West Suffolk NHS
NHS Foundation Trust

Board of Directors – August 2017

AGENDA ITEM:	
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:	August 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 1 C Diff (0 in June). Falls for the month were 66 (50 in June) and 10 pressure ulcers (20 in June)
- This month's report shows a continued improvement in the !8 week from point of referral to treatment in aggregate – patients on an incomplete pathway standard: July performance 85.92% against a target of 92% (83.36% in June) Page 21- 23
- The Trust saw a significant increase in the number of + 52 week breaches in July with a performance of 35 against a target of 0. Work is ongoing to proactively manage these long waiting patients, however there were significant numbers of patients who declined treatment during the summer holiday period and the unexpected sickness of one of the consultants led the cancellation of 2 clinics which were specifically arranged to see long waiting patients.
- Provisional data for July indicates that the Trust has achieved the 2WW cancer standard with a performance of 94.42% against a standard of 93% and also achieved the 2WW symptomatic breast standard with a performance of 98.06% against a standard of 93% Page 21
- Provisional data for July also indicates a performance of 84.38% against a standard of 85% for the 62 day referral to treatment cancer standard. Further improvement in this figure is anticipated as reallocations are finalised. Page 22
- The Trust missed the ED standard for the month of July with a performance of 92.47 % against a standard of 95%.

Linked Strategic objective (link to website)	

Issue previously considered by: (e.g. committees or forums)	
Risk description: (including reference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatory requirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	
Recommendation: The Board is asked to note the Trust Quality & Performance Report and agree the implementation of actions as outlined.	

1. CLINICAL QUALITY

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

Patient Safety Dashboard

Indicator	Target	Red	Amber	Green	May	Jun	Jul
HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	100	100
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 2b: Peripheral cannula ongoing	=100%	<85	85-99	= 100	97	98	92
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	85	100	95
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	92	93	87
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<85	85-99	= 100	NA	NA	
Total no of MRSA bacteraemia: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	0
Total no of MRSA bacteraemia: Community acquired (Trust level only)	No Target	No Target	No Target	No Target	0	0	
Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	NA	92	NA
MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	93	95	
Hand hygiene compliance	= 95%	<85	85-99	= 100	97	99	100
Total no of MSSA bacteraemia: Hospital	No Target	No Target	No Target	No Target	1	0	
Quarterly Standard principle compliance	90%	<80	80-90%	90-100	NA	95	NA
Total no of C. diff infections: Hospital	= 16 per yr	No Target	No Target	No Target	0	0	1
Total no of C. diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	0	2	
Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	NA	91	NA
Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	0	2	
Isolation data (Trust level only)	= 95%	<85	85-94	95-100	95	90	
Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	NA	91	NA
Quarterly VIP score documentation	= 90%	<80	80-89	90-100	NA	84	NA
PEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	100	90	100
No of patient falls	= 48	>=48	No Target	<48	52	50	
Falls per 1,000 bed days (Trust and Divisional levels only)	= 5.6	>5.8	5.6-5.8	<5.6	4.5	ND	ND
No of patient falls resulting in harm	No Target	No Target	No Target	No Target	17	20	
No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	ND	0
Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	0	ND	ND

Indicator	Target	Red	Amber	Green	May	Jun	Jul
No of patients with ward acquired pressure ulcers	< 5	>=5	No Target	<5	9	20	10
No of patients with avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target	3	ND	ND
Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	87	89	80
No of SIRIs	No Target	No Target	No Target	No Target	5	7	7
No of medication errors	No Target	No Target	No Target	No Target	81	69	78
Cardiac arrests	No Target	No Target	No Target	No Target	6	4	0
Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	1	0
Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	NA	NA	61
Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	NA	96	NA
Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	98.26	98.91	98.64
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4	1	3	4
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC	66	54	
Median NRLS upload 6 month rolling average	46days	>46	No Target	0-46	87	64	
SIRIs reported > 2 working days from identification as red	0	>1	1	0	0	0	
SIRI final reports due in month submitted beyond 60 working days	0	>1	1	0	1	0	
Green, Amber & Red Active / Accepted risk assessments in date [NEW]	0	>10	5-9	0-4	ND	ND	9
Datix risk register Red / Amber actions overdue [NEW]	0	>10	5-9	0-4	ND	ND	22
Total Verbal Duty of Candour outstanding at month-end	0	>3	1 - 3	0	0	0	0

Exception reporting for indicators in the Patient Safety Dashboard

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

% in June) – page

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 92 in July was a deterioration from 98 in June and was RAG-rated as amber for the third month in a row.

b) Recommended action

Changes to eCare documentation demonstrated some initial improvements in compliance however this still remains a challenge. The Senior Matron team will discuss performance at Monthly Quality Meeting so as to consider strategies for performance improvement. Senior Matrons to 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 will have impacted upon the completion of assessments from mid-July leading in to August. The Senior Matron Team on a daily basis attempt to mitigate the impact of these pressures on compliance through staff re-deployment in line with activity and acuity being experienced.

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

a) Current Position

A score of 87 in July was a deterioration from 93 in June.

b) Recommended action

The Senior Matron team will discuss performance at Monthly Quality Meeting so as to consider strategies for performance improvement. Senior Matrons to 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 will have impacted upon the completion of assessments from mid-July leading in to August. The Senior Matron Team on a daily basis attempt to mitigate the impact of these pressures on compliance through staff re-deployment in line with activity and acuity being experienced.

1.3 Nutrition: Assessment and monitoring

a) Current Position

A score of 80 in July was a deterioration from 89 in June and continues to be amber RAG rated and this will continue to be a major focus for the next few months. The month of July saw a decline in nutrition audit and this can be equated to non-compliance with recording the patient's weight on admission. On review of this issue, it is apparent that a weight is often not recorded when a patient is admitted late in the evening or during the night. In order to counteract this omission, a request has been made to Cerner to add in an additional prompt in e-Care to remind staff to weigh patients within the first 24 hours of admission.

b) Recommended action

A further action to support an improvement in compliance is the introduction of a Nutrition focus group. This will commence in September and will support joint working with the Dieticians, specialist nutrition nurse, ward nurses and nursing assistants. The main objective of this group will be to promote the sharing of good practice, raise awareness of the importance of accurate risk assessments and improve the delivery of diet and nutritional support for patients within our care.

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

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

1.4 Pain Management: Quarterly internal report

a) Current Position

Pain audit has declined to 61% overall and is now RAG rated as Red. The decline in compliance coincides with the change in methodology as pain scores and vital sign observations are now collected for all ward patients during the audit month, as opposed to 10 patients per ward as done previously.

b) Recommended action

Ward managers and matrons will receive ward specific feedback and will be addressing the issues at ward level.

1.5 Total no of C. difficile infections: Hospital

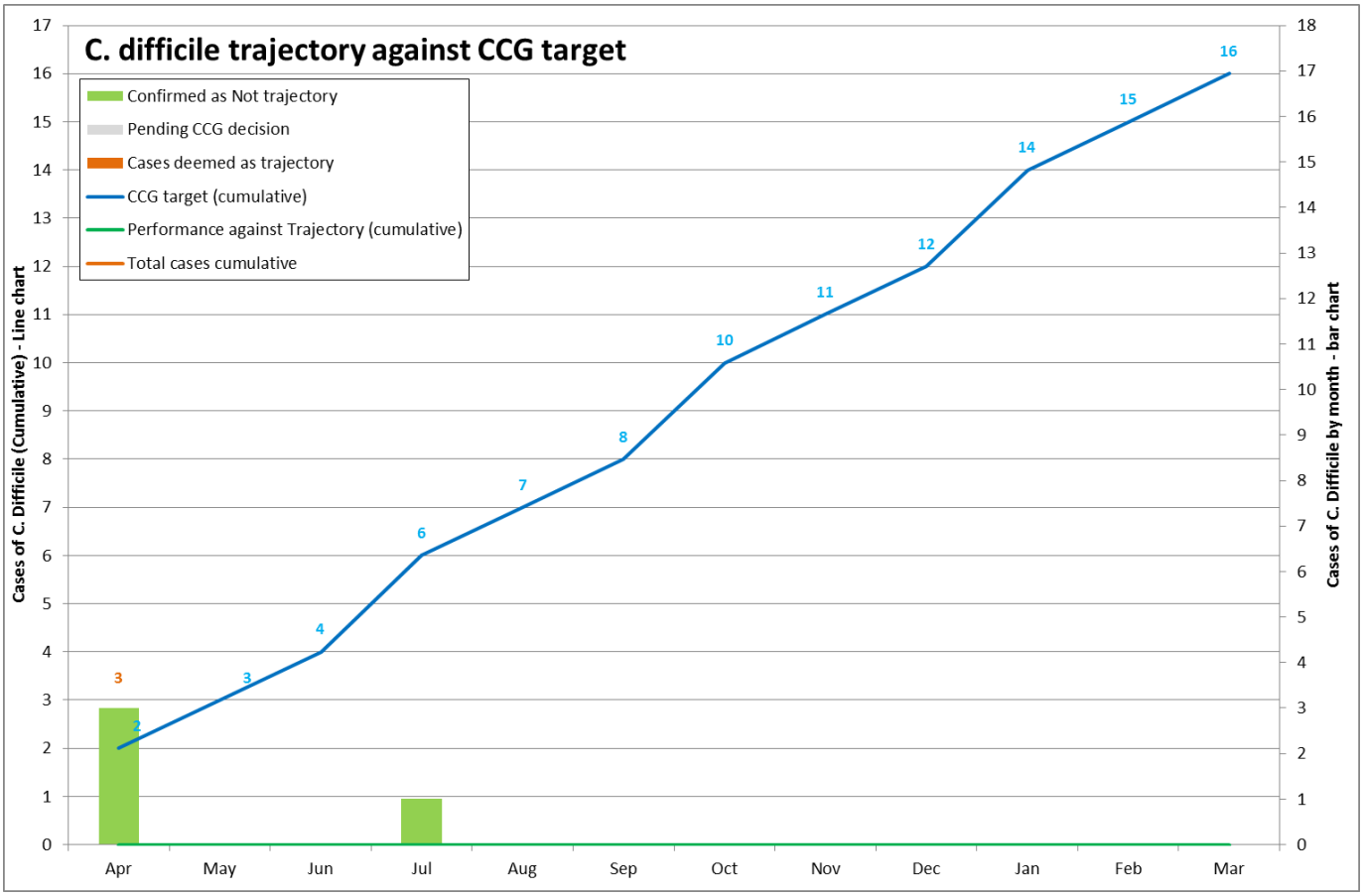
a) Current Position

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

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

b) Recommended Action

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



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

There were 66 falls in July (up from 50 in June), no major harm and one with moderate harm reported.

The figure of 50 falls for June has been updated to record 47 falls, the figure for Newmarket has increased from two to three.

Moderate Harm – Ward G1, 76 year old gentleman admitted with neutropaenic sepsis. Patient noted as high risk of falls due agitation and confusion along with increased risk associated with being nursed in a side room. First documented fall was 25/07/17, following this a low rise bed was requested but unable to be supplied. Subsequent fall 28/07/17 resulted in laceration to the patients head above the left eye requiring

closure by Steri-strips. Continued problems in regards of pain management and management of periods of disorientation. Development of probable HAP 30/07/17, discharge to Hospice 02/08/17 for palliation where patient passed away.

The areas of G1 (10 x falls) / G8 (10 x falls) / F9 (9 x falls) / G5 (9 x falls) were the areas with the highest numbers of patients falling. Cognitive and perceptual impairment were a significant factor in many cases especially those who repeatedly fell. High levels of staffing deficits and requirement for escalation capacity provision has resulted in the redeployment of staff to mitigate risk, this in turn has reduced core staffing levels on several occasions as well as the availability of staff to provide one to one care to those at risk of repeated falls.

Newmarket Hospital (4 x falls) one patient fell on 3 occasions / Glastonbury Court (3 x falls) – these falls are reported separately.

Three patients were assisted to floor (two in June) preventing them from falling

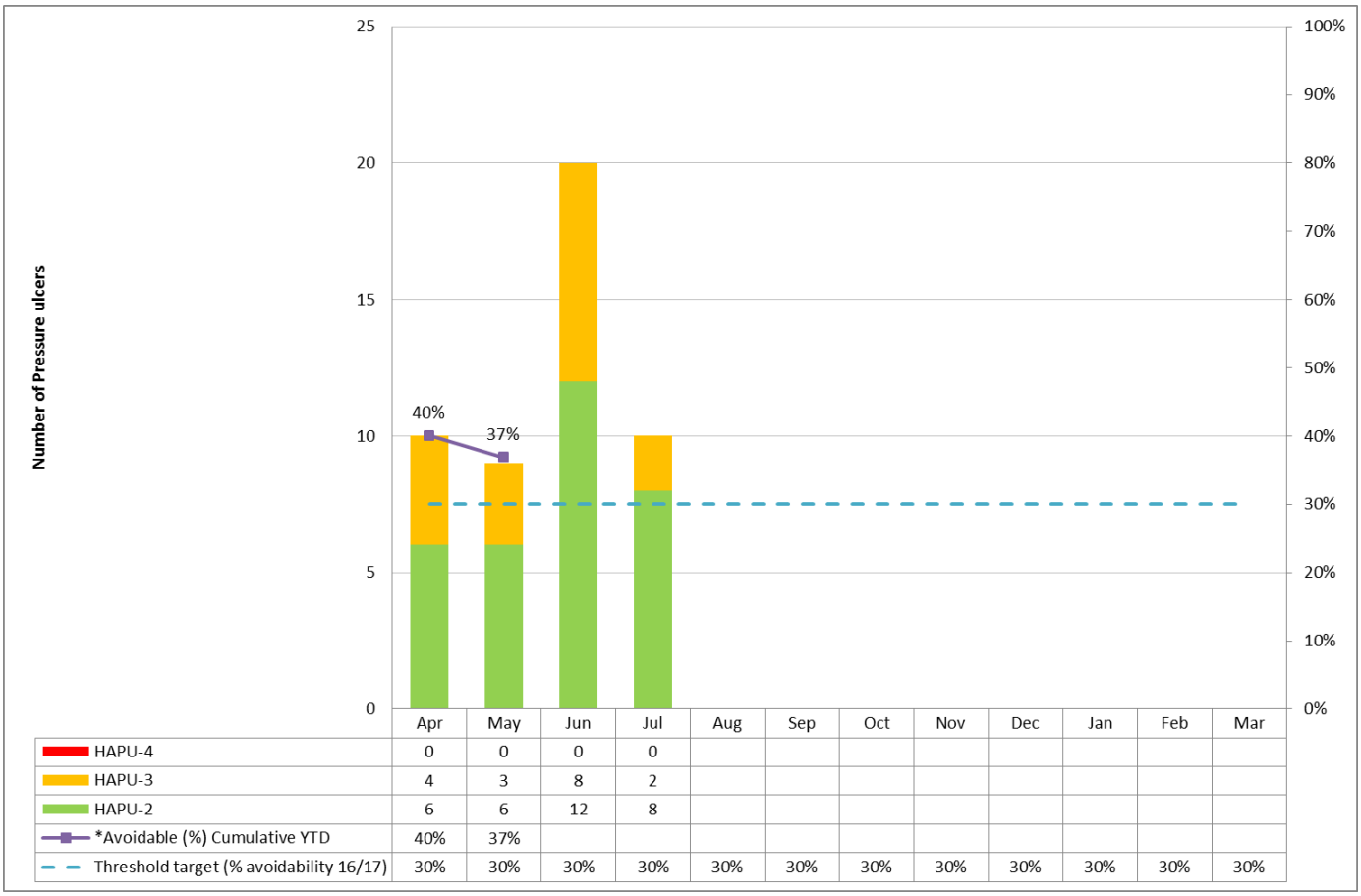
Five patients in total fell more than twice with two of those falling on four occasions (two in June).

Going forwards the Senior Matron Team has commenced a Falls Focus Group led by one of the Heads of Nursing. The group's membership will consist of Senior Matrons, Ward Staff (1 x Band 6, 5/4 and 2), Nurse Specialists AHP's, Pharmacy, Governance and eCare. The group will focus on the reduction of falls within the Trust through the sharing of best practice, modification of processes / documentation / reporting to reflect the current incidents, ward based 'Champions' promoting falls prevention / reduction and multi-professional input to ensure that the plans that are formulated utilise the full range of expertise and resources available. The initial meeting will take place on the14th September 2017 with meetings quarterly thereafter.

Data for the last year has already been collated and supplied to the relevant individuals in relation to falls by ward and by the time of day. This information will support the Focus Group in formulating strategies to reduce the number of falls.

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

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
HAPU-4	0	0	0	0								
HAPU-3	4	3	8	2								
HAPU-2	6	6	12	8								
*Avoidable (%) Cumulative YTD	40%	37%										
Threshold target (% avoidability 16/17)	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%

Judged as Avoidable following clinical review by Matron or TVN

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

There were five HAPU-2 in July. Two on G1 (both on the same patient) and one each on Critical care, G5 and G8.

There were two HAPU-3 in July. One each on F9 and F12 .

There were five DTI reported in July.

There were also three HAPU-2 reported at Rosemary Ward, Newmarket Hospital

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

Avoidable harm

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

At the end of July there had been 49 HAPU 2, 3 or 4 reported including five at Glastonbury Court / Newmarket Hospital. 13 of these have been classified as avoidable and 30 as unavoidable with another six 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

Following a significant increase in reported grade 2 and grade 3 HAPUs in June, the number reported in July has decreased significantly, leading to the conclusion that the increase in June was likely exacerbated by the prolonged period of high temperatures in the month. These variables will be continued to be monitored and working closely with the Tissue Viability Team, we continue to identify themes and trends of incidence.

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

continues to work in conjunction with the Matrons and Ward Managers to maintain the profile of pressure ulcer prevention. The TV team are currently targeting education and taking a 'ward round' approach to particularly the areas that are high with HAPU. This is still in the early stage but will be up and running in the coming months.

Commencing in September, the Heads of Nursing and Matrons are also planning some focussed sessions for the nursing teams on pressure ulcer prevention, falls prevention and maintaining adequate nutrition. These groups will be support joint working with Allied Health Professionals and Specialist Nurses to ensure practice is safe, current and evidence based. Ward Managers are currently being asked to identify team members of all bands to support these groups to promote the sharing of information at all levels.

The Pressure Ulcer Prevention focus group will be led by Matron Danni Elliott with the support of the Tissue Viability Nurse specialists. This group will 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.

One area keen to share good practice is Ward F5. At the end of August, this team will have achieved 500 days without a HAPU. This is a remarkable achievement for a busy, acute Surgical Ward with high acuity, and this will be celebrated and their experiences shared for the benefit of others.

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

a) Current Position

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

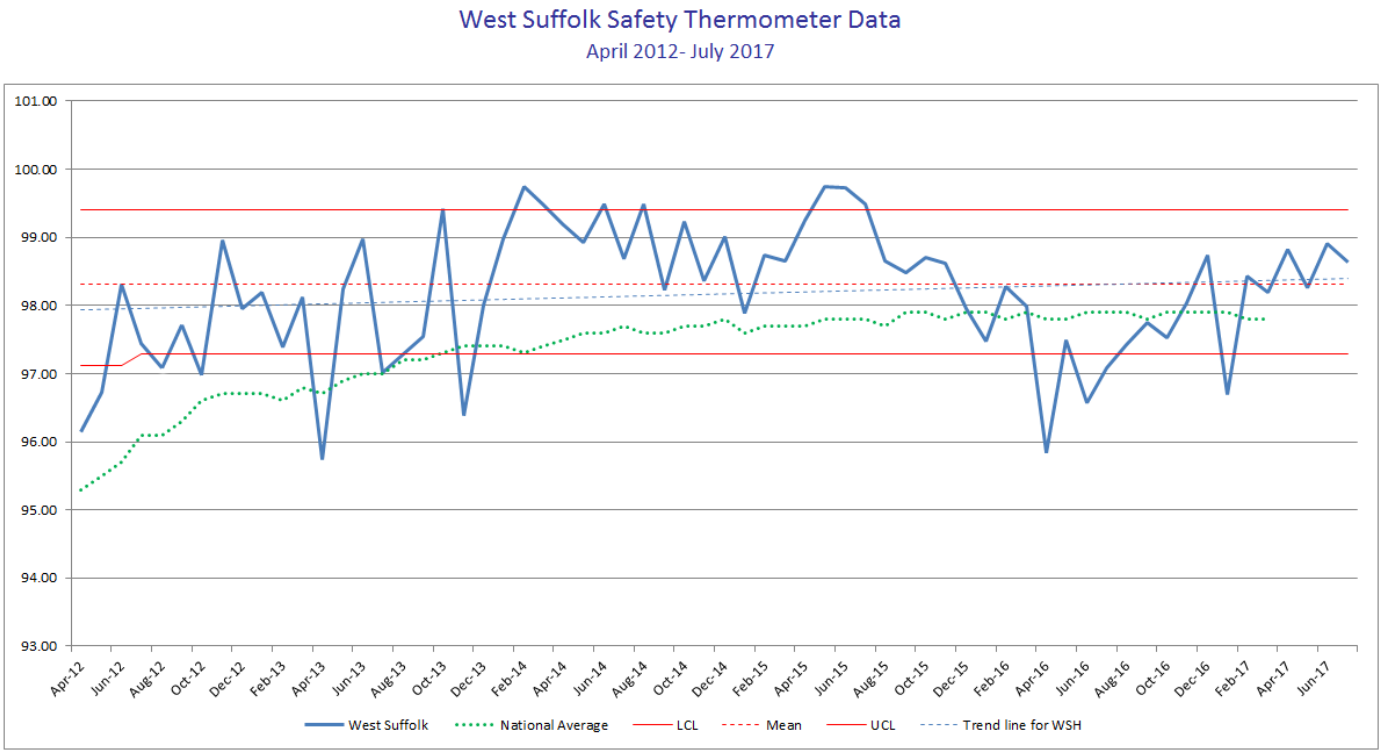
	Aug16	Sep16	Oct16	Nov16	Dec16	Jan17	Feb17	Mar17	Apr17	May17	Jun17	Jul17
Harm Free	92.25	92.71	92.31	92.61	93.16	91.35	93.72	94.06	94.12	91.30	92.92	93.21
Pressure Ulcers – All	3.88	5.03	5.49	5.67	3.80	5.34	4.71	3.62	5.00	5.22	4.90	4.08
Pressure Ulcers - New	1.29	1.01	1.65	1.23	0.51	1.53	1.05	0.52	0.88	0.87	0.54	0.82
Falls with Harm	0.00	0.75	0.55	0.49	0.76	0.76	0.00	0.00	0.00	0.29	0.00	0.27
Catheters & UTIs	3.62	1.51	2.20	1.23	2.28	2.04	1.31	1.81	1.18	3.48	2.18	2.17
Catheters & New UTIs	0.78	0.50	0.00	0.25	0.00	0.25	0.26	0.78	0.29	0.29	0.27	0.00
New VTEs	0.52	0.00	0.27	0.00	0.00	0.76	0.26	0.52	0.00	0.29	0.54	0.27
All Harms	7.75	7.29	7.69	7.39	6.84	8.65	6.28	5.94	5.88	8.70	7.08	6.79
New Harms	2.58	2.26	2.47	1.97	1.27	3.31	1.57	1.81	1.18	1.74	1.09	1.36
Sample	387	398	364	406	395	393	382	387	340	345	367	368
Surveys	18	18	17	18	18	18	18	18	18	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.

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

The data can be manipulated to just look at "new harm" (harm that occurred within our care) and with this parameter, our Trust score for July 2017 is **1.36 %** therefore, our new harm free care is **98.64%.** The National new harm is not available so the Trust figure has not been RAG rated

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



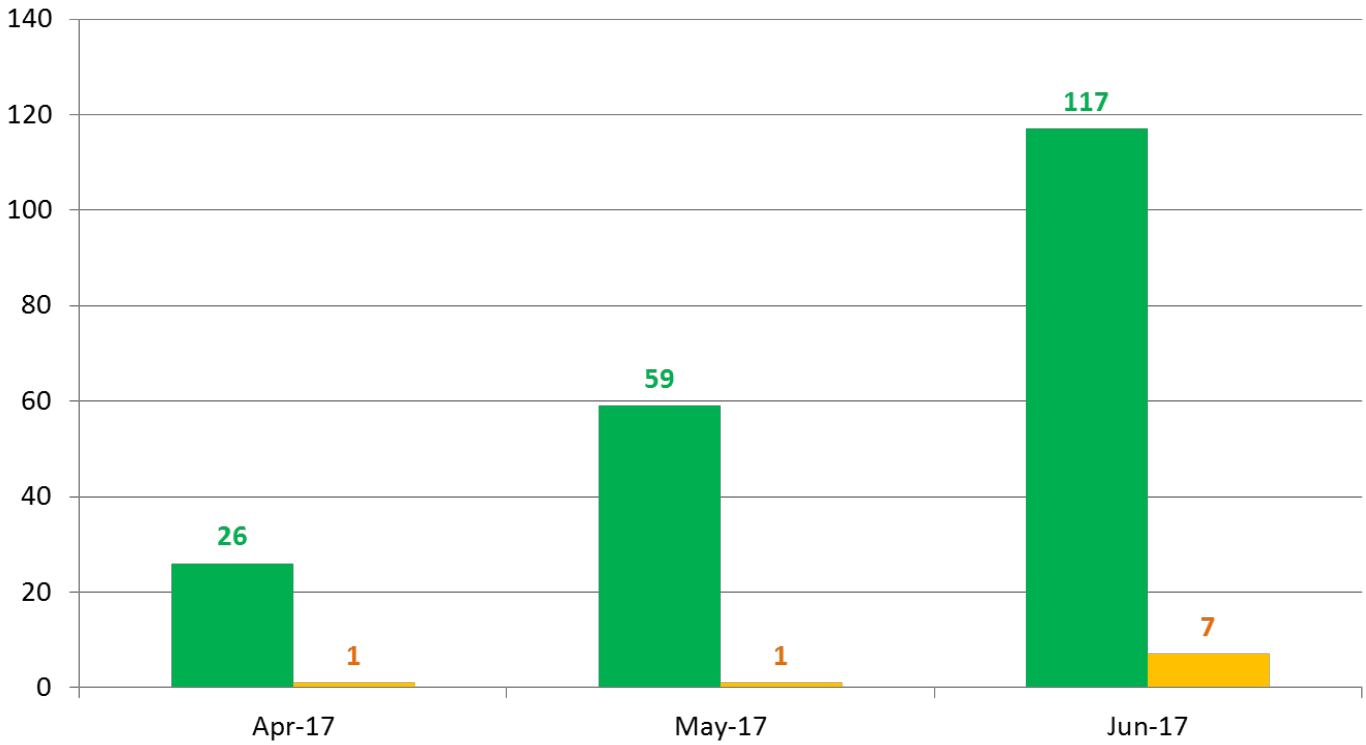
b) Recommended Actions

To continue to monitor actual harm against national benchmarks.

1.8 % of 'Green' PSI incidents investigated / Median NRLS upload 6 month rolling average

a) Current Position

Graph: Green and Amber incidents overdue by month.



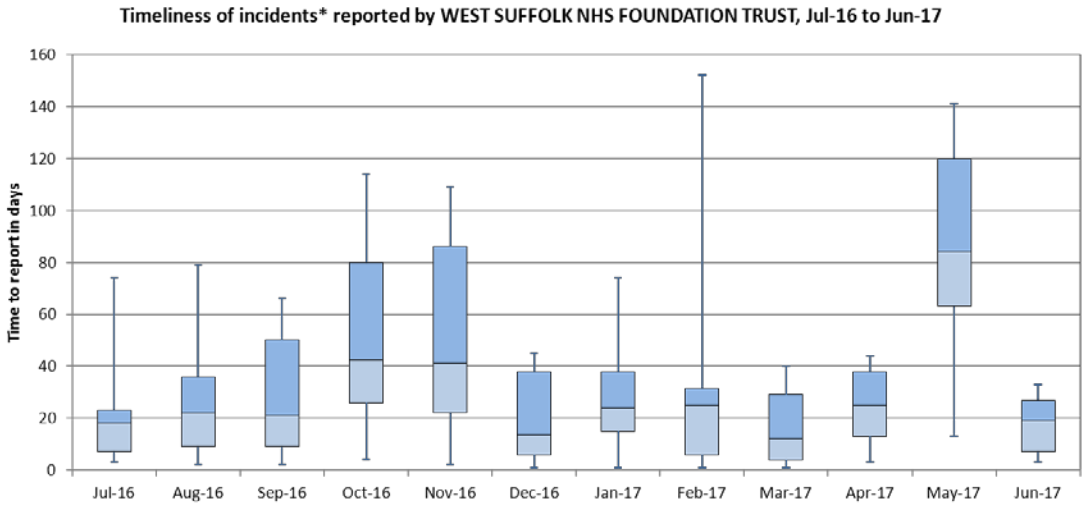
The graph above shows the number of green and amber incidents that are still awaiting investigation. There has been an increase in the overall number of overdue incidents and only 54% (221) of the June green incidents had been investigated at the time of this report compared to May (65%).

Please note there was an error in last month's graph which incorrectly showed the number of green overdue for April and May as 3 and 7 respectively whereas this was in fact the number of Ambers overdue

in the first draft of the report before the targeted follow-up reduced those numbers to 1 and 3 in the final version.

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

NHS Improvement is now publishing monthly information reports including timeliness indicators. The graph below shows the data available for WSFT to the end of June. This shows a 'typical' WSFT pattern where the response rate is poorest for the months around the six monthly NRLS closedown (Nov/May) when effort is focussed on chasing up and closing the previous six months' outstanding cases and therefore the current month suffers. More details of the NHSI report and the Trust's action plan to improve performance will be provided in the 'aggregated' report next month.

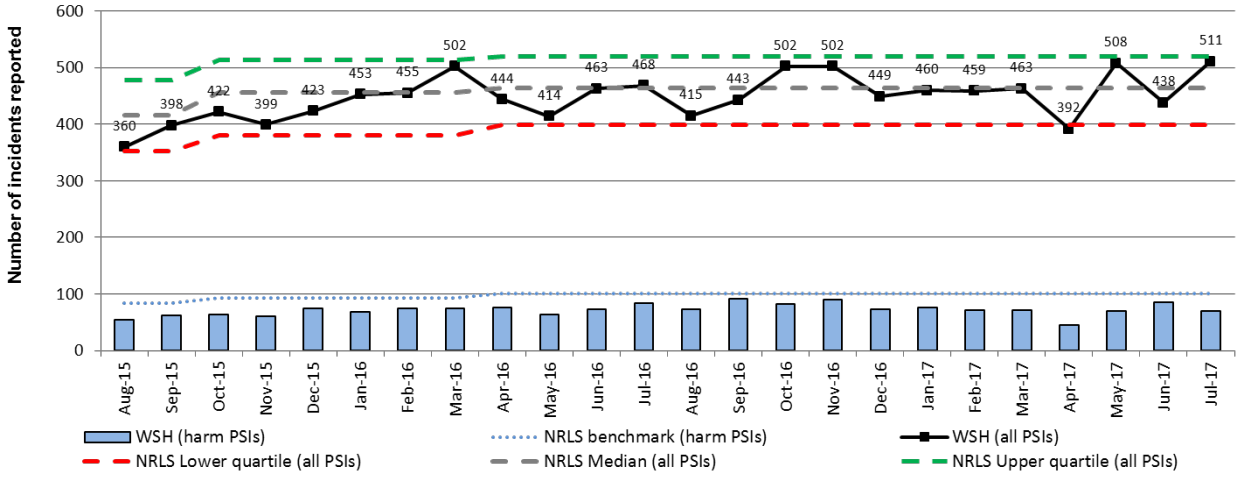


1.9 Patient Safety Incidents reported

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 609 incidents reported in July including 511 patient safety incidents (PSIs). This was higher than June. The number of 'harm' incidents remains low

Graph: Patient Safety Incidents reported



1.10 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

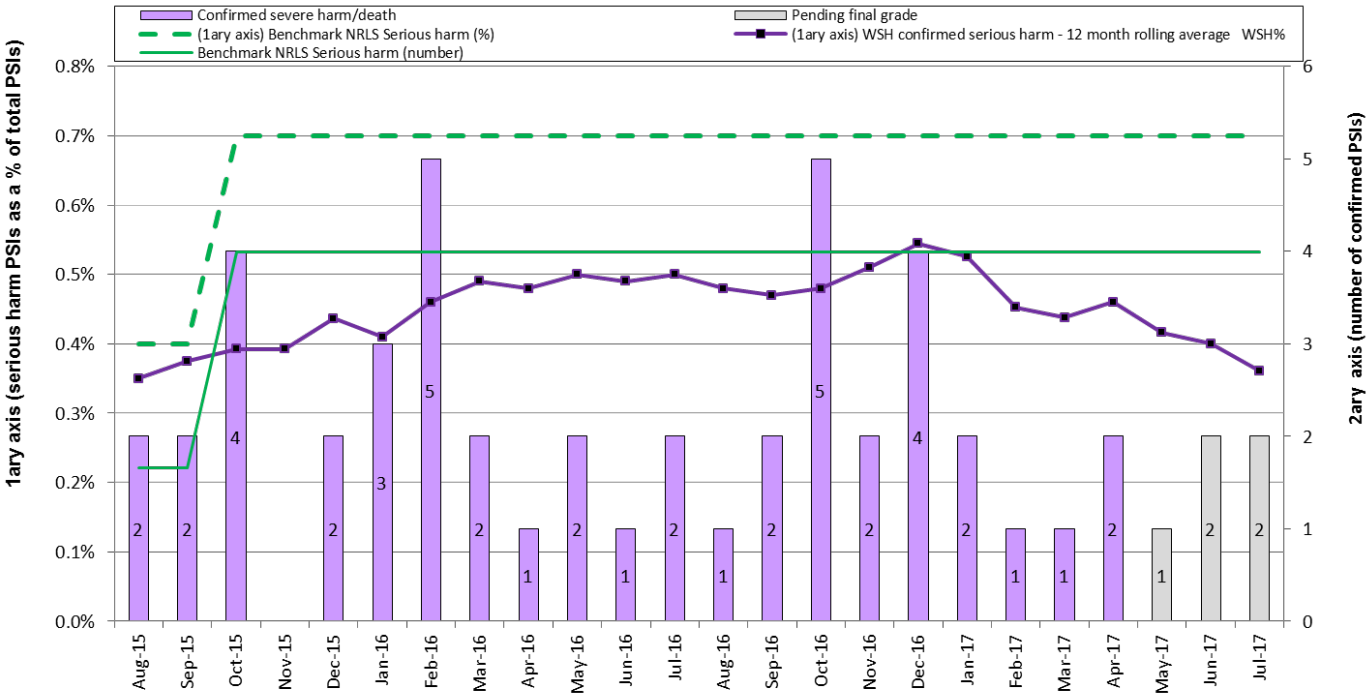
applies the peer group percentage serious harm to the peer group median total PSIs to give a comparison with the Trust's monthly figures. The WSH percentage data is plotted as a line which shows the rolling average over a twelve month period. The Trust percentage sits below the NRLS average. The number of serious PSIs (confirmed and unconfirmed) is plotted as a column on the secondary axis.

In July there were two cases reported: one mortality review of a patient with learning difficulties and one delay in diagnosis. Both cases are awaiting RCA to confirm harm grading.

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

- one delay in treatment
- one delay in diagnosis
- one fall resulting in fracture

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.

1.11 Datix risk register: Red / Amber actions overdue

a) Current Position

This is the first month for reporting against the two new risk register performance indicators and they have not met the target. *Green, Amber and Red Active & Accepted risk assessments in date* is graded amber and *Red / Amber actions overdue* is rated red. This reflects the postponed Board Assurance framework (BAF) review from July to September due to the timing of the Audit Committee which provides independent assurance of the risks. This will be addressed by the end of September.

b) Recommended action

All of the individual action and risk assessment leads have been contacted to update the relevant action or risk. A monthly report is distributed to all Service Managers highlighting all out of date risk assessments. Also a risk assessment report is submitted to the monthly Governance steering groups highlighting all risk assessments which are either out of date or going out of date for its next review.

<u>Patient Experience Dashboard</u>

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	May	Jun	Jul
Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	94	94	95
(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	96	99	98
Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	72	80	79
Patient Satisfaction: outpatient overall result	= 85%	<75	75-84	85-100	92	88	96
(Out-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	98	97	97
Were you informed of any delays in being seen?	= 85%	<75	75-84	85-100	73	65	76
Were you offered the company of a chaperone whilst you were being examined?	= 85%	<75	75-84	85-100	70	65	85
Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	99	99	98
(Short-stay) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	98	99	99
Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	98	94	94
(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	96	95	95
Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	100	94	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	96	95	ND
Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	100	100	100
How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	ND	100	100
Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	99	ND	94
Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	99	99	94
(F1 Parent & Young Person) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	100	92
Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	ND	98	99
(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	ND	95	100

Additional Patient Experience indicators

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

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.

1.11 Inpatient: Noise at night

a) Current Position

This remains an amber subject, scoring 79 in July from 80 in June.

a) Recommended Action

Disturbance from other patients continues to be the most common reason for noise at night. Ear plugs are routinely offered to aid sleep.

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

a) Current Position

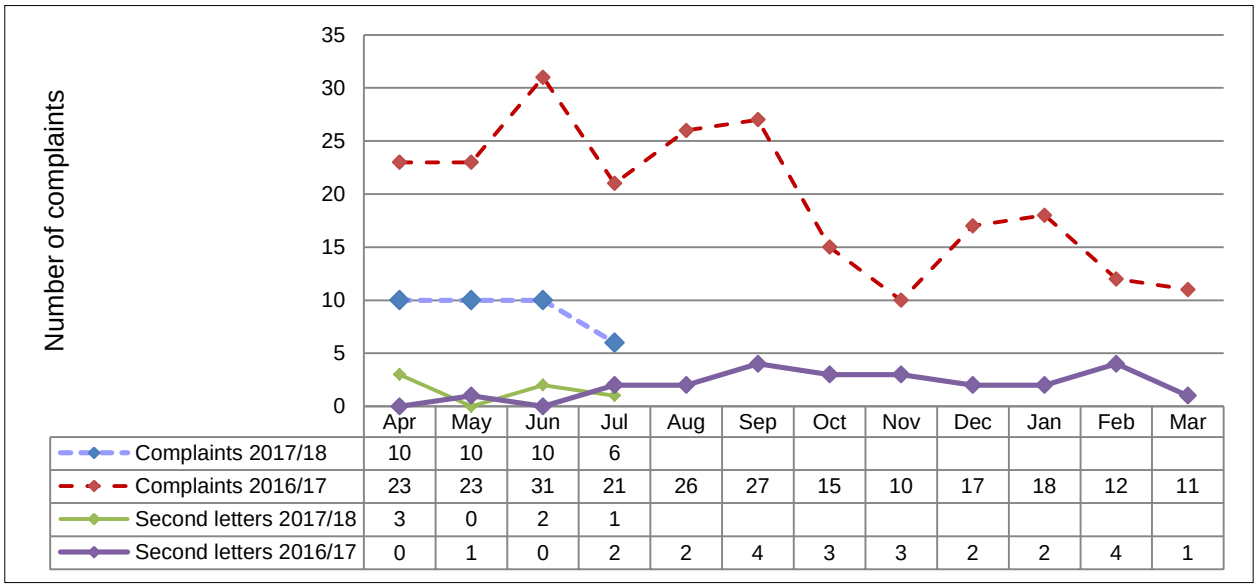
This score has improved from 65 in June to 76.

b) Recommended Action

Twenty new patient pagers are now in place within the Main Outpatient Department to allow patients to leave the department where there are significant delays. Issues with the scoring of this question have also been addressed which explains the fluctuation in the scores. This is now resolved and will be reflected in

August results.

1.14 Complaints



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

Six complaints were received in July. The breakdown of these complaints is as follows by Primary Division: Medical (2), Surgical (3) and Women & Children (1).

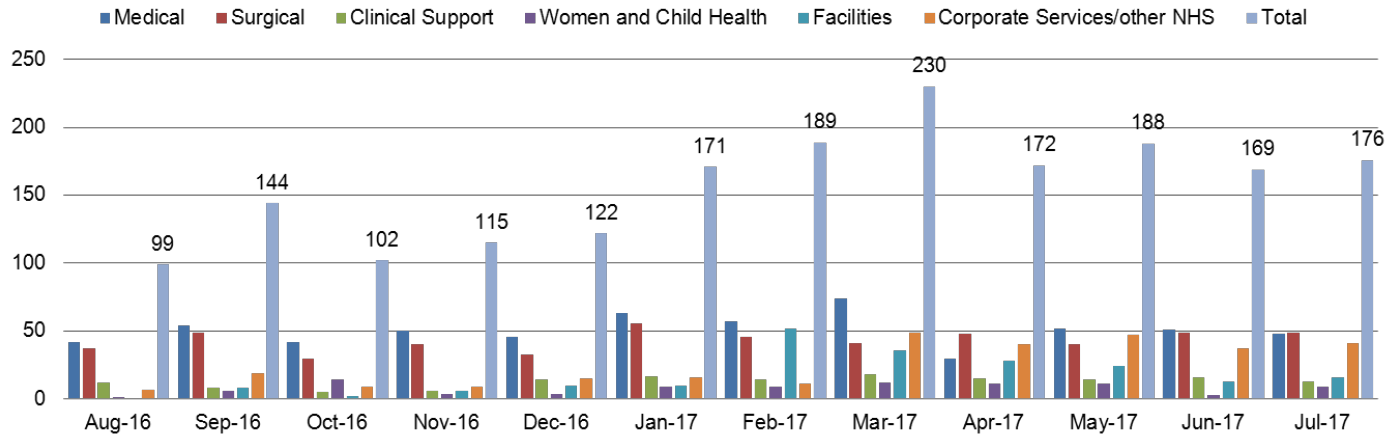
Trust-wide the top most common problem areas are as below:

Access to treatment or drugs	2

1.15 PALS

In July 2017 there were 176 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 Aug 16 – Jul 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 (43)
- Appointments; including delays and cancellations (27)
- Communications / Admissions, discharge and transfers (both 18)

Many patients have complained about the wait to receive a dermatology appointment. There were also several enquiries about Ward F7 where the Senior Matron and Executive Chief Nurse assisted with concerns. Due to the

high acuity in recent weeks the ward has been extremely busy resulting in some patients and relatives feeling the care did not meet their expected standards.
Car parking continues to flag as a high area of enquiry, in July most of these related to blue badge holder charges and queries about concessions.

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	May	Jun	Jul
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	99	NA
Trust participation in relevant ongoing National audits (Quarterly)	100%	<75	75 – 89	>=90	NA	94	NA
Babies admitted to NNU with normal temperature on arrival (term)	100%	<50%	50-80%	>80%	66	88	100
12 month Mortality standardised rate (Dr Foster)	100%	>100	90-100	<90	88.05	88.05	
CAS (central alerting system) alerts overdue	0	>=1	No target	0	0	0	0

Maternity dashboard

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

	Red	Amber	Green	May-17	Jun-17	Jul-17
ACTIVITY – Births						
Total Women Delivered	> 250 or < 2 00	>216 or <208	>208 or <216	190	208	213
Total Number of Babies born at WSH	> 250 or < 2 00	>216 or <208	>208 or <216	192	213	215
Twins	No target	No target	No target	2	5	2
Homebirths	< 1%	2% or less	2.5%	3.7%	2.4%	3.3%
Midwifery Led Birthing Unit (MLBU) Births	<=10%	13% or less	20%	17.4%	17.3%	18.8%
Labour Suite Births	<=64%	69% to 74%	75%	78.9%	80.3%	77.9%
BBAs	No target	No target	No target	4	1	1
Normal Vaginal deliveries	No target	No target	No target	123	154	162
Vaginal Breech deliveries	No target	No target	No target	1	1	0
Non operative vaginal deliveries	No target	No target	No target	65.3%	75%	76.1%
Water births	No target	No target	No target	14	12	20
Total Caesarean Sections	> 22.6%	No target	<22.6%	21.1%	15.9%	15.5%
Total Elective Caesarean Sections	>=13%	11 - 12%	10%	9.5%	4.3%	7%
Total Emergency Caesarean Sections	>=15%	13 - 14%	12%	11.6%	11.5%	8.5%
Second stage caesarean sections	No target	No target	No target	8	3	2
Forceps Deliveries	No target	No target	No target	8.9%	6.3%	5.6%
Ventouse Deliveries	No target	No target	No target	4.7%	3.4%	2.8%
Inductions of Labour	No target	No target	No target	41.1%	40.9%	36.6%
Failed Instrumental Delivery	No target	No target	No target	1.1%	0	0.9%
Unsuccessful Trial of Instrumental Delivery	No target	No target	No target	2	0	0
Use of sequential instruments	No target	No target	No target	ND	ND	ND
Grade 1 Caesarean Section (Decision to Delivery Time met)	<=95%	96 - 99%	100%	100%	100%	100%
Grade 2 Caesarean Section (Decision to delivery time met)	<=75%	76 - 79%	80%	93%	93%	83%
Total no. of women eligible for Vaginal Birth after Caesarean Section (VBAC)	No target	No target	No target	11	23	23
Number of women presenting in labour for VBAC against number achieved.	No target	No target	No target	6	15	8
ACTIVITY – Bookings						
Number of Bookings (1st visit)	No target	No target	No target	262	244	272
Women booked before 12+6 weeks	<=90%	91 - 94%	95%	95%	97%	95%
CLINICAL OUTCOMES - Maternal						
Postpartum Haemorrhage 1000 - 2000mls	No target	No target	No target	15	16	16
Postpartum Haemorrhage 2,000 - 2,499mls	No target	No target	No target	1	1	2
Postpartum Haemorrhage 2,500mls+	No target	No target	No target	0	1	3

	Red	Amber	Green	May-17	Jun-17	Jul-17
Post-partum Hysterectomies	1	1	0	0	0	0
Women requiring a blood transfusion of 4 units or more	1	1	0	0	0	0
Critical Care Obstetric Admissions	1	1	0	0	0	0
Eclampsia	1	1	0	0	0	0
Shoulders Dystocia	5 or more	3-4	2	4	3	5
3rd and 4th degree tears (All vaginal deliveries)	No target	No target	No target	9	6	10
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)	10	7-9	6	5	5	6
3rd and 4th degree tears (Instrumental Deliveries)				4	1	4
Maternal death	1	No target	No target	0	0	0
Female Genital Mutilation (FGM)	No target	No target	No target	0	0	0
Clinical Outcomes –Neonatal						
Number of babies admitted to Neonatal Unit (>36+6)	No target	No target	No target	9	17	0
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	No target	No target	No target	2	3	2
Number of Babies transferred for therapeutic cooling	1	No target	0	0	0	0
Cases of Meconium aspiration	No target	No target	No target	0	0	0
Cases of hypoxia	No target	No target	No target	0	0	0
Cases of Encephalopathy (grades 2 and 3)	No target	No target	No target	0	0	0
Stillbirths	No target	No target	No target	0	0	0
Postnatal activity						
Return of women with perineal problems, up to 6 weeks postnatally	No target	No target	No target	ND	ND	ND
Workforce						
Weekly hours of dedicated consultant cover on Labour Suite	<=55 hrs	56-59	60hrs or >	110	99	99
Midwife/birth ratio	>=1:32	No target	1:30	1:27	1:29	1:30
Supervisor to Midwife Ratio	No target	No target	No target			
Consultant Anaesthetists sessions on Labour Suite	< 8 sessions	8-9 sessions	10 sessions	10	10	10
ODP cover for Theatre 2	80%	90%	100%	100%	100%	100%
Anaesthetist response to request for epidural for pain relief within 30 mins	< 70%	70 - 79%	>=80%	ND	ND	ND
Risk incidents/complaints/patient satisfaction						
Reported clinical Incidents	>40	40-59	60 and above	62	46	64
Serious incidents	No target	No target	No target	0	0	0
Never events	No target	No target	No target	0	0	0
Complaints	No target	No target	No target	0	1	2
1 to 1 Care in Labour	<=95%	96 - 99%	100%	100%	100%	100%
Unit closures	No target	No target	No target	0	0	0
Massive Obstetric Haemorrhage protocol	No target	No target	No target	0	0	0
Maternal Postnatal readmissions	No target	No target	No target	ND	ND	ND
Completion of WHO Checklist	80%	90%	100%	93%	84%	94%
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	35	37	10+
Number of Women identified as smoking at delivery	No target	No target	No target	30	26	32
UNICEF Baby Friendly Audits	No target	No target	No target	10	10	30
Proportion of parents receiving a Safer Sleeping Suffolk Thermometer.	No target	No target	No target	170	174	205

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

1.16 Maternity - Shoulder Dystocia

The maternity service reported 5 cases of shoulder dystocia this month and triggered a red grading on the dashboard. There were no reports of neonatal injuries as a result of these incidents. An audit of shoulder dystocia cases will be undertaken.

1.17 Maternity - Shoulder Dystocia

The maternity service identified 10 3rd and 4th degree tears in July 2017. There is currently an audit in progress looking at this complication.

1.17 Maternity - Completion of WHO Checklist

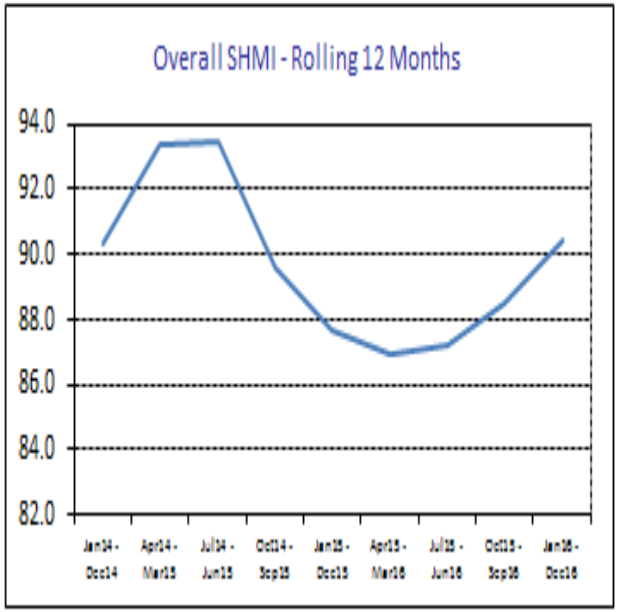
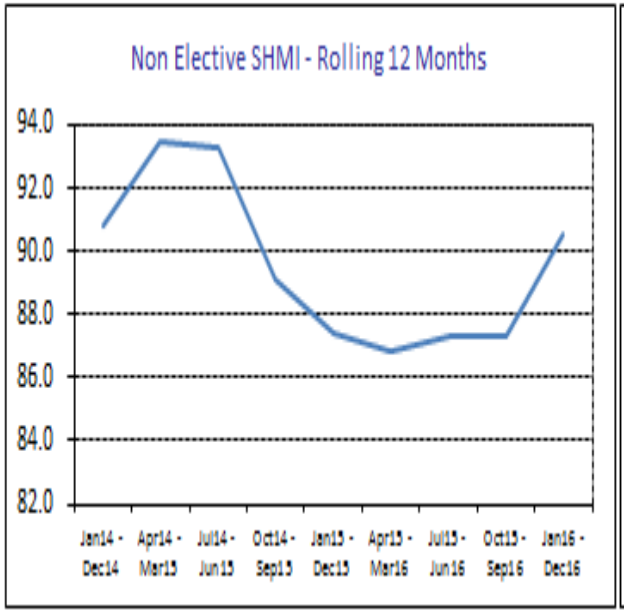
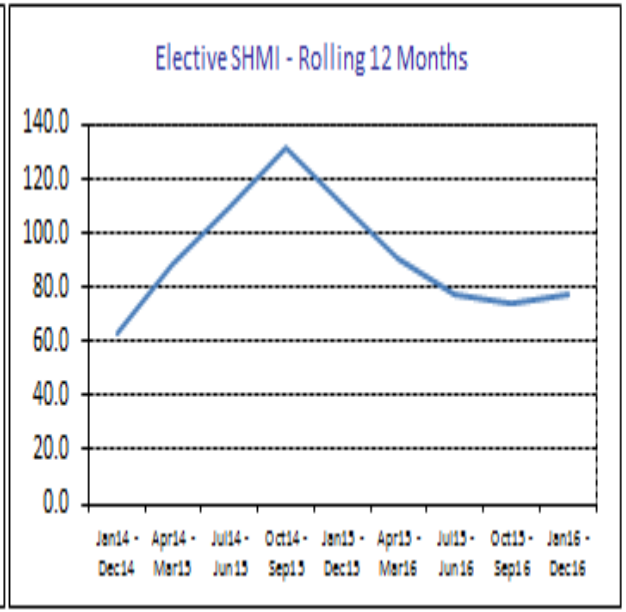
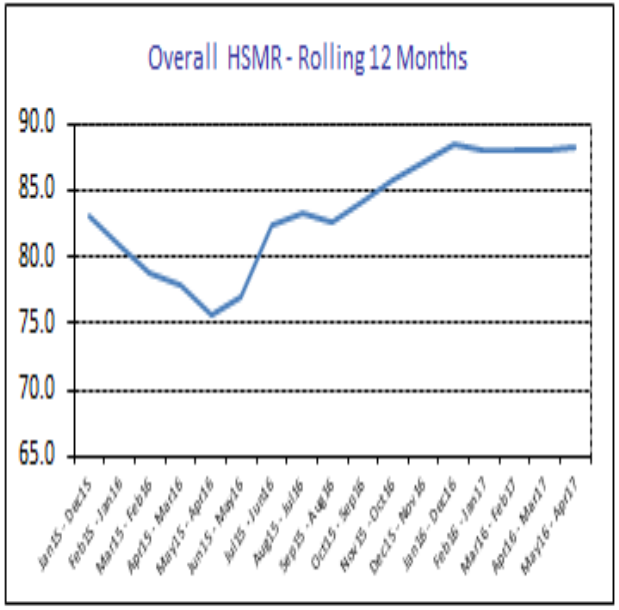
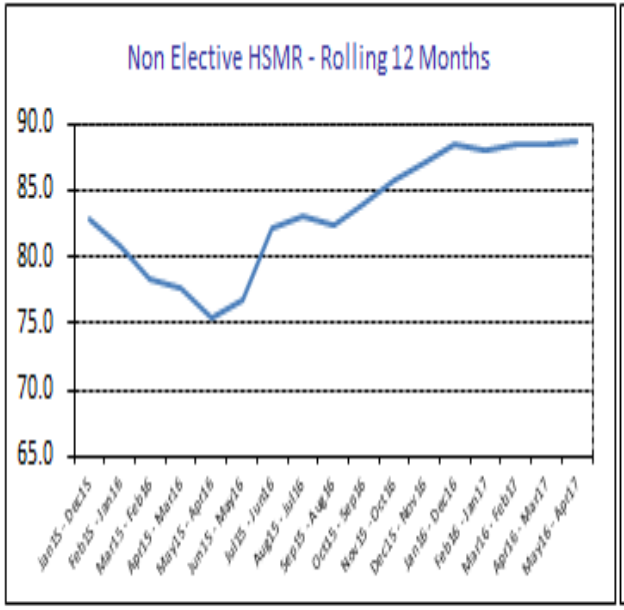
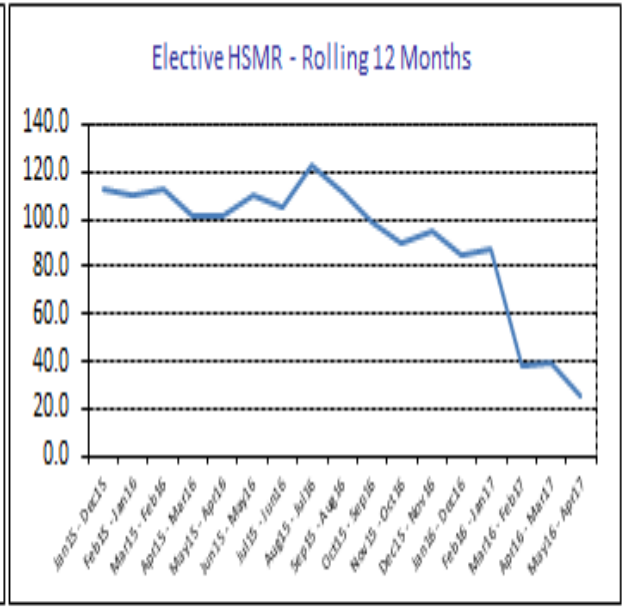
A documentation audit of the 50 maternity cases in theatre in July 2017 showed an improved compliance with the completion of the checklist from 84% in June 2017 to 94% in July 2017. The medical staff involved in the 3 cases that were non-compliant will each be asked to complete a reflection on this for the lead obstetrician.

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

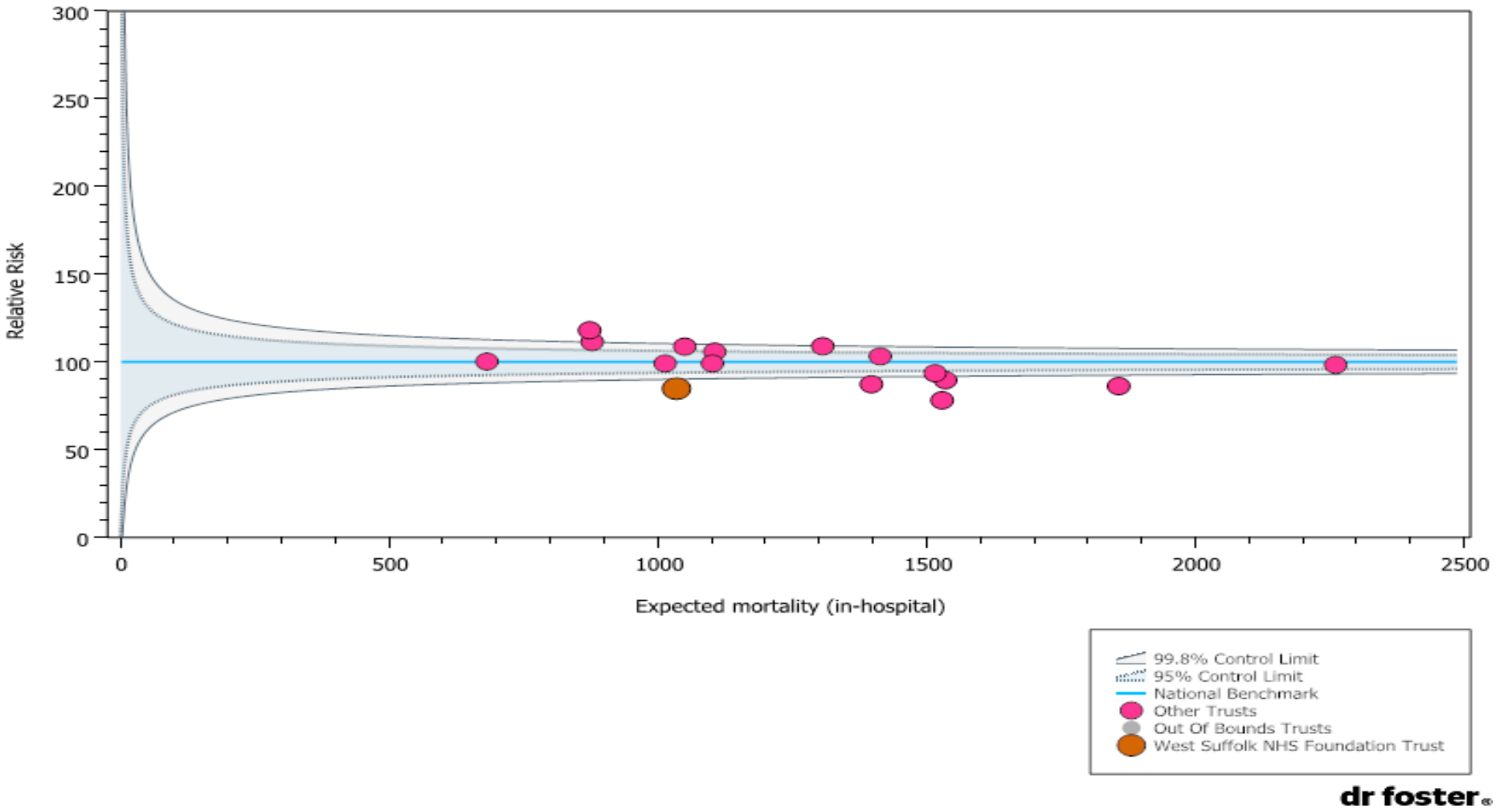
2. MORTALITY HSMR AND SHMI DATA

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								
No of Discharges	5,378	5,742	5,661	5531								
% Deaths	1.34%	1.20%	1.25%	1.12%								
HSMR*												

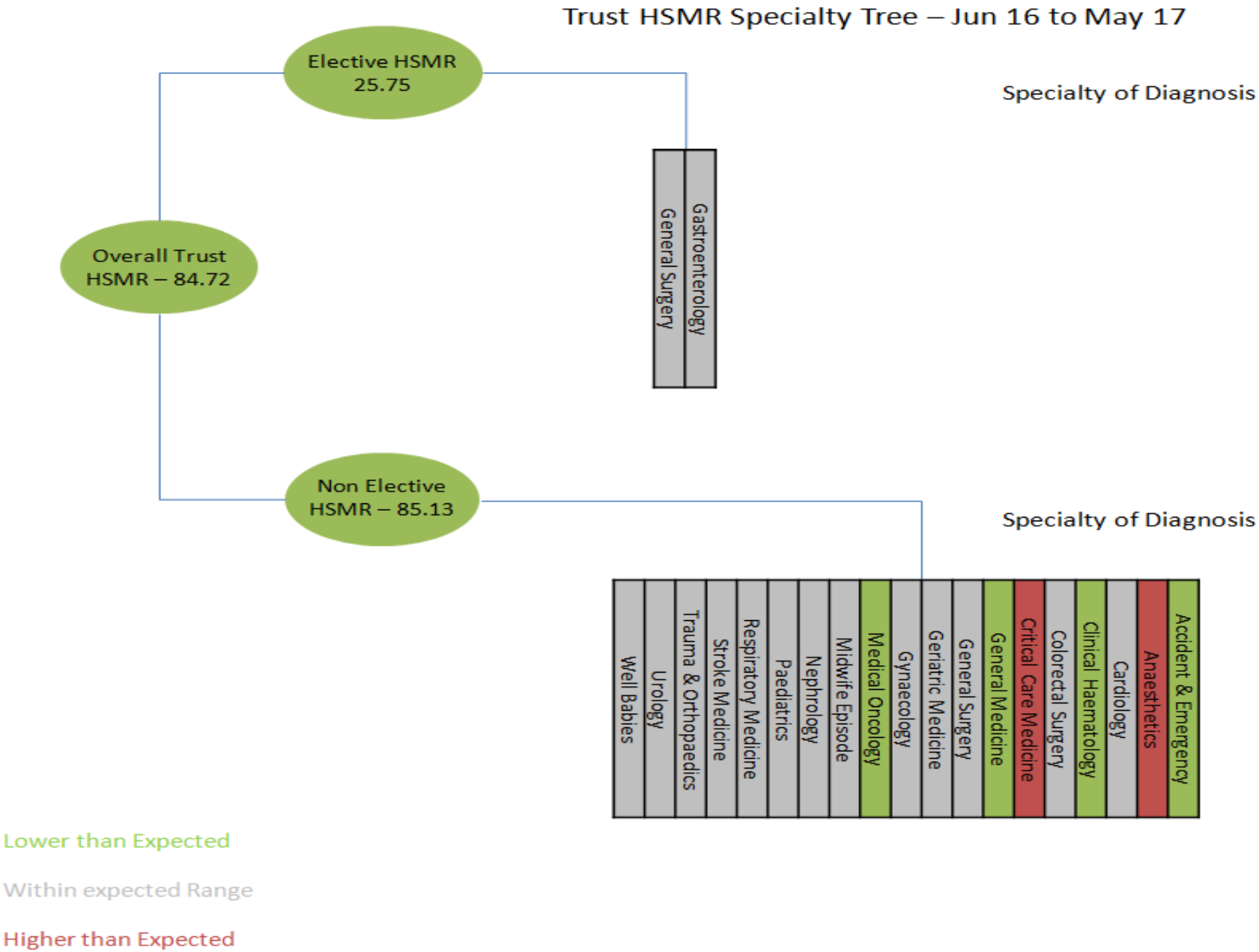
HSMR BENCHMARK IS USING FY 15 -16

	Overall	Non-Elective	Elective
SHMI			
HSMR			

HSMR - Jun 16 - May 17



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


Trust HSMR Specialty Tree – Jun 16 to May 17
Elective HSMR 25.75
Overall Trust HSMR – 84.72
Non Elective HSMR – 85.13
Specialty of Diagnosis
Gastroenterology
General Surgery
Specialty of Diagnosis
Accident & Emergency
Anaesthetics
Cardiology
Clinical Haematology
Colorectal Surgery
Critical Care Medicine
General Medicine
General Surgery
Geriatric Medicine
Gynaecology
Medical Oncology
Midwife Episode
Nephrology
Paediatrics
Respiratory Medicine
Stroke Medicine
Trauma & Orthopaedics
Urology
Well Babies
Lower than Expected
Within expected Range
Higher than Expected

3. NHS IMPROVEMENT'S SINGLE OVERSIGHT FRAMEWORK

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

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

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

NHS Improvement's Single Oversight Framework						May	June	July
Performance Indicator	Threshold	Month	QTD	Weighting	Lead Exec			
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	85.92%	85.92%	1.0	Helen Beck	79.71%	83.36%	85.92%
Number of RTT Waits over 52 weeks for incomplete pathways	0	35	35	-	Helen Beck	14	15	35
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	92.47%	90.84%	1.0	Helen Beck	94.66%	95.53%	92.47%
All cancers: 62-day wait for first treatment (5) from:Urgent GP referral for suspected cancer - **See Further detail below**	85%	84.38%	83.89%	1.0	Helen Beck	83.47%	85.98%	84.38%
All cancers: 62-day wait for first treatment (5) from: NHS Cancer Screening Service referral	90%	100.00%	100.00%		Helen Beck	100.00%	90.00%	100.00%
All cancers: 31-day wait for second or subsequent treatment, comprising: Surgery	94%	100.00%	100.00%	1.0	Helen Beck	100.00%	100.00%	100.00%
All cancers: 31-day wait for second or subsequent treatment, comprising: anti-cancer drug treatments	98%	100.00%	100.00%		Helen Beck	100.00%	100.00%	100.00%
All cancers: 31-day wait for second or subsequent treatment, comprising: radiotherapy - Not applicable to WSFT								
All cancers: 31-day wait from diagnosis to first treatment	96%	100.00%	83.89%	0.5	Helen Beck	100.00%	100.00%	100.00%
Cancer: two week wait from referral to date first seen (8), comprising: all urgent referrals (cancer suspected)	93%	94.41%	100.00%	0.5	Helen Beck	92.27%	96.59%	94.41%
Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)	93%	98.06%	100.00%		Helen Beck	99.28%	88.80%	98.06%
Outcomes:			1					
Clostridium (C.) difficile - meeting the C.difficile objective - MONTH	2	1		1.0	Rowan Proctor	0	0	1
Clostridium (C.) difficile - meeting the C.difficile objective - QUARTER	4		1		Rowan Proctor			
Clostridium (C.) difficile - meeting the C.difficile objective - ANNUALLY	16		4		Rowan Proctor			
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	-	-	0.5	Rowan Proctor			

West Suffolk NHS Foundation Trust Cancer Waits Performance Report - June 2017					
GP Suspected Cancer, Cancer Screening Referral Receipt to Start of 1st Treatment: 62 Days Waiting Times Standard 85%				Performance %	
Cancer Type	<62 days	>62 days	Total	Trust	England~
Breast	11+1x.5	1	12.5	92	92.8
Gynae	1		1	100	73.8
Haem	1		1	100	76.4
Head & Neck				NA	
Lower GI	6	1	7	85.7	69.8
Lung	1	1x.5	1.5	66.7	69.6
Other		1x.5	0.5	0	70.3
Skin	12		12	100	96.8
Upper GI	3		3	100	71.2
Urology	10+1x.5	4+1x.5	15	70	74.2
Total	45+2x.5	6+3x.5	53.5	86	80.4
Testicular	2	1	3	66.66	92

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

a) Current Position

85.92% against a threshold 92%

The July position shows a further improvement from June (83.36%) to 85.92% in July. This reflects the work being undertaken across all divisions to focus on reducing waiting times for our patients. The current waiting list now has a total of 18,676 patients with 2,629 patients breaching 18 weeks; however there some remaining data quality issues within this number which we continue to work through to correct. There continue to be significant capacity constrains within ENT, Vascular, Urology, and Dermatology services.

b) Recommended Action

Revised detailed action plans for each of the specialties have been developed and reviewed with the CCG. The CCG and NHSI have indicated that they have increased assurance with the Trust's plans to improve aggregate performance. Further validation work of the new PTL continues in all areas. NHSI IST are assisting the trust with demand and capacity modelling to support work around meeting the RTT targets. This is being further supported by colleagues from KPMG and initial speciality focused meetings commence in late August. Work continues across all specialities to maximise opportunity for additional capacity and support clinicians in delivering additional activity to reduce waiting times for patients.

3.2 Number of RTT waits over 52 weeks for incomplete pathways

a) Current Position

35 against a threshold of 0

The greatest proportion of patients breaching 52 weeks is in the ENT service which has known capacity issues. This was compounded in July by clinic reductions due to unavoidable clinician absence and patient choice to delay treatment until after the holiday period. In July 21 ENT patients breached 52 weeks, of these 14 will have completed at the end of August and a further 5 will complete in September. One further ENT patient on the OP Other PTL is awaiting an MRI and one further patient has a date for surgery in October. The remaining 14 breached patients are shared across Vascular Surgery, Audiology, T&O, Urology, and Ophthalmology. Seven of these patients have appointments or procedures due in August, three in September, and three await confirmed plans but are being closely monitored and proactively managed.

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. Clinicians have been reminded to follow appropriate governance processes and report any patient harm identified as a result of excessive waits for treatment.

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

a) Current Position

92.47% against a threshold of 95%

Expected specialty patients through ED higher in July than June due to bed capacity issues.

b) Recommended Action

ED medical cover pressures are being experienced; however demand and capacity activity now mapped and will continue to be mapped in readiness for October and GP streaming implementation.

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

a) Current Position

84.38% against a threshold of 85%

Local breaches at West Suffolk:

- Colorectal X4
- Head and Neck x2
- Lung x1
- Urology x3

Shared breaches 2 X.5 at Addenbrookes

- Colorectal Day x1
- Gynae Day x1

To expedite timely diagnosis and treatment and prevent breaches these patients were escalated to the teams and services from as early as the outcome of first seen appointment. The RCA of the breach pathway with clear timelines have been sent out to the relevant clinicians for review and learning opportunities for improvement and to prevent future recurrence.

b) Recommended Action

- Clinical support to further progress improvements in endoscopy capacity
- Lung team engaged to improve local communication on SMDT returned patient as late return leaves limited days in the pathway to treat them in time.
- There is a need to improve on template diagnostic capacity and turnaround time to reduce waits between each pathway events.
- Urology day 76 breach had patient safety reason for the delay.

3.5 104 day Cancer waits

a) Current Position

July monthly figures have one 104 days or beyond confirmed breach in the colorectal pathway to report.

b) Recommended Action

- Linked with the Trust's weekly Unify 62 days PTL returns, we are routinely reporting current status of all 104days or beyond long waiters to NHS/I/E.
- RCAs on all 104 days or beyond waiters with reported breaches at West Suffolk are reviewed by the relevant clinicians and services and they are requested to follow the Trust Governance protocols where the delay was found to have caused clinical harm to the patient and to record the incidence Datix.
- A report on this aspect of service will be presented to the next CSEC meeting with a view to present it to the Trust Board including open board meetings.

4. CONTRACTUAL AND KEY PERFORMANCE INDICATORS

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

Performance Indicator	Threshold	In Month Performance	YTD	Comments	Lead Exec	May	Jun	Jul	Change mth on mth	On Plan To Achieve	Area of Concern	Forecast to Breach
A&E												
A&E Time to treatment in department (median) for patients arriving by ambulance - CDM	Median time to treatment above 60 minutes	52	46		Helen Beck	43	52	52	↔			
A&E - Single longest total time spent by patients in the A&E department, for admitted and non-admitted patients	Should not exceed 6 hours	13:53	13:57	Patient refused X-ray until opiates received and alluded to suicidal intent so had to wait for out of hours psychiatric team.	Helen Beck	13:57	10:10	13:53	↘			
A&E Trolley Waits not longer than 12 hours	0 Patients waiting over 12 hours from DTA to Admission	0	0		Helen Beck	0	0	0	↔			
A&E - Threshold for admission via A&E	i) if the monthly ratio is above the corresponding 2012/13 monthly ratio for two month in a six month period ii) if year end is greater than 27%	30.75%	30.99%		Helen Beck	30.69%	30.80%	30.75%	↗			
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%	90.98%	91.22%		Helen Beck	91.10%	91.74%	90.98%	↘			
A&E - Ambulance Handovers above 30 minutes	0 handovers over 30 minutes - £200 per breach	ND	90	TBC from ED.	Helen Beck	38	31	ND				
A&E - Ambulance Handovers above 60 minutes	0 handovers over 60 minutes - £1000 per breach	ND	28		Helen Beck	16	9	ND				
Percentage of patients presenting at type 1 and 2 (major) A & E sites in certain high risk categories who are reviewed by an emergency medicine consultant before being discharged	14.00%	14.08%	72.00%		Helen Beck	86.96%	92.86%	14.08%	↘			
RTT												
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks	99.00%	94.31%	92.92%		Helen Beck	91.04%	94.04%	94.31%	↗			
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90.00%	72.92%	70.07%		Helen Beck	67.84%	70.32%	72.92%	↗			
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.00%	87.61%	87.01%		Helen Beck	86.95%	87.34%	87.61%	↗			
Stroke												
% of patients scanned within 1 hour of clock start	77% (Contract) 57.5% (Upper Quartile)	81.58%	80.00%		Helen Beck	79.59%	72.09%	81.58%	↗			
% of patients scanned within 12 hours of clock start	96% (Contract) 96% (Upper Quartile)	94.74%	96.57%		Helen Beck	97.96%	95.35%	94.74%	↘			
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75% (Contract) 70% (Upper Quartile)	77.78%	78.49%		Helen Beck	71.43%	76.19%	77.78%	↗			
>80% treated on a stroke unit >90% of their stay	90%	94.44%	91.76%		Helen Beck	87.76%	88.10%	94.44%	↗			
% of patients treated by a stroke skilled early supported discharge team	48% (Contract) 48% (Upper Quartile)	46.43%	54.41%		Helen Beck	47.50%	75.00%	46.43%	↘			
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80% (Contract) 79% (Upper Quartile)	92.11%	91.43%		Helen Beck	85.71%	95.35%	92.11%	↘			
% 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)	87.88%	86.08%	INDICATION ONLY - FINAL SSNAP LEVEL AVAILABLE WHEN RESULTS ARE AVAILABLE FROM SSNAP	Helen Beck	80.00%	90.24%	87.88%	↘			
% of eligible service users given thrombolysis	100% (RCA to be provided for breaches)	100.00%	100.00%		Helen Beck	100.00%	100.00%	100.00%	↔			
All stroke survivors to have a 6 month follow up assessment.	50%	ND	58.00%		Helen Beck	58.00%			-			
Provider rating to remain between A-C in each of the 9 domains covered in SSNAP where the Provider is at this level. For the one domain (SaLT) where the Provider is at level E, this will be improved to level to C by March 2017.	To remain at or above: National average or current performance (A-C) Improve performance to level C by end of the year (SaLT)	ND	C	Reports are generated by SSNAP every 4 months - this is as at March 2017, reported for June Board	Helen Beck	C			-			
Discharge Summaries												
Discharge Summaries - Outpatients	85% sent to GP's within 3 days	ND	ND	Outstanding report issues with Discharge Summaries which are currently being investigated.	Nick Jenkins	ND	ND	ND	-			
Discharge Summaries - A&E	95% of A&E Discharge Summaries to be sent to GPs within one working day	86.75%	98.25%	A&E Discharge Summaries report now built and tested.	Nick Jenkins	98.35%	87.53%	86.75%	↘			
Discharge Summaries - Inpatients	95% sent to GP's within 1 day	TBC	92.91%	Outstanding report issues with Discharge Summaries which are currently being investigated.	Nick Jenkins	93.29%	93.40%	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	1.00%	0.81%		Helen Beck	0.56%	1.05%	1.00%	↗			
Patients offered date within 28 days of cancelled operation	100%	88.46%	91.86%		Helen Beck	93.75%	93.10%	88.46%	↘			
No urgent operation should be cancelled for a second time	0 2nd Urgent Cancellations	0	0		Helen Beck	0	0	0	↔			
Maternity												
Access to Maternity services (VSB06)	90% of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy.	94.85%	95.64%		Rowan Procter	95.42%	97.54%	94.85%	↘			
Maintain maternity 1:30 ratio	1:30	01:30	01:29		Rowan Procter	01:27	01:29	01:30	↘			
Pledge 1.4: 1:1 care in established labour	1:1	100.00%	100.00%		Rowan Procter	100%	100%	100.00%	↘			
Breastfeeding initiation rates.	80%	77.30%	81.26%		Rowan Procter	80.50%	87.50%	77.30%	↘			
Reduction in the proportion of births that are undertaken as caesarean sections.	22.70%	15.49%	16.75%		Rowan Procter	21.05%	15.87%	15.49%	↗			

Other contract / National targets												
Mixed Sex Accomodation breaches	0 Breaches	0	0		Helen Beck	0	0	0	↔			
Consultant to Consultant referral	Commisioner to audit if concern about levels of consultant referrals	12.27%	10.35%		Helen Beck	9.59%	9.72%	12.27%	↘			
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	95.45%	98.35%		Helen Beck	97.94%	100.00%	95.45%	↘			
Acute oncology service: 1 hour to needle from diagnosis of neutropenic sepsis	100%	100.00%	93.75%	MacMillan	Helen Beck	100.00%	100.00%	100.00%	↔			
		58.33%	50.00%	ED	Helen Beck	40.00%	41.67%	58.33%	↗			
		68.75%	60.32%	Overall Trust (Inc AMU)	Helen Beck	47.06%	63.16%	68.75%	↗			
New to Follow up	Thresholds set at each speciality - overall Trust Threshold is 1.9	1.96	1.89		Helen Beck	1.87	1.97	1.96	↗			
Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test	99%	99.95%	99.92%		Helen Beck	99.87%	100.00%	99.95%	↘			
All relevant inpatients undergoing a VTE Risk assessment	95%	TBC	88.00%	Issues with new VTE workflow.	Helen Beck	88.62%	88.77%	TBC	-			

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

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

a) Current Position

ED was extremely busy from the time of the patients arrival, with black acuity from 20:00 until just gone midnight.
Post triage (patient triaged as category 4) and ED clerking this patient then refused to have his X-rays performed until he received opiates as an analgesia.
The patients X-rays were the found to be NAD.
The patient then had to wait for a prolonged period of time to be assessed by the out of hours psychiatric team, as he alluded to suicidal intent after his X-ray.
In this case there was no reason to admit the patient to hospital for his ED presentation and the patient was not suitable for CDU based psychiatric assessment therefore he encountered a long ED LOS.

b) Recommended Action

See above.

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

a) Current Position

30.75% against a threshold of 27%
Acuity of ED remains higher than average. 5% less than June.

b) Recommended Action

Admission avoidance work continues. High ED user project work in place, focusing on reviewing our Mental Health re-attending patients.
Expected speciality patients through ED higher in July than June
GP streaming to live by Oct 2017, stream patients to GP anticipated reduction in ED attendances.

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

a) Current Position

94.31% against a threshold of 99%.
There are on-going significant capacity issues within the ENT, Vascular, Urology, and Dermatology services. Patients are waiting 36 weeks for first OPA in ENT (an improvement form 40 weeks), and patients waiting over 30 weeks for surgery within Urology, 40 weeks for Vascular Surgery, and some patients are waiting over 24 week for surgery in Ophthalmology. There remains significant pressure on rapid access referrals in Dermatology.

b) Recommended Action
Detailed action plans for each of the above specialties have been developed with CCG input where appropriate. Validation work continues to support the data quality of the PTL.

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

a) Current Position
72.92% against a threshold of 90%.

b) Recommended Action
Patients continue to be treated in longest waiting order, close monitoring and proactive management continues to support RTT position in all specialities. New PTL and proactive manual validation continues to provide a clearer picture of the waiting times.

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

a) Current Position
87.61% against a threshold of 95%.
This continues to be predominantly due to excessive waits for first appointment in both ENT and Dermatology.

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

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

a) Current Position
94.74% against a threshold of:
96% (Contract)
96% (Upper quartile)

Two patients breached this standard. One initially thought to be sepsis and one a wake up stroke on a medical ward.

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

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

a) Current Position
46.43% against a threshold of:
48% (Contract
48% (Upper Quartile)

b) Recommended Action
All patients requiring ESD services were referred to ESD.

4.8 Patients offered date within 28 days of cancelled operation

a) Current Position
88.46% against a threshold of 100%

This represents three patients who were cancelled on the day of surgery but were unable to be rebooked within 28 days.

b) Recommended Action
One patient was under the care of urology and was cancelled as a consequence of running out of theatre time on the day of surgery; following this they had an inpatient stay which prevented rebooking in time to prevent breaching 28 days. The second patient was under the care of T&O and was cancelled as no bed was available for them due to emergency flow pressures. They subsequently left the UK for a period and could not then be rebooked within 28 days. The third patient was also under the care of T&O and was cancelled on the day of surgery as they required a different surgeon to undertake the procedure. Unfortunately due to capacity constraints this patient could not then be rebooked within 28days.

4.9 Breastfeeding initiation rates

a) Current Position

77.30% against a threshold of 80%
The maternity service failed to achieve the target of 80% of babies receiving breastmilk within the first 48 hours of life in July 2017.

b) Recommended Action
At present there is no obvious reason for this drop in the initiation rate from the 87.7% achieved in June. The maternity service continues to look at provision of information to women in pregnancy and the support offered around the time of initiation to try to ensure that we optimise the support for all women who have chosen this method of feeding for their babies.

4.10 Rapid Access - chest pain clinic

b) Current Position
95.45% against a threshold of 100%

5 breaches out of 116 patients

b) Recommended Action
The service continues to receive high numbers of referrals and have put on extra clinics which will be ongoing where consultants and registrars are able to accommodate them

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

a) Current Position
Macmillan – 100%
ED - 58.33%
Overall Trust figure of 68.75% against a threshold of 100%

b) Recommended Action
The performance figure for 1 hour to needle from diagnosis of neutropenic sepsis July Data showed that the Macmillan unit and AMU had no breeches during July , but the Emergency Department had 5 neutropenic sepsis patient breeches. This was a steady improvement on the past two months data.The breech cases will be undergoing detailed review. These issues will be escalated to the Emergency Department Clinical and Nursing management to address within the department.

4.12 New to follow up

a) Current Position

1.96 against a threshold of 1.9

c) Recommended Action

Position remains level and the backlog continues to be managed.

5. WORKFORCE

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

Performance Indicator	Threshold	July	Comments
Workforce			
Sickness absence rate	<3.5%	3.58%	
Turnover	<10%	9.86%	
Reviews	Grievance/Banding reviews	6	Includes 2 employment tribunals
Recruitment Timescales	Average number of weeks to recruit = 7	5.4	
DBS Checks	To complete 95% of required DBS checks	98.00%	
All Staff to have an appraisal	Both general and consultant staff each have a target of 90% to have had an apprasial within the previous 12 months. Appraisal is a rolling programme	ND	Appraisal figures are currently not available due to HR system issues.

5.1 Sickness Absence Rate

a) Current Position

3.58% against a threshold of <3.5%.

b) Recommended Action

Although still red, the sickness % is 0.08% away from the target. This is normally the case in July and August.

There is nothing significant to report, other than to encourage all staff to look out for the forthcoming annual flu campaign.

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 Dawn might want to change is the CiC comment on page 34.

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

Our FFT score for July was 97% from 307 responses. This month we received 4 extremely unlikely to recommend responses, 1 for Cardiac Rehab, 2 for Aldeburgh Community Hospital and 1 for Paediatric SLT. See page 12 of the patient experience report for further details.

- We received 2 formal complaints, 1 for Glastonbury Court, and 1 for a community health team, see page 10 of the patient experience report

- Delayed Transfers of Care have risen slightly in July to 58, from 52 in June. There has been a rise in the number of patients delayed waiting for domiciliary care packages

- Paediatric SLT waiting times have increased again slightly this month for both the community clinic and school service, for the mainstream school service, this will now be 'suspended' until school re-opens in September so figures appear high for July. See page 40

- There have been some breaches in the adult SLT service for patients needing to be seen within 20 days. This is the 3rd consecutive month that performance has dipped. See pages 32 & 34 for details.

- The Children in Care service has seen an improvement in the number of children offered appointments within 28 days of receipt of paperwork. Notification of child and receipt of necessary paperwork remains a challenge; this is being addressed with the county council.

- We have had 1 grade 4 pressure ulcer this month for a patient in their own home.

- The number of falls in July increased to 56, this was mainly due to 2 patients who fell 7 and 5 times each. Both patients were clinically complex and frail.

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**July 2017**	**July Comments / Queries 2017**	**May 2017**	**June 2017**
SCH		**D4-qoc1**	Number and % of service users who rated the service as 'good' or 'better'.	85%	Quarterly report from Provider				98.20%
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'better'.	85%	Quarterly report from Provider				93.63%
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'well informed'.	85%	Quarterly report from Provider				95.50%
SCH		**D5-acc4**	18 week referral to treatment for non-Consultant led services 15 services: Paed OT, PT, SALT, Adult, Wheelchairs, Podiatry, Biomechanics, Stoma nurses, Neuro nurses, Parkinson's, SCARC, Environmental, H Failure, Hand Therapy & Continence	95% patients to be treated within 18 weeks	Monthly report from Provider	98.06%		99.79%	99.80%
SCH		**D5-acc8**	18 week referral to treatment for Consultant led services Inpatient rules - Foot and Ankle Outpatient rules - Paediatrics (E&W)	95% patients to be treated within 18 weeks	Monthly report from Provider	99.58%		98.32%	99.53%
SCH		**PU-001-a PU-001-b**	No increase in the number of Grade 2 and Grade 3 pressure ulcers (as per agreed definition), developed post 72 hours admission into SCH care, compared to 12/13 outturn. This measure includes patients in in - patient and other community based settings. Zero grade 4 avoidable pressure ulcers (as per agreed definition) developed post 72 hours admission into SCH care, unless the patient is admitted with a grade 3 pressure ulcer, and undergoes debridement (surgical / non surgical) which will cause a grade 4 pressure ulcer. This will be evident through Serious Incident reporting.	No increase in 12/13 outturn. Zero	Monthly	0		0	0
SCH	Dementia	**c-gen4**	All community clinical staff to receive relevant dementia awareness training	95%	Monthly report from Provider	96.47%		95.30%	96.10%
SCH	Canc by Prov	**c-gen7**	% of clinics cancelled by the Provider Q3 2012-13 establish baseline. Where benchmarking of community services shows a DNA rate worse then the best quartile. Q4 2012-13 agree an appropriate reduction on baseline. Pcanc-01 ONLY - Q1 2013/14 establish baseline. Where benchmarking of community services shows a DNA rate worse than the best quartile: Q2 reduction of 2.5% on baseline, Q4 reduction of 10% on baseline		Quarterly report from Provider				1.60%
SCH	Safeguarding - children	**c-safe1**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.99%		96.41%	96.94%
SCH	Safeguarding - adults	**c-safe2**	% eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	Monthly report from Provider	96.64%		96.24%	96.77%
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%		100.00%	97.78%
InPt		**D3-str3**	% of patients requiring a joint community rehabilitation Care Plan have one in place ahead of discharge from acute hospital.	75%	Monthly report from Provider	100.00%		100.00%	100.00%
InPt		**D3-str4**	% of appropriate stroke survivors whose community rehabilitation treatment programme started within 7 days of leaving acute hospital, or ESD, where agreed as part of the care plan (SSNAP). The definition of 'Appropriate Patients' is - all patients requiring continued therapy input.	75%	Monthly report from Provider	100.00%		100.00%	100.00%
InPt	MRSA	**c-inf1**	Number of cases	No cases	Monthly report from Provider	0		0	0
InPt	MRSA	**c-inf2**	Completed RCAs on all community cases of MRSA	100%	Monthly report from Provider	N/A		N/A	N/A
InPt	C-Diff	**c-inf4**	Completed RCAs on all community hospital outbreaks of C difficile	100%	Monthly report from Provider	N/A		N/A	N/A
InPt	Comm Hosp	**s-ip7**	Number of inpatient falls resulting in moderate or significant harm	No more than 1.25 per month (15 per annum) falls/1000bed days	Monthly report from Provider	N/A		N/A	0.36
InPt	Step Up Adm Prevention Comm Beds	**s-apcb1**	The community beds will be available for access across the 24 hour 7 days a week	100%	Monthly report from provider	100.00%		100.00%	100.00%
InPt	Step Up Adm Prevention Comm Beds	**s-apcb6**	All Service Users will have a management plan agreed with them and their family/carer where applicable within 24 hours from arrival.	98%	Monthly report from provider	100.00%		100.00%	96.30%
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	100.00%		96.30%	91.89%
IHT	CCC	**D4-int1**	Care coordination centre - % of telephone calls answered within 60 seconds	95% in 60secs	Monthly report from Provider	95.94%	# of calls handled: 16050 # of calls answered in 0-60 seconds: 15399 **% 0-60 seconds: 95.94%** Number of abandoned calls: 329 Abandoned calls %: 2.01 % Average Wait Time: 14 seconds	95.78%	95.53%

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**July 2017**	**July Comments / Queries 2017**	**May 2017**	**June 2017**
SCH		**D4-qoc1**	Number and % of service users who rated the service as 'good' or 'better'.	85%	Quarterly report from Provider				98.20%
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'better'.	85%	Quarterly report from Provider				93.63%
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'well informed'.	85%	Quarterly report from Provider				95.50%
SCH		**D5-acc4**	18 week referral to treatment for non-Consultant led services 15 services: Paed OT, PT, SALT, Adult, Wheelchairs, Podiatry, Biomechanics, Stoma nurses, Neuro nurses, Parkinson's, SCARC, Environmental, H Failure, Hand Therapy & Continence	95% patients to be treated within 18 weeks	Monthly report from Provider	98.06%		99.79%	99.80%
SCH		**D5-acc8**	18 week referral to treatment for Consultant led services Inpatient rules - Foot and Ankle Outpatient rules - Paediatrics (E&W)	95% patients to be treated within 18 weeks	Monthly report from Provider	99.58%		98.32%	99.53%
IHT		**D4-ccc6**	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed.	85%	Quarterly				99.03%
IHT	Card Rehab	**s-card5**	Number of service users successfully discharged from phase 3.	600 per annum	Monthly report from Provider	no longer reporting as of July 16		no longer reporting as of July 16	no longer reporting as of July 16
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses offered	At least 500 courses offered pa	Monthly report from Provider	62 offered		72 offered	67 offered
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses completed	At least 250 courses completed pa	Monthly report from Provider	19 completed		27 completed	37 completed
IHT	COPD	**s-copd5**	Community pulmonary rehabilitation - review offered 6 months after completing the course	95%	Monthly report from Provider	100.00%		100.00%	97.30%
IHT	Comm Continence	**s-cc3**	% of Service Users re-assessed at 6 weeks	98%	Monthly report from Provider	no longer reporting as of November 16		no longer reporting as of November 16	no longer reporting as of November 16
IHT	Comm Continence	**s-cc4**	% of Service Users re-assessed at 12 monthly intervals (previously 6 monthly intervals)	98%	Monthly report from Provider	100.00%		100.00%	100.00%
IHT	H Failure	**s-hf4**	% of Service Users seen within 14 days of receipt of referral	85% within 14 days referral	Monthly report from Provider	no longer reporting as of July 16		no longer reporting as of July 16	no longer reporting as of July 16
IHT	MIU	**s-miu3**	Timeliness Indicators: 1) Total time spent in A& E department 2) Time to initial assessment (95th percentile) 3) Time to treatment in department (median) 1) 95% of Service Users waiting less than 4 hours 2) 95th percentile time to assessment above 15 minutes 3) median time to treatment above 60 minutes		Monthly Secondary Uses Services (SUS) data, A&E Commissioning data set (CDS)	#1 = 100%		#1 = 100%	#1 = 100.00%
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who rated the service as "good" or	85%	Quarterly report from provider				98.61%
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt	85%	Quarterly report from provider				100.00%
IHT	MIU	**s-miu4**	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "well	85%	Quarterly report from provider				100.00%
IHT	MIU	**s-miu5**	Total time spent in A+E department 95% of Service Users waiting less than 4 hours for Service Users	95%	Monthly Secondary Uses Services	99.84%		100.00%	100.00%
Mede	CES	**c-gen8**	Response times from receipt of referral: Within 4 hours – Service Users at end of life (GSF prognostic indicator)	98% for all standards	Monthly report from Provider	100% (148/148)		99.44% (179/180)	98.26% (169/172)
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	99.22% (893/900)		99.14% (921/929)	99.52% (1042/1047
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	98.91% (2359/2385)		99.82% (2185/2189)	99.55% (2441/2452)
Mede	CES	**c-gen8**	Within 10 working days - to support hospital discharge or prevent admission	98.00%	Monthly report from Provider	98.55% (542/550)		99.80% (508/509)	99.52% (625/628)
Mede	CES	**c-gen9**	Collection times: % of urgent next day collections for deceased Service Users	98% for all standards	Monthly report from Provider	99.52% (206/207)		96.37% (239/248)	100% (263/263)
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% (422/422)		99.01% (301/304)	99.61% (513/515)
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	97.54% (4992/5102)	This relates to 110 collections out of 5102 in the month. There was a combined reason for the late collections of holiday, sickness, mandatory training. 20 of these collections were late by less than 15hours.	98.45% (5014/5093)	98.68% (5154/5223)

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**July 2017**	**July Comments / Queries 2017**	**May 2017**	**June 2017**
Mede	Ass Tech	**s-at2**	All long term service users to have a minimum annual review	100%	Monthly report from provider	100.00%		100.00%	100.00%
Mede	Ass Tech	**s-at4**	Delivery of equipment within agreed time frames	95%	Monthly report from provider	100.00%		100.00%	100.00%
Mede	Wheelchair	**s-wchair1**	All Service Users have a first appointment/contact seen after initial response time according to priority / need: High Priority	within 6 weeks 100%	monthly report from provider	N/A		N/A	N/A
Mede	Wheelchair	**s-wchair1**	Medium Priority	within 12 weeks 100%	monthly report from provider	N/A		N/A	N/A
Mede	Wheelchair	**s-wchair1**	Low Priority	within 18 weeks 100%	monthly report from provider	100.00%		100.00%	92.86%
NCHC		**D2-ltc2-a**	% of people that have been identified by case finding, (using risk stratification, or other means), and deemed suitable for intervention by the MDT, and referred to SCH, that have a care lead.	95%	Monthly report from Provider	100.00%		100.00%	100.00%
NCHC		**D2-ltc2-b**	% of people identified via case finding, that have a care plan (including self-care) that has been shared with the GP practice within two weeks of the patient coming onto the caseload. The GP practice will require a copy of the care plan, and the information will be shared with the MDT, which includes a GP.	95%	Monthly report from Provider	N/A		N/A	N/A
NCHC		**D5-ccc7**	% of referrals seen following triage; Emergency - 2 hrs	Emergency - 100%	Monthly report from Provider	100.00%		100.00%	100.00%
NCHC		**D5-ccc7**	Urgent 4 hrs	Urgent - 95%	Monthly report from Provider	98.62%		99.03%	99.42%
NCHC		**D5-ccc7**	Intermediate - 72 hrs	Intermediate - 95%	Monthly report from Provider	98.60%		98.30%	98.28%
NCHC		**D5-ccc7**	18 weeks	18 weeks - 95%	Monthly report from Provider	99.58%		99.67%	99.77%
NCHC		**D4-int1**	Community Health Team Leads and/or Local Area Managers to work with GP practices and establish direct working relationships that aid mutual understanding and aim to improve the quality of services to patients. A schedule of face to face meetings is to be agreed and adhered to by both parties and a joint action plan is to be produced that shall be regularly reviewed.	80%	Quarterly report from Provider				
NCHC	PHP	**c-php1**	Number of Service Users with the following Long term conditions with a Personal Health plan (Parkinson's Disease, Multiple sclerosis, Muscular Dystrophy, Chronic Obstructive Pulmonary Disease, all other chronic respiratory diseases, Coronary Heart Disease, Heart Failure).	80% completed	Monthly	100.00%		100.00%	100.00%
NCHC	IDPT	**s-disch1**	Triage and assessment of referrals within 1 Operational Day	98%	Monthly report from Provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
NCHC	IDPT	**s-disch2**	Urgent discharge achieved (<24 hours from referral to the team) for Service Users terminally ill and wishing to die at home	85%	Monthly report from Provider	N/A	There were 3 referrals to the service in July. All were excluded: 1 - awaiting care package 1 - awaiting ontinuing care funding 1 - awaiting family to clear room for equipment delivery	0.00%	N/A
NCHC	IDPT	**s-disch4**	Transfer from acute hospital to community based provision from receipt of referral within a timescale not exceeding 48 hours providing the Service User is medically and physically fit for discharge	80% of Service Users medically and physically fit for discharge	Monthly report from provider	Service no longer supports this KPI - as agreed with CCG Oct 2016		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
NCHC	EAU CIS	**eau-cis-IHT**	% of patients seen within 2 hrs. of initial referral. The Senior Nurse (part of the CIS) allocated to the EAU at IHT will begin patient assessment within 2 hrs of consultant referral.	98%	monthly report from provider	N/A		N/A	N/A
NCHC	Verification of expected death training	**c-gen2**	Number of qualified nursing staff trained in Service User areas, community nursing teams and local Healthcare teams (to include all clinical staff from within planned care, urgent care, & intensive case management as the integrated service model is implemented)	90%	Monthly report from provider				
WSH	Adult SALT	**s-salt1**	All new referrals are triaged within 5 Operating Days of receipt of referral;	98%	Monthly report from Provider	100.00%		99.37%	100.00%
WSH	Adult SALT	**s-salt2**	Service Users seen within the following timescales after triage: Priority 1 within 10 Operating Days	Priority 1 - 100%	Monthly report from Provider	100.00%		100.00%	100.00%
WSH	Adult SALT	**s-salt2**	Priority 2 within 20 Operating Days	Priority 2 - 95%	Monthly report from Provider	59.00%	19 out of 46 patients were not seen within 20 days after triage. Of these 19: 5 were seen within 25 days 4 were within 26-30 days 8 were within 31-33 days This service has been affected by a high level of sickness, 2.64wte down in July. This combined with high numbers of referrals in the East but lack of staff to move around has resulted in these delays. The service has also taken on referrals for a new cohort of patients sinice April as a pilot, as agreed with the CCGs, which will have also had an effect on capacity.	85.00%	80.00%
WSH	Adult SALT	**s-salt2**	Priority 3 within 18 weeks	Priority 3 - 95%	Monthly report from Provider	100.00%		100.00%	100.00%
WSH	Medical Appliances	**s-ma1**	% of appointments available within 6 weeks	95%	Monthly report from provider	100.00%		100.00%	100.00%
WSH	Medical Appliances	**s-ma2**	% of urgent cases seen within one working day	100%	Monthly report from provider	No Urgent referrals received		No Urgent referrals received	No Urgent referrals received
WSH	Parkinson's Disease	**s-pd2**	% service users on caseload who have an annual specialist review	95%	Monthly report from provider	100.00%		100.00%	100.00%

Children's Services KPIs									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of Measurement**	**July 2017**	**June Comments/ Queries 2017**	**May 2017**	**June 2017**
WSH	All Paediatric Services	**GP-1**	18 week RTT for Consultant led services	95% of consultant led Service Users to be treated within 18 weeks	Monthly pledge 2 reporting by Children's Service	98.80%		95.83%	98.61%
WSH	All Paediatric Services	**GP-1**	18 week RTT for non-Consultant led services	95% of non-consultant led Service Users to be treated within 18 weeks	Monthly pledge 2 reporting by Children's Service	98.06%		98.92%	99.01%
WSH	All Paediatric Services	**PaedSLT-4**	All Children to have a Personal Health plan completed where required.	100% Service Users offered a PHP 80% completed a PHP	Monthly report from provider by Children's Service	100.00%		100.00%	100.00%
WSH	All Paediatric Services	**D4-qoc1 D4-qoc2 GP-4**	Quarterly Service User satisfaction surveys based on Suffolk Community Healthcare's processes prior to Effective Start Date. Number and % of service users who rated the service as "good" or better	85%	Quarterly report from provider	Now included in the Patient Experience		Now included in the Patient Experience	Now included in the Patient Experience
WSH	All Paediatric Services	**D4-qoc1 D4-qoc2 GP-4**	Number and % of service users who responded that they felt "supported" and "well informed".	85%	Quarterly report from provider	Now included in the Patient Experience		Now included in the Patient Experience	Now included in the Patient Experience
WSH	All Paediatric Services	**GP-6**	Safeguarding - % eligible staff who have completed level 1 training	98% - 95% from 1st Jan 2017	monthly report by provider	99.07%		100.00%	99.08%
WSH	All Paediatric Services	**GP-9** **PDL-01**	Discharge Letters - to be sent within 24 hours of discharge from a community hospital and 72 hours of discharge from all other caseloads (all discharge letters whether electronic/non electronic to clearly state date dictated, date signed and date sent)	95%	Monthly	100.00%		100.00%	100.00%
WSH		**PaedSLT-5**	Personalised Care Planning - Percentage of Transition (to adults) Care Plans completed	Q3 2012/13 establish baseline	Annual - Systmone				
WSH	Newborn Hearing Screening Service (West)	**NBHS-2**	Timely screening – where consented screens to be completed by four weeks of age	95%	Monthly Activity Report	98.89%		98.80%	99.59%
WSH	Newborn Hearing Screening Service (West)	**NBHS-3**	Screening outcomes set within 3 months	≥99%	Monthly Activity Report	98.86%		98.72%	99.18%
WSH	Community Children's Nursing	**CCN-14** **cps-ip02**	% of children identified as having high level needs being actively case managed.	Q3 2012/13 establish baseline Q4 2012/13 onwards >75%	Systmone	100.00%		100.00%	100.00%
WSH	Leapfrog Therapeutic Service	**Leap-8**	Outcomes achieved for children utilising the services	Annual report produced	Annual report				
WSH	Therapy Focus Suffolk	**TFS-6**	All relevant staff that have been 'Bobath' update trained	100%	Annual report				
WSH	Single Point of Access	**PSPOA-03**	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed	85%	Quarterly				
WSH	Single Point of Access	**PSPOA-04**	% of service users who were satisfied with the length of time waiting for assessment	85%	Quarterly report from Provider				
WSH	Single Point of Access	**PSPOA-05**	% of referrers who were satisfied with the length of time waiting for assessment	85%	Quarterly report from Provider				
WSH	Access	**cps-a02**	Children/young people in special schools receive speech and language interventions	100%	Systmone	100.00% 205 contacts		100% 270 contacts	100% 180 contacts
WSH	Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	Systmone	100.00% 148 contacts		100.00% 139 contacts	100% 156 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	94.74%	18 out of 19 children who had an IHA in July were offered their first appt within 28days of the service being made aware of the child.	83.33%	85.00%
WSH	Children in Care	**CiC-001b**	Initial Health Assessments that are completed within 28 days of receiving ALL relevant paperwork	100% in 28 days	Monthly report from Provider	78.95%	15 out of 19 children had an IHA completed within 28 days of the service being made aware of the child. Of the 4 appts outside the 28 day deadline (32days, 38days, 39days and 82 days): - initial appt date delayed whilst seeking engagement of process with child - initial appt date declined - initial appt date cancelled by service as clinician carrying out IHA was required to be a Paediatrician not nurse as originally booked - 3 declined appt dates, 1 DNA, child seen on 5th date arranged	72.22%	80.00%
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	10.53%	Of the 19 children with an IHA completed outside of the 28days of becoming CiC, 12 referrals were delayed by 20 days or more (11 were delayed for over 28days). The greatest delays were 294, 145 and 116 days.	0.00%	25.00%

1 C- gen 9 – Community Equipment Service - % Collections within 10 working days

a) Current Position
97.54% against a 98% target
This relates to 110 collections out of 5102 in the month. There was a combined reason for the late collections of holiday, sickness and mandatory training. 20 collections were late by less than 15hours.

b) Recommended Actions
- Review processes for approving holiday and booking mandatory training.

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

a) Current Position
s-salt2 - 59% against a 95% target

This relates to 19 out of 46 referrals, 5 patients were seen within 25 days, 4 were seen between 26-30days and 8 were seen within 31-33days. This service has been affected by a high level of sickness, 2.64wte down in July. This combined with high numbers of referrals in the East but lack of staff to move around has resulted in these delays. The service has also taken on referrals for a new cohort of patients since April as a pilot, as agreed with the CCGs, which will have also had an effect on capacity.

b) Recommended Actions
- Monitor the numbers of referrals and activity created by the new cohort of patients
- Review the pilot
- Continue to deploy staff flexibly

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3 **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 – 94.74% against a 100% target
CiC-001b – 78.95% against a 100% target
CiC -001a –10.53% against a 100% target

19 Initial Health Assessments were completed in July. 2 were completed within 28 days of becoming CiC, 15 were completed within 28 days of the service receiving ALL the paperwork and 18 appointments were offered within 28 days. There was a delay of greater than 20 days from the child becoming CiC and the service being notified for 12 of the 19 referrals which directly impacted on the statutory compliance target (11 of the referrals were delayed for greater than 28 days).

b) Recommended Action
- Associate Director is continuing to meet with the Social Care Manager. Social Care are working on improving systems to enable timely sharing of their information but this is not fully resolved as yet.
- Bi-Monthly meetings established to monitor pathway interface.
- There are meetings being arranged to review the pathway for Children in Care with the commissioners, Suffolk County Council and the Executive Chief Nurse.

	Units	Target	Red	Amber	Green	Feb	Mar	Apr	May	Jun	Jul
Patient Experience											
Service users who rated the service as 'good' or 'better' (Quarterly)	Nos.	No Target					1195			1528	
	%	85%	<80%	80%-85%	>=85%		97.00%			98.20%	
Service users who responded that they felt 'better'	Nos.	No Target				158	137	132	145	397	136
	%	85%	<80%	80%-85%	>=85%	96%	93%	94%	93%	93.63%	96.00%
Service users who felt 'well informed'	Nos.	No Target				200	177	198	159	509	193
	%	85%	<80%	80%-85%	>=85%	91%	94%	96%	94%	95.50%	96.00%
10% of long term condition patients feel "better supported" to self manage their conditions (Quarterly)	Nos.	No Target								104	
	%	No Target								93.69%	
Falls (Inpatient Units)											
Total numbers of inpatient falls (includes rolls and slips)	Nos.	No Target				33	48	30	47	40	56
Rolls out of Bed		No Target				5	1	1	4	4	1
Slip out of chair		No Target				3	5	0	4	2	3
Assisted Falls/ near misses		No Target				3	6	1	4	1	5
% of total falls resulting in harm	%	No Target				24%	23%	32%	23%	38%	39%
Numbers of falls resulting in moderate harm	Nos.	No Target				0	1	0	0	1	0
Numbers of falls resulting in severe harm	Nos.	No Target				0	1	0	0	0	0
Numbers of patients who have had repeat falls	Nos.	No Target				7	8	6	9	8	8
% of RCA reports for repeat fallers	%	100%	90%-95%	95%-100%	=100%	100%	100%	100%	100%	100%	100%
Numbers of falls per 1000 bed days (* includes Hazel Crt falls)		<1.25/1000 beddays	>1.50	1.25-1.50	<=1.25	10.5*	13.8*	8.96	13.96	12.5	16.47
Pressure Ulcers											
Pressure Ulcers – In Our Care Community											
Grade 2		100 pa	>110	100-110	<=100	31	27	34	32	27	24
Grade 3		26 pa	>30	27-29	<=26	13	10	6	8	7	7
Grade 4		0 pa	>1	1	0	1	2	1	0	1	1
Pressure Ulcers – In our care In-patient											
Grade 2		13 pa	>17	13-17	<=13	3	4	0	3	3	4
Grade 3		2 pa	>4	02-Apr	<=2	1	0	1	0	0	0
Grade 4		0 pa	>1	1	0	0	0	0	0	0	0
Safeguarding People Who Use Our Services From Abuse											
Number of adult safeguarding referrals made		No Target				2	3	2	4	1	3
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				100%	100%	100%	100%	100%	100%

	Units	Target	Red	Amber	Green	Feb	Mar	Apr	May	Jun	Jul
MRSA											
Bacteraemia – Number of cases		0	>2	>0 to 2	=0	0	0	0	0	0	0
MRSA RCA reports		100%	<95%	95%-100%	=100 %	0	0	0	0	0	0
Clostridium Difficile											
C.Diff number of cases		4 for 6 months	>4 YTD		<=4 YTD	0	0	0	0	0	0
C.Diff associated diseases (CDAD) RCA reports		100%	<95%	95%-100%	=100 %	N/A	N/A	N/A	N/A	N/A	N/A
Infection Control											
Infection control training		100%	<83%	83%-100%	=100 %	85.99%	89.70%	86.51%	91.80%	91.80%	89.10%
Essential Steps Care Bundles Including Hand Hygiene											
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	99.00%	98.00%	99.00%	99.00%	99.00%	98.70%
Isolation room audit		100%	<95%	95%-100%	=100 %	N/A	100%	100%	100%	100%	100%
Management of Medication -SCH NRLS Reportable Incidents											
Total number of medication incidents in month		No Target				18	25	19	17	18	13
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				16	20	15	12	13	13
(also includes those not attributed to SCH management)	Low harm	No Target				2	5	3	5	5	0
Number of medication incidents involving Controlled Drugs		No Target				7	5	1	0	2	0

Incidents											
NRLS (i.e. patient safety) reportable incidents in month		No Target				223	229	199	242	185	198
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				15	12	8	8	9	9
Number of SIs reported to CCG in month *4 STEIS for 2 pts (2 each)		No Target				17	17*	7	9	9	9
Percentage of SI reports submitted to CCG on time in month		No Target				100%	100%	100%	100%	100%	100%
Duty of Candour Applicable Incidents		No Target				13	16	8	9	9	8

Severity of NPSA Reportable Incidents											
None		No Target				122	145	131	163	108	133
Low		No Target				87	69	58	70	68	56
Moderate		No Target				13	11	8	9	8	8
Major		No Target				1	4	1	0	1	1
Catastrophic		No Target				0	0	0	0	0	0

Training Compliance											
Adult Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	95.59%	96.74%	96.02%	96.24%	96.77%	96.60%
Children Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	95.86%	96.92%	96.11%	96.41%	96.94%	96.90%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	92.57%	94.34%	94.81%	95.30%	96.10%	96.40%
WRAP						51.73%	67.33%	64.48%	66.82%	69.19%	72.20%
MCA / DoLs- Training compliance						68.46%	67.33%	73.59%	82.33%	83.27%	84.40%

Compliments/Complaints

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Total compliments	19	46	21	38	28	36	27	61	50	46	44	36	56
Formal complaints (No.)	**7**	**5**	**1**	**1**	**2**	**2**	**3**	**5**	**1**	**1**	**2**	**3**	**2**
Acknowledged within 3 working days (No.)	5	4	1	1	1	2	3	5	1	1	1	2	2
Acknowledged within 3 working days (%)	71%	80%	100%	100%	50%	100%	100%	100%	100%	100%	50%	67%	100%
Responded to within 25 working days (No.)	4	2	0	1	1	0	2	0	1	1	2	-	-
Responded to within 25 working days (%)	57%	40%	0%	100%	50%	0%	67%	0%	100%	100%	100%	-	-
Responded to outside 25 working days (No.)	3	3	1	0	1	2	1	5	0	0	0	-	-
Responded to outside 25 working days (%)	43%	60%	100%	0%	50%	100%	33%	100%	0%	0%	0%	-	-
Complaints upheld (No.)	4	2	1	-	-	-	1	2	1	1	1	-	-
Complaints partially upheld (No.)	3	2	-	-	-	-	-	3	-	-	-	-	-
Complaints not upheld (No.)	-	1	-	1	2	2	2	-	-	-	1	-	-
Average response time (days)	27.6	32.8	31.0	19.0	36.5	38.5	24.0	28.0	7.0	7.0	22.5	-	-

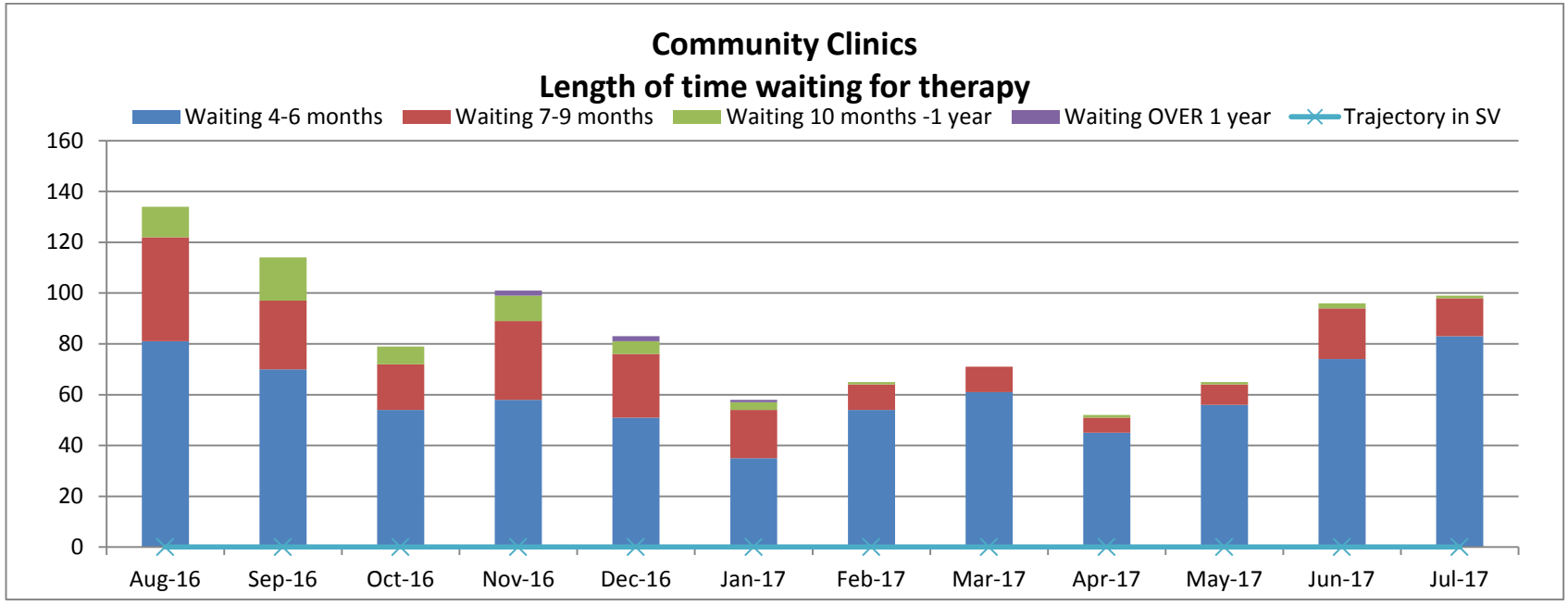
Paediatric Speech and Language Service Waiting times

Community Clinic

Clinic Waiting lists

Reports run 01/08/17

Length of wait Community Clinics *(pre-school caseload)*	No. of children waiting July 2015	No. of children waiting August 2016	No. of children waiting September 2016	No. of children waiting October 2016	No. of children waiting November 2016	No. of children waiting December 2016	No. of children waiting January 2017	No. of children waiting February 2017	No. of children waiting March 2017	No. of children waiting April 2017	No. of children waiting May 2017	No. of children waiting June 2017	No. of children waiting July 2017
Waiting up to 3 months	139	150	156	151	176	158	176	165	162	166	154	156	150
Waiting 4-6 months	139	81	70	54	58	51	35	54	61	45	56	74	83
Waiting 7-9 months	151	41	27	18	31	25	19	10	10	6	8	20	15
Waiting 10 months -1 year	106	12	17	7	10	5	3	1	0	1	1	2	1
Waiting OVER 1 year	0	0	0	0	2	2	1	0	0	0	0	0	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**535**	**284**	**270**	**230**	**277**	**241**	**234**	**230**	**233**	**218**	**219**	**252**	**249**
Already had PoC		97	72	75	67	72	55	60	85	53	51	73	86
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*		**381**	**342**	**305**	**344**	**313**	**289**	**290**	**318**	**271**	**270**	**325**	**335**

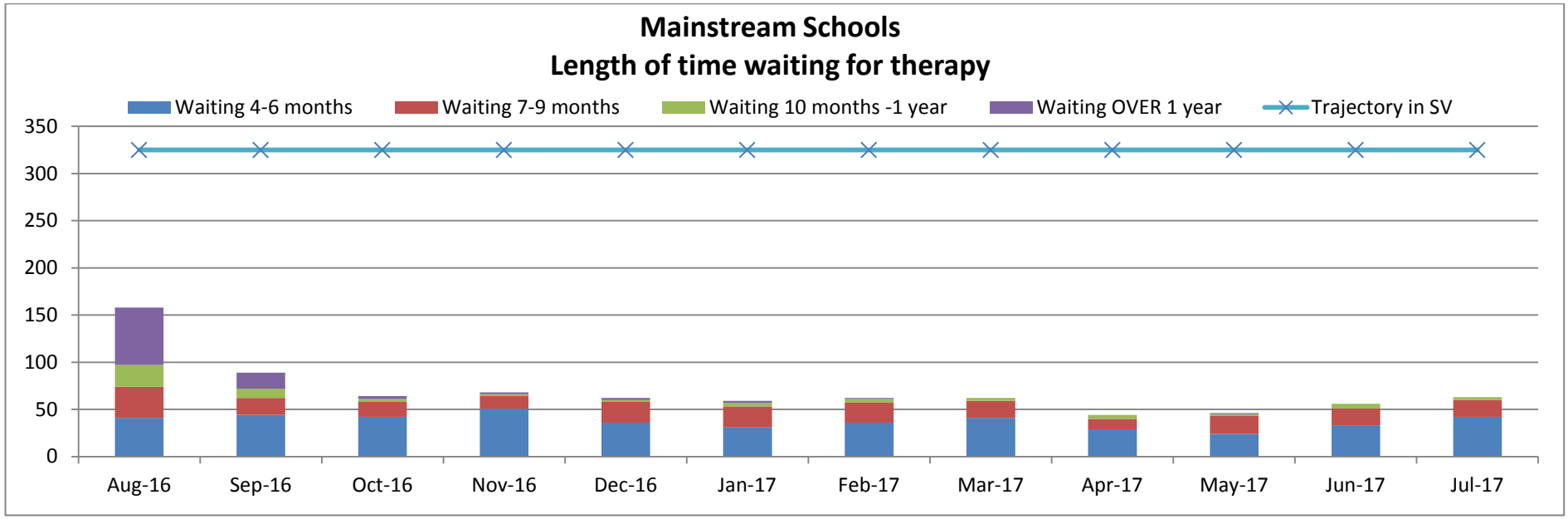


Mainstream Schools

Schools Waiting lists

No waiting data by months prior to May

Length of wait Mainstream Schools *(pre-school caseload)*	No. of children waiting July 2015	No. of children waiting August 2016	No. of children waiting September 2016	No. of children waiting October 2016	No. of children waiting November 2016	No. of children waiting December 2016	No. of children waiting January 2017	No. of children waiting February 2017	No. of children waiting March 2017	No. of children waiting April 2017	No. of children waiting May 2017	No. of children waiting June 2017	No. of children waiting July 2017
Waiting up to 3 months		119	88	72	68	59	56	56	73	87	89	84	113
Waiting 4-6 months		41	44	42	51	36	31	36	41	29	24	33	42
Waiting 7-9 months		33	18	16	13	22	22	21	18	11	19	18	18
Waiting 10 months -1 year		23	10	3	2	2	4	4	3	4	2	5	3
Waiting OVER 1 year		61	17	3	2	2	2	1	0	0	1	0	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*		**277**	**177**	**136**	**136**	**121**	**115**	**118**	**135**	**131**	**135**	**140**	**176**
Already had PoC		396	395	377	392	332	277	266	248	210	194	253	759
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*		**673**	**572**	**513**	**528**	**453**	**392**	**384**	**383**	**341**	**329**	**393**	**935**



West Suffolk NHS
NHS Foundation Trust

FINANCE AND WORKFORCE REPORT

July 2017 (Month 4)

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

Financial Summary

I&E Position YTD	£3.3m	loss
Variance against plan YTD	-£0.1m	adverse
Movement in month against plan	-£0.1m	adverse
EBITDA position YTD	-£0.1m	deficit
EBITDA margin YTD	-1.6%	deficit
Cash at bank	£7,493k	

Executive Summary

- The Month 4 YTD position is £62k behind plan.

Key Risks

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

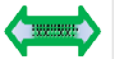
SUMMARY INCOME AND EXPENDITURE ACCOUNT - July 2017	Jul-17			Year to date			Year end forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
NHS Contract Income	18.3	18.3	0.1	74.1	74.1	(0.1)	223.6	223.2	(0.4)
Other Income	2.2	2.5	0.4	8.4	9.4	0.9	25.4	27.5	2.1
Total Income	**20.4**	**20.9**	**0.4**	**82.6**	**83.4**	**0.9**	**249.0**	**250.7**	**1.7**
Pay Costs	11.9	11.9	(0.0)	48.4	48.0	0.4	145.0	145.0	0.0
Non-pay Costs	9.1	9.5	(0.4)	36.8	38.0	(1.1)	106.5	108.2	(1.7)
Operating Expenditure	**21.0**	**21.4**	**(0.4)**	**85.2**	**86.0**	**(0.8)**	**251.5**	**253.2**	**(1.7)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	2.5	2.5	0.0
EBITDA	**(0.6)**	**(0.6)**	**0.0**	**(2.6)**	**(2.5)**	**0.1**	**(5.0)**	**(5.0)**	**(0.0)**
EBITDA margin	(0.7%)	(0.5%)	0.2%	(1.7%)	(1.6%)	0.1%	0.1%	0.1%	(0.0%)
Depreciation	0.2	0.2	(0.0)	1.3	1.4	(0.1)	4.7	4.7	0.0
Finance costs	0.1	0.2	(0.1)	0.6	0.6	(0.0)	1.4	1.4	0.0
SURPLUS/(DEFICIT) pre S&TF	**(0.8)**	**(0.9)**	**(0.1)**	**(4.5)**	**(4.5)**	**(0.1)**	**(11.1)**	**(11.1)**	**(0.0)**
S&T funding - Financial Performance	0.3	0.3	0.0	0.8	0.9	0.0	3.6	3.6	0.0
S&T funding - A&E Performance	0.1	0.1	0.0	0.4	0.4	0.0	1.6	1.6	0.0
SURPLUS/(DEFICIT) incl S&TF	**(0.4)**	**(0.5)**	**(0.1)**	**(3.2)**	**(3.3)**	**(0.1)**	**(5.9)**	**(5.9)**	**(0.0)**

FINANCE AND WORKFORCE REPORT – July 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

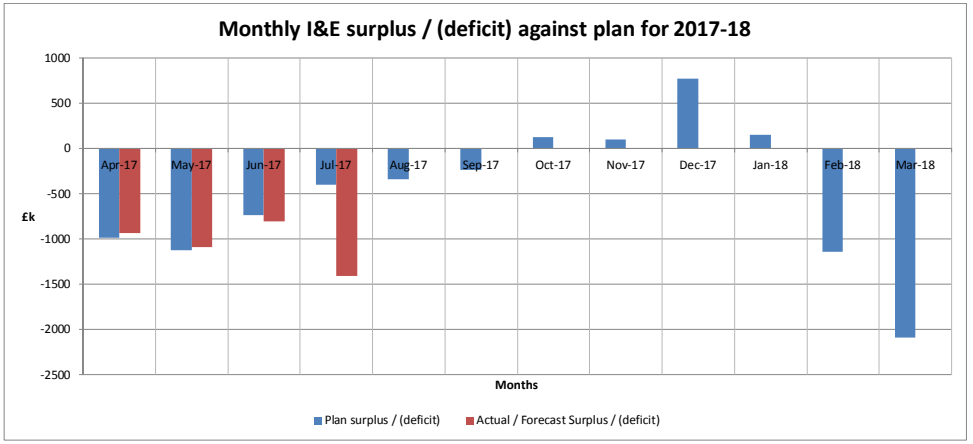
FINANCE AND WORKFORCE REPORT – July 2017

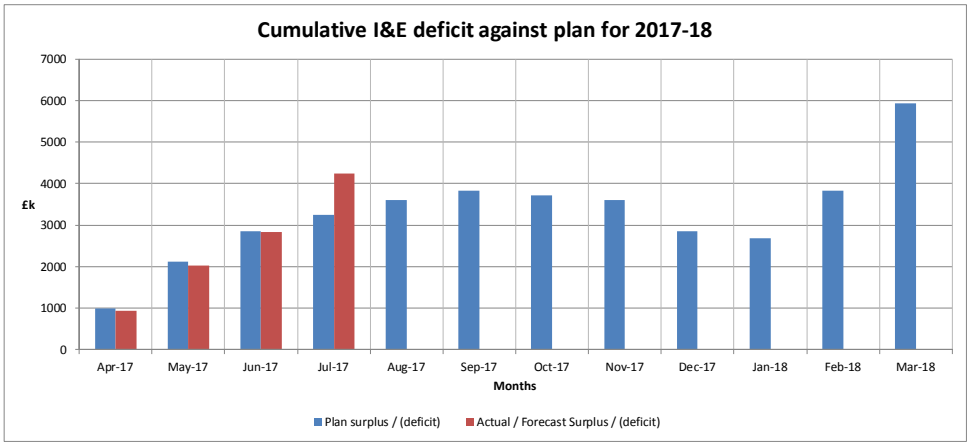
Income and Expenditure summary as at July 2017

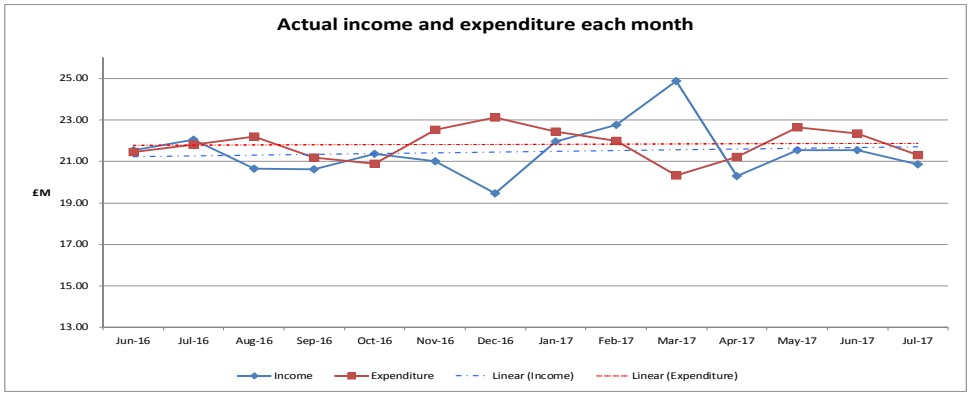
The reported I&E for July 2017 YTD is a deficit of £3,306k, against a planned deficit of £3,250k. This results in an adverse variance of £56k YTD.

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)	(402)	(463)	(62)	↓	Green
YTD surplus / (deficit)	(3,250)	(3,306)	(56)	↑	Green
Forecast surplus / (deficit)	(5,928)	(5,928)	0	↔	Green
EBITDA YTD	(1,416)	(1,320)	96	↑	Green
EBITDA (%)	(1.7%)	(1.6%)	0.1%	↔	Amber
Use of Resources (UoR) Rating fav / (adv)	3	3	0	↔	Amber
Clinical Income YTD	(74,150)	(74,066)	(84)	↑	Amber
Non-Clinical Income YTD	(9,656)	(10,604)	948	↑	Amber
Pay YTD	48,406	48,034	371	↓	Green
Non-Pay YTD	38,650	39,942	(1,291)	↑	Green
CIP target YTD	(3,521)	(3,473)	(48)	↑	Green





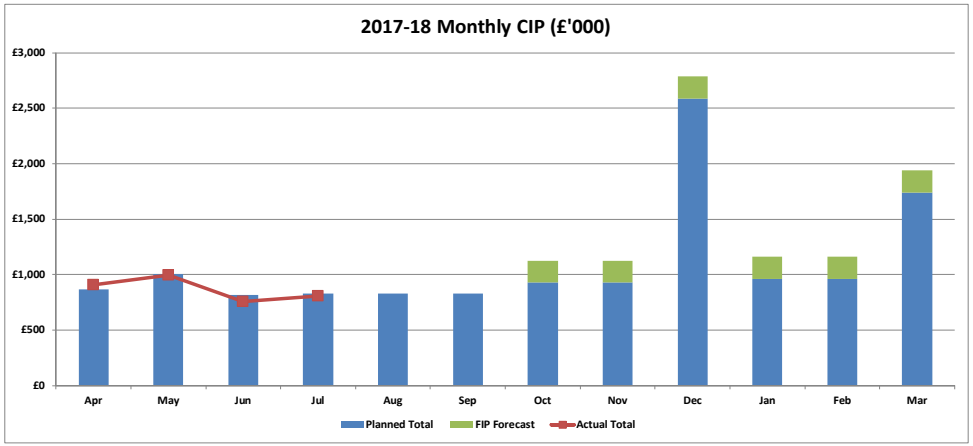


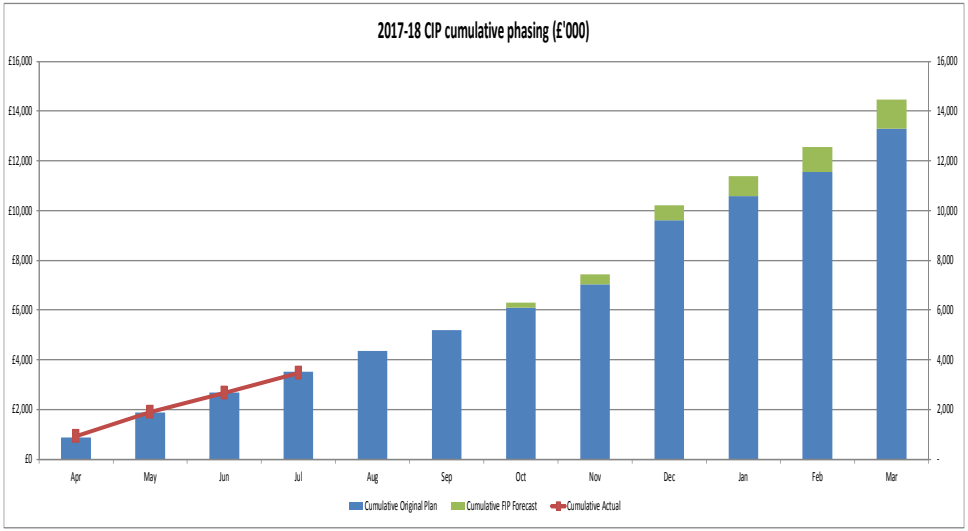
FINANCE AND WORKFORCE REPORT – July 2017

Cost Improvement Programme (CIP)

The July position includes a target of £3,521k YTD which represents 27% of the 2017-18 plan. There is currently a shortfall of £48k YTD against this plan.

Recurring/Non Recurring	Summary	2017-18 Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Activity growth	297	83	39
	Car Park Income	400	133	53
	Other Income	167	48	65
	Consultant Staffing	326	76	73
	Additional sessions	192	64	28
	Staffing Review	2,722	629	908
	Agency	482	161	64
	Procurement	1,801	467	361
	Community Equipment Service	465	133	52
	Contract review	8	2	4
	Drugs	326	44	116
	Capitalisation	480	160	115
	Other	2,047	755	730
Recurring Total		**9,712**	**2,755**	**2,609**
Non-Recurring	Activity growth	300	300	300
	Other Income	19	6	7
	Additional sessions	10	3	23
	Staffing Review	20	7	-
	Contract review	41	14	14
	Estates and Facilities	389	130	130
	Non-Recurring	396	-	-
	Capitalisation	350	150	200
	Other	393	156	191
	GDE revenue	1,650	-	-
Non-Recurring Total		**3,569**	**766**	**864**
Grand Total		**13,281**	**3,521**	**3,473**



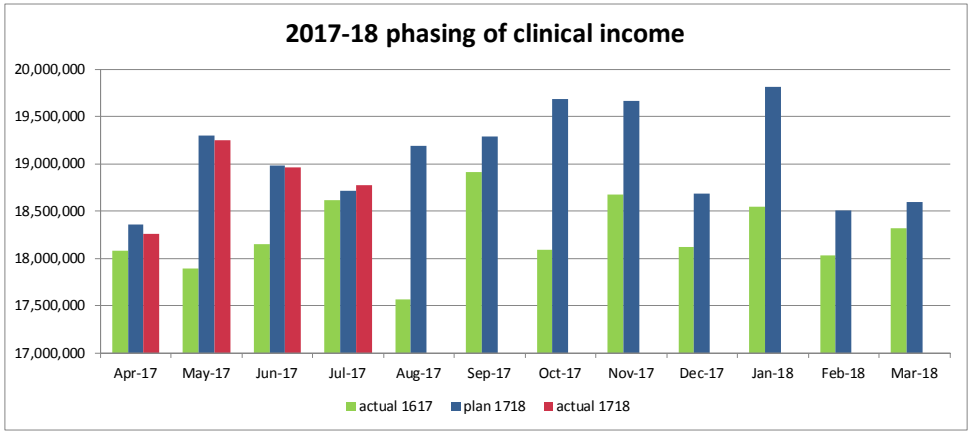


The FIP Programme has identified further CIP that increased this year's forecast to £14.4m. The over performance will be used in part to offset the KPMG fee. This has been phased from October 2017 as below.

2017-18 CIP	£m	£m
Original CIP schemes		13.27
Risk adjustments as per Phase 2		(0.66)
Revised CIP before Phase 3		12.61
Phase 3 CIP schemes		
Patient Flow	0.30	
Outpatients	0.07	
Theatres	0.90	
Endoscopy	0.03	
Nursing productivity	1.10	
Medical productivity	0.10	
Administrative and Clerical	0.60	
Pay Controls	0.56	3.66
Revised CIP plan		**16.27**
less KPMG fee		(1.14)
17-18 phasing risk		(0.72)
Net forecast CIP 17-18		**14.41**

Income Analysis

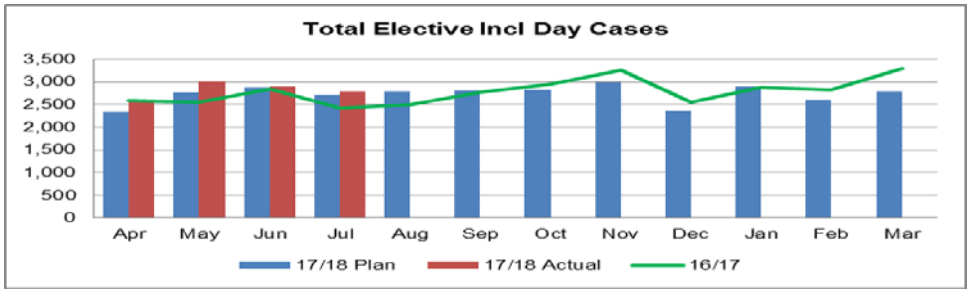
The chart below summarises the phasing of the clinical income plan for 2017-18, including a full year for Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.

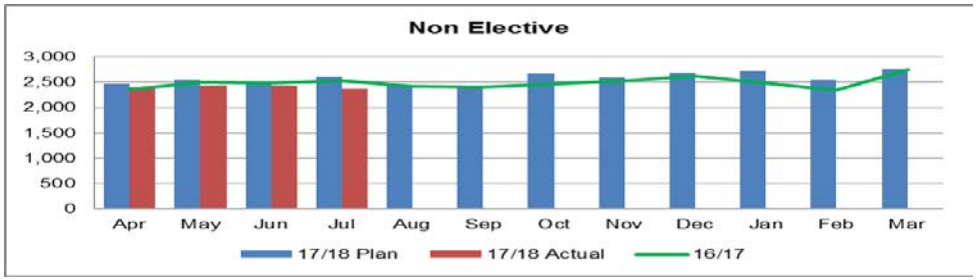


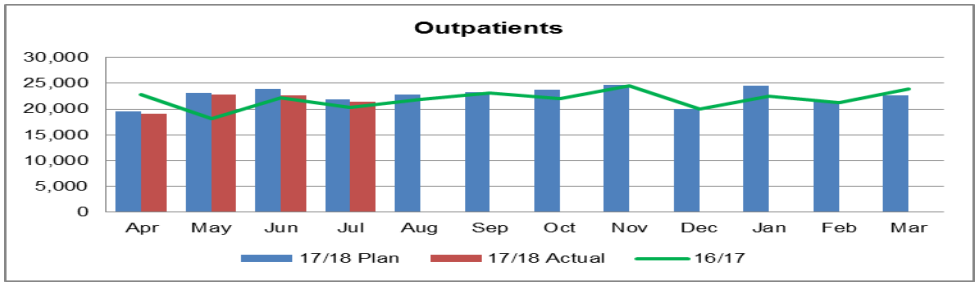
The income position was slightly behind plan in July. The main area of underperformance was seen within the non elective category during the month, with electives being over plan.

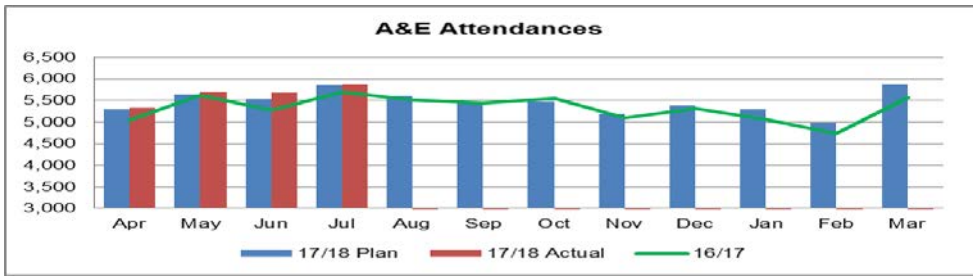
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	726	771	44	2,769	2,866	97
Other Services	1,761	1,770	9	8,864	8,115	(749)
CQUIN	301	303	1	1,184	1,193	9
Elective	2,599	2,731	133	10,212	10,963	751
Non Elective	5,187	5,063	(124)	20,146	20,420	274
Emergency Threshold Adjustment	(293)	(264)	29	(1,154)	(1,355)	(200)
Outpatients	2,626	2,594	(32)	10,613	10,346	(267)
Community	5,379	5,379	0	21,517	21,517	0
Total	**18,286**	**18,346**	**60**	**74,150**	**74,066**	**(84)**

Activity, by point of delivery

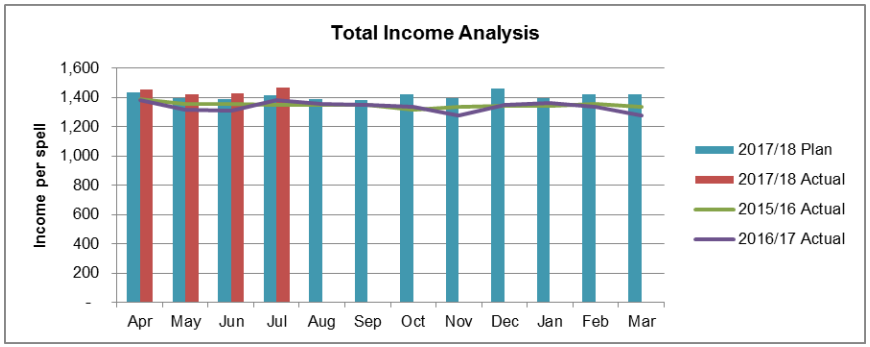


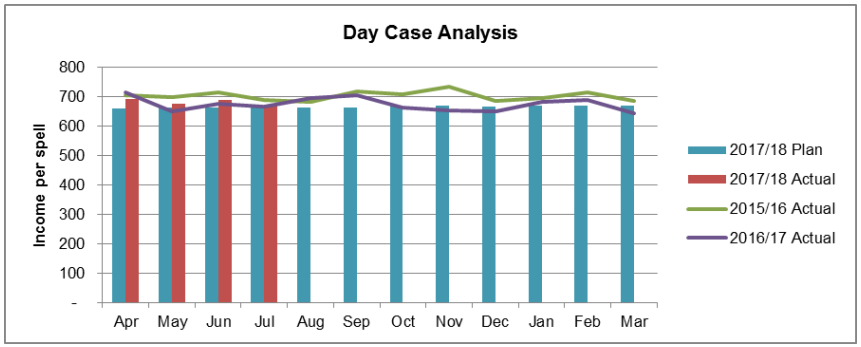


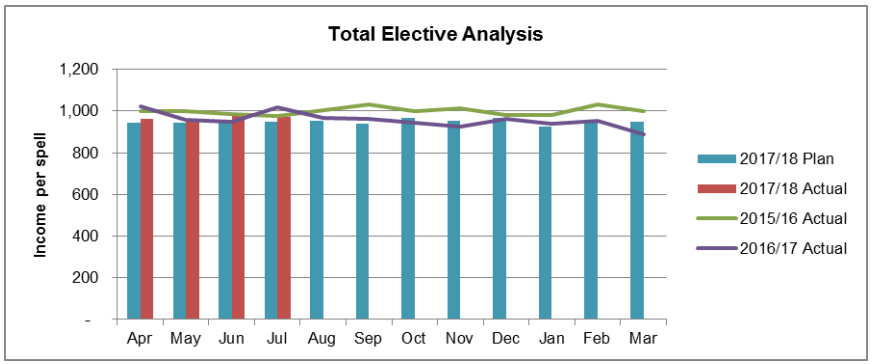


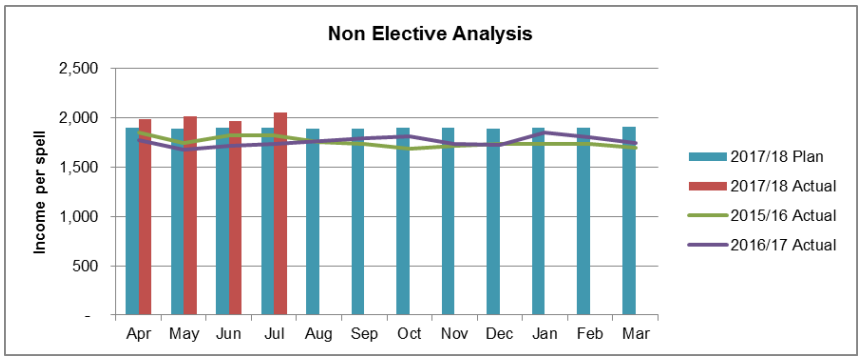


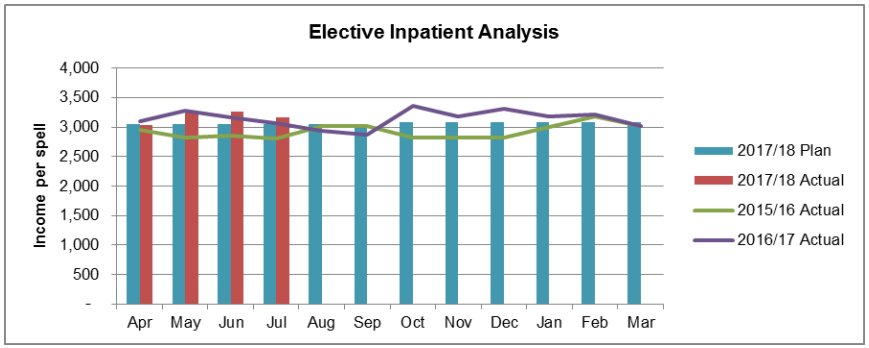
Trends and Analysis

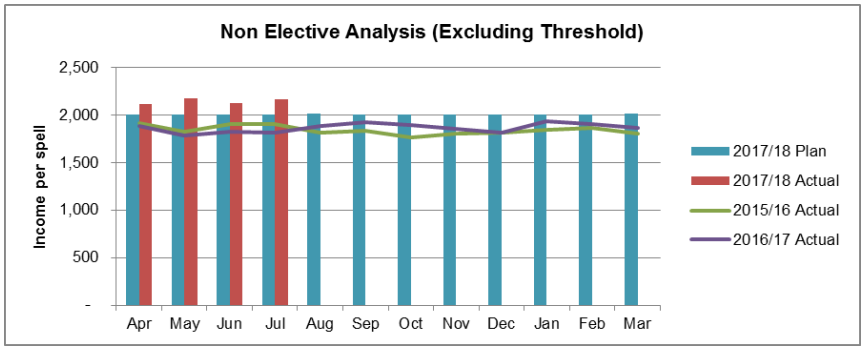












FINANCE AND WORKFORCE REPORT – July 2017

Workforce

Monthly Expenditure Acute services only				
As at July 2017	Jul-17	Jun-17	Jul-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,812**	**11,031**	**10,614**	**43,918**
Substantive Staff	9,517	9,935	9,265	38,686
Medical Agency Staff (includes 'contracted in' staff)	130	132	242	542
Medical Locum Staff	251	229	201	877
Additional Medical sessions	288	230	242	1,013
Nursing Agency Staff	74	81	187	292
Nursing Bank Staff	206	162	296	751
Other Agency Staff	88	49	179	255
Other Bank Staff	166	120	156	572
Overtime	73	88	64	360
On Call	44	55	39	205
Total temporary expenditure	1,322	1,147	1,606	4,867
Total expenditure on pay	**10,838**	**11,083**	**10,871**	**43,553**
Variance (F/(A))	(27)	(52)	(257)	364
Temp Staff costs % of Total Pay	12.2%	10.4%	14.8%	11.2%
Memo : Total agency spend in month	292	262	607	1,089

Monthly whole time equivalents (WTE) Acute Services only			
As at July 2017	Jul-17	Jun-17	Jul-16
	WTE	WTE	WTE
Budgeted WTE in month	**2,999.0**	**2,980.9**	**3,036.3**
Employed substantive WTE in month	**2718.5**	**2724.3**	**2,667.3**
Medical Agency Staff (includes 'contracted in' staff)	8.24	11.13	15.3
Medical Locum	18.86	16.46	15.7
Additional Sessions	25.06	18.21	23.7
Nursing Agency	11.47	12.5	28.8
Nursing Bank	67.23	52.86	96.6
Other Agency	16.63	16.41	60.9
Other Bank	79.36	57.73	77.4
Overtime	34.59	40.19	30.9
On call Worked	7.59	8.42	6.4
Total equivalent temporary WTE	**269.0**	**233.9**	**355.7**
Total equivalent employed WTE	**2,987.5**	**2,958.2**	**3,023.0**
Variance (F/(A))	11.4	22.7	13.2
Temp Staff WTE % of Total Pay	9.0%	7.9%	11.8%
Memo : Total agency WTE in month	36.3	40.0	105.1
Sickness Rates (July/June)	2.50%	3.61%	3.78%
Mat Leave	2.0%	1.8%	2.0%

Monthly Expenditure Community Service				
As at July 2017	Jul-17	Jun-17	Jul-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,123**	**1,123**	**1,010**	**4,488**
Substantive Staff	1,029	1,056	916	4,191
Medical Agency Staff (includes 'contracted in' staff)	12	13	0	53
Medical Locum Staff	3	4	3	13
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	0	0	5	3
Nursing Bank Staff	12	11	6	54
Other Agency Staff	32	15	41	105
Other Bank Staff	13	9	23	41
Overtime	4	4	2	17
On Call	1	1	1	5
Total temporary expenditure	78	57	81	290
Total expenditure on pay	**1,107**	**1,114**	**998**	**4,481**
Variance (F/(A))	17	9	(6)	7
Temp Staff costs % of Total Pay	7.0%	5.1%	8.1%	6.5%
Memo : Total agency spend in month	44	28	47	160

Monthly whole time equivalents (WTE) Community Services			
As at July 2017	Jul-17	Jun-17	Jul-16
	WTE	WTE	WTE
Budgeted WTE in month	**375.21**	**380.57**	**334.3**
Employed substantive WTE in month	**347.3**	**344.1**	**310.6**
Medical Agency Staff (includes 'contracted in' staff)	0.9	1.0	0.0
Medical Locum	0.4	0.4	0.4
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.1	0.0	0.9
Nursing Bank	4.0	3.8	1.6
Other Agency	7.7	5.4	8.7
Other Bank	3.5	2.3	4.5
Overtime	2.1	2.1	1.2
On call Worked	0.0	0.0	1.4
Total equivalent temporary WTE	**18.8**	**14.9**	**18.7**
Total equivalent employed WTE	**366.0**	**359.0**	**329.2**
Variance (F/(A))	9.2	21.6	5.1
Temp Staff WTE % of Total Pay	5.1%	4.2%	5.7%
Memo : Total agency WTE in month	8.7	6.4	9.6
Sickness Rates (May/April)	2.88%	3.55%	3.67%
Mat Leave	1.1%	1.1%	1.2%

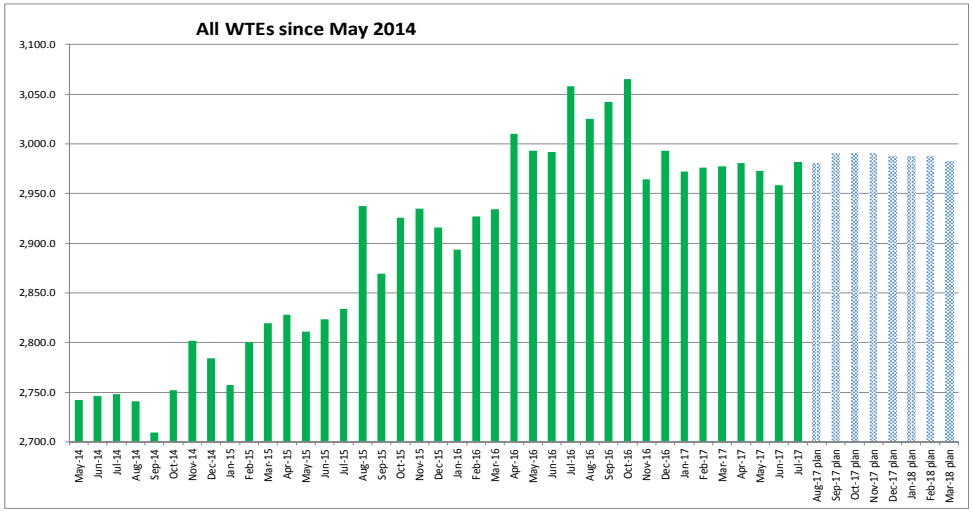
* Note the Acute tables includes Collaborative Procurement Hub staff on WSH Contracts
* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

FINANCE AND WORKFORCE REPORT – July 2017

Staffing levels

The following graphs exclude Community staff but include Capitalised staff.

The planned establishment from August 17 onwards is the level of staffing required to achieve the original CIP, although this needs to be updated to reflect the proposals in FIP. As at July 17 we employed 11 less WTE than planned and 29 WTE more than in June 2017.

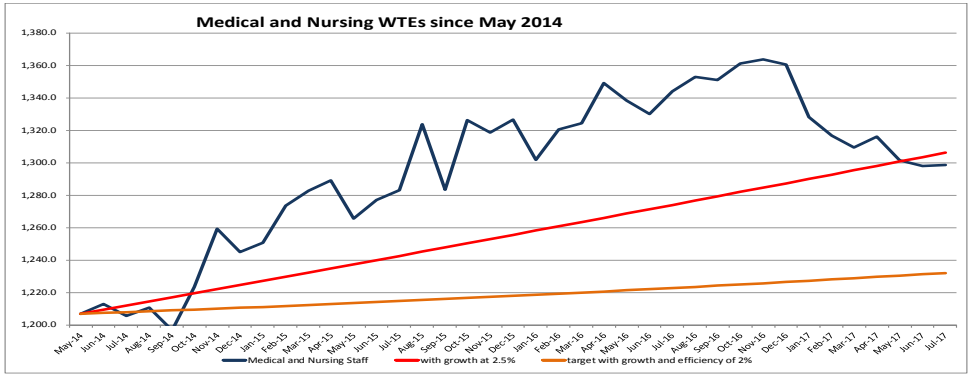


Since May 2014, (excluding Community staff) the Trust has employed 240 more WTEs, an increase of 8.8%. During this same period activity has grown by around 7.5%

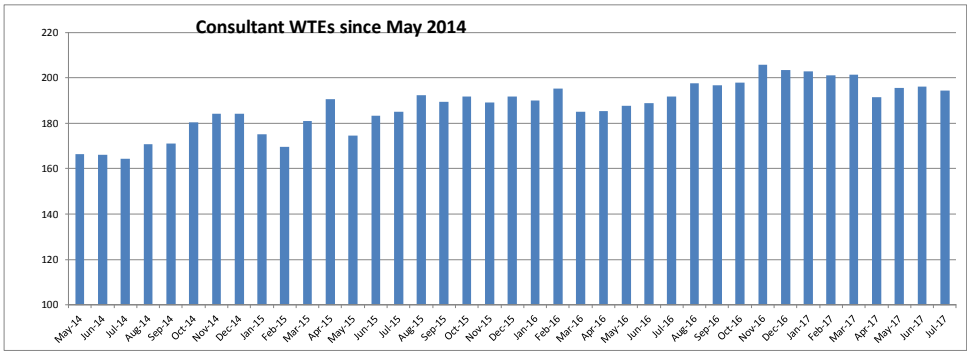
The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 92 WTEs (blue line). This includes around 28 WTE Consultants which are analysed further below.

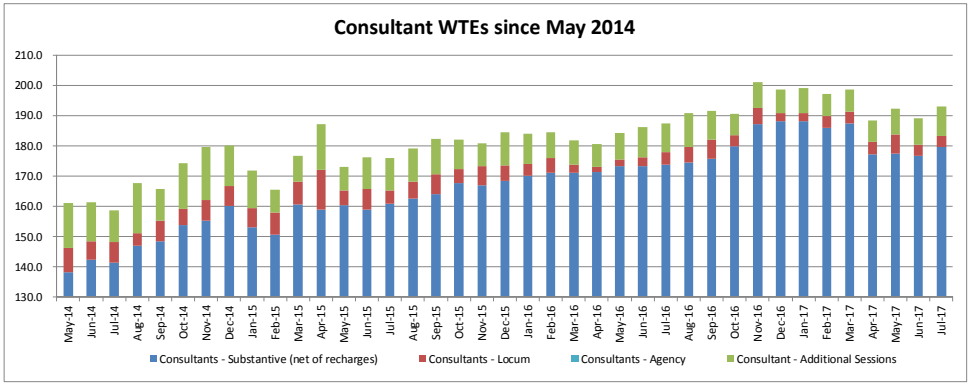
There has been an increase of 0.7 WTE during July. Medical staffing have increased by 12.4 WTE since April 2017, largely as the result of increases in medical locums and additional sessions.

If medical and nursing staffing levels had increased in line with our growth in activity of broadly 2.5% we would currently be employing 7.5 more WTEs (red line). In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 67 WTE fewer than at July 2017.



The graphs below highlight the increase in Consultant WTEs of 18% over the past 3 years. Substantive staff have increased by 40.5 WTEs whilst temporary staff have dropped by 7.5 WTEs.





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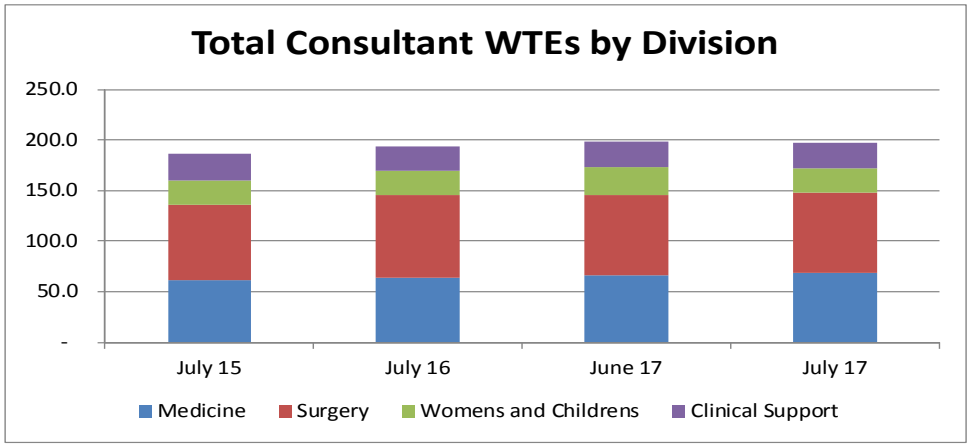
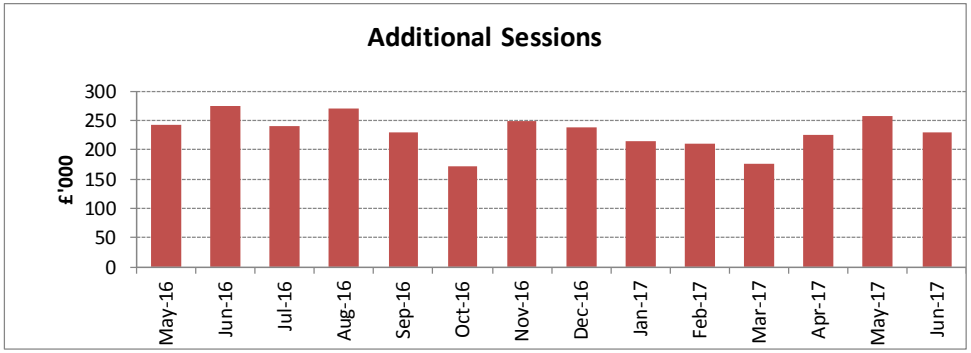
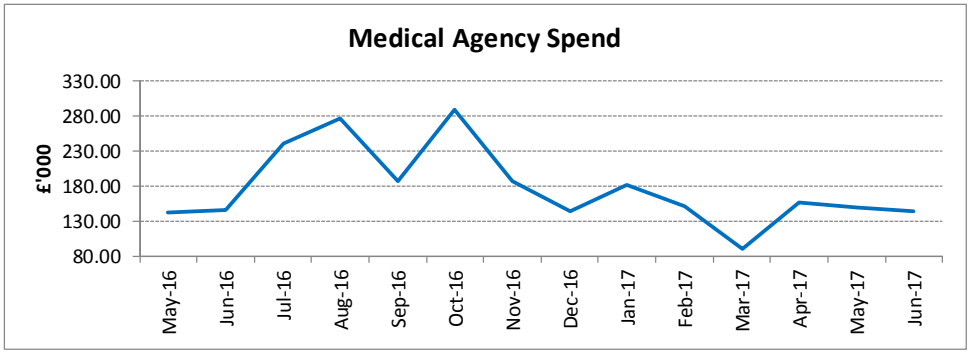


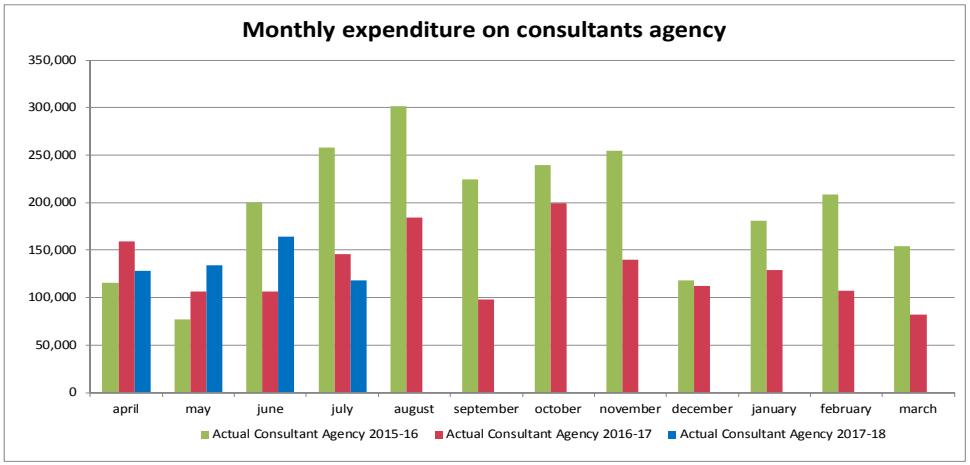
Division	Specialty	Sum of Jul-15	Sum of Jul-16	Sum of Jun-17	Sum of Jul-17
Medicine	A&E Medical Staff	5.9	6.4	7.7	8.1
	Cardiology	6.0	6.4	6.6	5.9
	Chest Medicine	4.0	4.0	4.4	4.0
	Chronic Pain Service	0.7	0.9	0.7	0.7
	Clinical Haematology	4.1	4.4	4.4	4.4
	Dermatology	5.0	4.8	4.0	5.0
	Diabetes	4.1	4.3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

Pay Trends and Analysis

The Trust overspent pay budgets by £10k in July (£371k YTD).







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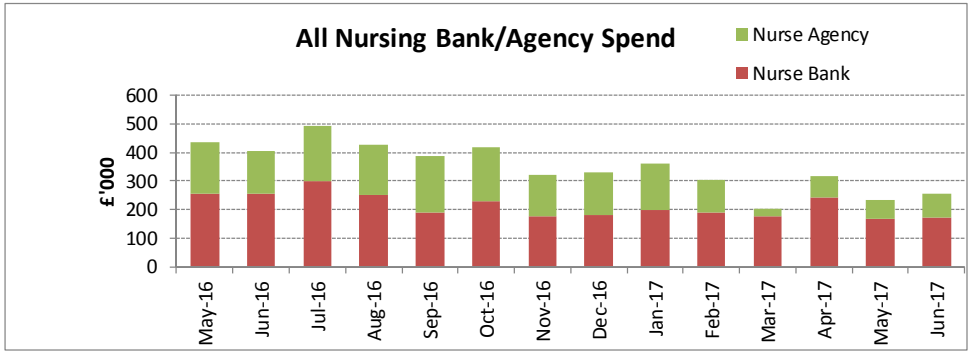
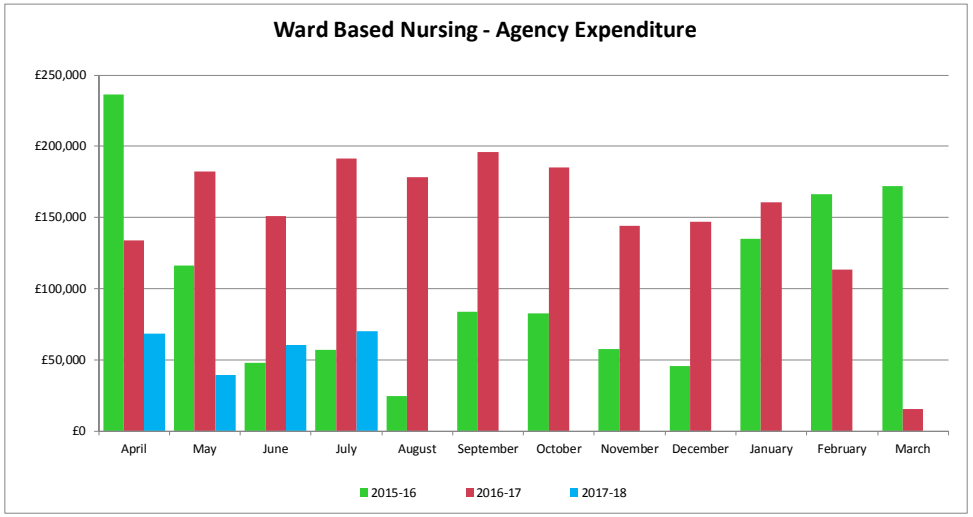
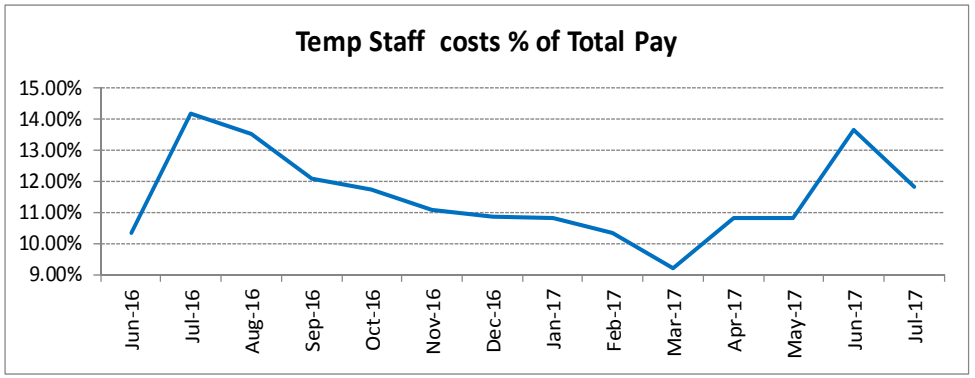
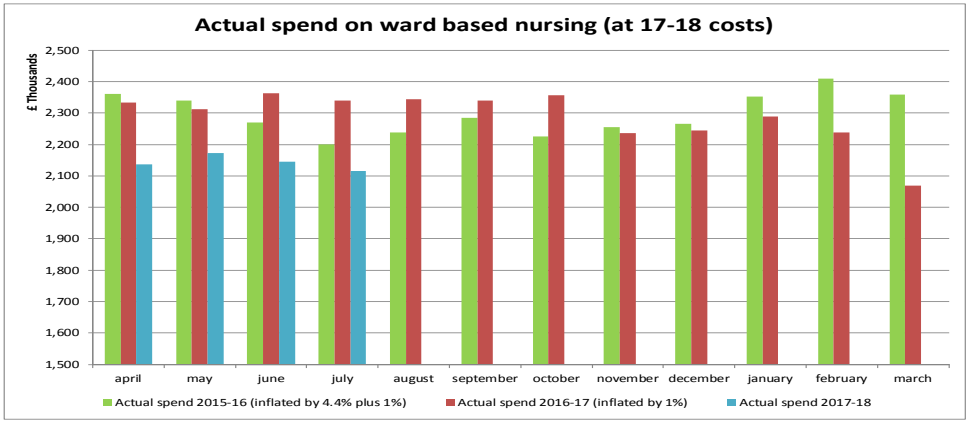
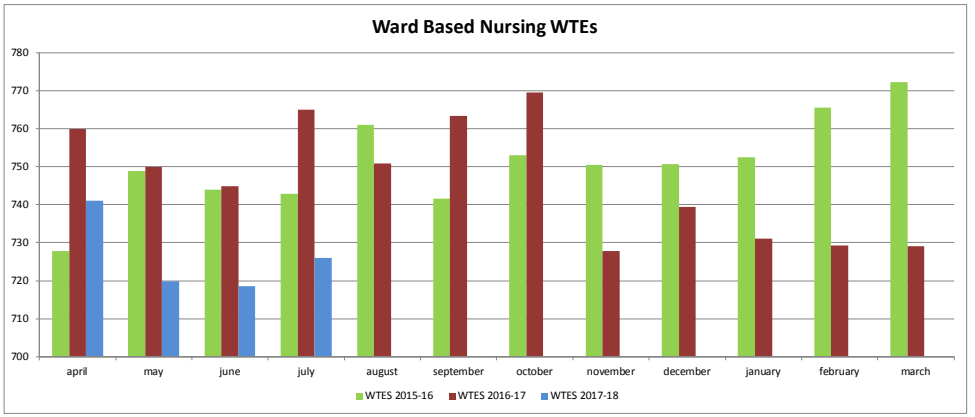


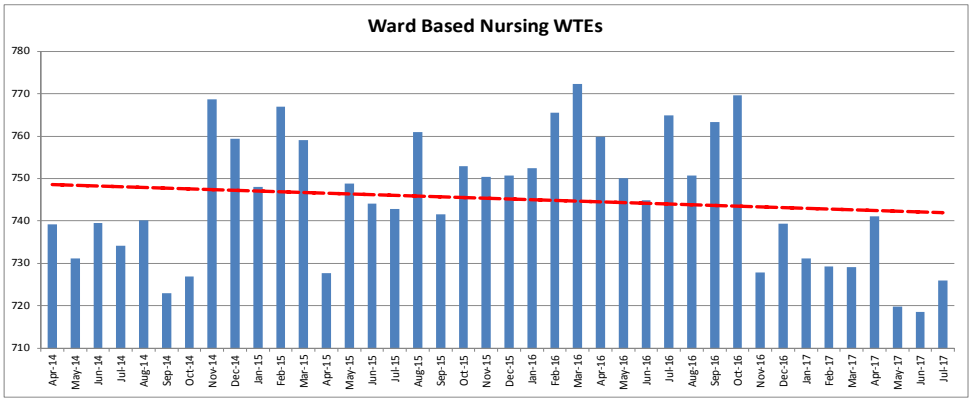




Ward Based Nursing







FINANCE AND WORKFORCE REPORT – July 2017

Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Jul-17 Budget £k	Jul-17 Actual £k	Jul-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	(5,535)	(5,623)	88	(21,610)	(21,815)	205
Pay Costs	3,378	3,376	3	13,564	13,513	51
Non-pay Costs	1,121	1,155	(33)	5,146	5,248	(102)
Operating Expenditure	**4,500**	**4,530**	**(31)**	**18,709**	**18,761**	**(52)**
SURPLUS / (DEFICIT)	**1,035**	**1,093**	**58**	**2,901**	**3,054**	**153**
SURGERY						
Total Income	(4,733)	(4,726)	(6)	(18,940)	(19,115)	175
Pay Costs	2,977	3,026	(49)	11,935	12,053	(117)
Non-pay Costs	1,036	1,133	(98)	4,140	4,260	(120)
Operating Expenditure	**4,013**	**4,159**	**(146)**	**16,075**	**16,312**	**(237)**
SURPLUS / (DEFICIT)	**720**	**567**	**(153)**	**2,865**	**2,803**	**(62)**
WOMENS and CHILDRENS						
Total Income	(2,238)	(2,255)	18	(8,252)	(7,886)	(366)
Pay Costs	1,105	1,120	(16)	4,419	4,439	(21)
Non-pay Costs	139	144	(5)	544	503	41
Operating Expenditure	**1,244**	**1,264**	**(21)**	**4,963**	**4,943**	**20**
SURPLUS / (DEFICIT)	**994**	**991**	**(3)**	**3,289**	**2,943**	**(346)**
CLINICAL SUPPORT						
Total Income	(894)	(818)	(76)	(3,831)	(3,664)	(166)
Pay Costs	1,627	1,590	38	6,771	6,628	143
Non-pay Costs	1,086	1,154	(68)	4,195	4,373	(178)
Operating Expenditure	**2,714**	**2,744**	**(30)**	**10,966**	**11,001**	**(36)**
SURPLUS / (DEFICIT)	**(1,819)**	**(1,926)**	**(106)**	**(7,135)**	**(7,337)**	**(202)**
COMMUNITY SERVICES						
Total Income	(10,831)	(10,828)	(3)	(43,322)	(43,374)	52
Pay Costs	1,123	1,107	17	4,488	4,481	7
Non-pay Costs	4,183	4,220	(36)	16,743	16,771	(28)
Operating Expenditure	**5,306**	**5,326**	**(20)**	**21,230**	**21,252**	**(21)**
SURPLUS / (DEFICIT)	**5,525**	**5,501**	**(23)**	**22,092**	**22,122**	**30**
ESTATES and FACILITIES						
Total Income	(371)	(340)	(31)	(1,484)	(1,365)	(120)
Pay Costs	749	707	41	2,994	2,937	57
Non-pay Costs	593	631	(38)	2,337	2,366	(28)
Operating Expenditure	**1,341**	**1,338**	**3**	**5,332**	**5,302**	**29**
SURPLUS / (DEFICIT)	**(970)**	**(999)**	**(28)**	**(3,847)**	**(3,938)**	**(90)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	3,592	3,294	298	13,363	12,550	815
Pay Costs	975	1,020	(44)	3,836	3,983	(147)
Non-pay Costs (net of contingency and reserves)	1,058	1,023	35	4,380	4,435	(55)
Finance & Capital	261	355	(95)	1,834	1,986	(152)
Operating Expenditure	**2,294**	**2,398**	**(104)**	**10,050**	**10,404**	**(354)**
SURPLUS / (DEFICIT)	**(5,886)**	**(5,692)**	**194**	**(23,414)**	**(22,953)**	**460**
TOTAL (including penalties, contingency and reserves)						
Total Income	(21,010)	(21,297)	287	(84,076)	(84,670)	595
Contract Penalties	0	0	0	0	0	0
Pay Costs	11,935	11,945	(10)	48,007	48,034	(28)
Non-pay Costs	9,216	9,460	(244)	37,485	37,955	(471)
Finance & Capital	261	355	(95)	1,834	1,986	(152)
Operating Expenditure (incl penalties)	**21,412**	**21,760**	**(349)**	**87,326**	**87,976**	**(650)**
SURPLUS / (DEFICIT)	**(402)**	**(463)**	**(62)**	**(3,250)**	**(3,306)**	**(56)**

Medicine (Annie Campbell)

The Division over performed by £58k in July (£153k YTD)

Contract Income was ahead of plan.

Net expenditure was £30k overspent and £51k over for the year to date.

Surgery (Simon Taylor)

The Division has underperformed by £153k in July (£62k YTD)

Income under achieved against plan by £6k. It has been a mix of fortunes for the specialties with the oral surgery service ending earlier than planned which caused an adverse variance. General surgery was significantly below plan due to lower numbers of non-elective patients. Orthopaedics and urology both performed well above plan.

Pay was overspent by £49k due to redundancy costs and agency usage. Surgery is reviewing all areas with regard to agency use.

Non-pay was overspent by £98k. The overspend is mainly in theatres, where there has been a significant increase in medical and surgical equipment. This is being investigated.

Surgery CIP's have over achieved by £63k YTD. There was some delivery of CIPs earlier than planned as well as higher vacancy management than plan.

Women and Children's (Rose Smith)

In July, the Division reported an under performance of £3k (£346k YTD).

Clinical income reported £17k ahead of plan in-month and £368k behind plan YTD. There were over performances in both Neonatal and Midwifery Services, due to higher than planned inpatients of £84k and £64k respectively, offset in the main by underperformances in both Obstetrics and Paediatrics non-elective patients resulting in in-month under-performances of £85k and £38k respectively.

Pay reported a £16k over spend in-month and £21k overspend YTD. There have been in-month overspends on medical staffing with in Paediatrics and on bank staff within Maternity Services, resulting in adverse variances of £11k and £10k respectively.

Clinical Support (Rose Smith)
The Division under performed by £106k in July (£202k YTD).

Clinical income for Clinical Support reported a £33k under performance in-month and £71k YTD, mainly due to an in-month underperformance in Diagnostic Imaging due to lower than planned activity for both radiology direct access activity and breast screening.

Income reported £43k behind plan in-month and £95k underperformance YTD. In-month variance includes a £20k one off credit note for breast screening relating to prior year. There has also been underperformance in Support to Go Home Service of £17k due to a delay in the pilot. This service is expected to commence in August. This variance has been offset against corresponding pay and non-pay underspends. Private Physiotherapy is £12k behind plan which is an improvement of £2k on the previous months position.

Pay reported a £38k underspend in-month and £143k YTD, mainly due to vacancies within Integrated Therapies in both Support to Go Home Service (£16k) and EIT (£22k).

Non pay reported a £68k over spend in-month and £178k overspend YTD. In-month variances include blood products (£21k non-recurring), external reporting for histopathology (£7k) and AGFA contract variation (£12k)

Community Services (Dawn Godbold)
The Division reported a £23k under performance (£30k over performance YTD).

Contract Income reported a £3k over recovery in-month and an over performance of £52k YTD. There has been an increase in Paediatric Services income from CCG to cover the cost of agency speech and language therapy to help meet performance targets.

Pay reported a £17k under spend in-month and £7k underspend YTD, mainly due to vacancies within Clinical Governance, Information and Paediatrics.

Non pay reported a £36k over spend in-month and a £28k overspend YTD. In-month variances include overspends relating to first dressings (£29k) and external consultants (£176k). These have been offset in part by income from IHT, and an under spend in Community Equipment Services of £79k due to increases in recycling credits and reduction in specials spend.

Use of Resources (UoR) Rating

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

The key features of the UOR ratings are as follows:

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

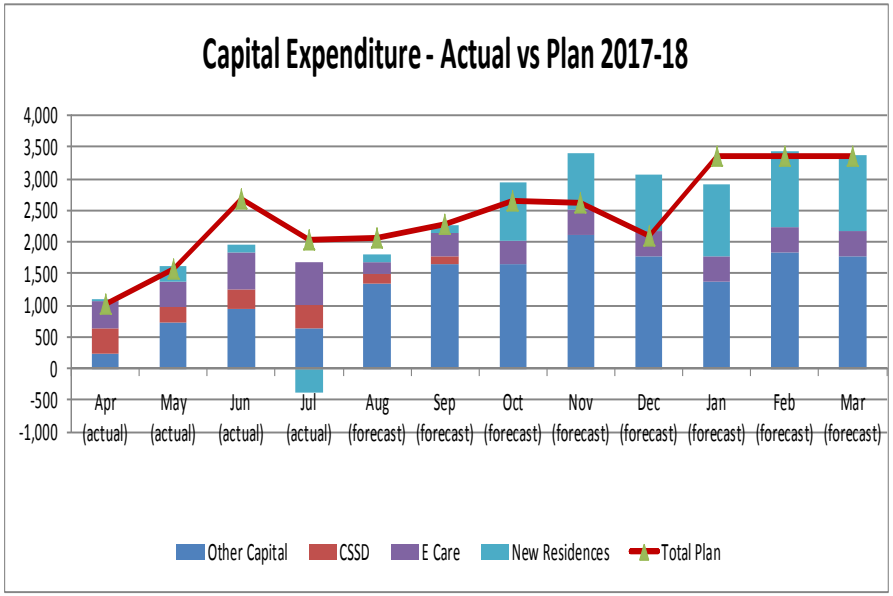
Metric	Value	Score
Capital Service Capacity rating	-2.175	4
Liquidity rating	-10.937	3
I&E Margin rating	-3.90%	4
I&E Margin Variance rating	0.10%	1
Agency	-39.50%	1
Use of Resources Rating after Overrides		**3**

The Trust is scoring an overall UoR of 3 again this month but the liquidity score has increased from 4 to 3 following receipt of Global Digital Excellence, Primary Care Streaming and Sustainability and Transformation cash.

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

FINANCE AND WORKFORCE REPORT – July 2017

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2017-18 £'000
E Care	415	381	567	683	163	390	390	390	390	390	390	390	4,937
CSSD	390	260	307	352	162	111	0	0	0	0	0	0	1,582
New Residences	43	246	121	-392	123	123	900	900	900	1,141	1,200	1,200	6,505
Other Schemes	247	726	952	642	1,344	1,655	1,639	2,107	1,778	1,379	1,840	1,770	16,081
Total forecast / Forecast	1,095	1,613	1,947	1,285	1,792	2,279	2,929	3,397	3,068	2,910	3,430	3,359	29,105
Total Plan	1,012	1,568	2,673	2,034	2,058	2,283	2,643	2,612	2,103	3,365	3,365	3,363	29,082

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

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

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

Expenditure on e-Care for the year to date is £2,046k and this is in line with the budget for the same period. The E-Care programme budget reflects the increased scope associated with the Global Digital Excellence (GDE) funding. The first tranche of this funding £3.3m was received in July. Initial indications are that the second tranche of funding will be received in December 2017, however past history would indicate that this timing is not guaranteed.

The forecasts for all projects have been reviewed by the relevant project managers. There are no significant financial risks to the budgets reported. Year to date the overall expenditure of £5,941k is below the plan of £7,287k.

FINANCE AND WORKFORCE REPORT – July 2017

Statement of Financial Position at 31st July 2017

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2017 £000	Plan 31 March 2018 £000	Plan YTD 31 July 2017 £000	As at 31 July 2017 £000	Variance YTD 31 July 2017 £000
Intangible assets	15,611	19,711	17,370	17,238	(132)
Property, plant and equipment	74,053	94,189	78,440	76,778	(1,662)
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**	**95,810**	**94,016**	**(1,794)**
Inventories	2,693	2,600	2,700	2,745	45
Trade and other receivables	18,345	11,700	16,675	18,004	1,329
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	5,500	7,493	1,993
Total current assets	**22,390**	**15,300**	**24,875**	**28,242**	**3,367**
Trade and other payables	(23,434)	(28,195)	(23,039)	(23,584)	(545)
Borrowing repayable within 1 year	(534)	(1,796)	(2,299)	(2,302)	(3)
Current ProvisionsProvisions	(61)	(61)	(84)	(89)	(5)
Other liabilities	(1,325)	(295)	(6,000)	(7,236)	(1,236)
Total current liabilities	**(25,354)**	**(30,347)**	**(31,422)**	**(33,211)**	**(1,789)**
Total assets less current liabilities	**86,700**	**98,853**	**89,263**	**89,047**	**(216)**
Borrowings	(44,375)	(55,951)	(45,968)	(45,704)	264
Provisions	(181)	(158)	(163)	(172)	(9)
Total non-current liabilities	**(44,556)**	**(56,109)**	**(46,131)**	**(45,876)**	**255**
Total assets employed	**42,144**	**42,744**	**43,132**	**43,171**	**39**
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)	(23,054)	(24,015)	(961)
Total taxpayers' and others' equity	**42,144**	**42,744**	**43,132**	**43,171**	**39**

Property Plant and Equipment (PPE)

The slippage on PPE is on Residences and Catheterisation Laboratory (Cath Lab) compared to the original forecast prepared before the start of the financial year.

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.

The Trust is not forecasting any overall slippage by the end of the financial year.

Trade and Other Receivables

These have decreased by £1.4m in July due to the receipt of Sustainability and Transformation Funding (STF) from DH offset by an increase in prepayments relating to maintenance and managed service contracts. We are still above plan with most of this attributable to the non-payment of invoices by Suffolk County Council for Community Medical Equipment.

Cash

The month end cash balance is £4.8 million higher than at the end of June. This is because we received Primary Care Streaming PDC, GDE funding and the balance of the 2016/17 STF payment. In order to avoid unnecessary interest charges the drawdown of capital loans has therefore been paused until needed.

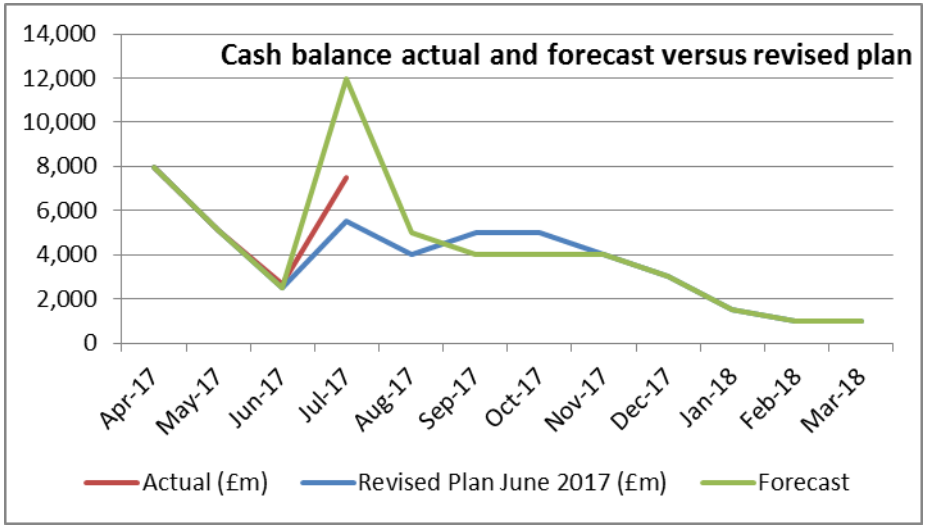
Trade and Other Payables

The balance on trade and other payables has decreased due to a reduction in capital accruals. There is still a backlog of invoices to be paid. An interface between the pharmacy system and the ledger is currently being tested which will reduce workload and help address the backlog.

Other liabilities

The increase on this balance is due to the contract payments for the block contract being 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.

Cash Balance Forecast for the year



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

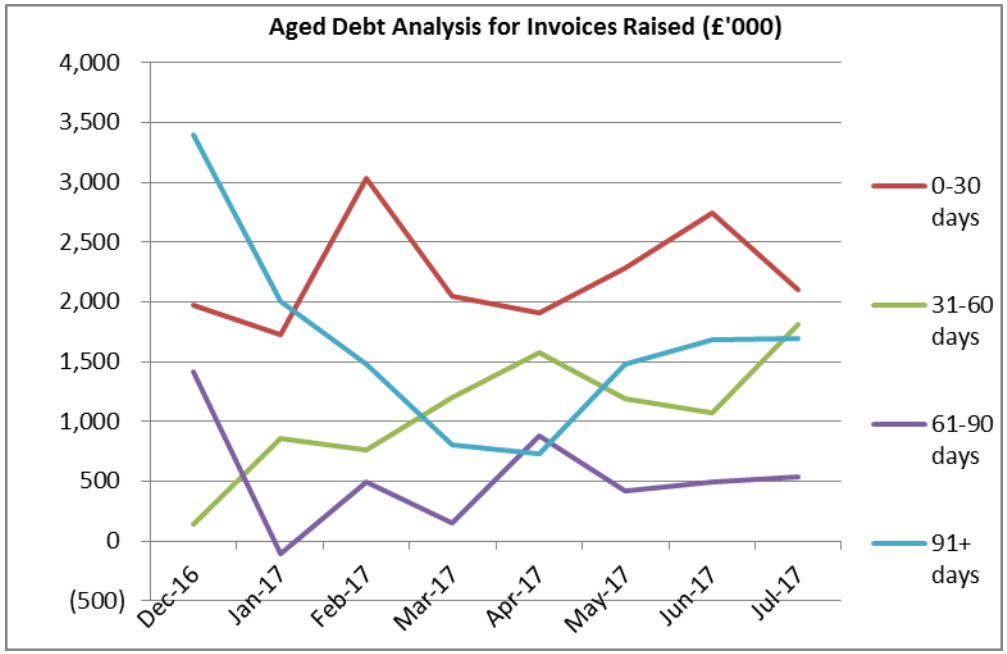
The July month end balance was lower than forecast last month because of a later payment run which helped to address the backlog of invoices.

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

Debt Management

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

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



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

£0.8 million of the debt outstanding for over 90 days relates to charges to Suffolk County Council for Community Equipment. Discussions are ongoing to resolve this matter. Of the remainder in this category £785k relates to other NHS bodies and is being actively pursued with issues escalated as appropriate.

The increase in the 31-60 category is due to an NHS England invoice raised relating to 2016/17 being in dispute. This is being actively pursued and requires additional information being provided by pharmacy via Contracting to NHS England.