trust had achieved its control total and as a result was to receive the STF funding. As a result of this, they had to consider a different angle to the audit strategy which resulted in e-Care implementation being highlighted as a risk and she explained the process behind this. Materiality – she explained the reflection of actual outturn in draft set of accounts. Key Audit and Accounting matters – LC advised they didn't identify any material statements but similarly to last year there were a number of mapping issues which had now been dealt with and as a result there were a number of adjustments that were made by the Finance Team, none were material however. Following discussion the committee agreed with managements response not to make the adjustments highlighted. ST asked around unadjusted audit differences, he referred to the £690k	

impairment for TPP and asked if this would be classed as an audit difference and referred to a conversation they had last year that this wasn't material. LC explained her recollection of the conversations, around a dispute on whether they would adjust for these monies. ST noted his recollection and that this wasn't impaired. LC noted that the uncorrected were not materially individually or in aggregate and had they been corrected, they would have reduced the deficit, this being a key message.

CB referred to the £654k around deposit and advised this was a calculation and he commented this wasn't robust as this was a theoretical figure and an unadjusted difference that was impossible to adjust for he noted. LC explained the matter additionally and what had happened and the process. LW gave her views also.

Control environment – LC advised they did not identify any significant deficiencies in control.

Use of Resources – LC advised they had done a large amount of work on this topic. She noted CB and herself had wanted to do more work around the CIP plans and on KPMGs imminent report, she noted this report would be factored in and that her and her team were working actively on this aspect. She noted a risk identified around e-Care and whether that had significantly impacted the Trusts ability to properly inform decisions but overall they were satisfied it had not.

Opinions – LC advised they expected to issue an unmodified opinion of financial statements and also on the remuneration and staff report and the annual report governance statement and the quality reports compliance, she advised they were still looking at use of resources as previously commented upon.

Quality Report – LC noted the headline message was that they were able to issue an unqualified report on the contents and compliance with quality report but similarly to last year they would need to qualify one of the indicators as a result of e-Care. LC referred to page 6 commitments and contingency, she advised the team were still liaising with the financial team in regard to outstanding queries. She noted that the annual report was now available and noted the management representation letter was appended to the report as a draft and they would obtain a signed version of that, when happy to sign.

HB asked in relation to the data quality and reporting issues with e-Care, she advised they had been visited by NHSI intensive support team who had given a very positive report, they reported a good grip on the issues and understanding the methodology the Trust was following which they had deemed was appropriate with a couple of small recommendations. LC noted that the situation with NHSI had been discussed and this had been factored in. HB noted the visit only took place the week prior but would forward written report when available (as this was most up to date information which wouldn't have been seen prior).

CB commented on use of resources and going concern opinion, he noted this was a forward looking opinion and the discussion that he and LC would have would be around the fact that the Trust met its control total in 16/17 and that the Trust was in a better position than 12 months ago and were confident in meeting the control total in 17/18, (this being a control total that has been set by NHSI on behalf of the Department of Health). CB commented in terms of the going concern review, he believed these were material, the issue being able to demonstrate confidence in meeting the Trust's control total in 17/18. CB advised

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	that the report KPMG were bringing to closed board was one that would be used as supporting evidence with BDO/LC, once it had gone through the board. LC echoed this. AR made reference to the planned 6% CIP, having achieved 4%, noting confidence has to be tempered by that. CB agreed and noted the KPMG report has a judgement in terms of the veracity of plans in place. LC commented around the Trust being a going concern and explained this in more depth. ST asked CB around use of resources, noting that he felt the Trust would get some kind of qualification as last year, CB noted his position that the Trust shouldn't. CB noted in the use of resources statement, there being a forward looking element to it, he explained in more depth why, (referring to the 5 year plan, 16/17, 17/18 plans) the Trust was considerably better than assumptions made in the 5 year plan, this being a debate that he and LC would have over the next few days. LC noted that it was a historical review on the last period that would be used for the opinion. There was a discussion around use of resources and a possible qualification and AR asked CB in regard to this. CB noted that in regard to the opinion, LC was considering was the same as previous year, however he felt this wasn't right and this was the debate he would have with LC. CB noted that the Trust's individual performance was better than the sector, therefore, when looking at the reports, from a central perspective he felt an 'except for' opinion would look odd. RJ asked LC if her conclusion would be in line with other organisations and consistent across the sector. LC explained the process which included a challenge process, which they had already been through, as a result they were proposing a modification, she noted that the KPMG report may change this now but this was all to be decided and discussed outside the meeting, any subsequent decision would again have to go via their challenge process. CB finally noted thanks to LC, Matthew and Liana and LW and Kim for all their efforts. LC noted that this would be her last sign off meeting and that David Eagles would return the next year. CB noted his thanks to LC also.	
3.4	***Quality report 2016/17 limited assurance review report to the council of governors***	
	LC noted the headline message as was stated in the report and took the report as read.	
3.5	***Internal Audit Opinion and Audit Report 2016/17***	
	ST referred to the closed board paper (14c) which had already been circulated to the board. RJ noted that no changes had been made and this had been supplied for completeness. ST echoed CB's thanks to LC and the team and wished LC the best for the future.	
4	**Date of Future Meetings**	
	2.00 p.m. – 4.30 p.m. – Committee Room	
	28 July 2017 3 November 2017	

West Suffolk NHS
NHS Foundation Trust

AUDIT COMMITTEE

MINUTES OF THE MEETING HELD ON FRIDAY 28th April, 2017, COMMENCING AT 14:00 IN THE COMMITTEE 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	√	
Asam Hussain	(**AH)**	Senior Manager, RSM		√
Dan Harris	**(DH)**	Partner, RSM	√	
Mark Kidd	**(MK)**	Counter Fraud, RSM	√	
Lisa Clampin	**(LC)**	Lead Partner, BDO		√
Liana Nicholson	**(LN)**	Manager, Public Sector, BDO	√	
Andrew Barnes	**(AB)**	Senior Manager, Public Sector, BDO		√
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	**(JBI)**	Executive Director Workforce & Communications	√	
Dawn Godbold	**(DG)**	Head of Operations, Suffolk Community Health		√
Rowan Procter	**(RP)**	Executive Chief Nurse	√	
Kathryn McMahon	**(KM)**	PA to Executive Director of Resources (Minutes)	√	
KPMG Team for deep dive		Duncan Calverley, Jason Parker, Ben Garside		

		Action
1.	**Apologies**	
	Apologies received as detailed above.	
	Steve Turpie asked everyone to introduce themselves to the new NED's and KPMG Team.	
2.	**Minutes of Previous Meeting**	
	Minutes of the meeting held on 27th January, 2017 were approved as a true and accurate reflection of the meeting.	

3.	**Matters Arising**	
	180 29/07/2016 5.2 LCFS Annual Report 2015/16 DH advised that there was no court case update and advised that due to this the action should be taken off and for an update to be brought back via a progress report. It was agreed that this action could be taken off the action list.	
	182 29/07/2016 7.3 Financial Reporting - Supply Chain Risk It was agreed to close this action point.	
	195 27/01/2017 6.2 LCFS Progress Report - 1 October - 31 December 2016 RJ updated the committee, noting he had gone through first review in terms of looking at entries in hospitality register. It was agreed this would not be a routine agenda item and would be reported on an exception basis only. It was agreed that RJ would Amend TOR to reflect this change to the reporting.	
	198 27/01/2017 9.1 Reporting, Accountability, Monitoring and Review of Effectiveness - Charitable Funds Annual Report & Accounts - Unadjusted Audit Differences RJ noted he had not heard back from other Trust's but could do an FOI in terms of gaining information from other Trusts. He advised that he would pick this up with the auditors.	
	Item 3 Phil Gadie paper LW introduced the Supply Chain Paper from Phil Gadie. She advised this was a response to a previous action made by Pam Chrispin around the 20 most important suppliers to the Trust. LW commented that Phil Gadie had looked at the work done in July and suggested few amendments to the approach, LW noted the same paper was due back to committee in June/July 2017 and asked if the committee were happy with Phil Gadies suggestions, that they were built into the paper that is due to come back in the summer? LW went on to note the 4th recommendation in the paper and advised they were not taking this forward at this stage and were addressing payments to pharmacies via another route. She asked if everyone was happy (advising the report would have a slight difference in suppliers when it was brought back). ST advised yes he was happy and if this meant refining the mechanism, that would be a positive. This was agreed.	
4.	**KPMG – Deep Dive**	
4.1	***Deep Dive – Financial Improvement Programme (FIP)***	
	Each member of the KPMG team introduced themselves to the committee with a little background about each of them and their work/achievements. The team took the Audit committee through their presentation. They also noted the process they had gone through with NHSI to be matched with WSH and what	

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	work they planned to do at WSH.	
	NH asked a question in regard to slide 3, bullet 2. Jason Parker explained what he meant in regard to structural issues and that he felt this was a fixable problem. RP asked around quality and patient safety impact assessments, Ben Garside picked the issue up, noting that all the opportunities for the financial position were subject to QIA's and impact assessments, he added that these were clearly already in place in WSH and that the team would work with established government process in order to enhance these. RP asked if there was a clear metric on what would be acceptable? Ben Garside noted that the team would work across three dimensions. ST commented that it was helpful that KPMG were here across a 7 month period and that there could be different ways at looking at their suggested ideas, which could be helpful. RP asked what were the skills and experience in delivery of real/sustainable change in NHS (of the KPMG team), Jason Parker noted that nearly all of the projects he had been involved in and of, for a number of years, had shown that it was better to spend money slower over a longer period of time by embedding systems/ways of working with divisions/directorates. SD asked how this message would get expressed in the plan and how would they give greater ownership of the problem back to the organisation/staff? He asked how the Trust could empower staff whilst giving the message that this is the right thing to do for the organisation. Jason gave his views, noting that the work should be WSFT led, supported by KPMG. SD noted previous work by four eyes etc, and asked how this was different. Ben Garside noted that they would be working with the hospital and wouldn't be leaving 'a plan on a shelf', he referred to examples of previous working over 6months/9months and went on to explain in more detail how they do things different. He also commented that hey used appreciative enquiry and that this was different to how other firms work. JB asked for examples of quickwins, i.e. within two weeks. Duncan Calverly noted these were mainly around grip and control, he noted at WSH he understood this was good but that that there was always scope to move from good to excellent, i.e putting vacancy controls panels in, tweaking recruitment processes looking at SFI's, understanding procurement process, amongst other things. These were where they usually found quick wins initially he commented. Ben Garside advised that in a first diagnostic phase (over two weeks) at a very similar organisation, they had used all their e rostering data in a way they hadn't before and were able to identify shift handovers/crossover issues and as a result, immediate shift changes happened overnight. NJ noted that a lot of the information he had heard was positive, his worry was that the team were used to working in organisations a lot different to WSH. He noted concerns that following the piece of work and when KPMG leave WSH they possibly may have broken the bits that did work. Jason Parker noted something he liked to do was in the form of an early workshop that went through what had been tried and tested before and what did/didn't work. This being an important workshop as this was a listening one he commented. NJ noted this would need to be a fine balance of scratching off methods that didn't work recently and those that may work now but hadn't previously (more historically). GN noted this thoughts that he was glad they got the balance of	

	sustainable/safe/challenge. He noted a question ref phases 1 and 2 around truly understanding what success looks like he asked where in the process would WSFT double back on the contract, numerically, quality and financially? Jason noted that as part of a national project they have to report back after two weeks. He noted that at phase 3 (6/7months), there was an onging dialogue in getting to a balanced and achievable plan and refining that as they go along. GN requested pinpointing a clear point in time to define optimum outcome. SD noted his views on this process. GN acknowledged SDs comments noting where he would like expert input, around what the ambition / optimum outcome could be. RQ gave his views on the comments from GN, advising the process was not an audit to drive change but was to help drive change and as a result, save money. GN and NH discussed their ambition for WSH as a result of the process. ST commented the importance to embed everything KPMG do in the WSH CIP Plans and 3 and 5 year plans. HB noted her 2 points, she absolutely welcomed this as an opportunity but was also very conscious the need to manage the process very carefully, she noted her recent work with the head of PMO and revamping PMO and getting buy in clinically for some major initiatives and what she didn't want to do was to damage that, what she wanted was to enhance these plans. She noted the second part being to check scope, she noted managing community services and asked if this was in the scope of KPMG work, which the KPMG team confirmed it was. ST referred to benchmarking noting this had already been done numerous times but the main focus was now around saving money, however, if there were structural issue then this piece of work would be a good catalyst to highlight such issues. Following ST's question, CB commented that the Trust Board and Scrutiny Committee would be used to update on progress. ST advised he would require more in-depth updates for either meeting. CB noted the background to the process that NHS Improvement had gone through in order to match KPMG to us and subsequently that internally KPMG had also gone through a selection process in order to ascertain the team to work with the Trust. CB asked KPMG why they felt this team were the right team to work with WSFT and what criteria had they established internally to match the team chosen. Jason Parker noted his view and that in regard to NHSI (and some close working he had previously with Mark Mansfield) they had felt Jason Parker would be a good cultural fit due to his improvement background together with Duncan Calverley and Ben Garside. Jason Parker commented they also looked at the Trusts levels of financial stress and control and grip on the organisation. CB asked what their assessment/summary was of the Hospital. Jason Parker advised that it appeared there were some areas that require support and challenge and that also there was good cultural and an engaged base to go from and also due to the punchy CIPs, there was a need to work fast. CB advised he felt this was a fair summary. AR asked whether procurement was fully in scope as in all procurement issues, which the team confirmed they were. AR also asked around medium/long term ideas or if this was short term only. Jason Parker gave his views, that they were looking at medium term strategic options also. Ben Garside noted that the team would look at the broader strategic goals and objectives including the STP but that they would be very focused upon the significant challenge in year and that the majority of focus would be around this initially.	

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	SD gave his view, he noted what he would be keen to do was not just engage clinicians around decisions but also better empower them when the KPMG Team are no longer present to take forward how to do both quality and financial improvement, moving forward. Jason Parker advised there would be lots of ways to do that and it would be very important who was involved in the programme, it musn't just be financial and an administrative group. Ben Garside gave his views on how to achieve this. RP asked how many people in total would be coming in? Jason Parker advised that they envisaged, over the course of work, around 10 - 12 in the team overall. This would be the optimal size of team to drive the pace of change that WSFT needs and to flex that with the support that WSFT require. Duncan Calverley advised in more depth how this would work and referred to Page 9 of the presentation provided. It was agreed that the start date would be from the following Monday. RP asked what time would be needed to be released. Duncan Calverley advised that to start off, CB would receive an information request list. He also noted in terms of access, yes they would need time from the senior team. Ben Garside noted that it was important to gain sponsorship from the organisation. NJ asked would there be a reverse commitment from KPMG, in respect of being available to make meetings first/last thing, which the KPMG team confirmed they would. JB asked around a communications plan, as there is a need to start to explain to staff what is going on and how it will feel? SD agreed, noting it would be important to have a clear narrative. Ben Garside asked for time the following week, to get a constructive narrative with the Executive Team.	
4.2	***Reflections & Discussions***	
	As per item 4.1 above. Following KPMG leaving the meeting, ST asked for reflections. RQ noted that this should be looked at as free consulting and treated positively, whereby some of the comments made were not positive he felt. CB noted his thoughts in regard to any possible cynicism within the Trust. He noted that this group were very different to the usual consultant groups that come into the Trust.	
	<u>Governance & Assurance</u>	
5.1	***Clinical Audit***	
	Paul Morris joined the meeting to introduce this item. Paul Morris noted the commentary around inflammatory bowel disease he noted it was to discuss, that while it is reported on, this wasn't a mandatory requirement. He additionally commented that they were already committed to some projects working in conjunction with addenbrookes. Paul Morris referred to secondary care and COPD Audit – he noted there was a delay and the trust was starting to fall behind regarding the handover of the clinical leads. Annie Campbell was discussing this with CD's and operational	

	lead and were waiting an outcome to see who was taking this project forward. Paul Morris referred to the TARN – he noted this had been partially resolved, they were now doing a process of trying to catch that up with a focussed effort. He commented from a clinical perspective, one of the consultants had picked that up but also another member of staff was helping additionally. Paul Morris commented on National ophthalmology – he advised that Hannah Knights was leading on this and it was the electronic system causing some of the backlog that was happening. Helen Beck noted that she would meet with Paul Morris to ensure he had right details as this wasn't in fact the actual reason. Paul Morris gave an update on Thyroid - that this has already been raised at surgical governance and Simon Taylor was seeking admin support to bring this back inline with timescales. Paul Morris commented on patient blood management (red overdue) which interlinked with TPP, which he commented was why this was starting to fall behind he explained. Paul Morris advised ref point 7 on third page of his report, that these were yet to be presented at surgical governance/orthopaedic governance and that he had already met with Sue Deakin to discuss they were coming her way and that she had advised that she had already appointed leads for that. ST commented that this had been a very good report. GN asked a question in regard to the audit programme, he asked what were we doing to ensure that the subjects audited were the most important. Paul Morris explained that the clinical audit and NICE best practice, they were trying to amalgamate the two so that they could ensure they were using best practice. Paul Morris made reference to the national mandated audits and areas of interest being used in order to ensure correct audits were done. AR asked if concept of clinical audit applied to community service activities and was there a history/relevance of that. Paul Morris noted they had a separate programme and ST noted they had had visibility of it at Audit Committee previously. ST noted one of the questions would be; what is the Trust visibility/management process in the Trust, he noted they weren't audits but quality assurance visits and suchlike, Clinical effectiveness RP noted. RJ gave his view, noting that for future they should make sure explicitly that they do the same for all other reports. ST noted an internal audit that reviewed the governance structures around community services and going forwards there being no reason why these could now not be integrated. RJ noted his thoughts, advising to be careful we are now one entity and that clinical audit is essential of that compliance and that they needed to think about putting in place a clinical audit process for the particular area of change in order to get a handle on whether people are following correct process (and not to see it as two entities more as a singular). AR asked that RJ picked this action up. ST gave his views on the report and noted it would be good to have a section in the report on process changes to the clinical audit process i.e. process for identifying which local audits WSH do. RJ noted a risk in this and a caution against this would be the duplication of same information in different committees (this information currently goes to CSEC). ST acknowledged this but	**RJ**

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	commented that the audit committee still require assurance that the process for clinical audit is doing what it needed to do. SD gave his views, he commented the key things he wanted to find out was, of all those audits, how and where the Trust benchmark? He asked if this information could be included? ST asked where this would be best discussed. RQ noted the latter would be picked up by group concerned with the audit. RP noted her thoughts, that this could be reported via divisions/Finance Performance/Quality Meetings. It was decided that CSEC should hold this information reporting.	
5.2	***Quality and Risk Committee Report***	
	RJ referred to the terms of reference provided.	
5.3	***Draft Annual Governance Statement***	
	RJ introduced the item and explained the colour coding. RQ commented around the governance structure, that it implied that the three board subcommittees report through quality and risk which they don't he advised. He asked if there was a way of showing that, RJ advised yes they could do a dotted line and narrative (if not on the actual diagram) to confirm that. AR made a comment around governors, he noted they were missing from the chart, RJ noted he could add them in. RP noted removing Pam Chrispin from the paper. RJ commented that in terms of the three items in terms of potential control issues for last year, the first one around pathology services, TPP position, both from financial and quality perspective, there was some narrative which included MHRA inspection and the work being undertaken in response to that. As well as the financial impact of the TPP on the accounts in terms of fixed assets and impairments. RJ referred to the Cost Improvement Programme (CIP), recognising that the Trust did hit the control total through non recurring CIPS, as a result there were some words around how/what the Trust was doing to improve the position, (i.e KPMG work). RJ noted the third was in the context of some of the 18 week reporting, the e care reporting issues and challenge the Trust had on that, this would include the mitigating work both internally and with Cerner, he advised that the June performance data would be provided to the July meeting. ST asked BDO and RSM for comment. LN concurred these were the risks they had also identified. DH agreed that only the CIP one would be a significant issue he felt. CB noted that in regard to the e-care reporting, they knew there was going to be reporting issues which had been flagged and had been raised before go live and what happened was as predicted, likewise with CIPS he additionally commented. CB advised the outcome was a good outcome, however it was done non recurrently and not in line with plans which is why they had felt it should be included and Pathology / TPP had to go in. RJ advised that he was happy to take any comments / feedback offline.	

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6	**Internal Audit & Counter Fraud**	
6.1	***Internal Audit Progress Report***	
	DH referred to page 3 and page 4 of the report advising that they had completed all of the work with 9 final reports, (2 in draft of those 9 finals issued), this was shown on page 5, 2 being partial assurance and 7 being reasonable assurance, he commented they had also undertaken a quarterly follow up of actions and put some commentary around 17/18 and had proposed five dates and drafted scopes for the Q1 audits. DH referred the committee to page 14 – which summarised the management action that had been looked at. In regard to the CIP transformation delivery actions, he commented the action was slightly misleading which he explained in more detail the reason for this. DH then referred to Appendix A, Cyber Security action where the date had been pushed back from March to July. He noted this information had been circulated for information. DH advised that in terms of two partial assurance, they have the first of those, he noted there was a summary of those in the paper. In regard to the equipment services review, they had received reassurance and were pleased to hear and see through discussion, that progress was being made. DH had pointed out that there needed to be better visibility on that, to get these on risk registers and on governance structures. DH noted in regard to incoming debt management there was a summary also provided around this. ST thanked the team for a great report. CB commented around income and debt management audit report he asked how close was that? DH noted that income debt was close to being reasonable and clinical services was close to no assurance. There was a discussion around this subject.	
6.2	***Annual Head of Internal Audit Opinion***	
	DH introduced the item.	
	DH advised that this report was the shortened version and a full version will be issued. He referred to Appendix A and commented this was a positive year end opinion. DH noted they issued very few of the full clean opinions.	
	DH commented there were no advisories noted in the AGS, to which RJ confirmed he would add to the AGS if they could advise him accordingly.	
6.3	***Counter Fraud Annual Plan 2017/18***	
	MK introduced this item. He noted that the annual report summarised all audit committee reports of the year. MK referred to page 12 the SRT and noted the Trust had come out overall as amber. Governance was green and all others were amber, however hold to	

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	account had come out as red. MK explained how the scoring worked and that the Trust had to be investigated in order to count.	
7	**External Audit**	
7.1	External Audit Progress Report LN introduced this item, she advised the progress report basically noted where they were up too. She commented that they were still in the process of reviewing internal controls but to date could not find anything significant. She noted they had received the draft accounts and were due to commence the audit the next week. LN noted they would send in the final report to audit committee at end of May and that all was on track. CB noted thanks to all the team for the work and efforts in meeting the deadline.	
7.2	External Audit Plan 2017/18 LN introduced the item. She noted that the paper was the Audit plan for the year ending 31st March 2017. He advised that since they had issued the plan they had received the draft accounts and had another planning update meeting where they had identified some additional points, which is why they now had a new updated paper. LN made reference to Management override – she advised they had just added in an area of focus in relation to the fact that the Trust was able to meet its control total and then received additional STF funding. She noted this would be an areas of focus for them. LN noted the next risk in relation to revenue recognition – she noted this was a risk factor of material income streams, which include patient care, non patient care etc, and focus would be on increased sample sizes in those areas. LN commented on the next risk around valuation of land and buildings – she commented they had upgraded this to a significant risk on the basis that the technical dept had said they would have too, as any small change in estimates could pose problems and in order to give a bit of extra testing in that area. LN made reference to TPP – in regard to the uncertainty of the future of the partnership and whether this would have an impact. LN referred back to the plan and on page 11, she noted the use of resources works, one being in relation to finances and CIPS and one in relation to e-Care. LN then noted on page 12 in relation to quality report in regard to indicator for the RTT data and the fact this is estimated, she commented that she had since had conversations with the trust around this issue. LN finally referred to page 14 audit fee, she noted this would be the same as the prior year, she commented there were some additional risks they weren't expecting, however, the fee should remain the same. AR asked LN, that in the same way they take some risks of the de merger of TPP, was there a similar but smaller risk around community services? LN advised this maybe something to think about going forward (in the next financial	

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	year 17/18).	
8	**Financial Reporting**	
8.1	***Review of Waivers***	
	LW introduced the item. ST commented on the losses around staff that have left that owe WSH money, RQ noted some of these were a long time ago. ST wondered if the Trust had processes in place now to catch such things as overpayment/accommodation charges. LW noted yes, specifically on accommodation, they used to bill staff but now they make agencies sign agreement and the agency pay the accommodation themselves, then they have to recover from individuals directly. ST asked around deducting monies from last wage packets which LW commented they did do this where possible but often there was not enough in some peoples last pay packed to pay back the debt. Also she noted, sometimes there is short notice of someone leaving and it's hard to action before pay has gone out/been processed. LW noted HR are working hard to educate Managers to notify them in good time. GN referred to a specific case detailed which involved a locum, he asked if we could warn other trusts or bar their ability to practice, LW noted they hadn't done but could do that. GN asked if this would be a duty of care type issue. CB noted for people overseas, when this is lodged on record they are not allowed back in the country. CB commented that the team go to extreme lengths to find people to recover costs (referring to a specific recent case of someone in Canada) which LW echoed. MK noted this could be added onto the Register of NHS Protect. Following discussion LW noted they also worked with HR to see if ex members of staff had gone to another NHS trust and to contact them via their new employer. An action was agreed that LW passes names of these people to MK to add to the Register of NHS Protect.	**MK / LW**
8.2	***Losses & Special Payments***	
	SD asked around the expired drugs write off issue. He asked if this was to do with WSH stock management processes, which LW explained this was as a result of a drug ordered for two patients and then the treatment stopped, the expiry date on those drugs was very short, so this had been investigated and Pharmacy were very good to minimise loss. ST explained a previous issue which had resulted in an audit in pharmacy and since the audit any losses had significantly reduced.	
8.3	**Year End Accounting Issues** LW summarised the key judgements which had been used for the accounts. She noted that the first one was for going concern, she noted the auditors had highlighted that this was an issue in their plan. She noted ultimately it was because the guidance had said if services continue to be provided in this area by government funded organisations, then they should be prepared on a going concern basis. LW advised that in regard to the accounting policies they do get draft policies	

	from the dept of health and the auditors and WSH were very keen to tailor to local circumstances, LW referred to appendix 1. In regard to significant accounting estimates highlighted, LW noted they had built into the accounts for current year an estimate of the recoverable deposits paid on community equipment and this had been shared with the auditors. LW highlighted to the committee that the amounts included in the accounts as owed to NHPS were £2.3m less than the invoices WSH had received, this was inline with the approach taken the previous year LW mentioned (the Trust now have 18months of dispute compared to 6 months previous year). LW referred to the next issue around pathology partnership where WSH had impaired the investment and taken it through the INE. ST asked around annually managed expenditure impairment in regard to TPP/Pathology partnership. LW noted it was a central government thing and the treasury had devised a system with AMY and DEL (LW explained what these meant) she explained the process in detail with the committee. There was some discussion around this. Basically, it meant that this had been written off and ST noted that this felt a good thing. ST went on to make reference to NHS PS, he asked what were WSH doing that's new in order to resolve the dispute with them and he asked LN from her perspective, what assurance have WSH got that the Trust had the right figures. CB noted that WSH had evidenced the fact that the amounts that WSH included in it's accounts, as per payment for the property, matched the information WSH was given pre tender for contract. He advised that the NHS PS position was that if the debt doesn't rest with WSH it then falls on CCG. CB noted that WSH had been trying to get the department of health to arbitrate on this but at the moment NHS PS and the CCG were in discussion about what form the arbitration takes, he mentioned this was being delayed due to personnel changes at CCG, but that resolution would be the WSH, NHSPS and CCG agreeing what it should be. CB noted that WSH were absolutely confident in the number for the property and this was in line with the estimates that WSH were given by CCG. CB went on to note that in effect the CCG and NHSPS need to resolve between themselves.	
9	**Reporting, Accountability, Monitoring and Review of Effectiveness**	
9.1	***Quality Review of FT audits for 2015/16 – Letter from NHS Improvement***	
	CB referred to the letter they had received, which ST commented was self explanatory (and had been provided to the committee). LN commented from their side they were pleased with the letter. SD commented around sector review and asked if there were any issues, LN advised she had seen a paper but it was pretty clear that there was nothing she could see. LW commented this was more around assessment of the audit.	
10	**Planned Agenda for Audit Committee**	
	LW noted that there was another sign off meeting on 26th May at 08:30am to sign off the accounts. RJ advised they had talked about starting the meeting earlier at 08:00, RJ asked for views? LN asked if 08:00 would be ok, to ensure	

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	there was enough time to cover the reports. 08:00 was agreed. It was agreed that an email would be sent to confirm this earlier start time of the meeting.	**KMc**
11	**Audit Committee Briefings**	
	CB noted that the briefings provided from RSM, were interesting and very useful for onward circulation.	
12	**Any Other Business**	
	ST made a point around the induction of new members of the audit committee, in regard to RD, AR and AE, to ensure there is a designed induction process for new members and to be able to confirm this had been actioned. ST also commented around when WSH did a tender for external audit there was an action around a schedule on value added work and for audit committee to get an update on that. This was for LW and LN to action. ST requested to see this as a schedule in the contract.	**RJ** **LW/LN**
13	**Reflections on Meeting**	
	It was noted there was a lot on the agenda. ST noted KPMG had taken a bit longer but was important. GN confirmed an appropriate amount of time had been given in his view. AR asked if there would be a programme board to manage KPMG to manage on a day to day basis. RQ advised that this would need to be thought through. ST noted JB had made a very important point around communications on the process. ST commented that it had been a long time since WSH had had an organisation that would be around and stay around. RQ noted Jason Parker had been here before.	
14	**Date of Future Meetings**	
	2.00 p.m. – 4.30 p.m. – Committee Room	
	26 May 2017 (8:00 am for 60 minutes) 28 July 2017 3 November 2017	

DRAFT

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30th June 2017

ITEM NO:	Item 19
PRESENTED BY:	Steve Turpie, Non-Executive Director
PREPARED BY:	Kathryn McMahon, PA
DATE PREPARED:	June 2017
SUBJECT:	Audit Committee report
PURPOSE:	To approve recommendations from meeting held on 28th April 2017 and 26th May 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 April 2017

- **KPMG Deep dive**- the KPMG team explained the course of their upcoming work with the Trust.
- **Governance and Assurance** – Clinical Audit was discussed together with Quality & Risk Committee report and the draft Annual Governance statement, which was subsequently agreed subject to some small amends.
- **Internal Audit and Counter Fraud** – the Internal Audit Progress Report was discussed together with Annual Head of Internal Audit Opinion and the Counter Fraud Annual Plan 2017/18.
- **External Audit** – both the External Audit Progress Report and External Audit Plan 2017/18 were discussed.
- **Financial Reporting** – Review of waivers was discussed together with Losses & Special Payments and Year End Accounting Issues.
- **Reporting, Accountability, Monitoring and Review of Effectiveness** - Quality Review of FT audits for 2015/16 – Letter from NHS Improvement was discussed.

26th May 2017

- **Annual Report and Accounts** - The annual report and accounts were considered, recommending approval by the Trust Board.

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		

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30 June 2017

AGENDA ITEM:	20
PRESENTED BY:	Steve Dunn, Chief Executive
PREPARED BY:	Richard Jones, trust Secretary & Head of Governance
DATE PREPARED:	21 June 2017
SUBJECT:	Certificate for NHS Improvement licencing
PURPOSE:	Approval

EXECUTIVE SUMMARY:

NHS Improvement has issued two self-certification requirements for approval by the Board as part of the annual reporting arrangements. These follow a similar structure and content to previous years and sit alongside the general condition 6 certificate which formed part of the annual report approval on 26 May 2017 (Annex B).

The Board is required to approve the following annual statements and certifications as part of our licencing submissions to NHS Improvement. These are set out below and in greater detail within **Annex A**:

1. **Corporate Governance statement - *Confirmed***
   A range of statements are detailed coving compliance with corporate governance best practice; effective systems and processes; and having the correct personnel in place.

   It is proposed to indicate that the requirement has been met. This is supported by a range of assurances including annual governance assessment; internal and external audit opinions; review by external agencies, including the CQC, performance and management information reported to the Board and its subcommittees.

2. **Training of governors - *Confirmed***
   The Board is asked to confirm that it is satisfied that during 2016/17 it provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure governors are equipped with the skills and knowledge they require.

   It is proposed to indicate that the requirement has been met. This is supported by the working and information received at the Council of Governors, its subcommittees and workshops; training provided during the year; and governor attendance at external events. This compliance position is supported by the Council of Governors commentary in the Annual Quality Report.

Linked Strategic objective (link to website)	To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	General condition 6 and Continuity of Services condition 7 certificate approves as part of Annual Report & Accounts.

Risk description: (including reference Risk Register and BAF if applicable)	BAF 1.1 (quality, governance or service failure)
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Governance and risk management framework underpinned by policy and procedures. Internal and external audit review of control environment. Annual governance review. Internal and External Audit opinions as part of Annual Report and Accounts.
Legislation / Regulatory requirements:	Set out in NHS Improvement Licence
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	None

Recommendation:

1. The Board approve the six corporate governance statements and certification for training of governors (**Annex A**)
2. The Board receive in public session the general condition 6 and continuity of cervices condition 7 certificates (**Annex B**).

Annex A

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Well-led assessment to be undertaken during 2017/18 by independent reviewer
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any	Confirmed	

	changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	Chair recruitment on schedule as current incumbent's term finishes in December 2017

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature	**Signature**
Name Roger Quince	**Name** Dr Stephen Dunn

Certification on governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statement. Explanatory information should be provided where required.

2 Training of Governors

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Confirmed

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature		Signature	
Name	Roger Quince	**Name**	Dr Stephen Dunn
Capacity	Chairman	**Capacity**	Chief Executive
Date	30 June 2017	**Date**	30 June 2017

Annex B

General condition 6 and Continuity of Services condition 7 certificate

A. For Condition G6 – Systems for compliance with licence conditions and related obligations

Question 1

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**

Requirements to comply - Guidance on Condition G6 (extract from Monitor Licence)

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
   (a) the Conditions of this Licence,
   (b) any requirements imposed on it under the NHS Acts, and
   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

B. For continuity of service – availability of resources

Question 2

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**

OR

After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30 June 2017

AGENDA ITEM:	21
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Ruth Williamson, PA, Trust Office
DATE PREPARED:	26 June 2017
SUBJECT:	Use of Trust Seal
PURPOSE:	Note

EXECUTIVE SUMMARY:

To note use of the Trust Seal, pursuant to Standing Order section 8. The Trust Seal was used on the following occasions:

- Seal No. 120

  Transfer of Part of Registered Title – Hardwick Manor, Hardwick Lane, Bury St. Edmunds. Transferor – Stuart Edward Whitworth Woodhead ref. SK136191. Transferee – West Suffolk NHS Foundation Trust

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

Recommendation:

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

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30 June 2017

AGENDA ITEM:	Item 22
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	22 June 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 – 28 July 2017

DESCRIPTION	OPEN	CLOSED	TYPE	SOURCE	DIRECTOR
Declaration of interests	✓	✓	Verbal	Matrix	All
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
DELIVERY FOR TODAY					
Quality & performance report, including: - Staff recommender - Mandatory training	✓		Written	Matrix	HB/RP
Finance & workforce performance report, include extra session data (links FIP)	✓		Written	Matrix	CB
Red risk report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP					
Aggregated quality report	✓		Written	Matrix	RP
Nurse staffing report	✓		Written	Matrix	RP
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Transformation report (Q2)	✓		Verbal	Matrix	HB
Stroke option paper		✓	Written	Action point - schedule	HB
National patient survey report (if available)	✓		Written	Matrix	JB
Equality annual report	✓		Written	Matrix	JB
Medical Revalidation annual report	✓		Written	Matrix	NJ
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
BUILD A JOINED-UP FUTURE					
e-Care report	✓		Written	Action point - schedule	CB
Financial improvement programme (FIP) report		✓	Written	Action point - schedule	CB
Procurement hub bid – Category Towers		✓	Written	Action point - schedule	CB
Scrutiny Committee report		✓	Written	Matrix	GN
Strategic update, including STP, ICO and TPP		✓	Written	Action point - schedule	SD
GOVERNANCE					
Trust Executive Group report	✓		Written	Matrix	SD
Q&R Committee report	✓		Written	Matrix	RQ
Remuneration Committee report	✓		Written	Matrix	NH
Board Assurance Framework (BAF)		✓	Written	Matrix – by exception	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JB
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	RQ