NHS
West Suffolk
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 3 November 2017 at 9.15** in the Northgate Room, 2nd Floor, Quince House at West Suffolk Hospital

Roger Quince
Chairman

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Introductions and apologies for absence** To note any apologies for the meeting	Roger Quince
2.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Roger Quince
3.	**Review of agenda** To agree any alterations to the timing of the agenda	Roger Quince
4.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Roger Quince
5.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 29 September 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 & new Integrated Performance Report	Helen Beck / Rowan Procter
9.	**Finance & Workforce Performance report (attached)** To accept the monthly Finance & Workforce report	Craig Black
10.	**Transformation report – Q2 (attached)** To approve the report	Helen Beck
11.	**Winter planning report (attached)** To approve report, including internal and system based focus to allow the Trust to sustain performance at the predicted level of activity	Helen Beck
10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
12.	**Aggregated quality report (attached)** To accept the aggregated analysis including serious incidents, red complaints and PALs enquiries	Rowan Procter / Nick Jenkins

13.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter
14.	**Mandatory training report (attached)** To approve the report	Jan Bloomfield
15.	**Safe staffing guardian report (attached)** To receive the report	Sarah Gull
16.	**Freedom to speak up guardian report (attached)** To receive the report	Nick Finch
17.	**Helpforce initiative (attached)** To receive an progress report	Jan Bloomfield
18.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
19.	**Consultant appointment report (attached)** To accept the report	Jan Bloomfield
10:50 BUILD A JOINED-UP FUTURE		
20.	**e-Care report (verbal)** To receive an update report	Craig Black
21.	**Alliance and community services (attached)** To receive an update report	Helen Beck
22.	**Sustainable carbon reduction strategy** To approve the annual report	Jan Bloomfield
11:00 GOVERNANCE		
23.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
24.	**Quality & Risk Committee report (attached)** To receive the report for the meeting held on 29 September 2017	Roger Quince
25.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:15 ITEMS FOR INFORMATION		
26.	**Any other business** To consider any matters which, in the opinion of the Chairman, should be considered as a matter of urgency	Roger Quince
27.	**Date of next meeting** To note that the next meeting will be held on Friday, 1 December 2017 at 9:15 am in the Committee Room.	Roger Quince

RESOLUTION TO MOVE TO CLOSED SESSION		
28.	The Trust Board is invited to <u>adopt</u> 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

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 29 SEPTEMBER 2017

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

Action

GENERAL BUSINESS

The Chairman welcomed everyone to the meeting and introduced Catherine Waller.

He explained that NHSI was very concerned about the lack of female representation on Trust Boards. Therefore a programme had been set up to provide support and training to individuals to enable them to be more eligible to apply for NED positions. The programme was for a year and Catherine Waller had been selected as a candidate. She would be attending WSFT Board meetings for at least the next six months and Alan Rose had agreed to be her NED mentor.

This role had been through the Scrutiny Committee and Council of Governors but NHSI had asked for the Board's formal approval.

The Board approved Catherine Waller's internship for a period of twelve months.

17/178 APOLOGIES FOR ABSENCE

There were no apologies for absence.

17/179 QUESTIONS FROM THE PUBLIC

- Joe Pajak congratulated Rowan Procter on her interview on Radio Suffolk this morning, which he considered to be very positive. He asked her if there was anything that she wanted to emphasise on falls, recruitment and staffing.

Rowan Procter explained that the Royal College of Nursing (RCN) had been very public about staff and the stress they were under, particularly that it was not always possible for there to be someone with a patient on a ward who was dying.

She said that WSFT had the best staff survey nationally; the staffing complement remained steady each month and there as an ongoing international recruitment programme. All areas were risk assessed at every meeting, ie four to five times a day, to ensure that they were safe and to help relieve stress on staff.

- Joe Pajak referred to item 20a, equality and diversity report and the likelihood of recruiting white staff, as opposed to BME staff. He asked for more detail on the Trust's strategy to recruit BME staff. The Chairman explained that Addenbrooke's had the same issue. This would be discussed later in the meeting.

- June Carpenter asked Nick Jenkins how the Trust was encouraging everyone to have a flu jab and if volunteers and Governors were eligible for these. It was explained that volunteers were eligible and if Governors wished to have a flu jab they should go to occupational health. However, volunteers and Governors would not count in the figures that the Trust was required to submit.

  In order to encourage staff and make it as easy as possible to have a flu jab a 'flu stop' area had been set up and they would also be available in Time Out for the next few weeks. On Monday this would be a key feature of core brief and there would be a communications programme from Monday onwards to try to get as many staff vaccinated as possible.

- June Carpenter asked about 52 week waits and ENT. It was explained that this would be followed up under agenda item 8.

- Liz Steele asked about A&E and readmissions. She also noted that the Trust was already under considerable pressure in A&E and asked what assurance could be given that it would manage through winter, which was the most difficult time.

  Nick Jenkins explained that 2.16% of patients at WSFT were readmitted. The national target was between 1%-5%, therefore he was comfortable with this figure. This information would be included in the Board report from next month.

  Helen Beck said that she would cover winter pressures and A&E under item 8.

- Judy Cory referred to chaperones in outpatients and suggested that appointment letters should say that people were welcome to bring a chaperone or friend with them. It was proposed that this should be followed up. **R Procter**

17/180 REVIEW OF AGENDA

The agenda was reviewed and it was noted that all Board members would have flu jabs between the open and closed meetings. There was also a retirement presentation to a consultant at 1.00pm which some Board members would be attending.

17/181 DECLARATION OF INTERESTS

There were no declarations of interest.

17/182 MINUTES OF THE MEETING HELD ON 28 JULY 2017

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

Page 6, paras 5 and 9, typo; “ultraism” should read “altruism”.

17/183 MATTERS ARISING ACTION SHEET

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

Item 1331 – provide Board with a stroke services option appraisal and sustainability report. Nick Jenkins explained that he and the Chief Executive had attended the recent STP meeting where it was acknowledged that stroke was one of the areas where all three hospitals provided good care but were challenged about the sustainability of this care. It was difficult to know the position until it was decided which organisations would do thrombectomy.

Alan Rose asked if this would then lead to a decision being made as to what each hospital within the STP would do. Nick Jenkins said that this discussion would need to include the ambulance service and would be wider than the local STP. Clarity around this would be provided to a future meeting. **N Jenkins**

Item 1395 – maternity WHO analysis to include further detail of performance and remedial action. Nick Jenkins reported that performance had deteriorated this month and he had arranged a meeting with senior leads and the head of midwifery about this.

Neville Hounsome said that this was an ongoing concern and a patient safety issue, due to individual clinicians not complying and completing forms correctly.

Gary Norgate asked if other staff involved in the process felt able to challenge the individual who was not following the correct process when completing the form. Nick Jenkins explained that he had discussed this with Rowan Procter and he would be following this up next week to stress that it was everybody’s job to make sure that this was done. He would provide an update to the Board next month on action being taken to improve this performance. **N Jenkins**

Item 1456 – confirm the reason for the ten consultants with delayed appraisals. Nick Jenkins reported that these were for a variety of very valid reasons and these had now been completed. He was confident that process for encouraging people to complete these on time was as robust as it could be.

Angus Eaton asked if there was any correlation with the ten delayed appraisals which could result in patient safety issues. Nick Jenkins confirmed that this was not the case and that all these individuals had good clinical performance.

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

Item 1402 – update on SLT services to include performance against original plan, work with local authority and assurance for future delivery. Neville Hounsome asked if this information could have gone to the open Board meeting. Rowan Procter explained that this was would not have been appropriate.

Item 1427 – it was noted that there was a typo, ie “hormonal” should read “horizontal”.

Item 1430 – document recent advice from police and others regarding site lockdown and report to the Emergency Planning Group with learning from recent events. Steve Turpie asked what would happen if WSFT was physically attacked and if the advice provided by the police has been seen by a Board member.

Helen Beck confirmed that this was the case and a report would be going to the next Corporate Risk Committee meeting.

Gary Norgate referred to a previous action around extra sessions and levels of efficiency. He was not assured that an outcome for this had been recorded. Richard Jones confirmed that he would follow this up. **R Jones**

17/184 CHIEF EXECUTIVE'S REPORT

The Chief Executive highlighted the following:-

- The Trust had had a very busy summer and this had continued during last week. For four out of five days more than 200 people had attended A&E and on the other day the number attending has been very close to this. On Monday WSFT had had the worst performance in A&E in the country at 61%. On Tuesday performance had been 75% and on Wednesday it had had the best performance in the region.

  There continued to be sustained pressure on the hospital and many of the initiatives to address this were mentioned in the report. The Trust was now actively providing discharge social care and from 1 October 2017 it would be running community services.

  It was unlikely that an escalation ward would be opened, due to the number of staff required. Therefore WSFT was considering opening a discharge lounge and looking at other ways to reduce length of stay over the winter. This had to be the key focus and priority for the leadership team to ensure that a safe hospital was maintained over the winter. This challenge would become more acute over this period and staff were already feeling under pressure in some parts of the hospital. There was currently a focus on timing of annual leave to ensure sufficient cover at all times.

- The CQC would be visiting the Trust in the near future and work was being undertaken for prepare for this.

- Diabetes care at WSFT had performed extremely well in the 2016 National Diabetes Inpatients Audit, with the results being well above the national average of 60%, ie 86% and 81%.

- A staff nurse's idea to introduce green cups to signify when a drink contained soluble medication was a great example of staff feeling empowered to put forward their ideas/initiatives.

The Chairman requested a paper for the next Board meeting detailing the preparation and plans for winter. The Chief Executive explained that the Trust would be developing further winter plans as a result of the challenges it had faced over the last few weeks. Details of these would be included in the report. Neville Hounsome suggested that this should also include the worst case scenario.

Steve Turpie referred to frequent A&E attenders and suggested that actions to reduce these should be included in the paper. Nick Jenkins confirmed that this was being addressed.

Helen Beck explained that a lot of the plan focussed around the backdoor and discharging patients. Indications showed that this was working well, but continued to be a challenge.

Gary Norgate suggested that the report should also include information on integrated care and work being undertaken with GPs to improve flow and being more effective at treating people in the right place. **H Beck**

DELIVER FOR TODAY

17/185 QUALITY & PERFORMANCE REPORT

The Chairman considered this to be good summary.

Rowan Procter referred to the task and finish group on falls, pressure ulcers and nutrition and explained that work had begun but had not yet been concluded. The increase in pressure ulcers had been due to acuity of patients being admitted and end of life patients.

WSFT was working with the ambulance trust on cannula insertion to ensure better patient experience and flow.

One duty of candour had been completed and finalised.

Neville Hounsome noted the improved performance on informing patients of delays and offering patients the company of a chaperone.

Helen Beck referred to 52 week waits and referral to treatment (RTT). The number of 52 week waits was worse than predicted; however a significant number of these were due to patient choice, which extended their waits. NHSI had just released a new model access policy and WSFT has rewritten its policy for internal comment. This would then go to the CCG for approval.

ENT waits to first appointment had improved from a worse case position of 40 weeks to 25 weeks currently and work continued to reduce these.

Audiology waits were also improving due to a number of extra sessions.

RTT last month was significantly ahead of trajectory; however performance had not been so good this month which meant that the Trust was on trajectory for its plan with the CCG. There was concern around the pressure from the emergency department and medical outliers which would be a challenge. There had also been an increase in emergency surgery. Rowan Procter reported that on Monday and Tuesday there had been a number of patients waiting for 52 week surgery and it was decided not to cancel these due to patient safety.

Alan Rose asked if information about medical outliers was shown in the Board report. Helen Beck explained that this was shown in a detailed capacity report at every bed meeting and these were all risk assessed and reviewed. Each surgical ward had a medical consultant and medical team attached to it and the Trust managed the risk of outliers very proactively.

Angus Eaton referred to elective surgery and asked if there was a problem building up around this. Helen Beck said that she did not think this was the case. Nick Jenkins explained that operations were only cancelled due to emergency surgery in a crisis. Cancellations on the day were lower than most organisations and normally re-booked within 28 days.

Helen Beck explained that a detailed outpatient and capacity in theatre demand analysis was being undertaken. Information for ENT had been put through this and sent to the elective intensive support team (IST) to confirm that it was correct. This would then follow with other specialties.

Neville Hounsome suggested that more commentary should be provided on actions for the number of RTT waits over 52 weeks for incomplete pathways. Helen Beck confirmed that there was a plan and she would include more detail in the next report. **H Beck**

Richard Davies referred to patients wishing to go home to die and said that from his experience it was very difficult to arrange for patients to go home to die. He considered this to be a good metric of whether integrated care was working and that it was good to have been able to send two patient homes to die.

Helen Beck explained that the discharge planning team was now working directly with the hospital transport service which had been very effective.

17/186 FINANCE AND WORKFORCE REPORT

Craig Black reported that financial performance year to date was £41k behind plan and the Trust was still forecasting to achieve the plan overall.

The key issue was spend on temporary staff due to extra sessions to deliver the RTT position and also to fill the increased number of vacancies due to annual leave. Historically temporary spend increased in August; however as the majority of annual leave was taken during this period this should not be an issue for the rest of the year.

The cash position was not good and the Trust had already had to borrow money to fund the capital programme. As it continued to lose money the amount it would have to borrow would increase. By the end of next year it would need to borrow £19m in order to continue to pay wages.

Alan Rose asked how difficult it was to draw cash down. Craig Black explained that the process had become very simple as more organisations needed to draw down cash. However, permission was still required and there was no guarantee that this would remain simple. The Board needed to understand that the organisation was fundamentally insolvent.

Gary Norgate referred to the volumes on page 5 and staffing levels on page 8 and a statement in the previous report showing the deficit across departments. He said that the three illustrations highlighted different aspects of performance. Craig Black explained that the illustration on page 5 depended on case mix and resource required. Weighted activity increased by approximately 2.5% per year. Page 8 included a benchmark increase of 2.5% per year and actual staffing was broadly starting to come back into line with this benchmark.

Gary Norgate asked how many extra sessions were due to inefficiency as opposed to lack of capacity. He noted that if the resource plan was correct the Trust would lose staff over the coming months. Craig Black explained that the CIP had been evenly phased this year, therefore it needed to continue along the current path. However, the issue was that as the Trust moved into next year it needed to surpass this year's plan in order to have the best opportunity to hit the year-end target.

Gary Norgate asked if there was a plan in place to reduce staffing to the required level.

Craig Black confirmed that plans were in place to hit this year's plan but he was more concerned about next year's plan and KPMG's work was moving towards focussing on next year.

Neville Hounsome referred to the CIP on page 4 and noted that there were three projects that were behind plan, ie car park income, agency and community equipment service. He asked for assurance that these would be achieved in the second half of the year.

Craig Black explained that he would not expect every programme to deliver exactly to plan and was expecting some variance. Divisions would be required to compensate in other areas for any shortfall if they could not bring savings back to plan.

Car parking was considered to be seasonal. There was more pressure on the organisation's ability to make savings around temporary staff. A re-focus would be required on community equipment services.

Neville Hounsome asked about the level of confidence that next year's CIP would be achievable. Craig Black said that he was concerned about this and a paper would be going to the closed Board meeting as there was a considerable gap to achieve the savings target. Achieving this year's plan of £13.3m was difficult and remained challenging, but achieving £18.3m next year was even harder.

Steve Turpie expressed concern about the poor performance on income in Women & Children and noted that if the current trend continued it would be approximately £2m behind plan. He requested that actions to address this were included in the next report. Nick Jenkins explained that over the summer the operating theatres at Lakenheath had been out of action, therefore 73 babies were delivered at WSFT which had provided private income of £200k. However, this had had an impact on the midwives to births ratio. **C Black**

Craig Black referred to the block contract and highlighted a significant over-performance in the corporate division. This meant that the current deficit in Women & Children did not have a cash consequence for the organisation. He stressed that divisions were monitored in terms of activity and income. More analysis would come to the next meeting.

Angus Eaton asked how the challenges on income could be solved. Craig Black explained that it was not possible to solve the organisational challenge through income and that this had to be addressed by managing expenditure. It was possible to create income from outside the Trust's catchment area, but this depended on capacity to deliver services.

The Chief Executive noted that page 8 showed that staffing levels had remained flat. He referred to ward based staff on page 10 and the significant decrease in spend on nursing compared to previous years, which highlighted why people were feeling under pressure. He suggested that further work was required on this.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/187 AGGREGATED QUALITY REPORT

The Board noted the content of this report.

17/188 NURSE STAFFING REPORT

Rowan Procter referred to areas with higher medication errors than others and explained that these had been reviewed and no harm had come to patients.

If there was a medication error the member of staff would have a one to one with the matron and letter would be put on their file. If more than one error occurred this would be escalated.

Areas with higher numbers of medication errors correlated with vacancies/fill rate.

KPMG were supporting work on managing the shortage of registered nurses by changing establishments on wards and developing staff to address these changes and maintain staffing levels.

Steve Turpie asked if any controls or actions that were taken to provide additional training or awareness where there was a concern, eg medication errors. Rowan Procter confirmed that when there was a concern in an area work was undertaken with staff on competencies that it was considered needed to be addressed, to give individuals confidence and training.

Neville Hounsome suggested that annual leave should be 5% of the total number of staff in an area off at any one time, but it appeared to be 12%. Rowan Procter explained that the average employee had annual leave equating to 12% of working days, therefore the target was correct. However, this was a challenging target which service managers were working to manage as tightly as possible, and she was monitoring carefully.

17/189 LEARNING FROM DEATHS REPORT

Nick Jenkins explained that this month the Board had been provided with both the old and the new way of reporting. He commended Helena Jopling and Penny Molkenthin for the work they had done and explained that WSFT had been asked to act as an exemplar site for this.

Angus Eaton referred to page 6 of the policy, item 5.6, engagement with families and carers, and suggested that it gave the impression that the Trust would be providing legal advice. Nick Jenkins explained that the Trust would advise relatives that they could seek legal advice if they wished to.

Richard Davies considered this to be a good report, but that there were significant workload implications for medical reviewers. Nick Jenkins said that assuming there were 1000 deaths per year, this would require 7-8 PA of consultant time. It was hoped to be able to recruit to these posts internally or from recently retired staff who would take on most of this work. This would mainly be funded from the fee that families paid for completion of the second part of the cremation form.

Alan Rose referred to preventable deaths on the dashboard and asked how this could be tracked over a longer period of time as data developed, so that any trend could be easily identified. Nick Jenkins explained that the dashboard below this should highlight this information. **N Jenkins**

The Chairman suggested looking at a similar cohort of trusts to confirm that WSFT was not an outlier. He asked if patients at Glastonbury Court were considered to be inpatients and included in these figures. Nick Jenkins would confirm whether this was the case. **N Jenkins**

The Chairman referred to the policy and suggested that it needed to be clear where duty of candour applied and when and what was discussed with patients or their families. Nick Jenkins confirmed that the policy would reflect this. **N Jenkins**

The Board accepted the new way of reporting and approved the Learning from Deaths policy for adoption and publication, subject to the above comments.

It was agreed to review this in six months' time so that any issues identified could be considered. **N Jenkins / R Jones**

17/190 LEADERSHIP DEVELOPMENT PROGRAMME

Neville Hounsome asked if this linked to the NHS Leadership Academy. It was confirmed that this was the case and it was also used for the coaching bank and mentoring network. The Trust was looking at how to encourage people to take this up.

Angus Eaton considered this to be a good report and asked how, after a year, the success of this could be measured. Jan Bloomfield explained that measurements would be built be in over time and these would include a number of metrics. It was requested that details of these metrics should come back to the Board. **J Bloomfield**

Alan Rose noted that there was little mention of the Board in relation to leadership within the organisation. Jan Bloomfield explained that this was included in the leadership routines (Appendix B) and Board development sessions.

Alan Rose suggested that this should be more specific, including succession planning for the executive team. The Chief Executive said that there was also a need to invest in service managers and general managers. Alan Rose said that it would be helpful to understand which individuals were being developed. The Chief Executive agreed and suggested that the Trust needed to involve Non Executive Directors in the development of individuals within the organisation.

Angus Eaton queried whether this was ambitious enough in ensuring that leaders were able to manage and cope with changes. Jan Bloomfield explained that this was being addressed through a number of initiatives and there would be a leadership summit for junior managers. It was proposed that change management should be included in leadership behaviours.

17/191 NATIONAL PATIENT SURVEY REPORT

It was noted that an action plan was being developed which would go to the Patient Experience Committee and then the Board. Richard Jones explained that there was a delay in the survey and the results being made available. Therefore before national benchmarking data was produced the Trust was looking at internal data to enable positive action to be taken early.

The Chief Executive noted that WSFT scored in the middle for most of the questions, which did not correlate with "happy staff equals happy patients". The Trust would be focussing on several areas to improve this.

The Chairman said that care needed to be taken in interpreting the results of the survey. The sample size meant that, statistically, small differences or changes were not significant. Also, due to the large number of questions, people might not pay equal attention to all of them. Gary Norgate agreed but said that there were a number of areas that needed to be addressed, eg privacy, although this was difficult due to the environment of the building.

It was confirmed that this would be reviewed by the Patient Experience Committee.

17/192 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that Annette Bendall, Health Care Support Worker (G4), Moira Lawson, Ward Clerk (G4), James Sibley, student volunteer and Paulene Gray, transformation team, had received Putting You First Awards this month.

Annette Bendall and Moira Lawson were nominated for the care and compassion they had shown to two patients on G4 who were extremely distressed.
In both cases they had sat with the patients and calmed then down, showing compassion, respect, care and human kindness.

James Sibley was nominated for the kindness he showed when a lady in front of him in the queue in the Courtyard Café had forgotten her purse. Without a second thought he offered to pay for the lady's coffee. His politeness and good manners were a credit to the Trust.

Paulene Gray was nominated for the fabulous job she had done writing the business case for the HR personnel file scanning project, organising resources and overseeing the whole project, to get this completed on time and within the allocated budget. The cost for this project was significantly less than the Trust would have had to pay to an outside company, and was completed with minimum risk. She did all of this in addition to her normal day job.

The Board congratulated the above for their dedication and commitment.

17/193 CONSULTANT APPOINTMENT REPORT

The Board noted the appointment of the following consultants:-

Jaspreet Sidana – Consultant in Anaesthetics

Emily McIntosh – Consultant in Care of the Elderly

BUILD A JOINED UP FUTURE

17/194 e-CARE REPORT

Craig Black reported that the programme board had met yesterday and had been assured that the management of risks was being addressed through a programme of work on testing and training.

Gary Norgate said that he was very impressed with the way that continuous improvement and change was being embedded within the organisation.

Alan Rose asked if plans for e-Care would cover all aspects of community services' operations in due course. Craig Black confirmed that this would happen in due course but was not part of the planning horizon. The Global Digital Excellence (GDE) programme ended next year but investment required in the community would be considerable and costings had not yet been agreed to implement this.

17/195 ALLIANCE AND COMMUNITY SERVICES UPDATE

It was noted that the new community contract arrangements would come into effect on 1 October 2017.

Helen Beck commended Dawn Godbold for all the work she had done on this and reported that feedback from staff had been very positive in terms of the transition and support they had been given.

Jan Bloomfield also commended Denise Needle and Karen Margetts who had worked on the HR aspect of this transition.

Alan Rose asked if community staff would be fully embraced in the 2018/19 CIP plans. It was explained that they were already involved in the 2017/18 plans and there was a CIP around community services which would continue in the future.

GOVERNANCE

17/196 ANNUAL REPORT AND ACCOUNTS

The Annual Report and Accounts for 2016/17 were received by the Board.

17/197 ANNUAL REPORTS FOR:

a) Equality and diversity

In response to the question asked by a Governor about statistics relating to BME appointments versus white appointments and how the Trust would be addressing this, the actions being taken were explained.

Internal audit would be looking into this to identify if there was a problem. Following the outcome of this a plan would implemented, including appointment of cultural ambassadors who would sit on interview panels to ensure that correct processes were being followed. Cultural ambassadors had been successfully introduced in other organisations and a significant difference had been seen in the number of appointments of BME made.

The Trust was also looking at unconscious bias and the training package used by Cambridge University Hospital Trust (CUHT) which was an e-learning module to help people understand how they might be reacting differently to people.

Richard Davies said that he been through CUHT's training and recommended this as an excellent initiative. The Chairman suggested that Denise Pora should look at the work undertaken by CUHT.

b) Infection prevention and control

This was considered to be a good, fair report.

The Chairman asked if there was any prospect of increasing the number of single rooms. Rowan Procter explained that this had been looked at in great detail and it was not feasible without taking beds out. She confirmed that this was managed on a day to day basis.

17/198 TRUST EXECUTIVE GROUP REPORT

Gary Norgate asked if all consultants were now engaged in the work of the Flow Action Group (FLAG). Nick Jenkins confirmed this was the case and they were now universally engaged. The Chief Executive agreed, from his experience of attending board rounds; however he said that board rounds could still be improved,

Nick Jenkins explained that there would be a new focus on the red to green process next week. This included red to green information sessions which representatives from across the whole organisation had been asked to attend.

The Board approved the updated risk management strategy.

17/199 AUDIT COMMITTEE REPORT

Steve Turpie reported that the committee had received a very good presentation on stroke and actions would go back to the Board. Nick Jenkins said that they would need to see how this was developed across the region.

17/200 COUNCIL OF GOVERNORS REPORT

The Board noted the content of this report.

Alan Rose reported that Governors were looking for clarity on the refurbishment of the front of the hospital. Craig Black explained that this would go the closed Board in October and then to the Council of Governors meeting in November.

17/201 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were approved.

ITEMS FOR INFORMATION

17/202 ANY OTHER BUSINESS

There was no further business.

17/203 DATE OF NEXT MEETING

a) The next meeting would take place on Friday 3 November 2017 at 9.15am in the Northgate Room.

b) The Board meeting dates for 2018/19 were received.

RESOLUTION TO MOVE TO CLOSED SESSION

17/204 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 – 3 November 2017

AGENDA ITEM:	Item 6
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	27 October 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
1466	Open	29/9/17	Item 6	Provide clarity on future provision of stroke service as part of STP service model		NJ	29/12/2017	Green
1467	Open	29/9/17	Item 6	Provide clear action and deliver improvement in maternity WHO compliance	NJ to meet with team to ensure effective action is taken. **QUALITY REPORT**	NJ	01/12/2017	Green
1473	Open	29/9/17	Item 12	A number of actions were identified from the new learning from deaths report: - Consider how to show preventability over time - Consider how to track performance against other trusts – 'peer group' or national - Confirm whether Glastonbury and Newmarket deaths are included process and reporting - Provide clarity as to how duty of candour is managed, and ensure this is fully reflected within the policy		NJ	01/12/2017	Green
1475	Open	29/9/17	Item 13	Develop a set of metrics which will provide an indication of the success of the leadership programme		JB	01/12/2017	Green

Completed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1449	Open	28/7/17	Item 2	Provide more visibility of the Helpforce initiative, including the training and governance arrangements	Project plan progress with a full report scheduled for the next Board meeting. **AGENDA ITEM**	JB	03/11/2017	Complete
1457	Open	28/7/17	Item 19	Review the functions of the Board committees in the context of establishing the new Quality Group.	Steps being taken to appropriately consolidate scopes of committees. Currently looking to integrate the Patient Safety Implementation Group's responsibilities within the improvement arm of the Quality Group. **AGENDA ITEM**	RJ	03/11/2017	Complete
1465	Open	29/9/17	Item 2	Consider how using outpatient appointment letters to communicate to patient regarding use of chaperones	It has been raised that including this language in the OPD appointment letter could unnecessarily raise patient anxiety about the messages to be communicated in a clinic. All surgical clinics have a nurse available to act as a chaperone and in the medical clinics the clinicians ask the nurse running their clinic to act as a chaperone. Currently reviewing how the role of chaperones is communicated in clinic areas.	RP	03/11/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1468	Open	29/9/17	Item 6	Provide a comprehensive report to the Board on actions being taken in preparation for winter. To include an internal and system based focus to allow the Trust to sustain performance at the predicted level of activity e.g. 210 attendances per day.	**AGENDA ITEM**	HB	03/11/2017	Complete
1469	Open	29/9/17	Item 6	Provide detail report on the activity and demand modelling work being undertaken with KPMG. Consider this in the context of previous action regarding theatre efficiency, additional sessions/activity and staffing costs.	**AGENDA ITEM - FIP report**	HB/CB	03/11/2017	Complete
1470	Open	29/9/17	Item 8	Provide a detail summary of the action being taken to manage 52 weeks for incomplete pathways	**AGENDA ITEM - quality report**	HB	03/11/2017	Complete
1471	Open	29/9/17	Item 9	If the shortfall for W&C CIPs is on-going then provide a detailed remedial action plan. This needs to demonstrate a reduction in cost when there is a reduction in activity.	**AGENDA ITEM - finance report**	HB	03/11/2017	Complete
1472	Open	29/9/17	Item 9	Provide further analysis of nursing numbers and expenditure based on actual staff on shifts	**AGENDA ITEM - finance report**	CB	03/11/2017	Complete
1474	Open	29/9/17	Item 12	Schedule a review report to the Board in April 2018 on the new learning from death policy and information being captured	Scheduled as part of the Board's future work programme	RJ	03/11/2017	Complete
1476	Open	29/9/17	Item 9	Provide a public summary of the concourse refurbishment plans to the Board in October	**Included in CEO report**	CB	03/11/2017	Complete

Board of Directors – 3 November 2017

AGENDA ITEM:	7
PRESENTED BY:	Steve Dunn, Chief Executive Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	25 October 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.

We continue to strive for the **integration of health and care services** in the west of Suffolk. This is in three key aspects on my report: the changes we are making to the delivery of community services; the system-based approach that we are taking to improve performance and prepare for winter; and the breadth of system-based experience of the our newly appointed chair.

Sunday 1 October saw the start of an exciting new way of working for the NHS in Suffolk, with staff from **community services, acute hospitals and primary care coming together in two alliances** to deliver high quality care for our patients. The alliances are made up of Ipswich Hospital NHS Trust (in the east) and us (in the west), with Norfolk and Suffolk NHS Foundation Trust (NSFT), Suffolk County Council and the Suffolk GP Federation in both. As part of these changes we welcome a new cohort of staff providing community services throughout the west of the county, as part of the west alliance, to the Trust. I am delighted to welcome our community colleagues, and through this development the work to deliver a fully integrated health and social care system for Suffolk.

We were delighted to share the news that **Sheila Childerhouse** has been appointed as our new chair. Sheila, who has vast experience of both the public and voluntary sector, will replace Mr Roger Quince, whose term ends in December. Having served on various local and regional health bodies since 1984 in non-executive and chair roles, most recently at the East of England Ambulance Service NHS Trust (EEAST) and Anglian Community Enterprise, Sheila brings a wealth of expertise to the position. I am very pleased to welcome Sheila's appointment and am confident that the Trust will benefit hugely from her extensive experience and expertise. I would also like to express our sincere thanks to Roger on behalf of everyone at the Trust. As a chair he has gone above and beyond, and we are immensely grateful for his unwavering dedication to, and leadership of, our hospital and services.

We have continued to face challenges with regards to the **four-hour A&E standard, and our referral to treatment (RTT) performance**. Following the launch of the BBC's NHS Tracker project (an online search tool that allows users to find out how their local services perform against the three key targets covering accident and emergency departments, cancer care and planned operations and treatment), the Trust did receive some local media interest on its performance during September. We are delighted to have met the national cancer standard, as we know it's vitally important that patients referred for cancer care start their treatment as quickly as possible. We're exceptionally proud that our scores are higher than the national average, and that we've also regularly had some of the best early detection rates in the country. However we are not complacent, and there is clearly

more to do. It's disappointing that we didn't meet the national A&E standard in September (88.9%), particularly after achieving it for the first quarter of the year, but the national average (89.7%) shows we are not the only ones tackling this challenge. We will continue to do everything we can to make sure that patients aren't waiting any longer than absolutely necessary. Whilst our referral to treatment (RTT) waiting times still aren't where we'd like them to be, we have made significant improvements; in October we were congratulated by Jeremy Hunt, Secretary of State for Health as the trust with the most improved monthly RTT performance in the country, and we have continued to make progress since.

September's performance shows referral to treatment (RTT) performance for patients on an incomplete pathway is 85.69% against a trajectory of 86.79%. Unfortunately we have reported 29 patients breaching 52 weeks. Patient choice continues to be a significant factor with many patients electing to wait longer for their treatment. I am pleased to report that we achieved the 62 day cancer standard with performance of 85.19% against a standard of 85% but failed to meet the two week wait rapid access standard with performance of 91.38% against a standard of 93% due to ongoing increased demand from dermatology. ED performance significantly deteriorated to 88.94%, a separate winter planning paper sets out actions to improve this position.

The **month 6 financial position** reports a loss of £652k for September which is worse than plan by £37k.The reported cumulative position is therefore £78k worse than plan. The 2017-18 budgets include a cost improvement plan (CIP) of £13.3m of which £5.94m has been achieved by the end of September (45%). Delivering the control total will ensure we receive Sustainability and Transformation Funding (S&TF) of £5.2m, resulting in a year end net deficit of £5.9m. We continue to work with KPMG as part of the financial improvement programme (FIP) for 2017/18 and beyond. The focus of FIP is to ensure that robust CIPs are in place to deliver the control total for 2017/18 and a CIP pipeline for future years.

In preparation for winter and as part of our on-going Red2Green programme we continue to drive a number of initiative across the health system to support patient flow:

- A simple scheme to reduce the time care home residents spend in hospital will be trialled from October. The **red bag initiative** will be run for three months in conjunction with six care homes, and it is hoped that, in addition to reducing length of stay, it will make patients' time with us less stressful. The process involves packing a specially numbered 'red bag' with all the information and personal belongings relevant to a care home resident when they need to go into hospital. The bag will contain personal items such as clothes, so that the patient can up and be dressed if possible, glasses, dentures, hearing aid and reading materials, and the patient's notes (the My Care Wishes folder) will be inserted into a clear pocket with a handover sheet from the care home.

- The newly launched **support to go home service**, which started on 11 September, is so far proving to be a great success. The service is hosted by the Trust and is provided in partnership with Suffolk County Council. The team consists of an occupational therapist, care co-ordinator and reablement support workers who help patients with washing, dressing, medication prompts and meal preparation in their own home. The team of health and care professionals led by Trust occupational therapist Suzie Myhill aims to prevent delays in discharge from the hospital, if there is a delay in the commencement of a planned care package. The reablement support workers provide short-term care to patients within their homes bridging the gap while they await their on-going package of care.

- We started the east-wide 100 day **#endPJparalysis** challenge three weeks ago, and are gradually rolling it out to all our wards. So far, across eight wards now participating, we have supported 955 patients to be up, dressed and moving where possible before midday. Helping patients retain their level of mobility is so important, for their health and wellbeing and particularly in helping to reduce their length of stay and keep their strength so they can continue their simple daily living tasks. This is one of a number of initiatives to support patient flow throughout the hospital. We'll keep you updated on others over the coming months.

In addition to these initiatives, we are looking to improve patient experience and flow through improvements to the **physical environment in ED**. Plans to improve our emergency department

are well underway, with building work ongoing to improve its functionality for staff and patients alike. As part of this work we're pleased to be implementing a primary care streaming unit; this front-door clinical streaming will mean our ED department is free to care for the sickest patients as a priority, whilst also ensuring those with a need for an urgent GP appointment see the right person for their health-complaint. We are working collectively with GPs, other acute trusts, and the wider health system to support people to see the right person, at the right time, for their healthcare needs, and we are always looking for ways of working collaboratively with partners to improve our patients' care and experience, and to transform our ways of working. The planned work in the ED is on schedule and due to be completed before the end of October.

Ward F5 has achieved an incredible **500 days without having a pressure ulcer** on the ward. With Helen Beard, matron, I have thanked all staff on the ward for their dedication to patient safety and high quality care.

We scored a hat trick in October, with three of its staff members bagging **awards for their work** with the Trust. Jan Bloomfield, director of workforce and communications, won the Lifetime Achievement Award at the Bury Free Press Business Awards, while Abigail Johnson won Apprentice/Trainee of the Year in the same ceremony. The Trust's diabetes inpatient specialist nurses also got in on the winning streak at the annual Quality in Care Diabetes Awards in Guildford. The team were presented with the Hypo Awareness Week Excellence Award for their efforts in raising awareness of diabetes complications during National Hypo Awareness Week, which took place from October 2 to 8.

Community consultant paediatrician, Dr Lucy Grove, has been awarded Best Doctor at the prestigious national **2017 WellChild Awards**. Picked from hundreds of nominations from across the UK, she collected her award on 16 October at the Royal Lancaster Hotel in London. The Awards are run by WellChild, the national charity for seriously ill children, to celebrate the courage of children coping with serious illnesses or complex conditions and honour the dedication of professionals who go the extra mile to help sick children and their families. Part of the integrated community paediatrics services team provided by West Suffolk NHS Foundation Trust, Dr Grove was one of the stars of the show at the high profile awards ceremony, attended by many of WellChild's celebrity supporters including royal patron Prince Harry. She was nominated by her colleagues Paula Veal, Julie Castle and Helen Hood and Charmaine Peploe, the mother of one of Dr Grove's patients, Katie.

We have been busy preparing for our next **Care Quality Commission (CQC) inspection**, which will include a 'well led' review on 30 November to 1 December 2017 and prior to this an unannounced inspection of at least one core area. Whilst the visit isn't anything to be concerned about, we are making sure we're prepared so we get the basics right and can showcase the things we're really proud of. We've produced a handy guidance booklet for staff and developed some useful work sheets to help staff reflect on their own practice. I also ran a day of drop-in briefing sessions for staff. What we do know is that we all love our hospital, that we are proud of the care we deliver, and are proud of where we work. We intend to show this off again to the CQC, and make this another opportunity to shine.

Like many NHS trusts, we are urging people to take action to protect themselves and others from the **flu this winter**. As well as providing the vaccine for free to staff and volunteers who aren't eligible to have a free elsewhere, we have been speaking out to the media to encourage the public to take precautions to prevent the virus spreading, such as washing hands frequently and thoroughly and getting the flu vaccine. Our consultant in respiratory medicine, Dr Thomas Pulimood, has been at the forefront of our flu campaign, and we're very grateful to him and the infection, prevention and control team for their ongoing support and efforts.

The Trust is well underway in its process to recruit its next term of **staff and public governors**. With a huge variety of candidate applications received and submitted, members are able to cast their votes to choose their governors until 22 November. We know our hospital governors play a vital role in the workings of our Trust; they represent the interests of staff and their community; they are the voice of the people, sharing ideas, concerns, and suggestions on a wider platform; they tell the Board what they think our hospital should offer, and work with them to ensure that community and staff needs are taken into account in the planning of services; they bring valuable perspective and contribution to the Trust's activities; and they have real influence on the strategic direction and governance of the Trust. I'd like to express our sincere thanks to all our current governors, whether

standing again or otherwise, for all their hard work and support of our Trust and its people.

After many weeks of preparation and testing the **phase 2 launch of e-Care** is taking place over the weekend 27/28/29 October. This will bring a number of functional improvements including:

- new TTO prescribing workflow
- New dynamic documents for clerking, progress notes, frailty and outcomes measures for AHPs
- Paediatrics department is going live with e-Care
- New nursing care plans, enhanced recovery pathways and admission pathways
- New diabetes care plan and insulin prescribing
- New admission, transfer and discharge workflows which will replace current functionality (patient flow)
- Introduction of portering and housekeeping requests via e-Care (patient flow)
- Medicines enhancements – alert for duplicate paracetamol prescribing, retrospective documentation following arrest/resuscitation and new pharmacy care organiser.

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

A business case for the **main entrance refurbishment** is being finalised for consideration by the Board on 1 December. The proposal is to fully refurbish the main hospital entrance concourse with an extended café, new pharmacy outlet and a new toilet block built. The proposal sets out to provide a clean, crisp, modern entry point to the hospital.

Chief Executive blog
http://www.wsh.nhs.uk/News-room/news-posts/The-next-inspection-a-sense-of-deja-vu.aspx

DELIVER FOR TODAY

New ambulance response standards go live
The East of England Ambulance Service NHS Trust (EEAST), which covers Suffolk, has gone live with new response standards. The new categories, which were approved by Health Secretary Jeremy Hunt in July, change how emergency calls are triaged, responded to and reported.
The Ambulance Response Programme, commissioned in 2015, has been the world's largest clinical ambulance trial, involving independent analysis of 14m emergency calls over 18 months. It's estimated the changes will save 250 lives annually across England.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Strengthening the culture for quality improvement at WSFT
West Suffolk's continued efforts to innovate and drive positive change has led to a new era of junior doctor quality improvement this month with the introduction of the West Suffolk Siklos Audit and Quality Improvement initiative for foundation doctors. This is in celebration of the services of recently retired medical consultant, Dr Siklos. The initiative has been set up to fuel meaningful changes in clinical practice and processes over the coming months. Over the coming year, the Siklos programme will be extended to staff working in any setting, clinical and non-clinical alike. Everyone at WSFT has the freedom to improve the way they work and it all contributes ultimately to better patient care.

Healthcare careers on the agenda at local jobs fair
To help support our recruitment ambitions, the Trust took part in an exciting careers fair on 14 October to help encourage people to join our fantastic Trust team. Staff from the Trust and Suffolk

County Council's Home First Service were on hand at the 'Careers in Health and Care' stand in the centre of Bury St Edmunds to provide advice and guidance on how to get into a career in health and social care, and talk over the many opportunities and career paths that exist locally. Here in West Suffolk we are seeking to bolster our team of nurses and nursing assistants to deliver the area's first 'Buurtzorg' style team, which tests a Dutch model of integrated health and personal care.

Caring for those who care for patients
Not just a place that cares for patients, we make it a priority to support our staff's health, and physical and mental wellbeing. This was celebrated on World Mental Health Day (10 October), to support the international theme of 'mental health in the workplace'. The Trust took it as an opportunity to raise awareness of the number of support mechanisms in place to help staff look after their own wellbeing, including: a 24 hour-a-day telephone and online counselling service; a range of books on self-help and mental wellbeing topics in the library; the 'Tea and Empathy' service, which offers on-call emotional support from a team of 25 senior staff; and our partnership with a debt management service for any staff who may be experiencing money worries. The Trust hopes to build on this work by providing line manager training in mental health awareness over the next 12-18 months.

See through the eyes of those with sight loss
Channel 4 has partnered with RNIB, alongside five advertisers, to enable viewers for the first time to 'see' an ad break through the eyes of two million people living with sight loss conditions in the UK today. The ad break was then repeated with audio description. The series of adverts first screened last Monday on Channel 4 for National Eye Health Week, simulate the vision of five common eye conditions. If you didn't see it, click on the link below and have a look: **http://www.rnib.org.uk/channel4-eyehealth**

BUILD A JOINED-UP FUTURE

Health campaign launched to keep antibiotics working
As experts around the world warn of a "post-antibiotic apocalypse" and "the end of modern medicine", Public Health England (PHE) has launched a major new campaign to help 'Keep Antibiotics Working'. The campaign warns people that taking antibiotics when they are not needed puts them at risk of a more severe or longer infection, and urges people to take their doctor's advice on antibiotics and whether they need them. Latest statistics show that, worryingly, four in 10 patients with an E.coli bloodstream infection in England cannot be treated with the most commonly used antibiotic in hospitals. The campaign will run across England for eight weeks and will be supported with advertising, partnerships with local pharmacies and GP surgeries, and social media activity.

NATIONAL NEWS

DELIVER FOR TODAY

New quality of life measure for recovering cancer patients
In a world leading move, quality of life for cancer patients will be tracked as part of ambitious plans by NHS England to radically improve care and support for people once treatment ends.
The ground-breaking new approach is set to drive improvements in after care which includes personalised plans for people with cancer outlining not only their physical needs, but also other support they may need, such as help at home or financial advice.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Cross-system sepsis action plan 2017
This action plan brings together the work on sepsis that is being taken forward nationally in the NHS in England. The over-arching purpose is to improve the prevention, early diagnosis and prompt treatment of sepsis in order to reduce the mortality and morbidity that it causes.

Case Study: Dietetics – care home work
A pathway has been devised for direct referral for care homes into the Nutrition and Dietetic service

following high risk Malnutrition Universal Screening Tool (MUST) assessment for residents that have lost weight to ensure appropriate prescribing of nutritional supplements. A Dietitian telephones the care home staff to provide a dietetic assessment and a meal plan is sent to the care home. A letter is sent to the GP and care home with treatment and type and quantity of nutritional supplement if meets ACBS Criteria. All residents prescribed a nutritional supplement are then reviewed by Nutrition and Dietetics resulting in 100% under Dietetic care rather than sporadic referral improved quality and cost savings.

Neonatal care improving, but key measures show variation in care
The latest National Neonatal Audit Programme report (NNAP), published today by the Royal College of Paediatrics and Child Health (RCPCH), shows improvements in care for preterm babies in England, Scotland and Wales, but also reveals variations in service delivery which means many babies are still not getting the care they need.

Bullying in the NHS – a bully's perspective
Thoughtful and reflective piece by retired CEO, Kate Grimes, on recognising bullying in her own behaviour, and on three aspects of bullying in the NHS.

BUILD A JOINED-UP FUTURE

NHS hospital beds: past, present and future
The number of NHS hospital beds in England has more than halved over the past 30 years. This briefing explores what lies behind this and highlights emerging signs of a shortage of hospital beds. Alongside the briefing, Leo Ewbank asks whether proposals in sustainability and transformation plans to reduce the number of hospital beds are realistic.

Home from hospital: How housing services are relieving pressure on the NHS
With over 30% of their residents living with a disability or aged 60 or over, and given the predicted surge in this demographic, housing associations have stepped in to ensure patients are not stuck in hospital longer than necessary. This has freed up the NHS to deliver its services to those who need them most and prevent hospital re-admissions. However, this contribution is often small-scale and localised – and the report highlights what the significant cost-benefits that could be achieved if these services were extended.

NHS Providers to play distinctive role in supporting trusts to shape new NHS landscape
NHS Providers is launching a major work programme to ensure there is the right support and a strong advocate making the case for NHS trusts as they move to accountable care structures that deliver more integrated care for the public.

Board of Directors – October (3rd November) 2017

AGENDA ITEM:	Integrated Performance Report
PRESENTED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer David Matthews, Interim Head of Performance
DATE PREPARED:	October 2017
SUBJECT:	Trust Quality & Performance Report
PURPOSE:	To update the Board on current quality issues and current performance against targets

EXECUTIVE SUMMARY:

This new style report provides an overview of quality and performance across the Trust. Key elements are:

- Aligned to the CQC ratings
- An Executive summary, following by detailed CQC section.
- Standardised exception reports in the detailed sections.
- Provision of benchmark information where available

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 new IPR Report and agree the implementation of actions as outlined.

West Suffolk NHS
NHS Foundation Trust

Board of Directors 3rd November 2017

AGENDA ITEM:	8
PRESENTED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer
DATE PREPARED:	October 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 two C Diff (0 in August). Falls for the month were 39 (68 in August and 15 pressure ulcers (13 in August) - pages 4-7.
- This month's report shows a significantly deteriorated ED performance of 88.94%. The separate winter planning paper sets out actions to improve this position.
- The Trust has achieved the 62 day cancer standard with a performance of 85.19% (85%) but failed to meet the 2 week wait standard with a performance of 91.38% (93%) due to ongoing increased demand from dermatology.
- RTT performance for patients on an incomplete pathway is 85.69% against a trajectory of 86.79%. Numbers of patients waiting over 18 weeks are 350 better than planned, however a significant decrease in the overall PTL size is impacting on the overall performance numbers. This is currently being investigated and validated.

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	Jul	Aug	Sep
HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	100	100	94
HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	96	100
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	97	100
HII compliance 2b: Peripheral cannula ongoing	=100%	<85	85-99	= 100	93	97	99
HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	100	100	100
HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	95	100	100
HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	= 100	100	100	100
HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	88	99	97
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<85	85-99	= 100	100	NA	NA
Total no of MRSA bacteraemia: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	2
Total no of MRSA bacteraemia: Community acquired (Trust level only)	No Target	No Target	No Target	No Target	0	1	0
Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	NA	NA	93
MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	95	90	91
Hand hygiene compliance	= 95%	<85	85-99	= 100	100	99	98
Total no of MSSA bacteraemia: Hospital	No Target	No Target	No Target	No Target	0	0	0
Quarterly Standard principle compliance	90%	<80	80-90%	90-100	NA	NA	95
Total no of C. diff infections: Hospital	= 16 per yr	No Target	No Target	No Target	1	0	2
Total no of C. diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	2	0	0
Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	NA	NA	94
Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	2	0	0
Isolation data (Trust level only)	= 95%	<85	85-94	95-100	90	88	88
Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	NA	NA	92
Quarterly VIP score documentation	= 90%	<80	80-89	90-100	NA	NA	80
PEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	100	100	90
No of patient falls	= 48	>=48	No Target	<48	66	68	39
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	17	18	10
No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	0	0
Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	ND	ND	ND
No of patients with ward acquired pressure ulcers	< 5	>=5	No Target	<5	7	13	15
% of patients with avoidable ward acquired pressure ulcers YTD	Less than 30%	>30%	No Target	<=30%	ND	ND	ND
Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	82	89	93
No of SIRIs	No Target	No Target	No Target	No Target	7	6	5
No of medication errors	No Target	No Target	No Target	No Target	78	70	69
Cardiac arrests	No Target	No Target	No Target	No Target	2	0	0
Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	0
Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	61	NA	NA
Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	NA	NA	97
Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	98.64	98.18	ND
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4	4	1	7
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC	53	68	58
Median NRLS upload 6 month rolling average	46days	>46	No Target	0-46	65	58	55
SIRIs reported > 2 working days from identification as red	0	>1	1	0	0	1	2
SIRI final reports due in month submitted beyond 60 working days	0	>1	1	0	0	0	4

Indicator	Target	Red	Amber	Green	Jul	Aug	Sep
Green, Amber & Red Active / Accepted risk assessments in date	0	>10	5-9	0-4	9	0	1
Datix risk register Red / Amber actions overdue	0	>10	5-9	0-4	22	0	0
Total Verbal Duty of Candour outstanding at month-end	0	>3	1 - 3	0	0	2	0

Exception reporting for indicators in the Patient Safety Dashboard

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

Data notes:

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

Data items Falls per 1000 Beds days and Falls with moderate/severe harm/death per 1000 bed days which had not been previously available from e-Care have been provided as a working estimate for Jan-May17 but not Jun/Jul with an aim to provide final figures for reporting from Q3 2016/17 onwards.

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

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

1.1 HII compliance 2b: Peripheral cannula ongoing

a) Current Position

A score of 99 was achieved for September which was an improvement from 97 in August, though this is still RAG-rated as amber for the fifth month in a row. Failing to document indication for continued insertion lowered the score from the target range.

b) Recommended action

Compliance with documentation following changes to eCare still remains a challenge. The Senior Matron team continue to discuss performance at the Monthly Quality Meeting and share learning and different approaches so as to improve performance in challenging areas.

Senior Matrons undertake regular discussions with Senior Ward Nursing Teams at 1:1's and Ward Team Meetings to highlight current performance and discuss options in improving practice. Specific action plans to be supported by Senior Matrons and Head of Nursing for areas with persistent poor performance.

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

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

a) Current Position

A score of 97 in September was a deterioration from 99 in August.

b) Recommended action

Despite the slight drop in compliance in September, there has been a continued trend of improvement in compliance in ongoing catheter care in the past two months. This has been achieved by targeted education

and monitoring in specific wards which were persistently failing to comply with the expected level of care and documentation.

The Infection Prevention Team have been linking with the Urology Nurse specialists to promote improved practice with catheter care and the introduction of 'Catheter passports', highlighting insertion dates and length of insertion as patients transition from acute care and the community.

The Senior Matron team also continue to support and promote compliance in order to sustain and further improve this area of practice. The team discuss performance at Monthly Quality Meeting so as to consider strategies for performance improvement. Senior Matrons continue with regular discussions with Senior

Ward Nursing Teams at 1:1's and Ward Team Meetings to highlight and monitor current performance.

Individual action plans continue to be put in place and supported by Senior Matrons and Head of Nursing for areas with persistent poor performance.

1.3 Isolation

a) Current Position

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

b) Recommended action

All of the cases were at the low end of the risk assessment for isolation and wards were advised on the measures required to mitigate onward transmission.

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

a) Current Position

The Trust achieved 91% compliance in September. This is a minor improvement on August, and no incident reports were required this month. The IPT have received the action plan from the ward with compliance issues last month.

b) Recommended action

Pharmacy team may have a solution within e-Care to incorporate the decolonisation regimen which could be tested soon and the ward staff are keen to progress.

1.5 Hand hygiene compliance

a) Current Position

The Trust overall performance dropped to 98% compliance in September. Only the Surgical division achieved 100% compliance, while the Women & Children's division and Clinical Support achieved 99% compliance with one episode of failure in Endoscopy and F11 respectively. The Medical division achieved only 96% compliance with 10 failures noted in ED, eight of which were medical staff. There were also four dress code failures noted in ED by doctors as part of the same audit.

b) Recommended action

The monthly audit is shared with all clinical areas. Names of staff will be recorded if the "support and challenge" approach does not result in compliance.

1.6 Quarterly Antibiotic Audit

a) Current Position

In Quarter Two, the Trust overall achieved 94% compliance against a target of 98%, up from 91% in Quarter One. Of the 398 patients audited, 132 (33%) were found to be receiving antibiotic therapy at the time of audit. This is slightly up from the 31% of patients receiving antibiotic treatment last quarter.

b) Recommended action

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

- The global shortage of Piperacillin/Tazobactam continues, as does the effect on the availability of other antibiotics, therefore it is essential to refer to the antibiotic guidelines on both the Trust intranet and the Microguide app when prescribing to ensure that you are using the most up-to-date guidance.

- The improved antibiotic review date alert went live at the end of August, staff are reminded to please continue to use this appropriately to enable timely and effective review of antibiotic treatment

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1.7 Quarterly VIP score documentation

a) Current Position

VIP score compliance rates have declined from 84% to 80%. Further changes in e-Care have changed documentation of VIP scores in the nurses accountability, to a prompt, to remind staff to document care of the IV peripheral cannula in 'Lines, drains & tubes'. This removes the previous disjointed view of the cannula care record whilst still providing a reminder to document the care. This documentation change occurred during quarter two. The Audit Team are also encouraging the use of 'inactivation' of the VIP documentation when a cannula has been removed and continue to provide ad-hoc training to ward staff on how to complete VIP score documentation on e-Care, as well as more formal training as required.

b) Recommended action

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

- Staff need to ensure cannula insertions, care of and removals are appropriately documented on e-Care.

- When a patient is transferred to a ward, staff should check if they have a cannula in-situ and that the insertion has been recorded as appropriate.

- Ensure VIP scores are documented during every shift.

1.8 Quarterly VTE: Prophylaxis compliance

a) Current Position

The audit was rated Amber against a Trust target of 100% of high-risk patients receiving the required prophylaxis. There is however an overall Trust improvement from 96% (Q1) to 97% (Q2) in high-risk patients receiving the required prophylaxis.

b) Recommended action

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

- Assessing VTE prophylaxis on admission in the medical (85%) division
- Re-assessing VTE prophylaxis risk within 24 hours in the medical (56%) and surgical (16%) divisions

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1.9 Nutrition: Assessment and monitoring

a) Current Position

The month of September has seen further improvement in compliance in weighing patients and completing the nutrition risk assessment and MUST score from 89% in August to 93% in September. This remains at an amber rating. The majority of wards have managed, with support and encouragement from the Senior Matron team and the Ward Managers, to improve their performance; however, there remain some pockets of poor compliance amongst teams, specifically with weighing patients every 7 days.

This overall improvement is encouraging, but it is recognised there is still some work to be done to improve compliance and teams are being encouraged to continue engaging with this.

b) Recommended action

The first meeting of the Nutrition focus group commenced in September supporting joint working with the Dieticians, specialist nutrition nurse, ward nurses and nursing assistants. The objective of this group is to promote the sharing of good practice, raise awareness of the importance of accurate risk assessments and

improve the delivery of diet and nutritional support for patients within our care. This initial meeting focussed on the challenge of achieving compliance with weighing patients and reviewing the information available from the patient safety dashboard. Actions were identified from the group and will be shared with ward teams to improve compliance.

A further initiative has been the introduction of a monthly report from the patient safety dashboard. This report captures the care of all patients admitted and focuses on Nutrition, as well as, pressure ulcer and falls prevention. Data from this report is shared with the Senior Matrons, Ward Managers and ward teams and identifies compliance with nutrition risk assessment recording, which is so far encouraging, demonstrating improving compliance.

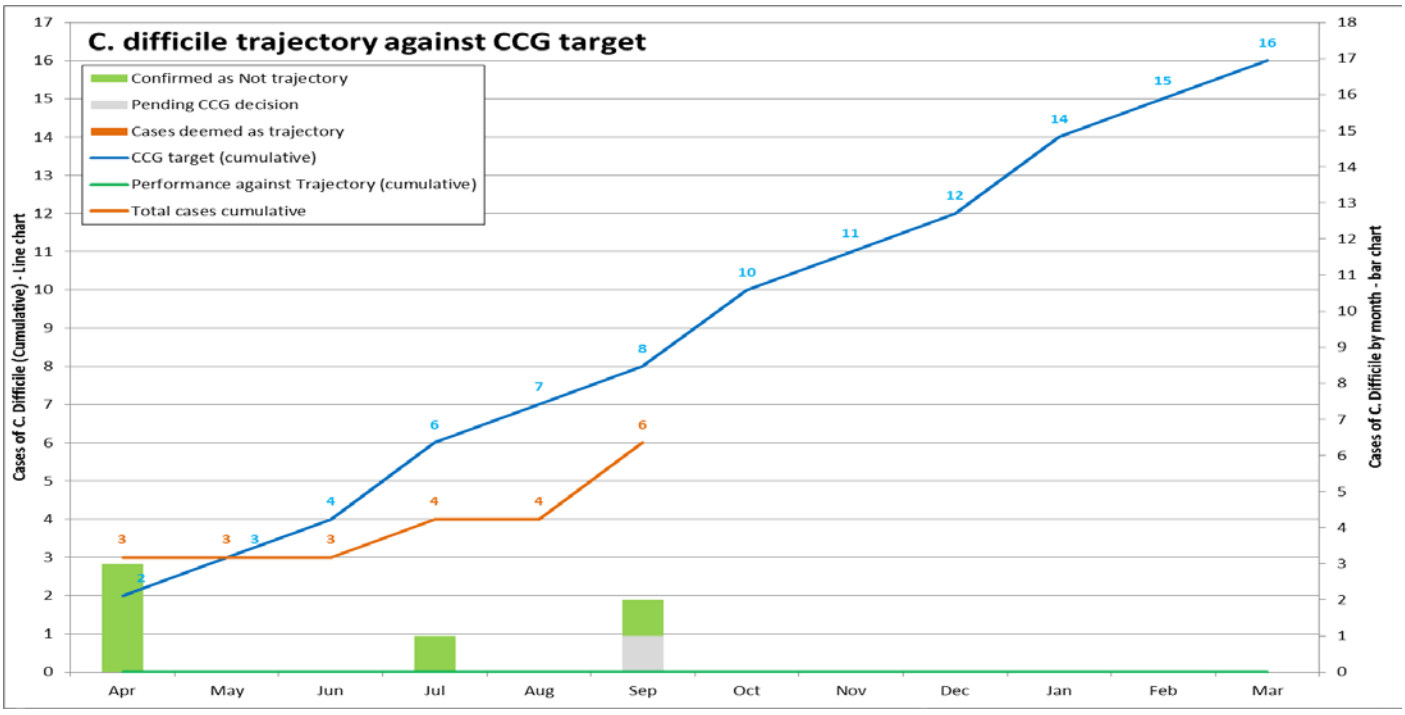
In the past month West Suffolk NHS Foundation Trust has been selected by NHSI to take part in the Nutrition collaborative. Launching in November, this is an exciting initiative for the Trust and will aid the ongoing improvements in patient care related to Nutrition.

1.10 Total no of C. difficile infections: Hospital

a) Current Position

Performance against trajectory is as follows: There were two cases of hospital attributable CDT in September. To date there have been six cases, of which five have been deemed non trajectory by our commissioners (no lapses of care) whereby they will not accrue a penalty, there are no trajectory cases and one is 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.

1.11 Total no of MRSA bacteraemia: Hospital

The Trust has recorded two MRSA bacteraemia in September 2017. Both cases have been investigated and have been submitted to NHS England for consideration as ‘Third Party’ assignment.

Case one was on F12 in a complex dermatology patient it is highly likely that this will be assigned as ‘Third Party’ but we await final decision. Case two was on F6 in a patient who presented to the Trust with a wound colonized with MRSA. We await the review by NHS England for assignment.

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

There were 39 falls in September (down from 68 in August), consisting of no major or moderate harm. This has resulted in a RAG rating of green due to less than 48 falls occurring, in contrast to the previous 5 months where a red rating had been recorded.

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

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

There were 6 patients in total who fell more than twice (10 in August), no patients fell more than 2 times during the month of September which is a significant improvement from August where some patients had fallen 3 to 4 times.

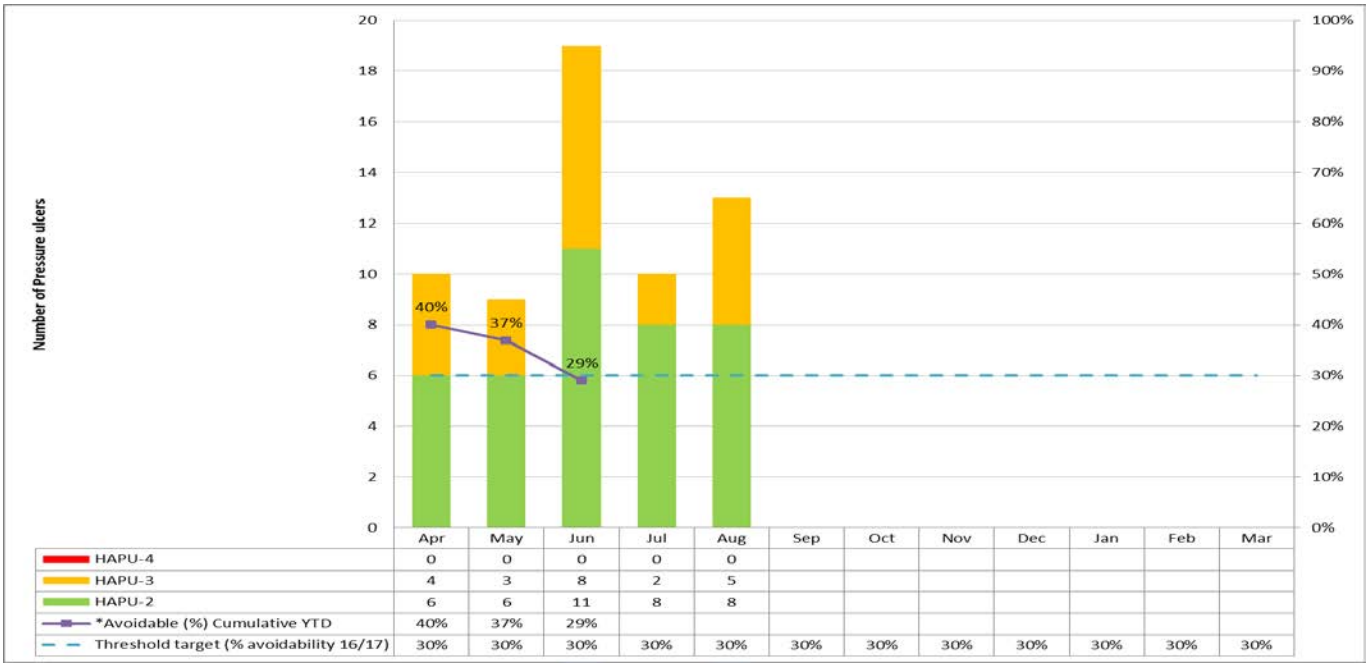
The Falls Focus Group will meet again this month to continue to drive falls reduction and prevention. Work has commenced on the updating of the current Datix and eCare systems to ensure that they are reflective of current practice and responsive in tackling the issue of patients falling.

Options relating to footwear are being considered at present to assist in safe mobilisation and reduction of falls. The cost involved with this is minimal but in other Trust this has demonstrated some positive results.

A staff pocket guide is currently under development to assist staff in the completion of lying and standing blood pressures as well as the commencement of appropriate tasks in reducing falls and minimising the impact if they have occurred. There would be a cost associated with this though previous use of staff pocket guides had been positively demonstrated in regards to MEWS scoring and Sepsis identification.

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

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



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

Judged as Avoidable following clinical review by Matron or TVN

There were ten HAPU-2 in September. Three on G8, two on both F3 and G1 and one each on Critical care, G3 and G4.

There were four HAPU-3 in September. Two on G5 and one each on F3 and G1.

There were five DTI reported in September.

Avoidable harm

The 2017/18 Trust quality priority target for avoidable pressure ulcers is to improve upon the 2016/17 year end performance of 30%. The line on the dashboard has been updated to report % (ytd) not actual numbers.

At the end of September there had been 73 HAPU 2, 3 or 4 reported including five at Glastonbury Court / Newmarket Hospital. 16 of these have been classified as avoidable and 37 as unavoidable with another 20 pending confirmation of grading as these cases are currently under investigation (HAPU-3 have a 60 working day deadline in line with the Serious incident framework).

Pressure ulcer prevention

September has seen a further increase in hospital acquired pressure ulcers (HAPUs) from the previous month. There were fifteen in total; however, a significant majority of these were reported on F3, G1, G5 and G8. Early indications are that many of these HAPUs were unavoidable, with the majority of these patients being at the end of life.

Acuity has been high in September, and despite the focus to get patients up and dressed, many wards have experienced an increase in bed-bound, frail, acutely unwell patients. Many of these individuals have been at the end of life. This has most likely impacted on the decrease in number of falls in September, though this is difficult to evidence.

Due to staff sickness and planned leave, the Tissue Viability team has experienced some deficits during September, leading to delayed review of reported potential HAPUs. There has been concern raised by the TV team that this has led to some inaccurate grading of ulcers by ward teams, in particular with regard to grading as pressure damage when moisture damage is evident. Further recruitment within the team to support Maternity leave will decrease this risk going forward.

The Tissue Viability team have however launched bite-size study sessions which commenced in September, these are on various subjects including pressure ulcer management and reporting, there has been a good initial turn out which should support the accuracy of pressure area grading and reporting on the wards. As well as this Heel Hero's is being launched and plans for the National Stop the Pressure day next month which will further raise the profile of pressure area prevention. TVN team has been working with ward staff to strengthen and develop wound care skills.

Despite some staff deficits, there generally remains good visibility and support for the Ward teams from the TV team. There has been greater focus from the team on those wards who experience the majority of reported HAPUs, with an increased promotion of pressure ulcer prevention and working in conjunction with the Ward Managers and Senior Matrons to actively support the improvement of staff knowledge and practice in promoting skin health and integrity.

The first meeting of the Pressure Ulcer Prevention focus group was in early September, with the next meeting on the 25th October. This was led by Senior Matron Danni Elliott, with the support of the Tissue Viability Nurse specialists. The aim of this group is to promote the concept of sharing good practice amongst teams and highlight the importance of accurate risk assessment and early preventative measures. Ultimately, the objective with the focus group is to improve knowledge and awareness to eliminate the occurrence of avoidable pressure damage.

Coupled with this, is the launch of the compliance report from the patient safety dashboard. The information team are now able to extract data from the dashboard, in order to, monitor compliance with the patient safety assessments related to falls prevention, nutrition risk assessments and pressure ulcer prevention. This report also provides data regarding the timeliness of assessments and initiation of care plans and is a useful tool for Ward Managers and Matrons to promote compliance and ultimately, improve patient care. Early indicators demonstrate that this report is already influencing an improvement in compliance with risk assessment.

As indicated last month, the Trust remains under significant staffing pressures and many of the wards are experiencing daily deficits. Coupled with this, capacity pressures and high acuity make it challenging for staff to consistently manage pressure ulcer prevention in a timely manner and there is concern that Community acquired pressure ulcers are sometimes missed by over stretched admitting teams. These challenges, risks and deficits continue to be reviewed daily by the Senior Nursing team and measures put in place to mitigate the risks to patient safety wherever possible.

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

a) Current Position

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

	Sep16	Oct16	Nov16	Dec16	Jan17	Feb17	Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sept17
Harm Free	92.71	92.31	92.61	93.16	91.35	93.72	94.06	94.12	91.30	92.92	93.21	94.29	92.37
Pressure Ulcers – All	5.03	5.49	5.67	3.80	5.34	4.71	3.62	5.00	5.22	4.90	4.08	4.16	5.08
Pressure Ulcers - New	1.01	1.65	1.23	0.51	1.53	1.05	0.52	0.88	0.87	0.54	0.82	1.56	2.26
Falls with Harm	0.75	0.55	0.49	0.76	0.76	0.00	0.00	0.00	0.29	0.00	0.27	0.26	0.56
Catheters & UTIs	1.51	2.20	1.23	2.28	2.04	1.31	1.81	1.18	3.48	2.18	2.17	1.56	2.26
Catheters & New UTIs	0.50	0.00	0.25	0.00	0.25	0.26	0.78	0.29	0.29	0.27	0.00	0.00	0.00
New VTEs	0.00	0.27	0.00	0.00	0.76	0.26	0.52	0.00	0.29	0.54	0.27	0.00	0.00
All Harms	7.29	7.69	7.39	6.84	8.65	6.28	5.94	5.88	8.70	7.08	6.79	5.71	7.63
New Harms	2.26	2.47	1.97	1.27	3.31	1.57	1.81	1.18	1.74	1.09	1.36	1.82	2.82
Sample	398	364	406	395	393	382	387	340	345	367	368	385	354
Surveys	18	17	18	18	18	18	18	18	17	17	17	17	17

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

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

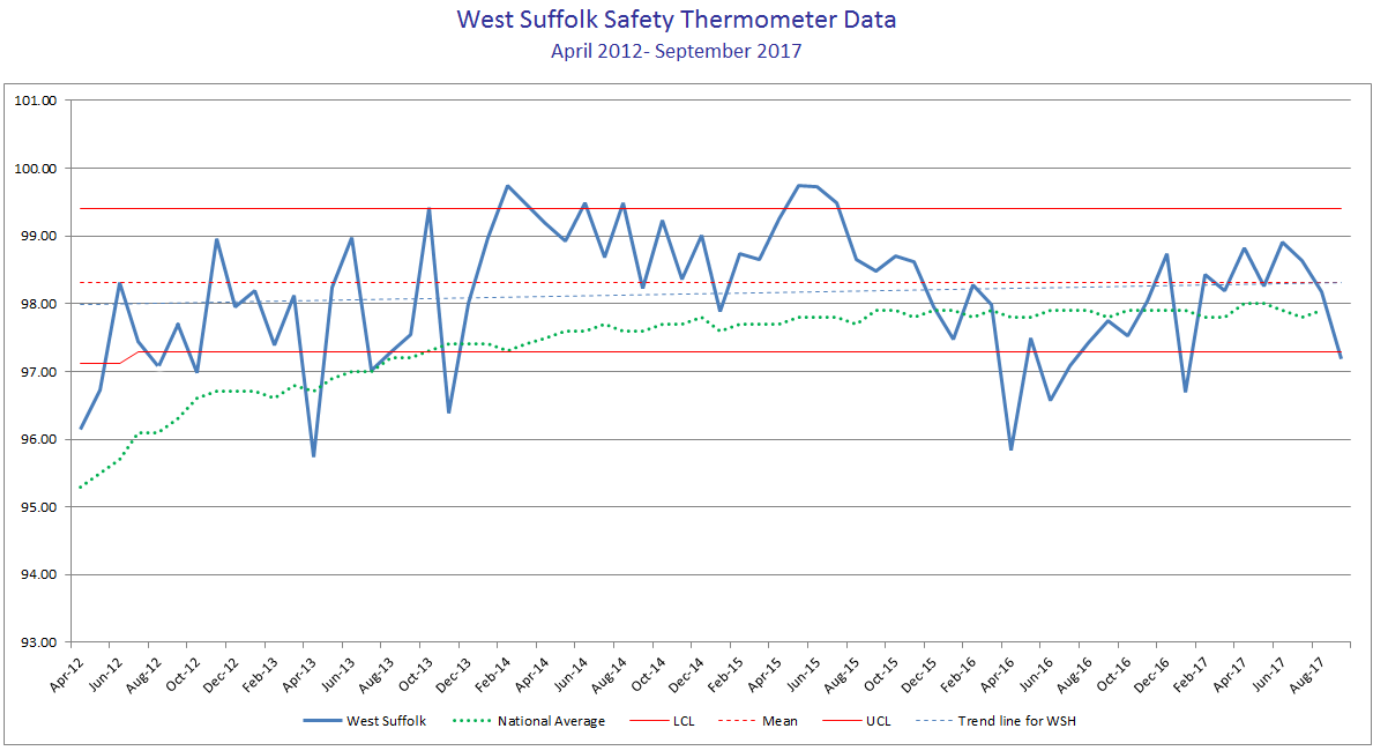
The data can be manipulated to just look at "new harm" (harm that occurred within our care) and with this parameter, our The Trust score for August 2017 was **1.82%** therefore, our new harm free care was **98.18%.** The National new harm for August has now been published and show the National new harm was **2.81%** therefore, the National new harm free care was **97.9%**

The Trust score for September 2017 is **2.82 %** therefore our new harm free care is **97.18%.**

The National new harm is not available for September at this time but if the figure remains the same as the previous month the Trust will be Red.

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 September 2017 with September 2017 data provided at Trust level only at this time.

October's data will include data from the community.



b) Recommended Actions

To continue to monitor actual harm against national benchmarks.

1.15 RCA actions overdue

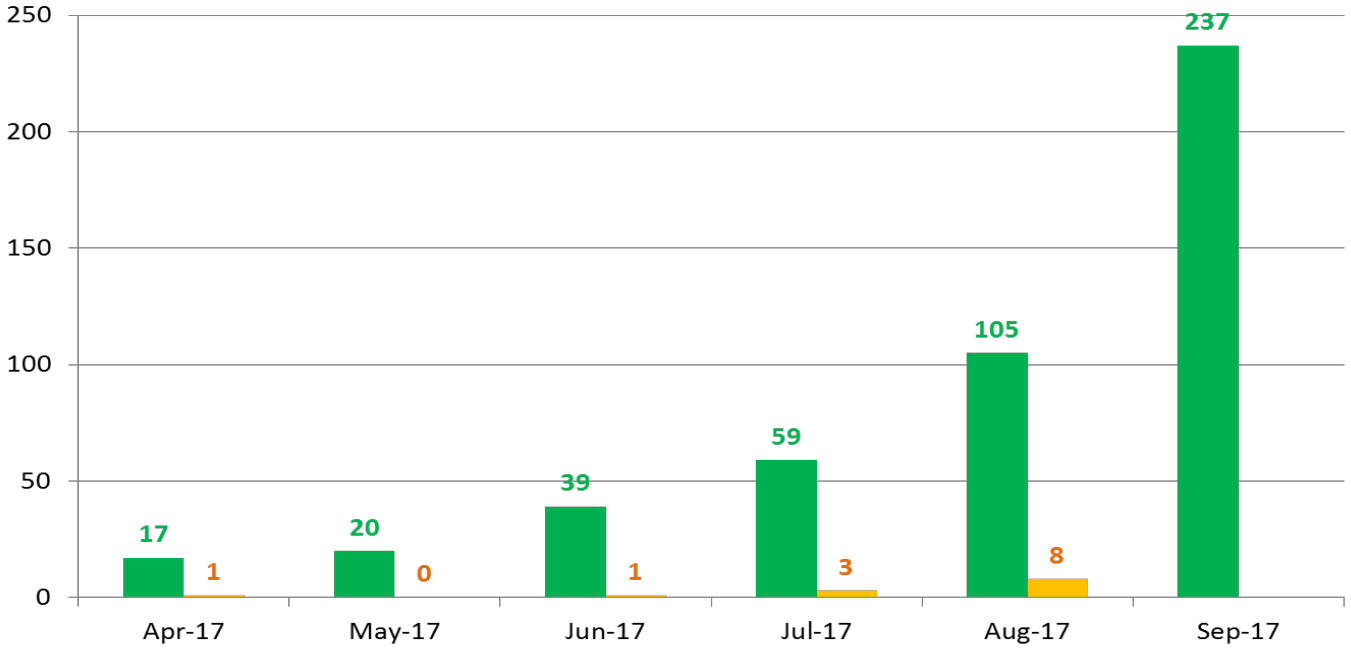
a) Current Position

A number of RCA actions are quite strategically medically significant, that if considered and implemented would support an improvement in practice trust wide. Whilst formally allocated to individuals these will benefit from senior medical collaboration across all divisions to be achieved. The Clinical Director user group will review these in their November meeting with a view to progressing their resolution.

1.16 % of 'Green' PSI incidents investigated / Median NRLS upload 6 month rolling average

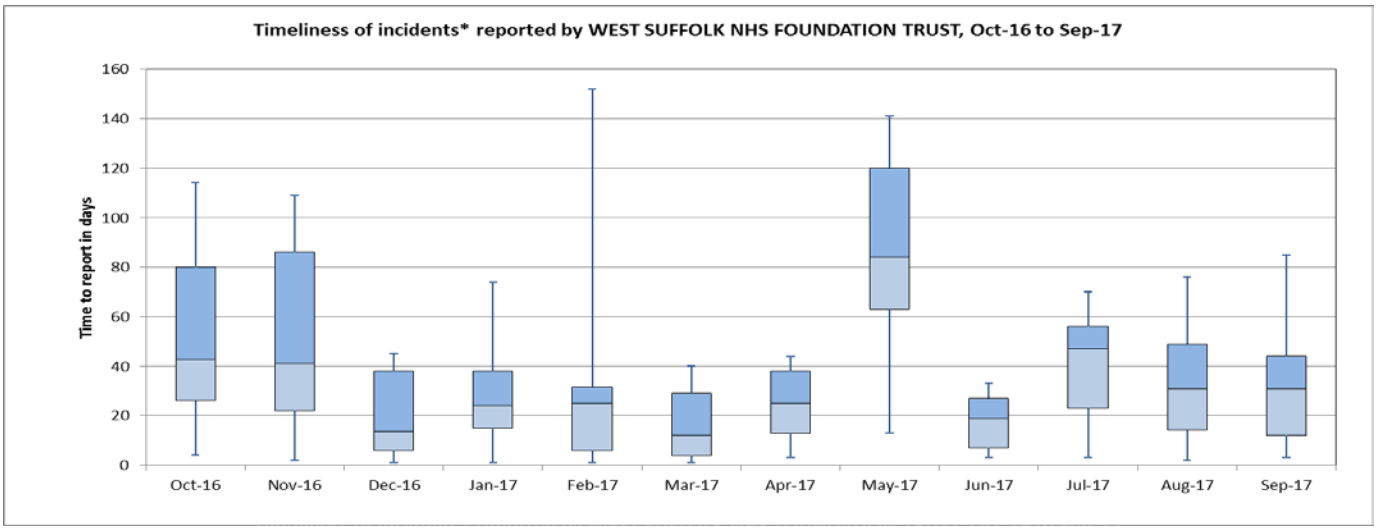
b) Current Position

Graph: Green and Amber incidents overdue by month.



The graph above shows the number of green and amber incidents that are still awaiting investigation. 58% (221) of the August green incidents had been investigated at the time of this report compared to July (68%).

In the most recent six-month period the median upload was 55 days which continues to improve but has not yet met the local target of 45 days achieved in the last NRLS report (Apr-Sept2016). NHS Improvement is now publishing monthly information reports including timeliness indicators which demonstrate improving performance in the more recent months.

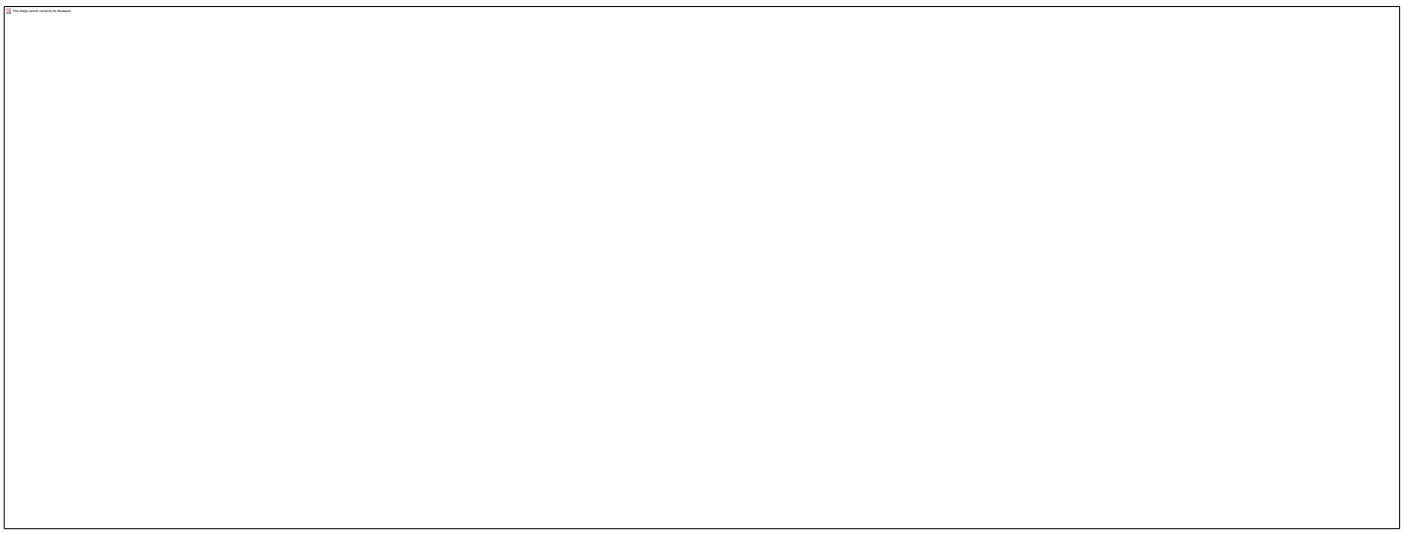


1.17 Patient Safety Incidents reported

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

There were 574 incidents reported in September including 461 patient safety incidents (PSIs). This was similar to August and remains above the NRLS median threshold. The number of 'harm' incidents remains low

Graph: Patient Safety Incidents reported



1.18 Patient Safety Incidents (Severe harm or death)

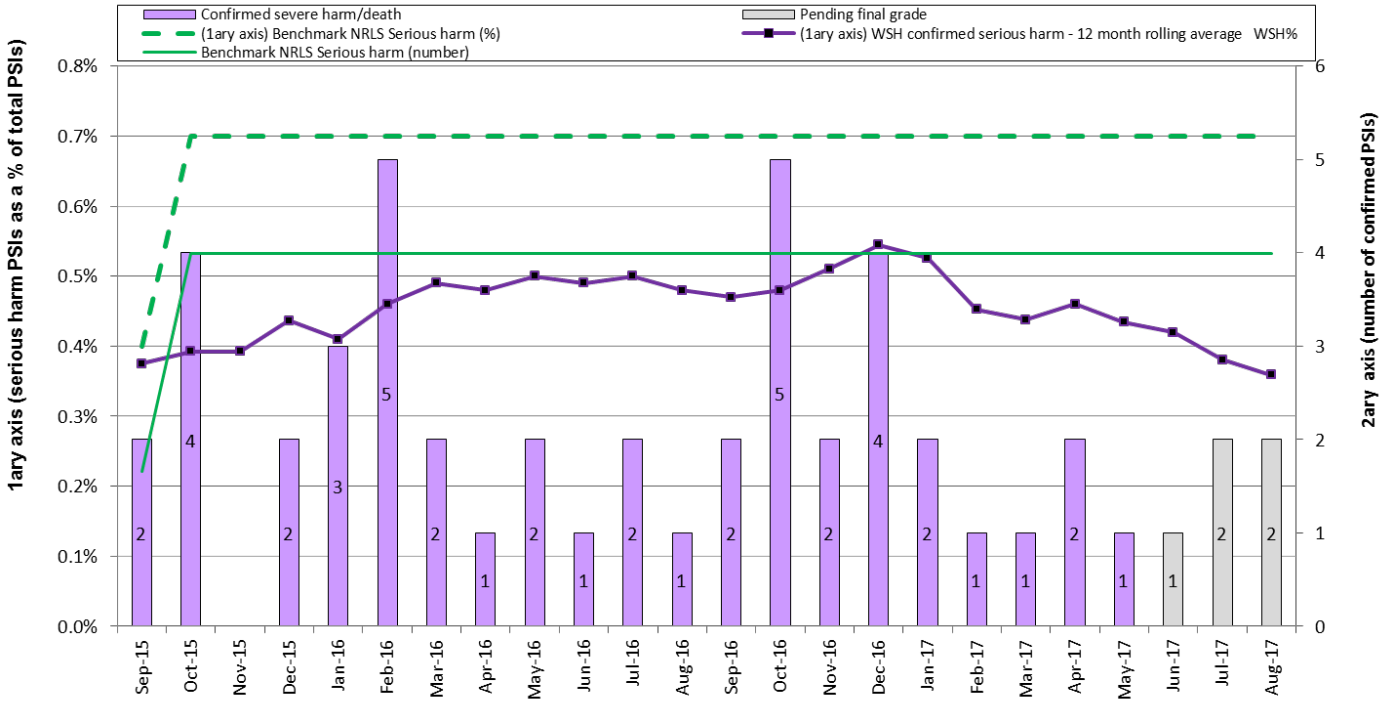
The percentage of PSIs resulting in severe harm or death is a nationally mandated item for inclusion in the Quality Accounts. The NRLS peer group average is from the period Apr – Sept16. The benchmark line applies the peer group percentage serious harm to the peer group median total PSIs to give a comparison with the Trust's monthly figures. The WSH percentage data is plotted as a line which shows the rolling average over a twelve month period. The Trust percentage sits below the NRLS average. The number of serious PSIs (confirmed and unconfirmed) is plotted as a column on the secondary axis.

In September there were two cases reported: an Intrauterine death and a deteriorating patient. Both cases are awaiting RCA to confirm harm grading.

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

- one delay in diagnosis
- one mortality review of a patient with learning difficulties
- one surgical complication
- one fall resulting in fracture
- one grade 4 pressure ulcer

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	Jul	Aug	Sep
Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	94	93	94
(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	98	98	98
Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	78	80	81
Timely call bell response	= 85%	<75	75-84	85-100	83	86	86
Patient Satisfaction: outpatient overall result	= 85%	<75	75-84	85-100	89	91	95
(Out-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	95	95	97
Were you informed of any delays in being seen?	= 85%	<75	75-84	85-100	60	87	88
Were you offered the company of a chaperone whilst you were being examined?	= 85%	<75	75-84	85-100	76	80	82
Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	99	99	99
(Short-stay) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	99	99	99
Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	94	95	94
(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	95	95	92
Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	ND	ND	ND
(A&E Children) How likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	ND	ND	ND
Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	100	100	100

Indicator	Target	Red	Amber	Green	Jul	Aug	Sep
[Maternity] How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	ND	ND
How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	ND	ND	100
Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	ND	ND	ND
(Young children) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	92	ND	100
Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	95	100	100
(F1 Parent & Young Person) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	92	100	100
Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	99	ND	95
(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	99	ND	99

Additional Patient Experience indicators

Indicator	Target	Red	Amber	Green	Jul	Aug	Sep
Acknowledged within three working days	100%	<75%	75 – 89%	>=90%	100	93	94
Response within 25 working days or negotiated timescale with complainant	100%	<75%	75 – 89%	>=90%	100	85	67
Number of second letters received	0	>6	2 - 6	0 - 1	1	1	1
Health Service Referrals accepted by Ombudsman	0	>=2	1	0	1	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	1	4	2

Exception reporting for indicators in the Patient Experience Dashboard

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

1.19 Inpatient: Noise at night

a) Current Position

This indicator had a slight improvement from 80 to 81, still flagging as an amber area.

a) Recommended Action

In a local survey conducted in September, 80% of patients said they slept ‘as well as could be expected’ and 80% state they were offered a form of sleeping aid e.g. ear plugs, an eye mask. Continue to monitor and make ear plugs available to patients.

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

a) Current Position

This score remains amber, moving from 80 to 82.

b) Recommended Action

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

1.21 Complaints

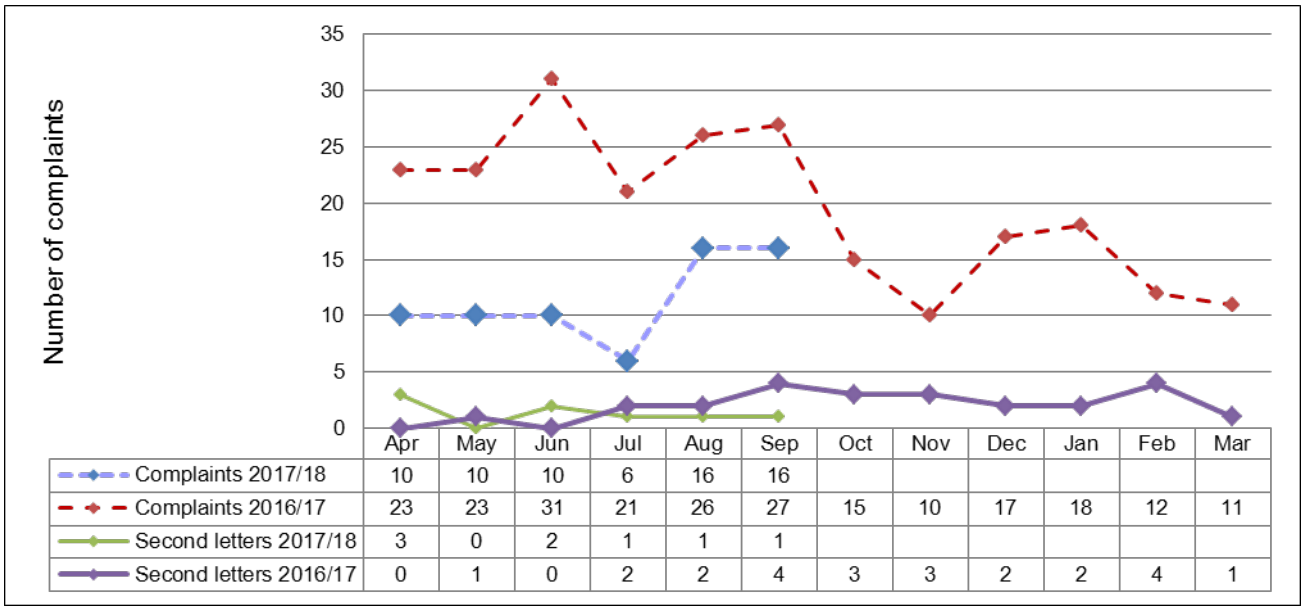
16 complaints were received in September. The breakdown of these complaints is as follows by Primary Division: Medical (6), Surgical (7), Clinical Support (1), Corporate Services (1), Estates & Facilities (1).

Complaints responded to within the agreed timeframe fell to 67% due to the impact of an increase in formal complaints in August. This was felt to be in relation to a reduced PALS service the previous two months. The team have now recruited an additional part-time member of staff and are actively recruiting to a vacancy in PALS.

Trust-wide the top three most common problem areas are as below:

Clinical Treatment – Surgical group	4

Clinical Treatment – Accident & Emergency	3
Patient Care – including Nutrition/Hydration	3
Values & Behaviours (staff)	3



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

1.22 PALS

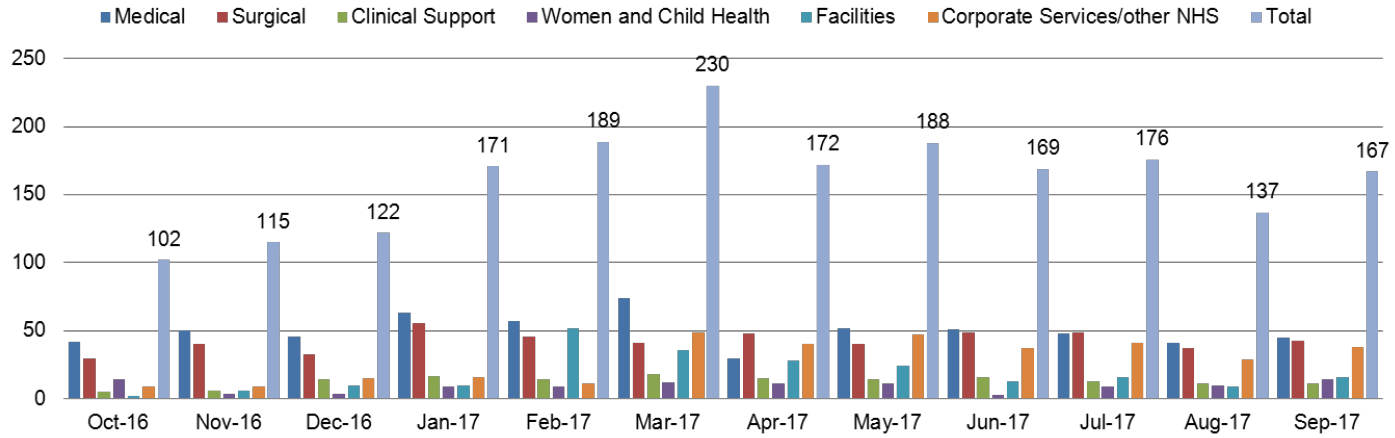
In September 2017 there were 167 recorded PALS contacts. This number denotes initial contacts and not the number of actual communications between the patient/visitor which can, in some particular cases, be multiple.

A breakdown of contacts by division from Oct 16 – Sep 17 is given in the chart and a synopsis of enquiries received for the same period is given below. Total for each month is shown as a line on a second axis.

Trust-wide the most common three reasons for contacts are shown as follows:

- Queries, advice & request information (42)
- Appointments; including delays and cancellations (31)
- Admissions, discharge and transfers (19)

There was a slight theme in patients in both Cardiology and Gastroenterology with concerns about cancelled appointments. Orthopaedic patients continue to contact PALS in relation to awaiting a date for their surgery, which the team is working closely with Waiting List Office on ensuring information is given as soon as possible. Several concerns were raised around wait for urological procedures and a feeling of general lack of support. Cost of parking continues to flag as a high area of enquiry as well as lost or damaged personal patient property.



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	Jul	Aug	Sep
TA (Technology appraisal) business case beyond agreed deadline	0	>9	4 – 9	0 – 3	0	0	0
WHO checklist (Quarterly)	100%	<90	90 – 94	>=95	NA	NA	99
Trust participation in relevant ongoing National audits (Quarterly)	100%	<75	75 – 89	>=90	NA	NA	96
Babies admitted to NNU with normal temperature on arrival (term)	100%	<50%	50-80%	>80%	100	100	86
12 month Mortality standardised rate (Dr Foster)	100%	>100	90-100	<90	88.35	84.72	
CAS (central alerting system) alerts overdue	0	>=1	No target	0	0	0	0

Maternity dashboard

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

	Red	Amber	Green	Jul-17	Aug-17	Sep-17
ACTIVITY – Births						
Total Women Delivered	> 250 or < 2 00	>216 or <208	>208 or <216	213	233	236
Total Number of Babies born at WSH	> 250 or < 2 00	>216 or <208	>208 or <216	215	233	240
Twins	No target	No target	No target	2	0	4
Homebirths	< 1%	2% or less	2.5%	3.3%	2.6%	2.1%
Midwifery Led Birthing Unit (MLBU) Births	<=10%	13% or less	20%	18.8%	15.5%	15.3%
Labour Suite Births	<=64%	69% to 74%	75%	77.9%	82%	82.6%
BBAs	No target	No target	No target	1	4	2
Normal Vaginal deliveries	No target	No target	No target	162	166	170
Vaginal Breech deliveries	No target	No target	No target	0	1	1
Non operative vaginal deliveries	No target	No target	No target	76.1%	71.1%	72.4%
Water births	No target	No target	No target	20	20	13
Total Caesarean Sections	> 22.6%	No target	<22.6%	15.5%	22.3%	18.2%
Total Elective Caesarean Sections	>=13%	11 - 12%	10%	7%	9.4%	6.4%
Total Emergency Caesarean Sections	>=15%	13 - 14%	12%	8.5%	12.9%	11.9%
Second stage caesarean sections	No target	No target	No target	2	5	4
Forceps Deliveries	No target	No target	No target	5.6%	2.6%	5.1%
Ventouse Deliveries	No target	No target	No target	2.8%	3.4%	4.2%
Inductions of Labour	No target	No target	No target	36.6%	38.2%	34.3%
Failed Instrumental Delivery	No target	No target	No target	0.9%	0	0
Unsuccessful Trial of Instrumental Delivery	No target	No target	No target	0	2	1
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%	83%	57%	82%
Total no. of women eligible for Vaginal Birth after Caesarean Section (VBAC)	No target	No target	No target	23	25	28
Number of women presenting in labour for VBAC against number achieved.	No target	No target	No target	8	6	14
ACTIVITY – Bookings						
Number of Bookings (1st visit)	No target	No target	No target	272	245	265
Women booked before 12+6 weeks	<=90%	91 - 94%	95%	95%	99%	93%
CLINICAL OUTCOMES - Maternal						
Postpartum Haemorrhage 1000 - 2000mls	No target	No target	No target	16	17	19
Postpartum Haemorrhage 2,000 - 2,499mls	No target	No target	No target	2	1	1
Postpartum Haemorrhage 2,500mls+	No target	No target	No target	3	2	1
Post-partum Hysterectomies	1	1	0	0	0	0
Women requiring a blood transfusion of 4 units or more	1	1	0	0	0	0
Critical Care Obstetric Admissions	1	1	0	0	0	1
Eclampsia	1	1	0	0	0	0
Shoulders Dystocia	5 or more	3-4	2	5	3	7
3rd and 4th degree tears (All vaginal deliveries)	No target	No target	No target	6	4	4
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)	10	7-9	6	6	4	4
3rd and 4th degree tears (Instrumental Deliveries)				4	0	0
Maternal death	1	No target	No target	0	0	0
Female Genital Mutilation (FGM)	No target	No target	No target	0	0	0

	Red	Amber	Green	Jul-17	Aug-17	Sep-17
Clinical Outcomes –Neonatal						
Number of babies admitted to Neonatal Unit (>36+6)	No target	No target	No target	0	13	15
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	No target	No target	No target	2	2	3
Number of Babies transferred for therapeutic cooling	1	No target	0	0	0	0
Cases of Meconium aspiration	No target	No target	No target	0	0	0
Cases of hypoxia	No target	No target	No target	0	0	0
Cases of Encephalopathy (grades 2 and 3)	No target	No target	No target	0	0	0
Stillbirths	No target	No target	No target	0	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 >	99	96	99
Midwife/birth ratio	>=1:32	No target	1:30	1:30	1:33	1:33
Consultant Anaesthetists sessions on Labour Suite	< 8 sessions	8-9 sessions	10 sessions	10	10	10
ODP cover for Theatre 2	80%	90%	100%	100%	100%	100%
Anaesthetist response to request for epidural for pain relief within 30 mins	< 70%	70 - 79%	>=80%	ND	ND	ND
Risk incidents/complaints/patient satisfaction						
Reported clinical Incidents	>40	40-59	60 and above	64	43	52
Serious incidents	No target	No target	No target	0	0	1
Never events	No target	No target	No target	0	0	0
Complaints	No target	No target	No target	2	1	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	0	0	ND
Maternal Postnatal readmissions	No target	No target	No target	ND	ND	ND
Completion of WHO Checklist	80%	90%	100%	94%	82%	98%
Babies assessed as needing BCG vaccine	No target	No target	No target	ND	ND	ND
Babies who receive BCG vaccine following assessment	No target	No target	No target	ND	ND	ND
Number of Women identified as smoking at booking	No target	No target	No target	10+	10+	ND
Number of Women identified as smoking at delivery	No target	No target	No target	32	30	37
UNICEF Baby Friendly Audits	No target	No target	No target	30	27	25
Proportion of parents receiving a Safer Sleeping Suffolk Thermometer.	No target	No target	No target	205	155	192

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

1.23 Maternity - Total Women Delivered / Total Number of Babies born at WSH

Activity within the maternity services remained high in September due to the support offered to USAF Lakenheath. This ceased on 18th September 2017.

1.24 Maternity - Critical Care Obstetric Admissions

There was one admission of a critically ill patient to ITU in September, was admitted unwell and multidisciplinary decision was that her care needs would more appropriately be met on ITU.

1.25 Maternity - Shoulders Dystocia

Seven cases of shoulder dystocia were identified in September. This will be added to the audit cycle for closer review.

1.26 Maternity - Midwife/birth ratio

The effect of delivering mothers from USAF Lakenheath has had an impact on the midwife to birth ratio again this month taking it to 1 to 33, above that which we would normally achieve. The formula used for this calculation however does not allow you to disregard any areas of care not provided, therefore this figure includes the provision of antenatal care to women from Lakenheath, where this was in fact limited. This has now ceased and it would be expected that the ratio will fall to 1:30 in October 2017. All women received

one to one care in labour.

1.27 Maternity - Completion of WHO Checklist

The maternity service achieved 98% compliance with completion of WHO checklists in September 2017. The service has now introduced a daily monitoring and the achievement for the month to date is highlighted at each staff handover on Labour Suite.

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

2. MORTALITY HSMR AND SHMI DATA

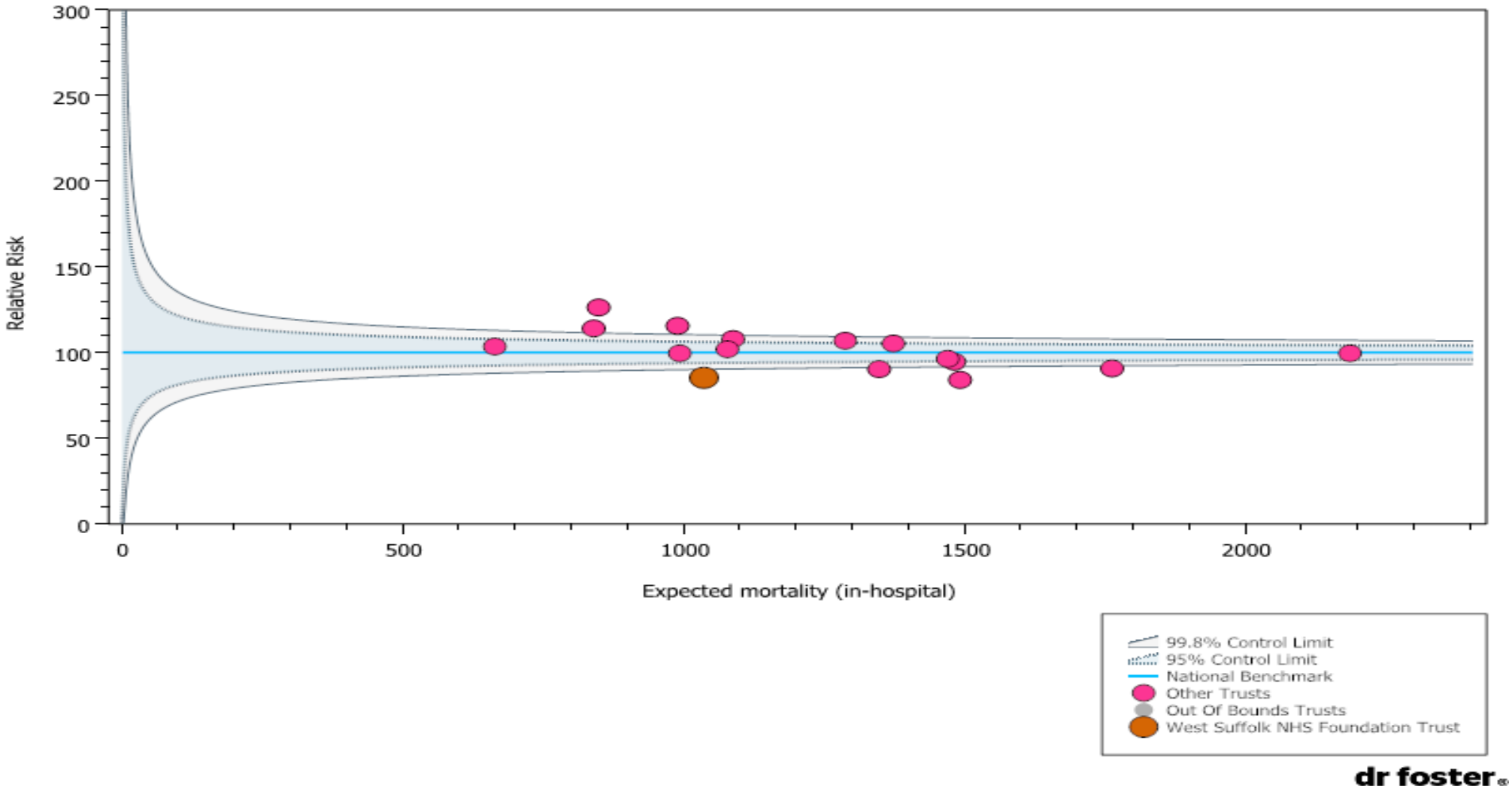
Mortality (Individual Months)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
No of Deaths	77	55	72	85	78	77	69	80	122	134	105	84
No of Discharges	5,153	5,026	5,072	5,493	4,921	5,298	5,642	5,269	5,313	5,311	4,838	5,360
% Deaths	1.49%	1.09%	1.42%	1.55%	1.59%	1.45%	1.22%	1.52%	2.30%	2.52%	2.17%	1.57%
HSMR*	82.1	71.1	83.4	107.2	106.7	94.9	78.1	94.4	104.9	106.5	108.6	86.7
Mortality (Individual Months)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
No of Deaths	79	73	70	55	70	52	67	73	78	109	91	84
No of Discharges	5,032	5,209	5,273	5,730	5,188	5,483	5,637	5,568	5,402	5,375	5,439	5,725
% Deaths	1.57%	1.40%	1.33%	0.96%	1.35%	0.95%	1.19%	1.31%	1.44%	2.03%	1.67%	1.47%
HSMR*	89.5	75.3	86.5	62.4	86.1	63.5	66.8	74.2	71.9	87.4	91.0	
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
No of Deaths	71	87	71	58	74	82	83	98	102	103	99	95
No of Discharges	5,321	5,427	5,691	5,410	5,400	5,674	5,733	5,950	5,401	5,577	5,426	6,444
% Deaths	1.33%	1.60%	1.25%	1.07%	1.37%	1.45%	1.45%	1.65%	1.89%	1.85%	1.82%	1.47%
HSMR*												
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
No of Deaths	72	69	71	62	76	70						
No of Discharges	5,378	5,742	5,661	5531	5592	5680						
% Deaths	1.34%	1.20%	1.25%	1.12%	1.36%	1.23%						
HSMR*												

HSMR BENCHMARK IS USING FY 15 -16

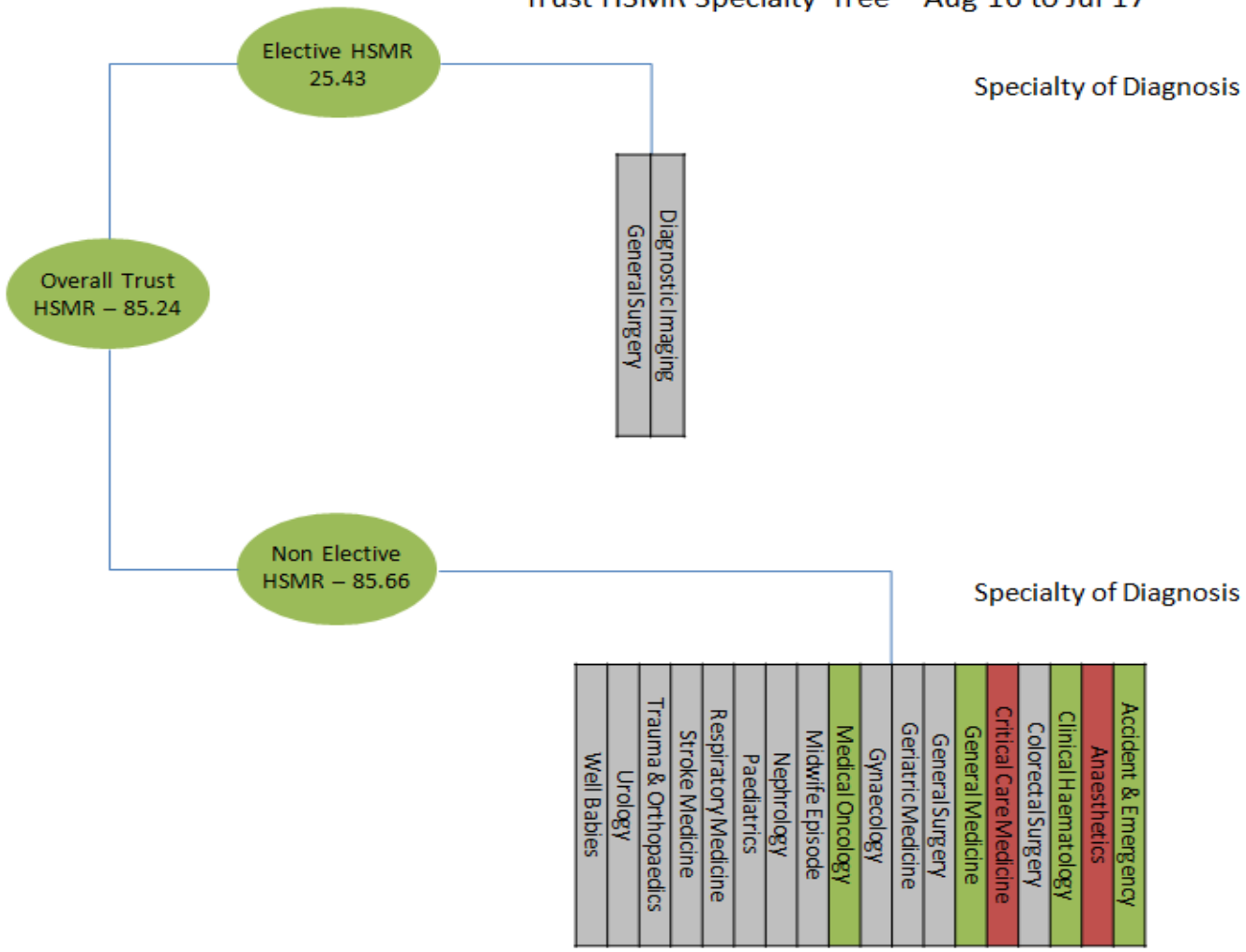

Overall
Non-Elective
Elective
SHMI
HSMR
Overall SHMI - Rolling 12 Months
Non Elective SHMI - Rolling 12 Months
Elective SHMI - Rolling 12 Months
Overall HSMR - Rolling 12 Months
Non Elective HSMR - Rolling 12 Months
Elective HSMR - Rolling 12 Months

HSMR - Aug 16 - Jul 17

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



Trust HSMR Specialty Tree – Aug 16 to Jul 17



Lower than Expected

Within expected Range

Higher than Expected

3. NHS IMPROVEMENT'S SINGLE OVERSIGHT FRAMEWORK

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

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

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

NHS Improvement's Single Oversight Framework					July	August	September
Performance Indicator	**Threshold**	**Month**	**QTD**	**Lead Exec**			
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	**85.69%**	85.85%	Helen Beck	85.92%	85.93%	85.69%
Number of RTT Waits over 52 weeks for incomplete pathways	0	**29**	90	Helen Beck	35	26	29
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	**88.94%**	90.54%	Helen Beck	92.47%	90.09%	88.94%
All cancers: 62-day wait for first treatment (5) from:Urgent GP referral for suspected cancer - **See Further detail below**	85%	**85.19%**	85.41%	Helen Beck	84.57%	86.30%	85.19%
All cancers: 62-day wait for first treatment (5) from: NHS Cancer Screening Service referral	90%	**90.91%**	96.23%	Helen Beck	100.00%	100.00%	90.91%
All cancers: 31-day wait for second or subsequent treatment, comprising: Surgery	94%	**100.00%**	100.00%	Helen Beck	100.00%	100.00%	100.00%
All cancers: 31-day wait for second or subsequent treatment, comprising: anti-cancer drug treatments	98%	**100.00%**	100.00%	Helen Beck	100.00%	100.00%	100.00%
All cancers: 31-day wait for second or subsequent treatment, comprising: radiotherapy - Not applicable to WSFT							
All cancers: 31-day wait from diagnosis to first treatment	96%	**100.00%**	100.00%	Helen Beck	100.00%	100.00%	100.00%
Cancer: two week wait from referral to date first seen (8), comprising: all urgent referrals (cancer suspected)	93%	**91.38%**	94.12%	Helen Beck	94.51%	96.02%	91.38%
Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)	93%	**98.28%**	98.81%	Helen Beck	98.06%	100.00%	98.28%
Outcomes:			**1**				
Clostridium (C.) difficile - meeting the C.difficile objective - MONTH	2	**2**		Rowan Proctor	1	0	2
Clostridium (C.) difficile - meeting the C.difficile objective - QUARTER	4		**3**	Rowan Proctor			
Clostridium (C.) difficile - meeting the C.difficile objective - ANNUALLY	16		**6**	Rowan Proctor			
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	-	-	Rowan Proctor			

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

a) Current Position

85.69% against a threshold 92%

The September position demonstrates a plateau in performance from August (85.93%) to 85.69% in September. This position is behind our planned trajectory of 86.79% due to a greater than anticipated reduction in the overall PTL size. A significant decrease in referrals and therefore new clock starts appears to be driving this and we are working with the CCG to establish if this represent an actual drop in referrals or is reflecting of improved workflows and therefore more accurate recording of referral activity. Our recovery trajectory forecast a total waiting list size of 19,138 at this stage with 2,823 above 18 weeks. The current actual waiting list now has a total of 17,236 patients with 2,467 patients breaching 18 weeks.

b) Recommended Action

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

Sustained improvement continues with reduced waiting times for first OPA in ENT which has now reduced to a maximum wait of 14 weeks. Although the performance against the aggregate target has plateaued from the Trust continues to work to maintain its RTT recovery trajectory.

An action plan has been developed in response to the IST, RTT capacity and sustainability audit recently undertaken with the operational teams. It is recommended that this detailed plan is the subject of review by the December scrutiny committee.

3.2 Number of RTT waits over 52 weeks for incomplete pathways

a) Current Position

29 against a threshold of 0

There were 29 patients who breached 52 weeks in September. Of these, 11 patients have since had their procedures completed. Of the 29 breaches, 10 were ENT, 6 Audiology, 6 Vascular, 3 T&O, 2 Urology, 1 Oral Surgery, and 1 Ophthalmology.

b) Recommended Action

Long waiting patients and are being actively monitored by the senior team to ensure patients are being booked in turn and proactively managed. A clinical harm review process is being developed to provide assurance that long waiting patients are not experiencing avoidable harm. A detailed paper relating to the plans to address patients waiting over 52 weeks has been included as an appendix to this report.

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

a) Current Position

88.94% against a threshold of 95%

The first week in September ED performance position started off in a reasonable position. However, as the month progressed the Trust continued to experience capacity issues which had a significant impact of flow through the hospital. The total attendees continues to rise, with the daily average now reaching 191 attendees. Medical staffing deficits continue despite aggressive recruitment strategies to fill the vacant gaps. This resulted in delays to be seen by a clinical decision maker, coupled with insufficient capacity.

b) Recommended Action

The division has developed a 4 hour emergency standard recovery plan to address the deficits in service as well as exploring alternative solutions to improve performance across the system. The winter plan paper included in this board pack outlines the range of Trust wide actions being taken to support the recovery of the Ed 4 hr standard.

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

a) Current Position

91.38% against a threshold of 93%

b) Recommended Action

This is due to capacity issues in managing the sustained high demand with GP suspected Skin cancer 2 WW referrals. The performance overall in this standard remained above 93% for the quarter (July- Sep),

The Trust is engaged with the CGG at various levels to improve on demand management. A locum Dermatology consultant is also brought in to enhance outpatient capacity recently. Consequently, some improvement is expected in this standard from the time of November monthly reporting.

3.5 104 day Cancer waits

a) Current Position

There are currently between 2 and 4 patients on a weekly returns and in the event of a breach, the relevant MDT clinician/s and services are requested to review and confirm any clinical harm on these patient and to follow the divisional governance procedure in case of a harm.

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	Jul	Aug	Sep	Change mth on mth	On Plan To Achieve	Area of Concern	Forecast to Breach
A&E						Jul	Aug	Sep				
A&E Time to treatment in department (median) for patients arriving by ambulance - CDM	Median time to treatment above 60 minutes	62	49		Helen Beck	52	50	62	↘			
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	12:01	13:57	Commentary available from Philippa Sharp.	Helen Beck	13:53	11:46	12:01	↘			
A&E Trolley Waits not longer than 12 hours	0 Patients waiting over 12 hours from DTA to Admission	0	0		Helen Beck	0	0	0	↔			
A&E - Threshold for admission via A&E	i) if the monthly ratio is above the corresponding 2012/13 monthly ratio for two month in a six month period ii) if year end is greater than 27%	34.19%	31.63%		Helen Beck	30.75%	31.79%	34.19%	↘			
A&E - Service User Impact Indicators	To satisfy at least one of the following Service User Impact Indicators: 1. Unplanned Reattendances within 7 days below 5% (Reattendances for the same condition) 2. Time to treatment in department (median) for all Service Users arriving by ambulance.	ONE MET	ONE MET		Helen Beck	ONE MET	ONE MET	ONE MET	↔			
A&E & AMU - Ambulance submit button complete	80%	90.25%	91.01%		Helen Beck	90.98%	89.94%	90.25%	↗			
A&E - Ambulance Handovers above 30 minutes	0 handovers over 30 minutes - £200 per breach	TBC	148		Helen Beck	39	19	TBC				
A&E - Ambulance Handovers above 60 minutes	0 handovers over 60 minutes - £1000 per breach	TBC	51		Helen Beck	7	16	TBC				
Percentage of patients presenting at type 1 and 2 (major) A & E sites in certain high risk categories who are reviewed by an emergency medicine consultant before being discharged	14.00%	TBC	91.31%	Due to eCare updates, report is now showing erroneous figures and will be rebuilt asap.	Helen Beck	TBC	TBC	TBC	↔			
RTT												
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks	99.00%	94.23%	93.41%		Helen Beck	94.31%	94.93%	94.23%	↘			
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90.00%	73.83%	70.64%		Helen Beck	72.92%	69.70%	73.83%	↗			
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.00%	87.28%	86.86%		Helen Beck	87.61%	85.84%	87.28%	↗			
Stroke												
% of patients scanned within 1 hour of clock start	77% (Contract) 57.5% (Upper Quartile)	78.05%	79.55%		Helen Beck	81.58%	79.17%	78.05%	↘			
% of patients scanned within 12 hours of clock start	96% (Contract) 96% (Upper Quartile)	90.24%	95.45%		Helen Beck	94.74%	95.83%	90.24%	↘			
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75% (Contract) 70% (Upper Quartile)	82.50%	79.15%		Helen Beck	77.78%	78.72%	82.50%	↗			
>80% treated on a stroke unit >90% of their stay	90%	92.50%	93.00%		Helen Beck	94.44%	97.87%	92.50%	↘			
% of patients treated by a stroke skilled early supported discharge team	48% (Contract) 48% (Upper Quartile)	51.43%	49.77%		Helen Beck	46.43%	33.33%	51.43%	↗			
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80% (Contract) 79% (Upper Quartile)	85.37%	89.77%		Helen Beck	92.11%	87.50%	85.37%	↘			
% 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)	92.11%	87.70%	INDICATION ONLY - FINAL SSNAP LEVEL AVAILABLE WHEN RESULTS ARE AVAILABLE FROM SSNAP	Helen Beck	87.88%	89.58%	92.11%	↗			
% of eligible service users given thrombolysis	100% (RCA to be provided for breaches)	100.00%	100.00%		Helen Beck	100.00%	100.00%	100.00%	↔			
All stroke survivors to have a 6 month follow up assessment.	50%	58.00%	58.00%		Helen Beck			58.00%	-			
Provider rating to remain between A-C in each of the 9 domains covered in SSNAP where the Provider is at this level. For the one domain (SaLT) where the Provider is at level E, this will be improved to level to C by March 2017.	To remain at or above: National average or current performance (A-C) Improve performance to level C by end of the year (SaLT)	D	D	Reports are generated by SSNAP every 4 months - this is as at July 2017, reported for October Board	Helen Beck			D	-			
Discharge Summaries												
Discharge Summaries - Outpatients	85% sent to GP's within 3 days	ND	ND	Cerner are currently in the process of resolving issues associated with Outpatient discharge summaries.	Nick Jenkins	ND	ND	ND	-			
Discharge Summaries - A&E	95% of A&E Discharge Summaries to be sent to GPs within one working day	85.85%	87.11%		Nick Jenkins	86.71%	85.68%	85.85%	↗			
Discharge Summaries - Inpatients	95% sent to GP's within 1 day	TBC	92.91%	Inpatient Discharge Summaries report is currently being built with completion expected in time for next month.	Nick Jenkins	TBC	TBC	TBC	-			
Choose & Book												
All 2 Week Wait services delivered by the Provider shall be available via Choose & Book (subject to any exclusions approved by NHS East of England)	100%	100.00%	100.00%		Helen Beck	100.00%	100.00%	100.00%	↔			
Cancelled Operations												
Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	i) 1% of all elective procedures	0.97%	0.90%		Helen Beck	1.00%	1.21%	0.97%	↗			
Patients offered date within 28 days of cancelled operation	100%	92.00%	88.11%		Helen Beck	88.46%	75.00%	92.00%	↗			
No urgent operation should be cancelled for a second time	0 2nd Urgent Cancellations	0	0		Helen Beck	0	0	0	↔			
Maternity												
Access to Maternity services (VSB06)	90% of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy.	92.83%	95.79%		Rowan Procter	94.85%	99.59%	92.83%	↘			
Maintain maternity 1:30 ratio	1:30	01:33	01:30		Rowan Procter	01:30	01:33	01:33	↔			
Pledge 1.4: 1:1 care in established labour	1:1	100%	100.00%		Rowan Procter	100.00%	100%	100%	↔			
Breastfeeding initiation rates.	80%	78.70%	81.43%		Rowan Procter	77.30%	84.80%	78.70%	↘			
Reduction in the proportion of births that are undertaken as caesarean sections.	22.70%	18.22%	18.02%		Rowan Procter	15.49%	22.32%	18.22%	↗			

Other contract / National targets												
Mixed Sex Accomodation breaches	0 Breaches	0	0		Helen Beck	0	0	0	↔			
Consultant to Consultant referral	Commisioner to audit if concern about levels of consultant referrals	10.19%	10.78%		Helen Beck	12.27%	12.88%	10.19%	↗			
MRSA - emergency screening	100% Screened within 24 hours	TBC	TBC	Figures will be available once MRSA report is finalised following Order Comms go-live.	Rowan Procter	TBC	TBC	TBC	-			
MRSA - Elective screening	100% Screened prior to admission		TBC		Rowan Procter	TBC	TBC	TBC	-			
Rapid access - chest pain clinic	100% of patients should have a maximum wait of two weeks	97.48%	97.99%		Helen Beck	95.45%	97.09%	97.48%	↗			
Acute oncology service: 1 hour to needle from diagnosis of neutropenic sepsis	100%	100.00%	94.74%	MacMillan	Helen Beck	100.00%	92.31%	100.00%	↗			
		40.00%	50.70%	ED	Helen Beck	58.33%	70.00%	40.00%	↘			
		62.50%	65.45%	Overall Trust (Inc AMU)	Helen Beck	68.75%	82.61%	62.50%	↘			
New to Follow up	Thresholds set at each speciality - overall Trust Threshold is 1.9	1.97	1.92		Helen Beck	1.96	2.01	1.97	↗			
Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test	99%	100.00%	99.93%		Helen Beck	99.95%	99.95%	100.00%	↗			
All relevant inpatients undergoing a VTE Risk assessment	95%	87.95%	87.91%		Helen Beck	85.81%	89.67%	87.95%	↘			

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

4.1 A&E Time to treatment in department (median) for patients arriving by ambulance - CDM

a) Current Position

62 against a median to treatment above 60 minutes

b) Recommended Action

The division has developed a 4 hour emergency standard recovery plan to address the deficits in service as well as exploring alternative solutions to improve performance across the system.

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

a) Current Position

12.01 - should not exceed six hours

The patient registered in ED at 17/9/17 23:21. At 23:55 the patient was triaged a priority 4, being seen by the ED doctors at 02:36 (3 hours length of stay). This patient was going to be sent home, however family expressed concern, pain management required so patient unsuitable for CDU. The patient was clinically managed until pain under control again. At 4:05 the patient was referred to Surgeons, the surgeons came to see the patient at 5:02. Due to no inpatient capacity the patient was not able to go to an inpatient surgical bed on F5 until 11:50am the morning of the 18/09/17.

b) Recommended Action

See above.

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

a) Current Position

34.19 against a threshold of 27%

b) Recommended Action

AEC continues to actively pull patients from ED with the emphasis of being discharged the same day. A revised e Care workflow will be implements following the current go live which will allow the Trust to record AEC activity separately from admissions.

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

a) Current Position

94.23% against a threshold of 99%.

There are on-going significant capacity issues within the ENT, Vascular, Urology, and Dermatology services. Patients are waiting over 30 weeks for surgery within Urology, 35 weeks for Vascular Surgery,

and some patients are waiting over 28 week for surgery in Ophthalmology. There remains significant pressure on rapid access referrals in Dermatology. The plastic surgery service has taken on a number of referrals from dermatology to support the service. However, this is giving the appearance of a drop in performance for the plastic surgery service itself.

b) Recommended Action
Detailed action plans for each of the above specialties are being developed with CCG input where appropriate. Targeted work is under way to reduce the back log in challenged specialties including ophthalmology but capacity issues remain in others such as ENT having a consequential effect on aggregate performance. Recruitment and sickness absence challenges in the theatre teams are impacting on the ability to run some additional theatre lists that have been planned to aid in reducing backlogs.

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

a) Current Position
73.83% against a threshold of 90%.
This reflects an improved position form the previous month (69.70%) indicating that treatment times are reducing in line with plans.

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

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

a) Current Position
87.28% against a threshold of 95%.
This continues to be predominantly due to excessive waits for first appointment in Dermatology with long but much improved waiting times in ENT.

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

4.7 Stroke: % of patients scanned within 12 hours of clock start

a) Current Position
90.24% against a threshold of:
96% (Contract
96% (Upper Quartile)

b) Recommended Action
Four patients breached this target – two were inpatient strokes, one a misdiagnosis and one was a delay in referral to Emergency Stroke Outreach Team. Work continues on educating the wards re diagnosis and referral of stroke patients.

4.8 Patients offered date within 28 days of cancelled operation

a) Current Position
92% against a threshold of 100%
Two patients were cancelled to facilitate organ retrieval during September.

b) Recommended Action
Unfortunately capacity constraints prevented these patients from being offered a date within 28 days.

4.9 Maintain maternity 1:30 ratio

a) Current Position

1:33 against a threshold of 1:30
The effect of delivering mothers from USAF Lakenheath has had an impact on the midwife to birth ratio again this month taking it to 1 to 33, above that which we would normally achieve. The formula used for this calculation however does not allow you to disregard any areas of care not provided, therefore this figure includes the provision of antenatal care to women from Lakenheath , where this was in fact limited.

b) Recommended Action
This has now ceased and it would be expected that the ratio will fall to 1:30 in October 2017. All women received one to one care in labour.

4.10 Breastfeeding initiation rates

b) Current Position
78.70% against a threshold of 80%

b) Recommended Action
The maternity service is not able to identify specific drivers which influence the rate of breast feeding initiation month by month but continues to work towards sustained improvement. Work continues to finalise the achievement of BFI Level 3 award.

4.11 Rapid Access - chest pain clinic

c) Current Position
97.48% against a threshold of 100%

b) Recommended Action
High levels of rapid access referrals, combined with trust grade having to take emergency leave meant that despite putting on extra clinics we were unable to accommodate every referral within the 2 week time frame. Extra clinics continue to be set up to meet the demand.

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

a) Current Position
Macmillan – 100%
ED - 40%
Overall Trust figure of 62.50% against a threshold of 100%

b) Recommended Action
The performance figure for 1 hour to needle from diagnosis of neutropenic sepsis September Data showed a drop from the last three months improved performance. AMU and the Macmillan Unit had no breaches during September. The Emergency Department had 9 neutropenic sepsis patient breaches. The breach cases will be undergoing detailed review. These issues will be escalated to the Emergency Department Clinical and Nursing management to address within the departments.

4.13 New to follow up

a) Current Position
1.97 against a threshold of 1.9

c) Recommended Action
Position remains level and the backlog continues to be managed. The planned care transformation programme will be reviewing this metric at specialty level.

4.14 All relevant inpatients undergoing a VTE Risk Assessment

a) Current Position
87.95% against a threshold of 95%

b) Recommended Action
The VTE assessment as required to be undertaken within 24 hours of admission.
We are seeing month on month improvements now we have the reporting capacity and this is part of the newly developed patient safety dashboard.

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	September	Comments
Workforce			
Sickness absence rate	<3.5%	3.58%	
Turnover	<10%	9.80%	
Reviews	Grievance/Banding reviews	6	Includes 2 employment tribunals
Recruitment Timescales	Average number of weeks to recruit = 7	6.7	
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 appraisal within the previous 12 months. Appraisal is a rolling programme	53.11%	Compliance percentages are expected to steadily rise over the coming months as data quality gaps are addressed in conjunction with area leads.

5.1 Sickness Absence Rate

a) Current Position
3.58% against a threshold of <3.5%.

b) Recommended Action
Sickness absence rate is 0.08% above target. Managers continue to be supported in the management of both long term and short term absences.

5.2 All Staff to have an appraisal

a) Current Position
53.11% against a target of 90%
Both general and consultant staff each have a target of 90% to have had an appraisal within the previous 12 months. Appraisal is a rolling programme

b) Recommended Action
The ESR system for recording and monitoring of appraisals has changed. We fully expect the appraisal figures to increase in the coming months.

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6. RECOMMENDATION

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

Appendix A – Community Data

Welcome to the community contract report for September. This is the last month for reporting the community services in one report:

- Our FFT for September was 98% from 431 responses.
- We received 2 ‘extremely unlikely to recommend’ responses relating to Community Equipment Services and Wheelchair services. No comments were left as to the reason for these ratings.
- There were 3 formal complaints received in September, Heart Failure, Children’s Services and MIU.
- The number of patients whose discharge was delayed in September was 54, an increase from 49 in August. Of these, the number waiting for care packages has also increased.
- The Paediatric SLT service positon has not altered significantly from the August position.
- The Community Equipment Service failed 4 out of 7 KPI’s this month.
- The Adult SLT service has had a number of breaches for both priority 1 and priority 2 referrals. The service continues to have a high absence rate of > 50% (sickness and vacancies) which have contributed to this position.
- The Children in Care service had 22 breaches for completion of health assessments within 28 days of the child becoming looked after. Of these 22, the delay of the service being notified was an average of 21.3 days and the greatest delay being 63 days.
- We had 1 case of C Difficile this month at Bluebird Lodge. A completed RCA has been sent to the CCG.

Adult KPI's										
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**Sep 2017**	**September Comments / Queries 2017**	**Jun 2017**	**Jul 2017**	**Aug 2017**
SCH		**D4-qoc1**	Number and % of service users who rated the service as 'good' or 'better'.	85%	Quarterly report from Provider	98.19%		98.20%		
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'better'.	85%	Quarterly report from Provider	97.50%		93.63%		
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'well informed'.	85%	Quarterly report from Provider	95.77%		95.50%		
SCH		**D5-acc4**	18 week referral to treatment for non-Consultant led services 15 services: Paed OT, PT, SALT, Adult, Wheelchairs, Podiatry, Biomechanics, Stoma nurses, Neuro nurses, Parkinson's, SCARC, Environmental, H Failure, Hand Therapy & Continence	95% patients to be treated within 18 weeks	Monthly report from Provider	99.38%		99.80%	98.06%	99.84%
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	97.89%		99.53%	99.58%	98.80%
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	0
SCH	Dementia	**c-gen4**	All community clinical staff to receive relevant dementia awareness training	95%	Monthly report from Provider	96.13%		96.10%	96.47%	96.47%
SCH	Canc by Prov	**c-gen7**	% of clinics cancelled by the Provider Q3 2012-13 establish baseline. Where benchmarking of community services shows a DNA rate worse then the best quartile. Q4 2012-13 agree an appropriate reduction on baseline. Pcanc-01 ONLY - Q1 2013/14 establish baseline. Where benchmarking of community services shows a DNA rate worse than the best quartile: Q2 reduction of 2.5% on baseline, Q4 reduction of 10% on baseline		Quarterly report from Provider	0.65%		1.60%		
SCH	Safeguarding - children	**c-safe1**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.82%		96.94%	96.99%	97.06%
SCH	Safeguarding - adults	**c-safe2**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.13%		96.77%	96.64%	96.20%
SCH	Disch summ	**dis summ-CQUIN**	% of discharge summaries from the following services; Community Hospital, Adult SaLT, Community Intervention & Leg ulcer service, that are provided to GP practices within 3 days of discharge from the service (previously within 1 day of discharge).	95%	Monthly report from provider	100.00%		97.78%	100.00%	98.33%
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%	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%	100.00%
InPt	MRSA	**c-inf1**	Number of cases	No cases	Monthly report from Provider	0		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	N/A
InPt	C-Diff	**c-inf4**	Completed RCAs on all community hospital outbreaks of C difficile	100%	Monthly report from Provider	100%		N/A	N/A	100%
InPt	Comm Hosp	**s-ip7**	Number of inpatient falls resulting in moderate or significant harm	No more than 1.25 per month (15 per annum) falls/1000bed days	Monthly report from Provider	0.28		0.36	N/A	N/A
InPt	Step Up Adm Prevention Comm Beds	**s-apcb1**	The community beds will be available for access across the 24 hour 7 days a week	100%	Monthly report from provider	100.00%		100.00%	100.00%	100.00%
InPt	Step Up Adm Prevention Comm Beds	**s-apcb6**	All Service Users will have a management plan agreed with them and their family/carer where applicable within 24 hours from arrival.	98%	Monthly report from provider	100.00%		96.30%	100.00%	96.24%
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	86.36%	9 out of 66 referrals breached the 18week target. 3 x 22-23wks, 2x24wks, 3 x 25-26wks and 1 x 26-27wks. Course starts were delayed due to high levels of staff sickness over the summer.	91.89%	100.00%	85.71%
IHT	CCC	**D4-int1**	Care coordination centre - % of telephone calls answered within 60 seconds	95% in 60secs	Monthly report from Provider	95.27%	# of calls handled: 15,632 # of calls answered in 0-60 seconds: 14,891 **% 0-60 seconds: 95.27%** Number of abandoned calls: 331 Abandoned calls %: 2.07% Average Wait Time: 15 seconds	95.53%	95.94%	95.94%

Adult KPI's										
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**Sep 2017**	**September Comments / Queries 2017**	**Jun 2017**	**Jul 2017**	**Aug 2017**
IHT		**D4-ccc6**	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed.	85%	Quarterly	94.66%		99.03%		
IHT	Card Rehab	**s-card5**	Number of service users successfully discharged from phase 3.	600 per annum	Monthly report from Provider	no longer reporting as of July 16		no longer reporting as of July 16	no longer reporting as of July 16	no longer reporting as of July 16
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses offered	At least 500 courses offered pa	Monthly report from Provider	52 offered		67 offered	62 offered	51 offered
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses completed	At least 250 courses completed pa	Monthly report from Provider	66 completed		37 completed	19 completed	7 completed
IHT	COPD	**s-copd5**	Community pulmonary rehabilitation - review offered 6 months after completing the course	95%	Monthly report from Provider	100.00%		97.30%	100.00%	100.00%
IHT	Comm Continence	**s-cc3**	% of Service Users re-assessed at 6 weeks	98%	Monthly report from Provider	no longer reporting as of November 16		no longer reporting as of November 16	no longer reporting as of November 16	no longer reporting as of November 16
IHT	Comm Continence	**s-cc4**	% of Service Users re-assessed at 12 monthly intervals (previously 6 monthly intervals)	98%	Monthly report from Provider	100.00%		100.00%	100.00%	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 November 16		no longer reporting as of July 16	no longer reporting as of July 16	no longer reporting as of July 16
IHT	MIU	**s-miu3**	Timeliness Indicators: 1) Total time spent in A& E department 2) Time to initial assessment (95th percentile) 3) Time to treatment in department (median) 1) 95% of Service Users waiting less than 4 hours 2) 95th percentile time to assessment above 15 minutes 3) median time to treatment above 60 minutes		Monthly Secondary Uses Services (SUS) data, A&E Commissioning data set (CDS)	#1 = 99.84%		#1 = 100.00%	#1 = 100%	#1 = 99.83%
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	97.83%		98.61%		
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "supported".	85%	Quarterly report from provider	100.00%		100.00%		
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "well informed".	85%	Quarterly report from provider	100.00%		100.00%		
IHT	MIU	**s-miu5**	Total time spent in A+E department 95% of Service Users waiting less than 4 hours for Service Users	95%	Monthly Secondary Uses Services	99.84%		100.00%	99.84%	99.83%
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	89.87% (213/237)	This relates to 24 items delivered to 11 clients. 12 items were 1 hour late, 5 items were 2 hours late, 4 items were 3 hours late and 3 items were 15 hours late	98.26% (169/172)	100% (148/148)	92.17% (200/217)
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	99.16% (944/952)		99.52% (1042/1047)	99.22% (893/900)	98.90% (898/908)
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	99.36% (2013/2026)		99.55% (2441/2452)	98.91% (2359/2385)	99.50% (2007/2017)
Mede	CES	**c-gen8**	Within 10 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider	97.10% (569/587)	This relates to 17 items delivered to 13 clients. 6 items were delivered 16hours after the target time.	99.52% (625/628)	98.55% (542/550)	97.98% (533/544)
Mede	CES	**c-gen9**	Collection times: % of urgent next day collections for deceased Service Users	98% for all standards	Monthly report from Provider	94.95% (188/198)	This relates to 10 items collected from 10 different clients.	100% (263/263)	99.52% (206/207)	97.66% (167/171)
Mede	CES	**c-gen9**	% of urgent collections within 2 working days	98.00%	Monthly report from Provider					
Mede	CES	**c-gen9**	% of urgent collections within 3 working days	98.00%	Monthly report from Provider	100.00% (595/595)		99.61% (513/515)	100.00% (422/422)	100.00% (306/306)
Mede	CES	**c-gen9**	% of urgent collections within 5 working days	98.00%	Monthly report from Provider					
Mede	CES	**c-gen9**	% of collections within 10 working days	98.00%	Monthly report from Provider	96.75% (3901/4032)	This relates to 131 items collected from 53 different clients. 46 items were collected within 11 days.	98.68% (5154/5223)	97.54% (4992/5102)	98.71% (4580/4640)
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%	100.00%
Mede	Ass Tech	**s-at4**	Delivery of equipment within agreed time frames	95%	Monthly report from provider	100.00%		100.00%	100.00%	100.00%
Mede	Wheelchair	**s-wchair1**	All Service Users have a first appointment/contact seen after initial response time according to priority / need: High Priority	within 6 weeks 100%	monthly report from provider	N/A		N/A	N/A	0.00%
Mede	Wheelchair	**s-wchair1**	Medium Priority	within 12 weeks 100%	monthly report from provider	N/A		N/A	N/A	N/A
Mede	Wheelchair	**s-wchair1**	Low Priority	within 18 weeks 100%	monthly report from provider	91.67%	11 out of 12 low priority referrals were seen within 18weeks, the 1 breach was Patient Choice as the patient cancelled 2 appointments.	92.86%	100.00%	100.00%
NCHC		**D2-ltc2-a**	% of people that have been identified by case finding, (using risk stratification, or other means), and deemed suitable for intervention by the MDT, and referred to SCH, that have a care lead.	95%	Monthly report from Provider	100.00%		100.00%	100.00%	100.00%

Adult KPI's										
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**Sep 2017**	**September Comments / Queries 2017**	**Jun 2017**	**Jul 2017**	**Aug 2017**
NCHC		**D2-ltc2-b**	% of people identified via case finding, that have a care plan (including self-care) that has been shared with the GP practice within two weeks of the patient coming onto the caseload. The GP practice will require a copy of the care plan, and the information will be shared with the MDT, which includes a GP.	95%	Monthly report from Provider	100.00%		N/A	N/A	N/A
NCHC		**D5-ccc7**	% of referrals seen following triage; Emergency - 2 hrs	Emergency - 100%	Monthly report from Provider	100.00%		100.00%	100.00%	N/A
NCHC		**D5-ccc7**	Urgent 4 hrs	Urgent - 95%	Monthly report from Provider	98.64%		99.42%	98.62%	95.59%
NCHC		**D5-ccc7**	Intermediate - 72 hrs	Intermediate - 95%	Monthly report from Provider	98.55%		98.28%	98.60%	98.16%
NCHC		**D5-ccc7**	18 weeks	18 weeks - 95%	Monthly report from Provider	98.93%		99.77%	99.58%	99.21%
NCHC		**D4-int1**	Community Health Team Leads and/or Local Area Managers to work with GP practices and establish direct working relationships that aid mutual understanding and aim to improve the quality of services to patients. A schedule of face to face meetings is to be agreed and adhered to by both parties and a joint action plan is to be produced that shall be regularly reviewed.	80%	Quarterly report from Provider					
NCHC	PHP	**c-php1**	Number of Service Users with the following Long term conditions with a Personal Health plan (Parkinson's Disease, Multiple sclerosis, Muscular Dystrophy, Chronic Obstructive Pulmonary Disease, all other chronic respiratory diseases, Coronary Heart Disease, Heart Failure).	80% completed	Monthly	100.00%		100.00%	100.00%	100.00%
NCHC	IDPT	**s-disch1**	Triage and assessment of referrals within 1 Operational Day	98%	Monthly report from Provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
NCHC	IDPT	**s-disch2**	Urgent discharge achieved (<24 hours from referral to the team) for Service Users terminally ill and wishing to die at home	85%	Monthly report from Provider	N/A		N/A	N/A	66.67%
NCHC	IDPT	**s-disch4**	Transfer from acute hospital to community based provision from receipt of referral within a timescale not exceeding 48 hours providing the Service User is medically and physically fit for discharge	80% of Service Users medically and physically fit for discharge	Monthly report from provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
NCHC	EAU CIS	**eau-cis-IHT**	% of patients seen within 2 hrs. of initial referral. The Senior Nurse (part of the CIS) allocated to the EAU at IHT will begin patient assessment within 2 hrs of consultant referral.	98%	monthly report from provider	N/A		N/A	N/A	N/A
NCHC	Verification of expected death training	**c-gen2**	Number of qualified nursing staff trained in Service User areas, community nursing teams and local Healthcare teams (to include all clinical staff from within planned care, urgent care, & intensive case management as the integrated service model is implemented)	90%	Monthly report from provider					
WSH	Adult SALT	**s-salt1**	All new referrals are triaged within 5 Operating Days of receipt of referral;	98%	Monthly report from Provider	96.80%	This relates to 4 referrals out of 125. All referrals were triaged within 7 operational days.	100.00%	100.00%	97.73%
WSH	Adult SALT	**s-salt2**	Service Users seen within the following timescales after triage: Priority 1 within 10 Operating Days	Priority 1 - 100%	Monthly report from Provider	100.00%	This service has had absences >50% (3.0wte actual against a 7.0wte budget) for 2-3 months.	100.00%	100.00%	75.00%
WSH	Adult SALT	**s-salt2**	Priority 2 within 20 Operating Days	Priority 2 - 95%	Monthly report from Provider	82.00%	This relates to 12 patients out of 75	80.00%	59.00%	46.00%
WSH	Adult SALT	**s-salt2**	Priority 3 within 18 weeks	Priority 3 - 95%	Monthly report from Provider	100.00%		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%	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	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%	100.00%

Children's Services KPIs										
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of Measurement**	**Sep 2017**	**September Comments/ Queries 2017**	**Jun 2017**	**Jul 2017**	**Aug 2017**
WSH	All Paediatric Services	**GP-1**	18 week RTT for Consultant led services	95% of consultant led Service Users to be treated within 18 weeks	Monthly pledge 2 reporting by Children's Service	94.52%	2 out of 41 (weeks 22.43 and 23.00) in the West Paediatric service breached and 2 out of 32 (weeks 18.71 and 19.71) in the East Paediatrics service breached.	98.61%	98.80%	94.74%
WSH	All Paediatric Services	**GP-1**	18 week RTT for non-Consultant led services	95% of non-consultant led Service Users to be treated within 18 weeks	Monthly pledge 2 reporting by Children's Service	99.39%		99.01%	98.06%	100.00%
WSH	All Paediatric Services	**PaedSLT-4**	All Children to have a Personal Health plan completed where required.	100% Service Users offered a PHP 80% completed a PHP	Monthly report from provider by Children's Service	100.00%		100.00%	100.00%	100.00%
WSH	All Paediatric Services	**D4-qoc1 D4-qoc2 GP-4**	Quarterly Service User satisfaction surveys based on Suffolk Community Healthcare's processes prior to Effective Start Date. Number and % of service users who rated the service as "good" or better	85%	Quarterly report from provider	Now included in the Patient Experience		Now included in the Patient Experience	Now included in the Patient Experience	Now included in the Patient Experience
WSH	All Paediatric Services	**D4-qoc1 D4-qoc2 GP-4**	Number and % of service users who responded that they felt "supported" and "well informed".	85%	Quarterly report from provider	Now included in the Patient Experience		Now included in the Patient Experience	Now included in the Patient Experience	Now included in the Patient Experience
WSH	All Paediatric Services	**GP-6**	Safeguarding - % eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	monthly report by provider	99.07%		99.08%	99.07%	99.07%
WSH	All Paediatric Services	**GP-9** **PDL-01**	Discharge Letters - to be sent within 24 hours of discharge from a community hospital and 72 hours of discharge from all other caseloads (all discharge letters whether electronic/non electronic to clearly state date dictated, date signed and date sent)	95%	Monthly	100.00%		100.00%	100.00%	100.00%
WSH		**PaedSLT-5**	Personalised Care Planning - Percentage of Transition (to adults) Care Plans completed	Q3 2012/13 establish baseline	Annual - Systmone					
WSH	Newborn Hearing Screening Service (West)	**NBHS-2**	Timely screening – where consented screens to be completed by four weeks of age	95%	Monthly Activity Report	98.82%		99.59%	98.89%	98.71%
WSH	Newborn Hearing Screening Service (West)	**NBHS-3**	Screening outcomes set within 3 months	≥99%	Monthly Activity Report	98.76%		99.18%	98.86%	97.84%
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%	100.00%
WSH	Leapfrog Therapeutic Service	**Leap-8**	Outcomes achieved for children utilising the services	Annual report produced	Annual report					
WSH	Therapy Focus Suffolk	**TFS-6**	All relevant staff that have been 'Bobath' update trained	100%	Annual report					
WSH	Single Point of Access	**PSPOA-03**	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed	85%	Quarterly					
WSH	Single Point of Access	**PSPOA-04**	% of service users who were satisfied with the length of time waiting for assessment	85%	Quarterly report from Provider					
WSH	Single Point of Access	**PSPOA-05**	% of referrers who were satisfied with the length of time waiting for assessment	85%	Quarterly report from Provider					
WSH	Access	**cps-a02**	Children/young people in special schools receive speech and language interventions	100%	Systmone	100.00% 320 contacts		100% 180 contacts	100.00% 205 contacts	100.00% 32 contacts
WSH	Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	Systmone	100.00% 196 contacts		100% 156 contacts	100.00% 148 contacts	100.00% 109 contacts
WSH	Children in Care	**CiC-001c**	Initial Health Assessment appointments that are OFFERED within 28 days of receiving ALL relevant paperwork	100% in 28 days	Monthly report from Provider	66.67%	16 out 24 children who had an IHA in September were offered their first appt within 28 days of the service being made aware of the child.	85.00%	94.74%	90.91%
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	41.87%	10 out of 24 children had an IHA completed within 28 days of the service being made aware of the child. Of the 14 appts outside the 28 day deadline (36-133days) 8 were patients who had been previously offered appts but DNA'ed or cancelled. The service increased the number of appts seen in September (24 seen compared to an average of 16 over the last 6 months) which has cleared some of the longer waits.	80.00%	78.95%	81.82%
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	8.33%	2 out of the 24 IHAs were within 28days of the child becoming placed in care. Of the 22 appts outside this time period (29-196days) the average delay was 21.3days. With the greatest delay being 63days.	25.00%	10.53%	18.18%

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

2

a) Current Position

86.36% against a 95% target

This relates to 9 patients out of 66 who completed in the month. Course starts were delayed due to high levels of staff sickness over the summer.

b) Recommended Actions

- Service lead exploring the sharing of staff between pulmonary re-hab, cardiac rehab and COPD services
- One service lead now managing all respiratory services together to provide increased resilience
- Sick health retirement policy invoked
- Recruitment and skill mix underway

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

a) Current Position

C-gen8 - delivery within 4 hours – 89.87% against a 98% target

213 out of 237 deliveries were compliant; the 24 non-complaint items were delivered to 11 clients. 12 items were 1 hour late, 5 items were 2 hours late, 4 items were 3 hours late and 3 items were 15 hours late

C-gen8 - delivery within 10 working days – 97.10% against a 98% target

569 out of 587 collections were compliant; the 17 non-complaint items were delivered to 13 clients. 6 items were delivered 16hours after the target time.

C-gen9 – collection by next working day – 94.95% against a 98% target

188 out of 198 collections were compliant; the 10 non-complaint items were collected from 10 different clients.

C-gen9 – collection by next working day – 96.75% against a 98% target

3901 out of 4032 collections were compliant; the 131 non-compliant items collected from 53 different clients. 46 items were collected within 11 days.

b) Recommended Actions

- Discuss at contract meeting on 25th October
- Request RCA and impact assessment of the 4 hour deliveries not executed until 15 hours
- Undertake review of the increasing amounts of equipment being requested for 4 hour delivery to ensure appropriateness

4 **S-Wchair1 – Wheelchair First appointments - % of first appointments/contact within 18 weeks of low need user referrals**

a) Current Position

91.67% against a 100% target

This relates to one low need user out of 12 referrals who breached the 18 week target.
The patient cancelled 2 previous appointments.

b) Recommended Actions

- Draft clock stop policy shared with CCG. Once agreed this will eliminate breaches where the patient has cancelled 2 or more appointments
- Complete wheelchair pathway has been reviewed, bottlenecks identified and remedial action being taken to improve supplier response and create additional rehab engineer capacity

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

a) Current Position
S-salt1 – new referrals triaged within 5 working days – 96.80% against a 98% target
This relates to 4 out of 125 referrals. All referrals were triaged within 7 operational days.
S-salt2 – Priority 2 patients seen within 20 working days – 82.00% against 95% target
This relates to 12 out of 75 referrals.
This service has had absences >50% (3.0wte actual against a 7.0wte budget) for 2-3 months.

b) Recommended Action
- This service has now disaggregated east and west
- West team lead now operating acute and community staffing resources as 'one team' to create capacity
- Skill mix review undertaken
- Additional band 5 post has been created which is out to advert

6 18 week RTT Cons led Paediatric Services – % of patients treated within 18weeks of referral for consultant led Paediatric Service

a) Current Position
94.52% against a 95% target
30 out of 32 children were seen within 18weeks in the East and 39 out of 41 children were seen within 18weeks in the West. Of the 4 breaches 2 were patient choice as the children attended joint appointments with their siblings.

b) Recommended Action
- Continue to monitor closely to ensure any breaches are not as a result of service issues

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

a) Current Position
CiC-001c – 66.67% against a 100% target
CiC-001b – 41.87% against a 100% target
CiC -001a – 8.33% against a 100% target

24 Initial Health Assessments were completed in September. 2 were completed within 28 days of becoming CiC, and 10 were completed within 28 days of the service receiving ALL the paperwork, 16 first appointments were offered within 28 days. Of the 14 appointments outside the 28 day deadline (36-133days) 8 were patients who had previously been offered appointments but had either DNA'ed or cancelled. The service increased the number of appointments seen in September (24 compared to an average of 16 over the last 6 months) which has cleared some of the longer waits.
Of the 22 appointments outside the 28 day time period (29-196days) from the child being placed in care to having their initial health assessment the average delay was 21.3days and the greatest delay was 63 days.

b) Recommended Action

- Continue to review this pathway jointly with SCC to eliminate delays
- Review 'breach criteria' within policy
- Escalate again to SCC Director of Children's Services

Quality Dashboard

	Units	Target	Red	Amber	Green	Apr	May	Jun	Jul	Aug	Sep
Patient Experience											
Service users who rated the service as 'good' or 'better' (Quarterly)	Nos.	No Target						1528			1412
	%	85%	<80%	80%-85%	>=85%			98.20%			98.19%
Service users who responded that they felt 'better'	Nos.	No Target				132	145	397	136	74	102
	%	85%	<80%	80%-85%	>=85%	94%	93%	93.63%	96.00%	100.00%	98.00%
Service users who felt 'well informed'	Nos.	No Target				198	159	509	193	121	116
	%	85%	<80%	80%-85%	>=85%	96%	94%	95.50%	96.00%	98.00%	94.00%
10% of long term condition patients feel "better supported" to self manage their conditions (Quarterly)	Nos.	No Target						104			69
	%	No Target						93.69%			95.83%
Falls (Inpatient Units)											
Total numbers of inpatient falls (includes rolls and slips)	Nos.	No Target				30	47	40	56	39	29
Rolls out of Bed		No Target				1	4	4	1	4	1
Slip out of chair		No Target				0	4	2	3	0	0
Assisted Falls/ near misses		No Target				1	4	1	5	0	12
% of total falls resulting in harm	%	No Target				32%	23%	38%	39%	28%	41%
Numbers of falls resulting in moderate harm	Nos.	No Target				0	0	1	0	0	0
Numbers of falls resulting in severe harm	Nos.	No Target				0	0	0	0	0	1
Numbers of patients who have had repeat falls	Nos.	No Target				6	9	8	8	4	5
% 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)		No Target				8.96	13.96	12.5	16.47	11.4	8.5
Pressure Ulcers											
Pressure Ulcers – In Our Care Community											
Grade 2		100 pa	>110	100-110	<=100	34	32	27	26	38	35
Grade 3		26 pa	>30	27-29	<=26	6	8	7	9	5	4
Grade 4		0 pa	>1	1	0	1	0	1	2	1	0
Pressure Ulcers – In our care In-patient											
Grade 2		13 pa	>17	13-17	<=13	0	3	3	4	3	4
Grade 3		2 pa	>4	02-Apr	<=2	1	0	0	0	1	1
Grade 4		0 pa	>1	1	0	0	0	0	0	0	0
Safeguarding People Who Use Our Services From Abuse											
Number of adult safeguarding referrals made		No Target				2	4	1	3	4	4
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				100%	100%	100%	100%	100%	100%

	Units	Target	Red	Amber	Green	Apr	May	Jun	Jul	Aug	Sep
MRSA											
Bacteraemia – Number of cases		0	>2	>0 to 2	=0	0	0	0	0	0	0
MRSA RCA reports		100%	<95%	95%-100%	=100 %	0	0	0	0	0	0
Clostridium Difficile											
C.Diff number of cases		4 for 6 months	>4 YTD		<=4 YTD	0	0	0	0	1	1
C.Diff associated diseases (CDAD) RCA reports		100%	<95%	95%-100%	=100 %	N/A	N/A	N/A	N/A	100%	100%
Infection Control											
Infection control training		100%	<83%	83%-100%	=100 %	86.51%	91.80%	91.80%	89.10%	87.91%	87.80%
Essential Steps Care Bundles Including Hand Hygiene											
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	99.00%	99.00%	99.00%	98.70%	98.00%	99.00%
Isolation room audit		100%	<95%	95%-100%	=100 %	100%	100%	100%	100%	100%	100%
Management of Medication -SCH NRLS Reportable Incidents											
Total number of medication incidents in month		No Target				19	17	18	13	10	6
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				15	12	13	13	9	6
(also includes those not attributed to SCH management)	Low harm	No Target				3	5	5	0	1	0
Number of medication incidents involving Controlled Drugs		No Target				1	0	2	1	1	0

Incidents											
NRLS (i.e. patient safety) reportable incidents in month		No Target				199	242	185	212	197	153
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				8	8	9	12	7	6
Number of SIs reported to CCG in month *4 STEIS for 2 pts (2 each)		No Target				7	9	9	9	10	6
Percentage of SI reports submitted to CCG on time in month		No Target				100%	100%	100%	100%	100%	100%
Duty of Candour Applicable Incidents		No Target				8	9	9	9	10	6

Severity of NPSA Reportable Incidents											
None		No Target				131	163	108	140	124	90
Low		No Target				58	70	68	58	66	56
Moderate		No Target				8	9	8	11	6	6
Major		No Target				1	0	1	2	1	10
Catastrophic		No Target				0	0	0	0	0	0

Training Compliance											
Adult Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	96.02%	96.24%	96.77%	96.60%	96.20%	96.13%
Children Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	96.11%	96.41%	96.94%	96.90%	97.06%	96.82%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	94.81%	95.30%	96.10%	96.40%	96.72%	96.13%
WRAP						64.48%	66.82%	69.19%	72.20%	73.49%	77.48%
MCA / DoLs- Training compliance						73.59%	82.33%	83.27%	84.40%	86.60%	85.47%

Compliments/Complaints

	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Total compliments	21	38	28	36	27	61	50	46	44	36	56	47	28
Formal complaints (No.)	**1**	**1**	**2**	**2**	**3**	**5**	**1**	**1**	**2**	**3**	**2**	**0**	**3**
Acknowledged within 3 working days (No.)	1	1	1	2	3	5	1	1	1	2	2	0	3
Acknowledged within 3 working days (%)	100%	100%	50%	100%	100%	100%	100%	100%	50%	67%	100%	-	100%
Responded to within 25 working days (No.)	0	1	1	0	2	0	1	1	2	0	1	-	-
Responded to within 25 working days (%)	0%	100%	50%	0%	67%	0%	100%	100%	100%	0%	50%	-	-
Responded to outside 25 working days (No.)	1	0	1	2	1	5	0	0	0	3	1	-	-
Responded to outside 25 working days (%)	100%	0%	50%	100%	33%	100%	0%	0%	0%	100%	50%	-	-
Complaints upheld (No.)	1	-	-	-	1	2	1	1	1	-	-	-	-
Complaints partially upheld (No.)	-	-	-	-	-	3	-	-	-	2	1	-	-
Complaints not upheld (No.)	-	1	2	2	2	-	-	-	1	1	1	-	-
Average response time (days)	31.0	19.0	36.5	38.5	24.0	28.0	7.0	7.0	22.5	42.6	27.5	-	-

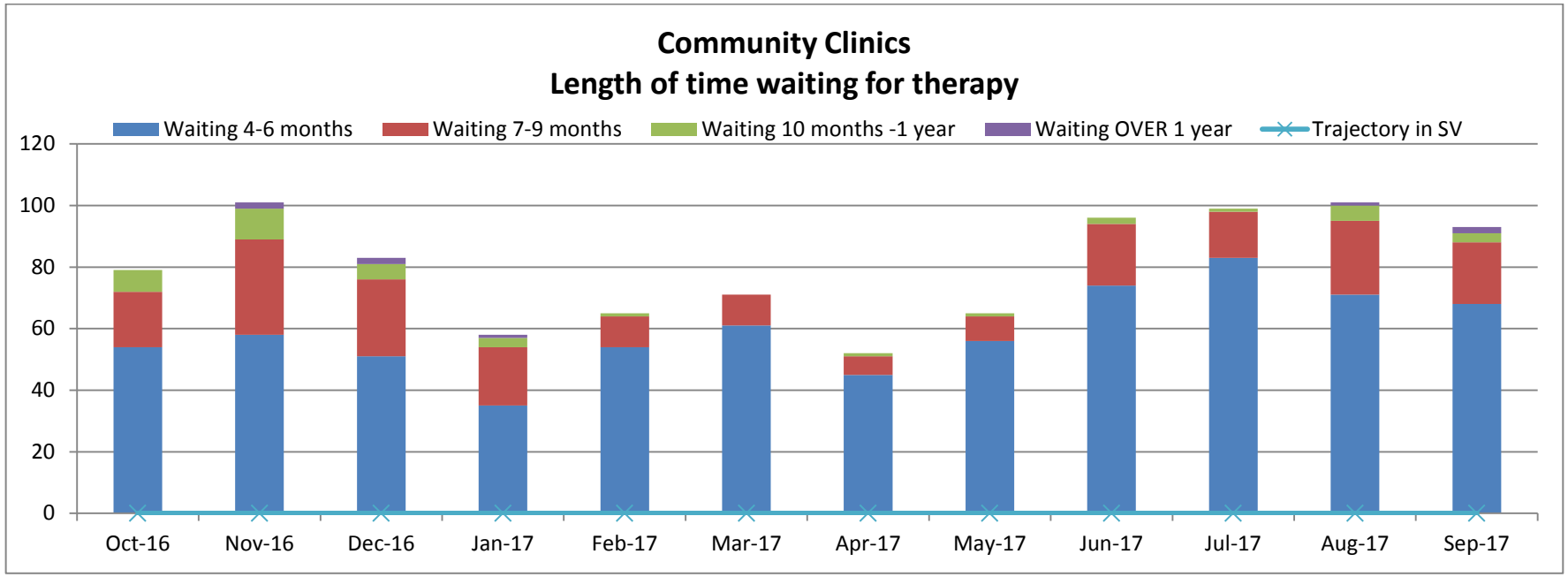
Paediatric Speech and Language Service Waiting times

Community Clinics

Clinic Waiting lists

Reports run 01/08/17

Length of wait Community Clinics *(pre-school caseload)*	No. of children waiting October 2016	No. of children waiting November 2016	No. of children waiting December 2016	No. of children waiting January 2017	No. of children waiting February 2017	No. of children waiting March 2017	No. of children waiting April 2017	No. of children waiting May 2017	No. of children waiting June 2017	No. of children waiting July 2017	No. of children waiting August 2017	No. of children waiting September 2017
Waiting up to 3 months	151	176	158	176	165	162	166	154	156	150	101	87
Waiting 4-6 months	54	58	51	35	54	61	45	56	74	83	71	68
Waiting 7-9 months	18	31	25	19	10	10	6	8	20	15	24	20
Waiting 10 months -1 year	7	10	5	3	1	0	1	1	2	1	5	3
Waiting OVER 1 year	0	2	2	1	0	0	0	0	0	0	1	2
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**230**	**277**	**241**	**234**	**230**	**233**	**218**	**219**	**252**	**249**	**202**	**180**
Already had PoC	75	67	72	55	60	85	53	51	73	86	67	58
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*	**305**	**344**	**313**	**289**	**290**	**318**	**271**	**270**	**325**	**335**	**269**	**238**

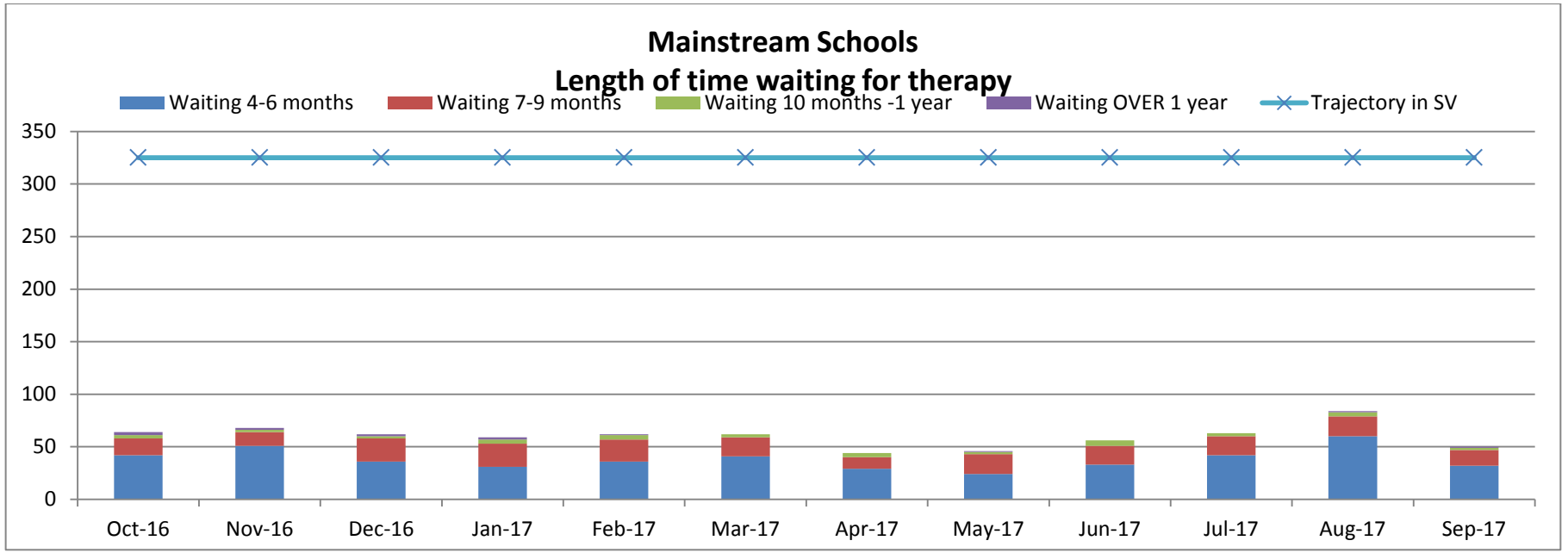


Mainstream Schools

Schools Waiting lists

No waiting data by months prior to May

Length of wait Mainstream Schools *(pre-school caseload)*	No. of children waiting October 2016	No. of children waiting November 2016	No. of children waiting December 2016	No. of children waiting January 2017	No. of children waiting February 2017	No. of children waiting March 2017	No. of children waiting April 2017	No. of children waiting May 2017	No. of children waiting June 2017	No. of children waiting June 2017	No. of children waiting August 2017	No. of children waiting September 2017
Waiting up to 3 months	72	68	59	56	56	73	87	89	84	113	100	64
Waiting 4-6 months	42	51	36	31	36	41	29	24	33	42	60	32
Waiting 7-9 months	16	13	22	22	21	18	11	19	18	18	19	15
Waiting 10 months -1 year	3	2	2	4	4	3	4	2	5	3	4	2
Waiting OVER 1 year	3	2	2	2	1	0	0	1	0	0	1	1
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**136**	**136**	**121**	**115**	**118**	**135**	**131**	**135**	**140**	**176**	**184**	**114**
Already had PoC	377	392	332	277	266	248	210	194	253	759	739	359
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*	**513**	**528**	**453**	**392**	**384**	**383**	**341**	**329**	**393**	**935**	**923**	**473**



Appendix B – 52 Weeks Breach Projection (Action 1470)

Position Statement as at 26/10/2017

Good practice highlights the need to review patients on the PTL with a 45 week plus wait as being at High risk of breaching a 52week period. Each week the focus will reduce by a week for detailed review so that there is gradual but sustained plan to reach 18 weeks for all patients.

Having already breached the 18 weeks standard, detailed plans have been established for all patients on the Live PTL (with RTT codes 20 and 30) who fall into this category.

A forecast position is proposed therefore to reduce to ZERO the numbers of patients who breach the 52 week standard for admitted care as soon as possible.

The tables below demonstrate the current status of these patients and suggests a reducing number of breaches commencing at the end of October. These plans are subject to TCIs and surgery proceeding as per plan.

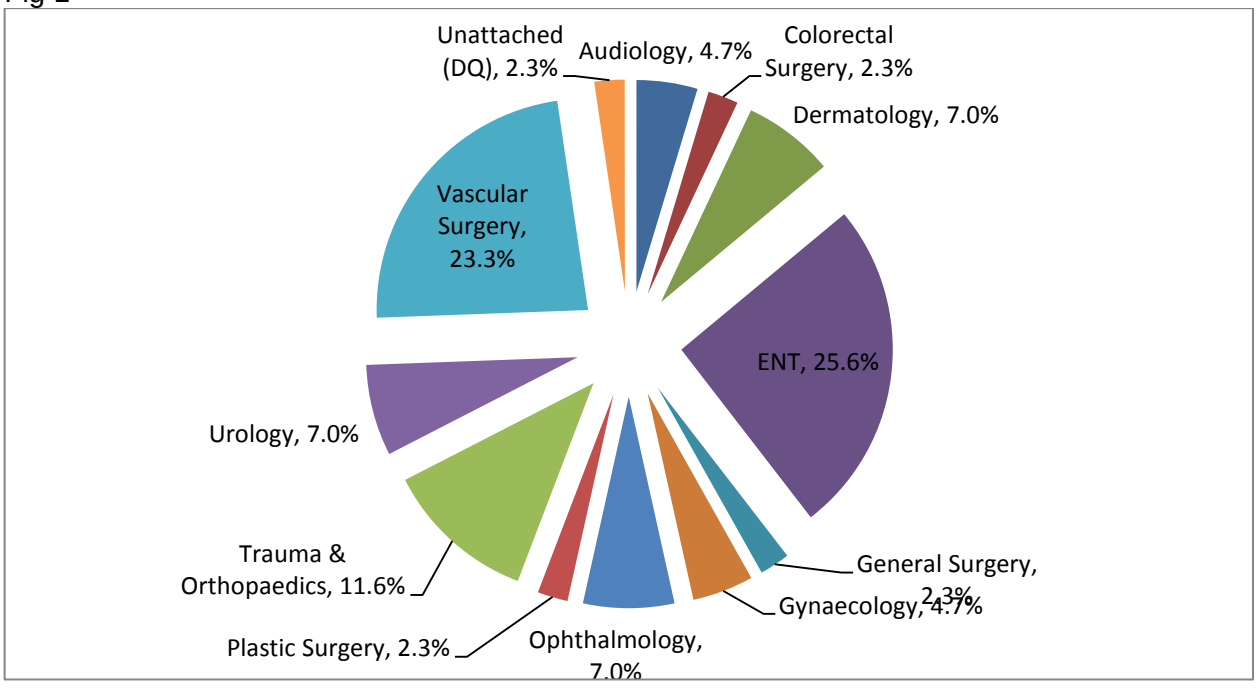
As at the Access Meeting 26/10/17 on the IPWL there were 55 patients listed over 45 Weeks.

- 35 patients with a Code 20 (Further activity anticipated)
- 11 patients with a Code 30 (Start of First Definitive Treatment)
- 1 patient with a Code 90 (After FDT)
- 1 patient with a Code 98 (Activity Not Applicable)
- 7 patients with a Code 21 (Transfer to another Healthcare Provider)

Of these 24 had already breached the 52 week standard.
43 Patients were therefore included in the 'live' report and 9 patients have been excluded currently as they are subject to further validation, DQ investigation or have activities unrelated to the RTT Pathway currently.

The breakdown by specialty is shown at figure 1:

Fig 1



The broad split by reason for the delay is 33% of patients have requested a delay in their FDT usually for work commitments or Holidays. There is a reasonable evidence trail available for these patients. The interim Head of Access will be driving adherance to 'availability' criteria to be applied (max 16 weeks) which will be incorporated into the Trust Access Policy; In addition staff will be provided support and materials to help

patients understand their obligations and definitions of ‘reasonable’. This will reduce the risk of the Trust being exposed to breaches without support from the referring GP and treating clinician.

Of the 13 ENT/Audiology Patients currently waiting over 45 weeks 3 patients Choice requests (2 over 52wks, 1 over 45wks but under 52wks); 1 Cancellation as patient in HMP (69wks) and 9 due to caapcity have been booked over 18 weeks (4 over 52wks and 5 over 45wks but NOT over 52wks).

To note the 2 Patient listed under Audiology have been incorrectly recorded and should be against ENT. (2+11 = 13)

Table 1 – Breakdown by weeks wait by specialty of patients currently waiting in excess of 45 weeks

Weeks Wait as at 26/10/17	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	TOTAL
AUDIOLOGY					1										1											2
COLORECTAL SURGERY			1																							1
DERMATOLOGY						2					1															3
ENT	1	1	1		4	1	2																		1	11
GENERAL SURGERY								1																		1
GYNAECOLOGY			2																							2
OPHTHALMOLOGY	1			1	1																					3
PLASTIC SURGERY							1																			1
TRAUMA & ORTHOPAEDICS	1		1					1					1						1							5
UROLOGY					1									1								1				3
VASCULAR SURGERY			1	1				1	2		1	1		3												10
(blank)			1																							1
TOTAL	3	1	7	2	7	3	3	3	2	0	2	1	1	4	1	0	0	0	1	0	0	1	0	0	1	43

Those patients reported in RED have not yet breached 52 weeks. These patients are considered to be “at risk” of failure if the admission is cancelled. These patient are planned to be treated as per Table 3.

Table 2 – Total of patient weeks wait by specialty of patients currently waiting in excess of 45 weeks across all specialties

Weeks Wait as at 16/10/17	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	
TOTAL	3	1	7	2	7	3	3	3	2	0	2	1	1	4	1	0	0	0	1	0	0	1	0	0	1	43

Table 3 – FDTs or Stop Clock events planned for those patients by week as at 26/10/17

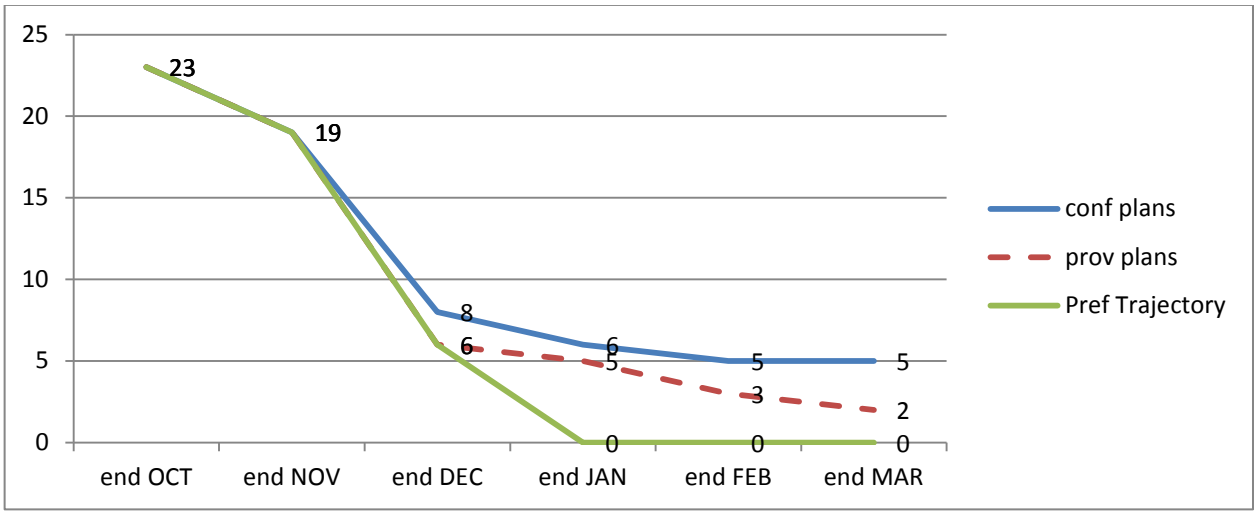
TREATMENTS PLANNED																										
OCT	0	0	0	0	1	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1
NOV	3	1	3	1	6	1	1	3	2	0	0	0	0	2	1	0	0	0	1	0	0	0	0	0	0	0
DEC	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
JAN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FEB	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MAR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ROTT	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
UNDATED	0	0	4	1	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Total	3	1	7	2	7	3	3	3	2	0	1	1	1	4	1	0	0	0	1	0	0	0	0	0	0	1
Unresolved 52	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0

This table attempts to show the treatments planned to address the patients in Table 1 and the planned deficit as at 26/10/17.

If current actual plans and “as yet unconfirmed” plans happen in the treatment period planned, there will be 2 patients waiting over 52 weeks at the end of March. These 2 patients are currently subject to further scrutiny and validation and have been shown as 52 week breaches.

It is projected that 52 week breaches will reduce from the end of October at the following rate based on current patient negotiated plans. Additional capacity for some specialties may help improve current TCIs which will focus on reducing the numbers of patients in the 52 week breach cohort; and “tip ins” from the patients hitting 45 weeks.

Table 4 – graph showing reduction in Patients waiting 52 weeks at month end based on confirmed and potential plans for Clock Stop events (mainly TCIs)



Work is ongoing to accelerate the reduction to ZERO 52 week breaches by the end of December. Currently 2 patients require further persuasion to come in sooner for their Clock Stop event as the revised Access policy is operationalised. The Trust will plan to ensure there are NO patients at risk of 52 week breaches going forward.

Therefore the current "best case" scenario based on actions identified at the 26/10/17 Access meeting is shown as the **RED** dotted line. Worst case scenario is shown as the solid **BLUE** line with caveats around cancellation of admission being avoided.

There is still work on going to ensure that every opportunity is utilised to quickly reduce the numbers of patients who breach or are at risk of breaching 52 weeks. Clinical directorates have been challenged to improve on the dates currently planned; conversations with patients requesting delays in their admission will be taking place to make the improvement steeper and therefore achieve ZERO 52 week patient quicker.

Controls in place are the weekly access meeting; individual targeted meetings to discuss individual patients; and validation of the DQ and RTT position on a daily basis.

Work is also being completed on the 9 patients who have been excluded from this detailed analysis. These tables will be dynamic and will be reviewed weekly by the Head of Access and General Managers of the clinical directorates.
Demand and Capacity is being modelled using the IST tool and additional ad Hoc caapcity is currently being delivered by the clinical directorates internally and externally to reduce the back log of undated pathways. These focus in the main on Vascular Surgery, ENT, Ophthalmology and T&O.

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Integrated quality and performance report



Month six: September 2017

Putting you first

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EXECUTIVE SUMMARY

DETAILED SECTIONS

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Putting you first

1 EXECUTIVE SUMMARY

ARE WE SAFE?

HCAIs - The Trust has no MRSA cases for the first 5 months but 2 for September 2017 which are under review for assignment, and a total of 6 Clostridium difficile cases for the year to September 2017, below the year-to-date (YTD) ceiling of 8 cases.

Never Events – No Never Events to September 2017.

NHS Patient Safety Alerts (PSAs) – A total of 4 PSAs have been received in 2017/8, including 2 in August. All the alerts have been implemented within timescale to date.

Patient Falls- 39 patient falls occurred in September, bringing the YTD total to 328, of these falls, 10 (91 YTD), resulted in harm. The rate of falls per 1000 bed days at West Suffolk NHS FT is just under 5, compared with the national average of 6.1. *(Recovery Action Plan (RAP) included in main report).*

Pressure Ulcers- The number of acquired pressure ulcers continues to be above the local Trust plan of 5 per month. In September 15 cases occurred, with a YTD total of 71. *(RAP included in main report).*

ARE WE EFFECTIVE?

Mortality Indicators – The SHMI indicators form part of the CQC acute hospital indicators and are detailed in the report. A new mortality dashboard has been developed which includes learning form deaths and this is provided in the Effective section of the main report.

Cancelled Operations for non-clinical reasons - The rate of cancelled operations for non-clinical reasons is below the 1% threshold, with performance at 0.97% in September, an improvement from the previous 3 months which were just above target. The YTD performance is below target at 0.90%.

Patients offered a new date within 28 days of a cancelled operation - The Trust offered 92% of patients a date within 28 days for the YTD, similar to the national average of 92.8%, but below the plan of 95 %. *(RAP included in the main report)*

Discharge Summaries- Performance to date is below the 95% target to issue discharge summaries within 48 hours. A&E has achieved a rate of 86% in September. *(RAP included in the main report)*

OP and Theatre Utilisation and productivity rates – KPMG are supporting the Trust to evaluate the effectiveness of theatres and outpatients and will be presented to the Board once complete.

ARE WE CARING?

Complaints and compliments - The number of complaints has fallen compared to last year, with a total of 68 for the YTD to September. The numbers of written compliments are increasing and the Trust has received a total of 220 compliments for the YTD. The Trust is in the best 10% of acute trusts for the written complaints rate and has approximately 50% less complaints than its peer group of small acute Trusts.

Mixed Sex Accommodation breaches (MSA) – No MSA breaches have occurred for the YTD, against a national average of over 4 per month.

Friends and Family (FFT) Results – The Trust continues to receive positive rating for all services, both in the overall experience and in the "Extremely likely or Likely to recommend" question. WSH is in the top 10% of all Trusts and receives higher average rating than its peer group, particularly for A&E services.

ARE WE RESPONSIVE?

A&E 4 hour wait - The Trust achieved the A&E target at Qtr. 1 with performance at 95% and achieved 90.5% for Qtr. 2. In July, August and September, performance has deteriorated to 92.47%, 90.09%, & 88.94% respectively. September performance is mixed with some exceptionally challenging days. For the period to September, WSH's performance is approximately 3% above its peer group average. *(RAP included in main report).*

Diagnostics with 6 weeks. The Trust continues to achieve the target of providing diagnostic tests with 6 weeks for 99% of activity with performance at 100% for each month since April and performs ahead of the peer group average.

Cancer – Cancer performance improved during August and September, but one target was missed. The Trust achieved 91% for 2-week wait for urgent GP referrals against the 93% target. Delivery of the 62 day GP referral target improved in September with provisional performance at 85.2% against the 85% target. Both the 31-day targets were achieved in September. The YTD performance for all cancer targets is ahead of the national threshold. *(RAP included in the main report)*

Referral to Treatment (RTT) - The percentage of patients on an incomplete pathway within 18 weeks is well below the national target of 92%, with performance in September of 86%. Data quality issues and validation of the list continue. The total waiting list has reduced to 17,236 in September. In September, 29 patients breached the 52-week standard, with a

YTD total of 134. RTT remains the most significant performance challenge facing the trust and KPMG and the Intensive Support Team are working with the Trust support performance improvement. *(RAP included in the main report).*

Emergency Care Flow – A national priority for acute hospitals in 2017 is to focus on improving patient flow, improving the management of patients as they move through stages of care. The new e-Care System will be used to collect some of the key new flow indicators which are listed on the "Responsive" section of the main report. An early view of Trust performance, benchmarked against the national average has been produced by the Model Hospital website and is included in the main report.

ARE WE WELL LED?

Staff FFT – The Qtr. 2 survey for the period to September 2017 was positive with 82% of staff recommending the Trust as a place to work and 95% of staff recommending the Trust for a place to receive treatment or care. This compared with the national averages of 64% and 81% respectively. The Trust is ranked 7th best in England for a place to work and 14th best for a place to receive care, both in the top decile of Trusts in England.

Staff Turnover – Turnover rates have improved recently with September performance at 9.8%, below the Trusts aim to maintain turnover rates below 10%.

Sickness Absence – Sickness absence rates are slightly above the local 3.5% ceiling at 3.58% for September. The Trust average is lower than the peer group average of 3.74% and the national average of 3.86%. *(RAP included in the main report).*

Agency Spend – Agency spend is well below the local plan and agency ceiling, with average spend £320k for the YTD.

ARE WE PRODUCTIVE?

Financial Position – The reported I&E for August 2017 YTD is a deficit of £3,301k, against a planned deficit of £3,260k. This results in an adverse variance of £41k YTD. The financial position remains on plan, with lower than planned agency costs. Long term borrowing has exceeded plan and activity levels are on plan.

Cost Improvement Programme (CIP) - The August position includes a target of £4,951k YTD which represents 37% of the 2017-18 plan. There is currently a shortfall of £15k YTD against this plan.

Use of Space – The percentage of non-clinical floor space is 31%, below the plan of no more than 35% and the Trust does not have any unoccupied floor space planned.

2. INTEGRATED PERFORMANCE REPORT DASHBOARD

The new dashboard highlights key targets that form the key lines of enquiry and KPIs of NHS Improvement and the CQC. These are reviewed in detail in the individual CQC aligned sections of the report. Exception reports are included in the detailed section of this report.

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WEST SUFFOLK HOSPITAL INTEGRATED PERFORMANCE REPORT															TRUST TOTAL									
Are we..	Ref.	KPI	ED	Target	R	A	G	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Av/YTD	WTG	Traffic	Sparkline
1. Safe	1.01	NHS E / I Improvement Patient Safety Alerts Total	RP	3				1	1	1	2	0	0	1	0	1	0	0	1	2	0	4			
	1.02	NHS E / I Improvement Patient Safety Alerts OS	RP	4	0	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6		
	1.03	Emergency C-Section Rate	RP	<12%	15%	13-14%	12%	10%	14%	15%	12%	12%	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	6		
	1.04	All relevant inpatients undergoing VTE Risk assessment	RP	95%	90%	90-95%	95%	86%	88%	88%	88%	87%	87%	87%	86%	87%	89%	89%	86%	90%	88%	88%	2		
	1.05	Clostridium difficile infections (CDI)	RP	16	>3	2-3	<2	4	2	3	3	2	0	0	1	3	0	0	1	0	2	6	6		
	1.06	MRSA	RP	0	>3	2-3	<2	3	0	0	0	0	0	0	0	0	0	0	0	0	2	2	6		
	1.07	MRSA Infection Rates	RP	0																					
	1.08	Never Events	NJ	0	1	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6		
2. Effective	2.01	Overall HSMR - DFI	NJ	<90	>95%	90-95%	<90%	77%	82%	83%	83%	84%				88%	88%	88%	88%	85%	87%	87%	6		
	2.02	Summary Hospital Mortality Indicator (SHMI)	NJ	<93	>95%	90-95%	<90%									87%	89%	90%				89%	6		
	2.03	Emergency Re-admissions within 30d	NJ		11%+	8-10%	8%																		
	2.04	Canc. Ops - Cancellations for non-clinical reasons	NJ	<1%	>1.5%	1-1.5%	<1%	0.69%	0.89%	1.30%	0.83%	1.28%	1.35%	0.49%	0.93%	0.62%	0.56%	1.05%	1.00%	1.21%	0.97%	0.90%	6		
	2.05	OP Clinic Utilisation Rate	RP																						
	2.06	Theatre Utilisation Rate	NJ																						
3. Caring	3.01	Compliments	JB					2	20	35	56	59	33	41	28	41	52	26	56	28	17	220			
	3.02	Complaints (Inpatient)	JB	19.50	30+	20-30	<=20	26	27	15	10	17	18	12	11	10	10	10	6	16	16	68	6		
	3.03	Mixed Sex Accommodation Breaches	RP	0.00	>2	1-2	0	0	2	0	0	0	0	2	0	0	0	0	0	0	0	0	6		
	3.04	IP - Extremely likely or Likely to recommend	RP	90%	<80%	80-89%	90%+	99%	98%	98%	97%	95%	99%	98%	99%	98%	97%	99%	98%	98%	98%	98%	6		
	3.05	OP - Extremely likely or Likely to recommend	RP	90%	<80%	80-89%	90%+	97%	96%	98%	97%	97%	97%	97%	96%	95%	96%	97%	95%	95%	96%	96%	6		
	3.06	A&E - Extremely likely or Likely to recommend	RP	90%	<75%	75-84%	85%+	94%	83%	80%	85%	95%	95%	96%	96%	97%	96%	95%	95%	95%	92%	95%	6		
	3.07	Maternity - How likely are you to recommend	RP	85%	<75%	75-84%	85%+	100%	ND	100%	95%	90%	91%	100%	100%	100%	100%	100%	100%		100%	100%	6		
	3.08	Community - Quarterly rating of good or better	RP	85%	<75%	75-84%	85%+											98%				98%	6		
4. Responsive	4.01	A&E - Under 4 hr. wait	HB	95%	<90%	90-95%	95%+	100%	88%	86%	85%	86%	87%	84%	93%	95%	95%	96%	92%	90%	89%	93%	4		
	4.02	RTT: % incomplete pathways within 18 weeks	HB	92%	<88%	88-92	92%+	90%	92%	92%	92%	92%	90%	90%	90%	82%	80%	83%	84%	86%	86%	83%	2		
	4.03	52-week waiters	HB	0%	10	5-10	<5	0	1	1	0	0	7	7	8	15	14	15	35	26	29	134	2		
	4.04	Diagnostics within 6 weeks	HB	99%	<95%	95-99%	99%+	92%	92%	96%	99%	95%	96%	99%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.05	Cancer: 2w wait for urgent GP Referrals	HB	93%	<90%	90-93%	93%	93%	95%	97%	98%	98%	90%	98%	98%	94%	92%	97%	95%	96%	91%	94%	6		
	4.06	Cancer 2w wait breast	HB	93%	<90%	90-93%	93%	58%	99%	98%	99%	93%	88%	96%	94%	94%	99%	89%	98%	100%	98%	96%	6		
	4.07	Cancer 31 d First Treatment	HB	96%	<92%	92-96%	96%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	6		
	4.08	Cancer 31 d Drug Treatment	HB	98%	<95%	95-98%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.09	Cancer 31 d Surgery	HB	94%	<91%	91-94%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.10	Cancer 62 d GP referral	HB	85%	<80%	80-85%	85%	87%	84%	89%	85%	86%	85%	88%	83%	89%	83%	86%	85%	86%	85%	86%	6		
	4.11	Cancer 62 d Screening	HB	90%	<85%	85-90%	90%	93%	100%	100%	100%	96%	100%	89%	97%	100%	100%	90%	100%	100%	91%	97%	6		
	4.12	Incomplete 104 day waits	HB	0	6+	1-5	0																		
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)	JB	75%	<70%	70-75%	>75%																		
	5.02	Staff F&F Test % Recommended - care (Qrtly)	JB	75%	<70%	70-75%	>75%		93%			94%			93%			95%			95%	95%	6		
	5.03	Staff F&F Test % Rec'mend - place to work (Qrtly)	JB	75%	<70%	70-75%	>75%		83%						79%			83%			82%	83%	6		
	5.04	Turnover (Rolling 12 mths)	JB	<10%	>14%	11-14%	<10%	10%	10%	10%	10%	10%	10%	11%	10%	10%	10%	10%	10%	10%	10%	10%	6		
	5.05	Sickness Absence	JB	<3.5%	>4%	3.5-4%	<3.5%	3.50%	3.91%	3.93%	4.41%	4.48%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%		3.58%	3.58%	3.61%	4		
	5.06	Executive Team Turnover	JB	<10%	13%+	10-12%	<10%	0%	0%	0%	29%	0%	0%	0%	0%	0%	17%	0%	0%	0%	10%	4%	6		
	5.07	Agency Spend	CB	19248	600k+	550-600k	<550k									307	323	292				1142	6		
	5.08	Monitor Assurance Governance Rating	JB	2	NA	NA	NA	0	3	3	3	4	4	4	3	3	3	3	3	3	3	3			
6. Productive	6.01	I&E Margin	CB	Variable													-5%	-4.3%	-3.9%	0.1%	-3.04%	-3%			
	6.02	Distance from Financial Plan	CB	Variable	>5%	3-5%	<3%										0.0%	0.4%	0.1%	0.0%	0.0%	0.4%	6		
	6.03	Capital service capacity	CB	Variable					- 0.20	0.25	- 0.65	- 2.59	- 6.74	- 2.81	1.41		3.19	- 2.50	- 2.18	- 1.04	0.88	0.88	2		
	6.04	Liquidity (days)	CB						- 6.61	- 7.78	- 11.30	- 16.45	- 19.70	- 21.76	- 7.28		12.15	- 15.72	- 10.94	- 11.03	-12.70	- 12.70	2		
	6.05	Long-Term Borrowing	CB		>47.8	NT	47.77	25.41	28.76	29.96	30.96	32.06	33.06	36.06	44.30	44.27	45.70	45.70	45.70	45.70	47.62	47.62	6		
	6.06	Variance to CIP plan	CB					-59	-60	-814	-1,826	-2,550	-3,268	-3,247		40	0	40	10		-54	-44			
7.Maternity	7.01	Total number of deliveries at WSFT	0	210	250, <20	216, <20	208-216	213	224	219	195	234	198	197	238	215	192	213	215	233	236	1304	6		
	7.02	% of all caesarean sections	0	<22.7%	>22.6%		<22.6%	19%	23%	21%	18%	19%	16%	13%	19%	15%	21%	16%	16%	22%	18.22%	18%	6		
	7.03	Midwife to birth ratio	0	1.3	>=1:32	1:30-32	<=1:30	1.29	1.29	1.29	1.28	ND	1.28	1.28	1.33	1.30	1.27	1.29	1.30	1.33	1.33	1.30	4		
	7.04	Unit Closures	0	0	NT	NT	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
	7.05	Completion of WHO checklist	0	1	<=90%	90-99%	100%	77%	90%	95%	82%	96%	93%	87%	89%	84%	93%	84%	94%	82%	98%	89%	2		
	7.06	Maternity SIs	0	NT	NT	NT	NT	1	1	2	0	3	0	1	1	1	0	0	0	0	1	2			
	7.07	Maternity Never Events	0	NT	NT	NT	NT	0	0	0	1	0	0	0	0	0	0	0	0	0	0	-			
	7.08	Breastfeeding Initiation Rates	0	0.8	<75%	75-80%	>80%	74%	80%	82%	80%	80%	74%	80%	76%	80%	81%	88%	77%	85%	79%	81%	6		
								34	37	36	36	36	35	35	37	36	39	42	36	32	43	YTD	222	of	252

Putting you first

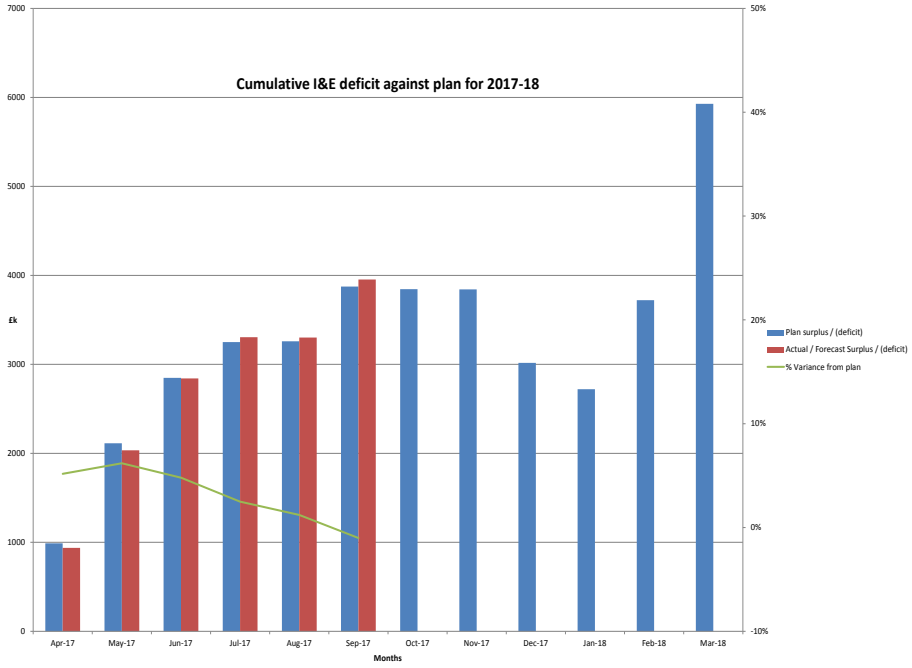
3. IN THIS MONTH – SEPTEMBER 2017, MONTH 6

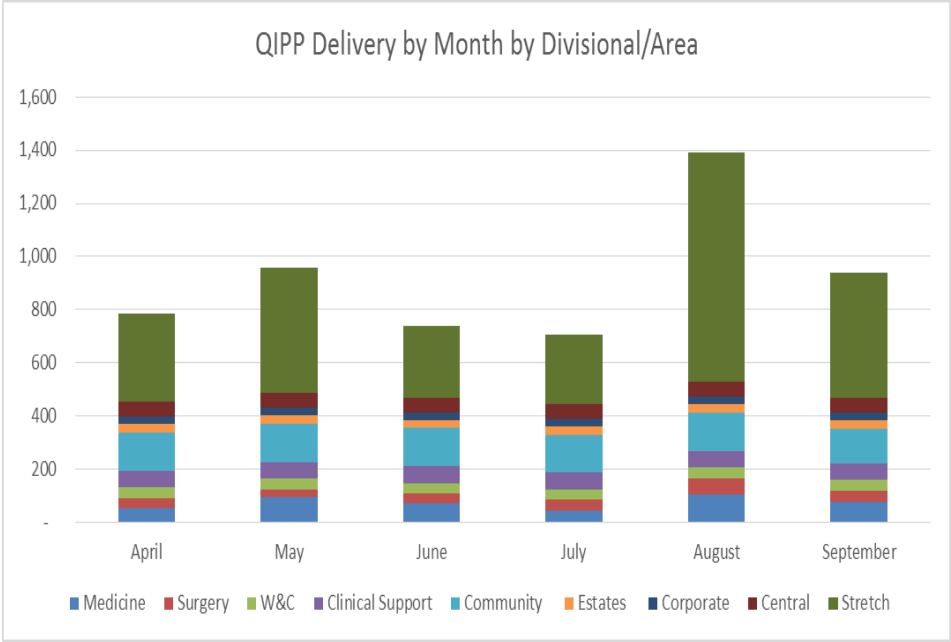
This table highlights incoming activity to the Trust, compared to the number of treatments and discharges from the Trust to provide a summary overview of overall capacity and demand. It provides a comparison to last year for the monthly and year-to-date activity.

WEST SUFFOLK HOSPITAL INTEGRATED PERFORMANCE REPORT - Summary of New Referrals & Completed treatment											
In this month…. September 2017											
Mth 6 We Received……	2017/18 September	2016/17 September	Variance	Var. %	Traffic	YTD We Received……	2017/18 To September	2016/17 To September	Variance	Var. %	Traffic
GP Referrals	5,660	5,572	88	2%	↑	GP Referrals	37,170	37,161	9	0%	↑
Other Referrals	4,512	4,473	39	1%	↓	Other Referrals	30,074	29,837	237	1%	↑
Ambulance Arrivals	1,742	1,664	78	5%	↑	Ambulance Arrivals	10,430	10,041	389	4%	↑
Community Referrals	11,450	10,681	769	7%	↑	Community Referrals	68,438	65,677	2,761	4%	↑
(Included in referrals above:)						***(Included in referrals above:)***					
Cancer Referrals	960	1,081	-121	-11%	↓	Cancer Referrals	5,698	6,174	-476	-8%	↓
Urgent Referrals	2,337	3,094	-757	-24%	↓	Urgent Referrals	14,973	16,583	-1,610	-10%	↓
Mth 6 We Delivered……	2017/18 September	2016/17 September	Variance	Var. %	Traffic	YTD We Delivered……	2017/18 To September	2016/17 To September	Variance	Var. %	Traffic
A&E Attendances	5,742	5,716	26	0%	↑	A&E Attendances	35,164	34,215	949	3%	↑
Outpatient Attendances	23,820	23,071	749	3%	↑	Outpatient Attendances	145,943	128,296	17,647	14%	↑
Elective (incl Daycase)	2,779	2,777	2	0%	↑	Elective (incl Daycase)	16,900	15,663	1,237	8%	↑
Nonelective Admissions	2,499	2,408	91	4%	↑	Nonelective Admissions	14,561	14,690	-129	-1%	↓
Inpatient Discharges	5,970	5,798	172	3%	↑	Inpatient Discharges	35,318	33,674	1,644	5%	↑
New Births	236	224	12	5%	↑	New Births	1,301	1,298	3	0%	↑
RTT Total Incompletes	17,326	18,840	-1,514	-8%	↓						

4. FINANCE SUMMARY

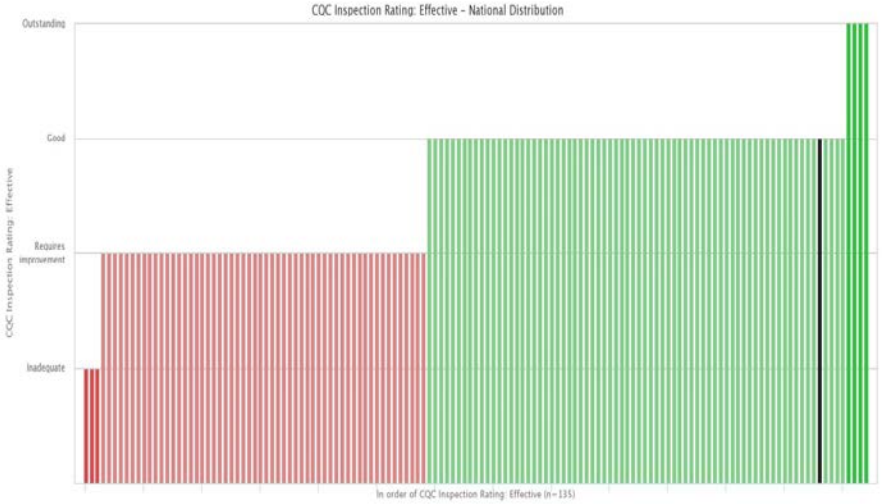
The financial position to September 2017 (Mth 5) shows a £4m deficit, which is £78k behind the financial plan. Contract income is £3m above plan, supported by underspends in the pay and agencies spend budgets, but off set by overspends in the non-pay of £2.8m, including pathology costs. The cash position remains close to the revised plan, but will become more challenging as the year progresses, requiring improved debtor/creditor management and CIP delivery. The overall Use of Resources rating remains at 3.

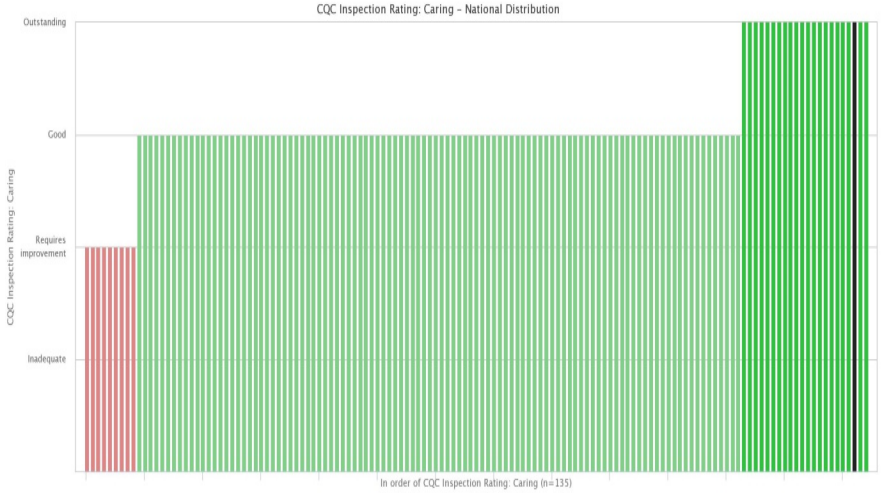


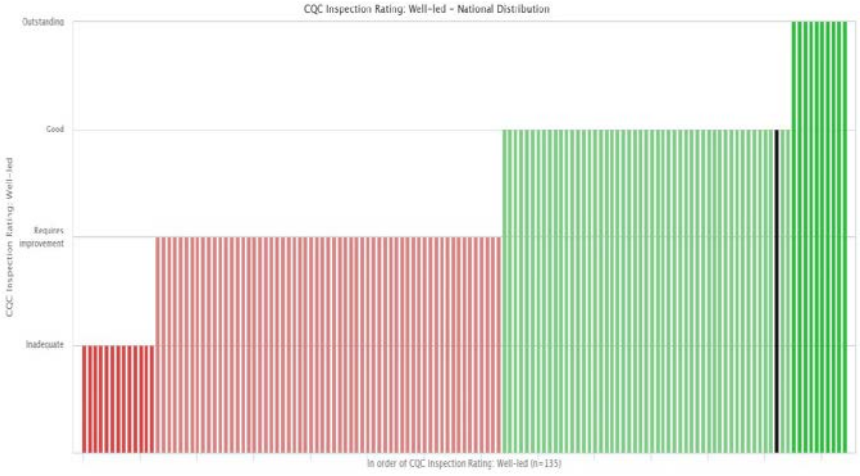


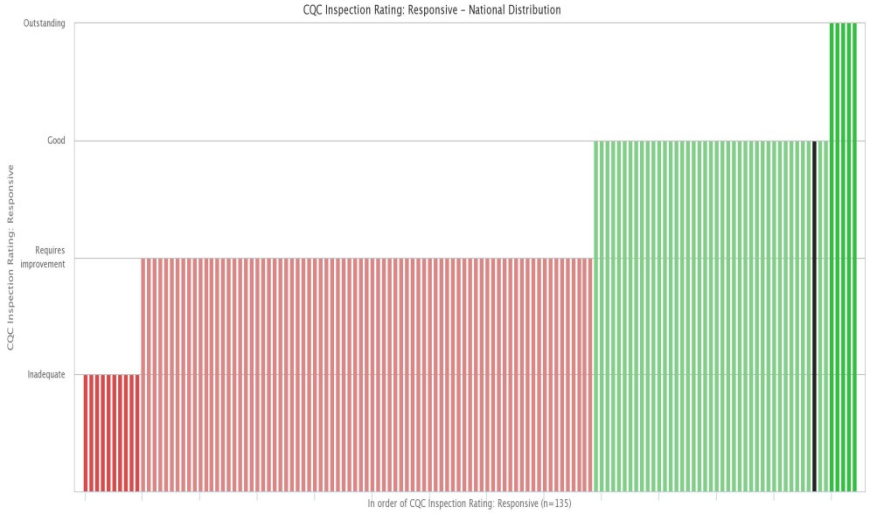
5. CQC OVERVIEW

The CQC have launched the Model Hospital website in *alpha* form which highlights comparative indicators in a number of key areas. The Quality of Care compartment: includes the CQC ratings as the principal assessment indicators, with additional indicators, including the Friends and Family Test, Ambulance outcomes, and Mental Health Services. The graphs below provide an oversight of the Trusts comparative performance against these key areas.


CQC Inspection Rating: Effective - National Distribution
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Effective
In order of CQC Inspection Rating: Effective (n=135)


CQC Inspection Rating: Caring - National Distribution
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Caring
In order of CQC Inspection Rating: Caring (n=135)


CQC Inspection Rating: Well-led - National Distribution
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Well-led
In order of CQC Inspection Rating: Well-led (n=135)


CQC Inspection Rating: Responsive - National Distribution
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Responsive
In order of CQC Inspection Rating: Responsive (n=135)

CQC - QUALITY OF CARE BENCHMARK DASHBOARD

The Quality of Care dashboard highlights comparisons with national and peer group averages. The peer group comprises 24 similar hospitals to West Suffolk, national categorised as small acute hospitals. Appendix 2. *(Source – Model Hospital)*

6. DETAILED SECTIONS - SAFE

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	ED	Target	R	A	G	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	YTD	WTG	Traffic	Trend
Safe	Dashboard	1.01	NHS E / I Patient Safety Alerts - Total		NT				1	1	1	2	0	0	1	0	1	0	0	1	2	0	4			
		1.02	NHS E / I Patient Safety Alerts outstanding		0	0	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6		
		1.03	Emergency C-Section Rate		12%	15%	13-14%	12%	10%	14%	15%	12%	12%	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	6		
		1.04	All relevant inpatients undergoing a VTE Risk assessment		95%	90%	90-95%	95%	86%	88%	88%	88%	87%	87%	87%	86%	87%	89%	89%	86%	90%	88%	88%	2		
		1.05	Clostridium difficile infections (CDI)		16	>3	2-3	<2	4	2	3	3	2	0	0	1	3	0	0	1	0	2	6	6		
		1.06	MRSA (Hospital)		0	>3	2-3	<2	3	0	0	0	0	0	0	0	0	0	0	0	0	2	2	6		
		1.07	MRSA infection rates		0																					
		1.08	Never Events		0	1	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6		
	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion		100%	<85%	85-99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	99%	3		
		1.10	HII Compliance 1b: Central venous catheter on-going care		100%	<85%	85-99%	100%	96%	100%	100%	86%	100%	100%	95%	100%	96%	100%	100%	100%	96%	100%	99%	2		
		1.11	HII Compliance 2a: Peripheral cannula insertion		100%	<85%	85-99%	100%	100%	100%	100%	100%	100%	98%	98%	98%	100%	100%	100%	100%	97%	100%	100%	2		
		1.12	HII Compliance 2b: Peripheral cannula on-going		100%	<85%	85-99%	100%	93%	98%	93%	96%	99%	93%	98%	95%	100%	97%	98%	93%	97%	99%	97%	2		
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative		100%	<85%	85-99%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		1.14	HII Compliance 4b: Preventing surgical site infection perioperative		100%	<85%	85-99%	100%	100%	100%	100%	87%	100%	100%	100%	100%	100%	85%	100%	95%	100%	100%	97%	2		
		1.15	HII Compliance 5: Ventilator associated pneumonia		100%	<85%	85-99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		1.16	HII Compliance 6a: Urinary catheter insertion		100%	<85%	85-99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		1.17	HII Compliance 6b: Urinary catheter on-going care		100%	<85%	85-99%	100%	97%	96%	90%	85%	93%	95%	95%	82%	81%	92%	94%	88%	99%	97%	92%	2		
		1.18	HII Compliance 7: Clostridium Difficile - prevention of spread		100%	<85%	85-99%	100%	NA	NA	NA	NA	NA	NA	NA	NA	ND	ND	ND	ND	ND	ND		3		
	Incidents	1.19	Safety Thermometer - Harm-Free Care (New Harms)		95%	<80%	80-95%	95%+	97%	98%	98%	98%	99%	97%	98%	98%	99%	98%	99%	99%	98%	97%	98%	3		
		1.20	No of SIRIs		NT				2	6	9	11	11	14	6	8	9	5	7	7	6	5	39			
		1.21	RIDDOR Reportable Incidents		NT				1	0	0	2	0	0	0	0	0	0	1	0	1		2			
		1.22	Catheters and New UTIs		NT					0.27	0.00	0.25	0.00	0.25	0.26	0.78	0.29	0.29	0.27	0.00	0.00	0.00	0.14	1		
		1.23	E. coli Infections		NT				21	26	15	16		19	9	9	2	0	2	2	0	0	6			
		1.24	E.Coli infection rate (Based on KH03)																							
		1.25	Patient Falls		<48	>52	48-52	<48	56	61	67	62	65	61	54	71	54	52	50	69	64	39	328	1		
		1.26	Patient Falls resulting in harm		<10	>15	10-15	<10	18	22	19	18	15	11	14	16	9	17	20	17	18	10	91	1		
		1.27	Falls - Per 1000 bed days		5.60	>5.8	5.6-5.8	<5.6	ND	ND	ND	ND	ND	5	5	5	5	5	ND	ND	ND	ND	10			
		1.28	Number of avoidable serious injuries/deaths resulting from falls		NT	>0	NA	0	0	0	ND	0	ND	0	0	ND	0	0	ND	ND	ND	ND	0			
		1.29	Number of medication errors		NT				13	8	4	9	16	23	18	25	64	80	69	78	70	69	430			
		1.30	Actual patient harm resulting from medication incidents		0.01				10	5	4	8	15	23	16	20	1	0	0	0			1			
		1.31	Pressure Ulcers - Inpatients		<5	7	6-7	5	9	13	24	22	14	22	10	4	9	8	19	7	13	15	71	1		
		1.32	Pressure Ulcers - Avoidable ward-acquired PUs		NT				3	4	7	ND	ND	ND	ND	ND	4	3	4	ND	ND	ND				
	Reporting	1.33	MRSA Quarterly Std (including admission and LOS screens)		90%	<85%	85-90%	>90%	NA	85%	NA	NA	89%	NA	NA	91%	NA	NA	92%	NA	NA	93%	93%	3		
		1.34	MRSA - Decolonisation (Trust level treatment and post screening)		90%	<85%	85-90%	>90%	94%	85%	92%	95%	96%	93%	90%	90%	92%	93%	95%	95%	90%	91%	93%	3		
		1.35	MRSA - RCA Reports		NA	NA	NA	NA	1	0%	0%	0%	0%	0%	0%	0%							0%			
		1.36	MSSA		NT	NA	NA	NA	1	1	ND	1	0	1	2	1	0	1	0	0	1	0	2			
		1.37	SIRI final reports due in month submitted beyond 60 working days		0	2+	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	4	5	2		
		1.38	SIRIs reported >2 working days from identification as red		0	>1	1	0			1	0	0	0	0	2	0	0	0	0	1	2	3	2		
		1.39	RAG active/accepted risk assessments in date		0	10	5-9	4	1	1	1	1	1				ND	ND	ND	9	0	1	10	3		
		1.40	Datix Risk Register Red / Amber actions overdue		0	10	5-9	4									ND	ND	ND	22	0	0	22	2		
		1.41	Outstanding actions complete in date for Red/Amber entries on Datix		95%	<75%	75-94%	>95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	3		
		1.42	Quarterly standard principle compliance		90%	<85%	85-90%	>90%	NA	95%	NA	NA	93%	NA	NA	95%	NA	NA	95%	NA	NA		95%	3		
		1.43	Rapid access chest pain clinic access within 2 wks.		100%	<95%	95-100%	100%	100%	97%	94%	73%	90%	52%	100%	100%	100%	98%	100%	95%	97%	97%	98%	2		
		1.44	Verbal Duty of Candour outstanding at month-end		0%	>3	1-3	0	1	0	1	1	1		ND	ND	3	0	0	0	2	0	5	2		
		1.45	Hand Hygiene Audits		95%	<85%	85-99%	100%	99%	100%	98%	99%	100%	99%	99%	98%	98%	99%	99%	100%	99%	98%	99%	2		
		1.46	Quarterly antibiotic audit		98%	80%	80-89%	90%	NA	93%	NA	NA	92%	NA	NA	93%	NA	NA	91%	NA	NA	94%	92%	3		
		1.47	RCAs beyond deadline for completion		=<4	9+	4-8	4	4	9	8	11	15	9	9	8	3	1	3	4	1	7	19	3		
		1.48	% of Green Patient Safety incidents investigated		NT				62%	59%	62%	59%	60%	69%	64%	60%	60%	66%	54%	53%	68%	58%	60%			
		1.49	PEWS documentation and escalation compliance		NT	<80%	80-99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	80%	100%	90%	100%	100%	90%	93%	2		
		1.50	Quarterly Environment/Isolation		90%	80%	80-89%	90%	NA	91%	NA	NA	93%	NA	NA	91%	NA	NA	91%	NA	NA	92%	92%	3		
		1.51	Quarterly VIP score documentation		90%	80%	80-89%	90%	NA	81%	NA	NA	83%	NA	NA	79%	NA	NA	84%	NA	NA	80%	82%	2		
		1.52	Isolation data		95%	85%	85-95%	95%	90%	90%	92%	95%	93%	90%	95%	89%	90%	95%	90%	90%	88%	88%	90%	2		
		1.53	Pain Mgt. Quarterly internal report		80%	70%	70-79%	80%	NA	NA	71%	NA	NA	68%	NA	NA	75%	NA	NA	61%	NA	NA	68%	1		
		1.54	Nutrition Risk Assessment 48hrs		95%	85%	85-94%	95%	93%	83%	81%	84%	83%	84%	83%	90%	91%	87%	89%	82%	85%	90%	87%	2		
		1.55	Median of NRLS upload (No. of days)		46	>46		<46	ND	ND	52	ND	ND	50	50	51	ND	87	64	65	58	55	329	1		
																								110	out of	141

6. EXCEPTION REPORTS – SAFE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

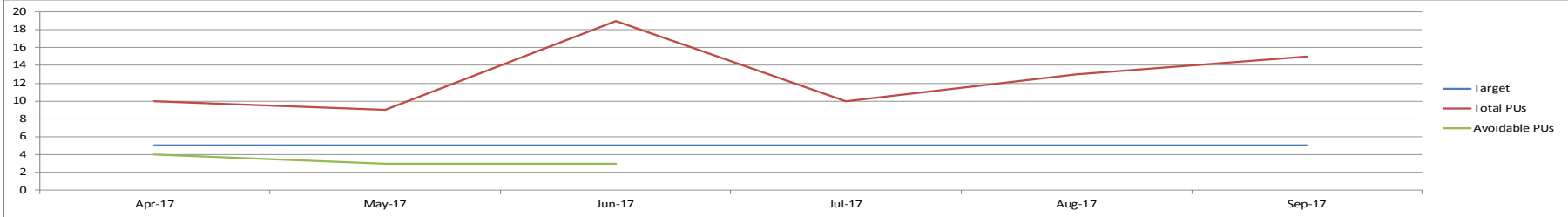
Indicator	Pressure Ulcers
Standard	Below 5 PU pm and <30% avoidable
Name	Rowan Procter
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Background

September has seen a further increase in hospital acquired pressure ulcers (HAPUs) from the previous month. There were fifteen in total; however, a significant majority of these were reported on F3, G1, G5 and G8. Early indications are that many of these HAPUs were unavoidable, with the majority of these patients being at the end of life.
Acuity has been high in September, and despite the focus to get patients up and dressed, many wards have experienced an increase in bed-bound, frail, acutely unwell patients. Many of these individuals have been at the end of life. This has most likely impacted on the decrease in number of falls in September, though this is difficult to evidence.
Due to staff sickness and planned leave, the Tissue Viability team has experienced some deficits during September, leading to delayed review of reported potential HAPUs. There has been concern raised by the TV team that this has led to some inaccurate grading of ulcers by ward teams, in particular with regard to grading as pressure damage when moisture damage is evident. Further recruitment within the team to support Maternity leave will decrease this risk going forward.
The Tissue Viability team have however launched bite-size study sessions which commenced in September, these are on various subjects including pressure ulcer management and reporting, there has been a good initial turn out which should support the accuracy of pressure area grading and reporting on the wards. As well as this Heel Hero's is being launched and plans for the National Stop the Pressure day next month which will further raise the profile of pressure area prevention. TVN team has been working with ward staff to strengthen and develop wound care skills.
Despite some staff deficits, there generally remains good visibility and support for the Ward teams from the TV team. There has been greater focus from the team on those wards who experience the majority of reported HAPUs, with an increased promotion of pressure ulcer prevention and working in conjunction with the Ward Managers and Senior Matrons to actively support the improvement of staff knowledge and practice in promoting skin health and integrity.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Target	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Total PUs	13	24	22	14	22	10	4	10	9	19	10	13	15								
Avoidable PUs	4	7	ND	ND	ND	ND	ND	4	3	3											



Key Recovery Actions

Description	Owner	Start	End
The first meeting of the Pressure Ulcer Prevention focus group was in early September, with the next meeting on the 25th October. This was led by Senior Matron Danni Elliott, with the support of the Tissue Viability Nurse specialists. The aim of this group is to promote the concept of sharing good practice amongst teams and highlight the importance of accurate risk assessment and early preventative measures. Ultimately, the objective with the focus group is to improve knowledge and awareness to eliminate the occurrence of avoidable pressure damage. Coupled with this, is the launch of the compliance report from the patient safety dashboard. The information team are now able to extract data from the dashboard, in order to, monitor compliance with the patient safety assessments related to falls prevention, nutrition risk assessments and pressure ulcer prevention. This report also provides data regarding the timeliness of assessments and initiation of care plans and is a useful tool for Ward Managers and Matrons to promote compliance and ultimately, improve patient care. Early indicators demonstrate that this report is already influencing an improvement in compliance with risk assessment.	RP	Apr-17	Mch 18
As indicated last month, the Trust remains under significant staffing pressures and many of the wards are experiencing daily deficits. Coupled with this, capacity pressures and high acuity make it challenging for staff to consistently manage pressure ulcer prevention in a timely manner and there is concern that Community acquired pressure ulcers are sometimes missed by over stretched admitting teams. These challenges, risks and deficits continue to be reviewed daily by the Senior Nursing team and measures put in place to mitigate the risks to patient safety wherever possible.	RP	May-17	Mch 19

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Infection Control: MRSA and Clostridium Difficile
Standard	MRSA 0, C.difficile ceiling 16
Name	Rowan Procter
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

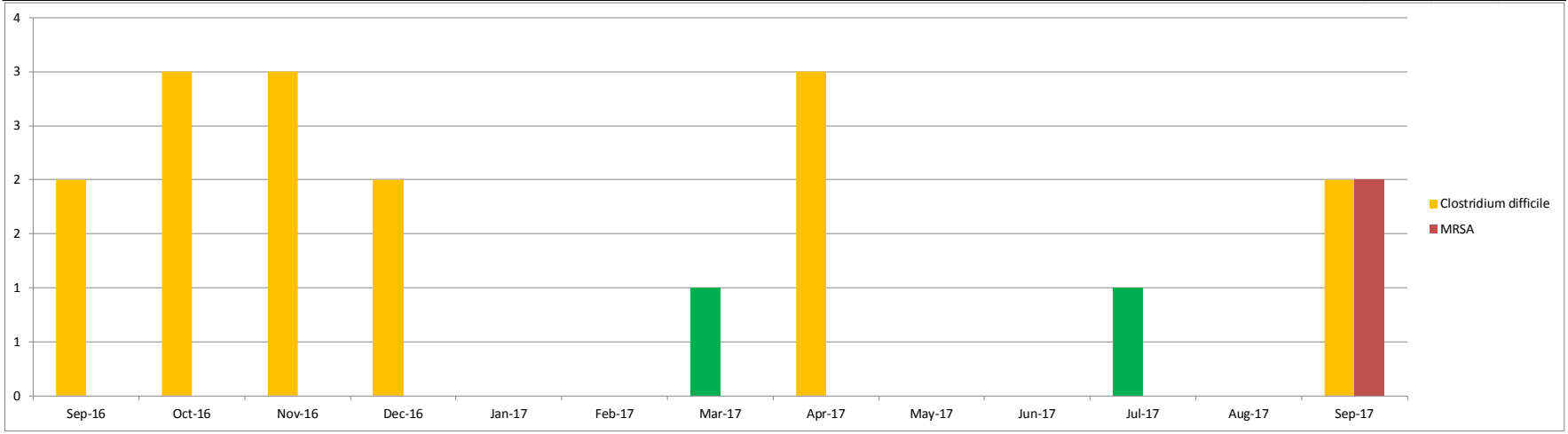
There were two cases of hospital attributable Clostridium difficile in September. To date there have been six cases, of which five have been deemed non trajectory by our commissioners (no lapses of care) whereby they will not accrue a penalty, there are no trajectory cases and one is pending.

The Trust has recorded two MRSA bacteraemia in September 2017. Both cases have been investigated and have been submitted to NHS England for consideration as 'Third Party' assignment.

Trend												Recovery Trajectory									
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Clostridium difficile	2	3	3	2	0	0	1	3	0	0	1	0	2								
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	2								

Key Recovery Actions

Description	Owner	Start	End
To continue to be vigilant to indentify symptoms of Clostridium difficile for early identification and testing. With respect to MRSA, case one was on F12 in a complex dermatology patient it is highly likely that this will be assigned as 'Third Party' but we await final decision. Case two was on F6 in a patient who presented to the Trust with a wound colonized with MRSA. We await the review by NHS England for assignment.	RP	Sep-17	Nov-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	VTE
Standard	95%
Name	Rowan Procter
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	11th Worst in England in Qtr 1

Background

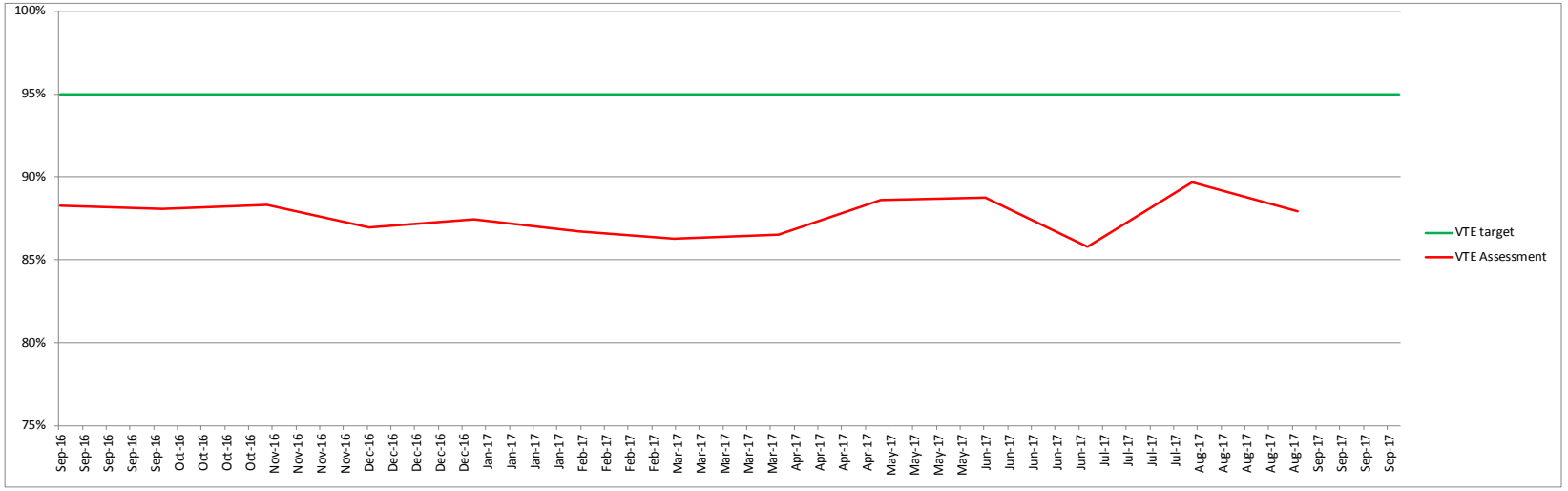
Venous thromboembolism (VTE) is a significant international patient safety issue. The first step in preventing dealth and disability from VTE is to identify those at risk so that preventative treatments (prophylaxis) can be given. The Trust has been unable to fully collate VTE data in 2016/17, but quality audits suggested that the Trust was delivering close to the 95% target. Since April 2017 data has been sent to UNIFY2 and performance has been below 90% for the YTD.

We are seeing month on month improvements now we have the reporting capacity and this is part of the newly developed patient safety dashboard.

Trend												Recovery Trajectory									
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
VTE target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
VTE Assessment	88%	88%	88%	87%	87%	87%	86%	87%	89%	89%	86%	90%	88%								

Key Recovery Actions

Description	Owner	Start	End
There has been historic issues with data collection and accuracy. The Trust is rectifying these issues and is in the process of producing a Recovery Action Plan to meet the national target of 95%. The VTE assessment as required to be undertaken within 24 hours of admission. We are seeing month on month improvements now we have the reporting capacity and this is part of the newly developed patient safety dashboard.	RP	Sep-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	HII Complaince 2b: Peripheral cannula ongoing
Standard	100%
Name	Rowan Procter
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

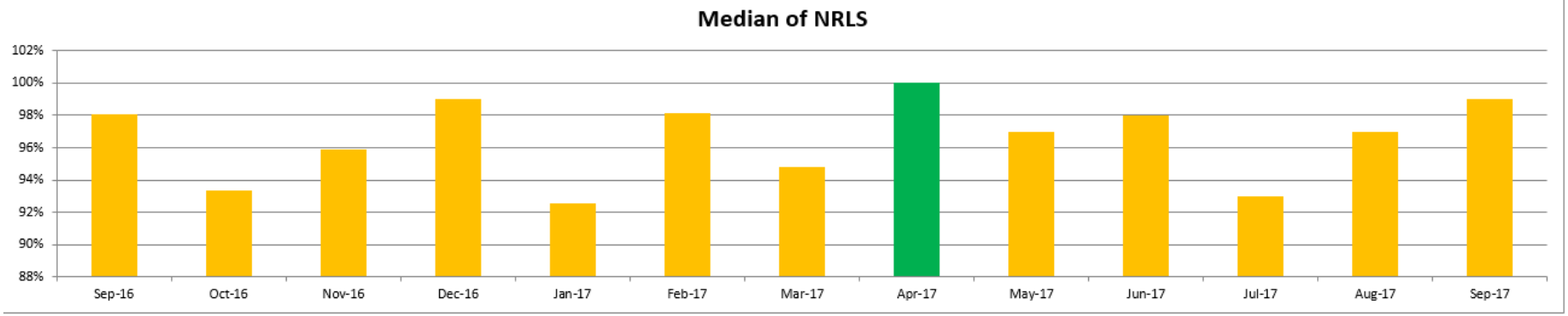
Background

A score of 99 was achieved for September 17 which was an improvement from 93 in July and 97 in August, though this is still RAG rated as amber for the fourth month in a row. Failing to document indication for continued insertion lowered the score from the target range.

Trend / Recovery Trajectory																				
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Median of NRLS	98%	93%	96%	99%	93%	98%	95%	100%	97%	98%	93%	97%	99%								
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%								

Key Recovery Actions

Description	Owner	Start	End
Compliance with documentation following changes to eCare documentation still remains a challenge. The Senior Matron team continue to discuss performance at the Monthly Quality Meeting so as to consider strategies for performance improvement. Senior Matrons continue with regular discussions with Senior Ward Nursing Teams at 1:1's and Ward Team Meetings to highlight and monitor current performance. Individual action plans to be put in place and supported by Senior Matrons and Head of Nursing for areas with persistent poor performance. High levels of staffing deficits coupled with the continue need for the provision of escalation capacity have impacted upon the accurate and timely completion of assessments and documentation. The Senior Matron and Operational Teams attempt to mitigate the impact of these pressures on compliance through staff re-deployment in line with activity and acuity being experienced.	RP	Aug-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	HII Compliance 6B: Urinary catheter ongoing care
Standard	100%
Name	Rowan Procter
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

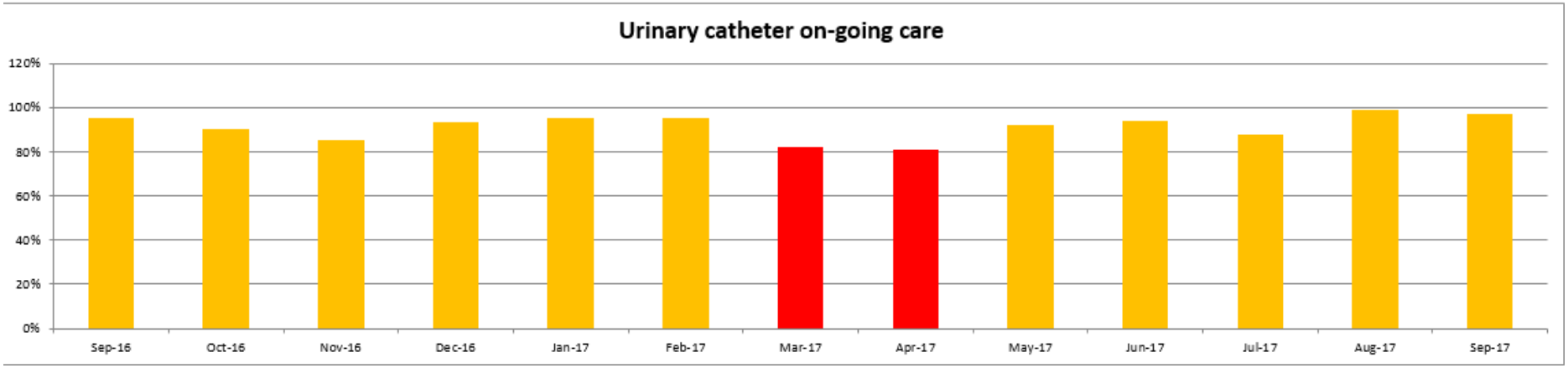
Background

There was a significant improvement in compliance from July from 83% to 97% in September. This was achieved by targeted education and monitoring in specific wards which were persistently failing to comply with the expected level of care and documentation.

Trend												Recovery Trajectory									
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Urinary catheter ongoing ca	96%	90%	85%	93%	95%	95%	82%	81%	92%	94%	88%	99%	97%								
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%								

Key Recovery Actions

Description	Owner	Start	End
The Senior Matron team will continue to support and promote compliance in order to sustain and further improve this area of practice. There is positive engagement from the teams with this, which is re-assuring despite the backdrop of staff deficits.	RP	Aug-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Falls
Standard	Less than 48 and less than 10 resulting in harm
Name	Rowan Procter
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Background

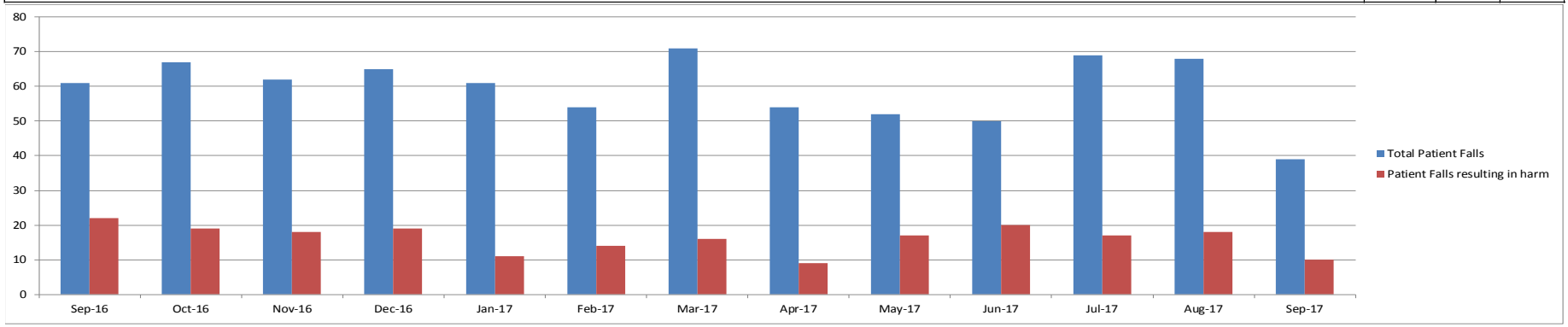
The ambition for WSH is to reduce falls to less than 48 per month and have no more than 10 resulting in harm.
There were 39 falls in Septmeber (down from 68 in August). The deataied analyis of falls in August highlight:
1 x Major Harm – Ward F3
1 x Moderate Harm – Ward F7
Newmarket Hospital (2 x falls) and Glastonbury Court (1 x fall) – these falls are reported separately.
A total of 4 patients were assisted to floor in August (3 in July) preventing them from falling.
There were 10 patients in total who fell more than twice (5 in July), this figure consisted of 7 patients falling on 2 occasions, 2 patients falling on 3 occasions and 1 patient falling on 4 occasions.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Total Patient Falls	61	67	62	65	61	54	71	54	52	50	69	68	39								
Patient Falls resulting in harm	22	19	18	19	11	14	16	9	17	20	17	18	10								
Percentage of falls resulting in harm	36%	28%	29%	29%	18%	26%	23%	17%	33%	40%	25%	26%	26%								

Key Recovery Actions

Description	Owner	Start	End
In response to the continued problem of patients falling the initial meeting of the Falls Focus Group took place on the 14th September. The multi-professional group led by the Senior Matron Team will feed in to the Trust Falls group led by Dr Suresh. The group is focusing on the reduction of patient falls through the following approaches: 1) The development of 'Ward Profiles' to establish the specifics behind the individual areas factors in relation to patient falls. Data by ward for the last year has already been provided to illustrate the number of falls by ward and the time of day, further data contained within the Datix reports will be supplied to support this process. 2) Establishing 'Ward Champions' who along with the Senior Matron and Ward Manager develop a ward specific 'Fall Reduction Action Plan' containing strategies that will address the areas current challenges. 3) A review of current eCare processes to ensure that the necessary tasks and care plan are set with the appropriate reminders and actions being triggered. 4) The updating of the incident reporting process (Datix) so that this reflects the current practice and provides the necessary information to be used in improvement of practice and patient safety. 5) The possible reproduction of staff pocket guides to aid in the prevention of patient falls. 6) Review an update of the current 'Slips, Trips and Falls' policy so that the information contained is up to date and reflects best practice. 7) Digital Reminiscence Therapy to be considered as a tool in the reduction of patient falls as other Trust have demonstrated some encouraging results following the introduction of this technology. The Trust has taken part in the National Falls Audit and we anticipate results to be available later in the year. The Trust are at present unable to provide data on Falls per 1000 bed days though the eCare team from Cerner are currently working on rectifying the situation	Dr Suresh	Aug-17	Mar-18



7. DETAILED REPORTS - EFFECTIVE

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we.		Ref.	KPI	Target	R	A	G	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	YTD 17/18	WTG	Tr	Trend
2. Effective	Dashboard	2.01	Overall HSMR - DFI	<90	>95%	90-95%	<90%	82%	83%	83%	84%				88%	88%	88%	88%	85%	87%	87%	6		
		2.02	Summary Hospital Mortality Indicator (SHMI)		>95%	90-95%	<90%								87%	89%	90%				89%	6		
		2.03	Emergency Re-admissions within 30d	8%	11%+	8-10%	8%																	
		2.04	Canc. Ops - Cancellations for non-clinical reasons	1%	>1.5%	1-1.5%	<1%	0.89%	1.30%	0.83%	1.28%	1.35%	0.49%	0.93%	0.62%	0.56%	1.05%	1.00%	1.21%	0.97%	0.90%	6		
		2.05	OP Clinic Utilisation Rate	TBA																				
		2.06	Theatre Utilisation Rate	TBA																				
	Mortality	2.05	No of Deaths	NT				82	83	98	102	103	99	95	72	69	71	62	76	70	420			
		2.06	Percentage of deaths	NT				1.45%	1.45%	1.65%	1.89%	1.85%	1.82%	1.47%	1.34%	1.20%	1.25%	1.12%	1.36%	1.23%	1.3%			
		2.11	Cardiac arrests	NT				7	5	6	7	3	8	13	4	6	4	2	3	0	19			
		2.12	Cardiac arrests identified as a SIRI	-	1		0	0	0	0	1	1	1	0	0	0	1	0	0	0	1			
	Incidents/Reports	2.13	CAS (central alerts system) alerts overdue	0	>=1		0	0	0	0	0	0	0	0	0	0	0				0	3		
		2.14	Pathology & Imaging BMs	0%																				
		2.15	WHO Checklist (Qrtly)	100%	<90%	90-94%	>=95%	99%			97%						99%				99%	3		
		2.19	Av. Elective LOS (excl. 0 days)					2.55	2.59	3.14	3.03	3.11	2.49	2.92	2.76	3.26	2.7	2.54	2.79	2.74	2.80			
		2.20	Av NEL LOS (excl 0 days)					8.23	8.45	8.3	8.65	8.88	8.83	7.73	7.59	7.85	7.66	7.47	7.94	7.66	7.70			
		2.21	% of NEL 0 day LOS					15%	17%	17%	20%	18%	18%	20%	19.40%	18.57%	20.32%	18.62%	17.33%	17.15%	19%			
		2.22	NHS number coding	99%				99%	100%	100%	100%	100%	100%	100%	99.75%	99.66%	99.70%	99.44%	99.43%	99.54%	100%			
		2.23	Fractured Neck of Femur : Surgery in 36 hours	85%				97%	89%	92%	97%	97%	97%	88%	97%	96%	96%	85%	97%		94%			
		2.25	Discharge Summaries (OP 85% 3d,)	85%	80%	80-85%	85%+	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND				
		2.26	Discharge Summaries (A&E 95% 1d)	95%	90%	90-95%	95%+	97%	97%	95%	99%	98%	98%	97%	98%	98%	88%	87%	86%	86%	90%	2		
		2.27	Discharge Summaries (IP 95% 1d)	95%	90%	90-95%	95%+	93%	93%	93%	92%	94%	93%	92%	92%	93%	93%	ND	ND	ND	93%	2		
		2.28	Choose and Book - Available Slots	95%	90%	90-95%	95%+	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		2.29	All Cancer 2ww services available on C&B	100%	<98%	98-99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		2.31	Canc. Ops - Patients offered date within 28 days	100%	<95%	95-100%	100%	91%	94%	100%	90%	100%	92%	97%	93%	94%	93%	88%	75%	92%	89%	1		
		2.32	Canc. Ops. - No. Cancelled for a 2nd time	NT	>0	NA	0	0	0	0	0		0	0	0	0	0	0	0	0	0	3		
																						38	out of	42

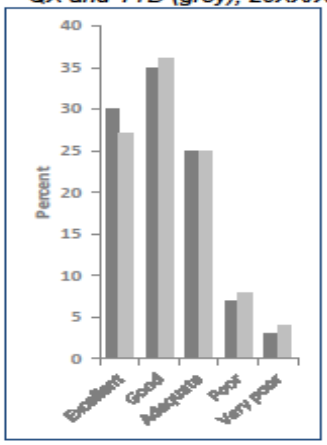
7. EXCEPTION REPORTS – EFFECTIVE

The mortality report is being redesigned and the current draft is provided below.

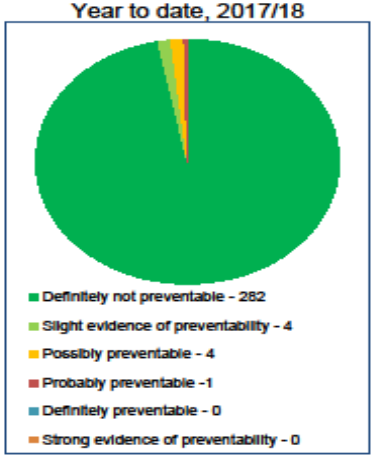
Learning from Deaths dashboard - September 2017

Inpatient deaths	Total	Reviews completed
Q1 + Jul + Aug 2017/18	366	283
Year to date	366	283

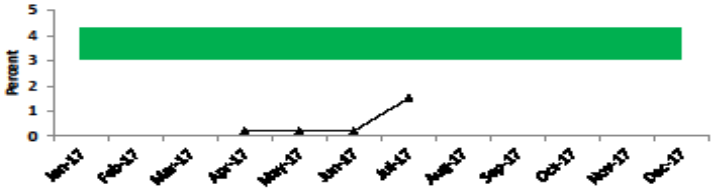
Overall quality of care
QX and YTD (grey), 20XX/XX



Outcomes of reviews
Year to date, 2017/18



Monthly profile of deaths judged to have had more than 50% likelihood of avoidability
Apr17 - Aug17



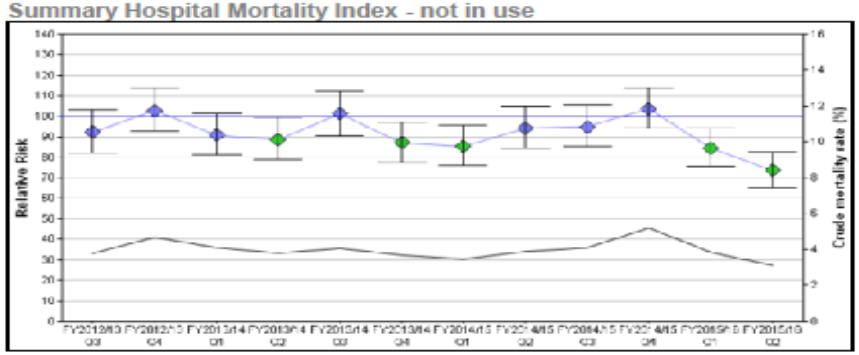
Deaths in people in groups under special focus - Q3, 2017/18 and YTD (brackets)

Group	Total	Multiagency reviews	Probably, strongly or definitely avoidable
People with learning disabilities	3 (9)	3 (8)	1 (4)
People with severe mental illness	2 (5)	2 (5)	1 (2)
Recipient of care from another organisation	15 (50)	12 (38)	2 (5)

Learning themes identified

Contributing to avoidable deaths	Avoidable fall Stroke after stopping anticoagulation for atrial fibrillation Inadequate fluid management Gastrointestinal bleed which could not be treated at WSFT
Not contributing to death	Over-treatment at end of life Insufficient community-based end-of-life support to allow people to die at home Noise on wards

Summary Hospital Mortality Index - not in use



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Discharge Summaries
Standard	95%
Name	Helen Beck
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

Clear and complete documentation in a patient's health record is directly linked to the quality of care they receive. Detailed and accurate documentation helps reduce negative outcomes, by ensuring that all clinical staff caring for patients have access to the information they need to deliver a good standard of care. Effective communication between secondary and primary care is vital to ensure a smooth and seamless transition of care for all patients when they leave hospital.

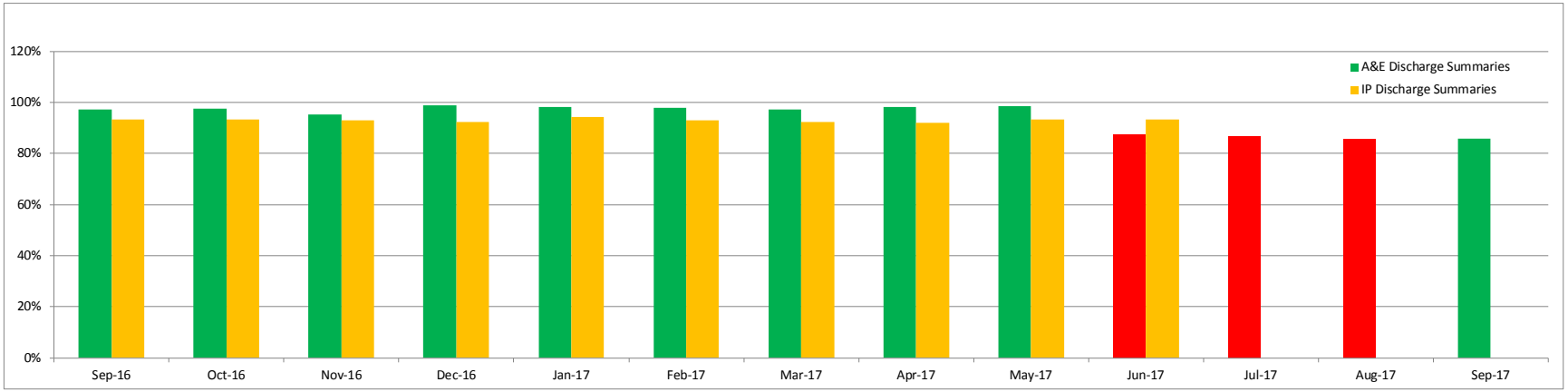
The information conveyed at the time of discharge from hospital has always been an important element of communication between secondary and primary care.

The immediate discharge summary is therefore among the most crucial pieces of documentation in the health record, as it is the basis of communication between secondary and primary care and essential for ensuring quality and continuity of care.

Trend													Recovery Trajectory								
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
A&E Discharge Summaries	97%	97%	95%	99%	98%	98%	97%	98%	98%	88%	87%	86%	86%								
IP Discharge Summaries	93%	93%	93%	92%	94%	93%	92%	92%	93%	93%	ND	ND	ND								

Key Recovery Actions

Description	Owner	Start	End
A range of initiatives are taking place to improve A&E discharge letters within 24 hours. 1. The locum cap has been increased and it is expected to generate cover in 50% of vacant posts. 2. ACPs are being used to suppport gaps in the rota. 3. ENPs are supporting treatment of minor injuries. 4. A new trail of a senior decision maker in assessment bays has taken place, report of success due 13th October. 5. A demand and capacity review has identified attendances per hour and breaches per hour. This will be used to flex working arrangements to cover peak breach times.	HB	Jun-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancelled Operations for non-clinical reasons
Standard	Less than 1%
Name	Helen Beck
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Effective
National Rank	NA

Background

When an operation is cancelled for a non clinical reason, the patient should be offered an alternative date within 28 days of the cancellation.

The Trust is under the 1% threshold for the YTD, althought the last 3 months have seen a gradual decline, it has come under the 1% limit for the number of cancelled operations in September 2017.

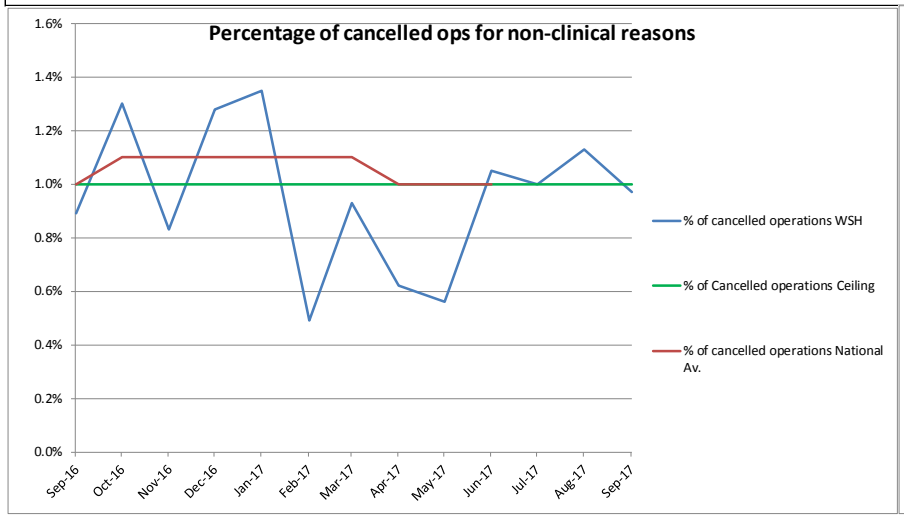
The Trust is below the national average for offering appointments within 28 days of the cancellation.

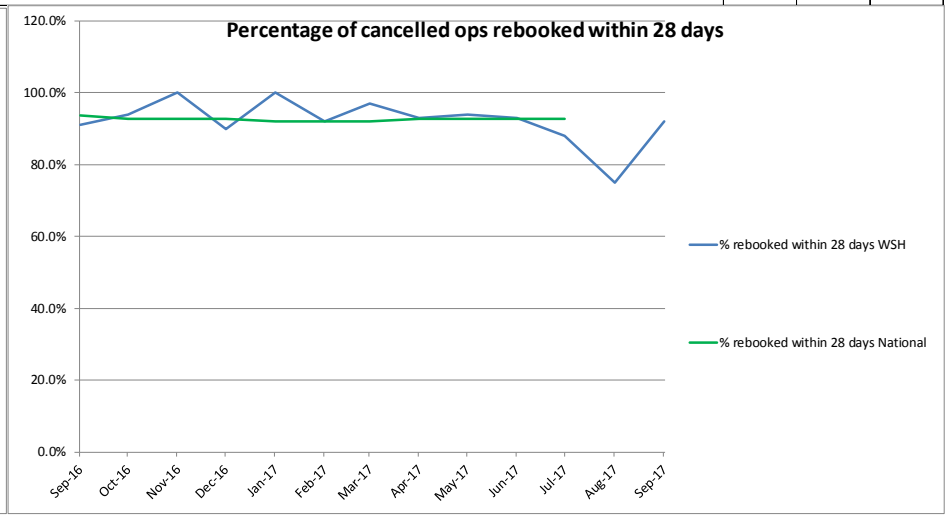
Trend / Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
% of cancelled operations WSH	0.9%	1.3%	0.8%	1.3%	1.4%	0.5%	0.9%	0.6%	0.6%	1.1%	1.0%	1%	1%								
% of Cancelled operations Ceiling	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
% of cancelled operations National Av.	1.0%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.0%	1.0%	1.0%											
% rebooked within 28 days WSH	91.0%	94.0%	100.0%	90.0%	100.0%	92.0%	97.0%	93.0%	94.0%	93.0%	88.0%	75%	92%								
% rebooked within 28 days National	93.7%	92.7%	92.7%	92.7%	92.1%	92.1%	92.1%	92.8%	92.8%	92.8%	92.8%										

Key Recovery Actions

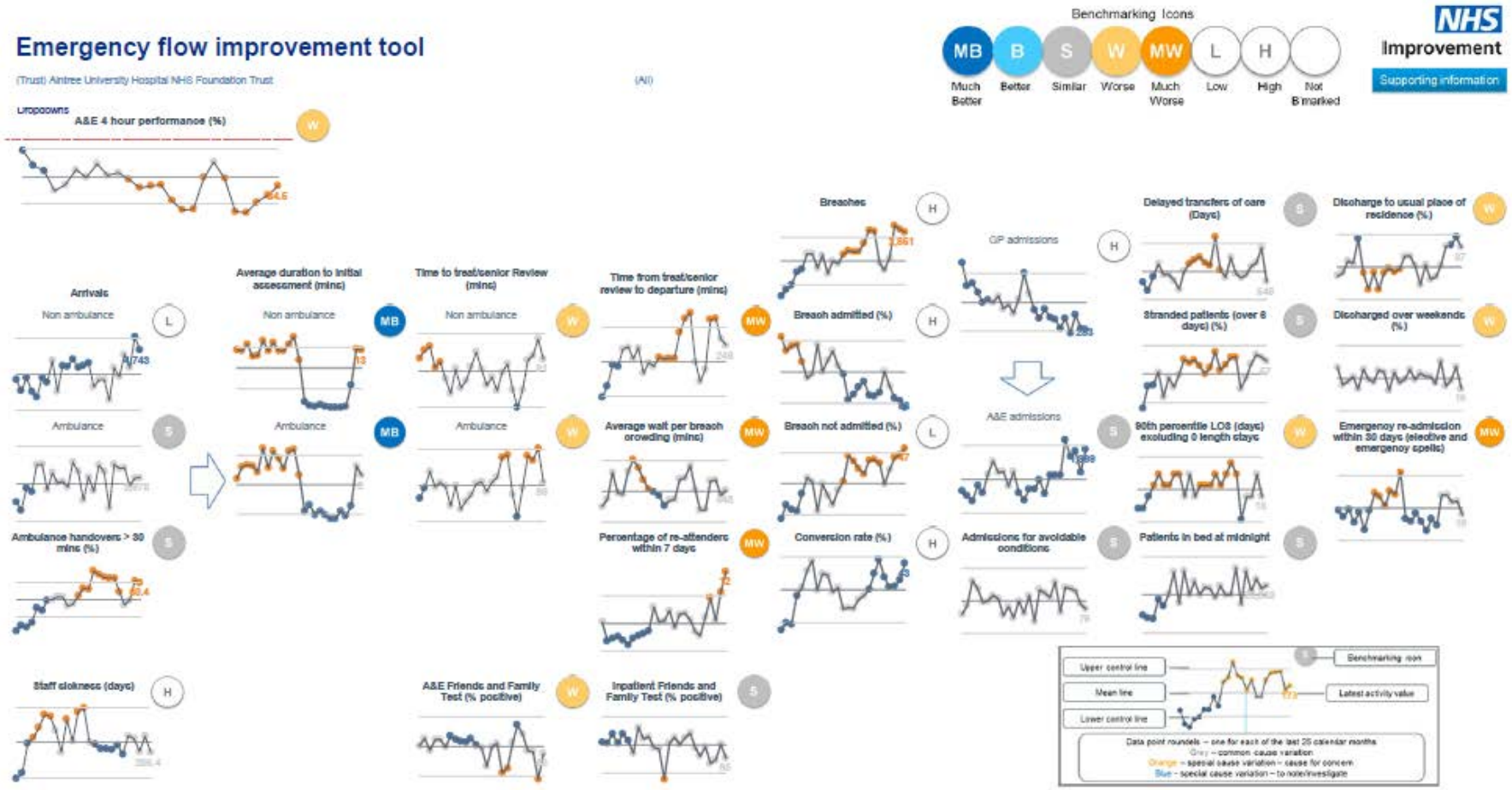
Description	Owner	Start	End
Route cause analysis of breach reasons is reviewed at the weekly operations meetings.	HB	Jul-17	Dec-17





Emergency Flow

The new indicators in the Effective dashboard will be populated using the new Cerner System. The CQC have produced a high level flow benchmark analysis which is set out below.



DETAILED REPORTS - CARING

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we.		Ref.	KPI	ED	Target	R	A	G	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD(AUG16-MAR17)	WTG	Traffic	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD	WTG	Traffic	Trend
3. Caring	Dashboard	3.01	Compliments						2	20	35	56	59	33	41	28	274			41	52	26	56	28	17							220			
		3.02	Complaints (Inpatient)		20	30+	20-30	<=20	26	27	15	10	17	18	12	11	136	6		10	10	10	6	16	16							68	6		
		3.03	Mixed Sex Accommodation Breaches		0	>2	1-2	0	0	2	0	0	0	0	2	0	5	4		0	0	0	0	0	0							0	6		
		3.04	IP - Extremely likely or Likely to recommend (FFT)		90%	<80%	80-89%	90%+	99%	98%	98%	97%	95%	99%	98%	99%	98%	6		98%	97%	99%	98%	98%	98%							98%	6		
		3.05	OP - Extremely likely or Likely to recommend (FFT)		90%	<80%	80-89%	90%+	97%	96%	98%	97%	97%	97%	97%	96%	97%	6		95%	96%	97%	95%	95%	96%							96%	6		
		3.06	A&E - Extremely likely or Likely to recommend (FFT)		85%	<75%	75-84%	85%+	94%	83%	80%	85%	95%	95%	96%	96%	90%	6		97%	96%	95%	95%	95%	92%							95%	6		
		3.07	Maternity - How likely are you to recommend our ward to friends and family?		85%	<75%	75-84%	85%+	100%	ND	100%	95%	90%	91%	100%	100%	97%	6		100%	100%	100%	100%	100%	100%							100%	6		
		3.08	Community - Extremely likely or likely to recommend			<75%	75-84%	85%+														98%									98%	6		
	Other Friends and Family Test Scores	3.09	IP overall experience result		85%	<75%	75-84%	85%+	92%	92%	92%	92%	92%	94%	93%	94%	93%	3		93%	92%	94%	94%	93%	93%							93%	3		
		3.10	OP overall experience result		85%	<75%	75-85%	85%+	93%	94%	93%	92%	91%	92%	92%	91%	92%	3		92%	85%	88%	89%	91%	89%							89%	3		
		3.11	A&E overall experience result		85%	<75%	75-84%	85%+	94%	94%	94%	93%	95%	96%	93%	94%	94%	3		94%	96%	94%	94%	95%	94%							95%	3		
		3.12	A&E children overall experience result		85%	<75%	75-84%	85%+	ND	ND	ND	ND	ND	ND	98%	100%	99%	3		ND	100%	94%	ND	ND	ND							97%	3		
		3.14	Short-stay overall result		85%	<75%	75-84%	85%+	99%	99%	99%	99%	99%	99%	99%	98%	99%	3		99%	99%	100%	99%	99%	99%							99%	3		
		3.15	Short-stay Extremely likely or Likely to recommend		90%	<80%	80-89%	90%+	99%	99%	100%	98%	100%	100%	100%	100%	99%	3		99%	99%	100%	99%	99%	100%							99%	3		
		3.16	Maternity - overall		85%	<75%	75-84%	85%+	100%	ND	98%	98%	97%	94%	96%	100%	98%	3		98%	99%	100%	100%	100%	100%							99%	3		
		3.17	Maternity - postnatal ward recommendation to F&F		90%	<80%	80-89%	90%+	100%	ND	100%	95%	90%	91%	100%	100%	97%	3		100%	100%	100%	ND	ND	ND							100%	3		
		3.18	Maternity - birthing unit recommendation to F&F		90%	<80%	80-89%	90%+	100%	100%	100%	100%	100%	ND	ND	ND	100%	3		100%	100%	100%	ND	ND	100%							100%	3		
		3.19	Maternity -antenatal community care rec. to F&F		90%	<80%	80-89%	90%+	98%	97%	100%	99%	100%	99%	100%	95%	99%	3		97%	98%	100%	ND	ND	ND							98%	3		
		3.20	Maternity -post-natal community care rec. to F&F		90%	<80%	80-89%	90%+	100%	100%	100%	93%	98%	100%	100%	100%	99%	3		100%	98%	ND	ND	ND	ND							99%	3		
		3.21	Children's services overall result		85%	<75%	75-84%	85%+	ND	ND	96%	97%	93%	99%	95%	ND	96%	3		95%	99%	97%	ND	ND	ND							97%	3		
		3.22	F1 Parent overall result		85%	<75%	75-84%	85%+	99%	99%	100%	ND	98%	97%	99%	97%	98%	3		97%	99%	99%	95%	100%	100%							98%	3		
		3.23	F1 Parent - Extremely likely or Likely to recommend (FFT)		90%	<80%	80-89%	90%+	98%	100%	97%	ND	96%	96%	100%	100%	98%	3		100%	100%	100%	92%	100%	100%							99%	3		
		3.24	Stroke Care - Overall FFT		85%	<75%	75-84%	85%+	100%	99%	95%	96%	93%	94%	95%	95%	96%	3		94%	ND	98%	99%	ND	99%							98%	3		
		3.25	Stroke Care - How likely is it that you would recommend the service to friends and family?		90%	<80%	80-89%	90%+	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		93%	ND	95%	100%	ND	95%							96%	3		
		3.26	Dementia Environment - Patient Score (annual)		76%	<72%	72-76%	>76%								76%	76%	2																	
	Complaints Handling	3.27	Complaints acknowledged within 3 working days		90%	<75%	75-89%	>=90%	100%	100%	50%						83%	2		ND	90%	100%	100%	93%	94%							95%	3		
		3.28	Complaints responded to within 25 working days		90%	<75%	75-89%	>=90%	64%	62%	81%	88%	100%	86%	86%	100%	83%	2		100%	90%	75%	100%	85%	62%							85%	3		
		3.29	Number of second letters received		1	>6	2-6	0-1	2	4	3	3	2	2	2	1	19	2		3	0	2	1	1	1							8	3		
		3.30	No. of cases accepted by Ombudsman						0	1	1	0	0	0	0	0	2																		
		3.31	No. of complaints to Ombudsman upheld		0	>=2	1	0									0	3		0	2	0	1	0	0							3	2		
		3.32	Red complaints actions beyond deadline for completion		0	>=5	1-4	0	0	0	0	0	0	0	0	0	0	3		0	0	0	0	0	0							0	3		
		3.33	No. of PALS contacts		NA				99	144	102	115	122	171	189	230	1172			172	188	169	176	137								842			
		3.34	No. of PALS contacts becoming formal complaints		<=5	>=10	6-9	<=5	0	0	0	0	2	0	0	1	3	3		0	0	0	1	4	2							7	3		
		3.35	ITU Wardable patients																															
		3.36	ITU Wardable patients over xx hours																															
		3.37	Environment & cleanliness - Patient Satisfaction Overall		75%	<70%	70-75%	75%+	91%	92%	92%	92%	91%	92%	91%	94%	92%	3		93%	92%	92%	92%	94%	93%							93%	3		
		3.38	Catering - Patient Satisfaction with food - overall		75%	<70%	70-75%	75%+												83%	81%	85%	78%									82%	3		
																																113	out of	114

EXCEPTION REPORTS - CARING

There are no exceptions to report to the Board. The graph below highlights complaints and compliments over the last 12 months

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

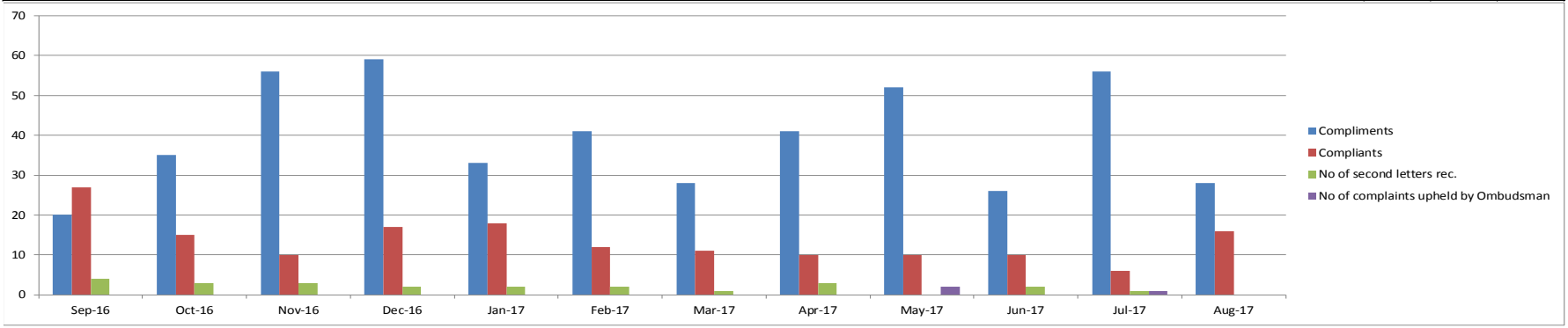
Indicator	Complainst and compliments
Standard	Less than 20 complaints
Name	Rowan Procter
Month	01-Aug-17
Data Frequency	Monthly
CQC Area	Caring
National Rank	

Background

Trend												Recovery Trajectory									
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Compliments	20	35	56	59	33	41	28	41	52	26	56	28	17								
Compliants	27	15	10	17	18	12	11	10	10	10	6	16									
No of second letters rec.	4	3	3	2	2	2	1	3	0	2	1										
No of complaints upheld by Ombudsman								0	2	0	1										

Key Recovery Actions

Description	Owner	Start	End



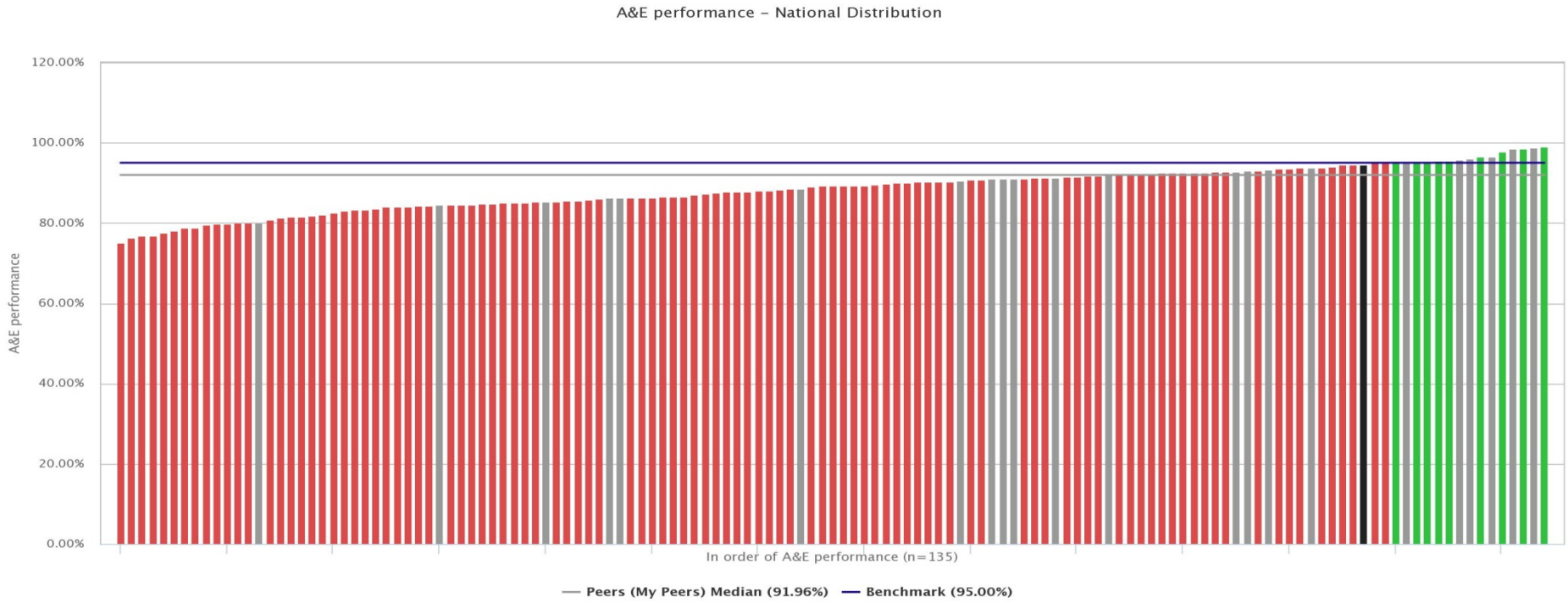
DETAILED REPORTS - RESPONSIVE

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

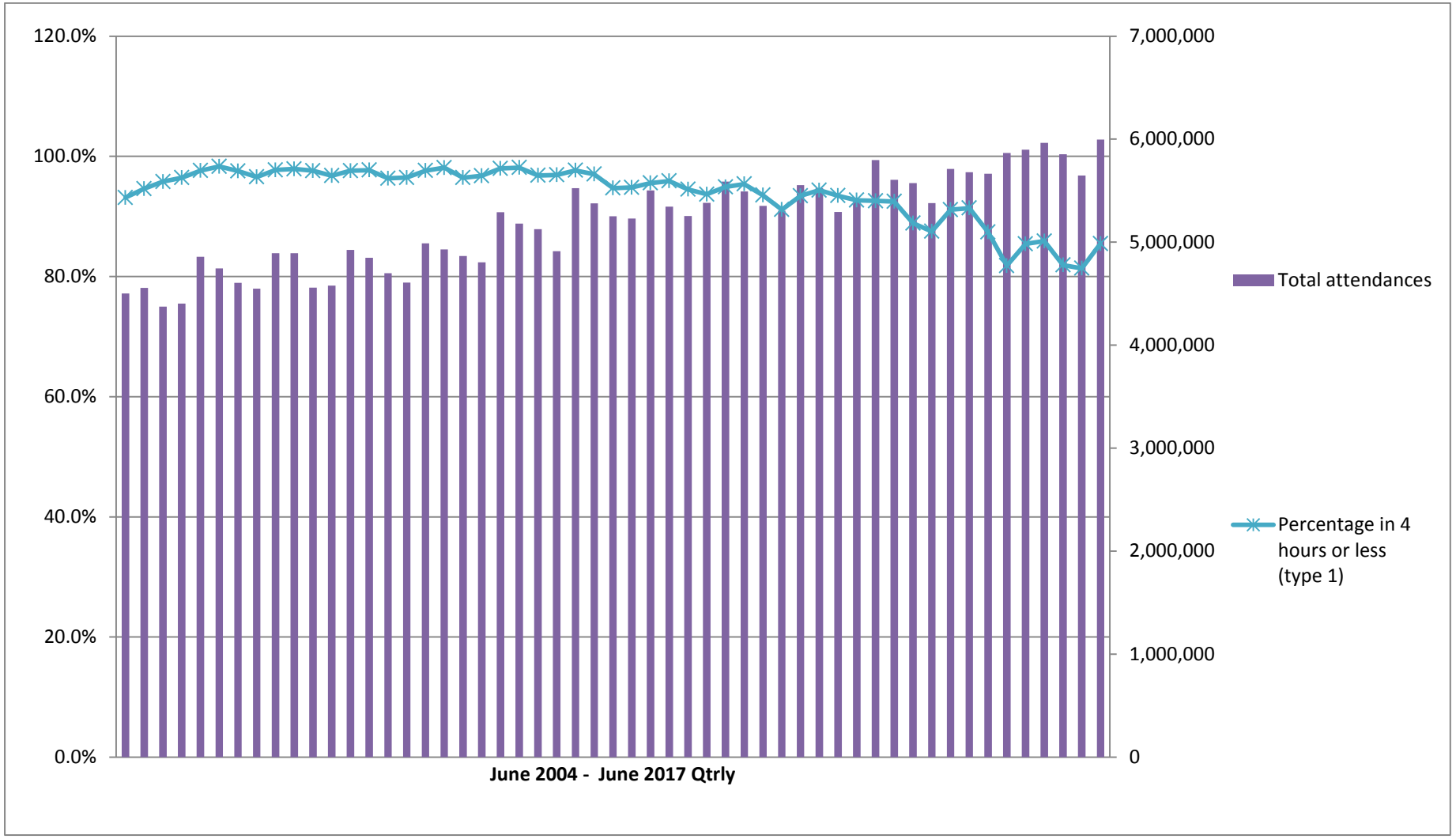
Are we..		Ref.	KPI	ED	Target	R	A	G	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	YTD	WTG	Traffic	Trend
4. Responsive	NHS I	4.01	A&E under 4 hr. wait		95%	<90%	90-95%	95%+	100%	88%	86%	85%	86%	87%	84%	93%	95%	95%	96%	92%	90%	89%	93%	4		
		4.02	RTT: % incomplete pathways within 18 weeks		92%	<88%	88-92	92%+	90%	92%	92%	92%	92%	90%	90%	90%	82%	80%	83%	84%	86%	86%	83%	2		
		4.03	52 week waiters		0	10	5-10	<5	0	1	1	0	0	7	7	8	15	14	15	35	26	29	134	2		
		4.04	Diagnostics within 6 weeks		99%	<95%	95-99%	99%+	92%	92%	96%	99%	95%	96%	99%	100%	100%	100%	100%	100%	100%	100%	100%	6		
		4.05	Cancer: 2w wait for urgent GP Referrals		93%	<90%	90-93%	93%	93%	95%	97%	98%	98%	90%	98%	98%	94%	92%	97%	95%	96%	91%	94%	6		
		4.06	Cancer 2w wait breast		93%	<90%	90-93%	93%	58%	99%	98%	99%	93%	88%	96%	94%	94%	99%	89%	98%	100%	98%	96%	6		
		4.07	Cancer 31 d First Treatment		96%	<92%	92-96%	96%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	6		
		4.08	Cancer 31 d Drug Treatment		98%	<95%	95-98%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
		4.09	Cancer 31 d Surgery		94%	<91%	91-94%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
		4.10	Cancer 62 d GP referral		85%	<80%	80-85%	85%	87%	84%	89%	85%	86%	85%	88%	83%	89%	83%	86%	85%	86%	85%	86%	6		
		4.11	Cancer 62 d Screening		90%	<85%	85-90%	90%	93%	100%	100%	100%	96%	100%	89%	97%	100%	100%	90%	100%	100%	91%	97%	6		
		4.12	Incomplete 104 day waits		0	6+	1-5	0																		
	Emergency Care &Emergency Flow Improvement Tool	4.13	Flow: % of Ambulance handover to ED within 15m		15m																					
		4.14	Flow: % of clinical assessments started within 30m		30m																					
		4.15	Flow: % clinically streamed to an alternative service		NT																					
		4.16	Flow: % MH needs assessed by MH team within 60m		90%																					
		4.17	Flow: % Emergency Admissions with care plan within 14hrs		100%																					
		4.18	Flow: % High Risk Emergency Admissions with care plan within 4hrs		100%																					
		4.19	Flow: % of discharges before mid-day		>35%																					
		4.20	Number of Delayed Transfer of Care - (DTOCs)		NT				612	816	589	443	565	566	464	294	417	411	511	481	565	337	454			
		4.21	A&E time to treatment in department (median) for patients arriving by ambulance - CDM		NT	150m+	120-150m	120m	71	61	58	46	56	50	48	53	35	43	52	52	50	62	294	3		
		4.22	A&E - Single longest Wait (Admitted & Non-Admitted)		6 hrs.	8hrs	6-8 hrs	<6 hrs	12:50	12:47	12:25	15:00	17:28	13:19	12:25	22:32	09:57	13:57	10:10	13:53	11:46	12:01	11:57	1		
		4.23	A&E -Waits over 12 hours from DTA to Admission		12 Hrs.	1	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3		
		4.24	A&E - Admission waiting 4-12 hours from dec. to admit			4.16		4.16	1	8	5	9	3	3	12	5	14	3	6	5	5	14	28	1		
		4.25	A&E - To inpatient Admission Ratio		27%	>38%	33-38%	<33%	33%	32%	32%	34%	34%	35%	34%	32%	32%	31%	31%	31%	32%	34%	32%	3		
		4.26	A&E Service User Impact (re-attendance in 7 days <5% & time to treat		1 met	0 met	NA	1-2 met	1	1	1	1	1	1	1	1	1	1	1	1	1	1	6	3		
		4.27	A&E/AMU - Amb. Submit button complete		80%	<70%	70-80%	80%+	83%	88%	92%	88%	90%	90%	84%	88%	93%	91%	92%	91%	90%	90%	91%	3		
		4.28	A&E - Amb. Handover above 30m		30m	70+	50-70	<50	19	20	45	36	46	39	53	48	21	38	31	39	ND		129	3		
		4.29	A&E - Amb. Handover above 60m		60m	40+	30-40	<30	1	3	7	10	13	21	34	18	3	16	9	7	ND		35	3		
		4.30	A&E - Type 1&2 high risk patients reviewed by a EMC		14%	<80%	80-85%	>85%	74%	79%	86%	83%	94%	80%	89%	100%	94%	87%	93%	ND	ND		91%	3		
	RTT	4.31	RTT - 18w Admitted (Completed)		90%	<85%	85-90%	>90%	77%	69%	68%	70%	71%	68%	69%	69%	69%	68%	70%	73%	70%	74%	71%	1		
		4.32	RTT - 18w Non-admitted (Completed)		95%	<90%	90-95%	>95%	94%	92%	88%	86%	89%	88%	85%	85%	86%	87%	87%	88%	86%	87%	87%	1		
		4.33	RTT waiting List			NT	NT	NT	18213	18840	18033	18164	17663	17816	18126	18127	22110	22144	19931	18676	17346	17236	19574			
		4.34	RTT waiting list over 18 weeks			NT	NT	NT	1288	1477	1413	1436	1407	1729	1833	1834	3929	4492	3316	2629	2441	2467	3212			
	Stroke	4.35	Stroke - % Patients scanned within 1 hr.		77%	<65%	65-77%	77%+	77%	84%	78%	78%	81%	76%	69%	88%	87%	80%	72%	82%	79%	78%	80%	3		
		4.36	Stroke - % patients scanned within 12 hrs.		96%	<90%	90-96%	96%+	98%	100%	100%	100%	97%	100%	91%	100%	98%	98%	95%	95%	96%	90%	95%	3		
		4.37	Stroke - % Patients admitted directly to stroke unit within 4 hrs.		75%	<65%	65-75%	75%+	77%	81%	76%	84%	77%	84%	63%	75%	89%	71%	76%	78%	79%	83%	79%	3		
		4.38	Stroke - % greater than 80% of treatment on a stroke unit		90%	<75%	75-80%	80%+	86%	94%	92%	83%	89%	92%	91%	88%	98%	88%	88%	94%	98%	93%	93%	3		
		4.39	Stroke - % of patients treated by the SESDC		48%	<40%	40-48%	48%+	42%	31%	41%	47%	68%	47%	42%	34%	50%	48%	75%	46%	33%	51%	51%	3		
		4.40	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start		80%	<70%	70-80%	80%+	86%	88%	93%	93%	86%	82%	84%	94%	93%	86%	95%	92%	88%	85%	90%	3		
		4.41	hrs., all rel. therapists within 72 hrs. and have negotiated goals within 5d.		75%	<70%	70-75%	75%+	76%	80%	88%	87%	89%	77%	80%	72%	87%	80%	90%	88%	90%	92%	88%	3		
		4.42	Stroke -% of eligible patients given thrombolysis		100%	<99%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		4.43	Stroke -% of stroke survivors who have a 6mth follow up		50%	<45%	45-50%	>50%	ND	ND	ND	ND	ND	50%	ND	ND	ND	58%	ND	ND	ND	58.00%	58%	3		
		4.44	Stroke -Provider rating to remain within A-C		C	E	D	A-C	ND	ND	ND	ND	ND	B	ND	ND	ND	C	ND	ND	ND	D	C	3		
	Othe	4.45	RCA Actions beyond deadline for completion		4	>9	4-8	<3			8	11	15	9	9	8	3	1	3	4	1		12	3		
		4.46	Sepsis - 1 hr neutropaenic sepsis		50%	<45%	45-50%	>50%	81%	84%	88%	88%	90%	72%	94%	80%	64%	47%	63%	69%	83%	62.50%	65%	3		
																								120	out of	138

EXCEPTION REPORTS – RESPONSIVE

A&E performance has fallen from 95.1% in Qtr. 1 to 90.5% in Qtr. 2 at West Suffolk. The first table shows the relative performance of West Suffolk compared with peers and the national average. The second chart show national attendances and A&E 4 hour performance over time and the final table reviews the recent performance of West Suffolk and associated recovery actions.



National A&E attendances and A&E 4-hour performance since June 2004.



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E 4 hour wait
Standard	95%
Name	Helen Beck
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	18th best

Background

The Trust's current position is 88.94% against a threshold of 95%.

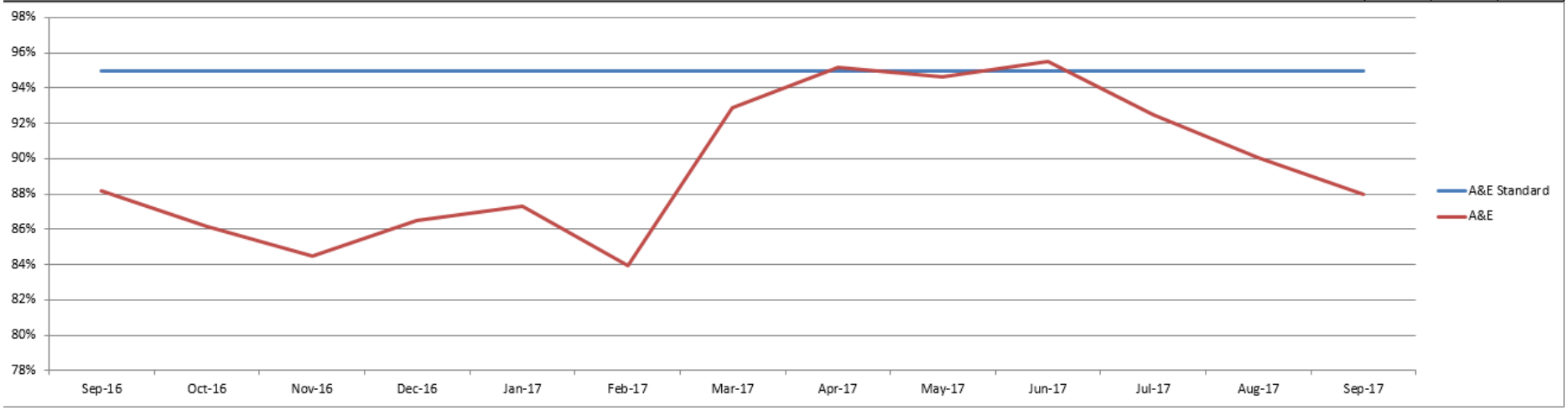
The first week in September ED performance position started off in a reasonable position. However, as the month progressed the Trust continued to experience capacity issues. The total attendees continue to rise, on an daily average of 191 attendees. For 8 days we achieved the 95% target of under 4 hours length of stay. Medical staffing deficits continue despite aggressive recruitment strategies to fill the vacant gaps. This resulted in delays to be seen by a clinical decision maker, coupled with insufficient capacity.

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
A&E Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%								
A&E	88%	86%	85%	86%	87%	84%	93%	95%	95%	96%	92%	90%	88%								

Key Recovery Actions

Description	Owner	Start	End
The division has developed a 4 hour emergency standard recovery plan to address the deficits in service as well as exploring alternative solutions to improve performance across the system.	HB	Jul-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Sepsis - 1-hr neutropaenic sepsis
Standard	100%
Name	Helen Beck
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Background

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

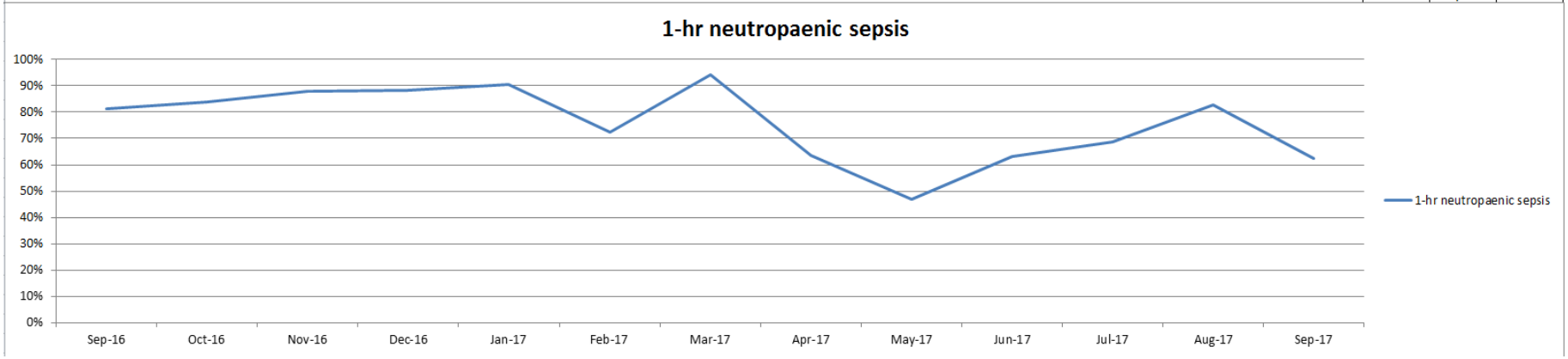
Current Position
Macmillan – 100%
ED - 40%
Overall Trust figure of 62.50% against a threshold of 100%

Trend | Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
1-hr neutropaenic sepsis	81%	84%	88%	88%	90%	72%	94%	64%	47%	63%	69%	83%	63%								

Key Recovery Actions

Description	Owner	Start	End
The performance figure for 1 hour to needle from diagnosis of neutropaenic sepsis September Data showed a drop from the last three months' improved performance. AMU and the Macmillan Unit had no breaches during September. The Emergency Department had 9 neutropaenic sepsis patient breaches. The breech cases will be undergoing detailed review. These issues will be escalated to the Emergency Department Clinical and Nursing management to address within the departments.	HB	Sep-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer: 2w wait for urgent GP Referrals
Standard	93%
Name	Helen Beck
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Background

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

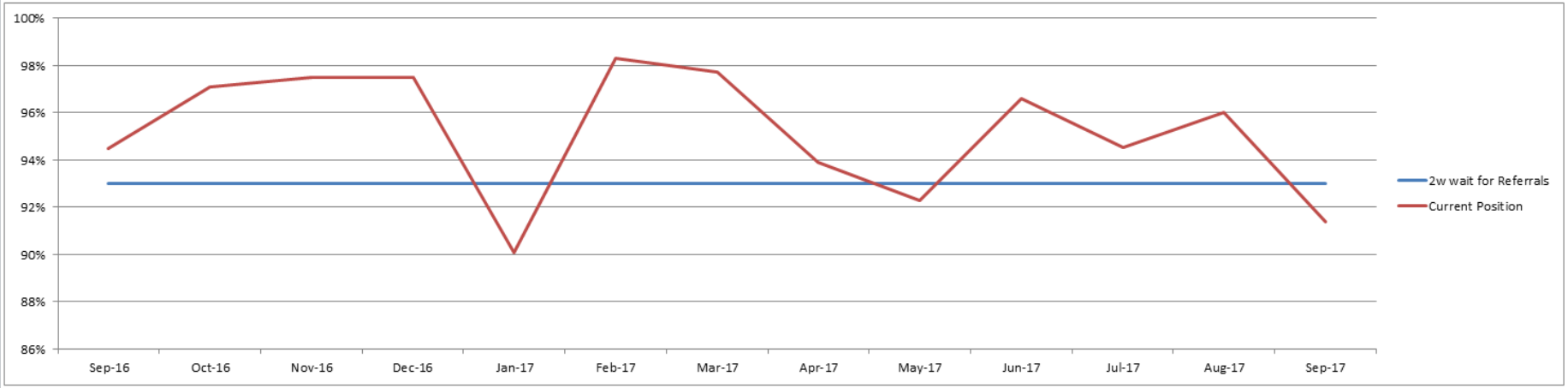
This failing is due to capacity issues in managing the sustained high demand on 2 week wait first appointment primarily with GP suspected Skin cancer 2 WW referrals. The performance in this standard has remained above 93% for the quarter Jun-Aug, though.

Trend / Recovery Trajectory

Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
2w wait for Referrals	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%								
Current Position	95%	97%	98%	98%	90%	98%	98%	94%	92%	97%	95%	96%	91%								

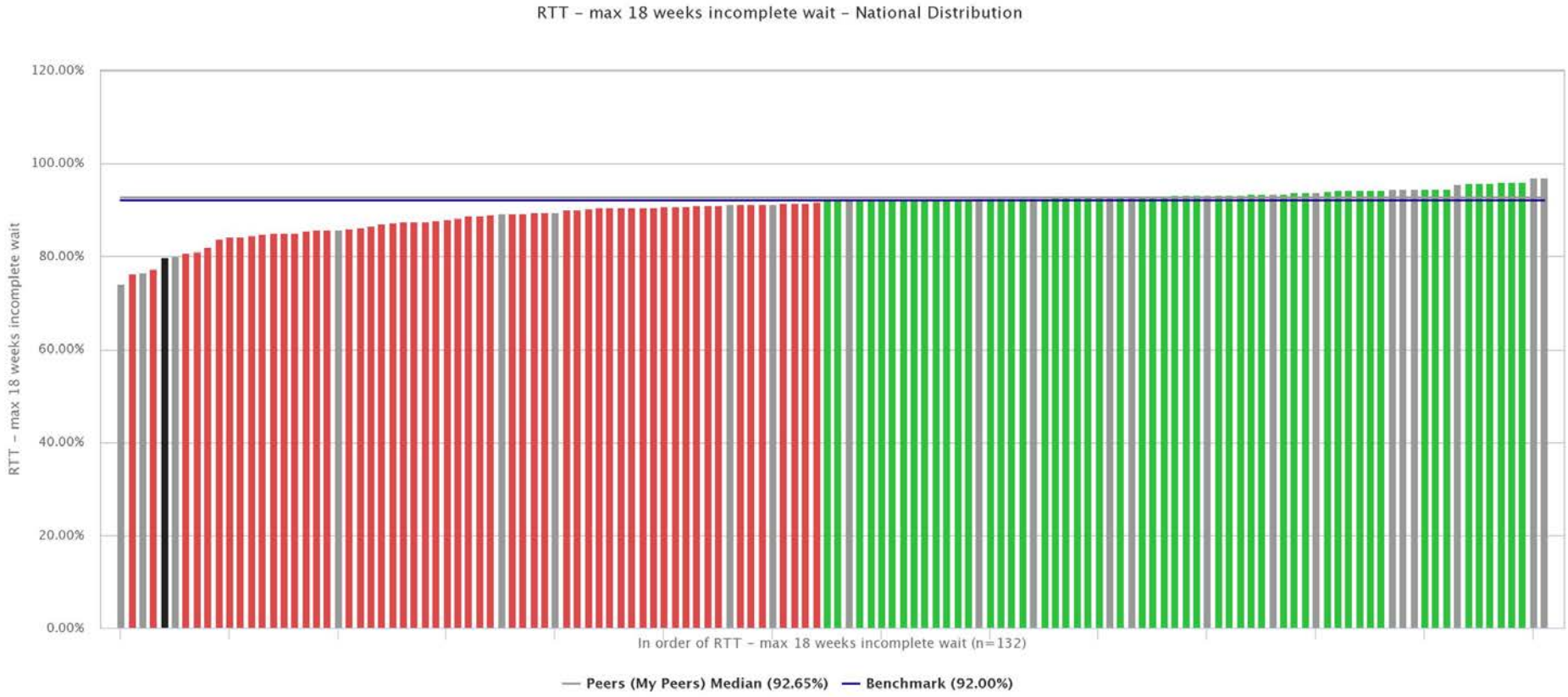
Key Recovery Actions

Description	Owner	Start	End
The Trust is seriously engaged with the CCG at various levels to improve on demand management. A locum Dermatology consultant is also brought in to enhance outpatient capacity recently. Consequently, some improvement is expected in this standard from the time of November monthly reporting.	HB	Jul-17	Dec-17

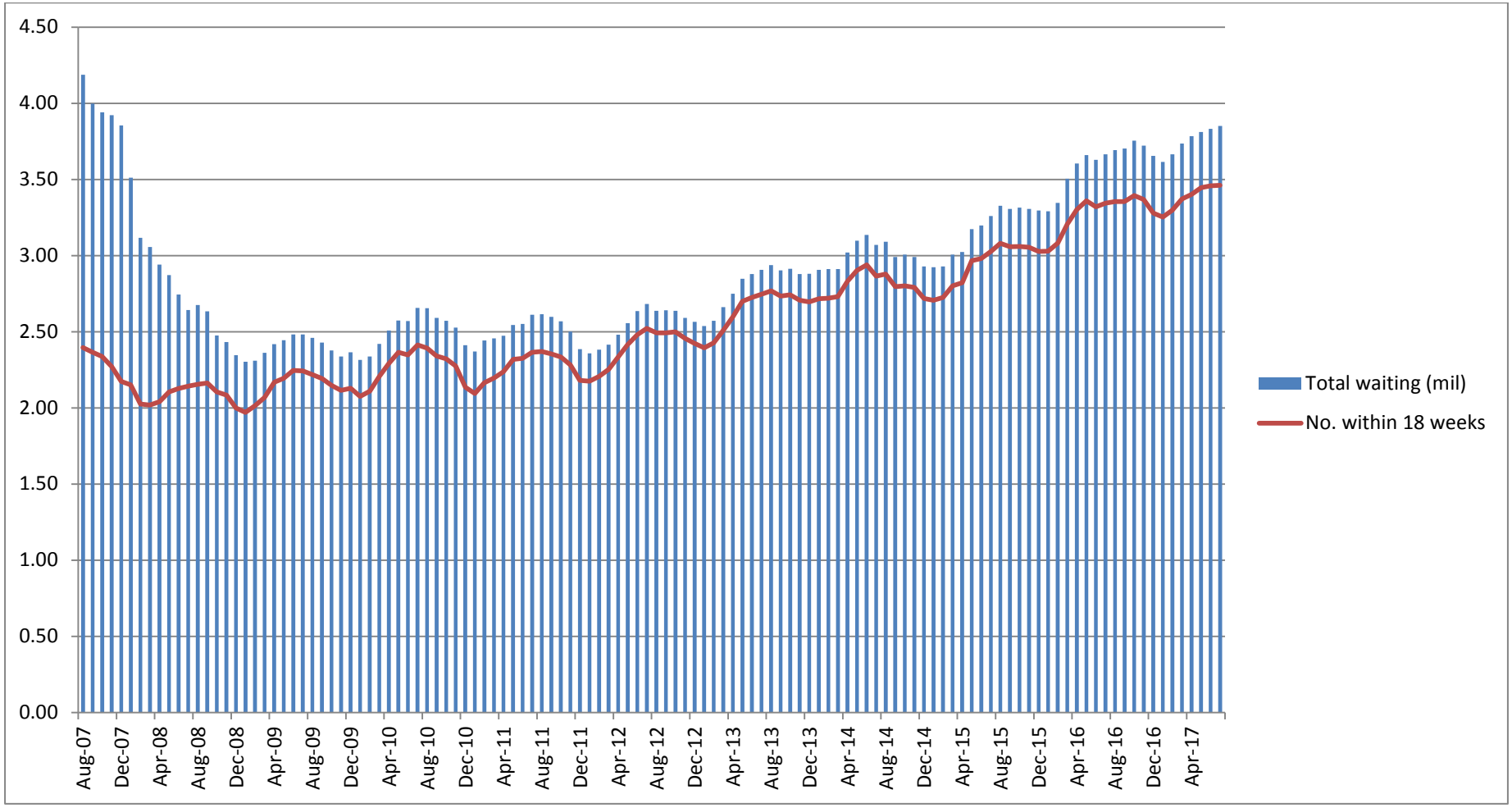


Referral to Treatment

Progress is being made to reduce the number of people on the RTT waiting list and to treat 92% of patients from point of referral to treatment in aggregate – patients on an incomplete pathway. However, the Trust remains a national outlier in term of overall performance as demonstrated in the slide below.



The national picture demonstrates that the percentage of patients being treated within 18 weeks is improving, but the number of patients on an incomplete waiting list is rising, causing some recent pressure on RTT performance.



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT - Incomplete waiting list
Standard	92%
Name	Helen Beck
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	6th Worst

Background

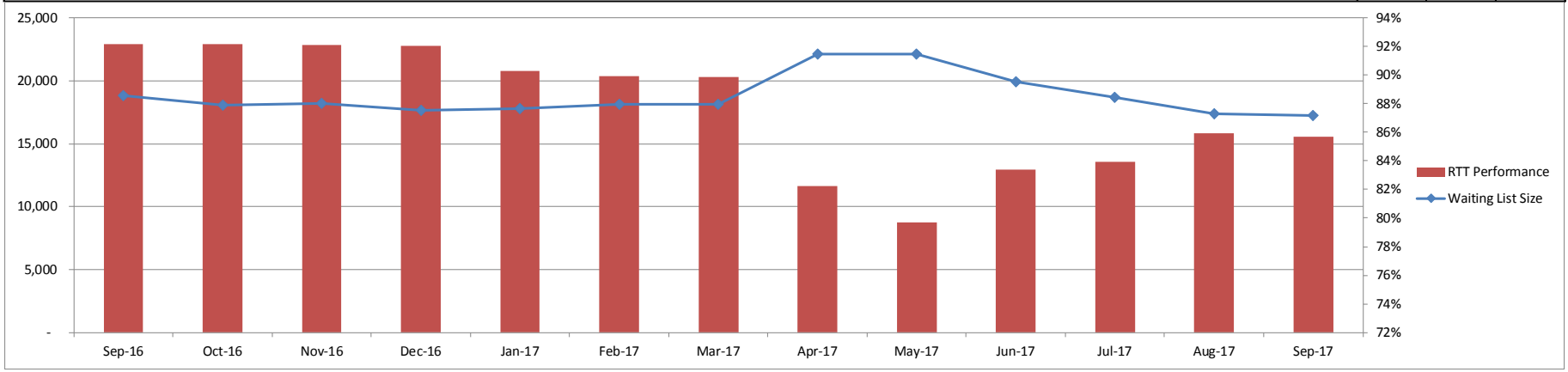
85.69% against a threshold 92%

The September position demonstrates a plateau in performance from August (85.93%) to 85.69% in September. The current waiting list now has a total of 17,236 patients with 2,467 patients breaching 18 weeks (2,441 in August). There remain on-going data quality issues within this number leading to a reported position which we believe is slightly worse than our actual position. There continue to be significant capacity constrains within ENT, Vascular, Urology, and Dermatology services.

Trend												Recovery Trajectory									
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Waiting List Size	18,840	18,033	18,164	17,663	17,816	18,126	18,127	22,110	22,144	19,931	18,676	17,346	17,236								
RTT Performance	92%	92%	92%	92%	90%	90%	90%	82%	80%	83%	84%	86%	86%								

Key Recovery Actions

Description	Owner	Start	End
Revised detailed action plans for each of the specialties have been developed and reviewed with the CCG. NHSI IST continue to assist the trust with demand and capacity modelling to support work around meeting the RTT targets, this is being further supported by colleagues from KPMG. Work continues across all specialities to maximise opportunity for additional capacity and support clinicians in delivering additional activity to reduce waiting times for patients. This is being challenged by high levels of emergency activity but operational teams are working closely with clinical teams to mitigate the impact as far as possible.	HB	Jul-17	Dec-17



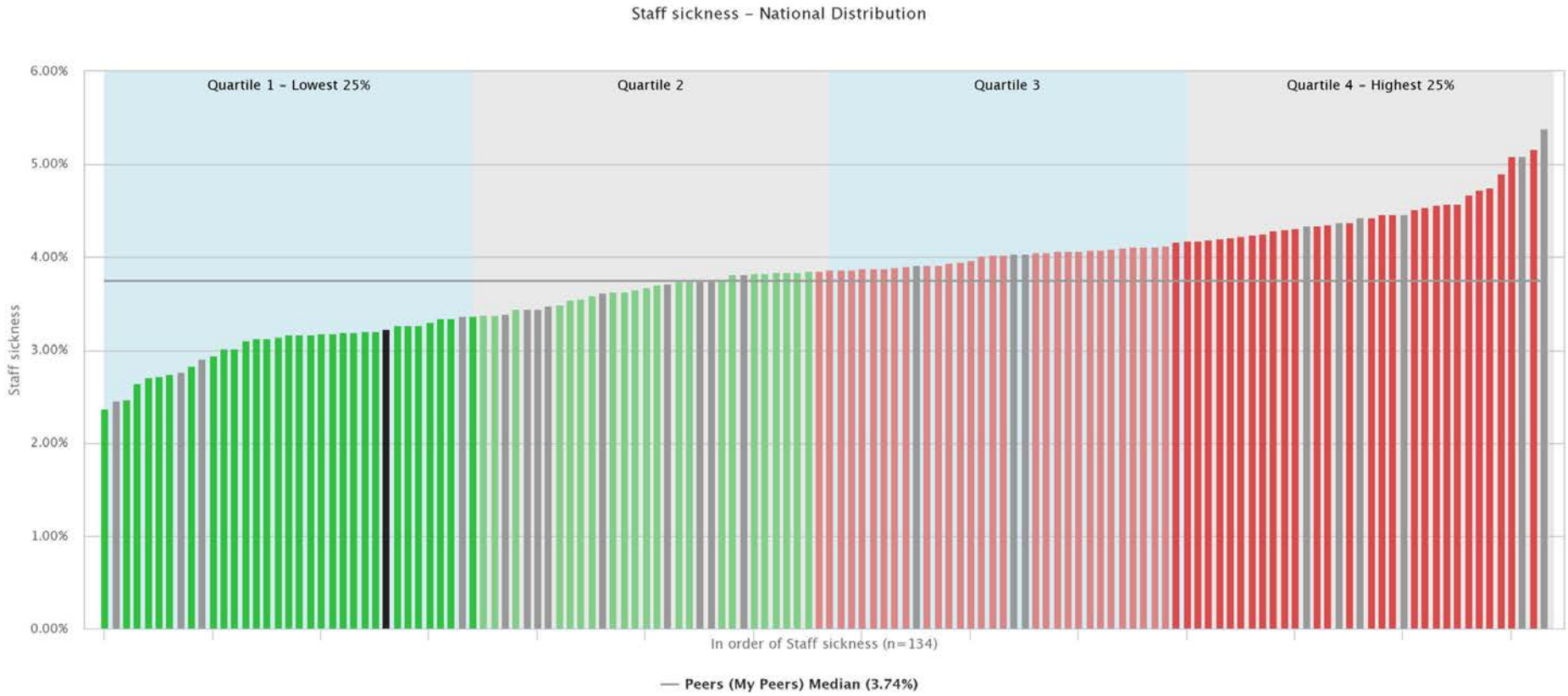
DETAILED REPORTS – WELL-LED

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we.	Are we	Ref.	KPI	Target	R	A	G	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	YTD	WTG	Traffic	Trend
5. Well Led	Key NHS I	5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	<70%	70-75%	>75%	93%			94%			93%			95%			95%	95%	6		
		5.03	Staff F&F Test % Recommended - place to work	75%	<70%	70-75%	>75%	83%						79%			83%			82%	83%	6		
		5.04	Turnover (Rolling 12 mths)	<10%	>14%	11-14%	<10%	10%	10%	10%	10%	10%	11%	10%	10%	10%	10%	10%	10%		10%	6		
		5.05	Sickness Absence	<3.5%	>4%	3.5-4%	<3.5%	3.91%	3.93%	4.41%	4.48%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.61%	4		
		5.06	Executive Team Turnover	<10%	13%+	10-12%	<10%	0%	0%	29%	0%	0%	0%	0%	0%	17%	0%	0%	0%	10%	4%	6		
		5.07	Agency Spend		600k+	550-600	<550k								307	323	292				922	6		
		5.08	Monitor Use of Resources Rating		NA	NA	NA	3	3	3	4	4	4	3	3	3	3				3			
	Agency, WTE & vacanci	5.09	Agency Spend Cap		1.8m+	1.6-1.8m	<1.6m								307	323	292	371			1293			
		5.10	Bank Spend																		-			
		5.11	Bank/agency Spend percentage		5%+	3-4%	<3%								3%	3%	3%	3%			3%	3		
		5.12	Proportion of Temporary Staff		13%+	12-13%	<12%								11%	11%					11%	3		
		5.14	Total Vacancies		13%+	10-12%	<10%										8%				8%	3		
		5.16	% Staff on Maternity/Paternity Leave					2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%		2%			
		5.17	% Fill rate of Reg. Nurse shifts	90%	<85%	85-90%	>90%																	
	Corporate	5.27	Recruitment Timescales - Av no. of weeks to recruit	7	>9	7-9	<7		6							6	5			7	18	3		
		5.28	DBS checks	95%	<90%	90-95%	95%+	88%	93%	93%	93%	93%	93%	93%	93%	93%	93%	92%	94%	99%	94%	2		
		5.29	Staff appraisal Rates (From Sept 17)	90%	<85%	85-90%	90%+	92%	92%	92%	92%	92%	92%	92%		92%	92%				92%	3		
		5.38	Trust Participation in on-going National Audits (Qtrly)	90%	<50%	50-80%	>80%	100%			100%						94%				94%	3		
	Training	5.39	Infection Control Training (classroom)	85%	<80%	80-85%	85%	95%	94%	94%	94%	94%	94%	95%	95%	96%	95%	95%	96%	94%	95%	3		
		5.40	Infection Control Training (eLearning)	185%	<80%	80-85%	85%	76%	86%	87%	87%	87%	88%	88%	88%	88%	90%	90%	88%	83%	88%	3		
		5.41	Manual Handling Training (Patient)	80%	<75%	75-80%	80%	78%	77%	78%	80%	82%	80%	79%	81%	83%	84%	83%	83%	80%	82%	3		
		5.42	Manual Handling Training (Non Patient)	80%	<75%	75-80%	80%	87%	71%	75%	86%	87%	84%	83%	81%	81%	83%	83%	82%	86%	82%	3		
		5.43	Staff Adult Safeguarding Training	80%	<75%	75-80%	80%	87%	87%	87%	87%	86%	87%	88%	88%	89%	90%	90%	89%	89%	89%	3		
		5.44	Safeguarding Children Level 1	90%	<75%	75-90%	90%	86%	87%	86%	87%	86%	87%	86%	86%	86%	87%	88%	87%	86%	87%	2		
		5.45	Safeguarding Children Level 2	90%	<75%	75-90%	90%	87%	86%	85%	86%	86%	87%	87%	87%	88%	90%	90%	87%	88%	88%	2		
		5.46	Safeguarding Children Level 3	90%	<75%	75-90%	90%	75%	80%	83%	81%	81%	79%	78%	85%	83%	81%	81%	76%	73%	80%	2		
		5.47	Health & Safety Training	80%	<75%	75-80%	80%	88%	86%	86%	87%	86%	87%	88%	88%	89%	89%	89%	89%	89%	89%	3		
		5.48	Security Awareness Training	80%	<75%	75-80%	80%	86%	86%	87%	87%	87%	87%	88%	88%	89%	90%	90%	89%	89%	89%	3		
		5.49	Conflict Resolution Training (eLearning)	80%	<75%	75-80%	80%	75%	76%	77%	76%	77%	81%	83%	81%	83%	85%	86%	80%	80%	82%	3		
		5.50	Conflict Resolution Training	180%	<75%	75-80%	80%	75%	73%	73%	74%	74%	74%	75%	75%	75%	77%	77%	76%	75%	76%	2		
		5.51	Fire Training (eLearning)	280%	<75%	75-80%	80%	87%	86%	87%	87%	86%	86%	85%	85%	86%	87%	87%	85%	85%	86%	3		
		5.52	Fire Training (classroom)	80%	<75%	75-80%	80%	87%	88%	88%	89%	89%	89%	89%	90%	90%	90%	90%	90%	89%	90%	3		
		5.53	IG Training	80%	<75%	75-80%	80%	76%	80%	81%	82%	82%	82%	82%	80%	81%	85%	84%	85%	84%	83%	3		
		5.54	Equality and Diversity	80%	<75%	75-80%	80%	90%	90%	91%	91%	91%	92%	93%	93%	94%	95%	95%	93%	92%	93%	3		
		5.55	Majax Training	80%	<75%	75-80%	80%	84%	85%	85%	85%	85%	86%	86%	86%	86%	88%	88%	87%	86%	87%	3		
		5.56	Medicines Management Training	80%	<75%	75-80%	80%	86%	86%	85%	85%	85%	86%	87%	87%	87%	88%	88%	87%	87%	87%	3		
		5.57	Slips, trips and falls Training	80%	<75%	75-80%	80%	84%	83%	83%	83%	82%	84%	85%	84%	85%	87%	87%	85%	85%	85%	3		
		5.58	Blood-borne Viruses/Inoculation Incidents	80%	<75%	75-80%	80%	82%	82%	82%	82%	81%	84%	85%	84%	84%	86%	86%	84%	84%	85%	3		
		5.59	Basic life support training (adult)	80%	<75%	75-80%	80%	82%	78%	78%	81%	81%	80%	81%	83%	85%	85%	85%	84%	82%	84%	3		
		5.60	Blood Products & Transfusion Processes (Refresher)	80%	<75%	75-80%	80%	69%	75%	77%	77%	76%	78%	80%	80%	82%	83%	82%	79%	79%	81%	3		

EXCEPTION REPORTS – WELL LED

The Trust has set a target of no more than 3.5% of sickness across all staff groups. Performance is consistently just above this threshold, but the Trust performs well against national and peer group levels.



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Sickness
Standard	4%
Name	Jan Bloomfield
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Well Led
National Rank	28th best

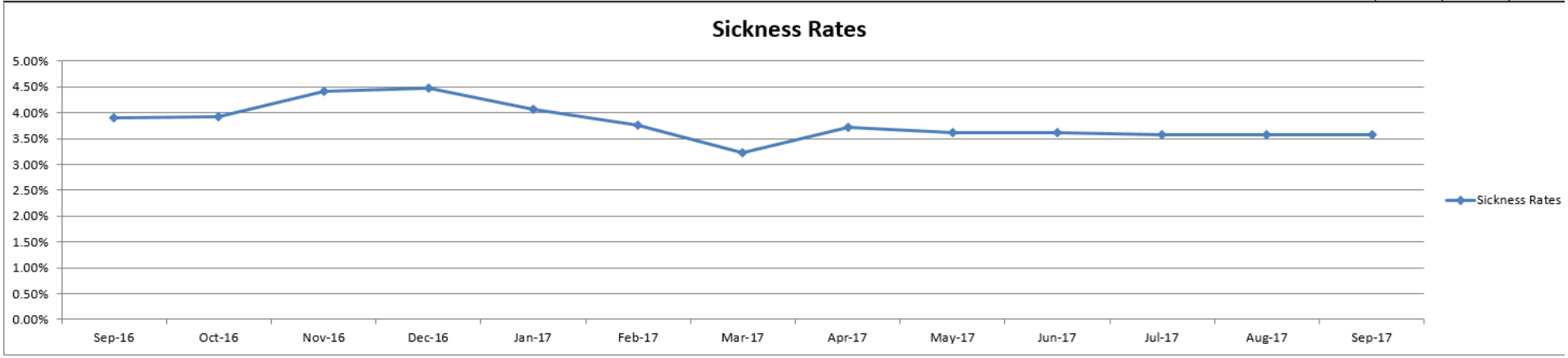
Background

The September position shows sickness rates at 3.58% against the 3.5% target. The tRust has seen a general redcution in sickness levels ove the last 12 months.

Trend												Recovery Trajectory									
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Sickness Rates	3.91%	3.93%	4.41%	4.48%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%								

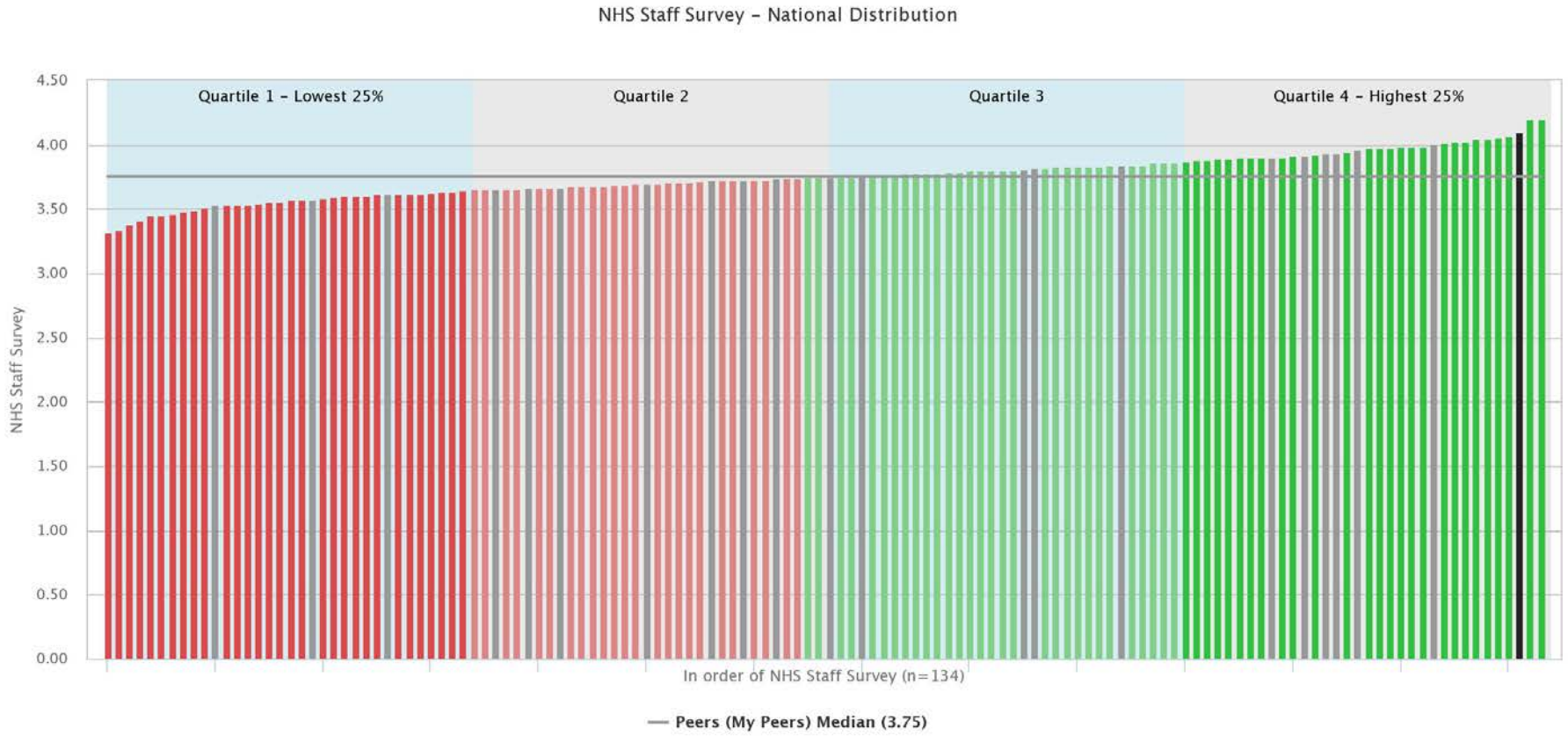
Key Recovery Actions

Description	Owner	Start	End
Sickness absence rate is 0.08% above target. Managers continue to be supported in the management of both long term and short term absences.	JB	Apr-17	Mar-18



Staff F&FT

The Trust performance for staff recommending West Suffolk as a place to work and be cared for remains very high, with performance in the top 3 Trusts in England.



DETAILED REPORTS – PRODUCTIVE

Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	ED	Target	R	A	G	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	YTD	WTG	Traffic	Trend
6. Productive	Dashboard	6.01	I&E Margin	CB	Variable				-3.73%	-3.07%	-2.76%	-3.39%	-4.93%	-5.13%	-5.10%	-1.50%		-5%	-4.3%	-3.9%	0.1%	-3.04%	-3%			
		6.02	Distance from Financial Plan	CB	Variable	>5%	3-5%	<3%										0.0%	0.4%	0.1%	0.0%	0.0%	0.4%	2		
		6.03	Capital service capacity	CB	Variable	<54%	54-61%	>61%		- 0.20	0.25	- 0.65	- 2.59	- 6.74	- 2.81	1.41		- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.88	2		
		6.04	Liquidity (days)	CB		14%	11-14%	<10%		- 6.61	7.78	- 11.30	- 16.45	- 19.70	- 21.76	7.28		- 12.15	- 15.72	- 10.94	- 11.03	- 12.70	- 12.70	2		
		6.05	Long Term Borrowing (£m)	CB	3.5%	>47.8	NT	47.77	25.41	28.76	29.96	30.96	32.06	33.06	36.06	44.30	44.27	45.70	45.70	45.70	45.70	47.62	47.62	6		
		6.06	CIP Plan Variance (£000s) YTD		1.9				-59	-60	-814	-1,826	-2,550	-3,268	-3,247	0	40	0	-40	10	0	-54	-44			
	Activity	6.07	A&E Activity	HB					5517	5439	5554	5100	5308	5064	4740	5570	5355	5705	5688	5885	5572	5743	33948			
		6.08	NEL Activity	HB					2417	2408	2465	2529	2623	2480	2350	2750	2409	2440	2429	2375	2409	2499	14561			
		6.09	OP - New Appointments	HB					7799	8376	7748	8767	7260	7828	7219	8180	6524	7571	7262	6756	6816	6681	41610			
		6.10	OP- Follow-Up Appointments	HB					14002	14695	14272	15709	12729	14703	13971	15684	12566	15218	15383	14679	15067	14487	87400			
		6.11	Electives (Incl Daycase)	HB					2491	2777	2949	3251	2553	2877	2819	3303	2593	3004	2898	2797	2829	2779	16900			
	Finance	6.13	Agency Rating (spend £000)						745	618	619	521	464	512	420	320	307	323	292	371	210	320	1823			
		6.14	Financial Position (YTD)		Variable				3927	3868	4048	5686	9228	10649	11736	3327	-937	-2906	-2758	-3290	-3300	-3953	-3290			
		6.15	Financial Stability Risk Rating		Variable				3	3	3	3	4	4	4	3	3	3	3	3	3	3	3			
		6.16	Cash Position (YTD £000s)		Variable				5162	8186	6843	4539	4302	3598	1538	1352	7,955	5093	2689	7460	3300	4846	4846			
	Ratios	6.17	% Consultant to Consultant Referrals						ND	ND	ND	ND	ND	ND	ND	ND	10%	10%	10%	12%	13%	10%	10.8%			
		6.18	New to FU Ratios		1.9				1.95	1.98	2.08	2.01	2.15	2.11	2.12	2.07	1.86	1.87	1.88	1.96	2.01	1.97	1.93			
		6.19	NHS Supply Chain Costs																							
		6.20	Non-Clinical Floor Space		<35%	>40%	35-40%	<35%								29%	31%	31%	31%	31%	31%	31%	31%	3		
		6.21	Unoccupied Floor Space		<2.5%				0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	CIPs	6.22	Plan (£000s) YTD		Variable				3,236	3,842	5,256	6,700	8,019	9,554	10,912	12,500	840	1000	820	810	1420	1094	5984			
		6.23	Actual (£000s) YTD						3,177	3,782	4,442	4,874	5,469	6,286	7,665	12,500	880	1000	780	820	1420	1040	5940			
																								15	out of	27

EXCEPTION REPORTS – PRODUCTIVE

There are no exceptions to report to the Board. The finance report contains full details.

MATERNITY

	Are we..	Ref.	KPI	ED	Target	R	A	G	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	YTD	WTG	Traffic	Trend
Maternity	Dashboard	7.01	Total number of deliveries at WSFT		210	>250, <200	>216, <208	208-216	213	224	219	195	234	198	197	238	215	192	213	215	233	236	1304	6		
		7.02	% of all caesarean sections		<22.7%	>22.6%		<22.6%	19%	23%	21%	18%	19%	16%	13%	19%	15%	21%	16%	16%	22%	18.22%	18%	6		
		7.03	Midwife to birth ratio		1.30	>=1:32	1:30-32	<=1:30	1.29	1.29	1.29	1.28	ND	1.28	1.28	1.33	1.30	1.27	1.29	1.30	1.33	1.33	1.30	6		
		7.04	Unit Closures		0	NT	NT	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		7.05	Completion of WHO checklist		100%	<=90%	90-99%	100%	77%	90%	95%	82%	96%	93%	87%	89%	84%	93%	84%	94%	82%	98%	89%	2		
		7.06	Maternity SIs		NT	NT	NT	NT	1	1	2	0	3	0	1	1	1	0	0	0	0	1	2			
		7.07	Maternity Never Events		NT	NT	NT	NT	0	0	0	1	0	0	0	0	0	0	0	0	0	0	-			
		7.08	Breastfeeding Initiation Rates		80%	<75%	75-80%	>80%	74%	80%	82%	80%	80%	74%	80%	76%	80%	81%	88%	77%	85%	79%	81%	6		
	Safe	7.09	Elective Caesarean Sections		10%	13%+	10-12%	<10%	9%	9%	5%	6%	7%	8%	5%	7%	5%	10%	4%	7%	9%	6%	7%	3		
		7.10	Emergency Caesarean Sections		<13%	15%+	12-14%	<12%	10%	14%	15%	12%	12%	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	3		
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)		100%	<=95%	96-99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)		80%	<=75%	76-79%	80%	85%	82%	90%	93%	81%	71%	70%	89%	92%	93%	93%	83%	57%	82%	83%	3		
		7.13	Number of Midwives																							
		7.14	Homebirths		2%	<1%	1-2.5%	2.5%+	3%	3%	3%	4%	ND	2%	3%	2%	1%	4%	2%	3%	3%	2.10%	3%	3		
		7.15	Midwifery led birthing unit (MLBU) births		>13%	<=10%	10-13%	13%+	16%	23%	18%	17%	21%	24%	19%	16%	18%	17%	17%	19%	16%	15.30%	17%	3		
		7.16	Labour Suite births		75%	<=64%	64-74%	75%+	80%	75%	80%	79%	76%	74%	78%	82%	81%	79%	80%	78%	82%	82.60%	80%	3		
		7.17	Induction of Labour		NT				33%	25%	37%	34%	34%	34%	36%	37%	43%	41%	41%	37%	38%	34%	39.0%			
		7.18	Instrument Assisted Deliveries (Forceps and VentoUse)		NT				6%	5%	3.85%	6.25%	4.35%	4.60%	4.85%	6.20%	4.45%	6.80%	4.85%	4.20%	3%	5%	5%			
		7.19	Critical Care Obstetric Admissions		0	>1	1	0	0	0	0	0	0	0	0	1	1	1	0	1	0	1	4	2		
		7.20	Eclampsia		0	>1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	3		
	Effective	7.21	Shoulder Dystocia		2	5+	3-4	2 less	4	7	6	5	7	3	2	8	2	4	3	5	3	7	24	2		
		7.22	Post-partum Hysterectomies		0	>1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	2		
		7.23	Women requiring a blood transfusion of 4 units or more		0	>1	1	0	0	0	ND	ND	ND	ND	0	ND	1	0	0	0	0	0	1	2		
		7.24	3rd and 4th degree tears (all deliveries)		12	10	7-9	7	6	11	9	7	4	5	4	7	8	9	6	10	4	4	41	2		
	Caring	7.25	Maternal death		NT				0	0	0	0	0	0	0	1	1	0	0	0	0	0	1			
		7.26	Stillbirths		NT				0	1	2	0	3	0	1	0	1	0	0	0	0	1	2			
		7.27	Complaints						1	5	0	0	1	0	0	0	0	0	1	2	1	0	4			
		7.28	No. of babies admitted to Neonatal Unit (>36+6)		NT				14	17	12	16	20	8	8	0	15	9	17	18	13	15	87			
	Responsive	7.29	No. of babies transferred for therapeutic cooling		0	1+	NT	0	0	0	0	1	0	1	1	1	0	0	0	0	0	0	0	3		
		7.30	% of babies admitted to NNU with normal temperature		80%	<60%	60-80%	>80%	100%	94%	100%	100%	100%	100%	100%	100%	87%	66%	88%	100%	100%	86%	88%	3		
		7.31	One to one care in established labour		100%	<=95%	96-99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		7.32	Reported Clinical Incidents		60	<40	40-60	>60	67	67	68	54	48	54	49	64	51	62	46	64	43	52	318	2		
		7.33	Hours of dedicated consultant cover per week		60	<40	40-60	>60	60	60	60	60	75	63	81	60	93	110	99	99	96	99	596	3		
		7.34	Consultant Anaesthetists sessions on Labour Suite		10	<9	9-10	=>10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	60	3		
		7.35	OPD cover for Theatre 2		100%	<98%	98-100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		7.36	No. of women identified as smoking at booking		NA				ND	ND	ND	ND	ND				27	35	37	32	30	37	198			
		7.37	No. of women identified as smoking at delivery		NT				ND	ND	ND	ND	ND				20	30	26	32	27	25	160			
		7.38	UNICEF Baby friendly audits		NT				ND	ND	24	26	10	10	10	10	10	10	10+	10+	10+	ND	20			
		7.39	No. of parents receiving a Safer Sleeping Suffolk Thermometer		NT				ND	ND	49	108	ND	156	157	165	143	170	174	205	155	192	1039			
	Other	7.40	No. of bookings (First visit)		NA	NA	NA	NA	252	272	254	255	226	262	247	275	208	262	244	272	245	265	1496			
		7.41	Access - Assessment of need by 12w		95%	<90%	90-95%	95%+	95%	94%	97%	97%	95%	93%	95%	96%	95%	95%	98%	95%	100%	92.83%	96%	3		
		7.42	Return of women with perinatal problems						ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	0			
		7.43	Female Genital Mutilation (FGM)		NT				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
																								83	out of	93

EXCEPTION REPORTS - MATERNITY

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity WHO Checklist
Standard	100%
Name	Rowan Procter
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Maternity WHO Checklist
National Rank	

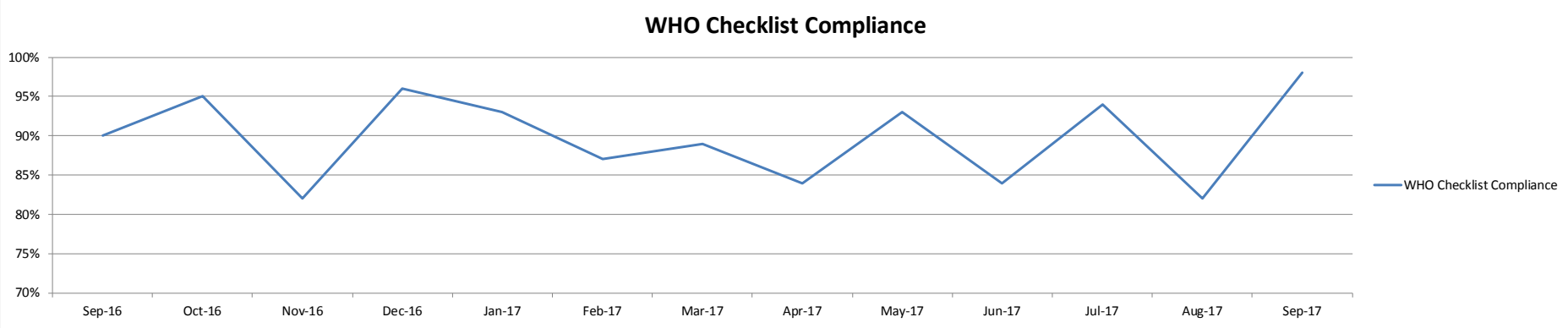
Background

The maternity service achieved 98% compliance with completion of WHO checklists in September 2017.

Trend												Recovery Trajectory									
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
WHO Checklist Compliance	90%	95%	82%	96%	93%	87%	89%	84%	93%	84%	94%	82%	98%								

Key Recovery Actions

Description	Owner	Start	End
The service has now introduced a daily monitoring and the achievement for the month to date is highlighted at each staff handover on Labour Suite.	RP	Apr-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

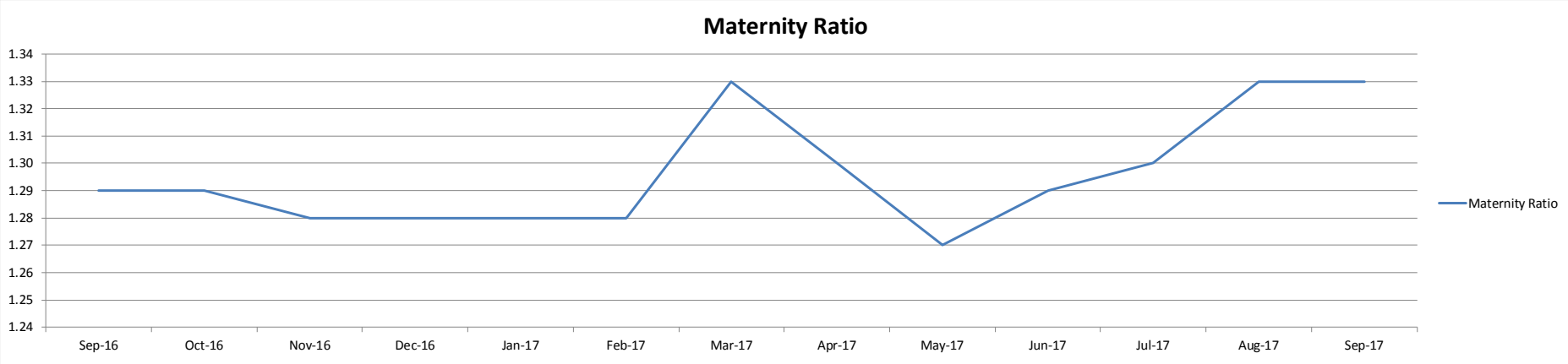
Indicator	Maternity Ratio
Standard	1:30 Ratio
Name	Rowan Procter
Month	01-Sep-17
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

Background

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

Trend												Recovery Trajectory									
Indicator	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Maternity Ratio	1.29	1.29	1.28	1.28	1.28	1.28	1.33	1.30	1.27	1.29	1.30	1.33	1.33								

Key Recovery Actions			
Description	Owner	Start	End
All women who delivered in September 2017 received one to one care in labour; however there was an increased use of the escalation processes.	RS	Jul-17	Nov-17



COMMUNTY INFORMATION

The Community dashboard is being developed by the consortium, and will be added when available. The current report is included in the current Qulaity and Performance Report.

APPENDIX 1: INDICATOR CHANGES

Comparison of KPI changes from the existing Performance Report

New Indicators	* CQC Indicator
Safe	
1.01	NHS E / I Patient Safety Alerts - Total
1.02	NHS E / I Patient Safety Alerts outstanding*
1.08	Never Events*
1.21	RIDDOR Reportable Incidents
1.29	Actual patient harm resulting from medication incidents
1.47	Severity of NRLS (or median NRLS upload 6 mths RA)
Effective	
2.03	Emergency Re-admissions within 30d*
2.05	OP Clinic Utilisation Rate
2.06	OP Clinic Productivity Rate
2.07	Theatre Utilisation Rate
2.08	Theatre Productivity Rate
2.15	CAS (central alerts system) alerts overdue
2.16	Pathology & Imaging BMs

2.16	Pathology & Imaging BMs
2.17	WHO Checklist (Qrtly)
2.19	No of ward days with Norovirus
2.20	Number of Black Alerts
2.21	Delayed Transfers of Care (DTOCs)
2.22	Av. Elective LOS (exl. 0 days)
2.23	Av NEL LOS (exl 0 days)
2.24	% of NEL 0 day LOS
2.25	NHS number coding
2.26	Fractured Neck of Femur : Surgery in 36 hours
2.27	Proportion of patients discharged to pre-admission address
2.32	All Cancer 2ww services available on C&B
Caring	
3.01	Compliments*
3.16	FFT - Maternity - overall
3.17	Maternity - post natal ward recommendation to F&F
3.18	Maternity - birthing unit recommendation to F&F
3.19	Maternity -antenatal community care rec. to F&F
3.20	Maternity -post-natal community care rec. to F&F
3.34	ITU Wardable patients
3.35	ITU Wardable patients over xx hours
3.36	Certification against compliance with requirements regarding access to healthcare for people with a learning disability
3.37	Ward Cleanliness - Patient Satisfaction Overall*
3.38	Catering - Patient Satisfaction with food - overall
Responsive	
4.12	Incomplete cancer 104 day waits*
4.13	Flow: % of Ambulance handover to ED within 15m
4.14	Flow: % of clinical assessments started within 30m

4.15	Flow: % clinically streamed to an alternative service
4.16	Flow: % MH needs assessed by MH team within 60m
4.18	Flow: % Emergency Admissions with care plan within 14hrs
4.19	Flow: % High Risk Emergency Admissions with care plan within 4hrs
4.20	Flow: % of discharges before midday
4.16	A&E - To inpatient Admission Ratio
4.16	A&E - Admission waiting 4-12 hours from dec. to admit*
4.24	RTT waiting List*
4.25	RTT waiting list over 18 weeks*
4.37	Sepsis - 1 hr neutropenic sepsis
Well Led	Some of these may be included in separate reports
5.01	NHS Staff Survey (Staff Engagement score -Annual)*
5.02	Staff F&F Test % Recommended - care (Qrtly)
5.03	Staff F&F Test % Recommended - place to work (Qrtly)
5.06	Executive Team Turnover
5.08	Monitor Assurance Governance Rating
5.12	Proportion of Temporary Staff
5.14	Total Vacancies
5.15	Corporate & Admin Costs as %
5.16	% Staff on Maternity/Paternity Leave
5.17	% Fill rate of Reg. Nurse shifts
5.20	% staff completing the staff survey
5.21	% use of Core First (Qtrly)
5.22	Delivering Workforce Race Equality Stds
5.27	Staff appraisal Rates (From Sept 17)
5.28	CHPPD (Care Hours Per Patient Day)
5.29	Flu Uptake Rates*
5.31	Infection Control Training
5.32	Manual Handling Training (Patient)

5.33	Manual Handling Training (Non Patient)
5.34	Staff Adult Safeguarding Training
5.35	Safeguarding Children Level 1 - 3 Years
5.36	Safeguarding Children Level 2
5.37	Safeguarding Children Level 3 - 1 Year
5.38	Health & Safety Training
5.39	Security Awareness Training
5.40	Conflict Resolution Training
5.41	Fire Training
5.42	IG Training
5.43	Equality and Diversity
5.44	Majax Training
5.45	Medicines Management Training
5.46	Slips, trips and falls Training
5.47	Blood Borne Viruses/Inoculation Incidents
5.48	Basic life support training
5.49	Blood Products & Transfusion Processes (Refresher)
Productive	
6.06	A&E Activity
6.07	NEL Activity
6.08	OP First Appointments
6.09	OP Follow Up Appointments
6.10	Day Cases
6.11	Electives
6.18	NHS Supply Chain Costs
6.19	Non Clinical Floor Space
6.20	Unoccupied Floor Space
Maternity	
7.13	Number of midwives*

KPIs REMOVED

Maternity (Mainly due to no data and/or no targets)

Total Women Delivered
Twins
Vaginal breach deliveries
Non-operative vaginal deliveries
Water births
Forceps delivery
Ventouse deliveries
Failed instrument delivery
Unsuccessful trial of Instrumental Delivery
Use of sequential instruments
Total no. of women eligible for Vaginal birth after Caesarean section (VBAC)
Postpartum Haemorrhage 1000-2000 mls
Postpartum Haemorrhage 2000-2499 mls
Postpartum Haemorrhage 2500+ mls
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)
4th and 4th degree tears (Instrumental Deliveries) - *But 3rd and 4th tears - All vaginal deliveries remain*
Cases of Meconium aspiration
Cases of hypoxia
Massive Obstetric Haemorrhage protocol
Maternal Postnatal readmissions
Babies assessed as needing BCG Vaccine
Babies who receive BCG vaccine following assessment

APPENDIX 2: PEER HOSPITAL LIST USED BY CQC

Airedale NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Bedford Hospital NHS Trust
Burton Hospitals NHS Foundation Trust
Dartford and Gravesham NHS Trust
Dorset County Hospital NHS Foundation Trust
East Cheshire NHS Trust
George Eliot Hospital NHS Trust
Harrogate and District NHS Foundation Trust
Hinchingbrooke Health Care NHS Trust
Homerton University Hospital NHS Foundation Trust
Isle of Wight NHS Trust
Kettering General Hospital NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northern Devon Healthcare NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Salisbury NHS Foundation Trust
South Tyneside NHS Foundation Trust
Tameside and Glossop Integrated Care NHS Foundation Trust
West Suffolk NHS Foundation Trust
Weston Area Health NHS Trust
Wye Valley NHS Trust
Yeovil District Hospital NHS Foundation Trust
West Suffolk NHS Foundation Trust

							Surgery								
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED
Patient Experience: in-patient	QR-PEI-10	Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	87	97	98	98	NA	NA	NA	NA	NA
	QR-PEI-180	(In-patient) How likely is it that you would recommend the service to friends and family?	= 95%	<70	70-89	90-100	100	98.81	100	100	NA	NA	NA	NA	NA
	QR-PEI-20	In your opinion, how clean was the hospital room or ward that you are in?	= 85%	<75	75-84	85-100	99	100	99	100	NA	NA	NA	NA	NA
	QR-PEI-340	Did you feel you were treated with respect and dignity by staff?	= 85%	<75	75-84	85-100	100	100	99	100	NA	NA	NA	NA	NA
	QR-PEI-330	Were Staff caring and compassionate in their approach?	= 85%	<75	75-84	85-100	100	100	99	100	NA	NA	NA	NA	NA
	QR-PEI-30	Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	14	99	87	88	NA	NA	NA	NA	NA
	QR-PEI-70	(In-patient) Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<75	75-84	85-100	97	100	100	100	NA	NA	NA	NA	NA
	QR-PEI-80	Were you involved as much as you wanted to be in decisions about your condition and treatment?	= 85%	<75	75-84	85-100	97	100	100	100	NA	NA	NA	NA	NA
	QR-PEI-90	Did staff talk in front of you as if you were not there?	= 85%	<75	75-84	85-100	97	100	98	100	NA	NA	NA	NA	NA
	QR-PEI-350	Were you given enough privacy when discussing your care?	= 85%	<75	75-84	85-100	100	100	100	100	NA	NA	NA	NA	NA
	QR-PEI-100	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	65	0	99	100	NA	NA	NA	NA	NA
		(In-patient) Were you given enough privacy when being examined or treated?	= 85%	<76	75-85	85-101	100	100	100	100	NA	NA	NA	NA	NA
	QR-PEI-150	Timely call bell response	= 85%	<75	75-84	85-100	43	69	89	80	NA	NA	NA	NA	NA
	QR-PEI-290	Same sex accommodation: total patients	= 0	>2	1-2	= 0	0	0	0	0	0	0	0	0	0
	QR-PEI-300	Complaints	= 0	>2	1-2	= 0	0	0	0	1	0	0	0	0	3
	QR-PEI-310	Environment and Cleanliness	= 90%	<80	80-89	90-100	94	93	93	96	95	90	97		89

							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	95
	QR-PES-60	(Short-stay) How likely is it that you would recommend the service to friends and family?	= 95%	<70	70-89	90-100	100	96.67	0	95.74
	QR-PES-20	(Short-stay) Were you given enough privacy when being examined and treated?	= 85%	<75	75-84	85-100	100	100	0	98
	QR-PES-30	(Short-stay) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	100	100	0	99
	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	86
	QR-PES-50	(Short-stay) Overall how would you rate the care you received in the department?	= 85%	<75	75-84	85-100	100	100	0	95
	QR-PES-70	Number of short stay surveys completed	No Target	No Target	No Target	No Target	107	30	0	47

							Medicine
Group		Indicator	Target	Red	Amber	Green	ED
Patient Experience: A&E	QR-PEA-10	Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	94
	QR-PEA-100	(A&E) How likely is it that you would recommend the service to friends and family?	= 95%	<70	70-89	90-100	92.33
	QR-PEA-30	Were A&E staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	98
	QR-PEA-110	Were you given enough privacy when discussing your condition at reception?	= 85%	<75	75-84	85-100	98
	QR-PEA-120	Did Doctors and Nurses listen to what you had to say?	= 85%	<75	75-84	85-100	98
	QR-PEA-130	Did staff tell you who to contact if you were worried about your condition after leaving A&E?	= 85%	<75	75-84	85-100	89
	QR-PEA-80	Did a member of staff tell you what danger signs to watch for when going home?	= 85%	<75	75-84	85-100	85
	QR-PEA-140	Number of A&E surveys completed	No Target	No Target	No Target	No Target	587

							Medicine
Group		Indicator	Target	Red	Amber	Green	ED
	QR-PEAC-70	Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	na
	QR-PEAC-80	(A&E Children) How likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	na

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

							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	na
	QR-PEM-120	How likely is it that you would recommend the post-natal ward to friends and family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	na
	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	na
	QR-PEM-140	How likely are you to recommend our post-natal care to friends and family?	= 75%	<70	70-74	75-100	na
	QR-PEM-30	(Maternity) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	na
	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	na
	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	na
	QR-PEM-60	(Maternity) Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	na
	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	na
	QR-PEM-80	Were you given adequate help and support to feed your baby whilst in hospital?	= 85%	<75	75-84	85-100	na
	QR-PEM-121	Number of maternity surveys completed	No Target	No Target	No Target	No Target	98

							Women & Children
Group		Indicator	Target	Red	Amber	Green	MLBU
Patient Experience: Birthing Unit	QR-PEBU-10	How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	100
	QR-PEBU-20	Did you feel that your community midwife gave you sufficient information about the birthing unit prior to you being referred?	= 85%	<75	75-84	85-100	na
	QR-PEBU-40	If you phoned for advice prior to admission to the birthing unit did you feel that the advice given to you was useful and appropriate?	= 85%	<75	75-84	85-100	0
	QR-PEBU-50	Do you feel that the 'home from home' environment had a positive effect on your birthing experience?	= 85%	<75	75-84	85-100	0
	QR-PEBU-60	Did you have confidence and trust in the midwives caring for you during labour?	= 85%	<75	75-84	85-100	0
	QR-PEBU-70	Were your birthing partners made to feel welcome by the midwives on the birthing unit?	= 85%	<75	75-84	85-100	0
	QR-PEBU-80	Were you at any time left alone by your midwife at a time when you felt worried?	= 85%	<75	75-84	85-100	0
	QR-PEBU-90	Thinking about your care during labour and birth, were you involved in the decisions about your care?	= 85%	<75	75-84	85-100	0
	QR-PEBU-100	Overall how would you rate the care you received on the MLBU during your labour and birth?	= 85%	<75	75-84	85-100	0
	QR-PEBU-110	Number of birthing unit surveys completed	No Target	No Target	No Target	No Target	6

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
Patient Satisfaction : Young Children	QR-PEYC-120	Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	na
	QR-PEYC-110	(Young children) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	100
	QR-PEYC-20	Did you understand the information given to you regarding your treatment and care?	= 85%	<75	75-84	85-100	NA
	QR-PEYC-10	Were you as involved as you wanted to be in decisions about your care and treatment?	= 85%	<75	75-84	85-100	na
	QR-PEYC-140	Did the Doctor or Nurses explain what they were doing in a way that you could understand?	= 85%	<75	75-84	85-100	na
	QR-PEYC-40	Were you offered age/need appropriate activities?	= 85%	<75	75-84	85-100	na
	QR-PEYC-60	Was your experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	75-84	85-100	na
	QR-PEYC-70	Was your experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	na

	QR-PEYC-150	If you were in pain, did the Doctor or Nurse do everything they could to help with the pain?	= 85%	<75	75-84	85-100	na
	QR-PEYC-160	Were staff kind and caring towards you?	= 85%	<75	75-84	85-100	na
	QR-PEYC-90	Is the environment child - friendly?	= 85%	<75	75-84	85-100	na
	QR-PEYC-100	Overall, how would you rate your experience in the Paediatric Unit?	= 85%	<75	75-84	85-100	na
	QR-PEYC-130	Number of young children surveys completed	No Target	No Target	No Target	No Target	11

							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?	= 95%	<70	70-89	90-100	100
	QR-PEF1-20	Did you understand the information given to you regarding your child's treatment and care?	= 85%	<75	75-84	85-100	88
	QR-PEF1-10	Were you and your child as involved as you wanted to be in decisions about care and treatment?	= 85%	<75	75-84	85-100	100
	QR-PEF1-130	Did the Doctor or Nurses explain what they were doing in a way that your child could understand?	= 85%	<75	75-84	85-100	100
	QR-PEF1-40	Were there appropriate play activities for your child (such as toys, games and books)?	= 85%	<75	75-84	85-100	98
	QR-PEF1-60	Was your child's experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	75-84	85-100	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	100
	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	98
	QR-PEF1-140	Were staff kind and caring towards your child?	= 85%	<75	75-84	85-100	100
	QR-PEF1-90	Is the environment child-friendly?	= 85%	<75	75-84	85-100	100
	QR-PEF1-100	Overall, how would you rate your experience in the Children's Unit?	= 85%	<75	75-84	85-100	100
	QR-PEF1-160	Number of F1 parent surveys completed	No Target	No Target	No Target	No Target	23

							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	99
	QR-PEST-80	(Stroke) How likely is it that you would recommend the service to friends and family?	= 95%	<80	70-89	90-100	95.35
	QR-PEST-20	In your opinion, how clean was the hospital room or ward you were in?	= 85%	<75	75-84	85-100	99
	QR-PEST-30	Did you feel you were treated with respect and dignity by staff?	= 85%	<75	75-84	85-100	99
		Were staff caring and compassionate in their approach?	= 85%	<76	75-85	85-101	99
		Have you been told you have had a stroke, which lead to your admission to hospital?	= 85%	<77	75-86	85-102	100
		Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<78	75-87	85-103	100
		Were you involved as much as you wanted to be in planning your recovery /rehabilitation?	= 85%	<79	75-88	85-104	98
	QR-PEST-40	Were you given enough privacy when discussing your condition or treatment?	= 85%	<75	75-84	85-100	98
	QR-PEST-50	Were you gicen enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	100
	QR-PEST-60	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	100
	QR-PEST-70	While you were in the Stroke Department, how much information about your condition or treatment was given to you?	= 85%	<75	75-84	85-100	95
	QR-PEST-90	Number of stroke surveys completed	No Target	No Target	No Target	No Target	43

Medicine													Women & Children			
CCU	G5	F9	F10	G1	G3	G4	G8	MTU	F12	G9	F7	F8	F1	F11	F14	MLBU
98	83	91	98	92	89	83	NA	NA	95	na	na	na	NA	NA	97	NA
100	94.12	96.43	100	100	90.63	100	NA	NA	100	na	na	na	NA	NA	100	NA
100	98	100	95	94	95	100	NA	NA	100	na	na	na	NA	NA	95	NA
100	91	97	100	97	97	90	NA	NA	100	na	na	na	NA	NA	100	NA
100	91	90	100	100	93	90	NA	NA	100	na	na	na	NA	NA	98	NA
88	86	79	100	92	40	25	NA	NA	75	na	na	na	NA	NA	100	NA
100	100	98	100	100	91	0	NA	NA	100	na	na	na	NA	NA	100	NA
100	85	86	100	94	84	100	NA	NA	93	na	na	na	NA	NA	98	NA
100	74	99	100	94	91	100	NA	NA	93	na	na	na	NA	NA	98	NA
100	100	99	100	100	97	100	NA	NA	93	na	na	na	NA	NA	96	NA
100	25	95	100	0	95	100	NA	NA	100	na	na	na	NA	NA	89	NA
100	100	100	100	100	100	100	NA	NA	100	na	na	na	NA	NA	96	NA
87	49	42	86	74	61	33	NA	NA	79	na	na	na	NA	NA	87	NA
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	1	0	0	0	0	0	2	0	0	0	0	0
		90	87	91	89	93	94	96	96	93	91	91	96	95	93	94

							Surgery								Medicine													Women & Children			
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	G5	F9	F10	G1	G3	G4	G8	MTU	F12	WEW - G9	F7	F8	F1	F11	F14	MLBU
Patient Safety	QR-PS-10	HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	83	NA	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-20	HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	No Data	No Data	100	100	NA	NA	NA	NA	No Data	No Data	100	100	100	100	100	No Data	NA	No Data	No Data	No Data	NA	NA	NA	No Data	NA
	QR-PS-30	HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	No Data	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	No Data	100	NA	NA	NA
	QR-PS-40	HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	100	100	100	100	NA	NA	NA	NA	100	89	100	100	100	100	100	100	NA	100	No Data	NA	NA	100	NA	100	NA
	QR-PS-50	HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	NA	100	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-60	HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	NA	100	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-90	HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-100	HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	100	NA	NA	100	NA	NA	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA
	QR-PS-110	HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	100	100	100	100	NA	NA	NA	NA	NA	No Data	100	100	100	100	100	80	100	NA	100	No Data	NA	NA	NA	NA	80	NA
	QR-PS-111	HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<80	80-99	= 100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-220	Total no of MRSA bacteraemias: Hospital	= 0 per yr	> 0	No Target	= 0	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	No Data	No Data
	QR-PS-400	Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	98	96	100	97	100	No Data	No Data	No Data	No Data	90	39	92	100	100	89	86	86	NA	100	No Data	100	92	No Data	100	100	NA
	QR-PS-250	Hand hygiene compliance	= 95%	<85	85-99	= 100	100	100	No Data	100	100	NA	100	100	64	100	100	100	100	100	100	100	100	100	100	No Data	100	100	100	90	100	100
	QR-PS-230	Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	QR-PS-117	Quarterly Standard principle compliance	90%	<80	80-90%	90-100	92	98	94	100	97	No Data	No Data	No Data	96	100	93	92	94	95	96	94	94	NA	95	No Data	88	98	100	100	100	NA
	QR-PS-240	Total no of C. diff infections: Hospital	= 16 per year	No Target	No Target	No Target	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	QR-PS-290	Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	93	90	88	94	NA	NA	NA	NA	NA	100	95	91	93	94	91	96	100	NA	100	No Data	98	100	100	100	No Data	NA
	QR-PS-440	Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	83	95	91	92	95	100	100	95	82	94	No Data	91	89	94	93	95	93	NA	97	No Data	80	89	100	100	100	NA
	QR-PS-450	Quarterly VIP score documentation	= 90%	<80	80-89	90-100	75	50	93	96	100	No Data	No Data	No Data	No Data	90	71	83	86	100	79	92	73	NA	100	No Data	68	100	75	40	80	NA
	QR-PS-120	No of patient falls	= 48	>=48	No Target	<48	1	2	3	3	0	NA	NA	NA	0	1	6	4	2	1	3	4	5	0	0	0	3	1	NA	0	0	NA
	QR-PS-130	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	0	0	0	0	0	NA	NA	NA	0	1	2	1	2	0	0	1	1	0	0	0	0	1	NA	0	0	NA
	QR-PS-140	No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	0	0	0	0	NA	NA	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	NA	0	0	NA
	QR-PS-470	No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	3	0	0	0	1	NA	NA	NA	NA	0	3	0	0	3	1	1	3	0	0	0	0	0	NA	0	0	NA
	QR-PS-480	No of avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PS-190	Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	100	100	100	100	100	NA	NA	NA	NA	100	78	100	100	100	100	80	50	NA	90	No Data	No Data	No Data	NA	NA	40	NA
	QR-PS-260	No of SIRIs	No Target	No Target	No Target	No Target	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	QR-PS-500	No of medication errors	No Target	No Target	No Target	No Target	8	4	2	4	2	0	0	0	4	0	2	2	3	3	4	6	2	0	2	1	8	3	1	0	0	0
	QR-PS-300	Cardiac arrests	No Target	No Target	No Target	No Target	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	QR-PS-490	Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-340	Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	No Data	No Data	No Data	No Data	NA	NA	NA	NA	NA	NA	No Data	No Data	No Data	No Data	No Data	No Data	No Data	NA	No Data	No Data	No Data	No Data	No Data	No Data	No Data	NA
	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	No Data	No Data
	QR-PS-390	Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	93.94	100	100	100	83.33	No Data	No Data	No Data	No Data	85.71	96.55	100	100	100	93.55	100	96.43	No Data	100	NA	96.97	No Data	No Data	100	100	No Data
Patient Experience: in-patient	QR-PEI-290	Same sex accommodation: total patients	= 0	>2	1-2	= 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

West Suffolk NHS
NHS Foundation Trust

FINANCE AND WORKFORCE REPORT

September 2017 (Month 6)

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

Financial Summary

I&E Position YTD	£4.0m	loss
Variance against plan YTD	-£0.1m	
Movement in month against plan	£0.0m	
EBITDA position YTD	-£0.2m	deficit
EBITDA margin YTD	-0.7%	deficit
Cash at bank	£4,846k	

Executive Summary

- The Month 6 YTD position is £78k behind plan.

Key Risks

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

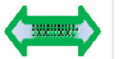
SUMMARY INCOME AND EXPENDITURE ACCOUNT - September 2017	Sep-17 Budget £m	Sep-17 Actual £m	Sep-17 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance £m
NHS Contract Income	20.3	19.7	(0.7)	112.9	112.4	(0.5)	224.7	223.9	(0.9)
Other Income	3.3	3.6	0.4	14.5	16.3	1.7	27.6	30.0	2.4
Total Income	**23.6**	**23.3**	**(0.3)**	**127.4**	**128.6**	**1.2**	**252.3**	**253.9**	**1.5**
Pay Costs	12.0	12.0	0.1	72.5	72.2	0.3	144.8	144.8	0.0
Non-pay Costs	12.1	11.9	0.2	57.9	59.3	(1.4)	110.0	111.6	(1.6)
Operating Expenditure	**24.1**	**23.8**	**0.3**	**130.4**	**131.5**	**(1.1)**	**254.8**	**256.3**	**(1.6)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	2.5	2.5	0.0
EBITDA	**(0.5)**	**(0.5)**	**(0.0)**	**(2.9)**	**(2.9)**	**0.1**	**(5.0)**	**(5.0)**	**(0.0)**
EBITDA margin	(0.7%)	(0.9%)	(0.2%)	(0.9%)	(0.7%)	0.1%	0.1%	0.1%	(0.0%)
Depreciation	0.4	0.3	0.0	2.0	2.1	(0.1)	4.7	4.7	0.0
Finance costs	0.1	0.1	(0.0)	0.8	0.9	(0.1)	1.4	1.4	0.0
SURPLUS/(DEFICIT) pre S&TF	**(1.0)**	**(1.0)**	**(0.0)**	**(5.7)**	**(5.9)**	**(0.2)**	**(11.1)**	**(11.1)**	**(0.0)**
S&T funding - Financial Performance	0.2	0.2	0.0	1.3	1.3	0.1	3.6	3.6	0.0
S&T funding - A&E Performance	0.1	0.1	0.0	0.5	0.6	0.0	1.6	1.6	0.0
SURPLUS/(DEFICIT) incl S&TF	**(0.6)**	**(0.7)**	**(0.0)**	**(3.9)**	**(4.0)**	**(0.1)**	**(5.9)**	**(5.9)**	**(0.0)**

FINANCE AND WORKFORCE REPORT – September 2017

Contents:

Key:

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

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

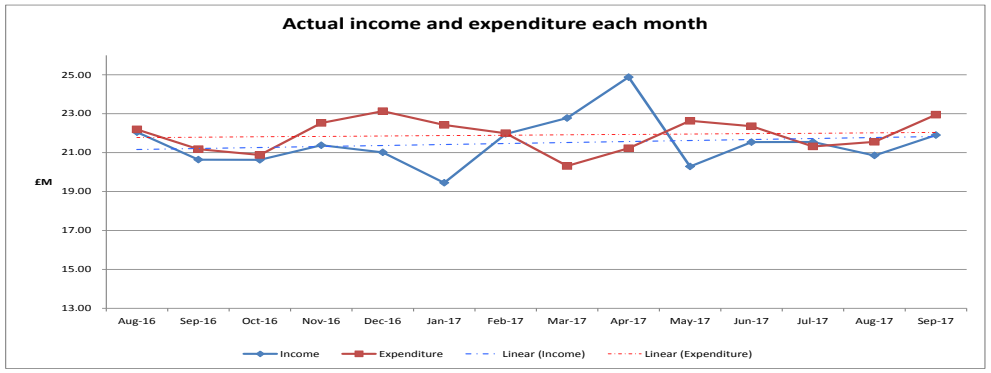
FINANCE AND WORKFORCE REPORT – September 2017

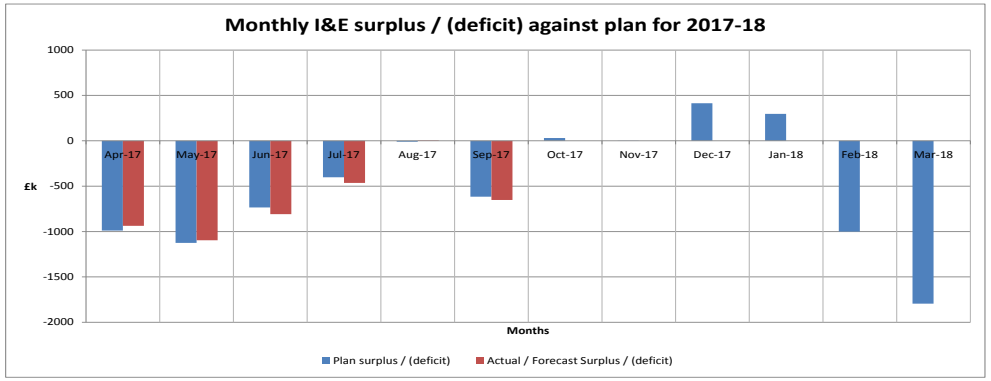
Income and Expenditure summary as at September 2017

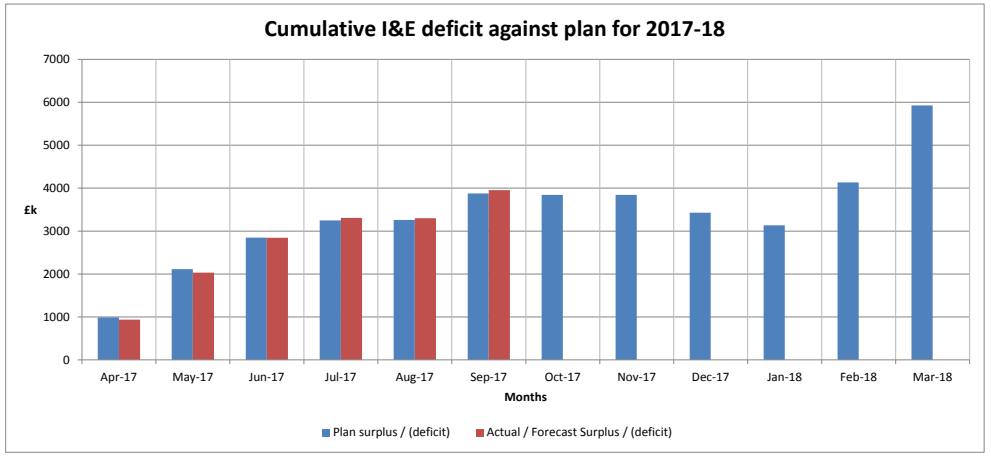
The reported I&E for September 2017 YTD is a deficit of £3,953k, against a planned deficit of £3,875k. This results in an adverse variance of £78k YTD.

Summary of I&E indicators

Income and Expenditure	Plan / target £'000	Actual / forecast £'000	Variance to plan (adv) / fav £'000	Direction of travel (variance)	RAG (report on Red)
In month surplus / (deficit)	(615)	(652)	(37)	↓	Green
YTD surplus / (deficit)	(3,875)	(3,953)	(78)	↓	Green
Forecast surplus / (deficit)	(5,928)	(5,928)	0	↔	Green
EBITDA YTD	(1,120)	(949)	171	↓	Green
EBITDA (%)	(0.9%)	(0.7%)	0.1%	↓	Amber
Use of Resources (UoR) Rating fav / (adv)	3	3	0	↔	Amber
Clinical Income YTD	(112,903)	(112,387)	(516)	↓	Amber
Non-Clinical Income YTD	(16,356)	(18,172)	1,816	↑	Green
Pay YTD	72,477	72,192	286	↑	Green
Non-Pay YTD	60,656	62,320	(1,665)	↑	Amber
CIP target YTD	(5,984)	(5,940)	(44)	↓	Green







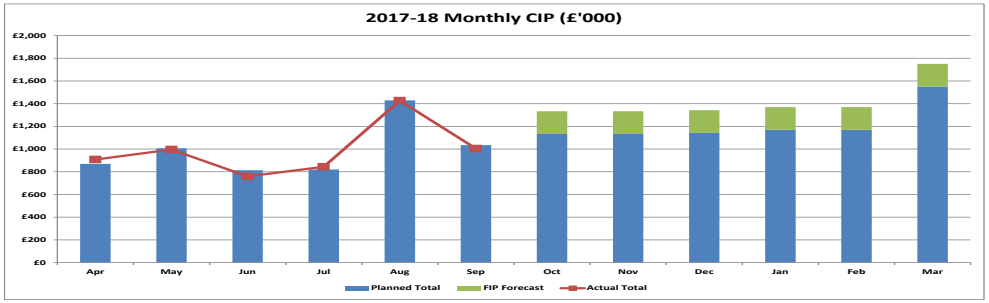
FINANCE AND WORKFORCE REPORT – September 2017

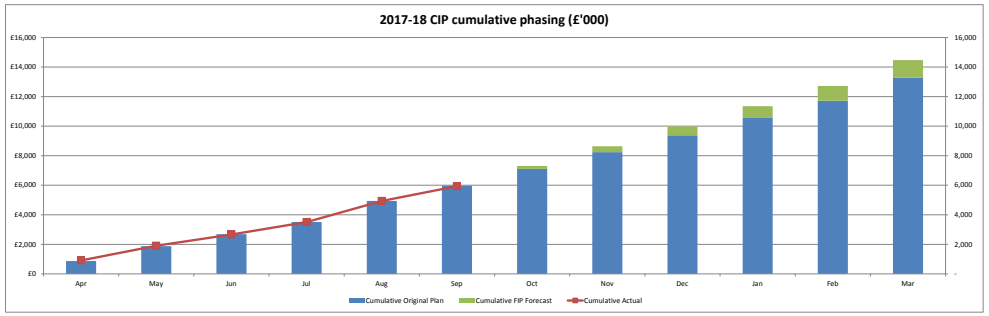
Cost Improvement Programme (CIP)

The September position includes a target of £5,984k YTD which represents 45% of the 2017-18 plan. There is currently a shortfall of £44k YTD against this plan.

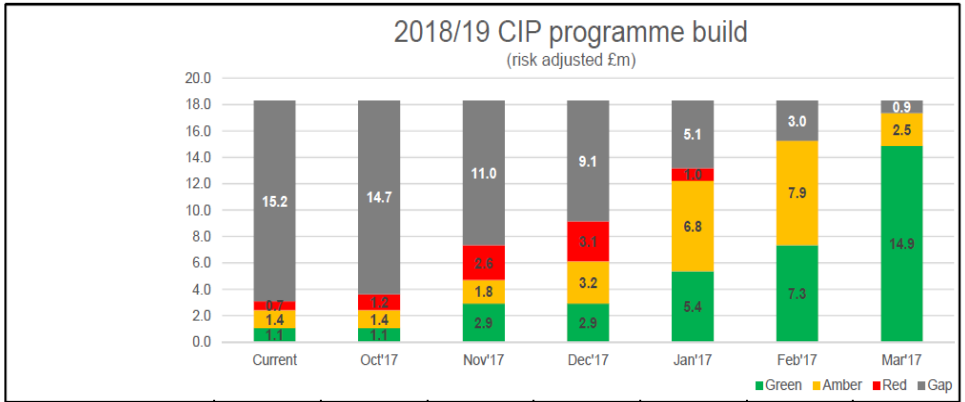
Recurring/Non Recurring	Summary	2017-18 Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Activity growth	297	136	62
	Car Park Income	400	200	157
	Other Income	167	78	70
	Consultant Staffing	326	128	118
	Additional sessions	192	96	50
	Staffing Review	2,722	952	1,347
	Agency	482	241	140
	Procurement	1,801	700	495
	Community Equipment Service	465	200	100
	Contract review	8	3	5
	Drugs	326	72	144
	Capitalisation	480	240	130
	Other	2,025	1,167	1,086
Recurring Total		**9,690**	**4,212**	**3,903**
Non-Recurring	Activity growth	300	300	300
	Other Income	19	10	13
	Additional sessions	10	5	27
	Staffing Review	20	10	-
	Contract review	41	21	21
	Estates and Facilities	389	195	195
	Non-Recurring	396	396	396
	Capitalisation	350	200	300
	Other	403	223	374
	GDE revenue	1,650	413	413
Non-Recurring Total		**3,579**	**1,772**	**2,037**
Grand Total		**13,269**	**5,984**	**5,940**

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





In order to deliver the Trusts pre-STF control total of £7.7m deficit in 2018-19 we need to deliver a CIP of £18.3m (8%). The chart below shows an indicative programme build to deliver this. This assumes it takes two months to move from red to amber and two months from amber to green. It also assumes that 80% of the initial red schemes become amber and 90% of amber schemes become green.



Forecast % (Risk adj)	17%	20%	40%	50%	72%	83%	95%
New red CIPs (non risk adj)	n/a	£2.7m	£10.4m	£4.8m	-	-	-

This programme assumes all schemes are identified by December (albeit at this point their value is risk adjusted down) and the majority are mature by March. This will require significant work over the next six months and progress will be monitored in the TSG.

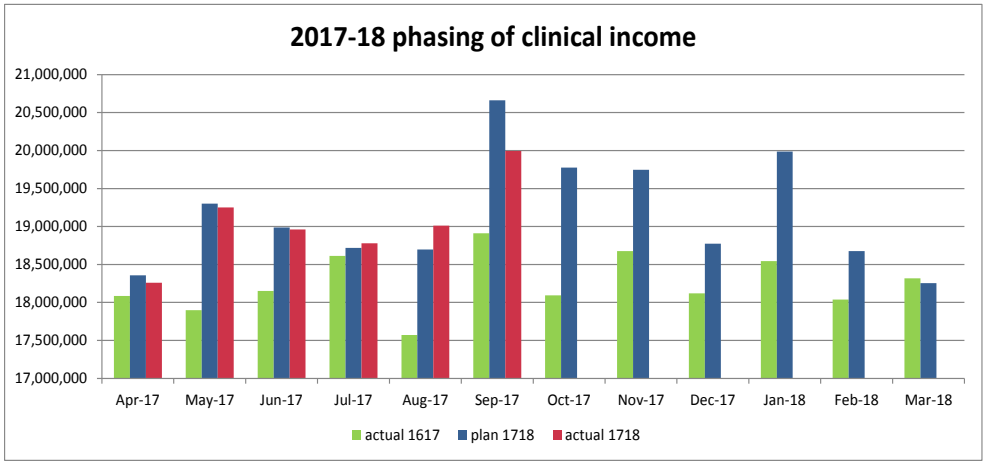
To date we have identified £3.7m of risk adjusted CIP schemes for 2018-19.

FINANCE AND WORKFORCE REPORT – September 2017

Income Analysis

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

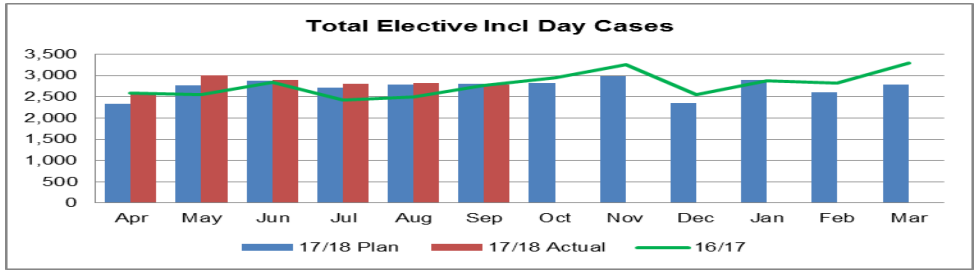
Income earned from within Suffolk is on plan since we have block contracts with Suffolk CCGs for their activity. However, variances can be seen within Divisions with any balances reflected within the Corporate Division.

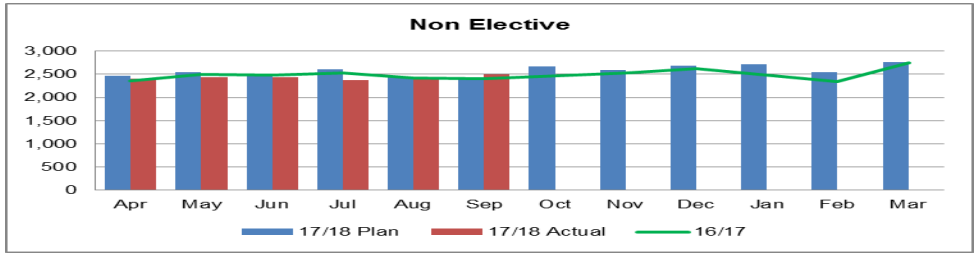


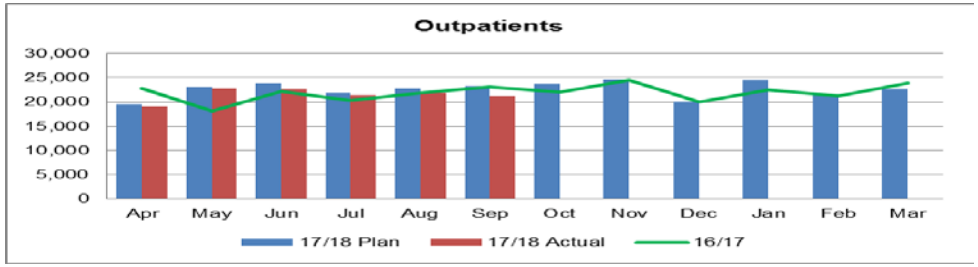
The income position was slightly behind plan in September. Inpatients over performed within the month (Elective and Non Elective), with outpatient being the largest are of underperformance.

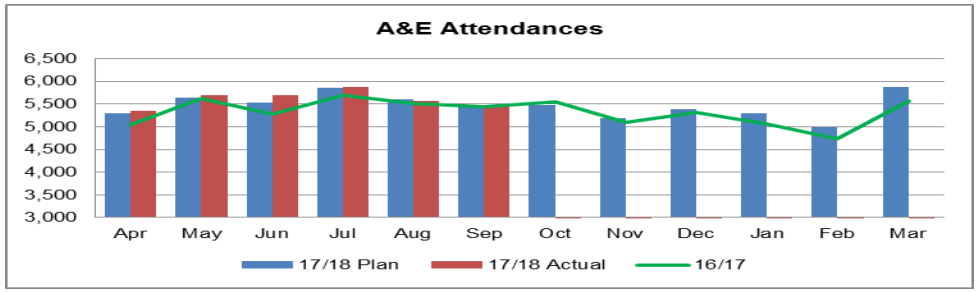
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	676	719	43	4,139	4,308	170
Other Services	3,983	2,953	(1,030)	14,941	12,823	(2,119)
CQUIN	296	306	10	1,778	1,807	29
Elective	2,657	2,816	159	15,555	16,515	961
Non Elective	4,819	5,377	558	29,808	31,327	1,520
Emergency Threshold Adjustment	(284)	(469)	(185)	(1,732)	(2,256)	(524)
Outpatients	2,787	2,569	(218)	16,138	15,586	(552)
Community	5,379	5,379	0	32,276	32,276	0
Total	**20,314**	**19,652**	**(662)**	**112,903**	**112,387**	**(516)**

Activity, by point of delivery









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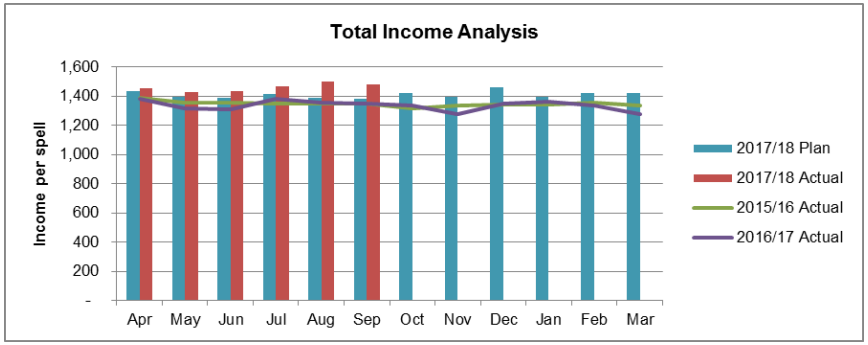
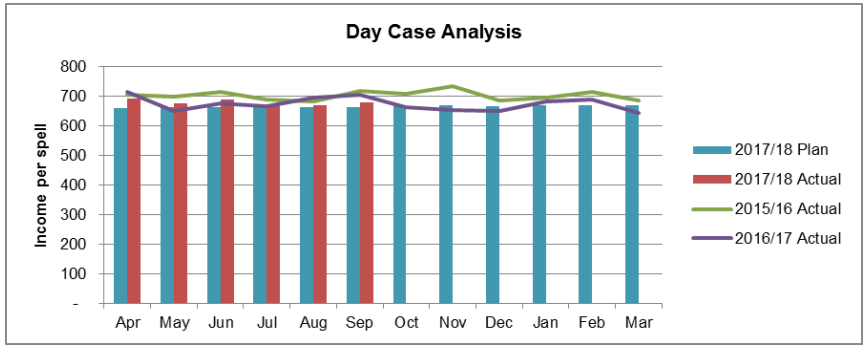
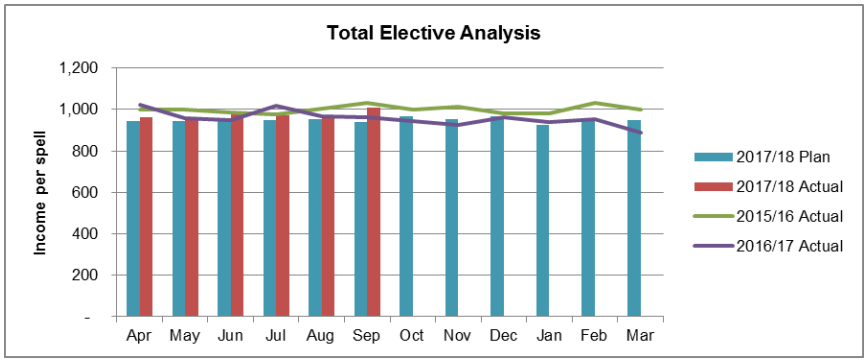
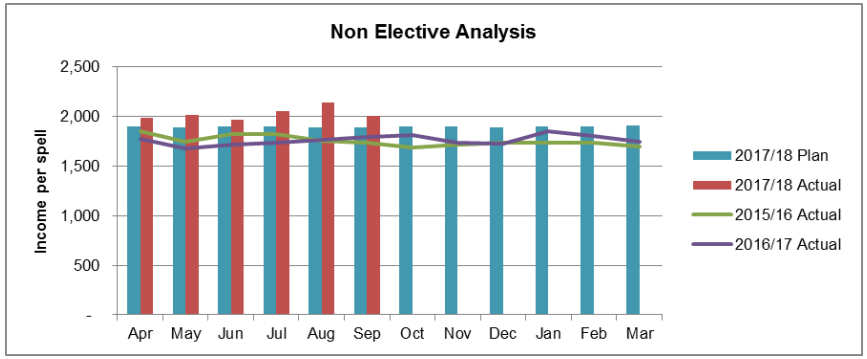
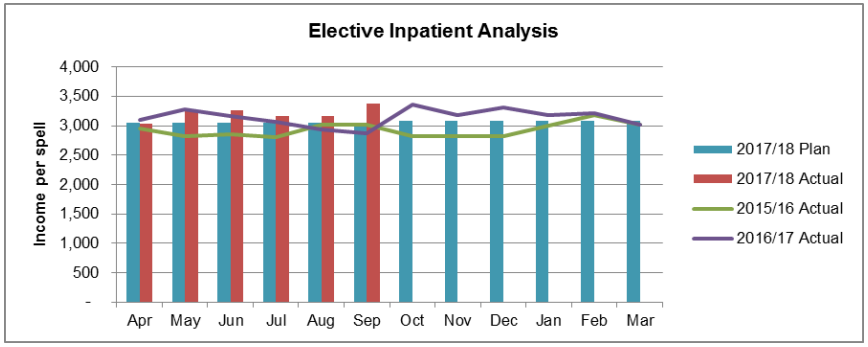
Trends and Analysis

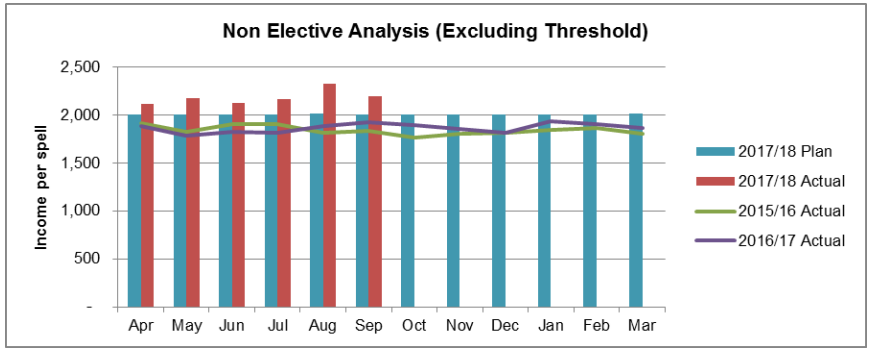












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Workforce

Monthly Expenditure Acute services only				
As at September 2017	Sep-17	Aug-17	Sep-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,906**	**10,917**	**10,729**	**65,740**
Substantive Staff	9,706	9,798	9,465	58,190
Medical Agency Staff (includes 'contracted in' staff)	100	114	187	756
Medical Locum Staff	169	233	160	1,279
Additional Medical sessions	233	373	231	1,619
Nursing Agency Staff	39	(2)	195	329
Nursing Bank Staff	247	178	187	1,175
Other Agency Staff	47	91	140	394
Other Bank Staff	175	137	139	884
Overtime	95	88	79	544
On Call	50	55	48	311
Total temporary expenditure	1,157	1,266	1,366	7,291
Total expenditure on pay	**10,862**	**11,064**	**10,831**	**65,480**
Variance (F/(A))	44	(148)	(102)	260
Temp Staff costs % of Total Pay	10.6%	11.4%	12.6%	11.1%
Memo : Total agency spend in month	187	203	522	1,479

Monthly whole time equivalents (WTE) Acute Services only			
As at September 2017	Sep-17	Aug-17	Sep-16
	WTE	WTE	WTE
Budgeted WTE in month	**3,021.0**	**2,992.9**	**3,036.3**
Employed substantive WTE in month	**2748.12**	**2751.1**	**2,710.5**
Medical Agency Staff (includes 'contracted in' staff)	8.26	7.9	16.0
Medical Locum	14.26	14.35	14.9
Additional Sessions	20.36	29.37	18.1
Nursing Agency	7.94	4.11	30.1
Nursing Bank	78.14	59.07	68.3
Other Agency	16.2	20.36	34.2
Other Bank	87.8	67.79	72.6
Overtime	29.61	40.52	36.7
On call Worked	7.02	8.87	8.0
Total equivalent temporary WTE	**269.6**	**252.3**	**299.0**
Total equivalent employed WTE	**3,017.7**	**3,003.4**	**3,009.5**
Variance (F/(A))	3.3	(10.5)	26.8
Temp Staff WTE % of Total Pay	8.9%	8.4%	9.9%
Memo : Total agency WTE in month	32.4	32.4	80.4
Sickness Rates (Sept/Aug)	2.68%	2.54%	3.85%
Mat Leave	2.3%	2.4%	2.1%

Monthly Expenditure Community Service				
As at September 2017	Sep-17	Aug-17	Sep-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,125**	**1,125**	**1,007**	**6,737**
Substantive Staff	1,035	1,053	971	6,278
Medical Agency Staff (includes 'contracted in' staff)	11	14	0	77
Medical Locum Staff	3	3	3	20
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	0	0	1	3
Nursing Bank Staff	15	14	3	82
Other Agency Staff	22	26	43	153
Other Bank Staff	12	10	13	63
Overtime	5	6	4	28
On Call	1	1	1	7
Total temporary expenditure	69	74	67	433
Total expenditure on pay	**1,104**	**1,127**	**1,038**	**6,712**
Variance (F/(A))	21	(3)	(6)	25
Temp Staff costs % of Total Pay	6.3%	6.6%	6.5%	6.5%
Memo : Total agency spend in month	33	40	44	233

Monthly whole time equivalents (WTE) Community Services			
As at September 2017	Sep-17	Aug-17	Sep-16
	WTE	WTE	WTE
Budgeted WTE in month	**377.25**	**375.25**	**334.1**
Employed substantive WTE in month	**345.6**	**349.7**	**317.5**
Medical Agency Staff (includes 'contracted in' staff)	0.7	0.9	0.0
Medical Locum	0.4	0.4	0.4
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.1	0.1	0.2
Nursing Bank	4.8	4.2	0.9
Other Agency	5.6	7.1	11.5
Other Bank	3.5	3.1	3.2
Overtime	1.9	3.1	2.0
On call Worked	0.0	0.0	0.0
Total equivalent temporary WTE	**16.9**	**18.7**	**18.2**
Total equivalent employed WTE	**362.6**	**368.4**	**335.7**
Variance (F/(A))	14.7	6.9	(1.5)
Temp Staff WTE % of Total Pay	4.7%	5.1%	5.4%
Memo : Total agency WTE in month	6.3	8.0	11.7
Sickness Rates (August /July)	4.32%	3.84%	3.96%
Mat Leave	1.3%	1.3%	1.3%

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

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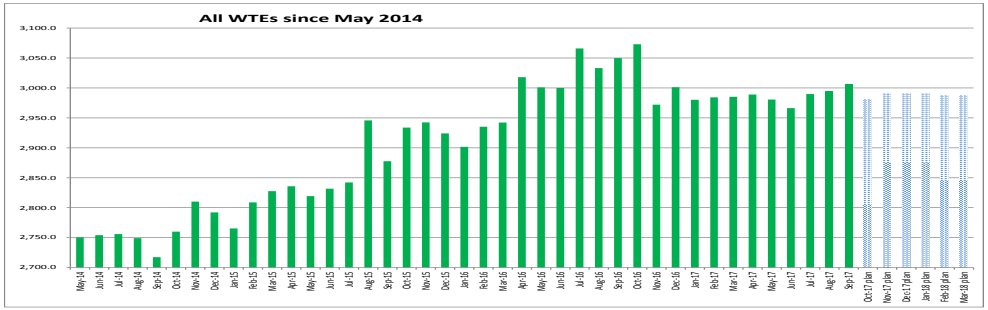
Staffing levels

The following graphs exclude Community staff and Glastonbury Court but include Capitalised staff. The impact of opening Glastonbury Court in November 2016 can be seen but if this were included around 28 WTE would be added to the actual WTEs.

They have been rebased to reflect hours worked by junior doctors before the new junior doctors contract was implemented.

The planned establishment from October onwards is the level of staffing required to achieve the original CIP, although this needs to be updated to reflect the proposals in FIP. As at September we employed 3.3 WTE less than planned and 8.2 WTE more than in September 2016.

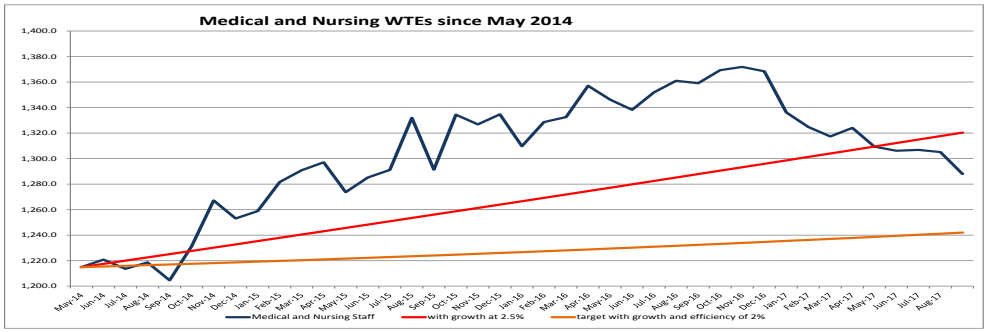


Since May 2014, (excluding Community staff) the Trust has employed 256 more WTEs, an increase of 7.8%. During this period activity has grown by around 7.5%

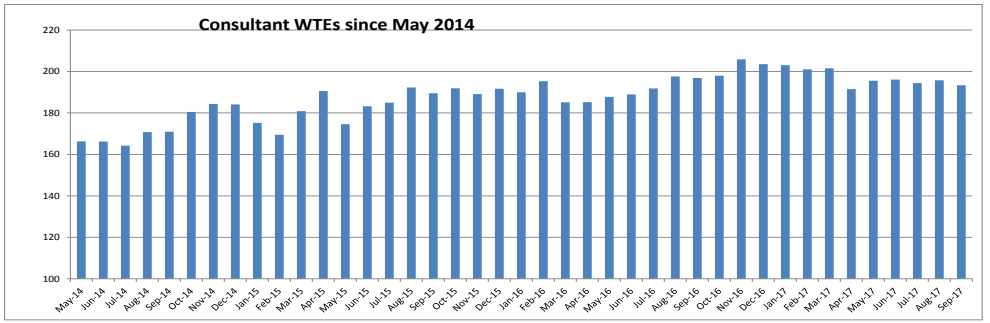
The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 73 WTEs (blue line). This includes around 27 WTE Consultants which are analysed further below.

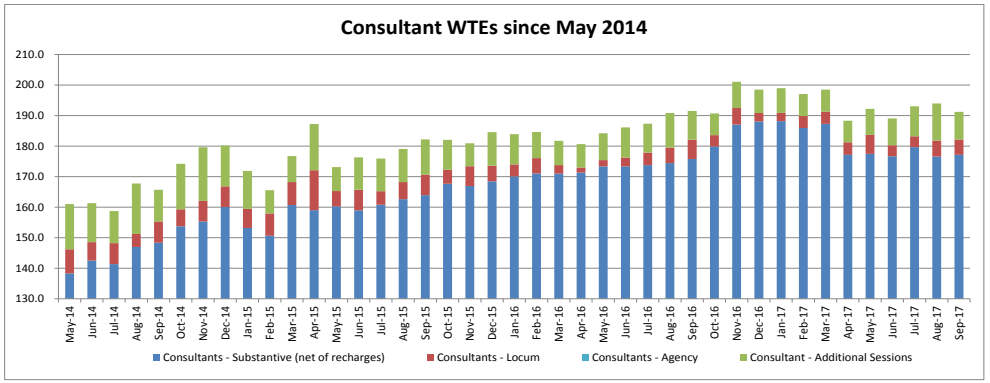
There has been a decrease of 17.2 WTE during September. Medical staff have increased by 15.5 WTE since April 2017, largely due to increases in junior doctors.

If medical and nursing staffing levels had increased in line with our growth in activity of broadly 2.5% we would currently be employing 32.0 more WTEs (red line). In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 46 WTE fewer than at September 2017



The graphs below highlight the increase in Consultant WTEs of 18% over the past 3 years. Substantive staff has increased by 37 WTEs whilst temporary staff have decreased by 11 WTEs.





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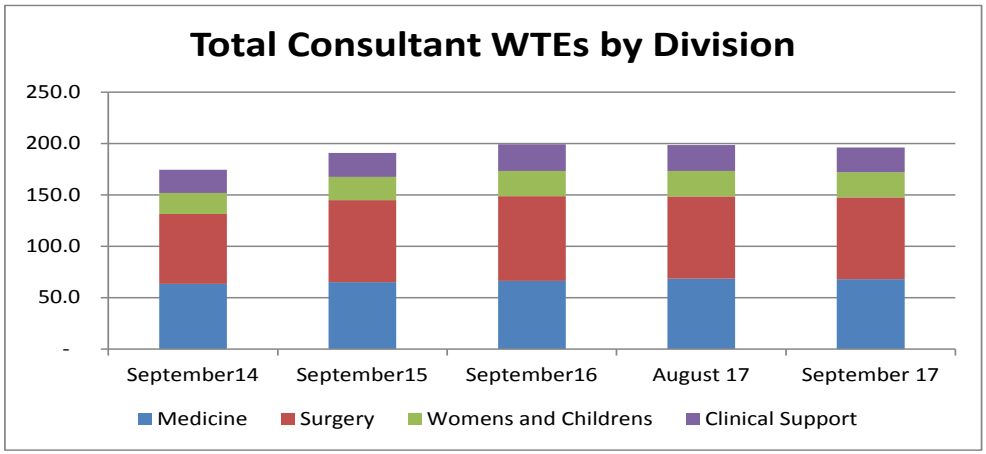
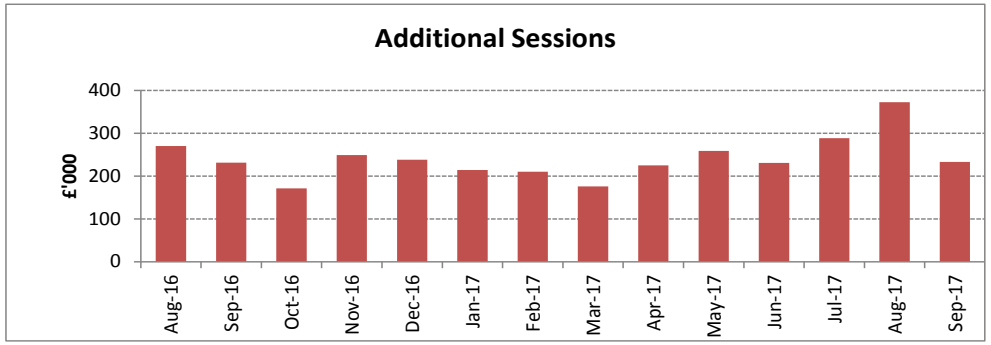
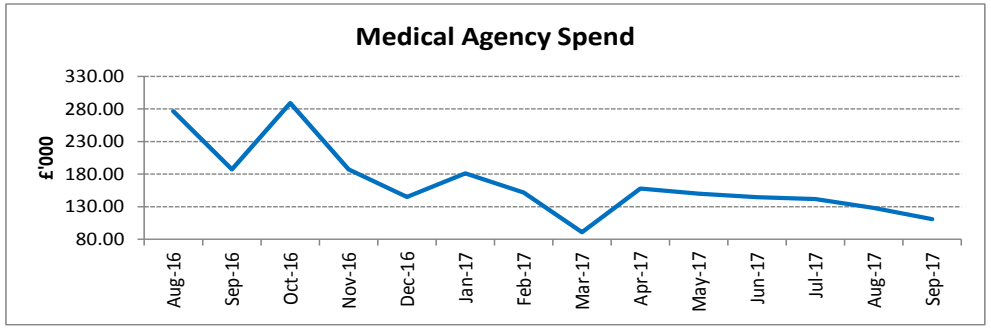


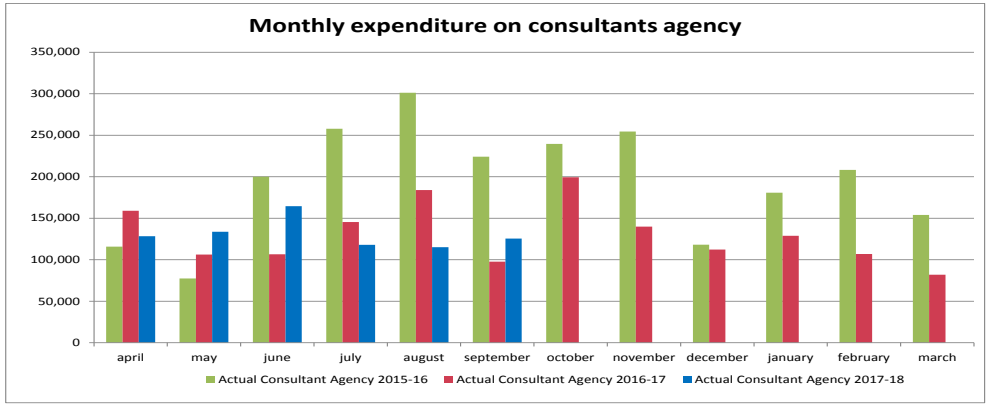
Division	Specialty	Sum of Sep-15	Sum of Sep-16	Sum of Jul-17	Sum of Aug-17	Sum of Sep-17
Medicine	A&E Medical Staff	5.8	8.5	8.1	8.2	8.2
	Cardiology	4.3	5.2	5.9	6.0	6.2
	Chest Medicine	4.1	4.1	4.0	4.0	4.2
	Chronic Pain Service	0.8	0.9	0.7	0.7	0.7
	Clinical Haematology	3.8	4.4	4.4	4.4	4.4
	Dermatology	5.2	4.5	5.0	3.5	4.3
	Diabetes	3.9	3.6	4.4	4.3	4.3
	Eau Medical Staff	9.6	7.5	7.2	9.6	7.2
	Gastroenterology	5.9	7.0	7.5	7.2	7.5
	General Medicine	7.7	7.3	5.8	4.6	5.3
	Nephrology	0.5	0.1	1.5	1.6	1.6
	Neurology	2.5	2.5	2.6	2.7	2.7
	Oncology	3.1	3.2	3.4	3.4	3.4
	Palliative Care	0.1	0.3	0.3	0.3	0.3
	Rheumatology	3.3	4.0	4.0	3.9	3.9
	Stroke	4.7	3.3	3.5	4.0	3.7
Medicine Total		**61.3**	**62.2**	**66.5**	**68.4**	**67.9**
Surgery	Anaesthetics	31.6	35.6	33.6	34.4	33.5
	E.N.T.	3.2	3.3	3.3	3.3	3.3
	General Surgery	13.1	10.3	9.8	9.8	9.8
	Ophthalmology	7.4	8.7	8.3	7.9	7.8
	Oral & Maxofacial Surg	1.6	1.0	0.0	0.0	0.1
	Plastic Surgery	3.1	2.4	3.0	2.3	2.4
	Trauma & Orthopaedic	13.2	13.9	14.2	14.7	14.0
	Urology	6.7	6.1	6.2	6.5	7.5
	Vascular Surgery	-	1.1	1.1	1.1	1.1
Surgery Total		**79.8**	**82.3**	**79.5**	**80.1**	**79.7**
Women and Childrens	Obstetrics	11.0	12.6	13.3	13.4	13.2
	Paediatrics	11.5	12.1	11.3	11.3	11.3
Women and Childrens Total		**22.5**	**24.6**	**24.6**	**24.7**	**24.4**
Clinical Support	Chemistry	0.6	0.8	-	0.6	0.3
	Histopathology	7.6	7.7	8.5	9.3	8.3
	Microbiology	3.3	3.3	3.2	3.2	3.2
	MRI	0.9	0.9	0.9	0.9	0.9
	Xray - Wsh	12.0	13.3	12.1	12.3	12.4
Clinical Support Total		**24.3**	**26.0**	**24.6**	**26.2**	**25.0**
Grand Total		**188.0**	**195.2**	**195.2**	**199.4**	**197.0**

Pay Trends and Analysis

The Trust underspent pay budgets by £65k in September (£286k YTD).







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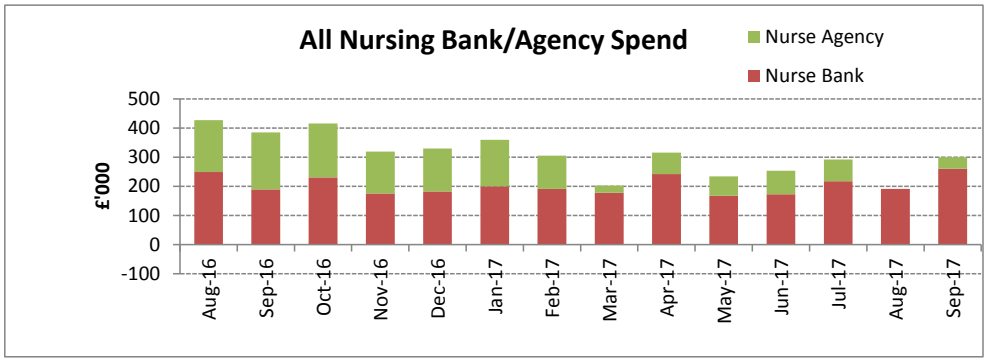
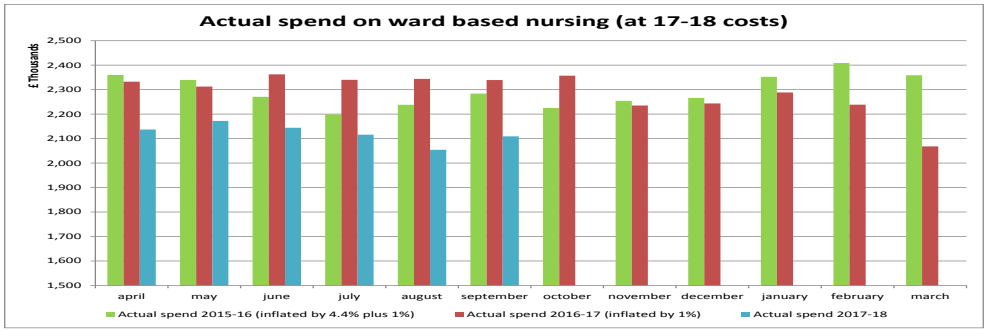
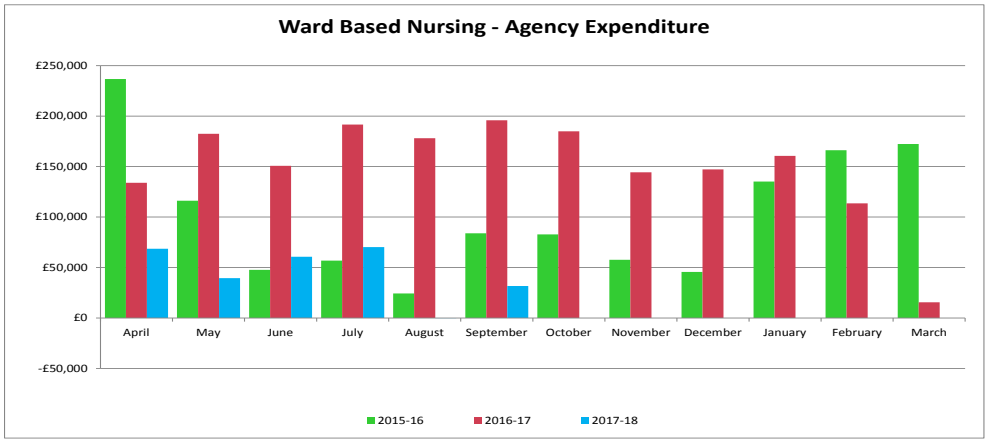
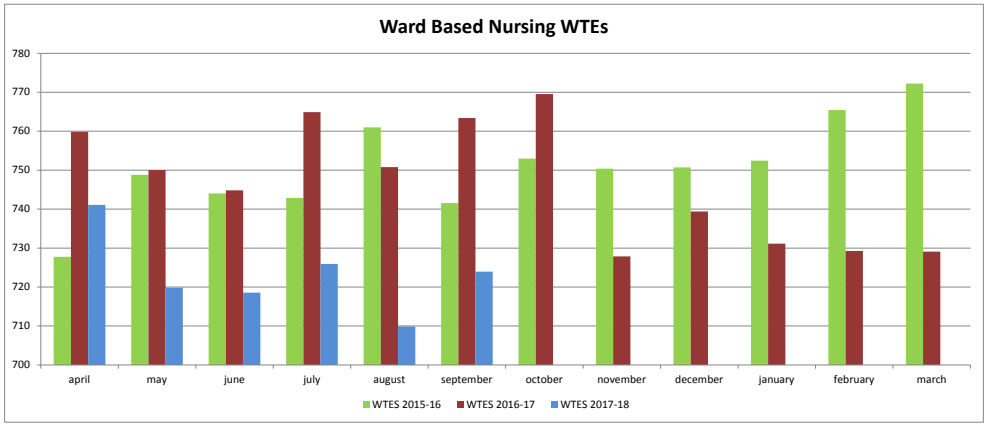
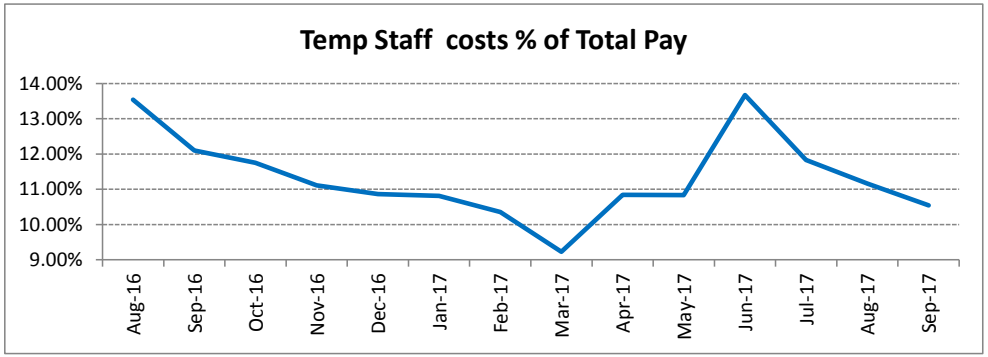


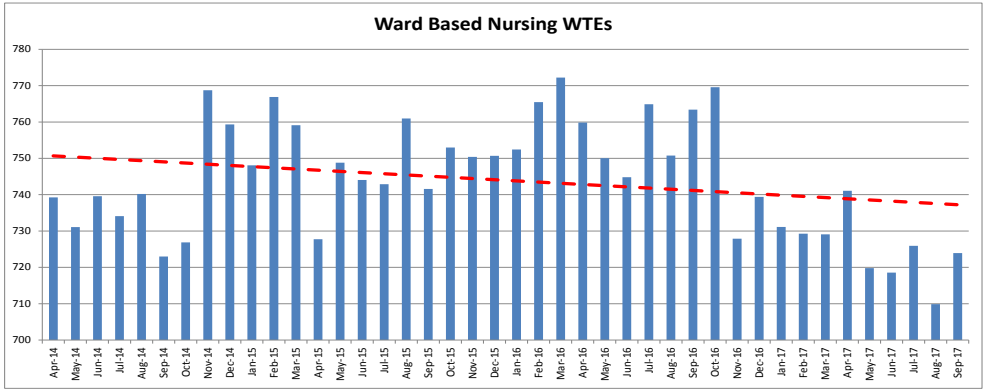
Ward Based Nursing











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Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Sep-17 Budget £k	Sep-17 Actual £k	Sep-17 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(5,499)	(5,549)	50	(32,676)	(33,019)	343
Pay Costs	3,357	3,320	37	20,299	20,224	75
Non-pay Costs	1,248	1,273	(25)	7,694	7,848	(153)
Operating Expenditure	**4,605**	**4,592**	**12**	**27,993**	**28,072**	**(79)**
SURPLUS / (DEFICIT)	**894**	**956**	**62**	**4,682**	**4,946**	**264**
SURGERY						
Total Income	(4,781)	(4,953)	172	(28,476)	(29,062)	585
Pay Costs	2,977	3,040	(63)	17,890	18,080	(190)
Non-pay Costs	1,042	1,148	(106)	6,263	6,619	(356)
Operating Expenditure	**4,020**	**4,188**	**(169)**	**24,152**	**24,699**	**(546)**
SURPLUS / (DEFICIT)	**761**	**764**	**3**	**4,324**	**4,363**	**39**
WOMENS and CHILDRENS						
Total Income	(1,962)	(2,057)	95	(12,156)	(11,915)	(241)
Pay Costs	1,105	1,093	11	6,628	6,691	(63)
Non-pay Costs	144	130	14	823	800	23
Operating Expenditure	**1,249**	**1,223**	**26**	**7,451**	**7,491**	**(40)**
SURPLUS / (DEFICIT)	**713**	**834**	**120**	**4,705**	**4,424**	**(281)**
CLINICAL SUPPORT						
Total Income	(981)	(976)	(5)	(5,795)	(5,548)	(248)
Pay Costs	1,679	1,677	2	10,126	10,042	84
Non-pay Costs	954	1,049	(95)	6,261	6,628	(367)
Operating Expenditure	**2,632**	**2,726**	**(93)**	**16,387**	**16,670**	**(283)**
SURPLUS / (DEFICIT)	**(1,651)**	**(1,749)**	**(98)**	**(10,591)**	**(11,122)**	**(531)**
COMMUNITY SERVICES						
Total Income	(11,273)	(12,955)	1,682	(65,426)	(67,188)	1,762
Pay Costs	1,125	1,104	21	6,737	6,712	25
Non-pay Costs	4,183	5,875	(1,692)	25,109	26,860	(1,750)
Operating Expenditure	**5,308**	**6,979**	**(1,671)**	**31,846**	**33,571**	**(1,725)**
SURPLUS / (DEFICIT)	**5,965**	**5,976**	**11**	**33,580**	**33,617**	**37**
ESTATES and FACILITIES						
Total Income	(371)	(315)	(56)	(2,263)	(2,044)	(219)
Pay Costs	744	737	7	4,487	4,405	82
Non-pay Costs	593	617	(24)	3,523	3,618	(94)
Operating Expenditure	**1,337**	**1,354**	**(17)**	**8,010**	**8,023**	**(12)**
SURPLUS / (DEFICIT)	**(966)**	**(1,039)**	**(73)**	**(5,748)**	**(5,979)**	**(231)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	3,094	3,163	(69)	19,295	18,216	1,080
Pay Costs	1,044	995	48	5,912	6,037	(126)
Non-pay Costs (net of contingency and reserves)	1,733	1,783	(50)	6,865	6,944	(79)
Finance & Capital	461	452	8	2,755	3,005	(249)
Operating Expenditure	**3,238**	**3,231**	**7**	**15,532**	**15,986**	**(454)**
SURPLUS / (DEFICIT)	**(6,332)**	**(6,394)**	**(62)**	**(34,827)**	**(34,202)**	**625**
TOTAL (including penalties, contingency and reserves)						
Total Income	(21,774)	(23,642)	1,868	(127,497)	(130,559)	3,063
Contract Penalties	0	0	0	0	0	0
Pay Costs	12,031	11,966	65	72,078	72,192	(113)
Non-pay Costs	9,898	11,875	(1,977)	56,538	59,316	(2,778)
Finance & Capital	461	452	8	2,755	3,005	(249)
Operating Expenditure (incl penalties)	**22,389**	**24,294**	**(1,905)**	**131,372**	**134,512**	**(3,140)**
SURPLUS / (DEFICIT)	**(615)**	**(652)**	**(37)**	**(3,875)**	**(3,953)**	**(78)**

Medicine (Annie Campbell)

The Division over performed by £62k in September (£264k YTD)

Contract income exceeded plan by £38k in the month. The number of attendances in ED was just above plan, but income was £43k over. Elective inpatients (£59k) and non-elective inpatients (£142k) were well above plan. However, the allocation of Emergency threshold, between divisions disproportionately affects Medicine. This is a known problem and is being reviewed. This depressed inpatients performance to a net £72k over performance.

Outpatients were £72k behind plan, primarily due to Dermatology since the specialty had difficulty securing locums in September, resulting in a £48k under performance. Other areas of concern were Respiratory Physiology (£26k due to vacancies) and Nephrology (£13k due to delays in transfer of work).

Pay expenditure continues to be under budget, particularly nursing. This has been due to the high level of vacancies, and the inability to obtain agency staff, as the Trust continues to adhere to the NHSI cap.

Transport and security continue to be an issue, and both have been overspent for most of the year.

CIP performance is now roughly on track and the Division is expected to meet its target by the year end.

Surgery (Simon Taylor)

The Division has over performed by £3k in September (£39k YTD)

Income over achieved the plan by £172k. It has been a very good month for activity however this has caused additional costs. The main overachievement is in emergency long stay. Elective has also achieved plan, Orthopaedics and ENT have both significantly over achieved their elective plan.

Pay is over spent by £63k, the main cost pressure has been temporary spend to deal with vacancies, and additional sessions to support RTT recovery.

Non-pay is overspent by £106k, the over spend is in theatre and eye treatment centre. This has been mostly due to increased activity to support the RTT. There

has been further pressure on the wards due the difficulties in getting some antibiotics.

Surgery CIP's has over achieved by £58k YTD this is due to favourable variance on several CIP's. There was some delivery of CIP's earlier than planned and also surgery achieved a higher vacancy management than plan.

Surgery is actively working to create a comprehensive CIP plan. This is being done through collaboration with clinical leads in CIP workshops

Women and Children's (Rose Smith)

In September, the Division reported a surplus of £120k and a deficit of £281k YTD.

Clinical income reported £95k ahead of plan in-month and is £241k behind plan YTD. Obstetric inpatient activity was lower than plan by £63k in the month. However, this under performance was mitigated by private patient income due to Lakenheath neonatal private patient activity.

Pay reported an £11k under spend in-month and £63k overspend YTD. There have been in-month underspends on registrar posts in Obstetrics which continue to put pressure on the service. A business case for a hybrid consultant is being worked on to provide a long term solution to a staffing issue that is becoming a persistent problem.

Non pay reports a £14k underspend in-month and a £23k underspend YTD. This is primarily due to underspends on drugs that have been driven by lower than expected levels of activity.

Clinical Support (Rose Smith)

In September, the Division reported a deficit of £98k and a deficit of £531k YTD.

Clinical income for Clinical Support reported a £5k under performance in-month and is £248k behind plan YTD. This can be attributed to lower than planned activity for radiology direct access and breast screening.

Pay is £2k underspent in-month and is £84k underspent YTD. This performance can be attributed to effective use of bank staff to cover rota gaps and a consultant radiologist vacancy that is proving difficult to fill and cover. The consultant microbiologist rota is currently short staffed due to sickness. This has temporarily been covered by a non-NHS locum. The division is looking to cover this position with an NHS locum as quickly as possible to reduce the financial impact.

Non pay reported a £95k over spend in-month and £367k overspend YTD. This is mainly attributable to continued pressures on the pathology services contract.

Community Services (Dawn Godbold)

Community Services reported an £11k over performance in-month (£37k YTD).

Income reported a £1.7m over recovery in-month and an over performance of £1.8m YTD. This month has seen an agreement reached with NHS property services and as part of this settlement the CCG and IHT have been invoiced for their share as well as recovery of costs relating to dressings.

Pay reported a £21k underspend in-month and £25k underspend YTD. There have been overspends within Glastonbury Court and Estates due to vacancies being covered by agency, overtime and additional hours. These additional costs have been offset against vacancies across the whole of the division.

Non-pay reports a £1.7m overspend in-month and a £1.8m overspend YTD. Adverse variances in-month relate to the NHS property services agreement and dressings.

Use of Resources (UoR) Rating

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

The key features of the UOR ratings are as follows:

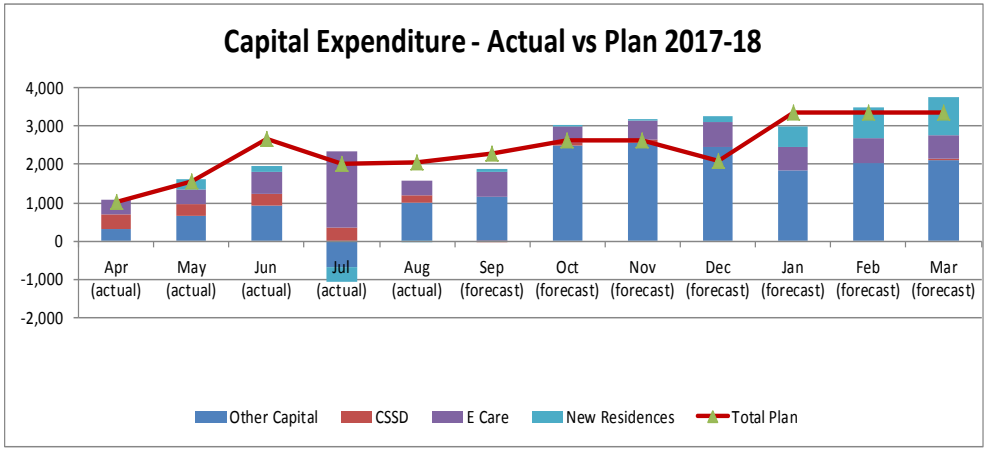
- 1 is the highest score and 4 is the lowest
- The I&E margin ratio is based on a control total basis rather than normalised surplus (deficit).
- The Agency rating measures expenditure on agency staff as a proportion of the ceiling set for agency staff. A positive value indicates an adverse variance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

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

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

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

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2017-18 £'000
E Care	415	382	567	1,990	369	654	448	501	648	599	648	599	7,821
CSSD	384	283	319	352	197	-10	50	75	0	0	0	25	1,675
New Residences	0	284	140	-373	-33	68	20	28	176	566	800	1,008	2,684
Other Schemes	296	665	922	-684	1,009	1,150	2,508	2,582	2,450	1,839	2,054	2,126	16,915
Total forecast / Forecast	1,095	1,613	1,947	1,285	1,542	1,862	3,026	3,186	3,274	3,004	3,502	3,759	29,095
Total Plan	1,012	1,568	2,673	2,034	2,058	2,283	2,643	2,612	2,103	3,365	3,365	3,363	29,082

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

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

The CSSD build is nearing completion and the build expenditure forecast is in line with its budget of £1.6m for the year. The delay in the implementation has meant that the value of interest capitalised has increased. Once the CSSD is in operation this will revert to a revenue cost. The final expenditure for this project (except for retentions) will be paid in November.

Expenditure on e-Care for the year to date is £4,377k and is in line with the revised E-Care budget. The E-Care programme budget reflects the increased scope associated with the Global Digital Excellence (GDE) funding. The first tranche of this funding £3.3m was received in July. Initial indications are that the second tranche of funding will be received in December 2017, however past history would indicate that this timing is not guaranteed.

The forecasts for all projects have been reviewed by the relevant project managers. The expenditure profiles of these schemes have been rephased. There are no significant financial risks to the budgets reported. Year to date the overall expenditure of £9,345k is below the plan of £11,905k. The current forecasts are in the stages of a major review and initial indications are that there will be some slippage on the Ambulatory Assessment Unit, Main Concourse, Labour Suite, Compartmentation, Staff Residences and Urology Relocation schemes. The review will be completed during November and at present the slippage cannot be quantified.

Statement of Financial Position at 30th September 2017

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2017 £000	Plan 31 March 2018 £000	Plan YTD 30 Sept 2017 £000	As at 30 Sept 2017 £000	Variance YTD 30 Sept 2017 £000
Intangible assets	15,611	19,711	18,180	18,148	(32)
Property, plant and equipment	74,053	94,189	81,074	78,674	(2,400)
Trade and other receivables	0	0	0	0	0
Other financial assets	0	0	0	0	0
Total non-current assets	**89,664**	**113,900**	**99,254**	**96,823**	**(2,431)**
Inventories	2,693	2,600	2,700	2,359	(341)
Trade and other receivables	18,345	11,700	15,000	19,923	4,923
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	5,000	4,846	(154)
Total current assets	**22,390**	**15,300**	**22,700**	**27,128**	**4,428**
Trade and other payables	(23,434)	(28,195)	(26,067)	(21,404)	4,663
Borrowing repayable within 1 year	(534)	(1,796)	(2,048)	(2,302)	(254)
Current ProvisionsProvisions	(61)	(61)	(84)	(89)	(5)
Other liabilities	(1,325)	(295)	(4,000)	(9,831)	(5,831)
Total current liabilities	**(25,354)**	**(30,347)**	**(32,199)**	**(33,625)**	**(1,426)**
Total assets less current liabilities	**86,700**	**98,853**	**89,755**	**90,325**	**570**
Borrowings	(44,375)	(55,951)	(47,326)	(47,618)	(292)
Provisions	(181)	(158)	(163)	(182)	(19)
Total non-current liabilities	**(44,556)**	**(56,109)**	**(47,489)**	**(47,800)**	**(311)**
Total assets employed	**42,144**	**42,744**	**42,266**	**42,524**	**258**
Financed by					
Public dividend capital	59,232	65,732	62,565	63,565	1,000
Revaluation reserve	3,621	3,621	3,621	3,621	(0)
Income and expenditure reserve	(20,709)	(26,609)	(23,920)	(24,662)	(742)
Total taxpayers' and others' equity	**42,144**	**42,744**	**42,266**	**42,524**	**258**

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

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

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

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

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

Trade and Other Receivables
These have reduced by £1.2m in September. This is mainly due STF received during September as well as Health Education England settling their invoices.. We are still above plan and the Trust plan assumes the year end receivables position in March 2018 will be £12m compared to £19.9m at the end of September which is a significant challenge.

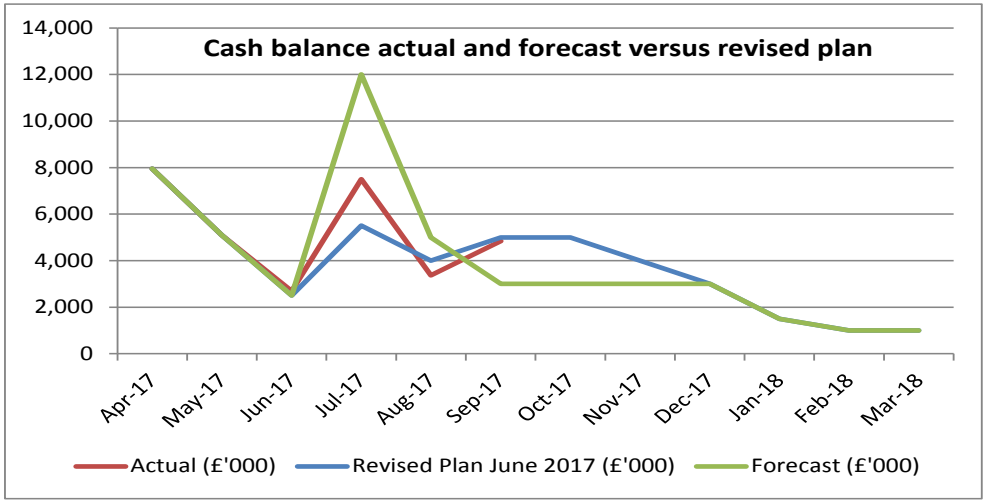
Cash
The cash balance has increased from £3.4m at the end of August to £4.9m at the end of September due to the receipt of STF. £2.1m of the loan drawdown facility was provided on 25th September.

Trade and Other Payables
The balance on trade and other payables has decreased since August by £0.4m and is below plan by £5.0m. In order to manage the Trust's cash position, as slippage on the capital programme reduces the payables balance may increase. The Trust will continue to manage its relationship with suppliers carefully.

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

FINANCE AND WORKFORCE REPORT – September 2017

Cash Balance Forecast for the year

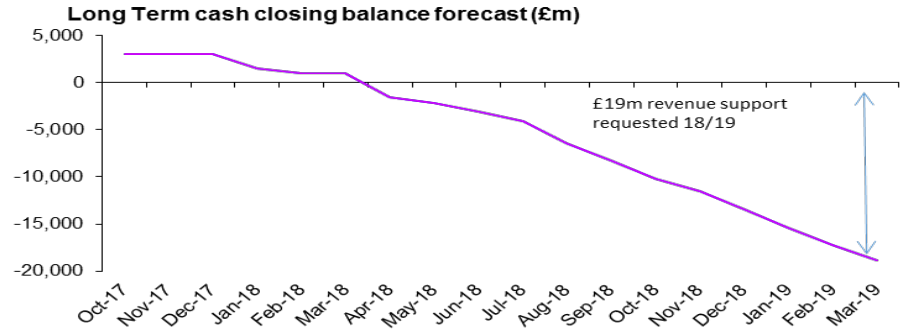


The graph illustrates the cash trajectory year to date, plan and revised forecast.

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

Longer Term Cash Forecast

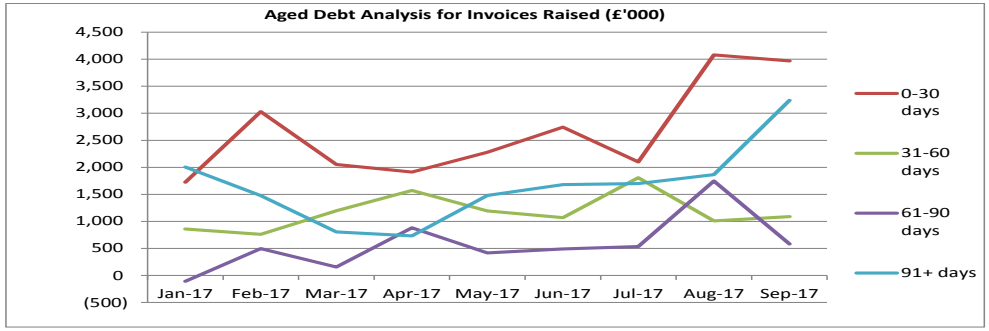
As explained previously, the Trust's revenue and capital plan to March 2019 exceeds the agreed finance available. To date the Trust has relied on slippage on the capital programme to fund this gap but in 2018/19 it is forecast we will need an additional £19 million revenue support in order to maintain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



Debt Management

It is important that the Trust raises invoices promptly for money owed and that the cash is collected as quickly as possible to minimise the amount of money the Trust needs to borrow. In order to manage the Trust's cash position the receivables balance needs to reduce significantly by year end.

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



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

A significant proportion of the debt outstanding for over 90 days relates to charges to Suffolk County Council for Community Equipment. This has now been resolved and payment should be received shortly.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3rd November 2017

AGENDA ITEM:	Item 9
PRESENTED BY:	Craig Black, Executive Director of Resources
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
DATE PREPARED:	27 October 2017
SUBJECT:	September Board report
PURPOSE:	Review

EXECUTIVE SUMMARY:
The reported I&E for September 2017 is a deficit of £652k (YTD £3,953k), against a planned deficit of £615k (YTD £3,875k) This results in an unfavourable variance of £37k (YTD £78k adverse).

We are therefore on plan to achieve our control total this year, which will mean we also receive STF funding of £5.2m. Therefore £1.9m of this funding is included in the September position in line with NHSI guidance.

We continue to work with KPMG as part of the financial improvement programme (FIP) for 2017-18 and beyond. The focus of FIP is to ensure that robust CIPs are in place to deliver the control total for 2017-18 and a CIP pipeline for future years. This Programme has identified further CIP that increases this year's forecast to £14.4m. To date we have identified £3.7m of risk adjusted CIP schemes for 2018-19.

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

West Suffolk NHS
NHS Foundation Trust

Board of Directors 3rd November 2017

AGENDA ITEM:	10
PRESENTED BY:	Helen Beck – Interim Chief Operating Officer
PREPARED BY:	Lesley Standring – Transformation Lead UEC Jane Rooney – Transformation Lead Planned Care Sheila Broadfoot - CQUIN Lead
DATE PREPARED:	18th October 2017
SUBJECT:	Transformation Board Report
PURPOSE:	Update

EXECUTIVE SUMMARY:

This report provides an update from the last reporting period and relates to the programs of work being undertaken by the Trust and CCG joint transformation teams.

The report contains details of plans to assist in the recovery of the ED 4hr standard from the Urgent and Emergency care team aimed at improving flow through the hospital and achieving discharges earlier in the day along with a review of processes at the weekend and an audit of admissions to identify options for alternative pathways.

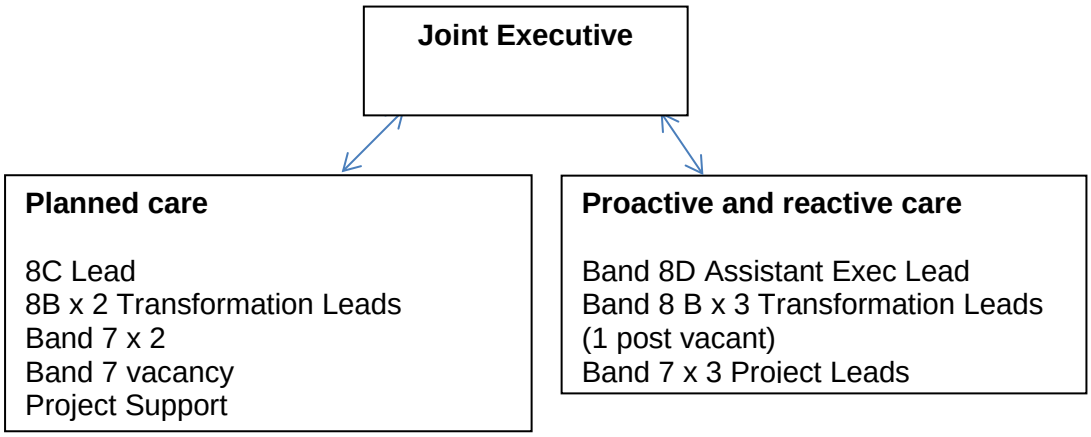
The recruitment of the planned care programme lead is driving a more robust and coordinated programme of work across primary and acute care aimed at reducing demand. This report contains an overview of the various projects within this programme.

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

Recommendation:

The Board is asked to note the Transformation Report.

1.0 Update of the WSFT and WSCCG Joint Transformation Team Staffing



Since the last Trust Board update, there has been recruitment to two of the vacant posts one within each of the areas. However, there is now a band 8B vacancy within the Proactive/Reactive Care team. Recruitment is underway to fill this post.

The Planned Care Transformation Team is now fully recruited to and is working across both organisations. Most posts within the team are joint appointments. There is one vacancy which relates to a post holder currently on secondment.

2.0 Integrated Care Programme Project highlights

2.1 Red to Green/SAFER

A check and challenge of the status of SAFER across all adult inpatient wards is taking place over the next 4 weeks supported by KPMG

.

#EndPJParalysis

WSFT is taking part of an East of England 100 day challenge to raise the importance of getting our patients up, dressed and moving to reduce the risk of deconditioning. From 14th September to 22nd December (100 days), across the east of England, the aim is for 100,000 patient days up, dressed and moving in their own clothes, rather than wearing hospital gowns or PJs. During this 100 day challenge we will be collecting the number of patients up & dressed on our wards and reporting this as part of the regional initiative. We have opted to take a staggered approach to this and we have started with 2-3 wards at a time so that by the end of October we are collecting data from the key areas this is applicable to.

For the period 18th September – 15th October there were 1530 patients days captured as dressed & up at WSFT.

2.2 Ambulatory Emergency Care

The AEC team continues to see at least a third of the medical cohort with a 10% or less conversion rate to inpatient admission. The winter plan includes an expansion of the service with an additional bay and up-skilling of the nursing team to host some elements of the surgical AEC service in order to alleviate pressure on ED. The surgical AEC team has joined the national network but have not been assigned a cohort as yet. Planned changes to the eCare workflow will be implemented post the Phase 2 go live, to enable us to better capture and report of our AEC activity.

2.3 GP/Primary Care Streaming

The first session of GP streaming will take place on Tuesday 31st October from 11:00 to 16:00. As the build will not be entirely finished the main ED entrance will be used initially. Usual times of the service will be weekdays 11:00 to 21:00 and weekends and bank holidays 09:00 to 21:00. Initially there will be a reduced service due to gaps in the GP Rota, however the GP Federation are confident that coverage will improve. Internal communication will be going out and a governance framework has been agreed.

2.4 Discharge to Optimise and Assess (D2OA)

5Qs and Support to go Home projects are now live. Support to go home saw a saving of 90 bed days within its first 10 days of operation.
Public Health are supporting the evaluation of D2OA across all pathways.

2.5 Red Bag

The Red bag project is due to go live in November. This programme will enable patients from care homes who attend ED or are admitted to be easily identified. The red bag contains essentials such as day clothes, medications and a copy of their 'My Care Wishes' folder. .

2.6 Early Intervention Team

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

3.0 Next steps - Supporting the operational recovery of the 95% target

The joint transformation team are delivering a range of initiatives aimed at supporting the recovery of the ED 4 hour standard

3.1 Pre Perfect week

The following initiatives will be looked into in more detail and background work completed prior to perfect week:

- **Audit patients arriving at ED over a weekend**

Aim	Expected Outcome
Over the weekend of 27th, 28th and 29th October - a team of staff including ED receptionists will ask all patients which services they approached prior to attending ED	Data will show other pathways patients could have accessed and identify gaps in system provision

- **Audit GP referral to AMU and FAU**

Aim	Expected Outcome
Community matron to support AMU consultant when taking GP expected calls Use of the ECIST 6As of managing Emergency Admissions: Advice – allow patient to stay in primary care Access – suggest referral to specialist OPA AEC FAU AMU Admission to specialty ward for agreed pathways	To enable GP/Consultant to sign post patients to alternative pathways and identify gaps in system provision

- **Weekend review**

Aim	Expected Outcome
Review roles and process during the weekend of: o Site Manager o Bed manger o Discharge Consultant o Discharge planning Team o ED Coordinator o Nurse in charge o Transport o Pharmacy	Identify process changes to ensure internal hospital flow is improved out of hours and weekend discharge rates improve from 50-70% of weekday average

- **Introduce a set of behavioral standards: 'the way we do things here…'**

Aim	Expected Outcome
To improve the working relationship between staff who are clear of the values and behaviors expected to support hospital flow and timely discharges	Staff are clear about expectations of the senior team Discharges before noon are improved Flow is improved as handoffs reduced

- **Golden patient/Discharge Waiting Area**

Aim	Expected Outcome
Every ward should ensure they 'pull' one patient from F7/8 before 10am. Moving a patient to the DWA to allow this to happen	Flow will begin earlier in the day

- **Check and challenge implementation of SAFER bundles**

Aim	Expected Outcome
Check the following is in place on all wards every day: • All patient to have a PDD • Patients & relatives aware of PDD • Clear treatment plan documented • Whiteboards used as a discharge planning tool	These key actions will improve patient flow & experience.

3.2 During Perfect week planned for 2-9 January 2018

- **RED to GREEN Board rounds**

Aim	Expected Outcome
Enhance the current Red to Green meetings to twice daily weekdays Review of patients at the weekend	Patients who are ready for discharge are discharged as soon as they are optimised.

- **Communication between F7/F8/ED & base wards**

Aim	Expected Outcome
Support ward teams & 358 to manage beds effectively: • Empty beds ready for next patient within 20 minutes • If bed is unable to be made within time frame, beds return to F7/F8 unmade • New handover process to be trialled. Handovers should be received on first attempt unless emergency on ward	Right patient in right place first time

- **Home for Lunch & Dressed for Lunch**

Aim	Expected Outcome
• Third of all discharges will take place before 12 noon • Patients are sat out of bed & dressed (where applicable)	Trust discharge profile advanced by 2-4hrs Expanding the patient's world beyond the bed & chair

- **Patient Flow**

Aim	Expected Outcome
Enable 358 to focus on flow only Use of e-care to support role	Standardised & consistent approach to bed management

- **Freedom to Improve**

Aim	Expected Outcome
• Listen & feedback to staff from around the hospital on ideas on how to improve patient flow & experience • Daily ED drop in sessions in Time Out during Perfect Week	Increase in number of staff that use intranet site to put forward ideas Staff have access & support from Executive Team

4.0 Planned Care Programme Project Highlights

4.1 100 Day challenge

This national programme is designed for primary and secondary care to jointly test ways of improving patient experience and speeding up access to elective care. The work will be done around three themes: Rethinking referrals/Shared decision making and Transforming Outpatients.
West Suffolk is in wave 3 of the programme and we expect the programme to start in the New Year. The other sites involved in Wave 3 are Doncaster and Bassetlaw, Somerset and Dudley.

The specialties involved in the 100 day challenge will be Cardiology, Urology and ENT and the process will be initiated by a Leadership Challenge event for all sites, followed by local launch events

and checkpoint events at 25, 50 and 75 days with a final close down event at 100 days.

4.2 Right Care Programme – CVD, Respiratory and Neurology

'RightCare' is about the whole health system taking an evidence based approach to focus on key areas that will improve health outcomes for the population, reduce unwarranted variation in care and save money. NHSE has provided data packs for the three specialties that have been identified for this approach Respiratory, Neurology and Cardiovascular Diseases and over the coming months we will be working with primary and secondary care to look at the data to identify areas where we can work together to make improvements. The work programme requires planned, integrated and medicine management colleagues to work together with clinicians. Key existing work streams:

- Review of Neurology and Pain pathways across the STP.
- Review of CHD pathways across the STP with a focus on Atrial Fibrillation and Hypertension.
- My COPD pathway.
- Medicines Management within these specialties.
- Reducing avoidable emergency attendances within these specialties.

4.3 Diabetes Prevention Programme

NHS Diabetes Prevention Programme is a joint initiative led by NHS England, Public Health England and Diabetes UK and aims to deliver services which identify people with non-diabetic hyperglycaemia who are at risk of developing Type 2 Diabetes and offer them behavioral intervention that is designed to lower their risk of onset of Type 2 Diabetes.

Treatment and Care Funding – Diabetes Management

This programme, led by NHS England, aims to help improve the outcomes of patients with diabetes in two key areas – increased attendance on structured education courses to improve understanding and self-management of individuals with diabetes, and improve achievement levels for the three core diabetes treatment targets, namely blood glucose control (HbA1c), blood pressure and cholesterol levels.

Our structured education achievement target is to deliver 40 education places for T1 patients (a 5-day Dafne course), and 300 education places for T2 patients, (a 1-day Desmond course), essentially doubling current Desmond course delivery. If a Dafne or Desmond course is not suitable there are smaller alternative education sessions are available, and attendance at these will be counted into the education targets. WSFT is involved in delivering all structured education.

It is important to note that structured education is now available to prevalent patients, not just the newly diagnosed.

There are several areas of work under way to ensure greater parity of care across the STP to raise achievements of the 3 main treatment level targets. This includes funding for several posts based at WSFT, both nursing and admin, to underpin the work being done in primary, secondary and community care, a GP incentive scheme and a diabetes dashboard using real-time data to proactively identify patients not meeting the 3 treatment targets and arrange for intervention

4.4 Integrated Pain Management Service (IPMS)

In West Suffolk Pain Management is currently provided by two providers, Suffolk GP Federation and West Suffolk Hospital. The organisations are now working together to merge their two services into one integrated pain management service which is expected to start from 1 April 2018. The IPMS will remove duplication and streamline existing pathways to seamlessly provide a range of education, therapeutic and medical services for patients suffering from acute and persistent pain.

- There has been a reduction in first OPD appointments of 37.5% compared to August last year.
- FUs reduced by 14.5% (15) compared to July 2017, however data shows the number of Tele FUs have increased by 15 compared to July 2017

4.5 Musculoskeletal Single Point of Referral (MSK SPoR)

The CCG and WSFT have taken the opportunity to implement an MSK SPoR Service with AHPS working to WSFT Consultant guidance to triage GP and consultant referrals. The aim is to improve system efficiencies, integration of T&O and physiotherapy with patients are being seen in the right setting first time or preparation for surgery. The expected impact to work as an accountable care system to reduce the number of acute first outpatient appointments by 26%, follow up appointments by 9% and 2.8% reduction in orthopaedic clinical threshold procedures across all providers. This is a mandated programme by NH England.

This work is now complete and will be handed to the contracts team shortly.

4.6 Ophthalmology

There is a need to change the delivery system of eye care services to enable a sustainable and affordable clinical model for the growing elderly population of Suffolk. The aim is to integrate eye services for the patient through a strategic partnership model of care where the consultants can direct where work should appropriately be undertaken and the clinical skill level required in the community. This requires the CCG to

- support the a strategic partnership of providers,
- procure the IT platform and the community management of optometrist with enhanced skills (ESPs),
- develop triage with WSFT ophthalmology consultants
- and with the WSFT ophthalmology consultants develop the clinical governance strategy

4.7 Stroke

This is an STP wide review about to start. A meeting is being arranged with clinical leads from the acute hospitals across the STP to agree the scope of the review. The aim is to enhance what we already have and future proofing stroke services. It is not about major reconfiguration. Current work is to define the current provision, issues, concerns and opportunities in advance of the meeting.

4.8 Demand Management

This work programme is still in the initial scoping stage and will deliver a range of schemes designed to manage demand e.g. improving Advice and Guidance between clinicians in different care settings and changing the way outpatient consultations are delivered.

The components of demand management and capacity modelling will reach across both primary and secondary care with the aim of creating a more cohesive approach to these areas. Within this programme the projects will be:

-Patient Choice
-Direct access diagnostics
-Electronic referral system
-Shared decision making
-Peer-to-Peer review for referrals
-Consultant to consultant referrals
-Alternatives to outpatients
-Advice and guidance
-Patient referral guidance
-First and follow up management

Referral to treatment times (RTT) are also included as part of this programme and will include the roll out and implementation of the IST Action Plan/Sustainability plans across the Trust.

5) CQUIN Projects 2017-8-9

Value £3,428,060 divided between 14 projects NATIONAL	Q1	Q2	Q3	Q4
1a) Staff Health & Wellbeing: Improve the support available to NHS Staff to help promote their health and wellbeing, for them to remain healthy and well. Achieve set targets on 2 of 3 Staff Survey questions. Trusts do not have to pre-select which two. **Year 1** Baselines x 3: 2015 staff survey. **i) General H&W -** Does your organisation take positive action on health & wellbeing? Yes, definitely: 45% or 5% improve. **ii) MSK** – In the last 12m have you experienced MSK as a result of work activities? No: 85% or 5% improve. **iii) Stress** – During the last 12m have you felt unwell as a result of work related stress? No: 75% or 5% improve.	**TARGET %**			
	Progress work	Progress work	Progress work	>5% or set targets: i) 45% ii) 85% iii) 75%
	FULL £114,269			
				Part payments available: Half £ for 3% Three quarters £ for 4% Result unknown until published Feb 2018
Year 2 As above but baseline x 3: 2016 staff survey				Result unknown to Feb 2019
1b) Healthy food for staff, visitors and patients **Year 1** **Part a)** Evidence to show: Health of food offered on premises - Items high in fat, sugar & salt – full ban on: 1) price promotions, 2) advertising & 3) items at checkouts; 4) ensure healthy options available; including for staff working at night. **NEW Part b)** i) 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). Also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). ii) 60% of confectionery and sweets do not exceed 250 kcal. iii) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g. Evidence of a) changes maintained & b) introduced with signed between Trust and food supplier: commitment to keep changes; Improvements reported to a public facing Board. **Additional:** Cap sales of sugary drinks to 10% March 2018	**TARGET %**			
	Progress work	Progress work	Progress work	Part a) evidence maintained Part b) i) 70% ii) 60% iii) 60%
	FULL £114,269			
				Part payments available: a) 2016-7 maintained = half £ b) 2017-8 changes introduced = half £ Both above for full £ Only risk is with a national Franchise following the rules.
Year 2 As above but part b) targets: i) 80%, ii) 80%, iii) 75%.				Part payments as above.
1c) Frontline clinical staff – flu vaccinations: **Year 1** Achieving an uptake of flu vaccinations by frontline staff of 70% by 28 February 2018. **Risk:** high target. 2015-6 = 53%. 2016-7 = 64.6%. Resource TBC invest (£) as per 2016-7.	**TARGET %**			
	Prep	Progress	Progress	70
	FULL £114, 269			
	N/A	N/A		Part payments: 50% or less 0 50-59% quarter £ 60-64% half £ 65-70% three quarters £
Year 2 As above except target increases to 75% for top £.				Part payments as above except pre top is 65-75%
2) Reducing Impact of Serious Infections Timely identification and treatment for sepsis and a reduction of clinically inappropriate antibiotic prescription and consumption. **Year 1** **2a) SEPSIS: Timely identification in Emergency Departments and Inpatients: Adult and Paediatrics.** Screening: via local protocol. Q1-4 top £ for 90%. Stepped payment available.	**TARGET %**			
	90	**90**	**90**	**90**
	FULL £85,701			
	Part payment available: 49.9% or less 0 50-89.9% = £8570 90% = £21,425	Part payment available: 49.9% or less 0 50-89.9% = £8570 90% = £21,425	Part payment available: 49.9% or less 0 50-89.9% = £8570 90% = £21,425	Part payment available: 49.9% or less 0 50-89.9% = £8570 90% = £21,425
Year 2 - as above.				

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

The percentage of patients who were found to have sepsis in sample 2a* and received IV antibiotics within 1 hour of the diagnosis.
*Interpretation: NICE 2016 guidance – specifies those who meet a high risk of sepsis (most Trusts call red-flag) should have IVABx within 1 hr. Not all levels of Sepsis.

Risk: part payments likely e.g: Q1: 82.97**%.** 90% is a high target. Stepped payment bracket: large gap between 50-89%: ideally would be another step between that: NHSE not agreed.
Note: e-Care added Pathology in June 2017 = aid in ID.

Year 2 – as above.

TARGET %			
90	**90**	**90**	**90**
FULL £85,701			
Part payment available: 49.9% or less 0 **50-89.9% = £8570** 90% = £21,425	Part payment available: 49.9% or less 0 50-89.9% = £8570 90% = £21,425	Part payment available: 49.9% or less 0 50-89.9% = £8570 90% = £21,425	Part payment available: 49.9% or less 0 50-89.9% = £8570 90% = £21,425

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

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

TARGET %			
25	**50**	**75**	**90**
FULL £85,701			
£21,425	£21,425	£21,425	£21,425

2d) Reduction in antibiotic consumption.
Per 1,000 admissions (Defined Daily Doses) by end Q4:

2% reduction compared to 2013/14 median value in:
1. Total antibiotic consumption
2. Total consumption of carbapenem
3. Total consumption of piperacillin-tazobactam

Risk: major challenge to reduce from a low base.
Note: Tazocin world-wide shortage may have a positive effect on 1 of the targets. Year 2 targets tbc

TARGET %			
			Tbc <2%
FULL £85,701			
Submit quarterly data to Public Health England	Submit quarterly data to Public Health England	Submit quarterly data to Public Health England	Each item is worth 33%

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

Mental health and acute providers work together with partners (e.g. primary care, police, ambulance, substance misuse, social care, voluntary sector).
Year 1
i) Reduce by 20% the number of attendances to A&E (0% increase) for those within a selected cohort of frequent attenders and establish improved services to ensure this reduction is sustainable. Develop a care plan for each, in collaboration with the patient and providers & make available to ED for use when the patient attends.
ii) Improve data quality, information sharing & robust coding for audit.
Q1)
i) Identify the people who attended each A&E most frequently during 2016/17 (e.g.10-15 times or more).
ii) Review this group and identify the sub-cohort of people for whom mental health and psychosocial interventions led by specialist mental health staff would have the greatest impact. The number of people in the cohort will need to be agreed locally e.g.10-15 people per hospital site or more.
iii) Set the baseline. Report to Unify.
iv) Evidence collaborative working: identify whether identified cohort also presenting frequently at other UEC system touch points.
Q2)
i) Review whether identified cohort were coded appropriately.
ii) Conduct audit of coding. Agree joint data quality improvement plan & arrangements for sharing of data.

TARGET %			
i) & ii) ID patients iii) baseline iv) joint working – did cohort present at other UEC system points	i) & ii) review coding including audit, iii) joint governance, iv) create care plans & in place. v) ID new frequent attenders & plan in place, vi) share info, vii) plan to sustain reduction.	i) & ii) Review progress on data quality plan & confirm systems in place for Q4 confidence: coding.	<20% Reduction of the frequent attenders
FULL £342,806 – tbc MH provider has own £			
i) – iv) Value 10%	i) & ii) Value total10% iii) Value 0%		Part payments available: Reduction of frequent attenders: 5-9.99% = £ one quarter 10-14.99% = £ half 15-19.99% = £ three quarters 20% & over = £ full payment

iii) Establish Acute & MH Trust – joint governance to review progress. iv) Create care plans (co-produced with the patient) & put in place. v) System to ID new frequent attenders & care plans in place quickly. vi) Share care plans with other partners (patient permission). vii) Agree development plan to support sustained reduction. **Q3)** i) MH trust, acute trust review progress against data quality improvement plan and all confirm that systems are in place to ensure that coding of MH need via A&E HES data submissions is complete and accurate, to allow confidence in Q4 submissions. Assurances provided to CCGs accordingly. ii) Agree formally and assure CCG confident that a robust and sustainable system for coding primary and secondary mental health needs is in place. **Q4)** 20% reduction in A&E attendances of those within the selected cohort of frequent attenders		iv), v) & vi) Value total10% **vii) Value 20%**	i) and ii) Value 10%	Value 40%
Year 2 i) Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions. ii) Reduce total number of attendances to A&E by 10% (compared to Year 1) all people with primary mental health needs. iii) Strengthen existing / develop new services to support people with mental health needs better and offer safe and more therapeutic alternatives to A&E where appropriate. iv) Repeat internal audit of mental health diagnostic coding in A&E to provide assurance of the quality of coding. **Q1** i) Baseline total number of attendances with primary mental health diagnosis in Q4 2017-8, total frequent attenders and submit to Unify. ii) Evaluation of progress signed off by local ED Board. Q3 i) Repeat internal audit of ED mental health coding to ensure improvement from year 1 is sustained. ii) Provide assurance of confidence in robust system for coding. Q4: i) Agree plan for 'business as usual' going forward. ii) 0% increase in number of A&E attendances of frequent attenders iii) 10% reduction in ED attendances with primary mental health diagnosis, compared to baseline Q4 2017-8. **Year 3** **Q1 2019-20** National data submission to NHS England via UNIFY2 for total number of A&E attendances during 2018/19 for those within the selected cohort of frequent attenders in 2017/18 who would benefit from mental health and psychosocial interventions. Evaluation report of 2 year CQUIN submitted.	Baseline (Q4 2017-8) Unify data submit Evaluation to ED Board May		Audit Coding Dec	Plan for BAU ii) 0% increase in frequent attenders iii) 10% reduction in ED attendances March
	FULL £			
	0%		10%	ii) 10% iii) 80% Part payments available: Reduction in ED attendances of all people with primary mental health diagnosis: 0-2.49% = £ 20% of value 2.5-4.99% = £ 40% of value 5-9.99% = £ 60% of value
	TARGET %			
6) Advice and Guidance to GP Improve GP to access consultant advice prior to referring patients in to secondary care. Set up and operate A&G service for non-urgent GP referrals Allowing GP access to Consultant advice before referring. Either through ERS platform or local solution: telephone, email, online. Can include: virtual review of test results, supply of plan, direct booking of tests or intervention, advice re: clinic referral. Review & decided on specialties e.g. Gynae, T&O, ENT, Dermatology, Ophthalmology. Suggested data: Average number of GP A&G queries relative to GP referrals. GP A&G queries which led to referrals.	Agree specialties with highest volume of GP ref; trajectory toward Q4; timetable and plan ;	Services mobilised for 1st tranche specialties; baseline data for main & supported indicators	Services operational for 1st tranche; data for main & supported indicators provided; timetable, implementation trajectory agreed toward Q4 2018-9.	Services operational for 35% of total GP referrals by start of Q4 & sustained. Data provided.
	Prep local quality standard incl: 80% responses in 2	Local quality standard finalised re: 80% responses in 2 working days	Quality standards met x 2 specialties- 80% responses in 2 working days	Quality standards met x 7 specialties 80% responses in 2 working days

Data source: Monthly Activity Return or tbc new data standard.
TBC – measure appointments booked rather than referrals received.

Year 1
Q1
• Agree specialties with highest volume of GP referrals for A&G implementation
• Agree trajectory for A&G services to cover a group of specialties responsible for at least 35% of GP referrals by Q4 2017/18
• Agree timetable and implementation plan for introduction of A&G to these specialties during the remainder of 2017/18
• Agree local quality standard for provision of A&G, including that 80% of asynchronous responses are provided within 2 working days
Q2
• A&G services mobilised for first agreed tranche of specialties in line with implementation plan and trajectory
• Local quality standard for provision of A&G finalised
• Baseline data for main indicator provided
Q3
• A&G services operational for first agreed tranche of specialties
• Quality standards for provision of A&G met
• Data for main indicators provided
• Timetable, implementation plan and trajectory agreed for rollout of A&G services to cover a group of specialties responsible for at least 75% of GP referrals by Q4 2018/19
Q4
• A&G services operational for specialties covering at least 35% of total GP referrals by start of Q4 and sustained across the quarter
• Quality standards for provision of A&G met
• Data for main indicator provided

working days			
FULL £342,806			
Value 25%	Value 25%	Value 25%	Value 25% Part payments available: 20-24.99% = £ 40% of value 25-29.99%= £ 60% of value 30-34.99% = £ 80% of value

Year 2
Continue project toward the Q4 target:

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

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

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

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

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

7) e-Referrals

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

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

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

ii) Adequate slot polling is taking place to allow patients to book – evidence reduction in 'Appointment Slot issues' to a rate of 4% or less by Q4

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

TARGET %

i) Submit baseline/ plan & trajectory to deliver Q2-4 targets ii) Supply a list of services/ clinics accepting 1st O/P referrals & detail NRS e-RS services mapped to: published.	i) 80% of referrals to 1st O/P Services able to be received through e-RS.	i) 90% of referrals to 1st O/P Services able to be received through e-RS.	i) 100% of referrals to 1st O/P Services to be received through e-RS.
	ii) Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and	ii) As per Q2	ii) As per Q2
	Appointment **Slot Issues by service reducing to 4% or less** in line with the agreed trajectory set in Q1 ASI = 16%	ASI 10%	Nat target 4% ASI

FULL £342,806

Value 25%	Value 25% Part payment available: i) 50-60% = £ 50% 61-70% = £ 60% 71-79% = £ 70%	Value 25% Part payment available: i) 61-70% = £ 50% 71-80% = £ 60% 81-89% = £ 70%	Value 25% Part payment available: i) 71-80%= £ 50% 81-90%= £ 60% 91-99%= £ 70%

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

2) Part b) Emergency Care Data Set (ECDS) upgrade (Cerner).
Risk: delayed

Note: Parts a) & c) are a <u>separate project</u> to Part b)

TARGET

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

FULL £342,806
FULL £342,806

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

Year 2: **Part a) P&SD** - Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 7.5% points from 2017/18. Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate. **Part b) ECDS** Completion and timely submission of data by provider in line with the collection requirements. Where part b is not applicable to a provider this weighting will be applied to part a. Q1 Type 1 or 2 A&E provider is returning data daily AND 99% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 99% of patients have a diagnosis AND 99% of patients have a measure of acuity recorded. Acuity should be any value from the ECDS acuity set Q2 Type 1 or 2 A&E provider is returning data daily AND 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis AND 100% of patients have a measure of acuity recorded AND 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number). Q3 Type 1 or 2 A&E provider is returning data daily AND 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis AND 100% of patients have a measure of acuity recorded AND 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number) AND 100% of patients have the referral source recorded. Referral source should be any value from the EDCS referral source set. Q4 Type 1 or 2 A&E provider is returning data daily AND 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis AND 100% of patients have a measure of acuity recorded AND 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number) AND 100% of patients have the referral source recorded AND 100% of patients have discharge status recorded. Discharge status should be any value from the EDCS discharge status set. **Part a / c)** Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 7.5% points from baseline 2017/18 (OR increase to 50% of patients). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.	Daily data & 99% patients has diagnosis & measure of acuity recorded (ECDS data set) Value split: Part b) 5%	Daily data & 100% patients has diagnosis & measure of acuity recorded (ECDS data set) & recorded discharge clinician number Part b) 5%	Daily data & 100% patients has diagnosis & measure of acuity recorded (ECDS data set) & recorded clinician number & referral source (ECDS) Part b) 5%	Daily data & 100% patients has diagnosis & measure of acuity recorded (ECDS data set) & recorded clinician number & referral source (ECDS) & discharge status (ECDS) --- **Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 7.5% points from baseline 2017/18 (OR increase to 50% of patients).** **Part a) 80%** Part payments available: Less than 3% increase = £0 3-6.49% = £ 50% 6.5-7.49% = 80% £ OR Less than 45% = £0 45-47.49% = 50% £ 47.5-49.9% = 80% £

2018-9 – preparation underway

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

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

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

TARGET %			
Information systems audit: i) proposed mechanisms, ii) data capture, iii) approach for case note audits b) Advice – Staff training i) ID & assess staff; ii) who will be trained; iii) training criteria; iv) how effective training; v) training schedule, process in place for new starters c) Baseline data	High target performance or improving performance % Targets tbc for 9a-9e	High target performance or improving performance % Targets tbc for 9a-9e	9a) 90% 9b) 90% 9c) 30% 9d) 50% 9e) 80%
FULL £			
	Part payments available Q2-4		

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

West Suffolk NHS
NHS Foundation Trust

Board of Directors – October (3rd November) 2017

AGENDA ITEM:	11
PRESENTED BY:	Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Helen Beck, Interim Chief Operating Officer
DATE PREPARED:	October 2017
SUBJECT:	Winter Planning
PURPOSE:	To update the Board on Trust and system plans to support resilience through the winter period

EXECUTIVE SUMMARY:

The Trust has been working with the CCG and system partners throughout the summer to implement a range of initiatives designed to support winter resilience. Despite the success of these schemes we continue to be under significant operational pressure and have seen a marked deterioration in our performance against the 4hr ED standard.
This paper outlines the initiatives undertaken to date and the impact upon bed capacity.
It also covers a range of additional measures which are being undertaken to address the following key areas:

- Discharges earlier in the day through the creation of a discharge waiting area
- Increased senior focus on patient flow within the Hospital Control Room
- Bed and ED capacity
- Improved discharges at weekends

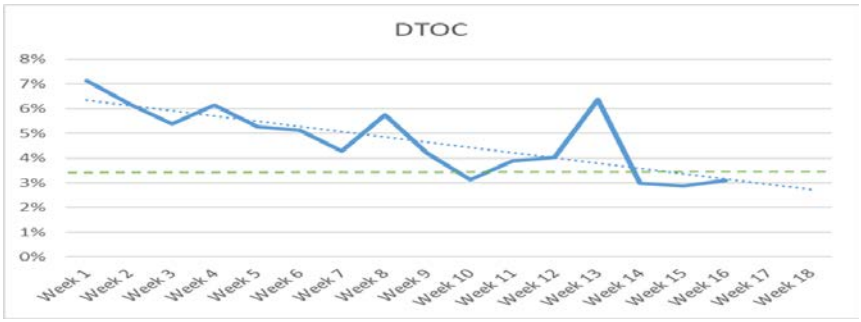
Linked Strategic objective (link to website)	
Issue previously considered by: (e.g. committees or forums)	
Risk description: (including reference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatory requirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	
Recommendation: The Board is asked to note the actions contained within this plan	

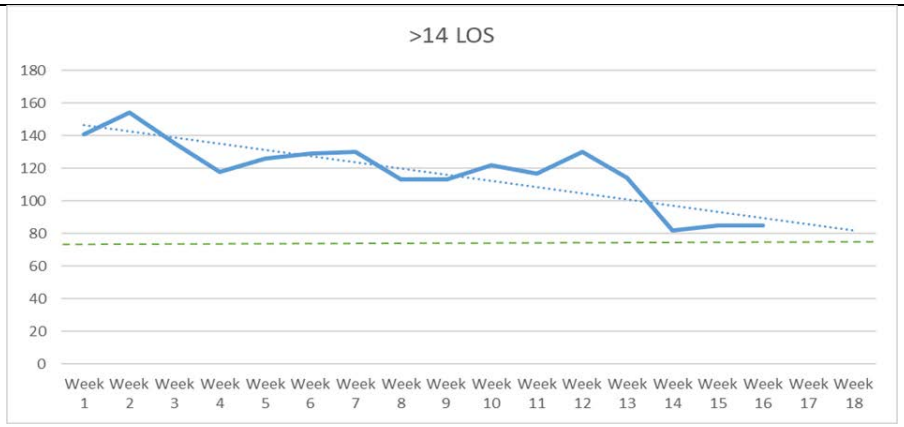
1.0	**Background**

The Trust has been working with the CCG and system partners through the summer period to implement the following range of measures to support winter resilience as part of the system wide winter plan:

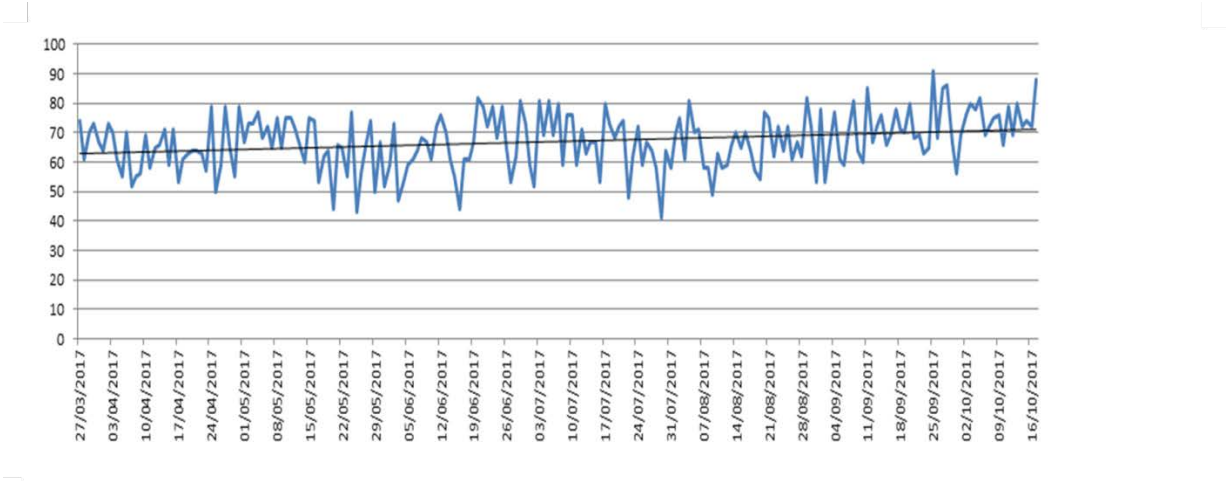
- SAFER
- Support to Go Home
- Discharge to Optimise and Assess
- 5Qs to reduce continuing health care delays
- #endpj paralysis aimed at reducing deconditioning in hospital
- Delivered the recommended 8 high impact changes to reduce delayed transfers of care
- Review and update of the patient choice on discharge policy in line with system partners.
- Introduced a care home specific discharge practitioner
- Implements the red bag scheme for care home residents
- Opened a frailty assessment unit

Across a range of indicators we can evidence that these plans are delivering the anticipated improvements in the flow of patients out of the hospital and we are seeing a reduction in the numbers of DTOCs and patients who are Medically fit for Discharge. Stranded patients overall are down although this number does fluctuate and is proving to be a good indicator of internal pressure within the Trust. The support to go home service has been successfully launched and is freeing up 6- 8beds per day.



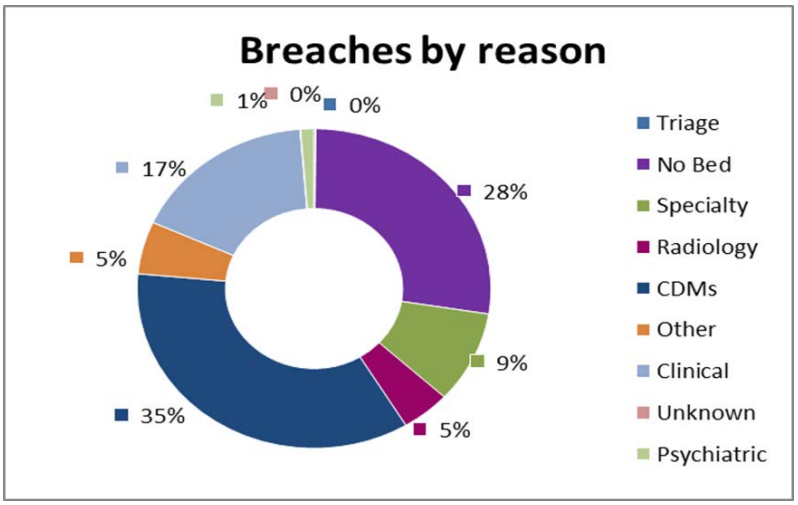


Despite all of these positive interventions the Trust has seen a significant deterioration in our ED performance indicating a failure to cope with the demand in the system. An increase in ED attendances and a 10% increase in admissions over the past 6 months had led to extremely high bed occupancy rates (97-98%) which have impacted flow from the emergency department.



From the above data it is clear the our focus on the back door of the hospital has delivered the anticipated results however we need to shift focus to address the increased demand from the front door and the flow through the hospital.

2.0 ED Breach Analysis



The breaches in September have all been analysed to identify the key areas of focus for the recovery plan:

- 17% being clinical are unlikely to be avoidable.

	• 35% of breaches are linked to operational issues within ED including staffing and departmental capacity. • 63% of breaches are linked to bed capacity, flow and support from specialties • There is no significant difference between the breaches in medicine or surgery.
3.0	**Hospital Flow**
3.1	From the breach analysis it is clear that the most significant contributor to the breach position is bed capacity and flow through the organisation. The key action to improve this will be the opening of a Discharge Waiting Area on ward G9 with effect from 13th November when the area is released from the current deep clean programme. Plans are in place and staff have been recruited to run this area. The DWA will select patients to be "pulled" from ward areas and cared for until they can leave the hospital eg. when transport arrives. Each ward will be expected to aim to send 2 patients to the DWA before 1000 am thus creating an earlier flow of patients through the Trust.
3.2	With immediate effect we have implemented changes to the management team portfolios to provide enhanced senior support to focus on patient flow throughout the day. The DCOO workload has been adjusted to enable greater focus on this and in addition a band 8A service manager and a band 7 flow manager have been seconded to the patient flow team. The DCOO and service manager will review current processes and make recommendations for the ongoing staffing requirements for this area. We have also implemented the e Care capacity management module and will be working to assess the opportunities which this presents as we operationalise it.
3.3	The Medical Director is leading on the implementation of Internal professional standards, in line with the 10 key principles included in NHSI rapid improvement guide. These principally focus on behaviours of all hospital teams to support effective emergency flow.
3.4	An ED task and finish group has been established to focus on actions internal to ED to support improved flow through the department.
4.0	**Capacity**
4.1	ED capacity will be increased when the GP streaming goes live on 31st October. It is anticipated that this service will be appropriate for approximately 25 patients per day from our current attendances although there is a risk that the service may drive an increased demand as patients become aware of its existence. Once fully up and running the service will have capacity for up to 50 patients per day so should be able to cope with any anticipated increase. The capital work to deliver the streaming space also provides additional capacity to deal with minor conditions so will assist with overcrowding at times of peak demand. All patients who are streamed to the GP service will count within our denominator in accordance with the national standards.
4.2	A review of the ED demand profile has been undertaken and will be used by the clinical lead and service manager to ensure all sections of the workforce are appropriately rostered to meet the increased demand.
4.3	Plans are in place to staff AMU 24/7 to provide increased assessment capacity. This will also provide planned additional overnight bed capacity, which will be freed up the next day through the use of the DWA.
4.4	Surgical Ambulatory care will be established along with a surgical assessment area subject to the ability to recruit an additional consultant to enable rotas to be re worked. This will significantly reduce the numbers of specialty breaches seen in ED.

4.5	A winter escalation ward is planned to be opened on the remaining 2 bays of ward G9. This area will take medically optimised patients with a reduced medical and nursing requirement.
4.6	All of the above initiatives require additional staffing which is a significant concern given the current level of vacancies within nursing. In order to support this we have set a target of 10 WTE nurses to be released from the specialist nursing compliment (10%) to support ward areas and we are seeking to recruit 30 WTE agency nurses on block contracts. We have acknowledged the need to breach the agency cap to secure these nurses but have prioritised patient safety.
5.0	**Demand Management**
5.1	The Joint CCG and Trust transformation team are supporting a clinical audit of a sample group of patients admitted through ED to understand if there was an appropriate alternative to admission, using the NHSI 6A's audit tool. This aims to identify other gaps in the care system which if addressed would support a reduction in demand. The Medical Director has agreed to take part in this audit and we are looking to secure a GP and community matron to complete the team.
5.2	Review of referrals to AEC to maximise use of this pathway is being undertaken by the team with support from KPMG.
5.3	A survey of all patients attending ED over the weekend of 28/29th October has been undertaken to establish what other alternative they have considered/ tried before attending ED.
6.0	**Weekend working**
6.1	Analysis of discharges over the weekend indicates that we typically discharge only 50% of the weekday average. This in turn leads to significant capacity pressure on Mondays impacting on flow through the hospital. A 10-15% improvement in this area will have a significant impact on ED performance on Mondays.
6.2	We will be undertaking a weekend diagnostic audit over the 3/4/5th November to identify opportunities to improve this rate. In addition we have identified some key sites where performance is better than ours and have arranged calls to gain an understanding of how they have achieved their success.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3rd November 2017

AGENDA ITEM:	Item 12
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:	October 2017
SUBJECT:	Aggregated Quality Report
PURPOSE:	Information

EXECUTIVE SUMMARY

- This report will be reflective of the data from September 2017
- In September there were 461 Patients Safety Incidents (PSI) reported; a small decrease from August (469).
- Level of harm in proportion to overall Patient Safety Incidents reported:
  - 85% (86% August) no harm (Green)
  - 11% (11% August) minor harm (Green)
  - 4% (3% August) moderate harm (Amber)
  - 0% (0.2% August) major harm (Red)
  - 0.02% (0.2% August) catastrophic harm (Red)
- In relation to type of incidents reported in September the highest categories of reporting related to Slips Trips & Falls, Pressure ulcers, and Medication, this is consistent over the past few months.
- 16 complaints were received in September and 16 in August.
- 167 PALS contacts were recorded in September and 137 in August

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

Table 1: Aggregated Patient Experience Report

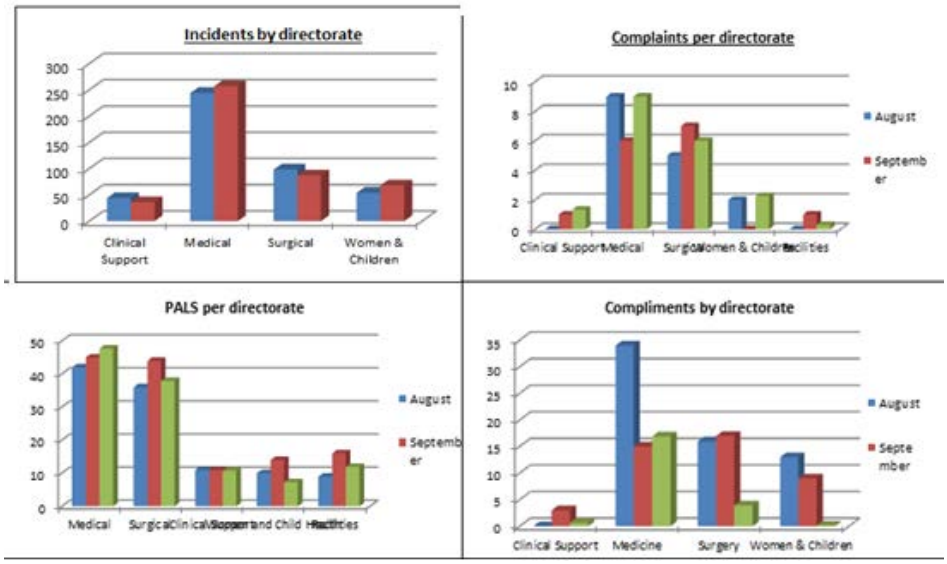


Table 2: PSIs reported by month (24 months)

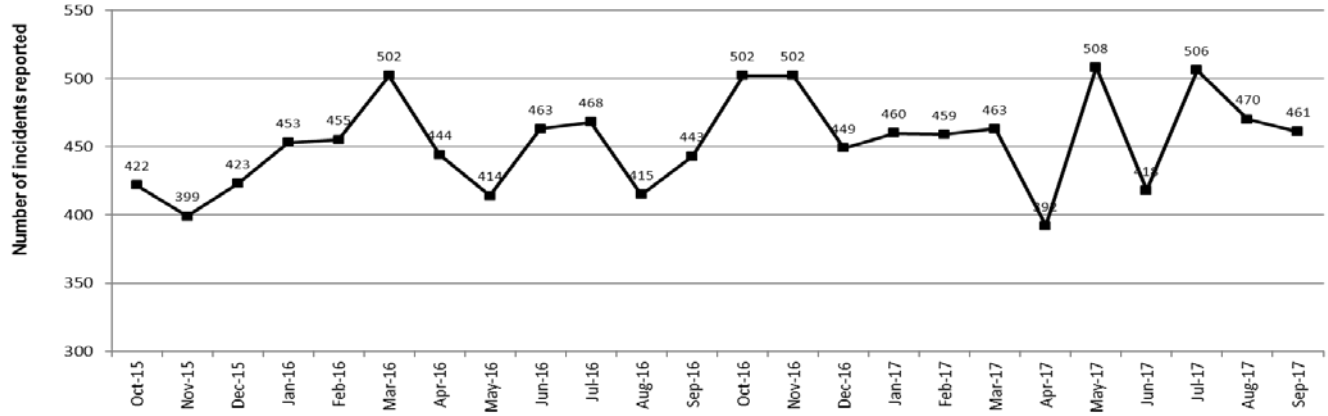
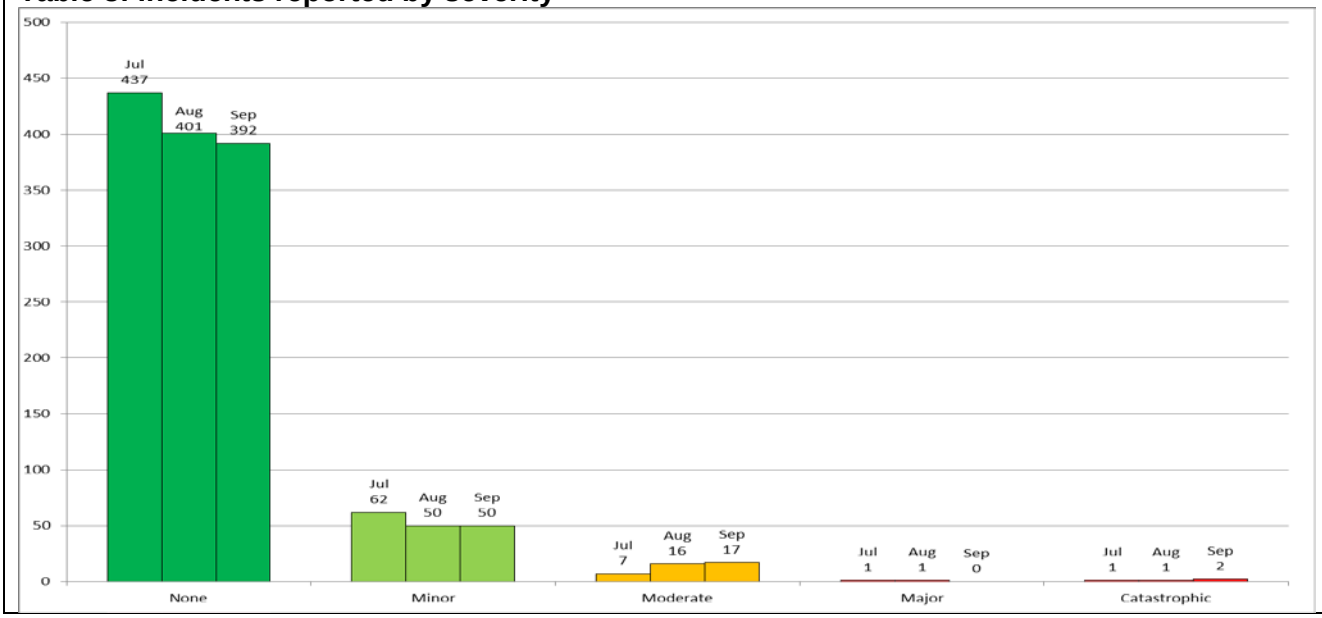


Table 3: Incidents reported by severity



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

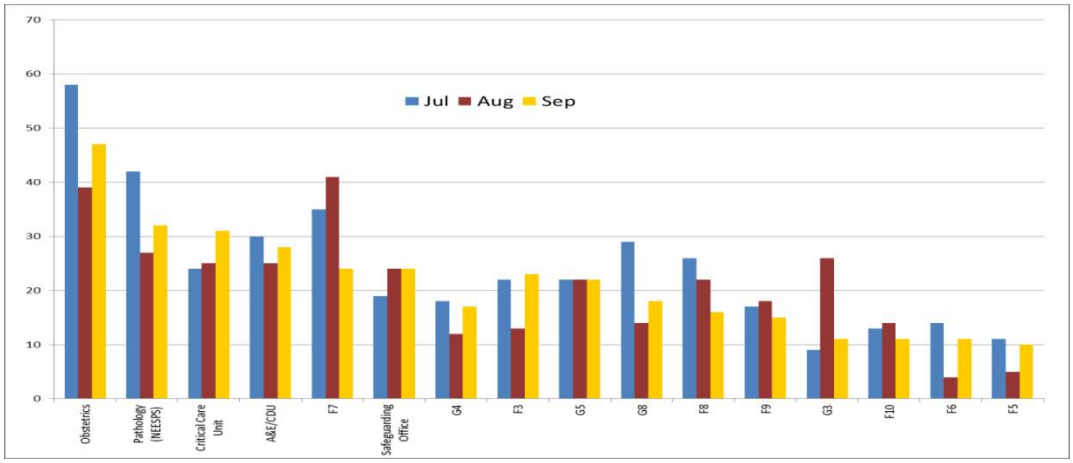
This month has seen a similar mixture as seen in the previous month; however an increase in Amber/moderate harm level incidents has been noted.

There are two Catastrophic harm incidents: these relates to an Intrauterine Death (IUD) and a deteriorating patient.

The 17 moderate harm incidents relate to:

Medicine (7)	
WSH-IR-33286	Pressure Ulcer
WSH-IR-33352	Pressure Ulcer
WSH-IR-33866	Medication Incidents
WSH-IR-33570	Infection Prevention Incidents
WSH-IR-33447	Infection Prevention Incidents
WSH-IR-33247	Infection Prevention Incidents
WSH-IR-33322	Infection Prevention Incidents
Surgical (3)	
WSH-IR-33881	Possible delay in providing treatment
WSH-IR-33424	MRSA
WSH-IR-33616	Medication Incidents
Women & Children (5)	
WSH-IR-33288	Blood and blood products - Anti-D detected
WSH-IR-33636	VTE
WSH-IR-33459	Shoulder dystocia
WSH-IR-33509	Complication during operation or procedure
WSH-IR-33912	Delivery of a stillborn with abnormalities not compatible with life
Clinical Support (2)	
WSH-IR-33423	Failure to provide or delay in providing diagnosis
WSH-IR-33508	Failure to provide or delay in providing diagnosis

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

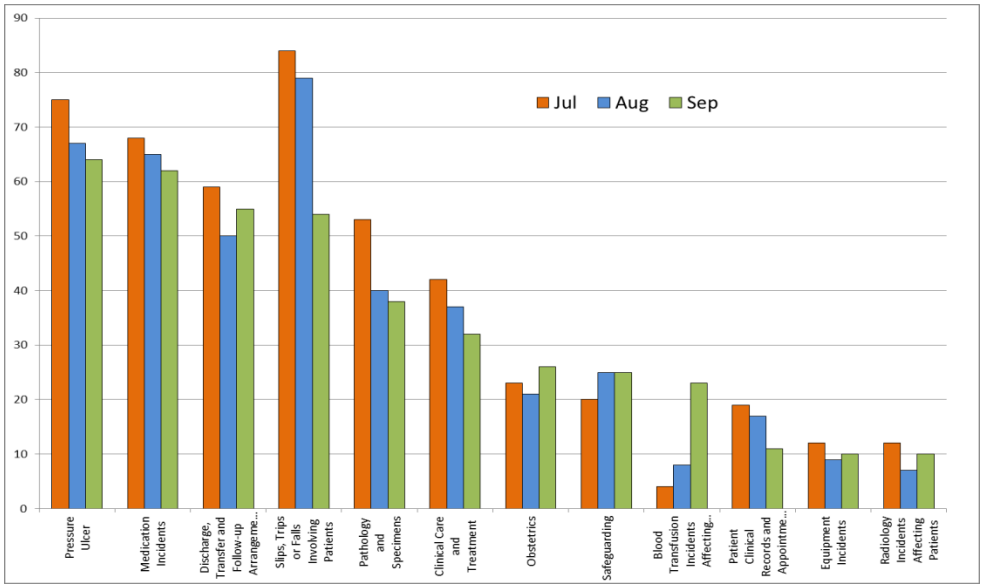


This month has seen an increase in reporting in F5, F6, F3, G4 and obstetrics. On review of these areas the following has been observed. F5 saw an increase in Medication incidents and falls. On discussion with the Matron there appears to be no obvious thematic issues however these will be monitored going forward.

F6 saw an increase in incidents from four to 11 in the month of September. Several of these incidents did affect the same person. Ten out of the 11 incidents reported, did result in no harm and one incidence of MRSA following investigation has been downgraded. F3 has also seen an increase in incidents this month from 13 to 23. All of these incidents were rated as green and affected 19 different patients. The two main areas of reporting were Pressure Ulcers and also Medication incidents. The Matron for the area is monitoring this to ensure any themes are detected and acted upon.

Obstetrics show a slight increase of three incidents, however no changes to level of harm or obvious trends.

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



There has seen an increase in Blood Transfusion incidents. There appears to be a wide range of incidents reported via the Blood transfusion service. This department has only recently joined Datix and there has been much encouragement to report incidents via the Datix system. To help get a greater understanding, a further section will be added to next month's report to see any thematic issues and actions taken.

Complaints

16 complaints were received in September. The breakdown of these complaints is as follows by Primary Division: Medical (6), Surgical (7), Clinical Support (1), Corporate Services (1), Estates & Facilities (1).

Patient Experience Themes

Area	Analysis	RAG
Car Park	Car parking complaints are continuing to be received in PALS, mostly relating to charges. Concessions are granted where necessary.	
Orthopaedics	Appointment and surgery cancellations have been highlighted as a theme in Orthopaedics. Due to bed status and emergency admissions, elective procedures have had to be cancelled in some cases. Affected patients are being rebooked as soon as possible. There are also known issues with RTT timeframes which the Trust is working hard to address.	
Green	*Problem area for only one month in the quarter*	
Amber	*Problem area for two consecutive months*	
Red	*Problem area for three consecutive months*	

Red rating = area for concern for >=3 months
Amber rating = area for concern for 2 months
Green rating = new area for concern

West Suffolk NHS
NHS Foundation Trust

Trust Board – 3rd November 2017

AGENDA ITEM:	13
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Sinead Collins, Clinical Business Manager
DATE PREPARED:	20th October 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 September's and progress of nurse staffing review made below.

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	4 medication errors	High agency use.
F7	8 medication errors	High bank and agency use. High sickness and vacancy
Theatres	-	High sickness
DSU	-	High sickness and bank use
G1	3 pressure ulcers	High sickness
G3	4 medication errors	High bank use & sickness
G4	6 medication errors	High bank use & sickness
G5	3 pressure ulcers	High bank use
G8	3 pressure ulcers	High bank use & sickness
F1	-	High bank use
F3	3 pressure ulcers and 8 medication errors	Higher vacancy in NA
F4	4 medication errors	High bank and agency use.
F5	-	High bank use
F6	4 medication errors	High agency use. High sickness
F9	-	High bank use & vacancy in RNs
Maternity	-	High bank use & sickness
F12	-	High bank use
Kings Suite	-	High bank use
Rosemary Ward	3 falls (with harm)	High bank use

Vacancies – There has been a significant increase in vacancies of registered staff. This has been highlighted operationally leading into the winter period and HR are aware. An escalation ward (G9) is not being opened due to this issue

Roster effectiveness – Out of 26 areas, 22 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is the same as August's amount. The reasoning for this has been put down to annual leave allocation, vacancies and staffing levels.

Sickness – Out of 27 areas, 19 are over the Trust Standard of 3.5% (three more than last month) (Day surgery unit & ward are counted as one area).

Update on progress of Nurse Staffing Review

Nurse Specialist review is currently with KPMG and Service Managers to action.

Due to different sizes of wards and external requirements, e.g. CCU has shared roles. KPMG, Service Managers and HR are in the process of agreeing the appropriate % of annual leave per ward and there will then be a performance process in place.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Sep-17			Establishment for the Financial Year 2017/18						Data for Sept 2017												
										Workforce											Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day (June 2017)	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night			Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	81.79	70.47%	29.53%	N/A	1 - 4	1 - 5	109.0%	90.4%	140.7%	106.7%	4.05%	6.41%	-0.23	-3.40	4.80%	N/A	23.20%	N/A	4	0
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	71.4%	76.9%	94.2%	100.0%	14.30%	3.55%	-5.70	-6.11	7.90%	6.57	23.30%	0	8	0
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	56.1%	N/A	103.4%	N/A	5.95%	0.00%	-0.40	-0.20	5.10%	N/A	25.80%	0	3	1
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	89.9%	83.4%	N/A	N/A	3.97%	0.00%	-4.13	0.00	2.70%	20.12	22.70%	1	2	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	103.6%	100.2%	N/A	N/A	2.00%	0.00%	-3.90	-0.40	9.90%	N/A	26.10%	0	1	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	138.4%	94.1%	79.0%	N/A	3.36%	0.00%	-2.73	-0.10	5.20%	N/A	19.50%	0	0	N/A
WSFT	Day Surgery Unit	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward area	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	59.7%	N/A	63.2%	N/A	0.42%	0.00%	0.00	-1.45	9.10%	N/A	26.70%	0	1	0
WSFT	Day Surgery Wards													10.55%	0.00%	-0.60	0.10	9.70%		24.70%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	100.8%	88.1%	51.1%	N/A	3.44%	0.00%	0.40	-0.70	3.00%	11.30	26.10%	0	0	1
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	88.6%	96.7%	104.0%	N/A	1.97%	0.00%	1.00	2.10	7.70%	7.65	29.20%	3	3	0
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	83.5%	76.1%	82.2%	115.3%	13.37%	0.25%	-2.86	-1.20	7.60%	4.76	24.30%	1	4	0
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	83.9%	75.4%	106.7%	114.8%	15.25%	0.00%	-2.43	-2.90	8.60%	5.65	24.60%	1	6	1
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	70.9%	79.2%	116.3%	100.0%	7.34%	0.23%	-4.33	-0.30	4.30%	I/D	22.50%	3	2	2
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	84.3%	81.6%	95.5%	99.8%	10.45%	0.00%	-3.80	-0.75	7.30%	6.09	24.70%	3	2	1
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	104.5%	123.6%	100.0%	N/A	13.15%	0.00%	-2.00	2.50	1.90%	N/A	29.20%	N/A	1	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	90.7%	99.4%	119.5%	97.9%	4.47%	2.05%	-2.20	-4.30	5.00%	4.87	21.30%	3	8	0
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	84.3%	88.2%	109.6%	207.4%	19.57%	4.06%	-1.93	-3.00	1.30%	6.08	25.10%	0	4	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	93.0%	85.7%	104.6%	126.1%	8.06%	0.25%	-3.26	0.70	2.40%	5.28	19.00%	0	2	0
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	80.6%	87.9%	98.3%	103.8%	2.40%	6.54%	-4.83	-1.90	7.10%	6.26	26.60%	0	4	0
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	87.7%	95.0%	91.6%	114.5%	10.20%	0.00%	-5.00	-1.59	1.40%	5.11	19.40%	0	2	1
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	112.2%	80.2%	78.3%	95.6%	0.67%	0.00%	-0.50	-0.10	5.60%	5.82	23.40%	0	3	2
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	110.1%	91.7%	97.7%	66.0%	15.51%	0.00%	-3.86	1.55	10.30%	N/A	28.80%	0	0	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1												0	0	0
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre recovery area, bereavement suite					1 - 2	1 - 2												0	0	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	96.5%	85.0%	28.0%	117.8%	15.41%	0.00%	-1.70	-0.60	6.80%	7.77	25.40%	0	2	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	100.0%	98.3%	N/A	N/A	1.44%	0.00%	-0.70	-0.40	0.60%	N/A	24.50%	0	0	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	9.00	80.00%	20.00%	N/A	5 - 8	N/A	95.7%	N/A	90.5%	N/A	0.00%	0.00%	-0.20	0.00	0.00%	N/A	16.10%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	103.3%	88.2%	13.6%	43.3%	3.80%	0.00%	-1.87	-1.40	4.90%	15.76	26.40%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	95.0%	86.7%	84.7%	123.3%	11.59%	0.00%	0.00	0.00	7.33%	6.20	N/A	0	0	3
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	100.0%	98.0%	92.0%	96.5%	12.24%	0.0%	0.10	-0.70	3.70%	4.90	26.50%	0	0	2
																-57.66	-24.55	Target - 3.5%		Trust standard is 20%			

Explanations

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

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

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3rd November 2017

PRESENTED BY:	Jan Bloomfield, Executive Director Workforce & Communications
AGENDA ITEM :	14
PREPARED BY:	Rebecca Rutterford, Training & OLM Manager
DATE PREPARED:	19th October 2017
SUBJECT:	Mandatory Training
PURPOSE:	For information and update
STRATEGIC OBJECTIVE:	To continue to secure, motivate, educate and develop a committed workforce providing high quality patient focused services

EXECUTIVE SUMMARY:

Appendix A is the October 2017 Mandatory Training Report, this represents data taken from the system on 10th October 2017.

Safeguarding Children Level 3 compliance continues to be a challenge. The named nurse for Safeguarding Children, along with training leads from high risk areas such as A&E and midwifery continue to monitor and chase all staff that are not compliant. Support has also been requested from the Acting Chief Operating Officer and Clinical Directors in improving uptake.

Corporate Trust Induction saw an unusual dip in compliance for July's new starters. August's Trust Induction was cancelled due to room availability, which resulted in Septembers Induction being full. Fire and Health and Safety, the statutory elements of Induction training, were provided separately to ensure staff were compliant until they were able to attend the full Induction. All staff who didn't attend have subsequently done so or are booked on to a future Induction.

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

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

Appendix D The National CQUIN 2015-6 target for Dementia staff training states that the Trust should include quarterly reports to Provider Boards of:
• Numbers of staff who have completed the training;
• Overall percentage of staff training within each provider'.

Appendix E shows mandatory training figures for SCH Community staff. SCH Community currently records training in a system called Staff Pathways.

New community staff hired by us from January 2018 will attend our Corporate Trust Induction, with the remaining clinical Inductions and mandatory training to continue to be provided by the Suffolk Community Healthcare Workforce Team until the end of March 2018.This will enable both ourselves and Ipswich Hospital Trust to ensure we have made sufficient provisions to provide a smooth transition for both Induction and on-going training for community staff.

	Suffolk Community Healthcare	West Suffolk Hospital
Corporate Trust Induction	Currently -Dec 2017	January 2018 onwards
Clinical Inductions	Currently - March 2018	April 2018 onwards

Mandatory Training	Currently - March 2018	April 2018 onwards

It is anticipated that the community training compliance figures will be included as part of our main mandatory training reports from May 2018. This is following the transfer of all training records into our Oracle Learning Management system (OLM) and the mapping of their training requirements.

Access to the Electronic Staff Record (ESR) is moving to a new Portal from 1st January 2018 which requires the browser Internet Explorer 11(IE11). IE11 is not widely available within the Trust and ESR is not compatible with any other browser. Due to current resource commitments the IT department are unable to start updating computers around the Trust until March 2018. They are in the process of updating the computers of core ESR users in Human Resources so they are able to perform their roles.

Risks

- The majority of computers in the Trust do not have IE11. There will be very limited computers in which staff can access and complete their mandatory training via eLearning. It will also restrict access to electronic payslips, and functions such as updating bank account details for payment. This will have a negative impact on mandatory training compliance.

- There are departments that use ESR Manager Self Service to input their staff's sickness information. This may result in the delay or non-entry of sickness details and effect sickness figures and potentially individuals pay.

Mitigating Action

- To reduce the risk the Workforce Information Team will be pushing the use of remote access and Employee Self Service Limited Access (ESSLA) which can be accessed via an Application on mobile devices & tablets. Staff are able to view payslips and update bank details off site; however they will not have the ability to complete e-learning. Those areas that are using ESR Manager Self Service will be informed of computers which have IE11 to enable them to access the system, alternatively they will need to revert to the paper based recording system.

- There are designated computers that have been identified within the Education Centre for staff to complete their e-learning.

- The IT Department are investigating various options including the possibility of installing Citrix Receiver on computer desktops which allows access to applications on servers and will allow the use of Internet Explorer 11.

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

Risk Implications for West Suffolk Hospital (including any clinical and financial consequences):	**Mitigating Actions**
Risk to patient safety due to untrained staff.	Mandatory Training action plan (attached) and risk assessment

Level of Assurance that can be given to the Committee from the report based on the evidence [significant, sufficient, limited, none]: Sufficient

Recommendation to the Board of Directors:
Acceptance of the action plan to further improve compliance

Appendix A

Subject Matter - High Level Mandatory Training Analysis October 2017

Competence Name	Trust Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
179|LOCAL|Infection Control - Classroom|	80%	94%	94%	94%	94%	95%	95%	96%	95%	95%	96%	94%	95%
179|LOCAL|Equality and Diversity|	80%	91%	91%	91%	92%	93%	93%	94%	95%	95%	93%	92%	93%
179|LOCAL|Safeguarding Adults|	80%	87%	87%	86%	87%	88%	88%	89%	90%	90%	89%	89%	90%
179|LOCAL|Fire Safety Training - Classroom|	80%	88%	89%	89%	89%	89%	90%	90%	90%	90%	90%	89%	90%
179|LOCAL|Health & Safety / Risk Management|	80%	86%	87%	86%	87%	88%	88%	89%	89%	89%	89%	89%	90%
179|LOCAL|Security Awareness|	80%	87%	87%	87%	87%	88%	88%	89%	90%	90%	89%	89%	90%
179|LOCAL|Safeguarding Children Level 2|	90%	85%	86%	86%	87%	87%	87%	88%	90%	90%	87%	88%	89%
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	90%	86%	87%	86%	87%	86%	86%	86%	87%	88%	87%	86%	88%
179|LOCAL|MAJAX|	80%	85%	85%	85%	86%	86%	86%	86%	88%	88%	87%	86%	88%
179|LOCAL|Information Governance|	95%	81%	82%	82%	82%	82%	80%	81%	85%	84%	85%	84%	87%
179|LOCAL|Medicine Management (Refresher)|	80%	85%	85%	85%	86%	87%	87%	87%	88%	88%	87%	87%	86%
179|LOCAL|Slips Trips Falls|	80%	83%	83%	82%	84%	85%	84%	85%	87%	87%	85%	85%	86%
179|LOCAL|Blood Bourn Viruses/Inoculation Incidents|	80%	82%	82%	81%	84%	85%	84%	84%	86%	86%	84%	84%	85%
179|LOCAL|Infection Control - eLearning|	80%	87%	87%	87%	88%	88%	88%	88%	90%	90%	88%	83%	85%
179|LOCAL|Fire Safety Training - eLearning|	80%	87%	87%	86%	86%	85%	85%	86%	87%	87%	85%	85%	85%
179|LOCAL|Moving and Handling Non Clinical Load Handler|	80%	75%	86%	87%	84%	83%	81%	81%	83%	83%	82%	86%	84%
179|LOCAL|Conflict Resolution - elearning|	80%	77%	76%	77%	81%	83%	81%	83%	85%	86%	80%	80%	81%
179|LOCAL|Basic Life Support - Adult|	80%	78%	81%	81%	80%	81%	83%	85%	85%	85%	84%	82%	81%
179|LOCAL|Moving and Handling - Clinical|	80%	78%	80%	82%	80%	79%	81%	83%	84%	83%	83%	80%	80%
179|LOCAL|Blood Products & Transfusion Processes (Refresher)|	80%	77%	77%	76%	78%	80%	80%	82%	83%	82%	79%	79%	80%
NHS|MAND|Safeguarding Children Level 3 - 1 Year|	90%	83%	81%	81%	79%	78%	85%	83%	81%	81%	76%	73%	79%
179|LOCAL|Conflict Resolution|	80%	73%	74%	74%	74%	75%	75%	75%	77%	77%	76%	75%	76%
179|LOCAL|Moving & Handling - elearning|	80%	77%	77%	77%	79%	79%	81%	81%	81%	81%	75%	75%	75%

July 2017 New Starters % Compliance – Trust	Total
No	11
Yes	36
Grand Total	47
% Compliance	76.60%

Appendix B

	Oct 2017 %	Method	Actions	Completion date	Responsibility	Progress
Safeguarding Children level 1	88%	E-learning	A bespoke report providing more detailed analysis of Safeguarding Children figures to be provided to the Named Nurse for Safeguarding Children.	Jan 2018	Lisa Sarson	Targeted emails, following up individuals and detailed reports have resulted in a 2% increase. This work to be continued until target is met.
Safeguarding Children level 2	89%	E-learning	A bespoke report providing more detailed analysis of Safeguarding Children figures to be provided to the Named Nurse for Safeguarding Children.	Jan 2018	Lisa Sarson	Targeted emails, following up individuals and detailed reports have resulted in a 2% increase. This work to be continued until target is met.
Safeguarding Children level 3	79%	Face to face	A bespoke report providing more detailed analysis of Safeguarding Children figures to be provided to the Named Nurse for Safeguarding Children, also to all high risk areas.	Jan 2018	Lisa Sarson	Targeted emails, following up individuals and detailed reports have resulted in a 6% increase from the previous month. Challenges with cancelled training, delayed attendance sheets and turn over have had an impact on the figures.
Moving & Handling–e-learning	75%	E-learning	Manual Handling Advisor to email mangers encouraging staff to be compliant and complete the eLearning package.	Jan 2018	Neil Herbert	The new intake of junior Doctors over the summer has resulted in a dip in compliance. Specific staff groups to be followed up.
Information Governance	87%	E-learning	IG team to target non-compliant staff directly with the training slides and compliance test.	Jan 2018	Sara Ames	The IG team continue to offer one off training sessions to departments that require it. Compliance continues to rise, seeing a 3% increase since last quarter. Compliance increase is likely to be slower than others as it's a yearly requirement for all staff.
Conflict Resolution	76%	Face to Face	To review whether additional Conflict Resolution courses are required to meet the demand of both substantial staff and our temporary workers.	Jan 2018	Darren Cooksey	A review has been carried out and there are sufficient spaces available to meet demand. As the longest, single subject course, Conflict Resolution continues to be a challenge for staff being released from the wards.

Appendix C

Subject	Issues	Risks	Description of Action	Lead	Status *
179|LOCAL| Moving and Handling –e-learning	• Poor uptake	• Potential staff injury • Financial implication such as sick pay, staff cover, court costs, compensation.	• Reminders to be sent to those who are non-compliant	Moving and Handling Advisor	Low
179|LOCAL| Conflict Resolution|	• Staffing levels and the Ward/ Departments ability to backfill will affect the numbers attending • Release of staff on clinical areas.	• Failure to recognise body language indications of possible aggression. • Failure to recognise warning signs when an aggressor is agitated or distressed. • Failure to recognise danger signs which may indicate imminent attack. • Failure to employ applicable communication skills • Litigation consequences • Potential staff injuries resulting in RIDDOR absenteeism. • Poor staff morale	• Training compacted to four hours to enable staff attendance. • LSMS and Portering can be called to via 2222 to assist staff in managing difficult situations • Police assistance can be summoned. • Restrictive Physical Intervention team may be employed when managing clinically confused patients. • Refresher sessions for staff who have expired, lasting 2 hours. • Discussion taking place to incorporate conflict resolution, dementia awareness and break away training into one package.	Portering and Security manager	Low
179|LOCAL|Information Governance|	• Annual training replaced 3 yearly training in 2014 • 95% compliance target explicit in 2015/16 IG toolkit	• Increased risk of IG breaches and vulnerability to ICO fine if staff awareness of IG is poor. • IG toolkit compliance will be unsatisfactory (level 1 only) if we cannot demonstrate achievement of 95% target.	• Outstanding staff are contacted on a monthly basis to update training. • Training materials and test attached to email to facilitate a quick and convenient way to carry out training.	IG Manager	Medium
NHS|MAND| Safeguarding Children Level 3 - 1 Year|	• Poor uptake • Specialised face to face learning • Annual dates for departmental sessions scheduled past staff expiry dates	• Failure to recognise signs & symptoms of abuse in a child • Failure to recognise parental factors that predispose a child to significant harm • Failure to understand how to report concerns for child • Failure to recognise and act upon more specialised areas of child protection	• Paediatric, neonatal and midwifery level 3 training offered over a number of dates throughout the year. • Extra training sessions advertised • Three sessions per year open to all Trust employees and partner agencies presenting a range of topics • Unit managers for areas with high contact with children and young people also receive lists of non-compliant staff. • Emails of those non-compliant sent to managers and risk assessments requested.	Named Nurse Safeguarding children	Medium

Subject	Issues	Risks	Description of Action	Lead	Status *
NHS|MAND| Safeguarding Children Level 1 - 3 Year| & 179|LOCAL| Safeguarding Children Level 2|	• Three yearly renewals approaching expiry. • Longer than the average eLearning course due to content requirement	• Failure to recognise signs & symptoms of abuse in a child • Failure to recognise parental factors that predispose a child to significant harm • Failure to understand how to report concerns for child	• Targeted emails, following up individuals and detailed reports have resulted in a 2% increase. This work to be continued until target is met.	Named Nurse Safeguarding children	Low

Appendix D – Dementia Training Figures

Month	Number require training	Total number trained	% Compliance
April	917	870	94.87%
May	919	874	95.10%
June	918	878	95.64%
Q1.	**2754**	**2622**	**95.21%**
July	905	866	95.69%
Aug	822	793	96.47%
Sep	811	783	96.55%
Q2.	**2538**	**2442**	**96.22%**
Oct	797	766	96.11%

Appendix E – SCH Community

Mandatory Training – as at September 2017

WSH									
Topic	All			Enabling**	Workforce	Leadership	Operations*	Quality and Governance	Paediatrics
	Compliant	NonCompliant	% Compliancy						
Conflict Resolution	386	15	96.26%	95.05%	N/A	100.00%	96.00%	100.00%	96.76%
Dementia Compliance	384	17	95.76%	91.09%	N/A	100.00%	94.67%	100.00%	98.15%
Equality and Diversity	383	18	95.51%	91.09%	N/A	100.00%	89.33%	100.00%	99.54%
Fire	368	33	91.77%	92.08%	N/A	100.00%	92.00%	100.00%	91.20%
Health & Safety	389	12	97.01%	96.04%	N/A	100.00%	89.33%	100.00%	100.00%
Infection Control	349	52	87.03%	76.24%	N/A	100.00%	90.67%	100.00%	90.28%
Information Governance	382	19	95.26%	99.01%	N/A	100.00%	94.67%	100.00%	93.52%
Learning Disabilities	379	22	94.51%	85.15%	N/A	100.00%	94.67%	100.00%	98.61%
Life Support	193	50	79.42%	N/A	N/A	N/A	84.06%	66.67%	77.78%
Mental Capacity	35	4	89.74%	N/A	N/A	N/A	89.19%	100.00%	N/A
Moving and Handling	359	42	89.53%	97.03%	N/A	100.00%	84.00%	87.50%	87.96%
Safeguarding Adults	384	17	95.76%	92.08%	N/A	100.00%	97.33%	87.50%	97.22%
Safeguarding Children	389	12	97.01%	91.09%	N/A	100.00%	98.67%	100.00%	99.07%
Overall % for all topics	**4380**	**313**	**93.33%**	**91.45%**	**N/A**	**100.00%**	**92.05%**	**96.77%**	**94.46%**
*** Enabling = Facilities, Finance & Informatics*									
*** Operations = Newmarket Hospital, Epilepsy, Neurology, Parkinsons, Adult SLT*									

West Suffolk NHS
NHS Foundation Trust

Board of Directors 3rd November 2017

AGENDA ITEM:	15
PRESENTED BY:	Nick Jenkins, Executive Medical Director
PREPARED BY:	Sarah Gull, Guardian of Safe Working Hours
DATE PREPARED:	October 2017
SUBJECT:	Safe staffing guardian report
PURPOSE:	Information

EXECUTIVE SUMMARY:

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

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaces monitoring of working hours. This is done using Allocate software, a system already in place at West Suffolk, but extended for this purpose. This report covers four months (June-September inclusive) to fall into line with the calendar year.

Linked Strategic objective (link to website)	Workforce
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:

West Suffolk NHS
NHS Foundation Trust

Item 15

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

7th June – 30th September 2017

Executive summary

Introduction

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

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaces monitoring of working hours. This is done using Allocate software, a system already in place at West Suffolk, but extended for this purpose. This report covers four months (June-September inclusive) to fall into line with the calendar year.

The report is also informed by the monthly Junior Doctors' Forum. This meeting has now developed into two parts: The first is an open (unminuted) forum for all junior doctors; the second is chaired by the GOSW and includes Junior Doctor representatives, including the mess president, chief resident and BMA representatives, and also the Director of Education, The Director of the Foundation Programme, members of HR, rota co-ordinators, and BMA advisors. This meeting is minuted.

Most trainees taking up appointments are now on the New Contract, although it should be noted that this does not include a further 49 doctors working in Trust grade positions. There are currently just 4 trainees left on the old contract: 3 on maternity leave and one due to change. From Dec 2016- July 2017 there were just 30 doctors involved. There was a large increase on August 2nd to 132 doctors when a change in rotation to this Trust occurred

Summary data

Number of doctors / dentists in training (total):	136
Number of doctors / dentists in training on 2016 TCS (total):	132 (includes p/t trainees)
Amount of time available in job plan for guardian to do the role:	1 PAs / 4 hours per week
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee[1]
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

a) Exception reports (with regard to working hours)

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

Patterns are now developing which may prompt reflection on working practice within some departments and highlight difficulties which are discussed below.

Exception Reports by DEPARTMENT

Specialty	No. exceptions carried over from before 30th Sept 17	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	0	25	16	9
Medicine	0	49	49	0
Woman & Child	0	4	1	3
Clinical Support	0	0	0	0
Total	0	78	65	13

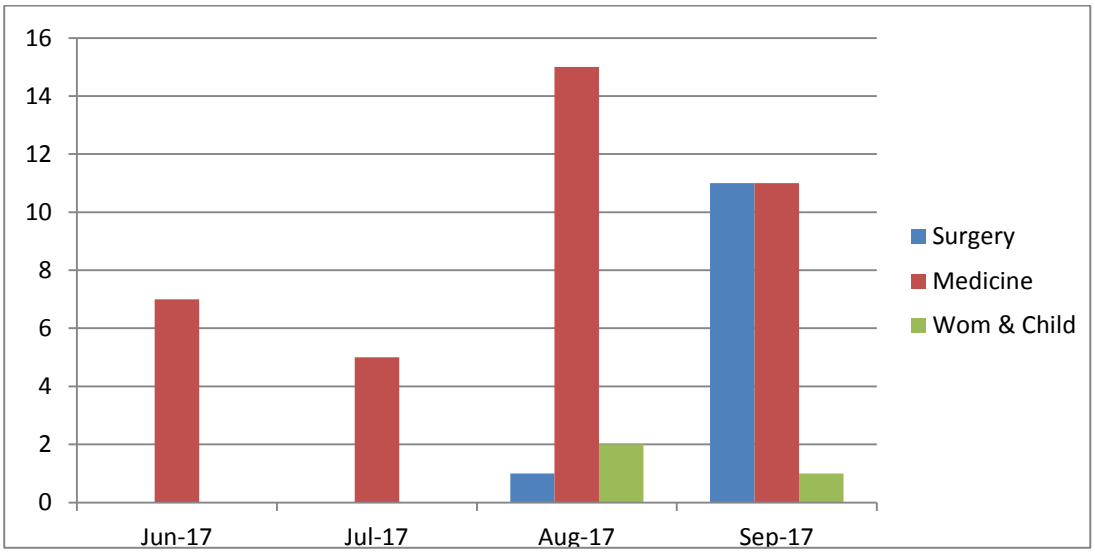
Exception reports by ROTA & GRADE

Specialty		Exceptions carried over from before 30th Sept 17	Exceptions raised	Exceptions closed	Exceptions outstanding
General Surgery	F1	0	6	3	3
	Junior	0	19	13	6
	Senior ST3+	0	0	0	0
General Medicine	F1	0	29	29	0
	Junior	0	20	19	1
	Senior ST3+	0	0	0	0
Woman & Child	F1	0	0	0	0
	F2	0	3	1	2
	ST3	0	1	0	1
Total		0	78	65	13

Exception reports – RESPONSE TIME

	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
Surgery (25)	7	4	13	1
Medicine (49)	0	34	14	1
Woman & Child (4)	0	0	1	3
Total	7	38	31	5

Exception Reports Raised during period



b) Work schedule reviews check last review- I think 6

Work schedule reviews for individuals may be requested by either the doctor, or the education/clinical supervisor, service manager or guardian in writing. None have been carried out in this period.

Any future reviews will be presented thus:

Work schedule reviews by grade	
F1	0
F2	0
ST3+	0

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

Locum Bookings : 7th June – 30th September 2017

TABLE 1 : Shifts requested between 7th June and 30th September 2017 by 'reason requested'

Department	Extra / Rota Compliance	Leave (Annual/Study/ Special)	Maternity/ Paternity	Sickness (inc Reduced House/Duties)	Vacancy	Grand Total
A&E	36	45		6	87	174
Anaesthetics					29	29
Cardiology					2	2
Dermatology					24	24
ENT		4		1		5
General Surgery	5	4		20	13	42
ITU		4		3	8	15
Medicine	90	21	13	21	108	253
O&G	4			10	37	51
Ophthalmology					35	35
Paediatrics	2			25	15	42
Surgery					27	27
T&O	10	2		2	37	51
Urology	1	12		2		15
Grand Total	**148**	**92**	**13**	**90**	**422**	**765**

TABLE 2 : Shifts requested between 7th June – 30th September 2017 by 'Agency / In house fill'

Department	Global Medics	ID Medical	Medacs	National Locums	NHS	Grand Total
A&E		2			172	174
Anaesthetics					29	29
Cardiology					2	2
Dermatology					24	24
ENT					5	5
General Surgery				1	41	42
ITU					15	15
Medicine					253	253
O&G	3		5		43	51
Ophthalmology					35	35
Paediatrics					42	42
Surgery				27		27
T&O				10	41	51
Urology					15	15
Grand Total	**3**	**2**	**5**	**38**	**717**	**765**

TABLE 3 : Shifts requested between 7th June – 30th September 2017 filled 'In house only by grade'

Department	Assoc Spec	F1	F2/ST	ST3/4	Grand Total
A&E			85	87	172
Anaesthetics			6	23	29
Cardiology				2	2
Dermatology	24				24
ENT			5		5
General Surgery		16	11	14	41
ITU		1	7	7	15
Medicine		1	189	63	253
O&G			3	40	43
Ophthalmology				35	35
Paediatrics			37	5	42
T&O			36	5	41
Urology		1	2	12	15
Grand Total	**24**	**19**	**381**	**293**	**717**

Vacancies

HR have provided details of current vacancies:

Department	Grade	June 2017	July 2017	Aug 2017	Sept 2017
Anaesthetics	CT	2	2		
A&E	GP	1		2	2
	ACCS			1	1
ENT	CF (ST3)	1	1		
General Surgery	F2	1	1		
Medicine	CT			2	2
	GP			2	1
	ACCS			1	1
	ST3+	1	1	1	1
	CF (ST3)		1		
Obs & Gynae	ST3+	2	2		
Ophthalmology	ST3+	2	2	1	
Paediatrics	GP			1	
Total		**10**	**10**	**11**	**8**

c) **Fines**

There is a system of financial penalty now in place where exception reporting demonstrates the following:
-a breach of the 48-hour average working week across the reference period agreed for that placement in the work schedule
-a breach in the maximum 72-hour limit in any seven days
- the mimimum 11 hours rest requirement between shifts has been reduced to fewer than 8 hours.

This quarter, exception reporting has one fine within Surgery (T&O) for breaching the 72 hour limit in a 7 day period.

Fines by department			
Department	Number of fines levied	Value of fines levied £	Reason for Fine
Surgery – T&O	1	£118.08	Breach of over 72 hrs in a 7 day period.
Total	1	£118.08	

Disbursement of Fines		
Total Amount of Fines	Amount to Drs	Amount to Guardian Fund
£118.08	£44.28	£73.80

Guardian Fund (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
0	£73.80	0	£73.80

Matters arising

-**Exception Reporting.** Whilst there has been an increase in the amount of Exception Reporting since August this has not been in proportion to the greatly increased number of doctors now involved in the contract. Reasons for this are likely to be complex, and have been discussed at length in the JD Forum. There is a general view that the figures under-represent the true picture. Possible causes of this include:

- a perception that the process of ER is cumbersome to complete

-reluctance on the part of the JD to bother the consultant on-call/ward consultant for permission

- discouragement from some consultants

The Guardian has tried to address these issues by writing to all the consultants to encourage reporting where it is actually necessary, but more importantly to ensure safe working practice within departments to ensure that JDs are not required to work beyond contracted hours. She has also written to all Junior staff to encourage them to overcome their hesitancy, for whilst we would wish to have a low level of Exception Reporting this should be for the right reasons, i.e because it is not necessary. She has spoken to individual consultants within Surgery and Acute Medicine to encourage support.

Concern remains from Junior Doctor reps that the need to gain permission from a consultant is acting as a deterrent. However, this should provide an opportunity for the consultant involved to resolve the issue .

-**Patterns of Reporting.** During these four months the majority of ERs have come from Medicine. It is clear that the JDs involved have a heavy workload and are doing their best to manage the patients safely. Narrative reports, which accompany the ER highlight a number of issues, which may involve other staff groups, including the nursing staff being understaffed, or consultants being away. There are references to ward rounds extending late in the afternoons, which then generates more ward work, and a need for family discussions, particularly around care of the dying.

Almost exclusively, ERs have been the F1/F2 doctors, rather than specialty trainees.

It may be significant that there are fewer ERs from surgical specialties since the introduction of ward-based working for F1 doctors. However, concern has been expressed this leads to a loss of training opportunities beyond the ward (in theatres or clinics), which should be addressed in Work Schedules.

Trust Doctors, who are also working similar working patterns, are not part of this contract and therefore are not included in any figures related to Exception Reporting.

-Fines For the first time a small fine has been levied within Surgery (Trauma and Orthopaedics)

-Other ways of working Use of non-medical staff, such as Clinical Skill Practitioners and Physician Assistants is generally welcomed. Two surgical CSP posts have been agreed. There may also be ways of streamlining work processes, which could reduce the workload on Junior Doctors safely: a member of the e-care team has been attending the early part of the JD Forum.

-Locums. The two biggest areas where locum support has been required are A&E, and Medicine. In both specialties this is due to a combination of vacancies, rota gaps, and leave arrangements. 717/765 shifts were filled with NHS staff "in-house". Could this be addressed through other ways of working? I wonder, for example, if there might be ways of reducing duplication of effort for admissions via A&E to Acute Medicine. The Guardian will explore this further with the consultants involved.

Appendices

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

Sarah Gull

Guardian of Safe Working Hours (October 2017)

Background

In February 2015, Sir Robert Francis published his final report which made a number of key recommendations under five overarching themes with actions for NHS organisations and professional and system regulators to help foster a culture of safety and learning in which all staff feel safe to raise a concern. Two key elements include the appointment of a local Guardian in each Trust and a national Guardian for the NHS. In April 2016 NHS Improvement published a national policy for raising concerns for NHS organisations in England to adopt as a minimum standard. The Francis report emphasises the role of the NHS constitution in helping to create a more open and transparent culture in the NHS which focuses on driving up the quality and safety of patient care.

Role of the Guardian

Independent In the advice they give to staff and trust's senior leaders, and free to prioritise their
actions to create the greatest impact on speaking up culture
and able to hold trusts to account for: creating a culture of speaking up; putting in place processes to support speaking up; taking action to make improvements where needed; and displaying behaviours that encourage speaking up.

Impartial and able to review fairly how cases where staff have spoken up are handled.

Empowered To take a leading role in supporting staff to speak up safely and to independently
report on progress on behalf of a local network of 'champions' or as the single role holder.

Visible To all staff, particularly those on the frontline, and approachable by all, irrespective of
discipline or grade.

Influential With direct and regular access to members of trust boards and other senior leaders

Knowledgeable In Freedom to Speak Up matters and local issues, and able to advise staff
appropriately about speaking up.

Inclusive and willing and able to support people who may struggle to have their voices heard

Credible with experience that resonates with frontline staff

Empathetic to people who wish to speak up, especially those who may be encountering difficulties

and able to listen well, facilitate constructive conversations, and mediate to help resolve issues satisfactorily at the earliest stage possible.

Trusted by all to handle issues fairly, take action as necessary, act with integrity and maintain
confidentiality as appropriate.

Self-aware and able to handle difficult situations professionally, setting boundaries and seeking
support where needed.

Forward thinking and able to make recommendations and take action to improve the handling of cases where staff have spoken up, and freedom to speak up culture more generally.

Supported with sufficient designated time to carry out their role, participate in external Freedom
to Speak Up activities, and take part in staff training, induction and other relevant activities
with access to advice and training, and appropriate administrative and other support.

Effective monitoring the handling and resolution of concerns and ensuring clear action, learning, follow up and feedback.

Updates

Current work undertaken by the FTSUG Guardian for West Suffolk NHS Foundation Trust to date includes:

- A secure route for staff to contact the FTSUG in and out of hours via a mobile phone or email.
- Advertising on the Hospital Intranet and how to make contact with the FTSUG.
- A dedicated notice board advertising the FTSUG and how to make contact.
- A working link with the Senior Independent Non – Executive Director .
- Working with the National Guardians Office.
- Working with the Eastern Region Guardians Office, attending meetings and telephone conferences.
- To organise a visit by Dr Henrietta Hughes to meet Trust staff and give a talk at the Five O Clock Club on January 11th 2018.
- Attend Trust Inductions.

- Attended training with the National Guardians Office.

- Regular meetings with Jan Bloomfield Director Workforce & Communications, Human Resources & Communications.

Concerns Raised from 1st April 2017

Concern	Numbers	Status
Behaviour/ attitude	2	Pending
Trust procedure/practice	1	Resolved
Capacity/workload	0	
Miscellaneous	4	Resolved

This table shows the number of concerns raised over the last three months where the FTSUG has been asked to investigate and currently working with staff.

Behaviour/attitude These are two cases where I am either working with staff and HR or where I have been asked to support staff.

Trust procedure/practice This case was raised by a member of staff who identified safety issues.
The case was forwarded to the line manager and director responsible. This resulted in a change in practice and all parties were satisfied with the outcome.

Capacity/workload No cases to date.

Miscellaneous I was approached by four different members of staff who raised issues but had not communicated with the line manager first**.** They were advised accordingly and matter resolved without the need of the FTSUG.

Future plans

- To arrange a meeting with all staff groups to advertise of the role and support where necessary.

- To work with the trusted partners and the new staff governors.

- Continue to raise the profile so that staff are fully aware who I am and how I can be approached.

- To continue all the work previously carried out (Update).

- A planned meeting with the CQC when they visit the Trust in November.

- To forge a link with our new community staff.

West Suffolk NHS
NHS Foundation Trust

Board of Directors 3rd November 2017

AGENDA ITEM:	16
PRESENTED BY:	Nick Finch
PREPARED BY:	Nick Finch
DATE PREPARED:	27th October 2017
SUBJECT:	Freedom to Speak Up Guardian Report
PURPOSE:	Information

EXECUTIVE SUMMARY:

Hello my name Nick Finch and I am the Freedom to Speak up Guardian for West Suffolk NHS Foundation Trust and have been in post since 1st April 2017, this is my first Board report as the Guardian.

Linked Strategic objective (link to website)	Workforce
Issue previously considered by: (e.g. committees or forums)	Nil
Risk description: (including reference Risk Register and BAF if applicable)	Delivery of the workforce plan with an engaged and motivated workforce (BAF 5.1)
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Arrangements have been put in place to meet regulatory requirements. The CQC will test arrangements as part of a well led inspection.
Legislation / Regulatoryrequirements:	In place as part of a well led inspection and part of the Robert Francis report 2015.
Other key issues: (e.g. finance, workforce, policy implications, sustainability&communication)	

Recommendation: As I am relatively new to role I will be reporting to the Trust board on a more regular basis outlining the work being carried out by the FTSUG and intend to submit a report every quarter.

HelpForce

MAKING MORE TIME FOR CARE

Appendix to board paper **Volunteer Services – Helpforce Initiative**

Two slides created by the national team:

1. 1. The high-impact points in the patient pathway where volunteer support could add significant value to patient flow and experience, and the new roles which pilot sites will be testing alongside them
2. 2. The high-level plan for evaluation 2018-21

NB these slides represent early plans which may well change as the project develops

1. Initial set of interventions

HelpForce
MAKING MORE TIME FOR CARE

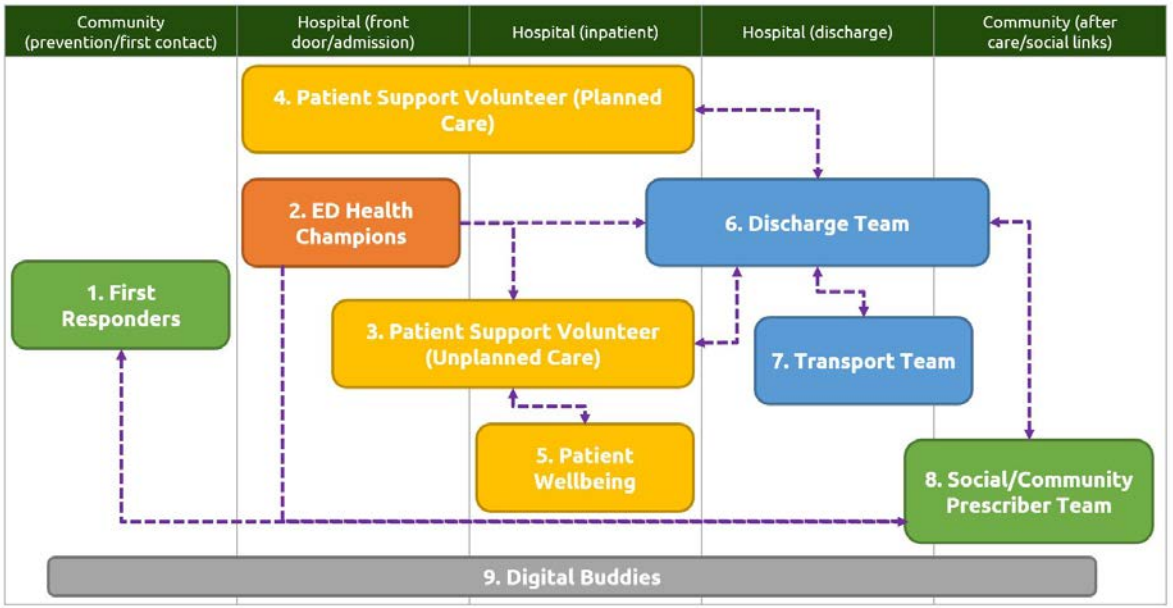
1. Sandwell
Scoping out four areas currently and will initially select two to focus on:

- (7) Volunteer transport service to help people get to appointments on time with added support
- (5) Volunteers to help with mobility on the wards, fit with our End PJ Paralysis campaign
- (4) Pathway coordinators for patients with dementia to aid with appointment reminders and to be a steady point of contact
- (6) Extension of our stay in touch service to keep contact with patients on discharge including a programme of visits and phone calls and coordinating support from other organisations

4. Chelsea & Westminster
We anticipate starting with the internal hospital roles ie (3), (4), and (5) and then moving to (6) and (7).

3. Northumbria

- (2) ED Health Champions
- (7) Discharge Team



While there is natural overlap between many of these interventions, where there are anticipated to be daily direct links, this is illustrated with a dashed purple arrow (▬▬►)

2. West Suffolk

- (6) and (7): Volunteers supporting the discharge planning process to help people get home as early as possible and safely
- (1) and (3): Volunteers supporting the early intervention team to help divert admissions and keep people at home during short acute illnesses
- (8): Volunteers located in people's communities who can provide support and company at home to overcome problems such as social isolation, reablement, and connecting people with clubs, services and other sources of local support."

5. UHS
(5) - Patient Wellbeing (through patient exercise programme)

2. High-level approach to evaluation

HelpForce
MAKING MORE TIME FOR CARE

When	Time frame	Year 1 2018	Year 2 2019	Year 3 2020	Year 4 2021
	HelpForce Strategy Phase	Phase 2: Develop the model		Phase 3: Create the pull	
		Pilots year 1	Pilots year 2	Scale Year 1	Scale Year 2
Approach	**Insight v Impact**	**Insight** → **Impact**			
	Type of 'Evaluation'	'Formative' • Evaluate the process to create the intervention • Done from day 1 of project • **"How can we make it work?"**		'Summative' • Evaluate the finished intervention • Done at the end of the project • **"So, did it work?"**	
	Purpose	• Test and learn - build confidence • Improve interventions, improve practice • Develop common set of impact metrics • Expose what is happening via data (dashboard)		• Stringent testing of proven interventions • Assess if interventions work in controlled situation • Academic / scientific approach to analysis • Study cost effectiveness as well as social impact	
	Partner role	Part of the team		Independent	
Impact Measures	Characteristics	• More QUAL → • Granular / many → • Locally defined →	• QUAL & QUANT → • Rolled up / fewer → • Common set (Pilots) →	• More QUANT • Few • Standard set nationally	
	Data source	Captured by team e.g. witness reports, data collection, surveys	Mix of self-captured and hospital systems	Hospital systems	
	Examples: Patient	• Stories & experiences • Level of contact time	• Improved medical recovery e.g. nutrition, exercise	• Patient satisfaction & wellbeing • FFT	
	Staff	• Staff feedback • Staff integration with volunteers	• Staff time with patients • Level of vol'teer support • Staff satisfaction	• Staff retention • Staff effectiveness	
	Volunteers	• Volunteer feedback • Volunteer engagement	• Quality & range of roles • Quality of role matching • Volunteer satisfaction	• Number active volunteers • Number 'certified' volunteers • Volunteer retention rate • Onboarding time needed	
	Services	• Discharge process design • Patient flow improvement	• Older inpatients wellbeing • Reduction hospital stays	• ROI of volunteer services • Length of stay / bed days • Readmission rate	

West Suffolk NHS
NHS Foundation Trust

Trust Board – 3rd November 2017

AGENDA ITEM:	17
PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Sinead Collins, Clinical Business Manager Helena Jopling, Public Health Registrar
DATE PREPARED:	20th October 2017
SUBJECT:	Volunteer Services – HelpForce Initiative
PURPOSE:	For Information

EXECUTIVE SUMMARY:

This paper aims to give you an understanding of the HelpForce initiative currently being run in Volunteer Services, and description of progress so far. The project has been running since November 2016. We have completed initial engagement, planning and preparation. Active delivery will begin in January 2018.

Coordinating the project are the volunteer services manager, public health registrar and business manager for the nursing directorate. The Director of Workforce & Communications is the senior responsible officer and the project has been championed by the Chief Executive and the outgoing Chairman.

In brief, Helpforce is a national initiative to raise the profile of the contribution volunteer services make to the quality of patient care in the NHS and improve the evidence base for it. It has been established by Sir Thomas Hughes-Hallett, chairman of Chelsea and Westminster NHS FT. Fourteen trusts across the country are participating in a learning network. From these fourteen, West Suffolk NHS Foundation Trust has been selected as one of 5 pilot sites which will test new volunteer roles and evaluate some of the existing ones. The aim is to work together to develop a model for best practice and disseminate it.

It has been clear during the early stages of the project that West Suffolk NHS FT enjoys an exemplar volunteer service with an extensive portfolio of volunteer roles and lean and effective management. Building on this success, we are using the Helpforce initiative to catalyse a new phase the service's development: extending our scope beyond the trust's walls to find new roles for volunteers which will support some of the integrated services we deliver with system partners.

The three roles we are hoping to develop are:

- Support for discharge planning - helping get people home quicker and more confidently from hospital
- Support for the early intervention team - helping prevent admissions in those who really just need more support at home
- Support for personal & community resilience - facilitating onward recovery, building social capital and preventing readmissions

We have engaged hospital teams, the clinical commissioning group, adult social care, community services, Suffolk Family Carers, the health and wellbeing board, Community Action Suffolk, the district councils and the county council. We have been delighted to receive enthusiastic support across the board.

We have a project plan agreed, seed funding from NHS England, a new volunteer coordinator recruited and a support offer from the national team. The next steps are to start to develop the detail for the volunteer roles, begin volunteer recruitment and plan the evaluation. Sir Tom is visiting the trust on 30th October for a tour and to meet volunteers. The next network event will be held on 5th December at Sandwell and West Birmingham Hospitals NHS Trust.	
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)	Not applicable
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Not applicable
Legislation / Regulatoryrequirements:	None
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	None
Recommendation: To receive this report	

1. Background to HelpForce

HelpForce is a new Community Interest Company founded in 2017 and led by Sir Thomas Hughes-Hallett, chair of Chelsea and Westminster Hospital NHS Foundation Trust. Sir Tom created HelpForce because he recognised that while there are some brilliant volunteer services making a substantial contribution to patient care across the NHS, they are by no means universal and volunteering is rarely integrated into NHS delivery plans.

West Suffolk NHS FT became involved in the Helpforce project at its outset in November 2016. Helpforce has convened a learning network of 14 trusts which will work together to improve volunteering practice and perceptions across the UK. Of these 14, West Suffolk NHS FT has been selected as one of 5 pilot sites to test and evaluate the ways in which volunteers can enhance the quality of patient care. Helpforce will share these insights more widely as they develop. Over the next three years the plan is to create and share a best practice model so that more patients, volunteers, NHS staff and healthcare providers can benefit more quickly.

Each of the pilot sites has received seed funding of £51,000 from NHS England in 2017/18 to spend as is most appropriate to support the project. The national team has secured funding from the Big Lottery to sustain their activity until 2020/21. Other sources of on-going funding for the individual trusts are being explored nationally and locally.

The plan is to ensure a more strategic approach is developed to support voluntary action within the NHS. Helpforce's intended outputs will expand the evidence base (which is currently patchy or contradictory), describe the case for action and establish a recommended delivery model to share with policy makers, commissioners and senior leadership teams in NHS and voluntary sector organisations.

2. West Suffolk NHS FT's participation - progress so far

Activity started in concert in July 2017.

Service management

While most pilot sites are investing their seed funding in a project manager, we are fortunate to have these skills and capacity available in-house, which has meant we can invest the money instead in a new post for a volunteer coordinator who will focus purely on developing and supporting the community-facing volunteer roles. This post has been successfully recruited to and the appointee has a background in social work, which is perfect for the purposes of this role.

We have also successfully recruited the successor to our retiring volunteer services manager, Linda Murrell, on whose excellent work and long-term commitment to the trust the Helpforce project will build. The new manager joins us from a national charity and will start on 1st November.

The volunteer service has been moved in the organisational structure from the Nursing Directorate into the Directorate of Workforce & Communications. This is in recognition of the close working relationship volunteers have with paid staff and the synergies between the recruitment, induction and coordination processes of the volunteer service and the human resources department.

Defining new roles to test

We have identified three potential roles for volunteers to support integrated services which the trust delivers with system partners. They are:

- Support for discharge planning - helping get people home quicker and more confidently from hospital

- Support for the early intervention team - helping prevent admissions in those who really just need more support at home
- Support for personal & community resilience - facilitating onward recovery, building social capital and preventing readmissions

These roles are shown on the diagram in the appendix, along with the roles the other pilot sites will be testing. They have been devised across the pilot sites to support high-impact points in the patient pathway, as defined by Helpforce in consultation with trusts and with input from Deloitte UK.

In addition to these three new community-facing roles, we are developing an idea to encourage more young people into volunteering: creating a role for digital buddies to help inpatients who are not familiar with technology to use the DAVE communication system. We have applied for dedicated funding for this idea from the Pears Foundation #iwill fund, the aim of which is to increase participation in social action by 10-20 year olds.

System engagement
The trust's participation in Helpforce has been multiagency from the outset – at the first exploratory network meeting in November 2016 the West Suffolk NHS FT team were accompanied by Sara Blake, Head of Localities and Partnerships at Suffolk County Council. The opportunity to extend the trust's volunteer roles into community settings was identified by Sara, and since then we have been working with West Suffolk Councils and the West Suffolk locality team of Suffolk County Council to understand how personal and community resilience could benefit from volunteers supported by the trust.

Liaison with the Helpforce project team
Sir Tom will visit the trust on 30th October for a tour and to meet volunteers.

We are participating in monthly teleconferences with the HelpForce project team and our fellow pilot sites:

- Sandwell & West Birmingham Hospitals NHS Trust
- Northumbria Healthcare NHS Foundation Trust
- Chelsea & Westminster Hospital NHs Foundation Trust
- University Hospital Southampton NHS Foundation Trust .

The last teleconference was 19th October 2017. There is also a monthly newsletter.

As well as the launch event in November 2016, the team attended a network day in June 2017 where they presented some of our existing volunteer success stories and our plan for participation in Helpforce.

West Suffolk NHS FT will be supported by a trust engagement lead starting after Christmas - Jullie Tran Graham, who the national charity Nesta's 'Helping in Hospitals' programme, creating new volunteer services in 10 NHS trusts in 2015/16.

A core role for the national team is to design and support evaluation of the project; they have secured consultancy and input from the King's Fund in this and are now seeking a formal evaluation partner. The high-level evaluation plan is also provided in the appendix.

Wider promotion
Our involvement with Helpforce was included in a presentation to the Suffolk Health and Wellbeing Board on 13th July 2017 about the trust's wide ranging work to protect and improve the health and wellbeing of our community.

We also joined colleagues from the national team and Royal Free London NHS Foundation Trust to present the initiative at the NHS Health and Care Innovation Expo 2017 in September.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3rd November

PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
AGENDA ITEM :	19
PREPARED BY:	Medical Staffing, HR and Communications Directorate
DATE PREPARED:	12th October 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 Histopathology
DATE OF INTERVIEW:	12th October 017
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]

	09/2006 – 07/2008
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	1 1 1

Item 21

Community Services Update

West Suffolk NHS Foundation Trust Board

3 November 2017

1.0 Introduction

1.1 Following the successful completion of a 'Most Capable Provider Process' on the 1st October 2017 the Community Services contract was awarded to West Suffolk Foundation Trust (on behalf of the West Suffolk Alliance) and Ipswich Hospital Trust (on behalf of the East Suffolk Alliance). The contract length is for a minimum of 7 years.

1.2 The West Suffolk Alliance is comprised of West Suffolk NHS Foundation Trust, Suffolk County Council, Suffolk GP Federation and Norfolk and Suffolk Mental Health Services Trust.

1.3 For contractual purposes it has been agreed that the Suffolk GP Federation will be a sub-contractor to the Ipswich Hospital contract. The delivery of the services provided by the GP Federation and Ipswich Hospital to the west of the county will be monitored through a joint Alliance Contract Group.

1.4 The successful award of this contract and the formation of the Alliance are both significant steps in realising the Trusts long held ambition to play a key role in the integration of services across the local health and care system.

1.5 All services and staff successfully transferred to the trust on 1st October with no disruption to services or adverse impact on patient services or staff. The tables below shows the community services and staff numbers that are now part of the trust, plus the services that are provided to the West of Suffolk by either the Suffolk GP Federation or Ipswich Hospital Trust.

Community services transferred to WSFT employment and services provided to the west from GP Federation and IHT

Services transferred / already hosted to / by WSFT	Services transferred to IHT and provided to the west	Services transferred to GP Fed and provided to the west	Posts transferred to the Central Education Hub (hosted by IHT)and provided to the west
Community Services Communication Officer	Care Co-ordination Centre	Clinic Clerks, Receptionists	District Nurse Development Lead
Informatics (county wide)	SystmOne Manager & Trainers	Falls Fracture Liaison	Practice Development Facilitators
Paediatrics (county wide)	Foot & Ankle Surgery	Podiatry	Tissue Viability Nurses
Lymphoedema Service	IT	Bladder & Bowel Service, including product procurement	Clinical Educator
Glastonbury Court			Bladder & Bowel Service, including procurement
Neurology Service, including Parkinson's & Epilepsy			Safeguarding Lead
Admission Prevention Service			Workforce (mandatory training/induction)
Adult Speech & Language Therapy			
Community Health Teams, including Local Area Managers, Team Admin & Business Support			
Community Matrons			
Community Hospitals			
COPD Service			
Pulmonary Rehabilitation			
Cardiac Rehabilitation			
Heart Failure			
Facilities Management			
Workforce Team			
Community Equipment Service (outsourced)			
Wheelchair Service (outsourced)			

The table below shows the community health locality teams that have transferred to WSFT, and are a combination of nurses, physios, OT's, generic workers, community matrons and phlebotomists.

Team	WTE	Headcount
Mildenhall and Brandon	20.90	24
Bury Town	26.68	34
Bury Rural	16.12	21
Newmarket	17.38	21
Haverhill	17.94	22
Sudbury	28.41	37
TOTALS	127.43	159

In addition the specialist services staff shown below have also transferred into the trust:

Service	WTE	Headcount
Admission Prevention Service (includes twilight and overnight community nursing service) nurses and support workers	12.41	15
COPD - nurses	10.75 (some to transfer)	13
Pulmonary Rehab - therapists, support workers, exercise instructors	6.73 (some to transfer)	8
Heart Failure nurses and Cardiac Rehab exercise instructors	7.94 (some to transfer)	11
Communications Officer	0.53	1
TOTALS	38.36	48

2.0 Current Position

2.1 Now that community services have successfully transitioned we can move to the next phase of our integration ambition and plan to: more formally integrate acute and community services and patient pathways, explore our opportunities across acute and community boundaries as well as continue to explore wider opportunities across Alliance partners and into the wider system.

2.2 We have put in place a temporary operational management structure for community services while we scope the next phase of this integration. **See Appendix 1.**

2.3 A number of meetings have been held to welcome community staff into the trust and to begin to engage both sets of staff in the integration discussion.

2.4 Senior community staff have attended the Trust Executive Group, senior community nurses have met with the Trust matrons and heads of nursing, community managers have met with the Trust general and service managers, infection control leads, governance lead and finance manager. A shared professional / clinical advice and support framework for therapists and nursing has been jointly designed and agreed.

2.5 The existing Trust Governance groups and board sub-committees are being reviewed to ensure the role and scope reflects the needs of community services and staff as well as having community personnel representation.

2.6 The community contract will continue to report in its current form for 3 months to December 2017. The reporting will then change to reflect the new integrated board report and the newly agreed contractual Key Performance Indicators that have been jointly designed by Alliance members and the CCG.

2.7 To ensure that we continue to operate successfully as two Alliances (one East one West) who provide services to each other and to navigate the complexities of Alliance working the following working groups are continuing to meet: Human Resources (to include workforce development / training and education functions), Communication and Engagement, Contracting and Commercials.

2.8 The framework for the Alliances to manage both the contract and the development of joint Alliance programmes of work is shown below.

2.9 In addition the West Suffolk Alliance is starting to explore ways of developing its structure, ways of working and reporting mechanism. This structure needs to provide a conduit to and from the locality teams, locality boards and senior executive group to provide a 'home to board' mentality and oversight.

3.0 Next Steps

3.1 The development of our vision, strategy and ambition is built on the work that has already begun as part of the previous Health and Care Review findings.

3.2 This is based on developing services in a locality model, primarily through the Connect programme of work. The Improved Better Care Fund will be used to enable key pieces of transformation work, such as Discharge to Assess, Trusted Assessment, Care Home Initiatives and Frailty pathways.

3.3 The Connect Programme is well established with progress made in many areas resulting in greater joint working between statutory, voluntary and community services. We have seen greater cooperation and working with primary health care, join up through Integrated Neighbourhood team meetings (INT's) of a range of public services and greater linkage with the VCS through, amongst other things, social prescribing.

3.4 The localities for the west of Suffolk have been agreed as: Newmarket, Haverhill, Sudbury, Brandon / Mildenhall, Bury Town and Bury Rural.

3.5 The Connect programme and the locality model are based on the following components:

- Community Resilience - the broader resilience of communities to provide social, cultural and leisure activities for their citizens; such activities being very relevant to the wider determinants of health and wellbeing related to, for example, social isolation, physical and mental stimulation and local access to services.

- Neighbourhood networks - the broader resilience of communities to provide social, cultural and leisure activities for their citizens; such activities being very relevant to the wider determinants of health and wellbeing related to, for example, social isolation, physical and mental stimulation and local access to services.

- Neighbourhood teams - The INTs will include a core range of generalist services from community health, adult social care, primary care and mental health all brought together as one co-located team within each locality.

- Pro-active and preventative care - A key focus of the changes we need to make to how we provide and deliver services is to ensure that we take every opportunity to identify to encourage people to be well and keep active, take responsibility for managing their own health and empower self- management wherever possible of any health need.

- Specialist services - Some services such as interface geriatricians, specialist admission avoidance services, neurology services, community and acute hospitals and specialist dementia advice will be organised on a wider geography.

- Urgent care - For people who require an urgent care response largely by secondary care the INTs will co-ordinate care to ensure that people are treated promptly by the most appropriate service, discharged and returned swiftly back to their own home.

3.6 Now that we have teams and services that work across both acute and community we can start to consider how we further align our historically 'hospital based' clinicians teams and services to localities to ensure that we maximise the opportunities that this brings. We also need to develop the structure and define the roles for each locality in terms of its operational leadership, locality board and clinical leadership.

3.7 We will do this through a series of workshops / discussions / meetings as well as seizing real time opportunities as and when they occur through business as usual discussions. We will also use the exiting primary care locality meetings to engage with GP's.

3.8 Our intended times frame is:

- Now to end of December, scope and agree extent of integration/re-structure
- January to March 2018 engage, plan and consult if necessary
- April 2018 implement, refine and evolve

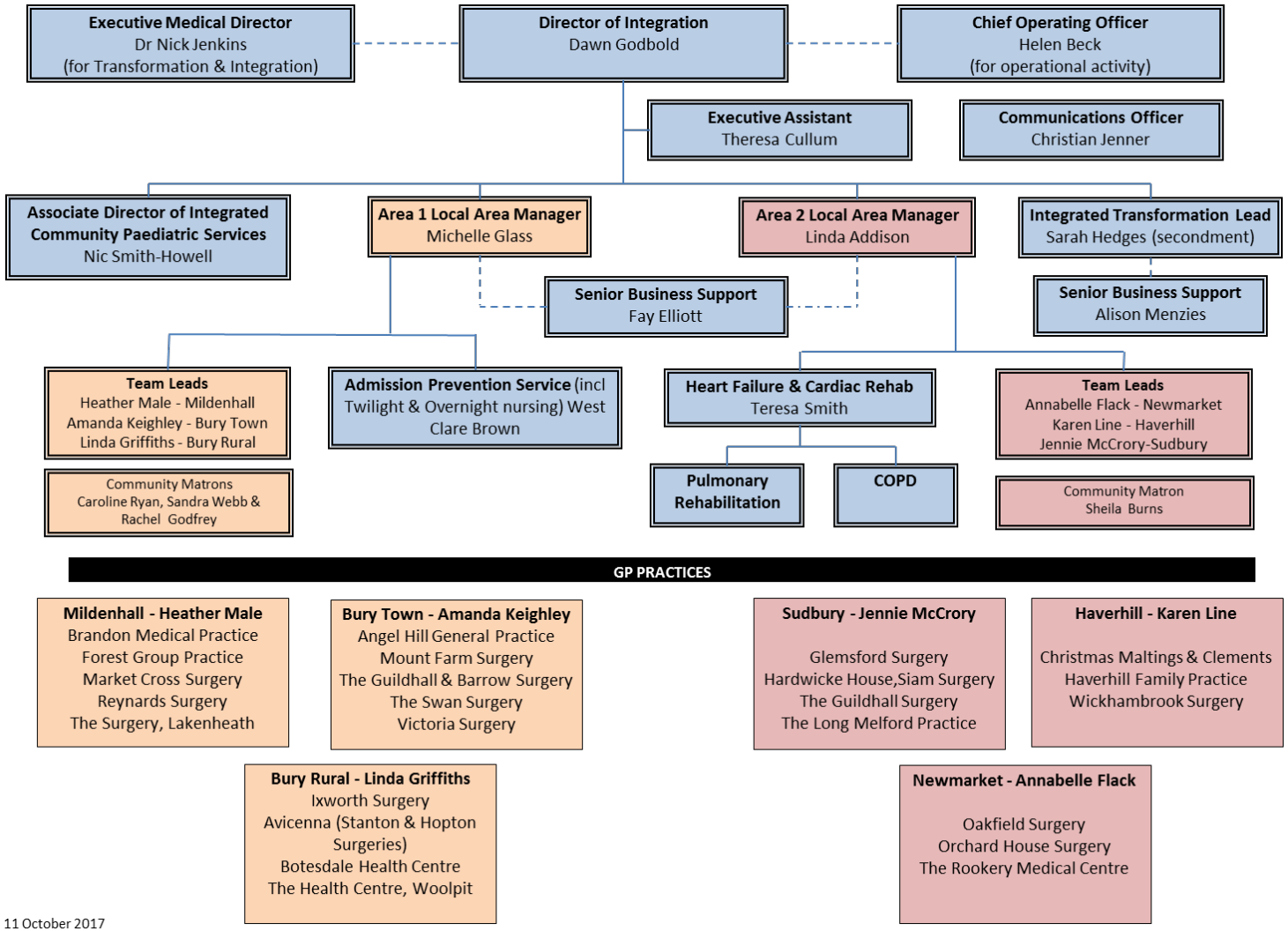
3.9 These changes will run in parallel to the phased development of the West Suffolk Alliance and integration of trust services (both acute and community) with Alliance partners. The development and formation of an Alliance for the west of Suffolk is a key step towards the formation of a fully integrated health and care system (ICS)

4.0 Conclusion

4.1 The award of the community services contract and the developing West Suffolk Alliance are key milestones to building an integrated health and care system for the west of Suffolk. The trust has signalled its ambition clearly and with purpose and can now embark on the exciting challenge with partners to re-design the way in which we both commission and provide care to our population. The trust will continue to drive, lead and support this change both internally and externally to ensure we maximise the opportunities that collaboration and partnerships can bring.

4.2 This strategy will present many challenges and yet more change for patients, staff, partners, stakeholders and the public. It is vital that the trust is a key influencer and enabler to this change, which will need to be built on its strong foundations of good leadership, clinical excellence and creative brave thinking and decision making.

Appendix 1 - West Suffolk Community Services Structure (interim)



11 October 2017

West Suffolk NHS
NHS Foundation Trust

Trust Board – 3rd November 2017

AGENDA ITEM:	21
PRESENTED BY :	Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Dawn Godbold, Director of Integration
DATE PREPARED:	23rd October 2017
SUBJECT:	Community Services Update
PURPOSE:	Information

EXECUTIVE SUMMARY:

Context

Following the development of a consortium in October 2015 with Norfolk Health and Care and Ipswich Hospital the Trust has been hosting some community services on an 'interim basis. Over the last 12 months the community services have undergone a most capable provider process and the contract has been awarded to the Trust for a minimum of 7 years from 1st October 2017. This is a key milestone in the Trusts strategic plan to develop an Integrated Health and Care system for the West of Suffolk

Key Points

- A successful transition was achieved – no disruption to services or adverse quality / safety impact on patients or their families
- 207 staff have now joined the trust
- Welcome and familiarisation sessions have been completed
- Interim operational management structure is in place and functioning
- Service and contract governance (both corporate and clinical) arrangements are in place
- This is a key stage in a phased programme to develop and implement a new way of working across traditional organisational boundaries
- This is a major step towards developing an Integrated Care System for the West of Suffolk
- Community Paediatric Services remain with the Trust on behalf of both East and West Alliances and are part of a re-design programme with the County Council, Public Health, Suffolk Education providers and the CCG
- A clear plan to achieve fuller integration is supported and endorsed by the Trust executive team

Linked Strategic objective (link to website)	Ambition 3 Build a Joined up Future
Issue previously considered by: (e.g. committees or forums)	Monthly reports to Board Weekly updates to Executive Directors meetings Regular updates to Trust Executive Group Ad hoc reports/presentations to Council of Governors, Scrutiny Committee and staff groups

Risk description: (including reference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatoryrequirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability&communication)	

Recommendation:

That the Board note and support:

- The successful transition of community services on the 1st October for a minimum period of 7 years
- The interim arrangements in place
- The future plan towards fuller integration
- The development of the West Suffolk Alliance
- The further development of a locality based model of health and care provision to include the alignment of current acute based resources to localities

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3rd November 2017

AGENDA ITEM:	22
PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Clare Farrant, Sustainability Officer
DATE PREPARED:	23rd October 2017
SUBJECT:	Sustainability Annual Report 2016-2017
PURPOSE:	For Information

EXECUTIVE SUMMARY:
As an NHS organisation and as a spender of public funds we have an obligation to work in a way that has a positive effect on the communities we serve.

- Good Corporate Citizen Self-assessment completed August 2016, scoring 45%.
- Updated Sustainable Development Management Plan and associated Action Plan March 17.
- Reduction in total electricity consumption and associated CO2e emissions.
- Reduction in total spend on energy.
- Re-launch of dedicated Liftshare platform, increase of Liftshare spaces on site to 59.
- Provision of 80 secure cycle space, increasing total capacity to 246 spaces.
- Recycling initiatives including furniture via Warp It and plastic bottle trial.

Linked Strategic objective (link to website)	
Issue previously considered by: (e.g. committees or forums)	Sustainable Development Steering Group
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:	"The NHS is committed to providing best value for taxpayers' money - it is committed to providing the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves." **NHS Constitution commitment No.6** Paragraph 18 of the NHS standard contract for 2016/17 and 2017/18
Other key issues: (e.g. finance, workforce, policy implications, sustainability&communication)	

Recommendation: The board is invited to receive this report.

West Suffolk NHS
NHS Foundation Trust

Sustainable Development Annual Report 2016 - 2017

Putting you first

Contents

Introduction

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As an NHS organisation and as a spender of public funds we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and effective use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health, both in the immediate and long term, even in the context of the rising cost of natural resources.

In order to fulfil our responsibilities for the role we play, West Suffolk NHS Foundation Trust has the following mission statement located in our Sustainable Development Management Plan:-

West Suffolk NHS Foundation Trust will distinguish itself by making sustainability a part of all we do.
In partnership with patients, staff and the local community, our plan captures the social, environmental and economic impact of our actions"

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) by 2020. It is our aim to meet this target, relative to patient activity, by reducing our carbon emissions using 2007 as the baseline year.

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). The Sustainable Development Steering Group updated our SDMP in March 2017, for presentation to the Trust Board, so our plans for a sustainable future are well known within the organisation and clearly laid out.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Good Corporate Citizenship (GCC) tool. The last time we used the GCC Self-assessment was in August 2016, scoring 45%.

Completing our sustainable development action plan for 2017 should enable us to improve the GCC self-assessment score to above 50% in all eight areas. However, it should be noted that the Good Corporate Citizen Tool is currently being reviewed by the Sustainable Development Unit, NHS Scotland and Nottingham Trent University. The revised tool should be more accessible and will align with the United Nations sustainable development goals.

Energy

Greenhouse Gas Emissions (MtC02e)	2013/2014	2014/2015	2015/2016	2016/2017
Total Gas	4.70	4.53	4.29	4.63
Total Electricity	5.58	5.48	5.53	5.29
Total Travel Emissions	0.37	0.33	0.65	0.73
Greenhouse Gas - Non-Financial (MtC02e)	**2013/2014**	**2014/2015**	**2015/2016**	**2016/2017**
Total gross emissions	9.33	9.10	7.40	7.71
Total net emissions	9.33	9.10	7.40	7.71
Gross emissions scope 1	6.02	5.62	5.01	5.30
Gross emissions scope 2 & 3	3.31	3.48	2.39	2.40
Energy Consumption (GWh)	2013/2014	2014/2015	2015/2016	2016/2017
Electricity Non-renewable	10.31	10.13	10.23	9.78
Gas	25.62	24.69	23.36	25.22
Oil (litres)	496,151	394,566	260,034	244,260
Expenditure on Energy (£M)	2013/2014	2014/2015	2015/2016	2016/2017
	£1.51	£1.30	£1.02	£0.95

CHP 24/7 – impact

Even with the increased patient activity during 2016-17 our carbon emission impact is only slightly higher than in 2015 - 16. This in large is attributed to the continued efficiency of running the Combined Heat and Power unit 24/7.

Actions that helped maintain the same level of carbon emissions, even with the increase in activity were:

- Continuation of operation of the site's Combined Heat & Power (CHP) unit 24/7.
- Improved energy efficient engineering plant currently being installed under the Trust backlog programme.
- Continued use of PC Power Saver system which turns off PC safely overnight if left on.
- Increase in recycling schemes.

CRC Energy Efficiency Scheme

The Carbon Reduction Commitment (CRC) Energy Efficiency Scheme is a UK government scheme. It is designed to improve energy efficiency and cut carbon dioxide (CO2) emissions in private and public sector organisations that are high energy users. The Environment Agency administers the scheme for the UK and regulates the scheme in England.

The CRC scheme operates in phases. Phase 1 ran from April 2010 until the end of March 2014. We are now in phase 2 which runs from 1 April 2014 to 31 March 2019.

To meet the requirements this year we need to do the following:

- collate information about our energy supplies
- submit a report about our energy supplies
- buy and surrender allowances equal to the CO2 emissions we have generated
- keep records about our energy supplies and organisation in an evidence pack

Financial Impact of Carbon Emissions

This scheme continues to impact financially on this Trust. To ensure we are meeting all the requirements and do not incur additional penalties we utilise the services of GEA Consulting Limited. The table below lists those costs.

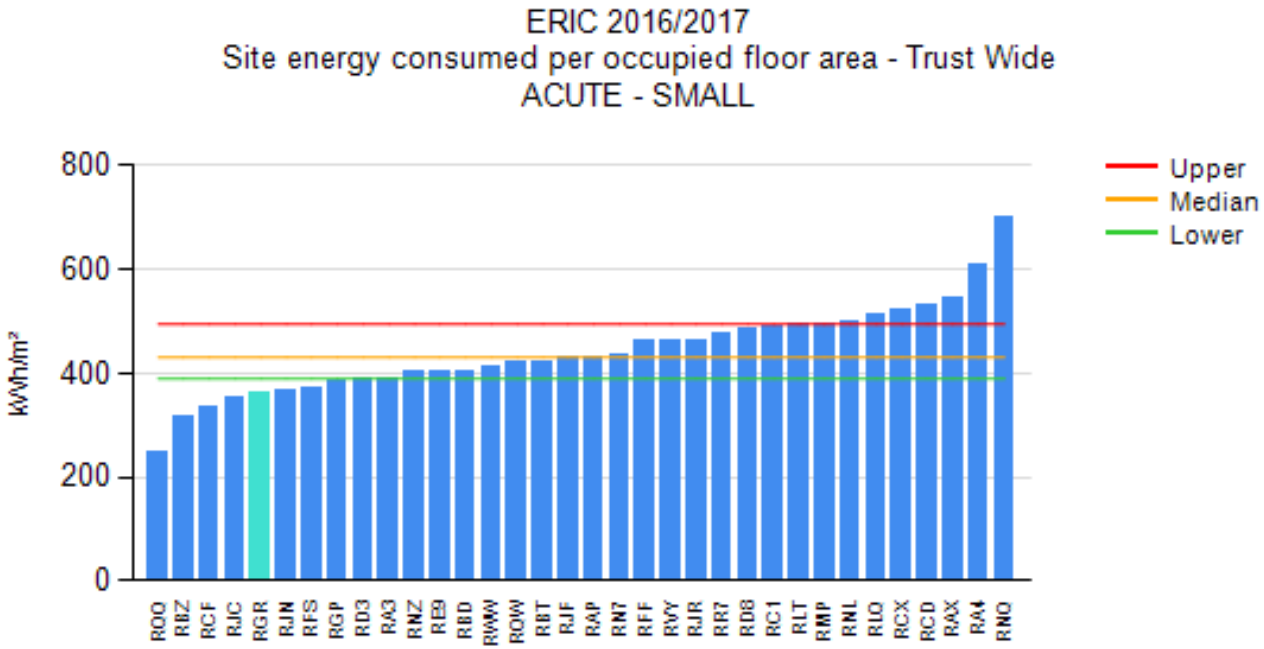
CRC EVIDENCE COSTINGS £ (2016/17)			
ITEM	COST	FREQ	NOTES
Annual Subsistence Charge	£1290	Annual	
GEA Consulting:	_	_	
CHPQA & CCL Management Package	£1200	Annual	
CRC & Sustainability Reporting Management Package	£5800	Annual	
Display Energy Certificates x 4	£1200	Annual	
TOTAL COST of FEES for 2016-17	£9,490		
Previous Year Total	£9,490		

Once again there are additional costs associated with the Trust generating carbon and this is illustrated below.

WEST SUFFOLK NHS FOUNDATION TRUST – CARBON REPORT 2013/14, 2014/15 2015/16 & 2016/17.				
SITE NAME	CARBON (tCO2)			
	2013/14	2014/15	2015/16	2016/17
West Suffolk Hospital	9,787	9,561	8,973	
Hospital Road Site	162	164	185	
St Leonards Hospital	25	18	N/A	N/A
Walnut Tree Hospital	79	54	N/A	N/A
Total Carbon (tCO2)	10,053	9,797	9,158	8,802
Total Excluded Carbon (tCO2)	2,301	2,050	3,179	2,953
Total Liable Carbon (tCO2)	7,752	7,747	5,979	5,849
Carbon Cost (£/tCO2)	£12.00	£16.40	£16.90	£17.20
Total CRC Cost	£93,000	£127,058	£101,045.10	£110,603
CRC Consultant Fees & Annual Sub Charge	£14,140	£9,490	£9,490	£9,490
Total Cost of CRC including fees.	£107,140	£136,548	£110,535	£120,093

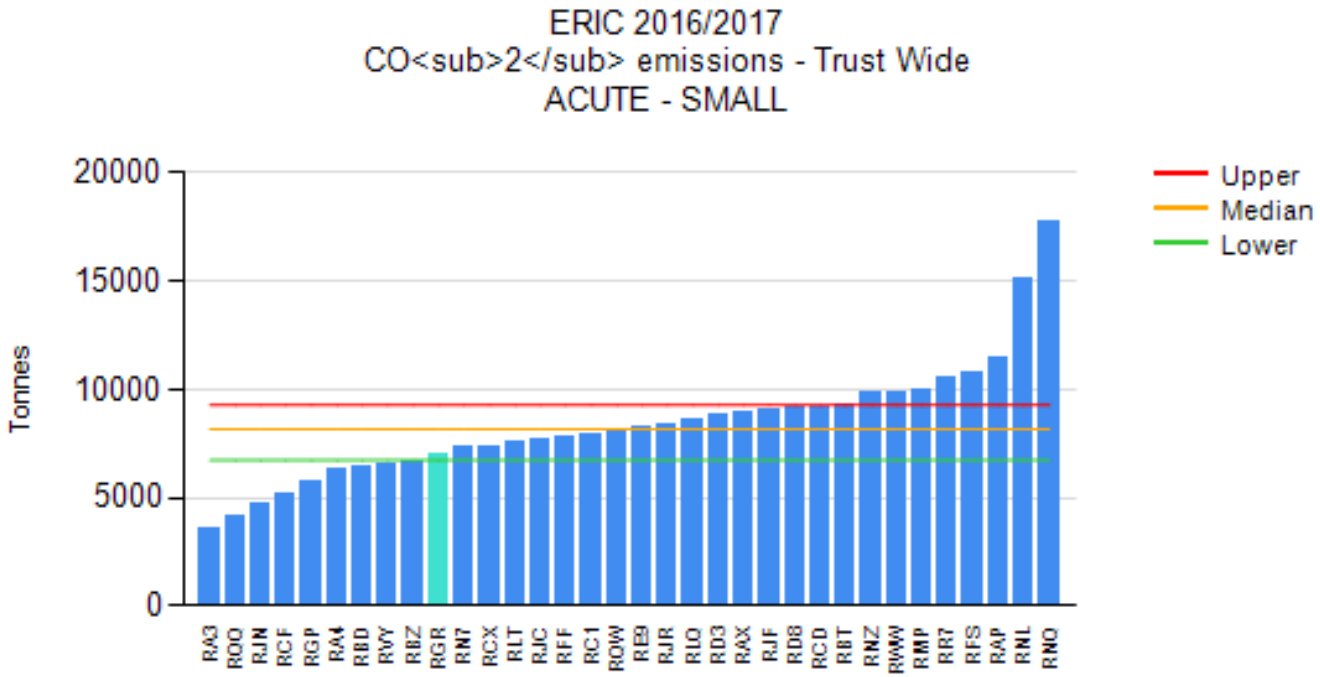
Comparative Information on Energy consumption 2016/17

Source of data is the ERIC returns to the Information Centre. West Suffolk NHS FT is identified by code RGR.



Comparative Information on CO2 Emissions 2015/16

Source of data is the ERIC returns to the Information Centre. West Suffolk NHS FT is identified by code RGR.



Water

Water – Non Financial (km3)	2013/2014	2014/2015	2015/2016	2016/2017
Water – Office Estate – Supplied	88.51	85.23	86.54	104.09
Water Office Estate - Abstracted	79.66	76.70	77.88	93.68
Water – Office Estate – Per FTE	2.98	2.49	2.42	2.83
Water- Non-Office Estate - Supplied	1.47	0.90	0.00	0.00
Water Non- Office Estate - Abstracted	1.32	0.81	0.00	0.00
Water – Financial (£k)	**2013/2014**	**2014/2015**	**2015/2016**	**2016/2017**
Water Supply Costs - Office Estate	24.14	23.68	76.91	49.52
Water Supply Costs – Non-Office Estate	1.79	1.24	0.00	0.00

Waste

	2013/2014		2014/2015		2015/2016		2016/2017	
	Weight	Cost (£k)	weight	Cost (£k)	Weight	Cost (£k)	Weight	Cost (£k)
Total Waste	1093.28	£334.16	1078.81	£337.58	1062.48	£277.14	1085.78	£288.06
Hazardous /Clinical waste	425.47	£252.90	441.312	£257.23	457.35	£211.91	455.06	£216.41
Landfill	389.72	£68.67	376.16	£68.65	406.46	£56.07		
Reused/recycled	278.09	£12.57	261.43	£10.67	198.67	£10.41	231.96	£16.79
Incinerated with energy recovery							398.76	£54.85

Any domestic waste from the hospital which is not recycled is sent to the energy-from-waste site at Great Blakenham. This facility takes domestic waste from Suffolk and Norfolk, reduces greenhouse gases by 75,000 tonnes a year and generates enough electricity to power 30,000 homes. Practically nothing goes to waste on this site. Metals are recycled and ash, left after the incineration process, is used as an aggregate for local building projects.

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Recycling at West Suffolk NHS FT

We are currently able to recycle the following:

- WEE Waste (Waste Electronic and Electrical Equipment)
- IT waste, including toners
- Wood and furniture
- Confidential paper
- Non confidential paper
- Cardboard
- Crushed lamps
- Waste cooking oil
- Scrap metal
- Batteries
- Uniforms
- Asthma inhalers
- Mobile phones

The recycling of cardboard, ‘precious’ metal and cooking oil generates a small income for the Trust.

Warp it

We have recently launched a West Suffolk NHS FT link to the **Warp it** website where colleagues can advertise surplus furniture for re-use within the Trust. Our **Warp it** group currently has 69 members and to date we have avoided 220kg of waste, saved 482kg CO2e emissions and saved £1205. Savings are shown on the Warp-it website and will be more widely reported to staff via the Green Sheet.

Plastic bottle recycling

We are also running a plastic bottle recycling trial in Time Out and the Courtyard café. This is a three month trial (30/1/17 – 28/4/17) and results of the trial (costs and weights) will be presented to the Sustainable Development Steering Group.

Travel

The Trust has re-launched a West Suffolk Liftshare community group. As part of the new car parking on site a further 20 Liftshare spaces have been designated bringing the total to 59.

A launch event in March 17 resulted in 49 people registering and 7 confirmed car share teams.

In order to reduce the carbon impact of and cost of grey fleet travel the Trust is trialling the use of an Enterprise Car Club pool car. Other schemes in the UK have resulted in a 30% reduction in CO2e emissions.

As a condition of planning permission for both Car Park R and Quince House, cycle storage on site has been increased. Two secure cycle storage units have been installed on site, one 60 space unit adjacent to the staff side entrance and one 20 space unit behind Quince House, bringing the total storage available on site to 246 spaces.

Procurement

The Purchasing Department have introduced An Introduction to Sustainable Procurement e-learning for its entire staff.

Following a peer review the Purchasing Department has achieved Level 1 of the Standards of Procurement 2016. Dimension 6.4 of the standards relates to Corporate Social Responsibility (CSR) and 6.5 relates to Small to Medium Sized Enterprises. (SME)

In the Financial year 2015 – 2016 WSFT spent over £7.7million with 82 local (IP and CB post code areas) Small and Medium Enterprises (SMEs). The Trust Procurement Sustainability Policy aims to consider and promote the use of SME and BME and social Enterprise, by raising the level of awareness of procurement opportunities by advertising all requirements on the e-tendering portal.

The introduction of eCare together with the installation of new Cannon photocopiers across the Trust, which delete any documents not printed within the same working day, has led to a 12% reduction in A4 paper use in the Trust and resulted in a saving of £5,005.

Food

An IMC Waste Station has been installed in the kitchen. The use of an IMC Waste Station can reduce the volume of food waste by up to 80% and the mass by 60%, thus reducing waste collection costs.

The machine processes food waste matter by maceration under an automatic water flow, dewatering the macerated food waste and discharging the waste into a receptacle. This is then disposed of in the domestic waste compactor. The grey water is discharged into the drainage system.

Buildings

Quince House will provide accommodation for the Trust Office, Estates and Facilities, Finance and Human Resources as well as for the Sterile Services Department which will be relocating from Hospital Road. The new build will incorporate many elements of sustainable building design including energy efficient sterile services equipment, LED lighting, PV panels on the roof and video conferencing facilities.

2017 – 2018 First quarter update.

Following the update of the Sustainable Development management plan and Action plan, the Sustainable Development Steering Group has agreed key performance indicators – see appendix 1.

Following the relocation of staff in to Quince House, a range of surplus furniture, mainly operator's chairs and pedestal units, was advertised and reused via Warp It. At 31st July 2017 use of Warp It had saved more than £15,000 in re-procurement costs and saved 6068kg of C02e emissions.

Looking ahead

Good Corporate Citizen

Complete the revised Good Corporate Citizen assessment in Autumn 2017 and amend/update action plan.

Recycling

The trial for recycling plastic bottles will be extended for a further six months 1st August 2017 - 31st January 2018

A proposal for a clothes recycling bank for staff is being compiled, any revenue generated will go the My WiSH charity.

Catering staff will carry out a customer survey in the Timeout Restaurant to gauge the reaction to a possible price increase due to changing hot food packaging to a recyclable option.

Buildings

Trials of replacement LED Lighting (e.g. G3/G4 corridor - Memory Walk)

A plan for the conversion of 217existing external street lights to Led is awaiting capital allocation/SALEX funding.

Models of care/ Adaptation

Introduce the Sustainability Impact Assessment in Quality Impact assessments across the Trust.

Appendix 1 – Sustainable Development Action Plan KPIs

West Suffolk NHS
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KPI's 2017 - 2018	APR	MAY	JUNE
Low Carbon Travel, Transport and Access			
% occupied cycle storage spaces	39%	40%	45%
Number of rentals	6	16	17
% occupied car share spaces	--	22%	13.50%
Energy and Carbon Management			
% carbon reduction target (ERIC target 28% reduction from 2013 level)			
% recycling of total waste			21.30%
% unserved patient meals (ordered by wards and returned unused)			
Procurement and Food			
WRAP Training module completed by all staff	90%	82%	77%
% of non pay spend with local SMEs			8.27%
Warpit targets - ROI	£1,859	£1,984	£3,531
Workforce			
Staff sickness rates			
Use of Care First			
Appraisal Rates			
Staff Turnover			
Community Engagement			
Hits on Website Sustainability Pages	31	22	4
Buildings			
Maintain gas usage relative to activity			
Maintain elctricity usage relative to activity			
Maintain water usage relative to activity			
External LED lights		23%	23%
Adaptation			
Plans tested on an annual basis, for instance through the major incident planning process			
Models Of Care			
Embed the Sustainability Impact Assessment in Quality Impact Assessments across the Trust			

West Suffolk NHS
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Board of Directors – 3 November 2017

AGENDA ITEM:	23
PRESENTED BY:	Dr Stephen Dunn, Chief Executive
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	27 October 2017 2017
SUBJECT:	Trust Executive Group (TEG) report
PURPOSE:	Information

EXECUTIVE SUMMARY:

2 October 2017

The meeting was used as a 'meet and greet' with community staff with presentation from acute and community services. The session was very helpful and encouraged collaborative working and communication.

The meeting reflected on **operational performance** noting the poor performance over the previous week and considering plans for winter resilience. This included working with community colleagues, as well as focus on red to green, ambulatory care and the 5Qs. This discussion was in the context of Q2 delivering 90.45% ED performance, which secures sustainability funding for the quarter. The RTT position was reviewed, this recognised the significant progress but also the challenge of recovering performance in line with the agreed trajectory.

The report from the **Flow Action Group (FLAG)** highlighted the importance of initiatives to reduce length of stay and achieve earlier discharge. It was noted that since the support to go home initiative has been running it has saved more than 90 bed days, which equates to six beds being available. The use of FLAG process to recover the ED performance was noted, moving from 60% on Monday to 98% on Wednesday.

The business case for **medical rostering** was approved on the basis of the identified saving in moving to e-rostering. The tending process for this initiative is ongoing.

TEG supported the proposed **GDE phased development plan**. This included development of a patient portal to access relevant health information. It was emphasised that lessons needed to continue to be learnt from CUH in term of implementation.

The updated **authorised signatory policy** was approved.

16 October 2017

Steve Dunn provided an introduction to the meeting including an update on **operational and financial performance**. He also welcomed the community staff now in attendance at TEG.

The **red risk report** was reviewed with discussion and challenge for individual areas. A new red risk was received approved regarding staffing concern blood sciences. Key controls for red risks were

noted as due to come into effect in the next two months.

A **winter planning** report was received which emphasised patient safety for winter is the priority. The Trust's plans are consistent with the Suffolk winter plan and it was confirmed that all schemes had been reviewed to ensure all relevant guidance has been implemented. The emphasis being to:

- Pull relevant patients into discharge pathway
- Further review of bed base and risks re staffing
- Develop diagnostic assessment for weekend
- Structure a 'perfect week' event for winter
- Bring back review of existing initiatives with assessment of marginal improvements

The **CQC Insight report** was received. This provides a monthly assessment of the assurance information received and reviewed by the CQC. Areas for improvement were noted and action agreed.

TEG supported the proposal that the next **leadership event** be focused on leading through challenging times and be targeted as middle grade staff and aspiring leaders.

The updated **intrauterine death (IUD) review** action plan was received and progress noted.

An update was received in **e-Care go live** over the weekend of 27-29 October. This included the new functions to support paeds, bed management and medicines management. Business continuity and plans were reviewed to support the planned system downtimes. The group recognised risk with patient flow module and medication token but focus continued to be on support through training and the enhanced support by floor walkers.

Relevant **policy documents** were considered. The trans policy was reviewed in draft and comments feedback as part of the engagement plans. The terms of reference for the surgical divisional steering group were approved.

Emphasis was given to the patient safety focus of staff having their **flu jab**. This will continue to be communicated across the organisation and uptake monitored.

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

Recommendation:

To note the report

Board of Directors – 3 November 2017

AGENDA ITEM:	24
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	30 October, 2017
SUBJECT:	Quality & Risk Committee report
PURPOSE:	Approval
STRATEGIC OBJECTIVE:	To deliver and demonstrate rigorous and transparent corporate and quality governance

EXECUTIVE SUMMARY:

Attached are the minutes of the QRC meeting held on 29 September 2017 (**Annex A**). The Board is asked to note these for information.

Previously considered by:	This is a regular report to the Board since the inspection took place
Risk description:	This is a regular report to the Board since the inspection took place
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Failure to appropriately respond to concerns raised could lead to a cease and desist order being made by MHRA
Legislation / Regulatory requirements:	WSFT management oversight of TPP action and regular discussion with MHRA
Other key issues:	European Blood Safety Directives / Blood Safety and Quality Regulations (BSQR)

Recommendation:

1. To note the report and any issues identified.

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QUALITY & RISK COMMITTEE
Minutes of the meeting held on Friday 29 September, 2017, Commencing at 2.00 p.m. in the Northgate Meeting Room, Quince House, WSFT

COMMITTEE MEMBER			Attendance	Apologies
Roger Quince	**(RQ)**	Chairman (Chair)	**X**	
Stephen Dunn	**(SD)**	Chief Executive	**X**	
Craig Black	**(CB)**	Director of Resources	**X**	
Nick Jenkins	**(NJ)**	Medical Director	**X**	
Helen Beck	**(HB)**	Interim Chief Operating Officer	**X**	
Jan Bloomfield	**(JBl)**	Director of Workforce & Communications		**X**
Rowan Procter	**(RP)**	Chief Nurse	**X**	
Gary Norgate	**(GN)**	Non-Executive Director	**X**	
Steve Turpie	**(ST)**	Non-Executive Director	**X**	
Neville Hounsome	**(NH)**	Non-Executive Director	**X**	
Richard Davies	**(RD)**	Non-Executive Director	**X**	
Richard Jones	**(RJ)**	Trust Secretary & Head of Governance	**X**	
Alan Rose	**(AR)**	Non-Executive Director	**X**	
Angus Eaton	**(AE)**	Non-Executive Director	**X**	
In attendance				
Anita Thoppil	(AT)	Chief Resident		
Julie Fountain	(JF)	Lead Nurse Dementia & Frail Elderly Care & Maggie Woodhouse		
Ruth Williamson	**(RW)**	PA to Medical Director (Minutes)		

Action

1. **Apologies for Absence**

No apologies were received.

2. **Minutes of Previous Meeting**

The minutes of the meeting held on 30 June, 2017 were accepted as a true and accurate reflection of the meeting.

3. **Matters Arising Action Sheet**

Action 34 – (Item 8 – 30.6.17) – Reflection on Meeting - Timescale for paediatric work -

Document reference Item 3a, circulated with today's papers refers. CB advised that the impact from these plans was envisaged as long term. ST queried, why, if the proposal was to be self-funding, this could not be run in conjunction with other surgeries. Noted two consultants undertaking extra duties, which could not, at present, be undertaken by the remainder within the department. NJ advised that with the department also expected to do other things, such as 7 day services etc., additional resource would be required. Discussions with commissioners are being undertaken.

Completion of matters arising reference 33 was duly noted.

4. **Chief Resident**

The group received a presentation from Anita Thoppil on her experiences as a Chief Resident.

NH was pleased to see the learning from this experience was being shared. He asked whether AT felt the Trust could have done anything differently in relation to her participation. AT advised that Health Education were proposing cancelling the programme due to lack of funding. She stressed the need for every Trust to ensure its continuation. She felt the organisation benefited from the different perspective offered from external participants.

NJ advised that the Trust were looking to include Chief Residents in the work being undertaken on quality and it was proposed to also include those who had applied and been unsuccessful, in order to harness their enthusiasm. (There are only two places available per course).

AT was thanked for her presentation and participation in the programme and wished well for the next stage of her training programme.

RP left at 3 pm.

5. **Dementia Care**

RP and HB joined at 2.15 pm.

JF and MW gave an interactive presentation to the committee, demonstrating the training undertaken by the Trust to provide a better insight to staff on how confusing a stay in hospital can be for a patient with dementia.

JF advised that champions from each clinical environment have been identified for intensive training and to pass on this learning to others. RP advised that diversion therapy was available for children on the Rainbow Ward, but there was nothing similar for dementia patients. However, the Trust was looking at training volunteers to help with this, aided by the digital reminiscence system. NH asked what the ideal number of volunteers would be. Noted the Trust could never have too many, but an am and pm volunteer on every ward, every day, would be preferred.

ST asked whether patients were admitted to the Trust because of their dementia. It was noted that 99% were here as a result of another illness; fall, delirium or escalation of behaviour.

AR asked when dementia became a mental health issue. MW advised that some patients were medically fit and therefore could not go in to a care home as their behaviour was too extreme and therefore would require sectioning. For most of the Trust's patients they were here for another medical reason, but had dementia.

RQ highlighted the lack of spending on the dementia award fund. Noted 8k is due to be spent on the digital reminiscence system.

Noted the Trust is looking at support for out of office hours, including training of the psychiatric team. RP advised that as part of this objective Darren Cooksey is producing a business case for the Trust to employ its own "specialing" team.

AR asked if there was a "marker" used for identifying patients with dementia on a ward. Noted the "forget me knot" flower is being used on patient white boards.

The Trust is also looking to place a flag on the e-Care system.

The committee thanked MW and JF for their informative presentation.

6. **Reports from Sub-Committees**

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

Meeting and plan approved.

NH noted the number of apologies from the meeting, with no clinicians or Medical Director in attendance. HB advised that it was the day the CQC return was due, but it had been ascertained in advance that the meeting would be quorate and at the time it was. However, there were a number of unexpected absences on the day and attendance levels were discussed at the meeting during reflections.

NJ advised that Monday pm was the mandated time for clinician availability to attend meetings. He suggested that the Trust would need to look at adjusting the timings of some committee meetings to accommodate clinical engagement. Agreed HB to look at possibility of changing date. **HB**

b. ***Corporate Risk Committee***

Report and plan approved.

c. ***Patient Experience Committee***

Report and plan approved. GN left at 3.25.

7. **Quality Group Report**

Received for information and duly noted. This was the first meeting of the newly formed Quality Group which, going forward, will take place on a monthly basis. Meeting will be chaired, in turn, by NJ and RP. Agreed RJ to action synopsis of progress on issues raised for this committee. **RJ**

AE asked how this group fitted in with the others and whether there was a hierarchy to show that the organisation was moving in the right direction. RJ advised that it was planned to bring a new structured quality report to the Board, which has been seen as a first draft by the Scrutiny Committee.

8. **Any Other Business**

No other business was noted.

9. **Reflection on Meeting and Identify Any Issues for Escalation or Capture/Review on the Risk Register**

No reflections were noted.

9. **Date and Time of Next Meeting**

Please note the meeting will start at 14:00 in the Northgate Meeting Room, Quince House, WSFT.

1 December, 2017

The meeting closed at 3.35p.m.

Board of Directors – 3 November 2017

AGENDA ITEM:	Item 25
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	27 October 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 – 1 December 2017

DESCRIPTION	OPEN	CLOSED	TYPE	SOURCE	DIRECTOR
Declaration of interests	✓	✓	Verbal	Matrix	All
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Quality & performance report, including staff recommender scores	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP					
Aggregated quality report	✓		Written	Matrix	RP
Nurse staffing report	✓		Written	Matrix	RP
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
BUILD A JOINED-UP FUTURE					
e-Care report	✓		Written	Action point - schedule	CB
Community service report	✓		Written	Action point - schedule	HB/NJ
Financial improvement programme (FIP) exit report		✓	Written	Action point - schedule	CB
Scrutiny Committee report		✓	Written	Matrix	GN
Strategic update, including Alliance, Integrated Care System (ICS) and STP		✓	Written	Action point - schedule	SD
GOVERNANCE					
Trust Executive Group report	✓		Written	Matrix	SD
Audit Committee report	✓		Written	Matrix	RQ
Confidential staffing matters		✓	Written	Matrix – by exception	JB
Operational plan 2018/19		✓	Written	Matrix	RJ
Well-led review		✓	Written	Action point - schedule	SD
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