West Suffolk NHS
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on Friday, **31 March 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 – Jon Green	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 3 March 2017	Roger Quince
6.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Roger Quince
7.	**Chief Executive's report (attached)** To accept a report on current issues from the Chief Executive	Steve Dunn
9:35 DELIVER FOR TODAY		
8.	**Quality & Performance reports (attached)** To receive the report	Helen Beck / Rowan Procter
9.	**Finance & Workforce Performance report** (a) To accept the monthly Finance & Workforce report (**attached**) (b) To approve the Capital programme (**attached**) (c) To approve the final budget setting paper, with quality impact assessment of CIPs (**attached**)	Craig Black
10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
10.	**Aggregated quality report (attached)** To accept the aggregated analysis including serious incidents, red complaints and PALs enquiries	Rowan Procter / Nick Jenkins
11.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter

12.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
13.	**Education report (attached)** To receive the report, including update on undergraduate training	Jan Bloomfield
14.	**Consultant appointment report (attached)** To note the report	Jan Bloomfield
15.	**NHS Staff Survey (attached)** To note the report	Jan Bloomfield
11:00 BUILD A JOINED-UP FUTURE		
16.	**e-Care report (verbal)** To receive a verbal update	Craig Black
11:10 GOVERNANCE		
17.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
18.	**Remuneration Committee report (attached)** To receive a report of meeting held on 3 March 2017	Rosie Varley
19.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:20 ITEMS FOR INFORMATION		
20.	**Any other business** To consider any matters which, in the opinion of the Chairman, should be considered as a matter of urgency	Roger Quince
21.	**Date of next meeting** To note that the next meeting will be held on Friday, 28 April 2017 at 9:15 am in the Committee Room.	Roger Quince
RESOLUTION TO MOVE TO CLOSED SESSION		
22.	The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act l960	Roger Quince

DRAFT

Item 5

West Suffolk NHS
NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 3 MARCH 2017

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Roger Quince	Chairman	•	
Craig Black	Executive Director of Resources	•	
Jan Bloomfield	Executive Director Workforce & Communications	•	
Richard Davies	Non Executive Director	•	
Steve Dunn	Chief Executive	•	
Jon Green	Executive Chief Operating Officer	•	
Neville Hounsome	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Gary Norgate	Non Executive Director	•	
Rowan Procter	Executive Chief Nurse	•	
Steven Turpie	Non Executive Director	•	
Rosie Varley	Non Executive Director	•	
In attendance			
Ali Bailey	Head of Communications		
Georgina Holmes	FT Office Manager *(minutes)*		
Richard Jones	Trust Secretary		

Action

GENERAL BUSINESS

17/26 APOLOGIES FOR ABSENCE

There were no apologies for absence.

The Chairman welcomed and introduced Richard Davies who had replaced John Benson as the nominated NED for Cambridge University.

17/27 QUESTIONS FROM THE PUBLIC

- Joe Pajak asked if there was any further update in relation to TPP. Craig Black explained that this had been discussed at the recent closed session of the Council of Governors meeting. A communication had gone out across the partnership over the last two days explaining the reconfiguration which was an East and West split, with Colchester, Ipswich and WSFT being the partnership in the East. WSFT was now working with both these organisations to establish a clear governance and finance structure. Staff employment would move to Colchester and the hub for the East would be in Ipswich, with smaller labs in Colchester and WSFT.

- June Carpenter referred to the press coverage on capping locum consultants pay and asked how this was progressing. Jan Bloomfield explained that this was a very difficult market and therefore it was currently not possible to operate below the agency cap, which was the same for other Trusts. HR Directors and Medical Directors were working together to look at how this could be controlled.

  Nick Jenkins reported that it was felt that the nurse agency cap had been successful, but this was not yet the case for the agency cap for doctors. This would need to be driven nationally and NHSI had communicated some of the national actions it was planning to take.

- Joe Pajak reported that Jo Churchill was currently live on the radio talking about car parking and this was coming across negatively from WSFT's perspective. Ali Bailey said that she was not aware that this was taking place.

  Jan Bloomfield considered this to be disappointing as Jo Churchill had been fully briefed and understood the Trust's decision around this. (Subsequently it was established that Jo Churchill had in fact been supportive of the Trust's position.)

17/28 REVIEW OF AGENDA

The Chairman explained that there was no presentation, which would allow more time for other items on the agenda. It was intended to hold more joint Board/CoG workshops, where there would be a presentation. There would also be a presentation as part of the Quality & Risk Committee meetings. He felt that this approach would be more beneficial with more time allowed for presentations and questions/ discussion.

17/29 DECLARATION OF INTERESTS

There were no declarations of interest.

17/30 MINUTES OF THE MEETING HELD ON 27 JANUARY 2017

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

Item 17/08 (page 5), first paragraph, second sentence to be amended to, "From February 2017 WSFT would no longer be taking any new referrals…"

17/31 MATTERS ARISING ACTION SHEET

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

Ref 1331 – provide Board with a stroke services option appraisal and sustainability report – Jon Green explained that this report was due to come back to the Board meeting on 31 March, however it may not be complete.

Ref 1368 – bring back explanation for the red rating for anaesthetics within the HSMR speciality tree (p21) – Nick Jenkins explained that this was a synopsis as mortality was not being reported very well and the quality and narrative were not right. Next month, as well as the normal report, he would bring a proposed new way of reporting mortality for discussion.

He stressed that this was not something to be concerned about, but it required further explanation. Rosie Varley felt that this would be extremely helpful.

Ref 1369 – seek clarification re what the local authority were doing to improve the quality of information provided for paediatric referrals. Also update on situation re paediatric redesign plan which was reported as on hold – Steve Turpie asked if the redesign would have any impact on a reduction in backlogs. Jon Green said yes, potentially; a new model on how the County Council planned to run paediatrics would be available later this year. This was only funded until the end of March but WSFT would continue to fund it until the end of April as it was a priority. However, there was no conclusion about continuing to fund the excess for this and this would potentially have an effect on the backlog.

Steve Turpie referred to the framework for looked after children and asked if it could be suggested to the local authority that they made this compulsory for foster carers.

Rowan Procter explained that this was a contractual requirement of foster parents, but they were not held to account. She would send a formal letter to the local authority to this effect. **R Procter**

Ref 1371 – undertake assessment of what additional sessions would look like if the Trust was running at optimum efficiency and based on this set out remedial action to improve current performance – Gary Norgate said that he understood that extra sessions were required to maintain waiting lists, but asked how many additional sessions were created by failure or aborted/cancelled sessions. Craig Black confirmed that an analysis of this would be included in the finance report for the next Board meeting. **C Black**

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

Ref 1356 – report on the planned site reconfiguration for car parking, include provision for disabled parking. The Chairman asked how many disabled spaces there would be. Jan Bloomfield confirmed that there would be 40 additional spaces for disabled drivers.

17/32 CHIEF EXECUTIVE'S REPORT

The Chief Executive congratulated Jon Green on his appointment as Chief Executive for the Queen Elizabeth Hospital, Kings Lynn. He then went on to highlight the following:-

- The Trust was under significant operational pressures which were detailed in the report. A&E was a particular area of concern to NHSI and NHS England. Issues around this, waiting times and RTT would be discussed later in the meeting.

- WSFT was not on target to hit its stretch CIP target of £3.9m. As a result a meeting had taken place with NHSI and the Trust would be under investigation and would be taking advantage of national support, as well as appointing a Turnaround Director to assist with this.

- At the recent joint CoG/Board meeting, the problems in returning equipment had been highlighted. A campaign to improve this had been launched.

- There had been significant media coverage relating to the CQC. Although this was generally a bad news story for the NHS, it had been a good news story for WSFT. However, as mentioned previously the Trust was now facing considerable operational challenges and needed to focus on those areas of concern.

- A planned inspection by the Medicine Healthcare Regulatory Authority (MHRA) of the blood transfusion service operated by TPP within WSFT had taken place and a number of serious concerns had been raised. The Chief Executive considered that the work being undertaken as a result had given the MHRA a degree of assurance and had identified actions that needed to be taken.

Rosie Varley asked about e-Care Ordercomms functionality. It was explained that this would be discussed later in the meeting.

The Chairman cautioned against using unqualified data in Board reports, ie 48% of people died within one year of hospital admission (page 1), given that in this area over 50% of people actually died in hospital. The Chief Executive explained that this data had been provided by ECIST (Emergency Care Intensive Support Team). It illustrated the need to ensure these people did not spend any longer in hospital than they really needed to, particularly when they were old, vulnerable or frail.

Neville Hounsome congratulated the executive team on the quality and quantity of media reports and TV appearances recently and the issues raised. However, he considered there was a need to reflect on the media coverage around parking which had not been favourable. The Chief Executive agreed and acknowledged that communication to staff could have been handled better.

DELIVER FOR TODAY

17/33 FLOW ACTION GROUP (FLAG)

Nick Jenkins explained that they were trying hard to challenge some of the long held beliefs about being in hospital, ie it is a safe place to be; somewhere where you should spend a period of time. It was important that the message was delivered so that people understood that early preparation for discharge was positive and caring. Individual patients needed to be asked what their goals were while they were in hospital, eg maintaining mobility and keeping walking, however this could result in an increase in the number of falls.

The flow focus had been red to green and the decision had been taken to adopt this throughout the organisation, which was ambitious but had worked on the whole.

Red to green was the enabler to the Safer Bundle and the focus was moving towards this.

The dashboards on pages 6 and 7 were available to staff on the intranet and showed the differences their participation was making. It was hoped to be able to see the live position by Easter and also the weekly position which would show trends over time.

Nick Jenkins stressed that this was work in progress. It had been challenging but there had been considerable support from across the organisation from every level, particularly senior matrons and service managers who had gone the extra mile to try to get this embedded. Benefits that were anticipated had not yet been seen but he hoped this would come.

Gary Norgate commended Nick Jenkins on this and said that it provided him with assurance. He asked about the fact that some wards were embracing this, but others were not, and how this had been perceived and adopted by consultants. Nick Jenkins explained that this had been varied and not necessarily in the areas he would have expected. Some areas had made this their own, eg G5. F10 had also taken this on but in a different way to G5. However, there were some areas/groups of people who had tried to ignore this in the hope that it would 'blow over'.

Nick Jenkins and the Clinical Directors were working with areas that were not engaging, eg general surgery. He and the General Manager for this area would be meeting with those consultants to find out what the issues were.

Rosie Varley asked how engaged Social Services had been. Nick Jenkins explained that Social Services were not critical to this as it was about putting WSFT's house in order. However, a representative from Social Services had been on board rounds and they were engaged.

Nick Jenkins stressed that although it was important to get people out of hospital, FLAG was trying to address areas where WSFT did not do everything as efficiently as it could do. Once this had been addressed and it could progress with challenges around social care.

The Chief Executive said that there had been good engagement across the hospital, particularly in G5. However, there was still a need to encourage consultant leadership in some areas and the executive team had also taken part in board rounds. He explained that flow was now being proactively driven throughout the hospital. He suggested that NEDs could also take part in these before the next Board meeting if they wished. **N Jenkins**

Richard Davies asked about the resistance in some areas that were not engaging well. Nick Jenkins said that this was partly due individuals to not liking being told what to do, they had always done it their way and did not see why they should do it any differently. He had tried to explain to them that if a new treatment had been found for a speciality they would be using this. This was similar as it was based on providing a good standard of care and they needed to move on and change the way they did ward rounds. This was evidence based and should drive change in what the Trust was trying to achieve.

Neville Hounsome asked if there was an over-arching goal to help energise people to achieve. Nick Jenkins explained that the plan was achieve as much as possible. Targets could be set around length of stay but he was not totally clear what they should be aiming for. The Chief Executive explained that an objective was to engage all members of staff. Also every patient should know their diagnosis, how long they would be in hospital and when they would be going home.

Jon Green agreed and said that there was not sufficient data to know what a reasonable target was.

The Chairman considered that monitoring and evaluation of processes was the right way to do this rather than a single number goal.

Nick Jenkins explained that red and green on the dashboard at the bottom of page 6 was designed to track this, ie the number of green days versus the number of red days.

The Chairman thanked Nick Jenkins and the team for this and asked Rowan Procter to pass on the Board's thanks to the senior matrons and Lesley Standring and Marie Marfleet who had been project managing this.

It was agreed that an update would be given on this in a few months' time.

Nick Jenkins suggested that the dashboard at the top of page 7 should be included in the report. Steve Turpie requested that a ward performance report should also be available. **N Jenkins**

The Chairman proposed reporting data and highlighting outliers and actions being taken to address this. Ideally this should be part of the performance report if possible.

17/34 QUALITY & PERFORMANCE REPORT

Rowan Procter reported that out of the 22 cases of *c.difficile* five were due to lapses of care from WSFT.

Jon Green explained that relatively speaking A&E performance during January had been reasonable, but this had not continued in February. The biggest problem had been due to variances with very good days and very bad days which meant that performance was not as he would wish it to be.

The cancer performance data was draft as it was not uploaded and completed until two months later. The data had now been completed and was above 85% which meant that WSFT had not missed the target for this quarter. Performance should improve again for this month but would be close to 85%. The final outcome would not be known until histology data had been received.

Rosie Varley referred to poor performance in nutrition assessment and noted that this was still not doing well. Rowan Procter explained that there were some difficulties with reporting on this and considerable work was being undertaken with therapists on reporting, ie if patients refused food, which they had a right to do. She had had a long meeting with senior matrons last night and they were refocusing on particular areas and it was hoped to see a change next month.

Rosie Varley requested that her concern around this was registered as it had been an area of concern for several months now.

Neville Hounsome referred to falls and asked what actions were being taken. Rowan Procter explained that a number of different actions could be taken but it was important to understand that due to changes in acuity and frailty of patients, performance could not be compared to a year or 18 months ago. Instead benchmarking against other organisations should be looked at. However, there were some things that were not being got right, eg lying and standing blood pressure. Different wards were going to focus on different areas to try and understand this.

Neville Hounsome requested more information on actions being taken to address this in each area.

Gary Norgate referred to last month's duty of candour and actions overdue and noted that these had decreased. He also noted that pressure ulcers remained a concern and had increased again. He asked if 'React to Red' would result in a difference and if not what could be done.

Rowan Procter explained that quality indicators moving in the wrong direction was an example of the pressure that the organisation was under and the number of beds that were open. Therefore each area would focus on one piece of work and look at what worked best and then share this learning with other areas, eg falls, pressure ulcers, nutrition.

The Chairman referred to the safety thermometer which was a snapshot of one day at WSFT, whereas the national data was for 150 Trusts over one day which was more relevant. He noted that WSFT was below the line for more months than it was above the line, eg new UTIs and VTEs. Until April 2016 it had never been below the national line and now this was happening on a regular basis. He asked Rowan Procter to look at this in more detail and come back with a report. **R Procter**

The Chairman noted that the Trust did not seem to be able to get to grips with informing patients about delays in being seen. Rosie Varley agreed and said that this made a major difference to patients' experience. It was requested that actions to improve this were brought to the next Board meeting. **R Procter**

He also referred to the graph on page 10 and said that it was not clear what this data meant. He asked that this was easier to understand in future reports.

Craig Black referred to 52 week waits and that the standard patients expected was treatment within 18 weeks. There were seven patients over 52 weeks in January and there were likely to be more in February and March, which was a serious breach of a standard.

Jon Green said that it was recognised that there was a problem in ENT, and this partly related back to the Patient Tracking List (PTL) which was not being managed as effectively as it should. If there was an effective reporting system this would probably not have occurred. It was also known that there was a capacity problem with ENT in theatres. These patients were incorrectly listed and therefore were not identified and picked up.

Jon Green acknowledged that the organisation should not be anywhere near 52 weeks and people should be seen and treated within 18 weeks.

He agreed with Craig Black that WSFT would be seen as an outlier and it needed a plan for when this would be cleared as well as individual plans for individual specialties. In the past WSFT had traditionally done well around these targets.

Jon Green explained that this was mainly due to capacity issues overall, although some patients had been "lost" due to an error, which was inappropriate,

The Chief Executive agreed that this was unacceptable and assured the Board that the executive team were focussing on this and looking at demand capacity.

17/35 FINANCE AND WORKFORCE REPORT

Craig Black explained that he was reporting a position that was consistent with the forecast which was significantly missing the control total. The drivers for this were also consistent with those seen previously, eg failure to deliver the stretch CIP which meant that the Trust would not receive STP funding. This resulted in a £1.2m variance each month, which was the main reason for deterioration in month.

The position for next year was detailed on pages 3 and 4. NHSI had encouraged WSFT to agree to a control total which required a CIP of 6.7%. This was way beyond anything that it had achieved in the past, which was an average of just below 4%.

If the Trust delivered 4% next year, as detailed in the Operational Plan, it would return a deficit of £14.5m, which was similar to this year's forecast. This had resulted in a degree of scrutiny from NHSI.

Since the last Board meeting the finance department had looked at the 'finance learning toolkit' which had been developed by NHSI. There were a number things detailed in this document with over 150 individual initiatives that organisations could consider, the vast majority of which had been considered by WSFT in the past. However seven initiatives had not been considered before and could have an impact on the financial position for next year and improve it by £1.8m. Therefore the Trust was saying that it had a CIP that could deliver a 4.7% improvement in the financial position. There was also a contingency of £2.5m built into this.

Craig Black explained that he was planning for a result that was reasonable but on the margins of achievability. WSFT was being encouraged to plan for the best possible position.

He was planning to bring the final budget setting paper to the Board meeting at the end of March. The budgets would be signed off by the Clinical Director and General Manager in each area.

However, there would still be elements within each individual budget where it was not certain how the CIP would be achieved. He explained that this was normal and divisions had delivered CIPs in the past, even though they did not know how they would achieve them, eg vacancies that would not be filled.

The Chairman noted that NHSI had suggested a target with a 5.4% CIP, which was the average included within the plans that other organisations had submitted. He asked if the provider sector was in general getting closer to its target than before. Craig Black said that it was very difficult to compare financial performance between organisations. WSFT had moved from one of the best financially performing organisations to the middle of the pack. This excluded STF.

When compared with similar organisations (DGHs) WSFT's performance looked better, which suggested a greater degree of improvement within specialist Trusts and teaching hospitals. This was not due to being driven by the tariff, but could be due to other sources of funding that these hospitals received.

The Chairman said that there as a concern that WSFT was missing something as its position was deteriorating. The Chief Executive explained that this was why it was under investigation and seeking external support.

The Chairman asked if the budget that would be presented to the next Board meeting would include full details of CIPs which had been signed off by the Medical Director and Nursing Director from a safety perspective. He considered this to be extremely important. Craig Black confirmed that this would be the case.

Ali Bailey asked what the £1.8m identified in the toolkit consisted of and how much confidence there was in this. Craig Black explained that this was detailed in the table on page 4.

Rowan Procter explained that one of the actions that had been identified was reviewing nurse specialists; this would be part of the nurse staffing review.

Steve Turpie asked why the Trust had not identified the £3m of opportunities in the past. Craig Black explained that he did not consider WSFT to be as efficient as it could be and he would continue to look for areas where there could be improvement, including local and national initiatives.

Neville Hounsome asked for a clear phased plan for these savings, eg FTEs. Craig Black confirmed that this would be measured against the number of beds open, which was key to the financial performance of the Trust.

The Chairman said that there were other initiatives that could be undertaken that did not relate to the number of beds.

Craig Black said that he would come back with a plan to save the additional £1.8m. **C Black**

Gary Norgate noted that the Trust was planning for the best outcome, which included £2.5m of contingency. He asked if the contingency was taken out if this would still be the best. Craig Black explained that £2.5m was 1% of turnover. He acknowledged that he was planning for the best but would spend the contingency, eg this year it was spent on the unplanned increase in capacity.

Gary Norgate asked if the Trust could avoid having a stretch target as in his experience this always gave people an excuse. If a number was going to be a target it should be called a target. Phasing that was back loaded to the second six months should be avoided and there should be prior indicators clearly planned.

Neville Hounsome referred to the executive summary and noted only half of the savings had currently been identified. Craig Black explained that there would be a vacancy factor that a division would achieve but it would not be included as a specified plan, eg it was not possible to say what the vacancy would be in advance.

The Chief Executive said that the lesson from this year was that the Trust did not achieve its stretch target mainly due to demand. It was important to ensure that the CIP for next year was achievable with clear plans not related to demand management.

NHSI had also said that an evaluation of the £2m invested in Glastonbury Court was required and a discussion with the CCG as to whether they should be funding this in the medium term.

The Chairman said that the executive team needed to come up with tangible CIPs that they were confident the Trust could deliver and this is what the Board would sign up to and submit to NHSI. He stressed that these needed to have gone through due diligence on quality and safety.

17/36 COMMUNITY SERVICES REPORT

The Chairman considered this to be a very good report but it would be helpful to have it earlier in the meeting. He proposed that in future this report should be included as part of the performance report on community services.

It was noted that this was a summary of the meeting.

Steve Turpie asked about actions being taken and if there had been any governance meeting with the CCG to discuss what was happening as a result of this. The Chief Executive confirmed that there had been a lengthy discussion on the issues and the problems. It was agreed that greater detail on actions to address areas of concerned was required in this report.

Rosie Varley said that she was very concerned about the quality and co-ordination of services provided in the community for stroke patients. At the recent CoG/Board workshop it had been acknowledged that this was a dire service and people discharged into the community were in a dreadful situation. After the initial six weeks when they received support, there was very little or poor support. She said that the Board needed to take a view as to whether WSFT was meeting its obligations to these patients.

Rowan Procter explained that after six weeks some of these patients received care from other organisations rather than WSFT or the local authority. Rosie Varley said this was not clear and after six weeks the majority of patients still required occupational, speech and/or physio therapy and some of these were very dependent patients.

The Chief Executive proposed that an integrated approach to this needed to be reviewed with the CCG. There was a need to understand the care patients required after the six week period that a number of patients qualified for, also the support available and how this could be organised. **J Green**

Rosie Varley also asked what responsibility consultants in stroke services had to ensure that patients would receive sufficient support when they were discharged.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/37 AGGREGATED QUALITY REPORT

Rowan Procter reported that complaints were reducing and PALs contacts increasing, which was moving in the right direction. It was explained that F7 was expected to have the most PALs contacts due to the acuity of patients.

17/38 NURSE STAFFING REPORT

Rowan Procter explained that there were currently significant staffing gaps. However, there were a small number of nursing assistant vacancies and ward vacancies for these had been filled, which was positive.

There were a high number of registered nurse vacancies but this included escalation areas. There were also significant vacancies on F7, which had not helped and was the reason for an increase in medication errors.

She assured the Board that if agency nurses did not meet WSFT's standards of care they were not employed again.

17/39 CQC ACTION PLAN

The Chairman asked Rowan Procter if there were any areas of concern about WSFT's ability to achieve the action plan to the required level. Rowan Procter confirmed that she was confident that this would be achieved. She explained that she had a monthly telephone call with the CQC and they received the Board papers and this feedback was working well.

Richard Jones explained that there would be changes around CQC assessments in the future and discussions had taken place about this with the divisions. Further detail would be brought to a future Board meeting. **R Jones**

The Chief Executive asked about wardable patients in ITU and if there was still an underlying issue with this. Rowan Procter said that there were still wardable patients in ITU and daily meetings took place. There had to be a balance between safety issues around this and bed availability for other patients. When a patient became wardable they were moved to a different end of ITU so they were not in a mixed sex area and to try and maintain privacy and dignity, even though from a clinical level of care they no longer needed to be on ITU. She was confident that it was less of a risk keeping wardable patients on ITU than moving them into a ward and increasing the risk to other patients.

Nick Jenkins said that he did not think the March deadline for achieving RTT would be met, although this was being worked towards.

It was agreed that the CQC should be updated on both these issues. **R Procter**

Gary Norgate asked it was considered that WSFT was a better, safer Trust as a consequence of this work. If CQC carried out an assessment would they consider WSFT had moved forward? Rowan Procter considered that compared to a year ago issues that were previously raised were now better embedded.

However, other issues had arisen relating to escalation, eg there had been no change in pace and some staff were more tired than before, although they were still dedicated to patients and the organisation. Some care issues might also be identified but not to a level of concern. Her concern was the continued escalation and pressure on staff.

Jon Green considered that staff and the organisation were definitely better for having gone through the process.

The Board approved the updated action plan, subject to the change in the deadline for RTT.

17/40 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that ward G9 had received the Putting You First Award this month.

This was the winter escalation ward and was considered to be best run escalation ward that WSFT had ever had. Their Service Manager wished to thank the team for all their ward work in getting them through the winter.

Rowan Procter said that Gary Ingalla had also done an extremely good job and he and Mark Manning should also be included.

The Board agreed with this testament and that both Gary and Mark should be recognised for this achievement.

17/41 CONSULTANT APPOINTMENT REPORT

The Board noted the appointment of the following consultants:-

Dr Sreejib Das – Consultant in A&E
Dr Alexander Martin – Consultant in Oncology
Dr Kate Thompson – Consultant in Geriatrics
Dr Mark Sykes – Consultant in Rheumatology
Dr Anup Sengupta – Consultant un Urology

Jan Bloomfield considered that WSFT's ability to attract staff highlighted the fact that it was a good organisation to work for. The fast track appointment process was also working successfully.

BUILD A JOINED UP FUTURE

17/42 e-CARE REPORT

Craig Black explained that these slides were being presented to the organisation to ensure that all the issues around e-Care had been properly identified.

A Programme Board meeting took place recently and focussed on reporting and Ordercomms which were planned to be addressed as part of phase 2. Ordercomms would go-live on Friday 5 May. He stressed that this was not without risk due to the need to co-ordinate actions within the organisation, Clinysis and TPP. The volume of work going through pathology meant that there was a greater risk. The go-live date of 5 May had moved internally to reflect the risk which was being mitigated with a very extensive testing programme and addressing issues when they arose before go-live.

This was the key focus of the programme group and would be monitored closely over the next few weeks.

Rowan Procter explained that Ordercomms would make huge difference to staff. Craig Black agreed and said that the Trust should start to realise the benefits of e-Care, with detailed records for each patient. He said that this was key to unlocking the potential of e-Care, although it represented the biggest risk.

Nick Jenkins noted that results endorsement was a big issue in every hospital in the country. The size of this problem would be identified and this would be a big number. WSFT was working on how this would be addressed. A risk log would be constructed and the Trust needed to initially address the issues that were really important.

17/43 COMMUNICATIONS STRATEGY

It was noted that this had been to the previous closed Board meeting and was well received.

17/44 OPERATIONAL PLAN 2017-19

It was explained that this was for information only and had been submitted to NHSI.

GOVERNANCE

17/45 TRUST EXECUTIVE GROUP REPORT

The Board noted the content of this report. There had been a lifestyle presentation from Helena Jopling and a TEG workshop had taken place on 6 February.

17/46 COUNCIL OF GOVERNORS REPORT – 8 FEBRUARY 2017

The Board received this report and approved the revised Engagement Strategy.

Richard Jones explained that interviews had taken place for a NED and the Council of Governors had approved the recommendation for a Board Advisor. The intention was that this individual would take over as Audit Chair when Steve Turpie stepped down from this role.

The Board approved the appointment of Angus Eaton as Board Advisor.

17/47 AUDIT COMMITTEE REPORT

Steve Turpie considered that the framework for the value people were authorised to spend was now better controlled than previously.

Richard Jones referred to quotation for tenders of less than £10k and that it should say “written” not “verbal” quotes.

The Board approved the review of Standing Orders, Standing Financial Instructions Reservations & Delegation of Powers

17/48 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were approved subject to the addition of a report on mortality.

It was noted that the stroke options papers would be going to the closed Board as it was likely to be commercial and in-confidence. It was confirmed that this would go to the open Board if it was considered that this was not the case. **R Jones**

ITEMS FOR INFORMATION

17/49 HEALTH AND SAFETY FRAMEWORK

Richard Jones explained that this was for information and the Board should be aware of the content of this.

17/50 ANY OTHER BUSINESS

Neville Hounsome reported that he had attended the opening of Glastonbury Court. He considered the facility, atmosphere, level of care and the team to be absolutely excellent.

The Chairman explained that this was the last meeting for Jon Green and Ali Bailey, both of whom were progressing in their careers.

Ali Bailey was leaving to become Director of Communications at Colchester Hospital and Jon Green Chief Executive at Kings Lynn.

He thanked Ali Bailey for the work she had done on the communications strategy and wished her well in her new role.

Jon Green had done a great deal in transforming the way that the operations team worked. He had been a great Board colleague and had a good relationship with the Council of Governors. The Chairman considered that he would be an excellent Chief Executive and he looked forward to seeing his progress at Kings Lynn.

Jon Green thanked everyone for their support and said that he had enjoyed his time at WSFT and was looking forward to his new challenge.

17/51 DATE OF NEXT MEETING

The next meeting would take place on Friday 31 March 2017 at 9.15am in the Committee Room.

RESOLUTION TO MOVE TO CLOSED SESSION

17/52 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 – 31 March 2017

AGENDA ITEM:	Item 6
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	23 March 2017
SUBJECT:	Matters arising action sheet
PURPOSE:	Approval

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

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

Actions are RAG rating as follows:

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

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

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1331	Open	30/9/16	Item 9	Provide Board with a stroke services option appraisal and sustainability report	Following discussion in October Board meeting it was agreed that this should consider the provision of care out of hospital. An initial review was considered by the executive team on 16 Nov. Based on this discussion a full option appraisal to be considered by the Board in Mar '17 (revised). **Agreed to include view on community stroke services as part of this review, linking with other agencies. Planned reporting date moved to May '17.**	JG	26/05/2017	Green
1367	Open	27/1/17	Item 5	Terms of reference for Q&RC to be reviewed at its next meeting sand submitted to the Board	Scheduled for review in April. Provisional meeting dates for 2017 - 30 Jun, 29 Sept and 1 Dec.	RJ	28/04/2017	Green
1368	Open	27/1/17	Item 8	Bring back explanation for the red rating for anaesthetics within the HSMR specialty tree (p21)	Preliminary analysis has confirmed that there is no basis of concern for the underlying patient data. **A new mortality report format is being developed based on the new national reporting requirements issued on 21/3/17.**	NJ	28/04/2016	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1370	Open	27/1/17	Item 8	Confirm with new clinical director whether a trust paediatric strategy group is still required	The new clinical director is delighted to have NED support and will be in touch shortly with dates. **Email exchange to arrangement planning meeting.**	JG	03/03/2017	Green
1371	Open	27/1/17	Item 9	In terms of additional sessions undertake assessment of what it would look like if we were running at optimum efficiency and based on the gap identified set out remedial action to improve current performance	Analysis of theatre productivity shows a downward trend in additional sessions. Further review is being undertaken at specify level and will be reported at the end of March. Clarification provided at meeting on 3/3/17 - how many sessions lost due to 'failure' e.g. lack of equipment. **CB to provide analysis as part of finance report**	JG	31/03/2017	Green
1382	Open	3/3/17	Item 8	Invite NED to ward board round as part of the FLAG process. Agreed that framework be developed to provide visibility of FLAG delivery as part if the quality/performance report.	**Invitation issued.**	NJ	31/03/2017	Green
1388	Open	3/3/17	Item 14	Report on proposed changes to CQC self-assessment process (as part of quality improvement)	Discussion taken place with operational leads and external organisations to consider options/best practice.	RP	28/04/2017	Green

Completed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1369	Open	27/1/17	Item 8	Seek clarification re what the local authority are doing to improve the quality of information provided for paediatric referrals. Also update on situation re paediatric redesign plan which are reported as 'on hold'.	The paperwork is reported to be improved but is obviously still a limitation due a to a known issue with foster families' delivering the requirements. The paediatric redesign is on hold until early 2018 while a full design can be worked through. In the meantime we are negotiating with the CCG with funding until the end of March for the planned deliver by Aug '17 and service continuity from this point. **Confirmed on 3/3/17 that RP has written to Council setting out requirement for foster careers to meet contractual requirements**	RP	31/03/2017	Complete
1383	Open	3/3/17	Item 9	Provide detail of action being taken to improve fall performance. Also provide analysis as to why performance against the safety thermometer has deteriorated e.g. UTIs	Further detail included in quality report	RP	31/03/2017	Complete
1384	Open	3/3/17	Item 9	Provide summary of action to improve 'communication of delays in being seen' within the patient experience dashboard	Further detail included in quality report	RP	31/03/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1385	Open	3/3/17	Item 10	Provide final budget setting paper to next meeting with quality impact for CIPs, including detail of the £800k ward based savings	**AGENDA**	CB	31/03/2017	Complete
1386	Open	3/3/17	Item 11	Move the PMG report to sit within the quality report with indication if action being taken to address any areas of concern.	**AGENDA**	JG	31/03/2017	Complete
1387	Open	3/3/17	Item 14	Update CQC action plan to reflect the position re wardable patients and RTT performance.	Plan updated and will be reported to the Board in April with the proposed arrangements for future CQC compliance monitoring and assurance	RP	31/03/2017	Complete

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 31 March 2017

AGENDA ITEM:	Item 7
PRESENTED BY:	Steve Dunn, Chief Executive Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	24 March 2017
SUBJECT:	Chief Executive's Report
PURPOSE:	Information

This report provides an overview of some of the key national and local developments, achievements and challenges that the West Suffolk NHS Foundation Trust (WSFT) is addressing. More detail is also available in the other board reports.

It is with regret that I report that we have declared a **never event** during March in relation to a patient who had a procedure in outpatients. The patient was made aware of the error before having a further procedure. Some initial learning has been identified for immediate implementation and, in accordance with the Trust's incident procedure, a full investigation is in progress.

The **Go Green this winter** campaign continues at pace across the Trust, with communications supporting the drive to ensure staff do as much as possible each day to action patients from a red to green day. The campaign, which aims to improve patient flow throughout Trust locations, has been focusing on working with staff to reduce deconditioning of patients by encouraging them to sit up, get dressed and keep moving. In a bid to #endPJparalysis, the Trust undertook a snapshot audit of patients that were:

- Dressed compared to those in pyjamas
- In bed compared to sat up in a chair
- Had clothes available compared to those that did not

Exercises like this, as well as the identification of both internal and external constraints to patient flow including delayed transfers of care, transport issues, to take out medicine delays, and awaiting care package/placement issues, for example, are resulting in solutions based approaches across multiagency teams to how we might do things differently.

February's **performance pack** reflects the on-going operational pressure which Go Green this winter is designed address. This pressure is being felt in the hospital and across region, including emergency flow with February performance showing a slight deterioration at 83.9%. However the focus on patient flow has started to translate into improvements in operation performance. While we still have some way to go, it was excellent that for a week in March we achieved the 4 hour target for 95% of patients in our emergency department (ED).

The improvement in patient flow is all the more impressive considering a number of our wards in the last month have been affected by **norovirus**. The Trust is asking people who have had sickness or diarrhoea to stay away from hospital until they have been symptom free for 48 hours. Norovirus is a highly contagious diarrhoea and vomiting virus and anyone visiting is urged to take extra care to wash their hands with soap and water both on arrival and when leaving the ward. Rowan Procter, chief nurse at West Suffolk NHS Foundation Trust, said: "Norovirus is very infectious and every year

there are cases in the community which transfer to the hospital. Because the virus has an incubation period of a few days, people are often unaware that they are carrying it until after they have passed it on."

The draft 62 day cancer performance for February shows just below target at 84.5% however indications are that we will achieve the target of 85% due to reallocations to other trusts. The stroke service has missed four performance targets in February - patients scanned within one hour and 12 hours of clock starts, patients treated by the early supported discharge team and patients admitted directly to Stroke Unit within 4 hours of clock start. We now have a functional patient tracking list (PTL) within e-Care and work is underway both manually and via automated scripts to address underlying data quality issues. The latest revised estimation of our incomplete referral to treatment (RTT) performance is 89.89% against a target of 92%. This is due to capacity issues in a number of services as detailed within the quality and performance report. The PTL has also highlighted a number of patients who have waited over 52 weeks for treatment. Each of these is being actively managed and treatment plans expedited.

The **month 11 financial position** includes a forecast deficit of £5.0m for 2016-17 which is in line with our control total. The improvement in our forecast since January reflects the Trust achieving the stretch CIP through non-recurring means and therefore receiving the majority of the Sustainability and Transformation Funding (£5.5m for 2016-17). Budget holders have now signed off their expenditure budgets in order to deliver the 2017-18 contracted activity and performance targets. These budgets include a CIP of £13.3m in order to deliver a control total of £11.1m deficit which has been proposed by NHSI. Delivering the control total will ensure the Trust receives Sustainability and Transformation Funding (S&TF) of £5.2m, resulting in a net deficit of £5.9m in 2017-18.

Jon Green, chief operating officer leaves the Trust on 13 April to take up the role of chief executive at Queen Elizabeth Hospital King's Lynn. I am delighted to confirm that Helen Beck, who is currently deputy COO at the Trust, has been appointed as **interim COO** for sixth months and a handover of the role is currently under way. As part of some wider changes to executive leadership roles, Rowan Procter, chief nurse, will lead community paediatrics as part of the development of our leadership of community services. Dr Nick Jenkins will be taking on a lead role in the community provider alliance for the transition and transformation of services.

I am delighted that we have once again improved in latest **NHS staff survey results** strengthening its position as the hospital in the East that is the most highly rated by its staff, according to the results of the latest NHS staff survey. Asked questions about whether they would recommend the hospital as a place to work or receive treatment, 88% of staff agreed that care of patients is the Trust's top priority. The national average was 76%. When asked if they would recommend the Trust for treatment of a friend or relative 85% of staff agreed that they would compared with a national result of 70%. West Suffolk NHS Foundation Trust remains in the top 20% of all similar NHS Trusts for staff engagement and has improved on its score for the previous year. It is also a leading trust for the extent to which staff look forward to going to work and being enthusiastic and absorbed in their jobs.

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

The **Medicine Healthcare Regulatory Authority (MHRA)** undertook an unannounced inspection of the blood transfusion service operated within the hospital by the pathology partnership (tPP). The inspection team were keen to see how much progress had been made since their last visit. The inspection highlighted that areas of concern remain and we are working closely with them to ensure action is taken by tPP to address these e.g. staffing and quality management systems.

In late February, **the pathology partnership (tPP)** formally announced a re-organisation and change of management structures. This has come after several months of work to develop a new approach following the announcement by Cambridge University Hospitals NHS Foundation Trust (CUH) last year of its intention to leave the partnership. A new model for the partnership has been agreed which means that services in the east of the partnership (West Suffolk, Colchester and Ipswich Hospitals) will be managed locally as a stand-alone network, with the hub laboratory remaining at Ipswich Hospital and Colchester Hospital University NHS Foundation Trust acting as host.

Our proposal is that East Pathology Services will be clinically led by four specialty clinical leads in each of the four service areas:

- Cellular Pathology
- Chemistry
- Haematology & Blood Transfusion
- Microbiology

Specialty clinical leads for each of these four service areas will lead across the three hospital locations.

Chief Executive blog
http://staff.wsha.local/Blog/TisforTwo-waycommunication%e2%80%a6andTrust.aspx

DELIVER FOR TODAY

West Suffolk Hospital opens care beds
We had the official opening of the Trust's new suite of beds at King Suite, part of Glastonbury Court care home in Bury St Edmunds. Opened by Mrs Dora Leeder, one of the first patients to be cared for at the unit, the King Suite is a 20-bed inpatient service managed by hospital staff, which is able to offer medically-fit patients from West Suffolk Hospital a period of optimisation, reablement and recovery, before they are discharged home.

Anglia News, evening bulletin
Following the CQC's *The state of care in NHS acute hospitals* report, Anglia News visited the hospital to interview Trust chief executive Steve Dunn about the way the hospital is delivering high quality care to patients in West Suffolk.

High performing stroke services at West Suffolk Hospital
Stroke services at West Suffolk NHS Foundation Trust continue to improve according to the latest Sentinel Stroke National Audit Programme (SSNAP) scores, with the Trust rated joint 6th nationally out of 144 trusts routinely admitting stroke patients in England and Wales. SSNAP is the national source of stroke data for the NHS and audits stroke services throughout the whole pathway of care: from admission to hospital, across the whole inpatient stay, including rehabilitation at home or in the community, and outcomes at six months after stroke.

In results for August to November 2016, West Suffolk NHS Foundation Trust's stroke services were rated an A overall, with a total score of 87; the hospital's highest overall rating yet. According to the Royal College of Physicians, which manages the programme, 'To achieve an 'A' in SSNAP reports indicates world class performance'. The most impressive result for the hospital was within its Speech and Language Therapy (SALT) department, which received an A; the team's highest rating ever.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Look out for a new look in outpatients this week!
Reception staff in outpatients have been provided with new uniforms designed to help patients identify the staff who can help them and provide a consistent look across the department.

Shining Lights staff awards

We are now in the final week of nominations of our annual staff awards, Shining Lights. Staff are urged to nominate their colleagues to be recognised for their achievements during 2016. The awards event will be held on 11 May 2017. This year the awards have been adapted with a range of new categories. **The deadline for entries is 31 March 2017.**

BUILD A JOINED-UP FUTURE

New cath lab and angio suite
The Board previously approved the business case to build a new cardiac catheterisation and pacing suite. This will replace the mobile unit that is currently used and reduce the number of patients transferring to Papworth for these procedures. It will also prevent our cardiac patients waiting in beds, often for prolonged periods of time, to be transferred to a tertiary centre. Having our own cath lab opens up the possibility of the cardiology department expanding the level of service we currently offer on site, whilst at the same time improving the extent and quality of service delivered to our patients. Work has started on site and you will begin to see new buildings rising from the ground.

Return Recycle Reuse
People in Suffolk have been asked to cut waste by returning as much unused NHS and social care equipment as possible during March. The NHS and the county council have been working with suppliers to ensure equipment, including crutches, walking frames and mattresses, can be returned easily as part of a month-long NHS amnesty from 1 to 31 March 2017. Last year local health services issued over 100,000 NHS community equipment items to Suffolk patients in need at a cost of more than £8.5m. By the end of the year nearly 40,000 items, costing £3.4m, had not been returned to the contractor Medequip. While some patients need equipment for long periods of time, NHS services lose thousands of pounds each year due to missing equipment.

Media coverage includes a BBC Radio Suffolk Breakfast Show programme which dedicated air time to the issue for the entire programme, causing a spike in calls to Medequip.

NATIONAL NEWS

DELIVER FOR TODAY

Sicker patients are the main reason for A&E winter pressures (press release)
Quarterly Monitoring Report from the Kings Fund finds that the rising number of patients with complex health needs is the key factor behind the increasing pressures on A&E departments. Kings Fund 6 March 2017

The cost of sepsis care in the UK – a report by the UK Sepsis Trust February 2017
The aim of this report is to highlight the considerable costs associated with sepsis in the UK. Sepsis is a potentially life-threatening condition caused by infection from numerous potential sources. In more severe forms it results in hospital admission and the most severe forms require treatment in intensive care. There is a high mortality rate associated with patients with sepsis. This implies significant costs to both the health care system and society more broadly.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

The state of care in NHS acute hospitals
This report covers the period 2014-2016 and presents findings from the CQC programme of NHS acute comprehensive inspections. Findings: Most hospitals are delivering good quality care and looking after patients well. But, some trusts have blind spots about the quality of care they are delivering in a particular core service, even in some trusts rated good overall. The overarching message from the inspections is that effective leadership delivers high-quality care. In hospitals rated good or outstanding, the trust boards had worked hard to create a culture where staff felt valued and empowered to suggest improvements and question poor practice. Where the culture is based around the needs and safety of patients, staff at all levels understand their role in making sure that patients were always put first.

Treat as one: bridging the gap between mental and physical healthcare in general hospitals
This report expresses concerns about a failure by general hospitals to integrate physical and mental healthcare services. It concludes that this is leading to poor care for patients with a physical illness who also happen to have a mental health condition.
National Confidential Enquiry into Patient Outcome and Death 2017

Better Beginnings – improving health for pregnancy
This review from the NIHR brings together research on different aspects of health before, during and after pregnancy. Quick stats: 697,852 = no. of live births in England and Wales in 2015; 15-20% = percentage of women who are overweight or obese; 1 in 5 = women experiencing mental health problems during pregnancy or the year after birth.
NIHR February 2017

Preventing avoidable admissions of full-term babies
Analysis, findings and guidance on the preventable factors that lead to full-term babies being admitted to neonatal units. NHS Improvement

BUILD A JOINED-UP FUTURE

Outcome-focused integrated care: lessons from experience
This paper captures some of the learning and experience from work on developing integrated practice. It aims to offer guidance to those embarking on a significant period of change on what they may need to consider. It draws on Institute of Public Care's practice-based experience of integration across a range of different organisational set-ups and cultures.
Institute of Public Care January 2017

Health and social care integration
This report warns that progress with integration of health and social care has, to date, been slower and less successful than envisaged and has not delivered all of the expected benefits for patients, the NHS or local authorities. It finds that the Better Care Fund has not achieved the expected value for money, in terms of savings, outcomes for patients or hospital activity.
National Audit Office 8 February 2017

'Borrowed time' to save social care system from collapse
A new report from Age UK has concluded that we are living on borrowed time to save the social care system for older people. Statistics include the stark finding that 1 in 8 over 65s are currently living with unmet care needs. Age UK 16 February 2017

Reform Report: Saving STPs – achieving meaningful health and social care reform
Experts interviewed for this paper reported that STPs have achieved some positive progress. However, in some STPs, the involvement of local authorities has been minimal. Collaboration has been difficult partly because of the chosen footprints of STPs, described by one interviewee as "mad geography". The priority for STPs has been eliminating financial deficits in the short term rather than drawing up plans for the future.

STPs asked for 'credible implementation plan'
Sustainability and transformation plan areas are being asked for a "credible implementation plan" to turn proposals into action and reconcile them with contracts and financial targets. HSJ 28 February 2017

Delivering sustainability and transformation plans: from ambitious proposals to credible plans
This report looks in detail at the content of the 44 STPs and the opportunities and challenges for implementation. The report is accompanied by a short briefing that discusses the seven key opportunities and challenges facing the STPs. Kings Fund

Seven big questions facing STPs
Kings Fund 21 February 2017

NHS ‘tobacco free’ campaign launched by Public Health England

A "truly tobacco-free NHS" needs to be created to help smoker patients quit their habit, health officials say. According to PHE, smoking causes 96,000 deaths a year in the UK, and for each of those deaths, about 20 smokers are suffering from a smoking-related disease. About 475,000 hospital admissions in England were attributable to smoking in 2014-15, and the annual cost is estimated at £2bn, with a further £1.1bn in social care costs. Smoking in hospitals grounds is already banned by law in Northern Ireland and Scotland. Legislation is earmarked for potential introduction in Wales later this year. The Department of Health in England says it has no plans to make it illegal at the moment. BBC News 26 February 2017

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30th March 2017

AGENDA ITEM:	Item 8
PRESENTED BY:	JON GREEN, CHIEF OPERATING OFFICER AND ROWAN PROCTER, EXECUTIVE CHIEF NURSE
PREPARED BY:	JON GREEN, CHIEF OPERATING OFFICER AND ROWAN PROCTER, EXECUTIVE CHIEF NURSE
DATE PREPARED:	23 MARCH 2017
SUBJECT:	TRUST QUALITY & PERFORMANCE REPORT
PURPOSE:	TO UPDATE THE BOARD ON CURRENT QUALITY ISSUES AND CURRENT PERFORMANCE AGAINST TARGETS

EXECUTIVE SUMMARY:

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

- This month the Trust had no C Diff (0 in January) - however, we have had 22 cases year to date against a threshold of 16. Falls for the month were 55 (61 in January) and 10 pressure ulcers (22 in January) - pages 5-6
- Looked after children performance: one was completed within 28 days, however 13 out of 15 were completed within 28 days of paperwork received (14 offered), the 15th appointment was offered and accepted within 36 days - page 34.
- RCA actions overdue are nine - page 9
- Stroke failed against four measures this month with the over-arching themes of poor triage and identification of Stroke leading to delays in referral and scanning along with lack of bed capacity - pages 27-28.

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

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

Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	
Recommendation: The Board is asked to note the Trust Quality & Performance Report and agree the implementation of actions as outlined.	

1. CLINICAL QUALITY

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

Patient Safety Dashboard

Indicator	Target	Red	Amber	Green	Dec	Jan	Feb
HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	100	95
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	98	99
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	99	93	98
HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	95	100	100
HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	100	100	100
HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	93	95	95
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<85	85-99	= 100	100	NA	NA
Total no of MRSA bacteraemias: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	0
Total no of MRSA bacteraemias: Community acquired (Trust level only)	No Target	No Target	No Target	No Target	0	0	0
Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	89	NA	NA
MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	96	93	90
MRSA Elective screening (Trust level only)	= 100%	<80	80-99	= 100	ND	ND	ND
MRSA Emergency screening (Trust level only)	= 100%	<80	80-99	= 100	ND	ND	ND
Hand hygiene compliance	= 95%	<85	85-99	= 100	100	99	99
Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	0	1	0
Quarterly Standard principle compliance	90%	<80	80-90%	90-100	93	NA	NA
Total no of C. diff infections: Hospital	= 16 per yr	No Target	No Target	No Target	2	0	0
Total no of C.diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	0	3	0
Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	92	NA	NA
Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	ND	19	9
Isolation data (Trust level only)	= 95%	<85	85-94	95-100	93	90	90
Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	93	NA	NA
Quarterly VIP score documentation	= 90%	<80	80-89	90-100	83	NA	NA
MEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	ND	ND	ND
PEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	100	100	100
No of patient falls	= 48	>=48	No Target	<48	65	61	55
Falls per 1,000 bed days (Trust and Divisional levels only)	= 5.6	>5.8	5.6-5.8	<5.6	ND	ND	ND
No of patient falls resulting in harm	No Target	No Target	No Target	No Target	19	11	14
No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	0	ND
Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	ND	ND	ND
No of patients with ward acquired pressure ulcers	< 5	>=5	No Target	<5	14	22	10
No of patients with avoidable ward acquired pressure ulcers	= 0	>0	No Target	= 0	2	ND	ND
Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	83.44	83.85	83.11
No of SIRIs	No Target	No Target	No Target	No Target	11	16	7
No of medication errors	No Target	No Target	No Target	No Target	57	51	54
Cardiac arrests	No Target	No Target	No Target	No Target	7	3	8
Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	1	1	1
Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	NA	68	NA
VTE: Completed risk assessment (monthly Unify audit)	> 98%	< 98	No Target	> 98	ND	ND	ND
Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	87	NA	NA

Indicator	Target	Red	Amber	Green	Dec	Jan	Feb
Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	98.73	96.69	98.43
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4	15	9	9
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC	60	69	64
Median NRLS upload	26days	>48	27-47	0-26	41	49	ND
SIRIs reported > 2 working days from identification as red	0	>1	1	0	0	0	0
SIRI final reports due in month submitted beyond 60 working days	0	>1	1	0	0	0	0
Number of SIRI reports open on STEIS more than 60 days after initial notification – Total	No Target	No Target	No Target	No Target	0	0	0
Number of SIRI reports open on STEIS more than 60 days after initial notification– Sitting with WSFT (excludes 'stop the clock')	0	>6	4-6	0-3	0	0	0
Active risk assessments in date	100%	<75%	75 – 94%	>=95%	100	100	100
Outstanding actions in date for Red / Amber entries on Datix risk register	100%	<75%	75 – 94%	>=95%	100	100	100
Non-compliance with Duty of Candour requirements	0	>3	1 - 3	0	0	0	4

Exception reporting for indicators in the Patient Safety Dashboard

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

Data notes:

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

In addition data items *Falls per 1000 Beds days Falls with moderate/severe harm/death per 1000 bed days*, *VTE: Completed risk assessment* and *Gynaecology (F14) 30-day readmissions* have not been possible to collate due to the transfer over to e-Care. The Information team are exploring ways to ensure this data is provided for future months.

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

1.1 HII compliance 2a: Peripheral cannula insertion

a) Current Position

A score of 98 in February was the same as January and was amber RAG rated for the second month in a row. This was based on one episode of non-compliance where gloves were not worn for cannula insertion in the ED.

b) Recommended action

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

1.2 HII compliance 2b: Peripheral cannula ongoing

a) Current Position

A score of 98 in February was higher than January (93) and was amber RAG rated for the ninth month in a row. This was based on two episodes of non-compliance where G3 had no continuing clinical indication and CCS had not done an administration set replacement.

b) Recommended action

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

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

a) Current Position

A score of 95 in February was the same as January and was amber RAG rated for the ninth month in a row. This was based on three episodes of non-compliance. There were two episodes of failure to document catheter checks on both F14 and G5, and one episode of poor bag positioning on G5.

b) Recommended action

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

1.4 MRSA decolonisation (treatment and post screening)

a) Current Position

A score of 90 in February was lower than January (93) and was amber RAG rated for the second month in a row.

b) Recommended action

The Infection Prevention Team will continue to work with Pharmacy to ensure compliance. No wards required completion of an incident on Datix as the majority of the elements were completed. Attaching a copy of the incomplete record to the feedback form appears to be useful and having a beneficial effect.

1.5 Hand Hygiene compliance

a) Current Position

A score of 99 in February was consistent with January and was amber rated for the second month in a row. F11 failed the hand hygiene audit where a Consultant obstetrician didn't wash hands before and after and was not bare below elbows.

b) Recommended action

Feedback was given to the individual at the time of the audit.

1.6 Isolation

a) Current Position

Compliance with isolation is at 90% this score predominantly reflects the outbreaks of Norovirus where there were either insufficient isolation or side-rooms were utilised to facilitate ward cleaning / reopening.

b) Recommended action

Continue to monitor.

1.7 Nutrition: Assessment and monitoring

a) Current Position

A score of 83.11 in February was consistent with 83.85 in January. Overall eighteen patients were not weighed on admission on F3, F14, G4, G8, and G9. Eight patients did not receive a nutritional assessment on admission on F3, F4, F14, G1, G4, and G9. Four patients were not reweighed at 7 days on F3, F4, G5 and G9 and two patients did not receive a nutritional assessment at 7 days on G1 and G9.

b) Recommended action

Due to continued failures of this important audit the matron team have been tasked to prioritise Nutritional care and documentation for the month of March, spot checking documentation, observing admissions and supervising meal times. We hope to ensure that patients' nutritional requirements can be better met in a more timely way.

1.8 Total no of C. difficile infections: Hospital

a) Current Position

Performance against trajectory is as follows:

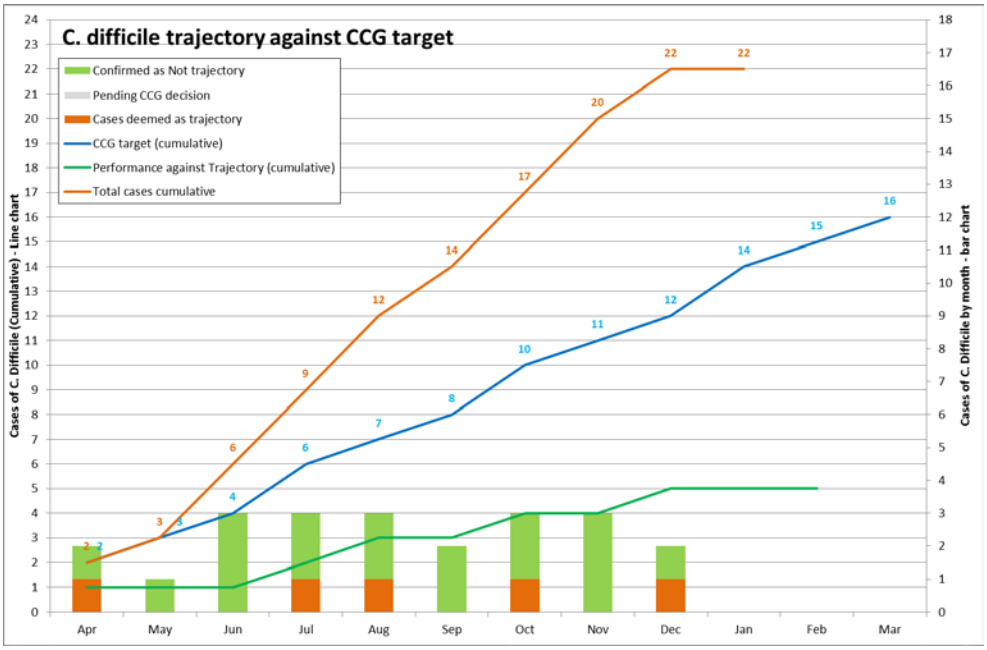
There were no cases of hospital attributable CDT in February

At the end of February the Trust had reported a total of 22 reported cases against a final total of no more than 16 trajectory cases for 2016-2017. Of the 22 cases; 17 have been deemed non trajectory by our commissioners (no lapses of care) whereby they will not accrue a penalty, there are five trajectory cases and none are pending.

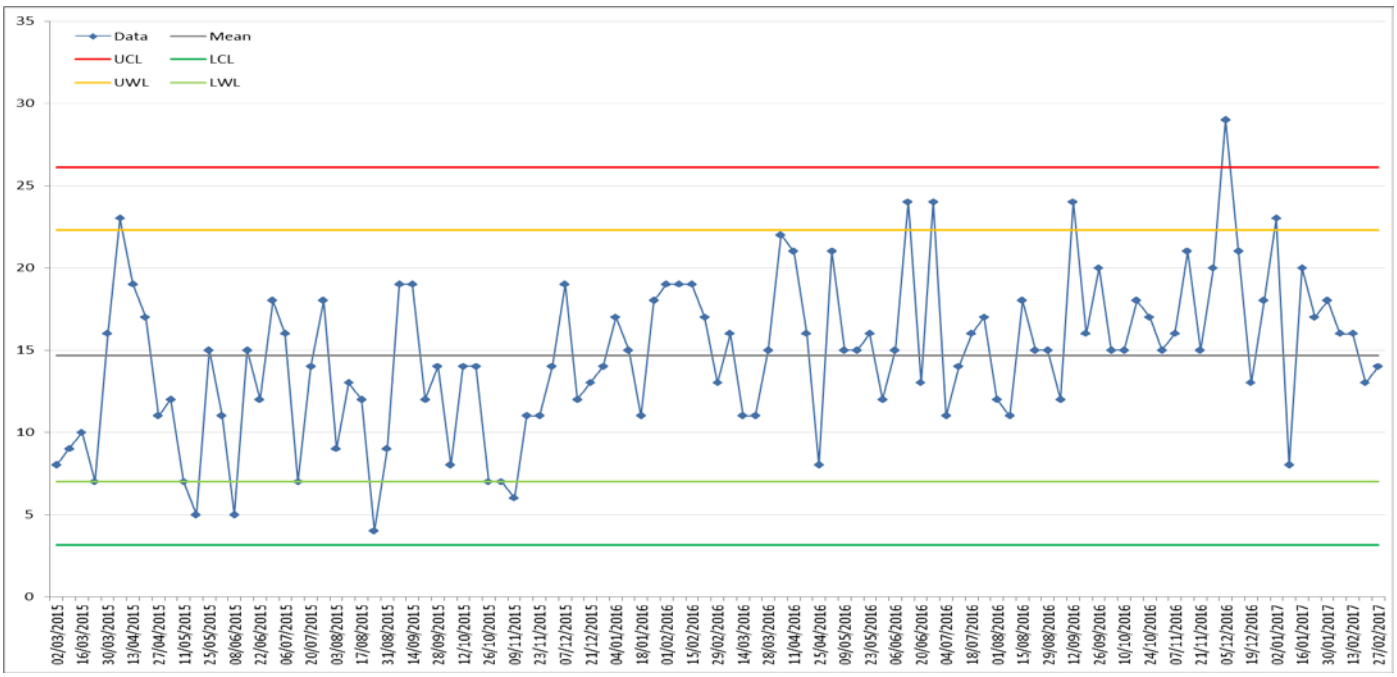
The graph below has been updated to demonstrate the Trust performance against the trajectory target set by the CCG.

b) Recommended Action

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



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



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

There were 55 falls in February (61 in January), no major harm, one moderate harm and 13 with minor harm.

Nine patients were assisted to the floor (2 in January) preventing them from falling including two at Newmarket.

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

Four patients fell at Newmarket Hospital (6 in January). No patients fell at Glastonbury Court (5 in January), these falls are reported separately.

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

Data items: Falls per 1000 beds days and falls with moderate/severe harm/death per 1000 bed days have not been possible to collate due to the transfer over to e-Care. The Information team are exploring ways to ensure this data is provided in the future.

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

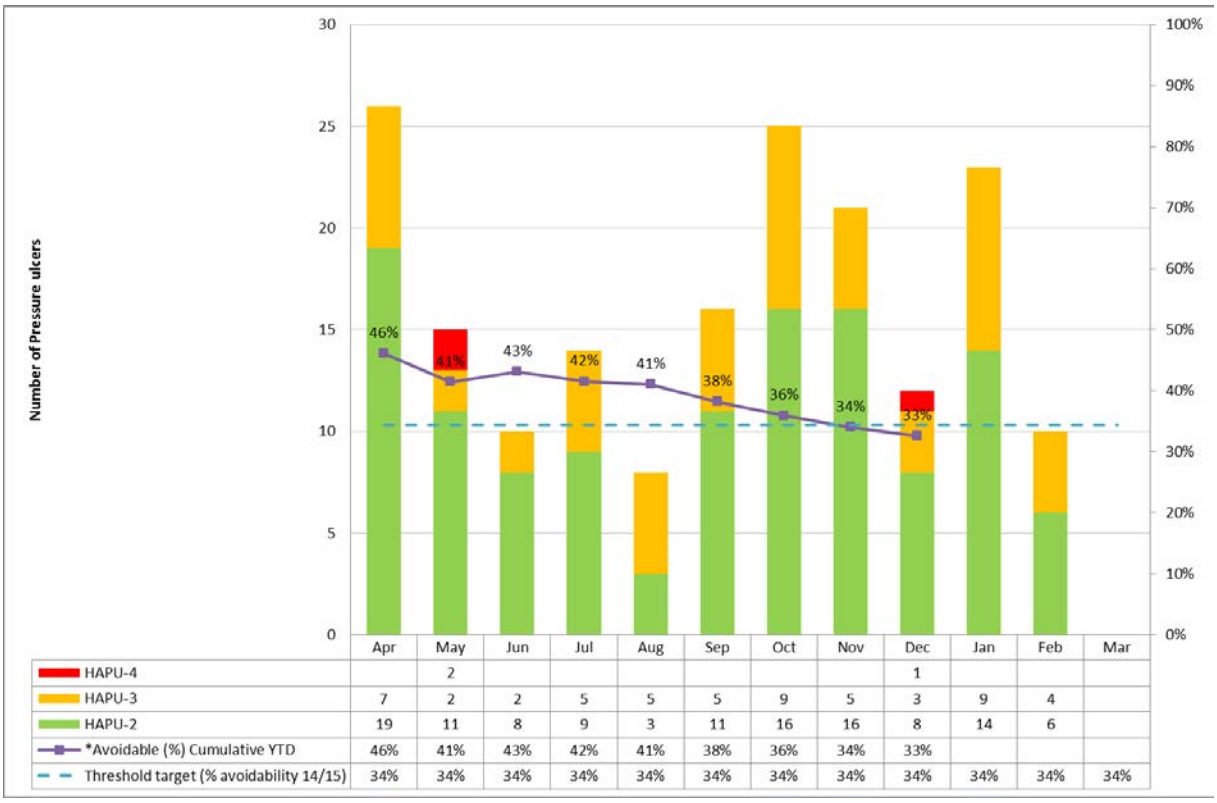
In April we reported 64 falls which was 5.06 falls per 1000 beds day, if we are to assume similar numbers of bed days this month our overall number of falls per thousand bed days will have reduced.

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

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

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

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
HAPU-4		2							1			
HAPU-3	7	2	2	5	5	5	9	5	3	9	4	
HAPU-2	19	11	8	9	3	11	16	16	8	14	6	
*Avoidable (%) Cumulative YTD	46%	41%	43%	42%	41%	38%	36%	34%	33%			
Threshold target (% avoidability 14/15)	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%

Judged as Avoidable following clinical review by Matron or TVN

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

There were six HAPU-2 in February. F3 had three ulcers, G4, G8 and G9 had one ulcer each.

There were four HAPU-3 in February. G1 had two ulcers, F9 and Glastonbury Court had one ulcer each.

There were four DTI reported in February.

Following a flag being raised for G9 at the last meeting it can be confirmed that the ward had only one HAPU in February and none to date in March.

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

Avoidable harm

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

At the end of February there had been 180 HAPU 2, 3 or 4 reported and currently 50 of these have been classified as avoidable, 117 as unavoidable with another 13 pending confirmation of grading as these cases are currently under investigation and these have a 60 working day deadline in line with the Serious incident framework.

This puts the Trust currently meeting the target to be below the 34% threshold which has consistently has fallen since the beginning of the year. The increase in staff recognising and reporting pressure ulcers together with the 'React to Red' campaign to ensure timely recognition of deep tissue injury is expected to reduce the percentage to below the target before the year end.

Benchmarking

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

Pressure ulcer prevention

Lead nurse for Tissue Viability and Senior Matron have been working on developments within the Trust since June 2016, with the aim of making the reporting of pressure ulcers more user-friendly and robust for staff.

The emphasis of the campaign has been on the importance of early skin assessment, prevention and identification of patients at high risk. As part of this Action plan (detailed in the Pressure ulcer project plan) training sessions available to all staff have been set up, the focus has been on e-Care assessments such as the Waterlow and skin assessment. Weekly ward walks are being undertaken by Matron Lead for PU and the Tissue Viability Lead to educate and support staff in area of high incidence.

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

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

a) Current Position

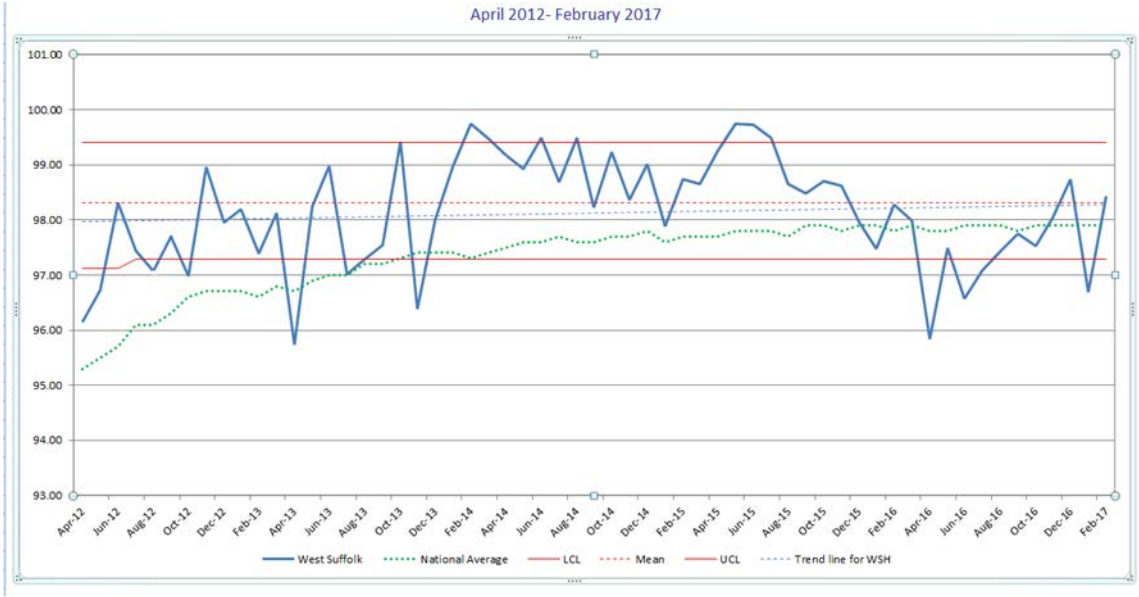
The National 'harm free' care composite measure is defined as the proportion of patients without a pressure ulcer (ANY origin, category II-IV), harm from a fall in the last 72 hours, a urinary tract infection (in patients with a urethral urinary catheter) or new VTE treatment.

	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec - 16	Jan-17	Feb-17
Harm Free	93.95	91.43	94.97	93.63	92.31	92.25	92.71	92.31	92.61	93.16	91.35	93.72
Pressure Ulcers – All	4.79	4.68	3.27	3.43	5.31	3.88	5.03	5.49	5.67	3.80	5.34	4.71
Pressure Ulcers - New	1.51	2.34	1.26	1.47	1.06	1.29	1.01	1.65	1.23	0.51	1.53	1.05
Falls with Harm	0.25	1.30	0.50	0.49	0.53	0.00	0.75	0.55	0.49	0.76	0.76	0.00
Catheters & UTIs	1.26	2.86	1.26	1.96	2.12	3.62	1.51	2.20	1.23	2.28	2.04	1.31
Catheters & New UTIs	0.00	0.78	0.50	0.98	0.53	0.78	0.50	0.00	0.25	0.00	0.25	0.26
New VTEs	0.25	0.00	0.25	0.49	0.80	0.52	0.00	0.27	0.00	0.00	0.76	0.26
All Harms	6.05	8.57	5.03	6.37	7.69	7.75	7.29	7.69	7.39	6.84	8.65	6.28
New Harms	2.02	4.16	2.51	3.43	2.92	2.58	2.26	2.47	1.97	1.27	3.31	1.57
Sample	397	3.85	398	408	377	387	398	364	406	395	393	382
Surveys	18	18	18	18	18	18	18	17	18	18	18	18

The data can be manipulated to just look at "new harm" (harm that occurred within our care) and with this parameter, our Trust score for February 2017 is **1.57 %** therefore, our new harm free care is **98.43%** The National new harm for February 2017 is **2.2%** or (**97.8**%).

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

The SPC chart below shows the Trust Harm free care compared to the national benchmark for the period April 2012 to February 2017. The Trust figures have risen above the National Average for February.



b) Recommended Actions

To continue to monitor actual harm against national benchmarks

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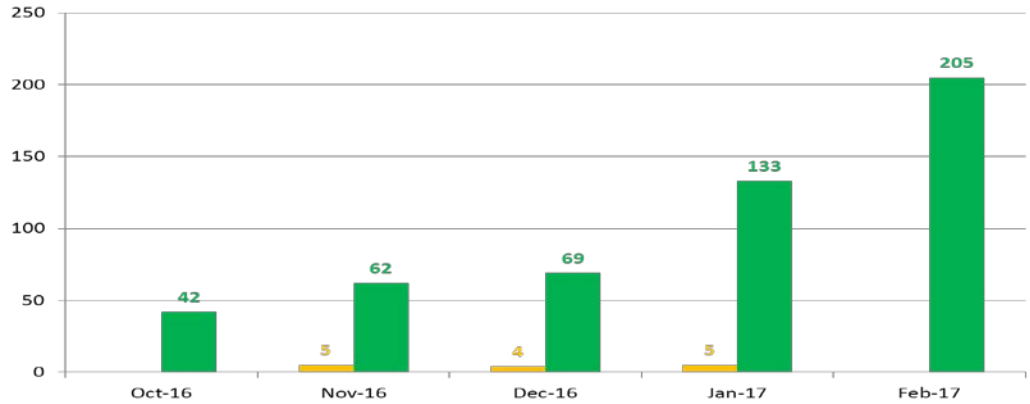
1.12 Incidents with investigation overdue

a) Current Position

Graph: Green and Amber incidents overdue* by month.



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

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

277 (64%) of the February green incidents had been investigated at the time of this report compared to (60%) last month.

It has been agreed by the Executive Chief Nurse that going forward a pragmatic approach should be taken for green incidents that are more than three months old and that these should be closed off centrally. The thematic analysis of cases and ward/department level monthly review would not be affected by this and it would take a burden off operational staff allowing them to focus on more recent incidents.

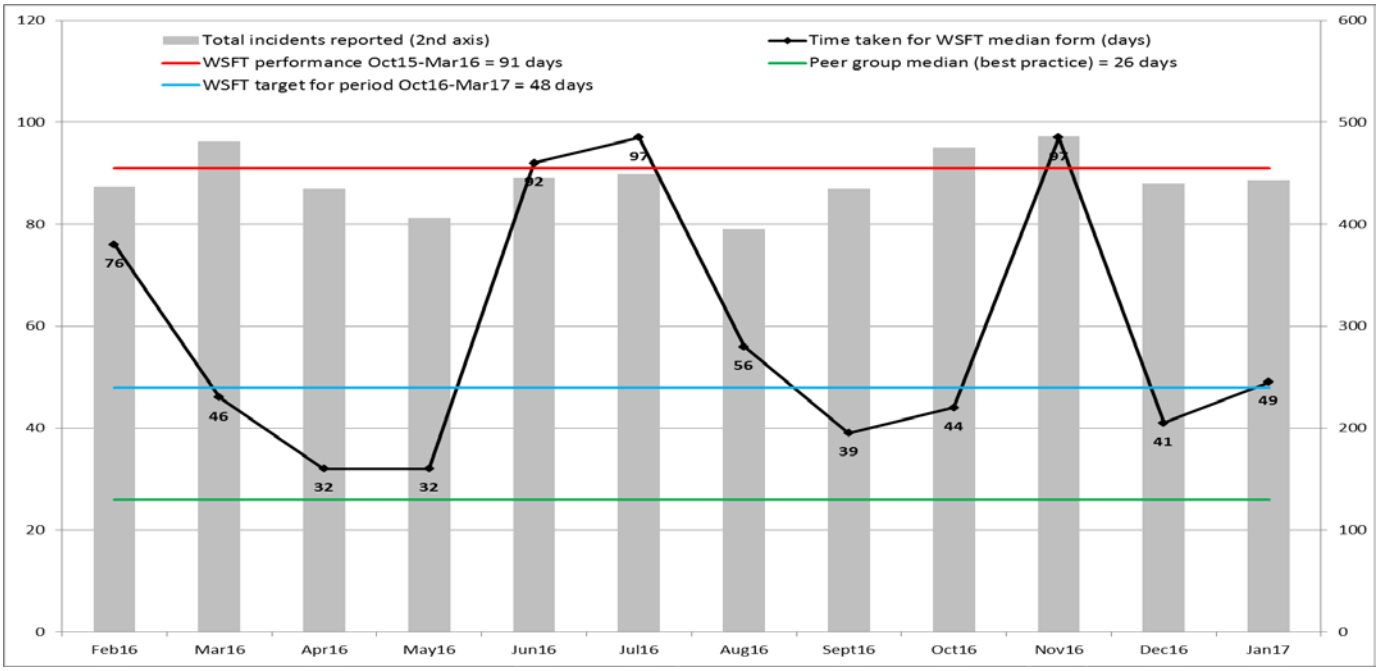
The indicator 50% of patient safety incidents uploaded to the NRLS has been added as a new KPI with 26 days (peer group median) as a best practice (green) and <48 days (threshold for the lower quartile in the most recent NRLS benchmark) as an in-year target (blue). The red line (91 days) is the last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

The data is provided up to January as February cases have not yet met the 50% of incidents uploaded threshold. The peak in November has three factors:

- There were a higher number of incidents reported in October and November (the grey bar) and this has built up a backlog of investigations outstanding.

- This was exacerbated by the level of activity (Black bed status) whereby the staff have not had as much administrative time to focus on incident closures.
- Finally there was an acknowledgement that November is now sufficiently far in the past that any cases uploaded to the NRLS will have automatically failed the 48 day target. The Datix administrator has therefore been directed to focus on the upload on completed incidents in more recent months to allow the best possible performance against the overall performance for the six month period (which is the public figure reported nationally). This can be demonstrated by the December and January figures being much closer to the target.

This will continue and, combined with the central closure of >3 month old incidents, should see an improvement on the month to month performance.



1.13 RCA Actions beyond deadline for completion

a) Current Position

There are currently nine RCA actions showing as overdue on Datix. Seven of these have a due date prior to February 2016.

b) Recommended Action

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

1.14 Duty of Candour

a) Current Position

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

b) Recommended Action

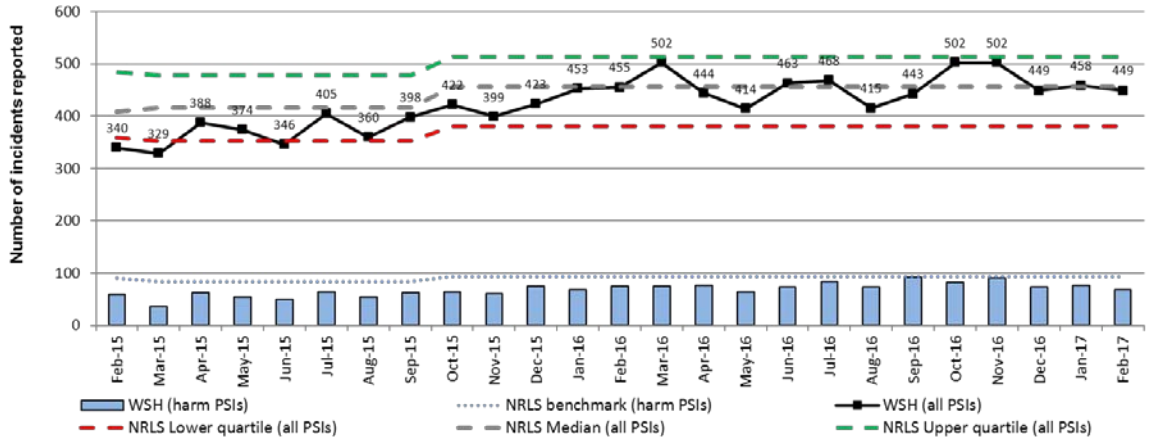
The individuals responsible for providing Duty of Candour have been contacted, non-compliance with Duty of Candour is escalated to the Clinical Directors.

1.15 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 Oct15 – Mar16.

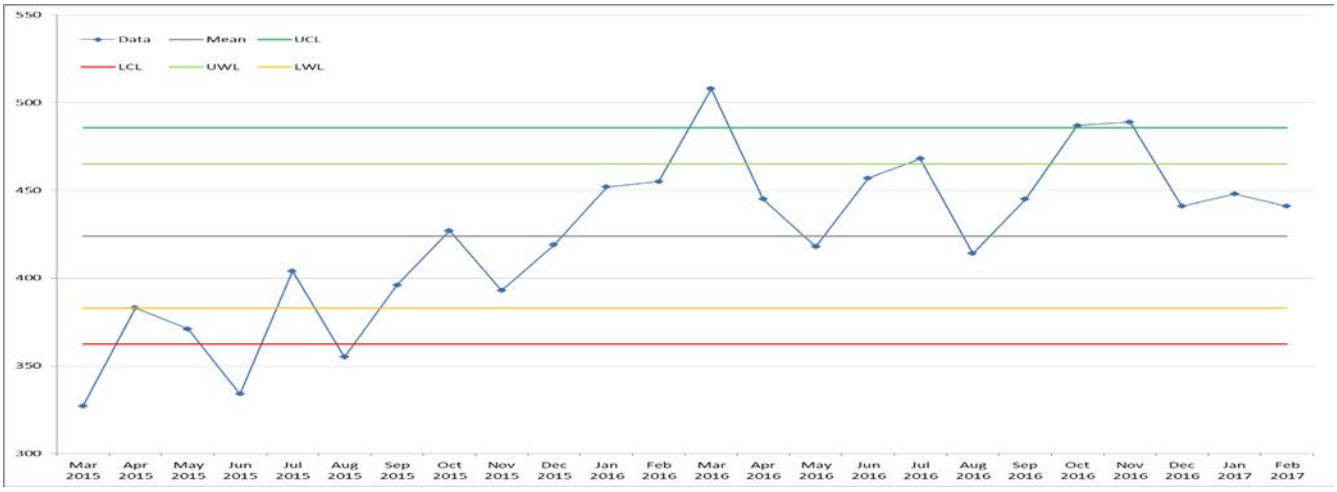
There were 544 incidents reported in February including 449 patient safety incidents (PSIs). This was similar to December / January and is just below the median threshold for the peer group. Community incidents are now being captured through Datix e-reporting as of the 1st August 2016.

Graph: Patient Safety Incidents reported



The SPC chart below plots all PSIs reported over a two year period.

Graph: Patient Safety Incidents reported over two years



1.16 Patient Safety Incidents (Severe harm or death)

The percentage of PSIs resulting in severe harm or death is a nationally mandated item for inclusion in the Quality Accounts. The peer group average (serious PSIs as a percentage of total PSIs) is from the NRLS period Oct15 - Mar16. This demonstrated an increase in the percentage of incidents resulting in serious harm across the peer group. 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.

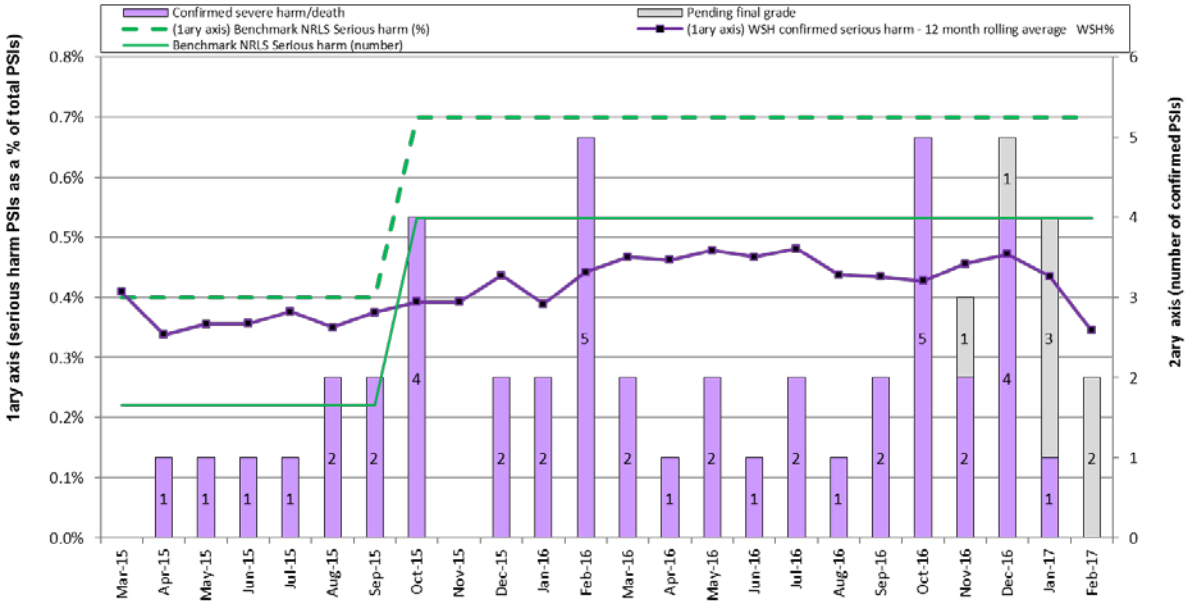
In February there were three cases reported: one intrauterine death and one mortality review in February both of which are awaiting RCA to confirm harm grading. There was also one incident, a mortality review, which was reported in February but occurred in January.

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

- one misdiagnosis in the emergency department,
- one cardiac arrest
- one post-operative complication

- one fall resulting in a fractured femur

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	Dec	Jan	Feb
Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	91	94	93
(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	95	99	98
Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	73	70	73
Timely call bell response	= 85%	<75	75-84	85-100	82	84	86
Patient Satisfaction: outpatient overall result	= 85%	<75	75-84	85-100	91	92	92
(Out-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	97	97	97
Were you informed of any delays in being seen?	= 85%	<75	75-84	85-100	67	63	69
Were you offered the company of a chaperone whilst you were being examined?	= 85%	<75	75-84	85-100	76	65	72
Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	99	99	99
(Short-stay) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	100	99
Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	95	96	93
(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	95	95	96
Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	ND	ND	98
(A&E Children) How likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	ND	ND	98
Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	97	94	96
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	90	91	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	100	ND	ND
How likely are you to recommend our antenatal department to friends and family?	= 90%	<80	70-89	90-100	100	99	100
How likely are you to recommend our post-natal care to friends and family?	= 90%	<80	70-89	90-100	98	100	100
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	96	100	78
How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	100	100

Indicator	Target	Red	Amber	Green	Dec	Jan	Feb
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	93	86	95
Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	93	ND	95
(Young children) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	96	ND	100
Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	98	ND	99
(F1 Parent) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	96	ND	100
Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	93	94	95
(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	100	100

Additional Patient Experience indicators

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

1.17 Inpatient: Noise at night

a) Current Position

Although three lower than last month (70, now 73), this area continues to flag as red.

a) Recommended Action

Staff are continuing to offer RoseVital trays to patients to aid their sleeping. A task and finish group met in January to review all patient surveys and wording of questions ahead of the new financial year. There is a proposal to reword this question which is hoped will encourage richer data.

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

a) Current Position

A large improvement can be seen this month (63, now 69).

b) Recommended Action

Further outpatient area observations with patient representatives are being planned across the Trust, reviewing information about delays specifically.

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

a) Current Position

The score improved from 65 to 72 this month.

b) Recommended Action

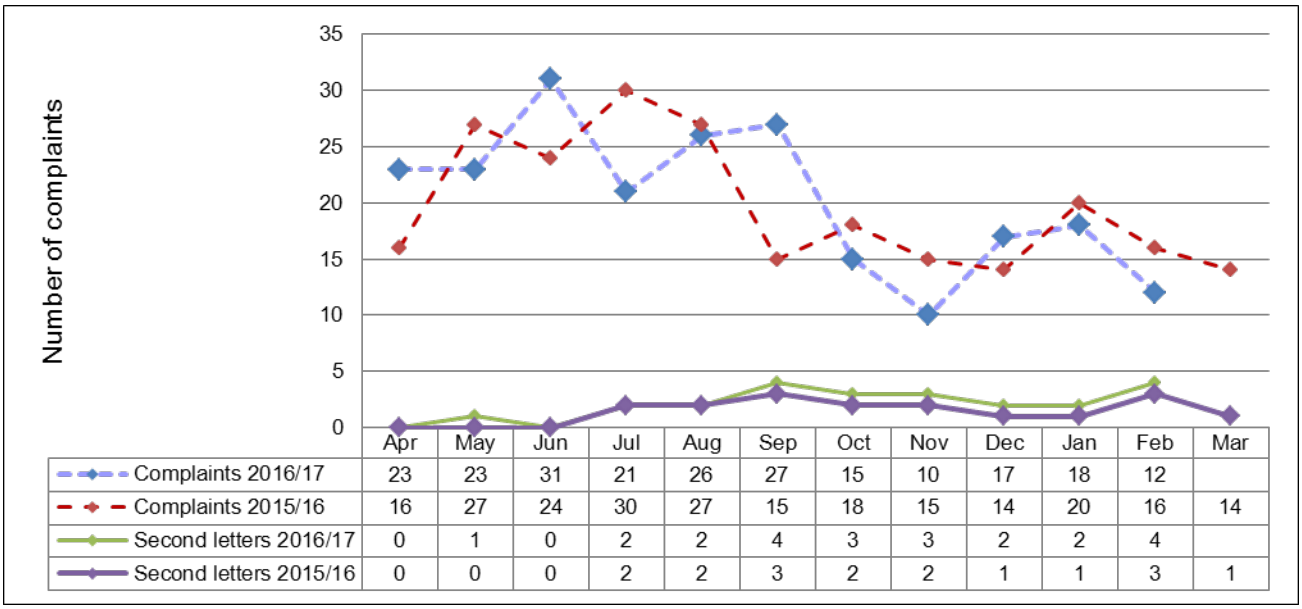
Staff will continue to chaperone patients in appointments. As per 1.13, this question is being changed in the new financial year which will eradicate any confusion caused by the wording, giving us a clearer understanding of whether this is an issue.

1.20 Complaints

12 complaints were received in February, a decrease compared to January (18). 86% of complaints were responded to in January within the Trust's preferred timeframe meaning that two were late. The breakdown

of the complaints received in February is as follows by Primary Division: Medical (6), Surgical (5), Clinical Support (1). Trust-wide the top three most common problem areas are as below:

Patient Care – including Nutrition/Hydration	4
Values & Behaviours (Staff)	3
Clinical Treatment – General Medicine group	2
Clinical Treatment – Surgical group	2



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

1.21 PALS

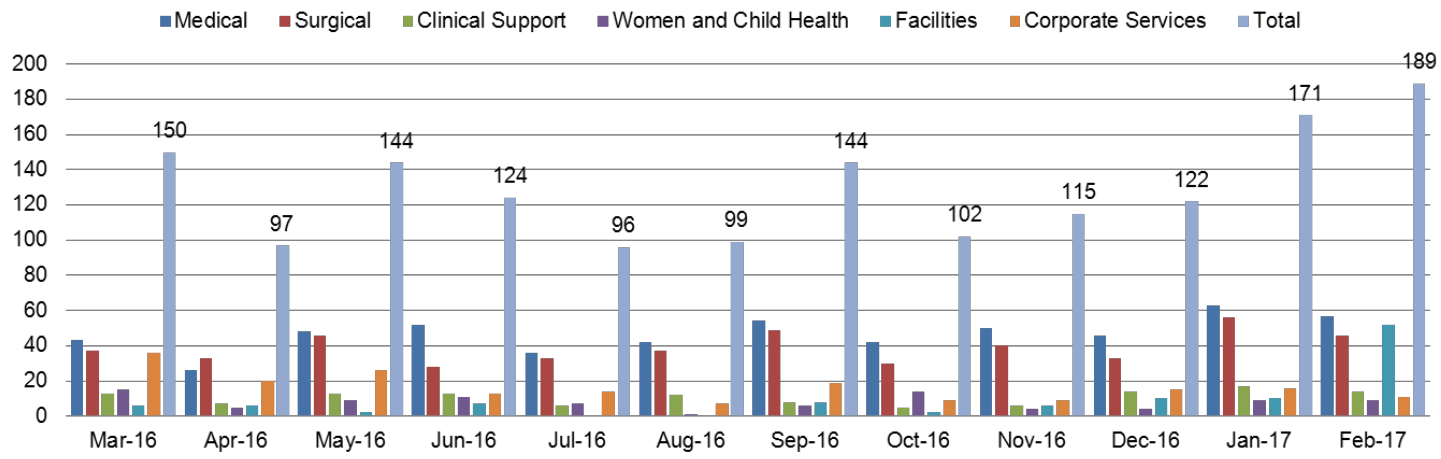
In February 2017 there were 189 recorded PALS contacts. This number denotes initial contacts and not the number of actual communications between the patient/visitor which can, in some particular cases, be multiple.

A breakdown of contacts by Division from Mar 16 – Feb 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:

- Facilities Services (60)
- Appointments; including delays and cancellations (28)
- Queries, advice & request information (25)

The category of 'Facilities Services" appeared as the top issues in February, the main theme in this data was charging for disabled parking. Appointments: including delays and cancellations, the main theme was cancellation of ENT appointments. The ENT Department is under pressure due to staff shortages and the service is working to resolve this.



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	Dec	Jan	Feb
TA (Technology appraisal) business case beyond agreed deadline	0	>9	4 – 9	0 – 3	0	0	
WHO checklist (Quarterly)	100%	<90	90 – 94	>=95	97	NA	NA
Trust participation in relevant ongoing National audits (Quarterly)	100%	<75	75 – 89	>=90	100	NA	NA
Gynaecology (F14) 30 day readmissions	No target	No target	No target	No target	ND	ND	ND
Babies admitted to NNU with normal temperature on arrival (term)	100%	<50%	50-80%	>80%	100	100	100
12 month Mortality standardised rate (Dr Foster)	100%	>100	90-100	<90	84.13	85.85	87.2
CAS (central alerting system) alerts overdue	0	>=1	No target	0	0	0	0

Maternity dashboard

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

	Red	Amber	Green	Dec-16	Jan-17	Feb-17
ACTIVITY – Births						
Total Women Delivered	> 250 or < 2 00	>216 or <208	>208 or <216	231	195	197
Total Number of Babies born at WSH	> 250 or < 2 00	>216 or <208	>208 or <216	234	198	197
Twins	No target	No target	No target	3	3	0
Homebirths	< 1%	2% or less	2.5%	ND	2.0%	3%
Midwifery Led Birthing Unit (MLBU) Births	<=10%	13% or less	20%	20.8%	24.1%	19.3%
Labour Suite Births	<=64%	69% to 74%	75%	76.2%	73.8%	77.7%
BBAs	No target	No target	No target	5	1	1
Normal Vaginal deliveries	No target	No target	No target	167	145	151
Vaginal Breech deliveries	No target	No target	No target	0	0	1
Non operative vaginal deliveries	No target	No target	No target	167	145	152
Water births	No target	No target	No target	21	20	16
Total Caesarean Sections	> 22.6%	No target	<22.6%	19%	16.4%	13.2%
Total Elective Caesarean Sections	>=13%	11 - 12%	10%	6.9%	8.2%	4.6%
Total Emergency Caesarean Sections	>=15%	13 - 14%	12%	12.1%	8.2%	8.6%
Second stage caesarean sections	No target	No target	No target	6	1	5
Forceps Deliveries	No target	No target	No target	3.5%	5.6%	5.1%
Ventouse Deliveries	No target	No target	No target	5.2%	3.6%	4.6%
Inductions of Labour	No target	No target	No target	34.2%	33.8%	36%
Failed Instrumental Delivery	No target	No target	No target	1	1	3

	Red	Amber	Green	Dec-16	Jan-17	Feb-17
Unsuccessful Trial of Instrumental Delivery	No target	No target	No target	1	0	0
Use of sequential instruments	No target	No target	No target	ND	ND	ND
Grade 1 Caesarean Section (Decision to Delivery Time met)	<=95%	96 - 99%	100%	100%	100%	100%
Grade 2 Caesarean Section (Decision to delivery time met)	<=75%	76 - 79%	80%	81%	71%	70%
Total no. of women eligible for Vaginal Birth after Caesarean Section (VBAC)	No target	No target	No target	24	11	18
Number of women presenting in labour for VBAC against number achieved.	No target	No target	No target	8	8	9
ACTIVITY – Bookings						
Number of Bookings (1st visit)	No target	No target	No target	226	262	247
Women booked before 12+6 weeks	<=90%	91 - 94%	95%	95%	93%	95%
CLINICAL OUTCOMES - Maternal						
Postpartum Haemorrhage 1000 - 2000mls	No target	No target	No target	15	10	11
Postpartum Haemorrhage 2,000 - 2,499mls	No target	No target	No target	0	0	1
Postpartum Haemorrhage 2,500mls+	No target	No target	No target	4	5	0
Post-partum Hysterectomies	1	1	0	0	0	0
Women requiring a blood transfusion of 4 units or more	1	1	0	ND	ND	0
Critical Care Obstetric Admissions	1	1	0	0	0	0
Eclampsia	1	1	0	0	0	0
Shoulders Dystocia	5 or more	3-4	2	7	3	2
3rd and 4th degree tears (All vaginal deliveries)	No target	No target	No target	4	5	4
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)	10	7-9	6	3	5	2
3rd and 4th degree tears (Instrumental Deliveries)				1	0	2
Maternal Sepsis	No target	No target	No target	ND	ND	ND
Maternal death	No target	No target	No target	0	0	0
Female Genital Mutilation (FGM)	No target	No target	No target	0	0	0
Clinical Outcomes –Neonatal						
Number of babies admitted to Neonatal Unit (>36+6)	No target	No target	No target	20	8	8
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	No target	No target	No target	5	0	1
Number of Babies transferred for therapeutic cooling	1	No target	0	0	1	1
Cases of Meconium aspiration	No target	No target	No target	0	0	0
Cases of hypoxia	No target	No target	No target	0	0	1
Cases of Encephalopathy (grades 2 and 3)	No target	No target	No target	0	1	1
Stillbirths	No target	No target	No target	3	0	1
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 >	75	63	81
Midwife/birth ratio	>=1:32	No target	1:30	1:30	1:28	1:28
Supervisor to Midwife Ratio	No target	No target	No target	1.:19	1:19	1:19
Consultant Anaesthetists sessions on Labour Suite	< 8 sessions	8-9 sessions	10 sessions	10	10	10
ODP cover for Theatre 2	80%	90%	100%	100%	100%	100%
Anaesthetist response to request for epidural for pain relief within 30 mins	< 70%	70 - 79%	>=80%	ND	ND	ND
Risk incidents/complaints/patient satisfaction						
Reported clinical Incidents	>40	40-59	60 and above	48	54	49
Serious incidents	No target	No target	No target	3	0	1
Never events	No target	No target	No target	0	0	0
Complaints	No target	No target	No target	1	0	0
1 to 1 Care in Labour	<=95%	96 - 99%	100%	100%	100%	100%
Unit closures	No target	No target	No target	0	0	0
Massive Obstetric Haemorrhage protocol	No target	No target	No target	ND	ND	ND
Maternal Postnatal readmissions	No target	No target	No target	ND	ND	ND
Completion of WHO Checklist	80%	90%	100%	96%	93%	87%
Babies assessed as needing BCG vaccine	No target	No target	No target	ND	ND	ND
Babies who receive BCG vaccine following assessment	No target	No target	No target	ND	ND	ND
UNICEF Baby Friendly Audits	No target	No target	No target	10	10	10
Proportion of parents receiving a Safer Sleeping Suffolk Thermometer.	No target	No target	No target	ND	156	157

Exception reporting for red indicators in the Clinical Effectiveness Dashboard

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

The total number of deliveries and babies born at WSH varies from month to month. The maternity service delivered less babies in February 2017 than would be expected, this follows the pattern over recent years for less deliveries during Quarter 1. It is not planned to take any action on this.

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

The maternity service undertook 10 grade 2 caesarean sections in February 2017, unfortunately three of these were not achieved within the 75 minute target of decision to delivery. These cases have all been discussed at the weekly case management meeting and it was not felt appropriate to take any further action. No harm was cased in any of the three cases.

1.24 Maternity - Number of Babies transferred for therapeutic cooling

In February 2017 one baby was transferred out to a tertiary centre for therapeutic cooling. An amber investigation is currently being undertaken at present.

1.25 Maternity - Reported clinical Incidents

The maternity service notes a slight reduction in the reporting of clinical incidents in February 2017, no cause noted but may be related to the lower delivery figure for the month, this will be monitored.

1.26 Maternity - Completion of WHO Checklist

In February 2017 the maternity service compliance with completion of the WHO checklist fell to 87%, identified in a continuous documentation audit. The service has actions in place to address this, which are on-going. There are no reports of any clinical incidents stemming from this lack of documentation.

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

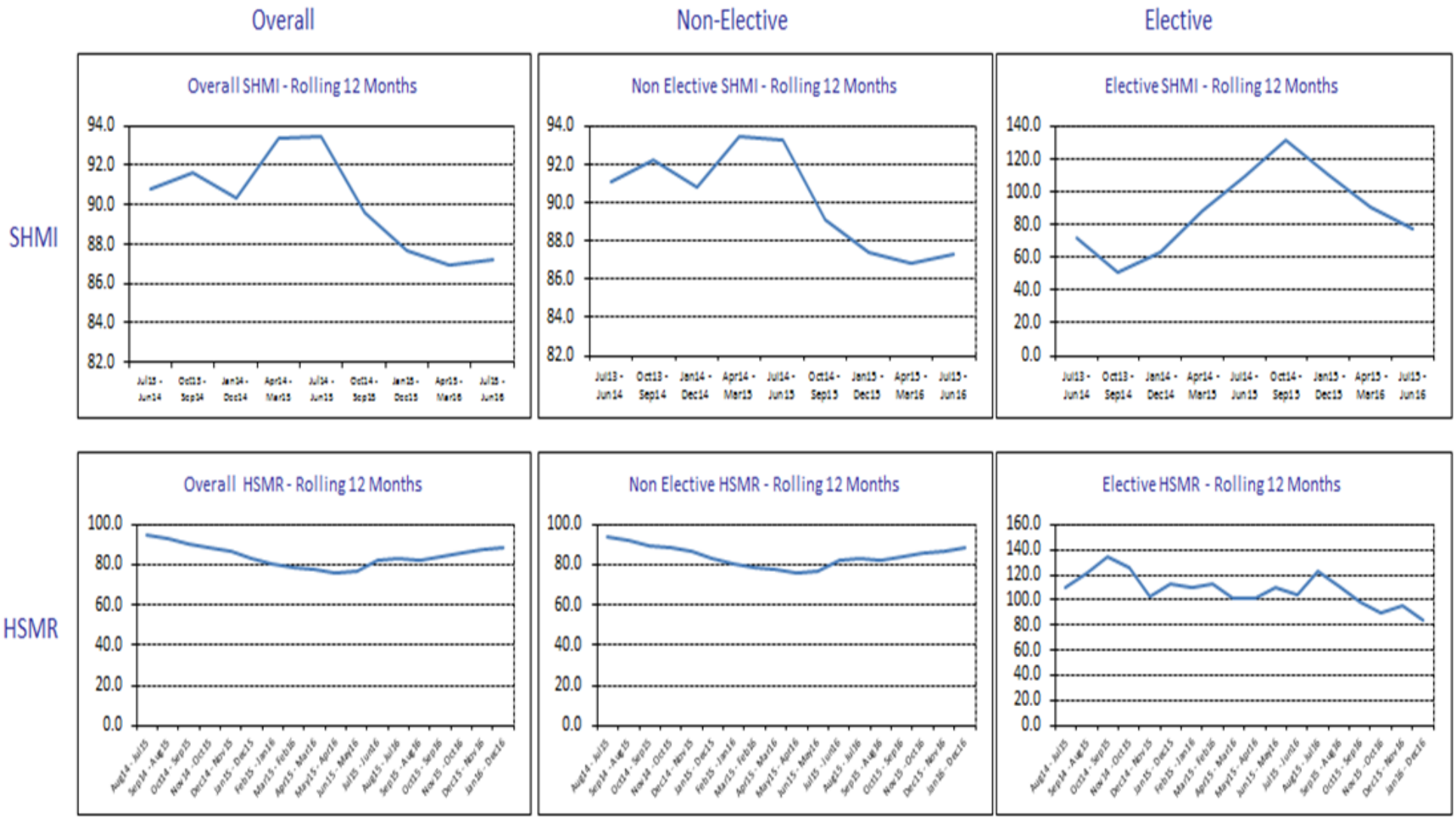
2. MORTALITY DATA

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

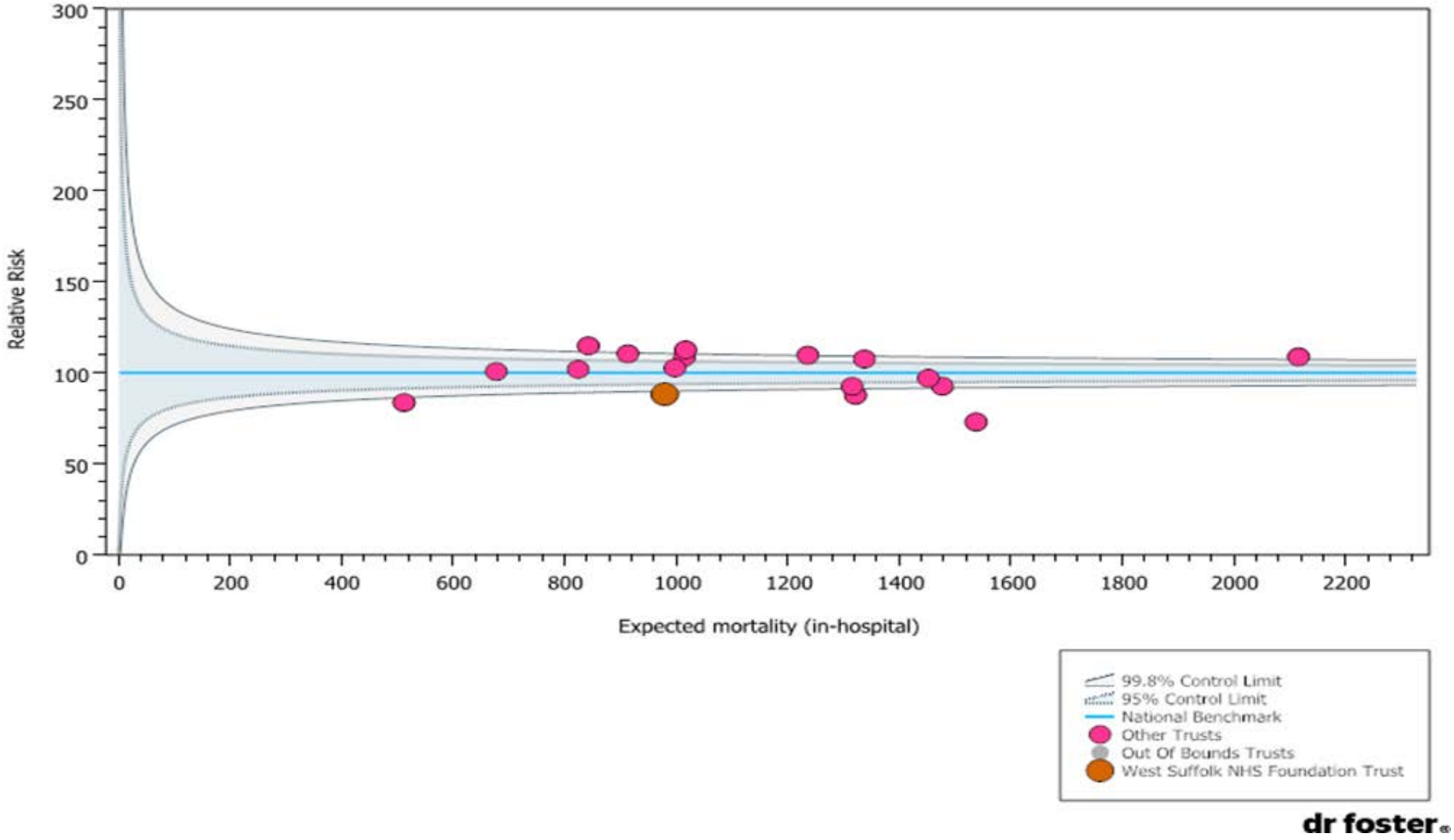
HSMR BENCHMARK IS USING FY 15 -16

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

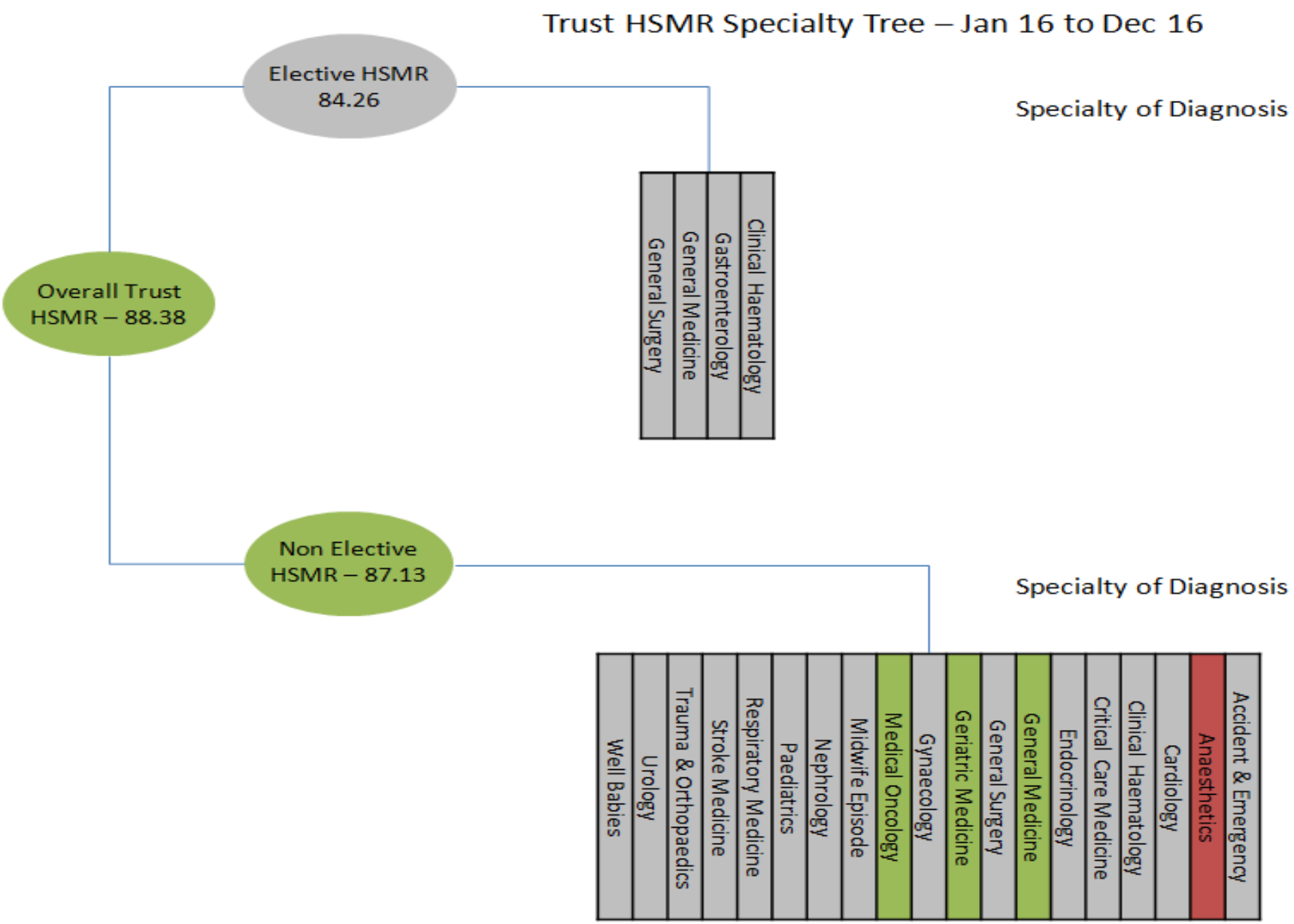
HSMR - Rolling 12 Months	Jun13 - May14	Jul13 - Jun14	Aug13 - Jul14	Sep13 - Aug14	Oct13 - Sep14	Nov13 - Oct14	Dec13 - Nov14	Jan14 - Dec14	Feb14 - Jan15	Mar14 - Feb15	Apr14 - Mar15	May14 - Apr15
Overall Observed Deaths	755	758	779	798	804	792	803	842	902	934	938	946
Overall Expected Deaths	883	894	902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


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 – Jan 16 - Dec 16



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


Trust HSMR Specialty Tree – Jan 16 to Dec 16
Elective HSMR 84.26
Specialty of Diagnosis
Clinical Haematology
Gastroenterology
General Medicine
General Surgery
Overall Trust HSMR – 88.38
Non Elective HSMR – 87.13
Specialty of Diagnosis
Accident & Emergency
Anaesthetics
Cardiology
Clinical Haematology
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

3. MONITOR ASSURANCE FRAMEWORK

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

Monitor Compliance Framework						December	January	February
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%	89.89%	90.09%	1.0	Jon Green	92.03%	90.30%	89.89%
Number of RTT Waits over 52 weeks for incomplete pathways	0	7	14	-	Jon Green	0	7	7
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	83.92%	87.18%	1.0	Jon Green	86.50%	87.28%	83.92%
All cancers: 62-day wait for first treatment (5) from:Urgent GP referral for suspected cancer - **See Further detail below**	85%	84.96%	84.58%	1.0	Jon Green	85.58%	84.21%	84.96%
All cancers: 62-day wait for first treatment (5) from: NHS Cancer Screening Service referral	90%	88.89%	94.44%		Jon Green	96.43%	100.00%	88.89%
All cancers: 31-day wait for second or subsequent treatment, comprising: Surgery	94%	100.00%	100.00%	1.0	Jon Green	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%		Jon Green	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	Jon Green	100.00%	100.00%	100.00%
Cancer: two week wait from referral to date first seen (8), comprising: all urgent referrals (cancer suspected)	93%	98.33%	94.20%	0.5	Jon Green	97.46%	90.06%	98.33%
Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)	93%	96.27%	92.28%		Jon Green	93.23%	88.29%	96.27%
Outcomes:								
Clostridium (C.) difficile - meeting the C.difficile objective - MONTH	2	0		1.0	Rowan Proctor	2	0	0
Clostridium (C.) difficile - meeting the C.difficile objective - QUARTER	4		0		Rowan Proctor			
Clostridium (C.) difficile - meeting the C.difficile objective - ANNUALLY	16		21		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	4.0

West Suffolk NHS Foundation Trust Cancer Waits Performance Report - January 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	12	2	14	85.7	94.4
Gynae	1+5x.5	2x.5	4.5	77.8	76.6
Haem	2		2	100	80.4
Head & Neck		3x.5	1.5	0	56.9
Lower GI	6+1x.5	1	7.5	86.7	68
Lung	3+1x.5	1x.5	4	87.5	69.3
Other	1		1	100	60.3
Skin	7	3	10	70	94.8
Upper GI	3+1x.5		3.5	100	70.5
Urology	9		9	100	78
Total	44+8x.5	6+6x.5	57	84.2	79.5
Testicular	1	0	1	100	86.7

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

89.89% against a threshold of 92%

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

b) Recommended Action

Detailed action plans for each of the above specialties are being developed with CCG input where appropriate. Validation of new PTL underway.

3.2 Number of RTT waits over 52 weeks for incomplete pathways

a) Current Position

7 against a threshold of 0

There are 6 ENT patients over 52 weeks due to reporting and capacity issues and 1 Vascular patient, who has been delayed due to capacity. Patient needs GA surgery and is for Mr Boyle only to do.

b) Recommended Action

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

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

a) Current Position

83.92% against a threshold of 95%

ED continues to experience high levels of demand.

b) Recommended Action

Actions in place include:

The Flow Action Group continues to work towards tackling challenges and limitations to patient flow and discharge. Red to Green work continues to be a significant focus across the organisation with new dashboards developed to monitor performance at ward and consultant level. ED has recently employed two fully qualified ACPs who will support the ED doctor team in improving the flow in ED.

The medical take, which is our largest take of patients into the Trust daily, we have enabled a 'closed unit' referral system, whereby when acutely unwell medical patients are admitted, the bed allocation is purely a ED coordinator to F8/7 coordinator clinical conversation, streamlining the process.

The AECC (Ambulatory Emergency Care Centre) are shortly interviewing for 2 ACPs as part of the MAT (Medical Assessment and Triage) project to ensure medical patients are seen, assessed and filtered more effectively, again to improve ED flow, reduce base bed usage and shorten the Trusts patient length of stay. The GP to medicine referred patients will be triaged in a collocated area. This will also enable the ED triage nurse to have a more cohesive rapport with the medical triage nurses enabling an increased number of ED patients to be streamed to AECC.

From an AMU short stay perspective 'criteria based discharge' SOPs are being formulated which will enable patients to be discharged earlier, planning for at least one/two patients a day to be discharged by 10am from short stay ward F7.

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

a) Current Position

The most up to date figures in Somerset so far for February - dependent on reallocation - is 84.96% pre-validation against a threshold of 85%. Post-validation figure is 85.5%.

b) Recommended Action

Continue with reallocation process.

3.5 All cancers: 62-day wait for first treatment (5) from NHS Cancer Screening Service referral

a) Current Position

88.89% against a threshold of 90%
We experienced unusually low levels of activity to report in February for this standard - only 5 patients. 4 local patients from the Breast Screening route and one patient screened at Addenbrookes for Bowel Cancer. This patient required further investigations to localise their disease accurately which delayed the pathway. The patient required postponement of original TCI date to supplement Thyroxin as it was found dangerously low to proceed with the surgery planned within target. The breach was unavoidable to treat comorbidity beforehand.

b) Recommended Action

RCA's continue to be undertaken for all breaches. No actions identified.

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

a) Current Position

0 for month against a threshold of 2
0 for QTD against a threshold of 4
21 for YTD against a threshold of 16

b) Recommended Action

See page 4 of the report.

4. CONTRACTUAL AND KEY PERFORMANCE INDICATORS

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

Performance Indicator	Threshold	In Month Performance	YTD	Comments	Lead Exec	Dec	Jan	Feb	Change mth on mth	On Plan To Achieve	Area of Concern	Forecast to Breach
A&E												
A&E Time to treatment in department (median) for patients arriving by ambulance - CDM	Median time to treatment above 60 minutes	48	64		Jon Green	56	50	48	↗			
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	12:25	17:28		Jon Green	17:28	13:19	12:25	↗			
A&E Trolley Waits not longer than 12 hours	0 Patients waiting over 12 hours from DTA to Admission	0	0		Jon Green	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%	33.61%	31.91%		Jon Green	34.02%	34.91%	33.61%	↗			
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		Jon Green	ONE MET	ONE MET	ONE MET	↔			
A&E & AMU - Ambulance submit button complete	80%	83.61%	84.69%		Jon Green	90.46%	90.16%	83.61%	↘			
A&E - Ambulance Handovers above 30 minutes	0 handovers over 30 minutes - £200 per breach	ND	281	**Unvalidated data until March; validated thereafter.**	Jon Green	46	39	ND				
A&E - Ambulance Handovers above 60 minutes	0 handovers over 60 minutes - £1000 per breach	ND	74		Jon Green	13	21	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%	89.47%	81.16%		Jon Green	93.55%	80.00%	89.47%	↗			
RTT												
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks	99.00%	95.56%	98.14%		Jon Green	97.15%	96.07%	95.56%	↘			
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90.00%	68.84%	73.62%		Jon Green	70.60%	67.88%	68.84%	↗			
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.00%	84.73%	91.65%		Jon Green	89.37%	87.51%	84.73%	↘			
Stroke												
% of patients scanned within 1 hour of clock start	77% (Contract) 57.5% (Upper Quartile)	68.75%	74.62%		Jon Green	80.56%	76.32%	68.75%	↘			
% of patients scanned within 12 hours of clock start	96% (Contract) 96% (Upper Quartile)	90.63%	97.00%		Jon Green	97.22%	100.00%	90.63%	↘			
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75% (Contract) 70% (Upper Quartile)	62.50%	74.01%		Jon Green	77.14%	83.78%	62.50%	↘			
>80% treated on a stroke unit >90% of their stay	90%	90.63%	88.47%		Jon Green	88.57%	91.89%	90.63%	↘			
% of patients treated by a stroke skilled early supported discharge team	48% (Contract) 48% (Upper Quartile)	42.31%	46.14%		Jon Green	68.18%	46.67%	42.31%	↘			
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80% (Contract) 79% (Upper Quartile)	84.38%	84.87%		Jon Green	86.11%	81.58%	84.38%	↗			
% 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%	78.36%		Jon Green	88.89%	77.14%	80.00%	↗			
% of eligible service users given thrombolysis	100% (RCA to be provided for breaches)	100.00%	83.52%		Jon Green	100.00%	100.00%	100.00%	↔			
All stroke survivors to have a 6 month follow up assessment.	50%	ND	57.59%		Jon Green		50.00%		-			
Provider rating to remain between A-C in each of the 9 domains covered in SSNAP where the Provider is at this level. For the one domain (SaLT) where the Provider is at level E, this will be improved to level to C by March 2017.	To remain at or above: National average or current performance (A-C) Improve performance to level C by end of the year (SaLT)	ND	B	Reports are generated by SSNAP every 4 months - this is as at November 2016, reported for February Board	Jon Green		B		-			
Discharge Summaries												
Discharge Summaries - Outpatients	85% sent to GP's within 3 days	ND	ND		Pam Chrispin	ND	ND	ND	-			
Discharge Summaries - A&E	95% of A&E Discharge Summaries to be sent to GPs within one working day	97.73%	97.72%		Pam Chrispin	98.85%	98.08%	97.73%	↘			
Discharge Summaries - Inpatients	95% sent to GP's within 1 day	TBC	92.15%	Due to data quality issues this will be reported on next month.	Pam Chrispin	92.30%	94.33%	TBC	-			
Choose & Book												
Provider failure to ensure that "sufficient appointment slots" are made available on the Choose and Book system	A maximum of 3% slots unavailable (£50 per appointment over 5%. Threshold applied over monthly figures)	ND	ND		Jon Green	ND	ND	ND	-			
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%		Jon Green	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	0.49%	0.93%		Jon Green	1.28%	1.35%	0.49%	↗			
Patients offered date within 28 days of cancelled operation	100%	92.31%	94.54%		Jon Green	89.66%	100.00%	92.31%	↘			
No urgent operation should be cancelled for a second time	0 2nd Urgent Cancellations	0	0		Jon Green	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.	95.14%	95.54%		Rowan Proctor	95.13%	93.13%	95.14%	↗			
Maintain maternity 1:30 ratio	1:30	01:28	01:29		Rowan Proctor	01:30	01:28	01:28	↔			
Pledge 1.4: 1:1 care in established labour	1:1	100.00%	99.95%		Rowan Proctor	100.00%	100.00%	100.00%	↔			
Breastfeeding initiation rates.	80%	80.21%	77.84%		Rowan Proctor	79.65%	73.98%	80.21%	↗			
Reduction in the proportion of births that are undertaken as caesarean sections.	22.70%	13.47%	18.38%		Rowan Proctor	19.0%	16.33%	13.47%	↗			

Other contract / National targets												
Mixed Sex Accomodation breaches	0 Breaches	2	7	2 patients on CCS in Feb 2017	Jon Green	0	0	2	↘			
Consultant to Consultant referral	Commisioner to audit if concern about levels of consultant referrals	ND	ND	Due to data quality issues with eCare we are unable to report on referrals at this time	Jon Green	ND	ND	ND	-			
MRSA - emergency screening	100% Screened within 24 hours	TBC	TBC	Figures currently unavailable due to issues with TPP providing us with the data required	Rowan Proctor	TBC	TBC	TBC	-			
MRSA - Elective screening	100% Screened prior to admission		TBC		Rowan Proctor	TBC	TBC	TBC	-			
Rapid access - chest pain clinic	100% of patients should have a maximum wait of two weeks	100.00%	91.08%	December revised as one less breach as patient cancelled	Jon Green	89.58%	51.58%	100.00%	↗			
Acute oncology service: 1 hour to needle from diagnosis of neutropenic sepsis	100%	100.00%	99.30%	MacMillan	Jon Green	100.00%	100.00%	100.00%	↔			
		90.91%	77.94%	ED	Jon Green	80.00%	54.55%	90.91%	↗			
		94.12%	85.59%	Overall Trust (Inc AMU)	Jon Green	90.48%	72.22%	94.12%	↗			
New to Follow up	Thresholds set at each speciality - overall Trust Threshold is 1.9	2.12	2.00		Jon Green	2.15	2.11	2.12	↗			
Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test	99%	99.42%	96.06%		Jon Green	94.83%	96.04%	99.42%	↗			
All relevant Inpatients undergoing a VTE Risk assessment	95%	TBC	TBC		Jon Green	TBC	TBC	TBC	-			

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

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

a) Current Position

The Trust remained outside the contractual target.
The breach that exceeded the wait was a chest pain patient who arrived at 03:18 was in a cubicle within 5 minutes, there was a 3 hour wait to see a junior doctor, and then following investigations and a senior review, there was no bed available for this patient.

b) Recommended Action

Continued focus on patient flow and bed capacity.

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

a) Current Position

33.61% against a threshold of 27%.

b) Recommended Action

Again, the Trust has continued to experience significant demand. As a result ‘sicker’ patients are presenting to our hospital requiring a more intense or prolonged period of therapy. Active challenge within the department is now common place to ensure patients are not unnecessarily admitted to wards. The revised CDU policy is promoting a more ‘appropriate’ cohort of patients being admitted in. This is demonstrating a higher turnover therefore allowing for more admissions into CDU. In addition, the Trust is creating a daily ‘pulling’ approach for ambulatory emergency care patients. We can see from this month’s threshold that we have improved performance against the target.

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

a) Current Position

95.56% against a threshold of 99%.
Due to significant capacity issues within ENT, Vascular, Urology, Dermatology. Patients waiting 30+ weeks for first OPA in ENT, and patients waiting over 28 weeks for Surgery within Vascular and Urology. Increased rapid access referrals in Dermatology, coupled with staffing deficits making it difficult to prioritise routine patients.

b) Recommended Action

Detailed action plans for each of the above specialties are being developed with CCG input where appropriate. Validation of new PTL underway.

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

a) Current Position
68.84% against a threshold of 90%.

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

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

a) Current Position
84.73% against a threshold of 95%.
Predominantly due to excessive waits for first appointment in both ENT and Dermatology.

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

4.6 Stroke - % of patients scanned within 1 hour of clock start

a) Current Position
68.75% against a threshold of:
77% (Contract)
57.5% (Upper quartile)
Unfortunately, there were 10 breaches this month, 6 of which occurred in ED, of these, 4 were a triage issue, and 2 were patients who required sedation before being scanned. Of the remaining 4, 2 were inpatient strokes, with a delay in referring to the stroke tam and 2 were initial misdiagnosis/complicated.

b) Recommended Action
ESOT continue with education in ED and will target triage staff again.

4.7 Stroke - % of patients scanned within 12 hour of clock start

a) Current Position
90.63% against a threshold of:
96% (Contract)
96% (Upper quartile)
Although scoring a SSNAP A, 3 patients breached, these are the same patients breaching the 1 hour scan time, 2 were misdiagnosis and 1 was too agitated to scan.

b) Recommended Action
ESOT continue with education in ED and will target triage staff again.

4.8 Stroke - % of patients admitted directly to Stroke Unit within 4 hours of clock start

a) Current Position
62.50% against a threshold of:

75% (Contract)
70% (Upper quartile)
2 patients, no stroke bed available, capacity issues in the Trust, 4 complicated diagnosis, resulting in admission elsewhere initially, 3 inpatient strokes with delays in informing stroke team, and 1 patient too sick to transfer.

b) Recommended Action

Again further education to be provided to ED.

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

a) Current Position
42.31% against a threshold of:
48% (Contract)
48% (Upper quartile)

b) Recommended Action
All patients meeting the referral criteria for ESD referrals were referred. This indicator is currently being reviewed.

4.10 Discharge Summaries – Inpatients

a) Current Position
Due to data quality issues this will be reported on next month.

4.11 Patients offered date within 28 days of cancelled operation

a) Current Position
92.31% against a threshold of 100%
This represents one patient was unable to be booked within their 28 days as it was then decided they needed to have their Orthopaedic operation before their Urology procedure, so it was not possible to bring them back in within 28 days.

b) Recommended Action
Continue proactive management of 28-day re-booking.

4.12 Mixed Sex Accommodation breaches

a) Current Position
2 against a threshold of 0
There was one breach involving two patients in February over a period of four hours and screens were provided to protect privacy and dignity for the two patients affected and the female patient was moved to HDU as soon as space was available. At the time of the breach ITU was at full capacity with five patients awaiting ward beds which were not available due to bed capacity and flow pressures.

b) Recommended Action

The situation was escalated to the black bed meetings during the course of the breach period to support the discharge of wardable patients from ITU.

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

a) Current Position

Macmillan - 100%
ED - 90.91%
Overall Trust figure (including AMU) of 94.12% against a threshold of 100%

b) Recommended Action

The performance figure for 1 hour to needle from diagnosis of Neutropenic Sepsis February Data is the highest it has been for over a year. The Emergency Department had only one patient breach the hour timescale due to a complex groshung line infection that required discussion with microbiology.

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	February	YTD	Comments
Workforce				
Sickness absence rate	<3.5%	4.01%		
Turnover	<10%	10.72%		
Reviews	Grievance/Banding reviews		4	
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		92.00%	

5.1 Sickness Absence Rate

a) Current Position

4.01% against a threshold of <3.5%.

b) Recommended Action

Short term Sickness absence has increased due to various winter ailments affecting staff in significant numbers. HR staff are also reminding managers of the “Care First” programme, which can assist staff in many ways. A recent review has shown a 256% increase in its usage.

5.2 Turnover

a) Current Position

10.72% against a threshold of <10%.

b) Recommended Action

Turnover continues to be above 10%, by 0.72%. Upon investigation there is no particular trend behind this figure, although the Trust has concluded a number of long term sickness and performance cases recently.

6. RECOMMENDATION

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

Appendix A – Community Data

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

- Our patient experience survey continues to be very positive with an overall FFT for February of 99%, from 386 responses. We had 2 "Unlikely to recommend" responses in the month.

- We received 5 complaints in the month, 1 each for Children's Services, Admission Prevention Service, Community Health Teams, Continence service and Chronic Obstructive Pulmonary Disease.

- Delayed Transfers of Care in February had a decrease in numbers from 67 patients in January to 52 in February, this relates to 619 bed days in February being identified as delayed transfers of care compared to 914 in January. Glastonbury Court has the highest number of Delayed Transfer of Care at 18 patients for February. Overall the % of Delayed Transfer of Care is 18.62%.

- The Care Co-ordination Centre has continued to achieve its target for SOA in 60 seconds, achieving 95.84% for February.

- There has been a reduction in the number of breaches of the 18 week RTT targets in consultant paediatric service, 5 patients treated over 18 week in February out of 78 clock stops (93.51%). All 5 breaches were in the East (5 out of 50 clock stops) .

- The Community Equipment Service achieved all their KPI's in February. This is the second month running that all targets have been met.

- The Children in Care performance has improved slightly in February up to 86.67% when compared to the January performance which was 71.43%.

- Overall there has been a further increase in the number of pressure ulcers and re-admissions back to the acute units from our community beds. Readmission rate for February was 25.22%, the service leads for the inpatient units are completing a deep dive into causes. The number of falls for the inpatient units has reduced in February when compared to January.

- There has been an increase in number of Datix notifications related to staffing/capacity challenges within Community Health teams. Norfolk Community colleagues are aware and monitoring.

c									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**Feb 2017**	**February Comments / Queries 2017**	**Dec 2016**	**Jan 2017**
SCH		**D4-qoc1**	Number and % of service users who rated the service as 'good' or 'better'.	85%	Quarterly report from Provider		Quarterly Report	97.00%	
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'better'.	85%	Quarterly report from Provider		Quarterly Report	94.18%	
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'well informed'.	85%	Quarterly report from Provider		Quarterly Report	92.87%	
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	100.00%		99.92%	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	96.57%		92.94%	93.89%
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	92.57%	An IT upgrade at e-learning for health has resulted in difficulties in accessing the module.	94.10%	94.62%
SCH	Canc by Prov	**c-gen7**	% of clinics cancelled by the Provider Q3 2012-13 establish baseline. Where benchmarking of community services shows a DNA rate worse then the best quartile. Q4 2012-13 agree an appropriate reduction on baseline. Pcanc-01 ONLY - Q1 2013/14 establish baseline. Where benchmarking of community services shows a DNA rate worse than the best quartile: Q2 reduction of 2.5% on baseline, Q4 reduction of 10% on baseline		Quarterly report from Provider		Quarterly Report	0.12%	
SCH	Safeguarding - children	**c-safe1**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	95.86%		97.12%	97.04%
SCH	Safeguarding - adults	**c-safe2**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	95.59%		96.94%	97.04%
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%		98.00%	100.00%
InPt		**D3-str3**	% of patients requiring a joint community rehabilitation Care Plan have one in place ahead of discharge from acute hospital.	75%	Monthly report from Provider	100.00%		100.00%	100.00%
InPt		**D3-str4**	% of appropriate stroke survivors whose community rehabilitation treatment programme started within 7 days of leaving acute hospital, or ESD, where agreed as part of the care plan (SSNAP). The definition of 'Appropriate Patients' is - all patients requiring continued therapy input.	75%	Monthly report from Provider	100.00%		100.00%	100.00%
InPt	MRSA	**c-inf1**	Number of cases	No cases	Monthly report from Provider	0		0	0
InPt	MRSA	**c-inf2**	Completed RCAs on all community cases of MRSA	100%	Monthly report from Provider	N/A		N/A	N/A
InPt	C-Diff	**c-inf4**	Completed RCAs on all community hospital outbreaks of C difficile	100%	Monthly report from Provider	N/A		N/A	N/A
InPt	Comm Hosp	**s-ip7**	Number of inpatient falls resulting in moderate or significant harm	No more than 1.25 per month (15 per annum) falls/1000bed days	Monthly report from Provider	N/A		0.58	0.55
IHT	IDPT	**s-disch4**	Transfer from acute hospital to community based provision from receipt of referral within a timescale not exceeding 48 hours providing the Service User is medically and physically fit for discharge	80% of Service Users medically and physically fit for discharge	Monthly report from provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
InPt	Step Up Adm Prevention Comm Beds	**s-apcb1**	The community beds will be available for access across the 24 hour 7 days a week	100%	Monthly report from provider	100.00%		100.00%	100.00%
InPt	Step Up Adm Prevention Comm Beds	**s-apcb6**	All Service Users will have a management plan agreed with them and their family/carer where applicable within 24 hours from arrival.	98%	Monthly report from provider	95.83%	This relates to 1 patient out of 24 step-up admissions. The management plan was completed within 28 hours of admission.	100.00%	100.00%

c									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**Feb 2017**	**February Comments / Queries 2017**	**Dec 2016**	**Jan 2017**
IHT		**D2-ltc4**	% of people with COPD who accept a referral to a pulmonary rehabilitation programme who complete the prescribed course and are discharged within 18 weeks of initial referral by a GP/health professional.	95%	Monthly report from Provider	88.89%	This relates to 2 out of 18 patients, both completed within 21 weeks after patient choice has been accounted for.	97.92%	N/A
IHT	CCC	**D4-int1**	Care coordination centre - % of telephone calls answered within 60 seconds	95% in 60secs	Monthly report from Provider	95.84%	# of calls handled: 15,637 # of calls answered in 0-60 seconds: 14,986 **% 0-60 seconds: 95.84%** Number of abandoned calls: 357 Abandoned calls %: 2.23%	93.75%	96.00%
IHT		**D4-ccc6**	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed.	85%	Monthly questionnaires for the first Quarter of operation and quarterly thereafter		Quarterly Report	95.12%	
IHT	Card Rehab	**s-card5**	Number of service users successfully discharged from phase 3.	600 per annum: (trajectory of 50 Service Users in total per month)	Monthly report from Provider	no longer reporting as of July 16		no longer reporting as of July 16	no longer reporting as of July 16
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses offered	At least 500 courses offered per year	Monthly report from Provider	67 offered	Over 500 courses have been offered in 16/17	39 offered	65 offered
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses completed	At least 250 courses completed per year	Monthly report from Provider	18 completed	Over 250 courses have been completed in 16/17	48 completed	0 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%	N/A
IHT	Comm Continence	**s-cc3**	% of Service Users re-assessed at 6 weeks	98%	Monthly report from Provider	no longer reporting as of November 16		no longer reporting as of November 16	no longer reporting as of November 16
IHT	Comm Continence	**s-cc4**	% of Service Users re-assessed at 12 monthly intervals (previously 6 monthly intervals)	98%	Monthly report from Provider	99.62%		100.00%	100.00%
IHT	H Failure	**s-hf4**	% of Service Users seen within 14 days of receipt of referral	85% within 14 days referral	Monthly report from Provider	no longer reporting as of July 16		no longer reporting as of July 16	no longer reporting as of July 16
IHT	MIU	**s-miu3**	Timeliness Indicators: 1) Total time spent in A& E department 2) Time to initial assessment (95th percentile) 3) Time to treatment in department (median) 1) 95% of Service Users waiting less than 4 hours 2) 95th percentile time to assessment above 15 minutes 3) median time to treatment above 60 minutes		Monthly Secondary Uses Services (SUS) data, A&E Commissioning data set (CDS)	#1 = 100%		#1 = 100%	#1 = 100%
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who rated the service as "good" or better	85%	Quarterly report from provider		Quarterly Report	98.72%	
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "supported".	85%	Quarterly report from provider		Quarterly Report	100.00%	
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "well informed".	85%	Quarterly report from provider		Quarterly Report	97.56%	
IHT	MIU	**s-miu5**	Total time spent in A+E department 95% of Service Users waiting less than 4 hours for admitted Service Users	95%	Monthly	100.00%		100.00%	100.00%
IHT	IDPT	**s-disch1**	Triage and assessment of referrals within 1 Operational Day	98%	Monthly report from Provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI	Service no longer supports this KPI
IHT	IDPT	**s-disch2**	Urgent discharge achieved (<24 hours from referral to the team) for Service Users terminally ill and wishing to die at home	85%	Monthly report from Provider	N/A	3 referrals to the service - All 3 patients were excluded from the figures for the following reasons: - A/w fast track paperwork Patient not medically stable and discharge destination not agreed - A/w family to clear room and a/w care package	0.00%	50.00%
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	100.00% (194/194)		96.95% (191/197)	98.82% (168/170)
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	99.24% (783/789)		99.74% (754/756)	99.42% (861/866)
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	99.28% (2060/2075)		99.74% (1939/1944)	99.48% (2090/2101)
Mede	CES	**c-gen8**	Within 10 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider	98.68% (524/531)		99.81% (526/527)	99.82% (549/550)
Mede	CES	**c-gen9**	Collection times: % of urgent next day collections for deceased Service Users	98% for all standards	Monthly report from Provider	98.64% (217/220)		99.53% (213/214)	98.38% (182/185)
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	99.37% (471/474)		99.16% (354/357)	98.47% (580/589)
Mede	CES		% of urgent collections within 5 working days	98.00%	Monthly report from Provider				
Mede	CES	**c-gen9**	% of collections within 10 working days	98.00%	Monthly report from Provider	98.32% (4850/4933)		99.38% (4456/4484)	99.05% (4884/4931)
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%	c
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	100.00%		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%	90.00%
NCHC		**D2-ltc2-a**	% of people that have been identified by case finding, (using risk stratification, or other means), and deemed suitable for intervention by the MDT, and referred to SCH, that have a care lead.	95%	Monthly report from Provider	100.00%		100.00%	100.00%
NCHC		**D2-ltc2-b**	% of people identified via case finding, that have a care plan (including self-care) that has been shared with the GP practice within two weeks of the patient coming onto the caseload. The GP practice will require a copy of the care plan, and the information will be shared with the MDT, which includes a GP. For clarity, the definition of an MDT is; 'A virtual or real team of health and care practitioners, who could be, or are involved in patient's care. An MDT does not	95%	Monthly report from Provider	100.00%		100.00%	100.00%
NCHC		**D5-ccc7**	% of referrals seen following triage; Emergency - 2 hrs	Emergency - 100%	Monthly report from Provider	100.00%		100.00%	100.00%
NCHC		**D5-ccc7**	Urgent 4 hrs	Urgent - 95%	Monthly report from Provider	99.46%		97.36%	98.76%
NCHC		**D5-ccc7**	Intermediate - 72 hrs	Intermediate - 95%	Monthly report from Provider	97.87%		98.81%	97.36%
NCHC		**D5-ccc7**	18 weeks	18 weeks - 95%	Monthly report from Provider	99.10%		98.88%	99.28%
NCHC		**D4-int1**	Community Health Team Leads and/or Local Area Managers to work with GP practices and establish direct working relationships that aid mutual understanding and aim to improve the quality of services to patients. A schedule of face to face meetings is to be agreed and adhered to by both parties and a joint action plan is to be produced that shall be regularly reviewed.	80%	Quarterly report from Provider		Quarterly Report		
NCHC	PHP	**c-php1**	Number of Service Users with the following Long term conditions with a Personal Health plan (Parkinson's Disease, Multiple sclerosis, Muscular Dystrophy, Chronic Obstructive Pulmonary Disease, all other chronic respiratory diseases, Coronary Heart Disease, Heart Failure).	80% completed	Monthly	100.00%		96.00%	100.00%
NCHC	EAU CIS	**eau-cis-IHT**	% of patients seen within 2 hrs. of initial referral. The Senior Nurse (part of the CIS) allocated to the EAU at IHT will begin patient assessment within 2 hrs of consultant referral.	98%	monthly report from provider	N/A		N/A	N/A
WSH	Adult SALT	**s-salt1**	All new referrals are triaged within 5 Operating Days of receipt of referral;	98%	Monthly report from Provider	100.00%		98.80%	95.65%
WSH	Adult SALT	**s-salt2**	Service Users seen within the following timescales after triage:	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	99.00%		99.00%	98.81%
WSH	Adult SALT	**s-salt2**	Priority 3 within 18 weeks	Priority 3 - 95%	Monthly report from Provider	100.00%		100.00%	100.00%
WSH	Medical Appliances	**s-ma1**	% of appointments available within 6 weeks	95%	Monthly report from provider	100.00%		100.00%	100.00%
WSH	Medical Appliances	**s-ma2**	% of urgent cases seen within one working day	100%	Monthly report from provider	No Urgent referrals received		No Urgent referrals received	No Urgent referrals received
WSH	Parkinson's Disease	**s-pd2**	% service users on caseload who have an annual specialist review	95%	Monthly report from provider	100.00%		100.00%	100.00%

Children's Services KPIs									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of Measurement**	**Feb 2017**	**Feb Comments / Queries 2017**	**Dec 2016**	**Jan 2017**
WSH	All Paediatric Services	**GP-1**	18 week RTT for Consultant led services	95% of consultant led Service Users to be treated within 18 weeks	Monthly RTT reporting	93.51%	There were 5 breaches (all in the East)out of 78 clock stops (50 in East and 28 in West)	80.00%	86.59%
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	100.00%		100.00%	99.55%
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 report		
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 report		
WSH	All Paediatric Services	**GP-6**	Safeguarding - % eligible staff who have completed level 1 training	98%	monthly report by provider	99.53%		99.04%	100.00%
WSH	All Paediatric Services	**GP-9** **PDL-01**	Discharge Letters - to be sent within 24 hours of discharge from a community hospital and 72 hours of discharge from all other caseloads (all discharge letters whether electronic/non electronic to clearly state date dictated, date signed and date sent)	95%	Monthly	100.00%		100.00%	100.00%
WSH	All Paed Services	**PaedSLT-5**	Personalised Care Planning - Percentage of Transition (to adults) Care Plans completed	Q3 2012/13 establish baseline	Annual - Systmone		Annual Report		
WSH	Newborn Hearing Screening Service	**NBHS-2**	Timely screening – where consented screens to be completed by four weeks of age	95%	Monthly Activity Report	98.37%		99.62%	98.40%
WSH	Newborn Hearing Screening Service	**NBHS-3**	Screening outcomes set within 3 months	≥99%	Monthly Activity Report	99.16%		99.65%	98.56%
WSH	Community Children's Nursing	**CCN-14** **cps-ip02**	% of children identified as having high level needs being actively case managed.	Q3 2012/13 establish baseline Q4 2012/13 onwards >75%	Systmone	100.00%		100.00%	100.00%
WSH	Leapfrog Therapeutic Service	**Leap-8**	Outcomes achieved for children utilising the services	Annual report produced	Annual report		Annual report		
WSH	Therapy Focus Suffolk	**TFS-6**	All relevant staff that have been 'Bobath' update trained	100%	Annual report		Annual report		
WSH	Single Point of Access	**PSPOA-03**	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed	85%	Monthly		Quarterly report		
WSH	Single Point of Access	**PSPOA-04**	% of service users who were satisfied with the length of time waiting for assessment	85%	Quarterly report from Provider		Quarterly report		
WSH	Single Point of Access	**PSPOA-05**	% of referrers who were satisfied with the length of time waiting for assessment	85%	Quarterly report from Provider		Quarterly report		
WSH	Access	**cps-a02**	Children/young people in special schools receive speech and language interventions	100%	Systmone	100.00% 167 contacts		100.00% 273 contacts	100.00% 241 contacts
WSH	Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	Systmone	100.00% 141 contacts		100.00% 193 contacts	100.00% 221 contacts
WSH	Children in Care	**CiC-001a**	The Provider will aim to achieve 100% compliance with the guidance to ensure that all CiC will have a Specific, Measurable, Achievable, Realistic and Time-scaled (SMART) health care plan completed within 28 days of a child becoming looked after. All initial health assessments and SMART care plans are shared with appropriate parties.	100% in 28 days	Monthly report from Provider	6.67%	1 out of 15 IHAs were witihin 28days of the child being put in care. There was one child put in care in June 2016 and the service only notified about them in January 2017.	14.29%	0.00%
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	86.67%	13 out of 15 IHAs were completed within 28 days of the service being notified about the	85.71%	71.43%
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	93.33%	14 out of 15 children were offered an appt within 28 days of the service being notified.	100.00%	92.86%

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

a) Current Position

Currently 92.57% against 95% target.

An IT upgrade at e-learning for health has resulted in difficulties for staff in accessing the module on laptops.

b) Recommended Action

- The issue has been escalated to the IT team
- Clinical staff have been informed to request an upgrade to their laptops.

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2 Step Up Admission Prevention Beds - s-apcb6 – Service users have a management plan agreed within them and their family/carer where applicable within 24hours from arrival.

a) Current Position

95.83% against 98% target.

24 step-up admissions in the month. 23 were agreed within 24 hours and 1 management plan was agreed within 28hours of arrival.

b) Recommended Action

- The community hospital matron has reminded staff of the importance of completing care planning within 24 hours.

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3 D2-ltc4 – % of people with COPD who accept a referral to the pulmonary rehabilitation programme who complete the prescribed course and are discharged within 18 weeks of initial therapy by a GP/health professional

a) Current Position

88.89% against a target of 95%

This relates to 2 patients out of 18. Both patients completed within 21 weeks. 1 of the patients had to have a pause in their pathway due to being unwell.

b) Recommended Action

- To ensure service provision provides adequate capacity to ensure all patients can complete within 18 weeks.

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4 18 week referral to treatment for Consultant led services – Paediatrics (E&W)

a) Current Position

93.51% against a 95% target

5 breaches (all in East) out of 78 patients (50 East and 28 West).

The 0.6 and 0.4wte vacancies in the East and West of the county respectively are now being covered by an agency locum who commenced on 1st March. This locum will target referrals across the county primarily in Stowmarket and mainly the school aged autism pathway, the service will monitor impact of this.

b) Recommended Action

- The service lead has completed a service review looking at capacity and demand. A paper has been produced outlining the options.

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

a) Current Position

CiC-001a – 6.67% against a 100% target

CiC-001b – 86.67% against a 100% target

CiC -001c – 93.33% against a 100% target

15 Initial Health Assessments were completed in February. 1 was completed within 28 days of becoming CiC, 13 were completed within 28 days of the service receiving ALL the paperwork and 14 appointments were offered within 28days. The 15th appointment was offered and accepted within 36 days.

b) Recommended Action

- Regular meetings are in place with the Head of Safeguarding in Suffolk County Council to agree shared action plans to improve the quality and compliance with the pathway.
- The service has secured the use of a retired GP who will work for 2 sessions a month (4 appointments/ month).
- Following the escalation of delays in notification of children in care with complete paperwork a meeting is being arranged to undertake a deep dive of 20 cases.
- An update paper has been shared with the Corporate Parenting Board.
- The specialist nurse for Children in Care is delivering training to foster carers regarding the importance of health assessments.
- Review with the CCG and designated Nurse the time allocated for each assessment and paperwork.
- The review of children who are placed in Suffolk from out of area, who need access to mental health services which is currently un-commissioned, has been escalated to the CCG and a response is awaited.

	Units	Target	Red	Amber	Green	Sep	Oct	Nov	Dec	Jan	Feb
Patient Experience											
Service users who rated the service as 'good' or 'better' (Quarterly)	Nos.	No Target				1557					
	%	85%	<80%	80%-85%	>=85%	98.23%					
Service users who responded that they felt 'better'	Nos.	No Target				106	159	179	115	141	158
	%	85%	<80%	80%-85%	>=85%	98%	94%	94%	94%	96%	96%
Service users who felt 'well informed'	Nos.	No Target				133	187	190	144	182	200
	%	85%	<80%	80%-85%	>=85%	94%	93%	90%	96%	96%	91%
10% of long term condition patients feel "better supported" to self manage their conditions (Quarterly)	Nos.	No Target				119					
	%	No Target				100%					
Falls (Inpatient Units)											
Total numbers of inpatient falls (includes rolls and slips)	Nos.	No Target				47	26	59	60	51	33
Rolls out of Bed		No Target				1	1	1	5	2	5
Slip out of chair		No Target				2	0	3	3	8	3
Assisted Falls/ near misses		No Target				5	4	0	1	0	3
% of total falls resulting in harm	%	No Target				19%	15%	29%	22%	31%	24%
Numbers of falls resulting in moderate harm	Nos.	No Target				1	0	0	0	0	0
Numbers of falls resulting in severe harm	Nos.	No Target				0	0	0	2	2	0
Numbers of patients who have had repeat falls	Nos.	No Target				8	6	10	13	11	7
% of RCA reports for repeat fallers	%	100%	90%-95%	95%-100%	=100%	100%	100%	100%	100%	100%	100%
Numbers of falls per 1000 bed days (* includes Hazel Crt falls)		<1.25/1000 beddays	>1.50	1.25-1.50	<=1.25	13.3	7.6	17.3	17.4	13.9	10.5*
Pressure Ulcers											
Pressure Ulcers – In Our Care Community											
Grade 2		100 pa	>110	100-110	<=100	13	18	13	23	26	29
Grade 3		26 pa	>30	27-29	<=26	5	10	10	6	8	11
Grade 4		0 pa	>1	1	0	0	0	0	1	2	1
Pressure Ulcers – In our care In-patient											
Grade 2		13 pa	>17	13-17	<=13	2	2	4	5	2	3
Grade 3		2 pa	>4	02-Apr	<=2	0	1	2	0	1	1
Grade 4		0 pa	>1	1	0	0	0	0	1	0	0
Safeguarding People Who Use Our Services From Abuse											
Number of adult safeguarding referrals made		No Target				1	5	3	5	4	2
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				100%	100%	100%	100%	100%	100%

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

Incidents											
NRLS (i.e. patient safety) reportable incidents in month		No Target				165	160	191	178	209	206
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				0	11	12	9	13	13
Number of SIs reported to CCG in month		No Target				0	11	10	9	13	17
Percentage of SI reports submitted to CCG on time in month		No Target				N/A	0%	100%	100%	100%	100%
Duty of Candour Applicable Incidents		No Target				7	11	9	10	13	13

Severity of NPSA Reportable Incidents											
None		No Target				115	117	125	119	139	110
Low		No Target				43	32	54	50	64	84
Moderate		No Target				7	11	12	6	9	11
Major		No Target				0	0	0	3	4	1
Catastrophic		No Target				0	0	0	0	0	0

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

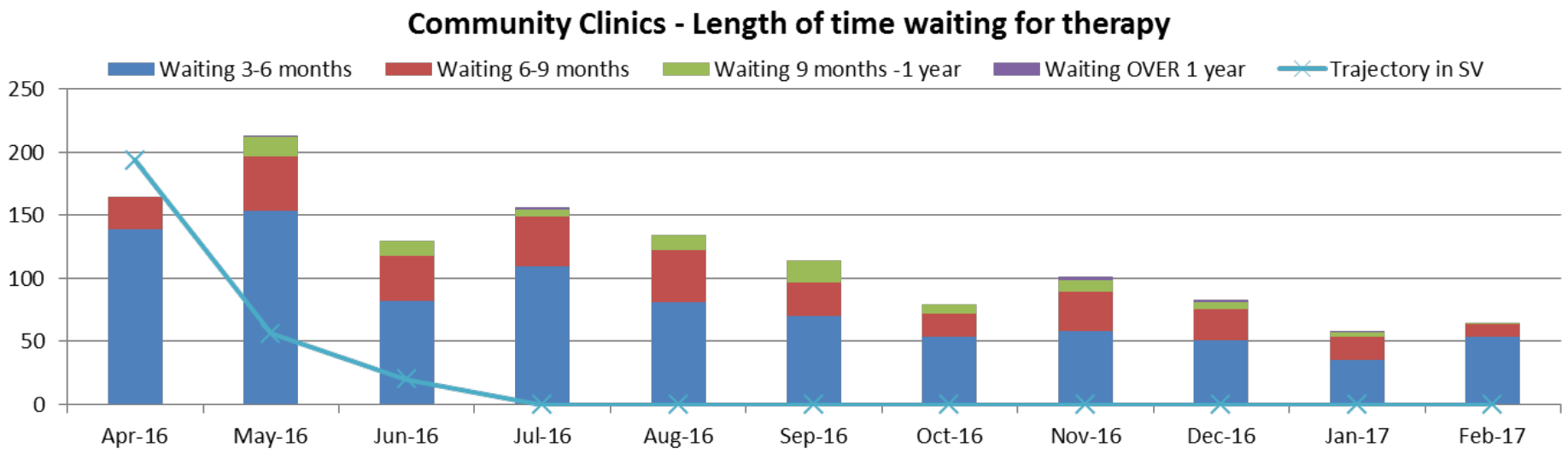
Compliments/Complaints

	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Total Compliments	47	52	21	33	19	46	21	38	28	36	27	61	50
Total SCH Complaints	4	3	4	2	6	7	5	1	1	2	2	4	5
Acknowledged within 3 days	100%	100%	60%	100%	50%	83%	100%	100%	50%	50%	100%	100%	100%
% of Responses within 25 days	50%	66%	25%	50%	33%	71%	TBC	0%	100%	50%	50%	100%	
Responded to within 25 days	2	2	1	1	2	5	TBC	0	1	1	2	4	
Responded to after 25 days	2	1	3	1	4	2	TBC	1	0	1	0	0	
Average response time (days)	23	29	31	33	30	24	TBC	31	19	TBC	TBC	TBC	

Paediatric Speech and Language Service Waiting times

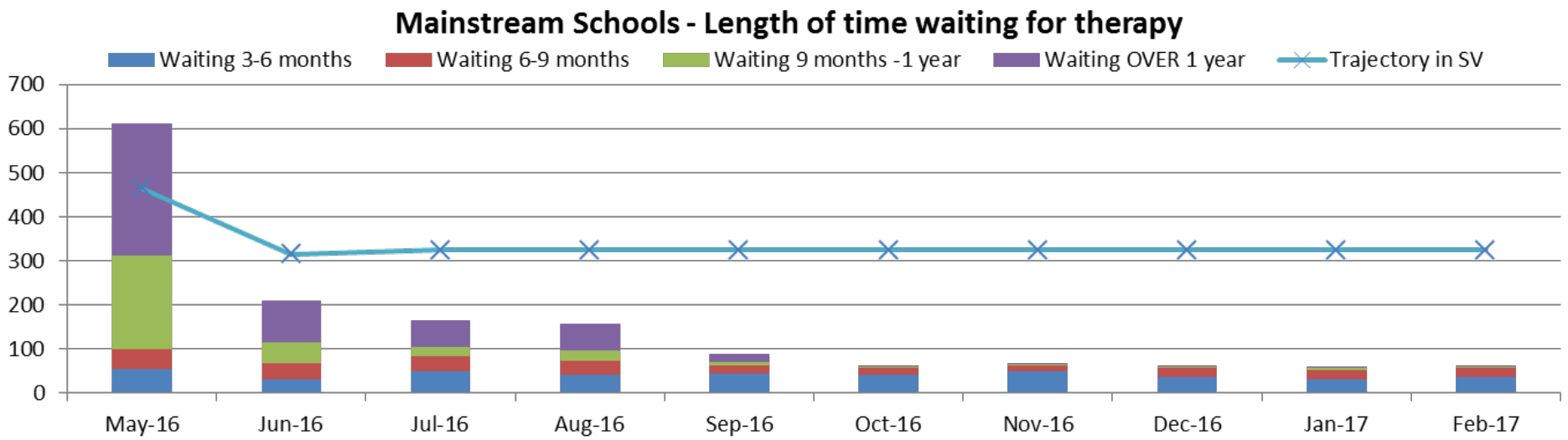
Community Clinic

Clinic Waiting lists												
Reports run 06/03/2017		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Length of wait Community Clinics *(pre-school caseload)*	**No. of children waiting July 2015**	**No. of children waiting April 2016**	**No. of children waiting May 2016**	**No. of children waiting June 2016**	**No. of children waiting July 2016**	**No. of children waiting August 2016**	**No. of children waiting September 2016**	**No. of children waiting October 2016**	**No. of children waiting November 2016**	**No. of children waiting December 2016**	**No. of children waiting January 2017**	**No. of children waiting February 2017**
Waiting up to 3 months	139	206	135	191	167	150	156	151	176	158	176	165
Waiting 3-6 months	139	139	154	82	110	81	70	54	58	51	35	54
Waiting 6-9 months	151	26	43	36	39	41	27	18	31	25	19	10
Waiting 9 months -1 year	106	0	15	12	6	12	17	7	10	5	3	1
Waiting OVER 1 year	0	0	1	0	1	0	0	0	2	2	1	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**535**	**371**	**348**	**321**	**323**	**284**	**270**	**230**	**277**	**241**	**234**	**230**
Already had PoC		78	70	66	119	97	72	75	67	72	55	60
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*		**449**	**418**	**387**	**442**	**381**	**342**	**305**	**344**	**313**	**289**	**290**



Mainstream Schools

Schools Waiting lists												
No waiting data by months prior to May												
Length of wait Mainstream Schools *(pre-school caseload)*	**No. of children waiting July 2015**	**No. of children waiting April 2016**	**No. of children waiting May 2016**	**No. of children waiting June 2016**	**No. of children waiting July 2016**	**No. of children waiting August 2016**	**No. of children waiting September 2016**	**No. of children waiting October 2016**	**No. of children waiting November 2016**	**No. of children waiting December 2016**	**No. of children waiting January 2017**	**No. of children waiting February 2017**
Waiting up to 3 months			142	126	117	119	88	72	68	59	56	56
Waiting 3-6 months			54	32	50	41	44	42	51	36	31	36
Waiting 6-9 months			46	36	33	33	18	16	13	22	22	21
Waiting 9 months -1 year			212	48	23	23	10	3	2	2	4	4
Waiting OVER 1 year			298	95	60	61	17	3	2	2	2	1
Caseload waiting for therapy *(Excluding patients who already had a package of care)*			**752**	**337**	**283**	**277**	**177**	**136**	**136**	**121**	**115**	**118**
Already had PoC			*unavailable*	264	356	396	395	377	392	332	277	266
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*			**752**	**601**	**639**	**673**	**572**	**513**	**528**	**453**	**392**	**384**


Mainstream Schools - Length of time waiting for therapy
Waiting 3-6 months
Waiting 6-9 months
Waiting 9 months -1 year
Waiting OVER 1 year
Trajectory in SV
700
600
500
400
300
200
100
0
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17

Appendix B – Provider Management Group Report

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

1. Contract Performance KPI Summary:

January Performance highlights were presented to PMG as follows:

- 3 complaints received for January – 1 for Paediatrics, 2 for Community Hospitals.
- A further rise in the number of DTOC – 67 patients in January in total across the community beds.
- Further improvement noted re: waiting times for Paediatric SaLT.
- The Remedial Action Plan has been closed for the Care Co-ordination Centre and formal notification of this has been received.
- 11 Breaches noted for Paediatric 18-week RTT.
- Medequip community equipment service – all KPIs achieved for January, against a backdrop of increased activity.
- An increased number of pressure ulcers and falls have been recorded. Work is underway to triangulate the data as readmission rates back to acute hospitals is running at 20%. The quality sub-group is investigating these issues. A paper on the findings will be presented to April PMG
- The FFT score for January was 97% from a total of 389 responses.

2. Provider updates

West Suffolk Foundation Trust

The adult Speech and Language Service pilot started on 1/3/17 – this involves relaxing of the criteria for provision of services for adults which has not previously covered dementia patients or those with a non-acquired condition. The pilot will run for 3 months and will then be reviewed.

Ipswich Hospital Trust

Care Co-ordination Centre Speed of Answer performance for February was 96%, with call abandon at 2%. There are two vacancies to recruit to. The previous recruitment challenges have eased with 7 vacancies appointed to.
Paediatric services referrals are scheduled to migrate into the Care Co-ordination Centre on 3/4/17.

NCH&C

A Therapy workshop to review therapy input into the community hospitals is taking place on 15/3/17, feedback will be given to PMG at April meeting.

Medequip

All performance targets have been met for January 2017.

Finance: for the 4th time in the contract history have exceeded £1million worth of equipment delivered, however, this 4th lowest net cost due to collections made.

PMG received an update on the Single site solution – one property had been identified, but this has since gone under offer within 2 weeks. A new-build option was available, but would not be complete until October. Two search agents are looking for properties at the moment.

The equipment amnesty campaign has been launched with local media to improve the number of items returned.

3. Risk Report

PMG received a summary of the risk report in its new format.
The high level identified risks are as follows:

1. High demand for Paediatric SaLT
2. Children in Care health assessments – this will be escalated via Executive Chief Nurse to the County Council
3. Estates and landlord not fulfilling responsibilities, significant risks remain, particularly water safety and fire compartmentation.

It was suggested and agreed by PMG that a new risk of "continuation of service during the period of transition" should be added to the register.

4. Cost Improvement /Service Improvement Plan update

- A new way of measuring savings has been produced and a productivity ratio has been included in this month's report.
- Finance teams to go through each project and measure what savings are achievable in order to come up with a joint full system approach to measure benefits.
- The community services transformation and integration projects were discussed and the differences/links between individual plans and consortium/system wide plans clarified.
- It was agreed to explore a project related to the Minor Injuries Unit as Felixstowe.

5. Paediatric updates

PMG received three papers from the Service Lead who attended to present and discuss:

- 'Did not Attend rates'
- Children in Care performance
- Paediatric Speech and Language Service demand and Capacity

PMG were assured of the improving 'Did not Attend Rates' following actions taken by the service. There is also now an agreed escalation process for foster carers.
The Children in Care improvements in service capacity and steps being taken to improve further were noted.
PMG supported the continued funding for 1 month of the locum therapist pending the service review of Speech and Language Therapy to mitigate against a deterioration of performance.

							Surgery												
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	F9	F10	G1
Patient Experience: in-patient	QR-PEI-10	Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	89	98	97	97	NA	NA	NA	NA	NA	97	83	98	97
	QR-PEI-180	(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	91.18	98.39	98.68	100	NA	NA	NA	NA	NA	100	100	100	100
	QR-PEI-20	In your opinion, how clean was the hospital room or ward that you are in?	= 85%	<75	75-84	85-100	99	99	99	100	NA	NA	NA	NA	NA	100	97	99	100
	QR-PEI-340	Did you feel you were treated with respect and dignity by staff?	= 85%	<75	75-84	85-100	96	100	100	100	NA	NA	NA	NA	NA	100	90	100	100
	QR-PEI-330	Were Staff caring and compassionate in their approach?	= 85%	<75	75-84	85-100	94	100	100	100	NA	NA	NA	NA	NA	100	88	100	100
	QR-PEI-30	Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	47	100	80	79	NA	NA	NA	NA	NA	76	38	79	81
	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	93	100	99	100	NA	NA	NA	NA	NA	100	81	100	95
	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	94	100	100	100	NA	NA	NA	NA	NA	100	89	100	100
	QR-PEI-90	Were you given enough privacy when discussing your care?	= 85%	<75	75-84	85-100	91	100	100	100	NA	NA	NA	NA	NA	98	100	100	100
	QR-PEI-350	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	97	100	100	100	NA	NA	NA	NA	NA	100	100	100	100
	QR-PEI-100	(In-patient) Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	100	100	100	100	NA	NA	NA	NA	NA	100	95	100	100
	QR-PEI-150	Timely call bell response	= 85%	<75	75-84	85-100	83	83	97	97	NA	NA	NA	NA	NA	97	53	100	95
	QR-PEI-290	Same sex accommodation: total patients	= 0	>2	1-2	= 0	0	0	0	0	2	0	0	0	0	0	0	0	0
	QR-PEI-300	Complaints	= 0	>2	1-2	= 0	0	0	1	1	0	0	0	0	2	0	0	0	0
	QR-PEI-310	Environment and Cleanliness	= 90%	<80	80-89	90-100	80	93	86	90	No Data	93	92	92	86	91	89	89	90

							Surgery		Medicine	
Group		Indicator	Target	Red	Amber	Green	F4	DSU	F7	F8
Patient Experience: short-stay	QR-PES-10	Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	100	100	0	0
	QR-PES-60	(Short-stay) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	100	0	0
	QR-PES-20	(Short-stay) Were you given enough privacy when being examined and treated?	= 85%	<75	75-84	85-100	100	100	0	0
	QR-PES-30	(Short-stay) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	100	100	0	0
	QR-PES-40	Were you told who to contact if you were worried after leaving hospital?	= 85%	<75	75-84	85-100	100	100	0	0
	QR-PES-50	(Short-stay) Overall how would you rate the care you received in the department?	= 85%	<75	75-84	85-100	99	99	0	0
	QR-PES-70	Number of short stay surveys completed	No Target	No Target	No Target	No Target	110	48	0	0

							Medicine
Group		Indicator	Target	Red	Amber	Green	ED
Patient Experience: A&E	QR-PEA-10	Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	93
	QR-PEA-100	(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	95.89
	QR-PEA-30	Were A&E staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	98
	QR-PEA-110	Were you given enough privacy when discussing your condition at reception?	= 85%	<75	75-84	85-100	92
	QR-PEA-120	Did Doctors and Nurses listen to what you had to say?	= 85%	<75	75-84	85-100	97
	QR-PEA-130	Did staff tell you who to contact if you were worried about your condition after leaving A&E?	= 85%	<75	75-84	85-100	90
	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	88
	QR-PEA-140	Number of A&E surveys completed	No Target	No Target	No Target	No Target	435

							Surgery	Medicine	Women & Children
Group		Indicator	Target	Red	Amber	Green			
Patient Experience: A&E (Children questions)	QR-PEAC-70	Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	Currently no data for this		
	QR-PEAC-80	(A&E Children) How likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100			
	QR-PEAC-30	Did the Doctor or Nurse listen to what you had to say?	= 85%	<75	75-84	85-100			
	QR-PEAC-100	Were staff friendly and kind to you and your family?	= 85%	<75	75-84	85-100			
	QR-PEAC-50	Did we help with your pain?	= 85%	<75	75-84	85-100			
	QR-PEAC-60	Did staff explain the care you need at home?	= 85%	<75	75-84	85-100			
	QR-PEAC-130	Number of A&E children surveys completed	No Target	No Target	No Target	No Target			

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F11
Patient Experience: Maternity	QR-PEM-10	Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	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?	= 90%	<80	70-89	90-100	100
	QR-PEM-130	How likely are you to recommend our labour suite to friends and family if they needed similar care or treatment?	= 75%	<70	70-74	75-100	NA
	QR-PEM-135	How likely are you to recommend our antenatal department to friends and family?	= 75%	<70	70-74	75-100	100
	QR-PEM-140	How likely are you to recommend our post-natal care to friends and family?	= 75%	<70	70-74	75-100	100
	QR-PEM-30	(Maternity) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	100
	QR-PEM-40	(Maternity) Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<75	75-84	85-100	100
	QR-PEM-50	Were you involved as much as you wanted to be in decisions about your care and treatment?	= 85%	<75	75-84	85-100	90
	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	78
	QR-PEM-80	Were you given adequate help and support to feed your baby whilst in hospital?	= 85%	<75	75-84	85-100	100
	QR-PEM-90	How many minutes after you used the call button did it usually take before you got the help you needed?	= 85%	<75	75-84	85-100	100
	QR-PEM-100	Has a member of staff told you about medication side effects to watch for when you go home?	= 85%	<75	75-84	85-100	100
	QR-PEM-110	Have hospital staff told you who to contact if you are worried about your condition after you leave hospital?	= 85%	<75	75-84	85-100	100
	QR-PEM-20	In your opinion, how clean was the hospital room or ward that you were in?	= 85%	<75	75-84	85-100	97
	QR-PEM-125	Number of maternity surveys completed	No Target	No Target	No Target	No Target	120

							Women & Children
Group		Indicator	Target	Red	Amber	Green	MLBU
Patient Experience: Birthing Unit	QR-PEBU-10	How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100
	QR-PEBU-20	Did you feel that your community midwife gave you sufficient information about the birthing unit prior to you being referred?	= 85%	<75	75-84	85-100	95
	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	100
	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	100
	QR-PEBU-60	Did you have confidence and trust in the midwives caring for you during labour?	= 85%	<75	75-84	85-100	100
	QR-PEBU-70	Were your birthing partners made to feel welcome by the midwives on the birthing unit?	= 85%	<75	75-84	85-100	100
	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	100
	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	100
	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	100
	QR-PEBU-110	Number of birthing unit surveys completed	No Target	No Target	No Target	No Target	11

							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	100
	QR-PEYC-110	(Young children) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100
	QR-PEYC-20	Did you understand the information given to you regarding your treatment and care?	= 85%	<75	75-84	85-100	100
	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	2
	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	99
	QR-PEYC-40	Were you offered age/need appropriate activities?	= 85%	<75	75-84	85-100	100
	QR-PEYC-60	Was your experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	75-84	85-100	100
	QR-PEYC-70	Was your experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	100
	QR-PEYC-150	If you were in pain, did the Doctor or Nurse do everything they could to help with the pain?	= 85%	<75	75-84	85-100	100
	QR-PEYC-160	Were staff kind and caring towards you?	= 85%	<75	75-84	85-100	100
	QR-PEYC-90	Is the environment child - friendly?	= 85%	<75	75-84	85-100	89
	QR-PEYC-100	Overall, how would you rate your experience in the Paediatric Unit?	= 85%	<75	75-84	85-100	100
	QR-PEYC-130	Number of young children surveys completed	No Target	No Target	No Target	No Target	100

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
F1 Parent	QR-PEF1-120	Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	100
	QR-PEF1-110	(F1 Parent) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100
	QR-PEF1-20	Did you understand the information given to you regarding your child's treatment and care?	= 85%	<75	75-84	85-100	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	10
	QR-PEF1-130	Did the Doctor or Nurses explain what they were doing in a way that your child could understand?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-40	Were there appropriate play activities for your child (such as toys, games and books)?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-60	Was your child's experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-70	Was your child's experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-150	If your child was in pain, did the doctor or nurse do everything they could to help with the pain?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-140	Were staff kind and caring towards your child?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-90	Is the environment child-friendly?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-100	Overall, how would you rate your experience in the Children's Unit?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-160	Number of F1 parent surveys completed	No Target	No Target	No Target	No Target	NA

							Medicine
Group		Indicator	Target	Red	Amber	Green	G8
Patient Experience: Stroke	QR-PEST-10	Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	95
	QR-PEST-80	(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100
	QR-PEST-20	Have you been told you have had a stroke, which lead to your admission to hospital?	= 85%	<75	75-84	85-100	100
	QR-PEST-30	Have you been involved in planning your recovery / rehabilitation?	= 85%	<75	75-84	85-100	85
	QR-PEST-40	While you were in the Stroke Department how much information about your condition or treatment was given to you?	= 85%	<75	75-84	85-100	90
	QR-PEST-50	Have you received the help you require while eating?	= 85%	<75	75-84	85-100	100
	QR-PEST-60	Do you feel cared for?	= 85%	<75	75-84	85-100	98
	QR-PEST-70	Were you given enough privacy when being examined or treated or when your care was discussed with you?	= 85%	<75	75-84	85-100	100
	QR-PEST-90	Number of stroke surveys completed	No Target	No Target	No Target	No Target	20

Medicine									Women & Children			
G3	G4	G8	MTU	F12	G5 - Ward (OLD G9)	WEW – G9	F7	F8	F1	F11	F14	MLBU
88	90	NA	NA	94	98	NA	89	88	NA	NA	94	NA
96.43	100	NA	NA	100	100	NA	96.49	92.59	NA	NA	100	NA
92	97	NA	NA	98	100	NA	95	96	NA	NA	95	NA
98	100	NA	NA	96	100	NA	98	100	NA	NA	100	NA
100	100	NA	NA	96	100	NA	96	100	NA	NA	98	NA
61	77	NA	NA	86	87	NA	53	56	NA	NA	81	NA
83	64	NA	NA	92	100	NA	88	75	NA	NA	86	NA
86	81	NA	NA	86	98	NA	96	85	NA	NA	96	NA
88	100	NA	NA	100	100	NA	97	96	NA	NA	96	NA
85	75	NA	NA	100	100	NA	97	89	NA	NA	100	NA
96	100	NA	NA	100	100	NA	NA	96	NA	NA	96	NA
81	78	NA	NA	87	98	NA	73	72	NA	NA	100	NA
0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	2	0	0	0	0	0	0	0
86	88	92	No Data	No Data	80	89	88	91	94	97	91	97

							Surgery								Medicine														Women &
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	F9	F10	G1	G3	G4	G8	MTU	F12	G5 - Ward (OLD G9)	WEW – G9	F7	F8	F1	F11
Patient Safety	QR-PS-10	HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	100	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	50	No Data	100	NA	NA	NA	NA	No Data	100	100	100	100	No Data	No Data	NA	100	No Data	No Data	No Data	NA	NA	NA
	QR-PS-30	HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	No Data	NA	NA	90	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	No Data	100	NA
	QR-PS-40	HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	100	100	100	90	NA	NA	NA	NA	100	100	100	100	80	100	100	NA	100	100	100	NA	NA	100	NA
	QR-PS-50	HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	NA	100	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-60	HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	NA	100	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-90	HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-100	HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	100	NA	NA	100	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA
	QR-PS-110	HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	100	100	100	100	NA	NA	NA	NA	NA	100	100	100	100	100	100	100	NA	100	60	100	NA	NA	NA	NA
	QR-PS-111	HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<80	80-99	= 100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-220	Total no of MRSA bacteraemias: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-250	Hand hygiene compliance	= 95%	<85	85-99	= 100	100	100	100	100	100	NA	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	67
	QR-PS-230	Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	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
	QR-PS-120	No of patient falls	= 48	>=48	No Target	<48	6	3	1	1	0	NA	NA	NA	0	0	5	1	9	0	3	8	0	3	4	5	3	3	NA	0
	QR-PS-130	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	1	1	0	1	0	NA	NA	NA	0	0	0	0	1	0	1	2	0	2	1	2	1	1	NA	0
	QR-PS-140	No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-141	Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-470	No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	3	0	0	1	0	NA	NA	NA	NA	0	1	0	2	0	1	1	0	0	0	1	0	0	NA	0
	QR-PS-480	No of avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-190	Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	20	90	100	100	100	NA	NA	NA	NA	100	100	90	80	100	60	90	NA	100	78	60	No Data	No Data	NA	NA
	QR-PS-260	No of SIRIs	No Target	No Target	No Target	No Target	0	0	1	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0
	QR-PS-500	No of medication errors	No Target	No Target	No Target	No Target	5	0	0	2	1	0	0	0	4	0	1	2	2	2	2	0	0	0	2	0	8	2	0	1
	QR-PS-300	Cardiac arrests	No Target	No Target	No Target	No Target	0	0	0	1	0	0	0	0	0	1	0	0	0	0	2	0	0	1	1	2	0	0	0	0
	QR-PS-490	Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-370	VTE: Completed risk assessment (monthly Unify audit)	> 98%	< 98	No Target	> 98	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	QR-PS-390	Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	95.24	100	100	100	100	No Data	No Data	No Data	No Data	100	96.97	100	100	100	96.88	96.88	No Data	100	96.88	100	100	No Data	No Data	100
Patient Experience: in-patient	QR-PEI-290	Same sex accommodation: total patients	= 0	>2	1-2	= 0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Children	
F14	MLBU
NA	NA
No Data	NA
NA	NA
100	NA
NA	NA
NA	NA
NA	NA
NA	NA
80	NA
NA	NA
0	0
100	100
0	0
0	0
0	NA
0	NA
NA	NA
NA	NA
0	NA
NA	NA
80	NA
0	0
2	1
0	0
0	0
No Data	No Data
83.33	No Data
0	0

West Suffolk NHS
NHS Foundation Trust

Board of Directors - February 2017

AGENDA ITEM:	Item 9
PRESENTED BY:	Craig Black, Executive Director of Resources
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
DATE PREPARED:	24 March 2017
SUBJECT:	February Board report
PURPOSE:	Review and approval

EXECUTIVE SUMMARY:

The February position includes a forecast deficit of £5.0m for 2016-17 which is in line with our control total. The improvement in our forecast since January reflects the Trust achieving the stretch CIP through non-recurring means and therefore receiving the majority of the Sustainability and Transformation funding (£5.5m for 2016-17).

The budget setting process has been outlined previously and budget holders have now signed off their expenditure budgets in order to deliver the 2017-18 contracted activity and performance targets (Appendix 1).

These budgets include a CIP of £13.3m in order to deliver a control total of £11.1m deficit which has been proposed by NHSI. Delivering the control total will ensure the Trust receives Sustainability and Transformation Funding (S&TF) of £5.2m, resulting in a net deficit of £5.9m in 2017-18. This includes a contingency of £2.5m. The Board is asked to approve this budget.

Linked Strategic objective (link to website)	**To provide value for money for the taxpayer and to maintain a financially sound organisation**
Issue previously considered by: (e.g. committees or forums)	
Risk description: (including reference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatory requirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	None
Recommendation: the 2017-18 budget	The Board is asked to review this report and approve

West Suffolk NHS
NHS Foundation Trust

Item 9

FINANCE AND WORKFORCE REPORT

February 2017 (Month 11)

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

Financial Summary

I&E Position YTD	£11.7m	loss
Variance against plan YTD	£7.8m	adverse
Movement in month against plan	£1.0m	adverse
EBITDA position YTD	£4.4m	loss
EBITDA margin YTD	1.93%	loss
Cash at bank	£1,537k	
Use of Resources Rating (UoR)	4	

Executive Summary

- The Month 11 YTD position is behind plan by £7.8m.
- The Use of Resources Rating (UoR) (previously Financial Sustainability Risk Rating), is 4 YTD
- We forecast an annual deficit of £5.0m before accounting for writing off the tPP investment. This forecast relies upon a significant non-recurring benefit

Key Risks

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

SUMMARY INCOME AND EXPENDITURE ACCOUNT - February 2017	Feb-17			Year to date			Year end forecast		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	18.0	18.0	0.0	200.6	200.7	0.1	219.7	219.4	(0.2)
Other Income	2.1	1.9	(0.3)	27.6	24.5	(3.0)	29.0	26.7	(2.3)
Total Income	**20.1**	**19.9**	**(0.2)**	**228.2**	**225.2**	**(3.0)**	**248.7**	**246.1**	**(2.6)**
Pay Costs	11.9	12.0	(0.2)	129.4	130.6	(1.2)	141.3	142.3	(1.1)
Non-pay Costs	8.1	8.2	(0.1)	100.7	101.9	(1.2)	110.6	106.2	4.4
Operating Expenditure	**20.0**	**20.3**	**(0.2)**	**230.1**	**232.5**	**(2.5)**	**251.9**	**248.5**	**3.4**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**0.1**	**(0.3)**	**(0.5)**	**(1.8)**	**(7.3)**	**(5.4)**	**(3.2)**	**(2.4)**	**0.8**
EBITDA margin	0.6%	(1.7%)	(2.3%)	(0.8%)	(3.2%)	(2.4%)	(1.3%)	(1.3%)	0.0%
Depreciation	0.6	0.7	(0.0)	5.6	5.8	(0.2)	6.2	6.4	(0.3)
Finance costs	0.1	0.1	(0.0)	1.5	1.5	0.0	1.7	1.6	0.1
SURPLUS/(DEFICIT) pre S&TF	**(0.6)**	**(1.1)**	**(0.5)**	**(9.0)**	**(14.6)**	**(5.6)**	**(11.1)**	**(10.5)**	**0.6**
Sustainability and Transformation funding	0.5	0.0	(0.5)	5.1	2.9	(2.2)	6.1	5.5	(0.6)
SURPLUS/(DEFICIT) incl S&TF	**(0.1)**	**(1.1)**	**(1.0)**	**(3.9)**	**(11.7)**	**(7.8)**	**(5.0)**	**(5.0)**	**(0.0)**

FINANCE AND WORKFORCE REPORT – February 2017

Contents:

Key:

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

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

Income and Expenditure summary as at February 2017

The reported I&E for February 2017 is a deficit of £1,086k, against a planned deficit of £68k. This results in an adverse variance of £1,019k (£7,825k YTD) which is predominantly due to the stretch CIP and lost Sustainability and Transformation funding.

A significant cause of the deterioration in plan over the last 4 months relates to the underachievement of the stretch CIP, being £650k per month (£3.3m YTD).

As a result of our failure to meet our financial plan to date we are not yet eligible for any Sustainability and Transformation funding in Q3 or Q4 (£2.5m YTD). However, we anticipate receiving all of this by the year end and this is reflected in our forecast.

The remaining variance from budget relates largely to delayed transfers of care.

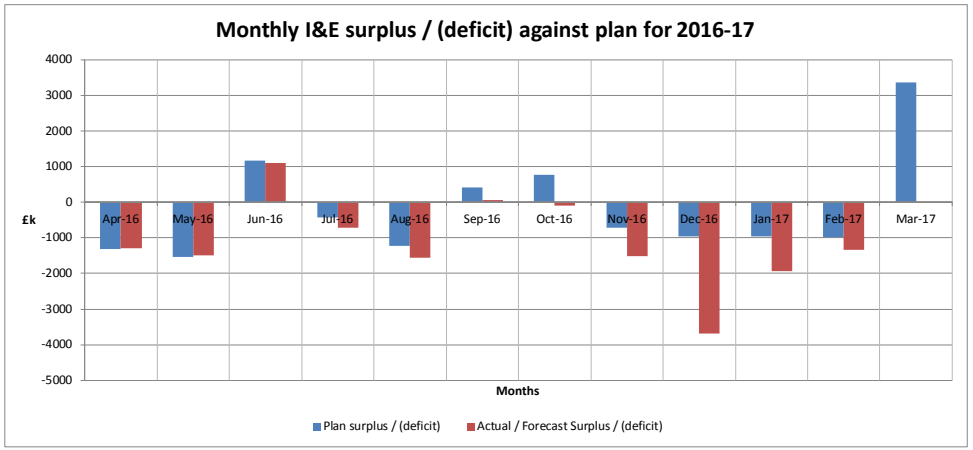
Cost Improvement Programme (CIP)
The February position includes a YTD CIP target of £10.9m of which £7.7m has been achieved. The shortfall largely relates to stretch CIP (£3.3m). The CIP target is £12.5m for the full year.

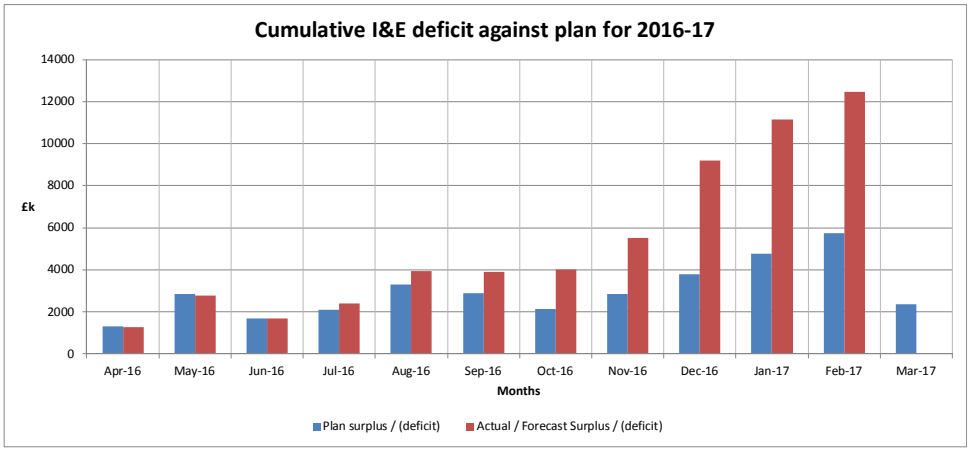
Forecast
The forecast has been revised to reflect the Trust accounting for non-recurring credits which include deposits for community equipment. These have been used to offset the stretch CIP. As a result the Trust will meet the planned control total and therefore receive Sustainability and Transformation funding for Q4 (£1.525m) and as a result we now forecast a deficit of £5.0m.

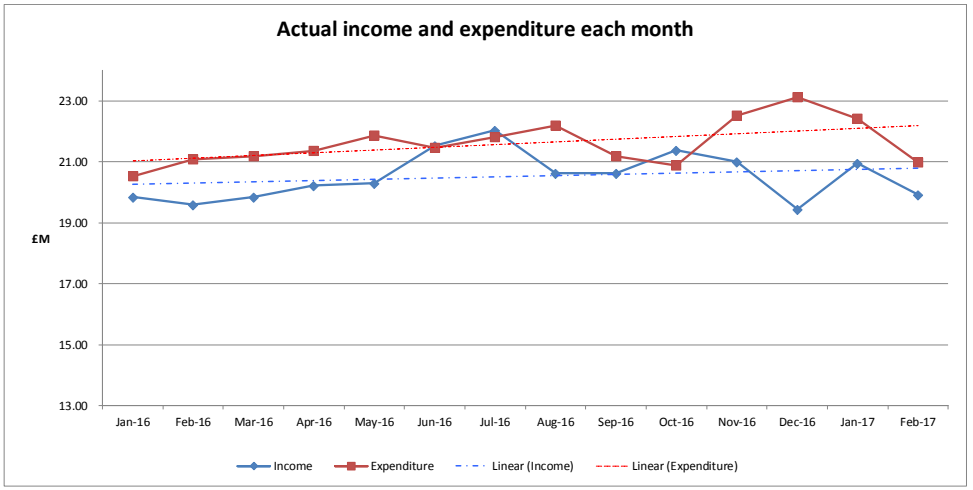
FINANCE AND WORKFORCE REPORT – February 2017

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)	(68)	(1,086)	(1,018)	↑	Red
YTD surplus / (deficit)	(3,911)	(11,736)	(7,825)	↑	Red
Forecast surplus / (deficit)	(5,000)	(5,000)	0	↑	Green
EBITDA YTD	3,236	(4,406)	(7,642)	↑	Red
EBITDA (%)	1.4%	(1.9%)	(3.3%)	↑	Red
Use of Resources (UoR) Rating fav / (adv)	3	4	1	↑	Amber
Clinical Income YTD	(200,643)	(200,700)	57	↑	Red
Non-Clinical Income YTD	(32,648)	(27,406)	(5,242)	↑	Red
Pay YTD	129,369	130,619	(1,250)	↑	Red
Non-Pay YTD	107,833	109,223	(1,390)	↑	Red
CIP target YTD	(10,912)	(7,665)	(3,247)	↑	Amber

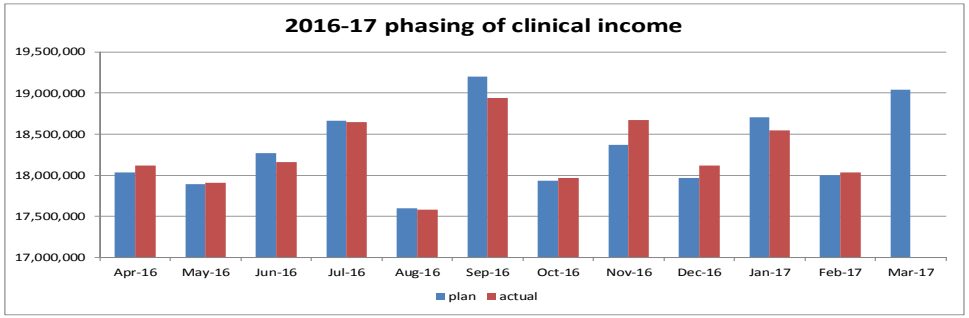






Income Analysis

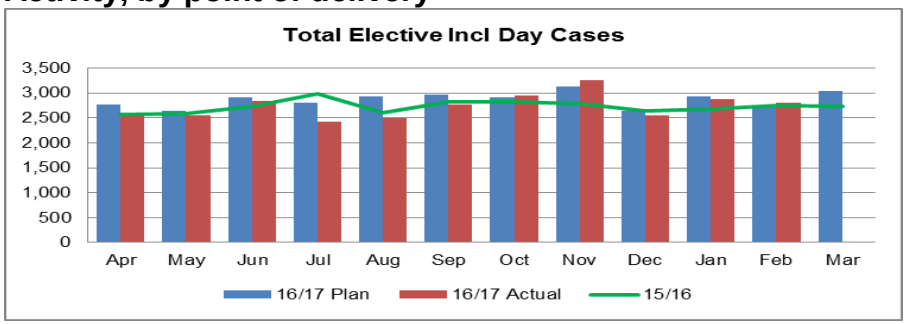
The chart below summarises the phasing of the clinical income plan for 2016-17, including Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.

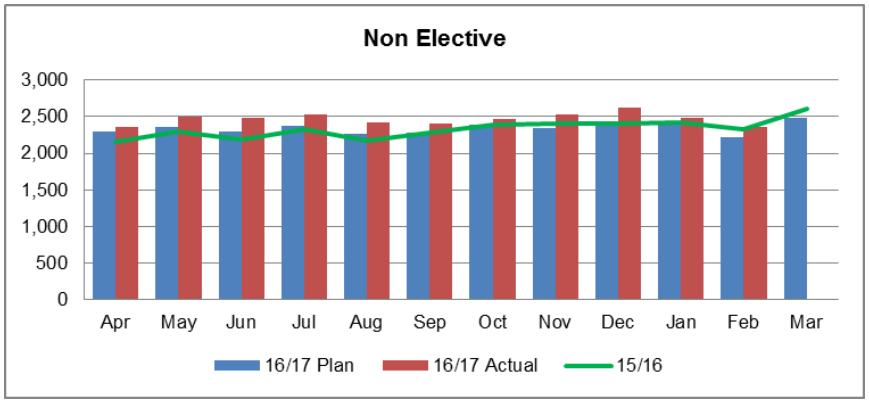


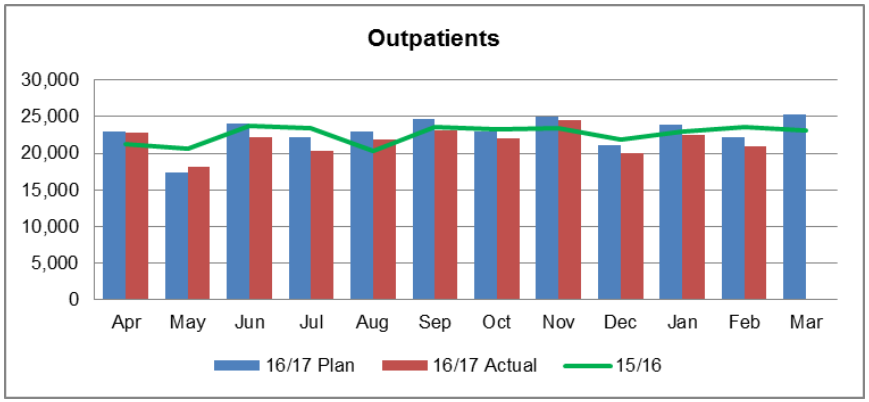
The income position was behind plan in February. Outpatient activity was the main area behind plan within the month and has been consistently throughout the year.

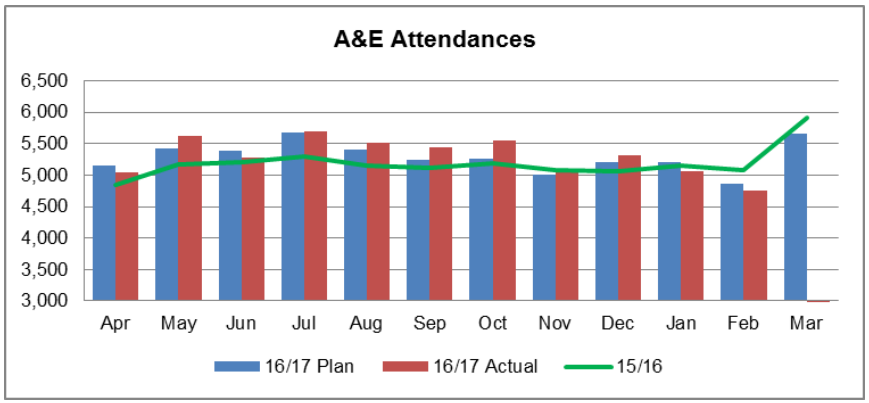
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	567	535	(33)	6,751	6,590	(160)
Other Services	2,417	2,509	92	23,946	28,161	4,215
CQUIN	291	291	(0)	3,348	3,237	(111)
Elective	2,770	2,739	(32)	31,957	29,281	(2,676)
Non Elective	4,370	4,580	210	50,479	51,713	1,234
Emergency Threshold Adjustment	(229)	(245)	(15)	(2,554)	(2,807)	(253)
Outpatients	2,870	2,687	(182)	32,359	30,168	(2,191)
Community	4,942	4,942	0	54,358	54,358	0
Total	**17,997**	**18,038**	**41**	**200,643**	**200,700**	**57**

Activity, by point of delivery

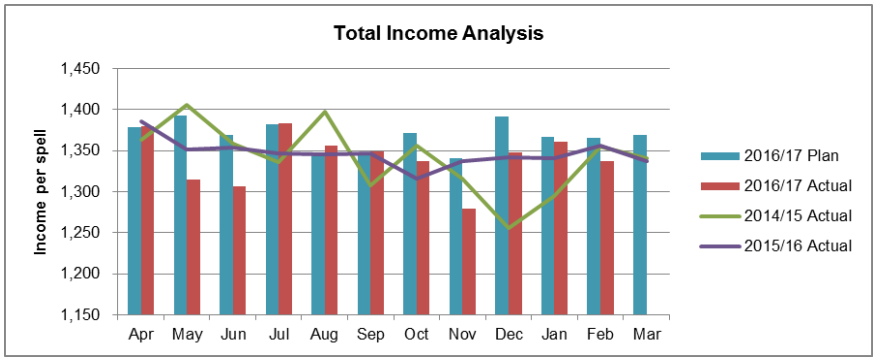


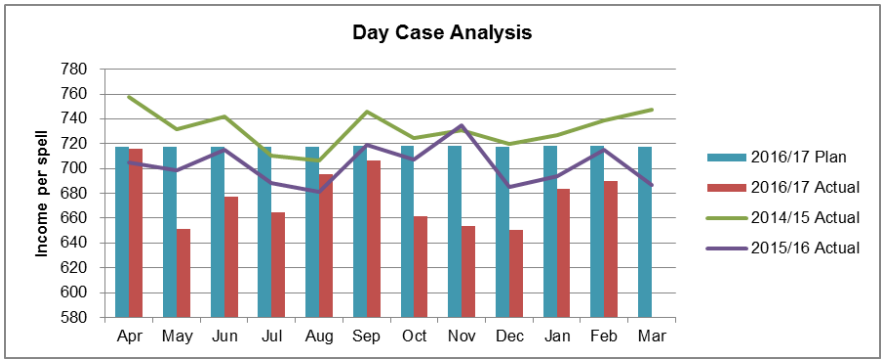


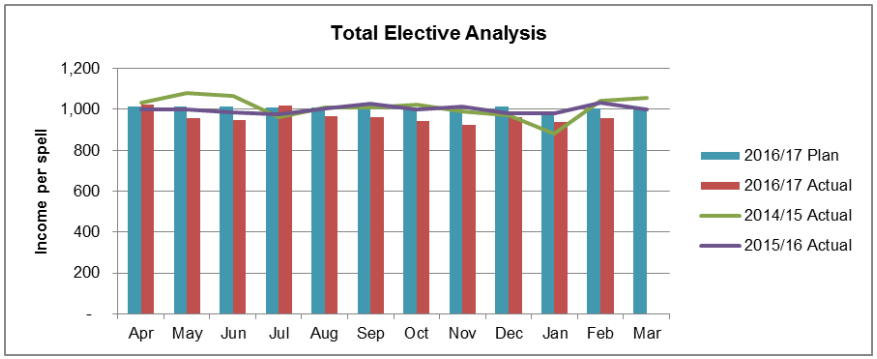


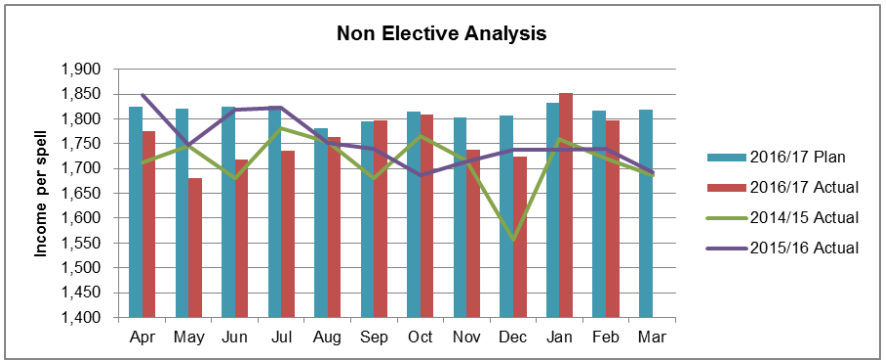


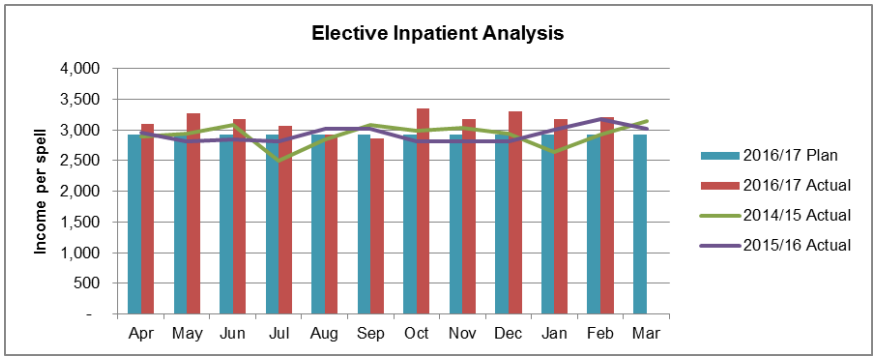
Trends and Analysis

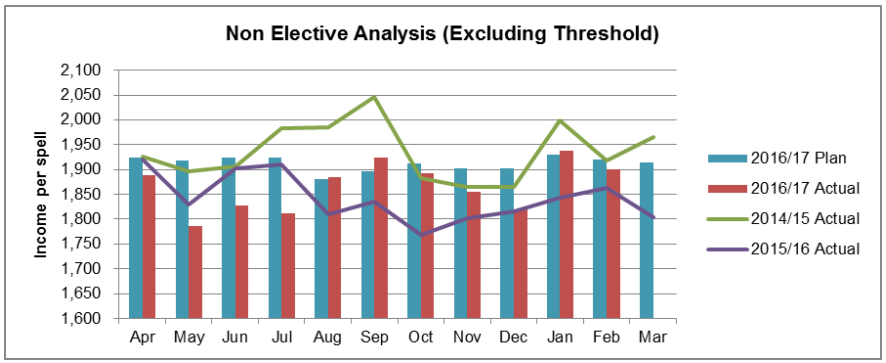












FINANCE AND WORKFORCE REPORT – February 2017

Workforce

Monthly Expenditure Acute services only				
As at February 2017	Feb-17	Jan-17	Feb-16	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,795**	**10,550**	**10,098**	**117,955**
Substantive Staff	9,627	9,625	9,139	104,247
Medical Agency Staff (includes 'contracted in' staff)	152	181	303	2,196
Medical Locum Staff	173	116	120	1,647
Additional Medical sessions	210	214	221	2,572
Nursing Agency Staff	112	157	160	1,748
Nursing Bank Staff	180	190	283	2,466
Other Agency Staff	62	76	125	1,210
Other Bank Staff	127	129	104	1,470
Overtime	101	92	62	883
On Call	58	54	51	561
Total temporary expenditure	1,175	1,210	1,430	14,752
Total expenditure on pay	**10,803**	**10,835**	**10,472**	**119,000**
Variance (F/(A))	(8)	(285)	(239)	(1,044)
Temp Staff costs % of Total Pay	10.9%	11.2%	12.3%	12.4%
Memo : Total agency spend in month	326	415	445	5,154

Monthly Expenditure Community Service				
As at February 2017	Feb-17	Jan-17	Feb-16	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,084**	**1,080**	**968**	**11,414**
Substantive Staff	1,179	1,027	887	10,890
Medical Agency Staff (includes 'contracted in' staff)	0	0	2	(15)
Medical Locum Staff	3	3	7	47
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	2	3	6	35
Nursing Bank Staff	11	10	5	73
Other Agency Staff	26	42	45	388
Other Bank Staff	13	13	9	136
Overtime	5	8	4	51
On Call	2	1	1	15
Total temporary expenditure	62	80	79	729
Total expenditure on pay	**1,241**	**1,107**	**966**	**11,619**
Variance (F/(A))	(157)	(27)	(6)	(205)
Temp Staff costs % of Total Pay	5.0%	7.3%	4.5%	6.3%
Memo : Total agency spend in month	28	45	20	408

Monthly whole time equivalents (WTE) Acute Services only			
As at February 2017	Feb-17	Jan-17	Feb-16
	WTE	WTE	WTE
Budgeted WTE in month	**3,019.2**	**2,991.4**	**2,931.3**
Employed substantive WTE in month	**2719.82**	**2701.04**	**2,676.9**
Medical Agency Staff (includes 'contracted in' staff)	11.75	11.34	21.3
Medical Locum	14.17	9.32	12.2
Additional Sessions	19.65	16.39	23.6
Nursing Agency	17.38	24.68	24.7
Nursing Bank	59.91	61.72	88.9
Other Agency	14.74	15.12	28.3
Other Bank	63.16	63.61	54.4
Overtime	46.57	41.58	30.4
On call Worked	9.99	8.51	8.9
Total equivalent temporary WTE	**257.3**	**252.3**	**264.3**
Total equivalent employed WTE	**2,977.1**	**2,953.3**	**2,941.2**
Variance (F/(A))	42.1	38.1	(11.4)
Temp Staff WTE % of Total Pay	8.6%	8.5%	9.0%
Memo : Total agency WTE in month	43.9	51.1	50.4
Sickness Rates (January/December)	4.01%	3.95%	4.0%
Mat Leave	2.0%	1.8%	1.8%

Monthly whole time equivalents (WTE) Community Services			
As at February 2017	Feb-17	Jan-17	Feb-16
	WTE	WTE	WTE
Budgeted WTE in month	**359.2**	**359.09**	**328.5**
Employed substantive WTE in month	**337.6**	**338.1**	**308.8**
Medical Agency Staff (includes 'contracted in' staff)	0.0	0.0	1.0
Medical Locum	0.4	0.4	0.8
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.3	0.6	1.1
Nursing Bank	3.5	2.9	1.8
Other Agency	15.9	11.4	11.5
Other Bank	3.6	3.8	2.8
Overtime	2.9	4.2	2.3
On call Worked	0.1	0.0	1.7
Total equivalent temporary WTE	**26.5**	**23.2**	**22.8**
Total equivalent employed WTE	**364.1**	**361.3**	**331.6**
Variance (F/(A))	(4.9)	(2.2)	(0.9)
Temp Staff WTE % of Total Pay	7.3%	6.4%	2.8%
Memo : Total agency WTE in month	16.1	12.0	2.7
Sickness Rates (January/ December)	4.08%	4.02%	
Mat Leave	1.4%	1.5%	

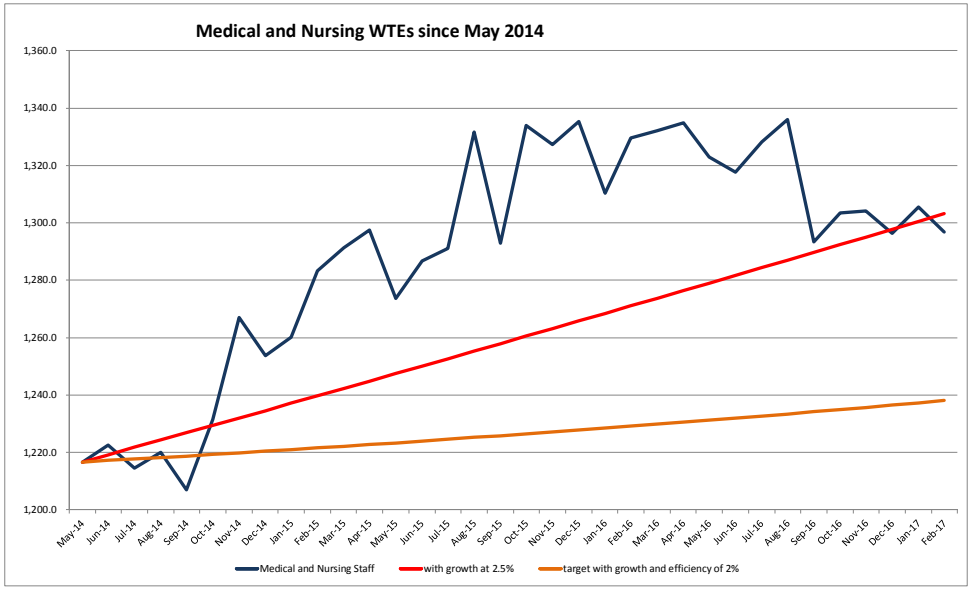
* Note the Acute tables includes Collaborative Procurement Hub staff on WSH Contracts

* 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 Trust overspent pay budgets by £166k in February (£1,250k YTD), with an underspend of £149k within Nursing (£431k overspent YTD).

The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 80 WTEs (blue line). There has been an decrease of 9 WTE during February.



Medical staffing have increased by 8 WTE since April 2016, largely as the result of increases in medical agency staff.

If our medical and nursing staffing levels had increased in line with our growth in activity of broadly 2.5% we would currently be employing 6 more staff (red line).

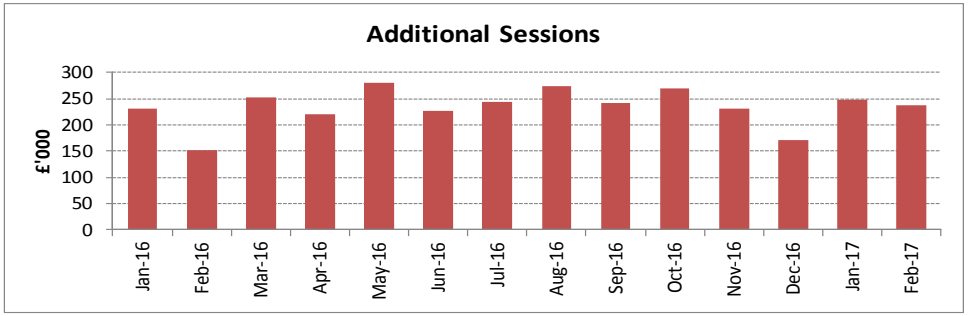
In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 59 WTE fewer than we were at February 2017.

Over the last 12 months the Trust has spent an average of £1.15m per month (£13.8m since March 2016) on the following non-substantive payments. Average monthly expenditure:

- Medical agency £218k
- Medical locums £151k
- Nursing agency £165k
- Nursing bank £245k
- Additional sessions £242k
- Overtime £78k
- On-call £51k

Pay Trends and Analysis

The monthly cost of additional sessions decreased by £44k to £210k. These costs are for both Medical and Non-Medical staff. However, Medical Agency staffing costs decreased by £29k, being £152k in February (£181k in January).



In order to investigate whether there is any decrease in efficiency whilst we continue to use additional sessions we have looked at our theatre efficiency comparing the last two years as follows. There appears to be no deterioration.

Theatre Session Usage	2015-16	2016-17	Variance
Cardiology	33%	34%	1%
Dermatology	60%	54%	(6%)
ENT	82%	80%	(2%)
General Surgery	81%	86%	4%
Gynaecology	74%	73%	(1%)
Maxilo-Facial Surgery	68%	75%	7%
Minor Oral Primary	50%	55%	5%
Ophthalmology	79%	69%	(10%)
Plastic Surgery	78%	73%	(5%)
Trauma & Orthopaedics	88%	92%	4%
Urology	89%	77%	(11%)
Total	**80%**	**80%**	**0%**

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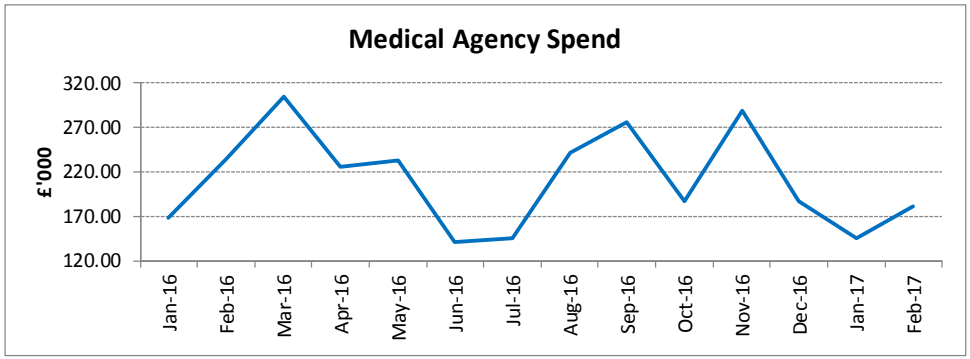
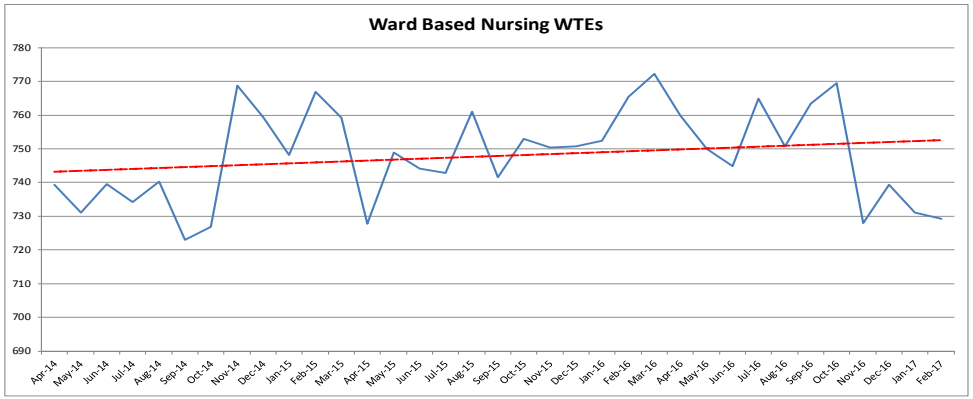
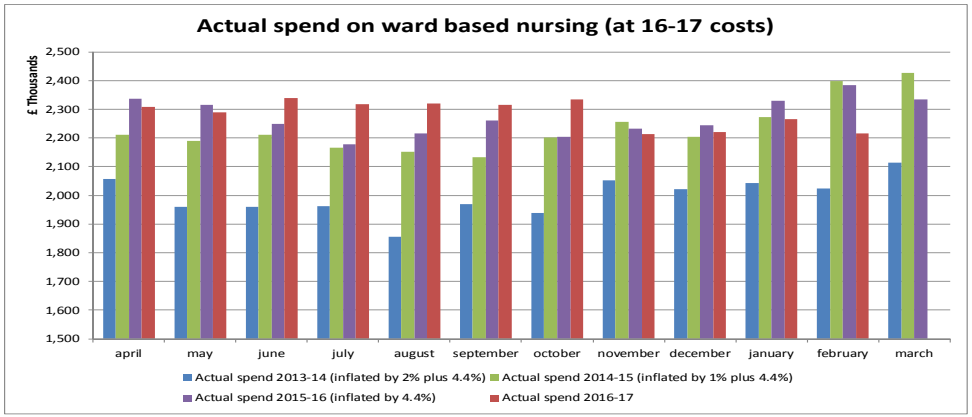
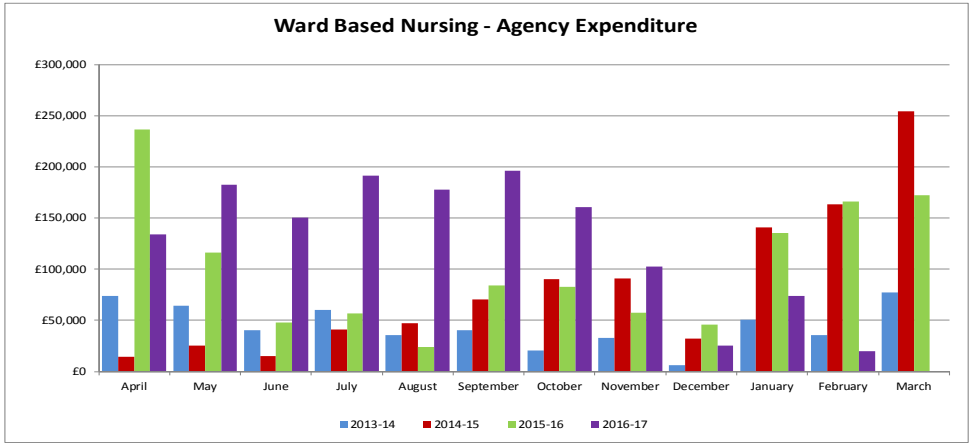


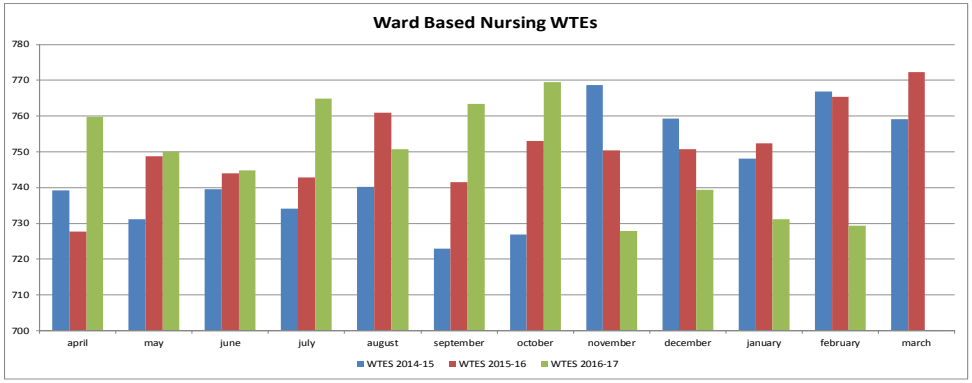


Ward Based Nursing

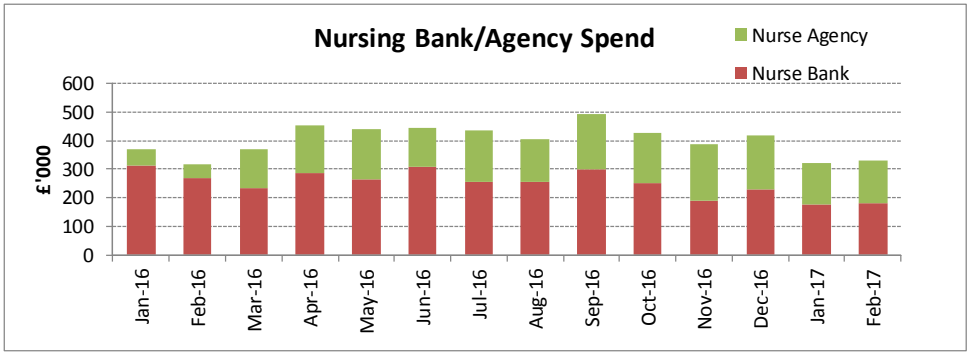




Ward based nursing costs decreased by £50k to £2.22m in February



All Nursing



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Summary by Division

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Feb-17 Budget £k	Feb-17 Actual £k	Feb-17 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(4,749)	(4,931)	182	(56,891)	(57,416)	525
Pay Costs	3,515	3,476	39	37,301	37,686	(385)
Non-pay Costs	1,226	1,227	(2)	14,329	14,562	(233)
Operating Expenditure	**4,741**	**4,703**	**38**	**51,631**	**52,248**	**(618)**
SURPLUS / (DEFICIT)	**8**	**227**	**219**	**5,261**	**5,168**	**(93)**
SURGERY						
Total Income	(5,136)	(4,934)	(202)	(56,662)	(54,605)	(2,057)
Pay Costs	2,977	2,910	67	32,835	32,482	353
Non-pay Costs	1,050	998	53	11,679	11,464	215
Operating Expenditure	**4,028**	**3,907**	**120**	**44,514**	**43,946**	**567**
SURPLUS / (DEFICIT)	**1,108**	**1,026**	**(82)**	**12,148**	**10,659**	**(1,489)**
WOMENS and CHILDRENS						
Total Income	(1,658)	(1,638)	(20)	(20,082)	(19,547)	(534)
Pay Costs	1,098	1,056	42	12,014	12,094	(80)
Non-pay Costs	144	160	(16)	1,542	1,641	(99)
Operating Expenditure	**1,242**	**1,215**	**26**	**13,556**	**13,735**	**(179)**
SURPLUS / (DEFICIT)	**416**	**423**	**7**	**6,525**	**5,812**	**(713)**
CLINICAL SUPPORT						
Total Income	(1,002)	(959)	(43)	(11,334)	(10,788)	(546)
Pay Costs	1,606	1,619	(13)	17,660	17,957	(297)
Non-pay Costs	1,006	985	21	11,390	11,059	331
Operating Expenditure	**2,612**	**2,604**	**8**	**29,050**	**29,016**	**34**
SURPLUS / (DEFICIT)	**(1,611)**	**(1,645)**	**(34)**	**(17,716)**	**(18,227)**	**(512)**
COMMUNITY SERVICES						
Total Income	(5,132)	(5,861)	729	(56,527)	(56,942)	415
Pay Costs	1,084	1,241	(157)	11,414	11,628	(214)
Non-pay Costs	3,568	4,119	(551)	44,866	45,150	(284)
Operating Expenditure	**4,652**	**5,360**	**(709)**	**56,280**	**56,778**	**(498)**
SURPLUS / (DEFICIT)	**480**	**501**	**21**	**247**	**165**	**(83)**
ESTATES and FACILITIES						
Total Income	(345)	(346)	1	(3,798)	(3,530)	(268)
Pay Costs	728	740	(12)	7,998	8,030	(32)
Non-pay Costs	645	624	22	6,740	6,722	19
Operating Expenditure	**1,373**	**1,363**	**9**	**14,738**	**14,752**	**(14)**
SURPLUS / (DEFICIT)	**(1,028)**	**(1,017)**	**10**	**(10,940)**	**(11,222)**	**(281)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	(2,360)	(1,249)	(1,111)	(27,063)	(24,044)	(3,018)
Pay Costs	871	1,003	(132)	10,148	10,860	(713)
Non-pay Costs (net of contingency and reserves)	224	96	128	9,205	9,945	(740)
Finance & Capital	707	751	(44)	7,147	7,329	(182)
Operating Expenditure	**1,802**	**1,850**	**(48)**	**26,499**	**28,134**	**(1,635)**
SURPLUS / (DEFICIT)	**558**	**(601)**	**(1,159)**	**564**	**(4,090)**	**(4,653)**
TOTAL (including penalties, contingency and reserves)						
Total Income	(20,382)	(19,918)	(464)	(232,357)	(226,874)	(5,482)
Contract Penalties	0	0	0	0	0	0
Pay Costs	11,879	12,044	(166)	129,369	130,738	(1,369)
Non-pay Costs	7,864	8,209	(345)	99,752	100,543	(791)
Finance & Capital	707	751	(44)	7,147	7,329	(182)
Operating Expenditure (incl penalties)	**20,450**	**21,004**	**(555)**	**236,268**	**238,609**	**(2,342)**
SURPLUS / (DEFICIT)	**(68)**	**(1,086)**	**(1,019)**	**(3,911)**	**(11,736)**	**(7,825)**

Medicine (Annie Campbell)

The Division over performed by £219k in February, (underperformed by £93k YTD).

Despite a drop in ED attendances (£33k) non-elective work was up considerably (£109k after threshold penalties). Emergency excess bed day income is low – whilst February was only £10k behind plan, the Division has lost approximately £250k YTD from the opening of Glastonbury Court. This is because any excess bed days relating to patients that are transferred from WSFT to Glastonbury Court cannot be charged.

Elective work was ahead of plan with Cardiology, Gastroenterology, and Oncology performing well. The Division has investigated and identified a number of areas where the implementation of e-care had caused a reduction in income, and this is expected to improve. The Division has extended the secondment of the person reviewing clinicians use of e-care as this has proven to be useful.

The Division continue to meet/underspend the expenditure budget with an underspend of £34k in February. This is partly due to phasing of budgets for winter pressures, but also as a result of reducing escalation costs, particularly in ED. Divisional spend on nurse agency was £91k for the month (£2k below budget) against a monthly average of £138k. Medical staffing was on budget as was non-pay spend, though there were issues with Patient Transport. The Division is engaging with the CCG in the design of the new No Emergency Patient Transport service, but this will not take effect until April 2018.

The Division exceeded its CIPs primarily due to Cardiology activity. The Division are developing a case to put to the CCG for additional funding regarding repatriated work from Addenbrookes.

The Division are trying to be ahead of plan by the year end. If reduction in expenditure continues, and activity continues to improve, this might be possible.

Surgery (Simon Taylor)

The Division has underperformed by £82k in February (£1,489k YTD).

The main area of pressure this month is outpatients across all types. The three specialties with the largest variance are Orthopaedics, General Surgery and Urology. However due to e-Care reporting issues it is still difficult to get a full understanding of the cause.

Pay is underspent by £67k. due to fewer additional sessions and vacancies in medical posts

Non-pay is underspent by £53k due to prosthesis and MSE.

In relation to CIP's Surgery has underachieved by £26k YTD due to slippage on service redesign.

Endoscopy additional sessions are £10k overspent due to additional weekend sessions necessary to meet waiting time requirements.

Non pay reported a £21k underspend in-month and £331k underspend YTD. The main underspend is within Pharmacy (£38k) of which £28k relates to a reduction in pharmacy drugs spend as a result of specific work undertaken to reduce stock levels across the organisation.

Women and Children's (Rose Smith)

The Division reported an over performance of £7k in-month and has underperformed by £713k YTD.

Clinical income was on plan in-month and £444k behind plan YTD. YTD performance due to a decrease in elective admitted patient care within Gynaecology.

Pay reported £42k underspends in-month and £80k overspend YTD. This is mainly due to consultant vacancies within both Paediatrics and Obstetrics accounting for £9k and £17k. The remaining underspend is due to vacancies across Maternity Services and Paediatrics.

Non pay reported a £16k overspend in-month and £99k YTD, of which £25k relates to maternity recharges charged by other hospitals.

Clinical Support (Rose Smith)

The Division reported under performance of £34k in-month and £512k YTD.

Clinical income for Clinical Support was on plan in-month and £127k behind plan YTD, mainly due to underperformance within Interventional Radiology and Diagnostics.

Other Income was £43k behind plan in-month and £385k YTD. Main variances include Private Physiotherapy Service (£15k) - activity is being monitored against planned trajectory, pharmacy income (£12k) - relating to the Norfolk and Suffolk Foundation NHS Trust, offset in part by a reduction in pharmacy costs, (this contract terminates in March 2017) and Radiology private inpatients (£9k).

Clinical Support pay reported a £13k overspend in-month, £297k YTD. The main overspends are within Pharmacy £9k due to additional hours worked which has increased this month due to staff sickness and paternity leave.

Community Services (Dawn Godbold)

Community Services reported a £21k over performance in-month and is £83k behind plan YTD.

Contract Income reported £729k over recovery in-month, and £415k over recovery YTD. This is largely due to invoices being raised to Suffolk County Council beyond the value of their block contract for additional equipment ordered through Central Equipment Store. This month's income also includes training income of £60k offset against non-pay and income from IHT relating to First Dressings which again is partly offset against dressing costs within non pay.

Pay reported £157k overspend in-month and £214k overspend YTD which includes a significant non-recurring item.

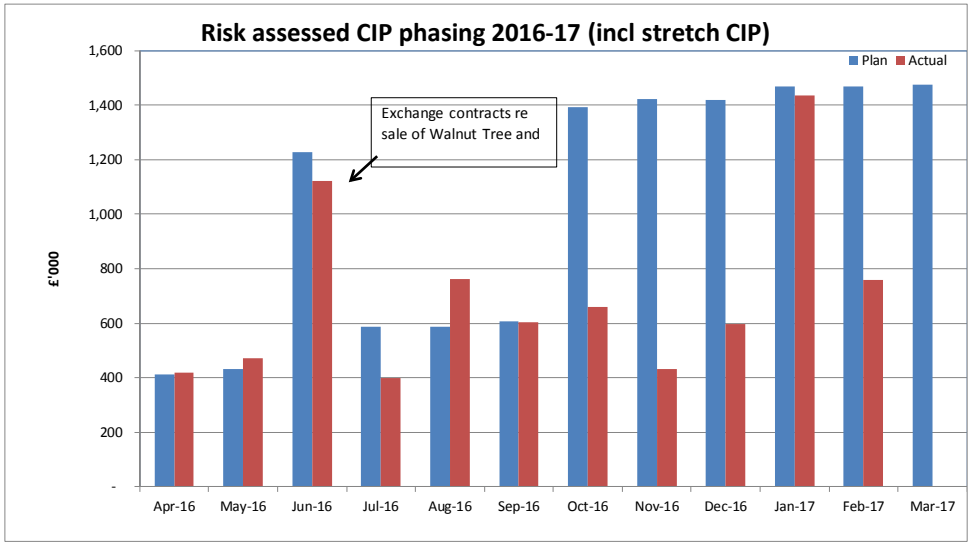
Non pay reported a £551k overspend in-month, and £284k underspend YTD. This includes items that have been recognised in our income position including :

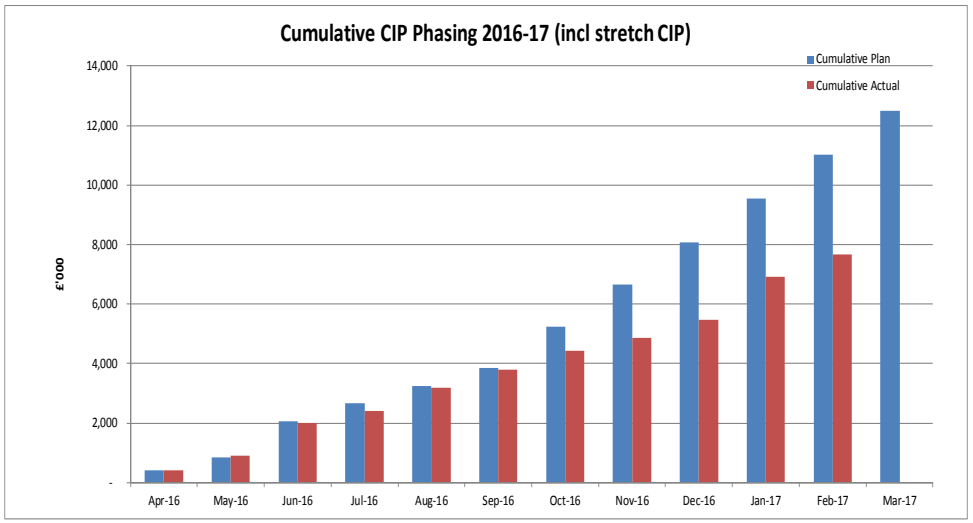
- Central Equipment Store, increase cost in month of £310k.
- First Dressings settlement for NCHC
- Continence Products £70k in month. There is an action plan in place to try to reduce these costs and it is expected this cost pressure will reduce over the next few months
- Education and Training £60k.

Corporate Services

This position includes the stretch CIP and Sustainability and Transformation funding.

Cost Improvement Programme (CIP)





Summary of year to date performance against CIP target

CIP schemes at Feb 17	Annual Plan	Plan YTD	Actual YTD	Forecast
	£'000	£'000	£'000	£'000
Activity growth	1,634	1,498	1,417	1,546
PCP	138	126	151	165
Price rise	31	28	28	31
Car parking	210	162	250	273
Staff review	552	500	412	450
Additional sessions	551	411	95	103
Agency reduction	405	286	200	218
Drugs	81	74	95	104
Pathology volume	68	61	-	-
Estates	375	322	106	116
DTOCs	540	490	250	273
Non-pay	407	419	499	544
Other	1,108	1,040	1,098	1,198
Non-recurring	2,500	2,354	3,065	7,481
Stretch CIP	3,900	3,140	-	-
Grand Total	**12,500**	**10,912**	**7,665**	**12,500**

The impact of the stretch CIP can be seen over the last 5 months. However, since no savings have been identified against these schemes, we have failed our CIP plans significantly since October, and in total YTD by £3.3m YTD. The table above demonstrates that we are forecasting to achieve our original CIP of £8.6m.

However, we believe we are able to meet the remaining CIP through non-recurring accounting treatments and are therefore forecasting the full CIP will be achieved.

FINANCE AND WORKFORCE REPORT – February 2017

2017-18 Budget Sign Off

The Clinical Director and General Manager for each Division have signed off their 2017-18 budget and these are included at Appendix 1. These schedules include :

- non-clinical income plan
- expenditure budget
- value of Local Cost Improvement plan (3%) with summary of schemes and any remaining unidentified balance
- value of PMO supported CIP attributable to that Division
- funding of £1m to provide capacity for growth at 2.5%

2017-18 Budget	2016-17 plan £'000	2017-18 adjustments and growth £'000	2017-18 underlying £'000	CIP (local & PMO allocation) £'000	2017-18 budget £'000
Clinical Income	(219,681)	(6,349)	(226,030)	0	(226,030)
Non-clinical income and expenditure					
Medicine	52,994	928	53,922	(2,031)	**51,891**
Surgery	46,618	578	47,196	(1,690)	**45,507**
Womens and Childrens	13,407	680	14,087	(524)	**13,564**
Clinical Support	26,896	1,139	28,035	(829)	**27,206**
Community Services	58,364	6,639	65,003	(1,792)	**63,211**
Estates and Facilities	12,012	533	12,545	(814)	**11,730**
Corporate	9,711	1,531	11,242	(337)	**10,904**
Overheads	9	6,359	6,368	0	**6,368**
Reserves *	2,170	2,162	4,332	(5,254)	**(922)**
Contingency	2,500	0	2,500	0	**2,500**
	224,681	**20,549**	**245,231**	**(13,271)**	**231,959**
Net Surplus / (Deficit)	**(5,000)**	**(14,200)**	**(19,200)**	**13,271**	**(5,928)**
* includes centrally managed CIP				**5.1%**	

Note there is a contingency of £2.5m.

2017-18 CIP Plan

The 2017-18 CIP required to meet the control total proposed by NHSI is £13.3m, being 5.1% of turnover. £11.3m of this has been identified and Quality Impact Assessed where appropriate by the Executive Chief Nurse and Medical Director.

	Target £m	Identified £m	Remaining £m	QIA
Divisions (3%)	6.8	5.8	1.0	yes
PMO supported	3.1	3.1	0.0	yes
Stretch CIP	3.4	2.4	1.0	not needed
Total	13.3	11.3	2.00	

The target in Community Services is particularly difficult since this budget includes large sub-contracts with Ipswich Hospital and NCHC that cannot release any savings. However, we believe there is more opportunity to deliver savings within Community Services

With regards to achieving the remaining gap, the Trust believes the first possibility is to discuss the funding of Glastonbury Court with the CCG. The costs associated with Glastonbury Court total £2m per year.

During 2017-18 progress against all CIP schemes totalling £13.3m will be monitored and included within this Board report.

Capital Budget 2017-18

The Trust has a five year risk assessed capital strategy which focusses on addressing backlog issues and essential clinical developments. This is further enhanced by an annual prioritisation process for the assessment of investment of capital resources. This is assessed via a multi-professional group using a forced risk ranking process which assesses the benefits of investment against four criteria, compliance with the estate strategy, operational/clinical need, financial impact and statutory compliance.

The assessment ensures that:

- risk priorities remain relevant and have not changed
- any change from statute/alerts/NHS Estates etc are incorporated.
- any maintenance issues are considered and incorporated.

The Trust has a borough council approved master plan for the development of the main hospital site. The key strategic developments included in the plan are linked to clinical service delivery, with each development subject to a Board approved business case.

The Trust routinely considers leasing as preferred option to investing capital for equipment through a partnership with Chrystal Leasing.

During 2015-16 the Trust successfully applied for a long term loan of £36.25m to support its long term capital programme. This loan will be drawn down until 2018-19.

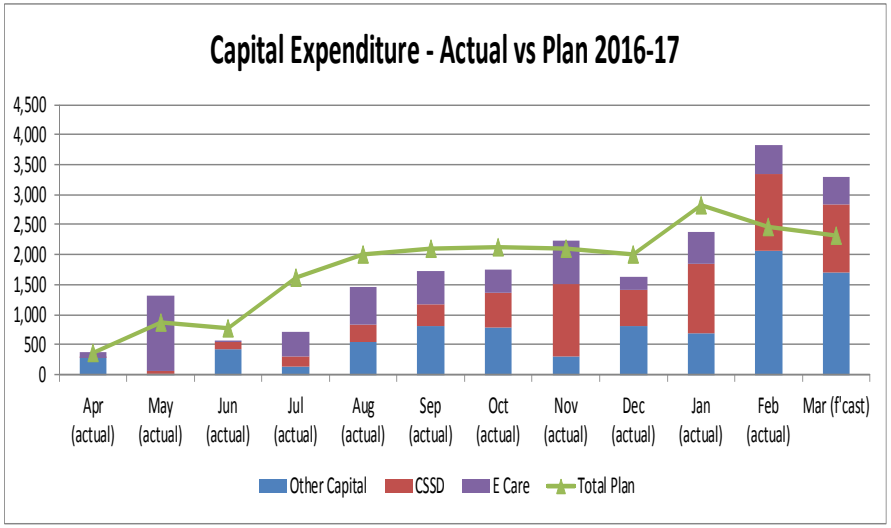
In 2016-17 the Trust successfully bid for £10m funding to become one of 10 centres of Global Digital Excellence (GDE). These centres will lead the way for the entire system to move faster in getting better information technology on the ground, delivering benefits for patients and sharing learning and resources with other local organisations through networks. The first year of funding was attributed to 2016-17 and the capital budget shows this spread over the remaining two years with an additional £2m per annum from internal resources.

In 2017-18 the Trust Capital Programme is budgeted at £28.1m.

Scheme	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000	Total £'000
Development Team/Feasibilites	499	504	509	514	519	2,545
Fire Compartmentation - above ceiling	1,028					1,028
Car Park R Cycle Storage	15					15
Site infrastructure resiliance - electrical	182					182
Plant Rooms	0	530	530	460		1,520
Roof Replacement	1,231	1,231				2,462
Replacement rooftop gas valves		225				225
Northlight repairs		363				363
Structural wall Panels			1,167	1,167	3,000	5,334
Environment improvement	100	100	100	100	100	500
Road repairs & relining	50	50	50	50	50	250
Replacement hot & cold water system	20					20
G5 mini refurbishment		45				45
Space heating replacement valves site wide		100	100	100	100	400
Replacement medical air plant			105			105
Insulation of Hot & Cold Water pipe distribution system.	222	222	222			666
Emergency lighting	82					82
Replacement fire alarm system DSU & ETC	75					75
Replacement street lighting with LED	75					75
Essential supply to UCT 8 & 9		45				45
Window replacement Rowan House A&B Block		55				55
Re-compact & renew gravel car park bays C,D & E					28	28
Drainage internal - including CCTV survey		145				145
Drainage external		268				268
Surge protection	25					25
Emergency Lighting (New Installations)	30	30	30	30	30	150
Repositioning of data cabinets		75	75			150
Neo natal reinsulate external AHU and ductwork.			30			30
Siting additional bulk medical oxygen storage on site		225				225
Secure access (cctv/swipe/ reader/mag locks)	15		23			38
Main concourse	1,550	1,425				2,975
New residences	7,538	2,898	1,000			11,436
SSD - including 2 additional floors	1,611					1,611
Decant ward	2,350	625				2,975
Cath lab (non Managed Service)	2,750	750				3,500
ETC 2nd passenger lift					225	225
Additional blue badge bays			280			280
ED redevelopment		1,000	4,000	4,000	1,000	10,000
Operational priorities - urology relocation	310					310
Operational priorities - ED paediatric wait	60					60
Operational priorities - labour suite refurbishment	950					950
Operational priorities - F9/10 procedure room		150				150
Operational priorities - Audiology refurbishment		400	200			600
Operational priorities - To be confirmed		450	800	1,000	1,000	3,250
Ecare all IT Capital	5,333	5,333				10,666
Backlog wards/departments/theatres			1,000	1,000	2,900	4,900
Contingency	1,981	1,087	1,762	2,143	2,048	9,021
	28,082	18,331	11,983	10,564	11,000	79,960

FINANCE AND WORKFORCE REPORT – February 2017

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Actual £'000	Feb Actual £'000	Mar Forecast £'000	Total 2016-17 £'000
E Care	94	1,262	19	412	625	561	378	705	198	545	505	473	5,777
CSSD	11	37	130	176	281	365	580	1,221	603	1,156	1,264	1,118	6,942
Other Schemes	270	15	426	124	548	806	793	299	819	685	2,068	1,710	8,561
Total Actual / Forecast	375	1,313	574	713	1,454	1,732	1,751	2,225	1,620	2,385	3,838	3,300	21,280
Total Plan	359	864	770	1,628	2,012	2,104	2,124	2,101	2,009	2,834	2,459	2,327	21,590

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

Overall the slippage on the 2016-17 Capital Programme is £1.3m to the end of February. This is mainly due to re-phasing of larger projects such as the CSSD building and the Cath Lab. Whilst these are forecast to continue to underspend in 2016-17 the overall capital programme is forecast to overspend by £0.8m due to increasing expenditure on e-Care.

The CSSD build has commenced and will incorporate two additional floors to facilitate future clinical development in the hospital core. Expenditure is £0.6m above plan in February and £2.2m behind plan YTD.

Slippage on the Cath Lab in 2016-17 is anticipated to be £2.6m by the end of the year and largely relates to 6 months slippage whilst looking at wider project that included F6 and F7. Enabling works have now started and building commenced mid-March.

Phase 1 E-Care went live at the beginning of May and the Capital Programme assumes Phase 2 of the original business case will be completed within this financial year. Expenditure on e-Care is £5.3m at the end of February, (against a total plan for 2016-17 of £3.4m)

The outcome of the Global Digital Excellence (GDE) bid has now been included in the M12 forecast although it is still subject to formal Treasury sign-off. The E-Care programme budget has been revised to take account of the increased scope associated with this funding.

Use of Resources (UoR) Rating

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

The key features of the UOR ratings are as follows:

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

Metric	Value	Score
Capital Service Capacity rating	-2.807	4
Liquidity rating	-21.76	4
I&E Margin rating	-5.14%	4
I&E Margin Variance rating	-2.84%	4
Agency	3.97%	2
Use of Resources Rating after Overrides		4

The Trust is scoring an overall UoR of **4**, the same as January 2017 which reflects the challenging financial position the Trust is in.

FINANCE AND WORKFORCE REPORT – February 2017

Statement of Financial Position at 28th February 2017

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2016 £000	Plan 31 March 2017 £000	Plan YTD 28 Feb 2017 £000	As at 28 Feb 2017 £000	Variance YTD 28 Feb 2017 £000
Intangible assets	10,876	13,487	13,349	16,246	2,898
Property, plant and equipment	61,923	74,893	73,664	68,805	(4,859)
Trade and other receivables	273	340	340	340	0
Other financial assets	1,688	2,409	2,359	2,534	175
Total non-current assets	**74,760**	**91,129**	**89,712**	**87,926**	**(1,786)**
Inventories	2,825	2,850	2,850	2,707	(143)
Trade and other receivables	11,191	9,230	9,530	12,251	2,721
Non-current assets for sale	1,400	0	0	0	0
Cash and cash equivalents	2,601	3,007	2,285	1,537	(747)
Total current assets	**18,017**	**15,087**	**14,665**	**16,495**	**1,830**
Trade and other payables	(21,692)	(20,686)	(20,308)	(28,198)	(7,890)
Borrowings	(130)	(130)	(130)	(130)	0
Provisions	(84)	(84)	(84)	(84)	0
Other liabilities	(1,892)	(295)	(602)	(709)	(107)
Total current liabilities	**(23,798)**	**(21,195)**	**(21,124)**	**(29,121)**	**(7,997)**
Total assets less current liabilities	**68,979**	**85,021**	**83,253**	**75,300**	**(7,954)**
Trade and other payables - Non current	(912)	(1,083)	(1,083)	(1,109)	(26)
Borrowings	(18,205)	(39,075)	(37,140)	(36,064)	1,076
Provisions- non current	(202)	(203)	(205)	(202)	3
Total non-current liabilities	**(19,319)**	**(40,361)**	**(38,428)**	**(37,376)**	**1,052**
Total assets employed	**49,660**	**44,660**	**44,825**	**37,924**	**(6,901)**
Financed by					
Public dividend capital	59,232	59,232	59,232	59,232	(0)
Revaluation reserve	2,151	2,151	2,151	2,151	0
Income and expenditure reserve	(11,723)	(16,723)	(16,558)	(23,459)	(6,901)
Total taxpayers' and others' equity	**49,660**	**44,660**	**44,825**	**37,924**	**(6,901)**

Intangible Assets and Property Plant and Equipment:
Overall the variance against plan for non-current assets has reduced this month. The £2.9m variance on Intangible Assets is due to E-care. The planned expenditure for E-Care is currently under review following the Global Digital Excellence (GDE) Award although no cash has been received yet for GDE and it is unclear when this will be received.
The variance on Property Plant and Equipment is due to slippage, mainly on CSSD and Cath Lab.

The Trust is now forecasting slippage overall for fixed assets at year end of £1.0m.

Other financial assets:
This investment relates to The Pathology Partnership (TPP). The investment has now increased by a further £675k and a further £2.5m is planned before year end financed by a DH loan. The associated risk since Addenbrookes has announced its withdrawal from the partnership continues to be reviewed regularly and a full impairment review will be carried out at year end.

Trade and other receivables:
These have reduced by £0.9m. As year end approaches some additional invoices have been raised, particularly relating to the Community contract. Work continues to reduce our receivables, particularly on old balances that are overdue.

Cash:
The cash balance has reduced to £1.5m at the end of February which is broadly in line with plan.

The Trust has still not received the anticipated £3.3m GDE cash which was expected by the end of January and there are on-going conversations with DH to determine when this is likely to be received.

The DH has still not given a firm indication of when the cash will be paid so to mitigate the risk of it not being received before year end, the Trust has accelerated the drawdown of the capital loan by £3.3m. In line with plan £2.5m working capital facility was drawn down in February and a further £2.5m has been drawn down in March 2017. In addition the working capital facility has been extended by a further £2.5m to cover an additional investment in tPP to facilitate payment of a tPP Public Health England (PHE) creditor. All tPP partners have made a similar contribution based on their relevant share.

The Trust is planning to finish the year with the £1m minimum balance it is required to maintain to comply with the working capital facility conditions.

FINANCE AND WORKFORCE REPORT – February 2017

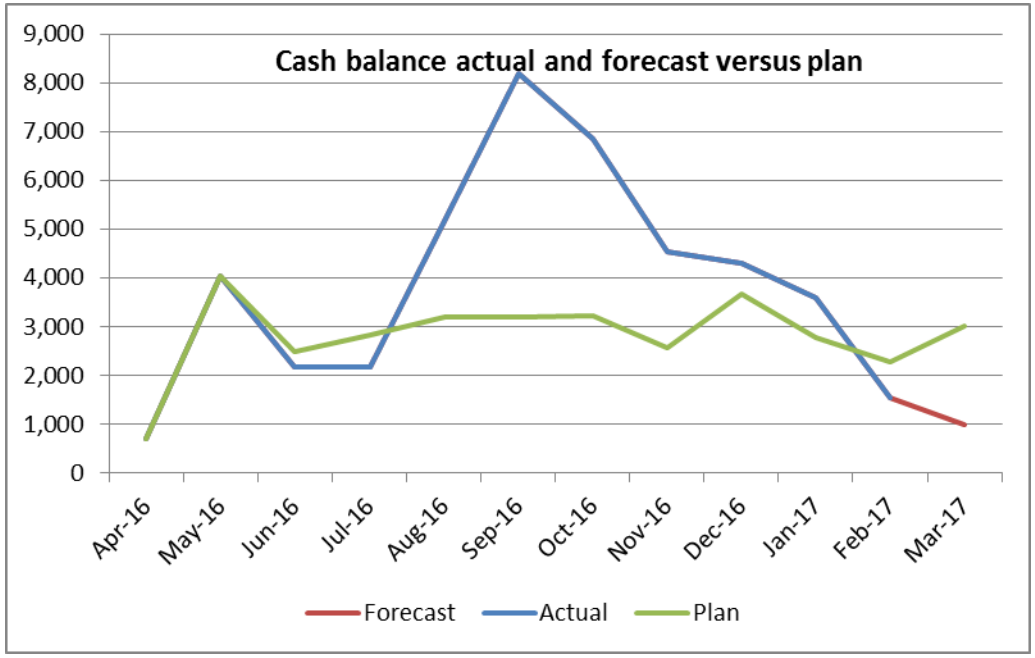
Trade and other payables:
Current payables have decreased by £0.2 million in February but still remain significantly above plan. Additional resources have been directed at accounts payable in March to reduce the backlog of invoices.

Borrowing:
Borrowing is less than planned at the end of February because the working capital financing facility is being drawn down in the last two months rather than across the year.

The year-end position will be higher than planned because of the need to borrow to cover the non-receipt of GDE cash and for the tPP PHE creditor.

The revenue and capital plan over the next two years exceeds the remaining loan finance available by £23m. This includes an assumption of £10m from the successful GDE bid. There is still no agreed source of funds to cover this gap although distress financing has been requested from DH.

Cash Balance Forecast for the year



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

APPENDIX 1

Budget Sign Off Sheets

2017/18 Budget - Medicine Division

	2017/18 £'000
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(52,994)
Transfers between Divisions	403
Cost Pressures	(974)
Other Movements	0
Funding for Growth	(357)
Budget for 17/18 in order to deliver the 2017-18 contracted activity and performance targets	(53,922)
CIPs	
DIVISION CIPs risk assessed	
Divisional CIP	1,250
Risk assessed gap	357
PMO CIPs	
Local Expenditure CIP	424
Local Revenue Generating CIP	
CIPs for 17/18	2,031
Budget 17/18 after CIP	(51,891)

Budget Authorisation

	Signature/Date
General Manager :	23rd March 2017
Clinical Director :	23.3.2017
Clinical Director :	27/3/17

2017/18 Budget - Surgery & Anaesthetics Division

	2017/18 £'000
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(46,618)
Transfers between Divisions	(40)
Cost Pressures	(195)
Other Movements	0
Funding for Growth	(343)
Budget for 17/18 in order to deliver the 2017-18 contracted activity and performance targets	(47,196)
CIPs	
DIVISION CIPs risk assessed	
Increased non contract income	144
Service redesign	359
Reduction in temporary staffing	262
Workforce controls	62
Non pay controls	236
Risk assessed gap	345
PMO CIPs	
Local Expenditure CIP	284
Local Revenue Generating CIP	
CIPs for 17/18	1,689
Budget 17/18 after CIP	(45,507)

Budget Authorisation

	Signature/Date
General Manager :	SIMON TAYLOR 24/3/17.
Clinical Director :	
Clinical Director :	

2017/18 Budget - Women & Children Division

	Women & Children Division £'000
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(13,407)
Transfers between Divisions	(40)
Cost Pressures	(540)
Other Movements	0
Funding for Growth	(100)
Budget for 17/18	(14,087)
CIPs	
DIVISION CIPs risk assessed	
Local Expenditure CIP	389
Local Revenue Generating CIP	0
Risk Assessed Gap	100
PMO CIPs	
Local Expenditure CIP	34
Local Revenue Generating CIP	0
CIPs for 17/18	523
Budget 17/18 after CIP	(13,564)

Budget Authorisation

	Signature/Date
General Manager :	27/3/17.
Clinical Director :	27/3/17

2017/18 Budget - Clinical Support Division

	Clinical Support Division £'000
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(26,896)
Transfers between Divisions	(28)
Cost Pressures	(911)
Other Movements	0
Funding for Growth	(200)
Budget for 17/18	(28,035)
CIPs	
DIVISION CIPs risk assessed	
Local Expenditure CIP	566
Local Revenue Generating CIP	0
Risk Assessed Gap	200
PMO CIPs	
Local Expenditure CIP	63
Local Revenue Generating CIP	0
CIPs for 17/18	829
Budget 17/18 after CIP	(27,206)

Budget Authorisation

	Signature/Date
General Manager :	27/3/17
Clinical Director :	27/3/17

2017/18 Budget - Community Division

	Community Division £'000
CLINICAL INCOME	
Recurring contract clinical plan based on 2016/17 (February 2017)	61,379
Non Clinical Income	3,711
Other movements	0
Growth	0
Income Target for 17/18	65,090
Indicative Income Plan split by type of income	
NET EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(63,202)
Reserves	(1,801)
Cost Pressures	
Other Movements	0
Funding for Growth	0
Budget for 17/18	(65,003)
CIPs	
DIVISION CIPs	
Local Expenditure CIP	1,789
Local Revenue Generating CIP	0
PMO CIPs	
Local Expenditure CIP	3
Local Revenue Generating CIP	0
CIPs for 17/18 (5% CIP applied against WSH Hosted Services)	1,792
Surplus / (Deficit)	1,879

Budget Authorisation

Signature/Date 23.3.17

Associate Director of Operations - Community :

Clinical Director :

2017/18 Budget -Estates and Facilities Division

	Estates and Facilities £'000
INCOME	
Non Clinical Income (based upon February 2017)	4,340
Inflation 2.3% (Non-Clinical except SCH)	
Other movements	
Growth	
Income Target for 17/18	4,340
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(16,351)
Funded through DD	(337)
Cost Pressures	(196)
Other Movements	0
Funding for Growth	0
Budget for 17/18	(16,884)
CIPs	
DIVISION CIPs	
Local Expenditure CIP (to be agreed)	376
Local Revenue Generating CIP	
PMO CIPs	
Local Expenditure CIPs	
Car Parking	400
Medical Products Usage	13
Local Revenue Generating CIP	25
CIPs for 17/18	814
Surplus / (Deficit)	(11,730)

Budget Authorisation

	Signature/Date
General Manager :	27.03.17
Clinical Director :	

2017/18 Budget -Corporate Trust Office Directorate

	Corporate Trust Office £'000
INCOME	
Non clinical income	0
Other movements	
Growth	
Income Target for 17/18	**0**
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(1,274)
Transfers between Divisions	
Cost Pressures	(182)
Other Movements	
Funding for Growth	
Budget for 17/18	**(1,456)**
CIPs	
DIVISION CIPs	
Local Expenditure CIP (to be agreed)	0
Local Revenue Generating CIP	
PMO CIPs	
Local Expenditure CIP	
Local Revenue Generating CIP	
CIPs for 17/18	**0**
Surplus / (Deficit)	**(1,456)**

Budget Authorisation

	Signature/Date
General Manager :	24/03/17
Clinical Director :	

2017/18 Budget -Corporate Nursing Directorate

	Corporate Nursing £'000
INCOME	
Non clinical Income	309
Other movements	
Growth	
Income Target for 17/18	309
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(2,379)
Transfers between Divisions	
Cost Pressures	(427)
Other Movements	
Funding for Growth	
Budget for 17/18	(2,806)
CIPs	
DIVISION CIPs	
Local Expenditure CIP (to be agreed)	84
Local Revenue Generating CIP	
PMO CIPs	
Local Expenditure CIP	
Local Revenue Generating CIP	
CIPs for 17/18	84
Surplus / (Deficit)	(2,413)

Budget Authorisation

Signature/Date

General Manager :

Clinical Director : DParker

2017/18 Budget -Corporate Medical Directorate

	Corporate Medical £'000
INCOME	
Non clinical income	949
Other movements	
Growth	
Income Target for 17/18	949
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(1,152)
Transfers between Divisions	
Cost Pressures	(185)
Other Movements	
Funding for Growth	
Budget for 17/18	(1,337)
CIPs	
DIVISION CIPs	
Local Expenditure CIP (to be agreed)	40
Local Revenue Generating CIP	
PMO CIPs	
Local Expenditure CIP	
Local Revenue Generating CIP	
CIPs for 17/18	40
Surplus / (Deficit)	(348)

Budget Authorisation

Signature/Date

General Manager :

Clinical Director :

2017/18 Budget -Corporate Operations Directorate

	Operations Directorate £'000
INCOME	
Non clinical income	0
Other movements	
Growth	
Income Target for 17/18	0
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(1,638)
Transfers between Divisions	40
Cost Pressures	421
Other Movements	
Funding for Growth	
Budget for 17/18	(1,177)
CIPs	
DIVISION CIPs	
Local Expenditure CIP (to be agreed)	35
Local Revenue Generating CIP	
PMO CIPs	
Local Expenditure CIP	
Local Revenue Generating CIP	
CIPs for 17/18	35
Surplus / (Deficit)	(1,142)

Budget Authorisation

	Signature/Date
General Manager :	21-3-17
Clinical Director :	

2017/18 Budget -Corporate Personnel Directorate

	Corp Personnel £'000
INCOME	
Non clinical income	54
Other movements	
Growth	-
Income Target for 17/18	54
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(2,206)
Transfers between Divisions	
Cost Pressures	(337)
Other Movements	
Funding for Growth	
Budget for 17/18	(2,543)
CIPs	
DIVISION CIPs	
Local Expenditure CIP (to be agreed)	76
Local Revenue Generating CIP	
PMO CIPs	
Local Expenditure CIP	
Local Revenue Generating CIP	
CIPs for 17/18	76
Surplus / (Deficit)	(2,413)

Budget Authorisation

	Signature/Date
General Manager :	Sue Slocomfield 27/3/17.
Clinical Director :	

2017/18 Budget -Corporate Finance and Information Directorate

	Corporate Finance & Information £'000
INCOME	
Non clinical income	
Other movements	
Growth	
Income Target for 17/18	0
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(16,053)
Transfers between Divisions	650
Cost Pressures	5,668
Other Movements	
Funding for Growth	
Budget for 17/18	(9,735)
CIPs	
DIVISION CIPs	
Local Expenditure CIP (to be agreed)	235
Local Revenue Generating CIP	
PMO CIPs	
Local Expenditure CIP	
Local Revenue Generating CIP	
CIPs for 17/18	235
Surplus / (Deficit)	(9,500)

Budget Authorisation

	Signature/Date
General Manager :	
Clinical Director :	21/3/17

2017/18 Budget - Reserves and Contingency

	Corporate Trust Office £'000
INCOME	
Non clinical income	0
Other movements	
Growth	1,000
Income Target for 17/18	1,000
EXPENDITURE	
Budget for 16/17, (based upon February 2017)	(4,670)
Transfers between Divisions	1,800
Cost Pressures	(2,452)
Contingency	(2,500)
Funding for Growth	
Budget for 17/18	(7,822)
CIPs	
DIVISION CIPs	
Local Expenditure CIP (to be agreed)	0
Local Revenue Generating CIP	
PMO CIPs	
Local Expenditure CIP	5,244
Local Revenue Generating CIP	
CIPs for 17/18	5,244
Surplus / (Deficit)	(1,578)

Budget Authorisation

	Signature/Date
General Manager :	
Clinical Director :	27/3/17

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 30th March, 2017

AGENDA ITEM:	Item 10
PRESENTED BY:	Rowan Procter , Executive Chief Nurse Paul Morris, Associate Chief Nurse, Head of Patient Safety
PREPARED BY:	Rebecca Gibson, Compliance Manager Cassia Nice, Patient Experience Manager
DATE PREPARED:	March 2017
SUBJECT:	Aggregated Quality Report
PURPOSE:	Information

EXECUTIVE SUMMARY

- This report will be reflective of the data from February 2017
- In February there were 458 Patients Safety Incidents (PSI) reported, similar to January (447).
- Level of harm in proportion to overall Patient Safety Incidents reported:
  - 85% (84% January) no harm (Green)
  - 11% (12% January) minor harm (Green)
  - 3% (4% January) moderate harm (Amber)
  - 0.2% (0.4% January) major harm (Red)
  - 0.2% (0.2% January) catastrophic harm (Red)
- In relation to type of incidents reported in February the highest areas of reporting related to Pressure ulcers, Slips Trips & Falls, and Discharge,Transfer and Follow up.
- 12 Complaints were received in February compared to 18 in January
- 189 PALS contacts were recorded in February compared to 171 in January.

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

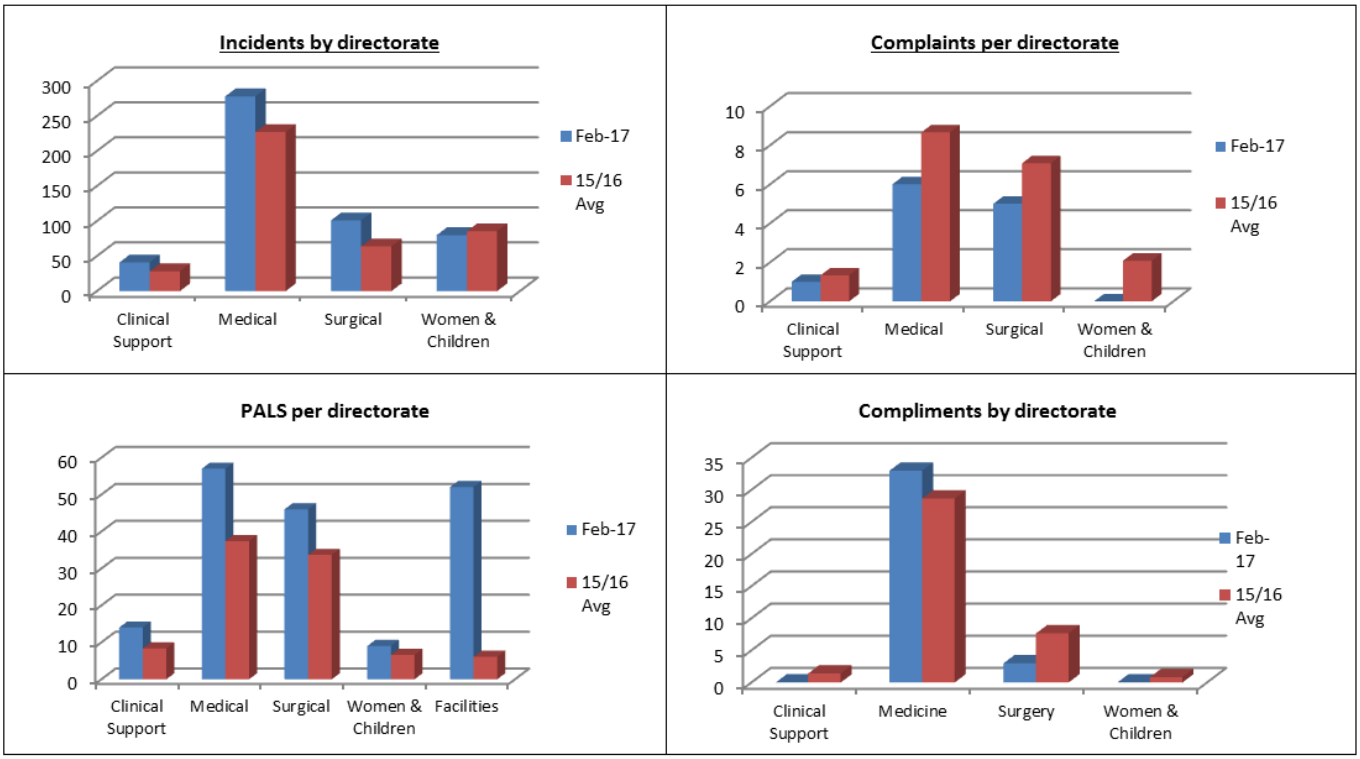


Table 2: PSIs reported by month (24 months)

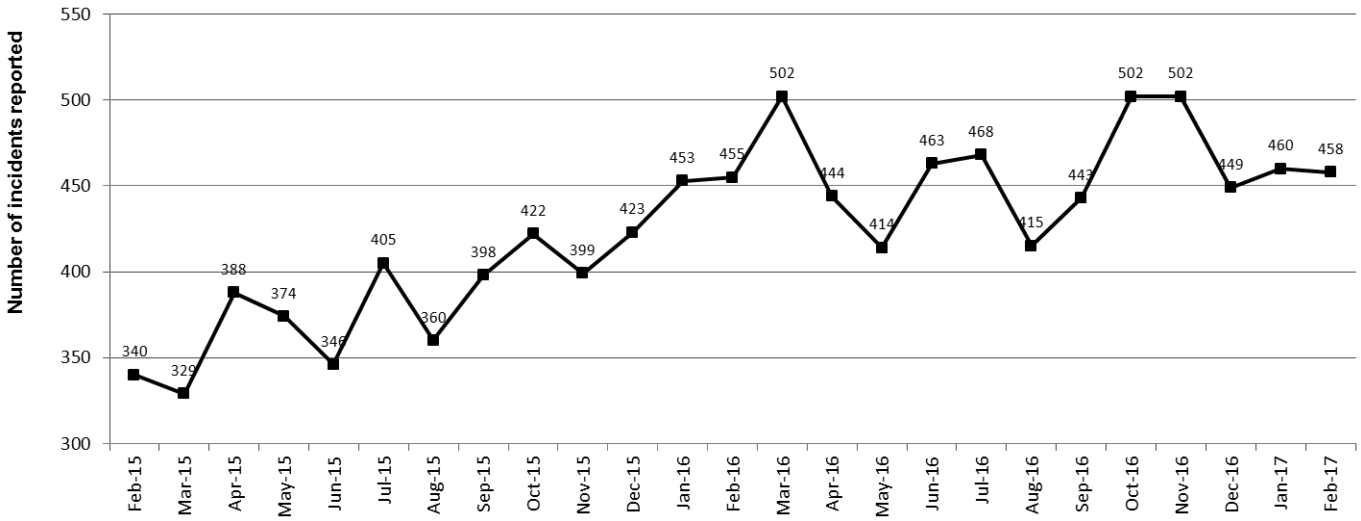
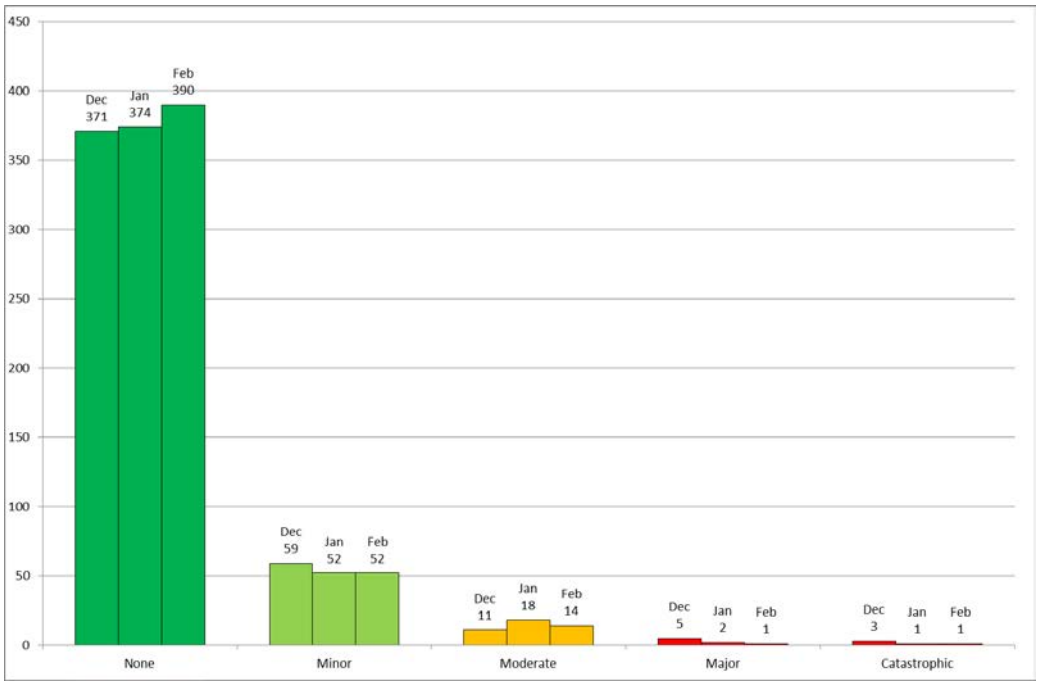


Table 3: Incidents reported by severity



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).

Within February there were a similar number of incidents reported as Major/Catastrophic (2) compared to January (3). There has been an decrease in Moderate harm incidents of which a significant proportion relate to Hospital acquired Grade 3 Pressure Ulcers.

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

- One intrauterine death
- One clinical care & treatment

The 14 moderate harm incidents relate to:

Medicine (8)

- Four Hospital acquired Grade 3 pressure ulcers
- Three infection prevention incident
- One blood traceability incident

Surgical (1)

- One unexpected death

Currently graded as an amber awaiting post-mortem report to allow consideration of whether any element of WSH care contributed to the death. Following a Day 5 review this incident will be either upgraded to red or downgraded to green.

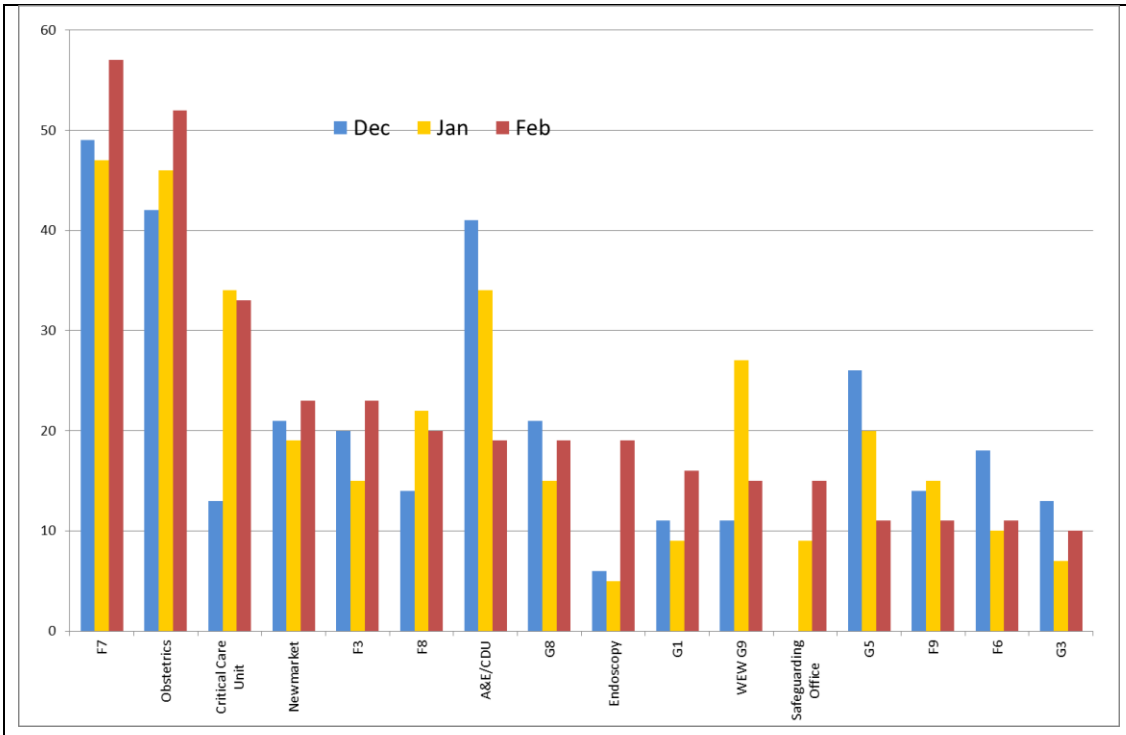
Clinical Support (1)

- One unexpected complication of Endoscopy

Women & Children (4)

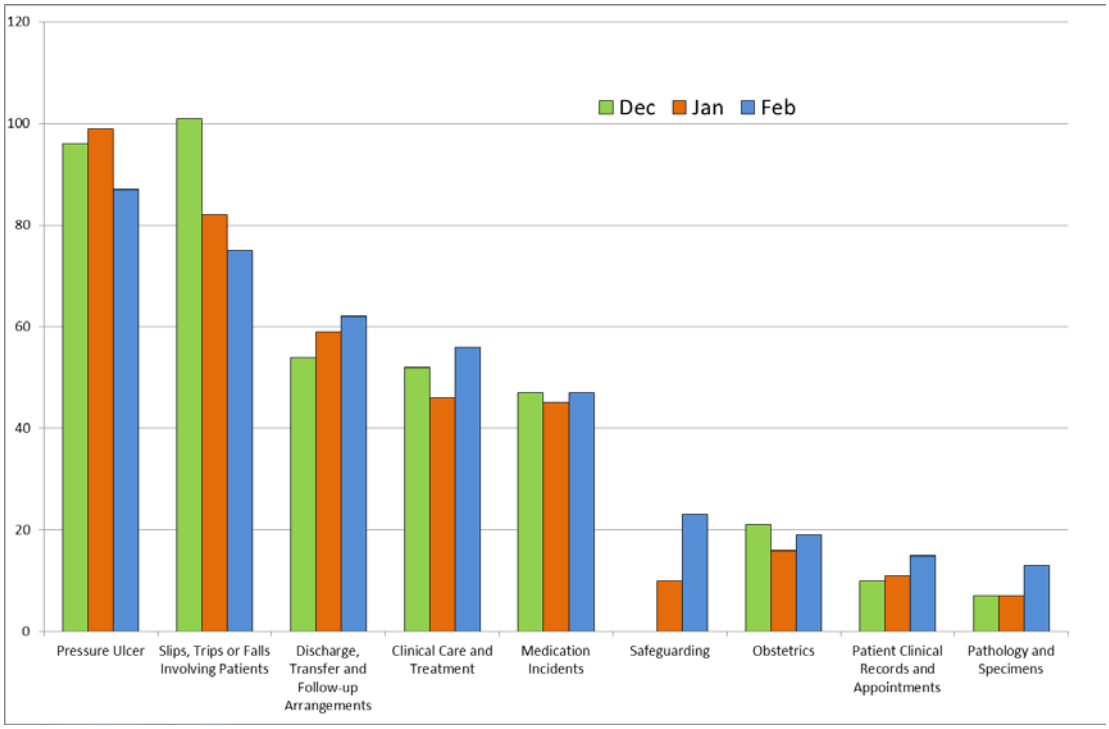
- One ward transfer
- One failure to monitor
- Two delay in diagnosis / treatment in Obstetrics

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



During February there was a continuation of the high reporting from Critical Care Services (CCS) which has seen a doubling of its incident reporting over the past 2 consecutive months. These continue to be related to delay in discharging patients from the CCS to the main ward environments and also capacity to accept new patients from ward base care environments requiring CCS (27/33 incidences).

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



Pressure ulcers, Slips, Trips & Falls, and Discharge, Transfer & Follow up incidents account for the highest number of incidents reported. There has been a considerable decrease in the number of Hospital acquired pressure ulcers in February (10 compared to 22 in January).

We have been working with some of the clinical area to identify reporting triggers to support staff to know

what should be reported in relation to both operational and quality of care issues. This work is being finalised within the Day Surgery Unit, Critical Care and Main Theatres and further detail will be provided in the April report.

Complaints

12 complaints received in February. The breakdown of these complaints is as follows by Primary Division: Medical (6), Surgical (5), Clinical Support (1).

Table 6: Complaints by location

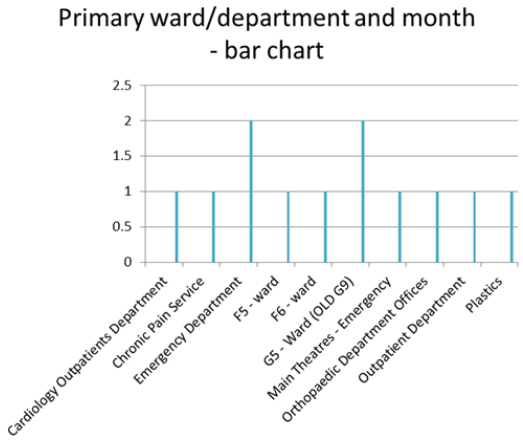
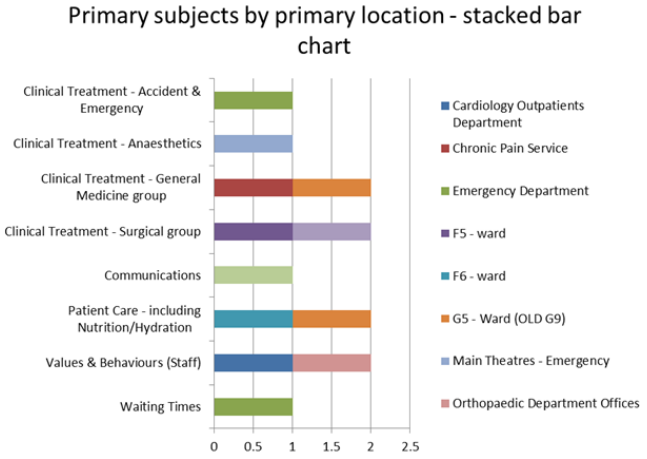


Table 7: Complaints by type



Patient Experience Themes

Area	*Analysis*	*RAG rating*
Car Parking	An influx of concerns about car parking was received throughout February in relation to the new charges and arrangements. Several issues were raised about new arrangements that needed further thought therefore a meeting took place with Facilities. Actions included the painting of wheelchair icons on the ground of the designated spaces, clarity around the different payment exceptions and an audit of the signage across the Trust is being organised.	
ENT	Ten PALS enquiries were received in relation to delays in obtaining outpatient appointments and multiple cancellations. This service is under pressure currently due to staff shortages which the team is working hard to rectify.	
Ward F7	Concerns were raised through PALS in relation to the business of the ward and bed moves. Several patients and relatives report poor communication. This has been raised with ward manager and Deputy Chief Nurse.	

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 – 31st March 2017

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

Observations

February

ED – 4 medication errors due to higher flow of patients but no falls due to increase in staff
F7 – 8 medication errors due to high vacancies, high % for roster effectiveness and high temporary staff use
F3 – 5 medication errors and had 3 pressure ulcers due to dependency of patients has increased
F4 – Has improved its figures from last month due to reduced sickness

High Vacancies – F7, AMU, G5, G8, Theatres

Roster effectiveness – Out of 27 areas, 18 are over the Trust standard of 20%.

Update on progress of Nurse Staffing Review

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

SCNT review of wards is currently being done and will be added into the paper in April following being shared with General Managers and respective Service Managers.

Critical Care is constantly submitting its staffing figures to local Network due National Guidance from NHS England and submitted their review in early March.

Paediatrics review has been postponed due to the General Manager's other duties

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Feb-17			Establishment for the Financial Year 2016/17						Data for February 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)	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 (Jan 2017)	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night			Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	65.24	77.64%	22.36%	TBU	1 - 4	1 - 5	121.6%	99.4%	127.4%	109.8%	8.00%	6.60%	-6.30	-3.30	7.10%	N/A	23.10%	N/A	4	0
WSFT	F7	Short Stay Ward	34	78.04	53.99%	46.01%	TBU	6	9	87.8%	91.5%	87.5%	88.1%	8.70%	13.60%	26.90	20.40	7.20%	6.56	23.10%	0	8	1
WSFT	AMU	Acute Medical Unit	12 beds, 10 trollies and 4 chairs				TBU	6	N/A					1.60%	0.00%			6.70%	N/A	25.80%	0	2	1
WSFT	CCS	Critical Care Services	9	48.69	96.14%	3.86%	TBU	1 -2	1 -2	91.7%	86.3%	N/A	N/A	3.50%	0.00%	0.90	0.10	5.80%	13.38	22.00%	0	1	0
WSFT	Theatres	Theatres	8 theatres	87.84	74.00%	26.00%	TBU	1/3	(1/3)	112.5%	100.1%	N/A	N/A	1.40%	0.00%	12.50	-7.60	6.40%	N/A	20.70%	N/A	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.56	96.00%	4.00%	TBU	1 -2	1 -2	141.8%	84.3%	76.4%	N/A	0.00%	0.00%	0.67	0.00	2.80%	N/A	22.20%	N/A	0	N/A
WSFT	DSU	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward area	51.15	78.00%	22.00%	TBU	1 - 1.5	N/A	93.3%	N/A	128.2%	N/A	3.60%	0.00%	-1.20	0.58	5.80%	N/A	18.60%	N/A	0	N/A
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	TBU	2 - 3	2 - 3	100.0%	97.6%	61.2%	N/A	1.70%	0.00%	-1.10	-0.40	6.90%	10.73	23.00%	0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	TBU	4	6	95.8%	100.0%	123.9%	N/A	1.00%	0.00%	0.80	-1.10	6.30%	7.35	22.30%	2	2	1
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	TBU	6	10	95.5%	94.3%	78.4%	90.4%	12.10%	0.00%	3.00	1.40	4.80%	4.80	17.60%	0	2	0
WSFT	G4	Elderly Medicine	32	48.04	50.06%	49.94%	TBU	6	10	96.0%	92.6%	94.4%	86.8%	15.40%	0.30%	4.50	4.04	5.70%	5.34	24.40%	1	2	1
WSFT	G5	Elderly Medicine	33	Waiting on Finance	Waiting on Finance	Waiting on Finance	TBU	6	11	93.8%	95.5%	92.9%	94.1%	6.20%	0.20%	5.73	0.80	3.70%	4.83	19.10%	0	2	1
WSFT	G8	Stroke	32	48.42	54.31%	45.69%	TBU	5	8	87.9%	89.5%	94.5%	92.7%	14.60%	0.60%	5.00	1.80	9.50%	6.29	25.90%	1	0	2
WSFT	G9	Winter Escalation	30	Waiting on Finance	Waiting on Finance	Waiting on Finance	TBU	6	10	96.9%	220.4%	89.2%	122.4%	25.30%	19.00%	-9.20	-10.20	2.60%	N/A	18.60%	0	0	2
WSFT	F1	Paediatrics	15 - 20	29.85	68.64%	31.36%	TBU	6	9	85.1%	107.8%	117.9%	N/A	10.60%	0.00%	3.73	-1.00	3.30%	N/A	22.40%	N/A	0	N/A
WSFT	F3	Trauma and Orthopaedics	33	37.89	59.07%	40.93%	TBU	7	11	98.8%	97.4%	125.1%	101.2%	3.40%	1.00%	2.50	-1.30	5.80%	5.12	15.80%	3	5	1
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	TBU	8	16	101.7%	88.7%	78.2%	192.0%	15.20%	4.50%	3.50	3.30	9.30%	6.32	24.40%	0	0	1
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	TBU	7	11	95.1%	97.6%	92.9%	114.4%	5.70%	1.20%	1.20	0.50	3.40%	5.44	18.10%	0	0	0
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	TBU	7	11	82.2%	94.1%	115.8%	102.0%	4.20%	9.20%	4.81	2.70	3.50%	7.62	18.40%	1	2	1
WSFT	F9	Gastroenterology	33	43.77	52.34%	47.66%	TBU	7	11	99.4%	97.5%	84.2%	99.8%	11.60%	0.20%	3.40	3.20	6.80%	4.72	21.30%	1	1	0
WSFT	F10	Respiratory	25	40.76	56.58%	43.42%	TBU	6	6	113.7%	85.9%	96.6%	88.3%	9.70%	0.50%	3.10	4.40	3.50%	5.87	19.90%	0	2	0
WSFT	F11	Maternity	29	54.71	72.14%	27.86%	TBU	7.25	14.5	121.3%	99.9%	85.2%	65.0%	11.70%	0.00%	3.45	1.40	4.30%	N/A	23.10%	0	1	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												N/A	1	N/A
WSFT	F12	Infection Control	8	16.43	68.59%	31.41%	TBU	4	4	90.0%	78.9%	89.3%	111.7%	12.50%	1.30%	3.90	0.20	6.20%	7.91	26.80%	0	0	2
WSFT	F14	Gynaecology	8	11.58	96.55%	3.45%	TBU	4	4	99.7%	100.4%	N/A	N/A	1.00%	0.00%	0.70	0.40	1.20%	N/A	17.90%	0	2	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	8.73	82.47%	17.53%	TBU	5 - 8	N/A	92.3%	N/A	76.5%	N/A	0.00%	0.00%	0.20	-0.30	6.10%	N/A	20.10%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.69	85.14%	14.86%	TBU	2 - 4	2 - 4	88.8%	87.5%	42.9%	39.3%	1.60%	0.00%	1.45	1.70	4.90%	N/A	23.90%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	TBU	8	8	98.3%	94.6%	90.6%	110.7%	7.23%	0.0%	0.35	2.19	5.98%	6.50	N/A	0	1	0
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	TBU	6.6	10	83.2%	97.6%	94.4%	91.8%	10.80%	4.1%	-10.10	-9.70	9.1%	5.40	22.60%	2	1	0
																64.39	14.21	Target - 3.5%		Trust standard is 20%			

Key findings

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

Key	
N/A	Not applicable or no data
ETC	Eye Treatment Centre
TBU	To be updated

West Suffolk NHS
NHS Foundation Trust

Trust Board of Directors – 31 March 2017

AGENDA ITEM:	Item 13
PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce & Communications
PREPARED BY:	Lorna Lambert, Medical Education Manager, Mr Peter Harris, Director of Medical Education, Denise Needle, Deputy Director of Workforce (Development), Diane Last, Non-Medical Clinical Tutor, and Dr John Clark, Associate Clinical Dean
DATE PREPARED:	15 March 2017
SUBJECT:	Education and Training
PURPOSE:	Information

EXECUTIVE SUMMARY:
This report provides an update on education and training issues of strategic and service delivery importance for Board Members' information.

Linked Strategic objective (link to website)	**Deliver for today:** • A sharp focus on improving patient experience, safeguarding patient safety and enhancing quality. • Continuing to achieve core standards **Invest in quality, staff and clinical leadership** • Invest in quality and deliver even better standards of care which, over time, should deliver an 'outstanding' CQC rating
Issue previously considered by: (e.g. committees or forums)	Education Strategy Committee
Risk description: (including reference Risk Register and BAF if applicable)	Patient safety, correct staffing levels, staff morale, turnover etc. internal and external reputation.
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Staff perception of Education, Training & Development opportunities through the annual NHS Staff Survey. Medical Education - Royal College and HEEoE visits and assessments Results of annual GMC annual survey of training grade doctors
Legislation / Regulatory requirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	

Recommendation: To receive this report.

Education and Training – Report for Trust Board Members 31st March 2017

Introduction
This report demonstrates how Education and Training is contributing to the three priorities of the Trust's proposed Strategic Framework 'Our patients, our hospital, our future, together'.

Priority 1: Deliver for today
- A sharp focus on improving patient experience, safeguarding patient safety and enhancing quality.
- Continuing to achieve core standards

Nursing, Midwifery and Allied Health Professionals

- Student feedback

The Trust has received the annual Student Survey Placement Summary Report. Congratulations must be given to the dietetics and operating department practitioner teams who received 100%with overall satisfaction with the pre-registration programmes. Areas of improvement have been highlighted within adult nursing, midwifery and radiography and following meetings with professional leads, action plans will be developed and implemented.

- Coaching model for student nurses

Following a pilot on G4 the coaching model of mentorship for student nurses has successfully been implemented on F6. Employment of a clinical educator has resulted in the development of a two year plan to continue the implementation within all clinical and specialist areas that can support the model.

Support Workforce/Other Staff Groups

Care certificate:

The following has been achieved for those undertaking the CC

- starts since Sept 2016 : 38 new staff, and 20 existing staff
- completions since Sept 2016: 33 new staff and 12 existing staff
- Total number of Care Certificates given 113 since March 2015

Priority 2: Invest in quality, staff and clinical leadership
- Invest in quality and deliver even better standards of care which, over time, should deliver an 'outstanding' CQC rating

All clinical staff groups

- ***Quality and Performance Review Visit***
  The Trust provided an update to Health Education East of England on its Quality and Performance Review (QPR) action plan in January 2017 and we are in the process of providing further information on some conditions at HEEoE's request.

In particular Board Members will remember from the September Board report that one of the requirements set by HEEoE was to allocate time (0.25PA) in the job plans of consultants who act as Educational Supervisors and Named Clinical Supervisors to junior doctors in approved training posts. The Trust currently allocates 0.125PA for accredited Educational Supervisors and clinical supervision is included in 1.5SPA allocated to all consultants. The Trust action plan includes a commitment to work towards this standard and there will be a further review of the affordability of meeting this standard on 15 May 2017. HEEoE have asked for an update on progress with this by 30.6.17.

Undergraduate and Postgraduate Medical Education

- ***Peer Mentoring for Foundation Doctors***
  West Suffolk is to pilot a programme of peer mentoring for foundation doctors from August 2017. New Foundation Year 1 doctors will be mentored by Foundation Year 2 doctors. The initiative is led by Dr Francesca Crawley and she will be providing training for the mentors following a successful bid for funding to HEEoE.

- ***Medical Students -new curriculum and increased numbers***
  The Clinical School introduced a new curriculum in September 2015 for both the Standard Course (conventional 6 year programme) and Cambridge Graduate Course. The first year of the new curriculum has generally worked very well.

  The Clinical School is increasing undergraduate medical student numbers which will impact on West Suffolk Hospital, as many of the students clinical attachments are based here. We should be able to effectively teach the larger number of students. Additional accommodation will be required which is planned to open in spring 2018. Additional funding will be received by WSH for teaching more students (SIFT).

- ***Clinical Leaders – College Tutors***
  Miss Lora Young has been appointed College Tutor for surgery.

Nursing, Midwifery and Allied Health Professionals

- Continued Professional Development (CPD) Funding

At present we have not received any funding for continuing professional development for 2017/2018 from HEE. We have compiled a list of development and training that is deemed essential for all non-medical professional groups and departments and are investigating ways that this could be funded.

- Nursing Associate Role

Norfolk and Suffolk were unsuccessful in their bid to become a pilot site for the nursing associate role. We continue to monitor the development of this new role and will communicate with colleagues in other organisations who are part of the pilot.

- Building Resilience in Leaders and Teams

F9 and F8 ward managers have attended a Building Resilience in Leaders and Teams programme devised by HEE and UoS. Both managers found this to be very beneficial and we have put forward F3, G8, G5 and F10 to participate in programmes later this year.

- Health Coaching

We have invested non-medical tariff to train another health coach. This means that students will now be able to access our health coaching programme

Support Workforce/Other Staff Groups

- ***Apprenticeships/Maternity Support Workers/Assistant Practitioners***

Target numbers and funding arrangements have been agreed with Health Education East of England for 2016/17. Please find below our current position

Apprenticeships					
Target	32	Starters	57	End of Year	
Maternity Support workers					
Target	0	Starters	0	End of Year	
Assistant Practitioners (Foundation Degrees)					
Target	16	Starters	14	End of year	

The target and budget for apprenticeships has been reduced by half from last year.

Priority 3: Build a joined up future

- Reduce non elective demand to create capacity to increase elective activity. Help develop and support new capabilities and new integrated pathways in the community

Nursing, Midwifery and Allied Health Professionals

- ***Promoting WSFT to Potential Healthcare Students***

The WSFT has hosted two insight days for 6th form students (nursing/midwifery and radiography/medicine/pharmacy) with positive feedback. Nursing have implemented a two day shadowing experience for 6th form students which is popular. We continue to visit schools, colleges and universities to promote healthcare careers within the WSFT and this year has seen us go over our target for nursing students who wish to have their placements with us. Physiotherapy have trialled a new method of interviewing resulting in jobs being offered to three newly qualified professionals who have all accepted.

Support Workforce/Other Staff Groups

- ***Work Experience Placements***

Since taking over on 1 August 2016 to date, we sought advice of consultants and area leads then set up our own formats/processes to incorporate what was known as 'Work Experience' into our Student Programme, which now includes -

- Student Volunteers – entails 50 hours, accredited, helping on wards at mealtimes and usually for 2 hours weekly over 6 months.
- Clinical Shadowing (+16 years)

The Deputy Voluntary Services Manager has liaised with and set up systems for Clinical Shadowing (1-2 day experience) not only in medicine but now in nursing, and AHPs, ensuring all students attending forward confirmation of their relevant studies from tutors, have been health screened, and individually Risk Assessed for fewer than 18s. Students receive Confirmation of Placement, where they sign our Confidentiality statement, and Information regarding Dress Code, Liability etc.

From 111 applications 52 students have completed with currently 50 applications in process.

Non-clinical Work Experience for Year 10/11s (15-16 years)

The Deputy Voluntary Services Manager has liaised with schools to ensure we support our local schools as much as possible as we are limited to offering only 2-3 placements for a couple of times a year. (Health screening and Parental Risk Assessments are undertaken for under 16s). 4 students took part last year from 5 applications and currently 7 have applied for this year.

Item 14 Trust Board of Directors – 31st March 2017

PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Medical Staffing, HR and Communications Directorate
DATE PREPARED:	23rd March 2017.
SUBJECT:	Consultant Appointments
PURPOSE:	To receive report
STRATEGIC OBJECTIVE:	To continue to secure, motivate, educate and develop a committed workforce providing high quality patient focused services.

POST:	Consultant in Gastroenterology
DATE OF INTERVIEW:	Monday 20th March 2017.
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	1 1 1

West Suffolk NHS
NHS Foundation Trust

Item 15 **Trust Board – 31st March 2017**

PRESENTED BY:	Jan Bloomfield, Executive Director Workforce & Communications
PREPARED BY:	Len Rowland, Workforce Information Manager
DATE PREPARED:	16/03/2017
SUBJECT:	**Annual Staff Survey 2016**
PURPOSE:	For information
STRATEGIC OBJECTIVE:	To continuously improve service quality and effectiveness through innovation, productivity and promoting wellbeing in patients and staff

EXECUTIVE SUMMARY:

The 2016 National Staff Survey was received into the Trust on 21th February 2017, but was embargoed from external publication until 7th March 2017.

The survey was completed by staff during the period September 2016 to December 2016. A sample of 1250 staff members were randomly selected, of which 624 responded. This is a 50.2% response rate, the average for acute trusts was 39.9% and the best was 52.2%.

The sample size has increased from 850 to 1250 staff this year and there has been an overall increase of 35% in the number of staff returning a staff survey compared to last year.

The best performing of the Picker acute trusts **decreased** by 2% despite the sample size increase. Which demonstrates that we continue our upward trend of response rate against the trend of other similar trusts.

The National NHS Staff Survey provides a very useful source of data on a number of the issues, especially staff engagement, staff views on quality of care, on willingness to raise concerns and to recommend the services of the organisation (the staff friends and family test).

Together with other data, this will enable us to identify key workforce and service issues and develop a strategy for dealing with areas for improvement.

Areas for improvement

The key areas for action coming out of this year's survey are the bottom 5 ranking scores. Those in **bold** also appeared in the bottom 5 in the 2015 survey:

- **KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months**
- KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- **KF11. Percentage of staff appraised in last 12 months**
- **KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month**
- KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

An action plan for the bottom 5 scores is currently in progress.

Matters resulting from recommendations in this report	**Present**	**Considered**
Financial Implications	Possibly*	no
Workforce Implications	yes	yes
Impact on Equality and Diversity	Possibly*	no
Legislation, Regulations and other external directives	yes	yes
Internal policy or procedural issues	yes	yes
Risk Implications for West Suffolk Hospital (including any	**Mitigating Actions**	

clinical and financial consequences): Risk to patient safety due to untrained staff. Risk also to staff.	Monitoring of the impact of e-Care refresher training.
Level of Assurance that can be given to the Committee from the report based on the evidence [significant, sufficient, limited, none]: Sufficient	
Recommendation: To receive this report and agree the action plan	
Possibly* - this will be reviewed as part of the full analysis of Staff Survey report.	

Annual Staff Survey 2016

Staff Engagement

The figure below shows how West Suffolk NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.97 was in the highest (best) 20% when compared with trusts of a similar type.

Our trust is also the top scoring acute trust in England for overall staff engagement.

	Trust Score 2015	Trust Score 2016	National Average 2015
Overall Staff Engagement	3.94	3.97	3.81

Overall staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7.

	2015	Nat average	2016	Nat average	+/- last year	Ranking, compared with all acute trusts
KF1. Staff recommendation of the trust as a place to work or receive treatment	4.07	3.76	4.10	3.77	**+0.03**	Highest (best) 20%
KF4. Staff motivation at work	3.99	3.94	4.03	3.94	**+0.04**	Highest (best) 20%
KF7. Staff ability to contribute towards improvements at work	70%	69%	73%	70%	**+3%**	Above (better than) average

Top and Bottom Five Ranking Scores

The 2016 staff survey report has 32 key findings. Overall the Trust has achieved the following as compared to other acute trusts:

Highest (in the best) 20%	12 Key Findings
Lowest (in the best) 20%	2 Key Findings
Above (better than) average	6 Key Findings
Below (better than) average	1 Key Finding
Average	6 Key Findings
Above (worse than) average	3 Key Findings
Below (worse than) average	2 Key Findings

This table highlights the five Key Findings for which West Suffolk NHS Foundation Trust compares most favourably with other acute trusts in England.

Top Five Ranking Scores	2015		2016		Target trend	Improvement / Deterioration	Trust KF Results against all acute trusts
	Trust	National Average	Trust	National Average	Up/Down	% / points since 2015	
KF1. Staff recommendation of the organisation as a place to work or receive treatment	4.07	3.76	4.10	3.77	+	**+0.04**	Highest (best) 20%
KF21. % believing the organisation provides equal opportunities for career progression / promotion	89%	87%	91%	86%	-	**+2%**	Highest (best) 20%
KF14. Staff satisfaction with resourcing and support	3.45	3.30	3.48	3.34	+	**+0.03**	Highest (best) 20%
KF5. Recognition and value of staff by managers and the organisation	3.53	3.42	3.64	3.46	+	**+0.11**	Highest (best) 20%
KF8. Staff satisfaction with level of responsibility and involvement	3.99	3.91	4.04	3.93	+	**+0.05**	Highest (best) 20%

The table highlights the five Key Findings for which West Suffolk NHS Foundation Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

Bottom Five Ranking Scores	2015		2016		Target trend	Improvement / Deterioration	Trust KF Results against other trusts
	Trust	National Average	Trust	National Average	Up / Down	% / points since 2015	
**** KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths***	23%	14%	16%	15%	+	**-7%**	Above (worse than) average
**** KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths***	30%	28%	28%	27%	-	**-2%**	Above (worse than) average
KF11. % appraised in last 12 mths	80%	86%	83%	87%	+	**+3%**	Below (worse than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	89%	90%	90%	90%		**+1%**	Below (worse than) average
**** KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure***	59%	59%	57%	56%	-	**-2%**	Above (worse than) average

There are other results related to the areas in the **bottom 5** where the trust score was low but, due to these results being combined with some high scoring question in NHS Staff Survey and weighting of scores, the negative results are somewhat disguised.

These include;

20e Appraisal/performance review: organisational values definitely discussed
20b Appraisal/review definitely helped me improve how I did my job
20c Clear work objectives definitely agreed during appraisal
20d Appraisal/performance review: definitely left feeling work is valued

Key Findings for all key factors

** lower scores are better,* decimal scores are on a scale of 1-5, 5 being highest

Key Findings for West Suffolk NHS Foundation Trust benchmarked against other acute trusts.

	2015		2016		Ranking compared to other Trusts in 2016	Change
	Trust	National Average	Trust	National Average		% / points since 2015
Appraisals & support for development						
KF11. % appraised in last 12 mths	80%	86%	83%	87%		+3%
KF12. Quality of appraisals	3.15	3.05	3.15	3.11		No change
KF13. Quality of non-mandatory training, learning or development	4.05	4.03	4.08	4.05		+0.03
Equality & diversity						
**** KF20. % experiencing discrimination at work in last 12 mths***	11%	10%	10%	11%		-1%
KF21. % believing the organisation provides equal opportunities for career progression / promotion	89%	87%	91%	86%		+2%
Errors & incidents						
**** KF28. % witnessing potentially harmful errors, near misses or incidents in last mth***	33%	31%	28%	31%		-5%
KF29. % reporting errors, near misses or incidents witnessed in last mth	89%	90%	90%	90%		+1%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.74	3.7	3.83	3.72		+0.09
KF31. Staff confidence and security in reporting unsafe clinical practice	3.61	3.62	3.73	3.66		+0.07
Health and wellbeing						

	2015		2016		Ranking compared to other Trusts in 2016	Change
	Trust	National Average	Trust	National Average		% / points since 2015
**** KF17. % feeling unwell due to work related stress in last 12 mths***	34%	36%	33%	35%		-1%
**** KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure***	59%	59%	57%	56%		-2%
KF19. Org and mgmt interest in and action on health and wellbeing	3.67	3.57	3.78	3.62		+0.11
Working patterns						
KF15. % satisfied with the opportunities for flexible working patterns	48%	49%	56%	51%		+8%
**** KF16. % working extra hours***	70%	72%	70%	71%		No change
Job satisfaction						
KF1. Staff recommendation of the organisation as a place to work or receive treatment	4.07	3.76	4.10	3.77		+0.03
KF4. Staff motivation at work	3.99	3.94	4.03	3.94		+0.04
KF7. % able to contribute towards improvements at work	70%	69%	73%	70%		+3%
KF8. Staff satisfaction with level of responsibility and involvement	3.99	3.91	4.04	3.93		0.05
KF9. Effective team working	3.76	3.73	3.79	3.75		+0.03
KF14. Staff satisfaction with resourcing and support	3.45	3.30	3.48	3.34		+0.03
Managers						
KF5. Recognition and value of staff by managers and the organisation	3.53	3.42	3.64	3.46		+0.11
KF6. % reporting good communication between senior management and staff	32%	32%	36%	33%		+4%
KF10. Support from immediate managers	3.72	3.69	3.79	3.73		+0.07
Patient care & experience						
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.06	3.93	4.02	3.97		-0.04
KF3. % agreeing that their role makes a difference to patients / service users	93%	90%	91%	90%		-2%
KF32. Effective use of patient / service user feedback	3.76	3.70	3.79	3.71		+0.03
Violence, harassment & bullying						
**** KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths***	23%	14%	16%	15%		-7%
**** KF23. % experiencing physical violence from staff in last 12 mths***	2%	2%	2%	2%		No change
KF24. % reporting most recent experience of violence	65%	53%	63%	67%		-2%
**** KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths***	30%	28%	28%	27%		-2%
**** KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths***	23%	26%	24%	24%		+1%
KF27. % reporting most recent experience of harassment, bullying or abuse	27%	37%	52%	45%		+25%

Summary of Staff Survey response

The following summaries provide details on response rates to the recent staff survey and how this compares to the previous years' results. West Suffolk NHS Foundation Trust is among the best 20%.

Overall staff survey response	No. eligible staff	Sample size	Returned	Trust response rate % and performance against previous survey	
2012 Sample	2818	798	430	54%	9% (decrease)
2013 Sample	2955	797	453	57%	3% (increase)
2014 Sample	2956	798	419	53%	4% (decrease)
2015 Sample	3068	850	462	54%	1% (increase)
2016 Sample	3490	**1250**	624	50%	4% (decrease) impacted by increase in sample size

Next Steps

Managers and Staff Governors will analyse the results of the staff survey, along with other data, to see which of the issues in the full report is of most relevance to the organisation.

We will develop a strategy for dealing with the priorities. This will be presented to the Trust Board of Directors for agreement.

Staff Survey Engagement and Improvement Plan

A summary of the action plan for 2015 will be published to demonstrate action taken on previous results as only 34% of staff feel that senior managers act on staff feedback. The action plan for 2016 will also be published once available.

The results from the staff survey at trust level as well as the top and bottom 5 results will also be published.

An update on the staff survey action plan will be published every quarter in line with the Staff Friends and Family Test (FFT) questionnaire to encourage an increase in the number of responses.

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Board of Directors – 31 March 2017

AGENDA ITEM:	Item 17
PRESENTED BY:	Dr Stephen Dunn, Chief Executive
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	24 March 2017
SUBJECT:	Trust Executive Group (TEG) report
PURPOSE:	Information

EXECUTIVE SUMMARY:

6 March 2017

Craig Black provided feedback from the Board meeting reflecting on **operational and financial performance** as well as the MHRA inspection. Detailed discussion took place on the year end position and the forecast deficit position of £12.7M. Performance for the 4 hour wait target was reviewed in the context of needing to sustainably delivery better than 90% performance.

It was recognised that patient waits had increased to what was now an unacceptable standard of **patients waiting 52 weeks** or more. The position was reviewed in detail and plans discussed to mitigation the position, including patient level review with surgery.

A report was received from the **Flow Action Group (FLAG).** Emphasis remained on Red to Green Board Rounds. Nick Jenkins thanks all involved for their effort in delivering progress and in particular thanked senior matrons and service managers who are doing a lot of work in supporting the process. Performance dashboards are now available on the intranet, including daily red to green dashboards (which were a snapshot of the previous day) and a SAFER dashboard with a weekly tracker.

The **red risk report** was reviewed with discussion and challenge for individual areas. A new risk regarding the management of deteriorating patients in ED was approved. It was also noted that risk assessments were being prepared to consider referral to treatment (RTT) and blood transfusion services. The need to risk assess 'results acknowledgement' as part of the next phase of e-Care implementation was highlighted.

It was noted that the **UCAS Histopathology Laboratory inspection** had gone well with the expectation to transfer to the new UCAS licence.

TEG approved the **pharmacy self-assessment** against the Carter metrics and model hospital benchmarks for submission to the Scrutiny Committee. The response had been developed in collaboration with Ipswich and Colchester hospitals. A key area for development for the WSFT is the use of biosimilar infliximab, switching patients to lower cost alternatives.

A review was undertaken of the revised **e-Care benefits** against the original business case. It was confirmed that the Cranfield methodology was being used to assess benefits. As part of this work business dependencies are being mapped to ensure interdependencies are understood.

An update was received on the **medical rostering project**. The structured clinical engagement in the development of this project was welcomed by the Medical Director and Clinical Directors.

20 March 2017

Steve Dunn provided an introduction to the meeting including feedback from **national and region meetings** he had attended. He emphasised the need to maintain focus on efficiency and responsiveness with forensic consideration of performance, productivity and finances. The focus of the agenda reflected this emphasis.

Overall performance against the **4 hour wait performance** for March was noted to have improved and currently sitting at 92%. This had improved the Trust's benchmark performance within the region.

Craig Black outlined the **financial position** for the Trust and that consideration is currently being given to specific accountancy treatments which could improve the Trust's outturn position for 201617.

The **FLAG report** focused on recent audit results with a focus to address 'Pyjama Paralysis' and ensure that patients who are out of bed are dressed. Evidence shows that dressed patients feel better and have more chance of going home quickly (with less chance of deterioration).

A detailed report of the **referral to treatment time (RTT)** position was considered. Specific specialty level plans were reviewed. The focus was to minimise future breaches and support the delivery of sustainable service access.

Feedback was received on compliance locally with the national guidance for **CPE (carbapenemase-producing enterobacteriacea) testing**. It was agree that a costed implementation plan be developed to support the Trust in delivering the expectation of the guidance. It was recognised that the limitation of the building, including the ability to isolate patients, would impact on the Trust's screening and isolation plans.

An update was received on **the Pathology Partnership (tPP)** restructuring plans and the action to address concerns identified by the MHRA.

An update on progress with **consultant job planning** was received. Significant progress was noted with 97% of job plans submitted for approval.

TEG reviewed and supported the updated **capital programme** noting the significant areas of expenditure around decant ward, global digital excellence (GDE) and staff residences.

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

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Board of Directors – 31 March 2017

AGENDA ITEM:	Item 18
PRESENTED BY:	Rosie Varley, Non-Executive Director
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	23 March 2017
SUBJECT:	Remuneration Committee report – 3 March 2017
PURPOSE:	Information

EXECUTIVE SUMMARY:

The Committee considered the following:

1. **Clinical Excellence Awards Scheme**
   Noted that the scheme will run during 2017/18 and will be linked to the Trust's priorities and values. The CEA criteria will be reviewed prior to issuing to the Trust Negotiating Committee.

2. **Executive director objectives**
   The committee reviewed the executive team's objectives for the current year. Discussion took place regarding the focus of objectives for the year ahead.

3. **Meeting and reporting schedule**
   The committee approved a reporting schedule for meetings being held to support the annual appraisal and objective setting cycle.

* Clinical Excellence Awards Scheme - scheme to recognise and reward NHS consultants and academic GPs who perform 'over and above' the standard expected of their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions [NHSE 2016]

Linked Strategic objective (link to website)	6. To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	The Committee meets on a six-monthly basis and provides a report to the Board summarising issues discussed and any issues for escalation.
Risk description: (including reference Risk Register and BAF if applicable)	Failure of the Board to maintain oversight of executive director responsibilities, objectives and performance.
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	The Committee provides assurance to the Board through its activities and escalation arrangements, reported after each meeting.
Legislation / Regulatory requirements:	NHSIr's code of governance
Other key issues:	

Recommendation:
The Board notes the report and decisions made.

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Board of Directors – 31 March 2017

AGENDA ITEM:	Item 19
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	24 March 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 April 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 presentation – none scheduled	✓		Written	Matrix	Execs
Quality & performance report, including quality priorities and Community services Provider Management Group report, staff recommender scores and mandatory training analysis	✓		Written	Matrix	HB/RP
Revised mortality reporting	✓		Written	Action point	NJ
Finance & workforce performance report	✓		Written	Matrix	CB
Transformation report (quarterly)	✓		Written	Matrix	HB
Red risk report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP					
Nurse staffing report	✓		Written	Matrix	RP
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
CQC self-assessment process	✓		Written	Matrix	RP
National staff survey report	✓		Written	Matrix	JB
Nursing strategy update	✓		Written	Matrix	RP
Appointment of senior independent director		✓	Written	Action point	RQ
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
BUILD A JOINED-UP FUTURE					
e-Care report	✓		Written	Action point - schedule	CB
Scrutiny Committee report		✓	Written	Matrix	GN
Estates strategy (master plan)	✓		Written	Matrix	CB
Clinical Excellence Awards Scheme assessment criteria		✓	Written	Action point - RemCom	JB
Strategic update, including STP, ICO and TPP		✓	Written	Action point - schedule	SD
Draft annual report narrative		✓	Written	Matrix	RJ
GOVERNANCE					
Trust Executive Group report	✓		Written	Matrix	SD
Quality & Risk Committee report, including review of terms of reference and annual governance review recommendations	✓		Written	Matrix	RQ
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