NHS
West Suffolk
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on **Thursday, 29 March 2018 at 9.15** in the Northgate Room, 2nd Floor, Quince House at West Suffolk Hospital

Sheila Childerhouse
Chair

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Introductions and apologies for absence** To note any apologies for the meeting and request that mobile phones are set to silent	Sheila Childerhouse
2.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Sheila Childerhouse
3.	**Review of agenda** To agree any alterations to the timing of the agenda	Sheila Childerhouse
4.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Sheila Childerhouse
5.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 2 March 2018	Sheila Childerhouse
6.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
7.	**Chief Executive's report (attached)** To accept a report on current issues from the Chief Executive	Steve Dunn
9:35 DELIVER FOR TODAY		
8.	**Integrated quality and performance report (attached)** To accept the report	Helen Beck / Rowan Procter
9.	**Discharge summary report (attached)** To accept the report	Nick Jenkins
10.	**Referral to treatment (RTT) report (to follow)** To receive the update in the context of winter pressures	Helen Beck
11.	**Finance and workforce report (attached)** To accept the monthly report	Craig Black
10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
12.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter
13.	**Education report (attached)** To receive the update, including undergraduate training	Jan Bloomfield

14.	**Gender pay gap report (attached)** To approve the report recommendations	Jan Bloomfield
15.	**Car parking strategy (attached)** To approve the report recommendations	Craig Black
16.	**CQUIN foods and drinks report (attached)** To approve the report	Jan Bloomfield
17.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
10:50 BUILD A JOINED-UP FUTURE		
18.	**e-Care report (attached)** To receive an update report	Craig Black
19.	**Alliance and community services report (attached)** To receive update	Dawn Godbold
11:00 GOVERNANCE		
20.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
21.	**Audit Committee report (attached)** To approve report recommendations	Steve Turpie
22.	**Council of Governors report (attached)** To receive report	Sheila Childerhouse
23.	**NED responsibilities (attached)** To note the updated responsibilities	Sheila Childerhouse
24.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:15 ITEMS FOR INFORMATION		
25.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
26.	**Date of next meeting** To note that the next meeting will be held on Thursday, 27 April 2018 at 9:15 am in the Committee Room.	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
27.	The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act 1960	Sheila Childerhouse

Item 5

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 2 MARCH 2018

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

Action

GENERAL BUSINESS

18/029 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and thanked them for attending, despite the weather.

She recorded her thanks to the Trust's staff and other services who had made the effort to come into the organisation during the past few days. They had coped extremely well as they came towards the end of a very difficult winter, even though they were very tired. The board agreed that staff had made a tremendous effort and that their commitment was an accolade to the Trust.

There were no apologies for absence.

18/030 QUESTIONS FROM THE PUBLIC

- Liz Steele reported that when attending a recent quality walkabout she had observed a number of pregnant nurses. She asked if a there was a positive approach to people returning to work, in particular flexibility around shifts, taking into account the need to retain nurses.

  Rowan Procter confirmed that there was an overarching hospital policy. She explained that staff had a legal right to request flexible working.

Jan Bloomfield assured Liz Steele that culturally the Trust was embracing flexible working. The organisation was working towards being more positive about this, recognising the need to manage rotas productively, which was part of the reason for moving towards 12 hour shifts or splitting into two six hour shifts.

The Chief Executive explained that people were sometimes flexibly re-deployed. He suggested that more needed to be done to communicate this to all staff.

- Barry Moult asked about clarification regarding performance against the WHO checklist for maternity and noted that were two conflicting figures in the performance report, ie 99% and 80%. It was explained that 80% referred to maternity and 99% was for the rest of the organisation.

  Nick Jenkins explained maternity performance was lower than he would like, but this related to a low number of caesareans. This was not due to failure to complete the form, but as a result of failure to complete all sections of the form correctly. He would continue to monitor this and had recently spoken to an individual about their failure to complete all sections on more than one occasion.

18/031 REVIEW OF AGENDA

The agenda was reviewed and there were no issues

18/032 DECLARATION OF INTERESTS

There were no declarations of interest for items on the agenda.

18/033 MINUTES OF THE MEETING HELD ON 26 JANUARY 2018

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

Page 5, 18/007, final paragraph, to be amended to, “Gary Norgate said that he was not yet fully assured about managing in March, as this was forecast to be the busiest month”.

Gary Norgate referred to the fifth paragraph on page 6, ie “Gary Norgate suggested that the organisation needed to look at collective data, as an NHS system, in order to understand and improve predictability”. He requested that this should be included as an action. The Chief Executive proposed including this as part of the review of winter pressures. He also suggested discussing with NHSI whether there was any predictive modelling to assist with this. **H Beck**

Craig Black suggested that this should also be part of the population aspect of the e-Care programme. Nick Jenkins explained that the population health work would be aiming to eventually look week by week as to whether people were buying cold and flu remedies from supermarkets as this could help to predict demand on the local healthcare system.

18/034 MATTERS ARISING ACTION SHEET

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

Item 1512 – develop the IQPR to include community data. Craig Black explained that the aim was to include this by April, but it was likely to be May

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Item 1529 – 2018-19 winter planning update to be received by the board in April. Angus Eaton acknowledged that planning for winter was important, but suggested that the Trust should also be looked at planning for the whole year.

Helen Beck agreed and explained that this was about reflecting on last winter and then starting to think about the rest of the year, ie referral to treatment (RTT). The report would include both of these. Rowan Procter explained that this would also include the deep cleaning programme over a rolling 12 months.

The completed actions were reviewed and there were no issues.

18/035 CHIEF EXECUTIVE'S REPORT

The Chief Executive echoed the Chair's thanks to staff over a very difficult winter. The organisation had been under significant pressure, particularly over the last week due to staffing pressures as a result of the weather conditions. This had shown the need for even greater focus on winter planning for the future and he anticipated that this pressure would continue for next year.

The executive team had discussed re-prioritising the capital programme to reflect the pressure experienced over the winter, including creating more capacity in the community as well as the in the hospital. A proposal at the next board meeting would be to put the re-development of the front of the hospital on hold and put the money into other areas in order to assist with patient flow and providing the best services possible for patients.

There was an ongoing focus on trying to clarify the Choice policy, particularly around discharges. Work was also being undertaken through the alliance and Strategic Transformation Partnership (STP) on driving system flow.

Orthopaedics had suffered the most as a result of the cancellation of the elective programme. As a result orthopaedic activity would be doubled over the next five weeks to address this position, which was a terrific response from the whole of the orthopaedic team.

There had also been a great response in the community to assist with the current pressures, and WSFT had been supporting and accommodating staff who had come into work and stayed overnight where necessary.

Richard Davies referred to the glaucoma service virtual clinic and asked for assurance that this would not impact on the quality of diagnosis of patients and if there were opportunities for expanding this to other specialities, eg dermatology. Helen Beck explained that the glaucoma clinic was supervised by the consultant base. The Trust was currently working with the CCG on dermatology and new referral patients, and looking at all other options to manage demand better.

Nick Jenkins explained that the ophthalmic consultants considered that this improved the quality of service as they were seeing patients who really needed to see a consultant.

He reported that later this month a physician associate would be joining the plastic surgery team. They would be focussing on dermatology work, which would be assisting the dermatology team.

The Chief Executive said that the glaucoma service and the improvement in diabetes care across Suffolk was a real testament to specialties starting to work in a different way and was a good example of integration. He agreed that expanding this across other specialties needed to be looked at.

He referred to the phenomenal achievement of WSFT being rated as the top hospital in the country for meeting best practice criteria for patients treated for hip fracture. This was a significant quality outcome and he commended the orthopaedic team for this achievement.

Angus Eaton said that he was pleased to see an increase in orthopaedic activity, but asked for assurance that there was the right balance from a safety perspective for patients. Rowan Procter confirmed that this had been taken into account and explained that the longer patients waited for surgery the more pain they were in and their condition could deteriorate. Helen Beck explained that the plan for this had been generated from the orthopaedic team who were working flexibly to ensure the longest waiting patients and those in the greatest need received their surgery as soon as possible.

Nick Jenkins said that it was a testimony to the Trust's outstanding staff that orthopaedic surgeons had been so flexible and were working to deliver what was best for patients. Nationally this was not always the case within orthopaedic teams.

The Chair recorded the appreciation of the board to the orthopaedic team for taking this approach.

Jan Bloomfield noted the King's Fund report on the impact of happy staff and good quality care, which underscored the health and wellbeing strategy. This had a direct correlation to the benefit of patients and demonstrated the value of health and wellbeing.

DELIVER FOR TODAY

18/036 INTEGRATED QUALITY & PERFORMANCE REPORT

Rowan Procter highlighted the increase in incidents, which was not unexpected due to the pressure the organisation was under. However, she considered it to be positive that these were still being recorded.

There had been as significant increase in pressure ulcers but these now included community patients. The number of falls resulting in harm to patients had also increased from 23 in December to 28 in January. These were all going through a governance and investigation process.

Gary Norgate considered this to be a good, open report and was particularly pleased to see the inclusion of action plans which he had requested last month. However, he expressed concern about pressure ulcers and suggested that there should be an internal measure to enable progress to be judged. He asked what the target number for these should be.

He also noted the deterioration in discharge summaries and asked for assurance that this was due to winter pressures, or if it was a developing trend. Nick Jenkins confirmed that discharge summaries were an ongoing problem. As reported last month, there was now a member of the team in place whose role was to improve the discharge summary position and he hoped that this would improve over the next few months.

Discharge summaries in the emergency department were the biggest problem and work was being focussed on this. There was now a daily report on discharge summaries by patient, which were being tracked. Ward staff appreciated the work that was being done on this, as they had been concerned about this for some time.

Nick Jenkins explained that discharge summaries were not the future, but this was about enabling patient records to be viewed by GPs. He confirmed that the target was 95% within 24 hours.

The Chair said that the board needed to see the trajectory improving. Nick Jenkins agreed but said that he did not know how quickly this would improve and proposed agreeing a target next month. **N Jenkins**

Rowan Procter referred to avoidable pressure ulcers (page 2) and explained that there had not been an increase in these over the year; and neither had there been a big increase in unavoidable pressure ulcers.

Richard Davies asked how a judgement was made as to whether a pressure ulcer was avoidable or unavoidable, and if all avoidable pressure ulcers related to end of life patients. Rowan Procter explained that there were national criteria set out on what was deemed avoidable and unavoidable. This included assessments within a timeframe which all had to be completed and documented to the national standard. There had to be clear evidence that all end of life patients were asked on an hourly basis if they would like to be repositioned and whether they said yes or no had to be documented. If this was not documented the pressure ulcer was deemed to be avoidable.

If it was being regularly recorded on the same ward that patients refused to be re-positioned Rowan Procter would look into how patients were being managed in this respect.

The board agreed that data for reporting against avoidable pressure ulcers should be amended to show the target as five per month. Rowan Procter explained that the increase in January was due to the merger of community data with acute data. **R Procter**

Alan Rose asked about incident reporting and if e-Care could assist with this. Rowan Procter explained that the increase in the delay in serious incident reporting was due to there being a number recently which required further information to enable it be understood as to whether or not they should be classified as a serious incident. These needed to be reported within two days but if they occurred at weekends or holidays this could have an impact.

Information on root cause analysis (RCAs) was only uploaded when it had been closed and was a conscious decision that the Trust had taken. This made WSFT look like an outlier as other organisations uploaded information whilst an incident was still being investigated.

She referred to RCA actions and explained that there had recently been a problem with staff having the capacity to go through RCAs due to winter pressures. However there was an expectation within the senior nursing team as to what they should be doing about this, including datex. The implementation of overdue actions plans was also being followed up, as well as ensuring that these were being shared elsewhere, where appropriate.

It was explained that ‘greatex’ had also been launched, which enabled the recording of good things that went really well. This was about best practice being shared with other people.

Catherine Waller asked about patient harm resulting from medication errors (page 18) and noted that there was no data or target available. She asked for assurance that no harm had been caused as a result of medication errors.
Rowan Procter assured the board that this was the case and explained how individuals who committed medication errors were managed.

Richard Davies referred to sepsis (page 40) and noted that performance in the MacMillan unit was 100% but the emergency department was much lower. He asked if this was an issue and also if the emergency department was the right place for these patients to be. Nick Jenkins agreed that these patients should not be in the emergency department and ideally they should be re-directed to G1 where feasible. He explained that this was being focussed on by a task and finish group. The Chief Executive confirmed that this had been focussed on for a considerable length of time.

Helen Beck explained that this had been the most challenging January and February ever experienced by this organisation and organisations across the country. The main challenges were in the emergency department where there was a lack of capacity and a high volume of patients. There was also a challenge around the capacity in the organisation for beds, even though the elective programme had been cancelled and 12 additional beds were in use in this area.

The other major challenge was staffing within the emergency department, mainly medical staff, where there were vacancy gaps in middle and junior grade rotas. The establishment was also being reviewed in the context of additional demand. However performance for A&E waiting times was 85% for February, which meant that WSFT was third in the Midlands & East, behind Ipswich and Colchester.

The organisation had frequently been full with no additional resources or capacity to see patients. The task & finish group would be reinstated, which would be chaired by Rowan Procter, and Helen Beck would be working with her to identify issues that needed to be focussed on. The performance report showed areas that needed to be addressed within the hospital and they would be using this information to target the work of this group. This would include looking at the workforce within the emergency department for both summer and winter.

Gary Norgate referred to the A&E performance graph on page 42 and noted that for several months throughout the year WSFT had been below its peer group. He asked if there was anything that other organisations were doing differently that the Trust could learn from. Helen Beck explained that the task & finish group would be looked at this. She believed that some of the poor performance was around flow within the organisation and a number of significant changes had been made towards addressing this, which was shown in the improvement against peers in January/February. There was also a need to understand staffing gaps within the organisation and their impact on performance and patient flow.

The Chief Executive agreed that this was a very useful graph and noted that there were a lot of underlying reasons that could be provided to explain the fluctuations in WSFT's performance, eg e-Care go-live and staffing issues. Steve Turpie suggested that it would be useful to have some understanding of the reasons for the fluctuations in this graph. The Chief Executive explained that a number of initiatives had been put in place to improve performance but agreed that the reasons needed to be understood.

Rowan Procter confirmed that the head of performance would be part of the task & finish group and would be looking into this further.

She explained that she would be talking to the Intensive Support Team this afternoon to see if there was anything that the Trust was missing and if there was anything else that could be done.

Nick Jenkins said that it was important not to ignore the effort that consultants in the emergency department were putting in and that they were volunteering to work additional weekends during the winter period.

If no locums were available WSFT's own consultants had been standing in. The main reason for the fluctuation in performance had been flow and the Trust now needed to look at what more could be done in the emergency department to improve flow. Management of flow further down the organisation had improved, therefore the focus needed to be on the emergency department.

Angus Eaton proposed that the work on planning should consider lead measures that could be looked at. The Chief Executive agreed and explained that these were looked at in some areas, eg length of stay, but further work was required to deliver this. He explained that although the graph on page 42 was a good measure, some hospitals recorded things differently, which meant this was not necessarily a like for like comparison.

Helen Beck explained that breach analysis was being produced by reason, by hour, by day on a daily basis, which meant that operational problems could be targeted as they occurred. NHSI had been impressed with this asked if WSFT could share the format.

Gary Norgate referred to children in care and noted three red ratings and that the audit report had minor concerns. He asked for assurance that the problem was understood. Dawn Godbold explained that overall responsibility of children in care was with the county council, but health assessments were the responsibility of the community.

There were a number of reasons why performance was poor in January, not only the capacity to undertake these. The main problem continued to be the number of out of area children based in Suffolk, which was resulting in a burden and this had been escalated. The possibility of initial assessments being undertaken before children were placed in Suffolk was being looked at.

Another issue was that notification was not always received in time to enable children to be seen within 28 days. This had been highlighted to the county council, who had said they would look into this.

An escalation meeting had taken place with the county council at the beginning of February and they were looking at whether children could have a health assessment with their own GP or foster family GP, before they were placed into care. The requirement of foster carers was also being reviewed, as part of the problem was that they did not attend appointments or refused appointments. They were also checking to see if people were being given reasonable choice or notice.

Steve Turpie noted that these issues were not new and said the Trust needed to consider what it was going to do about this. He considered that the local authority was not performing and asked how this could be escalated.

Rowan Procter explained that some things that were not being done were within the Trust's gift and some were within the local authority's gift. Both organisations were working together to address this. There were not enough GPs with a special interest who wanted to do initial health assessments, and appropriately trained nurses were no longer allowed to do initial health assessments. It was explained that GPs were not interested in doing these due to money and the amount of time allocated.

The Chair considered that the explanation of actions being taken was good, but there was a need to look at how these issues were being addressed and how this could be escalated. This related to alliance working and the issue needed to be addressed. She asked Dawn Godbold to keep the board updated so that concerns could be taken further if necessary.

Alan Rose asked if the alliance had its own risk register, rather than individual organisations. Dawn Godbold explained that this was being developed as part of the approach to alliance working. A shared metric dashboard was also being developed. Alan Rose asked if there would be a process for the board to see this risk register.

The Chair said that this was a core issue to be dealt with by the alliance and the Trust needed to know what it was doing about this. The Chief Executive proposed that he and Dawn Godbold should send a letter to the county council stating the Trust's desire to improve the position about caring for looked after children and asking what support they required in order to do this. He did not consider this to be a failure of will but a failure to focus due to the pressure systems were under, and this needed to be acknowledged.

S Dunn / D Godbold

18/037 REFERRAL TO TREATMENT (RTT) POSITION

Helen Beck explained that WSFT had cancelled most of its elective activity in January and February, ie approximately 200 procedures. This figure was artificially low as the Trust had stopped booking patients, which meant that there could be nearer 350-400 lost opportunities. However, in January RTT performance had improved due to ENT and dermatology patients being treated as outpatients and day case activity. ENT had waits had reduced by six weeks and was now at 21 weeks. Dermatology waits had reduced by four weeks to 20 weeks.

Areas of significant concern were trauma & orthopaedics and urology. As discussed earlier, the orthopaedics team were very engaged and had a plan. Urology was the biggest concern, with a wait of 24 weeks. It had depleted resources and had just lost a locum, but more of a concern was how to recover this. A conversation was being had with the team on what could be done differently and it was hoped to have a plan to improve this.

There had not been any cancellations of 52 week patients, but the numbers waiting over 45 weeks would increase. There were 12 patients for March and 21 patients for April who were at risk of becoming 52 weeks breaches; each patient was being monitored at specialty level and plans were being made for their treatment. Monthly detailed updates on the sustainability action plan were given to the scrutiny committee and a more detailed report would come back to the next board meeting.

Steve Turpie asked what communication had been given to patients. Helen Beck explained that she had personally written to all patients who were cancelled with an apology and explanation as to why they were cancelled. She, a member of the management team, or clinician had also spoken to patients who had been particularly upset at being cancelled. She explained that the hospital booking team had had a very difficult time dealing with all of the patient cancellations and that the executive team and leadership had all signed thank you cards which she had personally delivered to the booking team

Steve Turpie asked what the external message was. Tara Rose explained that WSFT was not an outlier and the press were not interested in referral to treatment, they were more interested in A&E performance. The letter sent to patients would cover the basis of communication sent to the media if requested. Richard Jones reported that this had been a focus for PALs and complaints, which was not surprising.

18/038 FINANCE AND WORKFORCE REPORT

Craig Black explained that the position in January was very similar to December. The main difference was that during January there had been a significant curtailment of elective work which had continued into February.

There had been a £300k overspend in January which was less than in December due to the reduction in elective work. Therefore, at the end of January the Trust was £900k adrift of the control total. If this continued in February and March the Trust would be £1.5m adrift, which meant that it would lose S&T funding and this would add a further £2m to the deficit.

During the next two months WSFT would be looking at what it could do in order to achieve the control total for this year, ie a discussion with commissioners and if west Suffolk CCG could use flexibility to support the Trust's financial position. The block contract meant that this would be help, rather than through contractual enforcement.

Flow was being looked at within the hospital. The intention was that as this improved the use of escalation capacity could be reduced, which would result in a reduction in costs. Costs associated with elective work were also being looked at and it was planned to reinstate F4.

The cash position continued to be managed very carefully and at the end of January there was just under £5m in the bank, which was better than forecast but mainly due to delaying payments. The cash position was related to I&E performance, therefore it would continue to come under pressure.

Steve Turpie asked if the CCG was likely to hit its control total and if WSFT was part of this. Craig Black explained that this was not the case and that organisations had individual control totals. Recent guidance on control totals and S&T funding for next year was broadly the same as this year, but the difference was that A&E performance for quarter four would be included. Also, where an organisation hit its control as a result of commissioners missing their control total this would not be included as part of assessment for S&T funding.

Gary Norgate referred to staffing levels and productivity (page 8) and asked if this meant that the Trust had missed its productivity target and that the organisation was becoming less productive. Craig Black explained that over the last three months the Trust had seen an activity level that significantly exceeded the 2.5% growth assumption. Gary Norgate asked if activity had grown by 2.5%, 5%, 7% or 9%. Craig Black explained that up two or three months ago it was approximately 2.5% but over the last few months there had been a considerable stepped increase.

Steve Turpie suggested overlaying the actual volume increase by month on this graph. Craig Black explained that the difficulty was that the Trust delivered different types of activity. It was very difficult to say what the activity was each month, as this was highly subjective, whereas long term 2.5% was considered to be a reasonable estimate of the increase in activity each year.

It was considered that this was a very complex issue which needed to be followed up outside the meeting. The Chief Executive reminded the board that that this piece of work had been undertaken as KPMG had just been into the Trust and done a deep dive on its productivity.

Gary Norgate agreed that this was complex but was not assured that this was fully understood. This was important with regard to CIPs being based on reducing the cost of staff.

It was proposed that Gary Norgate and Craig Black should consider how to include more detailed information on staffing and productivity in the finance report. **C Black**

Alan Rose asked what the position on CIPs was, considering that WSFT had paid KPMG to assist in achieving these. Craig Black confirmed that he was expecting that £14.4m would be achieved by the year end.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

18/039 CARE QUALITY COMMISSION INSPECTION REPORT

Rowan Procter explained that there were no 'must do' actions from the report but she would be ensuring that strategies were written for most services. The end of life strategy had been particularly commended and the same principle would be applied to maternity and paediatric services and this would also be developed for the emergency department.

Alan Rose noted that the Trust was rated good for outpatients, but there were still a lot of actions to be implemented. He suggested that at some stage in the future the board should receive a presentation or have a discussion about outpatients. This accounted for a large volume of the Trust's activity but there was little focus from the board. Helen Beck explained that there was an outpatient transformation group which was working on the actions required. It was proposed that report on this should be produced for a future board meeting. **H Beck**

Catherine Waller referred to the 'However' action plan and asked why the deadline was so far ahead (30 September), for obtaining an app that could assure governance concerns around photographic image storage, considering that an app was already available and had been tested. Rowan Procter explained that there needed to be a process and socialisation of this; the current clinical photographic service would need to be consulted, and this was why the deadline was not until September.

18/040 NURSE STAFFING REPORT

Rowan Procter referred to the dashboard and explained that the vacancy figures were different to those shown in agenda item 13, staffing forecast position and recruitment plan, as this showed interim vacancies rather than substantive vacancies.

There had been an increase in pressure ulcers, medication errors and falls resulting in harm and these could be closely correlated with areas with high vacancies. She explained that vacancies did not include escalation areas, which put additional pressure on staff.

Angus Eaton asked if there was any correlation with staff who had not had the flu jab and sickness. Rowan Procter confirm that this was not the case and that this was being monitored along with stress related sickness.

18/041 STAFFING FORECAST POSTION AND RECRUITMENT PLAN

Gary Norgate considered this to be a very good plan, but requested a copy of annex 2 which was not attached. **J Bloomfield**

The board was particularly impressed with the letter to Jo Churchill MP. Jan Bloomfield confirmed that this had been passed to the Minister of Employment and Minister of Health.

Richard Davies said that the nursing apprenticeship pathway looked excellent and asked if this had already begun. Jan Bloomfield explained that this would commence formally in September. It was also intended that this should be available in the community, however she explained that apprenticeships had to be meet apprenticeship standards.

Catherine Waller asked how systems could work together to maximise the apprenticeship levy and opportunities with partners. Jan Bloomfield explained that this levy was organisationally based, but organisations across the system were working collectively to ensure that apprenticeships would available.

18/042 QUALITY LEARNING AND IMPROVEMENT

a) Learning and improvement summary report – Q3

This was considered to be an excellent and very useful report.

Nick Jenkins referred to the lessons learned from the incident relating to a complication during an operation. He explained that the surgeon would be presenting the learning from this to the whole of the consultant body next week, which was a very new way of working. Alan Rose said that culturally this was a huge statement and asked if any publicity was planned around this. It was confirmed that this was being shared.

Nick Jenkins referred to the mortality review case and explained that as a result of this he, Helen Beck and Rowan Procter were now looking at developing a flag to indicate when a patient should not be moved.

Angus Eaton asked if some of the recommended infrastructural changes were being made, ie installation of a hand basin in an area. Rowan Procter confirmed that this was the case and these actions were followed up as quickly as possible by the estates team.

b) Learning from death report – Q3

The board received and noted the content of this report.

Nick Jenkins reported that the medical reviewers were now in post.

18/043 CONSULTANT APPOINTMENT REPORT

The board noted the appointment of Dr Helen Boys, consultant in anaesthetics.

18/044 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that the award for this month had been received by members of the housekeeping team; Bogdan Manafu, team cleaner supervisor, Joao Goncalves, Natalia Przbylska, Lorna Parker, Tiago Sousa and Aida Mazeikiene. Due to a serious road accident, they were called to the emergency department to clean the resus area after a massive blood loss incident.

Whilst this was a very unpleasant task the team all acted in an efficient and extremely professional manner and were a credit to the housekeeping team.

Nick Jenkins explained that in some organisations housekeeping teams would not do this and it would be the responsibility of the nursing team, which was not a productive use of their time.

The board acknowledged this and recorded their thanks to the team for their professionalism and commitment to the organisation.

BUILD A JOINED UP FUTURE

18/045 e-CARE REPORT

It was reported that the Trust had received more funding for cyber security.

Gary Norgate said that as the organisation was seeing the benefits of e-Care it should be delivering outcomes. Craig Black explained that the optimisation programme was designed to ensure the delivery of benefits. The Chief Executive agreed and said that the benefits needed to be highlighted in order to continue to engage staff.

Alan Rose considered that it had been very helpful for Dermot O'Riordan to have given a demonstration of the patient portal to the Council of Governors meeting on 21 February.

18/046 ALLIANCE AND COMMUNITY SERVICES UPDATE

Dawn Godbold explained that this was an update on work that was being undertaken around clinical pathways and the joint planning session on IT. Information on staffing and workforce planning would also be included in this report and other reports to the board where possible.

She referred to item 3, services for children and young people, where it was acknowledged by the alliance and system that this had not been progressing as it should and there were now clear milestones and timelines for actions on this.

Item 4 gave details of the development of group work which was now taking place.

The Chair said that she was pleased to see more detail on the plan around children's service. It was important that this was carefully monitored as there were a number of services within this and this was a vulnerable group. The board needed to keep a close eye on this.

It was proposed that it would be useful for the board to have a discussion on the alliance and how it was developing, as it was an important part of the way the STP was developing.

Steve Turpie asked about technology in the community and if any progress was being made. Craig Black explained that part of the capital plan for next year included improvements in the community, particularly WiFi in a number of locations.

Dawn Godbold reported that a session had taken place with Mike Bone and community leaders who had each identified their top five priorities and these were being followed up and progressed.

GOVERNANCE

18/047 TRUST EXECUTIVE GROUP REPORT

The board received and noted the content of this report.

18/048 QUALITY & RISK COMMITTEE REPORT

The board received this report and approved the change to incorporate the quality report into the risk escalation framework as part of the Trust's risk management strategy.

18/049 CHARITABLE FUNDS COMMITTEE REPORT

The board received and noted the content of this report.

It was noted that Gary Norgate was now the chair of this group.

18/050 USE OF THE TRUST SEAL

The board noted the use of the Trust seal.

18/051 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted.

The Chair said that as a result of discussions at today's meeting there needed to be a focus on children's services. A discussion on the Trust's productivity also needed to take place but this did not necessarily need to be an agenda item. The Chief Executive said that the focus should be around having a proper CIP in place for next year.

Alan Rose asked when the board would have a discussion about capital priorities. It was confirmed that this would take place at the next meeting.

Steve Turpie suggested that there needed to be a more detailed board discussion on the Board Assurance Framework (BAF), as this was an important document and drove the internal audit plan. Richard Jones proposed using the operational plan to reflect on whether the right issues were in the BAF.

ITEMS FOR INFORMATION

18/052 ANY OTHER BUSINESS

There was no further business.

18/053 DATE OF NEXT MEETING

The next meeting would take place on Thursday 29 March 2018 at 9.15am in the Northgate Room.

RESOLUTION TO MOVE TO CLOSED SESSION

18/054 RESOLUTION

The Trust board agreed to adopt the following resolution:-

"That members of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960.

NHS West Suffolk NHS Foundation Trust

Board of Directors – 29 March 2018

Agenda item:	Item 6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 March 2018			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

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

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

Actions are RAG rating as follows:

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

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**			**Invest in quality, staff and clinical leadership**		**Build a joined-up future**	
	X			X		X	
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	The Board received a monthly report of new, ongoing and closed actions.						
Risk and assurance:	Failure effectively implement action agreed by the Board						
Legislation, regulatory, equality, diversity and dignity implications	None						

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1475	Open	29/9/17	Item 13	Develop a set of metrics which will provide an indication of the success of the leadership programme	Denise Pora, Deputy Director of Workforce (Organisation Development) Progress made on developing our approach to evaluating the impact of our investment in leadership development: • developing an approach based on measuring impact through process and outcome indicators. - process indicators i.e. agreed programmes in place - outcome indicators e.g. internal: impact of leadership development programmes on participants' performance, internal v external appointment to leadership positions, external: staff survey (baselines to be established from 2017 report published this week), CQC well-led inspection • Next step is to bring proposal to the board. This will include agreeing target range for some indicators e.g. desired % internal v external appointments to leadership positions and agreeing investment to be measured*.	JB	27/04/2018 (revised)	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1519	Open	1/12/17	Item 15	Use the e-Care report (section 7) to structure communication of the e-Care deliverables internally and with stakeholders.	**AGENDA ITEM**	JB/HB	29/03/2018	Green
1529	Open	26/1/18	Item 7	2018-19 winter planning update to be received by the Board in April (including learning from 2017-18)	Being developed as part of system based learning exercise. **Agreed at meeting on 2/3/18 to consider 'big data' and consider e-Care population health as part of this work.**	HB	27/04/2018	Green
1536	Open	26/1/18	Item 15	Agreed that future mandatory training report to include exception reporting for key areas with performance concerns e.g. safeguarding with an explanation of underlying performance concerns	To be included in next scheduled quarterly report	JB	27/04/2018	Green
1537	Open	26/1/18	Item 18	e-Care - schedule report on the findings of the patient portal pilot		CB	27/04/2018	Green
1545	Open	2/3/18	Item 8	Agreed that based on the reported position at the meeting on 29/3 a recover trajectory for discharge summaries will be reported to the Board in April.		NJ	27/04/2018	Green
1547	Open	2/3/18	Item 10	Agreed that Gary Norgate and Craig Black consider how to provide greater visibility of staffing and productivity within the finance report		CB	27/04/2018	Green
1548	Open	2/3/18	Item 11	Agreed to provide the Board with a report detailing the outpatient service transformation project		HB	27/04/2018	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1508	Open	1/12/17	Item 6	Schedule report on private physiotherapy to the January Board meeting	Details included in January '18 finance report and service review report scheduled for Scrutiny Committee in February**. Report considered by Scrutiny Committee on 14/3/18. Recognised the original objective was to retain physiotherapy skills following the loss of the community physio activity. The report reviewed the current financial performance agreed options for improvement along with opportunities to regain the community activity through an Alliance model.**	HB	29/3/18 (revised)	Complete
1522	Open	1/12/17	Item 21	Implement NED responsibility changes as a result of SID appointment	Scheduled to report to Board meeting on 29/3/18 **AGENDA**	RJ	29/03/2018 (revised)	Complete
1533	Open	26/1/18	Item 9	Provide analysis of additional sessions to delivery RTT recover in the context of Trust's financial position	F4 remains closed for elective joint replace. Opening this facility w/c 26/2 will allow plan to be agreed. **AGENDA ITEM - anomalies in activity and reporting for Jan/Feb mean that this report will be delayed.**	CB / HB	26/3/18 (revised)	Complete
1535	Open	26/1/18	Item 14	Identify a NED to engage in the health and wellbeing programme	Will be considered as part of the NED responsibility review (action point 1522) **AGENDA ITEM**	SC / RJ	29/03/2018	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1538	Open	26/1/18	Item 18	e-Care - include detail of activities 'outside' the programme in next report. Also agreed at meeting on 2/3 to include outcomes e.g. interoperability	**AGENDA ITEM**	CB	29/03/2018	Complete
1544	Open	2/3/18	Item 8	Agreed to amend the pressure ulcer RAG rating so that five avoidable PUs is the target	Updated IQPR. Also need to ensure that explanation/action considers any trends for avoidable PUs **Updated IQPR**	RP	29/03/2018	Complete
1546	Open	2/3/18	Item 8	Update to be received on children in care performance, including how the Alliance can support this activity. Agreed that SD to write to County Council expressing concerns with performance in this area.	**Agreed at closed session that this action be incorporated into the existing action regarding SLT (ref 1499)**	DG	27/04/2018	Complete
1549	Open	2/3/18	Item 13	Provide additional staffing forecast information from report	Jan has shared available information with Gary Norgate by email.	JB	29/03/2018	Complete

Board of Directors – 29 March 2018

Agenda item:	Item 7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	22 March 2018			
Subject:	Chief Executive's Report			
Purpose:	X	For information		For approval

Executive summary:

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

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	X	X

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X

Previously considered by:	Monthly report to Board summarising local and national performance and developments
Risk and assurance:	Failure to effectively promote the Trust's position or reflect the national context.
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

To receive the report for information

Chief Executive's Report

With icy roads, freezing winds and seemingly endless snow, we had a very challenging week as we braved the polar storm nicknamed '**Beast from the East'**. Thanks to the efforts of staff based in the hospital and community alike however, we were largely able to operate as 'business as usual' despite staffing being difficult at points. We supported wherever we could, providing 4x4 transport for specialist clinical staff to help them get to work. But our staff collectively showed the very best of the NHS – coming together to lift-share where they could, and helping one another get to work safely to ensure our patients still got the care they needed. Our community staff had a particularly challenging week, many coming in on their days off and often having to try and reach patients in very rural and remote areas to keep them safe at home, so a special thank you to them for their efforts.

Once again our staff have gone **above and beyond** what is normally expected during times which continue to be incredible tough, with the pressure feeling at times relentless. But we cannot be complacent about the commitment of our incredible staff and the care and dedication they show to our patients. Recognising this pressure we continue to drive delivery of our **nurse recruitment plan**; based on recruitment estimates 64 registered nurses are planned to start by September and an additional 54 registered nurses by February 2019. We also try to get the little things right - we made sure that staff could have a free hot drink when the weather was bad. This week we have also provided all staff with water bottles to help them keep hydrated.

We have also begun our transition to new **vital signs monitors**, which are able to upload data directly into e-Care without needing to access a computer. They integrate with our Cerner technology, and allow automatic documentation in the patient record. In the first phase, these are replacing all mobile observation machines, and those wall-mounted in side-rooms. Most wards have now gone live with this new technology, including MTU and X-ray, with our emergency department and F1 ward (Rainbow) set to go live soon after Easter. The focus will then move to making the same devices available in outpatient areas as well. This is an exciting step that continues our GDE journey, the feedback we have received has been really positive including helping to release nursing '**time to care**'.

The 'Support all our staff' ambition in our strategic framework is about making the Trust a great place to work and I am truly proud that we have come **top of the national tables for staff recommending us as a place to work or receive care** in the latest NHS Staff Survey (2017). We scored the highest rating in the country (4.12) against other comparable acute hospital trusts in England (average score 3.76) for staff being likely to recommend it to others. Asked questions about the organisation, the care it provides, and the support they receive from managers, 93% of our staff agreed that their role made a difference to patients (national average 90%), 87% said that patient care was the Trust's top priority (national average 76%), and 71% said they felt they could contribute to improvements at work (national average 70%). We also scored in the top 20% of comparable acutes nationally for good communication between staff and senior managers, staff feeling valued by the organisation, and the Trust taking an active interest in the health and wellbeing of its people. We have also made a significant improvement on the number of staff experiencing harassment, bullying or abuse from colleagues, with 20% reporting issues compared to 25% last year (national average 2017, 25%).

We know that staff that feel engaged, happy and supported at work provide the best care, so we must also look very carefully at our staff survey as an indicator of the quality of care we give to our patients. We take the views of our staff very seriously – they are truly our most important asset and it's vital we know what they think and feel about working here. But we're not complacent. There is always more we need to do, with appraisals in particular, and we must now use these results to work with staff and understand where and how we can improve even further.

I welcome this week's proposal of a **three year pay deal** for our hard working staff (the framework does not affect medical or dental staff). We are currently working through the impact of the framework agreement changes which include:

- Starting salaries increased across all pay bands
- New pay structure with fewer pay points – overlapping pay points removed initially followed by further pay points
- New system of pay progression
- Top of pay bands to be increased by 6.5 per cent over the three years (apart from band 8d and 9 which will be capped at the increase of band 8c)
- Minimum rate of pay in the NHS to be set at £17,460 from 1 April 2018 – this will be ahead of the Living Wage Foundation Living Wage rates.

The final position will not be known until July 2018.

February's performance shows we reported no C. difficile cases in the month. We continue to focus on reducing patient falls and pressure ulcers, with 82 falls and 16 pressure ulcers reported. Referral to treatment (RTT) performance for patients on an incomplete pathway fell slightly to 89.5% against the target of 92%. Unfortunately we have reported 13 patients breaching 52 weeks. The year to date performance for all cancer targets is ahead of the national threshold however the Trust failed to deliver two of the 62 day Cancer targets in February. ED 4 hour wait performance was 85% for February, with some exceptionally challenging days. We experienced an 11.6% increase in attendances (589 patients) at ED in February 2018 compared to February 2017 and a 7% increase in ambulance attendances for the same period.

The **month 11 financial position** reports a deficit of £577k for February which is better than plan by £154k.The reported cumulative position is therefore £1,144k worse than plan. However, this takes into account reduced STF funding as a result of failure to meet our A&E target. Without this adjustment the Trust is behind plan by £408k, measured against our control total. We are forecasting to meet our control total at year end which will ensure we do receive the STF relating to financial performance.

There has been an increase in our costs relating to escalation capacity during the winter and this expenditure is continuing but without any further funding. The 2017-18 budgets include a cost improvement plan (CIP) of £14.4m of which £12.2m has been achieved by the end of February (84.5%).

It was humbling to have been featured in the Health Service Journal's annual assessment of the **top 50 NHS trust chief executives** for the first time. I'm obviously very proud to have made this list but I'm clear I am part of a bigger team that makes up WSFT. It's a great pleasure leading this Trust; I am surrounded by fantastic staff and leaders at all levels who are a real asset to the organisation and our local community. While the HSJ editor indicated that we are the best small hospital in the country, I would argue that we are the most integrated and best health and care system. I am genuinely proud of the care we provide and the difference we make to people's lives every day. But, we must not forget that there's always more we can do to improve further, and I'm excited to see what the next year brings us.

Chief Executive blog
http://www.wsh.nhs.uk/News-room/news-posts/Community-generosity.aspx

Deliver for today

Celebrating #HelloMyNameIs…

Last week (20 March) we were honoured to welcome a very special visitor to West Suffolk Hospital. Chris Pointon, husband of the late Dr Kate Granger MBE, joined us to celebrate our first #HelloMyNameIs… day. Together with Kate, Chris was co-founder of the worldwide 'Hello my name is' campaign, which encourages and reminds healthcare staff of the importance of introductions. We ran awareness stands, encouraged staff to take part via social media, and heard Chris speak as part of our monthly Five o'clock club, which was emotional and inspirational in equal measure. We have always been huge advocates of the campaign here at WSFT – in fact it's one of the first things we talk about at induction for new staff – and it was great to be able to embed that even further.

#WeAreWSFT in practice at litter pick

We know that many small things can add up to a big difference. Earlier this month a group of staff, plus local Jo Churchill MP, volunteered to take part in a litter pick around the grounds of West Suffolk Hospital in their lunch hours. We were lucky enough to get a sunny day, and feedback was that it was a really enjoyable and almost therapeutic way to spend an hour! Small acts like this show how lucky we are to have staff that truly take pride not only in what they do, but where they work. Our fantastic culture is very much made up of many small, marginal gains.

Nutrition and Hydration Week

The week aimed to reinforce consideration of nutrition and hydration as crucial elements in providing high quality care in a health and social care setting. As a department the dietetic team is encouraging increased focus on nutrition and hydration over the course of week, both in the hospital and the community. As part of Nutrition and Hydration Week we will be relaunching protected mealtimes for all hospital wards. Nutrition is a vital aspect for recovery and it is important to ensure all patients are able to have their meals without non-emergency interruption. The week was supported by a wide range of activities across the hospital and community

Invest in quality, staff and clinical leadership

Showcasing our allied health professionals

Last month (27 February) a special showcase was held in the education centre, where a wide range of conference posters, created by our allied health professional (AHP) teams, were displayed. The event was a great success, raising awareness of the different roles of AHPs and provoking many interesting discussions with visiting staff. It was fantastic to celebrate the dynamic and positive influence that AHPs are having on the organisation as a whole, and it was great that community teams were part of it too. A huge thank you and credit to Laura Wilkes and Helen Else, who work in our library and knowledge services, who were very much the driving force behind creating this special and learning-centred event.

HelpForce launch event

We held a launch event at Bury Town Football Club, to promote being a pilot site with the national initiative HelpForce. The morning was attended by a wide range of public and voluntary organisations representing the local community, and was a valuable opportunity for everyone to share ideas about developing volunteering opportunities within the community. Michelle Boor, community volunteers coordinator at our Trust, said: "The morning was very positive, and there was lots of interesting discussions. We now look forward to working with a smaller working group to develop new volunteering roles. The aim is create a more integrated approach to volunteering in line with the Trust vision." Today two new volunteers started at our Trust delivering a befriending role in the discharge waiting area. The role involves engaging in conversations with patients and building patients' confidence before they leave hospital.

Ward companion volunteers
Our ward companion volunteer service was launched to offer company, compassionate listening and comfort to patients who are near the end of their lives and has been up and running for almost six months. Volunteers are available to spend time with patients identified by nursing staff, to help improve the patients' and their relatives' experience and to support nursing staff in the provision of compassionate care. The service has been very well received by staff, patients and their friends and families, and is currently available from Monday to Friday, 8.00am - 8.00pm. However, we will be looking to expand the role, both in volunteer numbers and also the coverage that can be offered.

Build a joined-up future

New partnership to treat chronic condition
It's been good to see joined-up working coming to fruition this month, as patients living with a little known long-term condition that causes painful swelling and restricted mobility have been benefitting from a new service. The West Suffolk Alliance Lymphoedema Service, which is run by ourselves and Suffolk GP Federation, is helping patients to manage their condition and lead independent lives. It's been running since October last year, but was officially launched a few weeks ago to coincide with a Lymphoedema Awareness Day run by Lymphoedema Support Suffolk.

The new service is based at Drover's House in Bury St Edmunds. It is led by a lymphoedema nurse consultant who is supported by two lymphoedema practitioners and one healthcare practitioner. Treatments are planned and agreed with the patient and include lymphatic drainage, multi-layered bandaging and compression and advice on exercise, positioning and skin care. One patient, who has been living with lymphoedema since she was 15, said of the service: "Just knowing the service is there has been a great relief. The support and advice that they're able to provide is a huge help." Another added: "This service is so invaluable to the community. The whole team have been incredibly supportive in helping me to manage and understand my condition." Testament indeed to what we can achieve when we work together, and truly put patients at the heart of what we do.

Help avoid a double dip in blood donations this Easter
NHS Blood and Transplant (NHSBT) is urging current blood donors to help prevent a double dip in blood donations by making and keeping their appointments to give blood in the run up to Easter. Due to recent freezing weather and snow, many people have not been able to donate. The bad weather has also led to some sessions being cancelled and NHSBT lost 6-7,000 units of blood - the equivalent of a whole days' worth of stock. On top of that, blood stocks are more likely to drop around public holidays like Easter when people go on holiday or enjoy days out with the family. Current blood stocks are vulnerable and NHSBT need donors to help make sure they have enough to supply what is needed to hospitals.

Working with the NHSBY we have encouraged staff to make and keep their appointments by calling the Donor Line on **0300 123 23 23** or visit www.blood.co.uk.

National news

Deliver for today

Public satisfaction with the NHS and social care in 2017
Key findings of the British Social Attitudes (BSA) survey show overall public satisfaction with the NHS overall was 57% in 2017 – a 6 percentage point drop from the previous year. At the same time, dissatisfaction with the NHS overall increased by 7 percentage points to 29% – its highest level since 2007. The four main reasons people gave for being satisfied with the NHS overall were: the quality of care, the fact that the NHS is free at the point of use, the attitudes and behaviour of NHS staff, and the range of services and treatments available.

England's top A&E doctor says we must seize 'once in a generation' opportunity to remake NHS and local government partnership
England's top urgent care doctor today calls on health and local government leaders to seize "the greatest opportunity in 70 years" to remake the NHS and local authority partnership and improve the health of their communities. **Professor Keith Willett** said the two sectors had historically struggled to overcome their financial, cultural and operational differences preventing them from adapting to public need. But changing health and care needs, the imperative of financial pressures, and the advent of integrated care systems means the conditions are right for a major shift in attitude. NHS England

NHS England's Chief Executive praises NHS snow heroes
Simon Stevens has praised heroic NHS staff for defying arctic conditions that brought Britain to a standstill to ensure patient care has continued uninterrupted. NHS England's Chief Executive said: "In these adverse circumstances NHS staff have taken extraordinary measures to get into work and look after patients. Once again the NHS is showing that we are there for people when they need us and that's all down to our staff, so a huge thank you to everybody across the NHS who is going the extra mile for people at this highly pressurised time."

Invest in quality, staff and clinical leadership

Recovering after a hip fracture: helping people understand physiotherapy in the NHS
Hip fracture is a serious, life-changing injury that can affect older people, and is the commonest reason for them to need emergency anaesthesia and surgery. The Physiotherapy Hip Fracture Sprint Audit (PHFSA) is the biggest ever audit of UK physiotherapy, and has implications for physiotherapists working in many settings.

Five ways to improve junior doctor morale
Dissatisfaction among junior doctors has reached unprecedented levels: 80 per cent feel excessively stressed, and the number progressing directly to specialty training is declining. Some of the solutions to this can only be implemented at a national level, for example, increasing the number of medical school places. However, these changes take time to create an impact. Locally implemented 'quick wins' could help to improve the morale of today's workforce, thereby improving retention, productivity and patient safety. King's fund blog.

NHS England announces plans to recruit and deploy pharmacists in care homes
NHS England has announced plans to recruit and deploy hundreds of pharmacists into care homes to help reduce overmedication and cut unnecessary hospital stays. Around 180,000 people living in nursing or residential homes will have their prescriptions and medicines reviewed by the new pharmacists and pharmacy technicians. NHS trials show pharmacists reviewing medicines improved patients' quality of life by reducing unnecessary use and bringing down emergency admissions, with less time spent in hospitals. This approach also led to meaningful savings in unnecessary prescribing costs of £249 per patient in one pilot over a year.

Build a joined-up future

Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHs in England
NHS England has recently changed the name of accountable care systems to integrated care systems, which describes more accurately the work being done in the 10 areas of England operating in this way. This updated long read looks at work under way in these systems and at NHS England's proposals for an accountable care organisation contract. King's Fund.

Flagship NHS Type 2 Diabetes Prevention Programme exceeds expectations
More than half of overweight patients who routinely attended sessions on the NHS Type 2 diabetes prevention programme achieved an average weight loss equivalent to nearly 15 double cheese

burgers, new data has revealed. So far well over 50% of people have completed the flagship scheme after attending at least eight support sessions over a nine month period – losing an average of 3.3 kgs. However, when excluding those who already had normal weight and BMI but on the programme due to other health and lifestyle risks associated with developing Type 2 diabetes, this increased to 3.7kg. The diabetes prevention programme was first announced at the 2015 Diabetes UK conference, and it is now on the verge of achieving complete national coverage. In the last 21 months of roll-out, more than 154,000 people have been referred, with around 66,000 people taking up places.

The impact of Brexit: patient access to medical research

Patients will suffer unless there is a new partnership on science and research between the EU and the UK after Brexit. The Brexit Health Alliance believes that patients across the European Union, including the UK, currently benefit enormously from the current close collaboration between medical researchers who investigate, develop and test new treatments on an EU-wide basis. This briefing sets out how patients across Europe have benefited from pan-European collaboration on medical research. It outlines what is at stake if this collaboration is set back and how UK and EU decision-makers can mitigate the risks.

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Board of Directors – March (29th March) 2018

AGENDA ITEM:	8
PRESENTED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer Joanna Rayner, Head of Performance
DATE PREPARED:	March 2018
SUBJECT:	Trust Integrated Quality & Performance Report
PURPOSE:	To update the Board on current quality issues and current performance against targets

EXECUTIVE SUMMARY:

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

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

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

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Integrated quality and performance report



Month Eleven: February 2018

Putting you first

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CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

1 EXECUTIVE SUMMARY

The challenges from January continued in February 2018 with high demand through A&E (Feb 2018 compared to Feb 2017 saw a rise in attendances by 589 which equates to 12% and 120 additional ambulance attendances which is 7% increase on the same period last year). The cancellations associated with the winter pressures has resulted in a slight deterioration in the RTT 18 week waiting times and there is a risk of further 52 week waits breaches. Specific areas of concern remain in urology and T&O but ophthalmology is also an area that is causing concern and is receiving additional focus.

ARE WE SAFE?

HCAIs - The Trust recorded an MRSA bacteraemia case in February 2018. There were no cases of hospital-attributable Clostridium difficile case for February 2018; The Trust compliance with decolonization declined in February 2018 to 86%.

NHS Patient Safety Alerts (PSAs) – A total of 7 PSAs have been received in 2017/8, with none in February. All the alerts have been implemented within timescale to date.

Patient Falls - 82 patient falls occurred in February, bringing the YTD total to 688; of these falls, 26(209 YTD), resulted in harm. (Recovery Action Plan (RAP) included in main report).

Pressure Ulcers- The number of ward-acquired pressure ulcers continues to be above the local Trust plan of 5 per month. In February, 16 cases occurred, with YTD total of 171. *(RAP included in main report).*

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons - The rate of cancelled operations for non-clinical reasons was recorded at 1.22% in February. The YTD performance to February 2018 is above target at 1.09%. *(RAP included in the main report).*

Discharge Summaries- Performance to date is below the 95% target to issue discharge summaries (inpatients and ED). A&E has achieved a rate of 83.4% in February whereas Inpatient services have achieved a rate of 70.31%. *(RAP included in the main report).*

ARE WE CARING?

Complaints - The number of complaints has fallen compared to last year, with a total of 137 for the YTD to February. The Trust is in the best 10% of acute trusts for the written complaints received.

Mixed Sex Accommodation breaches (MSA) – No MSA breach occurred in February, against a national average of over 4 per month.

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

ARE WE RESPONSIVE?

A&E 4 hour wait - The quarterly A&E performance was 95%, 91%, & 87% from Qtr .1 to Qtr. 3 respectively. Recently WSH experienced some exceptionally challenging days and the performance was impacted with 85% reported for February. *(RAP included in main report).*

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

Cancer – Cancer performance (provisional figures) remains the same in February, with two targets that were missed. The Trust failed to deliver both 62-day wait targets for February. The YTD performance for all cancer targets is ahead of the national threshold. *(RAP included in the main report)*

Referral to Treatment (RTT) - The percentage of patients on an incomplete pathway within 18 weeks is below national target of 92%, however performance has been maintained despite winter pressures and cancellations with performance in February of 89.5%. Data quality issues and validation of the list continue. The total waiting list remains at 15,804 in February. In February, 13 patients breached 52-week standard, with YTD total of 223. *(RAP included in the main report).*

ARE WE WELL LED?

Staff FFT – The survey for the period to February 2018 was positive with 83% of staff recommending the Trust as a place to work and 95% of staff recommending the Trust for a place to receive treatment or care. This compared with the national averages of 64% and 81% respectively and placed WSH top in the region.

Staff Turnover – Turnover rates continue to improve with a rate of 8.65% for February, below the Trust's aim to maintain turnover rates below 10%.

Sickness Absence – Sickness absence rates are equivalent to the local 3.5% ceiling at 3.70% for February. The Trust average is lower than the peer group average of 3.74% and the national average of 3.86%. *(RAP included in the main report).*

ARE WE PRODUCTIVE?

Financial Position – The Month 11 YTD position is £1,144k behind plan, including shortfall on STF relating to A&E performance. Against our control total the Trust is £408k behind plan.

Cost Improvement Programme (CIP) - The February position includes a target of £12,636k YTD which represents 88% of the 2017-18 plan. There is currently a shortfall of £468k YTD against this plan.

Income & Expenditure Summary – The reported I&E for February 2018 YTD is a deficit of £6,384k, against a planned deficit of £5,240k. This results in an adverse variance of £1,144k YTD. This includes recognition of failing the A&E performance target for Q3 and Q4. Therefore against our control total (pre-STF) the Trust is £408k behind plan YTD.

2. INTEGRATED QUALITY & PERFORMANCE REPORT DASHBOARD

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

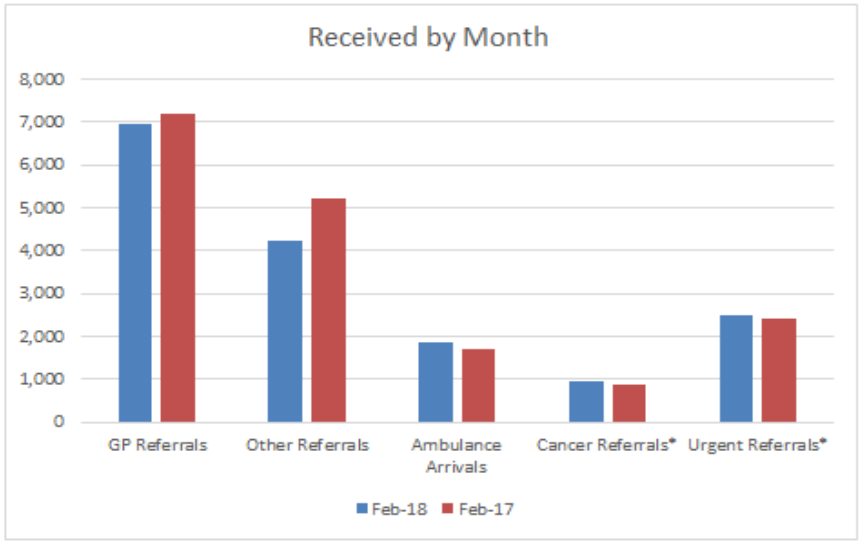
WEST SUFFOLK HOSPITAL INTEGRATED QUALITY & PERFORMANCE REPORT							TRUST TOTAL														
Are we..	Ref.	KPI	ED	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	AwYTD	WTG	Traffic	Sparkline
1. Safe	1.01	NHS E / I Improvement Patient Safety Alerts Total	RP	3	1	0	1	0	0	1	2	1	0	1	0	1	0	7			
	1.02	NHS E / I Improvement Patient Safety Alerts OS	RP	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6		
	1.03	Emergency C-Section Rate	RP	<12%	9%	12%	10%	12%	12%	9%	13%	12%	11%	10%	11%	14%	10%	11%	6		
	1.04	All relevant inpatients undergoing VTE Risk assessm	RP	95%	87%	86%	87%	89%	89%	86%	90%	88%	95%	97%	95%	97%	98%	92%	4		
	1.05	Clostridium difficile infections (CDI)	RP	16	0	1	3	0	0	1	0	2	6	4	0	1	0	17	6		
	1.06	MRSA	RP	0	0	0	0	0	0	0	0	2	0	0	0	0	1	3	6		
	1.07	Patient Safety Incidents Reported	RP	NT	459	463	392	508	418	506	466	467	520	588	479	634	544	5522			
	1.08	Never Events	NJ	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	6		
2. Ef	2.01	Overall HSMR - DFI	NJ	<90	ND	ND	88%	88%	88%	88%	85%	87%	ND	ND	ND	ND		87%	6		
	2.04	Canc. Ops - Cancellations for non-clinical reasons	NJ	<1%	0%	1%	1%	1%	1%	1%	1%	1%	1%	2%	1%	1%	1%	1%	4		
3. Caring	3.01	Compliments (Logged by Patient Experience)	JB		41	28	41	52	26	56	28	17	33	87	151	64	20	575			
	3.02	Complaints (Inpatient)	JB	19.50	12	11	10	10	10	6	16	16	17	13	8	12	19	137	6		
	3.03	Mixed Sex Accommodation Breaches	RP	0.00	2	0	0	0	0	0	0	0	0	0	1	0	0	1	6		
	3.04	IP - Extremely likely or Likely to recommend	RP	90%	98%	99%	98%	97%	99%	98%	98%	98%	99%	96%	98%	97%	98%	98%	6		
	3.05	OP - Extremely likely or Likely to recommend	RP	90%	97%	96%	95%	96%	97%	95%	95%	96%	96%	96%	99%	95%	96%	96%	6		
	3.06	A&E - Extremely likely or Likely to recommend	RP	90%	96%	96%	97%	96%	95%	95%	95%	92%	95%	94%	94%	96%	95%	95%	6		
	3.07	Maternity - How likely are you to recommend	RP	85%	100%	100%	100%	100%	100%	100%	ND	ND	99%	100%	97%	100%	92%	99%	6		
4. Responsive	4.01	A&E - Under 4 hr. wait	HB	95%	84%	93%	95%	95%	96%	92%	90%	89%	87%	90%	83%	84%	85%	90%	2		
	4.02	RTT: % incomplete pathways within 18 weeks	HB	92%	90%	90%	82%	80%	83%	84%	86%	86%	87%	89%	89%	90%	90%	86%	2		
	4.03	52-week waiters	HB	0%	7	8	15	14	15	35	26	29	26	21	15	14	13	223	2		
	4.04	Diagnostics within 6 weeks	HB	99%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.05	Cancer: 2w wait for urgent GP Referrals	HB	93%	98%	98%	94%	92%	97%	95%	96%	91%	83%	98%	97%	98%	98%	94%	6		
	4.06	Cancer 2w wait breast	HB	93%	96%	94%	94%	99%	89%	98%	100%	98%	100%	100%	99%	97%	93%	97%	6		
	4.07	Cancer 31 d First Treatment	HB	96%	100%	99%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	6		
	4.08	Cancer 31 d Drug Treatment	HB	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.09	Cancer 31 d Surgery	HB	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.10	Cancer 62 d GP referral	HB	85%	88%	83%	89%	83%	86%	85%	86%	87%	94%	90%	87%	86%	79%	87%	6		
	4.11	Cancer 62 d Screening	HB	90%	89%	97%	100%	100%	90%	100%	100%	91%	100%	83%	100%	93%	86%	95%	6		
5. Well Led	5.02	Staff F&F Test % Recommended - care (Qrtly)	JB	75%	NA	93%	NA	NA	95%	NA	NA	95%	NA	NA	ND	NA	NA	95%	6		
	5.03	Staff F&F Test % Rec'mend - place to work (Qrtly)	JB	75%	NA	79%	NA	NA	83%	NA	NA	82%	NA	NA	ND	NA	NA	83%	6		
	5.04	Turnover (Rolling 12 mths)	JB	<10%	11%	10%	10%	10%	10%	10%	10%	10%	9%	9%	9%	9%	9%	10%	6		
	5.05	Sickness Absence	JB	<3.5%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.57%	3.70%	3.59%	4		
	5.06	Executive Team Turnover (Trust Management)	JB	<10%	0%	0%	0%	20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	6		
	5.07	Agency Spend	CB	19248	354	258	307	316	289	336	244	220	187	475	183	ND	237	279	6		
	5.08	Monitor Assurance Governance Rating	JB	2	4	3	3	3	3	3	3	3	3	3	3	3	3	3			
6. Productive	6.01	I&E Margin	CB	Var	-5.10%	-1.50%	ND	-4.90%	-4.30%	-3.90%	0.13%	-3.04%	-2.55%	-2.47%	-2.60%	-2.34%	-2.56%	-2.85%			
	6.02	Distance from Financial Plan	CB	Variabl	ND	ND	ND	0.00%	0.40%	0.10%	0.00%	0.00%	0.03%	0.03%	ND	ND	ND	0.03%	6		
	6.03	Capital service capacity	CB	Var	- 2.81	1.41	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.01	0.00	0.00	- 0.00	0.01			
	6.04	Liquidity (days)	CB		- 21.76	- 7.28	ND	- 12.15	- 15.72	- 10.94	- 11.03	- 12.70	- 15.14	- 0.10	- 0.13	- 0.11	- 0.07	- 0.07			
	6.05	Long-Term Borrowing	CB		36.06	44.30	44.27	45.70	45.70	45.70	45.70	47.62	47.62	56.67	58.65	64.36	64.11	56.67	2		
	6.06	Variance to CIP plan	CB		-3247	0	40	0	-40	10	0	-54	-10	-35	-129	-201	-380	-72.6364			
7.Maternity	7.01	Total number of deliveries (births)	0	210	197	238	215	192	213	215	233	236	205	194	180	199	211	2293	6		
	7.02	% of all caesarean sections	0	<22.7%	13%	19%	15%	21%	16%	16%	22%	18%	17%	17%	18%	22%	17%	18%	6		
	7.03	Midwife to birth ratio	0	1.3	1.28	1.33	1.30	1.27	1.29	1.30	1.33	1.33	1.29	1.28	1.26	1.28	1.29	1.29	6		
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
	7.05	Completion of WHO checklist	0	100%	87%	89%	84%	93%	84%	94%	82%	98%	98%	98%	93%	93%	94%	92%	4		
	7.06	Maternity SIs	0	NT	1	1	1	0	0	0	0	1	1	0	1	2	ND	6			
	7.07	Maternity Never Events	0	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
	7.08	Breastfeeding Initiation Rates	0	0.8	80%	76%	80%	81%	88%	77%	85%	79%	81%	80%	80%	82%	76%	81%	6		

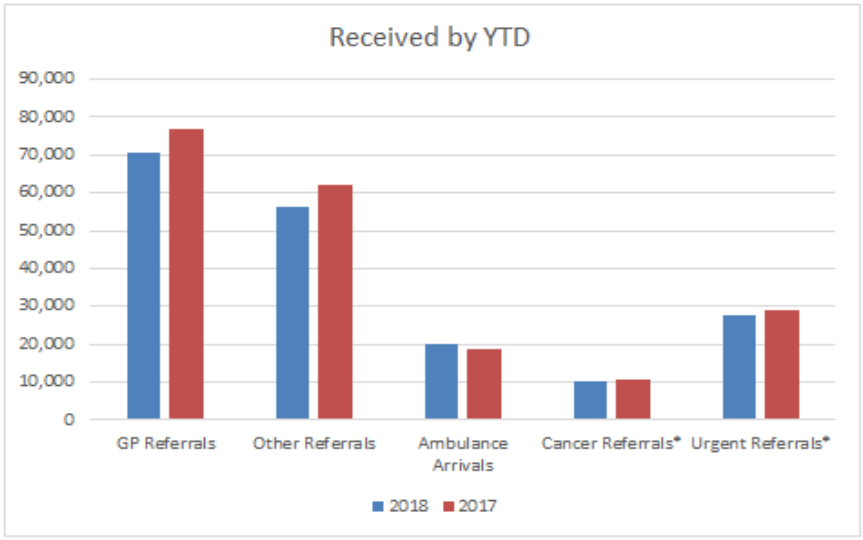
3. IN THIS MONTH – FEBRUARY 2018, MONTH 11

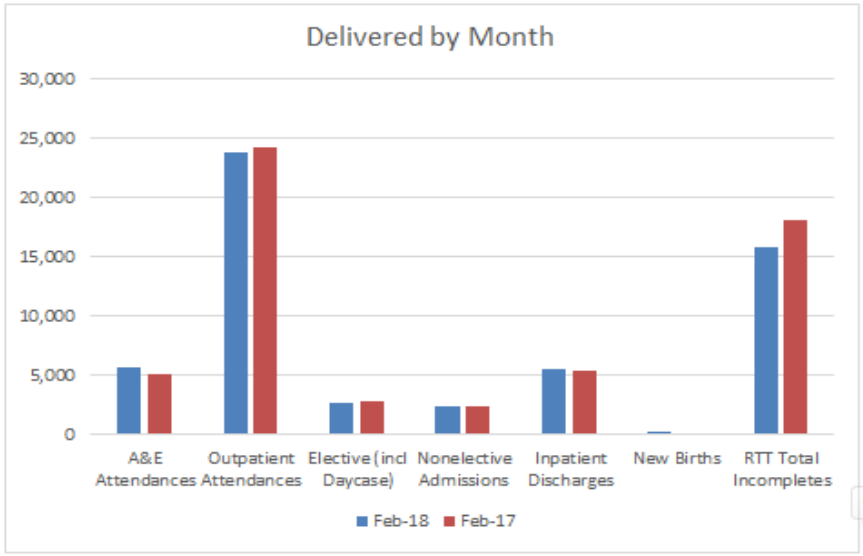
This table highlights incoming activity to the Trust, compared to the number of treatments and discharges from the Trust to provide a summary overview of overall capacity and demand. It provides a comparison to last year for the monthly and year-to-date activity.

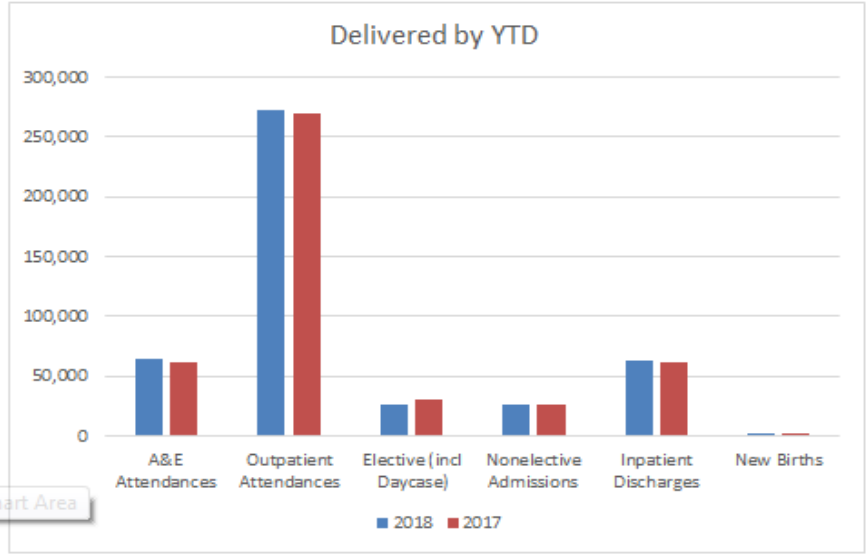
From Month Year	Feb-2018					To Month Year	Feb-2017				
WEST SUFFOLK HOSPITAL INTEGRATED QUALITY & PERFORMANCE REPORT - Summary of New Referrals & Completed treatment											
In this month…. February 2018											
Mth We Received……	**Feb-18**	**Feb-17**	**Variance**	**Var. %**	**Traffic**	**YTD We Received……**	**2018**	**2017**	**Variance**	**Var. %**	**Traffic**
GP Referrals	6,940	7,175	-235	-3%	↓	GP Referrals	70,633	76,842	-6,209	-8%	↓
Other Referrals	4,230	4,401	-171	-4%	↓	Other Referrals	56,208	61,390	-5,182	-8%	↓
Ambulance Arrivals	1,842	1,722	120	7%	↑	Ambulance Arrivals	19,930	18,911	1,019	5%	↑
Cancer Referrals*	954	864	90	10%	↑	Cancer Referrals*	10,347	10,677	-330	-3%	↓
Urgent Referrals*	2,505	2,423	82	3%	↑	Urgent Referrals*	27,575	29,158	-1,583	-5%	↓
Mth We Delivered……	**Feb-18**	**Feb-17**	**Variance**	**Var. %**	**Traffic**	**YTD We Delivered……**	**2018**	**2017**	**Variance**	**Var. %**	**Traffic**
A&E Attendances	5,639	5,050	589	12%	↑	A&E Attendances	64,850	61,336	3,514	6%	↑
A&E - To IP Admission Ratio	32.13%	33.6%	-1.48%	-1.48%	↓	Outpatient Attendances	272,083	269,642	2,441	1%	↑
Outpatient Attendances	23,852	24,207	-355	-1%	↓	Elective (incl Daycase)	27,087	30,112	-3,025	-10%	↓
Elective (incl Daycase)	2,634	2,819	-185	-7%	↓	Nonelective Admissions	27,087	27,137	-50	0%	↓
Nonelective Admissions	2,418	2,350	68	3%	↑	Inpatient Discharges	63,109	61,207	1,902	3%	↑
Inpatient Discharges	5,546	5,471	75	1%	↑	New Births	2,293	2,341	-48	-2%	↓
New Births	211	197	14	7%	↑						
RTT Total Incompletes	15,804	18,126	-2,322	-13%	↓						

* - Included in Referrals Above


Received by Month
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
GP Referrals
Other Referrals
Ambulance Arrivals
Cancer Referrals*
Urgent Referrals*
Feb-18
Feb-17


Received by YTD
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
GP Referrals
Other Referrals
Ambulance Arrivals
Cancer Referrals*
Urgent Referrals*
2018
2017

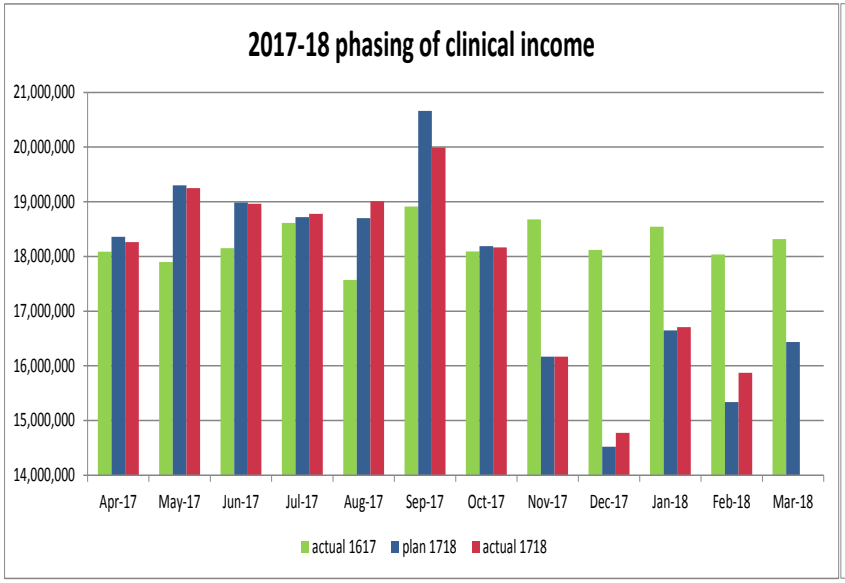

Delivered by Month
30,000
25,000
20,000
15,000
10,000
5,000
0
A&E Attendances
Outpatient Attendances
Elective (incl Daycase)
Nonelective Admissions
Inpatient Discharges
New Births
RTT Total Incompletes
Feb-18
Feb-17

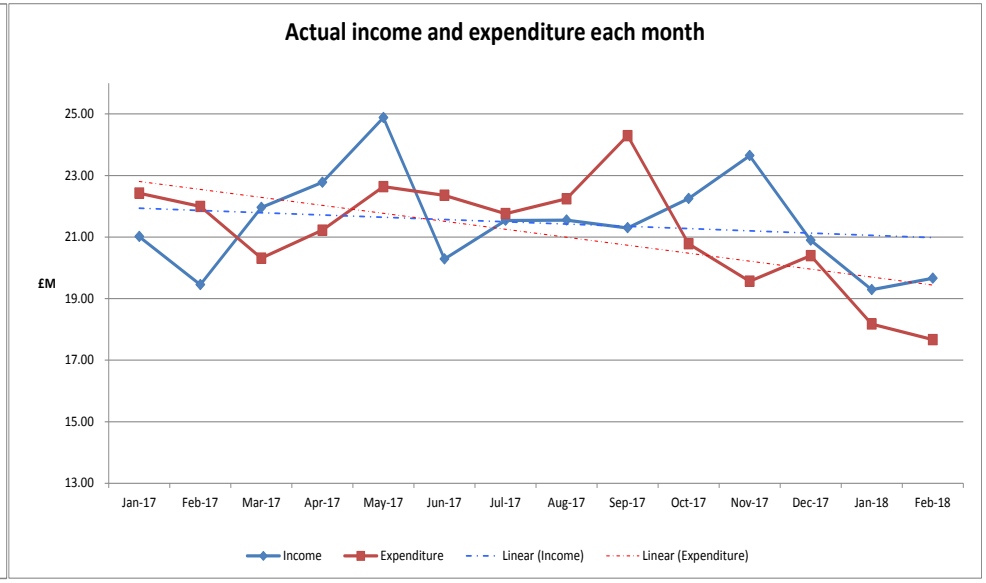

Delivered by YTD
300,000
250,000
200,000
150,000
100,000
50,000
0
A&E Attendances
Outpatient Attendances
Elective (incl Daycase)
Nonelective Admissions
Inpatient Discharges
New Births
2018
2017

4. FINANCE SUMMARY

The Month 11 YTD position is £1,144k behind plan, including shortfall on STF relating to A&E performance. Against our control total the Trust is £408k behind plan.

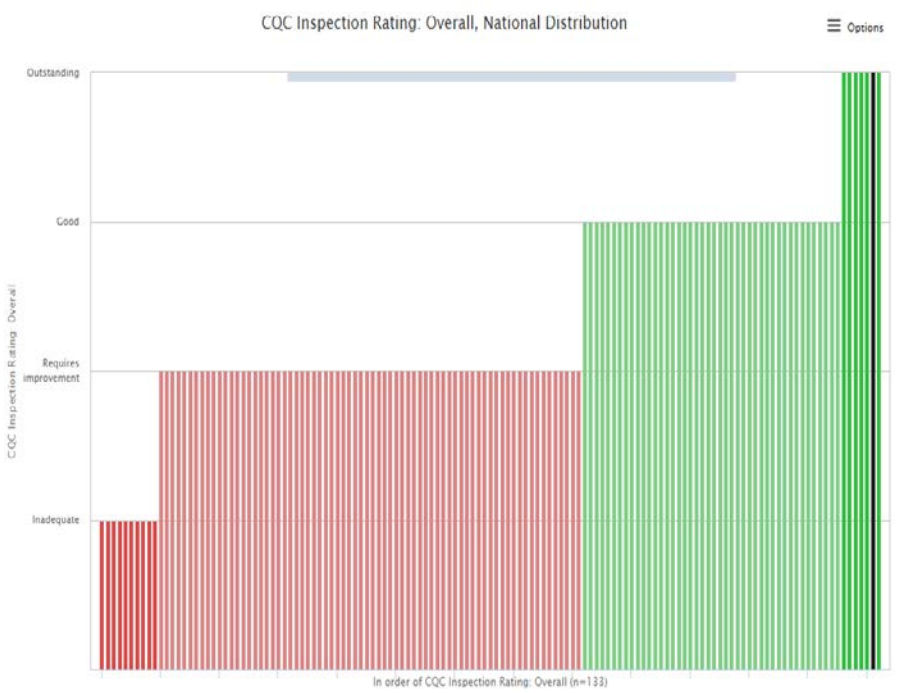
The chart below summarises the phasing of the clinical income plan for 2017-18, including Community Services. This phasing is in line with activity phasing and does not take into account the block payment. This graph includes the reduction in income relating to community services from October to March. Income earned from within Suffolk is on plan since we have block contracts with Suffolk CCGs for their activity. However, variances can be seen within Divisions with any balances reflected within the Corporate Division.

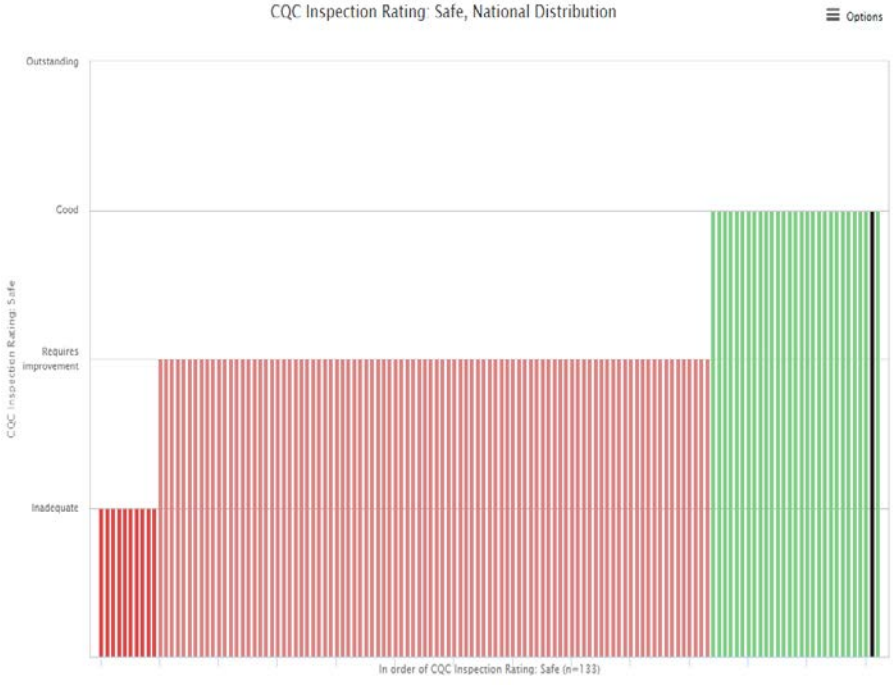


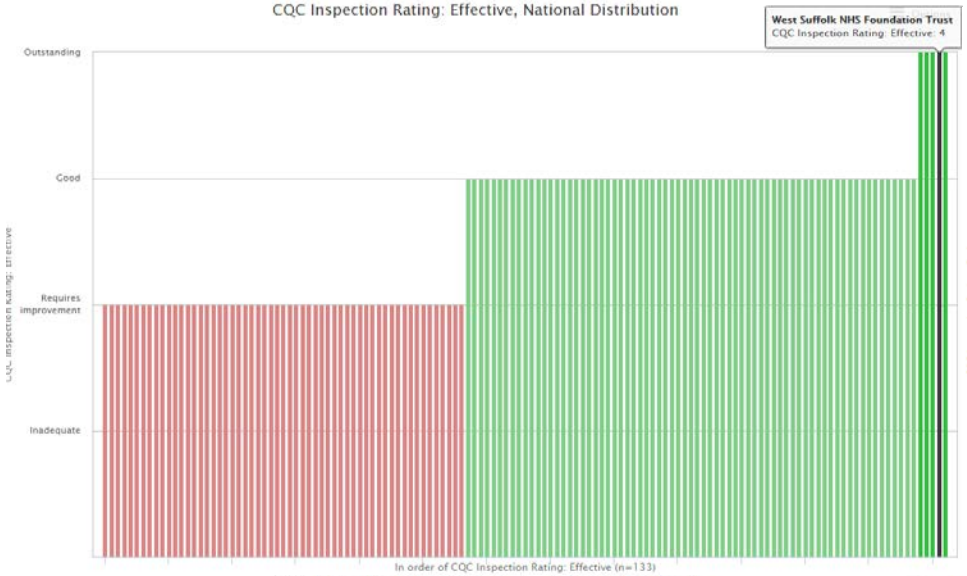


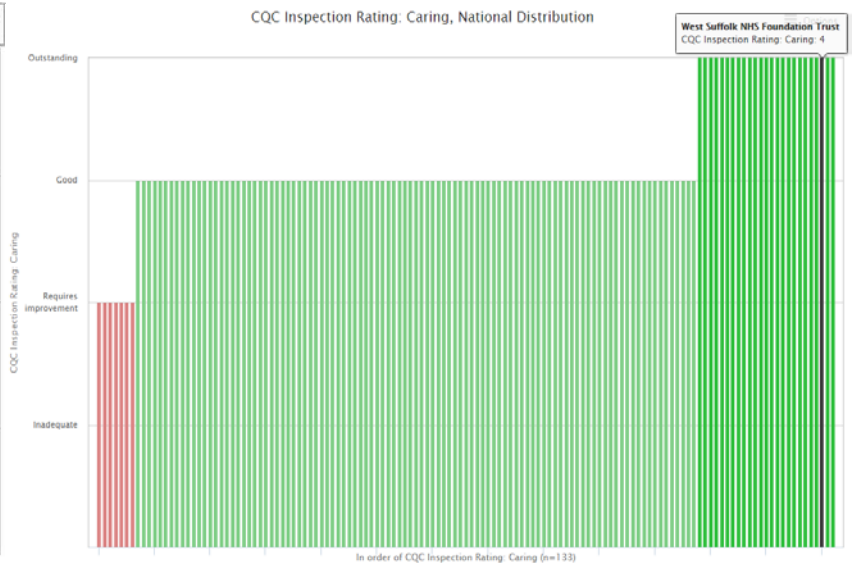
5. CQC OVERVIEW

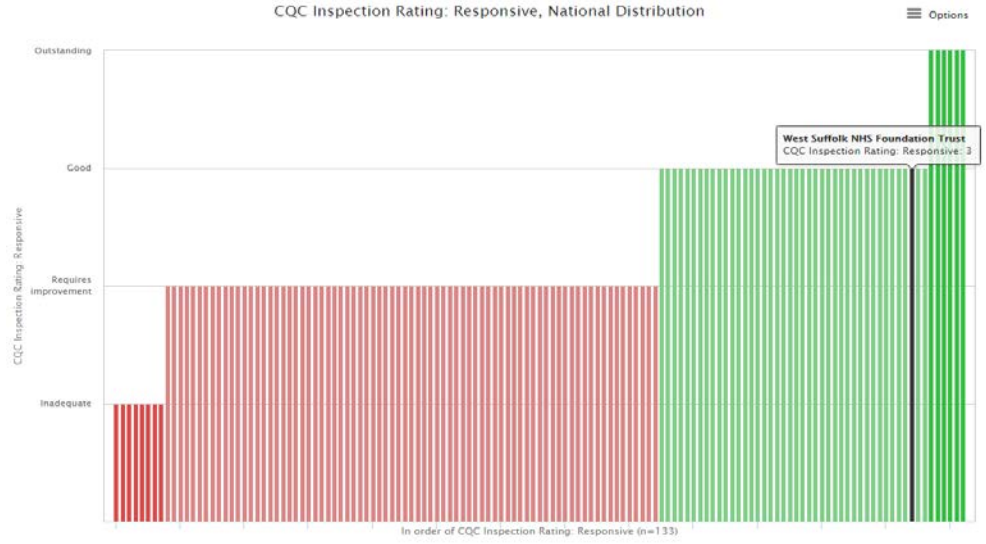
The CQC have launched the Model Hospital website in *alpha* form which highlights comparative indicators in a number of key areas. Quality of Care compartment: includes the CQC ratings as the principal assessment indicators, with additional indicators, including the Friends and Family Test, Ambulance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

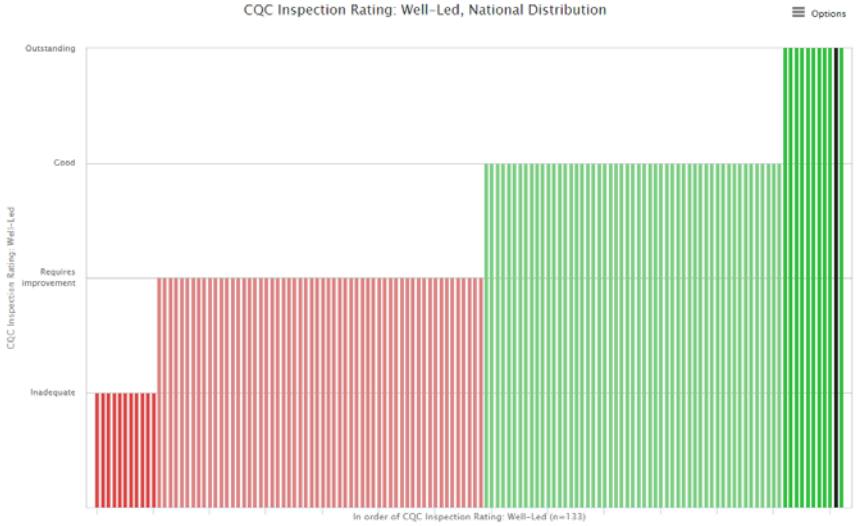





CQC Inspection Rating: Effective, National Distribution
West Suffolk NHS Foundation Trust
CQC Inspection Rating: Effective: 4
Outstanding
Good
Requires improvement
Inadequate
In order of CQC Inspection Rating: Effective (n=133)


CQC Inspection Rating: Caring, National Distribution
West Suffolk NHS Foundation Trust
CQC Inspection Rating: Caring: 4
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Caring
In order of CQC Inspection Rating: Caring (n=133)


CQC Inspection Rating: Responsive, National Distribution
Options
West Suffolk NHS Foundation Trust
CQC Inspection Rating: Responsive: 3
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Responsive
In order of CQC Inspection Rating: Responsive (n=133)


CQC Inspection Rating: Well-Led, National Distribution
Options
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Well-Led
In order of CQC Inspection Rating: Well-Led (n=133)

CQC - QUALITY OF CARE BENCHMARK DASHBOARD

The Quality of Care dashboard highlights latest comparisons with national & peer group averages. The peer group comprises 24 similar hospitals to WSHFT, national categorised as small acute hospitals. Appendix 1. *(Source – Model Hospital)*

Quality of Care, Single Oversight Framework

CQC Inspection Ratings (latest as at reporting date)	Period	Trust Actual	Info	Variation	Trend
CQC Inspection Rating: Overall	Latest	Outstanding			No trendline available
CQC Inspection Rating: Caring	Latest	Outstanding			No trendline available
CQC Inspection Rating: Effective	Latest	Outstanding			No trendline available
CQC Inspection Rating: Responsive	Latest	Good			No trendline available
CQC Inspection Rating: Safe	Latest	Good			No trendline available
CQC Inspection Rating: Well-Led	Latest	Outstanding			No trendline available

Friends and Family Test scores	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Staff Friends and Family Test % Recommended - Care	Q2 2017/18	94.1%	-	-		No variation available	
A&E Scores from Friends and Family Test - % positive	Oct 2017	94.9%	90.1%	88.8%			
Inpatient Scores from Friends and Family Test - % positive	Oct 2017	98.5%	97.2%	96.4%			
Maternity Scores from Friends and Family Test -question 2 Birth % positive	Oct 2017	100.0%	99.1%	97.7%			

Organisational health	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
CQC Inpatient Survey	Sep 2015/16	9	-	-		No variation available	No trendline available

Caring	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Written Complaints Rate	Q2 2017/18	12.79	24.62	23.65			

Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Emergency c-section rate	Dec 2017	11.43%	14.69%	15.67%			
VTE Risk Assessment	Q2 2017/18	87.82%	96.21%	95.77%			
Clostridium Difficile - infection rate	To Dec 2017	39.21	8.92	12.74			
MRSA bacteraemias	To Dec 2017	0.00	0.41	0.80			
Potential under-reporting of patient safety incidents	31/12/2017	140.41	43.15	42.55			

Safe	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
Clostridium Difficile - variance from plan	Dec 2017	-1.0	-1.0	0.0			

Effective	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Summary Hospital Mortality Indicator (SHMI)	30/04/2017	0.89	1.03	1.02			

Performance	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
A&E performance	Jan 2018	83.75%	85.28%	95.00%			
RTT - max 18 weeks incomplete wait	Dec 2017	89.04%	91.30%	92.00%			
Diagnostics - max 6 weeks wait	Dec 2017	99.96%	99.19%	99.00%			
Cancer - 62-day wait from urgent GP referral	Dec 2017	86.92%	85.94%	85.00%			
Cancer 62-day waits - NHS cancer screening service referral	Dec 2017	100.00%	98.00%	90.00%			

6. DETAILED SECTIONS - SAFE

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

Are we..		Ref.	KPI	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	YTD(Apr17-Mar18)	Traffic	Trend
Safe	Dashboard	1.01	NHS E / I Patient Safety Alerts - Total	NT	1	0	1	0	0	1	2	1	0	1	0	1	0	7		
		1.02	NHS E / I Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
		1.03	Emergency C-Section Rate	14%	9%	12%	10.3%	11.6%	11.5%	8.5%	12.9%	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	11%		
		1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	87%	86%	87%	89%	89%	86%	90%	88%	94.84%	96.87%	94.69%	96.93%	97.55%	92%		
		1.05	Clostridium difficile infections (CDI)	16	0	1	3	0	0	1	0	2	6	4	0	1	0	17		
		1.06	MRSA (Hospital)	0	0	0	0	0	0	0	0	2	0	0	0	0	1	3		
		1.07	Patient Safety Incidents Reported	NT	459	463	392	508	418	506	466	467	520	588	479	634	544	5522		
		1.08	Never Events	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0		
	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%	100%	99%		
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	95%	100%	96%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	99%		
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	98%	98%	100%	100%	100%	100%	97%	100%	98%	97%	100%	100%	100%	99%		
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	98%	95%	100%	97%	98%	93%	97%	99%	99%	97%	96%	99%	100%	98%		
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
		1.14	HII Compliance 4b: Preventing surgical site infection perioperativ	100%	100%	100%	100%	85%	100%	95%	100%	100%	100%	100%	100%	100%	95%	98%		
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	100%	**100%**	100%	100%	100%	100%	100%	78%	100%	100%	100%	98%		
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	78%	100%	100%	100%	100%	98%		
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	95%	82%	81%	92%	94%	88%	99%	97%	91%	92%	95%	100%	99%	93%		
	Incidents	1.19	Safety Thermometer - Harm-Free Care (New Harms)	95%	98%	98%	98.5%	98.3%	98.9%	98.6%	98.2%	97.2%	97.6%	98.4%	98.5%	97.9%	97.6%	98%		
		1.20	No of SIRIs	NT	6	8	9	5	7	7	6	5	11	14	10	20	11	105		
		1.21	RIDDOR Reportable Incidents	NT	0	0	0	0	1	0	1	0	2	0	3	0	0	7		
		1.22	Catheters and New UTIs	NT	0.26	0.78	0.29	0.29	0.27	0.00	0.00	0.00	0.15	0.16	0.44	0.14		0.17		
		1.23	Total No of E. Coli (Trust level only)	NT	ND	ND	2	0	2	2	1	2	1	2	2	2	1	17		
		1.25	Patient Falls	<48	54	71	54	52	50	69	68	39	56	73	69	76	82	688		
		1.26	Patient Falls resulting in harm	<10	14	16	9	17	20	17	18	10	23	18	23	28	26	209		
		1.27	Falls - Per 1000 bed days	5.60	5	5	5	5	ND	ND	ND	ND	ND	ND	ND	ND	ND	10		
		1.28	Number of avoidable serious injuries/deaths resulting from falls	NT	0	ND	0	0	ND	ND	0	0	0	ND	0	ND	ND	0		
		1.29	Number of medication errors	NT	18	25	64	80	69	78	70	69	70	78	63	72	49	762		
		1.30	Actual patient harm resulting from medication incidents	0.01	16	20	1	0	0	0	ND	ND	ND	ND	ND	ND	ND	1		
		1.31	Pressure Ulcers - Inpatients	<5	10	4	10	9	18	9	13	14	18	17	12	35	15	170		
		1.32	Pressure Ulcers - Avoidable ward-acquired PUs (YTD)	30%	31%	30%	40%	37%	30%	30%	34%	33%	32%	28%	28%	ND	ND	28%		

6 DETAILED SECTIONS - SAFE

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

Reporting	1.33	MRSA Quarterly Std (including admission and LOS screens)	90%	NA	91%	NA	NA	92%	NA	NA	93%	NA	NA	90%	NA	NA	92%		
	1.34	MRSA - Decolonisation	95%	90%	90%	92%	93%	95%	95%	90%	91%	98%	85%	91%	94%	86%	92%		
	1.35	MRSA - RCA Reports	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
	1.36	MSSA (Hospital)	NT	2	1	ND	1	0	0	1	1	0	1	1	1	0	6		
	1.37	SIRI final reports due in month submitted beyond 60 working days	0	0	0	0	1	0	0	0	4	5	4	0	0	1	15		
	1.38	SIRIs reported >2 working days from identification as red	0	0	2	0	0	0	0	1	2	3	6	5	7	3	27		
	1.39	RAG active/accepted risk assessments not in date	0			ND	ND	ND	9	0	1	5	0	2	1	4	22		
	1.40	Datix Risk Register Red / Amber actions overdue	0			ND	ND	ND	22	0	0	0	0	0	0	1	23		
	1.41	Outstanding actions complete in date for Red/Amber entries on Datix	95%	100%	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND	ND	100%		
	1.42	Quarterly standard principle compliance	90%	NA	95%	NA	NA	95%	NA	NA	95%	NA	NA	97%	NA	NA	96%		
	1.43	Rapid access chest pain clinic access within 2 wks.	100%	100%	100%	100%	98%	100%	95%	97%	97%	96%	100%	100%	100%	100%	99%		
	1.44	Verbal Duty of Candour outstanding at month-end	0%	ND	ND	3	0	0	0	2	0	1	2	0	2	2	12		
	1.45	Hand Hygiene Audits	95%	99%	98%	98%	99%	99%	100%	99%	98%	99%	99%	99%	99%	100%	99%		
	1.46	Quarterly antibiotic audit	98%	NA	93%	NA	NA	91%	NA	NA	94%	NA	NA	93%	NA	NA	92%		
	1.47	RCAs beyond deadline for completion	=<4	9	8	3	1	3	4	1	7	2	9	14	9	6	59		
	1.48	% of Green Patient Safety incidents investigated	NT	64%	60%	60%	66%	54%	53%	68%	58%	67%	56%	55%	59%	74%	61%		
	1.49	PEWS documentation and escalation compliance	NT	100%	100%	80%	100%	90%	100%	100%	90%	ND	ND	ND	ND	ND	93%		
	1.50	Quarterly Environment/Isolation	90%	NA	91%	NA	NA	91%	NA	NA	92%	NA	NA	92%	NA	NA	92%		
	1.51	Quarterly VIP score documentation	90%	NA	79%	NA	NA	84%	NA	NA	80%	NA	NA	87%	NA	NA	84%		
	1.52	Isolation data (Trust Level only)	95%	95%	89%	90%	95%	90%	90%	88%	88%	90%	88%	88%	90%	90%	90%		
	1.53	Pain Mgt. Quarterly internal report	80%	NA	NA	75%	NA	NA	61%	NA	NA	61%	NA	NA	59%	NA	64%		
	1.54	Nutrition Risk Assessment 48hrs	95%	83%	90%	91%	87%	89%	82%	89%	93%	89%	87%	93%	92%	89%	89%		
	1.55	Median of NRLS upload (No. of days)	41	50	51	81	87	65	65	58	55	48	61	66	75	65	66		

SAFE – WARD ANALYSIS

						Surgery									Medicine														Women & Children				
Group	Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	ETC	DSU	ED	CCU	G5	F9	F10	G1	G3	G4	G8	Newmarket	Glastonbury	MTU	F12	G9	F7	F8	F1	F11	F14	MLBU	NNU
Patient Safety	HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	=100					100										100				No Data	No Data	100									
	HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	=100	100	No Data	100	100	100						100	No Data	100	100	100	100	No Data	100				No Data						No Data		
	HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	=100					100	No Data				100									No Data	No Data	100				100	100				No Data
	HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	=100	100	100	100	100	100						100	100	100	100	No Data	100	100	100				100	100	100		100		100		No Data
	HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	=100							100	No Data	100																					
	HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	=100							100	No Data	90																					
	HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	=100					100																									
	HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	=100						100				100					100										100					
	HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	=100	100	100	100	100							100	100	100	100	100	100	90	100				100	100	100				100		
	Total no of MRSA bacteraemias: Hospital	= 0 per yr	>0	No Target	=0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data				No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data
	Hand hygiene compliance	= 95%	<85	85-99	=100	100	100	100	100	100		100	100	100		100		100	100	100	100	100	100			100	100		100	100	100	90	100		100
	Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Quarterly Standard principle compliance	90%	<80	80-90%	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data
	Total no of C. diff infections: Hospital	= 16 per year	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	No Data	No Data	No Data	No Data						No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data				No Data	No Data	No Data	No Data	No Data	No Data	No Data		
	Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data
	Quarterly VIP score documentation	= 90%	<80	80-89	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data			No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data
	MEWS documentation and escalation compliance	= 100%	<80	80-99	=100																														
	No of patient falls	= 48	>48	No Target	=48	4	0	2	7	1					2	0	12	4	6	3	7	3	5	4	4	0	2	4	8	3		1	0		
	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	1	0	0	4	0					1	0	5	3	0	0	4	2	2	1	0	0	0	2	0	1		0	0		
	No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	=0																														
	No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	0	0	0	0	0						0	1	2	2	0	4	5	0	0	0	0	0	0	0	0		1	0		
	No of avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target																														
	Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	100	No Data	100	100	100						100	90	80	100	78	100	50	70				100	80	90	No Data			90		
	No of SIRIs	No Target	No Target	No Target	No Target	1	0	0	1	0	0	0	0	0	0	0	2	0	1	1	0	1	0	1	0	0	0	0	0	1	0	1	0	0	0
	No of medication errors	No Target	No Target	No Target	No Target	5	2	2	0	2	0	0	1	0	6	0	0	1	1	0	1	0	1	1	0	0	0	5	3	1	0	3	0	0	0
	Cardiac arrests	No Target	No Target	No Target	No Target	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100																														
	VTE: Completed risk assessment (monthly Unify audit)	> 98%	<98	No Target	>98	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	=100																														
	Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<85	85-99	=100	91.67	100	100	100	100	No Data	No Data	No Data	No Data	No Data	86.71	100	100	92	100	93.94	90.62	95.65	100	100	No Data	100	94.12	100	No Data	No Data	100	100	No Data	No Data
Patient Experience: In-patient	Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	89	100	98	99							99	100	94	92	94	90	95					99	88	89				97		
	How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	100	100	100	100							100	100	96.77	100	100	88.89	100					100	85.71	100				100		
	In your opinion, how clean was the hospital room or ward that you were in?	= 85%	<75	75-84	85-100	97	99	95	100							100	100	97	74	100	97	100					100	95	83				100		
	Did you feel you were treated with respect and dignity by staff	= 85%	<75	75-84	85-100	100	100	100	100							100	100	100	94	100	100	100					100	93	100				97		
	Were staff caring and compassionate in their approach?	= 85%	<75	75-84	85-100	100	100	99	100							100	100	98	89	100	97	100					100	93	100				97		
	Did you experience any noise in the night time that you think could have been avoided?	= 85%	<75	75-84	85-100	15	97	98	94							92	100	97	100	100	81	86					100	57	50				94		
	Did you find someone in the hospital staff to talk about your worries and fears?	= 85%	<75	75-84	85-100	100	100	100	100							100	100	100	86	100	84	100					100	100	100				100		
	Were you involved as much as you wanted to be in decisions about your care and treatment?	= 85%	<75	75-84	85-100	100	100	98	100							100	100	97	89	85	83	100					96	100	75				88		
	Did staff talk in front of you as if you were not there?	= 85%	<75	75-84	85-100	100	100	98	100							100	100	100	94	90	81	100					100	71	100				100		
	Were you given enough privacy when discussing your condition or treatment?	= 85%	<75	75-84	85-100	100	100	100	100							100	100	100	100	100	94	100					100	100	100				100		
	Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	100	100	100	94							100	100	100	100	100	97	100					100	100	100				100		
	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	100	100	97	100							100	100	100	93	100	100	100					100	100	100				100		

6. EXCEPTION REPORTS – SAFE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Pressure Ulcers (Tissue Viability)
Standard	Hospital-Acquired Pressure Ulcers -
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Summary of Current performance & Reasons for under performance

Despite ongoing capacity pressures, escalation beds in use, staffing deficits and high acuity, there has been a decrease in hospital acquired pressure ulcers in February. There were fifteen in total, four grade 3 and twelve grade 2.

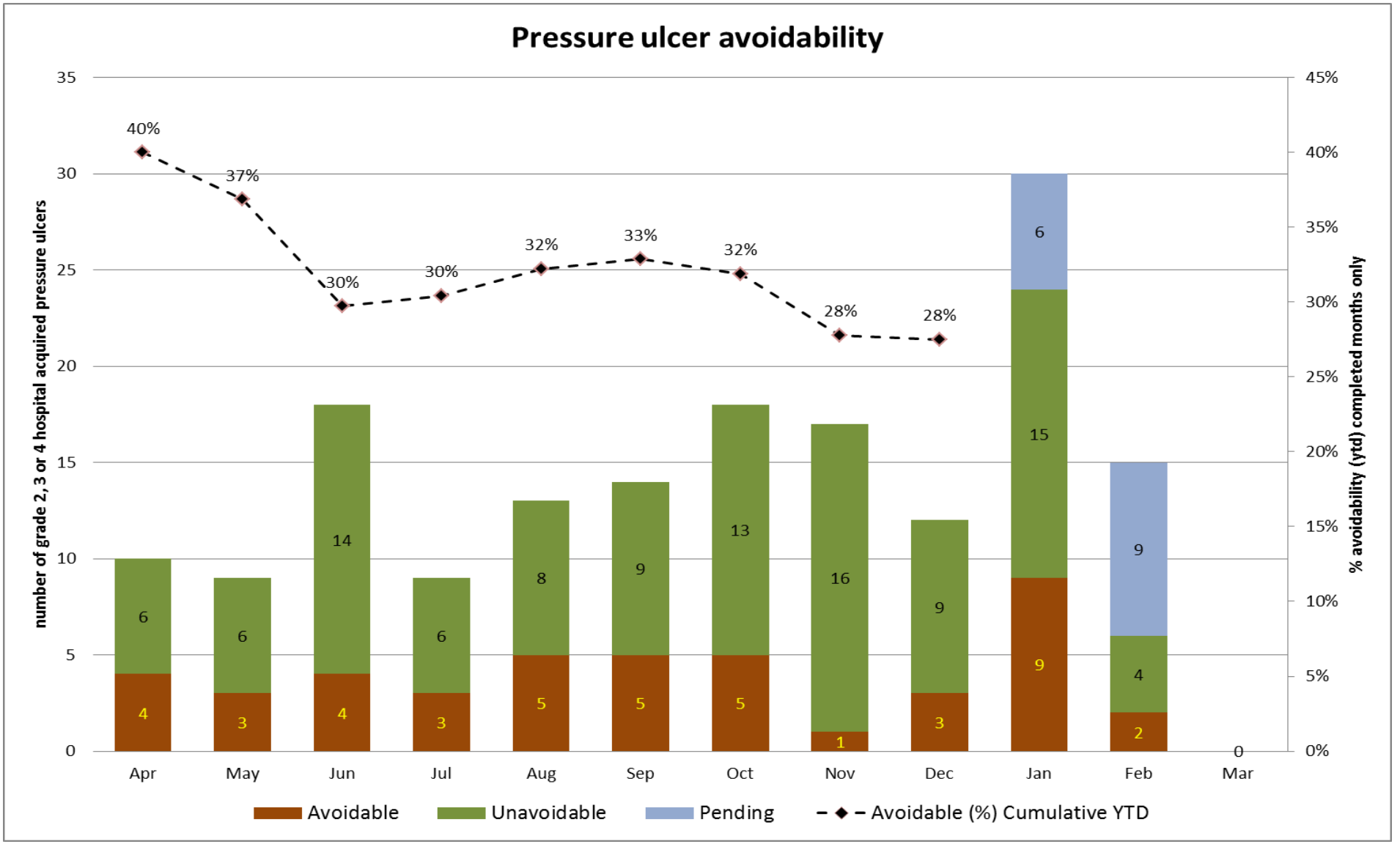
Many areas had no reported HAPUs in February, with the Surgical Division managing a month free of any hospital acquired pressure damage, despite high acuity, an increase in the number of medical outliers and decrease in lower acuity elective patients.

There continues to be an increased focus on early detection of risk, assessment of preventative measures and reporting of damage on admission. There is also a drive to promote timely completion of investigations to ascertain avoidability and promotion of learning from incidents.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Target	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%		
Total Pressure Ulcers	10	4	10	9	18	9	13	14	18	17	12	35	15		
% of patients with avoidable ward acquired pressure ulcers YTD	31%	30%	40%	37%	30%	30%	34%	33%	32%	28%	28%	ND	ND		

Actions in place to recover the performance — Expected timeframes for improvements

Description	Owner	Start	End
The Tissue Viability team continue to maintain visibility and support ward teams	TVN team	2018	Ongoing
The Tissue viability team are promoting pressure ulcer prevention via bite size teaching sessions and one to one education, promoting awareness to improve staff knowledge and practice in promoting skin health and integrity.	TVN team	2018	Ongoing
Active promotion by TVNs and Senior Matrons of elements of the SKIN bundle, specifically focussing on promoting regular position changes and appropriate use of reassure reliving equipment.	TVN/ Matrons	2018	Ongoing
Ongoing focus on the 'heel heroes' campaign, promoting heel protection and ensuring teams are aware of those patients who have increased risk of developing damage.	TVN/ Matrons	2018	Ongoing
Staff engagement via the Pressure ulcer prevention focus group, aiming to put pressure ulcer prevention at the forefront of care	PUP focus group	2018	Ongoing
Senior Matrons continue to monitor the implementation of pressure ulcer prevention and have commenced using the 'Perfect Ward' to ensure appropriate risk assessments and care plans are in place	Matrons	2018	Ongoing
Ongoing promotion to use the correct continence products and educating staff not to use procedure sheets inappropriately to minimise moisture damage	TVN/ Matrons	2018	Ongoing
Reduction of stock of procedure sheets across all wards	TVN team	2018	Ongoing
Active encouragement to achieve timely investigations and learning from incidents by Head of Nursing	Head of Nursing	2018	Ongoing
Tissue Viability team are exploring the concept of Kennedy grading for end of life patients. May 2018	TVN team	Mar-18	May-18


Pressure ulcer avoidability
number of grade 2, 3 or 4 hospital acquired pressure ulcers
% avoidability (ytd) completed months only
35
30
25
20
15
10
5
0
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
40%
37%
30%
30%
32%
33%
32%
28%
28%
6
6
14
6
8
9
13
16
9
15
9
4
0
4
3
4
3
5
5
5
1
3
9
2
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Avoidable
Unavoidable
Pending
Avoidable (%) Cumulative YTD

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Infection Control: MRSA and Clostridium Difficile
Standard	MRSA 0, C.difficile ceiling 16
Name	Rowan Procter
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

There were no cases of Hospital attributable CDT in February 2018. Overall summary as of 28th February, there have been 17 reported cases of C difficile, 10 of which are Non Trajectory, 7 are Trajectory. Whilst the Trust was under trajectory in the first two quarters, Q3 was over trajectory with 10 cases at 31/12/17 (5 trajectory 5 non trajectory). Q4 is on target in the first two months.

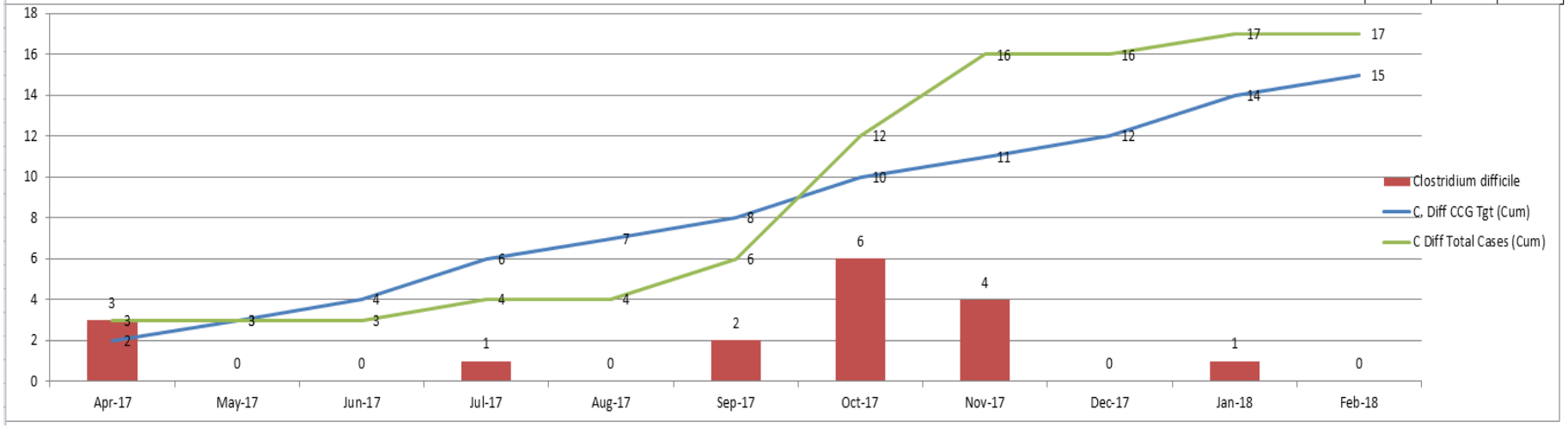
The Trust recorded an MRSA bacteraemia in February, however this is a patient with complex skin condition, and is his third episode, the previous two incidences have been assigned as third party by NHS England.

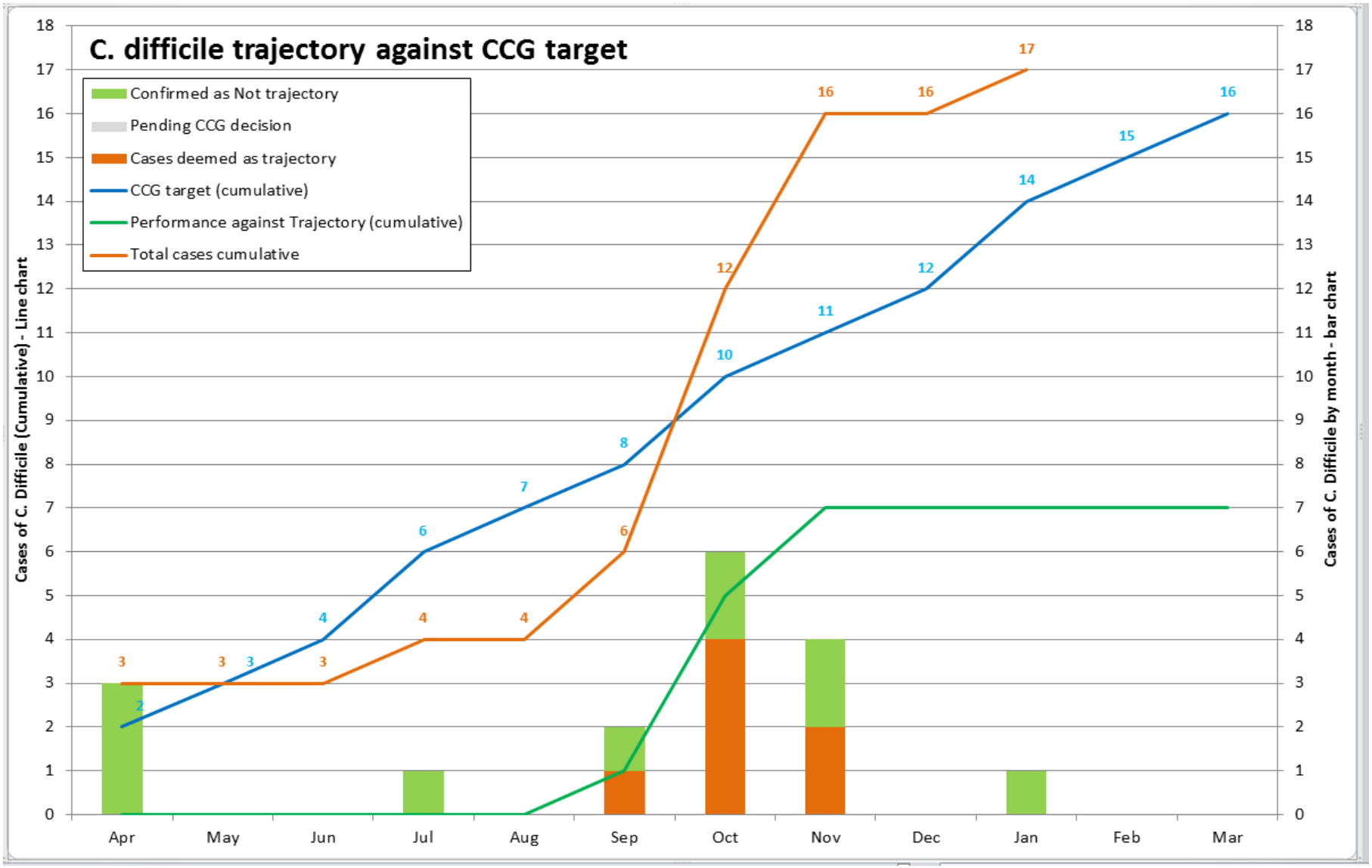
Indicator	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
C. Diff CCG Tgt (Cum)	2	3	4	6	7	8	10	11	12	14	15	16
Clostridium difficile	3	0	0	1	0	2	6	4	0	1	0	
C Diff Total Cases (Cum)	3	3	3	4	4	6	12	16	16	17	17	
MRSA	0	0	0	0	0	2	0	0	0	0	1	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
MRSA - Investigation is underway but it is anticipated that this will also be submitted for 'Third party'	RP	Feb-18	Mar-18




C. difficile trajectory against CCG target
Confirmed as Not trajectory
Pending CCG decision
Cases deemed as trajectory
CCG target (cumulative)
Performance against Trajectory (cumulative)
Total cases cumulative
Cases of C. Difficile (Cumulative) - Line chart
Cases of C. Difficile by month - bar chart
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	MRSA Decolonisation
Standard	90%
ED Name	Rowan Procter
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

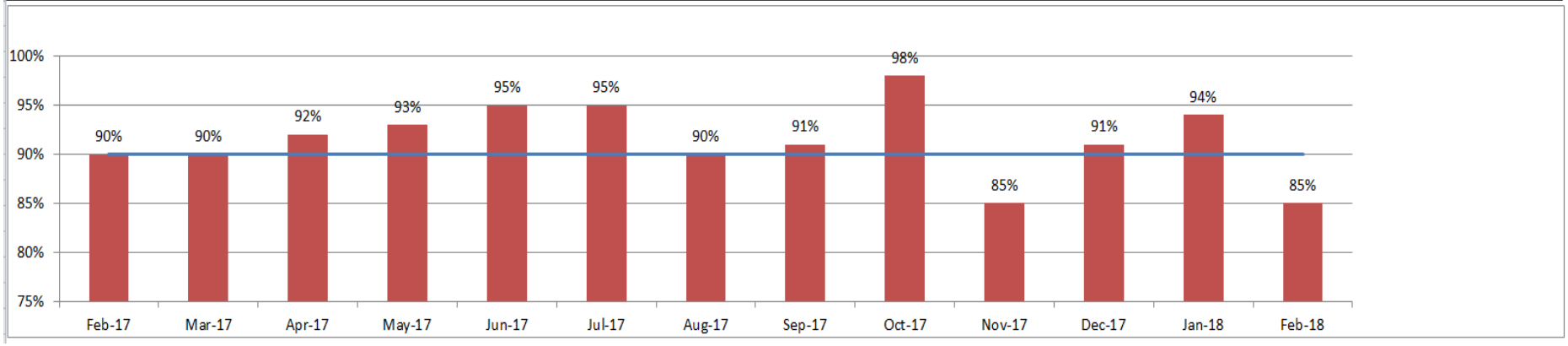
The Trust compliance with decolonization declined in February 2018 to 86%. This was in part due to only having 7 eligible patients for the audit

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	
MRSA Decolonisation	90%	90%	92%	93%	95%	95%	90%	91%	98%	85%	91%	94%	85%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Whilst no wards required a Datix (when all elements are not recorded) one ward (F6) only achieved 36% compliance a meeting is arranged to devise an action plan to improve going forward. The decolonisation record remains a paper document which may adversely affect results, pharmacy are devising a possible solution within the EPR (e-Care)	HB	Sep-17	Feb-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	VTE
Standard	95%
Name	Rowan Procter
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

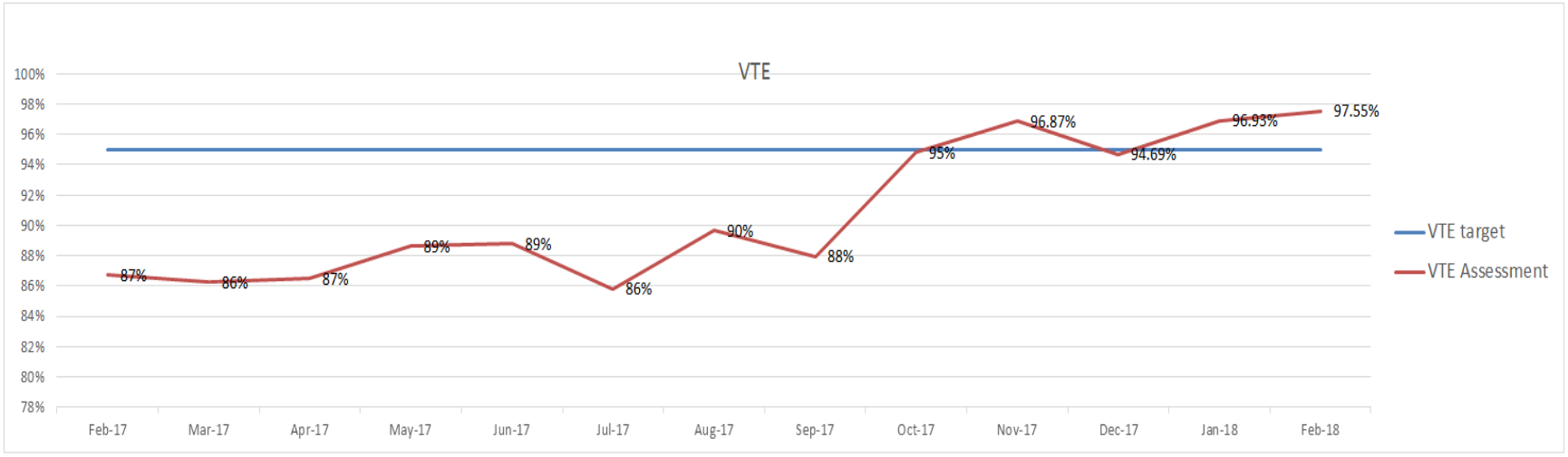
We now have EPR called e-Care, using which we have been able to properly and objectively collect data to inform our compliance. This has allowed us to exclude those areas that are not required to report as per the National Guidance. However, we undertake a monthly deep dive assurance process to ensure the assessments of a required standard and quality.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
VTE target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
VTE Assessment	87%	86%	87%	89%	89%	86%	90%	88%	95%	96.87%	94.69%	96.93%	97.55%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
We have achieved the target in month and are satisfied at the standard of assessments being undertaken, however, we are not complacement and continue to monitor.	RP	Sep-17	Mar-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Median NRLS upload 6 month rolling average
Standard	Trust internal target of 46 days
Name	Rowan Procter
Month	Feb 18
Data Frequency	Monthly
CQC Area	Safe
National Rank	Trust is in lowest quartile

Summary of Current performance & Reasons for under performance

Performance has slightly improved in February compared to a period of deterioration over the last quarter following a continued period of improvement from May to October 2017. Increasing numbers of incidents reported combined with the acuity of the hospital in recent months has led to a reduction in performance.

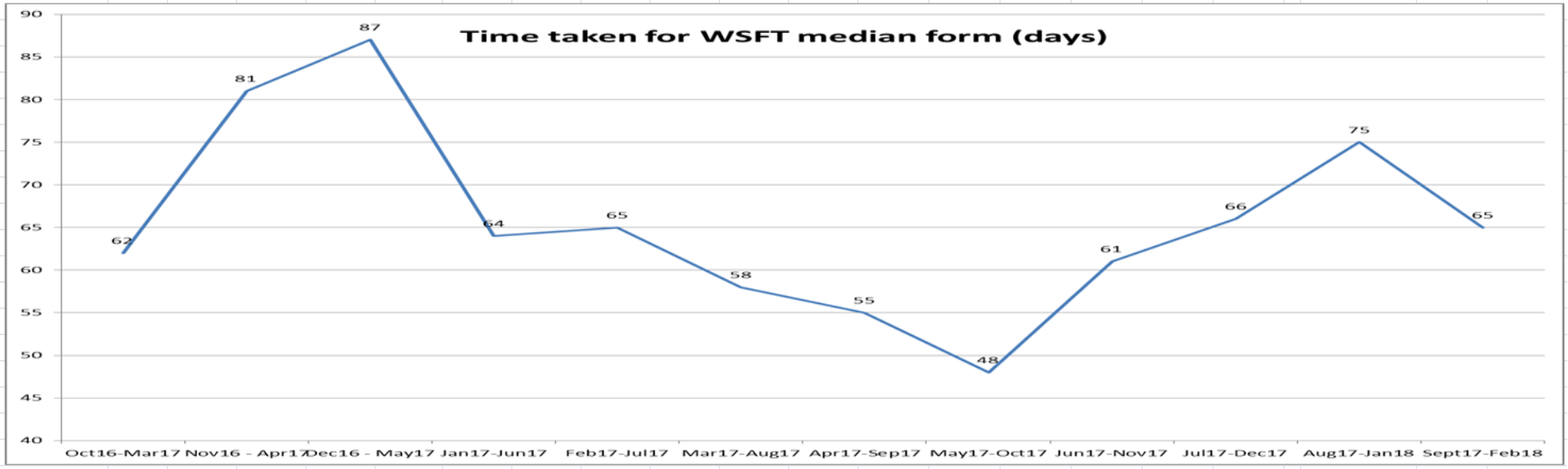
Actions taken in 2017/18 included: providing additional adminstrative resource to the Datix adminstration function, simplifying the green investigation process to allow 'single-sign off', creating a grade 2 pressure ulcer concise template to reduce the need to complete standalone reports and removing fields collating potential risk coding which are already captured in the risk register. Future plans for 2018/19 include a simplification of the falls investigation form.

Indicator	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Median NRLS	50	50	51	81	87	65	65	58	55	48	61	66	75	65	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Consider options for review of Datix	Governance	Jan-18	Apr-18
Targeted follow up with leads (Matrons, CDs)	Governance	Feb-18	Ongoing
Monitor against a peer based comparison (peer group is all non-specialist acute trusts)	Governance	Apr-18	Apr-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Patient Safety Incidents Reported
Standard	NA
Name	Rowan Procter
Month	Feb 18
Data Frequency	Monthly
CQC Area	Safe

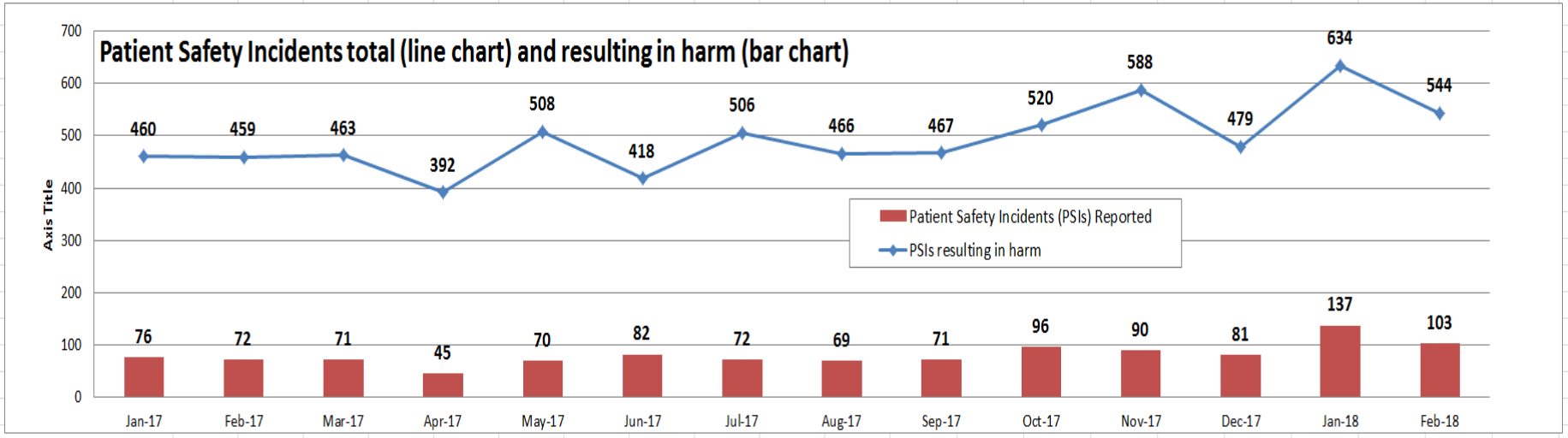
Background

There were 544 incidents reported in February. This was lower than January but similar to recent months. The number of 'harm' incidents remains low although it has risen in 2018 compared to 2017 and a review of the reasons for this increase is underway.

Indicator	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Patient Safety Incidents (PSIs) Reported	460	459	463	392	508	418	506	466	467	520	588	479	634	544	
PSIs resulting in harm	76	72	71	45	70	82	72	69	71	96	90	81	137	103	

Actions in place to recover the performance / Expected timeframes for improvements

Description	Owner	Start	End
The number of 'harm' incidents remains low although it has risen as a consequence of Community reporting, mainly relating to pressure ulcers. To monitor	RP	Jan-18	Feb-18
A review of harm incidents in 2018 is underway to provide an explanation as to why this is higher than 2017 and especially why it is higher than Oct-Dec 2017 as that period already included the new Community Services	RP	Mar-18	Apr-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	HII Compliance 2b: Peripheral cannula ongoing
Standard	100%
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

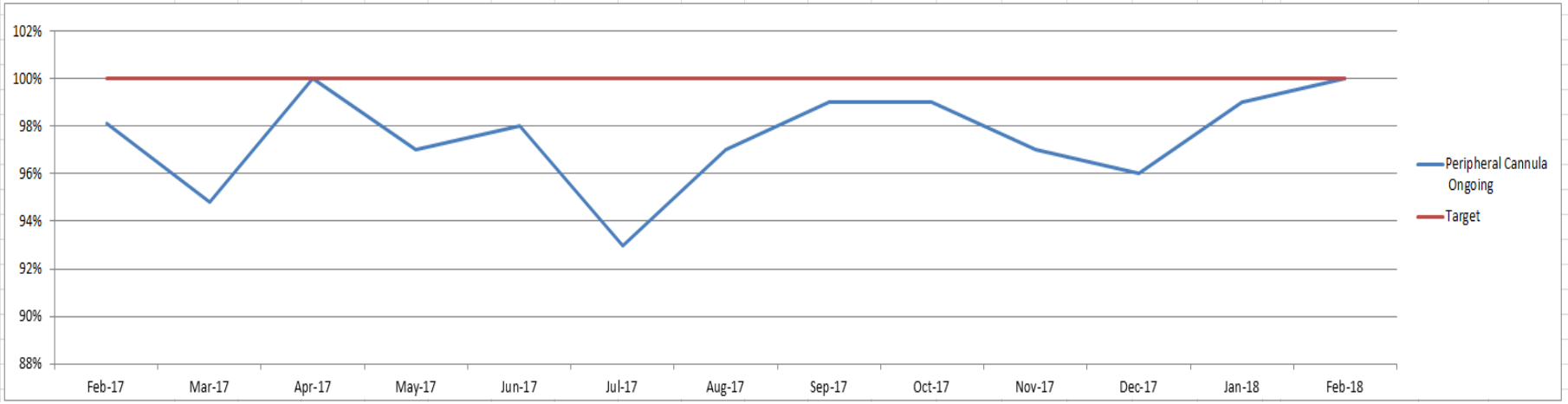
Performance for February was 100% which was an improvement from 99% in January.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Peripheral Cannula Ongoing	98%	95%	100%	97%	98%	93%	97%	99%	99%	97%	96%	99%	100%		
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Performance to be discussed at Senior Matron Meeting to establish areas of good practice to support shared learning for dissemination to clinical areas.	Matrons / Heads of Nursing	now complete	
Ward Senior Teams and Matrons to monitor performance and target areas of poor compliance so as to implement actions targeted at improvement in practice.	Matrons / Heads of Nursing	now complete	
New Perfect Ward audit tool to assist in the monitoring of practice compliance, so as to support staff education in following the correct peripheral cannula care and documentation	Matrons / Heads of Nursing	now complete	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Falls
Standard	No of patient falls No of patient falls resulting in harm No of avoidable serious injuries or deaths resulting from falls
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Summary of Current performance & Reasons for under performance

"There were 82 falls in February a rise from 76 in January of these falls none resulted in major harm though three resulted in moderate harm. At Newmarket Hospital four patients fell (five in January) and at Glastonbury Court four patients fell (three in January), these falls are reportedly separately.
In the month of February six patients were assisted to the floor (five in January) preventing them from falling.
A total of ten patients fell more than twice (two of which fell three times) during their inpatient stay in February (four in January).
The factors of cognitive and perceptual impairment continue to be reflected in the high numbers of patients falling. This has been exacerbated by the inability to meet core staffing levels, and to provide staff to 'special' patients in relation to the number of beds currently occupied in existing, escalation and surge capacity areas.
1 x Amber Fall – G4 - Elderly patient (EP) with history of dementia and recurrent falls. Fall resulting in head injury (intracranial bleed - no surgical intervention required), treated with Octaplex with good effect and subsequently discharged to place of residence. 1 x Amber Fall – G5 - Elderly patient (MC) with significant respiratory history and as such commenced on EOL medications following palliative review prior to the fall. Fall resulted in a # humerus which was not for surgical intervention in light of palliative needs. Patient passed away 2 days later as a result of bronchopneumonia and pulmonary fibrosis. 1 x Amber Fall – G8 - Patient admitted following a CVA, whilst reaching for an item the patient fell due to visual neglect and weakness. Currently under investigation, likely to be down graded in relation to level of harm sustained."

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Total Patient Falls	54	71	54	52	50	69	68	39	56	73	69	76	82	
Patient Falls resulting in harm	14	16	9	17	20	17	18	10	23	23	23	28	26	
Percentage of falls resulting in harm	26%	23%	17%	33%	40%	25%	26%	26%	41%	32%	33%	37%	32%	

Actions in place to recover the performance	Expected timeframes for improvements		
The Falls Focus Group meets on a bi-monthly basis, information from this group is then fed back in to the Trust higher level Falls Group led by Dr Suresh.	Falls Group	2018	Ongoing
The trust has now provided Falls Pocket Cards (currently being distributed by the Falls Focus Group / Senior Matron Team members).	Falls Group	now complete	
RCP information booklets for patients / relatives on preventing falls are currently being re-produced for the clinical areas to provide to these groups.	Falls Group	Apr-18	Mar-18
There are now 3 options in footwear available for in-patients at the WSFT to aid in safe mobility and reduce the number of slips, trips and falls.	Falls Group	2018	Ongoing
L&S BP task now set for all ii-patient areas at the WSH as per NICE guidance, this allows for the identification of individuals at risk of falling and the implementation of the appropriate care plans / order sets. There will be new observation machines rolled out to all WSH in-patient areas which will support this process and ensure the timely and accurate inputting of data.	Falls Group	2018	Ongoing
All 'Amber' classification falls will now be subject to the Level 1 Concise RCA for Falls to ensure appropriate lessons are learnt and information is available to support the duty of candour process.	Falls Group	Apr-18	Mar-18
The current falls care plan within eCare is being reviewed and possible amendments will be made to appropriately reflect interventions for consideration and to highlight actions taken.	Falls Group	Apr-18	Mar-18
The Falls Group and the sub Focus Group are currently exploring the option of the 'Catch a Falling Star' falls study day, focusing on the prevention of falls and appropriate treatment post fall. This has successfully ben implemented in a London Trust with good results and could be tailored for the specific purposes of the WSFT. The option of a Falls Prevention video for patients to watch (as used in Michigan – Bronson Healthcare Group) is being explored to try and assist in the reduction of falls.	Falls Group	May-18	Jun-18

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Nutrition - Asssessment & Monitoring
Standard	95%
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

With the ongoing capacity pressures and staffing deficits, February has seen a decrease in compliance with completing risk assessments and weighing patients from 92% to 89%. There continue to be pockets of poor compliance in some wards, with many of the medical wards experiencing poor compliance due to weights not being completed within the first 24hours of admission. This continues to be an area of focus for the admitting wards. The NHSi Nutrition Collaborative work is making some progress on the two focus wards and this continues to be monitored.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Nutrition Risk Assessment 48hrs	83%	90%	91%	87%	89%	82%	89%	93%	89%	87%	93%	92%	89%	
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
1 The Senior Matron team continue to support and promote compliance in risk assessments and weighing patients at ward level 2 Monitoring of compliance and performance via 'Perfect Ward' 3 Individual action plans continue to be put in place and supported by Senior Matrons and Head of Nursing for areas with persistent poor performance. 4 Promotion of staff engagement via the Nutrition focus group to support joint working with the Dieticians, specialist nutrition nurse, ward nurses and nursing assistants and the sharing of good practice. 5 Sharing of the Focus group action plan with all ward areas to promote compliance with weighing patients and improving on recording of risk assessments. 6 Monthly feedback on performance is shared via the patient safety dashboard 7 Project to relaunch protected mealtimes at ward level with the support of the communication team, Catering manager, Dietetic team and Senior Matrons 8 Baseline audit has been completed to monitor compliance with protected mealtimes 9 Focused work on two wards to improve compliance with nutrition assessments, promote quality of these assessments and monitor that interventions are appropriate. This is part of the NHSi Nutrition Collaborative initiative the Trust has been selected to be part of.	RP	Ongoing	

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Timeliness of SI notification and final report submission
Standard	NA
Name	Rowan Procter
Month	Feb 18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

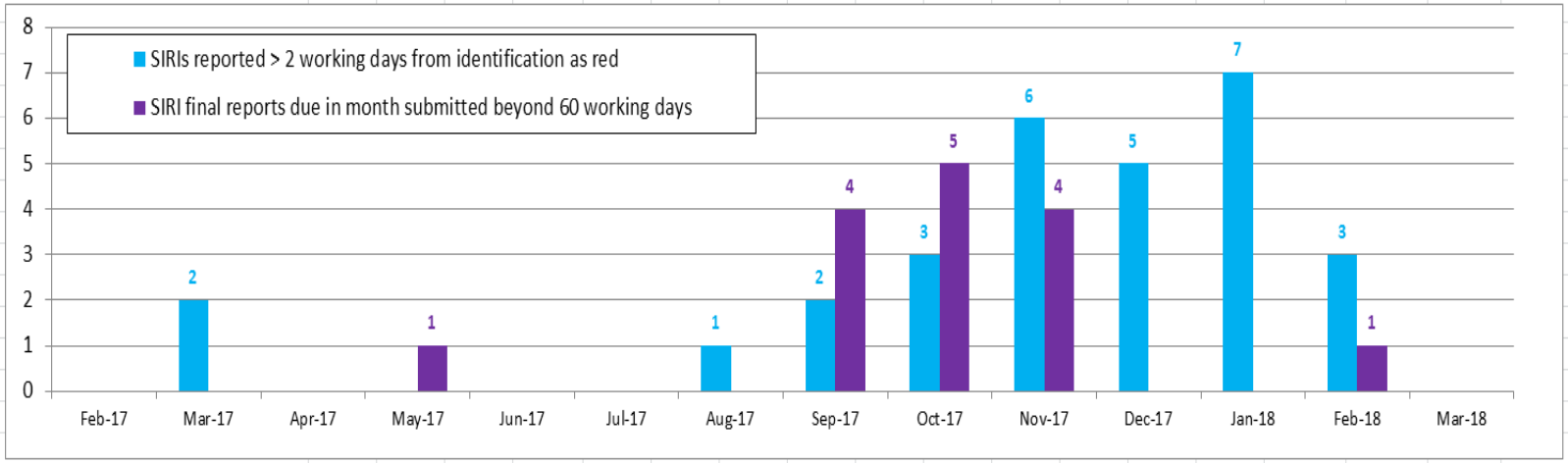
Performance against the two working day reporting target has improved since January. Two Community 'in our care' pressure ulcers were submitted after the 60 day timeframe. The Community TVN team are following up with the team leads to ensure more timely completion and the one team which has the majority of report are being helped by the other team leads to prevent any further target deterioration.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
SIRIs reported > 2 working days from identification as red	0	2	0	0	0	0	1	2	3	6	5	7	3	
SIRI final reports due in month submitted beyond 60 working days	0	0	0	1	0	0	0	4	5	4	0	0	1	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Continue to aim for 100% compliance	Governance	2018	Ongoing



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Isolation Data
Standard	95%
Name	Rowan Procter
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Safe

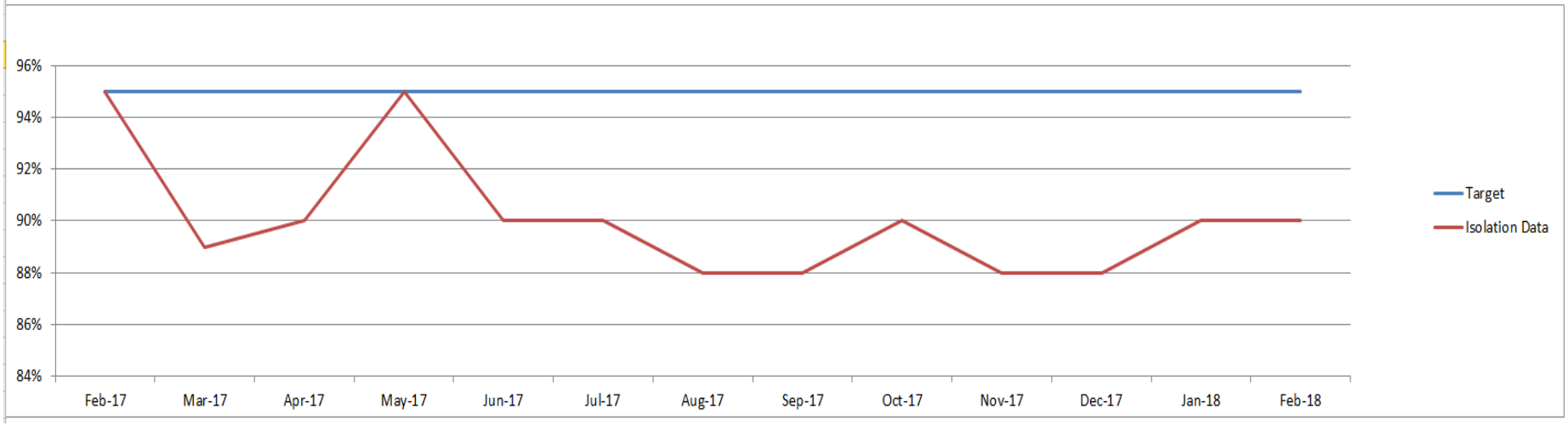
Summary of Current performance & Reasons for under performance

Compliance with Isolation is at 90%. F12 Adult Isolation ward was also at capacity throughout February.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Isolation Data	95%	89%	90%	95%	90%	90%	88%	88%	90%	88%	88%	90%	90%	

Actions in place to recover the performance — **Expected timeframes for improvements**

Description	Owner	Start	End
Wards were advised on the measures required to mitigate onward transmission and this is recorded in the embedded document that is part of the Infection Dashboard.	HB	Sep-17	Mar-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Timeliness of RCA action completion
Standard	RCA Actions beyond deadline for completion
Name	Rowan Procter
Month	Feb 18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

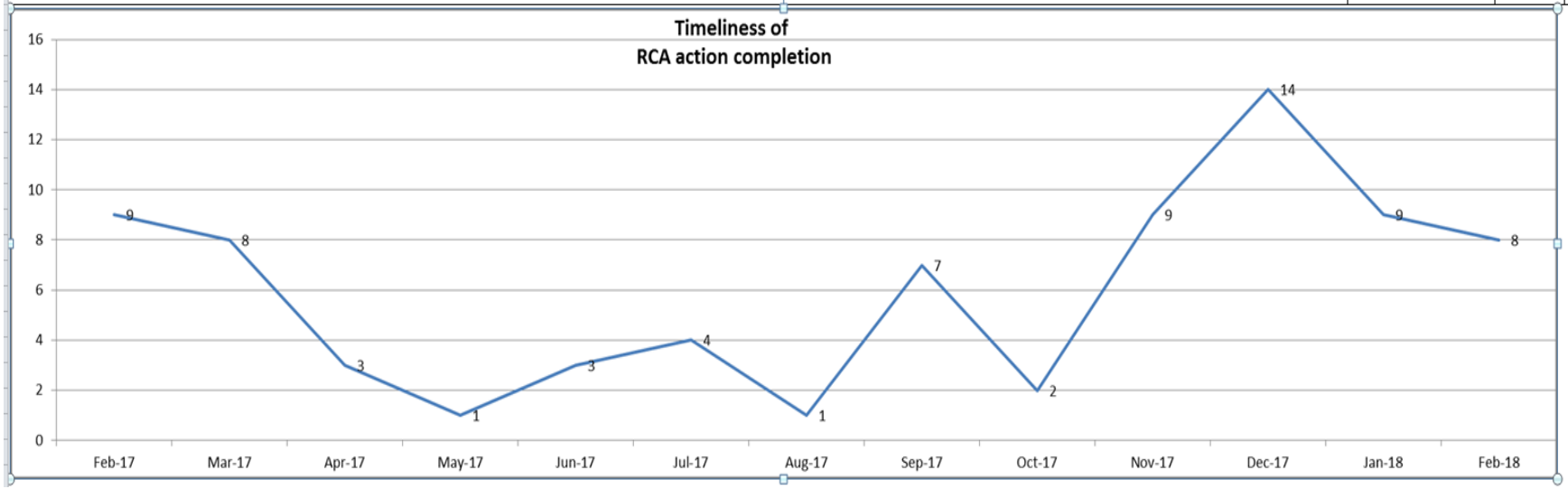
On completion of a SIRI investigation an action plan is developed to address the care or service delivery problems and root cause(s) and any additional lessons learned. Actions are designed to be SMART and are recorded on Datix with a named lead and completion target date. When an action reaches its completion date the lead is asked for an update to confirm completion. This is undertaken via an email from the Governance team and may also be discussed in the Divisional Steering groups and at the Clinical Directors meetings.
Where feedback is given that an action is in progress but completion deadlines have slipped for any reason this is recorded in the notes section and the deadline extended accordingly.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Timeliness of RCA action completion	9	8	3	1	3	4	1	7	2	9	14	9	6	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Clinical Directors meeting have agreed to take greater oversight of RCA action completion	Clinical Directors	2018	Ongoing
Discussion with Senior matrons and Ward Managers at Nursing & Midwifery and Clinical Council (NMCC)	NMCC	2018	Ongoing



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Safety Thermometer - Harm-Free Care (New Harms)
Standard	95%
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Safe

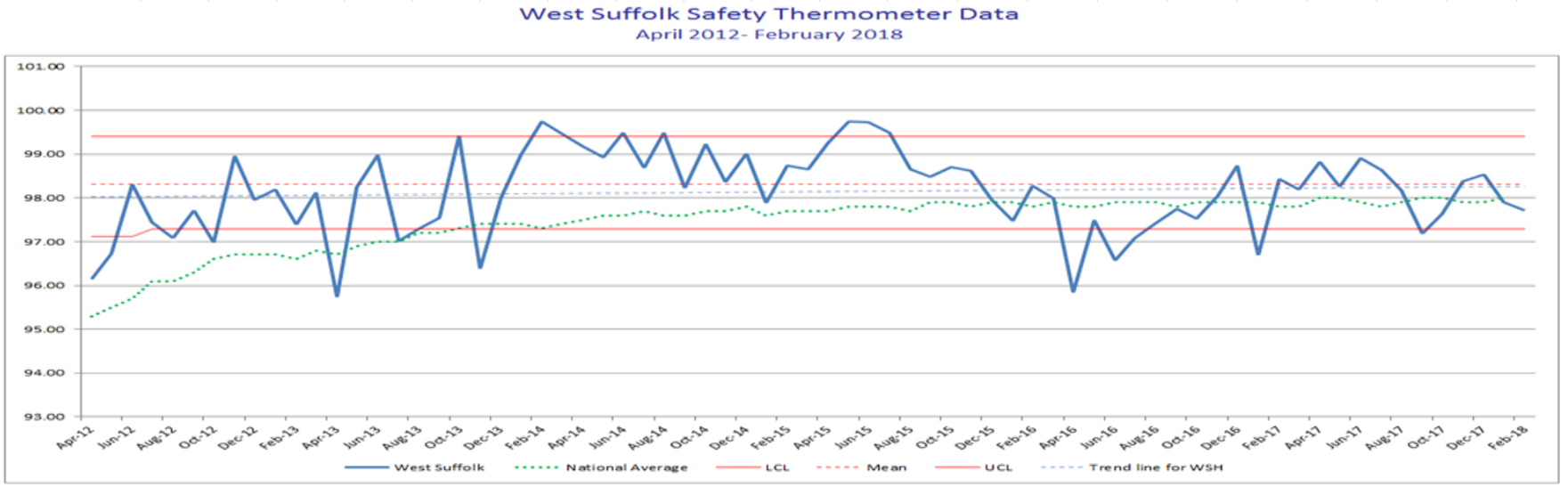
Background

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.
The Trust score for February 2018 for new harm free care was 97.71%. 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 January 2018 and the Trust results for February 2018.
RAG rating is defined by the Trust's score compared to the National average. February's National average was 97.9% making the Trust's score below the National average and therefore red.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Safety Thermometer - Harm-Free Care	98.43%	98.19%	98.53%	98.26%	98.91%	98.64%	98.18%	97.18%	97.63%	98.38%	98.54%	97.90%	97.71%		

Key Recovery Actions

Description	Owner	Start	End
To continue to monitor actual harm against national benchmarks.	HB	Sep-17	2018



7. DETAILED REPORTS - EFFECTIVE

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

Are we..		Ref.	KPI	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	YTD(Apr17-Mar18)	WTG	Traffic	Trend
	Mort Da	2.04	Canc. Ops - Cancellations for non-clinical reasons	1%	0.62%	0.56%	1.05%	1.00%	1.21%	0.97%	1.44%	1.85%	1.33%	0.75%	1.22%	1.09%	4		
		2.11	Cardiac arrests	NT	4	6	4	2	3	6	4	ND	ND	7	ND	36			
		2.12	Cardiac arrests identified as a SIRI	-	0	0	1	0	0	0	0	0	0	ND	ND	0.11			
2. Effective	Incidents/Reports	2.13	CAS (central alerts system) alerts overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	3		
		2.15	WHO Checklist (Qrtly)	100%	NA	NA	99%	NA	NA	99%	NA	NA	99%	NA	NA	99%	3		
		2.16	TA (Technology appraisal) business case beyond deadline	0%	0	0	0	0	0	0	0	0	0	0	0	0			
		2.19	Av. Elective LOS (excl. 0 days)		2.75	3.26	2.7	2.54	2.79	2.73	2.93	2.85	2.98	3.06	2.27	2.81			
		2.20	Av NEL LOS (excl 0 days)		7.59	7.85	7.66	7.47	7.93	7.54	8.23	7.66	7.56	8.40	7.66	7.78			
		2.21	% of NEL 0 day LOS		19.4%	18.6%	20.3%	18.6%	17.4%	17.5%	18.8%	16.6%	14.7%	13.2%	13.5%	17%			
		2.22	NHS number coding	99%	99.74%	99.66%	99.69%	99.44%	99.50%	99.59%	99.61%	99.66%	99.62%	99.69%	99.63%	100%			
		2.23	Fractured Neck of Femur : Surgery in 36 hours	85%	97%	96%	96%	85%	97%	97%	96%	84%	100%	100%	96%	95%			
		2.26	Discharge Summaries (A&E 95% 1d)	95%	87.9%	88.8%	87.5%	86.7%	85.7%	85.9%	83.6%	84.2%	82.6%	84.0%	83.4%	85%	1		
		2.27	Discharge Summaries (IP 95% 1d)	95%	91.98%	93.29%	93.40%	ND	ND	ND	ND	ND	70.87%	71.12%	70.31%	82%	1		
		2.28	Choose and Book - Available Slots	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		2.29	All Cancer 2ww services available on C&B	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		2.30	Canc. Ops - Patients offered date within 28 days	100%	93.33%	93.8%	93.2%	88.5%	75.0%	92.0%	84.6%	98.1%	76.7%	94.7%	96.6%	89.7%	1		
		2.31	Canc. Ops. - No. Cancelled for a 2nd time	NT	0	0	0	0	0	0	0	0	0	0	0	0	3		

7. EXCEPTION REPORTS – EFFECTIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Discharge Summaries (Inpatients)
Standard	95%
Name	Helen Beck
Month	01-Feb-18
requency	Monthly
CQC Area	Effective

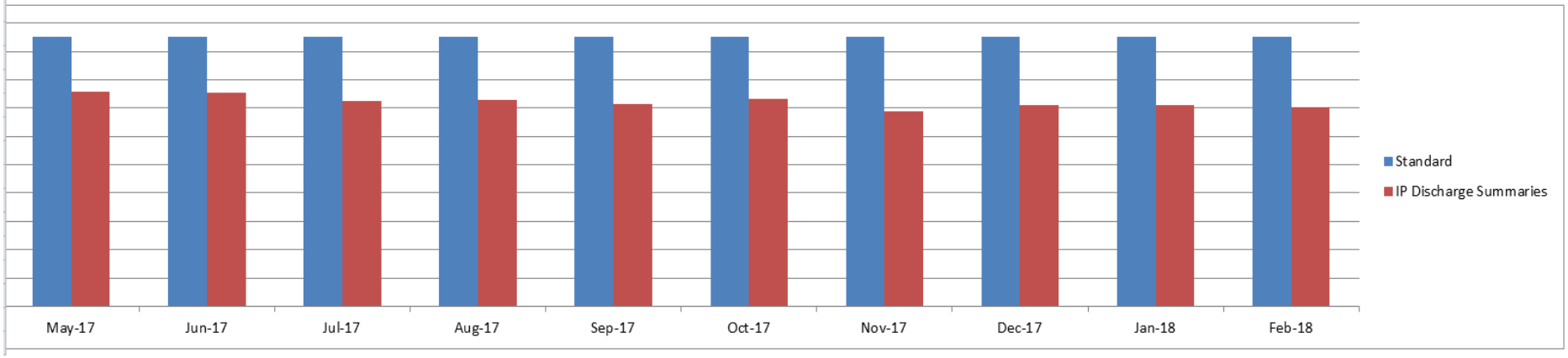
Summary of Current performance & Reasons for under performance

February figure of 70.3%. The trust takes the issue of prompt delivery and quality for discharge summaries very seriously. On this basis we have appointed a dedicated role in the trust to oversee improvements on performance for both speed and quality. The role has only recently been established but early indications are that this will make a significant difference. We will provide data at future boards confirming improvements.

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
74.0%	75.7%	75.5%	72.5%	72.7%	71.6%	73.3%	68.7%	70.9%	71.1%	70.3%	

Actions in place to recover the performance | **Expected timeframes for improvements**

Description	Owner	Start	End
e implementation of the workflow module in e-Care, due end of March.	NJ	Dec-17	Ongoing



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Discharge Summaries
Standard	95%
Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Effective

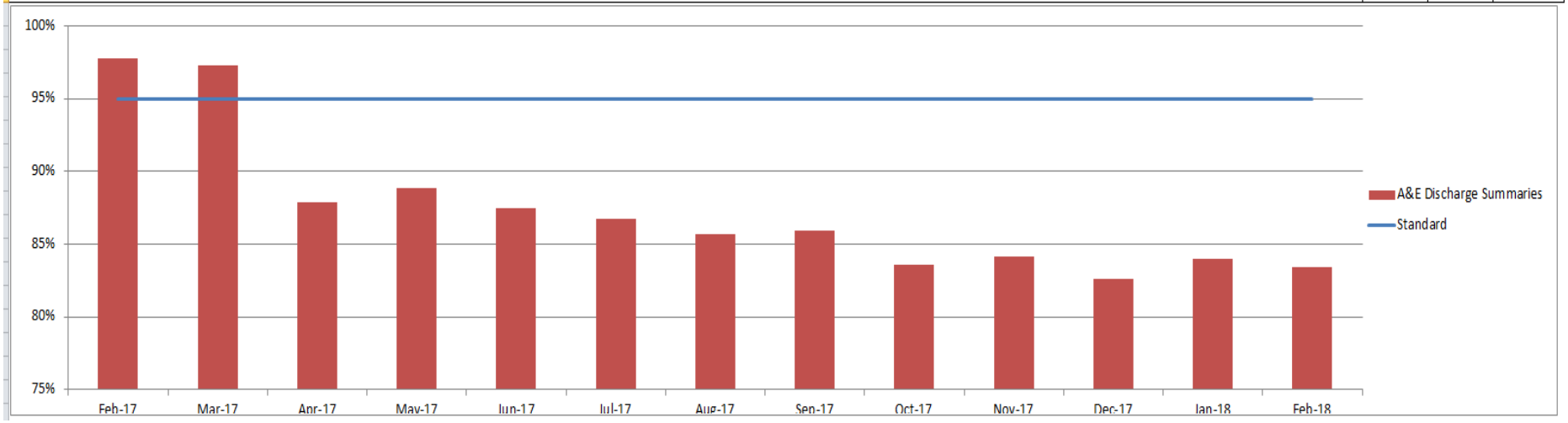
Summary of Current performance & Reasons for under performance

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

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
A&E Discharge Summaries	98%	97%	88%	89%	88%	87%	86%	86%	84%	84%	83%	84%	83%	

Actions in place to recover the performance — **Expected timeframes for improvements**

Description	Owner	Start	End
Around 40% of ED discharge summaries relate to patients that have been referred to other specialities and so should be completed by them (i.e. Surgery, Medical teams, O&G, etc). Information on outstanding discharge summaries is being sent to each speciality on a regular basis to ensure that these are completed. ED Medical staff are regularly reminded about completing discharge summaries on the day of discharge. There are also plans to improve automatic completion of discharge summaries as part of the ED optimisation project - the Clinical Workflow element of this is being implemented on 26th March.	NJ	Jun-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancelled Operations for non-clinical reasons
Standard	Less than 1%
ED Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission. Current Position - 1.22% against a threshold of 1%.

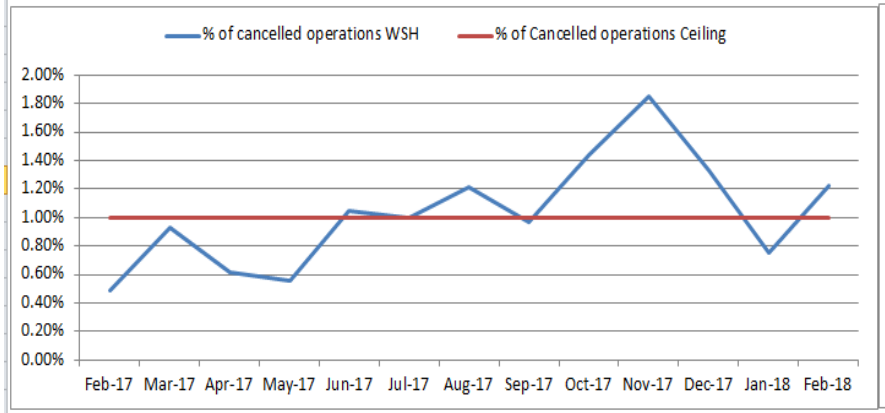
Patients offered date within 28 days of cancelled operation - Current Position: 96.60% against a threshold of 100%. This relates to one patient who was cancelled to release the surgeon to attend to an emergency case. Capacity issues prevented this patient being booked within 28 days. The patient is now rescheduled for their

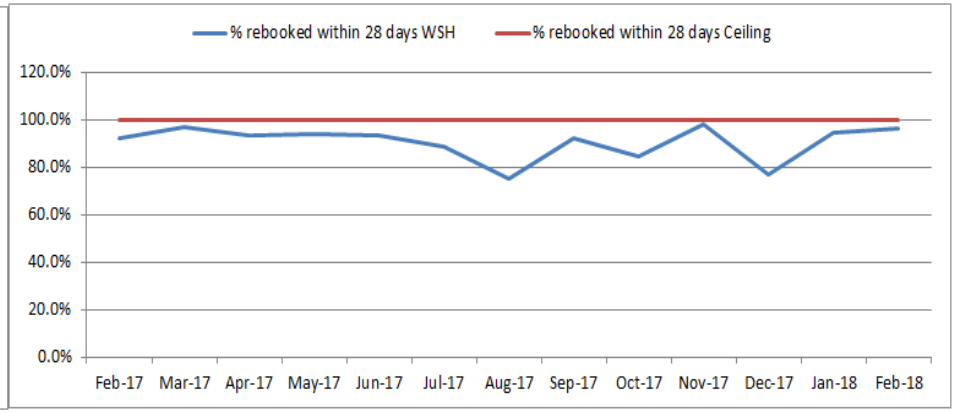
Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
% of cancelled operations WSH	0.49%	0.93%	0.62%	0.56%	1.05%	1.00%	1.21%	0.97%	1.44%	1.85%	1.33%	0.75%	1.22%	
% of Cancelled operations Ceiling	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	
% of cancelled Ops National Av.	1.1%	1.1%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	
% rebooked within 28 days WSH	92.1%	97.0%	93.3%	93.8%	93.2%	88.5%	75.0%	92.0%	84.6%	98.1%	76.7%	94.7%	96.6%	
% rebooked within 28 days Ceiling	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	

Actions in place to recover the performance

Expected timeframes for improvements

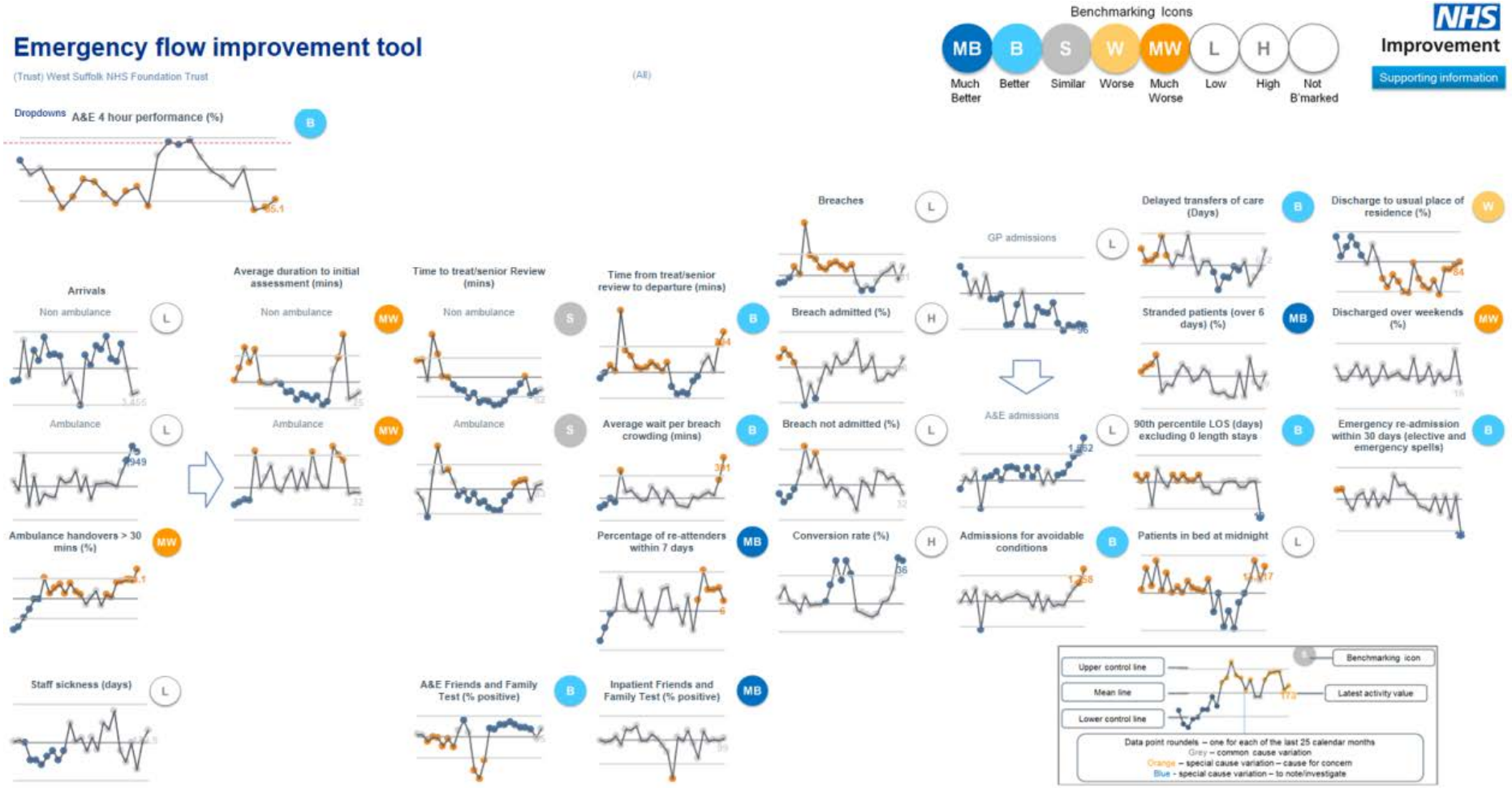
Cancelled Ops (Non-Clinical) This indicator is being closely monitored via the access meeting. The availability of Theatre staff and Anaesthetic cover has had some impact on cancellations however the larger proportion of cancellations have been as a result of ongoing winter pressures through February. Each patient is being clinically assessed prior to cancellation. This indicator is likely to recover as winter pressures begin to ease. Patients Offered within 28 Days – This indicator is not formally agenda'd on each Access meeting for discussion. The intention is to always re-date a patient cancelled for a non-clinical reason within 28 days but this can be restricted by patient choice and capacity constraints in some specialities. Each breach will be recorded on Datix.	HB	Jul-17	Feb-18





Emergency Flow

The new indicators in the Effective dashboard will be populated using the new Cerner System. NHS Improvement has produced a high-level flow benchmark analysis which is set out below (Trust data up to February 2018 for some Indicators- *Source: Model Hospital*).



DETAILED REPORTS - CARING

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

Are we..		Ref.	KPI	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	YTD(Apr17-Mar18)	WTG	Traffic	Trend
3. Caring	Dashboard	3.01	Compliments (Logged by Patient Experience)		41	28	41	52	26	56	28	17	33	87	151	64	20	575			
		3.02	Complaints (Inpatient)	20	12	11	10	10	10	6	16	16	17	13	8	12	19	137	6		
		3.03	Mixed Sex Accommodation Breaches	0	2	0	0	0	0	0	0	0	0	0	1	0	0	1	6		
		3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	98%	99%	98%	97%	99%	98%	98%	98%	99%	96%	98%	97%	98%	98%	6		
		3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	97%	96%	95%	96%	97%	95%	95%	96%	96%	96%	99%	95%	96%	96%	6		
		3.06	A&E - Extremely likely or Likely to recommend (FFT)	85%	96%	96%	97%	96%	95%	95%	95%	92%	95%	94%	94%	96%	95%	95%	6		
		3.07	Maternity - How likely are you to recommend our ward to friends and family?	85%	100%	100%	100%	100%	100%	100%	ND	ND	99%	100%	97%	100%	92%	99%	6		
	Other Friends and Family Test Scores	3.09	IP overall experience result	85%	93%	94%	93%	92%	94%	94%	93%	93%	96%	96%	95%	94%	95%	94%	3		
		3.10	OP overall experience result	85%	92%	91%	92%	85%	88%	89%	91%	89%	95%	94%	95%	96%	97%	92%	3		
		3.11	A&E overall experience result	85%	93%	94%	94%	96%	94%	94%	95%	94%	93%	94%	94%	94%	94%	94%	3		
		3.12	A&E children overall experience result	85%	98%	100%	ND	100%	94%	ND	ND	ND	ND	ND	ND	ND	ND	97%	3		
		3.14	Short-stay overall result	85%	99%	98%	99%	99%	100%	99%	99%	99%	99%	99%	99%	99%	99%	99%	3		
		3.15	Short-stay Extremely likely or Likely to recommend	90%	99.5%	99.6%	98.7%	98.6%	99.7%	99.5%	99.0%	99.0%	99.0%	97.0%	100.0%	99.4%	99.7%	99%	3		
		3.16	Maternity - overall	85%	96%	100%	98%	100%	100%	100%	100%	100%	100%	98%	95%	100%	88%	98%	3		
		3.17	Maternity - postnatal ward recommendation to F&F	90%	100%	100%	100%	100%	100%	ND	ND	100%	100%	ND	ND	ND	ND	100%	3		
		3.18	Maternity - birthing unit recommendation to F&F	90%	ND	ND	100%	100%	100%	ND	ND	100%	100%	100%	ND	100%	100%	100%	3		
		3.19	Maternity -antenatal community care rec. to F&F	90%	100%	95%	97%	98%	100%	ND	ND	100%	96%	ND	ND	ND	ND	98%	3		
		3.20	Maternity -post-natal community care rec. to F&F	90%	100%	100%	100%	98%	ND	ND	ND	100%	98%	ND	ND	ND	ND	99%	3		
		3.22	F1 Parent overall result	85%	99%	97%	97%	99%	99%	95%	100%	100%	99%	95%	98%	98%	98%	98%	3		
		3.23	F1 Parent - Extremely likely or Likely to recommend (FFT)	90%	100%	100%	100%	100%	100%	92%	100%	100%	100%	94%	97%	100%	100%	98%	3		
		3.24	Stroke Care - Overall Result	85%	95%	95%	94%	ND	98%	99%	ND	99%	100%	85%	ND	98%	95%	96%	3		
		3.25	Stroke Care - How likely is it that you would recommend the service to friends and family?	90%	100%	100%	93%	ND	95%	100%	100%	95%	100%	100%	ND	100%	100%	98%	3		
	Complaints Handling	3.27	Complaints acknowledged within 3 working days	90%	ND	ND	ND	90%	100%	100%	93%	94%	100%	100%	87%	92%	100%	96%	3		
		3.28	Complaints responded to within 25 working days	90%	86%	100%	100%	90%	75%	100%	85%	67%	81%	82%	50%	60%	17%	73%	1		
		3.29	Number of second letters received	1	2	1	3	0	2	1	1	1	2	0	1	0	0	11	3		
		3.30	Health Service Referrals accepted by Ombudsman		0	0	0	2	0	1	0	0	0	0	1	1	1	6	2		
		3.31	No. of complaints to Ombudsman upheld	0	ND	ND	ND	ND	ND	ND	ND	ND	ND	0	0	0	0	0			
		3.33	No. of PALS contacts	NA	189	230	172	188	169	176	137	167	190	167	124	161	178	1829			
		3.34	No. of PALS contacts becoming formal complaints	<=5	0	1	0	0	0	1	4	2	3	4	1	3	6	24	3		
	Other	3.37	Environment & cleanliness - Patient Satisfaction Overall	75%	91%	89%	93%	92%	92%	92%	94%	93%	94%	95%	94%	93%	94%	93%	3		
		3.38	Catering - Patient Satisfaction with food - overall	75%	83%	82%	83%	81%	85%	78%	85%	81%	87%	77%	85%	78%	88%	83%	3		

8. EXCEPTION REPORTS - CARING

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Complaints - Response Timeframe
Standard	90%
Name	Rowan Procter
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Caring

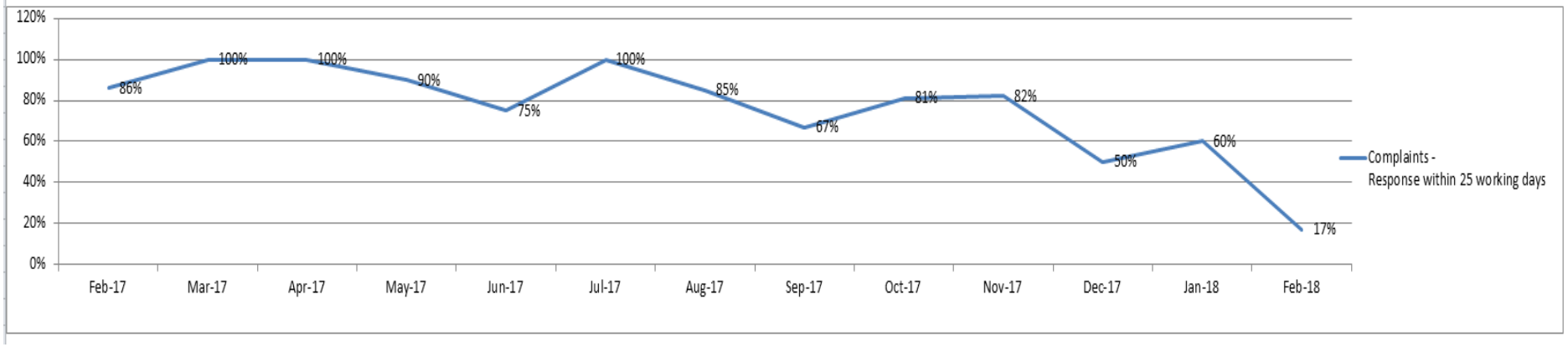
Summary of Current performance & Reasons for under performance

1 out of 6 complaint responses due in February were overdue. The reason only 6 responses were due is because many have had to have an extension agreed due to workload so will feature in future figures. This is a reflection on the capacity of the Patient Experience Team.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Complaints - Response within 25 working	86%	100%	100%	90%	75%	100%	85%	67%	81%	82%	50%	60%	17%	

Actions in place to recover the performance / **Expected timeframes for improvements**

Description	Owner	Start	End
To continue to monitor	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

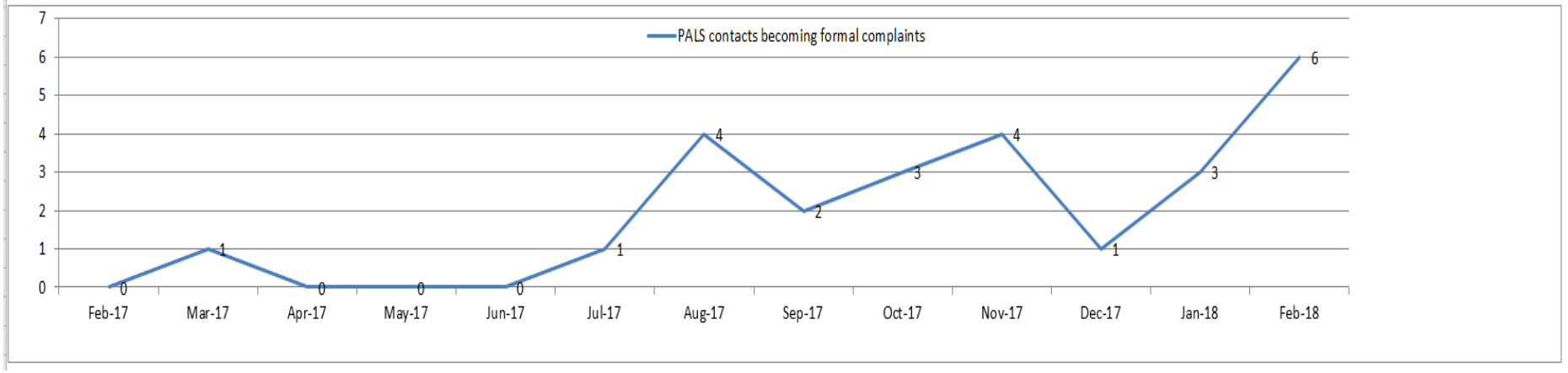
Indicator	PALS contacts becoming formal complaints
Standard	<=5
Name	Rowan Procter
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Six PALS enquiries were escalated to formal complaints in February. There was an increase in PALS activity in February, having dealt with the highest number of enquiries since October 2017 and May 2017 before that, so an increase in formal complaints was to be expected. We also received a high number of enquiries relating to rescheduled surgery whereby people preferred a formal investigation.

Indicator	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
PALS contacts becoming formal complaints	1	0	0	0	1	4	2	3	4	1	3	6	

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To continue to monitor	HB		



NHS West Suffolk NHS Foundation Trust

DETAILED REPORTS - RESPONSIVE

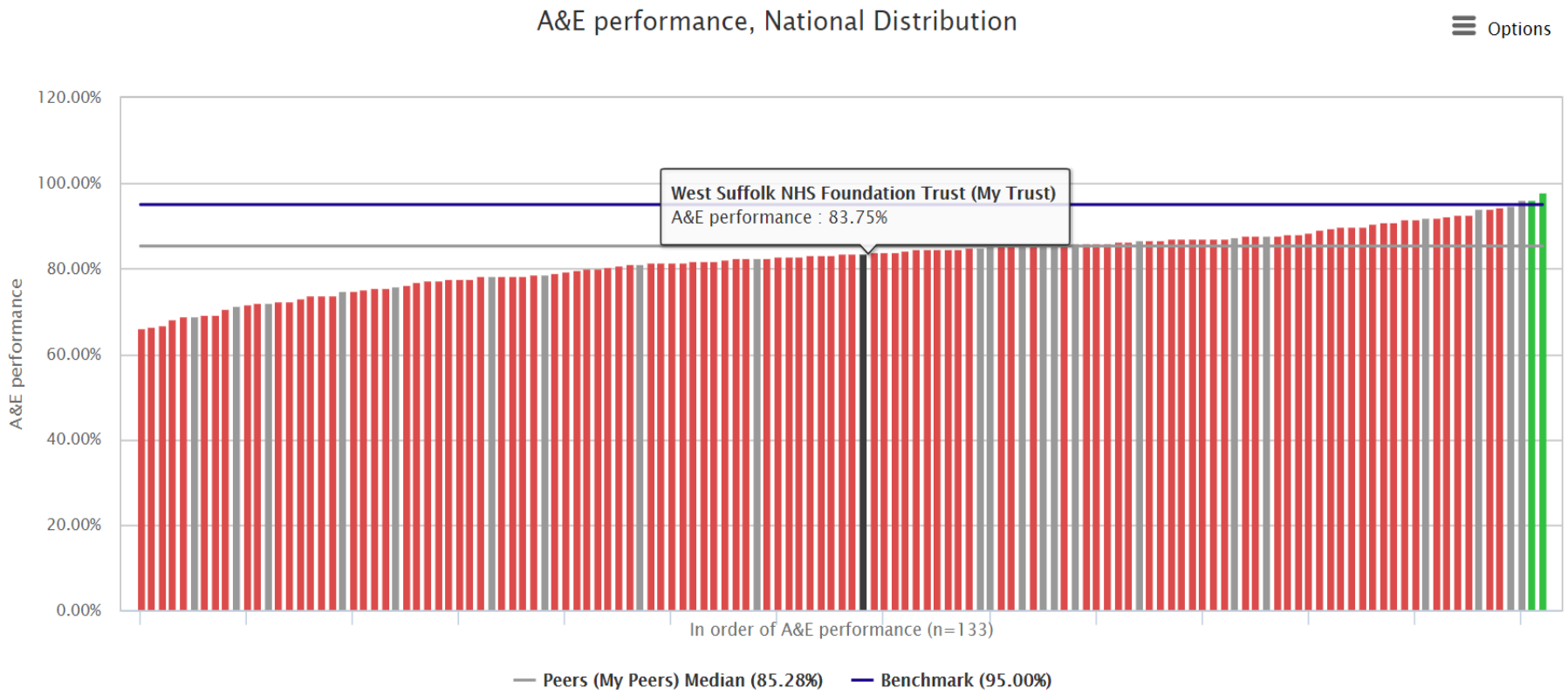
Are we safe? | Are we effective? | Are we caring? | **Are we responsive?** | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	YTD(Apr17-Mar18)	WTG	Traffic	Trend
4. Responsive	Dashboard	4.01	A&E under 4 hr. wait	95%	84%	93%	95%	95%	96%	92%	90%	89%	87%	90%	83%	84%	85%	90%	2		
		4.02	RTT: % incomplete pathways within 18 weeks	92%	90%	90%	82%	80%	83%	84%	86%	86%	87%	89%	89%	90%	90%	86%	2		
		4.03	52 week waiters	0	7	8	15	14	15	35	26	29	26	21	15	14	13	223	2		
		4.04	Diagnostics within 6 weeks	99%	99.42%	99.91%	99.86%	99.87%	100.00%	99.50%	99.95%	100.00%	100.00%	100.00%	99.95%	99.96%	99.80%	100%	6		
		4.05	Cancer: 2w wait for urgent GP Referrals	93%	98.3%	97.7%	93.9%	92.3%	96.6%	94.5%	96.0%	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94%	6		
		4.06	Cancer 2w wait breast	93%	96%	94%	94.0%	99.3%	88.8%	98.1%	100.0%	98.3%	100.0%	100.0%	99.1%	97.1%	92.9%	97%	6		
		4.07	Cancer 31 d First Treatment	96%	100%	99%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	6		
		4.08	Cancer 31 d Drug Treatment	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
		4.09	Cancer 31 d Surgery	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
		4.10	Cancer 62 d GP referral	85%	88%	83%	89%	83%	86%	85%	86%	87%	94%	90%	87%	86%	79%	87%	6		
		4.11	Cancer 62 d Screening	90%	89%	97%	100%	100%	90%	100%	100%	91%	100%	83%	100%	93%	86%	95%	6		
	Emergency Care &Emergency Fl	4.20	Number of Delayed Transfer of Care - (DTOCs)	NT	464	294	417	411	511	481	565	337	250	279	314	326	393	389			
		4.21	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	NT	48	53	35	43	52	52	50	62	59	41	62	57	75	588	3		
		4.22	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	12:25	22:32	09:57	13:57	10:10	13:53	11:46	12:01	15:44	22:04	16:48	18:11	17:18	14:42			
		4.23	A&E -Waits over 12 hours from DTA to Admission	12 Hrs.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3		
		4.24	A&E - Admission waiting 4-12 hours from dec. to admit		12	5	14	3	6	5	5	14	10	17	50	122	30	25.1	1		
		4.25	A&E - To inpatient Admission Ratio	27%	33.6%	32.0%	29.09%	29.03%	28.25%	27.92%	29.20%	30.48%	30.36%	30.01%	32.84%	31.86%	32.13%	30%	3		
		4.26	A&E Service User Impact (re-attendance in 7 days <5% & time to treat)	1 met	1	1	1	1	1	1	1	1	1	1	1	1	1	11	3		
		4.27	A&E/AMU - Amb. Submit button complete	80%	84%	88%	93.0%	91.1%	91.7%	91.0%	89.9%	90.3%	87.7%	88.2%	89.4%	85.7%	89.6%	90%	3		
		4.28	A&E - Amb. Handover above 30m	30m	53	48	21	38	31	39	19	15	0	84	110	72	ND	43	3		
		4.29	A&E - Amb. Handover above 60m	60m	34	18	3	16	9	7	16	30	0	46	54	38	ND	219	3		
	RTT	4.31	RTT - 18w Admitted (Completed)	90%	69%	69%	69.2%	67.8%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	71.15%	1		
		4.32	RTT - 18w Non-admitted (Completed)	95%	85%	85%	86.2%	87.0%	87.3%	87.6%	85.8%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	88%	1		
		4.33	RTT waiting List		18126	18127	22110	22144	19931	18676	17346	17236	16694	16641	16195	15363	15804	18013			
		4.34	RTT waiting list over 18 weeks		1833	1834	3929	4492	3316	2629	2441	2467	2171	1843	1775	1504	1650	2565			
	Stroke	4.35	Stroke - % Patients scanned within 1 hr.	77%	69%	88%	87%	80%	72%	82%	79%	78%	76%	74%	76%	87%	77%	79%	3		
		4.36	Stroke - % patients scanned within 12 hrs.	96%	91%	100%	98%	98%	95%	95%	96%	90%	97%	92%	96%	98%	100%	96%	2		
		4.37	Stroke - % Patients admitted directly to stroke unit within 4h	75%	63%	75%	89%	71%	76%	78%	79%	83%	72%	73%	60%	75%	79%	76%	3		
		4.38	Stroke - % greater than 80% of treatment on a stroke unit	90%	91%	88%	98%	88%	88%	94%	98%	93%	89%	93%	91%	93%	97%	93%	3		
		4.39	Stroke - % of patients treated by the SESDC	48%	42%	34%	50%	48%	75%	46%	33%	51%	50%	31%	32%	62%	50%	48%	3		
		4.40	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	84%	94%	93%	86%	95%	92%	88%	85%	83%	82%	89%	93%	83%	88%	3		
		4.41	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72 hrs	75%	80%	72%	87%	80%	90%	88%	90%	92%	77%	76%	78%	93%	86%	85%	3		
		4.42	Stroke -% of eligible patients given thrombolysis	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		4.44	Stroke -Provider rating to remain within A-C	C	ND	ND	ND	C	ND	ND	ND	ND	ND	ND	ND	C	ND	C			
	OI	4.46	Sepsis - 1 hr neutropaenic sepsis	100%	94.12%	80.00%	63.64%	47.06%	63.16%	68.75%	82.61%	62.50%	78.95%	73.91%	53.85%	80%	75%	68%	1		

Putting you first

EXCEPTION REPORTS – RESPONSIVE

A&E performance has fallen from 95.1% in Qtr. 1 to 87% in Qtr. 3 at West Suffolk. The first table (latest available data – January 2018) shows the relative performance of West Suffolk compared with peers and the national average. The second chart show performance of West Suffolk against the peers and national median (*Source: Model Hospital)*.



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E 4 hour wait
Standard	95%
Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

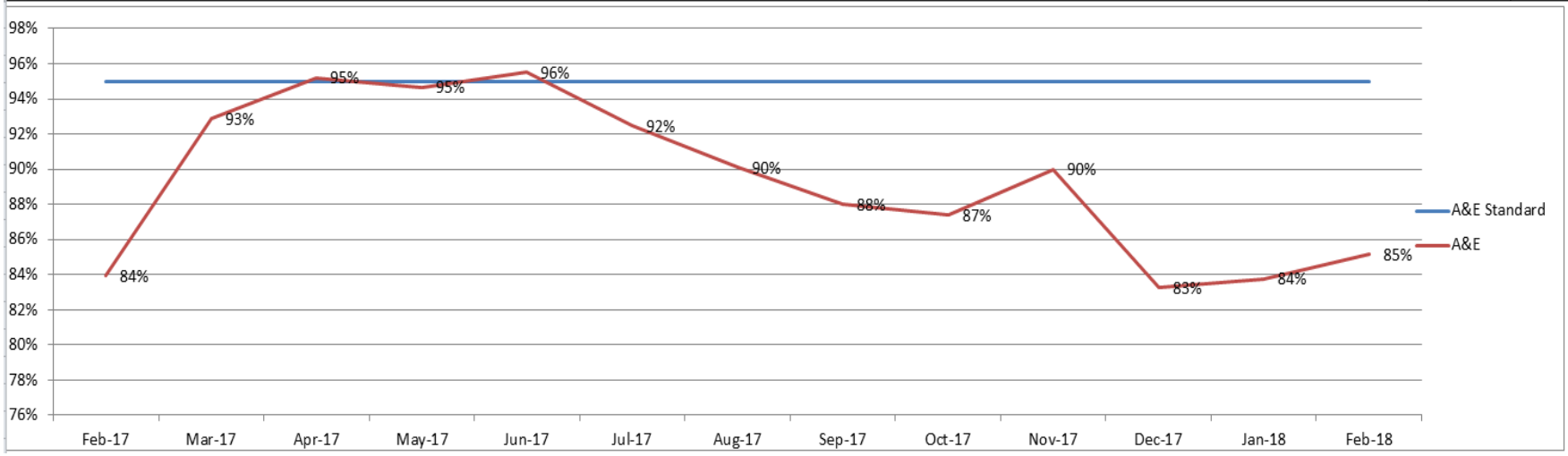
Demand remained high for February however performance improved from January. Patient flow has also been challenging with delays for patients waiting for beds and delays waiting to be seen by a clinical decision maker (CDM), with a majority of the delays being out of hours. This is due to gaps in the medical workforce which continue at middle grade level. It is envisaged that patient flow will continue to be a significant issue whilst escalation beds on F8 and G9 are open and demands remains high. The Single longest Wait (Admitted & Non-Admitted) in February was 17:18. This occurred on 20th February. This was a patient who had a delay to be assessed by the Mental Health team overnight and then required medical admission following a further overdose whilst in ED.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
A&E Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
A&E	84%	93%	95%	95%	96%	92%	90%	88%	87%	90%	83%	84%	85%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
The middle grade rota has been changed to a 6 person rota (from a 10 person) rota to allow 24-hour coverage. Additional middle grade level support will be starting in April and June. An ED task and Finish Group, Executive led, has been re established with numerous work streams to address challenges in the Department.	HB	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E To Inpatient Admission Ratio
Standard	27%
Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Responsive

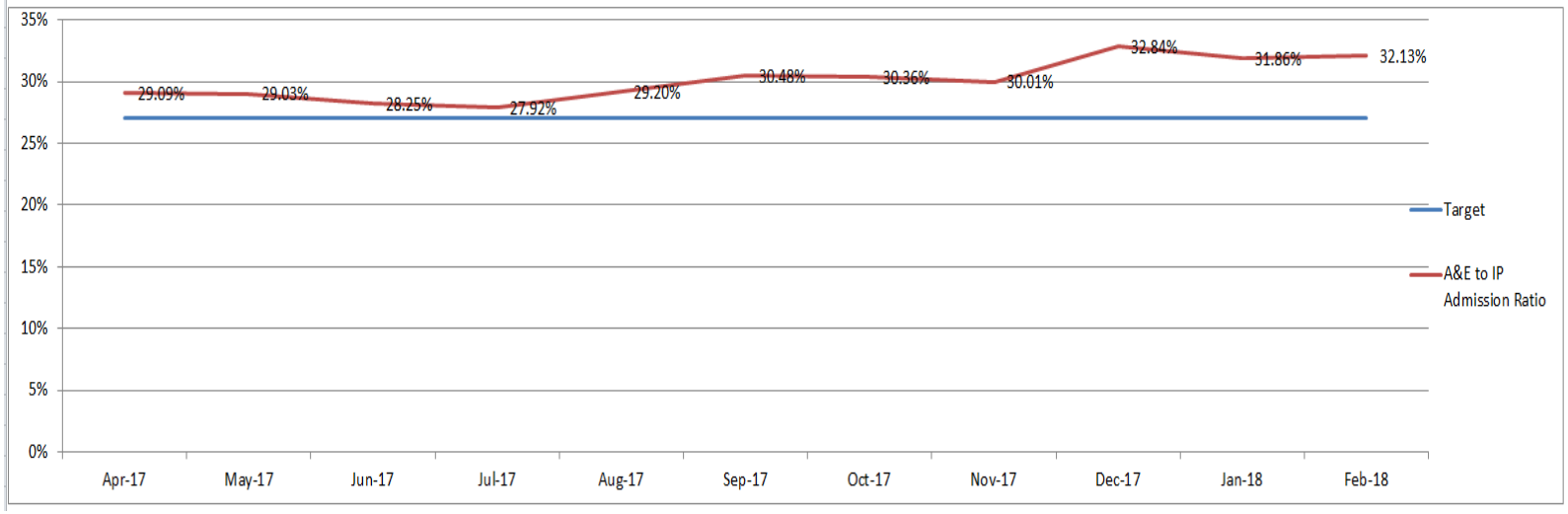
Summary of Current performance & Reasons for under performance

February continues to see an increase in the acuity of patients attending ED. It is difficult to identify whether there are other reasons which have also contributed to this higher than normal conversion rate.

Indicator	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Target	27%	27%	27%	27%	27%	27%	27%	27%	27%	27%	27%	
A&E to IP Admission Ratio	29.09%	29.03%	28.25%	27.92%	29.20%	30.48%	30.36%	30.01%	32.84%	31.86%	32.13%	

Actions in place to recover the performance — **Expected timeframes for improvements**

Description	Owner	Start	End
Further analysis has been commissioned in cluding working with ECIST, to understand the reasons for the higher conversion rate, after which specific actions can be agreed.	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Stroke
Standard	75% Target
Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

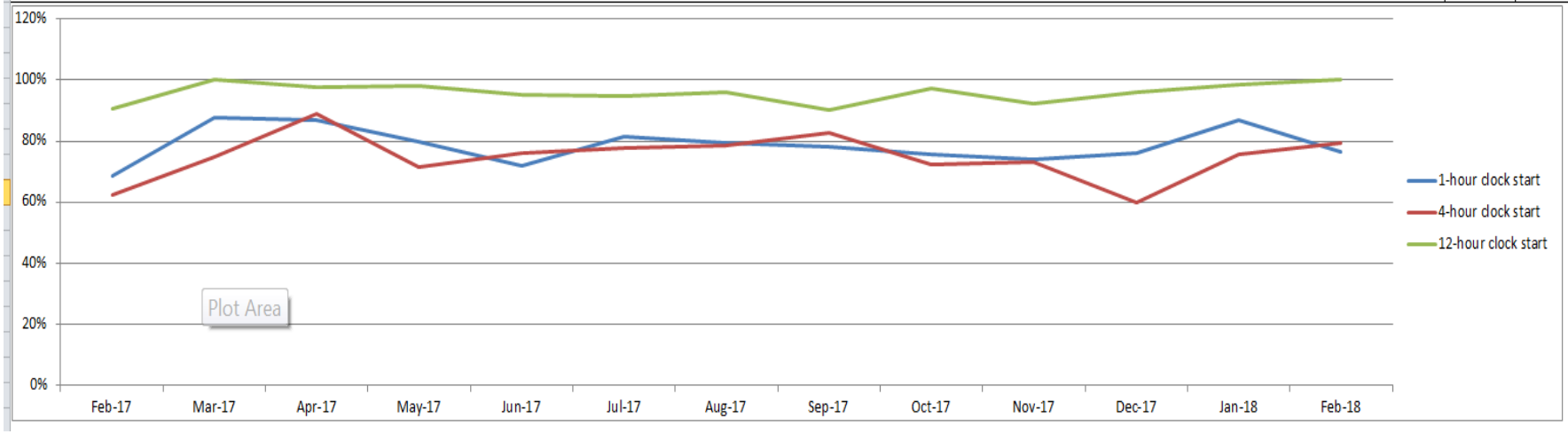
All contractural targets have been met except for the one hour to scan which very narrowly missed this month, 76.7% against a target of 77%. Out of the seven breaches, five of those were not appropriately referred to the stroke team on arrival. These patients were not seen as potential strokes on arrival, they were not immediately seen OR referred to the stroke team as stroke alerts, and therefore, not scanned in one hour. One patient was following the TIA pathway before being scanned and then admitted to the stroke unit, and one was inappropriately referred by a GP. It is possible this is an outcome of the high volume of patients in ED which has had an effect on the speed of referrals to the stroke team.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
1-hour clock start	69%	88%	87%	80%	72%	82%	79%	78%	76%	74%	76%	87%	77%	
4-hour clock start	63%	75%	89%	71%	76%	78%	79%	83%	72%	73%	60%	75%	79%	
12-hour clock start	91%	100%	98%	98%	95%	95%	96%	90%	97%	92%	96%	98%	100%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
To improve this metric, continue with staff education within the ED to improve performance against this target.	RP	Sep-17	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer: 2-week wait Breast Referrals
Standard	93%
Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

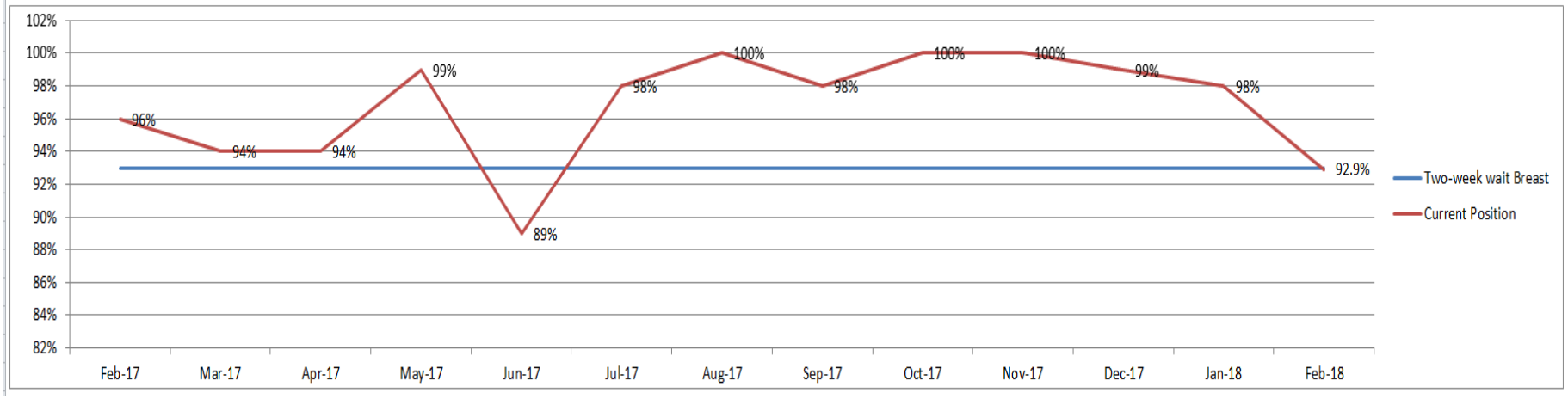
Current Performance 92.93% - the 7 patients that breached all cancelled their first appointment and despite extra clinics we were unable to offer the next appointment within 14days. the prison service was not able to bring back one patient after they DNA'd for late arrival and one choose and book system patient cancelled in time appointment and rebooked one day passed the breach date.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Two-week wait Breast	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	
Current Position	96%	94%	94%	99%	89%	98%	100%	98%	100%	100%	99%	98%	92.9%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
A new visiting size card patient information has now been agreed with the CCG for GPs to distribute to all 2 WW referred patients to help them remind the importance of accepting first offer of appointment.	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer: 62-day GP Referral
Standard	85%
Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

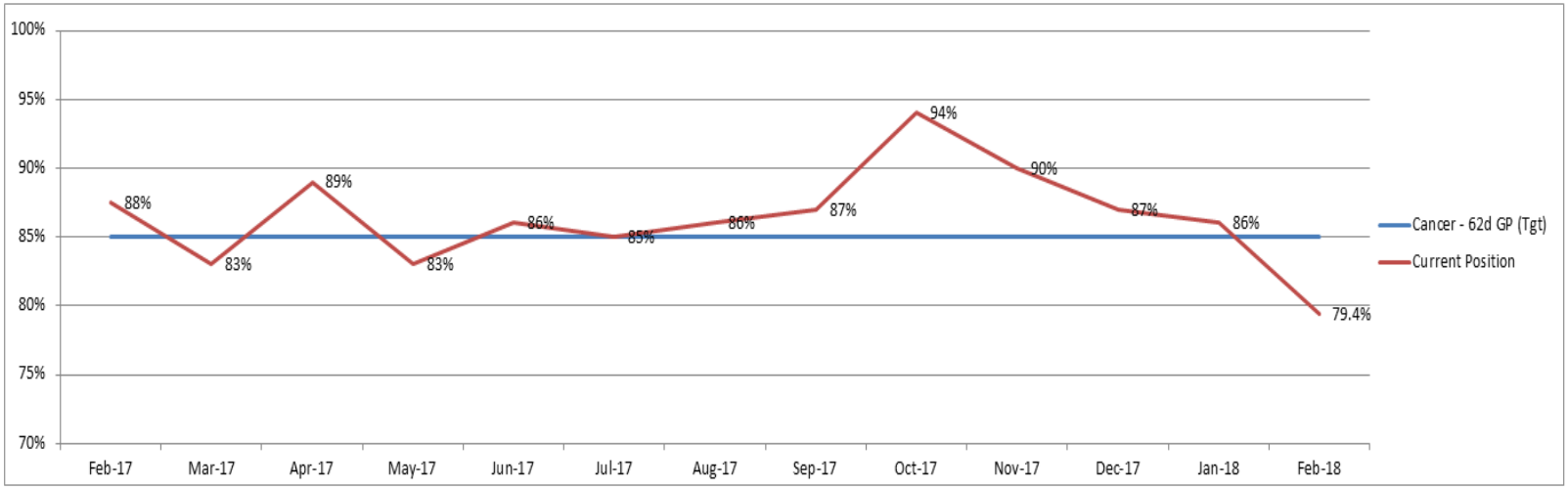
Current Performance: 79.4% This is provisional for February. There were five breaches in Urology- four in prostate pathways with combination of patient side and inadequate capacity to perform trans perineal biopsy for tissue diagnosis contributed to these breaches. In addition, endoscopy capacity delayed diagnosis of 2 colorectal patients resulting in breaches. One breach in Lung due to late return of a patient back for local treatment from Papworth. A Skin patient had a very long wait for diagnostic path result to book and offer treatment in time. February being a short month and there was less than average (>10 difference) patient treatment activities to report this month.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Cancer - 62d GP (Tgt)	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	
Current Position	88%	83%	89%	83%	86%	85%	86%	87%	94%	90%	87%	86%	79.4%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Trust Capacity to carry out transperineal biopsy is very limited and the trained bodies to do this procedure are also limited. Urology service is currently over stretched and recovery requires increase in capacity. Endoscopy capacity is inadequate to deliver timely diagnostic output required to achieve 62-day waiting times as delayed tissue diagnosis does not leave enough days for staging investigations to offer/agree plan and commence treatment on time.	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer: 62-day Screening
Standard	90%
Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

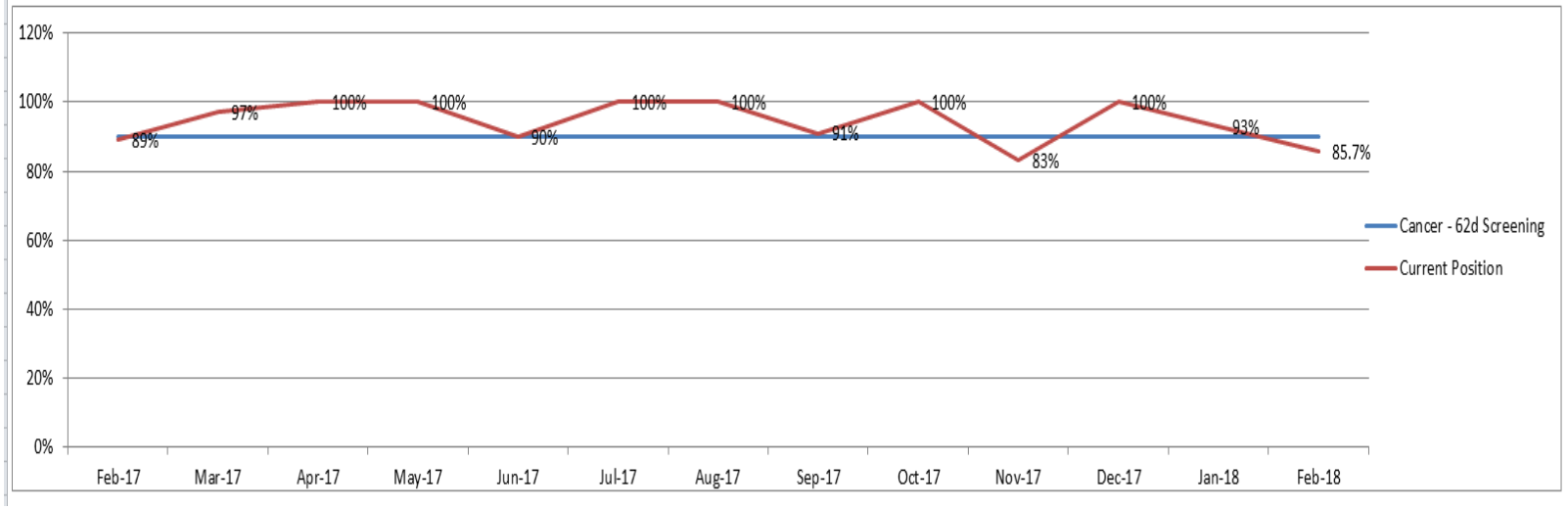
Current Position - 85.7% against a threshold of 90%. This is provisional figure for February. Very low activities to report resulting in to underperformance by one shared breach (0.5) Bowel cancer screening referral. This was not received until day 42 to stage/see and confirm and start treatment on time. This was unavoidable due to late referral (day 42) from the screening hub as they required time to stage, MDT review for treatment plan and commenced treatment on day 69.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Cancer - 62d Screening	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	
Current Position	89%	97%	100%	100%	90%	100%	100%	91%	100%	83%	100%	93%	85.7%	

Actions in place to recover the performance

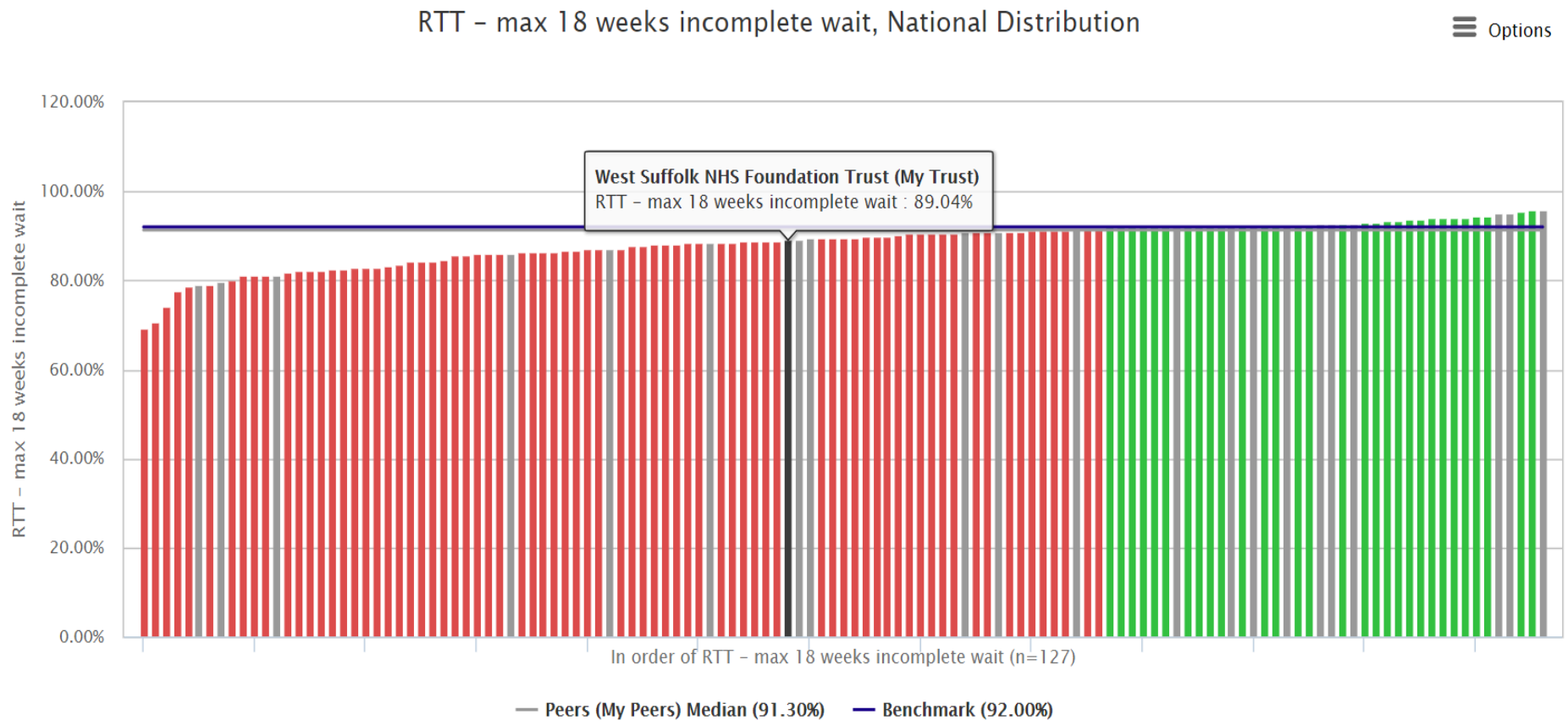
Expected timeframes for improvements

Description	Owner	Start	End
This issue of late referral been highlighted to the Addenbrookes screening programme and recovery in the standard depends on improvement in Endoscopy capacity at their end.	HB		

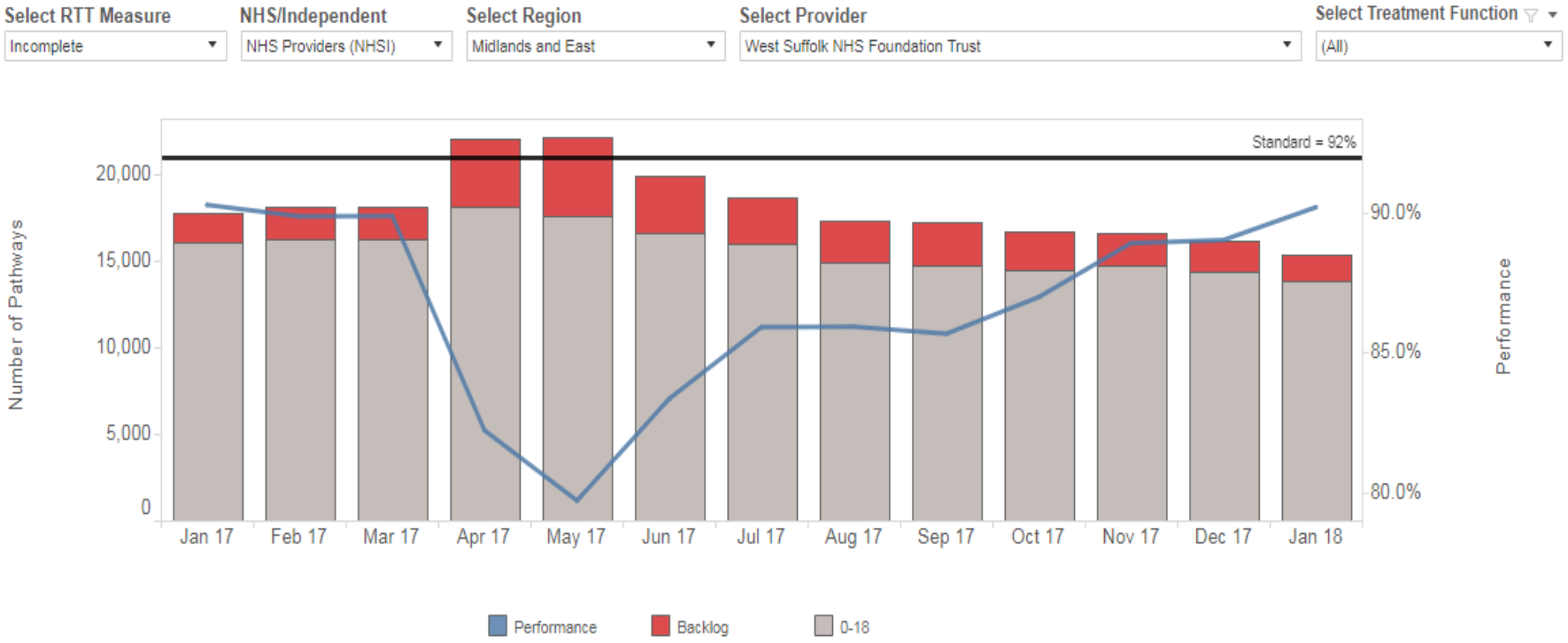


Referral to Treatment

Progress is being made to reduce the number of people on the RTT waiting list and to treat 92% of patients from point of referral to treatment in aggregate – patients on an incomplete pathway. However, the Trust remains a national outlier in term of overall performance as demonstrated in the slides below (*Source: Model Hospital-Data from December 2017)*.



Rolling 13 Month Performance against National Standard (Source – NHS-I)



	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18
Incomplete	90.3%	89.9%	89.9%	82.2%	79.7%	83.4%	85.9%	85.9%	85.7%	87.0%	88.9%	89.0%	90.2%
Admitted	67.9%	68.8%	68.9%	69.2%	67.8%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%
Non Admitted	87.5%	84.7%	84.8%	86.1%	87.0%	87.3%	87.6%	85.9%	87.3%	84.9%	85.8%	90.6%	88.7%

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT - Incomplete waiting list
Standard	92%
Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

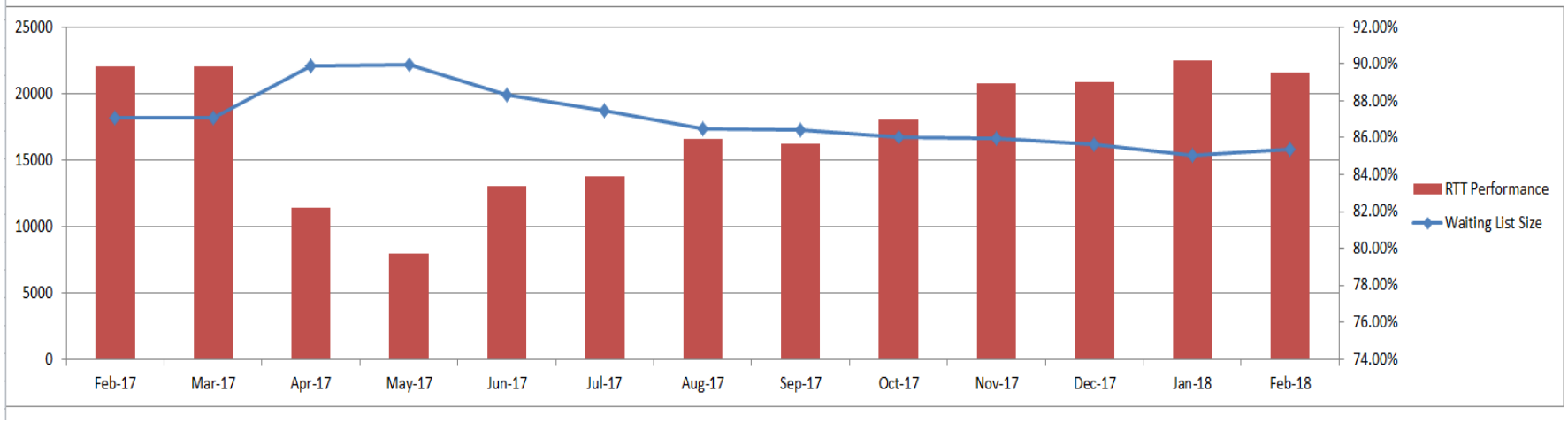
February has seen a slight deterioration as expected to a positon of 89.56%. Winter pressures have continued to impact through February with the elective programme restarting towards the end of the month. This has had a detrimental impact on our aggregate incomplete waiting list position. T&O remains an area of concern due to winter cancellations, however a programme of work is underway to begin to recover from this within available resources. The urology and opthalmology speciality remains under continued pressure due to national recruitment issues.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Waiting List Size	18126	18127	22110	22144	19931	18676	17346	17236	16694	16641	16195	15,363	15,804	
RTT Performance	89.89%	89.88%	82.23%	79.71%	83.36%	83.92%	85.93%	85.69%	87.00%	88.92%	89.04%	90.21%	89.56%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
1. Targeted work is being undertaken to reduce the back log in challenged specialties. 2. There is a specific focus to review the vascular surgery pathway to ensure appropriate referrals to treatment are in place and a meeting with the clinicians in this speciality is planned. 3. Focus to resolve recruitment and sickness absence challenges in the theatre teams continues with recent appointments beginning to improve the situation.	HB	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT - 52-week waiters
Standard	0%
Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Responsive

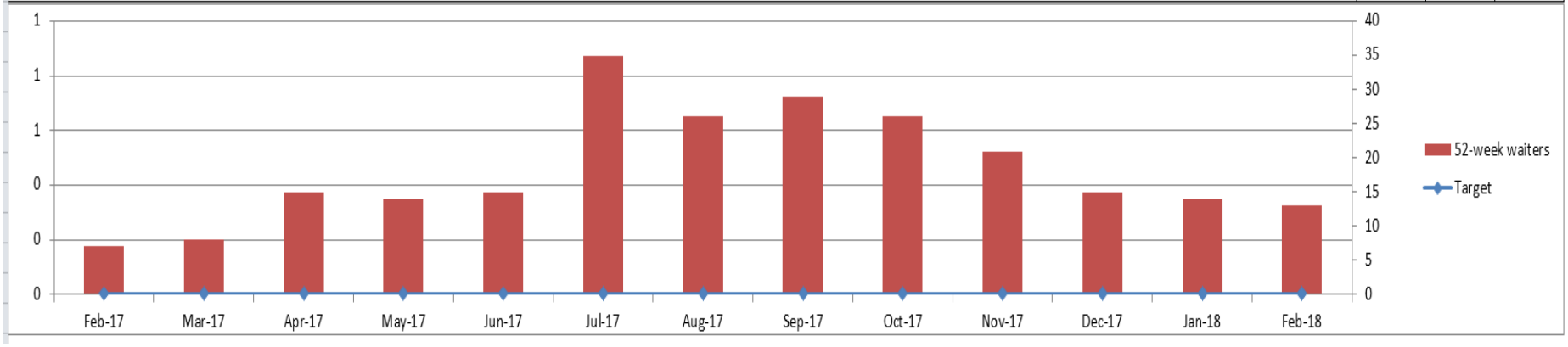
Summary of Current performance & Reasons for under performance

In February, 13 patients breached 52 weeks in the following specialities; 1 Audiology, 4 ENT, 2 Urology, 1 Neurology, 1 Plastic Surgery, 1 T&O, and 3 Vascular Surgery. Of these 13 patients, 6 have completed treatment in March, 1 has been transferred to another hospital, 3 have appointments or TCI dates in April and the remaining 2 are awaiting confirmation of treatment. The recovery has been impacted by the restrictions placed on the elective surgery programme by winter pressures.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	
52-week waite	7	8	15	14	15	35	26	29	26	21	15	14	13	

Actions in place to recover the performance — **Expected timeframes for improvements**

Description	Owner	Start	End
Long waiting patients and are being actively monitored by the senior team to ensure patients are being booked in turn and proactively managed. This is being monitored on a weekly basis. A clinical harm review process has been established to provide assurance that long waiting patients are not being exposed to harm.	HB	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT -18 wk Admitted & Non-Admitted
Standard	90% & 95%
ED Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

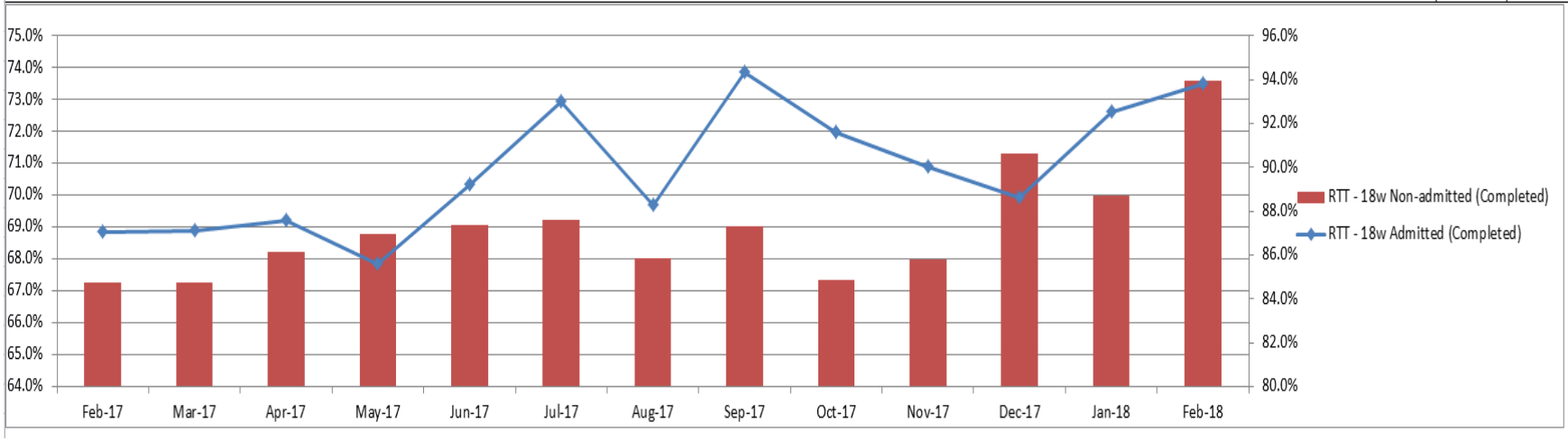
RTT 18 week admitted 74% against a target of 90% and RTT 18 week non-admitted 94% against a target of 95%. This continues to be predominantly due to longer waits for first appointment in Dermatology and Ophthalmology. Particular challenges remain evident in Urology, ENT, and Vascular Surgery on the elective waiting list and winter pressures have impacted T&O in particular.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
RTT - 18w Admitted (Completed)	68.8%	68.9%	69.2%	67.8%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	
RTT - 18w Non-admitted (Completed)	84.7%	84.8%	86.2%	87.0%	87.3%	87.6%	85.8%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Recovery plans are being developed to mitigate the impact of winter pressures cancellations alongside with proactive work within the divisions to manage waiting lists on an ongoing basis. Specific work with NHSI IST is ongoing in developing organisational resilience around RTT processes.	HB	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Sepsis - 1-hr neutropaenic sepsis
Standard	100%
ED Name	Helen Beck
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

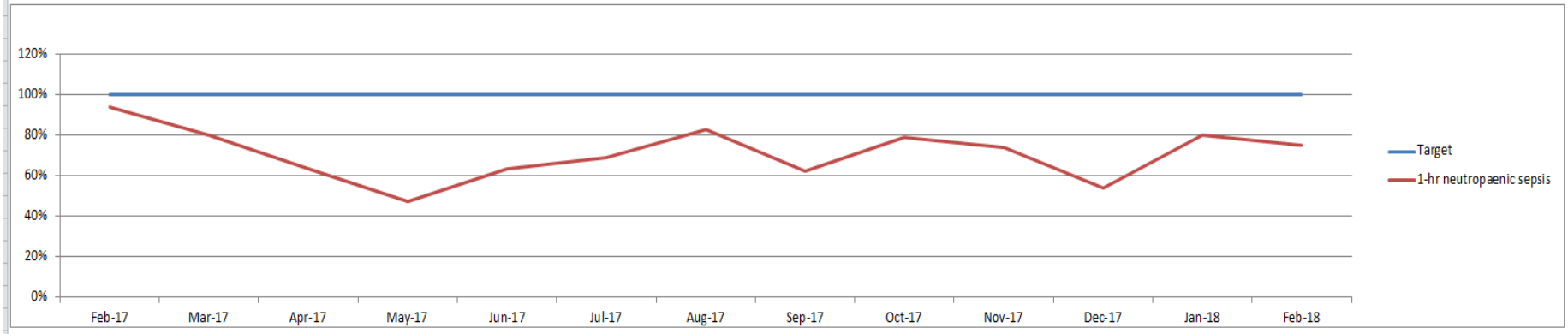
Macmillan – 100%. ED – 44.4%. Overall Trust figure (including AMU) of 75% against a threshold of 100%.

The performance figure for 1 hour to needle from diagnosis of neutropenic sepsis February Data showed a slight drop of 5% on last month's 80% performance . The Emergency Department had 5 neutropenic sepsis patient breaches. The breach cases will be undergoing detailed review. These issues will be escalated to the Emergency Department Clinical and Nursing management to address within the departments.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Macmillan Unit, G1	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Emergency Dept, ED	90.9%)	66.7%	71.4%	40.0%	41.6%	58.3%	70.0%	40.0%	66.7%	62.5%	14.2%	50.0%	44..4%	
Acute Medical Unit, AMU	NA	NA	100.0%	NA	NA	NA	0.0%	NA	NA	NA	NA	NA	NA	
1-hr neutropaenic sepsis	94.1%	80.0%	63.6%	47.1%	63.2%	68.8%	82.6%	62.5%	79.0%	73.9%	53.8%	80.0%	75.0%	

Actions in place to recover the performance — **Expected timeframes for improvements**

Description	Owner	Start	End
1.To achieve the backlog of Neutropaenic Sepsis Concise RCA's from June 2017 and complete ongoing. 2.Undertake a review of the changes made to the Neutropaenic Patient Pathway. If the patient has received a documented review by the onclogy specialist nurses prior to arrival, they can receive antibiotics immediately in ED.	DG	Mar-18	Ongoing



DETAILED REPORTS – WELL-LED

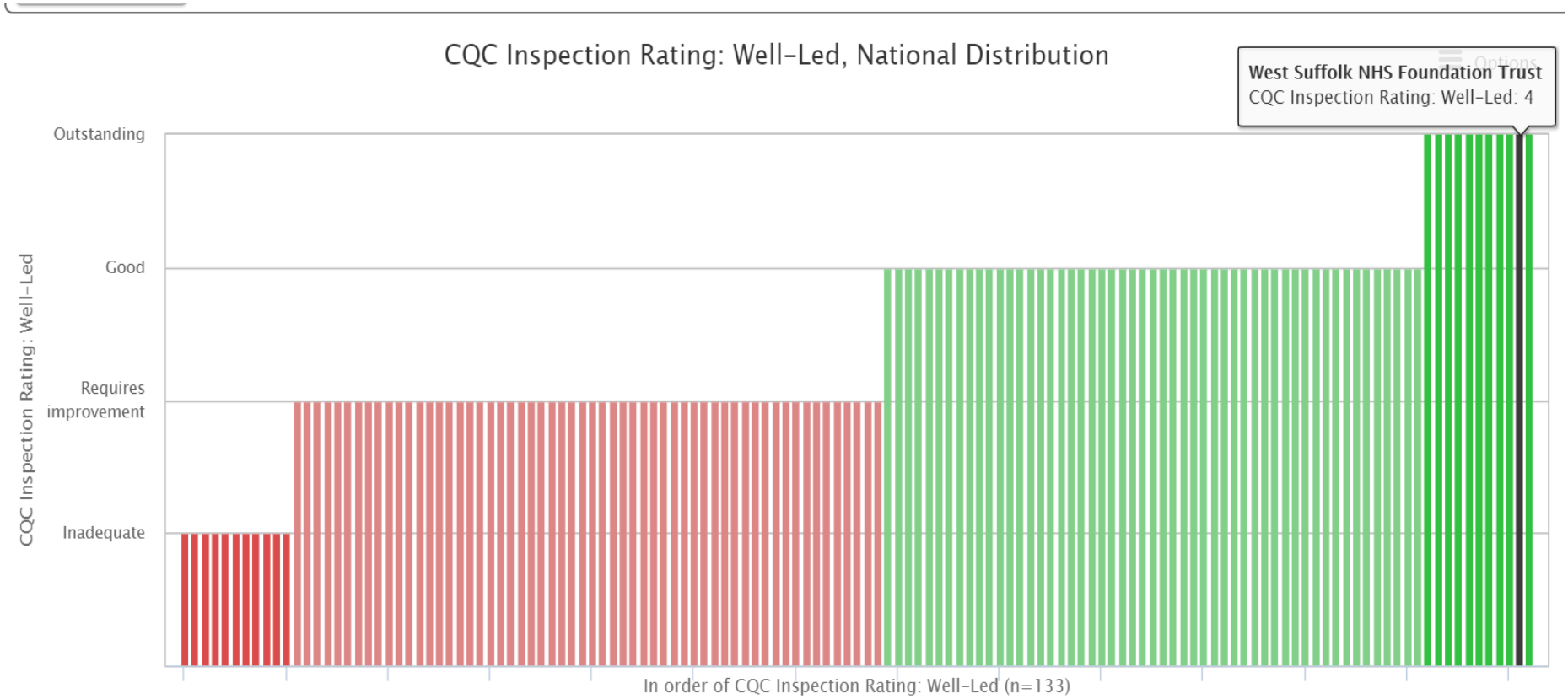
Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we		Ref.	KPI	ED	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	YTD (Apr17 Mar18)	WTG	Traffic	Trend
5. Well Led	Dashboard	5.01	NHS Staff Survey (Staff Engagement score -Annual)	JB	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	3.96%				
		5.02	Staff F&F Test % Recommended - care (Qrtly)	JB	NA	93%	NA	NA	95%	NA	NA	95%	NA	NA	ND	NA	NA	95%	6		
		5.03	Staff F&F Test % Recommended - place to work (Qrtly)	JB	NA	79%	NA	NA	83%	NA	NA	82%	NA	NA	ND	NA	NA	83%	6		
		5.04	Turnover (Rolling 12 mths)	JB	11%	10%	10.30%	10.32%	10.30%	9.86%	10.03%	9.80%	9.00%	9.07%	9.28%	9.28%	8.65%	10%	6		
		5.05	Sickness Absence	JB	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.57%	3.70%	3.59%	4		
		5.06	Executive Team Turnover (Trust Management)	JB	0%	0%	0%	20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	6		
		5.07	Agency Spend	CB	354	258	307	316	289	336	244	220	187	475	183	ND	237	279	6		
		5.08	Monitor Use of Resources Rating	CB	4	3	3	3	3	3	3	3	3	3	3	3	3	3			
	Agency, WTE & vacancies	5.09	Agency Spend Cap	CB	354	258	378	378	378	378	378	378	378	378	378	378	378	378			
		5.10	Bank Spend	CB	307	334	380	287	282	372	315	422	327	331	398	312	399	348			
		5.11	Bank/agency Spend percentage	CB	4.45%	4.15%	4.6%	3.9%	3.7%	4.9%	3.6%	4.7%	3.8%	4%	5%	5.7%	ND	4.2%	2		
		5.12	Proportion of Temporary Staff	CB	10.90%	9.30%	11%	11%	10%	12%	11%	10.6%	10%	11%	8%	11.1%	11.3%	11%	3		
		5.13	Locum and Medical agency spend	NJ	325	234	309	368	361	381	347	270	357	381	508	495	487	388			
		5.14	Total Vacancies	JB	5.82%	5.55%	7%	8%	6%	8%	7%	8%	8%	8%	8%	7.1%	7.9%	8%	3		
		5.15	Corporate & Admin Costs as %	JB	9.39%	9.56%	8.48%	8.57%	9.46%	9.47%	9.49%	9.50%	8.60%	8.60%	11.11%	13.31%	10.65%	9.75%			
		5.16	% Staff on Maternity/Paternity Leave	JB	2%	2%	2.15%	2.15%	1.98%	1.85%	1.94%	2.00%	2.00%	2.00%	2.00%	1.87%	1.98%	1.99%			
		5.17	% Fill rate of Reg. Nurse shifts	RP	71.93%	80.47%	83.20%	81.32%	83.60%	80.89%	79.60%	80.84%	ND	ND	ND	ND	ND	81.58%			
	Corporate	5.25	Grievance reviews	JB	4	4						6	6	6	5	5	5	33			
		5.27	Recruitment Timescales - Av no. of weeks to recruit	JB	ND	ND	ND	6	5	5.40	6.40	7	6.90	6.90	6.40	5.40	5.40	6	3		
		5.28	DBS checks	JB	93%	93%	92.80%	92.62%	92.64%	98.00%	98.40%	98.50%	97.50%	97.50%	98.50%	98.50%	98%	97%	3		
		5.29	Staff appraisal Rates	JB	92%	92%	ND	92.00%	92.00%	ND	ND	53.11%	50.83%	55.78%	62.00%	65.00%	62.28%	67%	1		
		5.38	Trust Participation in on-going National Audits (Qtrly)	NJ	NA	ND	NA	NA	94%	NA	NA	96%	NA	NA	96%	NA	NA	95%	3		
	Training	5.39	Infection Control Training (classroom)	JB	94%	95%	95%	96%	95%	95%	96%	94%	95%	95%	95%	94%	94%	95%	3		
		5.40	Infection Control Training (eLearning)	JB	88%	88%	88%	88%	90%	90%	88%	83%	85%	88%	88%	90%	90%	88%	3		
		5.41	Manual Handling Training (Patient)	JB	80%	79%	81%	83%	84%	83%	83%	80%	80%	84%	84%	79%	79%	82%	3		
		5.42	Manual Handling Training (Non Patient)	JB	84%	83%	81%	81%	83%	83%	82%	86%	84%	88%	88%	89%	89%	85%	3		
		5.43	Staff Adult Safeguarding Training	JB	87%	88%	88%	89%	90%	90%	89%	89%	90%	92%	92%	92%	92%	90%	3		
		5.44	Safeguarding Children Level 1	JB	87%	86%	86%	86%	87%	88%	87%	86%	88%	89%	90%	91%	91%	88%	2		
		5.45	Safeguarding Children Level 2	JB	87%	87%	87%	88%	90%	90%	87%	88%	89%	90%	92%	92%	92%	90%	2		
		5.46	Safeguarding Children Level 3	JB	79%	78%	85%	83%	81%	81%	76%	73%	79%	83%	86%	86%	88%	82%	2		
		5.47	Health & Safety Training	JB	87%	88%	88%	89%	89%	89%	89%	89%	90%	91%	91%	92%	92%	90%	3		
		5.48	Security Awareness Training	JB	87%	88%	88%	89%	90%	90%	89%	89%	90%	90%	91%	91%	91%	90%	3		
		5.49	Conflict Resolution Training (eLearning)	JB	81%	83%	81%	83%	85%	86%	80%	80%	81%	82%	95%	76%	85%	83%	3		
		5.50	Conflict Resolution Training	JB	74%	75%	75%	75%	77%	77%	76%	75%	76%	76%	75%	88%	76%	77%	2		
		5.51	Fire Training (eLearning)	JB	86%	85%	85%	86%	87%	87%	85%	85%	85%	85%	84%	84%	84%	85%	3		
		5.52	Fire Training (classroom)	JB	89%	89%	90%	90%	90%	90%	90%	89%	90%	91%	91%	90%	90%	90%	3		
		5.53	IG Training	JB	82%	82%	80%	81%	85%	84%	85%	84%	87%	86%	87%	84%	84%	84%	3		
		5.54	Equality and Diversity	JB	92%	93%	93%	94%	95%	95%	93%	92%	93%	94%	94%	88%	88%	93%	3		
		5.55	Majax Training	JB	86%	86%	86%	86%	88%	88%	87%	86%	88%	88%	89%	90%	90%	88%	3		
		5.56	Medicines Management Training	JB	86%	87%	87%	87%	88%	88%	87%	87%	86%	87%	88%	89%	89%	88%	3		
		5.57	Slips, trips and falls Training	JB	84%	85%	84%	85%	87%	87%	85%	85%	86%	88%	88%	87%	87%	86%	3		
		5.58	Blood-borne Viruses/Inoculation Incidents	JB	84%	85%	84%	84%	86%	86%	84%	84%	85%	86%	87%	86%	86%	85%	3		
		5.59	Basic life support training (adult)	JB	80%	81%	83%	85%	85%	85%	84%	82%	81%	81%	82%	80%	80%	82%	3		
		5.60	Blood Products & Transfusion Processes (Refresher)	JB	78%	80%	80%	82%	83%	82%	79%	79%	80%	78%	80%	75%	75%	79%	2		

A separate report is being presented on Appraisal to the board in addition to the information above.

EXCEPTION REPORTS – WELL LED

The Trust has set a target of no more than 3.5% of sickness across all staff groups. Performance is consistently just above this threshold, but the Trust performs well against national and peer group levels *(Source –Model Hospital-Jan 2018 data).*



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Sickness Absence Rate
Standard	<3.5%
Name	Jan Bloomfield
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

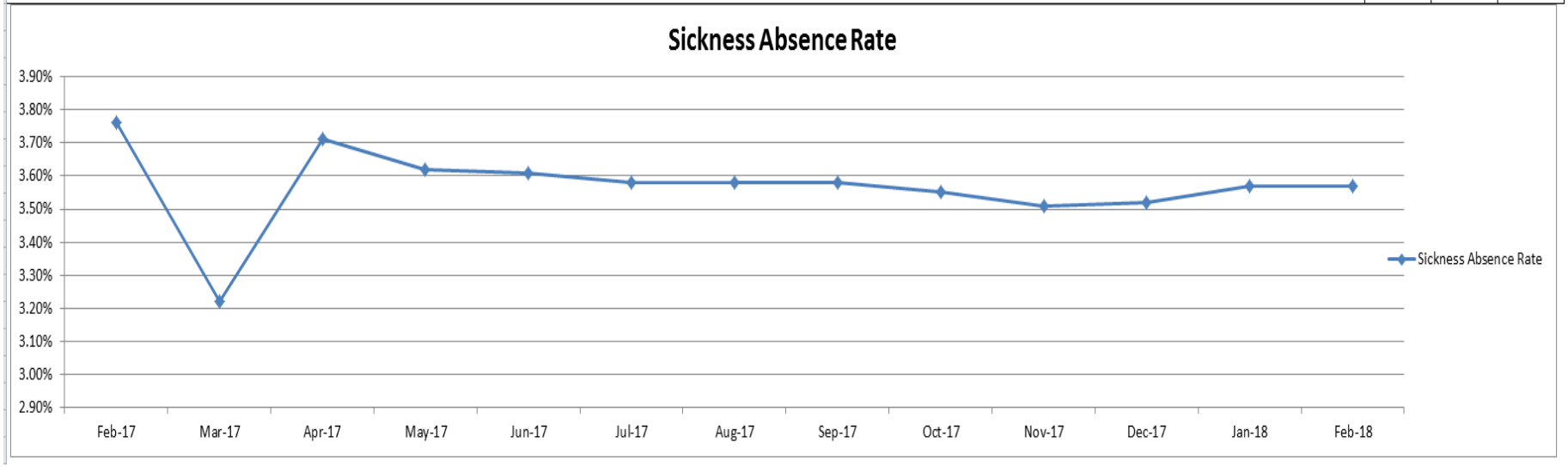
The sickness absence rate remains static this month, and significantly better than last year (3.76).

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Sickness Absence Rate	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.57%	3.57%	

Actions in place to recover the performance

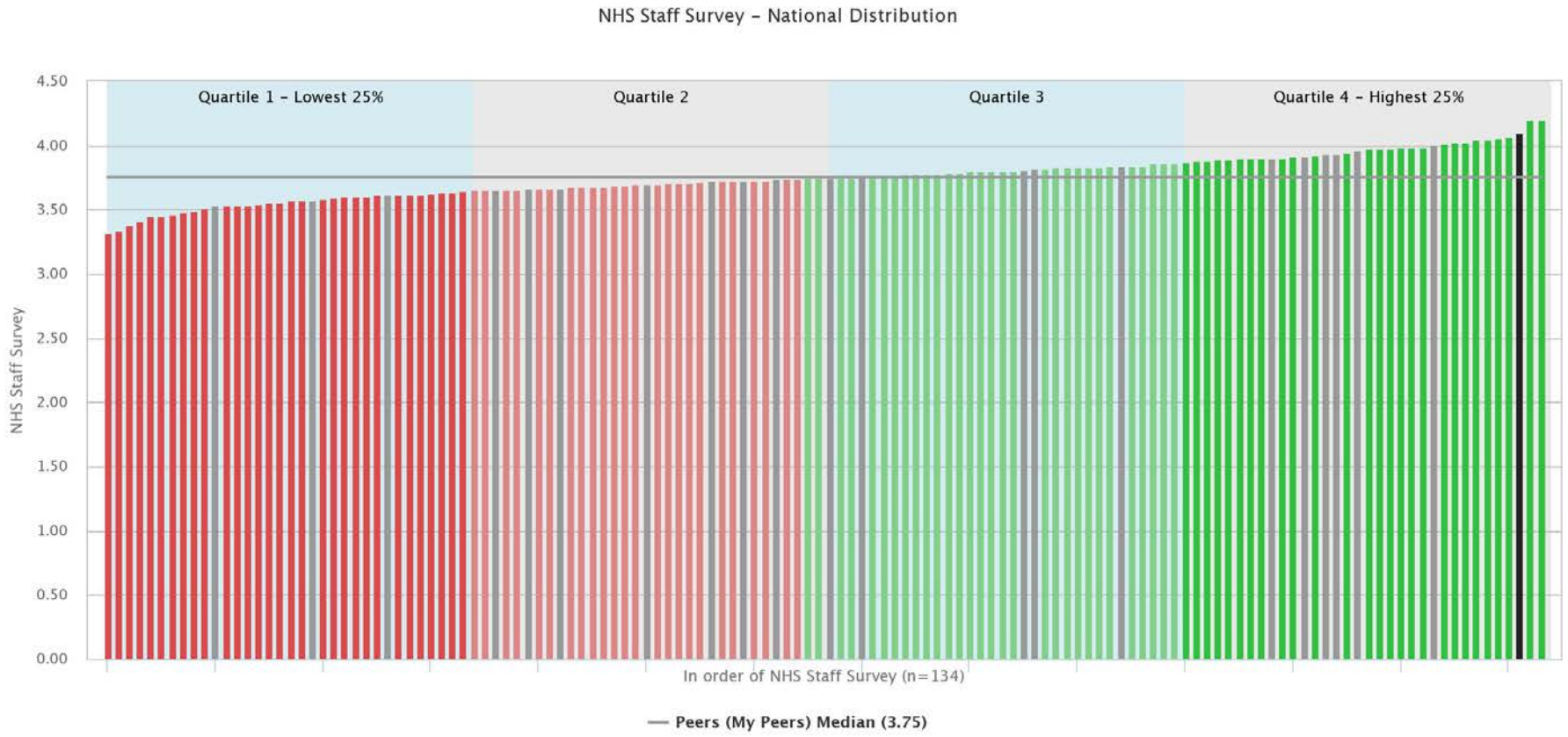
Expected timeframes for improvements

Description	Owner	Start	End
Actions are in place to support managers to manage both short term and long term absence. We would expect the sickness absence figure to remain at this level for the next month or so, and then show a small reduction as we move into the spring and summer months.	JB	Apr-17	TBC



Staff F&FT

The Trust performance for staff recommending West Suffolk as a place to work and be cared for remains very high, with performance in the top 3 Trusts in England *(Source –Model Hospital-Jan 2018 data).*



DETAILED REPORTS – PRODUCTIVE

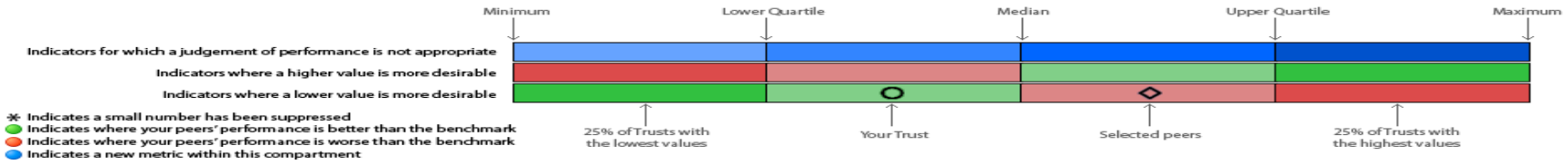
Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	YTD(Apr17-Mar18)	WTG	Traffic	Trend
6. Productive	Dashboard	6.01	I&E Margin	Var	-5.10%	-1.50%	ND	-5%	-4.3%	-3.9%	0.1%	-3.04%	-2.55%	-2.47%	-2.60%	-2.34%	-2.56%	-3%			
		6.02	Distance from Financial Plan	Var	ND	ND	ND	0.0%	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%	ND	ND	ND	0.0%	6		
		6.03	Capital service capacity	Var	- 2.81	1.41	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.52%	0.16%	0.24%	-0.07%	0.52%			
		6.04	Liquidity (days)		- 21.76	- 7.28	ND	- 12.15	-15.72	- 10.94	-11.03	-12.70	-15.14	-9.64%	-12.85%	-11.38%	-6.84%	-6.84%			
		6.05	Long Term Borrowing (£m)	3.5%	36.06	44.30	44.27	45.70	45.70	45.70	45.70	47.62	47.62	56.67	58.65	64.36	64.11	56.67	2		
		6.06	CIP Plan Variance (£000s)	1.9	-3,247	0	40	0	-40	10	0	-54	-10	-35	-129	-201	-380	-73			
	Activity	6.07	A&E Activity		5050	5887	5578	5971	5922	6124	5831	5743	6065	5985	5959	6033	5639	64850			
		6.08	NEL Activity		2350	2750	2409	2440	2429	2375	2385	2466	2588	2491	2528	2558	2418	27087			
		6.09	OP - New Appointments		5697	6849	5125	6244	6148	5706	5635	5633	6182	7230	5482	6768	5830	65983			
		6.10	OP- Follow-Up Appointments		11483	12790	9541	11667	11542	11147	11333	11116	11815	12668	9769	12673	11051	124322			
		6.11	Electives (Incl Daycase)		2819	3303	2593	3004	2898	2796	2829	2786	2868	3157	2545	2841	2634	30951			
	Finance	6.13	Agency Rating (spend £000)		354	258	307	316	289	336	244	220	187	475	183	ND	237	2794			
		6.14	Financial Position (YTD)	Var	11736	3327	-937	-2906	-2758	-3290	-3300	-3953	-3956	-4114	-5170	-6600	-6525	-6525			
		6.15	Financial Stability Risk Rating	Var	4	3	3	3	3	3	3	3	3	3	3	3	3	3			
		6.16	Cash Position (YTD £000s)	Var	1538	1352	7,955	5093	2689	7460	3300	4846	2654	4458	3518	4924	6870	6870			
	Ratios	6.17	% Consultant to Consultant Referrals		ND	ND	10%	10%	10%	12%	13%	10%	10.57%	10.03%	10.92%	12.66%	13.67%	11.1%			
		6.18	New to FU Ratios	1.9	2.12	2.07	1.86	1.87	1.88	1.96	2.01	1.97	1.91	1.78	1.79	1.87	1.90	1.89			
		6.20	Non-Clinical Floor Space	<35%		29%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	ND	31%	3		
		6.21	Unoccupied Floor Space	<2.5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	ND	0%			
	CIPs	6.22	Plan (£000s) YTD	Var	10,912	12,500	840	1000	820	810	1420	1094	1123	1504	1312	1356	4025	8611			
		6.23	Actual (£000s) YTD		7,665	12,500	880	1000	780	820	1420	1040	1113	1469	1183	1155	3645	8522			

OPERATIONAL PRODUCTIVITY – TRUST OVERVIEW

The Operational Productivity dashboard highlights comparisons with national and peer group averages. The Operational Productivity compartment focuses on high level data for each trust to give an overview of potential efficiency, productivity and quality. The weighted activity unit (WAU) and potential productivity opportunity metrics are derived from NHS reference costs (*Source – Model Hospital – Latest available data*)

Data from Accounts	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Operating Expenditure	2016/17	£262.13m	£207.08m	£356.24m			No trendline available
Income	2016/17	£254.48m	£198.87m	£350.09m			No trendline available
Surplus (or) Deficit	2016/17	£-7.65m	£-6.37m	£-3.55m			No trendline available
Surplus (or) Deficit as % of Expenditure	2016/17	-2.9%	-3.5%	-1.1%			No trendline available
Data from Reference Costs	**Period**	**Trust Actual**	**Peer Median**	**National Median**	**Info**	**Variation**	**Trend**
Expenditure reported in Reference Costs	2016/17	£188.22m	£176.49m	£311.10m			No trendline available
Reference Cost expenditure as % of Operating Expenditure	2016/17	72%	87%	86%			No trendline available
Cost Weighted Output expressed as Weighted Activity Units (WAUs)	2016/17	64,804	53,236	90,210			No trendline available
Cost per WAU (MFF adjusted)	2016/17	£3,023	£3,557	£3,484			No trendline available
Cost per WAU (no MFF adjustment)	2016/17	£2,904	£3,438	£3,436			No trendline available
Market Forces Factor (MFF)	2016/17	0.96	0.96	0.97			No trendline available
Potential Productivity Opportunity (PPO) £	2016/17	£18.89m	£19.31m	£30.34m			No trendline available
Potential Productivity Opportunity (PPO) %	2016/17	10.0%	10.6%	10.0%			No trendline available



EXCEPTION REPORTS – PRODUCTIVE

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

MATERNITY

		Ref.	KPI	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	YTD(Apr17-Mar18)	WTG	Traffic	Trend
Maternity	Dashboard	7.01	Total number of deliveries (births)	210	197	238	215	192	213	215	233	236	205	194	180	199	211	2293	6		
		7.02	% of all caesarean sections	<22.7%	13%	19%	15%	21%	16%	16%	22.32%	18.22%	17.10%	17.0%	18.3%	22.1%	17.1%	18%	6		
		7.03	Midwife to birth ratio	1.30	1.28	1.33	1.30	1.27	1.29	1.30	1.33	1.33	1.29	1.28	1.26	1.28	1.29	1.29	6		
		7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		7.05	Completion of WHO checklist	100%	87%	89%	84%	93%	84%	94%	82%	98%	98%	98%	93%	93%	94%	92%	4		
		7.06	Maternity SIs	NT	1	1	1	0	0	0	0	1	1	0	1	2	ND	6			
		7.07	Maternity Never Events	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	-			
		7.08	Breastfeeding Initiation Rates	80%	80%	76%	79.8%	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	81%	6		
	Safe	7.09	Elective Caesarean Sections	10%	5%	7%	5%	10%	4.3%	7.0%	9.4%	6.4%	5.9%	7.2%	7.8%	8%	7%	7%	3		
		7.10	Emergency Caesarean Sections	<13%	9%	12%	10%	12%	12%	9%	13%	12%	11%	10%	11%	14%	10%	11%	3		
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%	100%	91%	1		
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	70%	89%	92%	93%	93%	83%	57%	82%	88%	50%	80%	83%	83%	80%	3		
		7.14	Homebirths	2%	3.0%	2.1%	1.4%	3.7%	2.4%	3.3%	2.6%	2.1%	3.9%	2.6%	3.3%	3.0%	2.4%	3%	3		
		7.15	Midwifery led birthing unit (MLBU) births	>13%	19%	16%	18%	17%	17.3%	18.8%	15.5%	15.3%	17.1%	16%	15%	19.1%	18.0%	17%	3		
		7.16	Labour Suite births	75%	78%	82%	81%	79%	80.3%	77.9%	82.0%	82.6%	79.0%	81.4%	81.7%	77.9%	79.6%	80%	3		
		7.17	Induction of Labour	NT	36%	37%	43%	41%	40.9%	36.6%	38.2%	34.3%	35.1%	43.8%	43.9%	37.2%	41.2%	39.5%			
		7.18	Instrument Assisted Deliveries (Forceps & VentoUse)	NT	4.85%	6.20%	4.45%	6.80%	4.85%	4.20%	3%	4.65%	4.15%	7.20%	5.85%	7%	7.55%	5%			
		7.19	Critical Care Obstetric Admissions	0	0	1	1	1	0	1	0	1	0	0	0	2	0	6	2		
		7.20	Eclampsia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3		
	Effective	7.21	Shoulder Dystocia	2	2	8	2	4	3	5	3	7	6	4	5	4	5	48			
		7.22	Post-partum Hysterectomies	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	3		
		7.23	Women requiring a blood transfusion of 4 units or more	0	0	ND	1	0	0	0	0	0	0	0	ND	ND	ND	1	2		
		7.24	3rd and 4th degree tears (all deliveries)	12	4	7	8	9	6	10	4	4	6	3	8	9	7	74	3		
	Caring	7.25	Maternal death	NT	0	1	1	0	0	0	0	0	0	0	0	0	0	1			
		7.26	Stillbirths	NT	1	0	1	0	0	0	0	1	2	1	0	2	0	7			
		7.27	Complaints		0	0	0	0	1	2	1	0	0	0	1	0	0	5			
		7.28	No. of babies admitted to Neonatal Unit (>36+6)	NT	8	0	15	9	17	18	13	15	15	11	9	8	16	146			
	Responsive	7.29	No. of babies transferred for therapeutic cooling	0	1	1	0	0	0	0	0	0	1	0	1	0	0	2	3		
		7.30	% of babies admitted to NNU with normal temperature	80%	100%	100%	87%	66%	88%	100%	100%	86%	81%	92%	ND	ND	ND	88%	3		
		7.31	One to one care in established labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		7.32	Reported Clinical Incidents	60	49	64	51	62	46	64	43	52	61	57	49	63	46	594	2		
		7.33	Hours of dedicated consultant cover per week	60	81	60	93	110	99	99	96	99	99	108	90	102	93	1088	3		
		7.34	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	110	3		
		7.35	OPD cover for Theatre 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		7.36	No. of women identified as smoking at booking	NA	ND	ND	27	35	37	32	30	37	27	28	17	26	21	317			
		7.37	No. of women identified as smoking at delivery	NT	ND	ND	20	30	26	32	27	25	25	24	26	21	22	278			
		7.38	UNICEF Baby friendly audits	NT	10	10	10	10	10+	10+	10+	10+	10+	10+	10+	10+	ND	20			
		7.39	No. of parents receiving Safer Sleeping Suffolk Thermometer	NT	157	165	143	170	174	205	155	192	151	156	186	186	166	1884			
	Other	7.40	No. of bookings (First visit)	NA	247	275	208	262	244	272	245	265	259	245	193	279	253	2725			
		7.41	Access - Assessment of need by 12 weeks (women booked)	95%	95%	96%	95%	95%	98%	95%	100%	93%	99%	97%	97%	96%	96%	96%	3		
		7.43	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	0	0	0	0	0	0	1	1			

EXCEPTION REPORTS - MATERNITY

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Emergency Caesarean Sections
Standard	
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The emergency caesarean section rate in January 2018 was higher than has previously been experienced. The total caesarean section rate was 22.1%, below the commissioned figure of <22.6%. The total caesarean section rate for February 2018 was 17.1 %. 10% emergency caesarean sections and the remainder elective. All emergency caesarean sections are discussed at the weekly case management meeting and if there is any learning from individual cases which might influence decisions in future cases this is shared with the consultant team. Overall the maternity service has an extremely low rate of caesarean section.

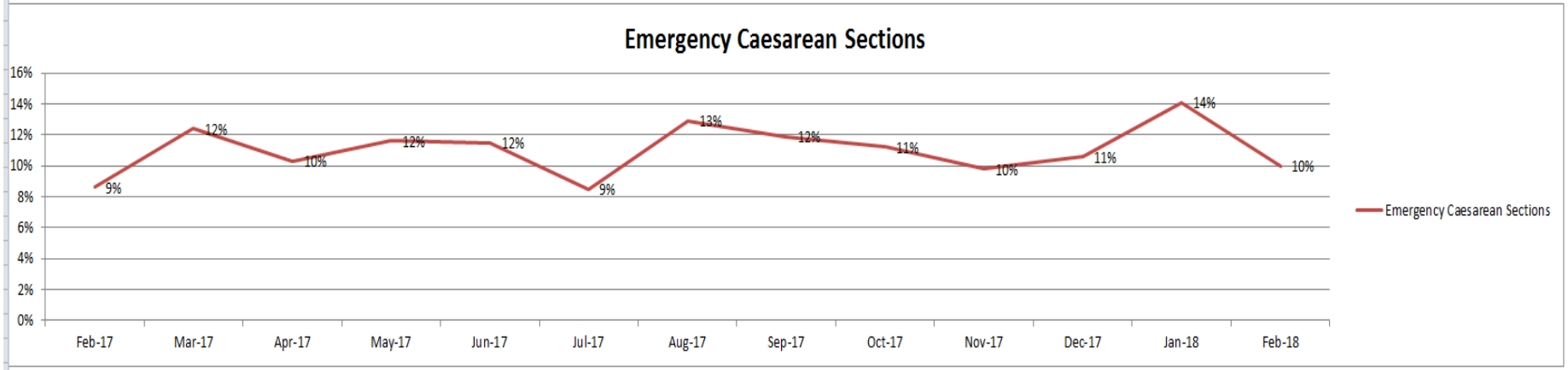
Trend — Recovery Trajectory

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Emergency Caesarean Sections	9%	12%	10%	12%	12%	9%	13%	12%	11%	10%	11%	14%	10%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Caesarean sections are reviewed weekly at the case management meeting and any learning is shared.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Total women delivered who breastfed babies within first 48 hours
Name	Rowan Procter
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

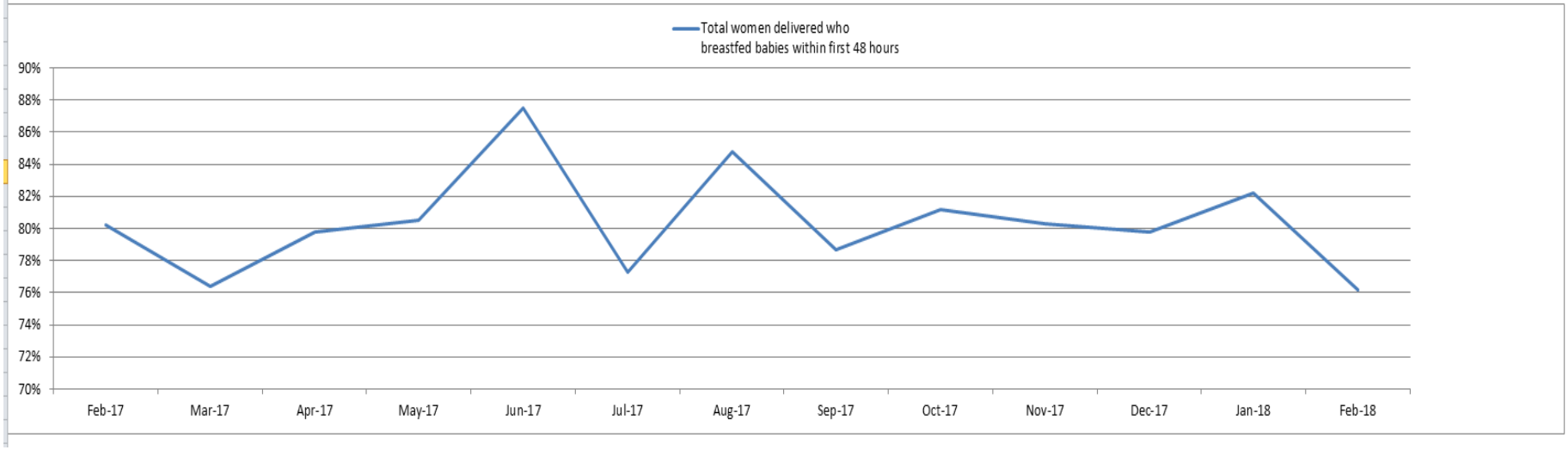
Compliance with the 80% target of babies receiving breastmilk within 48 hours of life was marginally missed in December 2017. However in January 2018 the 80% target was exceeded with an initiation rate of 82.2%. In February 2018 the breastfeeding initiation rate fell to 76.2% of women delivering. The maternity service is constantly looking at ways to improve the breastfeeding initiation rate and is currently working with the Maternity Voice Partnership on the possible introduction of a peer support service (voluntary) .

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Total women delivered who breastfed babies within first 48 hours	80%	76%	79.8%	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
There are a number of ongoing initiatives in place to support initiation of breastfeeding and these will continue.	RP		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Third and fourth Degree Tears
Standard	100%
Name	Rowan Procter
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

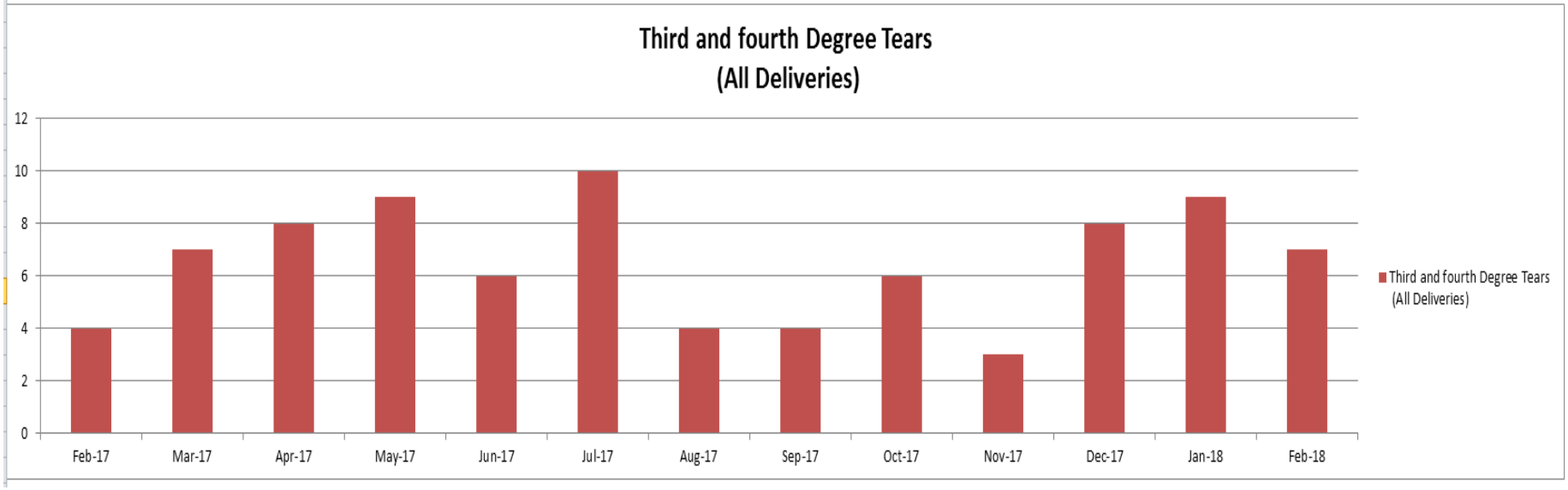
Rated as amber in December 2017and in January 2018. In February there were 7 third and fourth degree tears identified, a slight reduction on the number identified in the previous month, particularly noting that the delivery rate was higher than previous months. The maternity service has recently commenced a number of initiatives to try to reduce the rate of third and fourth degree tears including the use of Episcissors, which is part of a national initiative to reduce rates. The national increase in 3rd and 4th degree tear rates is identified in the National Maternity and Perinatal Audit 2017 as is descried as most likely due to increased awareness and detection following a concerted effort to educate clinicians.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Third and fourth Degree Tears (All Deliveries)	4	7	8	9	6	10	4	4	6	3	8	9	7	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Discussed at the Women's Health Governance meeting on 15th January 2018, to be monitored. A number of workstreams continue to look at perineal trauma, including the use of Episcissors.	RP	Mar-18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity WHO Checklist
Standard	100%
Name	Rowan Procter
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Maternity WHO Checklist

Summary of Current performance & Reasons for under performance

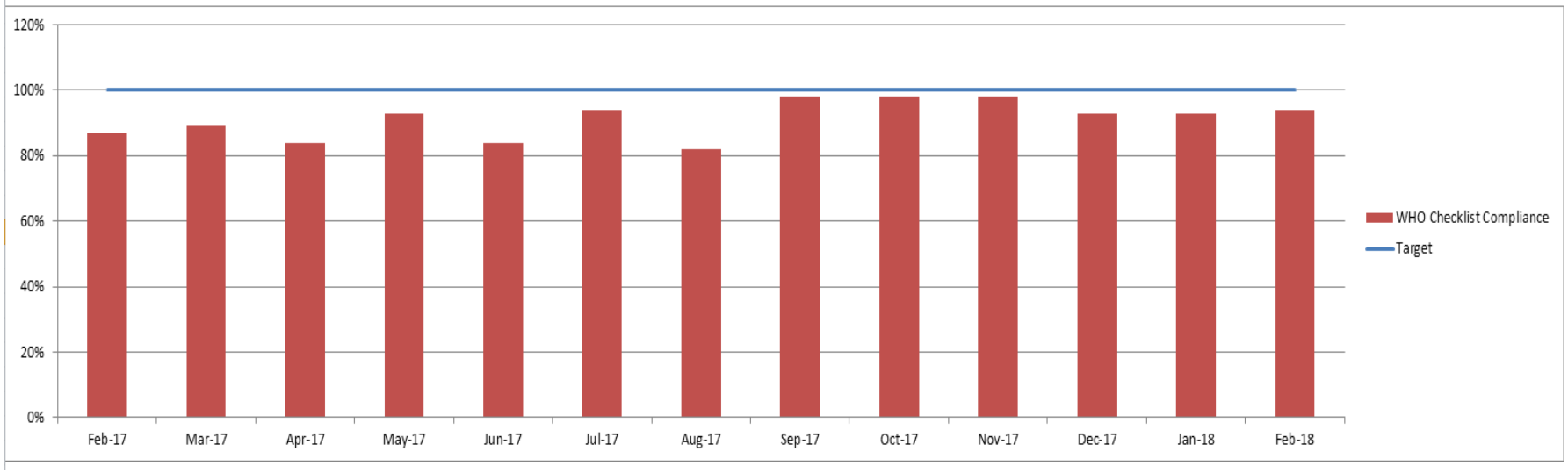
Despite the focus on completion of the Maternity WHO checklist completion rates reduced in December 2017. The completion rate January 2018 remained at 93%. The completion rate for maternity specific WHO checklists improved very slightly in February 2018 to 94%. Work to improve the design and the completion of the checklist has continued, led by a consultant obstetrician this has been taken to the surgical safety committee. It is hoped a revised format which is more familiar to doctors who have worked in other units will be available for use in April 2018 following final discussion at the maternity service clinical governance meeting in March 2018.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
WHO Checklist Compliance	87%	89%	84%	93%	84%	94%	82%	98%	98%	98%	93%	93%	94%	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
There were three forms which failed the audit and this has been followed up with individual members of staff. The maternity service has redesigned the WHO checklist which is felt will improve compliance and this is in the process of being approved by Trust committees.	RP	Feb-18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity - Shoulders Dystocia
Standard	100%
Name	Rowan Procter
Month	01-Feb-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

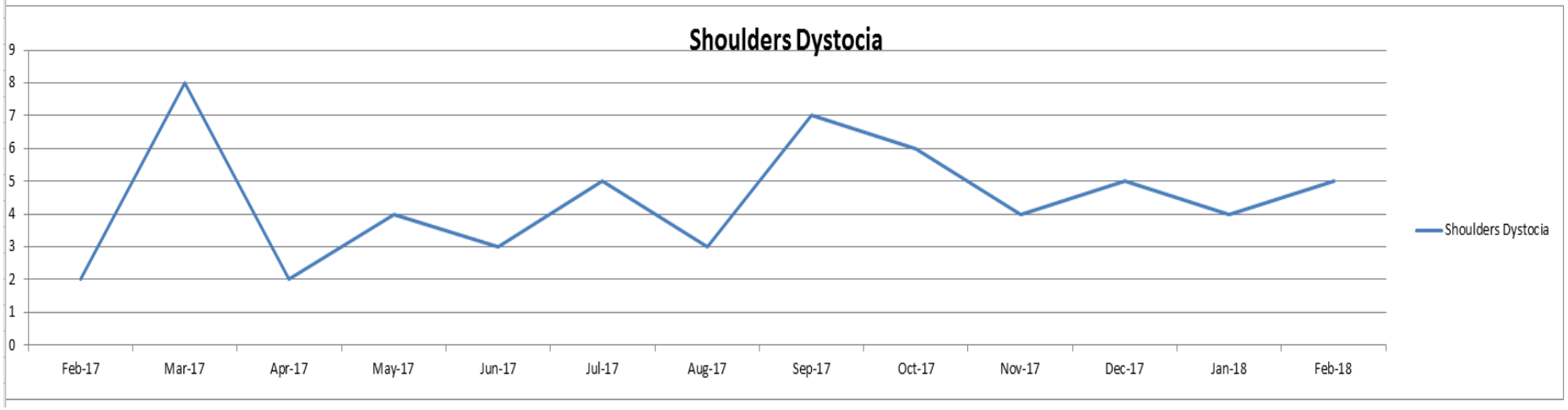
An increase level of incidents of shoulder dystocia were identified in December 2017, similar to previous months. This position improved slightly in January 2018 with just 4 cases. However there were 5 cases identified in February 2018. The maternity service has just completed an audit of shoulder dystocia, commissioned from the Women's Health Governance meeting due to the higher than expected number of cases identified on the dashboard. This audit was presented at the Clinical Governance Steering Group in February 2018 and identified that on review there were no cases where alternative care should have been provided.

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Shoulders Dystocia	2	8	2	4	3	5	3	7	6	4	5	4	5	

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Continue to monitor	RS	Jul-17	Ongoing



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COMMUNTY INFORMATION

Welcome to the Community contract report for February.

- Our FFT for February was 97.37% from 115 responses, with both Community Healthcare Teams & Glastonbury Court achieving 100%
- We received 1 formal complaint in February relating to the paediatric SLT service from a mother concerned about the level of support her child is receiving
- Our response time targets were all met, for the second month running there were no urgent 2 hour referrals received by the CHT's or the APS service. This activity is now being more appropriately directed to the Early Intervention Team
- Our number of patients whose discharge was delayed in February was 20, with a total of 127 bed days being lost. Although this is a rise in comparison to the January numbers, this is an improved performance when compared to previous months.
- The average length of stay in the community beds (DTOC patients excluded) is 13.76 days which remains good.
- The paediatric SLT service continues to experience difficulty with capacity and demand, however the total number of children waiting for their 1st therapy package has decreased for the 4th consecutive month for the community clinic service
- The focussed effort for handover of wheelchairs to service users within 18 weeks continues, with additional clinical and managerial resources allocated. Compliance is now at 66%.
- The Community Equipment Service improved its performance in February, achieving 4 out of the 7 targets compared to 2 out of 7 for January. The 3 targets that were missed also have an improved position from January
- The Children in Care Service continues to miss its targets due to increase in referrals, lack of timely notification and process issues. This has been escalated at CEO level to SCC and a meeting requested

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Service	Technical Reference	Quality Requirement	Threshold	Method of measurement	Feb 2018	February Comments / Queries 2018	Jan 2018
Community Matrons CHTs	**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	100.00%		100.00%
Community Matrons CHTs	**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.	95%		100.00%		100.00%
COPD West	**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	93.55%	29 out of 31 completed within 18 weeks. 2 breaches - referral received after course started patients attended first available course. Plan to start rolling program of courses	100.00%
All	**D4-qoc1**	Number and % of service users who rated the service as 'good' or 'better'.	85%	Quarterly			
All	**D4-qoc2**	Number and % of service users who responded that they felt 'better'.	85%	Quarterly			
All		Number and % of service users who responded that they felt 'well informed'.	85%	Quarterly			
CHTs	**D5-ccc7**	% of referrals seen following triage; Emergency - 2 hrs	100%	Monthly	N/A		N/A
CHTs		Urgent 4 hrs	95%		96.43%		100.00%
CHTs		Intermediate - 72 hrs	95%		98.03%		99.30%
CHTs		18 weeks	95%		99.92%		99.80%
Paed OT, PT, SLT, Adult SLT West, Wheelchairs, Neuro nurses, Parkinson's, SCARC, Environmental & Heart Failure West	**D5-acc4**	18 week referral to treatment for non-Consultant led services 10 services: Paed OT, PT, SLT, Adult SLT West, Wheelchairs, Neuro nurses, Parkinson's, SCARC, Environmental & Heart Failure West	95%	Monthly	99.77%		100.00%
NCH, Gst Crt	**PU-001-a**	Number of avoidable Grade 2 and Grade 3 pressure ulcers (as per agreed definition), developed post 72 hours admission into SCH care, This measure includes patients in in-patient and other community		Monthly	Grade 2 - 0 Grade 3 - 0		Grade 2 - 0 Grade 3 - 0
NCH, Gst Crt	**PU-001-b**	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.		Monthly	Grade 4 – 0		Grade 4 – 0
NCH, Gst Crt	**c-inf1**	Number of MRSA cases	No cases	Monthly	0		0
NCH, Gst Crt	**c-inf2**	Completed RCAs on all community cases of MRSA	100%	Monthly	N/A		N/A
NCH, Gst Crt	**c-inf4**	Completed RCAs on all community hospital outbreaks of C difficile	100%	Monthly	N/A		N/A
All	**c-gen4**	All community clinical staff to receive relevant dementia awareness training	95%	Monthly	92.68%	41 staff non compliant out of 511. Reduction in compliancy symptom of staffing pressures, patient contact prioritised over training. Team leads being emailed to highlight staff who are non compliant to ensure training is brought up to date	94.88%
All	**c-gen7**	% of clinics cancelled by the Provider		Quarterly			
CES	**c-gen8**	Response times from receipt of referral: Within 4 hours – Service Users at end of life (GSF prognostic	98%	Monthly	100% (184/184)	We had a carryover of work from orders placed in January. The additional; technicians that we had brought into the service to cope with the increased demand were trained during February, this will have a positive impact for the end of February and March. .	97.76% (262/268
		Next Working day - Urgent equipment	98%		99.45% (1267/1274)		98.83% (1351/13 67)
		Within 7 working days - to support hospital discharge or prevent admission	98%		96.95% (3145/3244)		95.66% (2951/30 85)
		Within 10 working days - to support hospital discharge or prevent admission	98%		97.44% (571/586)		95.02% (496/522
CES	**c-gen9**	Collection times: % of urgent next day collections for deceased Service Users	98%	Monthly	99.29% (140/141)		98.08% (102/104
		% of urgent collections within 3 working days	98%		97.91% (469/479)		95.03% (554/583
		% of collections within 10 working days	98%		98.19% (5975/6085)		94.22% (5933/62 97)

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Service	Technical Reference	Quality Requirement	Threshold	Method of measurement	Feb 2018	February Comments / Queries 2018	Jan 2018
All	**c-safe1**	% eligible staff who have completed Safeguarding Children level 1 training	95%	Monthly	95.69%		95.92%
All	**c-safe2**	% eligible staff who have completed Safeguarding Adults level 1 training	95%	Monthly	93.15%	35 staff non compliant out of 511. Reduction in compliancy symptom of staffing pressures, patient contact prioritised over training. Team leads being emailed to highlight staff who are non compliant to ensure training is brought up to date	94.08%
NCH, Gst Crt	**s-ip7**	Number of inpatient falls resulting in moderate or significant harm	No more than 1.25 per month (15 per annum) falls/1000b	Monthly	0.00		0.00
COPD West	**s-copd4**	Number of pulmonary rehab courses offered	At least 200 courses offered per year	Monthly	26 offered	Threshold - 100 pro rata for 6 months from October 125 offered from October to February	26 offered
		Number of pulmonary rehab courses completed	At least 100 courses completed per year	Monthly	31 completed	50 pro rata for 6 months from October Total from October to February = 68	4 completed
COPD West	**s-copd5**	Community pulmonary rehabilitation - review offered 6 months after completing the course	95%	Monthly	100.00%		100.00%
Adult SALT West	**s-salt1**	All new referrals are triaged within 5 Operating Days of receipt of referral	98%	Monthly	100.00%		98.41%
Adult SALT West	**s-salt2**	Service Users seen within the following timescales after triage: Priority 1 within 10 Operating Days	100%	Monthly	100.00%		100.00%
		Priority 2 within 20 Operating Days	95%		95.35%		75.51%
		Priority 3 within 18 weeks	95%		100.00%		100.00%
Adult SALT West	**s-salt4**	Care Plan aims and objectives documented as fully, partially or not achieved at discharge	Fully achieved = 50%,	Quarterly audit of Service User notes	97.70%		90.20%
		Care Plan aims and objectives documented as fully, partially or not achieved at discharge	Partially achieved = 40%		2.30%		3.90%
		Care Plan aims and objectives documented as fully, partially or not achieved at discharge	Not Achieved = 10%		0.00%		0.00%
Medical Appliances	**s-ma1**	% of appointments available within 6 weeks	95%	Monthly	100.00%		100.00%
Medical Appliances	**s-ma2**	% of urgent cases seen within one working day	100%	Monthly	No Urgent referrals received		No Urgent referrals
Parkinson's Disease	**s-pd2**	% service users on caseload who have an annual specialist review	95%	Monthly	100.00%		100.00%
Ass Tech	**s-at2**	All long term service users to have a minimum annual review	100%	Monthly	100.00%		100.00%
Ass Tech	**s-at4**	Delivery of equipment within agreed time frames	95%	Monthly	100.00%		100.00%
Wheelchair	**s-wchair1**	All Service Users have a first appointment/contact seen after initial response time according to priority / need: High Priority	100% within 6 weeks	Monthly	100.00%		n/a
		Medium Priority	100% within 12 weeks		0.00%	1/1 patient not assessed within 12 weeks due to service capacity. Patient assessed at 12.5 weeks.	n/a
		Low Priority	100% within 18 weeks		100.00%		93.33%
NCH, Gst Crt, Adult SLT West & Leg Ulcer	**dis summ-CQUIN**	% of discharge summaries from the following services; Community Hospital, Adult SLT West, 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	100.00%		100.00%
NCH, Gst Crt Step-up	**s-apcb1**	The community beds will be available for access across the 24 hour 7 days a week	100%	Monthly	100.00%		100.00%
NCH, Gst Crt Step-up	**s-apcb6**	All Service Users will have a management plan agreed with them and their family/carer where applicable within 24 hours from arrival. (Step up patients only)	98%	Monthly	100.00%		100.00%

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Service	Technical Reference	Quality Requirement	Threshold	Method of Measurement	Feb 2018	Feb Comments/ Queries 2018	Jan 2018
All Paediatric Services	**GP-1**	18 week RTT for Consultant led services	95% of consultant led Service Users to be treated within 18 weeks	Paediatric Cons Team	100.00%		98.73%
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: Paediatric SLT, OT, Physio, SCARC	99.48%		100.00%
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	100.00%		100.00%
All Paediatric Services	**GP-6**	Safeguarding - % eligible staff who have completed level 1 training	95%	Monthly report	97.75%		99.53%
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 report	100.00%		100.00%
Newborn Hearing Screening Service (West)	**NBHS-2**	Timely screening – where consented screens to be completed by four weeks of age	95%	Monthly report	98.50%		98.37%
Newborn Hearing Screening Service (West)	**NBHS-3**	Screening outcomes set within 3 months	95%	Monthly report	98.43%		98.35%
Community Children's Nursing	**CCN-14** **cps-ip02**	% of children identified as having high level needs being actively case managed.	>75%	Monthly report	100.00%		100.00%
Access	**cps-a02**	Children/young people in special schools receive speech and language interventions	100%	Monthly report	100% 191 contacts		100% 197 contacts
Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	Monthly report	100% 67 contacts		100% 106 contacts
Children in Care	**CiC-001c**	Initial Health Assessment appointments that are OFFERED within 28 days of receiving ALL relevant paperwork	100% offered in 28 days	Monthly report	35.71%	5 out of 14 Children seen in the month were offered their first appt within 28 days of the service being made aware of the child.The remaining 9 children were unable to be offered appts within 28 days due to lack of appt slots, caused by the increase in referrals (30 compared to an average of 16) experienced in December. A review of capacity needed is being undertaken 3 sibling groups presenting further challenges coordinating clinics within allocated slots/clinician availability, this has been escalated to Designated Nurse & Social Care Manager.	43.75%

Service	Technical Reference	Quality Requirement	Threshold	Method of Measurement	Feb 2018	Feb Comments/ Queries 2018	Jan 2018
Children in Care	**CiC-001b**	Initial Health Assessments that are completed within 28 days of receiving ALL relevant paperwork	100% IHAs completed in 28 days of the service beign notified	Monthly report	14.29%	2 out of 14 children had an IHA completed within 28 days of the service being made aware of the child. Of the 12 appts outside the 28 day deadline - 3 Children had declined appts, 1 child had 3 declined appts & 1 DNA, 8 Children seen outside 28 days at first apt (2 within 40 days, 2 within 50 days, 3 within 60 days and 1 at 71 days) Long waits due to increase in demand and appts already being filled. 71 day wait due to needing to see specific Paediatrician and no available slots in January, patient offered and seen at first available slot in February. Associate Director for ICPS met with CCG Nurse Improvement Consultant and Designated Nurse for Children in Care to clarify current pathway demand challenges and to highlight options to increase capacity.	12.50%
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 of the child being placed in care	Monthly report	0.00%	0 of the 14 IHAs were within 28 days of the child being placed in care irrespective of paperwork being received. 10 of the 14 IHAs had a delay of 16 or more days from being placed in care and the service being made aware. Recent trial of triaging referrals from available SystmOne information and booking appointment prior to receipt of Social Care Placement Risk Assessment is highlighting a number of quality issues – these are being monitored and will inform further discussion with the Local Authority regarding timely information exchange. Associate Director for ICPS is attending the Social Care/Independent Reviewing Officer meeting in April to discuss the challenges within the IHA pathway in order to improve	0.00%

1 **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.**

a Current Position

- 93.55% against a 95% target

b Recommended Actions

- Service to explore a rolling course programme to prevent delays from referral to start of next available course

2 **C-gen4 All community clinical staff to receive relevant dementia awareness training**

a Current Position

- 92.68% against a 95% target

b Recommended Actions

- All staff who are out of date with training are being contacted by their team lead and advised to undertake the training.
- Option of additional sessions being explored

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

a Current Position

C-gen8 - delivery within 7 working days – 96.95% against a 98% target
3145 out of 3244 deliveries were compliant; 99 non-complaint items

C-gen8 - delivery within 10 working days – 97.44 against a 98% target
571 out of 586 deliveries were compliant; 15 non-complaint items

C-gen9 – collection by 3 working days – 97.91% against a 98% target
469 out of 479 collections were compliant; 10 non-complaint items

b Recommended Actions

- A formal performance notice has been issued and an improvement plan received.
- Weekly monitoring of positon continues

4 **c-safe2 % - eligible staff who have completed Safeguarding Adults level 1 training**

a Current Position

- 93.15 % against a 95% target

b Recommended Actions

- Team Leads with staff who are out of date with training are being contacted and asked to ensure staff are compliant.
- Option of additional sessions being explored

5 S-wchair1 - All Service Users have a first appointment/contact seen after initial response time according to priority / need: Medium Priority

a. Current Position

- 0.00% against a target of 100% - This relates to 1 patient out of 1. Patient was seen at 12.5 weeks

b. Recommended Actions

- Ongoing work with Wheelchair service to improve processes, pathway delays, supplier contracts, increase stock

6 **CIC-001a,b & c Children in Care – WSH –**

Initial Health Assessment appointments that are OFFERED within 28 days of receiving ALL relevant paperwork

a Current Position

CiC -001c –35.71% against a 100% target

5 out of 14 children were offered their first appt within 28 days of the service being made aware of the child. 9 not offered due to appointments already taken with December and early January referrals

CiC-001b Initial Health Assessments that are completed within 28 days of receiving ALL relevant paperwork

a Current Position

CiC -001b –12.50% against a 100% target

2 out of 14 children had an IHA completed within 28 days of the service being made aware of the child.

CiC-001a - All CiC will have a SMART health care plan completed within 28 days of a child becoming looked after.

a Current Position

CiC -001a –0.00% against a 100% target

0 of the 14 IHAs were within 28 days of the child being placed in care irrespective of paperwork being received.

10 of the 16 IHAs had a delay of 16 or more days from being placed in care and the service being made aware.

b Recommended Action

- The increase in referral numbers continues and (30 in December, 19 in January compared to an average of 16 a month previously) is being investigated to determine cause.
- Meeting held with CCG and SCC colleagues to agree options and actions for improvement. See separate document

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Quality Dashboard

	Units	Target	Red	Amber	Green	Jan	Feb
Patient Experience							
Service users who rated the service as 'good' or 'better' (Quarterly)	Nos.	No Target					
	%	85%	<80%	80%-85%	>=85%		
Service users who responded that they felt 'better'	Nos.	No Target					
	%	85%	<80%	80%-85%	>=85%		
Service users who felt 'well informed'	Nos.	No Target					
	%	85%	<80%	80%-85%	>=85%		
10% of long term condition patients feel "better supported" to self manage their conditions (Quarterly)	Nos.	No Target					
	%	No Target					
Falls (Inpatient Units)							
Total numbers of inpatient falls (includes rolls and slips)	Nos.	No Target				9	9
Slip out of chair		No Target				0	1
Rolls out of Bed		No Target				5	5
Assisted Falls/ near misses		No Target				1	0
% of total falls resulting in harm	%	No Target				11%	11%
Numbers of falls resulting in moderate harm	Nos.	No Target				0	0
Numbers of falls resulting in severe harm	Nos.	No Target				0	0
Numbers of patients who have had repeat falls	Nos.	No Target				1	2
% of RCA reports for repeat fallers	%	100%	90%-95%	95%-100%	=100 %	N/A	N/A
Numbers of falls per 1000 bed days (* includes Hazel Crt falls)		No Target				7.11	7.49
Pressure Ulcers							
Pressure Ulcers – In Our Care Community							
Grade 2		100 pa	>110	100-110	<=100	3 (+10 pend)	0 (+16 pend)
Grade 3		26 pa	>30	27-29	<=26	1 (+ 5 pend)	0 (+3 pend)
Grade 4		0 pa	>1	1	0	0 (0 pend)	0
Pressure Ulcers – In our care In-patient							
Grade 2		13 pa	>17	13-17	<=13	0	0
Grade 3		2 pa	>4	02-Apr	<=2	0	0
Grade 4		0 pa	>1	1	0	0	0
Safeguarding People Who Use Our Services From Abuse							
Number of adult safeguarding referrals made		No Target				0	2
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				0	0

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	Units	Target	Red	Amber	Green	Jan	Feb
MRSA							
Bacteraemia – Number of cases		0	>2	>0 to 2	=0	0	0
MRSA RCA reports		100%	<95%	95%-100%	=100 %	N/A	N/A
Clostridium Difficile							
C.Diff number of cases		4 for 6 months	>4 YTD		<=4 YTD	0	0
C.Diff associated diseases (CDAD) RCA reports		100%	<95%	95%-100%	=100 %	N/A	N/A
Infection Control							
Infection control training		100%	<83%	83%-100%	=100 %	89.39%	88.85%
Essential Steps Care Bundles Including Hand Hygiene							
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	98%	99%
Isolation room audit		100%	<95%	95%-100%	=100 %	N/A	N/A
Management of Medication -SCH NRLS Reportable Incidents							
Total number of medication incidents in month		No Target				3	6
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				3	6
(also includes those not attributed to SCH management)	Low harm	No Target				0	0
Number of medication incidents involving Controlled Drugs		No Target				0	0
Incidents							
NRLS (i.e. patient safety) reportable incidents in month		No Target				132	107
Number of Never Events in month		No Target				0	0
Number of Serious Incidents (SIs) that occurred in month		No Target				4	2
Number of SIs reported to CCG in month *4 STEIS for 2 pts (2 each)		No Target				7	2
Percentage of SI reports submitted to CCG on time in month		No Target				<100%	<100%
Duty of Candour Applicable Incidents		No Target				7	6
Severity of NPSA Reportable Incidents							
None		No Target				88	73
Low		No Target				32	29
Moderate		No Target				12	3
Major		No Target				0	0
Catastrophic		No Target				0	0
Training Compliance							
Adult Safeguarding – Mandatory Training Compliance		95%	<90%	90%-95%	>=95%	94.08%	93.15%
Children Safeguarding – Mandatory Training Compliance		95%	<90%	90%-95%	>=95%	95.92%	95.69%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	93.27%	91.98%
WRAP						79.43%	76.85%
MCA / DoLs- Training compliance						75.61%	71.68%

Compliments/Complaints

There was 1 complaint received in February 2018 concerning community services. This relates to the paediatric SLT service.

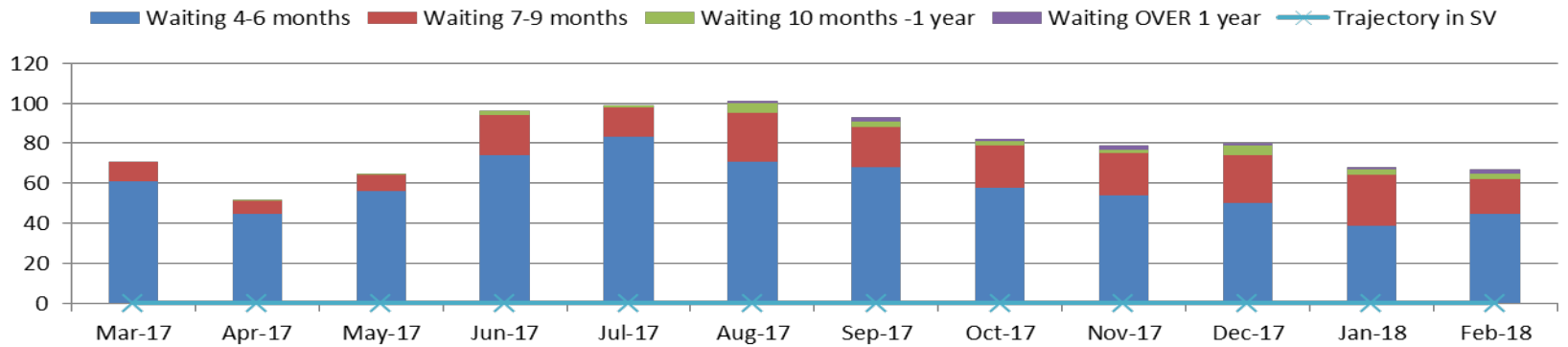
	Feb 18
Total Compliments	5
Formal complaints (No.)	1
Acknowledged within 3 working days (No.)	1
Acknowledged within 3 working days (%)	100
Responded to within 25 working days (No.)	-
Responded to within 25 workings days (%)	-
Complaints upheld (No.)	-
Complaints partially upheld (No.)	-
Complaints not upheld (No.)	-
Average response time (days)	-

Paediatric Speech and Language Service Waiting times

Community Clinics

Length of wait Community Clinics *(pre-school caseload)*	**No. of children waiting March 2017**	**No. of children waiting April 2017**	**No. of children waiting May 2017**	**No. of children waiting June 2017**	**No. of children waiting July 2017**	**No. of children waiting August 2017**	**No. of children waiting September 2017**	**No. of children waiting October 2017**	**No. of children waiting November 2017**	**No. of children waiting December 2017**	**No. of children waiting January 2018**	**No. of children waiting February 2018**
Waiting up to 3 months	162	166	154	156	150	101	87	97	105	91	97	83
Waiting 4-6 months	61	45	56	74	83	71	68	58	54	50	39	45
Waiting 7-9 months	10	6	8	20	15	24	20	21	21	24	25	17
Waiting 10 months -1 year	0	1	1	2	1	5	3	2	2	5	3	3
Waiting OVER 1 year	0	0	0	0	0	1	2	1	2	1	1	2
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**233**	**218**	**219**	**252**	**249**	**202**	**180**	**179**	**184**	**171**	**165**	**150**
Already had PoC	85	53	51	73	86	67	58	50	41	57	39	42
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*	**318**	**271**	**270**	**325**	**335**	**269**	**238**	**229**	**225**	**228**	**204**	**192**

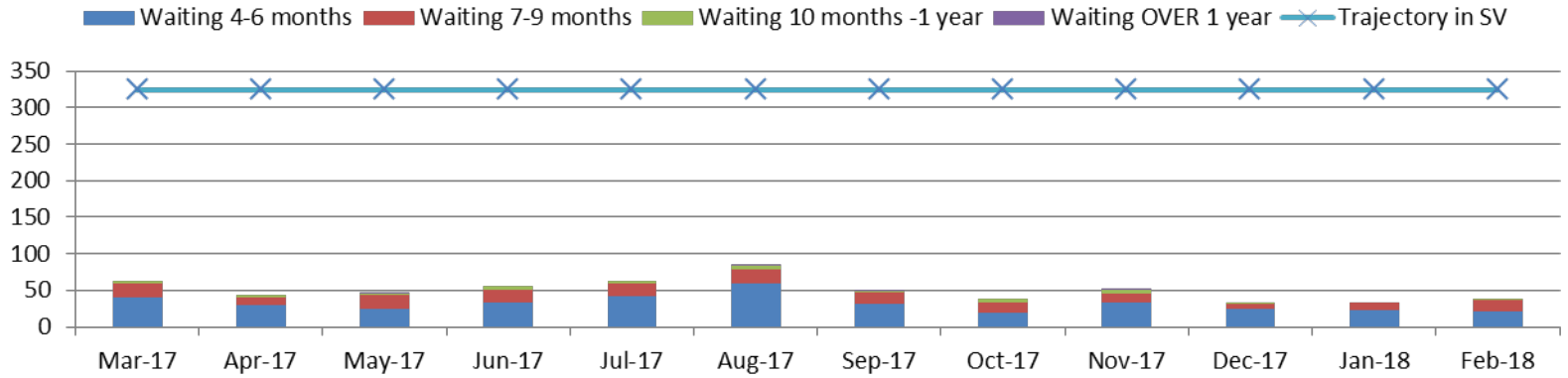
Community Clinics
Length of time waiting for therapy



Mainstream Schools

Length of wait Mainstream Schools *(pre-school caseload)*	**No. of children waiting March 2017**	**No. of children waiting April 2017**	**No. of children waiting May 2017**	**No. of children waiting June 2017**	**No. of children waiting June 2017**	**No. of children waiting August 2017**	**No. of children waiting September 2017**	**No. of children waiting October 2017**	**No. of children waiting November 2017**	**No. of children waiting December 2017**	**No. of children waiting January 2018**	**No. of children waiting February 2018**
Waiting up to 3 months	73	87	89	84	113	100	64	68	61	52	75	68
Waiting 4-6 months	41	29	24	33	42	60	32	20	33	25	23	21
Waiting 7-9 months	18	11	19	18	18	19	15	14	12	6	10	16
Waiting 10 months -1 year	3	4	2	5	3	4	2	4	5	2	0	2
Waiting OVER 1 year	0	0	1	0	0	1	1	0	1	0	0	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**135**	**131**	**135**	**140**	**176**	**184**	**114**	**106**	**112**	**85**	**108**	**107**
Already had PoC	248	210	194	253	759	739	359	346	314	327	265	258
Total waiting *(Including patients who have already receive 1 POC and are waiting for another)*	**383**	**341**	**329**	**393**	**935**	**923**	**473**	**452**	**426**	**412**	**373**	**365**

Mainstream Schools
Length of time waiting for therapy



APPENDIX 1: PEER HOSPITAL LIST USED BY CQC

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

						Surgery									Medicine																Women & Children				
Group	Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	ETC	DSU	ED	CCU	G5	F9	F10	G1	G3	G4	G8	Newmarket	Glastonbury	MTU	F12	G9	F7	F8	F1	F11	F14	MLBU	NNU
Patient Safety	HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100					100										100				No Data	No Data	100									
	HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	No Data	100	100	100						100	No Data	100	100	100	100	No Data	100				No Data						No Data		
	HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100					100	No Data				100									No Data	No Data	100				100	100				No Data
	HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	100	100	100	100						100	100	100	100	No Data	100	100	100				100	100	100		100		100		No Data
	HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100							100	No Data	100																					
	HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100							100	No Data	90																					
	HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	= 100					100																									
	HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100						100				100					100										100					
	HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	100	100	100	100							100	100	100	100	100	100	90	100				100	100	100				100		
	Total no of MRSA bacteraemias: Hospital	= 0 per yr	> 0	No Target	= 0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data				No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data
	Hand hygiene compliance	= 95%	<85	85-99	= 100	100	100	100	100	100		100	100	100		100		100	100	100	100	100	100			100	100		100	100	100	90	100		100
	Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Quarterly Standard principle compliance	90%	<80	80-90%	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data
	Total no of C. diff infections: Hospital	= 16 per year	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	No Data	No Data	No Data	No Data						No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data				No Data	No Data	No Data	No Data	No Data	No Data	No Data		
	Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data
	Quarterly VIP score documentation	= 90%	<80	80-89	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data
	MEWS documentation and escalation compliance	= 100%	<80	80-99	= 100																														
	No of patient falls	= 48	>=48	No Target	<48	4	0	2	7	1					2	0	12	4	6	3	7	3	5	4	4	0	2	4	8	3		1	0		
	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	1	0	0	4	0					1	0	5	3	0	0	4	2	2	1	0	0	0	2	0	1		0	0		
	No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0																														
	No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	0	0	0	0	0						0	1	2	2	0	4	5	0	0	0	0	0	0	0	0		1	0		
	No of avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target																														
	Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	100	No Data	100	100	100						100	90	80	100	78	100	50	70				100	80	90	No Data			80		
	No of SIRIs	No Target	No Target	No Target	No Target	1	0	0	1	0	0	0	0	0	0	0	2	0	1	1	0	1	0	0	0	0	0	0	0	1	0	1	0	0	0
	No of medication errors	No Target	No Target	No Target	No Target	5	2	2	0	2	0	0	1	0	6	0	0	1	1	0	1	0	1	1	0	0	0	5	3	1	0	3	0	0	0
	Cardiac arrests	No Target	No Target	No Target	No Target	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100																														
	VTE: Completed risk assessment (monthly Unify audit)	> 98%	< 98	No Target	> 98	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100																														
	Safety Thermometer: % of patients experiencing new harm-free care	> 95%	<95	95-99	= 100	91.67	100	100	100	100	No Data	No Data	No Data	No Data	No Data	85.71	100	100	92	100	93.94	90.62	95.65	100	100	No Data	100	94.12	100	No Data	No Data	100	100	No Data	No Data
Patient Experience: in-patient	Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	89	100	98	99							99	100	94	92	94	90	95					99	88	89				97		
	How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	= 95%	<70	70-89	90-100	100	100	100	100							100	100	96.77	100	100	88.89	100					100	85.71	100				100		
	In your opinion, how clean was the hospital room or ward that you were in?	= 85%	<75	75-84	85-100	97	99	95	100							100	100	97	74	100	97	100					100	95	83				100		
	Did you feel you were treated with respect and dignity by staff	= 85%	<75	75-84	85-100	100	100	100	100							100	100	100	94	100	100	100					100	93	100				97		
	Were staff caring and compassionate in their approach?	= 85%	<75	75-84	85-100	100	100	99	100							100	100	98	89	100	97	100					100	93	100				97		
	Did you experience any noise in the night time that you think could have been avoided?	= 85%	<75	75-84	85-100	15	97	98	94							92	100	97	100	100	81	86					100	57	50				94		
	Did you find someone in the hospital staff to talk about your worries and fears?	= 85%	<75	75-84	85-100	100	100	100	100							100	100	100	86	100	84	100					100	100	100				100		
	Were you involved as much as you wanted to be in decisions about your care and treatment?	= 85%	<75	75-84	85-100	100	100	98	100							100	100	97	89	85	83	100					96	100	75				88		
	Did staff talk in front of you as if you were not there?	= 85%	<75	75-84	85-100	100	100	98	100							100	100	100	94	90	81	100					100	71	100				100		
	Were you given enough privacy when discussing your condition or treatment?	= 85%	<75	75-84	85-100	100	100	100	100							100	100	100	100	100	94	100					100	100	100				100		
	Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	100	100	100	94							100	100	100	100	100	97	100					100	100	100				100		
	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	100	100	97	100							100	100	100	83	100	100	100					100	100	100				100		

Trust Open Board Meeting – 29th March 2018

Agenda item:	9			
Presented by:	Nick Jenkins, Medical Director			
Prepared by:	Sarah Jane Relf, e-Care/Global Digital Exemplar Operational Lead			
Date prepared:	19 March 2018			
Subject:	To receive update on discharge summary incident			
Purpose:	X	For information		For approval

Executive summary:
This paper provides an update on the discharge summary incident investigation. It confirms that fixes have been implemented for all errors identified and that the investigative review is nearing completion. The report also confirms that our reviews have shown no reported harm to any patient at this stage.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X		

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	x	X					

Previously considered by:	*This incident is overseen by an incident management group which meets weekly with Nick Jenkins as chair.*
Risk and assurance:	*The issue is listed on the corporate risk register and monitored through usual internal processes.*
Legislation, regulatory, equality, diversity and dignity implications	*Not relevant*

Recommendation:
The Board is asked to note the report

To receive update on discharge summary incident

1. Background

1.1 In April 2017, the Trust identified an issue with inaccuracies in some of its inpatient discharge summaries. Due to a data transfer error in one of our systems, some patients' medications were being recorded inaccurately when they were discharged. These discharge summaries are issued to a patient's GP once they have been discharged from hospital, to update the GP on the care they have received.

This was a complex issue created by a combination of the following elements:

- Issues with the automated transfer of discharge summaries (a system called DTS). This particular issue was affecting how dose units, frequency and routes were displayed and in some cases, omitting prescribed items entirely.
- An error in the Cerner system where information from subsequent encounters was pulled through into historical summary information.
- Issues around how medication displayed when the prescriber did not follow the exact workflow when starting, amending or discontinuing a medication.

1.2 The issue was raised as a serious incident, and an incident management group was established. The group has met weekly for the past year with Nick Jenkins, medical director as chair.

1.3 The group has been managing a number of components of the incident:

- Implementing immediate mitigations that were put in place at the point the incident was identified
- Pursuit of permanent solution
- Identifying the patient records that needed to be reviewed, with a team of pharmacists, GPs and hospital clinicians working together to look at each case individually
- Detailed investigation of the incident.

The remainder of this report provides an update on the incident against each of these.

2. Immediate mitigations

2.1 When we discovered the error, we immediately stopped the use of this part of the system and implemented a manual process to send medication information to GPs via secure email addresses. This mitigated the problem, and remained in place until the error was fixed on 7 August, 2017.

2.2 In addition, we took immediate measures to support staff in using the correct workflows. A 'red border' communication was issued, briefings were given to all handover meetings, dedicated training sessions were held and e-learning packages released. Audits were undertaken after these interventions to ensure the workflows were being followed correctly.

3. Pursuit of permanent solution

3.1 We worked closely with Cerner to correct the errors within the system and to create a more user friendly and intuitive workflow. A new medication token was created to address the issues. The new token was successfully implemented as part of our wider go live in October 2017.

3.2 Extensive audits were undertaken after the implementation which confirmed that the

token was working effectively and the issues had been corrected.

3.3 We have one residual issue remaining following the implemented fixes. Currently we are manually producing, checking and distributing any discharge summary copies that are requested for the period prior to the new token being implemented (i.e. prior to October 2017). There is no known fix for this currently and therefore the manual process will continue. Obviously the numbers requested will decrease over time.

4 Lookback review of historical discharge summaries

4.1 We identified 3,709 patients that needed to be reviewed. A team of pharmacists, GPs and hospital clinicians has worked together to look at each case individually. To date, our investigation has not revealed any patient harm. With the support of the Local Medical Committee and the clinical commissioning group, 3,351 (90%) of the required reviews are now complete. We are very grateful to GP colleagues for supporting us with these reviews.

4.2 We have regularly communicated with and provided support to GP practices through this review process. We have sent a final reminder to the practices with the outstanding 10% of reviews to complete, and will be escalating to regulators should no response be received.

4.3 In addition, we are completing detailed pharmacist reviews for any patients that have died since the incorrect summaries were sent. To date we have reviewed 1,389 encounters, covering 785 patients. To date, 246 of these encounters have been subject to more detailed review in partnership with the relevant GP surgery. Again, to date no patient harm has been identified.

5. Detailed investigation of incident

5.1 In line with the serious incident policy, a detailed investigation was undertaken into the root cause of the incident. This covered four areas:

- workflow design
- testing completed prior to go-live
- training offered prior to go-live
- response of the Trust

5.2 A number of observations and recommendations were made as a result of the investigation which have been accepted and implemented within the Trust, to ensure learning has been embedded and the risk of a repeat incident is mitigated as far as possible. The Trust recognises the importance of sharing these lessons, and has taken action to share learning with others:

- A joint letter from Cerner and the Trust was sent to all NHS organisations that are using Cerner software, confirming the issues identified and actions taken to resolve
- Session with the Professional Records Standards Body (PRSB) who are responsible for setting the national standards on hospital communications. The learning from our incident has fed into their review of discharge summaries.
- Speaking at a number of Cerner events to share learning.
- Plans to host a webex discussion with other global digital exemplar sites as part of the learning network.

6. Onward improvements

6.1 Whilst the incident investigation itself is reaching a conclusion, with no patient harm identified to date, we have found opportunities for further improvements during our forensic review of the discharge summary process. Some of these have already been acted upon, but we have also placed a dedicated post to work with clinicians and administrative staff to improve the content quality and timeliness of summaries sent. This post has only been in place a short while, but the potential impact is already evident.

7. Recommendations

7.1 The Board is asked to note the update on discharge summary incident.

NHS West Suffolk NHS Foundation Trust

Board of Directors – February 2018

Agenda item:	11			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	21st March 2018			
Subject:	Finance and Workforce Board Report – February 2018			
Purpose:	x	For information		For approval

Executive summary:
The reported I&E for February 2018 YTD is a deficit of £6,384k, against a planned deficit of £5,240k. This results in an adverse variance of £1,144k YTD. This includes recognition of failing the A&E performance target for Q3 and Q4. Therefore against our control total (pre-STF) the Trust is £408k behind plan YTD.

We are monitored by NHSI against our pre STF position. The year-end forecast is that the pre STF performance will be better than plan by £218k. This forecast assumes we will not receive A&E performance STF in Q4, but that we will achieve our pre-STF control total and therefore receive STF in relation to our financial performance

The monthly favourable variance is £518k. This predominantly relates to a reduction in costs resulting from initiatives to manage flow through the hospital and reducing the associated cost of temporary medical and nursing staff.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X		

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X					

Previously considered by:	*This report is produced for the monthly trust board meeting only*
Risk and assurance:	*These are highlighted within the report*
Legislation, regulatory, equality, diversity and dignity implications	*None*
Recommendation: *The Board is asked to review this report*	

West Suffolk NHS
NHS Foundation Trust

FINANCE AND WORKFORCE REPORT

February 2018 (Month 11)

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

Financial Summary

I&E Position YTD	£6.4m	loss
Variance against plan YTD	-£1.1m	
Movement in month against plan	£0.2m	
EBITDA position YTD	£1.7m	deficit
EBITDA margin YTD	-0.2%	deficit
Cash at bank	£6,870k	

Executive Summary

- The Month 11 YTD position is £1,144k behind plan, including shortfall on STF relating to A&E performance. Against our control total the Trust is £408k behind plan.
- We are forecasting to beat our control total by £0.2m

Key Risks

- Delivering the cost improvement programme.
- Containing the increase in demand to that included in the plan (2.5%).

SUMMARY INCOME AND EXPENDITURE ACCOUNT - February 2018	Feb-18 Budget £m	Feb-18 Actual £m	Feb-18 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance £m
NHS Contract Income	14.7	14.8	0.1	191.0	191.4	0.4	206.8	207.4	0.6
Other Income	2.9	3.1	0.1	32.4	32.7	0.2	35.1	35.3	0.3
Total Income	**17.7**	**17.9**	**0.3**	**223.4**	**224.0**	**0.6**	**241.9**	**242.8**	**0.9**
Pay Costs	12.0	12.3	(0.3)	134.3	134.9	(0.6)	146.8	147.7	(0.9)
Non-pay Costs	8.2	8.2	0.0	92.6	93.6	(1.0)	99.1	98.8	0.3
Operating Expenditure	**20.2**	**20.6**	**(0.3)**	**226.9**	**228.4**	**(1.6)**	**245.9**	**246.5**	**(0.5)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**(2.5)**	**(2.7)**	**(0.1)**	**(3.4)**	**(4.4)**	**(1.0)**	**(4.0)**	**(3.7)**	**0.3**
EBITDA margin	(11.0%)	(13.5%)	(2.6%)	0.5%	(0.3%)	(0.8%)	0.5%	0.2%	(0.3%)
Depreciation	(0.7)	(0.7)	(0.1)	4.9	4.8	0.1	5.4	5.3	0.1
Finance costs	(0.5)	(1.2)	0.7	1.5	1.0	0.5	1.6	1.8	(0.2)
SURPLUS/(DEFICIT) pre S&TF	**(1.3)**	**(0.8)**	**0.5**	**(9.8)**	**(10.2)**	**(0.4)**	**(11.1)**	**(10.9)**	**0.2**
Sustainability and Transformation Funding									
S&T funding - Financial Performance	0.4	0.2	(0.2)	3.2	3.2	0.0	3.6	3.6	0.0
S&T funding - A&E Performance	0.2	0.0	(0.2)	1.4	0.6	(0.8)	1.6	0.6	(1.0)
SURPLUS/(DEFICIT) incl S&TF	**(0.7)**	**(0.6)**	**0.2**	**(5.2)**	**(6.4)**	**(1.2)**	**(5.9)**	**(6.7)**	**(0.8)**

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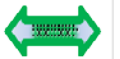
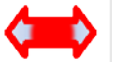
Contents:

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 – February 2018

Income and Expenditure summary as at February 2018

The reported I&E for February 2018 YTD is a deficit of £6,384k, against a planned deficit of £5,240k. This results in an adverse variance of £1,144k YTD. This includes recognition of failing the A&E performance target for Q3 and Q4. Therefore against our control total (pre-STF) the Trust is £408k behind plan YTD.

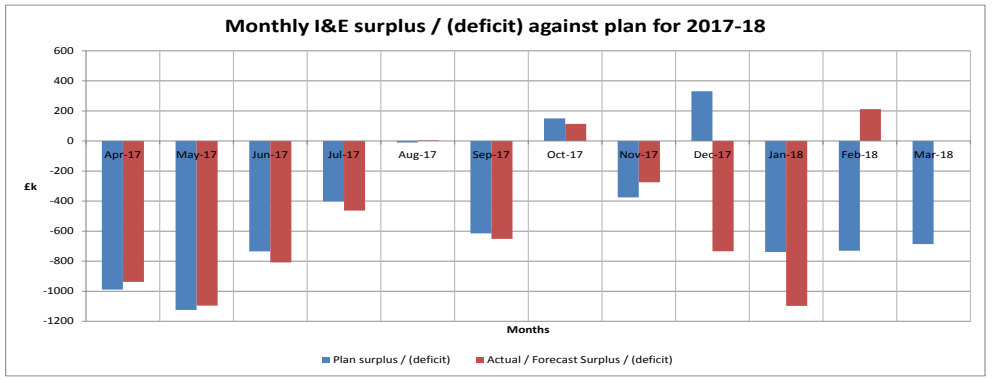
The monthly favourable variance is £518k. This predominantly relates to a reduction in costs resulting from reduced elective activity and a reduction in the costs associated with escalation.

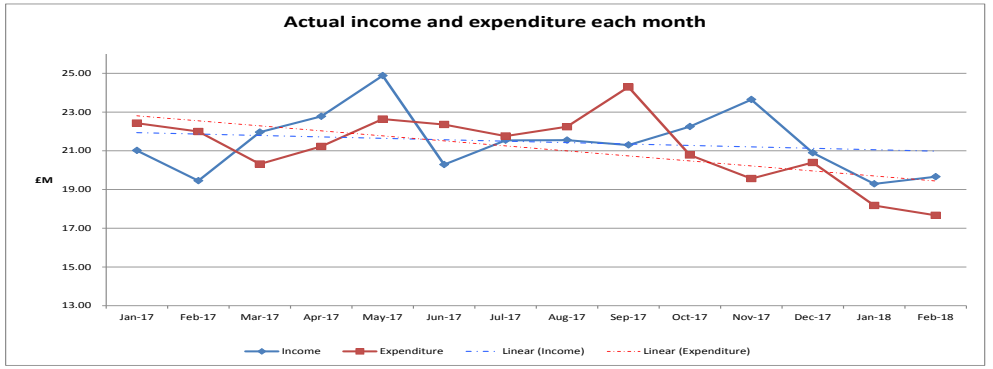
In order to manage the year-end position we are in discussion with our commissioners to understand if there is any flexibility with our income position.

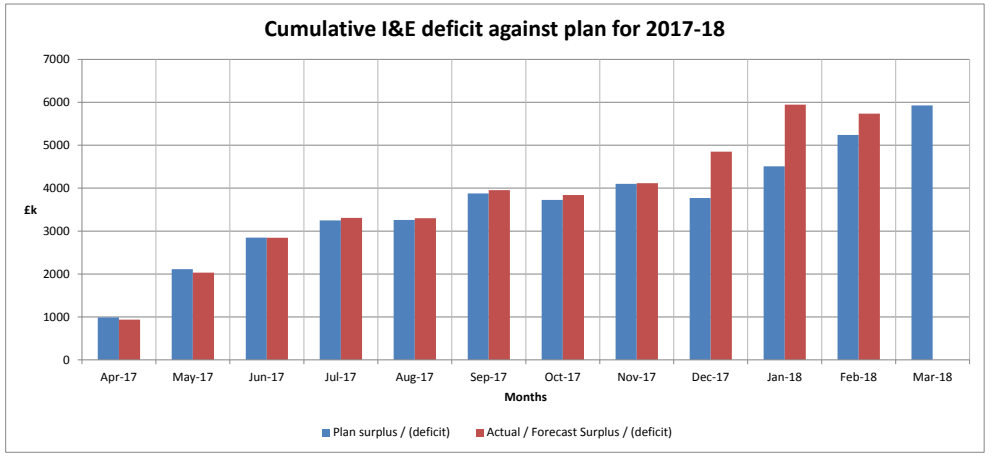
We are monitored by NHSI against our pre STF position which is an unfavourable variance of £408k. The year-end forecast is that the pre STF performance will be better than plan by £218k.

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)	(731)	(577)	154	↑	Amber
YTD surplus / (deficit)	(5,240)	(6,384)	(1,144)	↓	Red
Forecast surplus / (deficit)	(5,926)	(6,926)	(1,000)	↓	Amber
EBITDA YTD	1,154	(559)	(1,713)	↓	Red
EBITDA (%)	0.5%	(0.2%)	(0.8%)	↓	Red
Use of Resources (UoR) Rating fav / (adv)	3	3	0	↔	Amber
Clinical Income YTD	(190,990)	(191,360)	369	↑	Green
Non-Clinical Income YTD	(37,113)	(36,581)	(532)	↑	Red
Pay YTD	134,302	134,873	(571)	↑	Red
Non-Pay YTD	99,041	100,241	(1,199)	↓	Red
CIP target YTD	(12,636)	(12,168)	(468)	↑	Amber







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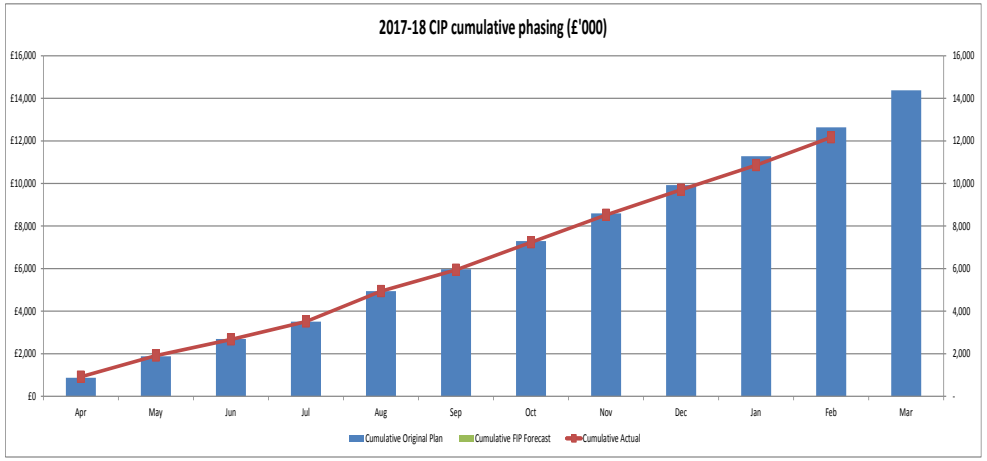
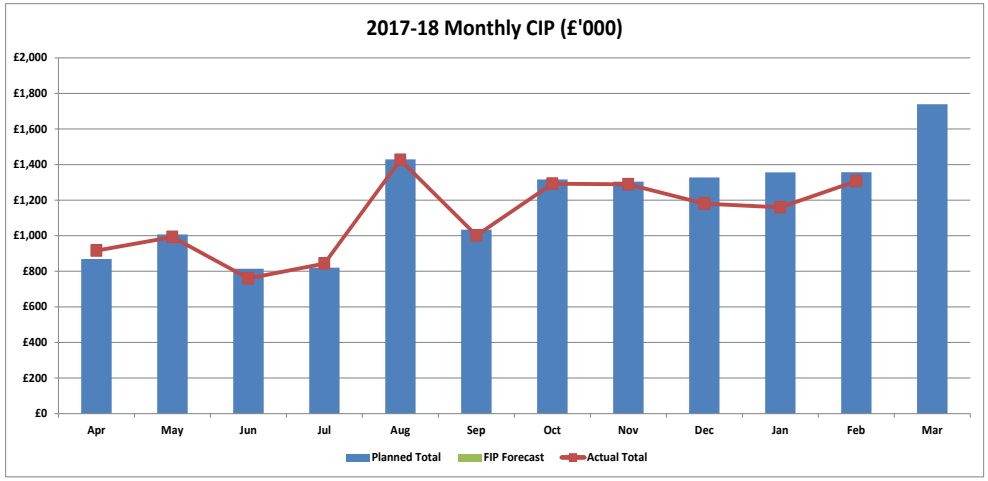
Cost Improvement Programme (CIP) 2017-18

The February position includes a target of £12,636k YTD which represents 88% of the 2017-18 plan. There is currently a shortfall of £468k YTD against this plan.

Recurring/Non Recurring	Summary	2017-18 Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Activity growth	297	270	108
	Car Park Income	400	367	207
	Other Income	167	152	104
	Consultant Staffing	326	292	288
	Additional sessions	192	176	81
	Staffing Review	2,722	2,038	2,716
	Agency	482	442	203
	Procurement	1,801	1,617	1,292
	Community Equipment Service	465	412	273
	Contract review	8	8	12
	Drugs	326	283	207
	Capitalisation	466	426	316
	Other	2,048	1,968	1,898
	Theatre Efficiency	275	229	229
	Patient Flow	300	250	250
	Pay controls	337	281	281
	Outpatients	190	158	158
Recurring Total		**10,801**	**9,368**	**8,622**
Non-Recurring	Activity growth	300	300	300
	Other Income	19	18	24
	Additional sessions	10	9	37
	Staffing Review	20	18	-
	Contract review	41	38	45
	Estates and Facilities	389	357	357
	Non-Recurring	396	396	396
	Capitalisation	350	325	425
	Other	398	363	517
	GDE revenue	1,650	1,444	1,444
Non-Recurring Total		**3,573**	**3,267**	**3,545**
Grand Total		**14,375**	**12,636**	**12,167**





In order to deliver the Trusts pre-STF control total of £8.1m deficit in 2018-19 we need to deliver a CIP of £17.9m (7.8%).

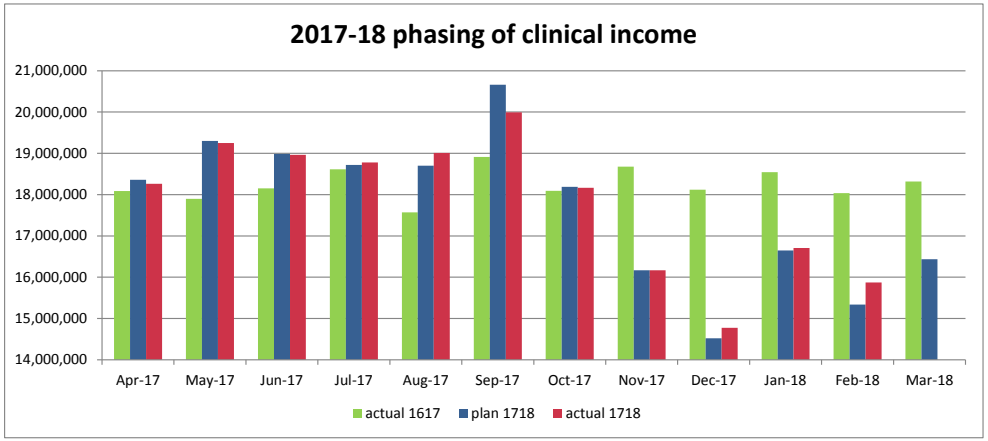
To date we have identified £7.0m of risk adjusted CIP schemes, (£9.4m non-risk adjusted) for 2018-19. We therefore have a gap of £8.5m against the 2018-19 target which we are discussing with NHSI

FINANCE AND WORKFORCE REPORT – February 2018

Income Analysis

The chart below summarises the phasing of the clinical income plan for 2017-18, including Community Services. This phasing is in line with activity phasing and does not take into account the block payment. This graph includes the reduction in income relating to community services from October to March.

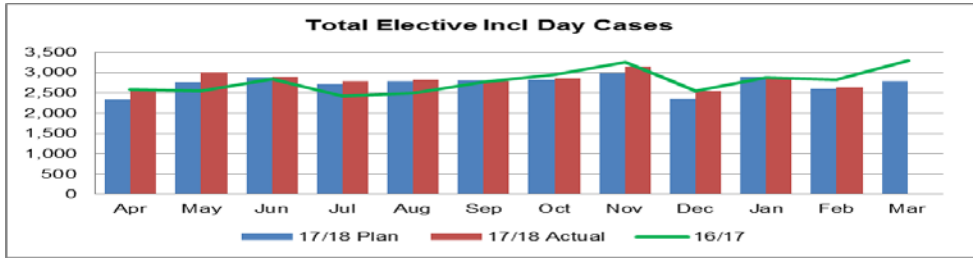
Income earned from within Suffolk is on plan since we have block contracts with Suffolk CCGs for their activity. However, variances can be seen within Divisions with any balances reflected within the Corporate Division.

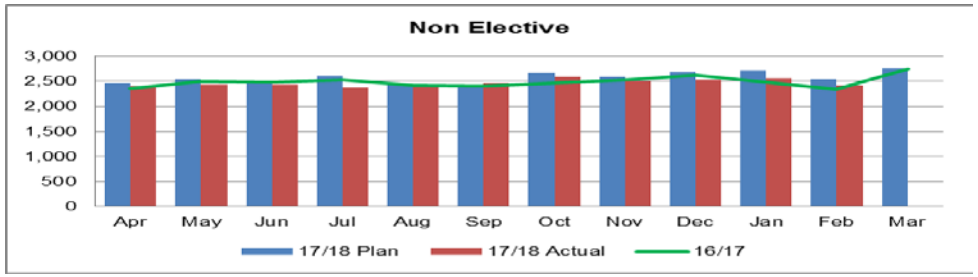


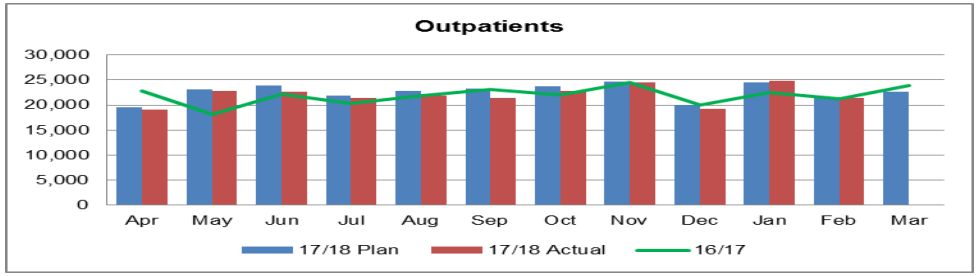
The income position was ahead of plan for February, with over performance being seen within the Non Elective and the subsequent cancellation of Elective work causing under performance in this area.

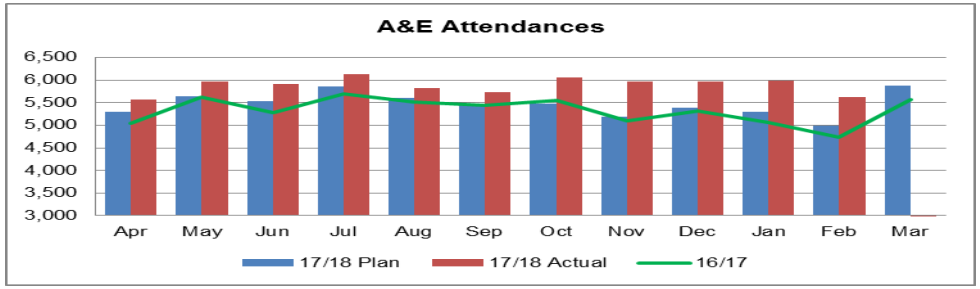
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	619	662	43	7,406	7,829	423
Other Services	1,871	2,049	178	25,504	22,783	(2,721)
CQUIN	292	288	(3)	3,304	3,351	46
Elective	2,509	2,214	(295)	28,705	29,387	682
Non Elective	5,065	5,373	308	56,133	58,728	2,595
Emergency Threshold Adjustment	(265)	(385)	(121)	(3,161)	(3,670)	(509)
Outpatients	2,595	2,599	4	29,891	29,200	(691)
Community	2,046	2,046	0	43,208	43,752	544
Total	**14,731**	**14,846**	**114**	**190,990**	**191,360**	**369**

Activity, by point of delivery









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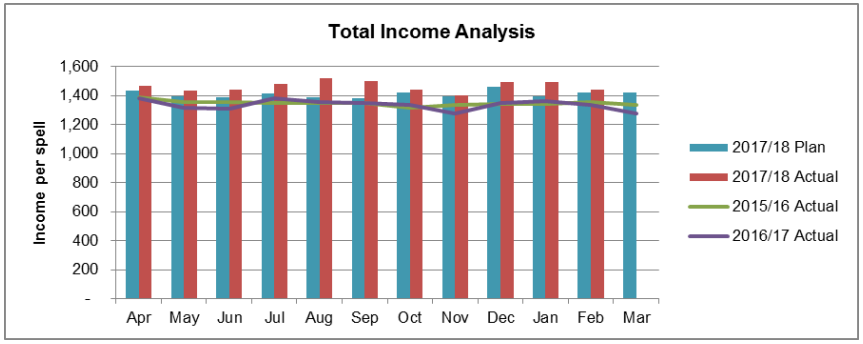
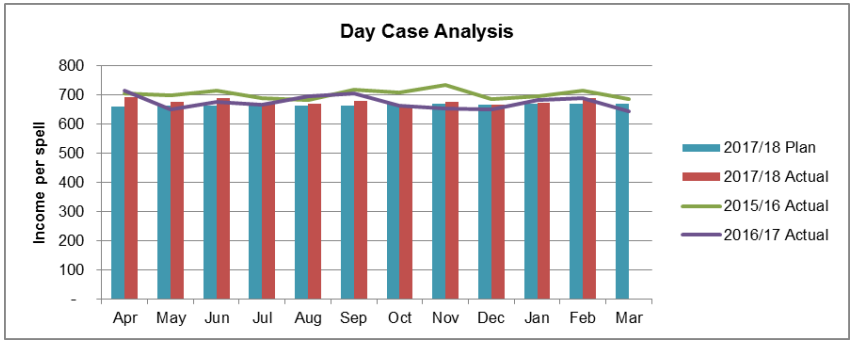
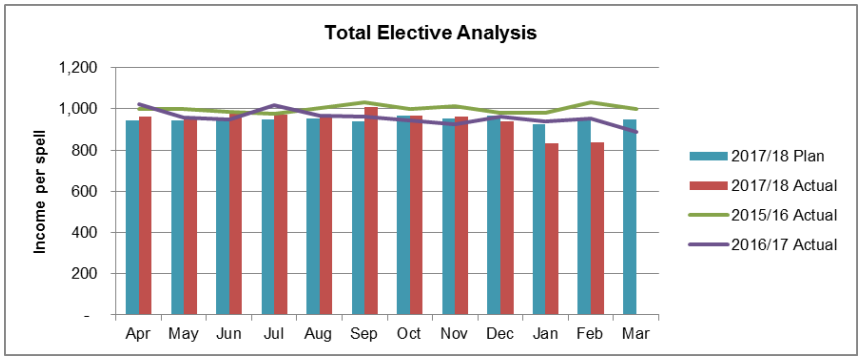
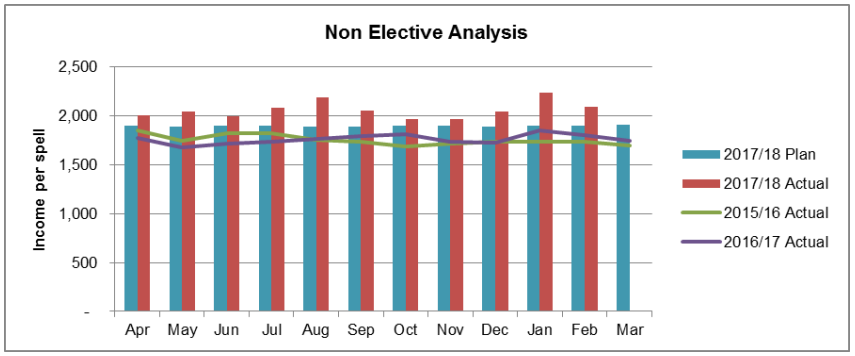
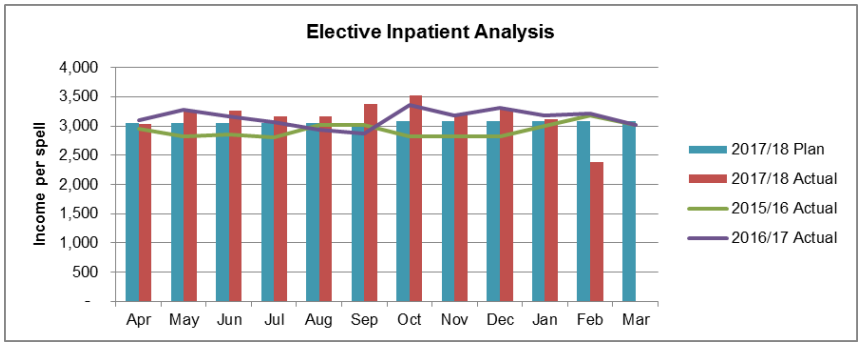
Trends and Analysis

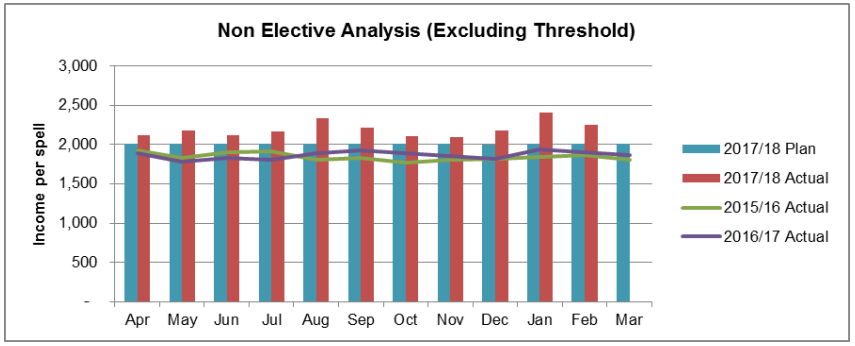












FINANCE AND WORKFORCE REPORT – February 2018

Workforce

Monthly Expenditure Acute services only				
As at February 2018	Feb-18	Jan-18	Feb-17	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,477**	**11,011**	**10,795**	**119,788**
Substantive Staff	9,626	9,893	9,627	106,945
Medical Agency Staff (includes 'contracted in' staff)	110	169	152	1,302
Medical Locum Staff	363	314	173	2,890
Additional Medical sessions	235	186	210	2,854
Nursing Agency Staff	170	171	112	910
Nursing Bank Staff	364	170	180	2,313
Other Agency Staff	(78)	67	62	608
Other Bank Staff	(2)	120	127	1,392
Overtime	114	103	101	1,135
On Call	29	67	58	569
Total temporary expenditure	1,306	1,366	1,175	13,972
Total expenditure on pay	**10,932**	**11,260**	**10,803**	**120,917**
Variance (F/(A))	(455)	(249)	(8)	(1,129)
Temp Staff costs % of Total Pay	11.9%	12.1%	10.9%	11.6%
Memo : Total agency spend in month	202	407	326	2,820

Monthly whole time equivalents (WTE) Acute Services only			
As at February 2018	Feb-18	Jan-18	Feb-17
	WTE	WTE	WTE
Budgeted WTE in month	**2,920.6**	**2,935.8**	**3,019.2**
Employed substantive WTE in month	**2748.07**	**2749.64**	**2,719.8**
Medical Agency Staff (includes 'contracted in' staff)	9.86	10.54	11.8
Medical Locum	22.03	22.1	14.2
Additional Sessions	19.22	18.16	19.7
Nursing Agency	33.78	33.91	17.4
Nursing Bank	80.19	55.23	59.9
Other Agency	11.17	13.13	14.7
Other Bank	58.5	56.25	63.2
Overtime	43.53	31.66	46.6
On call Worked	7.37	7.72	10.0
Total equivalent temporary WTE	**285.7**	**248.7**	**257.3**
Total equivalent employed WTE	**3,033.7**	**2,998.3**	**2,977.1**
Variance (F/(A))	(113.2)	(62.6)	42.1
Temp Staff WTE % of Total Pay	9.4%	8.3%	8.6%
Memo : Total agency WTE in month	54.8	57.6	43.9
Sickness Rates (Feb / Jan)	3.68%	3.56%	4.01%
Mat Leave	2.2%	2.2%	2.0%

Monthly Expenditure Acute services only				
As at February 2018	Feb-18	Jan-18	Feb-17	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,477**	**11,011**	**10,795**	**119,788**
Substantive Staff	9,626	9,893	9,627	106,945
Medical Agency Staff (includes 'contracted in' staff)	110	169	152	1,302
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Other Agency Staff	(78)	67	62	608
Other Bank Staff	(2)	120	127	1,392
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Total temporary expenditure	1,306	1,366	1,175	13,972
Total expenditure on pay	**10,932**	**11,260**	**10,803**	**120,917**
Variance (F/(A))	(455)	(249)	(8)	(1,129)
Temp Staff costs % of Total Pay	11.9%	12.1%	10.9%	11.6%
Memo : Total agency spend in month	202	407	326	2,820

Monthly whole time equivalents (WTE) Community Services			
As at February 2018	Feb-18	Jan-18	Feb-17
	WTE	WTE	WTE
Budgeted WTE in month	**496.6**	**496.6**	**359.2**
Employed substantive WTE in month	**433.4**	**436.5**	**337.6**
Medical Agency Staff (includes 'contracted in' staff)	0.7	0.6	0.0
Medical Locum	0.4	0.4	0.4
Additional Sessions	0.0	0.0	0.0
Nursing Agency	2.6	0.7	0.3
Nursing Bank	5.0	4.1	3.5
Other Agency	3.3	0.8	15.9
Other Bank	1.0	0.7	3.6
Overtime	2.4	1.5	2.9
On call Worked	0.0	0.0	0.1
Total equivalent temporary WTE	**15.2**	**8.7**	**26.5**
Total equivalent employed WTE	**448.7**	**445.2**	**364.1**
Variance (F/(A))	47.9	51.4	(4.9)
Temp Staff WTE % of Total Pay	3.4%	1.9%	7.3%
Memo : Total agency WTE in month	6.5	2.1	16.2
Sickness Rates (Feb / Jan)	3.82%	3.63%	4.08%
Mat Leave	1.6%	1.7%	1.4%

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

* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

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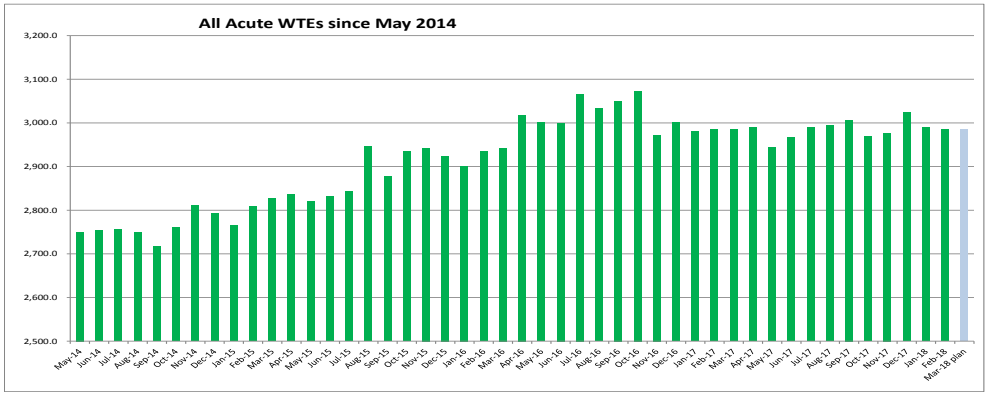
Staffing levels

The following graphs exclude Community staff and Glastonbury Court but include Capitalised staff. The impact of opening Glastonbury Court in November 2016 can be seen but if this were included around 28 WTE would be added to the actual WTEs. They have been rebased to reflect hours worked by junior doctors before the new junior doctors contract was implemented.

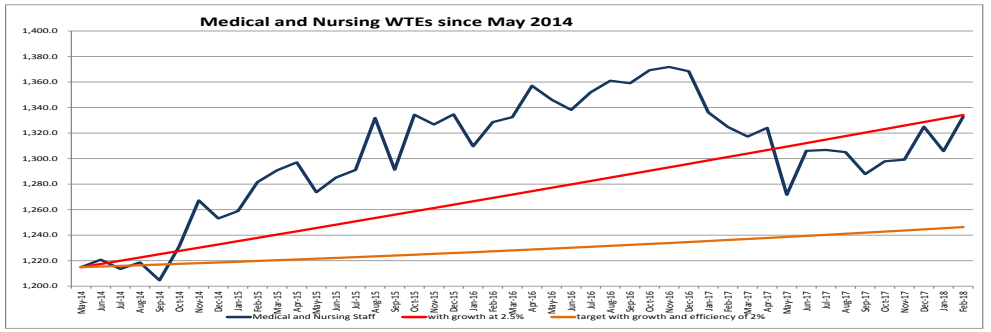
The planned establishment from March onwards is the level of staffing required to achieve the original CIP, although this needs to be updated to reflect the proposals in FIP2. As at February 2018 we employed a total of 113.2 WTE more than planned and 57 WTE more Acute staff than in February 2017.



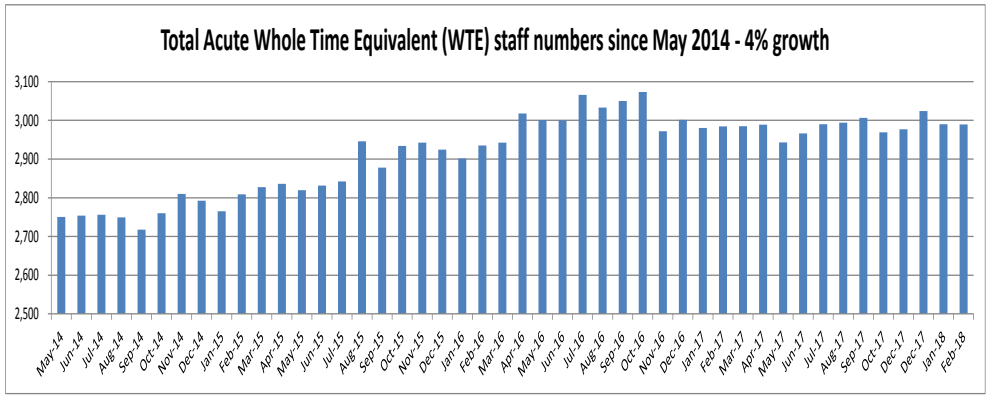
Since May 2014, (excluding Community staff) the Trust has employed 239 more WTEs, an increase of 8.7%. During this period activity has grown by around 10%

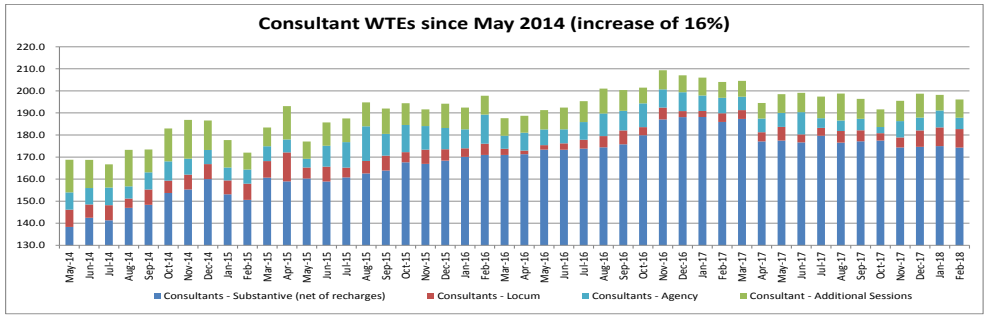
The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 91 WTEs (blue line). This includes around 27 WTE Consultants which are analysed further below. There has been a decrease of 2 WTE during February. Medical staff have increased by 30 WTE since April 2017, due to increases in junior doctors.

If medical and nursing staffing levels had increased in line with our growth in activity of broadly 2.5% we would currently be employing 1.4 more WTEs (red line). In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 86 WTE fewer than at February 2018



The graphs below highlight the increase in Consultant WTEs of 16.1% since May 2014. Substantive staff has increased by 36.0 WTEs whilst temporary staff have decreased by only 8.7 WTEs.





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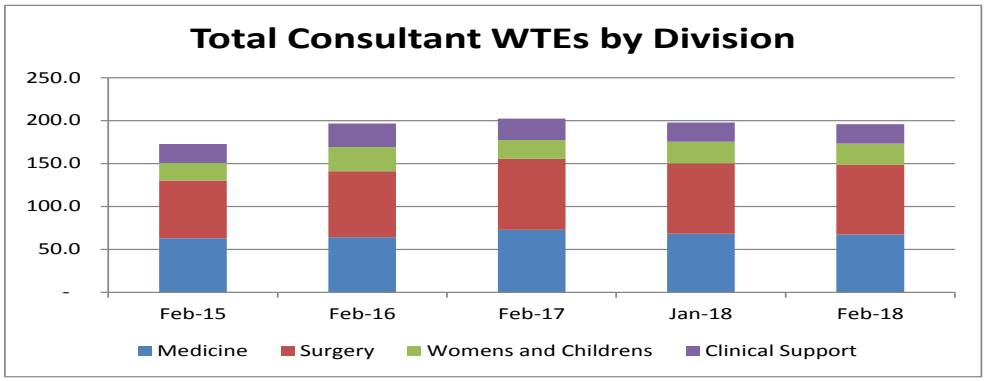
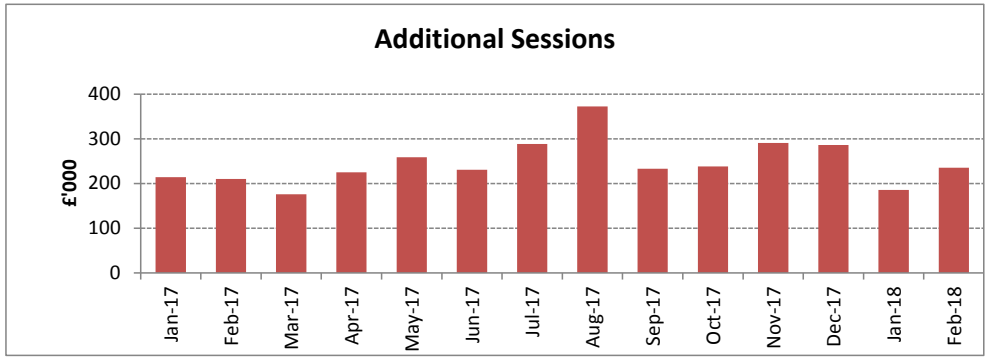
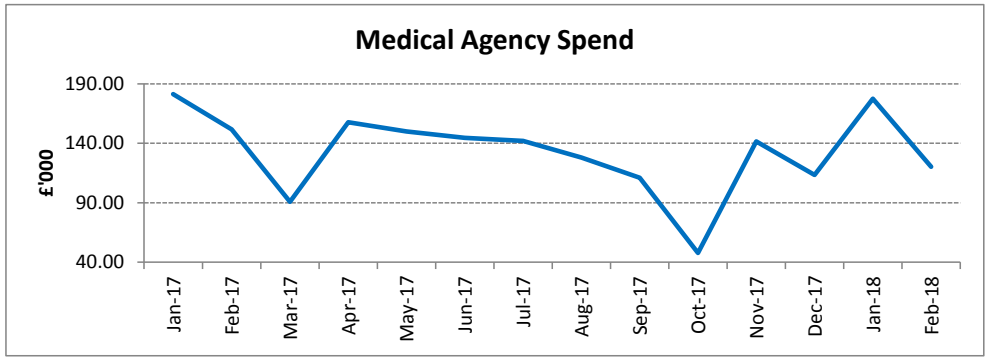


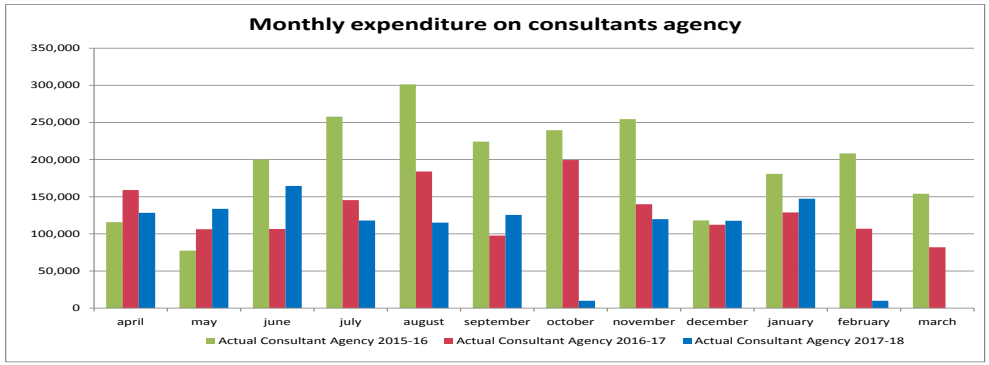
Division	Specialty	Sum of Feb-16	Sum of Feb-17	Sum of Jul-17	Sum of Aug-17	Sum of Sep-17	Sum of Oct-17	Sum of Nov-17	Sum of Dec 17	Sum of Jan 18	Sum of Feb 18
Medicine	A&E Medical Staff	6.3	7.2	8.1	8.2	8.2	7.5	7.9	7.0	8.1	7.5
	Cardiology	4.4	5.9	5.9	6.0	6.2	4.8	4.8	4.8	6.5	5.5
	Chest Medicine	4.0	4.3	4.0	4.0	4.2	3.8	4.2	3.8	3.7	4.4
	Chronic Pain Service	0.8	0.8	0.7	0.7	0.7	0.8	0.9	0.7	0.7	0.8
	Clinical Haematology	3.9	4.4	4.4	4.4	4.4	4.4	4.4	4.4	4.4	4.5
	Dermatology	4.5	4.7	5.0	3.5	4.3	3.5	5.6	4.0	4.6	4.6
	Diabetes	4.3	4.4	4.4	4.3	4.3	4.3	4.3	4.3	4.5	4.4
	Eau Medical Staff	8.4	7.4	7.2	9.6	7.2	7.6	7.4	8.0	8.6	8.7
	Gastroenterology	7.0	6.8	7.5	7.2	7.5	7.1	7.2	6.8	6.5	6.7
	General Medicine	7.5	6.7	5.8	4.6	5.3	5.4	4.8	5.2	4.6	4.4
	Nephrology	- 0.4	1.0	1.5	1.6	1.6	1.5	1.5	1.5	1.6	1.6
	Neurology	2.5	2.6	2.6	2.7	2.7	2.7	2.7	2.7	2.7	2.7
	Oncology	3.2	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.5	3.4
	Palliative Care	-	0.6	0.3	0.3	0.3	0.3	0.3	0.3	-	0.3
	Rheumatology	3.7	3.9	4.0	3.9	3.9	4.0	4.0	4.0	4.0	4.1
	Stroke	3.9	3.5	3.5	4.0	3.7	4.1	3.9	4.5	4.1	3.7
Medicine Total		**66.3**	**67.2**	**66.5**	**68.4**	**67.9**	**65.1**	**67.1**	**65.5**	**68.1**	**67.2**
Surgery	Anaesthetics	30.7	35.4	33.6	34.4	33.5	33.6	33.3	32.2	32.7	32.3
	E.N.T.	3.1	3.0	3.3	3.3	3.3	3.3	4.6	5.1	5.2	4.9
	General Surgery	12.3	10.3	9.8	9.8	9.8	9.8	10.6	10.7	11.1	11.0
	Ophthalmology	7.5	8.0	8.3	7.9	7.8	7.7	8.4	8.1	7.4	7.3
	Oral & Maxofacial Surg	1.3	1.1	0.0	0.0	0.1	-	-	0.0	1.4	-
	Plastic Surgery	2.8	4.2	3.0	2.3	2.4	3.4	3.4	3.7	3.6	3.6
	Trauma & Orthopaedic	13.7	12.7	14.2	14.7	14.0	14.5	13.7	15.2	13.8	14.1
	Urology	5.6	6.9	6.2	6.5	7.5	5.0	7.2	7.2	5.3	6.7
	Vascular Surgery	-	1.1	1.1	1.1	1.1	1.3	1.4	1.3	1.6	1.2
Surgery Total		**76.9**	**82.7**	**79.5**	**80.1**	**79.7**	**78.7**	**82.5**	**83.5**	**82.2**	**81.2**
Women and Childrens	Obstetrics	13.4	11.0	13.3	13.4	13.2	13.0	13.4	13.2	12.8	12.7
	Paediatrics	14.8	11.0	11.3	11.3	11.3	10.4	10.1	12.7	12.2	12.1
Women and Childrens Total		**28.2**	**22.0**	**24.6**	**24.7**	**24.4**	**23.4**	**23.5**	**25.9**	**25.0**	**24.8**
Clinical Support	Chemistry	0.6	0.7	-	0.6	0.3	-	-	-	-	-
	Histopathology	8.1	7.2	8.5	9.3	8.3	9.0	7.6	8.0	8.1	7.8
	Microbiology	3.3	3.2	3.2	3.2	3.2	3.5	3.5	4.3	3.3	3.3
	MRI	0.9	1.0	0.9	0.9	0.9	0.9	-	-	-	-
	Xray - Wsh	14.2	12.9	12.1	12.3	12.4	12.5	12.8	13.2	13.2	13.5
Clinical Support Total		**27.1**	**24.9**	**24.6**	**26.2**	**25.0**	**25.9**	**24.0**	**25.5**	**24.5**	**24.6**
Grand Total		**198.5**	**196.9**	**195.2**	**199.4**	**197.0**	**193.2**	**197.1**	**200.4**	**199.8**	**197.7**

Pay Trends and Analysis

The Trust overspent pay budgets by £341k in February (£571k overspent YTD).







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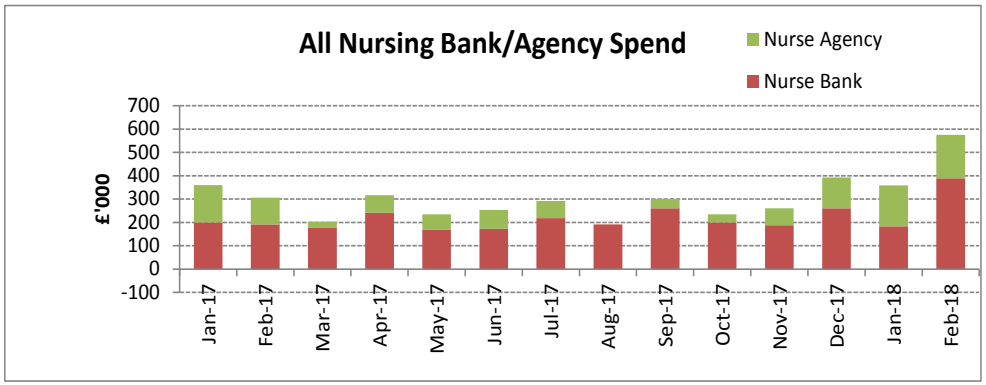
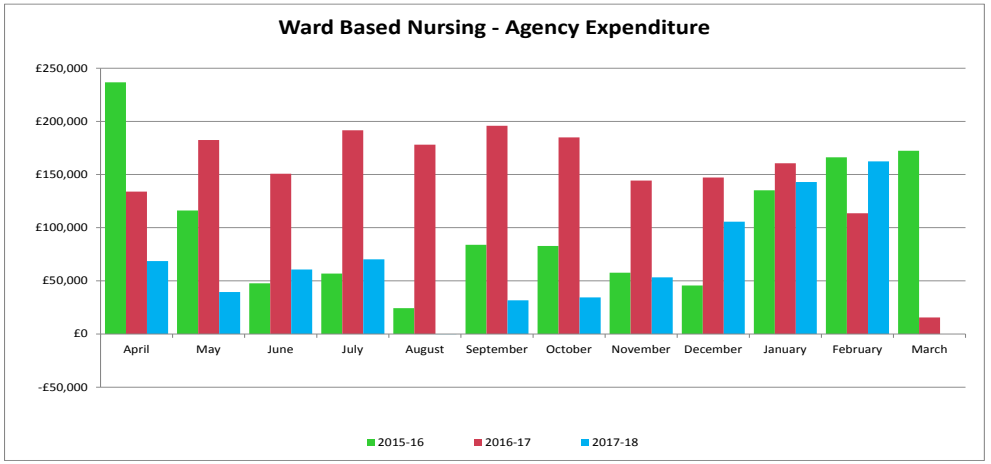
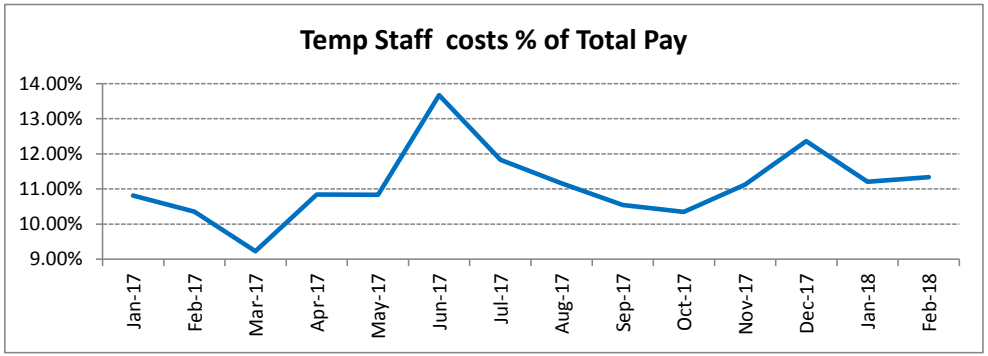
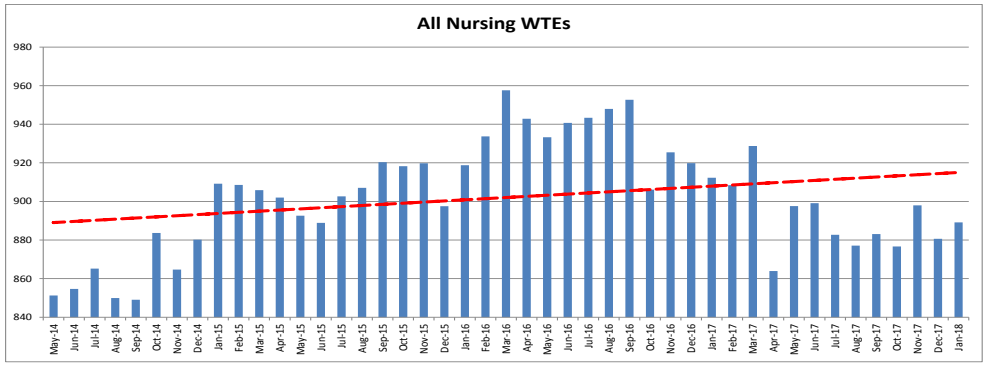
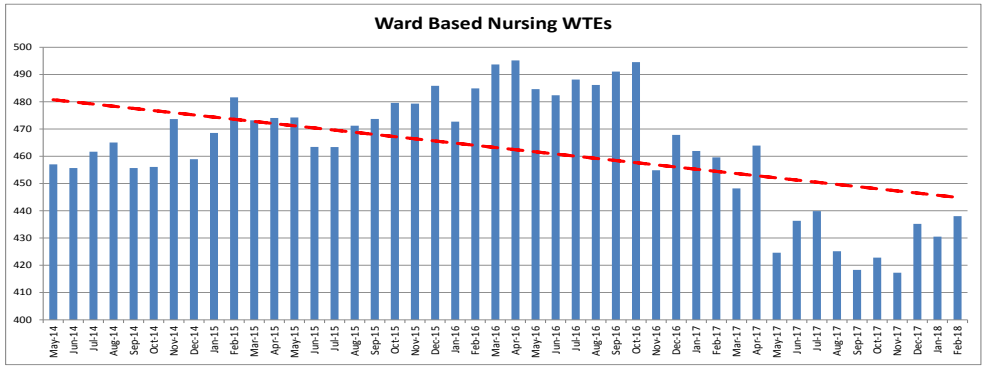




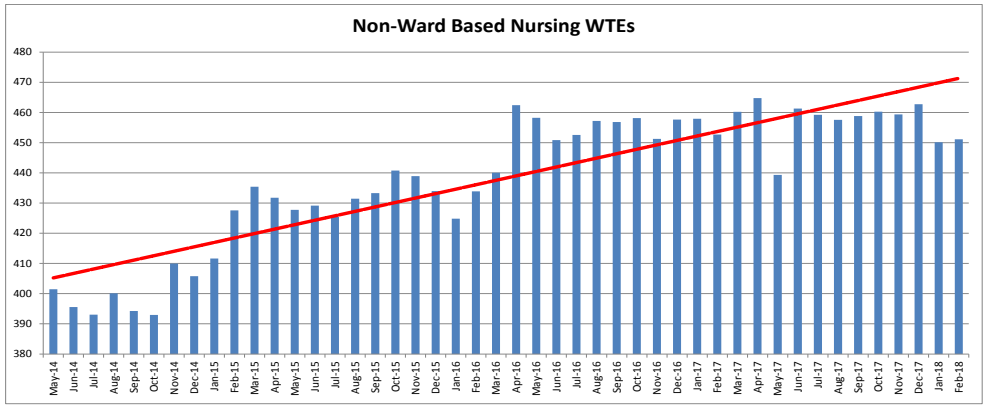


Acute Nursing





Note the drop in Ward based nurses in November 2016 is when Glastonbury Court was opened (c 26 WTE)



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Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Feb-18 Budget £k	Feb-18 Actual £k	Feb-18 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(5,204)	(5,660)	456	(60,254)	(61,850)	1,596
Pay Costs	3,477	3,532	(55)	37,583	37,746	(163)
Non-pay Costs	1,303	1,357	(54)	14,678	15,084	(406)
Operating Expenditure	**4,780**	**4,889**	**(109)**	**52,261**	**52,831**	**(570)**
SURPLUS / (DEFICIT)	**424**	**771**	**347**	**7,993**	**9,020**	**1,027**
SURGERY						
Total Income	(4,496)	(4,237)	(260)	(52,168)	(52,808)	641
Pay Costs	2,887	3,063	(177)	32,150	32,941	(792)
Non-pay Costs	1,028	955	73	11,618	12,409	(790)
Operating Expenditure	**3,915**	**4,018**	**(103)**	**43,768**	**45,350**	**(1,582)**
SURPLUS / (DEFICIT)	**581**	**218**	**(363)**	**8,400**	**7,458**	**(941)**
WOMENS and CHILDRENS						
Total Income	(1,789)	(1,828)	39	(22,013)	(21,873)	(140)
Pay Costs	1,109	1,144	(35)	12,195	12,304	(110)
Non-pay Costs	140	129	11	1,524	1,697	(173)
Operating Expenditure	**1,249**	**1,273**	**(24)**	**13,718**	**14,001**	**(283)**
SURPLUS / (DEFICIT)	**540**	**555**	**15**	**8,295**	**7,871**	**(423)**
CLINICAL SUPPORT						
Total Income	(953)	(969)	16	(10,692)	(10,299)	(393)
Pay Costs	1,710	1,881	(170)	18,731	19,055	(324)
Non-pay Costs	1,463	1,022	441	11,162	11,291	(129)
Operating Expenditure	**3,173**	**2,903**	**270**	**29,893**	**30,347**	**(454)**
SURPLUS / (DEFICIT)	**(2,221)**	**(1,934)**	**287**	**(19,201)**	**(20,047)**	**(847)**
COMMUNITY SERVICES						
Total Income	(2,973)	(3,002)	29	(48,360)	(50,309)	1,950
Pay Costs	1,530	1,413	117	13,997	13,953	44
Non-pay Costs	1,374	1,707	(333)	33,521	36,152	(2,631)
Operating Expenditure	**2,904**	**3,120**	**(216)**	**47,518**	**50,105**	**(2,587)**
SURPLUS / (DEFICIT)	**69**	**(118)**	**(187)**	**842**	**204**	**(637)**
ESTATES and FACILITIES						
Total Income	(371)	(348)	(23)	(4,118)	(3,995)	(124)
Pay Costs	745	742	4	8,215	8,081	134
Non-pay Costs	614	735	(120)	6,595	7,012	(416)
Operating Expenditure	**1,360**	**1,476**	**(117)**	**14,810**	**15,092**	**(282)**
SURPLUS / (DEFICIT)	**(989)**	**(1,128)**	**(140)**	**(10,692)**	**(11,098)**	**(406)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	(2,556)	(2,778)	221	(30,809)	(27,742)	(3,066)
Pay Costs	468	493	(25)	11,250	10,711	539
Non-pay Costs (net of contingency and reserves)	2,427	2,277	150	14,041	10,210	3,831
Finance & Capital	(1,203)	(1,052)	(151)	6,393	6,614	(220)
Operating Expenditure	**1,692**	**1,719**	**(26)**	**31,684**	**27,534**	**4,150**
SURPLUS / (DEFICIT)	**864**	**1,059**	**195**	**(876)**	**208**	**1,083**
TOTAL (including penalties, contingency and reserves)						
Total Income	(18,343)	(18,821)	478	(228,414)	(228,877)	464
Contract Penalties	0	0	0	0	0	0
Pay Costs	11,927	12,268	(341)	134,121	134,792	(671)
Non-pay Costs	8,350	8,182	168	93,139	93,855	(716)
Finance & Capital	(1,203)	(1,052)	(151)	6,393	6,614	(220)
Operating Expenditure (incl penalties)	**19,074**	**19,398**	**(325)**	**233,653**	**235,261**	**(1,607)**
SURPLUS / (DEFICIT)	**(731)**	**(577)**	**154**	**(5,240)**	**(6,384)**	**(1,144)**

Medicine (Annie Campbell)

The Division over performed by £347k in February (£1,027k YTD)

Medicine Division exceeded plans in all major areas of contract income. Given "winter pressures", and the switch between elective to non-elective work required by NHSE, it was no surprise that ED was £43k above plan and Emergency work £200k above plan. ED 4 hour performance improved in February, where nationally there was a continued deterioration.

Elective performance was able to be maintained on the whole, so that daycases, inpatients and outpatients all exceeded target, despite cancellations due to areas such as MTU used for additional bed capacity. This improved performance meant the Division was able to exceed the 92% in every specialty, with Dermatology the last specialty to improve.

The increased activity impacted upon costs with both staffing and non-pay above budget. Trust initiatives meant that pay overspends were limited to £55k. This was achieved by a significant swing away from agency (4.4% of overall pay budget), towards bank (10.9%) and overtime 1%. This was due to the inability to recruit agency staff and the inducements to substantive staff to offer up additional staff. Whilst the additional help was welcome it is not sustainable, and the Division is concentrating its efforts on filling vacancies, to address the reducing shift fill rates (84.5% achieved in February).

Drug expenditure was reasonably well controlled with just FP10 invoices causing an issue. The major issues were patient transport and security.

CIP performance was above target in the month but is forecast to be £188k behind for the year for defined projects. All 2018/19 Quality Impact Assessments have been reviewed, and therefore the Division is in a position to take the approved schemes forward to help deliver for the forthcoming year.

Surgery (Simon Taylor)

The Division under performed by £363k in February (£941k YTD)

Income underachieved against plan by £260k, which predominantly relates to the reduction in elective activity. Orthopaedics elective was £391k below plan, due to the escalation into F4 meaning all major joints had to be cancelled. General Surgery overachieved by £79K on elective, but underachieved by £85K on non-

elective. Non-elective income overall was £41k below plan, largely relating to General Surgery.

Pay is overspent by £177k. The main overspend is on agency nursing (£83k), followed by consultants additional sessions (£56k) and locums junior doctors (£49k). A significant amount of the nurse agency cost is due to winter pressures, and the requirement to staff F4 as an escalation ward.

Non-pay is underspent by £73k. The under spend is predominantly related to prosthesis and disposable MSE due to under achievement of elective plan, partly offset by an overspend on community glaucoma.

Surgery CIPs have underachieved by £65k YTD, due to an underachievement of £54k in month. This is mainly owing to the final quarter phasing of the Service Redesign CIP, as well as continued low levels of private patient income in month.

Surgery has identified significant possibilities for additional CIP in 18/19 and these are currently being worked up.

Women and Children's (Rose Smith)

Women and Children's reported an over performance of £15k in-month (£423k under performance YTD).

Clinical income reported £39k ahead of plan in-month and is £140k behind plan YTD. In month, inpatient activity was higher than plan. However, year-to-date income from inpatient and outpatient activity has been lower than expected which has pushed the YTD clinical income position behind plan.

Pay reported a £35k overspend in-month and £110k overspend YTD. In-month, the Obstetrics and Gynaecology budget came under pressure from the need to cover gaps in the middle grade rota with agency and locum registrars. Year to date, there have been problems covering the specialist registrar rotas in both Paediatrics and Obstetrics & Gynaecology which has resulted in unbudgeted spend on locum registrars.

Non pay reported a £11k underspend in-month and a £173k overspend YTD. The year-to-date position has been mainly dictated by the unbudgeted maternity pathway charges anticipated from surrounding Trusts.

Clinical Support (Rose Smith)

Clinical Support reported an over performance of £287k in-month (under performance of £847k YTD).

Clinical income for Clinical Support reported a £16k over performance in-month and is £393k behind plan YTD. Year to date, there has been lower than planned activity for radiology direct access, breast screening and physiotherapy outpatients. In addition, Private Physiotherapy service has not been able to generate the planned level of income.

Pay is £170k overspent in-month and is £324k overspent YTD. The pathology and radiology services have had difficulties in filling the gaps in the senior medical rotas and are currently employing unbudgeted locums. The vacant posts are going back out to advert with the expectation of successful recruitment due to the interest shown.

Non pay reported a £441k underspend in-month and is £129k overspent YTD. Year-to-date, the radiology service has experienced significant non pay pressures due to increased consumable spend and the pathology service has had additional cost pressures by having to commission Addenbrooke's for tests where national standards dictate that these can no longer be performed in house.

Community Services (Dawn Godbold)

Community Services reported a £187k under performance in-month (£637k YTD)

Contract Income reported a £29k over recovery in-month and £1,950k over performance YTD, mainly due to additional income relating to CUHFT occupancy of Newmarket hospital.

Pay reported a £116k underspend in-month and £441k over spend YTD. In-month underspends are mainly due to vacancies within Local Area Teams £53k, Other Community Overheads £37k and Paediatrics £46k. Overset against minor overspends of £20k.

Non pay reported a £333k overspend in-month and a £2,631k overspend YTD. In part this relates to invoices received from NHSPS for rental of property.

Use of Resources (UoR) Rating

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

The key features of the UOR ratings are as follows:

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

Metric	Value	Score
Capital Service Capacity rating	-0.067	4
Liquidity rating	-6.843	2
I&E Margin rating	-2.56%	4
I&E Margin Variance rating	-0.08%	2
Agency	-42.66%	1
Use of Resources Rating after Overrides		**3**

The Trust is scoring an overall UoR of 3 again this month. The liquidity rating may deteriorate towards the end of the financial year as cash decreases.

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.

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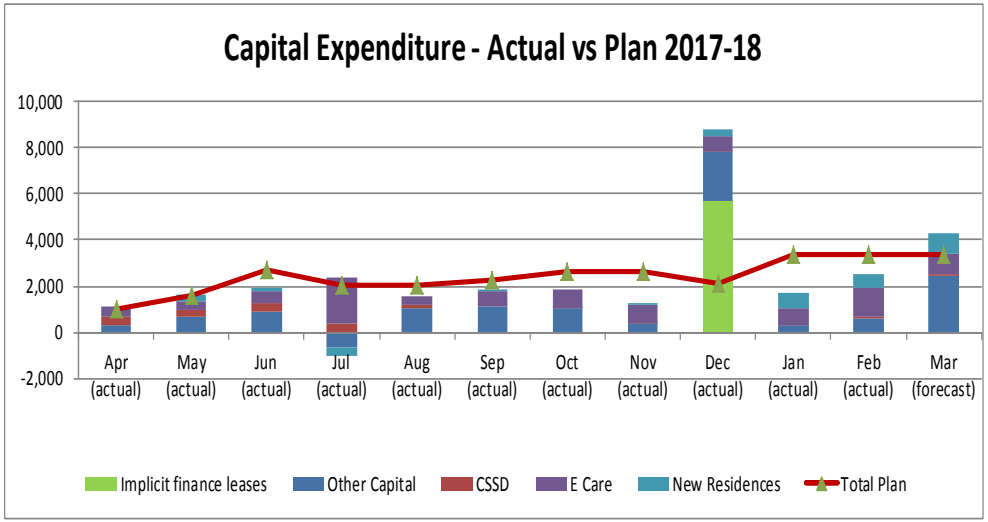
Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Actual £'000	Feb Actual £'000	Mar Forecast £'000	Total 2017-18 £'000
E Care	415	382	567	1,990	369	654	769	764	629	773	1,324	899	9,535
CSSD	384	283	319	352	197	-10	8	12	26	2	32	101	1,707
New Residences	0	284	140	-373	-33	68	-9	26	300	655	519	822	2,399
Implicit finance leases	0	0	0	0	0	0	0	0	5,667	0	0	0	5,667
Other Schemes	296	665	922	-684	1,009	1,150	1,057	397	2,154	279	607	2,437	10,288
Total / Forecast	1,095	1,613	1,947	1,285	1,542	1,862	1,826	1,199	8,777	1,710	2,482	4,258	29,596
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. Further PDC of £571k is to be received in respect of ECare projects

The CSSD build is now complete within the forecast build cost of £1.6m for the year. The delay in the implementation has meant that the value of interest capitalised has increased. The final outstanding expenditure on this project relates to the payment of retentions and some monies withheld pending satisfactory completion of minor works.

Expenditure on e-Care for the year to date is £8,637k. 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. The second tranche of GDE PDC funding was received in February with the revenue element expected in March.

The forecasts for all projects have been reviewed by the relevant project managers. The expenditure profiles of these schemes have been rephased. There are no significant financial risks to the budgets reported. Year to date the overall expenditure of £25,338k is below the plan of £25,719k. This is as a result of the implicit finance lease review (noted below) offset by slippage on a number of key projects. The forecast also reflects the additional spending on Ecare for which PDC is to be received.

As reported in the October report all significant managed service agreements have been reviewed to ensure the correct accounting treatment is being applied to any embedded leases. As a result of this a total of £5.7m of finance leases have been identified. This does not have an impact on cash but increases our capital assets and associated borrowing. This is shown in the graph with the spike in expenditure in December. The managed services reviewed include MRI, Radiology and Endoscopy. Given the size of the adjustments and that these contracts were in place before the start of the current financial year, a prior period adjustment will be reflected in the balance sheet at year end. This treatment has been discussed with the auditors who have not raised any concerns about this accounting treatment.

FINANCE AND WORKFORCE REPORT – February 2018

Statement of Financial Position at 28th February 2018

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2017 * £000	Plan 31 March 2018 £000	Plan YTD 28 Feb 2018 £000	As at 28 Feb 2018 £000	Variance YTD 28 Feb 2018 £000
Intangible assets	15,611	19,711	19,455	21,644	2,189
Property, plant and equipment	74,053	94,189	91,618	87,067	(4,551)
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**	**111,073**	**108,711**	**(2,362)**
Inventories	2,693	2,600	2,700	2,578	(122)
Trade and other receivables	18,345	11,700	13,668	21,274	7,606
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	1,000	6,870	5,870
Total current assets	**22,390**	**15,300**	**17,368**	**30,722**	**13,354**
Trade and other payables	(23,434)	(28,195)	(27,120)	(27,319)	(199)
Borrowing repayable within 1 year	(534)	(1,796)	(2,049)	(3,083)	(1,034)
Current ProvisionsProvisions	(61)	(61)	(84)	(94)	(10)
Other liabilities	(1,325)	(295)	(1,000)	(2,214)	(1,214)
Total current liabilities	**(25,354)**	**(30,347)**	**(30,253)**	**(32,710)**	**(2,457)**
Total assets less current liabilities	**86,700**	**98,853**	**98,188**	**106,723**	**8,535**
Borrowings	(44,375)	(55,951)	(54,824)	(64,217)	(9,393)
Provisions	(181)	(158)	(163)	(196)	(33)
Total non-current liabilities	**(44,556)**	**(56,109)**	**(54,987)**	**(64,413)**	**(9,426)**
Total assets employed	**42,144**	**42,744**	**43,201**	**42,310**	**(891)**
Financed by					
Public dividend capital	59,232	65,732	65,732	65,232	(500)
Revaluation reserve	3,621	3,621	3,621	3,621	(0)
Income and expenditure reserve	(20,709)	(26,609)	(26,152)	(26,543)	(391)
Total taxpayers' and others' equity	**42,144**	**42,744**	**43,201**	**42,310**	**(891)**

*The 1st April 2017 figures stated agree to the 2016/17 audited accounts and have not yet been adjusted for the implicit lease PPA. This would have no impact on the current figures.

Non-Current Assets

Non-current assets are now £2.4m behind plan but the year-end position is expected to be closer to the plan. The difference is partly due to the change in asset profile following the finance lease capitalisation having an impact on the rate of depreciation.

Trade and Other Receivables

These have increased by £1.2m in February and are £7.6m above plan, the balance includes:

- The £0.5m winter pressure money received in March.
- An assumed £0.5m contribution from NHSI towards consultancy costs which is taking longer than expected to resolve and is still outstanding despite frequent chasing at a senior level.
- £1.6m of the GDE revenue funding expected from DH via the CCG which has since been paid in March 2018.
- £2.2m STF money which has been drawn down in advance as a loan but the income has not yet been received.
- £1.0m income from Health Education England which has been received in March.

Cash

Cash is £5.9m higher than plan at the end of February. Additional resources have been used to increase payment runs in March. Loan repayments and public dividend capital (PDC) interest payments in March mean the cash balance is still expected to decrease significantly by year end but may finish at £2.0m rather than the planned £1.0m.

Trade and Other Payables

The balance on trade and other payables has increased since January by £3.6m but is broadly in line with plan. The Trust is not currently delaying any payments to suppliers for cash reasons. Accruals are included in this balance of which significant amounts relates to NHS Property Services and PDC dividend which are both expected to be paid in March.

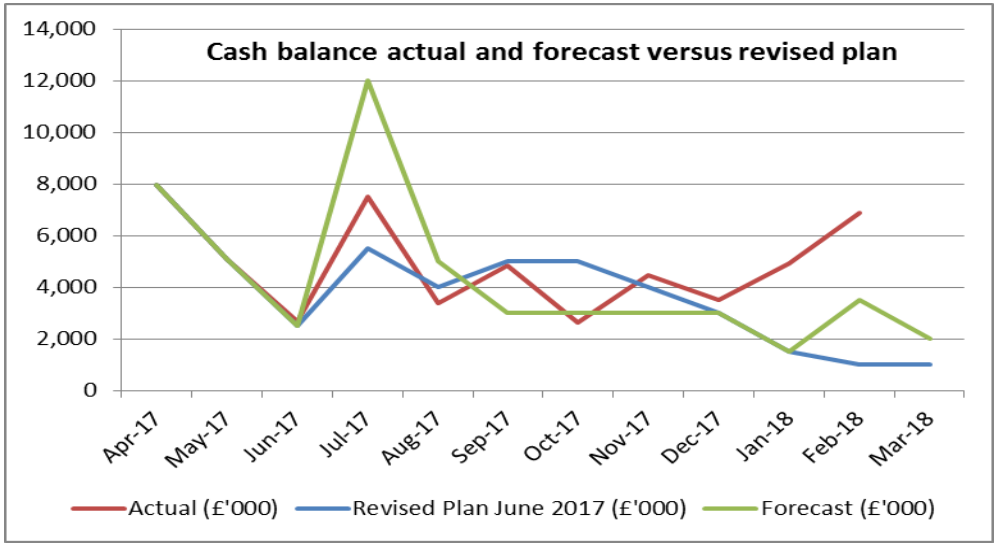
Other liabilities

This balance continues to reduce reflecting that the payments for the block contract are weighted towards the earlier months in the financial year for cash purposes but the income cannot be recognised until it has been earned in terms of patient care being delivered. The block contract cash payments reduced from September and will reduce further in March 2018.

Borrowing

Borrowing has increased by £0.5 net of repayments in February which includes a planned drawdown of a capital loan of £0.8m.

Cash Balance Forecast for the year



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

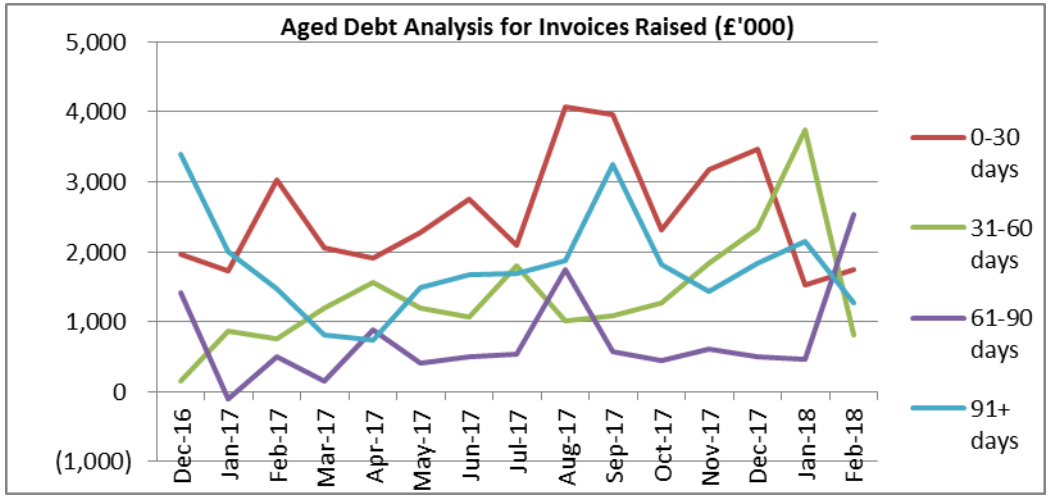
The Trust is required to keep a minimum balance of £1 million.

The Trust had planned to finish the financial year with £1 million cash but based on the latest forecast this may be closer to £2 million.

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.



The overall level of invoices raised but not paid has decreased by £1.2m in February.

The invoice for the revenue element of GDE funding £1.6m remains unpaid at the end of February but has been paid in March; this is the main cause of the increase in debts overdue by 61-90 days. In addition the £0.5m being chased from NHSI towards consultancy costs is included in this category of debt.

Of the total £6.7m invoices raised but not paid, £5.4m relates to other NHS bodies or local authorities.

Of the £1.9m debt over 91 days, £1.0m relates to NHS or local government organisations. Of the remainder £0.3m relates to tPP and £0.2m relates to one complex Tricare patient.

NHS
West Suffolk
NHS Foundation Trust

Trust Board – 30th March 2018

Agenda item:	12			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sinead Collins, Clinical Business Manager			
Date prepared:	20 March 2018			
Subject:	Quality and Workforce Dashboard – Nursing			
Purpose:	X	For information		For approval

Executive summary:
The aim of the Quality and Workforce Dashboard is to enhance the understanding ward and theatre staff have of the service they deliver, identify variation in practice, investigate and correct unwarranted variation and lead change to demonstrate value. This dashboard has been created to give the Trust Board a quick overview staff levels and quality indicators of areas within the trust. It also complies with national expectation to show staffing levels within Open Trust Board Papers

For in depth review of areas, please inquire for the Matrons' governance reports that are completed monthly for their divisions. Included are any updates in regards to the nursing review

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X					X

Previously considered by:	-
Risk and assurance:	-
Legislation, regulatory, equality, diversity and dignity implications	-

Recommendation:
Observations in February's and progress of nurse staffing review made below.

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	6 medication errors	High agency and bank use. High RN & NA vacancy. High amount of overtime.
F7	-	High agency and bank use. High RN & NA vacancy. High amount of overtime. High sickness
F8	-	High agency and bank use. High amount of overtime.
Theatres	-	High RN vacancy. High sickness. High amount of overtime
DSU	-	High sickness and bank use.
CCU	-	High bank use. High amount of overtime
G1	-	High bank use. High sickness.
G3	4 falls with harm & 4 pressure ulcers	High bank use. High RN & NA vacancy. High amount of overtime
G4	5 pressure ulcers	High bank use. High amount of overtime. High sickness.
G5	5 falls with harm	High bank use & sickness. High RN vacancy. High amount of overtime
G8	-	High bank and agency use. High sickness. High RN & NA vacancy.
F1	-	High bank use. High RN vacancy. High amount of overtime.
F3	5 medication errors	High RN vacancy. High amount of overtime. High agency use
F4	-	High agency and bank use. High RN vacancy. High sickness
F5	-	High bank use. High RN vacancy. High amount of overtime.
F6	4 falls with harm	High agency use. High RN vacancy. High amount of overtime. High sickness
F9	3 falls with harm	High bank use & vacancy in RNs. High sickness. High amount of overtime
F10	-	High bank use & vacancy in RNs. High sickness. High amount of overtime
Maternity	-	High bank use & sickness. High midwife vacancy.
F12	-	High bank use & vacancy in RNs.

MTU	-	High sickness
Kings Suite	-	High bank use. High amount of overtime
Rosemary Ward	-	High amount of overtime

Vacancies – There are significant vacancies in registered staff, and is 98.15 WTE and there is a increasing amount in unregistered (38.90WTE). This has been highlighted operationally in this winter period and HR are aware. A discharge ward has been opening, with 15 patients on average using it per day. Also an escalation ward has opened on G9 as of 13th December with bed being normally 30 patients.

Roster effectiveness – Out of 26 areas, 21 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is 5 areas higher than January.

Sickness – Out of 27 areas, 19 are over the Trust Standard of 3.5% (five less than last month) (Day surgery unit & ward are counted as one area).

Updates in March

As of next month community areas will be included in this report and dashboard, however in the interim period what is included needs to be agreed as there data collected in the hospital that can't be replicated.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Feb-18			Establishment for the Financial Year 2017/18						Data for Feb 2018														
										Workforce													Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Overtime (Hrs)	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day (June 2017)	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night				Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	81.79	70.47%	29.53%	N/A	1 - 4	1 - 5	115.6%	93.5%	118.8%	101.9%	4.85%	8.29%	426	-5.73	-6.40	4.90%	N/A	21.90%	N/A	6	2
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	72.7%	82.2%	98.9%	90.7%	10.34%	10.25%	236	-8.90	-3.23	6.50%	6.17	25.50%	0	3	0
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	92.3%	90.5%	92.1%	133.6%	25.76%	5.39%	213	-2.20	0.20	4.50%	N/A	27.00%	0	1	1
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	96.7%	93.2%	N/A	N/A	0.73%	0.00%	68	-1.45	0.00	3.00%	21.04	20.80%	0	2	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	98.7%	100.1%	N/A	N/A	1.00%	0.00%	364	-9.65	-1.40	6.80%	N/A	24.60%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	142.8%	86.8%	77.8%	N/A	2.67%	0.00%	19	-0.50	-0.10	2.60%	N/A	20.50%	0	0	N/A
WSFT	Day Surgery Unit	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	55.3%	N/A	95.3%	N/A	0.48%	0.00%	49	-2.00	-1.00	12.70%	N/A	26.40%	0	0	0
	Day Surgery Wards													7.72%	0.00%	0	0.00	0.10	10.00%		24.90%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	97.0%	84.7%	51.0%	N/A	9.62%	0.00%	135	-1.60	-0.70	3.00%	11.04	22.50%	0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	84.9%	100.2%	98.4%	N/A	7.18%	0.25%	90	-2.25	0.60	7.60%	8.28	24.70%	0	0	0
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	90.4%	78.7%	78.3%	96.3%	16.00%	0.25%	122	-3.20	-5.26	4.10%	4.20	24.80%	4	1	4
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	79.3%	76.8%	110.3%	106.1%	18.63%	1.06%	378	-2.80	-2.68	5.70%	5.42	29.20%	5	0	2
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	70.0%	85.7%	87.9%	97.8%	7.20%	1.52%	143	-3.52	-0.60	10.20%	4.37	23.70%	1	0	5
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	69.1%	87.5%	74.9%	97.2%	16.56%	7.69%	44	-8.43	-6.41	13.60%	5.19	28.20%	0	1	2
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	66.9%	137.8%	133.1%	N/A	13.82%	0.00%	180	-3.91	2.50	3.80%	N/A	24.00%	N/A	0	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	87.7%	94.8%	133.6%	115.5%	1.10%	3.48%	454	-3.20	-1.10	3.80%	5.34	22.10%	0	5	1
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	107.1%	115.8%	91.1%	196.5%	19.25%	22.60%	47	-5.70	-2.20	5.50%	12.68	22.70%	1	2	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	89.6%	95.2%	109.8%	110.5%	4.74%	0.99%	104	-3.32	-0.53	1.40%	5.51	17.40%	0	2	0
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	82.1%	92.3%	109.5%	103.7%	2.72%	4.92%	397	-5.05	-1.60	7.30%	5.12	17.10%	0	0	4
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	82.8%	85.6%	86.1%	106.3%	9.73%	2.12%	288	-7.00	-1.80	6.00%	4.64	18.70%	2	1	3
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	94.5%	73.3%	91.5%	93.3%	8.53%	1.04%	217	-5.42	-2.20	5.50%	5.50	22.70%	2	1	0
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	114.8%	96.4%	59.7%	58.6%	10.91%	0.00%	39	-4.04	-1.30	6.90%	N/A	24.20%	1	3	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1													0	0	0
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre					1 - 2	1 - 2													0	1	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	80.7%	70.0%	22.7%	109.8%	21.46%	0.00%	78	-3.92	0.10	4.20%	7.31	25.20%	0	0	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	101.7%	98.7%	N/A	N/A	0.78%	0.00%	90	-0.70	-0.40	2.50%	N/A	15.90%	0	0	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	9.00	80.00%	20.00%	N/A	5 - 8	N/A	93.8%	N/A	50.0%	N/A	0.00%	0.00%	2	-0.20	-0.80	9.10%	N/A	19.80%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	97.1%	91.0%	14.3%	32.6%	2.50%	0.00%	36	-2.26	-1.40	2.70%	I/D	22.50%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	100.4%	96.4%	93.8%	107.1%	3.67%	0.00%	192	0.00	-0.69	3.28%	6.60	N/A	0	1	1
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	100.0%	95.3%	90.0%	104.5%	8.72%	0.4%	137	-1.20	-0.60	2.80%	4.90	20.10%	0	0	0
										91.26% AVG	92.10% AVG	86.20% AVG	103.43% AVG	8.45% AVG	2.51% AVG	4546 TOTAL	-98.15 TOTAL	-38.90 TOTAL	5.71% AVG		22.86% AVG			

Explanations

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

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

ETC had one medication error. G9 had two falls with harm and five medication errors in Feb

Board of Directors – 29th March 2018

Agenda item:	13			
Presented by:	Jan Bloomfield, Executive Director Workforce & Communications			
Prepared by:	Jan Bloomfield, Executive Director Workforce & Communications			
Date prepared:	22nd February 2018			
Subject:	Education Report			
Purpose:	☑	For information		For approval

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

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	Deliver for today	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	☑	☑	☑

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		☑					☑

Previously considered by:	January 2018 Trust board paper
Risk and assurance:	Risk to patient safety due to lack of staff training and education, patient safety, correct staffing levels, staff morale, turnover etc. internal and external reputation. Staff perception of Education, Training & Development opportunities through the annual NHS Staff Survey. Medical Education - Royal College and HEEoE visits and assessments Results of annual GMC annual survey of training grade doctors
Legislation, regulatory, equality, diversity and dignity implications	Legislation & regulatory implications, linked to professional body requirements. Equality and health and safety legislation regarding skills, equipment and behaviours of all staff.

Recommendation: For information

Education and Training – Report for Trust Board Members 29th March 2018

Introduction

Future reporting of Education matter to the Trust Board.

At the December 2017 meeting of the Education Strategy committee a decision was made to disband the meeting as it was felt that the committee dealt with information only and that no decisions were made by the group. Attendance was also historically very low, especially from clinical members (due to other clinical commitments).

It was however recognised that the trusts external partners expected education to be a key aspect of the trusts business. Health Education England are significantly reducing the funding coming into the Trust. It was also discussed that the meeting draws all the various elements of training together and would it therefore be more appropriate for the Trust Executive Group (TEG) to take responsibility for this.

It was therefore proposed that a core group would be useful to discuss what would need to go into a six monthly TEG paper; however this would not be a formal group and would meet with the express purpose of providing and update on current educational and training issues and developments.

It was agreed that this informal group would prepare a six monthly briefing paper for TEG, which could then go to the Trust Board meeting. The first paper will therefore be sent to TEG in September 2018.

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

Priority 1: Deliver for today

- A sharp focus on improving patient experience, safeguarding patient safety and enhancing quality.
- Continuing to achieve core standards

Leadership development

- The trust's leadership and quality improvement forum, the 5 O'clock Club continues to meet regularly and is well attended by leaders from across the organisation and outside. The National Guardian, Freedom to Speak Up, Dr Henrietta Hughes, was guest speaker at the January meeting.

Undergraduate Medical Education

- Undergraduate Medical Education continues to run very smoothly at the West Suffolk Hospital with a large number of medical staff involved in teaching the students.

- From September 2018 the Cambridge Graduate Course in Medicine will double its intake numbers (from 20 – 41). The West Suffolk Hospital and the teaching faculty are currently working on how this increase will impact on the hospital and making appropriate plans.

Postgraduate Medical Education

- **Junior Doctors Induction**

The Doctors Induction programme was extended over two days (2 & 3rd Aug) instead of one (2nd Aug) to cover more in-depth IT training. This proved successful and will continue for future inductions moving forwards at the trust.

- **Exception Reporting**
  The Trust reports to HEEoE on any fitness to practice concerns about doctors in training. This is for onward reporting to the GMC. Reports are required for:
  1. Serious incidents where the trainee has been named and investigated
  2. Complaints naming the doctor
  3. Concern about probity or conduct

  The Trust received no incidents to report on since November 2017.

Nursing, Midwifery and Allied Health Professionals

- ***Quality Improvement Performance Framework (QIPF)***
  We submitted our risk assessment for the Quality Improvement Performance Framework to Health Education England in December. We are awaiting the outcome of our assessment.

- **Adult Nursing Student Numbers**
  Numbers of students applying to complete their placements at the University of Suffolk and the WSFT remain below target:

Cohort	Target	Actual
February 2018	20	8
September 2017	30	16
February 2017	20	17
September 2016	30	31
February 2016	20	7
September 2015	30	13

We are continuing to offer placements to students studying with the University of East Anglia and these have been well received. We will be hosting 10 first year students from UEA from May and continue to offer placements to their 2nd year students.

We have 4 assistant practitioners who have commenced the Adult Nurse Degree Apprenticeship (2 year programme) who will qualify in February 2020. We are planning to advertise for 14 students to begin the 4 year Adult Nurse Degree Apprenticeship in September 2018.

An advert was recently placed for newly qualified student nurses. 17 applications were received from a variety of different universities. Interviews will be held on the 10th April.

- **Multi-professional Pre-registration Students**

We continue to support a range of pre-registration students from various professions across the healthcare sector. These include physiotherapy, pharmacy, dietitics, physician associates, ODPs and paramedics. In all we support 16 different types of pre-registration students with clinical placements within the Trust. An action plan has been developed to address any issues identified within the student survey. This will be reviewed bi-monthly by the Pre-registration Educators Forum.

- **International Registered Nurses**

We are waiting for our first group of nurses from the Philippines to arrive. Although we have offered places to 55 nurses they are all at different stages of the NMC process. We have employed a registered nurse to support preparation for the OSCE exam when they arrive in the UK which is the final part of the NMC requirements.

The NMC have recently updated the requirements for overseas nurses applying for NMC registration and this has allowed nursing assistants currently working in the UK with lapsed registration within their own country to apply. We have identified 10 nursing assistants that could apply for NMC registration and be supported through the process. We are talking to each nursing assistant to discover if they would like to apply for nurse registration.

Support Workforce/Other Staff Groups

- **Care certificate:**
  All health care support workers are required to complete a basic qualification to undertake their role.
  The following has been achieved for those undertaking the Care Certificate

Starts since April 2017:	New staff	= 83
	Existing staff	= 15
Completions since April 2017:	New staff	= 83
	Existing staff	= 22
Total number of Care Certificates		= 105

Starts Jan 2018 – 15/03/18 = 24

Completions Jan 2018 – 15/03/18 = 17

Total number of care certificates awarded by WSFT = 216

Care certificates are co-ordinated by the Nursing Directorate.

- **Apprenticeship levy:**
  The Government Apprenticeship Levy, commenced in May 2017, and requires approximately £770,000 p.a. being charged from the Trust to the Levy in 2017/18.

  The Trust is now able to commission apprenticeship training, which allows the education provider the opportunity to draw down the cost of the training from the Levy. This new process is proving to be complicated and time consuming, as both the providers and the Trust are learning the new rules and procedures.

  For apprenticeships we now have 17 individuals on the Digital Apprenticeship Service (DAS) account and have spent £7,464.86 of our levy funds.

  Clinical apprenticeship starts:
  - January 2018 - 6 on Senior Healthcare Support Worker level 3 programme
  - January 2018 - 3 on Assistant Practitioner (level 5 foundation degree)
  - February 2018 - 4 on Degree Nurse Apprenticeship (shortened two year course)

Priority 2: Invest in quality, staff and clinical leadership

- Invest in quality and deliver even better standards of care which, over time, should deliver an 'outstanding' CQC rating

Leadership development

- A winter leadership summit 'Leading self through challenging times' was held for around 50 band 4 to 6 team leaders on 11 December. The day provided participants with opportunities to learn more about trust priorities and their role in achieving them; the trust's leadership behaviours and to learn practical techniques and tools for managing challenging events as well as developing a personal action plan. A 'marketplace of helpfulness' was held as part of the day. This was an exhibition of internal (e.g. human resources, health and wellbeing, estates) and external resources (e.g. Neyber which works with staff to help them be more confident when it comes to personal finances) available to team leaders to help them deliver an excellent service. Feedback on the summit from participants was excellent. The next summit, for bands 7+ leaders will be held in May.

- The first stage of the trust's talent management programme has been completed and executive directors have identified 22 participants for 'Key Leaders'. These senior staff will participate in 360 feedback using the NHS Leadership Academy Healthcare Leadership Model 360 feedback tool and agree a bespoke development plan based on their individual needs.

Postgraduate Medical Education

- **QM3**

The annual QM3 return to HEEoE was submitted in September 2017. This is used to compile the regional report on postgraduate medical education for the GMC. It comprises of a range of indicators of the quality of postgraduate medical education and also draws on reports prepared for their Schools by the Trust's College Tutors.

- **HEE East of England Risk & Quality Governance Handbook & Educational Quality Report**

The above has replaced the QM3 return to HEEoE.
The HEE Risk and Quality Governance Handbook is used to benchmark on education and quality performance (both medical and non-medical) against the HEE Quality Framework Standards. The report was submitted on the 8th January 2018 with 'sign off' by the Chief Executive.
Key points used for the report are;

- HEE non-medical student survey data to be used
- GMC Survey data to be used
- Identifiable High level risks (12 or above) should be reported to HEE within 7 days. Lower level risks to be discussed with Training Programme Director and/or Quality Team member, so they are aware of them.
- This is to become a continuously updated document used to feed information into the Board and governance processes. It is anticipated to be updated at a minimum of once a quarter with any new risks highlighted to HEE via the escalation template included in the HEE Risk and Quality Governance Handbook.

To date we have not heard the outcome of the panel meeting following submission of our report but have been assured HEE would be in contact with us if there were any issues.

- **Faculty Development**
  A Medical Careers Fair was held on the 11th October in the lecture theatre. Representatives from specialties across the hospital manned stalls; this was well attended by many junior doctors who found it helpful and a good resource for information gathering about future careers guidance.

Nursing, Midwifery and Allied Health Professionals

- **Continued Professional Development (CPD) Funding**
  We have not been allocated any funds from Health Education England for CPD training. This means that individuals are required to fund the costs independently or ask if their

department is able to assist. This will see a reduction in the development of further skills and knowledge for staff and will impact on staff morale.

Support Workforce/Other Staff Groups

- **Work Experience Placements:**
  To date (Q1, 2 & 3) 68 work experience students have taken part in programmes across the Trust.

  Total of 25 students – 19 female and 6 male
  16 – 18 years – 19
  19-24 years – 4
  25+ years – 2

  Work experience is co-ordinated by the Voluntary Services Department.

Priority 3: Build a joined up future

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

Leadership development

- Four West Suffolk staff have been active participants in the systems leadership programme 'Bringing People and Organisations Together' since May 2017. Programme participants have undertaken a joint systems development projects. The West Suffolk cohort is made up of staff from this and the mental health trusts, general practice, Suffolk Police and Suffolk County Council. Jan Bloomfield and Rose Smith from WSH have worked closely with the participants as senior project sponsors. The two West Suffolk cohort projects are: Alliance Values: looking at a set of values/expected behaviours for relationships between the organisations ("white space"), to enable collaborative/system working and Integrated Neighbourhood Teams (INTs): Relating to Suffolk Connect teams and making best use of the integration opportunities.

Postgraduate Medical Education

- **Education/Clinical Supervisors Training 17th Jan 2018**
  Requirements of the GMC state that all Educational and Named Clinical Supervisors must attend an approved training course for the role and then undertake refresher training every three years.
  Peter Harris & Francesca Crawley will be running an accredited 3 hour long "in-house" WSH course in the Education Centre to cover both initial and refresher training. 28 candidates have registered for the course to date.

- **Simulation Training for Junior Doctors**
  A mandatory ½ day SIM training for all FY1/2 and trust grade F1/2 trainees to manage complex situations is being run by the Simulation Team. Sessions accommodate up to 5 trainees per session and provide participants with exposure to 4 simulation scenarios. These will be based on medical and surgical emergencies which Foundation Trainees commonly encounter on the wards and will map to the Foundation curriculum. Outcomes will include:
  - Communication, team-working & leadership
  - Recognition of the sick/ deteriorating patient
  - Good Clinical care & Patient Safety

  Feedback from attendees at these sessions has been very encouraging.

- **#2tired2drive Scheme**

As a result of junior doctors taking risks by driving home after a night shift when they are too tired to drive the Trust is trying to improve both the places to rest when taking a break and after a shift if required. All junior doctors employed by the trust (Foundation, Career grade, Trust grade, SAS, & Locums) can collect the keys for a room from switchboard at the cost of £15. PGME has agreed to reimburse the first 20 nights of use and in return request some data so Dr Pete Harris can campaign on their behalf.
To date the room has been used 6 times.

Nursing, Midwifery and Allied Health Professionals

- **Promoting WSFT to Potential Healthcare Students**
  We continue to promote healthcare careers to local schools and colleges. The Clinical Education Lead has been approached by the New Anglia Enterprise Adviser Network to work as an Enterprise Adviser with a local school. This will further enhance the opportunities to promote the WSFT as a place to seek employment and career development.

- **Community Education Team**
  We have close links with the community education team and are sharing educational resources and programmes.

Support Workforce/Other Staff Groups

- **Health Ambassadors: (careers advice to schools and colleges)**
  We have 34 staff registered as health ambassadors, in Q3 15 visits were made and 531 students were engaged

NHS
West Suffolk
NHS Foundation Trust

Trust Board – 29 March 2018

Agenda item:	14			
Presented by:	Jan Bloomfield, Director of Workforce and Communications			
Prepared by:	Denise Pora, Deputy Director of Workforce (Organisation Development)			
Date prepared:	6 March 2018			
Subject:	Gender Pay Gap Report			
Purpose:		For information	X	For approval

Executive summary:
All employers with 250 or more employees are required by law to publish their gender pay gap each year on their own and the Government's website. The Trust must publish this data by 30 March 2018.

The gender pay gap looks at the difference in the average pay between all men and women in an organisation, taking account of the full range of jobs and salaries. It is different from 'equal pay', which guarantees equal reward for men and women for doing the same or similar jobs of equal value.

In April 2017 the gender pay gap (median earnings) for full-time employees in the UK was 9.1%.

WSH gender pay gap – average pay (hourly rates)
- 8.1% median average – the mid-point salary for women is 8% lower than for men.
- 24.2% mean average – overall men are paid almost a quarter more than women

The reason for this gap is that we have proportionately more men in in more skilled, senior, higher paying jobs than we have women. In particular senior management roles and senior medical staff.

WSH gender pay gap – bonus pay
- Using both mean and median averages men's bonus pay is just over 33% higher than that paid to women who receive bonuses.

Bonus payments for gender pay gap reporting are made up of Clinical Excellence Awards (CEA) and Discretionary Points paid to consultant medical staff. No other bonus payments are made to Trust staff.

The reason for this gap is more male than female consultants receive the highest level (and paying) CEA. We have evidence of balance in the payment of awards up to level 7 and amongst consultant medical staff with up to 16 years' service with the Trust.

The gender pay gap in bonus pay is expected to close over time as the proportion of female consultants with longer service increases.

What are we doing to close the gender pay gap?
The Trust has a number of processes in place to help ensure gender pay equality e.g. structured recruitment process using the national NHS jobs website, helping to support us make unbiased recruitment decisions and use of the national Agenda for Change job evaluation system.

Additional measures to be put in place are:

- Introduction of unconscious bias training. This will be available for all staff and compulsory for those undertaking recruitment and selection and sitting on the Trust Employer Based Awards Committee (EBAC).
- A review of our policy and processes for making employer based awards to ensure any scope for bias on any basis is identified and removed.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
			X				
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
							X
Previously considered by:	*[Detail committees or forums that have previously considered the report]* Trust Executive Group 19.2.18						
Risk and assurance:	*[Detail relevant issues within the report]* Pay data in this report was provided by our electronic staff record ESR.						
Legislation, regulatory, equality, diversity and dignity implications	*[Detail relevant issues within the report]* Equality Act 2010 (Gender Pay Gap Information) Regulations 2017						

Recommendation:
[If you are seeking for the Board to agree to specific recommendations or action, please use this place to summarise]
Trust Board is invited to approve the action identified to address the Trust's gender pay gap.

NHS
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Gender Pay Gap Report 2017-18

1. What is the gender pay gap?

The gender pay gap looks at the difference in the average pay between all men and women in an organisation, taking account of the full range of jobs and salaries.

In April 2017, the gender pay gap (for median earnings) for full-time employees in the UK was 9.1%, a decrease from 9.4% in 2016. This is the lowest since the survey began in 1997, where the gender pay gap was 17.4%, although the gender pay gap has changed relatively little in recent years.

The gender pay gap is **not** about equal pay for work of equal value i.e. paying men and women the same for doing the same or broadly similar jobs or for work of equal value. Our arrangements for ensuring equal pay for work of equal value are detailed in section 6.

2. Gender Pay Gap - Average Pay

The figures reported below show West Suffolk NHS Foundation Trust's gender pay gap in two ways – as median and mean average hourly rates.

The mean calculates the total amount earned across the organisation, divided by the number of people employed. The median looks at all the salaries in the range and identifies the mid-point.
For example, in a team of 20 people five have a salary of £10k a year, five have a salary of £20k a year and ten have a salary of £30k a year. The mean salary is £22.5k and the median salary is £25k a year.

Average hourly rates:

- 8.1% median average – the mid-point salary for women is 8% lower than for men.
- 24.2% mean average – overall men are paid almost a quarter more than women

What causes this gap?

- We have proportionately more men in more skilled, senior, higher paying jobs than we have women; in particular amongst senior management roles and senior medical staff.

3. Gender Pay Gap – Bonus Pay

What bonuses are paid to staff?
71 employees receive 'bonus' pay. These are some of our consultant medical staff who receive 'clinical excellence awards' (CEA) or discretionary points pay. CEA and discretionary points recognise and reward those consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services. These are counted as bonus payments when making calculations about gender pay.

- Using both mean and median averages men's bonus pay is just over 33% higher than that paid to women who receive bonuses.

- 38 male consultants (i.e. 4.5% of all men employed by the trust) receive bonus pay and 33 female consultants (i.e. 1.0% of all women receive bonus pay). NB: 81% of our workforce is female and 19% is male. This means that whilst the numbers of men and women receiving bonuses are similar there is a greater difference in the percentage between men and women.

What causes this gap?

- The average bonus paid to men is 33% higher than that paid to women because more male than female consultants receive the highest level (and paying) CEA.

- There are nine levels of CEA and the payment up to level 7 demonstrates balance between the level of award made to men and women as below:

Level 1		Level 2		Level 3		Level 4		Level 5		Level 6		Level 7	
M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
13 62 %	8 38 %	5 38 %	8 62 %	4 40 %	6 60 %	4 50 %	4 50 %	3 60 %	2 40 %	1 50 %	1 50 %	2 40 %	3 60 %

- No female consultants receive the top two levels of the award (8 and 9). Six male consultants receive CEA in the top two levels.

- Historical recruitment patterns have resulted in there being more male consultants with longer service (i.e. 16+ years) than female. Generally, higher level CEA are awarded to those with longer service. It may follow that more male consultants would be expected to be in receipt of the highest level CEA.

- This gender pay gap in bonus pay is expected to close over time as the proportion of female consultants with longer service increase. Payment of CEA to consultants with 1 to 15 years' service appears to demonstrate this:

    - Amongst consultant medical staff with between 1 and 15 years' service 49% of those in receipt of CEA are male and 51% are female. 54% of consultants with between 1 and 15 years' service are male and 46% are female. Therefore, amongst consultants with up to 16 year service females are slightly more likely than males to receive a CEA.

- One member of the consultant body (a female) is in receipt of discretionary points.

4. What are we doing to close the gender pay gap?

We are committed to promoting greater equality, diversity and inclusion across the Trust. This means making sure men and women have equal opportunities on recruitment, pay, training and career progression. We have processes in place that help ensure gender equality including:

- A structured recruitment process using the national NHS jobs website, helping to support us make unbiased recruitment decisions.
- We use the national job evaluation scheme for all staff on agenda for change terms and conditions of employment. This makes sure all non-medical jobs are measured against the same criteria and weighting of job elements is consistent. Medical staff have national terms and conditions of service and pay arrangements (see section 6 below: Equal pay for work of equal value).
- An agreed, standard process is in place for consultant job planning to ensure it is bias free.
- All trust staff are encouraged to undertake unconscious bias training and we are making it mandatory for everyone who is involved in recruitment
- A range of family friendly policies, including for maternity, paternity, shared parental leave, and flexible working that help support work/life balance for women and men.
- We are participating in the NExT Director Scheme to support women make successful applications to become Non-Executive Directors.
- Clinical Excellence Awards are made on the basis of national guidance set out by the Advisory Committee on Clinical Excellence Awards. An internal process is in place to monitor the distribution of awards. Additionally in 2018/19 we will review our policy and processes to ensure any scope for bias on any basis is identified and removed.

5. Key statistics from our 2017-18 gender pay gap report

The reference (or snapshot) date for the gender pay gap data in this report is 31.3.17. 31 March each year is the date all public sector organisations must use.

- Difference in mean pay between male and female staff 24.2%
- Difference in median pay between male and female staff 8.1%
- Difference in mean bonus pay between male and female staff 33.1%
- Difference in median bonus pay between male and female employees 33.3%
- The proportion of men receiving a bonus 4.5%
- The proportion of women receiving a bonus 1.0%
- Proportion of men and women working for the Trust by pay quartile

Quartile	Men %	Women %
Upper (higher pay)	29.4	70.6
Upper middle	14.1	85.9
Lower middle	16.6	83.4
Lower quartile	18.2	81.8

- Proportion people working for the Trust by gender

Men %	Women %
19	81

6. How we ensure equal pay for work of equal value

West Suffolk NHSFT delivers equal pay through adopting nationally agreed terms and conditions for our workforce. These are the National NHS Agenda for Change Terms and Conditions of Service (AfC).

AfC is negotiated nationally by the NHS Staff Council, led by NHS Employers. The national NHS Staff Council has overall responsibility for the AfC pay system and has representatives from both employers and trade unions. AfC provides the framework for pay arrangements which are in place at West Suffolk NHSFT. Typically, AfC terms and conditions apply to nursing, allied health professionals and administration, management and clerical staff, which are the majority of the workforce.

Medical staff are employed on national terms and conditions of service and pay arrangements. These pay arrangements are negotiated nationally on behalf of employers by NHS Employers with the NHS trade unions. These terms and conditions include all Consultants, Medical and Dental staff and Doctors and Dentists in Training.

March 2018

Trust Open Board Meeting – March 2018

Agenda item:	15			
Presented by:	Mr Craig Black, Executive Director for Finance and Resources			
Prepared by:	Mrs Jean Le Fleming, Administration Manager, Facilities and Mrs Julie Pettitt, Business Manager, Facilities			
Date prepared:	5th March 2018			
Subject:	Car Parking Strategy			
Purpose:		For information	X	For approval

Executive summary:

The Trust aims to provide adequate, safe and accessible car parking for all users of the site at fair and equitable rates. This paper sets out the current position regarding the current car parking management arrangements, highlighting problems to be addressed.

This paper also submits a number of proposals to improve the parking experience of all users of the site to include a streamlined and simplified payment system.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X			X		X

Previously considered by:	Annual review of car parking strategy and tariff review considered by Executive Team, Scrutiny Committee and Board of Governors
Risk and assurance:	Robust access monitoring system with clarity of payment methods. This will ensure a good parking experience and protect the Trust's income.
Legislation, regulatory, equality, diversity and dignity implications	Trust policy on car parking management; equality impact assessment and BPA car parking regulations.

Recommendation:

Trust Board to approve this strategy

INDEX

WEST SUFFOLK NHS FOUNDATION TRUST

CAR PARK MANAGEMENT STRATEGY - MARCH 2018

1. BACKGROUND

The Trust continues to actively encourage cycling, walking and car sharing, as well as the use of a park and ride off-site location, in accordance with its current Green Travel Plan. Considerable improvements have also been made around the site to increase cycle storage facilities; improve the shower facilities; and provide a dedicated car sharing car park.

The current car free day scheme encourages staff to park off site (one mile away) and either walk or use a shuttle bus to and from the hospital at least once a week.

Irrespective of these actions, a number of staff continue to park on roads adjacent to the hospital causing inconvenience to the local residents. The Borough and County Councils are therefore keen to work closely with the Trust to ensure the Travel Plan initiatives are actively and successfully addressed. This has also necessitated the Trust and Council working together on a number of capital planning developments, as planning permission is closely connected with the Trust's adherence to the agreed Travel Plan.

Irrespective of these actions and other measures to restrict the number of vehicles coming on site (e.g. new employees are not automatically allowed access to site), capacity remained a constant problem. The Trust therefore provided a new car park on the western boundary offering an additional 400 parking spaces.

The provision of these spaces which, due to the location, are primarily for staff, allowed an additional 30 spaces to be provided in the senior staff car park and 100+ spaces to be released for patients and visitors at the rear of the site. This has relieved pressure on car parking spaces at the front of the hospital and enabled patients and visitors to more easily park near to external units such as the Day Surgery, Eye Treatment Centre, Macmillan Unit and Ward F1 as well as Pathology and Pharmacy.

2. CURRENT POSITION

(a) Capacity

Whilst the additional car parking spaces released in February 2017 relieved the capacity pressure, considerable capital development across the site is currently having a negative impact on available spaces. The car parking staff and Facilities staff work closely with the Development Team and contractors to keep this impact to a minimum. On the basis that this reduction in spaces is short term, there are no immediate actions required by the Trust other than to monitor the situation and continue to promote alternative modes of transport in line with the Travel Plan.

(b) Barrier control

Control of the site is by entry and exit barriers. One system serves the patients/visitors in the main car park (A) at the front of the hospital and a second system serves all users of the rear of the site (S).

The Trust agreed barrier control in the current locations when appointing the existing car parking management company (OCS/Legion) in June 2013. These particular barrier controls were at that time considered to be the most appropriate for access and financial control as well as being able to accommodate the variety of user profiles requiring access on a daily basis.

The current system can provide comprehensive data of vehicular movement on an hourly basis. This has assisted the car parking company to vigorously police the site and the Trust to maintain tighter financial control.

However, a number of problems have arisen with existing arrangements that need to be addressed in order to maintain control, protect the Trust's income and improve everyone's parking experience.

This is timely in that a review of access and financial arrangements coincides with the Trust's review of its contract with OCS/Legion. A potential two year extension is to be considered with effect from 1st July 2018.

Whilst there are some daily operational issues with car park A due to the current layout of this car park, the main concerns that need to be addressed promptly are linked to access to the rear of the site (S).

These include:

Number of vehicles entering/leaving the site at peak times causes tail back onto Hardwick Lane and potential risk if delaying emergency vehicle access

Methods of payment are various – automatic number plate recognition (ANPR); daily payment (staff PAYG card) and patients/visitors' taking a chip coin – all of which can cause delay at barriers

Barrier lifts (necessary on times to ease congestion or to deal with a fault) result in loss of chip coins with considerable financial impact for the Trust

Barrier repair and maintenance by external contractors not always timely adding to financial impact for the Trust

Increased heavy traffic with access only to left hand lane can cause delays/congestion

(c) Tariffs

After four years of no increases in car parking charges, the Trust introduced new tariffs on 1st February 2017.

The main changes included:

- introduction of an hourly rate of £2 for patients and visitors
- maximum daily rate for patient/visitor parking £12 i.e. six-24 hours
- weekly ticket - £15
- concessions for identified patient groups e.g. Macmillan (increased to maximum £5)
- concessionary parking for family carers – no charge

- staff rates based on contractual hours adjusted to accommodate three days shift working i.e. up to 15 hours, 15.5 - 22.5 hours, 23 - 30 hours, 30+ hours
- parking at the Rugby Club and shuttle bus service to and from the hospital to remain free

3. PROPOSALS

A number of proposals have been considered with the aim of improving access to the site as well as to protect the Trust's income. These include review of existing barrier control, tariff structure and concessions as well as off-site parking arrangements.

3.1 Access arrangements/barrier control

The existing barrier manufacturer/supplier (Scheidt & Bachmann) recently provided the Trust with some assurances on how the current situation could be improved. Their proposals were evaluated against two other car park control companies (Newpark and Veripark).

It is now proposed that the Trust progresses the scheme promoted by Newpark. This is on the basis that, in addition to a comprehensive presentation, they met the criteria for streamlined method of payment, removal of barriers and replacement of chip coin system, improved control of site with car park counting system at a more reasonable (value for money) cost than S&B or Veripark.

It is anticipated that the new system for managing the West Suffolk Hospital site will be introduced from 1st July 2018.

3.2 Car parking tariffs

Consideration has been given to how the Trust can maximise income whilst still maintaining a fair and equitable charging system. **Appendix B** sets out the potential increased income by a percentage uplift on general tariffs, adjusting concessions, and giving consideration to introducing charges for parking at the Rugby Club. The factors/risks to be considered in adopting these changes are also highlighted.

3.3 Rugby Club and Shuttle bus

KPMG suggested that the Trust could introduce charging for parking at the Rugby Club. After extensive investigations, it is not considered feasible to adopt this proposal. The administrative resources to manage this scheme within the Trust would be cost prohibitive. The Rugby Club Management was also approached to take on this venture but declined. The Trust therefore has two options.

> Remain as now at a current cost of £82,000 per annum or remove these services at a saving of £82,000.

4. FINANCIAL IMPLICATIONS

4.1 Barriers

There is a financial implication for introducing a new barrier scheme with OCS sub-contractors, Newpark. OCS will initially bear these capital costs which will be subsequently incorporated into the Trust's monthly management fee, at an increase of cost of £3,467 per month. This will be over a 5 year period, if OCS were unsuccessful in the re-tender the incoming contractor would absorb the remaining capital cost into their proposal. The increased monthly costs would be offset by a reduction in chip coins, responder cards and barrier maintenance costs, estimated at £2,000 per month.

4.2 Tariffs

The financial impact of adopting the proposals outlined in Appendix B are summarised below:

		Potential Increase p.a. £
Weekly ticket	Increase from £15 to £30	**62,200**
Carers	Introduce £5 max daily charge	**48,300**
Patients/visitors Tariff	3% uplift	**42,264**
Staff tariff	3% uplift	**19,176**

5. RECOMMENDATIONS

The Trust Board to support the following recommendations:

1. Extend car parking management contract with OCS/Legion from 1st July 2018 to 30th June 2020.

2. Authorise OCS/Legion to sub-contract with Newpark for improved car parking management system, with an indicative increase to the monthly management fee. The anticipated implementation date to be 1st July 2018.

3. Increase patient/visitor car parking charges by 3% with effect from 1st April 2018, including charges for blue badge holders. Tariffs would be rounded up to the nearest 5p or 10p.

4. Review concessionary charges with effect from 1st April 2018:

   Increase weekly ticket to £30 (seven days parking)
   Concession for Macmillan patients to remain at maximum of £5
   Family carers to pay daily – up to a maximum of £5

Appendix B

SCHEME	OUTLINE OF PROPOSAL	COMMENTS	RISKS	FINANCIAL BENEFIT based on 46 weeks	Annual Increase	IMP. DATE
WEEKLY TICKET	Currently £15 for seven days	The general public purchase weekly tickets for two days or more if spending minimum of four hours on site daily, as this is a cheaper option		On average 90 tickets sold p.w.	£	
Patient/visitor concession	Increase to £30 for seven days		£25 may discourage the general public from purchasing weekly tickets for the shorter periods reducing anticipated increased income	90 x £30 = £2,700 p.w. 90 x £25 = £2,250 p.w. 90 x £20 = £1,800 p.w.	£62,200 £41,500 £20,800	01.04.18
Income approx £62k pa exc £5 deposit	Also propose a restriction that ticket is for minimum of seven days(not to be used for shorter stays)		£20 may encourage existing practice of buying a weekly ticket for two or more days	Difficult to assess unless car parking staff able to specify dates and/or timespan for use		
CARERS concession *No charge*	Reintroduce a minimum charge e.g. first two hours - £4	Carers badges are given to more than one member of the family caring for the patient		On average 30 concessions a day for carers equating to lost income of approx £120 per day, £840 pw	38,640	01.04.18
Visitor concession	OR Token payment of £2 per visit	Free parking was only introduced in February 2017 Carers had concessionary rate previously			19,320	
Current lost income for the Trust is estimated £65,000 p.a.	OR Maximum daily charge of £5				48,300	
TARIFFS for PATIENTS/VISITORS	Increase by	Any increase to be co-ordinated with improved barrier(less) control of the site	Bad publicity that the Trust is only increasing rates each year and not considering concessions for certain patient groups eg disabled, regular attendees, OPD appointments	Increased income		
£1,635,732	2.50%			£1,676,940	41,208	01.04.18
	3.00%	This gives odd payments/round up or down to nearest 5/10p		£1,677,996	42,264	01.04.18
TARIFFS for STAFF	Increase by	Any increase to be co-ordinated with improved barrier(less) control of the site	Bad publicity that the Trust is only increasing rates each year and not considering concessions for certain patient groups eg disabled, regular attendees, OPD appointments	Increased income		
£639,336	2.50%			£655,320	15,984	01.04.18
	3.00%	This gives odd payments/round up or down to nearest 5/10p		£658,512	19,176	01.04.18
	Daily rate to be increased from £2 to £3	To encourage more staff to pay by salary deduction	Encourage more staff to park on residential roads	difficult to assess without exact numbers		
RUGBY CLUB & SHUTTLE BUS STAFF service	Charge for parking/use of shuttle bus n.b. some staff already pay for parking on WSH site and use Rugby Club on car free day only. Others park for free - new staff since March 2017 no automatic right to park at WSH	Number of staff already paying for parking to be assessed against those who do not pay at present. There is no official record of who parks at Rugby Club	Staff will park on residential roads on car free day Staff will revert to parking back on site rather than parking more than one day off site	To be assessed Conservative est. 50 staff at suggested rate of £1 daily		01.04.18
Current cost to the Trust £81,700 pa		Charge for parking or for shuttle bus?	If payment is for shuttle bus, staff will walk rather than ride	£50 a day £250 pw £11,500 pa (46 weeks)		
Shuttle Bus £52,700 Rugby Club £30,000		How is the money to be taken?	Salary deduction or payment in advance if not employed by WSFT	provided no change in current practice & same number of staff park at Rugby Club		
		How is the site to be policed?	Financial implication if the site is to be policed by car parking attendant, as current car parking contract does not include off-site locations.			
			Staff will not park here if charge made; also need to account for those who pay by salary deduction and possible need to change method of charging at the Trust i.e. for days parked each week			
			flexible car free day			
LONGER TERM SOLUTION	Return all staff to the Trust	Additional parking would need to be provided Cost of this provision to be offset by car parking charges	Staff already parking free at Rugby Club not willing to pay to come back on site so a number of incentives needed	£81,700 no longer paid to provide the current services plus increased income from staff who park on site (who are not already park on site (who are not already	81 ,700	30.06.20
			More staff may park on residential roads	Conservative est. 50 x £3 a day	34,500	

STAFF TARIFFS

	2017 TARIFF		
Tariff Band	Contracted Hours	Monthly tariff	Effective Daily Rate (42 Wks)
A	0-15	£8	£1.14
B	15 - 23	£16	£1.52
C	23 - 30	£24	£1.71
D	30+	£30	£1.71

	Visits	
Daily Rate	4929	£2.00

S1	Senior 1 Day	£12	£3.43
S2	Senior 2 Day	£24	£3.43
S3	Senior 3 Day	£36	£3.43
S4	Senior 4 Day	£48	£3.43
S5	Senior 5 Day	£60	£3.43

2017	
Employee Profile	Monthly Income
129	£1,032
190	£3,040
254	£6,096
892	£26,760
1465	£36,928
	£9,858
5	£60
7	£168
14	£504
20	£960
80	£4,800
126	£6,492
	£53,278

UPLIFT 2.5%	
2018 TARIFF	
Contracted Hours	Monthly tariff
0-15	£8.20
15 - 23	£16.40
23 - 30	£24.60
30+	£30.75

Visits	
4929	£2.05

£12.30	
£24.60	
£36.90	
£49.20	
£61.50	

UPLIFT 2.5%	
2018	
Employee Profile	Monthly Income
129	£1,058
190	£3,116
254	£6,248
892	£27,429
1465	£37,851
	£10,104
5	£62
7	£172
14	£517
20	£984
80	£4,920
126	£6,654
	£54,610

	2017 TARIFF		
Tariff Band	Contracted Hours	Monthly tariff	Effective Daily Rate (42 Wks)
A	0-15	£8	£1.14
B	15 - 23	£16	£1.52
C	23 - 30	£24	£1.71
D	30+	£30	£1.71

	Visits	
Daily Rate	4929	£2.00

S1	Senior 1 Day	£12	£3.43
S2	Senior 2 Day	£24	£3.43
S3	Senior 3 Day	£36	£3.43
S4	Senior 4 Day	£48	£3.43
S5	Senior 5 Day	£60	£3.43

2017	
Employee Profile	Monthly Income
129	£1,032
190	£3,040
254	£6,096
892	£26,760
1465	£36,928
	£9,858
5	£60
7	£168
14	£504
20	£960
80	£4,800
126	£6,492
	£53,278

UPLIFT	3.0%
2018 TARIFF	
Contracted Hours	Monthly tariff
0-15	£8.24
15 - 23	£16.48
23 - 30	£24.72
30+	£30.90

Visits	
4929	£2.06
	£12.36
	£24.72
	£37.08
	£49.44
	£61.80

UPLIFT	3.0%
2018	
Employee Profile	Monthly Income
129	£1,063
190	£3,131
254	£6,279
892	£27,563
1465	£38,036
	£10,154
5	£62
7	£173
14	£519
20	£989
80	£4,944
126	£6,687
	£54,876

Tariffs would be rounded up to the nearest 5p or 10p

PATIENT/VISITOR TARIFFS

	Activity %	28%	45%	14%	6%	2%	1%	3%	0%	0%		
	Time Interval	1	2	3	4	5	6	6-10 Hrs	10+ Hrs	MACM	Blue Badge	Monthly Income
2016		**£3.30**	**£3.30**	**£4.80**	**£4.80**	**£7.60**	**£7.60**	**£7.60**	**£7.60**	**£4.80**		
		£24,602	£38,825	£17,506	£7,392	£5,016	£2,797	£6,300	£942	£125	£0	**£103,504**
2017	£2 per hour	**£2.00**	**£4.00**	**£6.00**	**£8.00**	**£10.00**	**£12.00**	**£12.00**	**£12.00**	**£5.00**		
		£14,910	£47,060	£21,882	£12,320	£6,600	£4,416	£9,948	£1,488	£130	£17,557	**£136,311**
2018 Tariff	Uplift **2.5%**	**£2.05**	**£4.10**	**£6.15**	**£8.20**	**£10.25**	**£12.30**	**£12.30**	**£12.30**	**£5.13**		
		£15,283	£48,237	£22,429	£12,628	£6,765	£4,526	£10,197	£1,525	£160	£17,996	**£139,745**
2018 Tariff	Uplift **3.0%**	**£2.06**	**£4.12**	**£6.18**	**£8.24**	**£10.30**	**£12.36**	**£12.36**	**£12.36**	**£5.15**		
		£15,283	£48,237	£22,429	£12,628	£6,765	£4,526	£10,197	£1,525	£160	£18,083	**£139,833**

Tariffs would be rounded up to the nearest 5p or 10p

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Trust Board – March 2018

Agenda item:	16			
Presented by:	Jan Bloomfield, Director Workforce & Communications			
Prepared by:	Sheila Broadfoot, Project Manager (CQUIN), Transformation			
Date prepared:	16th March 2018			
Subject:	CQUIN 1b) Food & Drinks sold on WSFT premises			
Purpose:	X	For information		For approval

Executive summary:
This report is to demonstrate WSFT has met the NHS England 2016-7 and 2017-8 Commissioning for Quality & Innovation (CQUIN) project specifications re: food and drinks sold on site, including products classified as high in fat, sugar or salt (HFSS). In addition, to meet the requirement that: 'Evidence of improvements is provided to a public facing board meeting'.

Scope: WSFT Outlets - Time Out Restaurant, Courtyard Café, Friends of WSFT Shop & Trolleys. Franchise: W H Smith has a direct agreement with NHSE plus liaised with WSFT.

2016-7 rules have been maintained:
- Ban on price promotions, advertising or display at checkouts re: HFSS food and drinks.
- Providing healthy options, including for staff working at night.

2017-8 rules have been introduced:
- 70% of drinks lines stocked must have less than 5 grams of added sugar per 100ml.
- 60% of confectionery & sweets, each 'packet' or 'box' counted as a whole, do not exceed 250 kcal.
- 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g

In addition: NHSE Voluntary Agreement on reducing Sugary Drinks sales to 10% on NHS premises.

Trust priorities	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	Improve patient experience		Support all our staff to be the best		Focus on prevention and wellbeing		
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
					X	X	X
Previously considered by:	This report will be provided as CQUIN evidence for Q4 2017-8 to the WSCCG in April 2018. The 2016-7 evidence was provided to WSCCG in 2017.						

Risk and assurance:	N/A
Legislation, regulatory, equality, diversity and dignity implications	NHS England: • 2017-8 – CQUIN 1b specification. • Voluntary Agreement on Sugary Drinks sales on NHS premises.
Recommendation: The requirement of 'Evidence of improvements provided to a public facing board meeting' has been achieved.	

Evidence to show the NHS England specification has been followed

CQUIN requirement Q4 2017-8:
This report is to demonstrate WSFT has met the NHS England 2016-7 and 2017-8 Commissioning for Quality & Innovation (CQUIN) project specifications re: food and drinks sold on site, including products classified as high in fat, sugar or salt (HFSS). In addition, to meet the requirement that: 'Evidence of improvements is provided to a public facing board meeting'.

NHSE rationale for the CQUIN project:

- PHE's report "Sugar reduction – The evidence for action" October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country.
- Almost 25% of adults in England are obese, with significant numbers also being overweight. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year.
- Sugar intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy.
- Consumption of sugar and sugar sweetened drinks tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences.

It is important for the NHS to start leading the way on tackling some of these issues, starting with the food and drink that is provided & promoted in hospitals.

Scope:
WSFT self-managed outlets: Time Out Restaurant, Courtyard Café & the Friends of WSFT Shop including trolleys: plans were put in place and the criteria were met as demonstrated below.

Franchise: W H Smith has worked direct with NHS England and with this Trust in order to deliver the goals, as they did nationally with other NHS Trusts.

2016-7 rules maintained

All of the required changes made in 2016-7 remain for sugary drinks and foods high in fat, sugar or salt (HFSS) i.e. there is no price promotions, advertising or such items at any checkout.
WSFT has also ensured healthy food and drink options are available.

All evidence of 'before & after' the changes was provided to WSCCG in Q4 2016-7 which was agreed as 'target met' and examples are also shown here as confirmation.

a) The ban of price promotions on sugary drinks & foods high in fat, sugar & salt.

WSFT Friends Shop: any such price promotions were removed. There were no other WSFT outlets running HFSS product price promotions.

W H Smith: deals on non-compliant foods were removed and new deals on healthier options were introduced, both on individual products and as part of 'meal deals'.

b) The ban of advertisements on NHS premises of sugary drinks and foods high in fat, sugar and salt

WSFT outlets: there were no advertisements on display, however, the sugary drink branded cups & straw holder were replaced with clear cups.

W H Smith: all display graphics with HFSS branded items e.g. product photographs featuring logos such as 'Cadburys' were removed and replaced with plain or non-branded illustrations.

c) The ban of sugary drinks and foods high in fat, sugar and salt from checkouts

WSFT Courtyard Café and Time Out: all pastries and cakes previously sited next to the checkout were moved and the offer of fruits plus foods complying with the rules was increased.

WSFT Friends Shop: seasonal products created by the Friends Shop volunteers e.g. knitted Christmas pudding covers for single chocolates and 'Easter chick' covers for Cadbury's crème eggs at Easter: were moved away from the checkout to elsewhere in the shop.

W H Smith: changed the items offered from a large 'mixed box of sweet bags' and other HFSS products near the checkout station, to products agreed with NHSE e.g. sugar free mints.

Vending is not classified as a 'checkout'; therefore a variety of products can be available.

d) Ensuring that healthy options are available at any point including for those staff working night shifts.

Food and drinks in the Time Out staff Restaurant and Courtyard Café includes healthy options for which a Gold Award 'Eat out, Eat well' was received.

As well as featuring calorie counts on Time Out menus and an H for 'Healthier option based on fat & salt content', in 2018 Time Out introduced a trial of Slimming World recipes, as appreciated by staff on social media. Fresh salads are also available.

Time Out nutrition information is available to staff on the WSFT intranet.

The Friends shop does not sell meals or sandwiches but there is a range of drinks.

W H Smith sells a variety of options during their opening hours.

Staff working night shifts
To improve the offer for staff working at night, financial investment was made to provide both hot and increase cold food vending with healthy options.

The chosen supplier for hot food vending helped over 40 NHS hospitals to offer a wide range of high quality, healthy and tasty hot food choices. A microwave is provided with the vending machine.

2017-8 rules introduced

The new rules are based on % stock displayed re: a limit on sugary drinks and high calorie pre-packed sandwiches / savoury pre-packed meals & confectionery. To ensure the criteria are met, the managers of the WSFT outlets are monitoring stock plus regularly reviewing shelves.

Other individual target notes are as below.

a) 70% drinks stocked must have less than 5 grams of added sugar per 100ml; including energy drinks, fruit juices (with added sugar of over 5g) and milk based drinks (with sugar content of over 10g per 100ml).

Plus - Voluntary NHSE scheme WSFT has signed up to (SSB only 10% sales):

- Reduce SALES of sugar-sweetened beverages (SSB), reaching target of 10% or less total volume drinks sales for March 2018 & continue thereafter.
- Note: NHSE is to advise if a total ban should be enforced, once the voluntary scheme results have been reviewed in May 2018.

Quarterly data has been supplied to NHSE as noted below, showing reductions. Q4 data will be due at the start of April 2018 re: reduced to 10%.

Venue for SSB sales	Q2 (July-Sept 2018)	Q3 (Oct-Dec 2018)
Time Out	13.8%	9.2%
Courtyard Café	17.5%	11.1%
Friends of WSFT Shop	30.5%	21.1%

- As a result of the above voluntary scheme, formulated after the CQUIN start, SSB sales are already reduced, therefore the display for the CQUIN rule will naturally be met.

- It has been noted that manufacturers have started to reduce their sugar content in some drinks to under 5g per 100ml, therefore this will help.

W H Smith: has also signed up to the Voluntary SSB scheme and any amends to their display will be made in March 2018.

b) Confectionery & Sweets – 60% stock do not exceed 250 kcals (within the whole)

Chocolate confectionery

Includes chocolate bars, filled bars, assortments, carob, diabetic and low calorie chocolate, seasonal products e.g. Easter eggs, chocolate produced for Christmas.

Sweet confectionery

Includes boiled sweets, gums, pastilles, fudge, chews, mints, rock, liquorice, toffees, chewing gum, sweet and sweet & savoury popcorn, nougat and halva, seasonal products e.g. sweets produced for Christmas.

- WSFT has taken the above on board and adjusted displays accordingly.
- In the Friends Shop, where most of the WSFT outlet confectionery is available, the previous large bags of sweets on a 'hanging stand-alone display' has now been removed and the large bags from it merged in with the other confectionery on offer, as per the % ratio allowed.
- In addition, the trolley taken around to patients on the wards was reviewed and amended.

W H Smith: WSFT has been assured that their displays will change in March 2018.

c) Pre-packed sandwiches & other savoury pre packed: e.g. wraps, salads, pasta salads – 60% contain 400kcal or less & not exceed 5.0g saturated fat per 100g

Within both the Timeout Restaurant and Courtyard Café are ready made sandwiches, baguettes and wraps.

These are freshly prepared onsite by the in-house team following a standard recipe for which, via the use of labelling software, the nutritional information is added to the pack outer.

The shelf displays adhere to the 60% (400kcal or less)/ 40% (over 400kcals) product split.

In addition to the CQUIN rule:

- For future ease of reference, new 'healthy' option pack outers have been sourced:

- WSFT is also in the process of changing from the nutritional information box to the more visual traffic light system.

W H Smith: WSFT has been assured that their displays will change in March 2018.

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Trust Open Board Meeting – 29th March 2018

Agenda item:	18			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Jane Relf, e-Care/Global Digital Exemplar Operational Lead			
Date prepared:	22 March 2018			
Subject:	To receive update on e-Care and Global Digital Exemplar Programme			
Purpose:	X	For information		For approval

Executive summary:
This paper describes progress against delivery of the Global Digital Exemplar (GDE) programme. In particular this paper highlights progress with the roll out of the new vital signs monitors and patient portal pilot.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	**X**

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X

Previously considered by:	*e-Care/GDE Programme Board*
Risk and assurance:	*All risks are monitored by the e-Care/GDE Programme Board and Programme Group*
Legislation, regulatory, equality, diversity and dignity implications	*Compliance with forthcoming General Data Protection Regulation (GDPR)*

Recommendation:
The Board is asked to note the report

To receive update on e-Care and Global Digital Exemplar Programme

1. Background

1.1 In May 2016, the trust embarked on a major change programme to introduce a new electronic patient record (EPR). The programme was branded e-Care. At that initial phase, the programme introduced the following functionality:

- A new replacement Patient Administration System (PAS)
- FirstNet – a dedicated emergency department system
- EPMA – medicines management (prescribing and administration)
- OrderComms – requesting and reporting for cardiology and radiology
- Clinical documentation

1.2 Further enhancements have been made over the last 18 months including:

- Acute kidney injury (AKI) and sepsis alerts
- Full OrderComms functionality including pathology
- Paediatrics
- Capacity management – new functionality to improve patient flow
- New clinical documentation, care plans and care pathways
- Medication enhancements including duplicate paracetamol alerting
- New diabetic care plan

1.3 The West Suffolk Hospital NHS Foundation Trust (WSFT) is one of 16 hospitals chosen to become a flagship Global Digital Exemplar (GDE). As part of the GDE programme funding was awarded to those hospitals considered to be the most advanced digitally with the hospital receiving £10million.

1.4 Our GDE programme comprises of four pillars:

Pillar 1	Digital acute trust	Completing the internal e-Care journey of digitisation
Pillar 2	Supporting the integrated care organisation	Creating the digital platform to support the regional ambitions of integrated care and population health.
Pillar 3	Exemplar digital community	Building the organisation into a centre of digital excellence and acting as mentor and guide for other developing organisations.
Pillar 4	Hardware and infrastructure	Ensuring that we have a robust and compliant infrastructure at the foundation of the programme

The remainder of this paper provides an update on implementation of the GDE programme.

2. Pillar one – digital acute trust

2.1 The focus in this reporting period has been on launching the new vital signs monitors. These new machines will measure blood pressure, temperature, oxygen saturation and pulse and all other required parameters to enable immediate calculation of Early Warning Scores (EWS). These readings will be placed directly into e-Care. These have now been rolled out to all inpatient areas with the exception of F1 which will go live on 4 April. The emergency department will go live on 09 April. Outpatients and maternity will

follow later.

2.2 Generally the roll out has gone very smoothly with no significant issues identified. Staff feedback has been very positive on the new workflow. We have shared all learning from go live with our fast followers Milton Keynes University Hospitals NHS Foundation Trust (MKUFT).

2.3 We anticipate four main benefits from implementation of the machines:

- Patient safety improvement with real time alerting of MEWS on the device at the bedside (alerts will also continue to fire within e-Care).
- Patient safety improvement in that information will feed directly into e-Care and will not need to be transcribed by members of staff.
- Time to care improvement – we anticipate that as staff become proficient with the new machines they will save considerable time from their observation rounds.
- Availability of hardware – we often receive feedback from staff that it can become difficult to secure a workstation on wheels (WOW) during the busier periods on a ward. Previously staff would have used a WOW during an observation round but with the new machines this will not be necessary.

These benefits will be monitored once the go live is complete.

2.4 We are also piloting the new 'Powerchart Touch' functionality. This enables the clinician to review a reduced version of the patient record on different devices with the ability to use voice recognition. This is currently in use by a small number of clinicians as part of a pilot with intention to roll out more widely later this year. To date pilot users have been very pleased with the flexibility that this new way of working offers.

2.5 We have experienced a delay in launching the new nationally mandated emergency department (ED) data collection set (ECDS) as our testing raised concerns regarding our ability to report correctly. The information team have a manual workaround for the remaining issues which will allow us to launch this on 9 April. In addition we have a range of improvements being implemented within ED to optimise their workflows. This includes new workflow pages for clerking and the implementation of 'Launchpoint', both of which provide more intuitive workflows for clinicians within ED.

2.6 Since the last board meeting we have held numerous engagement sessions for clinicians and secretaries on MMODAL voice recognition software. The feedback has been overwhelmingly positive from clinicians with recognition of the significant potential productivity gains for all staff.

3. Pillar two – supporting the integrated care organisation

3.1 Our main focus for pillar two in this reporting period has been on launching the patient portal pilot. As reported previously the pilot is running from 12 February until end of May and is focussing on three main groups:

- Staff (as patients)
- Rheumatology patients
- Small number of dietetic patients

At the time of writing this report we had received 305 expressions of interest from staff. We also went live in rheumatology on 12th March and have received 65 expressions of interest in the first two weeks. We have therefore received a total of 370 expressions of interest since the start of the pilot. At this stage 288 of these accounts have been activated. Our original target was to recruit 300 users during the pilot and therefore we are on target to exceed this.

3.2 We have also taken the opportunity to demonstrate the portal to key stakeholders. This includes a demonstration to the trusts patient Voices group and to the west Suffolk GP education event where we were able to discuss this with 60 GP representatives. Generally feedback has been extremely positive with one member of the Voices group saying “Thank goodness patients will finally be out of the dark”. GPs also generally welcomed the intervention and two surgeries have offered to work with us so that we can properly understand the implication of the portal in primary care. This will be pursued after the initial pilot ends.

3.3 We continue to work with Cerner to develop the portal and have submitted our ‘wish list’ of new functionality that we wish to pursue.

4 Pillar three – exemplar digital community

4.1 We continue to support our fast follower MKUFT as they are rapidly approaching their go live on 14 April. This includes sending some of our expert staff to provide floor walking support at their go live. MKUFT are also implementing some new functionality ahead of us (maternity and ‘Launchpoint’) and we will therefore have the opportunity to observe and learn from their go live.

4.2 We have met with the NHS England lead for blue printing. Nationally more than 400 ideas have been submitted as blueprint ideas and this list is currently being rationalised by the national team. We will be expected to produce five blue prints per year and the national team will be providing clear methodology and templates to support us.

4.3 We have delivered our first webinar as part of the GDE Learning Network which was focussed on operational readiness and hosted by Helen Beck, Interim Chief Operating Officer. We are also hosting our second webinar on patient safety in April. We will be required to host further subjects through the year.

5. Pillar four – hardware and infrastructure

5.1 A key component of the GDE programme is to ensure that our supporting infrastructure is sound and enabling the new initiatives described above. We continue to focus on security, storage and network functionality. To date we are on target to achieve all GDE milestones as required under pillar four.

6. Optimisation

6.1 Whilst it is good to introduce new initiatives we recognise the need to work with staff to improve the user experience on what we have already implemented. As such we have established a dedicated optimisation team under the leadership of Ian Coe, Chief Nursing Information Officer. Further updates on the priorities and progress of this team will be reported to future meetings.

7. Benefits

7.1 As we approach the two year anniversary of our original implementation we are focussing attention on analysing benefits achieved to date. This requires detailed analysis and observations for each benefit to identify actual achievement. A more detailed summary will be provided to a future board meeting.

8. Reporting

8.1 We continue to work with Cerner to correct the outstanding reporting issues. In particular a new patient tracking list (PTL) was published at the end of February that incorporated a number of fixes to support referral to treatment (RTT) performance. There are four outstanding issues which are minor in nature and which do not affect our ability to track patients. The information team are now focussed on developing a planned PTL which addresses the final outstanding RTT issue. We also continue to work with Cerner on the final fix for reporting on historical bed occupancy.

9. Communications

9.1 There is much to celebrate around our digital achievement s to date. In addition we

have ambitious plans for the future as detailed in previous board reports. The communications team has linked with the e-Care project team and are developing a compelling narrative that describes our journey (what we have achieved already, what we are working on now and what we hope for the future. This will describe the impact for patients, partners and the wider population.

9.2 The following are in consideration for development to ensure much wider engagement and understanding around these plans.

- A page on the WSFT website, explaining our GDE ambitions and journey.
- A downloadable leaflet/brochure, available on our website and that can also be sent to relevant stakeholders.
- A series of articles for our internal and external stakeholders to showcase our GDE progress.
- An animation video.

These initiatives will be delivered over the next few months.

WSFT Board Meeting – 29 March 2018

Agenda item:	19			
Presented by:	Dawn Godbold, Director of Integration and Community Services			
Prepared by:	Dawn Godbold, Director of Integration and Community Services			
Date prepared:	20/03/2018			
Subject:	Community Services and West Alliance update			
Purpose:	x	For information		For approval

Executive summary:

The community services contract transferred to the trust on 1 October 2017. The trust is working as part of an Alliance of providers to deliver community services. The trust is committed to building, shaping and being at the centre of, a collaborative integrated health and care system that operates without organisational boundaries.

Main Points:

This paper describes the progress being made on:

- Integration between acute and community services
- Development of the West Suffolk Alliance
- Update on the Buurtzorg Test and Learn project

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
		x	**x**

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	x	x	x			x	x

Previously considered by:	Monthly update to board

Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: The board is asked to note the progress being made.	

West Suffolk NHS
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Community Services Update

West Suffolk NHS Foundation Trust Board

29th March 2018

1.0 Introduction

1.1 The community services contract transferred to the trust on 1 October 2017. The trust is working as part of an Alliance of providers to deliver community services. The trust is committed to building, shaping and being at the centre of, a collaborative integrated health and care system that operates without organisational boundaries.

1.2 This paper describes the progress being made on:

- Integration between acute and community services
- Development of the West Suffolk Alliance
- Update on the Buurtzorg Test and Learn

2.0 Acute and Community Integration

2.1 Members of staff across community and acute are now regularly working together as part of 'normal business'. There is now consistent attendance from community staff at acute board rounds, MDT's, red-to-green meetings and stranded patient reviews.

2.2 Staff usually based in the acute are now attending meetings in the community and assisting with activity, patient reviews and offering professional advice and support if needed.

2.3 A joint session on the current and future work force challenges has been held. As a result a number of flexible and creative ideas to improve staff development, recruitment and retention were discussed. These ideas and actions will now be populated into a joint work force plan containing short, medium and longer term challenges and solutions.

2.4 At the session it was agreed that we would no longer hold separate interviews or undertake separate recruitment processes for any therapy roles. From now on there will be joint adverts and recruitment for all posts regardless of whether they are for community or acute. All posts will also be offered as rotations where appropriate. This will reduce duplication, save HR time, save management time, ensure we are not competing for staff and improve the flexibility in the range of roles we can offer, plus improved development opportunities.

2.5 The 'Warm Handover' project went live in the community on the 12th March 2018. This project enables the sharing of information and the making of referrals to multiple

agencies using only one form. This can be used for statutory and non-statutory organisations such as Fire Prevention, Age UK Suffolk, Suffolk Family Carers and Warm Homes Healthy People. This will save staff time, ensure consistency in information sharing and encourage the use of non-statutory services.

2.6 The planning and preparation to bring the clinical element of the wheelchair service back in house on the 1st April 2018 is continuing smoothly. This will result in the TUPE transfer-in of 15 members of staff. The team will be integrated into the joint community/acute therapies team, under the Head of Therapies.

2.7 The recruitment for the new joint post 'Associate Director for Children and Young Peoples Transformation' has taken place with a successful appointment made.

2.8 The Integrated Therapies Service will transfer from clinical support services line management to community line management on the 1st April 2018.

2.9 Colleagues from across the system have jointly participated in the system leadership programme which will test a new way of 'whole system management' of multi-disciplinary meetings for our highest users.

3.0 Buurtzorg Test and Learn Update

3.1 The Buurtzorg Test and Learn went live at the beginning of March. The Test and Learn will run for 12 months, during which time work will be undertaken to understand how the model could be replicated at scale.

3.2 The team currently has 6 members with a further 3 recruited. The ideal number for a team is between 8-12. Working at a neighbourhood level is a key element of the Buurtzorg practice, enabling the team to work closely with GPs and other professionals and draw on local support from friends, families and volunteers.

3.3 The team is working in Barrow, Suffolk, as the locality for the Test and Learn and an area where one of the team has strong connections. This will not only enable a robust test of the model in a rural setting but will also support strong connection between the team and the community, one of the key features of the model.

3.4 In the Netherlands teams are embedded within their communities, enabling strong working relationships and dialogue with informal networks - the voluntary and community organisations and formal networks - such as GPs, police and paramedics, to provide holistic care. In delivering it in an area that is well known to the team these relationships are largely established. The team will have an office base within the local GP practice.

3.5 The Test and Learn patient profile will be adults needing care and support at home, with varying complexity of care needs to test the model robustly with the population accessing community care services in West Suffolk.

3.6 A key purpose of the Test and Learn is to understand the implementation issues around introducing the model into the English NHS. With this focus in mind any review process will need to take into account:

- That the process will be iterative and that the model must be allowed to grow, develop and change over the course of the Test and Learn.
- This means the approach, scope and scale of the project will change over the year itself.
- This is likely to impact on the range of evidence collected throughout the Test period.
- As an early pilot, the scale of the Test and Learn and the resulting statistic evidence will be relatively small.

3.7 The review will focus on identifying two key areas establishing:

i. An operational framework for a UK-adapted Buurtzorg operational model
ii. Early indications of the outcomes and impacts of the model on people, the workforce and the wider system to establish a business case for wider implementation.

3.8 The review is being carried out by the King's Fund and Health Watch Suffolk. It would be proposed that a full evaluation process is carried out once, and if, there is a broader introduction of the model established through a wider pilot of the stable model established through this early process.

4.0 West Suffolk Alliance Development

4.1 The newly established System Executive Group continues to meet monthly. The group brings together system leaders from all Alliance partners, the CCG and the Borough Council. The most recent session held was a workshop discussion, facilitated by the NHS Advisory Board, where our ambition, commitment and values were explored. The outputs will inform our system strategy document.

4.2 The group is evolving to become the main joint decision making forum for the west system. In line with STP ambition, the group will eventually take on some responsibility for local commissioning decisions.

4.3 The group has committed to reviewing its membership to ensure there is whole system representation, avoiding duplication with other forums where possible. The group will continue to evolve its functions and responsibilities as the changes to CCG and STP level functions emerge.

4.4 The group has agreed to review existing forums and meetings with a commitment to 'closing down' those that do not add value or do not provide whole system discussion.

4.5 The Alliance partners have commenced the production of a strategy and implementation plan that will be reviewed by the STP board in April. The strategy and plan will be a simple high level explanation of: our vision, ambitions, our challenges, our timelines and milestones.

4.6 The first ICS project board has taken place. The ICS Project Board brings together those leading key work streams to develop of the various components of an Accountable Care System (ICS) for Suffolk and North East Essex.

4.7 The ICS Project Board is NOT a decision making body and reports into the STP Board who will provide oversight of the delivery of ICS work streams in the same way that they provide oversight to other STP Delivery Programmes.

4.8 The role of the ICS Project Board is to:

- Regularly bring together those leading key ICS work streams
- Ensuring that ICS work streams work in a way that is aligned to one another
- Provide central co-ordination to ICS development across the whole footprint
- Provide the time and space for open and honest conversations around key issues to support the development of proposals for decision by the STP Board
- Ensure engagement with the public in plans and activities
- Build support and partnerships across the footprint
- Ensure a true partnership approach
- Identify the issues where leadership will be necessary to cut through long standing and difficult issues
- Identify where resolution is needed on key issues between STP partner organisations
- Identify and deliver innovative solutions
- Be a conduit for NHS England and NHS Improvement to work with the system on ICS

5.0 Conclusion

5.1 Work is underway in key areas that will both, encourage and enable collaboration and maturing of relationships across the system.

5.2 The Board is asked to note the progress being made.

Board of Directors – 29 March 2018

Agenda item:	20			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	22 March 2018			
Subject:	Trust Executive Group (TEG) report – 19 March 2018			
Purpose:	X	For information		For approval

Executive summary

Steve Dunn provided an introduction feeding back on a national meeting he had attended with Simon Stevens in attendance. Nationally transformation remained a priority accepting the need to streamline regulation. In the context of the difficult winter recognition was provided to hospital and community services during what has been, and remains, a difficult time. It was noted that the first west Suffolk system education afternoon had been held with strong WSFT input for local GPs.

The **integrated quality and performance report** (IQPR) was reviewed. The continued operational pressure was recognised, with a weekend which had been very difficult despite discharging more patients on a Saturday then ever previously achieved. We continue to work with the emergency care intensive support team (ECIST) and the focus of the newly established task and finish group will be the pathways from the front door. The operational plans for the Easter period were reviewed including working with social care colleagues to ensure appropriate access to assessment and packages of care.

An updated was received on **referral to treatment (RTT) performance**. Despite the significant operational pressure it was confirmed that the elective programme had been maintained during the previous week – including significantly delayed hip and knee patients. It was confirmed that no 52 week breaches had been cancelled in January or February, but the number of 40+ week waiters had increased with a rising risk for 5-10 patients as future 52 week breaches.

The **red risk report** was reviewed with discussion and challenge for individual areas. No new red risks were received. It was confirmed that action had been taken to mitigate the risk regarding mortuary capacity, the risk was downgraded to amber.

The **car parking strategy** was received and the recommendations supported, recognising that engagement is taking place on the proposed changes to carer and weekly ticket tariffs.

The **capital programme** was considered as part of the review of the draft operational plan. The total borrowing for the Trust set out in the plan increases from £60m to £100m. This includes a significant capital programme of £30m, including residences, global digital exemplar (GDE) programme, upgrade of emergency department (ED) and phase 1 of the new acute assessment unit (AAU).

An update was received from community services on the **trusted assessment project**. A trusted assessment is an agreed approach to assessing the needs of a person that is applied across organisation and service boundaries. The hallmarks of such an approach are:

- Trust between organisations and professionals as to the validity of assessment carried out across the system
- A focus on maximising the independence of the people assessed, including the use of

community and family based support
- A person-centred conversation, driven by them as experts in their own needs
- An assessment that can be updated by a range of practitioners as the needs and circumstances of the person change

The development was welcomed by TEG and it recognised that good information flows would be an important enabler for the project.

Relevant **policy documents** were considered and approved:

a) Loses and compensation policy
b) GDPR briefing (attached)

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	**X**

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X

Previously considered by:	The Board receives a monthly report from TEG
Risk and assurance:	Failure to effectively communicate or escalate operational concerns.
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

The Board note the report

GDPR briefing

The General Data Protection Regulation (GDPR) is a new European directive and will replace the Data Protection Act 1998. It's the most significant change in privacy law in the last 20 years and will unify and strengthen the privacy rights of all EU citizens.

The new law becomes effective on **25 May 2018** and The Information Commissioner's Office will remain the regulatory body.

Notable changes are:

- Mandatory 72 hours to report an information governance breach
- Privacy Impact Assessments for all new projects/systems are mandatory
- All public authorities must appoint an accountable Data Protection Officer
- **All organisation information processes must be mapped** and recorded and legal/consent basis for processing agreed
- Non-compliance with the law or breaches of the law will be subject to a maximum € 20 million fine.

Rights of data subjects will now include:

- Right to be forgotten
- Right to have information changed
- Right to have information erased
- Right to restrict processing.

Key risks

- Information process mapping by the organisation is not completed by 25/5/2018 – supports assessment of consent requirements to process data
- GDPR e-Care module is still in consultation and key compliance areas of data subjects rights are unknown – mitigating action being taken to put in place relevant procedures, for example right for information to be forgotten.

Trust Board Meeting – 29th March 2018

Agenda item:	21			
Presented by:	Steve Turpie, Non-Executive Director			
Prepared by:	Louise Wishart, Assistant Director of Finance			
Date prepared:	March 2018			
Subject:	Audit Committee report - meeting held on 2nd March 2018			
Purpose:		For information	X	For approval

Executive summary:

The draft minutes of the meetings of the Audit Committee on 2nd March 2018 are attached. **Please note these have yet to be approved.** The key issues and actions discussed were:-

- **Board Assurance Framework 'deep dive'**- Due to the adverse weather conditions this was postponed to the next meeting.
- **Governance and Assurance** – Paul Morris, Head of Patient Safety and Clinical Effectiveness, presented a report on Clinical Audit. Paul highlighted areas of improvement in data reporting and documentation identified from 2 recent audits which he was following up. The reporting arrangements for Clinical Audit were clarified as being through the Clinical Safety and Effectiveness Committee (CSEC). Paul explained to the Committee how the methodology is evolving through the increasing use of benchmarking and the integration of Community Services. The Committee was keen to learn more about this in future reports.
- **Draft Annual Governance Statement (AGS)** – the Committee reviewed an early draft of the Annual Governance Statement. The Committee discussed the control issues highlighted and whether this was pitched at the right level. The discussion was supported by input from External and Internal Audit. The final report will be approved at the Audit Committee in May.
- **Internal Audit and Counter Fraud** – the 2018/19 Internal Audit Plan which had been developed through risk assessments and discussion with a range of Trust staff, including the Executive Team, was agreed. The Committee reviewed the 2017/18 Internal Audit Progress report and challenged the assurance level on one audit to ensure it was robust. The Committee also sought assurance that the delay to responding to Internal Audit requests for evidence to demonstrate recommendations had been implemented had been addressed. The draft Head of Internal Audit Opinion was discussed and the final version will be received at the May Audit Committee.

  The Local Counter Fraud Specialist (LCFS) presented the results of the most recent staff fraud survey. The number of respondents had increased significantly and the results had been used to inform the draft 2018/19 Counter Fraud Plan which was presented and approved. There will be a particular focus on Community staff as they were less responsive to the survey comparatively.
- **Internal Audit And Counter Fraud Services Contract** – the current three year Internal Audit

and Counter Fraud Services contract has been extended to March 2019. A timetable for the tender was agreed by the Committee and will involve Audit Committee members.

- **External Audit** – External Audit presented their 2017/18 Audit Plan. The main audit risk highlighted was the risk of management override given that the Trust is likely to be very close to its control total at year end. The Audit will be tailored to address this risk.
- **Waivers** – the number of waivers in the last quarter had reduced which was pleasing but it is already known that the following quarter will see an increase again. The Trust had contacted the Council recommended by the auditors to discuss how the number of waivers could be reduced further. An action plan has been agreed by Executive Directors.
- **Losses & Compensation** – the level of losses has increased this quarter. The Trust is investigating ways that controls can be improved to address this issue. It could include rolling out the Vital tray to all wards to help prevent loss of patients' personal items such as dentures.
- **Financial Reporting** – the issues associated with the preparation of the year-end accounts were considered including significant estimates.
- **HFMA Self-Assessment Checklist** – the Committee agreed to complete this checklist by the end of April to help inform future development plans and changes required.
- **Supply Chain Risk** – the Committee received a report from the Head of Purchasing on supply chain risk. Tthe methodology has changed this year to include suppliers that are critical to the Trust even if the amount spent with them is relatively small. The report identified some suppliers as red and amber risk either because of their credit score or because they would be very difficult to replace, or a combination of both. Controls were agreed in relation to this.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	**X**

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X				X

Previously considered by:	*This report has been produced for the monthly Trust Board meeting only*
Risk and assurance:	*None*
Legislation, regulatory, equality, diversity and dignity implications	*None*

Recommendation:
The Board is asked to:

- receive and note the Audit Committee report for meeting held on 2nd March 2018

Board of Directors – 29 March 2018

Agenda item:	22			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	23 March 2018			
Subject:	Report from Council of Governors, 21 February 2018			
Purpose:	X	For information		For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 21 February 2018. The report is presented to the Board of Directors for information to provide insight into these activities. Key points from the meeting were:

- It was noted that this was the first meeting of the six new elected public governors and five staff governors. Andrew Hassan was also attending his first meeting as a partner governor representing primary care.
- A report was received from the Chair giving details of the activities she had been involved in, both internally and externally.
- The Chief Executive's report provided an update on the challenges facing the Trust and recent achievements. He commended all staff for their involvement in achieving the outstanding rating from the CQC.
- Response to governors issues raised were received.
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge.
- An update on e-Care was received and Dermot O'Riordan demonstrated the patient portal, including information that would be available and how this would be displayed.
- The timetable for producing the Operational Plan and Annual Quality Report was explained. Four governors volunteered to act as readers.
- The governors agreed with the recommendation to test the Trust's local Friends and Family data as part of the external auditor's limited assurance report of the Annual Quality Report.
- The summary of the register of governors' interests was reviewed and there were no comments or amendments
- The membership of the engagement committee was confirmed as the six governors who had put volunteered to sit on this committee.
- An anonymous ballot took place for the three seats for public governors on the nominations committee (five nominations had been received). The staff governor and partner governor nominations (one of each) were also confirmed as members.
- A report was received from the lead governor.
- The process for election to the NHS Providers advisory committee was explained and governors received details of the candidates.
- Future dates for meetings for 2018 were noted.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.						
Risk and assurance:	Failure of directors and governors to work together effectively. Attendance by non executive directors at Council of Governor meetings and vice versa. Joint workshop and development sessions.						
Legislation, regulatory, equality, diversity and dignity implications	Health & Social Care Act 2012. Monitor's Code of Governance.						
Recommendation: To note the summary report from the Council of Governors.							

NHS West Suffolk NHS Foundation Trust

Board of Directors – 29 March 2018

Agenda item:	23			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	20 March 2018			
Subject:	Non-executive director responsibilities			
Purpose:	X	For information		For approval

The responsibilities of the Trust's non-executive directors (NEDs) are periodically reviewed by the Chair following discussion with the NEDs and chief executive. As part of this process this report sets out the updated NED responsibilities, taking into account the planned change for Angus Eaton to take on responsibility for chairing the Audit Committee.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
		X	

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
							X

Previously considered by:	The non-executive director responsibilities are periodically reviewed
Risk and assurance:	Failure effectively to appropriately allocate or communicate lead responsibilities.
Legislation, regulatory, equality, diversity and dignity implications	The NHS Foundation Trust Code of Governance (July 2014).

Recommendation:

To note the allocated NED responsibilities

Non-executive directors' responsibilities (April 2018)

NHS West Suffolk NHS Foundation Trust

	Primary responsibilities	Responsibilities as required	Lead roles
Sheila Childerhouse **Chair and Non-executive director** **Term:** 1 Jan 2018 - 31 Dec 2020	• Chair Board – Public, Closed (**Chair**) • Quality & Risk Committee (**Chair**) • Charitable Funds Committee • Scrutiny Committee • Remuneration Committee • STP chairs meeting (Chair) *Option to attendance any other Board committee*	• Board Workshops • External relationships • Consultant appointments • CCG Board meetings	• Chair • STP
Richard Davies **Non-executive director** **Term:** 1 Mar 2017 – 28 Feb 2020	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Remuneration Committee • Charitable Funds Committee Subcommittees of Q&RC: • Lead – Clinical Safety & Effectiveness Committee	• Board Workshops • Consultant appointments	• NED link to Medical Director***** • Learning from deaths • End of life • Children services, including, including safeguarding
Angus Eaton **Non-executive director** **Term:** 1 Jan 2018 – 31 Dec 2020	• Board meeting – Public, Closed • Audit Committee (**Chair)** • Remuneration Committee (**Chair**) • Charitable Funds Committee	• Board Workshops • Consultant appointments • Attend Q&RC	• NED link to Director of Finance • Health and wellbeing programme
Gary Norgate **Non-executive director** **Term:** 1 Sept 2013 - 31 August 2016 **Reappointed:** 1 Sept 2016 – 31 August 2019	• Board meeting – Public, Closed • Audit Committee • Scrutiny Committee (**Chair**) • Remuneration Committee • Charitable Funds Committee (**Chair**) Subcommittees of Q&RC: • 2nd Corporate Risk Committee	• Board Workshops • Consultant appointments • Attend Q&RC	• Senior Independent Director • e-Care • Whistleblowing • Procurement

	Primary responsibilities	Responsibilities as required	Lead roles
Alan Rose **Non-executive director** **Term:** 1 April 2017 – 31 March 2020	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Scrutiny Committee • Remuneration Committee • Charitable Funds Committee Subcommittees of Q&RC: • Patient Experience Committee • 2nd NED Corporate Risk Committee	• Board Workshops • Consultant appointments	• Safeguarding - adults • Security • RTT • Patient experience and public engagement
Steven Turpie **Deputy Chair and Non-executive director** **Term:** 1 March 2010 – 28 Feb 2014 **Reappointed**: 1 March 2014 – 28 Feb 2017 **Reappointed:** 1 March 2017 – 28 Feb 2019	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Remuneration Committee • Charitable Funds Committee Subcommittees of Q&RC: • Corporate Risk Committee (from April 2018) • 2nd Patient Experience Committee (from April 2018) • 2nd Clinical Safety & Effectiveness Committee (from April 2018)	• Board Workshops • Consultant appointments	• Deputy Chair

Catherine Waller **Intern Non-executive director** **Term:** 1 Sep 2017 – 31 Aug 2018	In attendance at: • Board meeting – Public, Closed • Audit Committee • Remuneration Committee • Charitable Funds Committee	In attendance at: • Board Workshops	

Board of Directors – 29 March 2018

Agenda item:	Item 24			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 March 2018			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

The attached provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points.

The final agenda will be drawn-up and approved by the Chair.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	X	X

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 27 April 2018

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Integrated quality & performance report, including mandatory training and appraisals	✓		Written	Matrix	HB/RP
2018-19 winter planning report	✓		Written	Action point - 1529	HB
Finance & workforce performance report	✓		Written	Matrix	CB
Transformation report (including outpatient programme)	✓		Written	Matrix	HB
Speech & language services and children in care report	✓		Written	Action point - 1499	DG
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
e-Care report	✓		Written	Matrix	CB
Safe staffing guardian report	✓		Written	Matrix	NJ
Freedom to speak up guardian	✓		Written	Matrix	JB
Voluntary services report	✓		Written	Action point - 1496	JB
National staff survey report	✓		Written	Matrix	JB
Experience of care strategy	✓		Written	Action point	RP
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
Alliance and community service report, including SLT patients that are waiting or a package of care	✓		Written	Matrix	DG
Operational plan 2018/19, including control total and capital programme		✓	Written	Matrix	CB/RJ
Strategic update, including Alliance, System Executive Group and System Transformation Partnership (STP)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Quality & Risk Committee report	✓		Written	Matrix	AE
Scrutiny Committee report, including private physiotherapy report		✓	Written	Matrix	GN
Board assurance framework – review of new risks from operational plan		✓	Written	Matrix	RJ

Confidential staffing matters		✓	Written	Matrix – by exception	JB
Annual governance review		✓	Written	Matrix	RJ
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	RQ