NHS
West Suffolk
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 2 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 26 January 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.	**RTT position (verbal)** To receive the update in the context of winter pressures	Helen Beck
10.	**Finance and workforce report (attached)** To accept the monthly report	Craig Black
10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
11.	**Care Quality Commission inspection report (attached)** To receive the report and approve the action plan	Rowan Procter
12.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter
13.	**Staffing forecast position and recruitment plan (attached)** To receive report	Jan Bloomfield

14.	**Quality learning and improvement:** **(a) Learning and improvement summary report – Q3 (attached)** To receive the following report **(b) Learning from deaths report – Q3 (attached)** To receive the following report	 Rowan Procter Nick Jenkins
15.	**Consultant appointment report (attached)** To receive the report	Jan Bloomfield
16.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
10:50 BUILD A JOINED-UP FUTURE		
17.	**e-Care report (attached)** To receive an update report	Craig Black
18.	**Alliance and community services report (attached)** To receive update	Dawn Godbold
11:00 GOVERNANCE		
19.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
20.	**Quality & Risk Committee report (attached)** To approve report recommendations	Sheila Childerhouse
21.	**Charitable Funds Committee report (attached)** To receive report	Gary Norgate
22.	**Use of Trust seal (attached)** To note the report	Richard Jones
23.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:15 ITEMS FOR INFORMATION		
24.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
25.	**Date of next meeting** To note that the next meeting will be held on Thursday, 29 March 2018 at 9:15 am in the Committee Room.	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
26.	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 26 JANUARY 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		
Anna Hollis	Communications Manager		
Catherine Waller	Intern Non Executive Director		

Action

GENERAL BUSINESS

18/001 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting; she was very pleased to see so many governors, including those who were newly elected. She welcomed Angus Eaton to his first board meeting as a Non-Executive Director (NED).

She thanked everyone in the Trust for being so welcoming during the past few weeks. This has been the case wherever she had visited throughout the hospital, which was a great reflection on the Trust and staff. She was very pleased to be joining WSFT at a time when it had been rated as outstanding by the CQC and she acknowledged the role that Roger Quince had played in this, alongside the management team. It was proposed that a letter was sent thanking him for his contribution.

S Childerhouse

She said that it was right to celebrate CQC's report and that it was very important to acknowledge the Trust's excellent staff who should be very proud of this achievement. However, there were very big challenges ahead, some of which would be covered in the board papers today, and some of which were not yet known about. There were also great opportunities around integration, and west Suffolk as a system needed to get on and tackle the challenges and take advantage of these opportunities.

Apologies were received from Dawn Godbold.

18/002 QUESTIONS FROM THE PUBLIC

- June Carpenter congratulated the board on the CQC report.

  She noted that the media were reporting that A&E attendances were increasing and asked if WSFT should provide a breakdown of these to the public to make people realise they should not attend unless absolutely necessary. Nick Jenkins said that this might be worth doing in some hospitals, but WSFT did not see many people who should not come to A&E, which was a good reflection on primary care in west Suffolk.

- June Carpenter referred to cancelled elective operations. She asked how long it would take to clear the backlog and if the Trust would be undertaking extra lists. Helen Beck that part of this related to referral to treatment (RTT) and 92% was now being achieved. The model showed that this should be cleared by the end of March, however this was now likely to be June. Additional sessions continued to be undertaken as far as possible. More detail would be provided under agenda item 10.

- June Carpenter asked if the Trust had received the funding for KMPG. It was explained that this would be covered in the finance report.

- June Carpenter asked about the MHRA pathology lab visit. It was explained that this would be covered under agenda item 13.

- Judy Cory referred to item 14, health and wellbeing report. She had read in the press that 30% of trusts had not signed up to the sugar tax, and asked who monitored this overall to ensure that this was actually happening in hospitals. Craig Black explained that part of the standard contract requirement was to comply with this. CCGs had a responsibility as part of normal contact management to ensure that trusts were discharging their duty in line with the contract.

- Jo Pajak referred to agenda item 6, actions arising item 13, and asked why the Trust was recruiting nurses from the Philippines rather than the rest of Europe. Jan Bloomfield explained that the agency had advised the Trust that there were a lot of unemployed nurses in the Philippines; therefore this was the best place to go to recruit nurses.

- Liz Steele referred to the story on the front page of the Bury Free Press last week where a patient had been discharged from WSFT in her nightie. She asked for assurance that lessons had been learned from this. Rowan Procter confirmed that this had been investigated and the Trust had apologised to the family. Unfortunately due to the pressure that the hospital and staff were under the fact that she was not adequately dressed had been not been noticed.

18/003 REVIEW OF AGENDA

The agenda was reviewed and there were no issues. It was noted that Helena Jopling would be joining the meeting for item 14.

18/004 DECLARATION OF INTERESTS

As it was her first meeting Sheila Childerhouse declared that she was a trustee of East of England Children's Hospices.

18/005 MINUTES OF THE MEETING HELD ON 1 DECEMBER 2017

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

Page 3, 17/238 (item 1497), Steve Turpie requested that the second sentence be amended to, "Steve Turpie reported on the good work being initiated by WSFT around children's services as a result of integration including, for example, asthma pathways. He said that the Trust needed to work towards more of this across other services."

Page 7, 17/240, third paragraph, second sentence to be amended to, "He explained that a review of this had shown that this was as a result of careful consideration and putting the patient first and not giving them a general anaesthetic…."

18/006 MATTERS ARISING ACTION SHEET

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

Item 1466 – provide clarity on future provision of stroke services as part of STP service model. Nick Jenkins considered the target date of 26 January to be unrealistic as this was in the hands of the STP. He would update the board at the next meeting. **N Jenkins**

Item 1475 – develop a set of metrics which will provide an indication of the success of the leadership programme. Jan Bloomfield explained that was currently being worked on but was behind schedule. It was important to get this right and it could be worked on in parallel with leadership and health and wellbeing. The target date was amended to the March board meeting. **J Bloomfield**

Item 1513 – provide separate RTT report to next board, setting out revised recovery trajectory and detail specific number for 52 week breaches by specialty/patient choice. Helen Beck explained that the date for this had been revised based on recent cancellations of electives.

Item 1515 – provide more detailed information for Gary Norgate on the exit rate run required and 'calendarisation' for 2018-19 delivery. Gary Norgate confirmed that he had received this information.

Item 1522 – implement NED responsibility changes as a result of SID appointment. It was noted that the target date for this had been revised to the board meeting on 29 March.

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

Item 1517 – provide an indication of the proposal and timescale for improved health and wellbeing reporting, including sickness and consultant burn-out survey. It was noted that the results of the consultant burn-out survey would come back to a future board meeting.

Item 1519 – use the e-Care report to structure communication of the e-Care deliverables internally and with stakeholders. Steve Turpie asked how the Trust could articulate the benefits of e-Care that could be seen by the lay person and what this would mean for them. The Board needed to understand what it was getting for the £20m investment. Gary Norgate explained that this had been discussed yesterday at the e-Care board and a report had been requested to show efficiency gains and improvement in patient experience.

Craig Black noted Rowan Procter's comments at yesterday's meeting that this would enable those making decisions about bed pressures to have full visibility of the acuity etc of patient. This report would be available for the next e-Care board.

The Chief Executive proposed circulating the comments he made at the leadership event in the summer.

Steve Turpie said that this report needed to show what had been done and the benefits that would be seen over the next three years. Angus Eaton suggested that it would be helpful to see further possibilities once the e-Care project had been completed.

The Chair reminded everyone that this was also part of the whole system, not just the hospital.

18/007 CHIEF EXECUTIVE'S REPORT

The Chief Executive welcomed the Chair to WSFT, which was now an outstanding FT. He considered this to be a massive achievement and that it showed how much work had been done to respond and react to the previous CQC report. This was a testament to all staff as there where only six other acute hospitals in the country, out of 135, which had been rated outstanding. The Trust had amazing staff and volunteers across the whole organisation who went the extra mile.

The established leadership within the Board and support from governors was a reflection of this achievement and he commended the executive team for everything they had done. Rowan Procter for her work following the last CQC inspection, particularly within end of life care. Jan Bloomfield had undertaken a lot of work around staff engagement, the staff survey and putting in place leadership programmes. Work around global digital excellence (GDE) and investment in e-Care had been undertaken by Craig Black, together with Helen Beck who had focussed on the transformation required to make this a success. The work being undertaken on RTT had been recognised by the CQC, although this still required further work. Also the work done by Nick Jenkins on mortality reviews, Richard Jones on governance and Dawn Godbold on the integration of community services, which had been noted by the CQC.

He said that ultimately this was a testament to staff, particularly over the very challenging last few weeks. WSFT had prepared for winter pressures better than ever before, (apart from the escalation ward). There had been a 6-7% increase in admissions compared to last year. On 2 January 40 additional beds had been opened which had not been planned for and he commended staff for the way they had enabled and managed this in a safe and orderly manner. The following week continued to be very challenging and there continued to a great response from those staff who contributed to patient care.

He considered that the major challenge was that there was an elderly population and a number of very sick people who came into A&E for very valid reasons. There were a large number of complex patients coming into the hospital and work still needed to be undertaken to change this in the future and work with the community to discharge people to a safe place as quickly as possible. WSFT had excellent working relationships with partners but there continued to be a real challenge around this.

The emergency department achieved 95% last week and was hoping to achieve 95% again this week, but the situation remained challenging.

Gary Norgate congratulated the Chief Executive and the Trust on the CQC result and agreed that this was a very good report.

He also recognised the hard work put in by staff during this difficult period. However, he was concerned that March was forecast to experience the busiest period in A&E and asked if this had been planned for.

Helen Beck confirmed that March was expected to be busy and that escalation areas would be open. However, she explained that the difference in January was that there were a large number of patients in beds who had been in hospital for more than seven days. Following the Christmas break WSFT's social care partners could not have done any more to help. However, there had been an issue over the Christmas period. She considered that as long as all processes were in working normally this should assist in managing this.

Craig Black explained that the real issue was the number of emergency admissions which was forecast to be high in March as there were 31 days. Also in December and January there were days when the emergency department was quieter, eg Christmas day and New Year. The challenge was that the organisation then had exceptionally busy days during this period. Gary Norgate referred back to last year which showed that admissions in March were considerably higher than in January or December.

Nick Jenkins explained that these figures did not reflect case mix. By March this tended to be sports injuries etc, rather than acutely ill patients. The Chair said that the Board needed to be assured that the emergency department would be able to manage during this period. Nick Jenkins said that currently this was a concern and there were significant staffing gaps. However, he considered that by March as there would be lower acuity patients this should be less of a concern and nurse practitioners would be able to assist in this.

Alan Rose referred to the CQC ratings and noted that two of the five areas remained good. He asked if there was a specific plan to achieve outstanding in these areas and also about achieving an outstanding care system in relation to integration through the STP or Alliance. He proposed looking at how to achieve outstanding across the community. Rowan Procter confirmed that there were action plans for all areas that were still required to be outstanding and these were monitored through the quality group.

The Chief Executive explained that there was still work to be undertaken in a number of areas and that not all areas had been inspected. The Trust needed to work hard to continue to maintain and achieve outstanding in all areas. He agreed that this now needed to be taken into the community. The CQC were likely to be inspecting community services that were provided by WSFT.

Richard Davies referred to winter pressures and the assumption that these would increase further next year. He asked if there was scope to think about how to work in the system to provide additional capacity and to undertake more elective work in the summer than the winter. The Chief Executive confirmed that discussions were already taking place around this. WSFT would be starting to plan for additional capacity and further changes were required to provide resilience for next winter, taking into account lessons learned from this winter. An update on winter planning for 2018-19 would be provided to the board at the end of April. **H Beck**

Gary Norgate said that he was not yet fully assured about managing in March. Steve Turpie considered that the biggest challenge was the ability to forecast and this year it had not got the escalation area quite right. He asked what affected the ability to forecast activity over this period, and what the ongoing process was to forecast volumes.

Rowan Procter explained that from a clinical and operational point of view despite the level of forecasting and preparation had been done, the Trust could not have forecast the unprecedented peak in acuity across the whole of the NHS which had increased substantially. Nick Jenkins agreed and said that it was the peaks that had been an issue and he would explain the details of this to individuals outside the meeting.

The Chair said that it was essential that plans were in place to manage the variance over the next couple of months and it would be very important to review this. She stressed the importance of this being about the system, ie social care's input over the Christmas and New Year period which had an effect on pressures on the hospital.

Nick Jenkins said that resilience was not about ensuring that the system did not 'fall over', but about safety and the ability to recover from a challenging situation. The organisation had remained safe and the community had responded in the right way.

The Chair said that she had been very impressed by the system working together when it needed to and this was very encouraging.

Gary Norgate suggested that the organisation needed to look at collective data, as an NHS system, in order to understand and improve predictability.

DELIVER FOR TODAY

18/008 INTEGRATED QUALITY & PERFORMANCE REPORT

Rowan Procter highlighted a number of peaks and troughs in performance, including pressure ulcers and *c.difficile.* There had been an increase in the number of cases of *c.difficile,* but the Trust remained below trajectory for cases due to hospital lapses or omission of care.

Richard Davies referred to the total number of deliveries in maternity (page 56) and queried whether the green and red ratings were the wrong way round. Rowan Procter said that she would follow this up. **R Procter**

Richard Davies asked about the fall in the rate of GP discharge summaries and the issues around capacity in the patient experience team. Nick Jenkins said that he did not think that this was a temporary issue; the discharge summary problem had been known about for a long time and was only improving slowly. There was now a full time person in post to focus on the change management required to get discharge summaries right. She would be working with the clinical teams to understand the problem and hopefully make an improvement.

Gary Norgate considered this report to be very good in terms of the amount of data provided, however he said that compared to the previous report it lacked information on actions being taken around low numbers and what was being done, ie exception reporting. It was proposed that actions being taken to address issues should be included in future reports. **R Procter / N Jenkins / H Beck**

Gary Norgate referred to RCA actions and noted that performance in November/ December was worse than in previous months. He assumed that this was due to the pressure that the organisation was under. Rowan Procter assured the board that this was being addressed and should be back on target by March. **R Procter**

Richard Davies noted the good safety data for November/December considering the pressure the organisation had been under. Catherine Waller commented that cancer figures were also good for this period.

The Chief Executive stressed that there had been a real focus to ensure that people did not suffer as a result of the pressures the Trust was under.

18/009 FINANCE AND WORKFORCE REPORT

Craig Black highlighted the actual variance of £900k for the month.

Failure to achieve the A&E performance target for Q3 would result in losing just over £500k of Sustainability and Transformation Funding (STF). All bills had now been received in relation to KPMG and plans around this scheme were due to incur an additional £1.1m of expenditure, over and above the element specifically promised by NHSI, ie £500k. This cost of £1.1m was designed to be covered by the additional CIP and the target had been increased from £13.3m to £14.4m. Having accounted for all the bills that had been received, an additional £400k had been incurred in December in advance of CIPs being delivered, which had resulted in a variance for the month.

He had had a number of discussions with NHSI about the £500k which had still not been received and they confirmed that they were committed to this but said they were having problems accessing cash. If this money was not received there would be a further deterioration in the Trust's financial position.

A further issue affecting the financial position in December was an over spend of £0.5m on pay and non-pay. However, £0.5m of winter pressures funding had been received which had balanced out this overspend, but this meant that the Trust had spent all its winter pressures funding in December. The pressures had continued into January and the extra capacity continued to be delivered, but without the funding, ie additional nursing staff and junior doctors, and extra sessions.

The reduction in elective work in January had a favourable impact on the financial position as expenditure decreased when fewer extra sessions were undertaken.

Craig Black explained that following December he was more concerned about the financial position than he had been previously. All of the issues he had described were what was driving this position.

Steve Turpie asked what the year-end forecast was as a result of the above. Craig Black said that it was very difficult to get to a figure and this was being worked on. If STF funding was taken out of the equation the position was currently £500k adrift of the control total. If the expenditure during December continued throughout January and February this could possibly result in an additional deficit of £1m and would also mean that the Trust would not get STF funding.

Craig Black explained that the Trust was not planning to spend additional money, but decisions were having to be made on a daily basis to maintain the safety of the hospital. Additional junior doctors were still being employed; however there had not been as much escalation as in December, therefore nursing spend should reduce. He was not expecting there to be additional sessions in January, but recovering the RTT position could result in an increase in additional sessions in February and March.

Steve Turpie asked about KPMG and if it had been agreed that they would not be paid if they did not achieve the planned CIP. It was explained that this was not the case as WSFT had not negotiated the contract. The Chair asked if it was in writing that WSFT would receive £500k towards KPMG from NHSI. Craig Black said that it was not actually in writing but assurance had been provided in minutes of meetings with NHSI.

Alan Rose asked if there were any planned cost savings from 2018/19, or any non-recurrent elements that could be pulled forward, or if it was more important to get RTT back on track. He thought that it was not possible to do both. Craig Black explained that he had been having discussions with all the divisions about accelerating the CIP and a meeting would be taking place on Monday to look at this. Recently managing the pressure the organisation had been under had taken precedence over achieving CIPs.

The Chief Executive proposed that the options available needed to be discussed; taking everything into account and looking at what further actions could be taken. He stressed that the board had been very clear that the priority was safety over financial delivery.

Gary Norgate referred to the significant number of extra sessions every month and the work undertaken by KPMG on gains that could be made in theatre efficiency. He asked for an analysis of what it was expected to see happen to extra sessions and RTT in relation to theatre efficiency and impact this would have on finance. Helen Beck explained that there was now a model that enabled the impact of reduction and increases in levels of activity to be understood, which meant that the RTT element could be looked at.

C Black / H Beck

18/010 RTT REPORT

Helen Beck confirmed that there would be a written update at the next meeting. She explained that even though the inpatient elective programme had been cancelled the Trust continued to maximise day case activity. The weekly RTT position fluctuated; on 24 November it was at 89.5% and she had been optimistic that it would be at 90% by the end of December. However, with the cancellation of elective activity performance had reduced.

Performance was now back at 89.5% and the new model showed a reduction of 400 patients on the waiting list. The wait for treatment in ENT had reduced by a further week to 27 weeks (originally 40 weeks), mainly due to additional sessions. Dermatology, which was very reliant on expensive locums, had reduced by a further two weeks and was now at 24 weeks to treatment for routine patients.

However, the overall impact of cancellations had had on waiting times across the Trust was an increase of one week and the profile of the waiting list had changed, which was the same as had been experienced by Ipswich hospital. The model had prolonged the trajectory to get back on track by two months, as a result of cancellations, but that could change if the Trust started to deliver elective activity again.

One of the areas of main concern was trauma and orthopaedics, where the overall wait was now 24 weeks. This had been badly affected by the cancellation programme and staffing issues. The other area of concern was urology which was now at 25 weeks due to significant consultant manpower issues and the recent loss of another locum.

The 52 weeks position had only got slightly worse as a result of the cancellation programme. The number of operations over 45 weeks had reduced during December and there were no patients on the waiting list over 45 weeks who did not have a plan for definitive treatment. There were 15 patients at 52 weeks in December, eight projected for January and three for February.

The Chief Executive asked if patients were being added to the 52 week waiting list. Helen Beck confirmed that this was not the case and that the new access policy would manage this.

Steve Turpie asked what happened to patients who continually elected to delay their treatment and if they were referred back to their GP to start the process again. Helen Beck explained that there was not a clear policy, but the Trust tried to be reasonable and ensure that there was no risk of harm if patients were referred back to their GP.

Angus Eaton said that this was a great example of using data to report this. He asked whether the actions had been permeated throughout the system to enable this improvement to be maintained. Helen Beck explained that the culture in all the operational teams meant that this had permeated all the way through and the CQC had picked up on this. However, she was concerned that people, particularly clinicians and nursing staff, in areas such as theatres and day surgery who had worked very hard to clear the backlog would have to continue to work above and beyond to maintain this. She said that the Trust needed to start thinking about delivering an elective programme over eleven months and not plan to do any in December, apart from day cases.

The Chair agreed and said that one of the key challenges was to plan ahead. She asked if it was possible to do what Gary Norgate had requested with the new model and data that was now available. Helen Beck confirmed that this was possible but the caveat was that it was locally developed and new, but it appeared to be working well over the last three months.

18/011 TRANSFORMATION REPORT

Helen Beck explained that this was the first time this report provided more information about the transformation work in elective and this was an area that was now starting to be focussed on. She highlighted the risk around appointments to the Project Management Office (PMO), but this was progressing.

Rowan Procter referred to section 6, next steps, and explained that WSFT was working with the discharge planning team and CCG on the trusted assessor model.

Steve Turpie referred to category towers procurement and asked where the Board had visibility of this. Gary Norgate explained that this went to the Scrutiny Committee but proposed that it should also be included in the transformation report. Helen Beck explained that this was a quarterly report, which meant that it would not be reported on monthly. Steve Turpie confirmed that he was happy with this proposal. **H Beck / R Jones**

Craig Black reported that interviews for a chief executive for category towers would be taking place in the next couple of weeks.

Alan Rose asked about GP/primary care streaming which showed that 20 patients per day were being managed through this initiative, and if Nick Jenkins was happy that there was a good relationship with the A&E team. Nick Jenkins explained that there was not meant to be a relationship with A&E as they were not meant to be part of A&E. He felt that 20 patients per day was an acceptable number but the way they referred patients to the emergency department needed to be improved and this was being worked on. The Chair asked if this would be reviewed from a value for money point of view. The Chief Executive confirmed that this would be reviewed in the system. He considered that this was helping more than might have been anticipated.

Jan Bloomfield reported that the Trust continued to work on achieving the target for the number of staff having a flu jab. The number had increased to 69.03% but this still needed to improve and she was confident that 70% would be achieved by the end of February.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

18/012 NURSE STAFFING REPORT

Rowan Procter explained that compared to the national average, sickness levels were still low. The senior nursing team reviewed safe staffing across the whole organisation four times a day, seven days a week. Although vacancies were high, 30 out of 74 of these were pregnant nurses, which was particularly high.

From April the nurses from the Philippines would start to arrive and the same team would be going out again in June to recruit more nurses.

The dashboard showed that when an area was short staffed the number of incident increased, ie F7.

Richard Davies asked if it was considered that the 55 nurses who had been recruited from the Philippines would actually join the Trust, eg due to visa issues etc. Jan Bloomfield explained that the English language test would be the biggest issue. She would be pleased if 40 of these nurses actually joined WSFT. Rowan Procter confirmed that these nurses would need to be registered before they arrived, otherwise they would have to go through clinical placement.

Gary Norgate noted that the alarming number of medication errors and that pressure ulcers performance had also deteriorated. He asked if any of the medication errors had resulted in harm. Rowan Procter confirmed that there had been no harm. She considered that it to be positive that reporting was still taking place, even though staff were very busy.

Steve Turpie referred to the number of vacancies in the emergency department, considering the pressure that the organisation was under. Rowan Procter explained that as a result of Nick Jenkins' work with Lakenheath, members of their staff had come to WSFT and worked in different areas. The Chief Executive agreed that this had been a great help and highlighted the benefit of working with partners, particularly when the Trust was under pressure. Nick Jenkins agreed and said that it had benefited both organisations as it assisted Lakenheath in enabling their staff to continue to work, whilst at the same time helping WSFT. Rowan Procter reported that Lakenheath staff were also going to work in paediatrics to help give them experience in this area.

Catherine Waller referred to the overtime figures and asked if this would continue. Rowan Procter said that she hoped this was not the case but this was required during the busy period; it would be reviewed at the end of this month. She confirmed that the Trust continued to keep an eye on staff being over worked or stressed.

18/013 PATHOLOGY SERVICES REPORT

Nick Jenkins explained that this was the same report that went to the Scrutiny Committee and in future there would be monthly report. Colchester would produce an updated report at the end of every month and he proposed taking this to the Scrutiny Committee so that it could be monitored nearer the time it was produced.. Gary Norgate said that this provided greater visibility and more assurance.

Nick Jenkins reported that the Medicines & Healthcare products Regulatory Agency (MHRA) had visited WSFT to inspect blood transfusion services again. This was the first opportunity to test if what North East Essex & Suffolk Pathology Services (NEESPS) was borne out by MHRA, and the inspector had agreed with what they had been saying.

There were still two major concerns which were already known about. One was the validation of laboratory information management system and there was a process in place to get this validated by June. The other issue was staffing and NHSI had now appointed someone to focus on pathology and this person would provide regulator input from a specialist point of view.

MHRA wanted to know what was being done about staffing and the plan was to try to recruit to band 7 rather than band 6.

Nick Jenkins said that overall he remained cautiously positive.

The board confirmed that they were happy with the proposal that reports would go regularly to the Scrutiny Committee where they would be thoroughly scrutinised.

18/014 HEALTH AND WELLBEING REPORT

The Chair welcomed Helena Jopling who explained that it was important to look after the ageing workforce.

Richard Davies asked if this was available to community staff and if there were fully engaged with this. Helena Jopling confirmed that this was the case but the she still needed to ensure that it was made equally available to community staff working in different formats and areas. The Chair said that as well as ensuring that this was available across the system, it also needed to be available to Wedgewood staff. Helen Jopling confirmed that this was the case and they were now working together to provide support to all staff.

Alan Rose referred to the statement of the Chief Executive from the CQC, one of which was to highlight the role of Helen Jopling within the Trust as being different and innovative. The Chair agreed and said that this was a visible demonstration of caring for staff.

Angus Eaton said he was very pleased to see this work and asked how the board would remain engaged in this. Jan Bloomfield agreed that this was important and said that it would be helpful to have a NED's overview of this activity. The Chair confirmed that she would follow this up. **S Childerhouse**

The Chief Executive agreed that this was a priority and that happy staff equalled happy patients. He particularly liked the forward plan and working with other organisations including West Suffolk College and Abbeygate. The appendix to this report showed the tracking that was being done which was very important and he agreed that there should be NED engagement in this.

18/015 MANDATORY TRAINING REPORT

Jan Bloomfield assured the board that this continued to be monitored on a monthly basis and line managers received information on levels of training for individual staff. There was a slight glitch at the moment with IT, which they were trying to resolve, and also the operational demands that were currently being experienced. Overall she was very pleased that this was improving.

Richard Davies asked who decided what was and what was not mandatory, eg dementia training for various groups of staff. Jan Bloomfield explained that some mandatory training was set by commissioners. The Trust had a mandatory training steering group and the matrix of training requirements was signed off by Nick Jenkins and Rowan Procter.

There were also national requirements for training is some areas, eg conflict resolution.

Rowan Procter referred to appendix E and explained that facilities referred to porters.

Gary Norgate noted that safeguarding was still a concern and asked failure to complete this affected individual's fitness to practise. Jan Bloomfield explained that managers of these individuals were asked to carry out a risk assessment and if they considered that there was an issue with fitness to practise they would not be allowed to practise until they had completed their mandatory training. She explained that to date this had not occurred and that this often related to refresher training, rather than initial training.

Angus Eaton asked how failure to complete safeguarding training could affect the Trust's reputation; he queried whether this approach was robust enough, or if there should be more of a top down approach. Rowan Procter explained that when an individual joined the Trust they had three months to complete their mandatory training. Therefore the percentage achieved figures could relate to staff who were within the first three months of joining WSFT. The named nurse for safeguarding would escalate any risks or concerns direct to Rowan Procter and this would be followed up. This was the same process for doctors.

The Chief Executive proposed that the next report should include an exception report which highlighted actions put in place as part of the escalation policy if a specific risk was identified. Catherine Waller considered that this would be very helpful from a scrutiny perspective. **J Bloomfield**

The Chair noted that the community mental capacity figures were also low and could be a litigation issue.

Jan Bloomfield explained that dementia training was far more important that conflict resolution training.

The Chief Executive proposed that there should be a deep dive for key areas where progress was not being made in order to provide additional understanding of the issues. **J Bloomfield**

18/016 SAFE STAFFING GUARDIAN REPORT

Nick Jenkins explained that Sarah Gull who was currently the guardian of safe working hours would be retiring, and the Trust was in the process of recruiting a replacement. She would provide a further report to the board in person before she retired.

The board noted the content of this report.

18/017 PUTTING YOU FIRST AWARD

Jan Bloomfield explained that the Putting You First award was becoming very popular and a number of nominations had been received, therefore the first of these referred back to last August.

Maria Pinhal, a nursing assistant on ward G8 stroke unit was nominated by her ward manager. she thought that the patients on G8 would benefit from having some form of social activity at a weekend as there is little to entertain them. Therefore she organised a garden party which took place in August. There was no charge to attend but there were collection buckets for donations and £270 was raised which had gone towards improving patient experience on G8. More importantly, patients and visitors thoroughly enjoyed themselves and it was a very successful event.

Pedro Lopas, ward G3, was nominated by the niece of a patient for going '"above and beyond the call of duty". He showed outstanding compassion to both the patient and his family, particularly his commitment to providing the best possible care on the night the patient died. She said that, "It was a difficult time for my family but they all agreed that it was made so much more bearable because of Pedro's innate empathy, care and treatment of my uncle."

The board congratulated both the above and said that they were great examples of staff at WSFT.

BUILD A JOINED UP FUTURE

18/018 e-CARE REPORT

Craig Black explained that this had been discussed at the e-Care programme board yesterday.

Helena Jopling was leading on the population health development. She was also working on health information exchange and ensuring that information was visible to secondary and primary care.

Gary Norgate said that he was very impressed with the patient portal work that was being undertaken. This would be a real step forward that the community would benefit from and would give people more control and access to information. Assurance was provided that this was taking into account all of the population.

Craig Black explained that a report from the patient portal pilot would be brought back to the board in a few months' time. This would enable a lot to be learned about how to share information and what information should be shared. **C Black**

Steve Turpie considered it to be very good that WSFT was helping Milton Keynes. Craig Black explained that a key part of the GDE programme was to work with a 'fast follower'.

18/019 ALLIANCE AND COMMUNITY SERVICES UPDATE

It was confirmed that 5.3 referred to the secondment of the Chief Operating Officer from the CCG to the Strategic Transformation Partnership (STP).

Steve Turpie asked about the performance and quality report for the community and if there were any concerns that the board should be aware of. Rowan Procter reported that there had been an increase in community acquired pressure ulcers. Nick Jenkins said that there were other issues in the community that he would like the board to know about, ie excellent turnover through community beds.

It was confirmed that Dawn Godbold was working to improve the detail in this report. The Chair requested that development of this report should be accelerated so that the board was aware of and able to understand both the good and bad issues. Steve Turpie agreed and said that he was uncomfortable that the board was not receiving this information. Craig Black confirmed that this would be looked at with the new head of performance.

GOVERNANCE

18/020 TRUST EXECUTIVE GROUP REPORT

The board received and noted the content of this report.

18/021 REMUNERATION COMMITTEE REPORT

The board received and noted the content of this report.

18/022 CHARITABLE FUNDS COMMITTEE REPORT

The board received and noted the content of this report.

It was noted that the accounts had been approved at a meeting earlier this morning.

18/023 COUNCIL OF GOVERNORS REPORT

The board received and noted the content of this report.

The Chair thanked the governors for inviting her to attend the first part of their informal meeting last week.

18/024 REGISTER OF INTERESTS

The board received and noted the content of this report.

18/025 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were approved. It was requested that there should be more focus on community reporting on the agenda.

Angus Eaton requested information around workforce. It was confirmed that this would come back as a report for the next meeting as part of action point 1493.

ITEMS FOR INFORMATION

18/026 ANY OTHER BUSINESS

There was no further business.

18/027 DATE OF NEXT MEETING

The next meeting would take place on Friday 2 March 2018 at 9.15am in the Northgate Room.

RESOLUTION TO MOVE TO CLOSED SESSION

18/028 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 – 2 March 2018

Agenda item:	Item 6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 February 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
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 rescheduled for Scrutiny Committee (14/3).**	HB	29/3/18 (revised)	Amber
1512	Open	1/12/17	Item 8	Develop the IQPR to include community data	Reviewing with Joanna Rayner, new Head of Performance. **Requested 26/1/18 that a definitive timescale is set to include community within the IQPR - the IQPR received by the Board on 29/3 will**	CB	02/03/2018	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
					include community information and this will be subject to development in subsequent months. In the interim the community report is appended to the current IQPR.			
1513	Open	1/12/17	Item 8	Provide separate RTT report to next Board setting out revised recovery trajectory. Also detail specific number for 52 week breaches by specialty/patient choice.	Covered to some extend in the IQPR. A update will be provided at the meeting regarding the RTT position and progress with re-establishing elective surgical capacity. This will remain a main agenda item for the meeting on 26/3/18.	HB	2/3/18 (revised)	Green
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.	The communications team has linked in with the e-Care project team to develop a narrative around the ambitions of WSFT becoming a GDE. The following are in consideration for development:- 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 communications to articulate our GDE progress. At meeting on 26/1 asked that communications articulate the functionality being implemented and describe how this will impact patients in terms of experience, efficiency and service/quality improvement. Agree to bring this back via the e-Care programme board relating to functionality implemented to date, scheduled for 2018-19 and planned for the future. The focus for impact should be on the health system, not just the hospital. UPDATEContent and narrative now in	JB/HB	29/03/2018	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
					development about our journey (what we've achieved already, what we're working on now, and what we hope for the future); we're looking to produce a page on our website, an e-leaflet/brochure that we can update as we go, and potentially an animation video. It's likely to take a few months to deliver.			
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	RJ	29/03/2018 (revised)	Green
1529	Open	26/1/18	Item 7	2018-19 winter planning update to be received by the Board in April	Being developed as part of system based learning exercise	HB	27/04/2018	Green
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.	CB / HB	26/3/18 (revised)	Amber
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)	SC / RJ	29/03/2018	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

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		CB	29/03/2018	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1466	Open	29/9/17	Item 6	Provide clarity on future provision of stroke service as part of STP service model	Updates will be provided in the quarterly Transformation Report to the Board (included in the planned care programme section of report to January Board)	NJ	02/03/2018	Complete
1493	Open	3/11/17	Item 13	Bring back a medium term assessment of the forecast staffing position and plans to recruit/mitigate nursing gaps	The Trust is in the progress of pulling together a workforce and capacity plan which will drive the longer term nursing recruitment plan this will be presented to the Board in February. In the meantime that Trust has had a successful recruitment trip to Philippines and made 55 appointments – it is now about taking them through the rigorous migration process. The HR department has restructured in order to appoint a Nursing Workforce Lead whose main focus will be recruitment and retention of nurses. A Nursing apprenticeship plan is being pulled together with the intention of presenting this to the Board in February. In the short term the Trust has introduced a bonus scheme to encourage more substantive and bank staff to work more shifts until the end of March (20 Bank staff are signed up with another 10 in the	JB	02/03/2018	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
					pipeline). In addition we are introducing where possible more flexible working in order to retain and attract nurses back to the Trust **AGENDA ITEM**			
1528	Open	26/1/18	Item 1	Write to Roger Quince on behalf of the Board thanking him for his contribution to the Trust and the CQC findings	Letter of thanks sent.	SC (RJ)	02/03/2018	Complete
1530	Open	26/1/18	Item 8	Review RAG rating for number of deliveries in IQPR	See IQPR – the rating has been reviewed with the team and is based on a green rating for the optimum number of births, with amber/red if the number of births is above or below this level.	RP	02/03/2018	Complete
1531	Open	26/1/18	Item 8	Improve the narrative to describe the action being taken to improve performance for indicators triggering exception reports	See updated IQPR	RP/NJ/ HB	02/03/2018	Complete
1532	Open	26/1/18	Item 8	Improve compliance with RCA action completion	See updated IQPR	RP	02/03/2018	Complete
1534	Open	26/1/18	Item 11	Include Category Towers in future quarterly transformation reports	Highlighted to transformation team and included in Board reporting schedule. Also included in procurement hub report to Scrutiny Committee.	RJ	02/03/2018	Complete

Board of Directors – 2 March 2018

Agenda item:	Item 7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	26 February 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

I felt immensely proud for all our staff when we received the highest rating**, 'outstanding', from the Care Quality Commission (CQC)** – one of just seven general hospitals in England, and the only one in the Midlands and East region, to hold the accolade.

Inspectors said WSFT staff 'truly respected and valued patients and individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional and distinctive service.' They also said: 'On all the wards we visited, staff displayed a culture of compassion and positivity, and had a genuine desire to want to provide the best possible care to patients'. The Care Quality Commission visited the Trust in November last year, inspecting its end-of-life and outpatient services and reviewing how well-led the organisation was. The Trust was rated outstanding for being caring, effective and well-led, and good for being safe and responsive. This is a testament to everyone's hard work and unwavering commitment. I am privileged to see the incredible care our staff provide 24/7, 365 days a year, and I'm delighted that their efforts have been recognised by the CQC. I am particularly proud that our end-of-life service has moved from having one requires improvement rating in our last inspection, to outstanding. Good end of life care is tailored to the person who needs it, and this report shows that our staff go above and beyond to ensure comfort, dignity and kindness is at the heart of what they do.

We have continued to see sustained **winter pressure** during January and February, with high numbers of attendances and admissions of very sick patients. As a result of this pressure in addition to our planned escalation beds, the significantly higher than expected numbers of admissions, have meant we have had to continue to use surge beds during February. This was required to ensure that we had capacity to appropriately care for patients. We have struggled to get additional temporary staff to nurse these additional beds despite increasing pay to substantive, bank and agency nurses. We have had to mitigate this risk across the organisation which has resulted in many areas working with staffing levels which are below our core numbers. Our staffing plans have been reviewed at regular intervals each day by a senior matron, including weekends. Appropriate mitigations are put in place to maintain safety.

Staff have continued to go above and beyond what is normally expected and I have to say that times are tough, with the pressure feeling at times relentless; but I see our hospital and community staff pull together time and time again, and I thank them all for their professionalism and commitment. The sustained pressure and decisions we have had to take have impacted on performance in a number of areas but the priority as always was patient safety. Some of the difficult decisions taken include. During February we have had to continue:

- Cancelling routine elective activity – we have continued to provide urgent elective surgery, including cancer treatment
- Opening our ultraclean elective F4 ward to selected emergency surgical patients. The emergency patients admitted to F4 have been carefully chosen to reduce the impact and allow the ward to be returned to its intended purpose as soon as possible. After deep cleaning over the weekend of 24 and 25 February ward F4 is now once again available for elective operations.

It is hugely disappointing that since the New Year we have had to cancel more than 200 patient admissions for planned operations – the team have worked incredible hard and all of these patients have now been offered new operation dates. We recognise the impact this has on patients and their families but also our staff. Staff have worked incredibly hard to improve the Trust's referral to treatment (RTT) time and we have seen improved performance against the RTT target and fewer 52 week wait breaches. These measures will deteriorate while we respond to the current levels of demand.

As a consequence of the cancellations, trauma and orthopaedics is now the most challenged specialty in term of waiting times for operations. While major joint surgery is not life-saving it is life changing and it is testimony to our staff that the orthopaedic team has put in place plans to double the number of joint replacements they are able to perform in the next few months.

I am very proud to have added to our clinical accolades, with the National Hip Fracture Database (NHFD) rating us as the **top hospital in England in meeting best practice criteria for patients treated for a hip fracture**. The criteria assesses against things like the time for someone to have surgery; bone protection medication; having specialist falls and nutrition assessments; and being seen by a physiotherapist in the days after surgery, amongst others. We achieved an amazing 94.3% against the best practice criteria in 2017, against a national average of 62.2%. With one of the oldest populations in the country, this is particularly pleasing; hip fractures are cracks or breaks in the top of the thigh bone (femur) close to the hip joint, and are one of the most common serious injuries for older people. We understandably see a lot of hip fracture injuries, so it's fantastic to see that we're really delivering positive patient outcomes. We have also seen quality improvement in a glaucoma and diabetes which are described in more detail later in my report.

I am delighted to say that last Friday (16 February) we had our 1,000th patient through the **discharge waiting area**. Using the discharge waiting area (DWA) has made a huge difference to our early discharge times, opening up ward space and enabling positive patient flow across the Trust. This means less pressure for staff and most importantly it is making a real difference to patient experience. We will continue to respond to the high levels of demand and working with colleagues across the health and care system we are making decisions to ensure patient safety is our first priority.

January's performance shows we reported no C. difficile cases in the month. We continue to focus on reducing patient falls and pressure ulcers, with 76 falls and 35 pressure ulcers reported. Referral to treatment (RTT) performance for patients on an incomplete pathway was above 90% against the target of 92%. Unfortunately we have reported 14 patients breaching 52 weeks. RTT remains the most significant performance challenge facing the Trust. Cancer performance improved in January, with all targets being achieved. ED 4 hour wait performance was 84% for January, with some exceptionally challenging days. We experience a 12.7% increase in attendances (680 patients) at ED in January 2018 compared to January 2017 and a 5% increase in ambulance attendances for the same period.

The **month 10 financial position** reports a deficit of £1,058k for January which is worse than plan by £319k.The reported cumulative position is therefore £1,398k worse than plan. There has been an increase in our costs relating to escalation capacity during December and January and this expenditure is continuing but without any further funding. STF is dependent upon achieving financial and performance targets and our Q4 plan is reliant on achieving £1.8m STF income. The 2017-18 budgets include a cost improvement plan (CIP) of £14.4m of which £10.9m has been achieved by the end of January (75.5%).

We continue to work with **North East Essex and Suffolk Pathology Services (NEESPS)** to address regulatory and accreditation concerns. The MHRA undertook a wide ranging inspection of the blood transfusion service on 18 and 19 January 2018. While improvements were identified by the inspector two areas of 'major concern' were identified relating to staffing and validation of systems/equipment. Plans to address these concerns are in place and have been submitted to the MHRA. Progress with this work is managed by NEESPS and progress monitored through monthly reviews with the management team.

The business case for the **main entrance refurbishment** is under review as part of a reprioritisation of the capital programme. This is in recognition of the need to ensure adequate clinical capacity is available for winter 2018-19. This will be considered further by the Board as part of the updated capital programme at the end of March.

Chief Executive blog
http://www.wsh.nhs.uk/News-room/news-posts/To-2017-and-beyond.aspx

Deliver for today

Wards improve 'family carer friendly' rating

Ward G4, our frail elderly ward, and G8, our stroke ward, have received a silver recognition award from local charity Suffolk Family Carers for staff commitment to supporting patient carers in hospital. In September we were recognised as a whole with a Family Carer Friendly Hospital Award, with eight wards and the outpatient department also receiving special recognition for the care and commitment provided. Now ward G4 and G8 have been upgraded from a bronze to silver Suffolk Family Carers Award, to recognise best practice such as staff's good engagement and communication, the use of proactive and trained carer champions, and very flexible visiting times for family carers. We are really proud to show our continued commitment to family carers and our staff's efforts to make their stay as easy as possible whilst they attend to the needs of their loved one. We know it is crucial for our patients' health and wellbeing that they stay connected to those closest with them while they are in hospital, which is why family carers play a vital role in a patient's recovery. It can be a stressful time and ensuring we help carers cope is just as important as the care we provide our patients.

Glaucoma service saves patient and NHS time

We've had some fantastic patient feedback scores for our glaucoma service, which is provided jointly with West Suffolk Clinical Commissioning Group, and sees more people being treated closer to home. A staggering 97% of patients seen in December said they'd recommend the service to their friends and family. Patients have a simple puff test to see if they're at risk of developing glaucoma when they visit the opticians, and are then referred to the community glaucoma service for additional tests. The test team works closely with hospital consultants to review around 100 to 120 patient test results every week in a 'virtual glaucoma clinic' allowing for faster diagnosis and treatment. Previously patients would have been offered an appointment with a hospital consultant for both a follow-up test and a review, which took around double the time. This means consultants are now free to spend more time with patients who require a face-to-face review. Initiatives like these are fantastic not only for our patients, as it saves them time, but for the NHS. It saves valuable NHS resources, and means consultants can spend more time caring for the people that need them most. Now, only around 20% of these new patients need to meet a consultant in hospital. This really does show that collaboration works.

Invest in quality, staff and clinical leadership

More patients getting 'oustanding' support to control diabetes

We were delighted to receive results from an independent review into diabetes care, which showed that more patients across Suffolk than ever before are getting the support they need to control their diabetes. The NHS Ipswich and East Suffolk and NHS West Suffolk clinical commissioning groups (CCGs) have both received the top rating of providing 'outstanding' care for 2016/17. We're very proud of our role in this, particularly of the joint working between our hospital diabetes service and GPs to improve care for people with this condition. Specialist diabetes nurses from West Suffolk Hospital now attend GP surgeries and see local patients with their practice nurse, helping the GP team improve the management of their patients' diabetes. Our hospital nurses also run education courses for all people with newly diagnosed type 2 diabetes, and specialist training courses for type 1 diabetes. We've had very impressive feedback from patients and GP teams about the positive impact their advice and guidance has had on helping people manage the condition.

Build a joined-up future

New volunteering roles on the cards

We've taken further steps in our volunteering journey this month with a fantastic HelpForce summit last week; lots of local organisations came together at the event to start exploring an integrated volunteering process, and there was some valuable and exciting discussion. We are one of just 12

acute NHS hospital trusts working with HelpForce, an organisation set up to accelerate improvements in the involvement of volunteers in the NHS, to develop new volunteer roles and create a best practice model for volunteering. A new discharge volunteer, who can accompany a patient whilst they're waiting for transport, is launching soon. We're also exploring the potential for a volunteering role that would support patients in their own home; helping them to initially resettle at home after they've left hospital if they don't have family or friends there to support them.
Our volunteers do an incredible job and have a very genuine impact on patient experience; I'm looking forward to seeing what these collaborations will bring.

Pre-referral 'advice and guidance' services to GPs via eRS
We are now operating excellent pre-referral advice and guidance services to GPs via the national Electronic Referral System (eRS).This follows NHS England recommendations, via one of the 2017-8-9 CQUIN goals. NHS England has noted that there are case studies from around the country where advice and guidance has already begun to be implemented, and concludes that there is substantial opportunity to reduce the number of patients who are seen in outpatient clinics. The advice and guidance is structured, non-urgent advice and guidance provision, to for example provide a suggested treatment or management plan to a GP (may include carrying out further investigations in primary care) or advice on the appropriate clinic referral (reducing redirected appointments).

National news

Deliver for today

New figures show larger proportion of strokes in the middle aged
Public Health England have re-launched the Act FAST stroke campaign urging the public to dial 999 if they notice even one of the signs of stroke in themselves or in others. The campaign was launched on the same day as new statistics reveal first time strokes are happening at an earlier age compared to a decade ago.

State of child health: England one year on
This report warns that the current fragmented approach to child health poses risks to the long-term health of the nation. While the report acknowledges progress in some areas, such as the digital child health strategy and the implementation of the sugar tax, it argues that there has been a lack of improvement in several fundamental areas. It highlights the public health cuts as a particular area for concern and argues that the cuts are disproportionately affecting children's services

Invest in quality, staff and clinical leadership

Building the foundations – tackling obesity through planning and development
This report produced in partnership with Public Health England looks at how planning 'healthy-weight environments' can help tackle obesity through encouraging active lifestyles and healthier eating.

Labelling the point: towards better alcohol health information
This new report from the Royal Society for Public Health highlights the contribution that could be made by better alcohol labelling- and recommends a best-practice labelling scheme that could help raise awareness and reduce harm.

The risks to care quality and staff wellbeing of an NHS system under pressure
This report, written in conjunction with The King's Fund, considers the relationships between the self-reported experiences and wellbeing of NHS staff, measures of workforce pressures in the health system, and patients' experiences of their care. It uncovers striking associations between the experiences of NHS staff and patients in hospitals and NHS trusts' reliance on agency health care workers

Build a joined-up future

In and out of hospital
This report by the Red Cross suggests introducing automatic home assessments and other simple interventions for older and vulnerable people who are often admitted to hospital to reduce avoidable hospital admissions. The report contains analysis of first-hand accounts of frontline health and care workers who argue that there are too many missed opportunities to prevent many of these avoidable admissions.

Reimagining community services: making the most of our assets
Growing financial and workforce pressures are having an impact on the ability of community service providers to meet the needs of the population and to make a reality of the vision set out in the *NHS five year forward view*. Community services are often fragmented and poorly co-ordinated, and are frequently not well integrated with other services in the community. This results in duplication as well as gaps between teams delivering care. Kings Fund Report

Rapid response: a multi-professional approach to hospital at home.
Dowell S. *British Journal of Nursing* 2018;27(1):24-30.
'Hospital at home' is not new to the 21st century but pressure from the reduction in the number of hospital beds, population growth, an ageing population and long-term conditions means such services are increasingly necessary. However, existing services do not operate 24 hours a day or provide a single multi-professional approach. Gloucestershire's rapid response (RR) service provides specialist, coordinated and comprehensive assessment and treatment 24 hours a day in the patient's home.

STPs and accountable care background briefing.
This sustainability and transformation partnerships (STPs) and accountable care briefing brings together an overview of how national policy has evolved to promote system-based collaboration, including the development of STPs, accountable care systems (ACSs) and accountable care organisations (ACOs).

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Board of Directors – February (2nd 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:	February 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 Ten: January 2018

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CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

1 EXECUTIVE SUMMARY

January 2018 was a challenging month with increased demand with a 12.7% increase in attendances (680 patients) at ED in January 2018 compared to last January 2017 and a 5% increase in ambulance attendances for the same period. The RTT position improved to 90% in January despite the challenges and cancellations from the winter pressures with some specialties reducing their waiting time. Urology and T&O have become areas of concern.

ARE WE SAFE?

HCAIs - The Trust has no MRSA cases for January 2018. There was one Clostridium difficile case for January 2018; As acknowledged on the Trust risk register, this may reflect the Global shortage of Tazocin which has required the use of antibiotics associated with a higher risk of Clostridium difficile infection.

NHS Patient Safety Alerts (PSAs) – A total of 7 PSAs have been received in 2017/8, including one in January. All the alerts have been implemented within timescale to date.

Patient Falls - 76 patient falls occurred in January, bringing the YTD total to 606; of these falls, 28(183 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 January 35 cases occurred, with YTD total of 155. *(RAP included in main report).*

ARE WE EFFECTIVE?

Mortality Indicators – A new mortality dashboard has been developed which includes learning from deaths and will be presented as a separate agenda item to the Board, second month of every quarter. This will not be included in the IQPR anymore.

Cancelled Operations for non-clinical reasons - The rate of cancelled operations for non-clinical reasons has come down to 0.75% in January. The YTD performance to January 2018 is above target at 1.08%.

Discharge Summaries- Performance to date is below the 95% target to issue discharge summaries within 48 hours. A&E has achieved a rate of 84% in January whereas Inpatient services have achieved a rate of 71%. *(RAP included in the main report).*

ARE WE CARING?

Complaints - The number of complaints has fallen compared to last year, with a total of 118 for the YTD to January. The Trust is in the best 10% of acute trusts for the written complaints rate and has approximately 50% less complaints than its peer group of small acute Trusts.

Mixed Sex Accommodation breaches (MSA) – No MSA breach occurred in January, 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. The January performance has fallen to 84% with some exceptionally challenging days. *(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) improved during January, with achieving all the targets. The Trust achieved the 62-day wait for first treatment from NHS Cancer Screening Service referral target in January with performance of 93% against a target of 90%. The YTD performance for all cancer targets is ahead of the national threshold.

Referral to Treatment (RTT) - The percentage of patients on an incomplete pathway within 18 weeks is below the national target of 92%, however performance continues to improve with performance in January of 90%. Data quality issues and validation of the list continue. The total waiting list has reduced to 15,363 in January. In January, 14 patients breached the 52-week standard, with YTD total of 210. RTT remains the most significant performance challenge facing the trust and KPMG and the Intensive Support Team are working with the Trust support performance improvement. *(RAP included in the main report).*

ARE WE WELL LED?

Staff FFT – The survey for the period to January 2017 was positive with 75% of staff recommending the Trust as a place to work and 86% of staff recommending the Trust for a place to receive treatment or care. This compared with the national averages of 64% and 81% respectively.

Staff Turnover – Turnover rates continue to improve with a rate of 9% for January, below the Trusts aim to maintain turnover rates below 10%.

Sickness Absence – Sickness absence rates are equivalent to the local 3.5% ceiling at 3.57% for January. 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 reported I&E for January 2018 YTD is a deficit of £5,907k, against a planned deficit of £4,509k. This results in an adverse variance of £1,398k YTD. The monthly adverse variance is £319k which relates to the unfunded costs of winter escalation capacity.

Cost Improvement Programme (CIP) - The January position includes a target of £10,860k YTD which represents 79% of the 2017-18 plan. There is currently a shortfall of £418k YTD against this plan. In order to deliver the Trusts pre-STF control total of £7.7m deficit in 2018-19 we need to deliver a CIP of £18.3m (8%). To date we have identified £5.1m of risk adjusted CIP schemes, (£9.4m non-risk adjusted) for 2018-19. We therefore have a gap of £8.9m against the 2018-19 target which we are discussing with NHSI.

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

2. INTEGRATED 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.

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WEST SUFFOLK HOSPITAL INTEGRATED QUALITY & PERFORMANCE REPORT								TRUST TOTAL												
Are we..	Ref.	KPI	ED	Target	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	AvYTD	WTC	Traffi	Sparkline
1. Safe	1.01	NHS E / I Improvement Patient Safety Alerts Total	RP	3	0	1	0	1	0	0	1	2	1	0	1	0	1	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%	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	10%	11%	14%	11%	6		
	1.04	All relevant inpatients undergoing VTE Risk asse	RP	95%	87%	87%	86%	87%	89%	89%	86%	90%	88%	95%	97%	95%	97%	91%	4		
	1.05	Clostridium difficile infections (CDI)	RP	16	0	0	1	3.00	0.00	0	1	0	2	6	4	0	1	17	6		
	1.06	MRSA	RP	0	0	0	0	0.00	0.00	0	0	0	2	0	0	0	0	2	6		
	1.07	Patient Safety Incidents Reported	RP	NT	460	459	463	392	508	418	506	466	467	521	592	471	617	4958			
	1.08	Never Events	NJ	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	2		
2. Ef	2.01	Overall HSMR - DFI	NJ	<90	ND	ND	ND	88%	88%	88%	88%	85%	87%	ND	ND	ND	ND	87%	6		
	2.04	Canc. Ops - Cancellations for non-clinical reason	NJ	<1%	1%	0%	1%	1%	1%	1%	1%	1%	1%	1%	2%	1%	1%	1%	4		
3. Caring	3.01	Compliments (Logged by Patient Experience)	JB		33	41	28	41	52	26	56	28	17	33	87	151	64	555			
	3.02	Complaints (Inpatient)	JB	19.50	18	12	11	10	10	10	6	16	16	17	13	8	12	118	6		
	3.03	Mixed Sex Accommodation Breaches	NR	0.00	0	2	0	0	0	0	0	0	0	0	0	1	0	1	6		
	3.04	IP - Extremely likely or Likely to recommend	FR	90%	99%	98%	99%	98%	97%	99%	98%	98%	98%	99%	96%	98%	97%	98%	6		
	3.05	OP - Extremely likely or Likely to recommend	FR	90%	97%	97%	96%	95%	96%	97%	95%	95%	96%	96%	96%	99%	95%	96%	6		
	3.06	A&E - Extremely likely or Likely to recommend	FR	90%	95%	96%	96%	97%	96%	95%	95%	95%	92%	95%	94%	94%	96%	95%	6		
	3.07	Maternity - How likely are you to recommend	FR	85%	91%	100%	100%	100%	100%	100%	100%	ND	ND	99%	100%	97%	100%	100%	6		
4. Responsive	4.01	A&E - Under 4 hr. wait	HB	95%	87%	84%	93%	95%	95%	96%	92%	90%	89%	87%	90%	83%	84%	90%	4		
	4.02	RTT: % incomplete pathways within 18 weeks	HB	92%	90%	90%	90%	82%	80%	83%	84%	86%	86%	87%	89%	89%	90%	86%	2		
	4.03	52-week waiters	HB	0%	7	7	8	15	14	15	35	26	29	26	21	15	14	210	2		
	4.04	Diagnostics within 6 weeks	HB	99%	96%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.05	Cancer: 2w wait for urgent GP Referrals	HB	93%	90%	98%	98%	94%	92%	97%	95%	96%	91%	83%	98%	97%	98%	94%	6		
	4.06	Cancer 2w wait breast	HB	93%	88%	96%	94%	94%	99%	89%	98%	100%	98%	100%	100%	99%	98%	98%	6		
	4.07	Cancer 31 d First Treatment	HB	96%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	99%	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%	85%	88%	83%	89%	83%	86%	85%	86%	87%	94%	90%	87%	86%	87%	6		
	4.11	Cancer 62 d Screening	HB	90%	100%	89%	97%	100%	100%	90%	100%	100%	91%	100%	83%	100%	93%	96%	6		
5. Well Led	5.02	Staff F&F Test % Recommended - care (Qrtly)	JB	75%	NA	NA	93%	NA	NA	95%	NA	NA	95%	NA	NA	ND	NA	95%	6		
	5.03	Staff F&F Test % Rec'mend - place to work	JB	75%	NA	NA	79%	NA	NA	83%	NA	NA	82%	NA	NA	ND	NA	83%	6		
	5.04	Turnover (Rolling 12 mths)	JB	<10%	10%	11%	10%	10%	10%	10%	10%	10%	10%	9%	9%	9%	9%	10%	6		
	5.05	Sickness Absence	JB	<3.5%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.57%	3.58%	4		
	5.06	Executive Team Turnover (Trust Management)	JB	<10%	0%	0%	0%	0%	20%	0%	0%	0%	0%	0%	0%	0%	0%	2%	6		
	5.07	Agency Spend	CB	19248	459	354	258	307	316	289	336	244	220	187	475	183	558	312	6		
	5.08	Monitor Assurance Governance Rating	JB	2	4	4	3	3	3	3	3	3	3	3	3	3	3	3			
6. Productive	6.01	I&E Margin	CB	Var	-5.13%	-5.10%	-1.50%	ND	-4.90%	-4.30%	-3.90%	0.13%	-3.04%	-2.55%	-2.47%	-2.60%	-2.34%	-2.89%			
	6.02	Distance from Financial Plan	CB	Variabl	ND	ND	ND	ND	0.00%	0.40%	0.10%	0.00%	0.00%	0.03%	0.03%	ND	ND	0.03%	6		
	6.03	Capital service capacity	CB	Var	- 6.74	- 2.81	1.41	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.01	0.00	0.00	0.01			
	6.04	Liquidity (days)	CB		-19.70	- 21.76	- 7.28	ND	- 12.15	- 15.72	- 10.94	- 11.03	- 12.70	- 15.14	- 0.10	- 0.13	- 0.11	- 0.10			
	6.05	Long-Term Borrowing	CB		33.06	36.06	44.30	44.27	45.70	45.70	45.70	45.70	47.62	47.62	56.67	58.65	64.36	56.67	6		
	6.06	Variance to CIP plan	CB		-3268	-3247	0	40	0	-40	10	0	-54	-10	-35	-129	-201	-41.9			
7.Maternity	7.01	Total number of deliveries (births)	0	210	198	197	238	215	192	213	215	233	236	205	194	180	199	2082	6		
	7.02	% of all caesarean sections	0	<22.7%	16%	13%	19%	15%	21%	16%	16%	22%	18%	17%	17%	18%	22%	18%	6		
	7.03	Midwife to birth ratio	0	1.3	1.28	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	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%	93%	87%	89%	84%	93%	84%	94%	82%	98%	98%	98%	93%	93%	92%	4		
	7.06	Maternity SIs	0	NT	0	1	1	1	0	0	0	0	1	1	0	1	2	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	74%	80%	76%	80%	81%	88%	77%	85%	79%	81%	80%	80%	82%	81%	6		

Putting you first

3. IN THIS MONTH – JANUARY 2018, MONTH 10

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	Jan-2018		To Month Year	Jan-2017

WEST SUFFOLK HOSPITAL INTEGRATED QUALITY & PERFORMANCE REPORT - Summary of New Referrals & Completed treatment

In this month.... January 2018

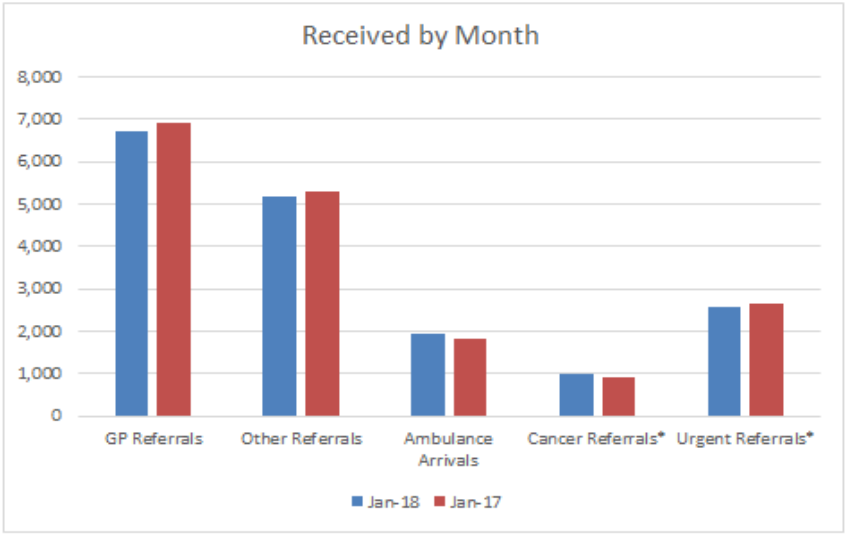
Mth We Received.....	Jan-18	Jan-17	Variance	Var. %	Traffic
GP Referrals	6,725	6,900	-175	-3%	⇩
Other Referrals	5,193	5,300	-107	-2%	⇩
Ambulance Arrivals	1,956	1,840	116	6%	⇧
Cancer Referrals*	1,009	924	85	9%	⇧
Urgent Referrals*	2,568	2,641	-73	-3%	⇩

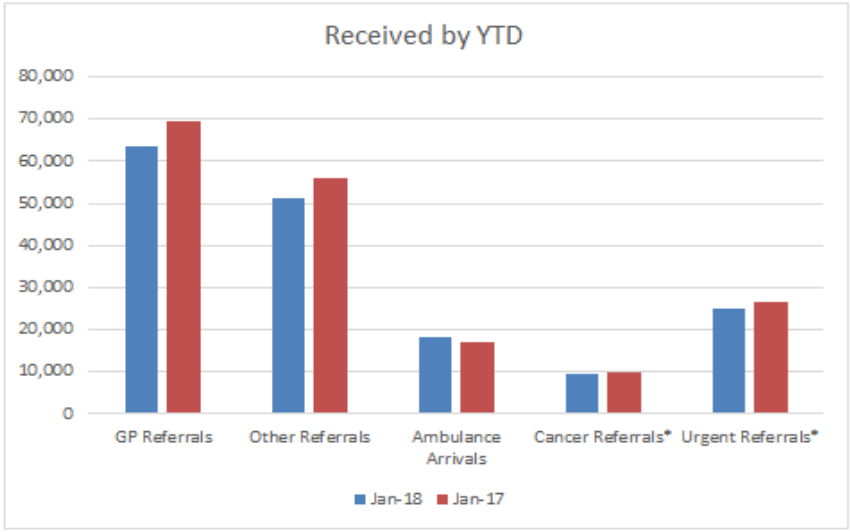
YTD We Received.....	Jan-18	Jan-17	Variance	Var. %	Traffic
GP Referrals	63,357	69,667	-6,310	-9%	⇩
Other Referrals	51,307	56,096	-4,789	-9%	⇩
Ambulance Arrivals	18,088	17,189	899	5%	⇧
Cancer Referrals*	9,386	9,813	-427	-4%	⇩
Urgent Referrals*	24,970	26,731	-1,761	-7%	⇩

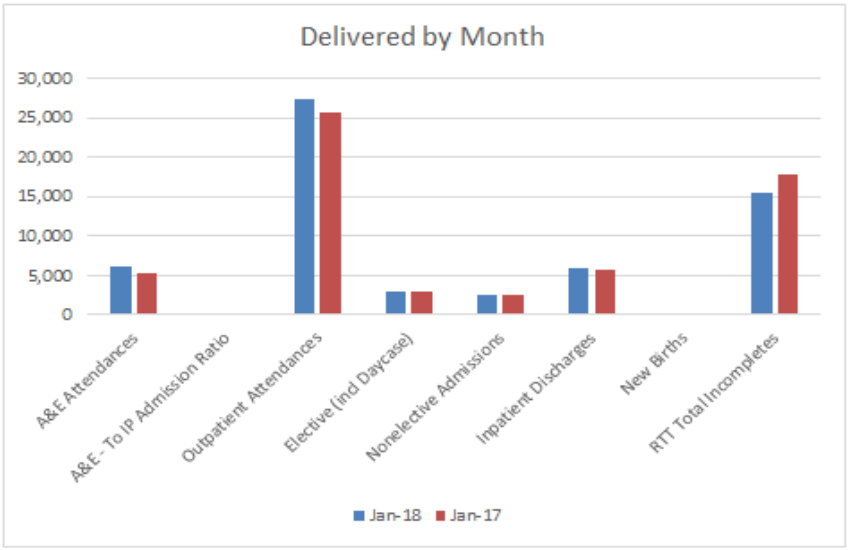
Mth We Delivered.....	Jan-18	Jan-17	Variance	Var. %	Traffic
A&E Attendances	6,033	5,353	680	13%	⇧
A&E - To IP Admission Ratio	32%	35%	-3%	-3%	⇩
Outpatient Attendances	27,360	25,724	1,636	6%	⇧
Elective (incl Daycase)	2,840	2,877	-37	-1%	⇩
Nonelective Admissions	2,547	2,480	67	3%	⇧
Inpatient Discharges	5,917	5,754	163	3%	⇧
New Births	199	198	1	1%	⇧
RTT Total Incompletes	15,363	17,816	-2,453	-14%	⇩

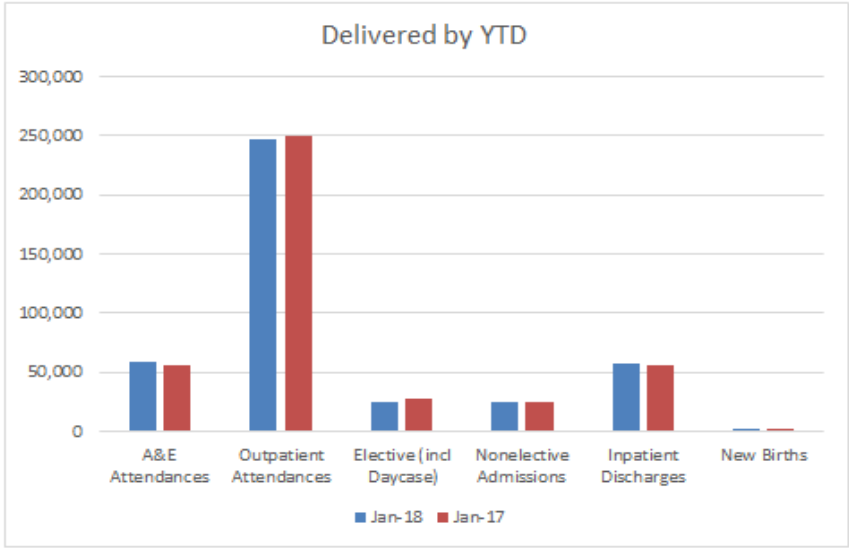
* - Included in Referrals Above

YTD We Delivered.....	Jan-18	Jan-17	Variance	Var. %	Traffic
A&E Attendances	58,441	56,244	2,197	4%	⇧
Outpatient Attendances	247,653	249,591	-1,938	-1%	⇩
Elective (incl Daycase)	24,675	27,293	-2,618	-10%	⇩
Nonelective Admissions	24,675	24,787	-112	0%	⇩
Inpatient Discharges	57,562	55,935	1,627	3%	⇧
New Births	2,082	2,144	-62	-3%	⇩


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*
Jan-18
Jan-17


Received by YTD
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*
Jan-18
Jan-17

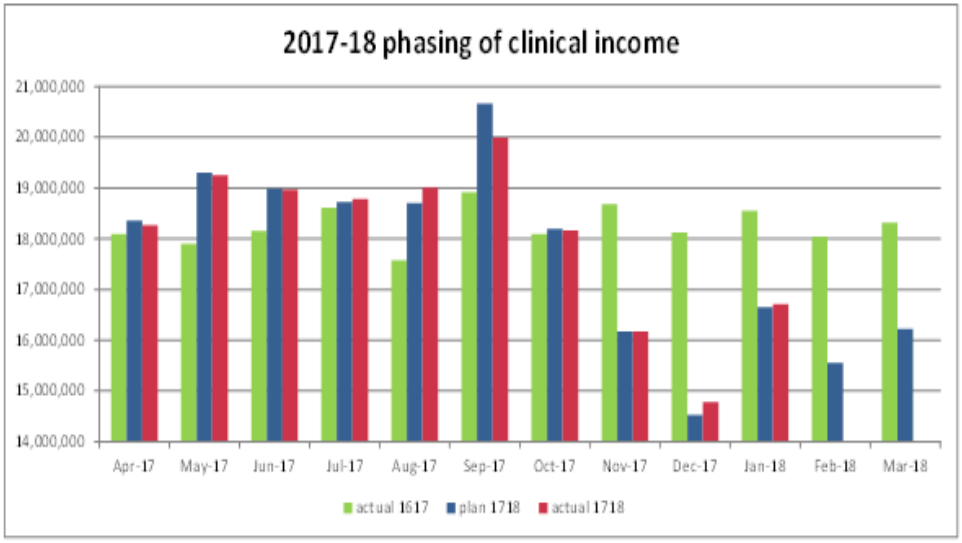

Delivered by Month
30,000
25,000
20,000
15,000
10,000
5,000
0
A&E Attendances
A&E - To IP Admission Ratio
Outpatient Attendances
Elective (ind Daycase)
Nonelective Admissions
Inpatient Discharges
New Births
RTT Total Incompletes
Jan-18
Jan-17

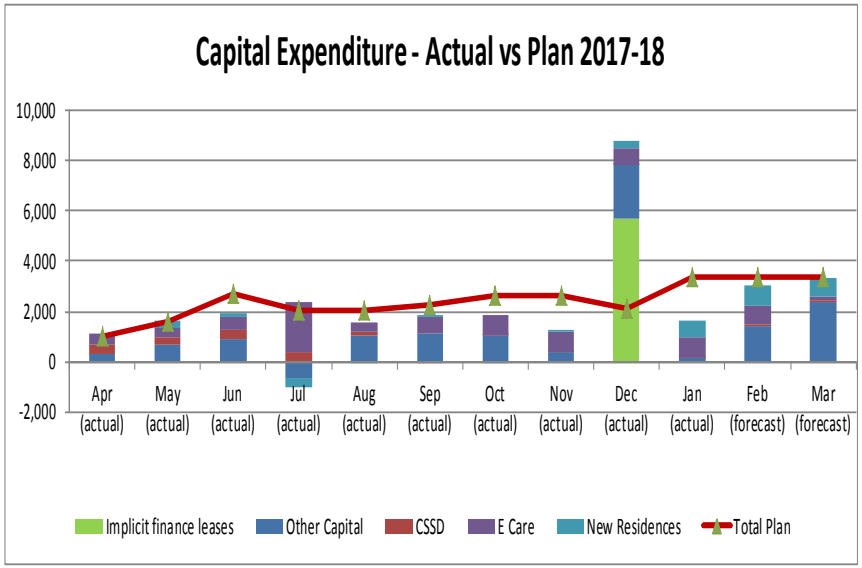

Delivered by YTD
300,000
250,000
200,000
150,000
100,000
50,000
0
A&E Attendances
Outpatient Attendances
Elective (incl Daycase)
Nonelective Admissions
Inpatient Discharges
New Births
Jan-18
Jan-17

4. FINANCE SUMMARY

The reported I&E for January 2018 YTD is a deficit of £5,907k, against a planned deficit of £4,509k. This results in an adverse variance of £1,398k YTD. The monthly adverse variance is £319k which relates to the unfunded costs of winter escalation capacity.

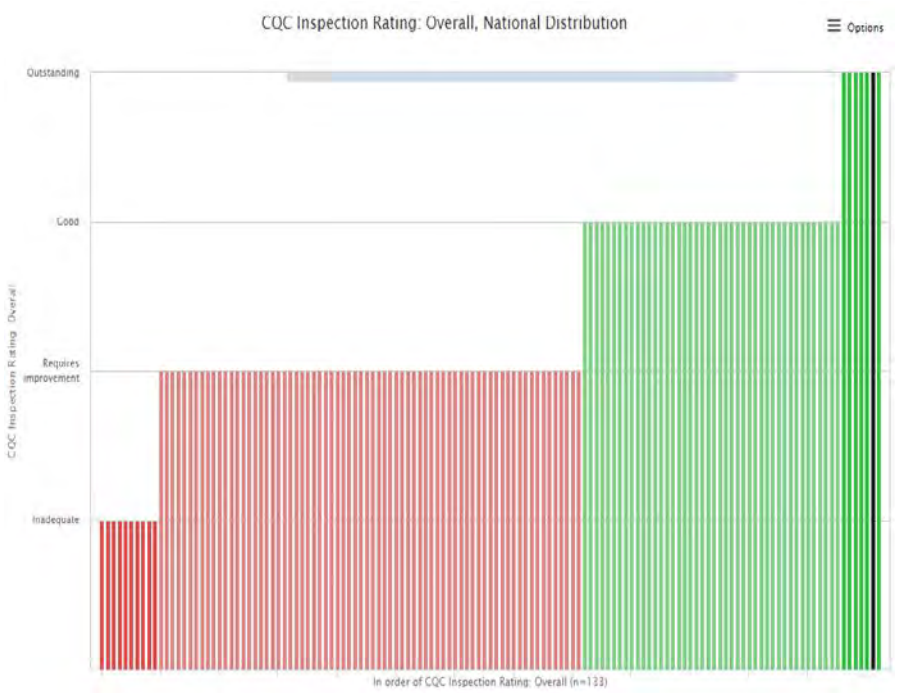
The chart below summarises the phasing of the clinical income plan for 2017-18, including Community Services. This phasing is in line with activity phasing and does not take into account the block payment. This graph includes the reduction in income relating to community services from October to March.

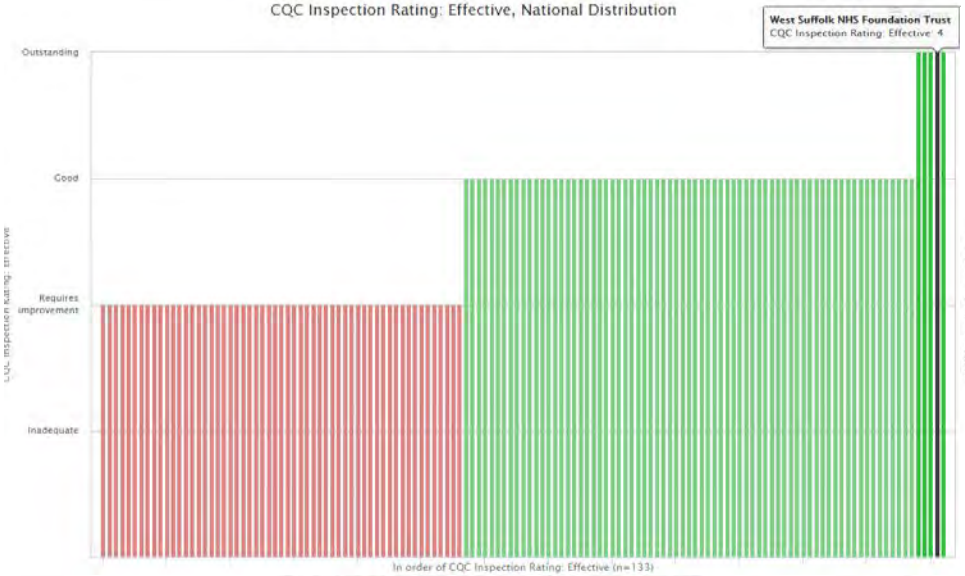




5. CQC OVERVIEW

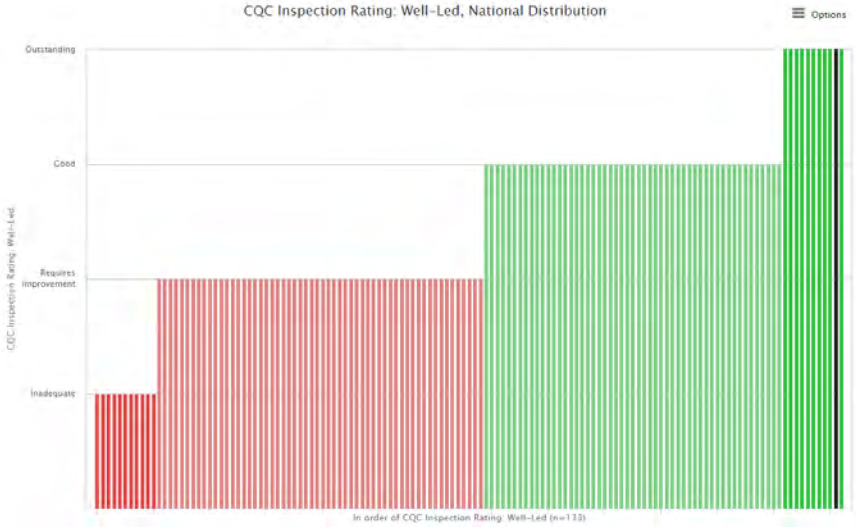
The CQC have launched the Model Hospital website in *alpha* form which highlights comparative indicators in a number of key areas. Quality of Care compartment: includes the CQC ratings as the principal assessment indicators, with additional indicators, including the Friends and Family Test, Ambulance 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
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
In order of CQC Inspection Rating: Responsive (n=133)


CQC Inspection Rating: Well-Led, National Distribution
Options
Outstanding
Good
Requires improvement
Inadequate
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%			

NHS West Suffolk NHS Foundation Trust

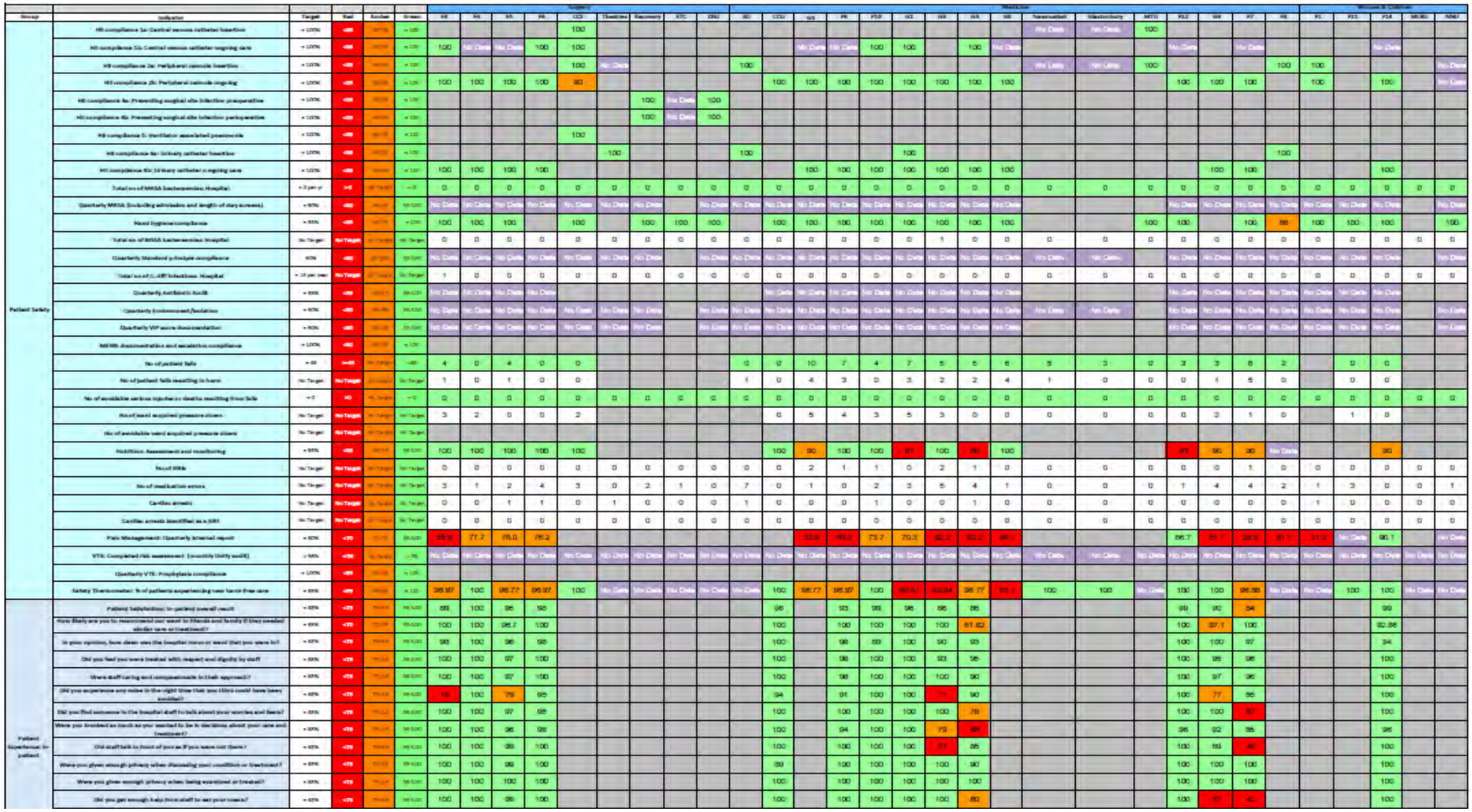
6. DETAILED SECTIONS - SAFE

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

Are we		Ref.	KPI	Target	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	YTD(Apr17-Mar18)	WTE	Traffi	Trend
Safe	Dashboard	1.01	NHS E / I Patient Safety Alerts - Total	NT	0	1	0	1	0	0	1	2	1	0	1	0	1	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	6		
		1.03	Emergency C-Section Rate	14%	8%	9%	12%	10.3%	11.6%	11.5%	8.5%	12.9%	11.9%	11.2%	9.8%	10.6%	14.1%	11%	6		
		1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	87%	87%	86%	87%	89%	89%	86%	90%	88%	94.84%	96.87%	94.69%	96.93%	91%	4		
		1.05	Clostridium difficile infections (CDI)	16	0	0	1	3	0	0	1	0	2	6	4	0	1	17	6		
		1.06	MRSA (Hospital)	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2	6		
		1.07	Patient Safety Incidents Reported	NT	460	459	463	392	508	418	506	466	467	521	592	471	617	4958			
		1.08	Never Events	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	2		
	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%	99%	2		
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	100%	95%	100%	96%	100%	100%	100%	96%	100%	100%	100%	100%	100%	99%	2		
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	98%	98%	98%	100%	100%	100%	100%	97%	100%	98%	97%	100%	100%	99%	2		
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	93%	98%	95%	100%	97%	98%	93%	97%	99%	99%	97%	96%	99%	98%	2		
		1.13	HII Compliance 4a: Preventing surgical site infection preop	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		1.14	HII Compliance 4b: Preventing surgical site infection perio	100%	100%	100%	100%	100%	85%	100%	95%	100%	100%	100%	100%	100%	100%	98%	2		
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	78%	100%	100%	98%	2		
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	78%	100%	100%	100%	98%	2		
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	95%	95%	82%	81%	92%	94%	88%	99%	97%	91%	92%	95%	100%	93%	2		
		1.18	HII Compliance 7: Clostridium Difficile - prevention of spre	100%	NA	NA	NA	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND				
	Incidents	1.19	Safety Thermometer - Harm-Free Care (New Harms)	95%	97%	98%	98%	98.5%	98.3%	98.9%	98.6%	98.2%	97.2%	97.6%	98.4%	98.5%	97.9%	98%	3		
		1.20	No of SIRIs	NT	14	6	8	9	5	7	7	6	5	11	14	10	20	94			
		1.21	RIDDOR Reportable Incidents	NT	0	0	0	0	0	1	0	1	0	2	0	3	0	7			
		1.22	Catheters and New UTIs	NT	0.25	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	19	9	9	2	0	2	2	1	2	1	2	2	2	16			
		1.25	Patient Falls	<48	61	54	71	54	52	50	69	68	39	56	73	69	76	606	1		
		1.26	Patient Falls resulting in harm	<10	11	14	16	9	17	20	17	18	10	23	18	23	28	183	1		
		1.27	Falls - Per 1000 bed days	5.60	5	5	5	5	5	ND	ND	ND	ND	ND	ND	ND	ND	10	3		
		1.28	Number of avoidable serious injuries/deaths resulting from	NT	0	0	ND	0	0	ND	ND	0	0	0	ND	0	ND	0	3		
		1.29	Number of medication errors	NT	23	18	25	64	80	69	78	70	69	70	78	63	72	713			
		1.30	Actual patient harm resulting from medication incidents	0.01	23	16	20	1	0	0	0	ND	ND	ND	ND	ND	ND	1			
		1.31	Pressure Ulcers - Inpatients	<5	22	10	4	10	9	18	9	13	14	18	17	12	35	155	1		
		1.32	Pressure Ulcers - Avoidable ward-acquired PUs	30%	ND	ND	ND	40%	37%	30%	30%	34%	33%	32%	ND	ND	ND	2	1		
	Reporting	1.33	MRSA Quarterly Std (including admission and LOS screer	90%	NA	NA	91%	NA	NA	92%	NA	NA	93%	NA	NA	90%	NA	92%	3		
		1.34	MRSA - Decolonisation (Trust level treatment and post scr	90%	93%	90%	90%	92%	93%	95%	95%	90%	91%	98%	85%	91%	94%	92%	3		
		1.36	MSSA (Hospital)	NT	1	2	1	ND	1	0	0	1	1	0	1	1	1	6			
		1.37	SIRI final reports due in month submitted beyond 60 worki	0	0	0	0	0	1	0	0	0	4	5	4	0	0	14	2		
		1.38	SIRIs reported >2 working days from identification as red	0	0	0	2	0	0	0	0	1	2	3	6	5	7%	17	2		
		1.39	RAG active/accepted risk assessments not in date	0				ND	ND	ND	9	0	1	5	0	2	1	18	3		
		1.40	Datix Risk Register Red / Amber actions overdue	0				ND	ND	ND	22	0	0	0	0	0	0	22			
		1.41	Outstanding actions complete in date for Red/Amber entrie	95%	100%	100%	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND	100%	3		
		1.42	Quarterly standard principle compliance	90%	NA	NA	95%	NA	NA	95%	NA	NA	95%	NA	NA	97%	NA	96%	3		
		1.43	Rapid access chest pain clinic access within 2 wks.	100%	52%	100%	100%	100%	98%	100%	95%	97%	97%	96%	100%	100%	100%	98%	2		
		1.44	Verbal Duty of Candour outstanding at month-end	0%	ND	ND	ND	3	0	0	0	2	0	1	2	0	2	10	2		
		1.45	Hand Hygiene Audits	95%	99%	99%	98%	98%	99%	99%	100%	99%	98%	99%	99%	99%	99%	99%	2		
		1.46	Quarterly antibiotic audit	98%	NA	NA	93%	NA	NA	91%	NA	NA	94%	NA	NA	93%	NA	92%	3		
		1.47	RCAs beyond deadline for completion * To be reviewed	=<4	9	9	8	3	1	3	4	1	7	2	9	14	9	53	2		
		1.48	% of Green Patient Safety incidents investigated	NT	69%	64%	60%	60%	66%	54%	53%	68%	58%	67%	56%	55%	59%	60%			
		1.49	PEWS documentation and escalation compliance	NT	100%	100%	100%	80%	100%	90%	100%	100%	90%	ND	ND	ND	ND	93%	2		
		1.50	Quarterly Environment/Isolation	90%	NA	NA	91%	NA	NA	91%	NA	NA	92%	NA	NA	92%	NA	92%	3		
		1.51	Quarterly VIP score documentation	90%	NA	NA	79%	NA	NA	84%	NA	NA	80%	NA	NA	87%	NA	84%	2		
		1.52	Isolation data (Trust Level only)	95%	90%	95%	89%	90%	95%	90%	90%	88%	88%	90%	88%	88%	90%	90%	2		
		1.53	Pain Mgt. Quarterly internal report	80%	68%	NA	NA	75%	NA	NA	61%	NA	NA	61%	NA	NA	59%	64%	1		
		1.54	Nutrition Risk Assessment 48hrs	95%	84%	83%	90%	91%	87%	89%	82%	89%	93%	89%	87%	93%	92%	89%	2		
		1.55	Median of NRLS upload (No. of days)	41	50	50	51	81	87	65	65	58	55	48	61	66	75	66	1		

Putting you first

SAFE – WARD ANALYSIS



6. EXCEPTION REPORTS – SAFE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Pressure Ulcers (Tissue Viability)
Standard	Hospital-Acquired Pressure Ulcers - Below 5 PU pm and <30% avoidable
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Summary of Current performance & Reasons for under performance

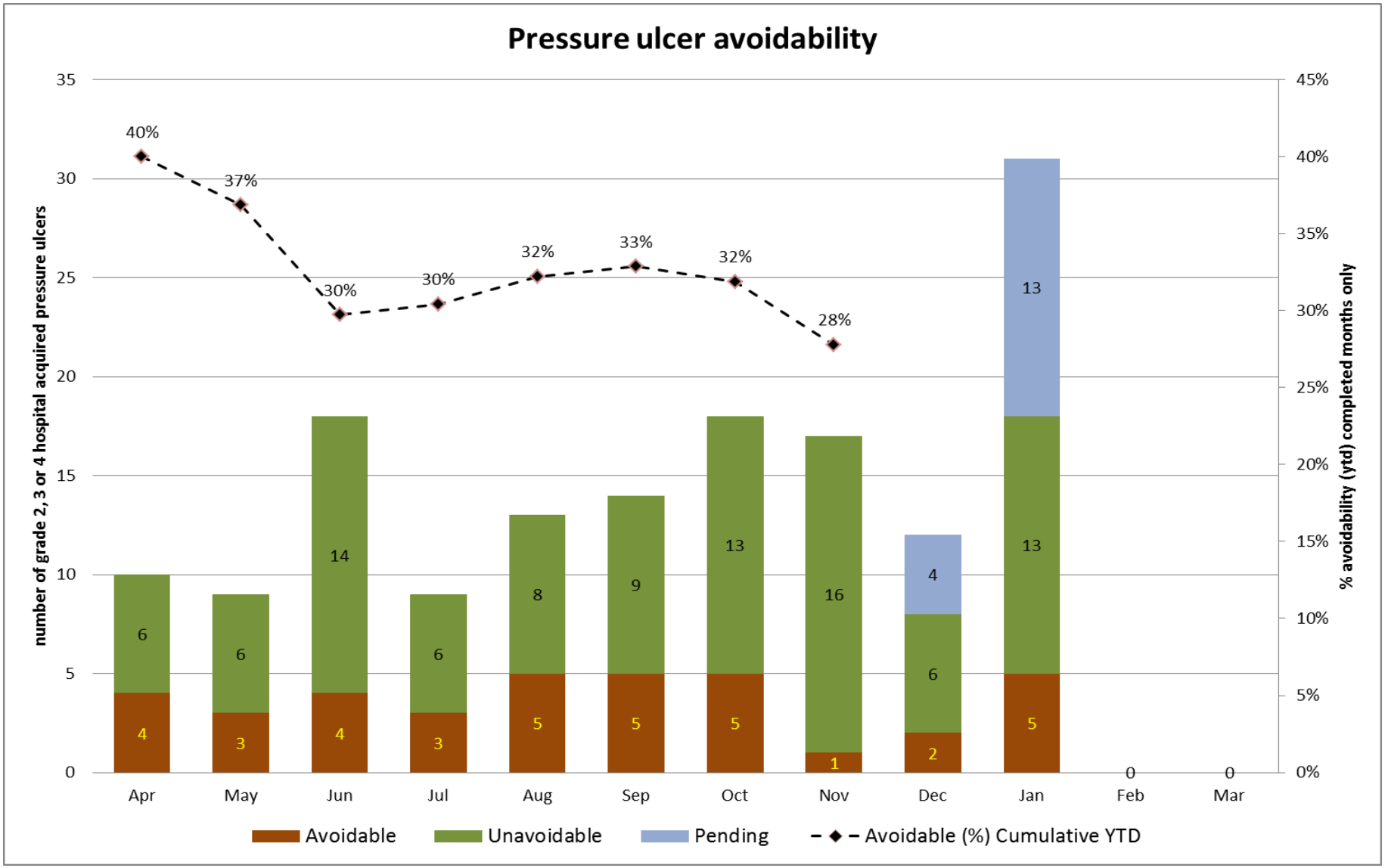
January has seen a significant increase in the number of hospital acquired pressure ulcers (HAPUs) from the previous month. There were thirty one in total, an increase from twelve in December. An increase in numbers of pressure ulcers has also been reported in the community, with high numbers of frail, elderly and end of life patients requiring primary and secondary care.
Acuity and capacity has exceeded expectation in January, with multiple escalation beds in use, placing wards and departments under increasing pressure against a backdrop of staff shortages due to vacancy and sickness. This, along with delays in waiting for available beds in the Emergency Department, continues to have a significant impact on patient safety and the quality of care and is representative of the high number of Grade 3 HAPUs, an increase from December. Staffing deficits are reviewed by the senior nursing team daily with the aim to mitigate the risks, but there is an awareness that teams are struggling to ensure all preventative measures are put in place in a timely manner.

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
Target	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Total Pressure Ulcers	10	4	10	9	19	10	13	15	19	18	13	35		
avoidable ward acquired	ND	ND	40%	37%	30%	30%	34%	38%	32%	ND	ND	ND		

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

No.	Description	Owner	Start	End
1	The Tissue Viability team continue to maintain visibility and support ward teams	TVN team	2018	ongoing
2	The Tissue viability team is promoting pressure ulcer prevention via bite size teaching sessions and one to one education, promoting awareness to improvee staff knowledge and practice in promoting skin health and integrity.	TVN team	2018	ongoing
3	Active promption 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
4	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
5	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
6	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
7	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
8	Reduction of stock of procedure sheets across all wards	TVN team	2018	ongoing
9	Active encouragement to achieve timely investigations and learning from incidents by Head of Nursing	Head of Nursing	2018	ongoing


Pressure ulcer avoidability
number of grade 2, 3 or 4 hospital acquired pressure ulcers
% avoidability (ytd) completed months only
0
5
10
15
20
25
30
35
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%
40%
37%
30%
30%
32%
33%
32%
28%
6
6
14
6
8
9
13
16
4
6
13
4
3
4
3
5
5
5
1
2
5
0
0
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-Jan-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Summary of Current performance & Reasons for under performance

There was 1 case of Hospital attributable CDT in January (on ward F3).
Overall summary - As of 31 January 2018, there have been 17 reported cases (cumulative) of Clostridium difficile, 10 of which are Non Trajectory and 7 are Trajectory.

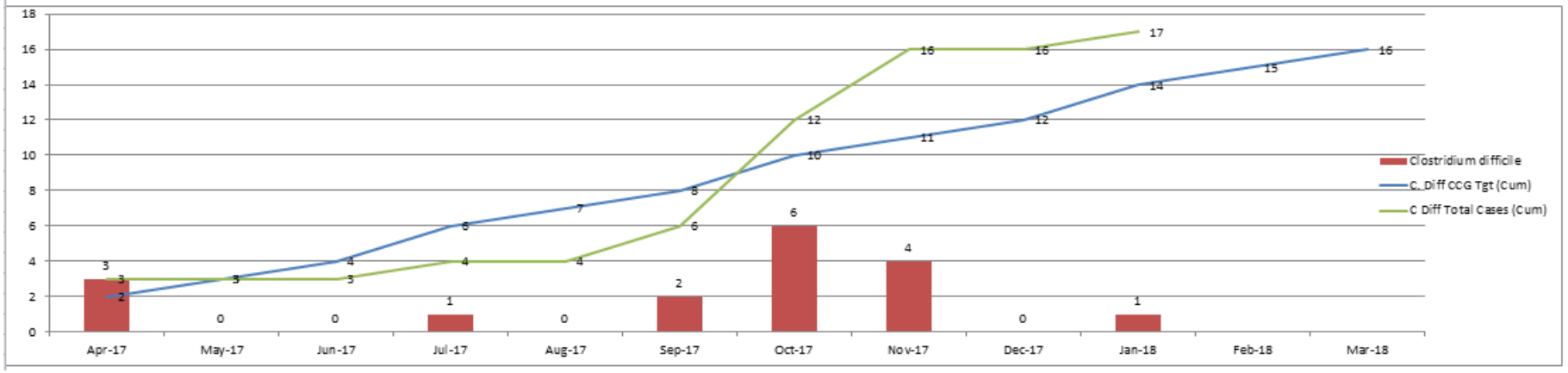
Trend | Recovery Trajectory

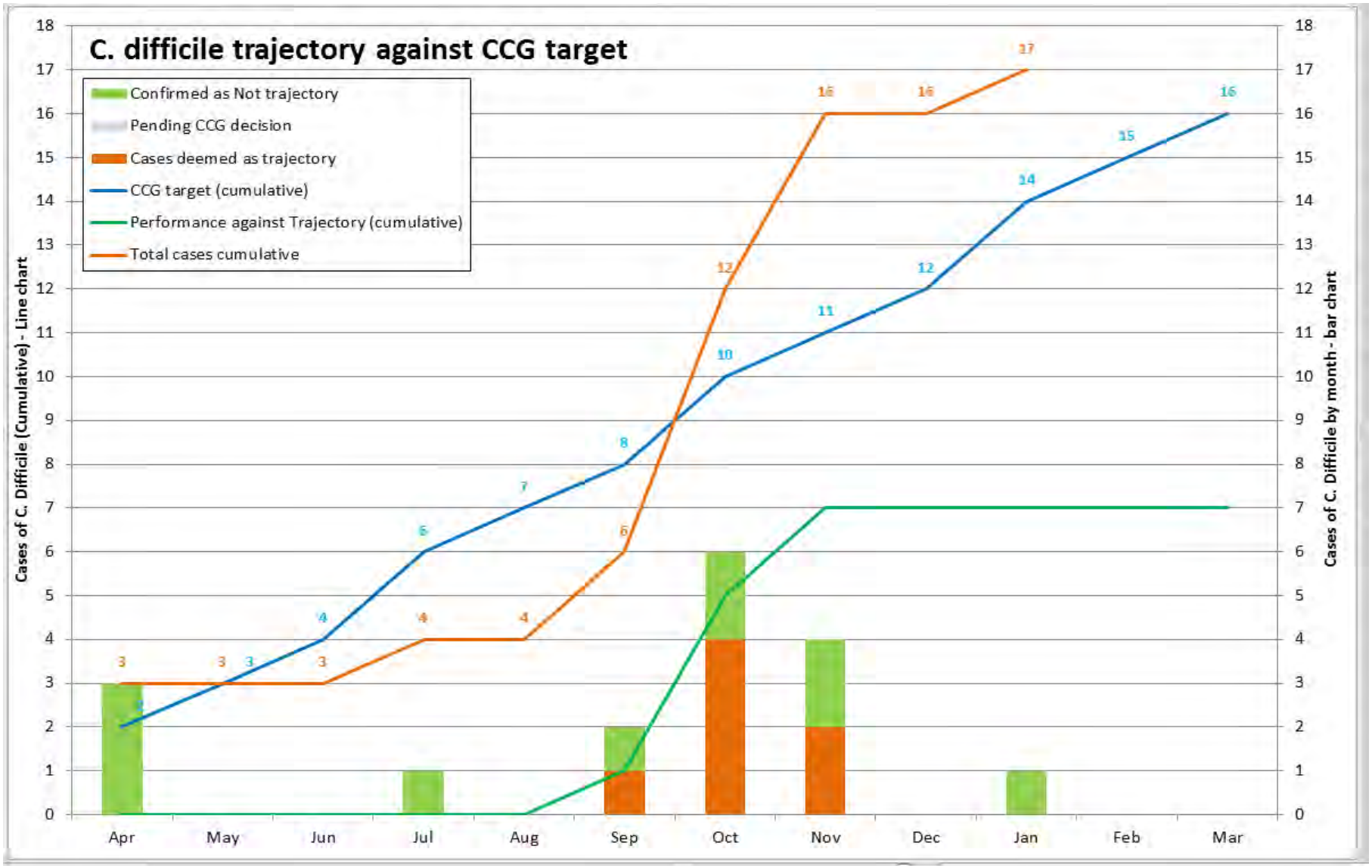
Indicator	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
C. Diff CCG Tgt (Cum)	2	3	4	6	7	8	10	11	12	14	15	16
Clostridium difficile	3	0	0	1	0	2	6	4	0	1		
C Diff Total Cases (Cum)	3	3	3	4	4	6	12	16	16	17		
MRSA	0	0	0	0	0	2	0	0	0	0		

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Whilst the Trust was under trajectory in the first two quarters, the first two months of Q3 have been over trajectory with a total of 10 cases at 30/11/17. Whilst there were no cases in December 2017 the Trust is over trajectory for Q3. As acknowledged on the Trust risk register this may reflect the Global shortage of Tazocin which has required the use of antibiotics associated with a higher risk of Clostridium difficile infection. The cases recorded on G8 in October & November have been investigated as a serious incident and an action plan devised and implementation of the recommendations is underway.	RP	Sep-17	Jan-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%
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Summary of Current performance & Reasons for under performance

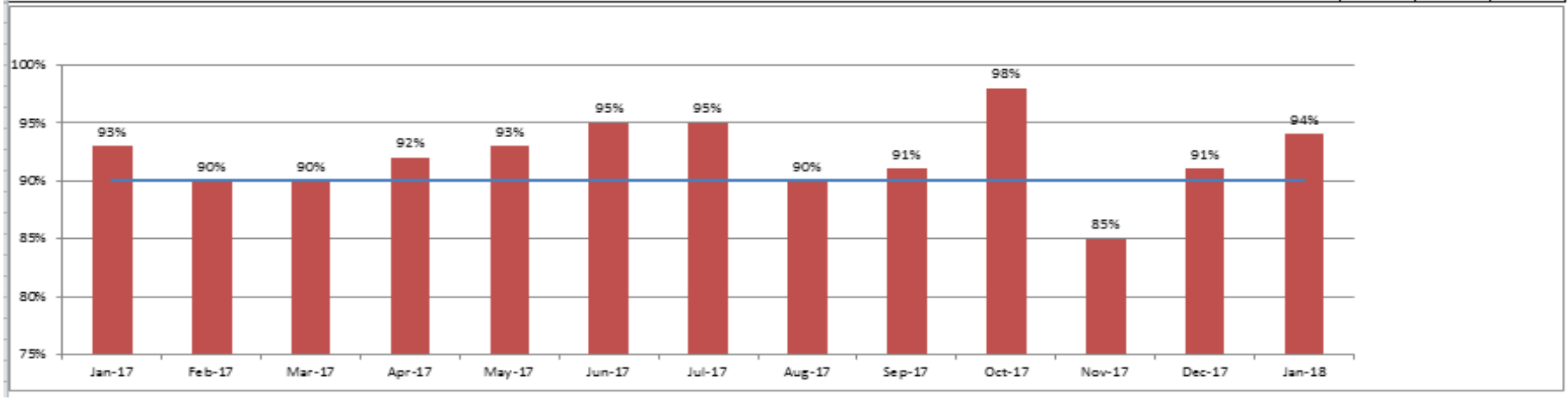
The Trust compliance with decolonisation improved in January 2018 to 94% from 91% in December 2017.

Trend												Recovery Trajectory			
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
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
MRSA Decolonisation	93%	90%	90%	92%	93%	95%	95%	90%	91%	98%	85%	91%	94%		

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
The decolonisation record remains a paper document which may adversely affect results, pharmacy are devising a possible solution within eCare. Wards were visited in 'real time' in order to improve compliance no wards required a Datix (when all elements are not recorded).	HB	Sep-17	Feb-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

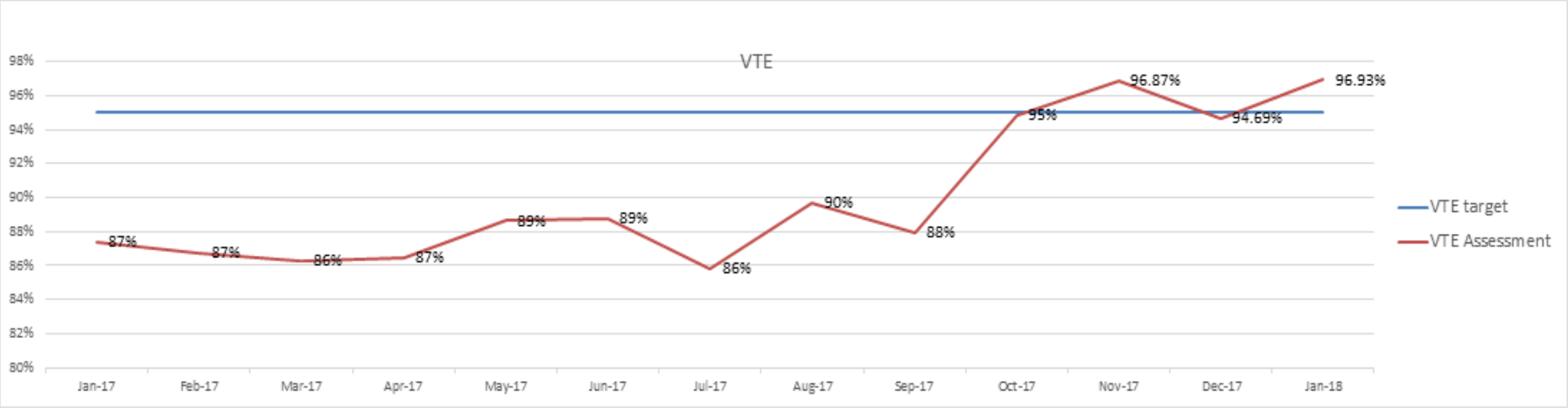
We now have EPR called e-Care, using which we have been able to properly and objectively collect data to inform our compliance. This has allowed us to exclude those areas that are not required to report as per the National Guidance. However, we undertake a monthly deep dive assurance process to ensure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

Trend | Recovery Trajectory

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
VTE target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
VTE Assessment	87%	87%	86%	87%	89%	89%	86%	90%	88%	95%	96.87%	94.69%	96.93%		

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

Description	Owner	Start	End
Monthly audit and reporting	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	01-Jan-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	Trust is in lowest quartile

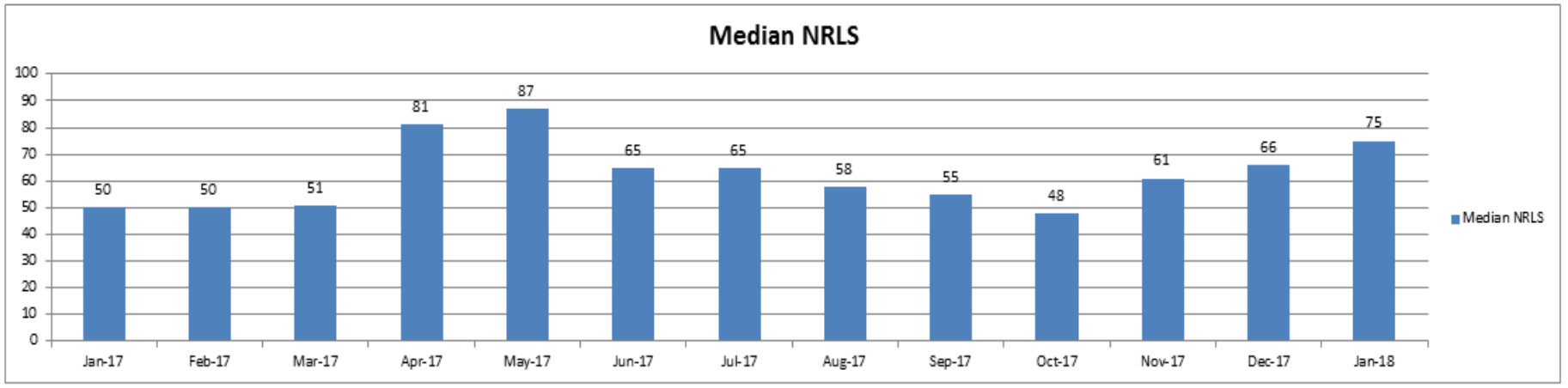
Summary of Current performance & Reasons for under performance

Performance has dropped over the last quarter following a continued period of improvement from May to October 2017. There has been an increase in the numbers of incidents reported and this combined with the acuity of the hospital in recent months has led to a reduction in performance. Options to simplify the investigation process on Datix are being considered in consultation with the clinical teams.

Trend												Recovery Trajectory			
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		

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Patient Safety Incidents Reported
Standard	NA
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

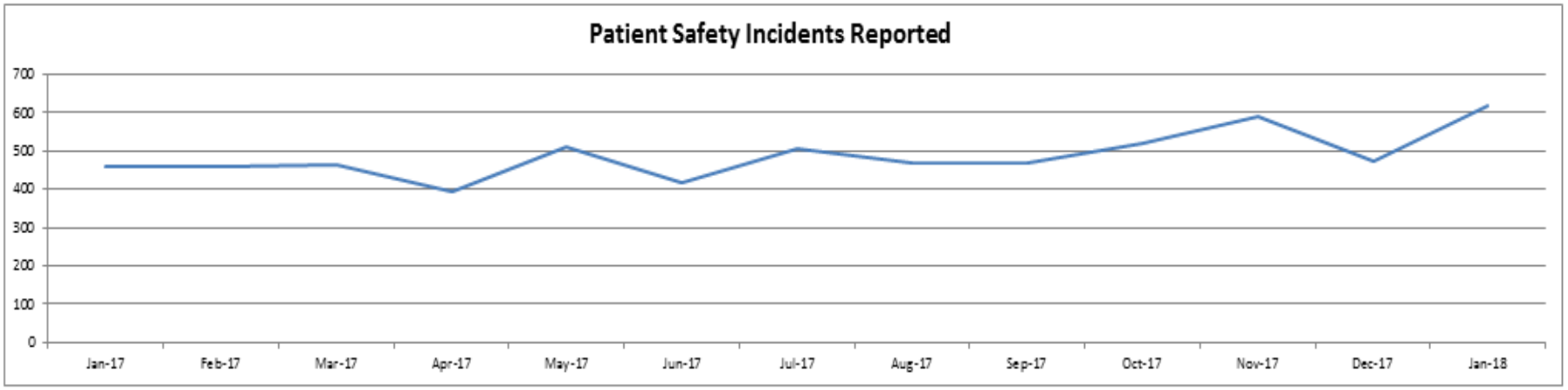
There were 617 incidents reported in January. This was higher than December and reflects the increased reporting now that the Community services have joined the trust. This is above the NRLS median threshold. The number of 'harm' incidents remains low although it has risen as a consequence of Community reporting, mainly relating to pressure ulcers.

Trend | Recovery Trajectory

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 Reported	460	459	463	392	508	418	506	466	467	521	591	471	617		

Key Recovery Actions

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		



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
National Rank	NA

Summary of Current performance & Reasons for under performance

Performance for January was 99% which was an improvement from 96% in December; this has been at an amber rating for nine months. The factor affecting this target has been the failure to document effectively, reassuringly there has not been an increase of incidents relating to the on-going care of peripheral cannulae.

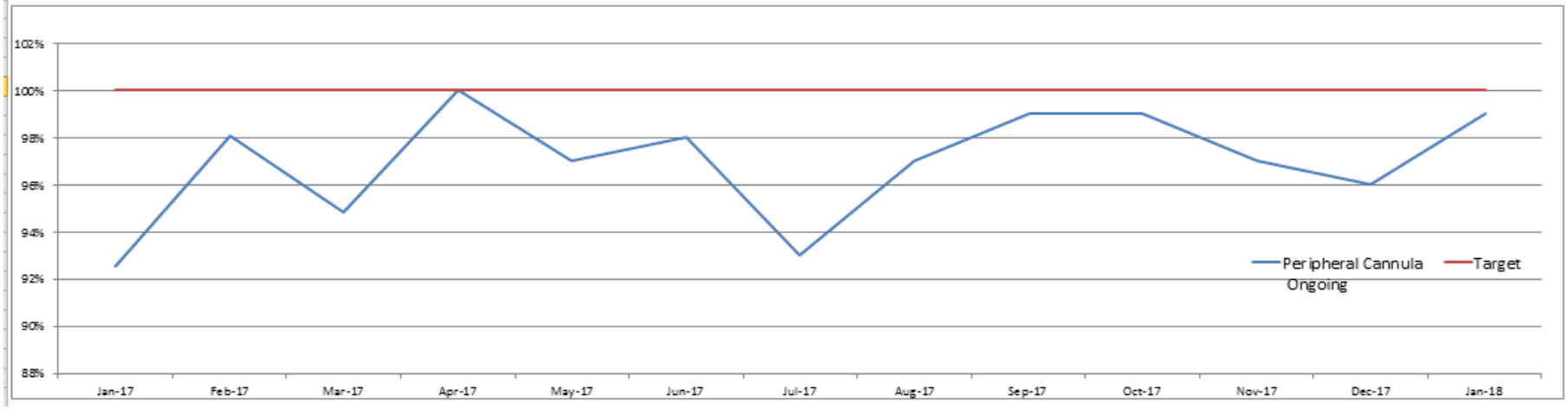
Trend | Recovery Trajectory

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
Peripheral Cannula Ongoing	93%	98%	95%	100%	97%	98%	93%	97%	99%	99%	97%	96%	99%		
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	Feb-18	Mar-18
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	Feb-18	Ongoing
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	Feb-18	Ongoing



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 76 falls in January a rise from 69 in December, of these falls one resulted in major harm and three in moderate harm. At Newmarket Hospital five patients fell (three in December) and at Glastonbury Court three patients fell (six in December), these falls are reportedly separately.
In the month of January five patients were assisted to the floor (four in December) preventing them from falling.
A total of four patients fell more than twice during their inpatient stay during January (eight in December).
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 Red Fall – G3 - Elderly patient with cognitive impairment and a significant cardiac medical history. The patient had been mobilising independently with a frame however when she attempted to mobilise unaided to the toilet at approximately 04:00 she fell resulting in a #NOF. The patient was transferred to F3 and had surgery to repair the #, the patient sadly passed away approximately 2 weeks later. 1 x Amber Fall – F5 - Elderly patient who fell resulting in #ribs which delayed surgery for approximately 2 weeks, the patient has fallen a further 3 times despite appropriate assessments / measures being put in to place. 1 x Amber Fall – F7 - Elderly patient who suffered a fall resulting in a # humerus which was managed conservatively, the patient was transferred to ward G8 and was subsequently discharged. 1 x Amber Fall – G8 - Elderly patient who suffered a fall whilst an in-patient resulting in a dislocation of her prosthetic hip (the patient had suffered 3 x dislocations at home previously). The hip was relocated successfully in theatre; the patient has since been discharged home.

Trend — Recovery Trajectory

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
Total Patient Falls	61	54	71	54	52	50	69	68	39	56	73	69	76		
Patient Falls resulting in harm	11	14	16	9	17	20	17	18	10	23	23	23	28		
Percentage of falls resulting in harm	18%	26%	23%	17%	33%	40%	25%	26%	26%	41%	32%	33%	37%		

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	Feb-18	Mar-18
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	Feb-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	Feb-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
National Rank	NA

Summary of Current performance & Reasons for under performance

Despite a busy month with high demand, December has seen an increase in compliance in weighing patients and completing the nutrition risk assessment and MUST score from 87% in November to 93% in December. There remain some small pockets of poor compliance amongst teams, specifically with weighing patients on admission and every 7 days.

Trend | Recovery Trajectory

Indicator	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Nutrition Risk Assessment 48hrs	83%	84%	83%	90%	91%	87%	89%	82%	89%	93%	89%	87%	93%	92%		
Target	95%	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	Feb-18	Ongoing

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Timeliness of SI Reporting
Standard	2 working days for initial notification. 60 working days submission of final report
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Summary of Current performance & Reasons for under performance

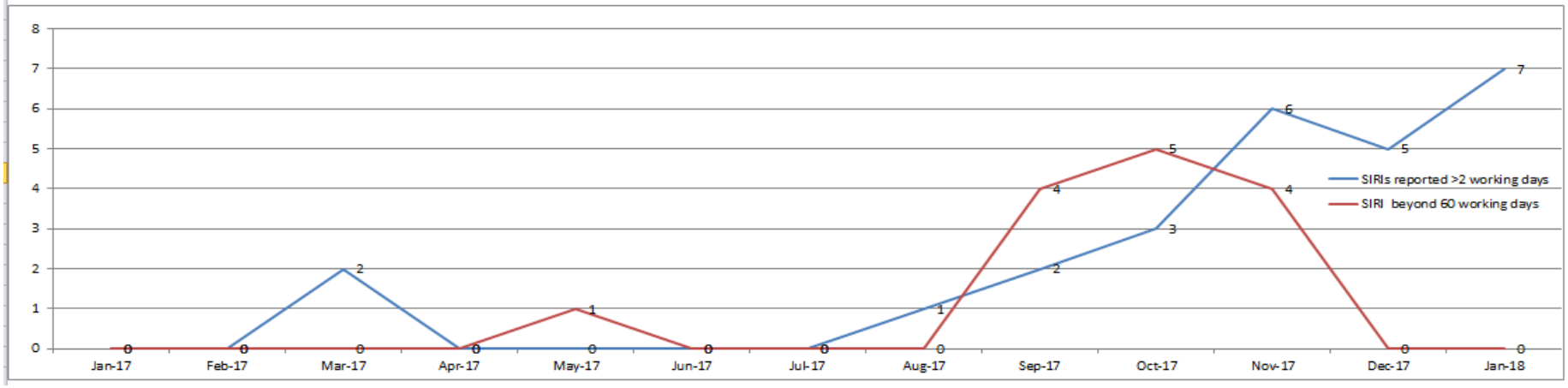
The Trust has a target for timely reporting and investigation of cases reported as a Serious incident (SI). These are national targets and are monitored by the CCG. Recent changes in reporting requirements associated with the Community Health teams have led to some delays around reporting primarily of pressure ulcers. In addition two SIs in Maternity were also reported after the deadline in January.

Trend | Recovery Trajectory

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
SIRIs reported >2 working days	0	0	2	0	0	0	0	1	2	3	6	5	7		
SIRI beyond 60 working days	0	0	0	0	1	0	0	0	4	5	4	0	0		

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

Description	Owner	Start	End
Continue to aim for 100% compliance	Governance	Aug-17	Ongoing
Feedback a reminder about the two working day target	Governance	Feb-18	Feb-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

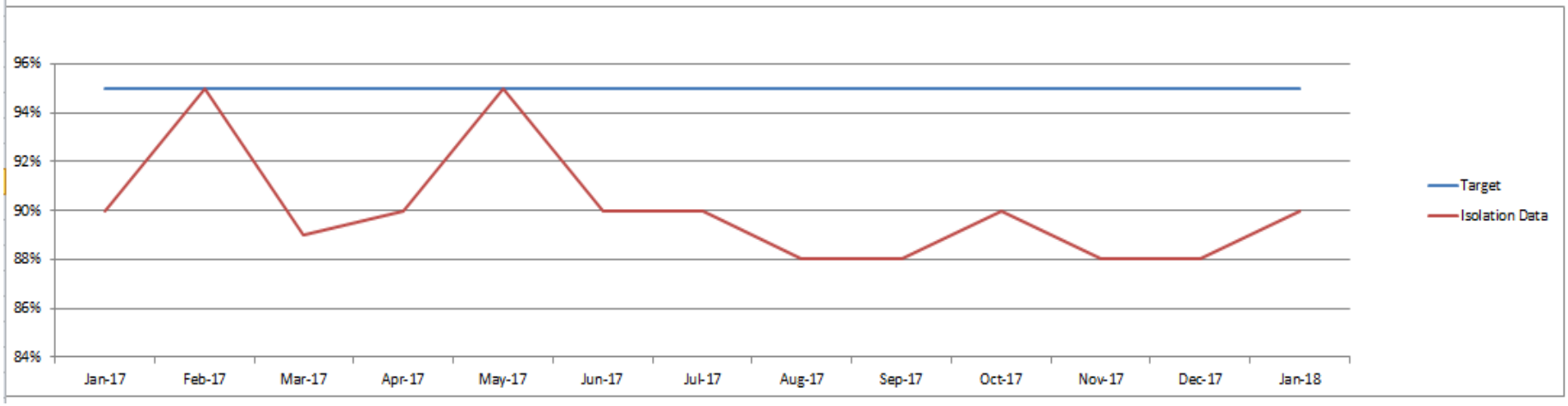
Summary of Current performance & Reasons for under performance

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

Trend												Recovery Trajectory			
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
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Isolation Data	90%	95%	89%	90%	95%	90%	90%	88%	88%	90%	88%	88%	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	01-Jan-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Summary of Current performance & Reasons for under performance

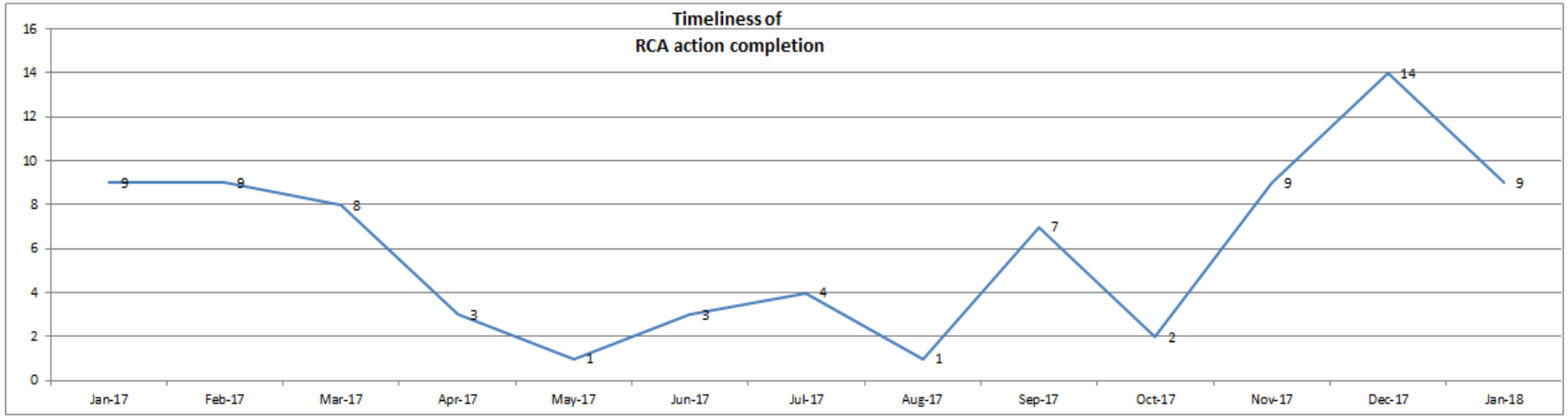
On completion of an SIRI investigation an action plan is developed to address the care or service delivery problems and root cause(s) and any additional lessons learned. Actions are designed to be SMART and are recorded on Datix with a named lead and completion target date. When an action reaches its 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.

Trend | Recovery Trajectory

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
Timeliness of RCA action completion	9	9	8	3	1	3	4	1	7	2	9	14	9		

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
National Rank	

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.

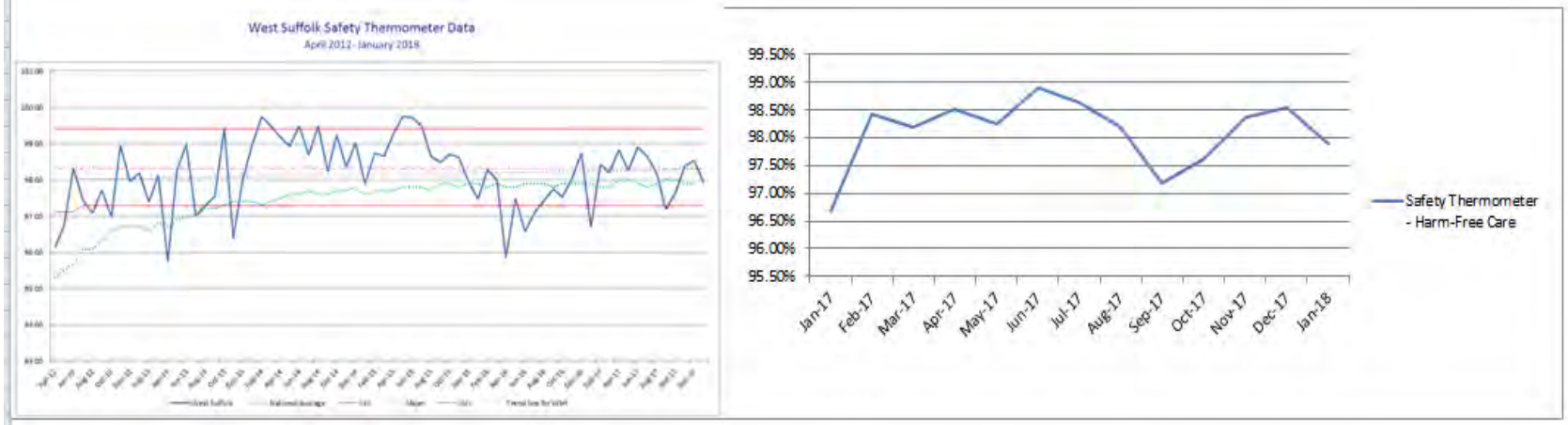
The Trust score for January 2018 for new harm free care was 97.90%. It should be noted that the Safety Thermometer is a spot audit and data is collected on a specific day each month. The SPC chart below shows the Trust Harm free care compared to the national benchmark for the period April 2012 to November 2017 and the Trust results for December 2017.

Trend | Recovery Trajectory

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
Safety Thermometer - Harm-Free Care	96.69%	98.43%	98.19%	98.53%	98.26%	98.91%	98.64%	98.18%	97.18%	97.63%	98.38%	98.54%	97.90%		

Key Recovery Actions

Description	Owner	Start	End
To continue to monitor actual harm against national benchmarks.	HB	Sep-17	Feb-18



7. DETAILED REPORTS - EFFECTIVE

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

Are we..		Ref.	KPI	Target	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	YTD(Apr17 Mar18)	WTG	Traffic	Trend
	Mort D:	2.04	Canc. Ops - Cancellations for non-clinical reasons	1%	1.35%	0.49%	0.93%	0.62%	0.56%	1.05%	1.00%	1.21%	0.97%	1.44%	1.85%	1.33%	0.75%	1.08%	4		
		2.11	Cardiac arrests	NT	3	8	13	4	6	4	2	3	6	4	ND	ND	7	36			
		2.12	Cardiac arrests identified as a SIRI	-	1	1	0	0	0	1	0	0	0	0	0	0	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	0	0	3		
		2.15	WHO Checklist (Qrtly)	100%	NA	NA	ND	NA	NA	99%	NA	NA	99%	NA	NA	99%	NA	99%	3		
		2.16	TA (Technology appraisal) business case beyond deadline	0%	ND	ND	ND	0	0	0	0	0	0	0	0	0	0	0			
		2.19	Av. Elective LOS (excl. 0 days)		3.11	2.49	2.92	2.75	3.26	2.7	2.54	2.79	2.73	2.93	2.85	2.98	3.06	2.86			
		2.20	Av NEL LOS (excl 0 days)		8.88	8.83	7.73	7.59	7.85	7.66	7.47	7.93	7.54	8.10	7.26	7.18	7.56	7.61			
		2.21	% of NEL 0 day LOS		18%	18%	20%	19.4%	18.6%	20.3%	18.6%	17.4%	17.5%	18.8%	16.6%	14.9%	13.29%	18%			
		2.22	NHS number coding	99%	100%	100%	100%	99.74%	99.66%	99.69%	99.44%	99.50%	99.59%	99.61%	99.66%	99.62%	99.62%	100%			
		2.23	Fractured Neck of Femur : Surgery in 36 hours	85%	97%	97%	88%	97%	96%	96%	85%	97%	97%	96%	84%	100%	100%	95%			
		2.26	Discharge Summaries (A&E 95% 1d)	95%	98%	98%	97%	98%	98%	88%	87%	86%	86%	84%	84%	83%	84%	88%	1		
		2.27	Discharge Summaries (IP 95% 1d)	95%	94%	93%	92%	92%	93%	93%	ND	ND	ND	ND	ND	71%	71%	84%	1		
		2.28	Choose and Book - Available Slots	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	3		
		2.29	All Cancer 2ww services available on C&B	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	ND	100%	3		
		2.30	Canc. Ops - Patients offered date within 28 days	100%	100%	92%	97%	93%	94%	93%	88%	75%	92%	85%	98%	77%	95%	89%	1		
		2.31	Canc. Ops. - No. Cancelled for a 2nd time	NT	ND	0	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
Standard	95%
Name	Helen Beck
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Effective
National Rank	NA

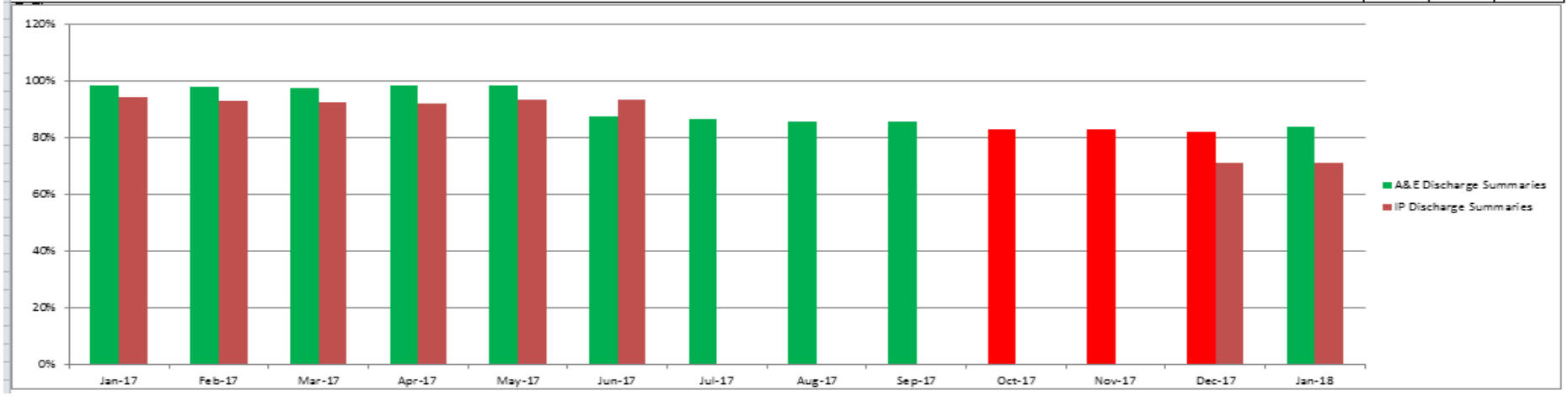
Summary of Current performance & Reasons for under performance

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

Trend													Recovery Trajectory		
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
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
A&E Discharge Summaries	98%	98%	97%	98%	98%	88%	87%	86%	86%	83%	83%	82%	84%		
IP Discharge Summaries	94%	93%	92%	92%	93%	93%	ND	ND	ND	ND	ND	71%	71%		

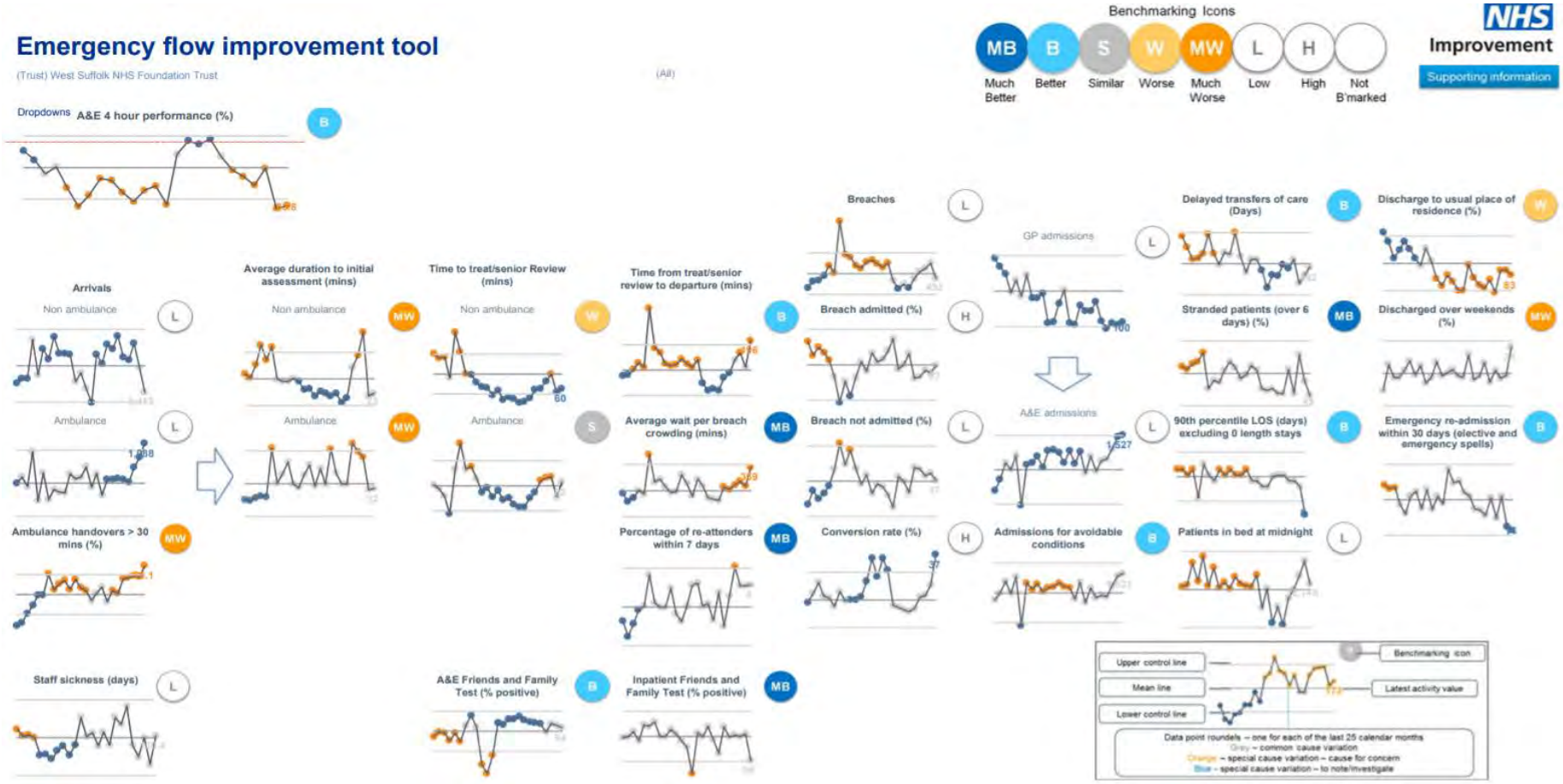
Actions in place to recover the performance

Description	Expected timeframes for improvements: 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). It is planned to start providing information on outstanding discharge summaries 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 improving automatic completion of discharge summaries as part of the ED optimisation project over the next few months.	NJ	Jun-17	TBC



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 January 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?

Ref.	KPI	Target	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	YTD(Apr17-Mar18)	WTG	Traffic	Trend
3.01	Compliments (Logged by Patient Experience)		33	41	28	41	52	26	56	28	17	33	87	151	64	555			
3.02	Complaints (Inpatient)	20	18	12	11	10	10	10	6	16	16	17	13	8	12	118	6		
3.03	Mixed Sex Accommodation Breaches	0	0	2	0	0	0	0	0	0	0	0	0	1	0	1	6		
3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	99%	98%	99%	98%	97%	99%	98%	98%	98%	99%	96%	98%	97%	98%	6		
3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	97%	97%	96%	95%	96%	97%	95%	95%	96%	96%	96%	99%	95%	96%	6		
3.06	A&E - Extremely likely or Likely to recommend (FFT)	85%	95%	96%	96%	97%	96%	95%	95%	95%	92%	95%	94%	94%	96%	95%	6		
3.07	Maternity - How likely are you to recommend our ward to friends and family?	85%	91%	100%	100%	100%	100%	100%	100%	ND	ND	99%	100%	97%	100%	100%	6		
3.09	IP overall experience result	85%	94%	93%	94%	93%	92%	94%	94%	93%	93%	96%	96%	95%	94%	94%	3		
3.10	OP overall experience result	85%	92%	92%	91%	92%	85%	88%	89%	91%	89%	95%	94%	95%	96%	91%	3		
3.11	A&E overall experience result	85%	96%	93%	94%	94%	96%	94%	94%	95%	94%	93%	94%	94%	94%	94%	3		
3.12	A&E children overall experience result	85%	ND	98%	100%	ND	100%	94%	ND	ND	ND	ND	ND	ND	ND	97%	3		
3.14	Short-stay overall result	85%	99%	99%	98%	99%	99%	100%	99%	99%	99%	99%	99%	99%	99%	99%	3		
3.15	Short-stay Extremely likely or Likely to recommend	90%	100%	100%	100%	99%	99%	100%	100%	99%	99%	99%	97%	100%	99%	99%	3		
3.16	Maternity - overall	85%	94%	96%	100%	98%	100%	100%	100%	100%	100%	100%	98%	95%	100%	99%	3		
3.17	Maternity - postnatal ward recommendation to F&F	90%	91%	100%	100%	100%	100%	100%	ND	ND	100%	100%	ND	ND	ND	100%	3		
3.18	Maternity - birthing unit recommendation to F&F	90%	ND	ND	ND	100%	100%	100%	ND	ND	100%	100%	100%	ND	100%	100%	3		
3.19	Maternity -antenatal community care rec. to F&F	90%	99%	100%	95%	97%	98%	100%	ND	ND	100%	96%	ND	ND	ND	98%	3		
3.20	Maternity -post-natal community care rec. to F&F	90%	100%	100%	100%	100%	98%	ND	ND	ND	100%	98%	ND	ND	ND	99%	3		
3.22	F1 Parent overall result	85%	97%	99%	97%	97%	99%	99%	95%	100%	100%	99%	95%	98%	98%	98%	3		
3.23	F1 Parent - Extremely likely or Likely to recommend (FFT)	90%	96%	100%	100%	100%	100%	100%	92%	100%	100%	100%	94%	97%	100%	98%	3		
3.24	Stroke Care - Overall Result	85%	94%	95%	95%	94%	ND	98%	99%	ND	99%	100%	85%	ND	98%	96%	3		
3.25	Stroke Care - How likely is it that you would recommend the service to friends and family?	90%	100%	100%	100%	93%	ND	95%	100%	100%	95%	100%	100%	ND	100%	98%	3		
3.27	Complaints acknowledged within 3 working days	90%	ND	ND	ND	ND	90%	100%	100%	93%	94%	100%	100%	87%	92%	95%	3		
3.28	Complaints responded to within 25 working days	90%	86%	86%	100%	100%	90%	75%	100%	85%	67%	81%	82%	50%	60%	79%	2		
3.29	Number of second letters received	1	2	2	1	3	0	2	1	1	1	2	0	1	0	11	2		
3.30	Health Service Referrals accepted by Ombudsman		0	0	0	0	2	0	1	0	0	0	0	1	0	4	2		
3.31	No. of complaints to Ombudsman upheld	0	ND	ND	ND	0	2	0	1	0	0	0	0	0	0	3			
3.33	No. of PALS contacts	NA	171	189	230	172	188	169	176	137	167	190	167	124	161	1651			
3.34	No. of PALS contacts becoming formal complaints	<=5	0	0	1	0	0	0	1	4	2	3	4	1	3	18	3		
3.37	Environment & cleanliness - Patient Satisfaction Overall	75%	89%	91%	89%	93%	92%	92%	92%	94%	93%	94%	95%	94%	93%	93%	3		
3.38	Catering - Patient Satisfaction with food - overall	75%	80%	83%	82%	83%	81%	85%	78%	85%	81%	87%	77%	85%	78%	82%	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-Jan-18
Data Frequency	Monthly
CQC Area	Caring
National Rank	

Summary of Current performance & Reasons for under performance

5 out of 6 complaint responses due in January were overdue. The reason only 6 responses were due is because many have had to have an extension agreed so will feature in February figures.

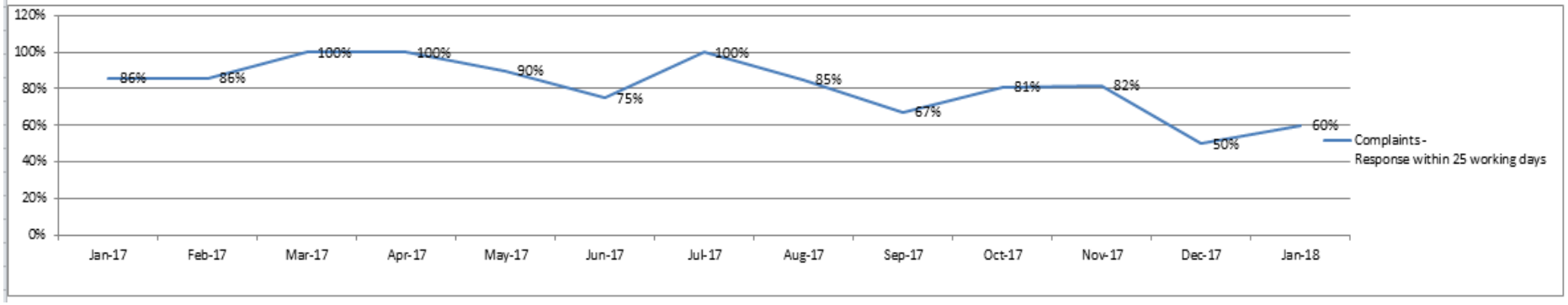
This is a reflection in part of the pressures across the organisation and subsequent delays in providing statements and also the capacity of the Patient Experience Team.

Trend | Recovery Trajectory

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
Response within 25 working days	86%	86%	100%	100%	90%	75%	100%	85%	67%	81%	82%	50%	60%		

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

Description	Owner	Start	End
To continue to monitor	HB		



NHS
West Suffolk
NHS Foundation Trust

DETAILED REPORTS - RESPONSIVE

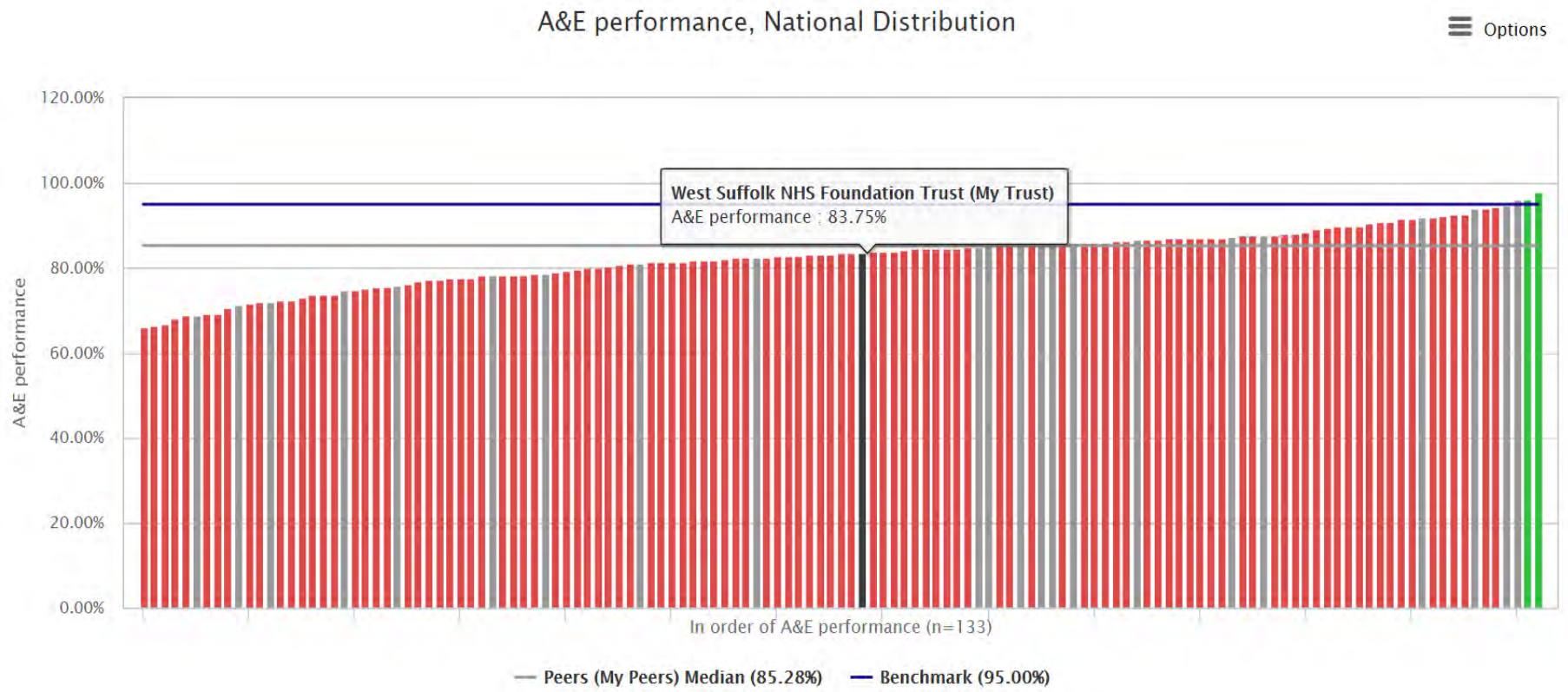
Are we safe? | Are we effective? | Are we caring? | **Are we responsive?** | Are we well-led? | Are we productive?

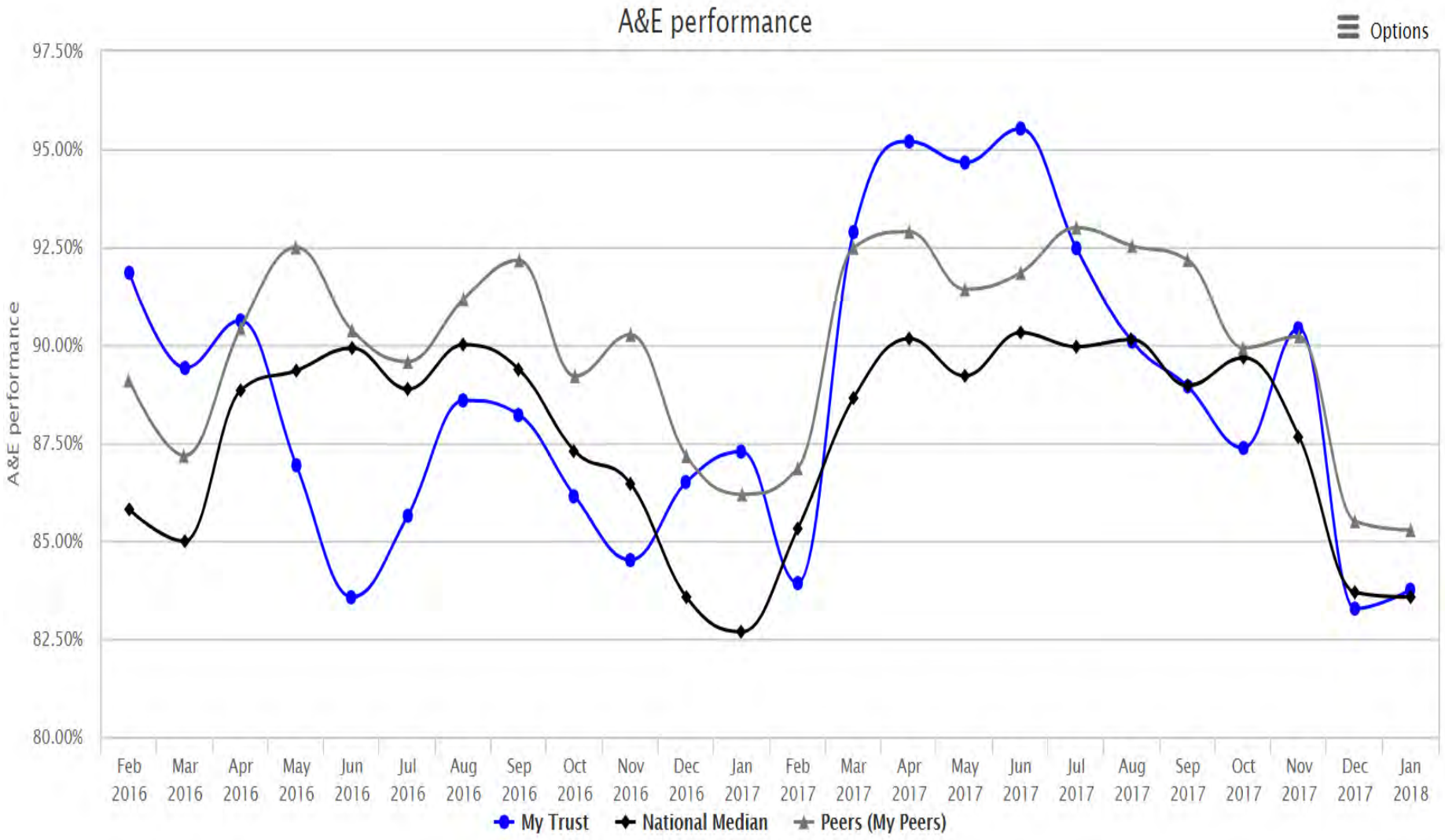
Are we..		Ref.	KPI	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	YTD(Apr17-Mar18)	WTG	Traffic	Trend
4. Responsive	Dashboard	4.01	A&E under 4 hr. wait	95%	87%	84%	93%	95%	95%	96%	92%	90%	89%	87%	90%	83%	84%	90%	4		
		4.02	RTT: % incomplete pathways within 18 weeks	92%	90%	90%	90%	82%	80%	83%	84%	86%	86%	87%	89%	89%	90%	86%	2		
		4.03	52 week waiters	0	7	7	8	15	14	15	35	26	29	26	21	15	14	210	2		
		4.04	Diagnostics within 6 weeks	99%	96.03%	99.42%	99.91%	99.86%	99.87%	100.00%	99.50%	99.95%	100.00%	100.00%	100.00%	99.95%	99.96%	100%	6		
		4.05	Cancer: 2w wait for urgent GP Referrals	93%	90%	98%	98%	94%	92%	97%	95%	96%	91%	83%	98%	97%	98%	94%	6		
		4.06	Cancer 2w wait breast	93%	88%	96%	94%	94%	99%	89%	98%	100%	98%	100%	100%	99%	98%	98%	6		
		4.07	Cancer 31 d First Treatment	96%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	99%	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%	85%	88%	83%	89%	83%	86%	85%	86%	87%	94%	90%	87%	86%	87%	6		
		4.11	Cancer 62 d Screening	90%	100%	89%	97%	100%	100%	90%	100%	100%	91%	100%	83%	100%	93%	96%	6		
	Emergency Care & Emergency Flow	4.20	Number of Delayed Transfer of Care - (DTOCs)	NT	566	464	294	417	411	511	481	565	337	250	279	314	326	389			
		4.21	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	NT	50	48	53	35	43	52	52	50	62	59	41	62	57	513	3		
		4.22	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	13:19	12:25	22:32	09:57	13:57	10:10	13:53	11:46	12:01	15:44	22:04	16:48	18:11	14:27			
		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		3	12	5	14	3	6	5	5	14	10	17	50	122	246	1		
		4.25	A&E - To inpatient Admission Ratio	27%	35%	34%	32%	27%	26%	26%	26%	27%	28%	28%	29%	34%	32%	28%	2		
		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	10	3		
		4.27	A&E/AMU - Amb. Submit button complete	80%	90%	84%	88%	93%	91%	92%	91%	90%	90%	88%	88%	89%	86%	90%	3		
		4.28	A&E - Amb. Handover above 30m	30m	39	53	48	21	38	31	39	19	15	ND	ND	ND	ND	163	3		
		4.29	A&E - Amb. Handover above 60m	60m	21	34	18	3	16	9	7	16	30	ND	ND	ND	ND	81	3		
		4.30	A&E - Type 1&2 high risk patients reviewed by a EMC	14%	80%	89%	100%	94%	87%	93%	ND	ND	ND	ND	ND	ND	ND	91%	3		
	RTT	4.31	RTT - 18w Admitted (Completed)	90%	68%	69%	69%	69%	68%	70%	73%	70%	74%	72%	71%	70%	73%	71%	1		
		4.32	RTT - 18w Non-admitted (Completed)	95%	88%	85%	85%	86%	87%	87%	88%	86%	87%	85%	86%	91%	89%	87%	1		
		4.33	RTT waiting List		17816	18126	18127	22110	22144	19931	18676	17346	17236	16694	16641	16195	15363	18234			
		4.34	RTT waiting list over 18 weeks		1729	1833	1834	3929	4492	3316	2629	2441	2467	2171	1843	1775	1504	2657			
	Stroke	4.35	Stroke - % Patients scanned within 1 hr.	77%	76%	69%	88%	87%	80%	72%	82%	79%	78%	76%	74%	76%	87%	79%	3		
		4.36	Stroke - % patients scanned within 12 hrs.	96%	100%	91%	100%	98%	98%	95%	95%	96%	90%	97%	92%	96%	98%	96%	2		
		4.37	Stroke - % Patients admitted directly to stroke unit with	75%	84%	63%	75%	89%	71%	76%	78%	79%	83%	72%	73%	60%	75%	76%	3		
		4.38	Stroke - % greater than 80% of treatment on a stroke uni	90%	92%	91%	88%	98%	88%	88%	94%	98%	93%	89%	93%	91%	98%	92%	3		
		4.39	Stroke - % of patients treated by the SESDC	48%	47%	42%	34%	50%	48%	75%	46%	33%	51%	50%	31%	32%	62%	48%	2		
		4.40	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	82%	84%	94%	93%	86%	95%	92%	88%	85%	83%	82%	89%	93%	89%	3		
		4.41	within 24h. All rel. therapists within 72 hrs. and have negotiated	75%	77%	80%	72%	87%	80%	90%	88%	90%	92%	77%	76%	78%	93%	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		
		4.43	Stroke -% of stroke survivors who have a 6mth follow up	50%	50%	ND	ND	ND	58%	ND	ND	ND	58%	ND	ND	ND	61%	59%	3		
		4.44	Stroke -Provider rating to remain within A-C	C	B	ND	ND	ND	C	ND	ND	ND	ND	ND	ND	ND	C	C			
	Othe	4.45	RCA Actions beyond deadline for completion	4	9	9	8	3	1	3	4	1	7	2	9	14	9	53	2		
		4.46	Sepsis - 1 hr neutropaenic sepsis	100%	72%	94%	80%	64%	47%	63%	69%	83%	63%	79%	74%	54%	80%	67%	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)*.




A&E performance
Options
97.50%
95.00%
92.50%
90.00%
87.50%
85.00%
82.50%
80.00%
A&E performance
Feb 2016
Mar 2016
Apr 2016
May 2016
Jun 2016
Jul 2016
Aug 2016
Sep 2016
Oct 2016
Nov 2016
Dec 2016
Jan 2017
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
My Trust
National Median
Peers (My Peers)

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

January perforamcne was similar to December, with increased demand combined with increased bed occupancy resulting in reduced patient flow.

The Single longest Wait (Admitted & Non-Admitted) in January was 16:48. This occured on 2nd January which was an exceptionally busy day and for the reasons stated above.

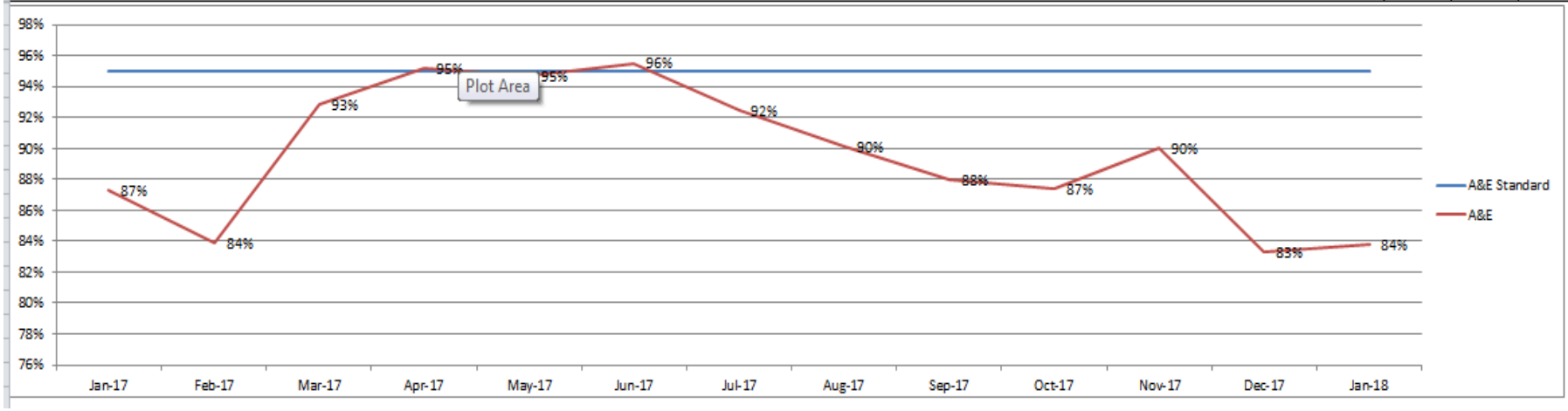
Trend | Recovery Trajectory

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
A&E Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%		
A&E	87%	84%	93%	95%	95%	96%	92%	90%	88%	87%	90%	83%	84%		

Actions in place to recover the performance

Expected timeframes for im

Description	Owner	Start	End
1. There has been agreement for additional consultant support during weekend days which commenced in Q4 and additional locum consultant cover which has provided some additional support overall. Delays in being seen by a clinical decision maker (CDM) continues to be the main reason (36.6%) with a majority of the delays being out of hours. Gaps in the medical workforce continue at middle grade and junior doctor level and despite locum requests and increased hourly rates of pay. Recruitment has been successful but the new doctors do not start in post until March/April and May.	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-Jan-18
Data Frequency	Monthly
CQC Area	Responsive
National Rank	NA

Summary of Current performance & Reasons for under performance

January has seen an increase in the acuity of patients attending ED, particularly in the first few weeks of the month. It is difficult to identify whether there are other reasons which have also contributed to this higher than normal conversion rate.

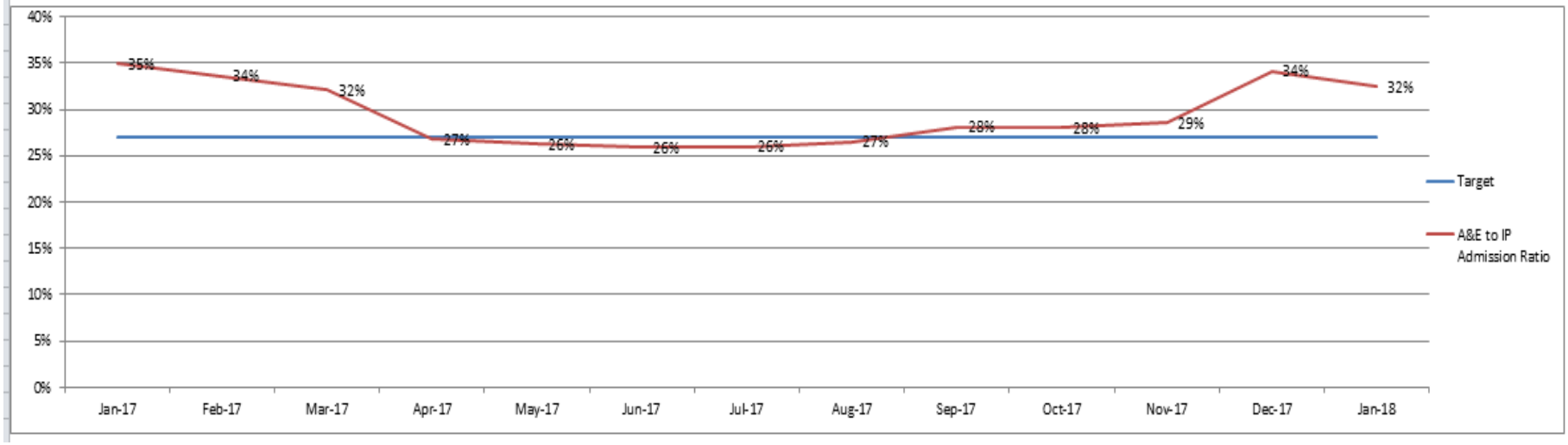
Trend | Recovery Trajectory

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
Target	27%	27%	27%	27%	27%	27%	27%	27%	27%	27%	27%	27%	27%		
A&E to IP Admission Ratio	35%	34%	32%	27%	26%	26%	26%	27%	28%	28%	29%	34%	32%		

Actions in place to recover the performance

Expected timeframes for improver

Description	Owner	Start	End
Further analysis has been commissioned 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-Jan-18
Data Frequency	Monthly
CQC Area	Responsive
National Rank	NA

Summary of Current performance & Reasons for under performance

For the month of January 2018 all stroke targets were met, which is an excellent acheivement given the pressures the Trust experienced during this time.

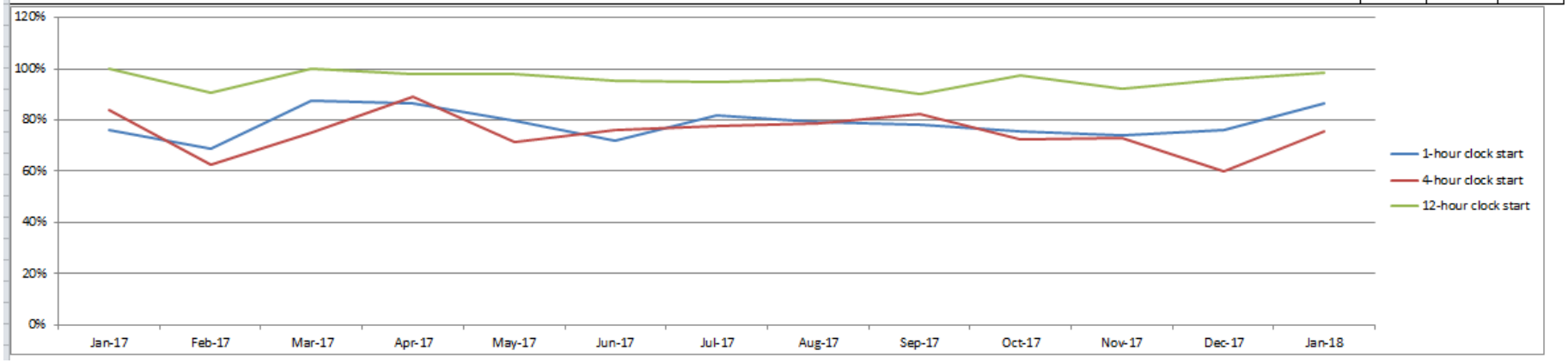
Trend | Recovery Trajectory

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
1-hour clock start	76%	69%	88%	87%	80%	72%	82%	79%	78%	76%	74%	76%	87%		
4-hour clock start	84%	63%	75%	89%	71%	76%	78%	79%	83%	72%	73%	60%	75%		
12-hour clock start	100%	91%	100%	98%	98%	95%	95%	96%	90%	97%	92%	96%	98%		

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Stroke: % of patients scanned within 1 hour of clock start: Main area for further work is for ESOT to continue to work with ED staff in stroke recognition and the importance of referring to ESOT immediately a stroke is suspected. ESOT senior nurse is continuing to do this. 12 hours to scan - To continue to review cases at validation, if a theme is identified this will be addressed. Stroke Unit in 4 hours - This is being tackled at Trust level.	RP	Sep-17	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer: 2-week wait for urgent GP Referrals
Standard	93%
Name	Helen Beck
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Summary of Current performance & Reasons for under performance

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

Current Position - 98% against a threshold of 85%

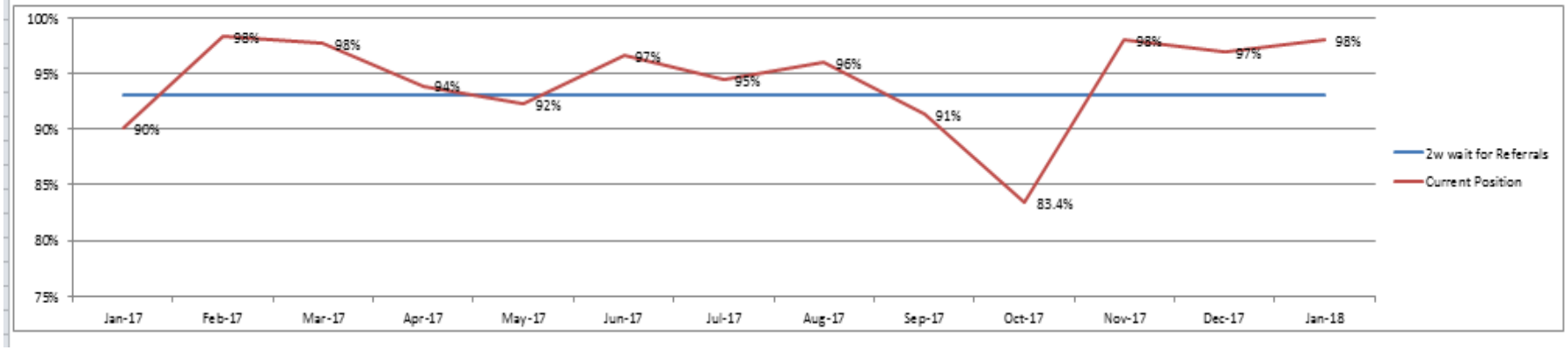
Trend | Recovery Trajectory

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
2w wait for Referrals	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%		
Current Position	90%	98%	98%	94%	92%	97%	95%	96%	91%	83.4%	98%	97%	98%		

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
The Trust is seriously engaged with the CCG at various levels to improve on demand management. Following significant efforts from clinicians and all involved in this service, they have recovered the situation in November 2017, and achieved targets since then	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

Cancer: 62-day Screening

Current Position - 93% against a threshold of 90%

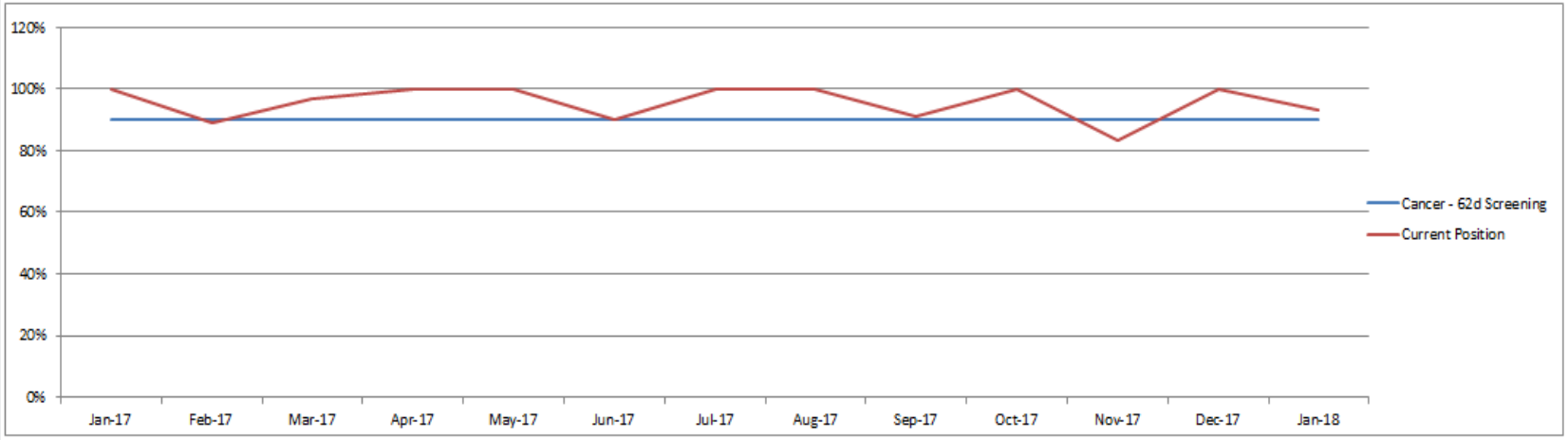
Trend | Recovery Trajectory

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
Cancer - 62d Screening	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Current Position	100%	89%	97%	100%	100%	90%	100%	100%	91%	100%	83%	100%	93%		

Actions in place to recover the performance

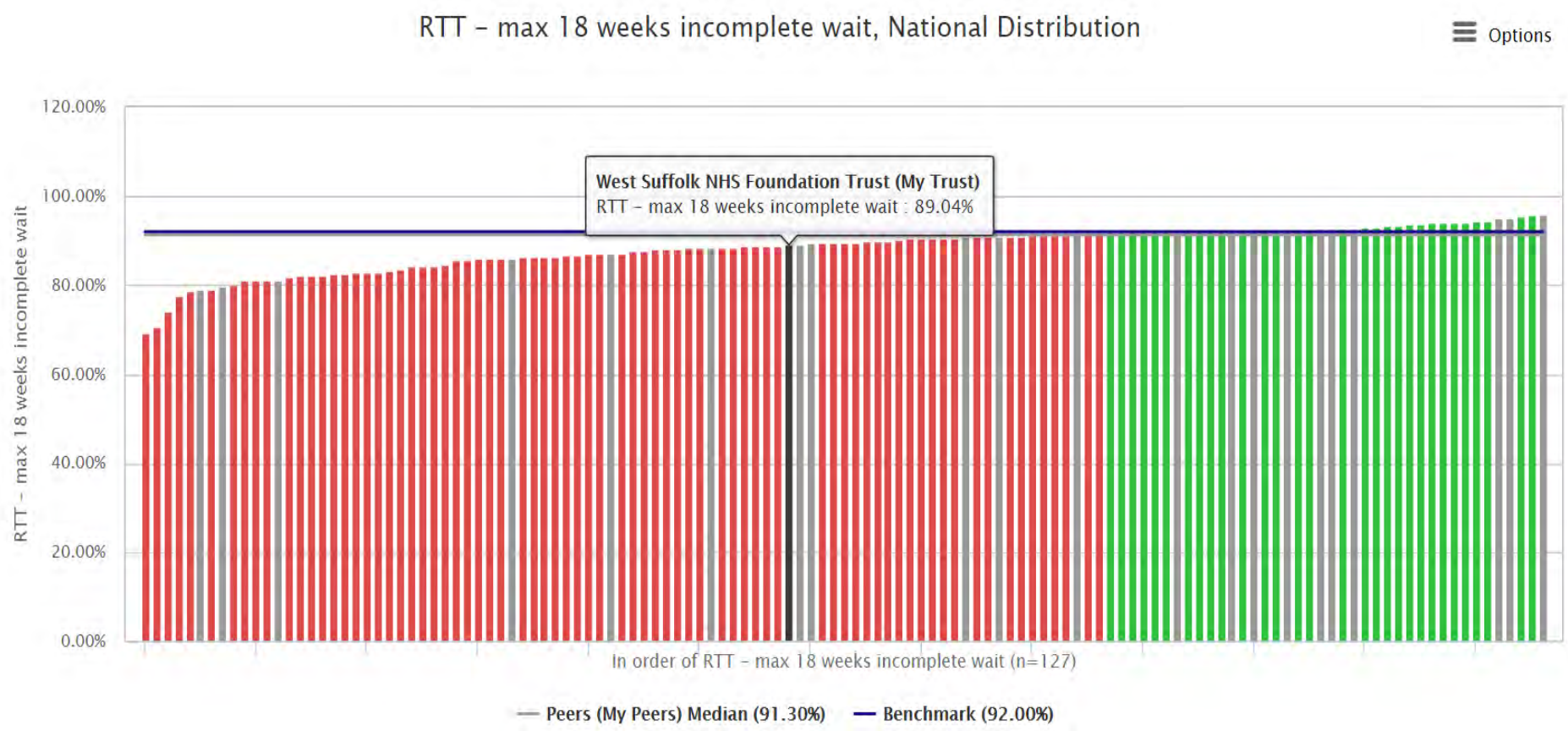
Expected timeframes for improvements

Description	Owner	Start	End
Achieved the target of 90% in December 2017 and January 2018	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 slide below (*Source: Model Hospital-Data from December 2017)*.



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

Despite the challenges through January, our position improved to 90% for January with a reduction in waiting times across a number of specialties. Areas that remain of concern are T&O which has been impacted by winter pressures and cancellations and urology.

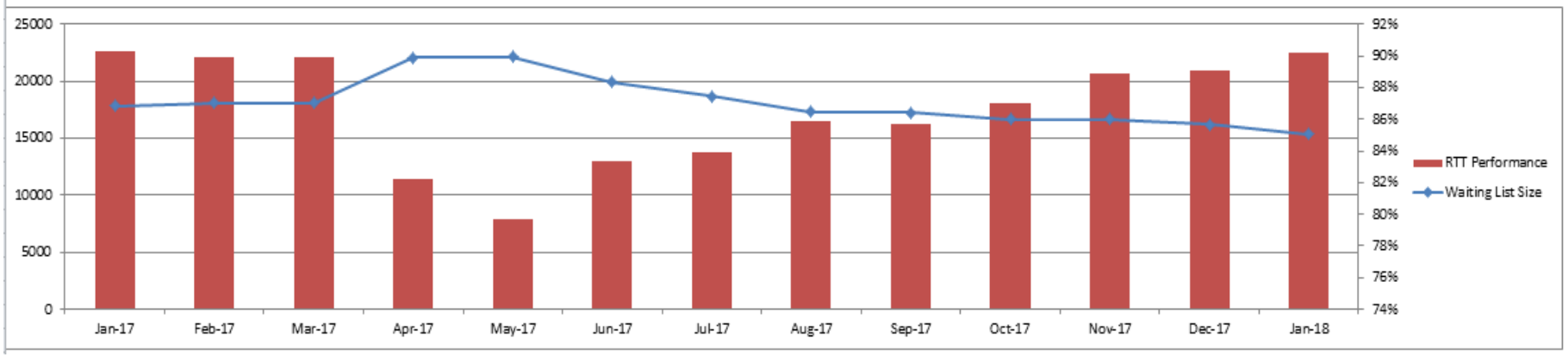
Trend | Recovery Trajectory

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
Waiting List Size	17816	18126	18127	22110	22144	19931	18676	17346	17236	16694	16641	16195	15,363		
RTT Performance	90%	90%	90%	82%	80%	83%	84%	86%	86%	87%	89%	89%	90%		

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 . The Plastic Surgery position remains challenged as a consequence of work to support the dermatology position. 2. There is a specific focus to review the vascular surgery pathway to ensure appropriate referrals to treatment are in place. 3. Focus to resolve recruitment and sickness absence challenges in the theatre teams continues.	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-Jan-18
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Summary of Current performance & Reasons for under performance

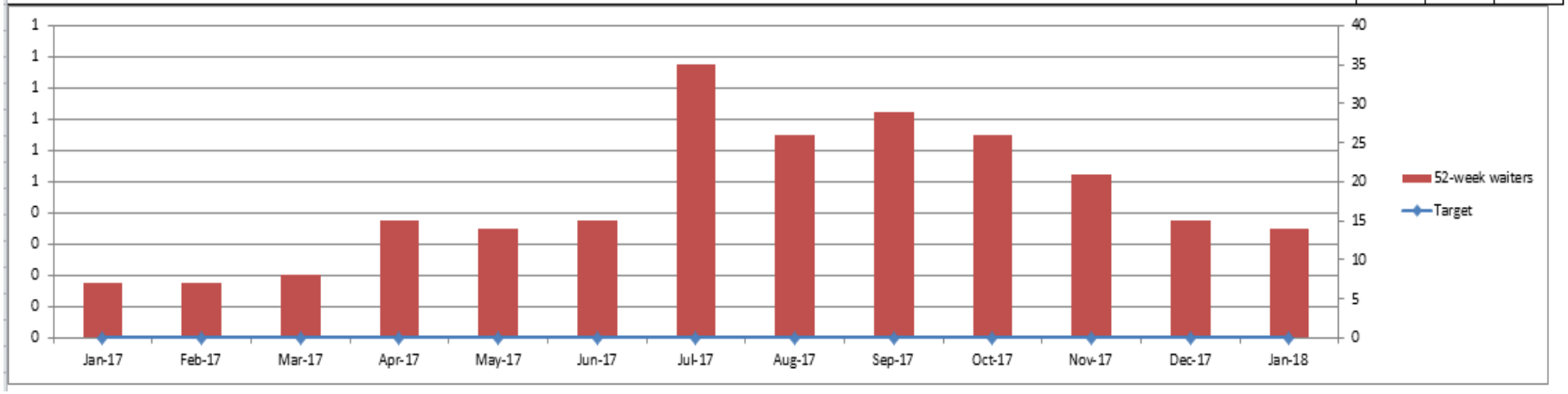
In January 14 patients breached 52 weeks in the following specialities; 3 Audiology, 5 ENT, 3 Urology, 1 Pain Management, and 2 Vascular Surgery. Of these 14 patients, at the time of reporting on the 21st of February, 4 have completed treatment in the first two weeks of February. The recovery trajectory for this indicator will be impacted by the restrictions placed on the elective surgery programme by winter pressures.

Trend | Recovery Trajectory

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
Target	0	0	0	0	0	0	0	0	0	0	0	0	0		
52-week waiter	7	7	8	15	14	15	35	26	29	26	21	15	14		

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 is underway 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%
Name	Helen Beck
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Summary of Current performance & Reasons for under performance

The RTT 18 week admitted performance continues to be below target predominantly due to excessive waits for first appointment in Dermatology with much improved waiting times in ENT. There are particular challenges in Urology, T&O, and Ophthalmology.

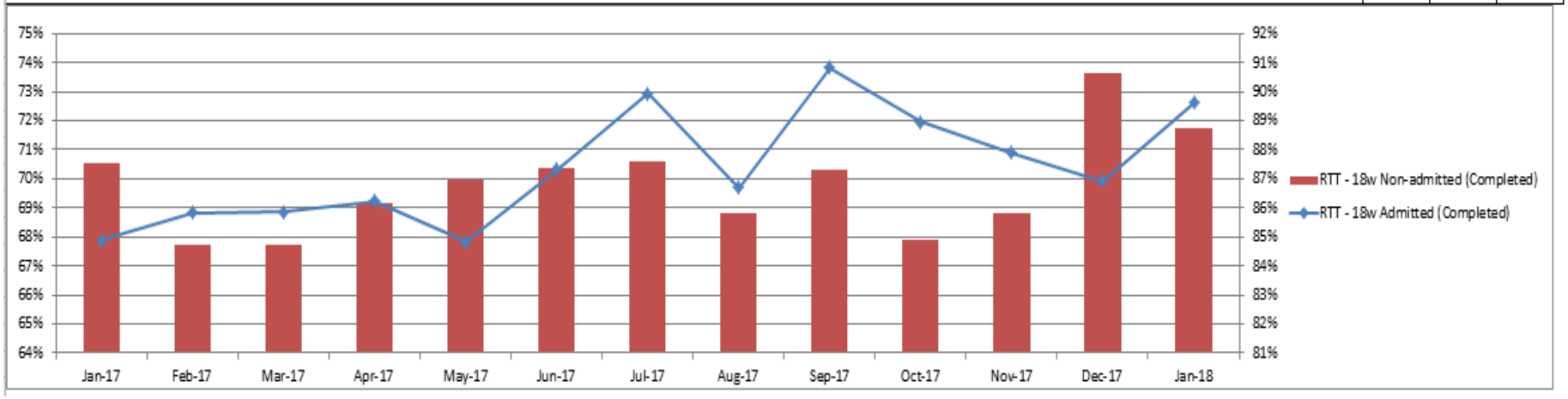
Trend | Recovery Trajectory

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
RTT - 18w Admitted (Completed)	68%	69%	69%	69%	68%	70%	73%	70%	74%	72%	71%	70%	73%		
RTT - 18w Non-admitted (Complete	88%	85%	85%	86%	87%	87%	88%	86%	87%	85%	86%	91%	89%		

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%
Name	Helen Beck
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Summary of Current performance & Reasons for under performance

Macmillan – 100%
ED – 50.5%
Overall Trust figure (including AMU) of 80% against a threshold of 100%
The performance figure for 1 hour to needle from diagnosis of neutropenic sepsis January Data showed an improvement of 26% from last month's drop to 53.84% . The Emergency Department had 5 neutropenic sepsis patient breeches. The breech cases will be undergoing detailed review. These issues will be escalated to the Emergency Department Clinical and Nursing management to address within the departments.

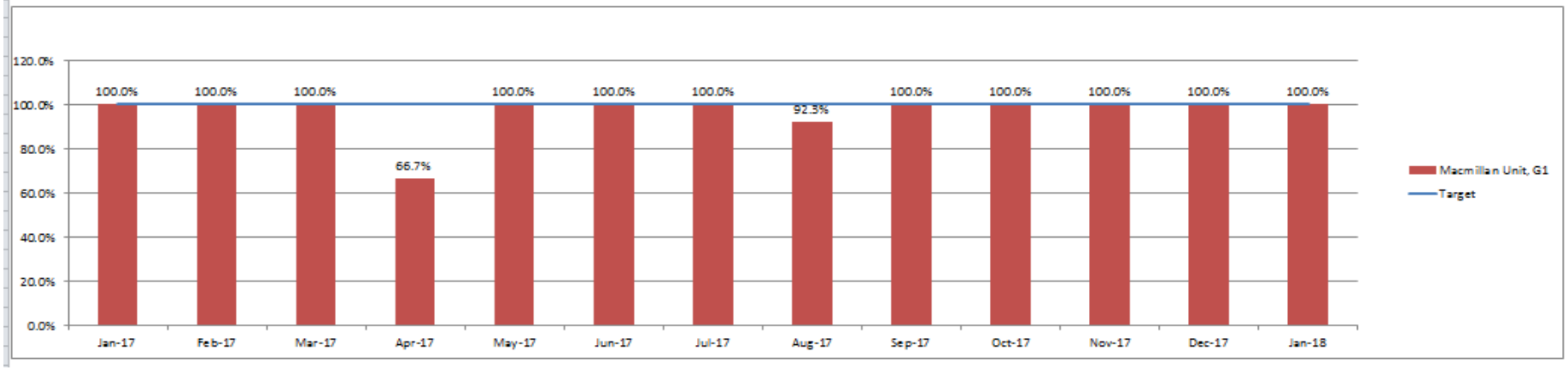
Trend | Recovery Trajectory

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
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Macmillan Unit, G1	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%		
Emergency Dept, ED	54.5%	90.9%)	66.7%	71.4%	40.0%	41.6%	58.3%	70.0%	40.0%	66.7%	62.5%	14.2%	50.0%		
Acute Medical Unit, AMU	NA	NA	NA	100.0%	NA	NA	NA	0.0%	NA	NA	NA	NA	NA		
1-hr neutropaenic sepsis	72.2%	94.1%	80.0%	63.6%	47.1%	63.2%	68.8%	82.6%	62.5%	79.0%	73.9%	53.8%	80.0%		

Actions in place to recover the performance

Expected timeframes for improvements

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



DETAILED REPORTS – WELL-LED

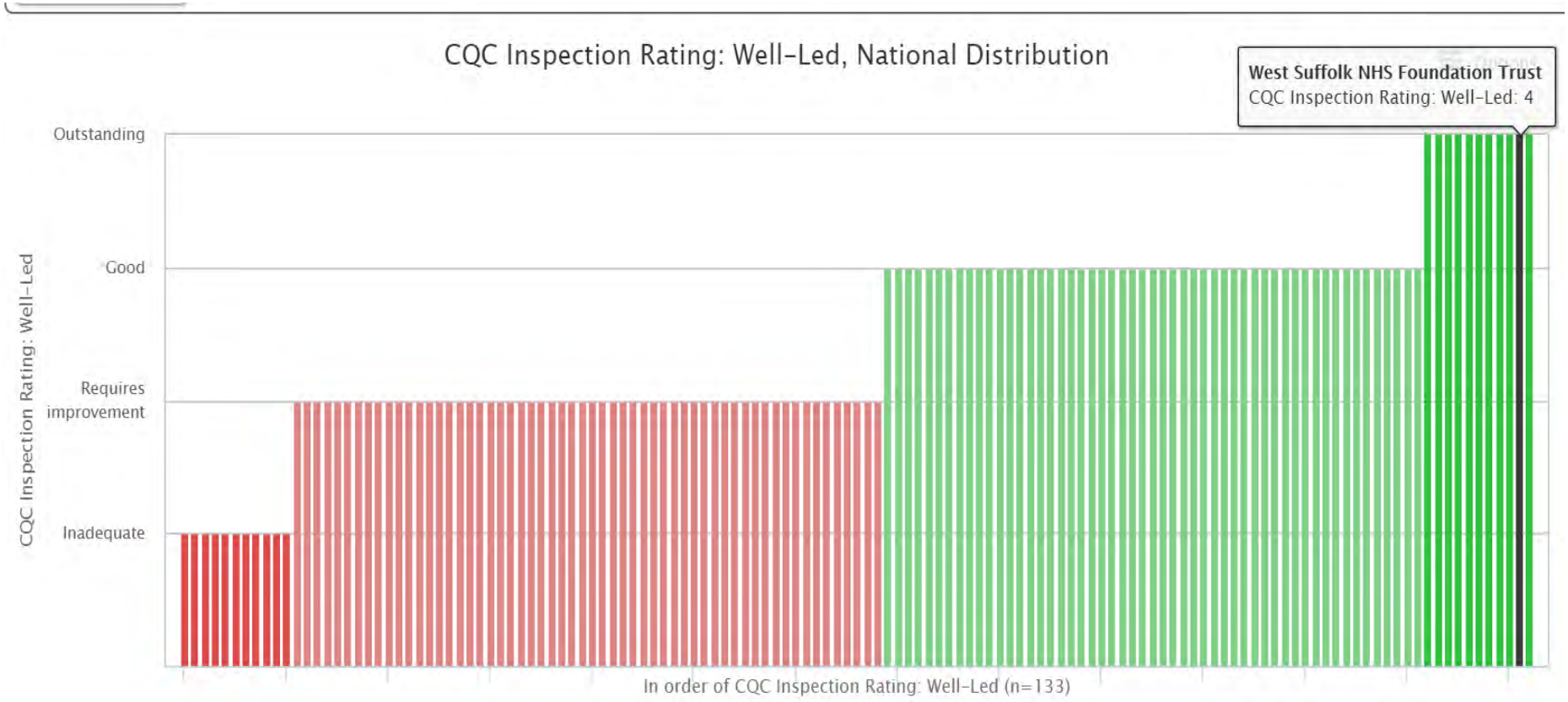
Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we		Ref.	KPI	Target	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	YTD(Apr17-Mar18)	WTG	Traffic	Trend
5. Well Led	Dashboard	5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	NA	NA	93%	NA	NA	95%	NA	NA	95%	NA	NA	ND	NA	95%	6		
		5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	NA	NA	79%	NA	NA	83%	NA	NA	82%	NA	NA	ND	NA	83%	6		
		5.04	Turnover (Rolling 12 mths)	<10%	10%	11%	10%	10%	10%	10%	10%	10%	10%	9%	9%	9%	9%	10%	6		
		5.05	Sickness Absence	<3.5%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.57%	3.58%	4		
		5.06	Executive Team Turnover (Trust Management)	<10%	0%	0%	0%	0%	20%	0%	0%	0%	0.0%	0%	0%	0%	0%	2%	6		
		5.07	Agency Spend		459	354	258	307	316	289	336	244	220	187	475	183	558	312	6		
		5.08	Monitor Use of Resources Rating		4	4	3	3	3	3	3	3	3	3	3	3	3.00	3			
	Agency, WTE & vacancies	5.09	Agency Spend Cap		459	354	258	378	378	378	378	378	378	378	378	378	378	378			
		5.10	Bank Spend		319	307	334	380	287	282	372	315	422	327	331	398	312	343			
		5.11	Bank/agency Spend percentage		5.78%	4.45%	4.15%	4.63%	3.93%	3.73%	4.93%	3.63%	4.73%	3.83%	4%	5%	5.72%	4.23%	2		
		5.12	Proportion of Temporary Staff		11.20%	10.90%	9.30%	11%	11%	10%	12%	11%	10.63%	10%	11%	8%	11.11%	11%	3		
		5.13	Locum and Medical agency spend		297	325	234	309	368	361	381	347	270	357	381	508	495	378			
		5.14	Total Vacancies		5.89%	5.82%	5.55%	7%	8%	6%	8%	7%	8%	8%	8%	8%	7.1%	8%	3		
		5.15	Corporate & Admin Costs as %	<7%	9.36%	9.39%	9.56%	8.48%	8.57%	9.46%	9.47%	9.49%	9.50%	8.60%	8.60%	11.11%	13.31%	9.66%			
		5.16	% Staff on Maternity/Paternity Leave		2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2.1%	2.02%			
		5.17	% Fill rate of Reg. Nurse shifts	90%	69.15%	71.93%	80.47%	83.20%	81.32%	83.60%	80.89%	79.60%	80.84%	ND	ND	ND	ND	81.58%			
	Corporate	5.23	% use of Core First (Qtrly)		ND	ND	ND	2%	ND	ND	5%	ND	ND	ND	ND	ND	ND	4%			
		5.25	Grievance reviews		3	4	4						6	6	6	5	5	28			
		5.27	Recruitment Timescales - Av no. of weeks to recruit	7				ND	6	5	5.40	6.40	7	6.90	6.90	6.40	5.40	6	3		
		5.28	DBS checks	95%	93%	93%	93%	93%	93%	93%	98%	98%	99%	98%	98%	99%	99%	96%	3		
		5.29	Staff appraisal Rates	90%	92%	92%	92%	ND	92%	92%	ND	ND	53%	51%	56%	62%	65%	67%	1		
		5.38	Trust Participation in on-going National Audits (Qtrly)	90%	NA	NA	ND	NA	NA	94%	NA	NA	96%	NA	NA	96%	NA	95%	3		
	Training	5.39	Infection Control Training (classroom)	85%	94%	94%	95%	95%	96%	95%	95%	96%	94%	95%	95%	95%	94%	95%	3		
		5.40	Infection Control Training (eLearning)	185%	87%	88%	88%	88%	88%	90%	90%	88%	83%	85%	88%	88%	90%	88%	3		
		5.41	Manual Handling Training (Patient)	80%	82%	80%	79%	81%	83%	84%	83%	83%	80%	80%	84%	84%	79%	82%	3		
		5.42	Manual Handling Training (Non Patient)	80%	87%	84%	83%	81%	81%	83%	83%	82%	86%	84%	88%	88%	89%	84%	3		
		5.43	Staff Adult Safeguarding Training	80%	86%	87%	88%	88%	89%	90%	90%	89%	89%	90%	92%	92%	92%	90%	3		
		5.44	Safeguarding Children Level 1	90%	86%	87%	86%	86%	86%	87%	88%	87%	86%	88%	89%	90%	91%	88%	2		
		5.45	Safeguarding Children Level 2	90%	86%	87%	87%	87%	88%	90%	90%	87%	88%	89%	90%	92%	92%	89%	2		
		5.46	Safeguarding Children Level 3	90%	81%	79%	78%	85%	83%	81%	81%	76%	73%	79%	83%	86%	86%	81%	2		
		5.47	Health & Safety Training	80%	86%	87%	88%	88%	89%	89%	89%	89%	89%	90%	91%	91%	92%	90%	3		
		5.48	Security Awareness Training	80%	87%	87%	88%	88%	89%	90%	90%	89%	89%	90%	90%	91%	91%	90%	3		
		5.49	Conflict Resolution Training (eLearning)	80%	77%	81%	83%	81%	83%	85%	86%	80%	80%	81%	82%	95%	76%	83%	3		
		5.50	Conflict Resolution Training	180%	74%	74%	75%	75%	75%	77%	77%	76%	75%	76%	76%	75%	88%	77%	2		
		5.51	Fire Training (eLearning)	280%	86%	86%	85%	85%	86%	87%	87%	85%	85%	85%	85%	84%	84%	85%	3		
		5.52	Fire Training (classroom)	80%	89%	89%	89%	90%	90%	90%	90%	90%	89%	90%	91%	91%	90%	90%	3		
		5.53	IG Training	80%	82%	82%	82%	80%	81%	85%	84%	85%	84%	87%	86%	87%	84%	84%	3		
		5.54	Equality and Diversity	80%	91%	92%	93%	93%	94%	95%	95%	93%	92%	93%	94%	94%	88%	93%	3		
		5.55	Majax Training	80%	85%	86%	86%	86%	86%	88%	88%	87%	86%	88%	88%	89%	90%	88%	3		
		5.56	Medicines Management Training	80%	85%	86%	87%	87%	87%	88%	88%	87%	87%	86%	87%	88%	89%	87%	3		
		5.57	Slips, trips and falls Training	80%	82%	84%	85%	84%	85%	87%	87%	85%	85%	86%	88%	88%	87%	86%	3		
		5.58	Blood-borne Viruses/Inoculation Incidents	80%	81%	84%	85%	84%	84%	86%	86%	84%	84%	85%	86%	87%	86%	85%	3		
		5.59	Basic life support training (adult)	80%	81%	80%	81%	83%	85%	85%	85%	84%	82%	81%	81%	82%	80%	83%	3		
		5.60	Blood Products & Transfusion Processes (Refresher)	80%	76%	78%	80%	80%	82%	83%	82%	79%	79%	80%	78%	80%	75%	80%	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-Jan-18
Data Frequency	Monthly
CQC Area	Well Led
National Rank	28th best

Summary of Current performance & Reasons for under performance

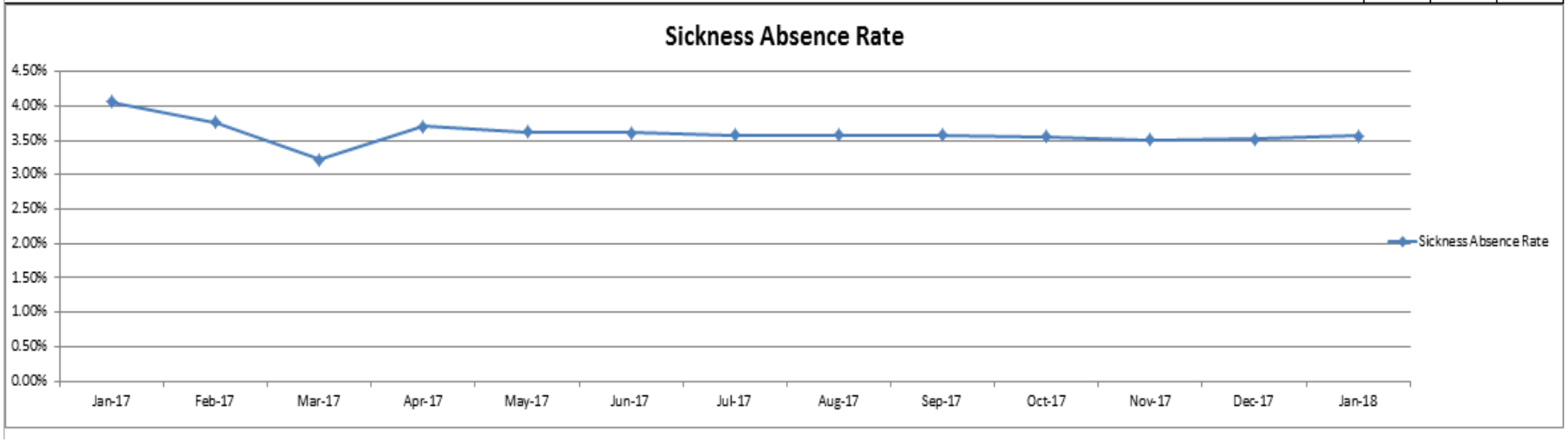
The sickness absence figure has gone up by 0.05% since last month, however this time last year it was 4.06%

Trend												Recovery Trajectory			
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
Sickness Absence Rate	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.57%		

Actions in place to recover the performance

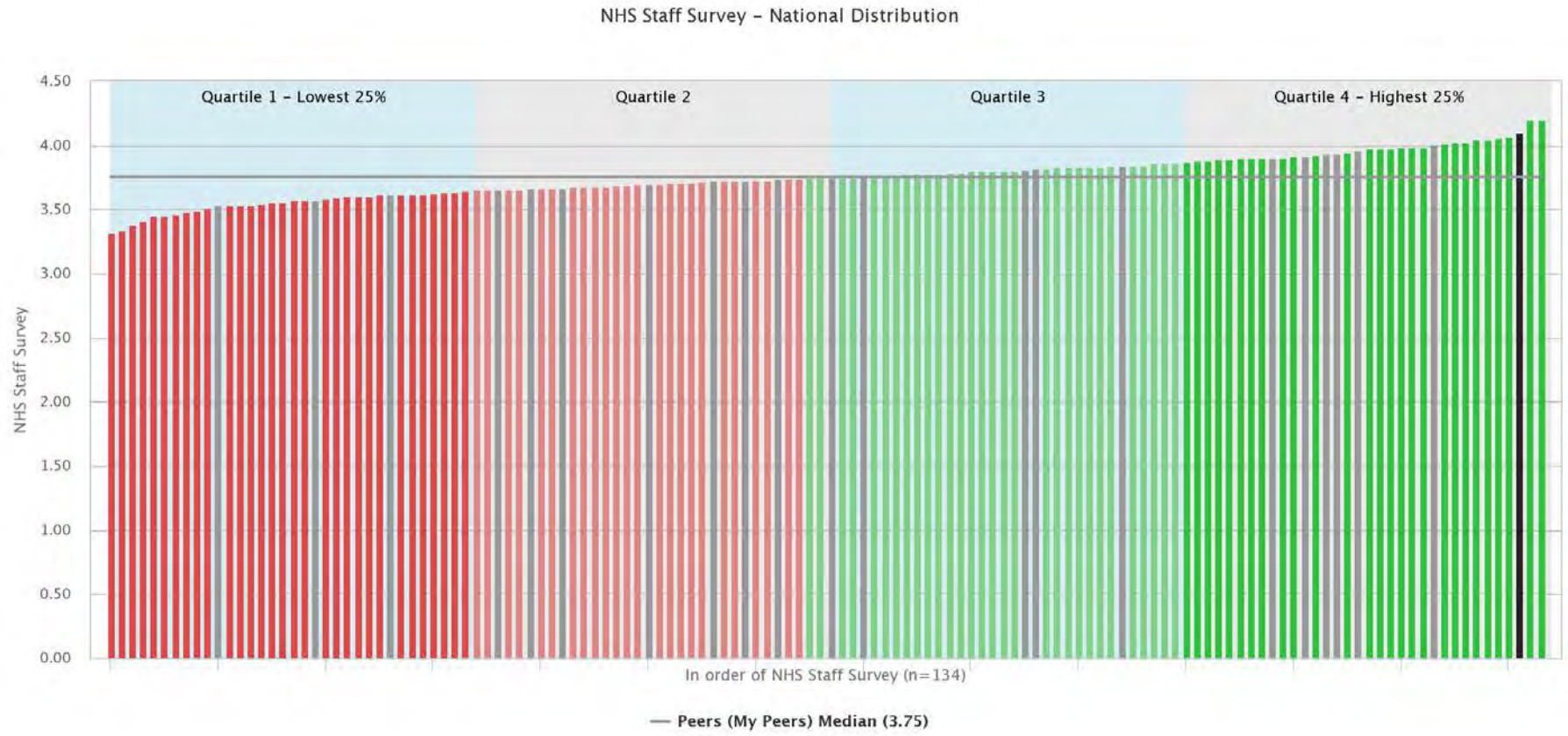
Expected timeframes for improvement

Description	Owner	Start	End
We are reporting high levels of gastro intestinal sickness in the community teams, which is to be expected at this time of year.	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

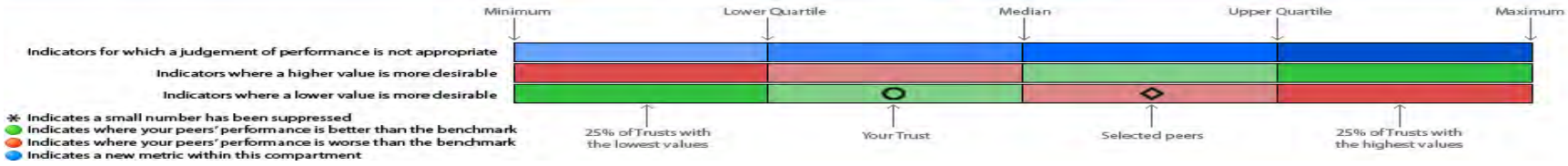
Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	Target	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	YTD(Apr17-Mar18)	WTG	Traffic	Trend
6. Productive	Dashboard	6.01	I&E Margin	Var	-5.13%	-5.10%	-1.50%	ND	-5%	-4.3%	-3.9%	0.1%	-3.04%	-2.55%	-2.47%	-2.60%	-2.34%	-3%			
		6.02	Distance from Financial Plan	Var	ND	ND	ND	ND	0.0%	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%	ND	ND	0.0%			
		6.03	Capital service capacity	Var	- 6.74	- 2.81	1.41	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.52%	0.16%	0.24%	0.52%			
		6.04	Liquidity (days)		- 19.70	- 21.76	- 7.28	ND	- 12.15	- 15.72	- 10.94	- 11.03	- 12.70	- 15.14	-9.64%	-12.85%	-11.38%	-9.64%			
		6.05	Long Term Borrowing (£m)	3.5%	33.06	36.06	44.30	44.27	45.70	45.70	45.70	45.70	47.62	47.62	56.67	58.65	64.36	56.67	6		
		6.06	CIP Plan Variance (£000s)	1.9	-3,268	-3,247	0	40	0	-40	10	0	-54	-10	-35	-129	-201	-42			
	Activity	6.07	A&E Activity		5064	4740	5570	5574	5970	5922	6124	5828	5741	6058	5736	5455	5466	57874			
		6.08	NEL Activity		2480	2350	2750	2409	2440	2429	2375	2385	2466	2588	2491	2545	2547	24675			
		6.09	OP - New Appointments		6119	5697	6849	5125	6244	6148	5706	5635	5633	6182	7230	5482	6766	60151			
		6.10	OP- Follow-Up Appointments		11999	11483	12790	9541	11667	11542	11147	11333	11116	11815	12668	9769	12662	113260			
		6.11	Electives (Incl Daycase)		2877	2819	3303	2593	3004	2898	2796	2829	2786	2868	3157	2546	2840	28317			
	Finance	6.13	Agency Rating (spend £000)		459	354	258	307	316	289	336	244	220	187	475	183	558	3115			
		6.14	Financial Position (YTD)	Var	10649	11736	3327	-937	-2906	-2758	-3290	-3300	-3953	-3956	-4114	-5170	-6600	-4114			
		6.15	Financial Stability Risk Rating	Var	4	4	3	3	3	3	3	3	3	3	3	3	3	3			
		6.16	Cash Position (YTD £000s)	Var	3598	1538	1352	7,955	5093	2689	7460	3300	4846	2654	4458	3518	4924	4458			
	Ratios	6.17	% Consultant to Consultant Referrals		ND	ND	ND	10%	10%	10%	12%	13%	10%	10.57%	10.03%	10.92%	12.65%	10.9%			
		6.18	New to FU Ratios	1.9	2.11	2.12	2.07	1.86	1.87	1.88	1.96	2.01	1.97	1.91	1.78	1.79	1.87	1.89			
		6.20	Non-Clinical Floor Space	<35%			29%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	3		
		6.21	Unoccupied Floor Space	<2.5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	CIPs	6.22	Plan (£000s) YTD	Var	9,554	10,912	12,500	840	1000	820	810	1420	1094	1123	1504	1312	1356	8611			
		6.23	Actual (£000s) YTD		6,286	7,665	12,500	880	1000	780	820	1420	1040	1113	1469	1183	1155	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	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	YTD(Apr17-Mar18)	WTG	Traffic	Trend
Maternity	Dashboard	7.01	Total number of deliveries (births)	210	198	197	238	215	192	213	215	233	236	205	194	180	199	2082	6		
		7.02	% of all caesarean sections	<22.7%	16%	13%	19%	15%	21%	16%	16%	22.32%	18.22%	17.10%	17.0%	18.3%	22.1%	18%	6		
		7.03	Midwife to birth ratio	1.30	1.28	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	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%	93%	87%	89%	84%	93%	84%	94%	82%	98%	98%	98%	93%	93%	92%	4		
		7.06	Maternity SIs	NT	0	1	1	1	0	0	0	0	1	1	0	1	2	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%	74%	80%	76%	79.8%	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	81%	6		
	Safe	7.09	Elective Caesarean Sections	10%	8%	5%	7%	5%	10%	4.3%	7.0%	9.4%	6.4%	5.9%	7.2%	7.8%	8%	7%	3		
		7.10	Emergency Caesarean Sections	<13%	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	10%	11%	14%	11%	2		
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%	90%	1		
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	71%	70%	89%	92%	93%	93%	83%	57%	82%	88%	50%	80%	83%	80%	3		
		7.14	Homebirths	2%	2%	3%	2%	1%	4%	2.4%	3.3%	2.6%	2.1%	3.9%	2.6%	3.3%	3%	3%	3		
		7.15	Midwifery led birthing unit (MLBU) births	>13%	24%	19%	16%	18%	17%	17.3%	18.8%	15.5%	15.3%	17.1%	16%	15%	19.1%	17%	3		
		7.16	Labour Suite births	75%	74%	78%	82%	81%	79%	80.3%	77.9%	82.0%	82.6%	79.0%	81.4%	81.7%	77.9%	80%	3		
		7.17	Induction of Labour	NT	34%	36%	37%	43%	41%	40.9%	36.6%	38.2%	34.3%	35.1%	43.8%	43.9%	37.2%	39.4%			
		7.18	Instrument Assisted Deliveries (Forceps & VentoUse)	NT	4.60%	4.85%	6.20%	4.45%	6.80%	4.85%	4.20%	3%	4.65%	4.15%	7.20%	5.85%	7%	5%			
		7.19	Critical Care Obstetric Admissions	0	0	0	1	1	1	0	1	0	1	0	0	0	2	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	3	2	8	2	4	3	5	3	7	6	4	5	4	43			
		7.22	Post-partum Hysterectomies	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	2		
		7.23	Women requiring a blood transfusion of 4 units or more	0	ND	0	ND	1	0	0	0	0	0	0	0	ND	ND	1	2		
		7.24	3rd and 4th degree tears (all deliveries)	12	5	4	7	8	9	6	10	4	4	6	3	8	9	67	3		
	Caring	7.25	Maternal death	NT	0	0	1	1	0	0	0	0	0	0	0	0	0	1			
		7.26	Stillbirths	NT	0	1	0	1	0	0	0	0	1	2	1	0	2	7			
		7.27	Complaints		0	0	0	0	0	1	2	1	0	0	0	1	0	5			
		7.28	No. of babies admitted to Neonatal Unit (>36+6)	NT	8	8	0	15	9	17	18	13	15	15	11	9	8	130			
	Responsive	7.29	No. of babies transferred for therapeutic cooling	0	1	1	1	0	0	0	0	0	0	1	0	1	0	2	3		
		7.30	% of babies admitted to NNU with normal temperature	80%	100%	100%	100%	87%	66%	88%	100%	100%	86%	81%	92%	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	54	49	64	51	62	46	64	43	52	61	57	49	63	548	2		
		7.33	Hours of dedicated consultant cover per week	60	63	81	60	93	110	99	99	96	99	99	108	90	102	995	3		
		7.34	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	100	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	ND	27	35	37	32	30	37	27	28	17	26	296			
		7.37	No. of women identified as smoking at delivery	NT	ND	ND	ND	20	30	26	32	27	25	25	24	26	21	256			
		7.38	UNICEF Baby friendly audits	NT	10	10	10	10	10	10+	10+	10+	10+	10+	10+	10+	10+	20			
		7.39	No. of parents receiving Safer Sleeping Suffolk Thermometer	NT	156	157	165	143	170	174	205	155	192	151	156	186	186	1718			
	Other	7.40	No. of bookings (First visit)	NA	262	247	275	208	262	244	272	245	265	259	245	193	279	2472			
		7.41	Access - Assessment of need by 12 weeks (women booked)	95%	93%	95%	96%	95%	95%	98%	95%	100%	93%	99%	97%	97%	96%	96%	3		
		7.43	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0			

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
National Rank	

Summary of Current performance & Reasons for under performance

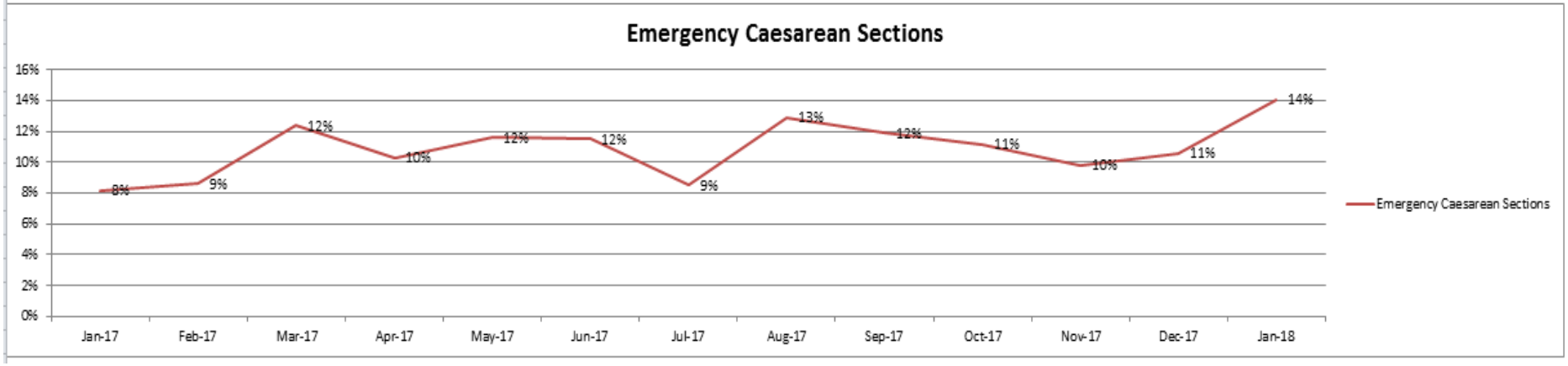
The emergency caesarean section rate in January 2018 was higher than has previously been experienced. The total caesarean section rate was 22.1%, below the commissioned figure of 22.6%.

Trend / Recovery Trajectory

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
Emergency Caesarean Sections	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	10%	11%	14%		

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
Standard	
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

Summary of Current performance & Reasons for under performance

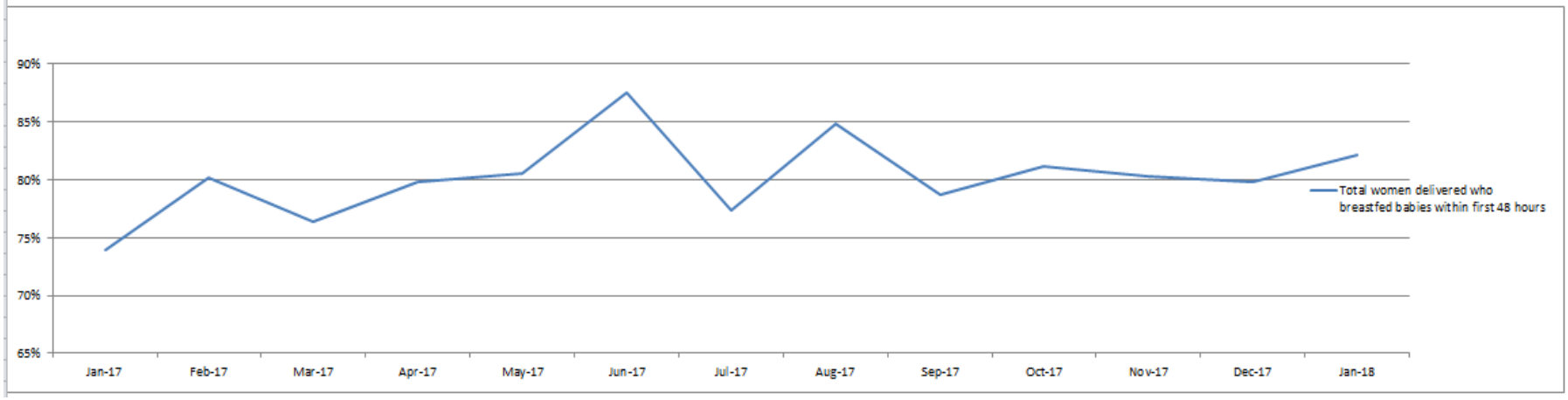
Compliance with the 80% target of babies receiving breastmilk within 48 hours of life was marginally missed in December 2017. However in January 2018 the 80% target was exceeded with an initiation rate of 82.2%

Trend / Recovery Trajectory

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
Total women delivered who breastfed babies within first 48 hours	74%	80%	76%	79.8%	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%		

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

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-Jan-18
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

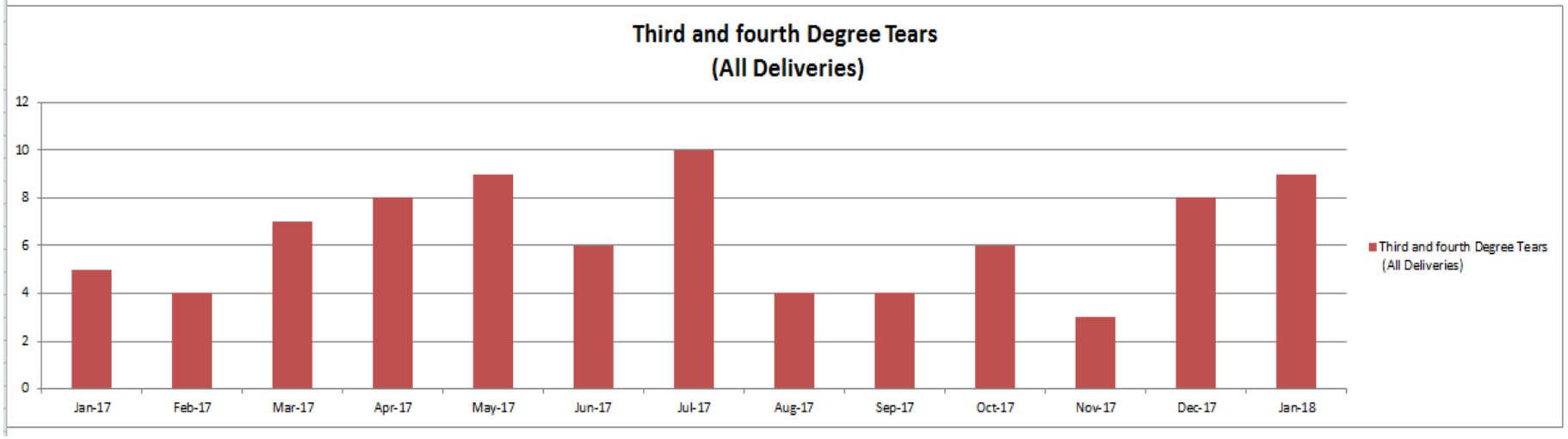
Summary of Current performance & Reasons for under performance

Rated as amber in December 2017and in Janurary 2018.

Trend												Recovery Trajectory			
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
Third and fourth Degree Tears (All Deliveries)	5	4	7	8	9	6	10	4	4	6	3	8	9		

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 work streams continue to look at perineal trauma, including the use of Episissors			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity WHO Checklist
Standard	100%
Name	Rowan Procter
Month	01-Jan-18
Data Frequency	Monthly
CQC Area	Maternity WHO Checklist
National Rank	NA

Summary of Current performance & Reasons for under performance

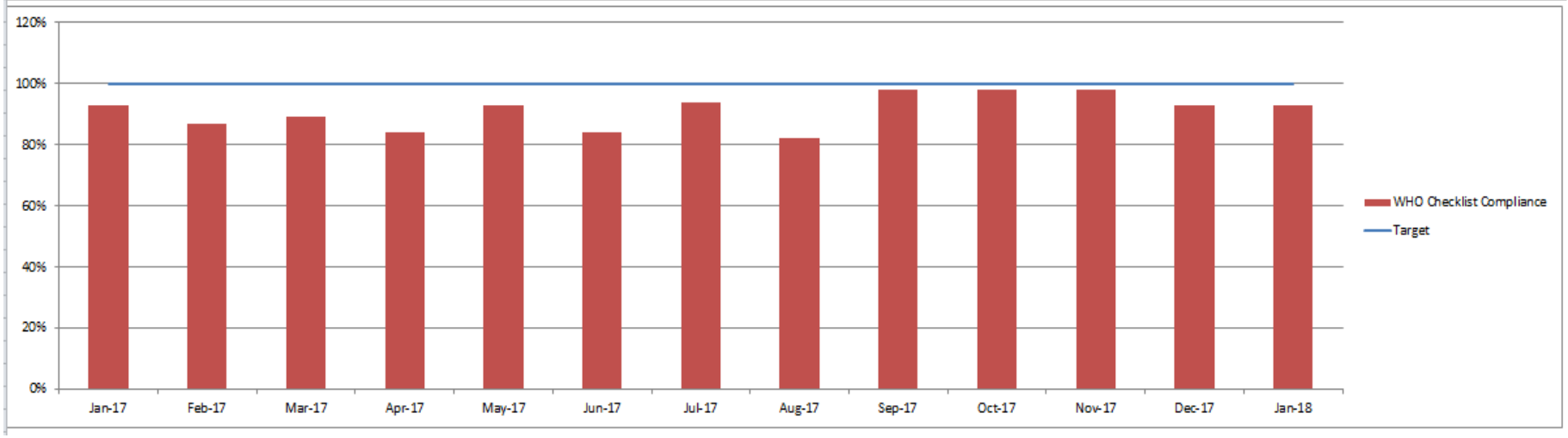
Despite the focus on completion of the Maternity WHO checklist completion rates reduced in December 2017. The completion rate Janurary 2018 remained at 93%

Trend												Recovery Trajectory			
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
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
WHO Checklist Compliance	93%	87%	89%	84%	93%	84%	94%	82%	98%	98%	98%	93%	93%		

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.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

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.

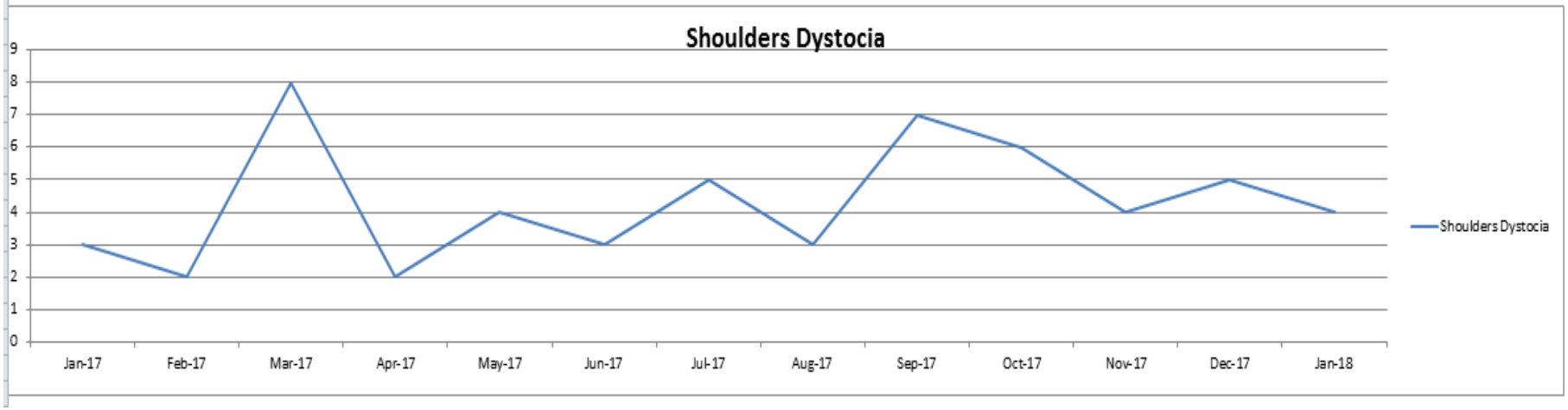
Trend | Recovery Trajectory

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
Shoulders Dystocia	3	2	8	2	4	3	5	3	7	6	4	5	4		

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Currently an audit is in progress to look at these, due to report to the Clinical Governance meeting in February 2018.	RS	Jul-17	



COMMUNTY INFORMATION

Welcome to the Community contract report for January.

- Our FFT for January was 95.15% from 103 responses, with both children's services and patients with a long term condition achieving 100%.
- There were no formal complaints received for community services in January
- There has been a notable increase in referrals and activity for the COPD (approx 40%) and pulmonary Rehab services in January. This is consistent with the rise in respiratory activity experienced in the hospital.
- All the response targets for the community health teams have been met, with both nursing and therapy seeing an increase in activity compared to December.
- The paediatric speech and language therapy service has again seen an overall reduction in the total number of children waiting therapy for the third consecutive month.
- The community beds length of stay has remained good at an average of 15 days (excluding DTOC's
- The community bed sites have an improved position for delayed transfers of care. In January there were only 12 patients whose discharge was delayed with a loss of 93 bed days compared to 23 patients in December with a total of 188 beds days lost. Newmarket CH is 15.12%, Glastonbury Court is 3.8% against the 3.5% target. There were no DTOC this month at Hazel Court.
- The community equipment service has missed 5 out of 7 KPI's in January. Although the margin of non-compliance has improved when compared to December. A formal performance notice has been issued and an improvement plan received.
- The Children in Care service has experienced a rise in referrals, plus several late notifications during January which have resulted in poor compliance. An escalation meeting at Director level has been held between WSFT, CCG and SCC resulting in an action plan.

Adult KPI's							
Service	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of measurement**	**Jan 2018**	**January Comments / Queries 2018**	**Dec 2017**
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	100.00%		83.33%
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	No referrals	100.00%
CHTs		Urgent 4 hrs	95%		100.00%		100.00%
CHTs		Intermediate - 72 hrs	95%		99.30%		97.98%
CHTs		18 weeks	95%		99.80%		100.00%
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	100.00%		99.67%
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	94.88%		95.47%
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 indicator)	98%	Monthly	97.76% (262/268)	There has been a significant change in prescriber ordering behaviour. This change along with key staff shortages has meant that the performance has dropped. There was also an increase in some of the reason code usage due the 2 major incidents. The Orwell Bridge had closed twice in consecutive weeks. This had a major impact on the road network and impacted a large amount of orders.	94.93% (281/296)
		Next Working day - Urgent equipment	98%		98.83% (1351/1367)		99.33% (1188/1196)
		Within 7 working days - to support hospital discharge or prevent admission	98%		95.66% (2951/3085)		95.35% (3240/3398)
		Within 10 working days - to support hospital discharge or prevent admission	98%		95.02% (496/522)		95.98% (717/747)
CES	**c-gen9**	Collection times: % of urgent next day collections for deceased Service Users	98%	Monthly	98.08% (102/104)		98.81% (83/84)
		% of urgent collections within 3 working days	98%		95.03% (554/583)		96.54% (446/462)
		% of collections within 10 working days	98%		94.22% (5933/6297)		93.80% (6037/6436)
All	**c-safe1**	% eligible staff who have completed Safeguarding Children level 1 training	95%	Monthly	95.92%		95.98%
All	**c-safe2**	% eligible staff who have completed Safeguarding Adults level 1 training	95%	Monthly	94.08%		93.98%
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

Service	Technical Reference	Quality Requirement	Threshold	Method of measurement	Jan 2018	January Comments / Queries 2018	Dec 2017
COPD West	**s-copd4**	Number of pulmonary rehab courses offered	At least 200 courses offered per year	Monthly	26 offered		14 offered
		Number of pulmonary rehab courses completed	At least 100 courses completed per year	Monthly	4 completed		6 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	98.41%		95.65%
Adult SALT West	**s-salt2**	Service Users seen within the following timescales after triage: Priority 1 within 10 Operating Days	Priority 1 - 100%	Monthly	100.00%		66.67%
Adult SALT West		Priority 2 within 20 Operating Days	Priority 2 - 95%		75.51%	Increase in Priority 2 referral in Jan, average = 27, 49 received in Jan 12 patients out of 49 not seen within 20 days Activity impacted by 100% compliance for Priority one.	81.25%
Adult SALT West		Priority 3 within 18 weeks	Priority 3 - 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	90.20%		87.20%
Adult SALT West			Partially achieved = 40%		3.90%		10.60%
Adult SALT West			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 received
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	n/a		100.00%
		Medium Priority	100% within 12 weeks		n/a		100.00%
		Low Priority	100% within 18 weeks		93.33%	14 out of 15 referrals 1 breach service capacity Assessed at 18.71 weeks	100.00%
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%		92.96%
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%

Children's Services KPIs							
Service	**Technical Reference**	**Quality Requirement**	**Threshold**	**Method of Measurement**	**Jan 2018**	**Jan Comments/ Queries 2018**	**Dec 2017**
All Paediatric Services	**GP-1**	18 week RTT for Consultant led services	95% consultant led treated within 18 weeks	Paediatric Cons Team	98.73%		98.36%
All Paediatric Services	**GP-1**	18 week RTT for non-Consultant led services	95% non-consultant led treated within 18 weeks	Monthly Pledge 2 reporting: Paediatric SLT, OT,	100.00%		99.30%
All Paediatric Services	**PaedSLT-4**	All Children to have a Personal Health plan completed where required.	100% offered PHP 80% completed PHP	Monthly report	100.00%		100.00%
All Paediatric Services	**GP-6**	Safeguarding - % eligible staff who have completed level 1 training	95%	Monthly report	99.53%		99.07%
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	98.37%		98.24%
Newborn Hearing Screening Service (West)	**NBHS-3**	Screening outcomes set within 3 months	95%	Monthly report	98.35%		98.21%
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% 197 contacts		100% 100 contacts
Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	Monthly report	100% 106 contacts		100% 59 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	43.75%	7 out of 16 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 referrals There has been an increased number of referrals to the team in the two weeks prior to Christmas. 30 Referrals in December, compared to an average of 16 a month. The impact of the high referral rate, out of county referrals and delay in notification were escalated to the Designated Nurse for CiC in December.	100.00%
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	12.50%	2 out of 16 children had an IHA completed within 28 days of the service being made aware of the child. Of the 14 appts outside the 28 day deadline (31-63 days) • 4 Children had declined appts (3 carers declining 2 appts, 1 carer declining 3). • 3 Children had DNA'd previous appts. • 7 Children seen as 1st appt out of the 28 day target, impact of referral increase in December. (2 seen at 31 days, 3 at 35 days and 2 at 43 days)	100.00%
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 16 IHAs were within 28 days of the child being placed in care irrespective of paperwork being received. 14 of the 16 IHAs had a delay of 16 or more days from being placed in care and the service being made aware. Two large sibling groups placed from out of area authorities in December, all of which had been Looked After over 28 days before placement in Suffolk A meeting was held with the Designated Nurse and SCC Director of Children and Young People's Services on 12.02.18 to review the current position and challenges within the Initial Health Assessment Pathway. Agreement made for the Associate Director of ICPS and the Designated Nurse to meet and compile an options appraisal document to explore options to improve system capacity and processes.	63.64%

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

a Current Position

- 94.88% 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 book onto next available training.

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

a Current Position

C-gen8 - delivery within 4 hours – 97.76% against a 98% target
262 out of 268 deliveries were compliant; 6 non-compliant items

C-gen8 - delivery within 7 working days – 95.66% against a 98% target
2951 out of 3085 deliveries were compliant; 134 non-complaint items

C-gen8 - delivery within 10 working days – 95.02% against a 98% target
496 out of 522 deliveries were compliant; 26 non-complaint items

C-gen9 – collection by 3 working days – 95.03% against a 98% target
554 out of 583 collections were compliant; 29 non-complaint items

C-gen9 – collection by 10 working days – 94.22% against a 98% target
5933 out of 6297 collections were compliant; 364 non-compliant items

b Recommended Actions

- A formal performance notice has been issued and an improvement plan received.
- To receive weekly updates and data on performance rather than monthly until compliance has improved

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

a Current Position

- 94.08% 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.

4 **S- salt2 – Adult Speech and Language - Priority 2 patients seen within 20 working days**

a Current Position

Priority 2 patients seen within 20 working days. 75.51% against 95% target
This relates to 12 patients out of 49.
Increase in Priority 2 referrals in Jan, average = 27, 49 received in Jan.

b Recommended Action

- Continue to deploy staffing across acute and community to direct resource to high priority areas
- Band 4 administrative role to be skill mixed to a clinical role to increase resources
- 2 new staff members commenced

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

a Current Position

- 93.33% against 100% target. This relates to 1 patient out of 15. Patient assessed at 18.71 weeks

b Recommended Action

- 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 –43.75% against a 100% target
7 out of 16 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 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 16 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 16 IHAs were within 28 days of the child being placed in care irrespective of paperwork being received.

14 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 (30 in December compared to an average of 16 a month previously) is being investigated to determine cause.
- The impact of the high referral rate, out of county referrals and delay in notification were escalated to the Designated Nurse for CiC in December.
- Continued monitoring of notifications and escalation with County Council and CCG
- A meeting was held with the Designated Nurse and SCC Director of Children and Young People's Services on 12.02.18 to review the current position and challenges within the Initial Health Assessment Pathway.
- Agreement made for the Associate Director of ICPS and the Designated Nurse to meet and compile an options appraisal document for executive consideration and decison to improve system capacity and processes.

Quality Dashboard

	Units	Target	Red	Amber	Green	Dec	Jan
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
Rolls out of Bed		No Target				4	5
Slip out of chair		No Target				0	0
Assisted Falls/ near misses		No Target				1	1
% of total falls resulting in harm	%	No Target				44%	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				0	1
% 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				7.35	7.11
Pressure Ulcers							
Pressure Ulcers – In Our Care Community							
Grade 2		100 pa	>110	100-110	<=100	0 (+0 pend)	3 (+10 pend)
Grade 3		26 pa	>30	27-29	<=26	1 (+3 pend)	1 (+ 5 pend)
Grade 4		0 pa	>1	1	0	0 (0 pend)	0 (0 pend)
Pressure Ulcers – In our care In-patient							
Grade 2		13 pa	>17	13-17	<=13	0 (+1 pend)	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				1	0
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				0	0

	Units	Target	Red	Amber	Green	Dec	Jan
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 %	90.96%	89.39%
Essential Steps Care Bundles Including Hand Hygiene							
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	98%	98%
Isolation room audit		100%	<95%	95%-100%	=100 %	100%	N/A
Management of Medication -SCH NRLS Reportable Incidents							
Total number of medication incidents in month		No Target				6	3
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				6	3
(also includes those not attributed to SCH management)	Low harm	No Target				0	0
Number of medication incidents involving Controlled Drugs		No Target				1	0
Incidents							
NRLS (i.e. patient safety) reportable incidents in month		No Target				71	132
Number of Never Events in month		No Target				0	0
Number of Serious Incidents (SIs) that occurred in month		No Target				5	4
Number of SIs reported to CCG in month *4 STEIS for 2 pts (2 each)		No Target				5	7
Percentage of SI reports submitted to CCG on time in month		No Target				100%	<100%
Duty of Candour Applicable Incidents		No Target				5	7
Severity of NPSA Reportable Incidents							
None		No Target				48	88
Low		No Target				17	32
Moderate		No Target				6	12
Major		No Target				0	0
Catastrophic		No Target				0	0
Training Compliance							
Adult Safeguarding – Mandatory Training Compliance		95%	<90%	90%-95%	>=95%	93.98%	94.08%
Children Safeguarding – Mandatory Training Compliance		95%	<90%	90%-95%	>=95%	95.98%	95.92%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	95.18%	93.27%
WRAP						78.89%	79.43%
MCA / DoLs- Training compliance						75.15%	75.61%

Compliments/Complaints

There is limited historical information as the services disaggregated in October.

There were no formal complaints received for community services in January

	Jan 18
Total Compliments	6
Formal complaints (No.)	
Acknowledged within 3 working days (No.)	
Acknowledged within 3 working days (%)	
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)	-

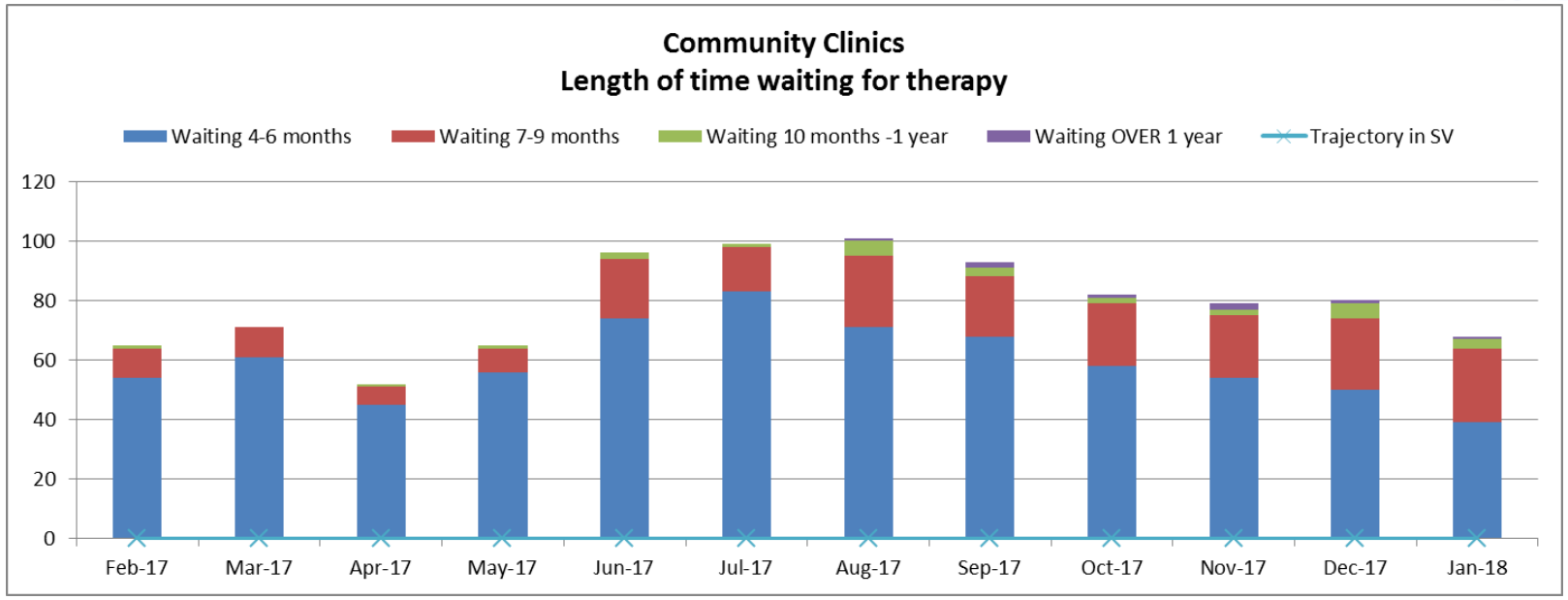
Paediatric Speech and Language Service Waiting times

Community Clinics

Clinic Waiting lists

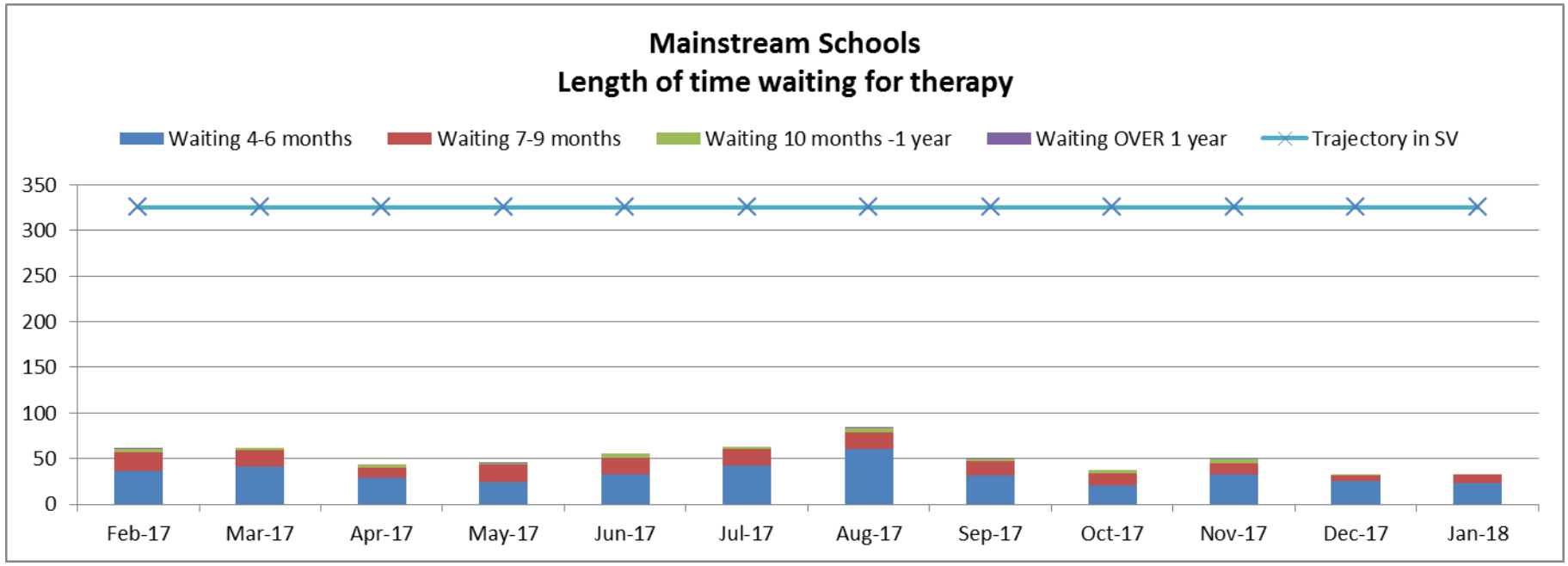
Reports run 01/02/18

Length of wait Community Clinics *(pre-school caseload)*	**No. of children waiting February 2017**	**No. of children waiting March 2017**	**No. of children waiting April 2017**	**No. of children waiting May 2017**	**No. of children waiting June 2017**	**No. of children waiting July 2017**	**No. of children waiting August 2017**	**No. of children waiting September 2017**	**No. of children waiting October 2017**	**No. of children waiting November 2017**	**No. of children waiting December 2017**	**No. of children waiting January 2018**
Waiting up to 3 months	165	162	166	154	156	150	101	87	97	105	91	97
Waiting 4-6 months	54	61	45	56	74	83	71	68	58	54	50	39
Waiting 7-9 months	10	10	6	8	20	15	24	20	21	21	24	25
Waiting 10 months -1 year	1	0	1	1	2	1	5	3	2	2	5	3
Waiting OVER 1 year	0	0	0	0	0	0	1	2	1	2	1	1
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**230**	**233**	**218**	**219**	**252**	**249**	**202**	**180**	**179**	**184**	**171**	**165**
Already had PoC	60	85	53	51	73	86	67	58	50	41	57	39
Total waiting ***(Including patients who have already receive 1 POC and are waiting for another)***	**290**	**318**	**271**	**270**	**325**	**335**	**269**	**238**	**229**	**225**	**228**	**204**



Mainstream Schools

Length of wait Mainstream Schools *(pre-school caseload)*	**No. of children waiting February 2017**	**No. of children waiting March 2017**	**No. of children waiting April 2017**	**No. of children waiting May 2017**	**No. of children waiting June 2017**	**No. of children waiting June 2017**	**No. of children waiting August 2017**	**No. of children waiting September 2017**	**No. of children waiting October 2017**	**No. of children waiting November 2017**	**No. of children waiting December 2017**	**No. of children waiting January 2018**
Waiting up to 3 months	56	73	87	89	84	113	100	64	68	61	52	75
Waiting 4-6 months	36	41	29	24	33	42	60	32	20	33	25	23
Waiting 7-9 months	21	18	11	19	18	18	19	15	14	12	6	10
Waiting 10 months -1 year	4	3	4	2	5	3	4	2	4	5	2	0
Waiting OVER 1 year	1	0	0	1	0	0	1	1	0	1	0	0
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**118**	**135**	**131**	**135**	**140**	**176**	**184**	**114**	**106**	**112**	**85**	**108**
Already had PoC	266	248	210	194	253	759	739	359	346	314	327	265
Total waiting ***(Including patients who have already receive 1 POC and are waiting for another)***	**384**	**383**	**341**	**329**	**393**	**935**	**923**	**473**	**452**	**426**	**412**	**373**


Mainstream Schools
Length of time waiting for therapy
Waiting 4-6 months
Waiting 7-9 months
Waiting 10 months -1 year
Waiting OVER 1 year
Trajectory in SV
350
300
250
200
150
100
50
0
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18

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														No Data	No Data	100									
	HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	No Data	No Data	100	100							No Data	No Data	100	100		100	No Data				No Data		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	90						100	100	100	100	100	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	100																					
	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	100					100	100				100		
	Total no of MRSA bacteraemias: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	86	100	100	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	1	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	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 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
	MEWS documentation and escalation compliance	= 100%	<80	80-99	= 100																														
	No of patient falls	= 48	>=48	No Target	<48	4	0	4	0	0					0	0	10	7	4	7	5	5	6	5	3	0	3	3	8	2		0	0		
	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	1	0	1	0	0					1	0	4	3	0	3	2	2	4	1	0	0	0	1	5	0		0	0		
	No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	3	2	0	0	2						0	5	4	3	5	3	0	0	0	0	0	0	2	1	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	100	100	100	100						100	90	100	100	67	100	50	100				83	90	90	No Data			90		
	No of SIRIs	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	2	1	1	0	2	1	0	0	0	0	0	0	1	0	0	0	0	0	0
	No of medication errors	No Target	No Target	No Target	No Target	3	1	2	4	3	0	2	1	0	7	0	1	0	2	3	5	4	1	0	0	0	1	4	4	2	1	3	0	0	1
	Cardiac arrests	No Target	No Target	No Target	No Target	0	0	1	1	0	1	0	0	0	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0
	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	55.6	77.7	78.0	76.2								33.9	68.8	73.7	70.3	62.3	62.3	48.1				86.7	51.7	25.8	61.7	21.0	No Data	90.1		No Data
	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	96.97	100	96.77	96.97	100	No Data	No Data	No Data	No Data	No Data	100	96.77	96.97	100	90.91	93.94	96.77	93.1	100	100	No Data	100	100	96.88	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	95	98							98		93	99	96	86	86					99	90	84				99		
	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	96.7	100							100		100	100	100	100	81.82					100	87.1	100				92.86		
	In your opinion, how clean was the hospital room or ward that you were in?	= 85%	<75	75-84	85-100	98	100	96	98							100		98	89	100	90	93					100	100	97				94		
	Did you feel you were treated with respect and dignity by staff	= 85%	<75	75-84	85-100	100	100	97	100							100		98	100	100	93	95					100	95	96				100		
	Were staff caring and compassionate in their approach?	= 85%	<75	75-84	85-100	100	100	97	100							100		98	100	100	100	90					100	97	96				100		
	Did you experience any noise in the night time that you think could have been avoided?	= 85%	<75	75-84	85-100	19	100	79	95							94		91	100	100	71	90					100	77	85				100		
	Did you find someone in the hospital staff to talk about your worries and fears?	= 85%	<75	75-84	85-100	100	100	97	95							100		100	100	100	100	78					100	100	67				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	96	98							100		94	100	100	79	65					96	92	85				96		
	Did staff talk in front of you as if you were not there?	= 85%	<75	75-84	85-100	100	100	99	100							100		100	100	100	57	85					100	89	46				100		
	Were you given enough privacy when discussing your condition or treatment?	= 85%	<75	75-84	85-100	100	100	99	100							89		100	100	100	100	90					100	100	100				100		
	Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	100	100	100	100							100		100	100	100	100	100					100	100	100				100		
	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	100	100	99	100							100		100	100	100	100	80					100	67	42				100		

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – January 2018

Agenda item:	10			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	26th February 2018			
Subject:	Finance and Workforce Board Report – January 2018			
Purpose:	x	For information		For approval

Executive summary:
The reported I&E for January 2018 YTD is a deficit of £5.9m, against a planned deficit of £4.5m. This results in an adverse variance of £1.4m YTD. We are monitored by NHSI against our pre STF position which is an adverse variance of £930k. The year-end forecast, in the absence of any corrective action, is that the pre STF performance will be adverse to plan by £1.5m.

If we were to miss our control total our Q4 STF relating to financial performance would be affected. We are also unlikely to receive A&E performance STF in Q4. The forecast including a £1.5m overspend against our control total and lost STF would result in an adverse variance to overall plan of £3.8m.

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

January 2018 (Month 10)

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

Financial Summary

I&E Position YTD	£5.9m	loss
Variance against plan YTD	-£1.4m	
Movement in month against plan	-£0.3m	
EBITDA position YTD	£1.3m	deficit
EBITDA margin YTD	0.8%	deficit
Cash at bank	£4,923k	

Executive Summary

- The Month 10 YTD position is £1,398k behind plan.

Key Risks

- Delivering the cost improvement programme.
- Containing the increase in demand to that included in the plan (2.5%).
- Our Q3 A&E performance was below the 90% target for the receipt of Sustainability and Transformation Funding and achieving the Q4 target is looking increasingly unlikely.
- Working across the system to minimise delays in discharge and requirement for escalation beds

SUMMARY INCOME AND EXPENDITURE ACCOUNT - January 2018	Jan-18			Year to date			Year end forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
NHS Contract Income	16.0	16.1	0.1	176.3	176.5	0.3	206.8	207.3	0.5
Other Income	4.2	2.7	(1.5)	29.6	29.8	0.2	34.7	34.8	0.1
Total Income	**20.2**	**18.8**	**(1.4)**	**205.8**	**206.3**	**0.5**	**241.5**	**242.1**	**0.6**
Pay Costs	12.5	12.8	(0.2)	122.3	122.5	(0.2)	147.3	147.9	(0.6)
Non-pay Costs	8.3	7.2	1.2	84.4	85.5	(1.1)	96.3	97.7	(1.4)
Operating Expenditure	**20.9**	**19.9**	**0.9**	**206.7**	**208.0**	**(1.3)**	**243.6**	**245.6**	**(2.0)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**(0.7)**	**(1.2)**	**(0.5)**	**(0.9)**	**(1.8)**	**(0.9)**	**(2.2)**	**(3.5)**	**(1.4)**
EBITDA margin	(0.3%)	(3.0%)	(2.7%)	1.5%	0.9%	(0.6%)	1.3%	(0.3%)	(1.5%)
Depreciation	0.6	0.4	0.2	5.6	5.5	0.1	6.7	6.6	0.1
Finance costs	0.1	0.1	0.0	2.0	2.2	(0.2)	2.2	2.4	(0.2)
SURPLUS/(DEFICIT) pre S&TF	**(1.3)**	**(1.7)**	**(0.3)**	**(8.5)**	**(9.4)**	**(0.9)**	**(11.1)**	**(12.6)**	**(1.5)**
Sustainability and Transformation Funding									
S&T funding - Financial Performance	0.4	0.4	0.0	2.8	2.8	0.0	3.6	2.4	(1.3)
S&T funding - A&E Performance	0.2	0.2	0.0	1.2	0.7	(0.5)	1.6	0.5	(1.0)
SURPLUS/(DEFICIT) incl S&TF	**(0.7)**	**(1.1)**	**(0.3)**	**(4.5)**	**(5.9)**	**(1.4)**	**(5.9)**	**(9.7)**	**(3.8)**

FINANCE AND WORKFORCE REPORT – January 2018

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 – January 2018

Income and Expenditure summary as at January 2018

The reported I&E for January 2018 YTD is a deficit of £5,907k, against a planned deficit of £4,509k. This results in an adverse variance of £1,398k YTD. We are monitored by NHSI against our pre STF position which is an adverse variance of £930k. The year-end forecast, in the absence of any corrective action, is that the pre STF performance will be adverse to plan by £1.5m

The monthly adverse variance is £319k which relates to the unfunded costs of winter escalation capacity.

If we were to miss our control total our Q4 STF relating to financial performance would be affected. We are also unlikely to receive A&E performance STF in Q4. The forecast including a £1.5m overspend against our control total and lost STF would result in an adverse variance to overall plan of £3.8m.

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 also seeking to manage flow through the hospital and the associated cost of temporary medical and nursing staff (this is currently costing c£300k per month).

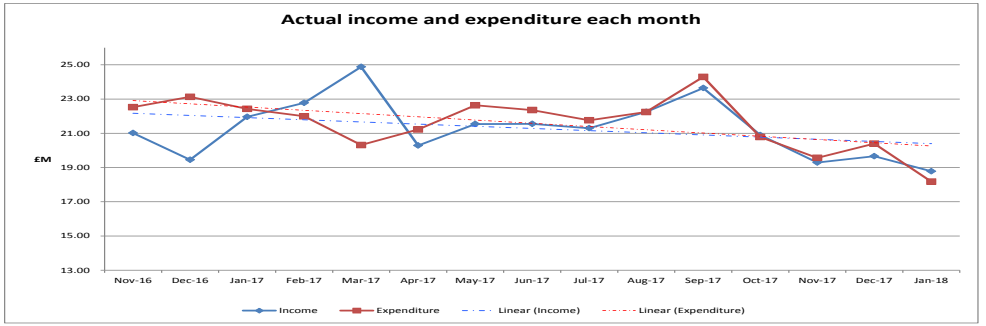
The impact of delaying elective activity during January and February has reduced the overall expenditure on additional theatre sessions but pressure in this area will return. This is forecast to cost c£250k during March.

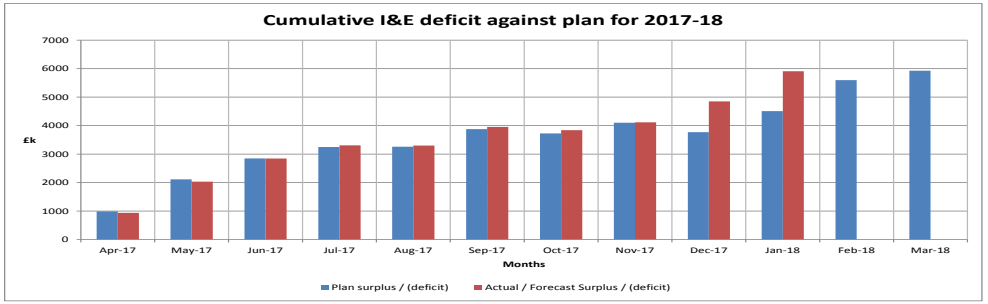
We have not forecast a benefit associated with the remedial action detailed above but collectively they have the potential to address the identified shortfall in financial performance.

This year's contingency has been largely deployed against costs relating to RTT, Pathology Services, NHSPS settlement and the SCH community contract.

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)	(739)	(1,058)	(319)	↓	Red
YTD surplus / (deficit)	(4,509)	(5,907)	(1,398)	↓	Red
Forecast surplus / (deficit)	(5,926)	(9,726)	(3,800)	↓	Red
EBITDA YTD	3,087	1,759	(1,328)	↓	Red
EBITDA (%)	1.5%	0.8%	(0.6%)	↓	Amber
Use of Resources (UoR) Rating fav / (adv)	3	3	0	↔	Amber
Clinical Income YTD	(176,259)	(176,514)	255	↑	Green
Non-Clinical Income YTD	(33,542)	(33,274)	(268)	↓	Amber
Pay YTD	122,294	122,524	(230)	↓	Amber
Non-Pay YTD	92,016	93,171	(1,155)	↓	Red
CIP target YTD	(11,279)	(10,860)	(419)	↓	Amber



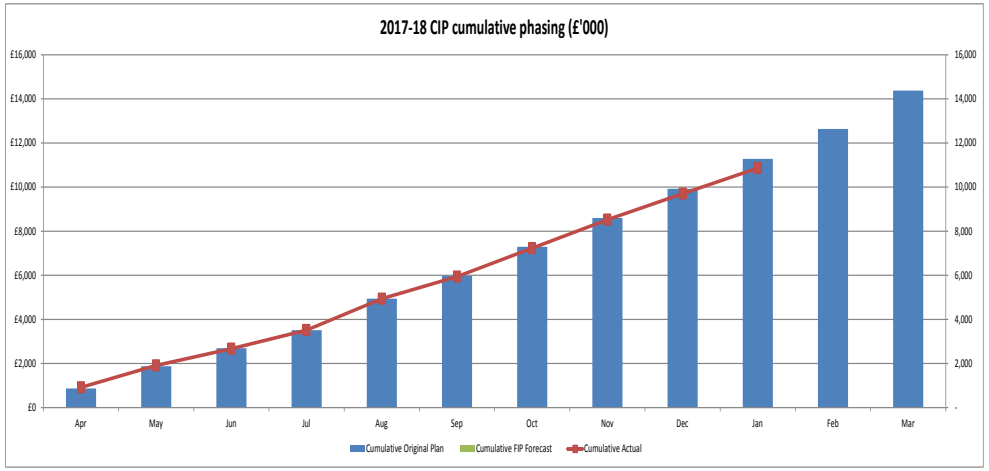


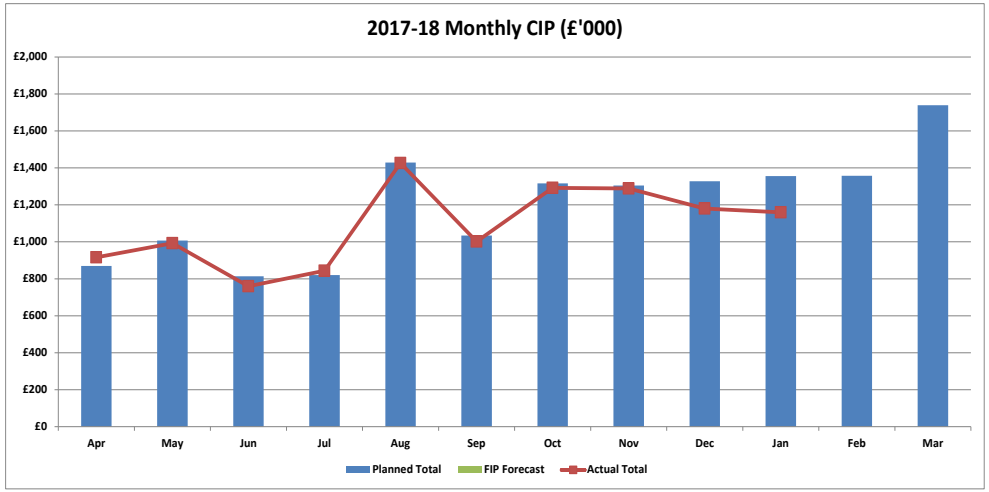
FINANCE AND WORKFORCE REPORT – January 2018

Cost Improvement Programme (CIP) 2017-18

The January position includes a target of £10,860k YTD which represents 79% of the 2017-18 plan. There is currently a shortfall of £418k YTD against this plan.

Recurring/Non Recurring	Summary	2017-18 Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Activity growth	297	243	101
	Car Park Income	400	333	197
	Other Income	167	137	116
	Consultant Staffing	326	257	249
	Additional sessions	192	160	80
	Staffing Review	2,722	1,802	2,486
	Agency	482	402	174
	Procurement	1,801	1,434	1,133
	Community Equipment Service	465	358	116
	Contract review	8	7	9
	Drugs	326	241	185
	Capitalisation	466	386	276
	Other	2,048	1,821	1,761
	Theatre Efficiency	275	183	183
	Patient Flow	300	200	200
	Pay controls	337	225	225
	Outpatients	190	127	127
Recurring Total		**10,801**	**8,317**	**7,616**
Non-Recurring	Activity growth	300	300	300
	Other Income	19	16	22
	Additional sessions	10	8	36
	Staffing Review	20	17	-
	Contract review	41	34	40
	Estates and Facilities	389	324	324
	Non-Recurring	396	396	396
	Capitalisation	350	300	400
	Other	398	329	488
	GDE revenue	1,650	1,238	1,238
Non-Recurring Total		**3,573**	**2,962**	**3,244**
Grand Total		**14,375**	**11,279**	**10,860**





In order to deliver the Trusts pre-STF control total of £7.7m deficit in 2018-19 we need to deliver a CIP of £18.3m (8%).

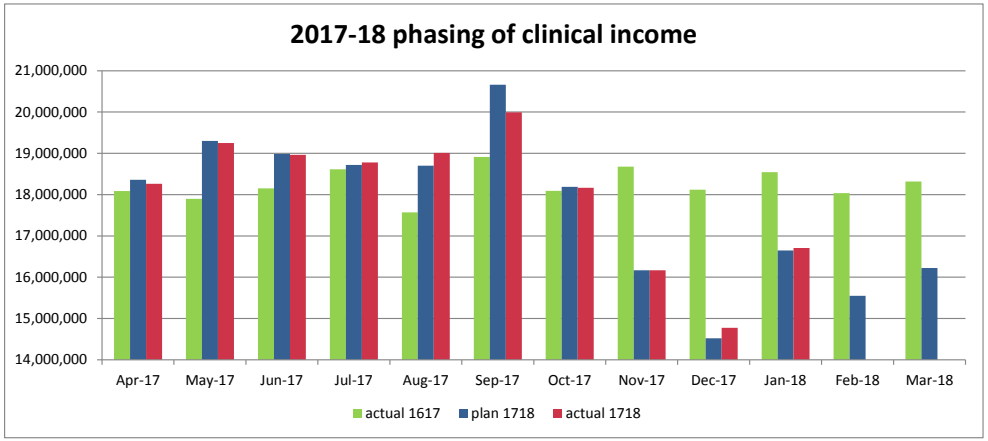
To date we have identified £5.1m of risk adjusted CIP schemes, (£9.4m non-risk adjusted) for 2018-19. We therefore have a gap of £8.9m against the 2018-19 target which we are discussing with NHSI

FINANCE AND WORKFORCE REPORT – January 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.

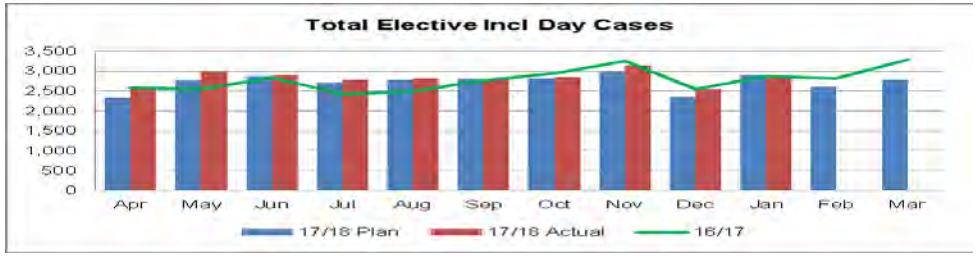
Income earned from within Suffolk is on plan since we have block contracts with Suffolk CCGs for their activity. However, variances can be seen within Divisions with any balances reflected within the Corporate Division.

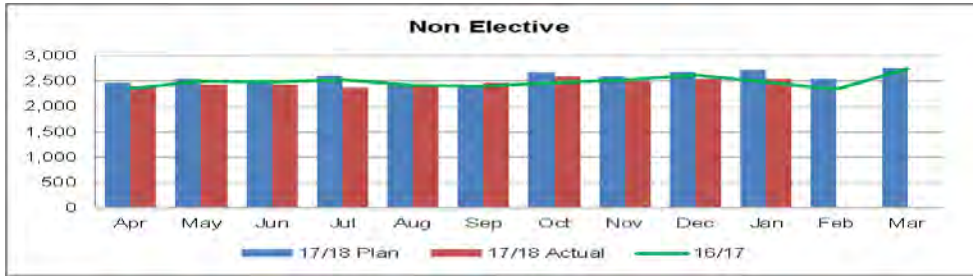


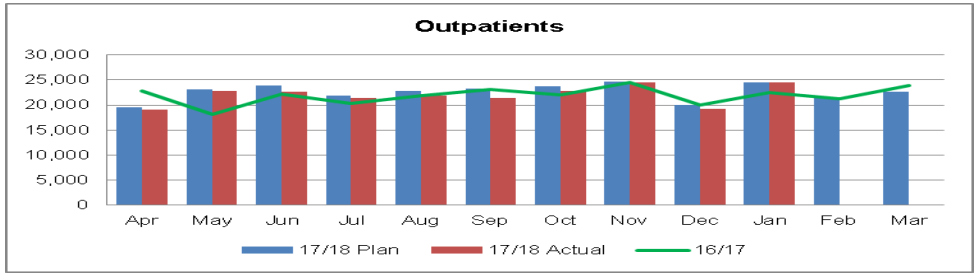
The income position was ahead of plan for January, with over performance being seen within the Non Elective and the subsequent cancellation of Elective work causing under performance in this area.

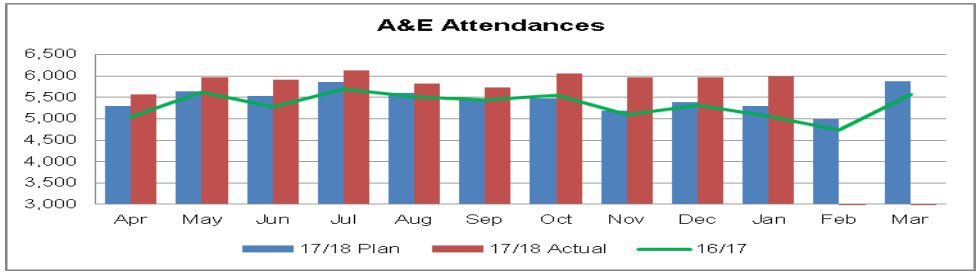
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	656	696	40	6,787	7,175	388
Other Services	2,230	2,255	25	23,569	21,361	(2,209)
CQUIN	317	318	1	3,013	3,045	33
Elective	2,717	2,371	(346)	26,196	27,170	974
Non Elective	5,423	6,049	627	51,068	53,343	2,275
Emergency Threshold Adjustment	(293)	(518)	(225)	(2,896)	(3,943)	(1,048)
Outpatients	2,944	2,887	(57)	27,296	26,594	(702)
Community	2,046	2,046	0	41,162	41,706	544
Total	**16,040**	**16,103**	**64**	**176,195**	**176,451**	**255**

Activity, by point of delivery



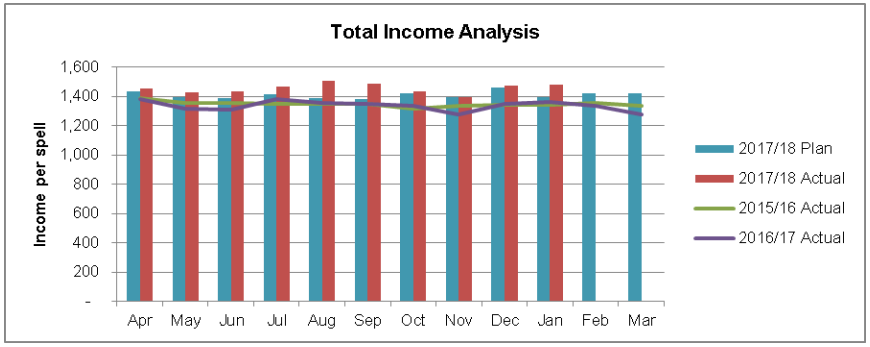


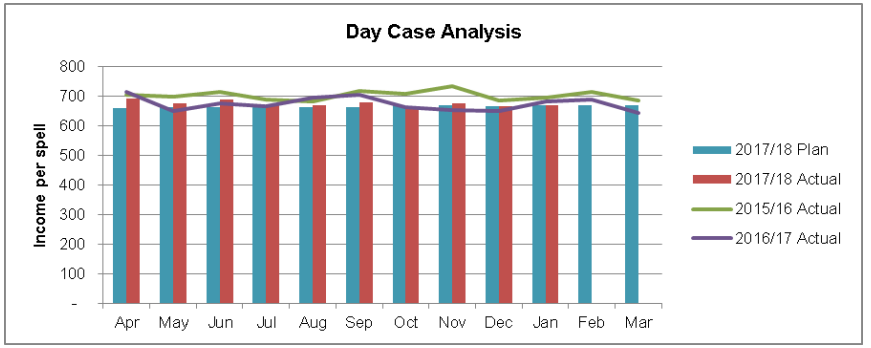


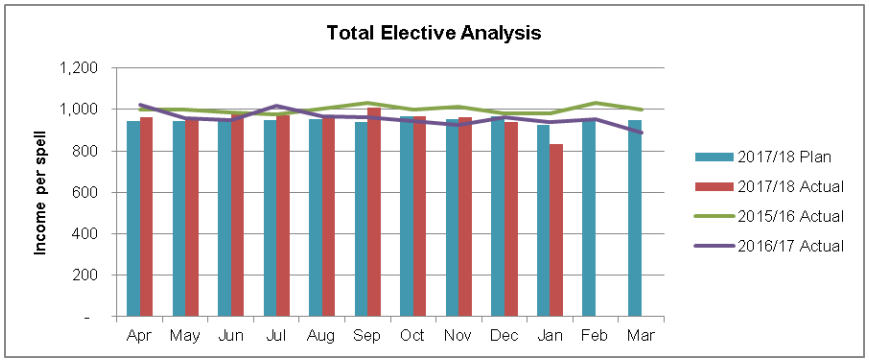


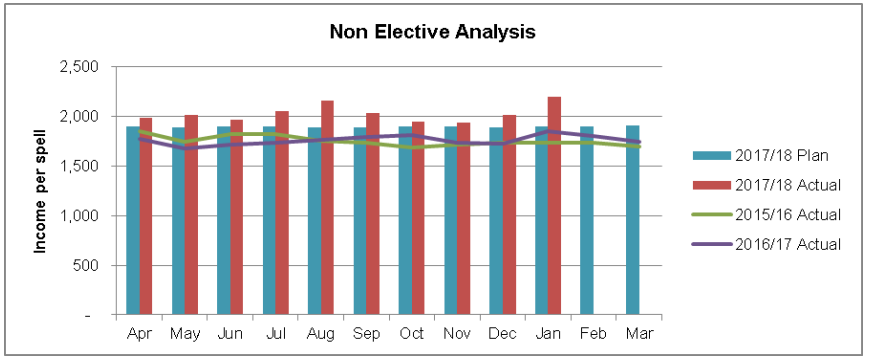
FINANCE AND WORKFORCE REPORT – January 2018

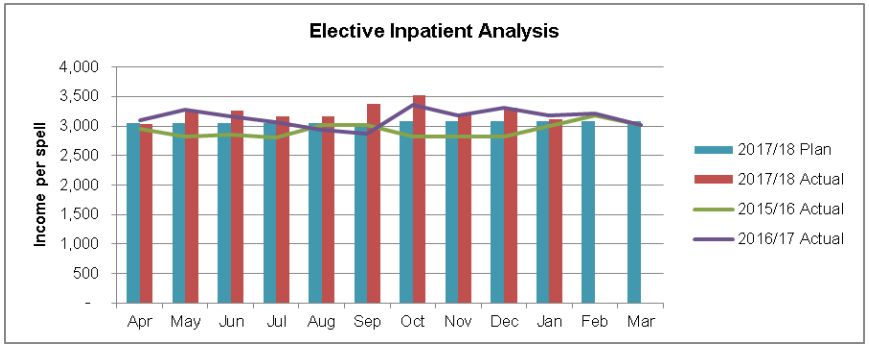
Trends and Analysis

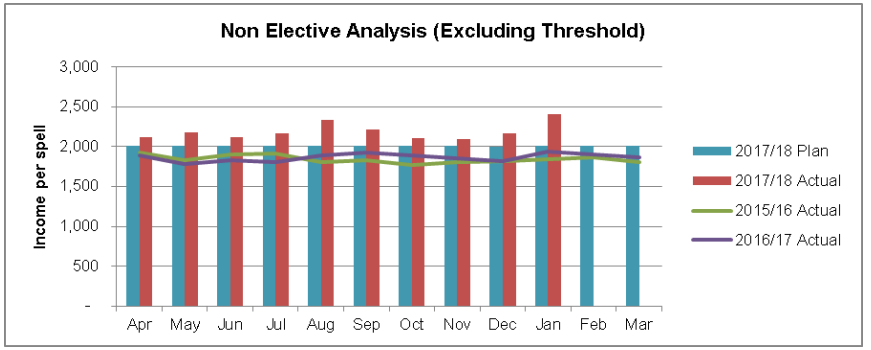












FINANCE AND WORKFORCE REPORT – January 2018

Workforce

Monthly Expenditure Acute services only				
As at January 2018	Jan-18	Dec-17	Jan-17	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**11,011**	**10,920**	**10,550**	**109,433**
Substantive Staff	9,893	9,753	9,625	97,303
Medical Agency Staff (includes 'contracted in' staff)	169	102	181	1,192
Medical Locum Staff	314	391	116	2,527
Additional Medical sessions	186	286	214	2,618
Nursing Agency Staff	171	123	157	740
Nursing Bank Staff	170	245	190	1,948
Other Agency Staff	67	47	76	686
Other Bank Staff	120	135	129	1,416
Overtime	103	128	92	1,021
On Call	67	51	54	539
Total temporary expenditure	1,366	1,509	1,210	12,688
Total expenditure on pay	**11,260**	**11,262**	**10,835**	**109,991**
Variance (F/(A))	(249)	(343)	(10,824)	(558)
Temp Staff costs % of Total Pay	12.1%	13.4%	11.2%	11.5%
Memo : Total agency spend in month	407	273	415	2,618

Monthly whole time equivalents (WTE) Acute Services only			
As at January 2018	Jan-18	Dec-17	Jan-17
	WTE	WTE	WTE
Budgeted WTE in month	**2,935.8**	**2,931.4**	**2,991.4**
Employed substantive WTE in month	**2749.64**	**2745.58**	**2,701.0**
Medical Agency Staff (includes 'contracted in' staff)	10.54	8.44	11.3
Medical Locum	22.1	21.64	9.3
Additional Sessions	18.16	22.21	16.4
Nursing Agency	33.91	24.31	24.7
Nursing Bank	55.23	76.63	61.7
Other Agency	13.13	12.17	15.1
Other Bank	56.25	67.16	63.6
Overtime	31.66	35.42	41.6
On call Worked	7.72	6.64	8.5
Total equivalent temporary WTE	**248.7**	**274.6**	**252.3**
Total equivalent employed WTE	**2,998.3**	**3,020.2**	**2,953.3**
Variance (F/(A))	(62.6)	(88.8)	38.1
Temp Staff WTE % of Total Pay	8.3%	9.1%	8.5%
Memo : Total agency WTE in month	57.6	44.9	51.1
Sickness Rates (Jan/Dec)	3.56%	3.51%	3.95%
Mat Leave	2.2%	1.3%	1.8%

Monthly Expenditure Community Service				
As at January 2018	Jan-18	Dec-17	Jan-17	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,530**	**1,528**	**1,080**	**12,861**
Substantive Staff	1,461	1,397	1,027	11,906
Medical Agency Staff (includes 'contracted in' staff)	9	12	0	117
Medical Locum Staff	4	3	3	33
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	5	8	3	6
Nursing Bank Staff	13	16	10	141
Other Agency Staff	1	5	42	188
Other Bank Staff	9	2	13	77
Overtime	5	4	8	47
On Call	3	2	1	18
Total temporary expenditure	48	53	80	627
Total expenditure on pay	**1,509**	**1,449**	**1,107**	**12,533**
Variance (F/(A))	21	79	(27)	328
Temp Staff costs % of Total Pay	3.2%	3.6%	7.3%	5.0%
Memo : Total agency spend in month	14	25	45	311

Monthly whole time equivalents (WTE) Community Services			
As at January 2018	Jan-18	Dec-17	Jan-17
	WTE	WTE	WTE
Budgeted WTE in month	**496.6**	**497.6**	**359.1**
Employed substantive WTE in month	**436.5**	**447.8**	**338.1**
Medical Agency Staff (includes 'contracted in' staff)	0.6	0.7	0.0
Medical Locum	0.4	0.4	0.4
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.7	1.3	0.6
Nursing Bank	4.1	4.6	2.9
Other Agency	0.8	1.4	11.4
Other Bank	0.7	0.7	3.8
Overtime	1.5	1.4	4.2
On call Worked	0.0	0.0	0.0
Total equivalent temporary WTE	**8.7**	**10.5**	**23.2**
Total equivalent employed WTE	**445.2**	**458.3**	**361.3**
Variance (F/(A))	51.4	39.3	(2.2)
Temp Staff WTE % of Total Pay	1.9%	2.3%	6.4%
Memo : Total agency WTE in month	2.1	3.4	12.0
Sickness Rates (Jan/Dec)	3.63%	3.55%	4.02%
Mat Leave	1.7%	2.1%	1.5%

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

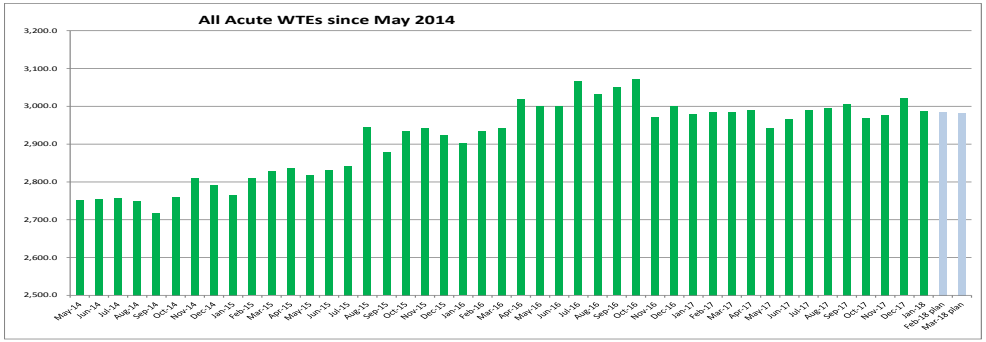
FINANCE AND WORKFORCE REPORT – January 2018

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.

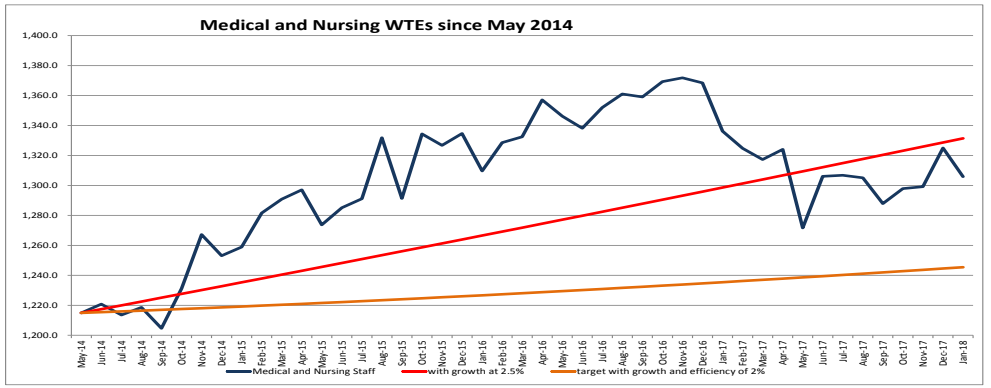
The planned establishment from February onwards is the level of staffing required to achieve the original CIP, although this needs to be updated to reflect the proposals in FIP2. As at January 2018 we employed a total of 62.6 WTE more than planned and 45 WTE more Acute staff than in January 2017.



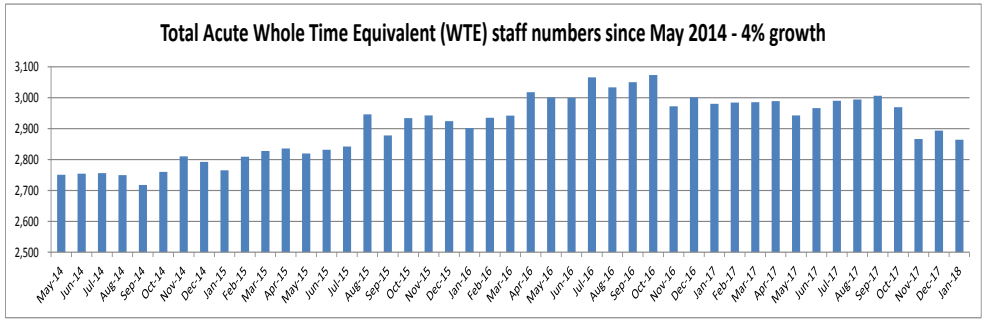
Since May 2014, (excluding Community staff) the Trust has employed 113.6 more WTEs, an increase of 8%. During this period activity has grown by around 9%

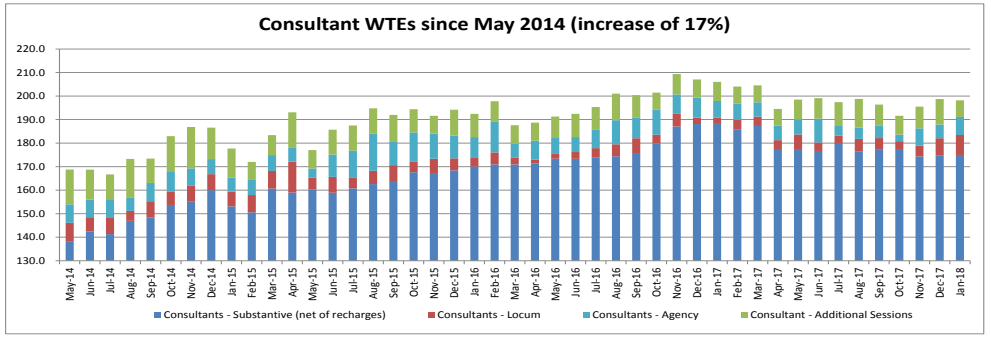
The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 91 WTEs (blue line). This includes around 29 WTE Consultants which are analysed further below. There has been an decrease of 20 WTE during January. Medical staff have increased by 30 WTE since April 2017, due 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 25.5 more WTEs (red line). In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 60 WTE fewer than at January 2018



The graphs below highlight the increase in Consultant WTEs of 17.4% since May 2014. Substantive staff has increased by 36.7 WTEs whilst temporary staff have decreased by only 7.3 WTEs.





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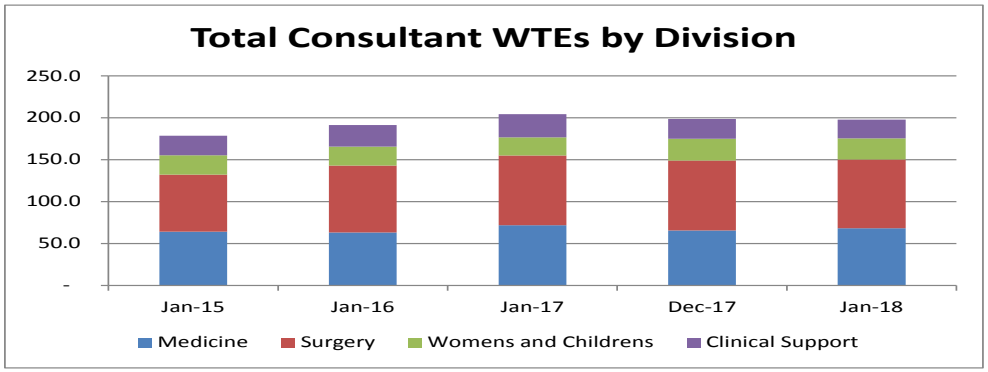
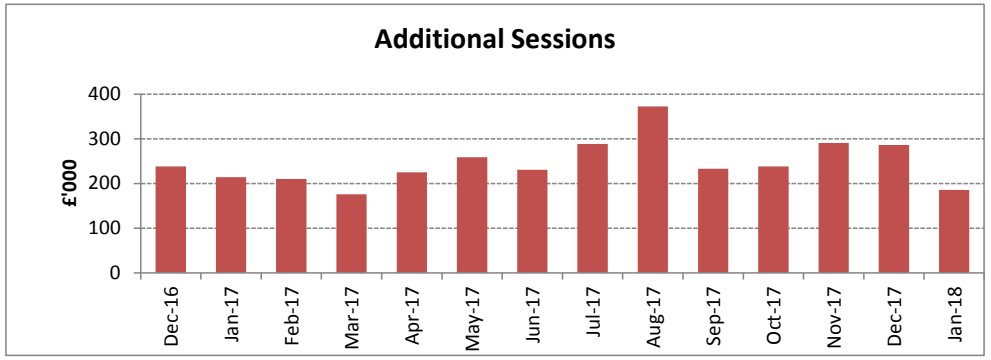
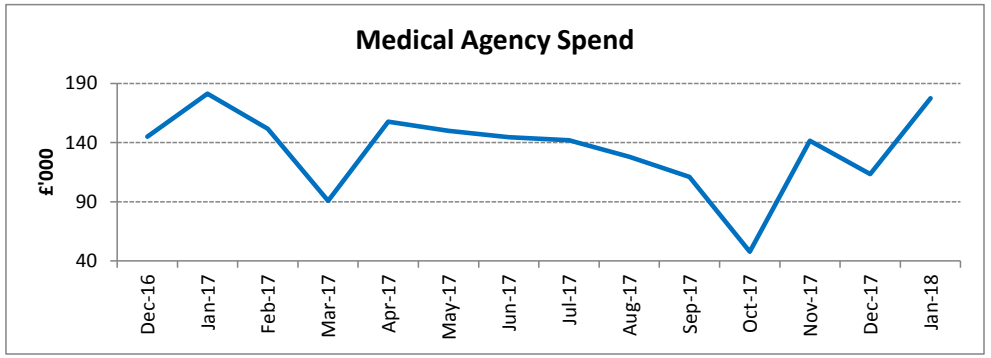


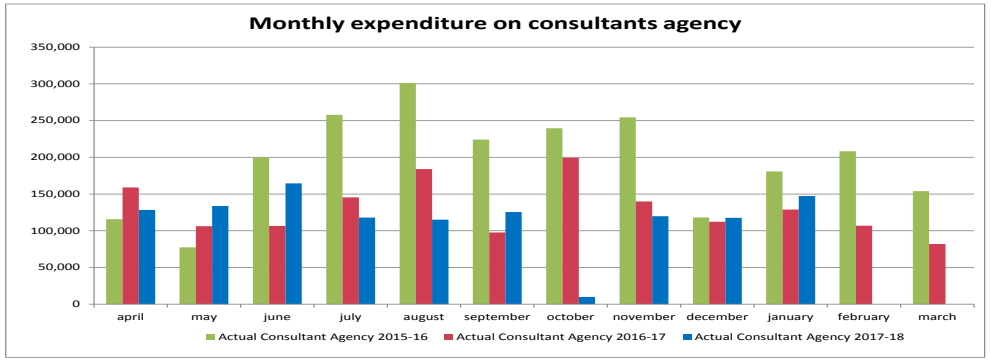
Division	Specialty	Sum of Jan-16	Sum of Jan-17	Sum of Jul-17	Sum of Aug-17	Sum of Sep-17	Sum of Oct-17	Sum of Nov-17	Sum of Dec 17	Sum of Jan 18
Medicine	A&E Medical Staff	6.2	7.9	8.1	8.2	8.2	7.5	7.9	7.0	8.1
	Cardiology	4.0	5.9	5.9	6.0	6.2	4.8	4.8	4.8	6.5
	Chest Medicine	4.1	4.1	4.0	4.0	4.2	3.8	4.2	3.8	3.7
	Chronic Pain Service	1.3	0.7	0.7	0.7	0.7	0.8	0.9	0.7	0.7
	Clinical Haematology	4.2	4.4	4.4	4.4	4.4	4.4	4.4	4.4	4.4
	Dermatology	4.6	4.7	5.0	3.5	4.3	3.5	5.6	4.0	4.6
	Diabetes	4.6	4.3	4.4	4.3	4.3	4.3	4.3	4.3	4.5
	Eau Medical Staff	8.9	6.7	7.2	9.6	7.2	7.6	7.4	8.0	8.6
	Gastroenterology	6.9	7.0	7.5	7.2	7.5	7.1	7.2	6.8	6.5
	General Medicine	5.9	6.4	5.8	4.6	5.3	5.4	4.8	5.2	4.6
	Nephrology	0.6	0.1	1.5	1.6	1.6	1.5	1.5	1.5	1.6
	Neurology	2.2	2.5	2.6	2.7	2.7	2.7	2.7	2.7	2.7
	Oncology	3.1	3.2	3.4	3.4	3.4	3.4	3.4	3.4	3.5
	Palliative Care	-	0.3	0.3	0.3	0.3	0.3	0.3	0.3	-
	Rheumatology	3.2	3.9	4.0	3.9	3.9	4.0	4.0	4.0	4.0
	Stroke	3.3	3.5	3.5	4.0	3.7	4.1	3.9	4.5	4.1
Medicine Total		**65.3**	**66.2**	**66.5**	**68.4**	**67.9**	**65.1**	**67.1**	**65.5**	**68.1**
Surgery	Anaesthetics	30.6	35.1	33.6	34.4	33.5	33.6	33.3	32.2	32.7
	E.N.T.	3.4	3.4	3.3	3.3	3.3	3.3	4.6	5.1	5.2
	General Surgery	12.7	10.5	9.8	9.8	9.8	9.8	10.6	10.7	11.1
	Ophthalmology	7.1	8.0	8.3	7.9	7.8	7.7	8.4	8.1	7.4
	Oral & Maxofacial Surg	1.9	1.2	0.0	0.0	0.1	-	-	0.0	1.4
	Plastic Surgery	3.5	3.7	3.0	2.3	2.4	3.4	3.4	3.7	3.6
	Trauma & Orthopaedic	13.5	13.8	14.2	14.7	14.0	14.5	13.7	15.2	13.8
	Urology	7.2	6.3	6.2	6.5	7.5	5.0	7.2	7.2	5.3
	Vascular Surgery	-	1.3	1.1	1.1	1.1	1.3	1.4	1.3	1.6
Surgery Total		**79.8**	**83.2**	**79.5**	**80.1**	**79.7**	**78.7**	**82.5**	**83.5**	**82.2**
Women and Childrens	Obstetrics	11.3	10.8	13.3	13.4	13.2	13.0	13.4	13.2	12.8
	Paediatrics	11.3	11.0	11.3	11.3	11.3	10.4	10.1	12.7	12.2
Women and Childrens Total		**22.7**	**21.9**	**24.6**	**24.7**	**24.4**	**23.4**	**23.5**	**25.9**	**25.0**
Clinical Support	Chemistry	0.5	0.7	-	0.6	0.3	-	-	-	-
	Histopathology	7.8	8.6	8.5	9.3	8.3	9.0	7.6	8.0	8.1
	Microbiology	3.3	3.2	3.2	3.2	3.2	3.5	3.5	4.3	3.3
	MRI	0.9	1.0	0.9	0.9	0.9	0.9	-	-	-
	Xray - Wsh	13.5	14.2	12.1	12.3	12.4	12.5	12.8	13.2	13.2
Clinical Support Total		**25.9**	**27.6**	**24.6**	**26.2**	**25.0**	**25.9**	**24.0**	**25.5**	**24.5**
Grand Total		**193.7**	**198.9**	**195.2**	**199.4**	**197.0**	**193.2**	**197.1**	**200.4**	**199.8**

Pay Trends and Analysis

The Trust overspent pay budgets by £228k in January (£230k overspent YTD).







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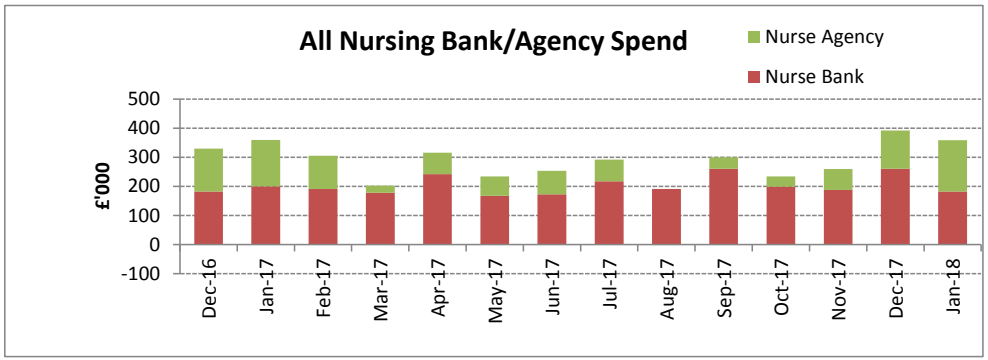
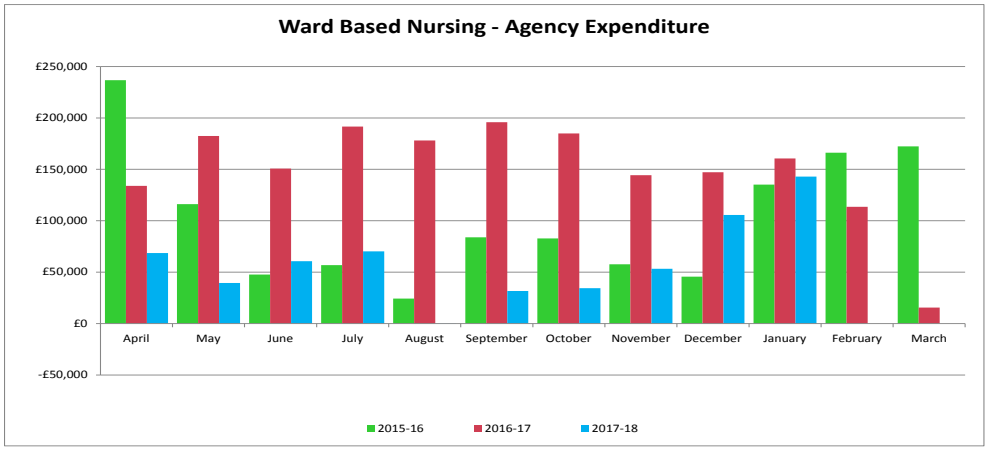
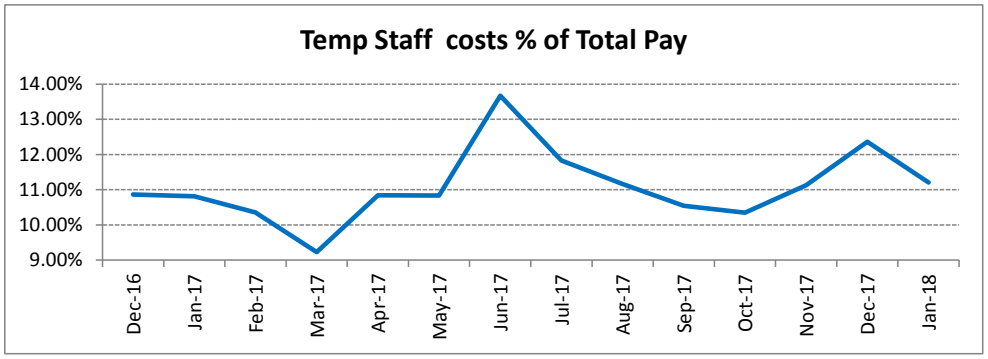
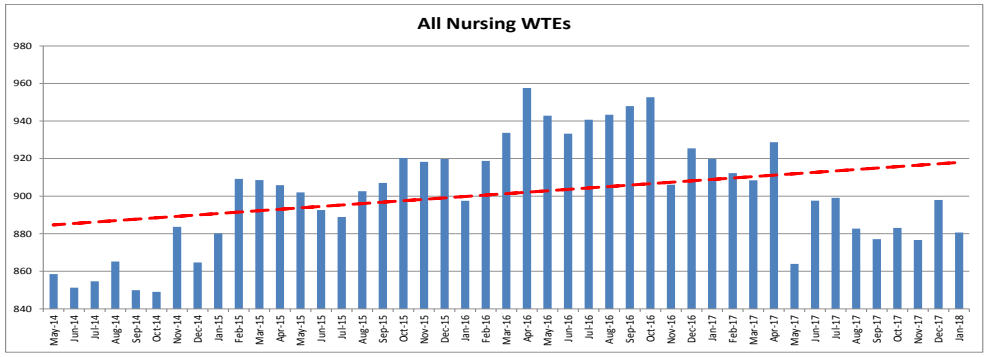
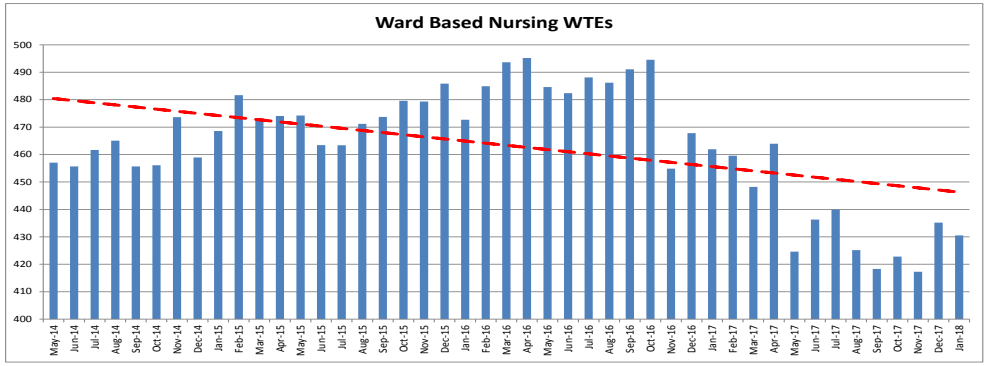




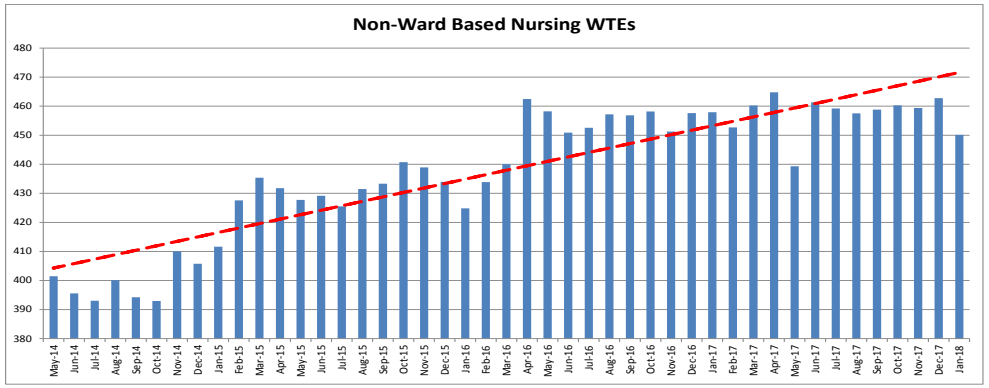


Acute Nursing





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	Jan-18 Budget £k	Jan-18 Actual £k	Jan-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	(5,714)	(6,240)	526	(55,011)	(56,190)	1,179
Pay Costs	3,497	3,560	(62)	34,106	34,214	(109)
Non-pay Costs	1,500	1,637	(138)	13,337	13,728	(391)
Operating Expenditure	**4,997**	**5,197**	**(200)**	**47,443**	**47,942**	**(499)**
SURPLUS / (DEFICIT)	**717**	**1,043**	**326**	**7,569**	**8,248**	**680**
SURGERY						
Total Income	(4,919)	(4,714)	(206)	(47,671)	(48,572)	900
Pay Costs	2,879	2,985	(106)	29,263	29,878	(615)
Non-pay Costs	1,110	1,102	8	10,590	11,454	(864)
Operating Expenditure	**3,989**	**4,087**	**(98)**	**39,853**	**41,332**	**(1,479)**
SURPLUS / (DEFICIT)	**931**	**627**	**(304)**	**7,818**	**7,240**	**(579)**
WOMENS and CHILDRENS						
Total Income	(1,865)	(1,835)	(30)	(20,223)	(20,045)	(179)
Pay Costs	1,123	1,097	26	11,064	11,161	(96)
Non-pay Costs	145	222	(77)	1,383	1,568	(184)
Operating Expenditure	**1,268**	**1,320**	**(52)**	**12,448**	**12,728**	**(281)**
SURPLUS / (DEFICIT)	**597**	**516**	**(82)**	**7,776**	**7,316**	**(459)**
CLINICAL SUPPORT						
Total Income	(1,008)	(968)	(41)	(9,740)	(9,330)	(409)
Pay Costs	1,713	1,806	(93)	17,021	17,175	(154)
Non-pay Costs	989	1,089	(100)	9,699	10,269	(570)
Operating Expenditure	**2,702**	**2,895**	**(193)**	**26,720**	**27,444**	**(724)**
SURPLUS / (DEFICIT)	**(1,694)**	**(1,927)**	**(234)**	**(16,980)**	**(18,113)**	**(1,133)**
COMMUNITY SERVICES						
Total Income	(2,973)	(2,838)	(135)	(45,387)	(47,307)	1,921
Pay Costs	1,530	1,509	21	12,467	12,539	(73)
Non-pay Costs	1,374	1,523	(149)	32,147	34,445	(2,298)
Operating Expenditure	**2,903**	**3,032**	**(129)**	**44,614**	**46,985**	**(2,371)**
SURPLUS / (DEFICIT)	**70**	**(194)**	**(264)**	**773**	**323**	**(450)**
ESTATES and FACILITIES						
Total Income	(371)	(379)	8	(3,747)	(3,647)	(100)
Pay Costs	745	753	(7)	7,470	7,339	131
Non-pay Costs	614	675	(61)	5,981	6,277	(296)
Operating Expenditure	**1,360**	**1,428**	**(68)**	**13,451**	**13,616**	**(165)**
SURPLUS / (DEFICIT)	**(989)**	**(1,049)**	**(60)**	**(9,704)**	**(9,969)**	**(266)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	(4,134)	(2,642)	(1,492)	(28,253)	(24,925)	(3,326)
Pay Costs	1,053	1,059	(6)	10,804	10,218	586
Non-pay Costs (net of contingency and reserves)	2,767	1,161	1,607	11,614	7,993	3,620
Finance & Capital	686	496	190	7,596	7,665	(69)
Operating Expenditure	**4,506**	**2,715**	**1,791**	**30,014**	**25,877**	**4,137**
SURPLUS / (DEFICIT)	**(372)**	**(73)**	**299**	**(1,761)**	**(952)**	**810**
TOTAL (including penalties, contingency and reserves)						
Total Income	(20,986)	(19,615)	(1,371)	(210,032)	(210,017)	(15)
Contract Penalties	0	0	0	0	0	0
Pay Costs	12,541	12,768	(228)	122,194	122,524	(330)
Non-pay Costs	8,499	7,409	1,089	84,751	85,734	(983)
Finance & Capital	686	496	190	7,596	7,665	(69)
Operating Expenditure (incl penalties)	**21,725**	**20,673**	**1,052**	**214,542**	**215,923**	**(1,382)**
SURPLUS / (DEFICIT)	**(739)**	**(1,058)**	**(319)**	**(4,509)**	**(5,907)**	**(1,398)**

Medicine (Annie Campbell)

The Division over performed by £326k in January (£680k YTD)

The Division exceeded its contract income plan in January, unsurprisingly led by ED attendances and non-elective activity. At times during the month more than 65 escalation beds were open. Admission to attendance rates, normally expected at no more than 25-27% were running regularly at 35-45% suggesting acuity of patients was high, GPs were referring appropriately and that there was unusual pressure on beds.

Outpatient attendance income was £58k above plan despite some clinics being cancelled to allow medical staff to concentrate on non-elective flow. The main driver was Dermatology, where an agency consultant has been helping the specialties performance against the 18 week referral to treatment (RTT) pathway. In December the specialty was at 77.56% against the target of 92%. By the end of January performance was up to 90.43% and continuing to improve. Dermatology is crucial to the Trust achievement of the RTT target as it accounts for 10% of all patients on waiting lists.

The flexing between elective and non-elective work did impact upon outpatient procedures (£26k below plan), due to MTU being used as one of the key escalation areas.

The opening of additional capacity, increased acuity and reduced flow meant expenditure was £187k above budget, with pay particularly affected (£62k). To provide the extra capacity and cope with unprecedented vacancies, the trust has had to rely upon agency staff (£111k spend). Trust initiatives meant there was significantly more overtime worked as well (£47k spend).

Medical staffing also relied upon agency (£154k spend), though some of this was to support RTT performance in Cardiology and Dermatology.

Vacancies are a major risk to the Division, both nursing and medical. The Division has got plans to address the issues in the two specialties affected by RTT, to make the service more robust and sustainable.

Given demand and flow, non-pay costs (£137k) were an issue. This included drugs (£57K overspent), patient transport (£21k) and security (£44k). The latter was the subject of considerable debate at the Division's Finance and Quality meeting where it was decided to bring the service in-house, primarily on quality grounds.

FINANCE AND WORKFORCE REPORT – January 2018

Surgery (Simon Taylor)
The Division under performed by £304k in January (£579k YTD)

Income underachieved against plan by £206k, which is predominantly related to elective activity. Orthopaedics elective activity was £367k below plan due to escalation into F4 meaning all major joints had to be cancelled. However, this was partly offset by elective overachievements on Plastic Surgery, General Surgery and Ophthalmology. Non-elective income was £15k above plan.

Pay is overspent by £106k. The main overspend is on agency nursing (£60k), followed by consultants additional sessions (£28K). 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 £8k.The underspend is predominantly related to prosthesis and disposable MSE due to under achievement of elective plan, partly offset by overspends on drugs and community glaucoma.

Surgery CIPs have underachieved by £11k YTD, due to an underachievement of £19K in month. This is mainly owing to the final quarter phasing of the Service Redesign CIP, as well as a low level of private patient income in month.

Women and Children's (Rose Smith)
Women and Children's reported an under performance of £82k in-month (£459k YTD).

Clinical income reported £30k behind plan in-month and is £179k behind plan YTD. Overall inpatient, outpatient and antenatal activity levels were below plan for the month which has pushed the YTD clinical income position behind plan.

Pay reports a £26k underspend in-month and £96k overspend YTD. In-month the Paediatric consultant budget has returned to full establishment. 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 reports a £77k overspend in-month and £184k 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 under performance of £234k in-month (£1,133k YTD).

Clinical income for Clinical Support reported a £41k under performance in-month and is £409k behind plan YTD. This can be attributed to lower than planned activity for radiology direct access and breast screening. In addition, the West Suffolk Physiotherapy service has not been able to generate the planned level of income.

Pay is £93k overspent in-month and is £154k underspent YTD. The pathology and radiology services have had difficulties in filling gaps in the senior medical rotas and are currently employing unbudgeted locums. It is hoped that by offering posts on a locum basis it may become easier to fill the permanent vacancies.

Non pay reported a £100k overspend in-month and is £570k overspent YTD. The radiology service has experienced significant non pay pressures due to increased consumables spend and the pathology service has had additional cost pressures by having to commission CUHFT for tests where national standards dictate that these can no longer be performed in house.

Community Services (Dawn Godbold)
Community Services reported a £264k under performance in-month (£450k YTD)

Contract Income reported a £135k under recovery in-month and £1,921k over performance YTD.

Pay reports a £21k underspend in-month and £73k over spend YTD. In-month underspends are mainly due to vacancies within Local Area Teams. These are offset against prior month adjustment for doctors in training within Paediatrics resulting in an £84k adverse variance creating an overall adverse variance in-month within Paediatrics of £49k.

Non pay reports £149k overspend in-month and £1,523k overspend YTD. In January there were overspends within Community Equipment Service £76k and also a one off accrual of £228k for NHS property charges covering the period 1st April 17 through to 30th September 17. These additional charges are currently being investigated with NHS Property Services.

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:

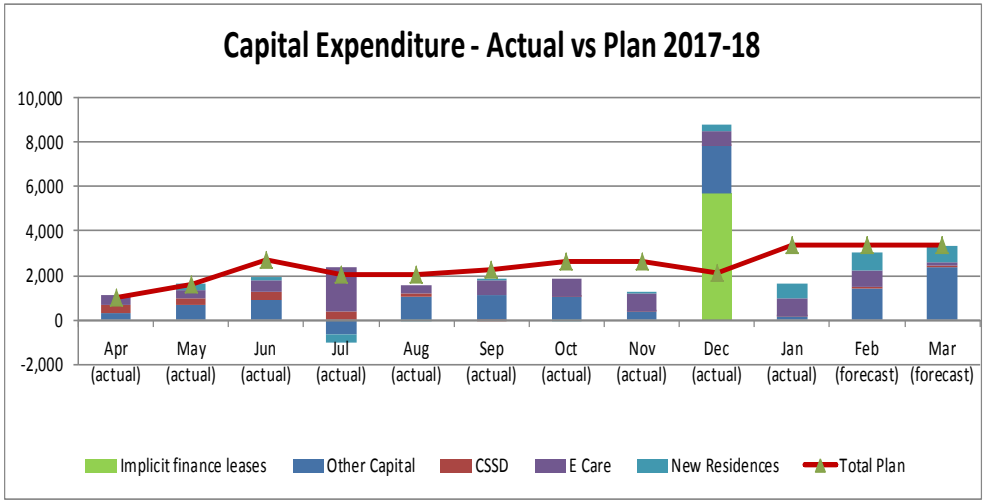
- 1 is the highest score and 4 is the lowest
- The I&E margin ratio is based on a control total basis rather than normalised surplus (deficit).
- The Agency rating measures expenditure on agency staff as a proportion of the ceiling set for agency staff. A positive value indicates an adverse variance 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	0.235	4
Liquidity rating	-11.386	3
I&E Margin rating	-2.34%	4
I&E Margin Variance rating	0.23%	1
Agency	-23.85%	1
Use of Resources Rating after Overrides		3

The Trust is scoring an overall UoR of 3 again this month. The liquidity rating is still expected to 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.

Capital Progress Report



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	2017-18
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
E Care	415	382	567	1,990	369	654	769	764	629	773	738	152	8,202
CSSD	384	283	319	352	197	-10	8	12	26	2	50	83	1,707
New Residences	0	284	140	-373	-33	68	-9	26	300	655	800	741	2,599
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	176	1,415	2,364	10,920
Total forecast / Forecast	1,095	1,613	1,947	1,285	1,542	1,862	1,826	1,199	8,777	1,607	3,003	3,339	29,095
Total Plan	1,012	1,568	2,673	2,034	2,058	2,283	2,643	2,612	2,103	3,365	3,365	3,363	29,082

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

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

The CSSD build is 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 £7,312k and is in line with the revised E-Care budget. The E-Care programme budget reflects the increased scope associated with the Global Digital Excellence (GDE) funding. The first tranche of this funding £3.3m was received in July. 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 £22,753k is above the plan of £22,383k. This is as a result of the implicit finance lease review (noted below) offset by slippage on a number of key projects.

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.

Statement of Financial Position at 31st January 2018

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2017 * £000	Plan 31 March 2018 £000	Plan YTD 31 Jan 2018 £000	As at 31 Jan 2018 £000	Variance YTD 31 Jan 2018 £000
Intangible assets	15,611	19,711	19,200	20,439	1,239
Property, plant and equipment	74,053	94,189	88,959	86,533	(2,426)
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**	**108,159**	**106,973**	**(1,187)**
Inventories	2,693	2,600	2,700	2,322	(378)
Trade and other receivables	18,345	11,700	15,631	20,055	4,424
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	1,500	4,923	3,423
Total current assets	**22,390**	**15,300**	**19,831**	**27,300**	**7,469**
Trade and other payables	(23,434)	(28,195)	(25,619)	(23,719)	1,900
Borrowing repayable within 1 year	(534)	(1,796)	(2,049)	(2,358)	(309)
Current ProvisionsProvisions	(61)	(61)	(84)	(94)	(10)
Other liabilities	(1,325)	(295)	(2,000)	(2,872)	(872)
Total current liabilities	**(25,354)**	**(30,347)**	**(29,752)**	**(29,043)**	**709**
Total assets less current liabilities	**86,700**	**98,853**	**98,238**	**105,231**	**6,992**
Borrowings	(44,375)	(55,951)	(53,657)	(64,468)	(10,811)
Provisions	(181)	(158)	(163)	(192)	(29)
Total non-current liabilities	**(44,556)**	**(56,109)**	**(53,820)**	**(64,660)**	**(10,840)**
Total assets employed	**42,144**	**42,744**	**44,418**	**40,570**	**(3,849)**
Financed by					
Public dividend capital	59,232	65,732	65,732	63,565	(2,167)
Revaluation reserve	3,621	3,621	3,621	3,621	(0)
Income and expenditure reserve	(20,709)	(26,609)	(24,935)	(26,616)	(1,681)
Total taxpayers' and others' equity	**42,144**	**42,744**	**44,418**	**40,570**	**(3,848)**

*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 £1.2m behind plan but the year-end position is expected to be much 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 decreased by £0.9m in January but are still £4.4m above plan, the balance includes:

- The £0.5m winter pressure money not yet received.
- An assumed £0.5m contribution from NHSI towards consultancy costs which is taking longer than expected to resolve and is still outstanding.
- £1.6m of the GDE revenue funding expected from DH via the CCG 1 March 2018.
- £0.7m SLA income from Ipswich Hospital that should have been paid by 15/1/18 had not been paid by the end of the month but has been paid subsequently plus the February SLA has been paid.

Cash

Cash is £3.4m higher than plan at the end of January. Payment runs were lower than expected in January but the Trust is currently identifying additional resource to increase the throughput of invoices as we approach the end of the financial year.

Trade and Other Payables

The balance on trade and other payables has decreased since December by £1.6m and is £1.9m below plan. The Trust is not currently delaying any payments to suppliers for cash reasons.

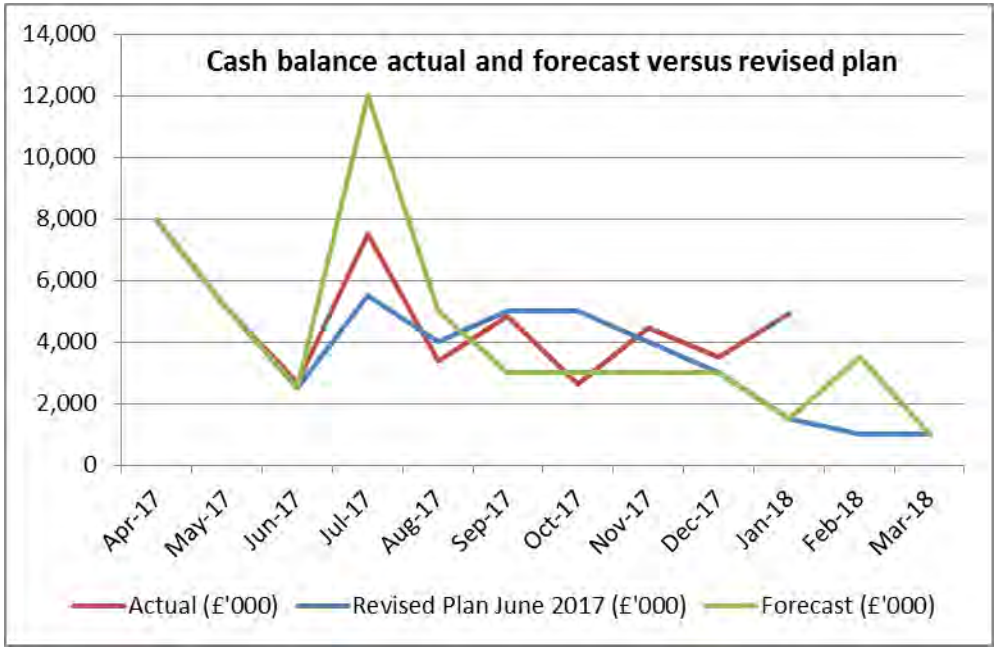
Other liabilities

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 £5.7m net of repayments in January. This includes £2.5m capital borrowing from a commercial loan provider for the Catheterisation Laboratory, £1.1m planned capital borrowing from DH, £0.8m revenue deficit and £1.6m advance for STF earned but not yet received.

Cash Balance Forecast for the year



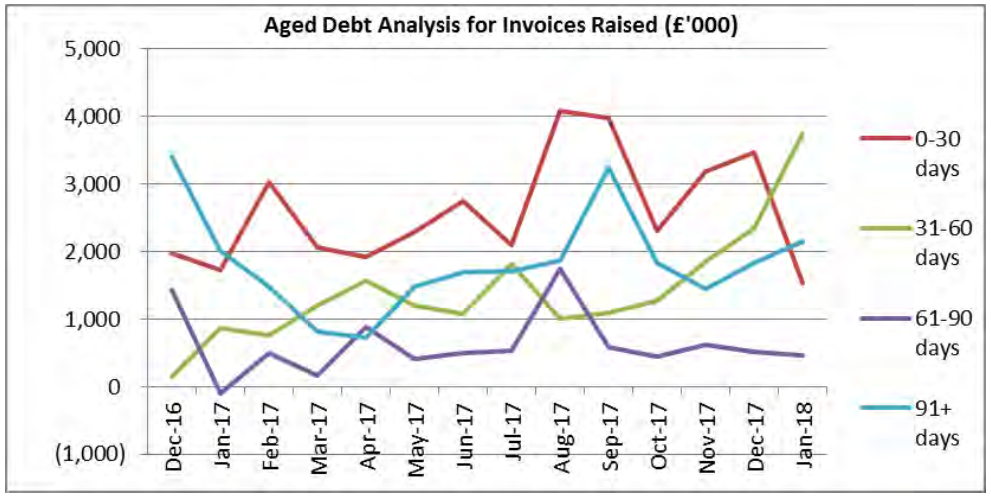
The graph illustrates the cash trajectory year to date, plan and revised forecast.

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

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 £0.3m in January.

The invoice for the revenue element of GDE funding £1.6m remains unpaid pending approval at national level; this is the main cause of the increase in debts overdue by 31-60 days. It is expected this will be paid 1 March 2018.

Of the £2.1m debt over 91 days, £1.4m relates to NHS or local government organisations. Of the remainder £0.3m relates to tPP and £0.2m relates to one complex Tricare patient.

Trust Board – 2nd March 2018

Agenda item:	11			
Presented by:	Rowan Procter – Executive Chief Nurse			
Prepared by:	Sinead Collins, Clinical Business Manager; Rebecca Gibson, Compliance Manager; and Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	21st February 2018			
Subject:	CQC - Action Plan following January 2018 Report			
Purpose:	X	For information	X	For approval

Executive summary:

On 24th January 2018, the Care Quality Commission (CQC) published the result of a rigorous inspection of two core services (end of life care and outpatients) on 9th/10th November 2017, and a well-led inspection on November/1st December 2017. The Trust was given an overall rating of "outstanding". This report means we are currently rated in the top 12 in the country and the only "outstanding" hospital in the midland and eastern region.

The report is available on the CQC website via the link http://www.cqc.org.uk/location/RGR50 . Summary report is included in Appendix 1.

The report included no requirement notices (these are where the CQC has indicated that a trust is not meeting the CQC 'Fundamental standards' and action is required to address the relevant Regulations).

The Trust's action plan to address the issues raised in the report is listed below and will be included WSFT CQC report for presentation at the CQC quality summit.

The aim of each action plan is to provide robust assurance of the work the Trust has undertaken since the visit as well as highlight work ongoing. To this end the document will be sent to board on a regular basis (6-monthly) with updates with general monitoring completed by the quarterly Quality Group.

The End of Life team were rated Outstanding and the report highlighted that
"*The end of life strategy, supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. The end of life care strategy patient centred and was fundamentally supported by the trust's nursing strategy and aligned to the overall trust strategy*"

The focus of the organisation in 2018 should now be to prepare for future inspections, expected to be within the other 'Requires Improvement' areas (Critical Care, Maternity and ED) and, based on the experience of End of Life, forming a strategy based approach (embedded and implemented) with these teams would be advantageous.

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	X
Previously considered by:	Quality Group						
Risk and assurance:	-						
Legislation, regulatory, equality, diversity and dignity implications	-						
Recommendation: Note publication of the CQC inspection report and approve the proposed action in response to the 'Should' and 'However' comments							

CQC - Action Plan following January 2018 Report

SHOULD Action Plan

Issue	Action	Progress summary	Subject Lead	Exec Lead	Deadline	Status	Source of assurance
Found several pieces of equipment that did not have electrical testing date stickers. The trust supplied data which did not assure us that all equipment was regularly tested for electrical safety.	Ensure that all equipment in outpatients is appropriately electrically safety checked.	05/02/18 – Engineer in process of clearing backlog and specifically targeting main outpatients first	Gary Stannard	Craig Black	31/03/2018	In Progress	
Appraisal rates were not consistent across staff groups and did not meet trust targets – Outpatients and EOLC	Ensure that all staff receives an appraisal.	31/01/18 - Appraisals are a Trust issue and a report went to Board in November 2017. This will be an ongoing HR monitoring process until standards are near Trust's set percentage	Denise Needle	Jan Bloomfield	30/08/2018	In Progress	Managers are informed of their department compliance on a monthly basis, using ESR system. The report shows who is in date and who has expired, and offers a column to update the information and return it. The Trust Board and

							Directorates are sent overall compliance figures monthly, as part of performance reporting (directorate performance scorecard). Based on a 5 % increase in compliance on a monthly basis, we should be at 95% by August. This is totally dependent upon line managers sending in their figures.
The overall referral to treatment times for non-admitted pathways were slightly worse than the England. The trust had a cohort of patients on a 'backlog' or patient tracking list (PTL) awaiting outpatient	Ensure that patients receive treatment in a timely way.	28/01/18 - Operational Directorate are risk managing the patients on the non-admitted pathways who have waited more than 52 weeks for an appointment.	Alex Baldwin	Helen Beck	31/12/2018	**In Progress**	

appointments some of whom had been waiting more than 52 weeks for an appointment.		The monitoring process of RTT has improved and plans are in place to improve compliance with the standards Improvements have been noted to date and are, subject to winter pressures, are expected to continue through 18/19.					
Although outpatient services had regular team meetings we were not provided with minutes to ascertain content so were not assured that all information was passed to all staff from 'board to ward'.	Ensure team meetings are minuted in outpatient's	14/01/18 - This action has been completed. This was an action the execs agreed not to dispute with CQC. K. Rawlings had misinterpreted the 'board to ward' aspect – M&S meetings do disseminate Executive strategic news	Kirsty Rawlings	Helen Beck	31/01/2018	**Completed**	Contact Anita Bruce or Kirsty Rawlings for minutes

HOWEVER Action Plan

Issue	Action	Progress summary	Subject Lead	Exec Lead	Deadline	Status	Source of assurance
There was no obvious information available to patients regarding the availability of chaperones which meant that patients did not know to ask for a chaperone if required	Develop information sheet in regards to chaperones	26/01/18 - Wording has been agreed. Will then be sent to Communications for formatting, then printed and distributed to all OPD areas.	Chris Bowen	Rowan Procter	28/02/2018	**In Progress**	
There were ongoing concerns regarding photographic image governance, and this remained an issue on this	Obtain an app that can assure governance concerns around photographic image storage	Mobile Application business case approved at Trust Executive Group but there was no implementation date as yet.	Mike Bone	Craig Black	30/09/2018	**In Progress**	

Issue	Action	Progress summary	Subject Lead	Exec Lead	Deadline	Status	Source of assurance
inspection							
Mandatory training was below trust targets and the trust had not addressed the training of clinicians to Safeguarding level three for children – Outpatients and EOLC	Improve on figures	14/01/18 - Mandatory training subjects are owned by their specific leads and meet quarterly to discuss improvements with Denise Needle and submit a report to board. This is already business as usual. The Level 3 Safeguarding for children of clinicians is not required in Outpatients and would contact a specialist for opinion.	Denise Needle	Jan Bloomfield	31/01/2018	**Completed**	Contact Denise Needle
In outpatients we found the local register had two risks that had no initial date on the register and, whilst immediate action had been taken, lacked updates or further actions.	Review risk register	26/01/18 - There was a duplicated Active Risk which has now been removed. Working through 'Accepted' risks when their review dates are due whereby we will update the progress notes and record any necessary actions.	Kirsty Rawlings	Rowan Procter	28/02/2018	**In Progress**	
Outpatients - clinical equipment was cleaned daily by nursing staff but this was not recorded anywhere.	Develop a process to record clinical equipment has been cleaned	26/01/18 - Going to add a column to the existing 'closing down sheet' for the morning cleaning schedule whereby staff will initial when rooms have been cleaned.	Chris Bowen	Rowan Procter	28/02/2018	**In Progress**	The closing down sheets are regularly audited. The new morning schedule will be included in that audit.
In main outpatients and other	Use the green ‘I am clean’	26/01/18 - In the interim this	Chris	Rowan	28/02/2018	**In**	

Issue	Action	Progress summary	Subject Lead	Exec Lead	Deadline	Status	Source of assurance
areas we did not see, and staff confirmed that they did not routinely use, the green 'I am clean' stickers on equipment	stickers on equipment	is mitigated staff would clean equipment if they had any doubts before using. Will implement the 'I am clean' stickers across the whole department. SOP will be produced and in house training will take place.	Bowen	Procter		Progress	
There was no standardised IPC procedure for seeing patients with suspected communicable diseases.	Education as to existing advice in A-Z guideline. Addendum to guideline for specific outpatient setting. Link Practitioner for department to act as resource. Link Practitioner Education morning March 2018 topic communicable diseases & management in all settings	07/02/18 - Infection Control manual is available on the Intranet for all staff including outpatient department. Additionally any specific infections that require a designated guideline will reference outpatient interactions as they are updated.	Anne How	Rowan Procter	28/02/2018	In Progress	
Overhear confidential information being given – Main outpatients, ophthalmology clinics and the fracture and orthopaedic clinic consulting rooms.	Ongoing audit plan for all areas - plan and template for audit available on request.	01/02/18 - On target	Sara Taylor	Nick Jenkins	Review June 2018	In Progress	
The WHO checklist was completed on paper and then scanned onto the patients electronic notes. We were unable to assess the efficacy of checks as the trust did not audit this process	To become part of audit programme for OPD	26/01/18 - Has been included in the 18/19 audit programme. Will be shared with Clinical Governance.	Kirsty Rawlings	Nick Jenkins	28/02/2018	In Progress	
The paediatric outpatient department did not have	Incorporate consideration of children leaving the	Discussion with the chief nurse at the time confirmed	Darren Cooksey	Craig Black	20/04/2018	In Progress	

Issue	Action	Progress summary	Subject Lead	Exec Lead	Deadline	Status	Source of assurance
lockable or security enabled external doors to prevent children leaving the department unaccompanied.	department unaccompanied into the existing generic security risk assessment.	that there was no specific risk assessment for this area and that parents were expected to be responsible for their own children.					
We found two out of date bottles of acetone stored in the same drug cupboard as inhaled medication in the respiratory physiology department.	Remove and change location of in date acetone storage	14/01/18 - Acetone removed and disposed of safely by Porters. Acetone no longer kept in Department, no longer needed as practice changed - earlobe probe now available for pulse oximetry readings. All meds now kept in separate medicines cabinet.	Tracey Cross	Rowan Procter	31/01/2018	**Completed**	Contact Tracey Cross
The main outpatient medicine fridge did not record minimum and maximum temperatures	Obtain thermometer for fridge	26/01/18 – Thermometer has arrived. This has now been installed and temperatures are now being recorded. Will be included in audit programme.	Chris Bowen	Rowan Procter	31/01/2018	**Completed**	Contact Chris Bowen for order and can physically check fridge
Most *hospital outpatient prescriptions* were dispensed at the pharmacy dispensary. This was some distance away from the main outpatient department. (*however the pharmacy department is for Oncology, paediatrics and ophthalmology outpatients*)	A feasibility study is being considered by the Trust to open an outpatient dispensary in the hospital main concourse. This is however a significant investment requiring additional space, staff and stock. This outpatient dispensary will be closer to the main outpatients	27/01/18 - Clinic staff and Trust volunteers assist patients with mobility issues to access their medication from the existing pharmacy department, if necessary. The Current outpatient dispensary has provision for wheelchair access, a hearing induction loop and aids for patients with sight	Simon Whitworth / Luke Goldfinch	Rowan Procter	Business case process April 2018, if approved building work completion will be approximat-ely April	**In Progress**	Business case being developed by the estates team, minutes of ED's, TEG, and Scrutiny Committee

Issue	Action	Progress summary	Subject Lead	Exec Lead	Deadline	Status	Source of assurance
	department, but further from the oncology, paediatric and ophthalmology clinics)	impairment A detailed business case is being considered for the redevelopment of the main hospital concourse. This includes a proposal for an outpatient dispensary. The provision of a separate outpatient dispensary will require significant investment for the required space, equipment, staff and duplicate stock holding required to operate this area efficiently			2020		s, Minutes of Trust board meeting.
During the inspection CQC saw that there was an entry in the communications book in the main outpatient department which was a potential incident. However, we were not assured that staff reported all incidents for investigation appropriately and that appropriate learning took place.	No action required	The entry in the communication book was to share the results of a recent audit with staff. This was appropriate to improve staff understanding and future compliance. A retrospective incident form would not be completed as a result of audit findings.	Hannah Sullivan	Rowan Procter	31/01/2018	**Completed**	Contact Hannah Sullivan
There was no formal duty of candour training package mandated by the trust	No action required	The CQC report indicated that “staff aware of the need to be open and honest when something went wrong. Local policy and national documents for duty of candour were available via the trust intranet patient	Rebecca Gibson	Rowan Procter	31/01/2018	**Completed**	Contact Rebecca Gibson

Issue	Action	Progress summary	Subject Lead	Exec Lead	Deadline	Status	Source of assurance
		safety section".					
The trust did not report on either Mental Capacity Act or Deprivation of Liberty Safeguards training as individual training modules.	Review feasibility of separating training modules	Due to limited space in induction and the workload of the Safeguarding team, it has been deemed appropriate to keep MCA, DoLs and Safeguarding in one module. There are links and guidance for staff if they want to find out more information	Helen Beard	Rowan Procter	31/01/2018	**Completed**	Contact Helen Beard
In the main outpatient area there was no natural light and staff described the space as being very warm in the summer. We noticed fans in use during the inspection in November	Review utilisation of main outpatient services	27/01/18 - It is true that there is no natural light in the waiting area and reception; however all consulting rooms have access to natural light and natural ventilation. Would require the installation of significant mechanical services that would be costly, disruptive to business as normal and there is no confirmation at this stage that there is room in the ceiling grids for additional pipework	Marcus Powling	Craig Black	31/01/2018	**Completed**	Contact Marcus Powling
There was no hearing loop in existence. Patients who were hard of hearing were at a disadvantage and usually required extra assistance from the nursing staff.	To investigate feasibility and effectiveness of hearing loop	26/01/18 - Quotes required and consideration of installation	Kirsty Rawlings	Craig Black	31/03/2018	**In Progress**	
The trust did not measure	To investigate if an issue	26/01/18 - Routinely	Kirsty	Helen	30/06/2018	**In**	

Issue	Action	Progress summary	Subject Lead	Exec Lead	Deadline	Status	Source of assurance
average wait once patients had been booked in.	via different measures	monitored via the FFT dashboard. The trend shows that patients aren't finding this a problem. However, through the OPD Transformation project, start and finish times of clinic times are being investigated. Also one off piece of work could take place in a specific area to determine an approximate average. (Limitations of E-Care)	Rawlings	Beck		Progress	
Outpatient services appears to be a somewhat fractured line of responsibility although in practice appeared to work well.	Review management of outpatient services	27/01/18 - We have reviewed the management of the outpatient services in light of the CQC observations. Our analysis suggested that management separation of outpatients and administration of outpatient bookings has not had a detrimental impact on the provision of service and has been an effective management structure to date. We will, however, keep this under review and take necessary steps to resolve any issues should they arise in the future	Alex Baldwin	Helen Beck	31/01/2018	Completed	Contact Alex Baldwin
The general manager was not as well known, having	Be more visible within the department.	07/02/18 - Deputy General Manager to undertake a	Rosemary Smith	Helen Beck	31/05/2018	In Progress	

Issue	Action	Progress summary	Subject Lead	Exec Lead	Deadline	Status	Source of assurance
recently returned from a long period of leave.		'back to the floor' in outpatients to improve visibility beyond the outpatient management team. The outpatient management team (Sister, Outpatient Administrator, and Team Leads) are all familiar with both the General Manager and Deputy Manager.					
None of the junior staff we spoke to felt that they would approach staff of a higher grade than the outpatients and health records manager.	Improve junior staff knowledge of how to approach higher grade members of staff	06/02/18 - WSFT has a Freedom to Speak Up Guardian who is well known and his role is well publicised across the organisation, both in public areas and on the intranet. All staff are expected and encouraged to make use of the Trust incident reporting system for any governance concerns. Senior staff said they had an 'open door policy' for staff to bring concerns.	Rosemary Smith	Jan Bloomfield	31/01/2018	**Completed**	Contact Rosemary Smith
There was no specific strategy for outpatients.	Develop a strategy for outpatient services	26/01/18 - Transformation Project has moved forward. Project Plan and PID have been produced. Work has commenced. Strategy document can also be written as a part of the project	Kirsty Rawlings	Helen Beck	31/08/2018	**In Progress**	
A dashboard had been	Dashboard agreed and	26/01/18 - Going Live on	Kirsty	Helen	31/03/2018	**In**	

Issue	Action	Progress summary	Subject Lead	Exec Lead	Deadline	Status	Source of assurance
developed to monitor the KPIs but this was not yet a live document at the time of inspection.	live date set	the 2nd February on the Intranet. Training will be given to SM's, DGM's and GM's and any interested parties.	Rawlings	Beck		Progress	
Staff said team meetings were variable in frequency and discussed issues related only to their team. There was not a clear indication of cascade of issues discussed at directorate level meetings.	To improve recording of discussion points at team meetings	26/01/18 - M&S meetings take place monthly with all Corporate strategic news. Any relevant information from those meetings is disseminated by either the communications book in OPD or via team meetings. Discussion points will be noted from now on. Copies of the Green Sheet and the Staff Bulletin are always printed off and made available in the staff room.	Kirsty Rawlings	Helen Beck	31/03/2018	In Progress	

West Suffolk NHS Foundation Trust

Inspection report

Hardwick Lane
Bury St Edmunds
Suffolk
IP33 2QZ
Tel: 01284713000
www.wsh.nhs.uk

Date of inspection visit: <xx Mon> to <xx Mon> 2017
Date of publication: 23/01/2018

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Outstanding** ☆
Are services caring?	**Outstanding** ☆
Are services responsive?	**Good** ●
Are services well-led?	**Outstanding** ☆

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

The West Suffolk NHS Foundation Trust has one acute hospital site in Bury St. Edmunds, Suffolk. The hospital was built as 'Best buy' hospital in the 1970s as a serves a population of around 280, 000 in West Suffolk and surrounding areas. The trust also provides care in the community through Newmarket Hospital and community health services in West Suffolk that transferred to the trust in October 2017.

Acute services are provided at West Suffolk Hospital and encompass urgent and emergency care, planned medical and surgical care, critical care, maternity, neonatal and paediatric care, end of life and outpatient care. The hospital has a total number of 477 beds that includes 443 general and acute beds, 31 maternity beds and 11 critical care and six coronary care beds.

Prior to the acquisition of community services the trust employed 3, 063 staff of which 411 were medical, 975 were Nursing and 1, 787 other clinical and non-clinical staff.

For the last full year there were 62, 673 inpatient admissions, 389, 701 outpatient attendances and 62, 106 accident and emergency attendances.

The trust was last inspected in March 2016 as part of our comprehensive inspection programme. At the 2016 inspection we rated the Trust good overall. Safe, effective, responsive and well led were rated as good with caring being rated outstanding.

We rated urgent and emergency care, surgery, intensive care, services for children and young people, end of life care, maternity and outpatients as good overall with medical care being outstanding.

West Suffolk NHS FT is a part of the Suffolk and North East Essex STP.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Outstanding ☆ ↑

What this trust does

West Suffolk NHS Foundation Trust provides acute, maternity and community health services across the following locations; West Suffolk Hospital and Newmarket community hospital. Shortly before our inspection the trust was registered for providing community health services for people in West Suffolk.

Acute services are provided at West Suffolk Hospital and encompass urgent and emergency care, planned medical and surgical care, critical care, consultant led maternity, neonatal and paediatric care, end of life care and diagnostic and therapy services. Newmarket community hospital were taken on by the Trust in October 2015.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Summary of findings

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. Following our March 2016 inspection we served three Requirement Notices; one in relation to Regulation 11, Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 Need for Consent, Regulation 10 Dignity and respect and Regulation 13 Safeguarding service users.

Between 9th November and 1st December 2017 we inspected the following core services; end of life care and outpatients. We also undertook a well led review of the trust which included interviewing executive and non-executive directors.

We inspected the above services provided by this trust as part of our continual checks on the safety and quality of healthcare services.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed, Is this organisation well-led?

What we found

Overall trust

See guidance note 5 then add your text after the standard text paragraph below (and delete this help text).

Our rating of the trust improved. We rated it as outstanding because:

Safe remained good, effective improved to outstanding, caring remained outstanding and responsive and well led were good. Trust level leadership was rated outstanding.

Our inspection of the core services covered West Suffolk Hospital. Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.

- End of life care improved to outstanding overall, with the effective rating improved from requires improvement to good and well led from good to outstanding. Staff had improved knowledge around the use and implementation of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). There were clear escalation plans and improved performance in audit. National guidance and best practice was embedded in the service and there was clear, strong leadership that was widely respected by staff.
- Outpatients remained good overall. The trust had had difficulties in reporting some referral to treatment (RTT) times following the introduction of eCare. With support from stakeholders, this had been addressed and the trust were able to report accurate RTT data.
- On this inspection we did not inspect urgent and emergency care, medicine, surgery, critical care, maternity or children's and young people's services. The ratings we gave to these services on the previous inspection in August 2016 are part of the overall rating awarded to the trust this time.

Are services safe?

Our rating of safe stayed the same. We rated it as good because:

- End of life care had sufficient, competent staff to support the service. Staff recognised incidents and reported them appropriately using the services electronic incident-reporting tool. There were good infection control practices. Staff

used control measures to prevent the spread of infection. Medicines were prescribed, given, recorded and stored appropriately. Patients received the right medication at the right dose at the right time. Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date, and available to all staff providing care. The service had implemented an electronic patient records system since our last inspection. Staff completed individualised care, which was in line with national guidance, and record keeping had improved since our last inspection. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- In outpatients there were reliable systems in place to prevent and protect people from a healthcare associated infection. Staff kept themselves, equipment and the premises clean. The service prescribed, gave, recorded and stored medicines well. Prescriptions were stored and monitored safely. Resuscitation equipment was regularly checked and there was suitable personal protection equipment available for staff. Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. Staff understood how to protect patients from abuse and had training on how to recognise and report abuse and they knew how to apply it. However, we found several pieces of equipment that did not have electrical testing date stickers. The trust supplied data which did not assure us that all equipment was regularly tested for electrical safety.

Are services effective?

Our rating of effective improved. We rated it as outstanding because:

- End of life care improved to good as the team provided care and treatment based on national guidance. Staff in the SPCT informally monitored their response times, preferred place of death and preferred place of care, and audited this data. The trust monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Staff always had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. All staff had access to an electronic patient records system that they could all update. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Consent to treatment was sought in line with legislation and guidance. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms completed well. We reviewed seven DNACPR forms and found that these included records of discussions with patients and relatives and signed by a senior clinician, this was an improvement since our last inspection.
- We do not rate outpatients for effectiveness. The service provided care and treatment based on national guidance and evidence of its effectiveness. There were processes to ensure that the most recent guidance was reviewed and applied. Staff gave patients enough food and drink to meet their needs. The main outpatients had introduced a volunteer service to provide refreshments following minor procedures The service made sure staff were competent for their roles and there was good support and access to training for staff to develop. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. However, appraisal rates were not consistent across staff groups and did not meet trust targets.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- End of life care stayed the same as outstanding. Staff truly respected and valued patients as individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional and distinctive service. Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. Patients said that staff went that extra mile and their care and support exceeded their expectations. The end of life service had a strong, visible person-centred culture. Staff were highly

motivated and inspired to offer care that was kind and promoted people's dignity. We found strong caring, respectful and supportive relationships between people who used the service, those close to them and staff. Staff highly valued these relationships and felt promoted by leaders. Staff saw people's emotional and social needs as being as important as their physical needs.

- In outpatients staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness and we observed staff were friendly and welcoming and offered assistance when it was needed. Staff involved patients and those close to them in decisions about their treatment. We observed staff discussing options with patients and relatives and making joint decisions about care. However, there was no obvious information available to patients regarding the availability of chaperones which meant that patients did not know to ask for a chaperone if required.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- In end of life care, the trust planned and provided services in a way that met the needs of local people. People could access the service when they needed it. Waiting times from treatment were, arrangements to admit, treat, and discharge patients were in line with good practice. The service took account of patients' individual needs The end of life care services received no complaints in the 12 months prior to our inspection. However, service knew how to treat concerns and complaints seriously, investigate them and learn lessons from the results, to share with all staff.
- In outpatients The trust planned and provided services in a way that met the needs of local people. Clinics were easily accessible and the newer specialist clinics were well planned and comfortable. The trust has consistently performed better than the England average for people being seen within two weeks of an urgent GP referral, and receiving treatment within 31 days for a suspected cancer. The service took account of patients' individual needs. The trust provided good extra support for those who needed it and ensured people were seen in clinics in a timely way when there were transport needs. The overall referral to treatment times for non-admitted pathways were slightly worse than the England average between September 2016 and August 2017 (89.6% versus 85.9%). However 11 specialties were better than the England average with 7 worse. The trust had a cohort of patients on a 'backlog' or patient tracking list (PTL) awaiting outpatient appointments some of whom had been waiting more than 52 weeks for first treatment .

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- End of life care improved to outstanding. The trust had compassionate, inclusive, and effective leadership at all levels. Leaders at all levels demonstrated high levels of experience, capacity, and capability needed to deliver excellent and sustainable care. Comprehensive and successful leadership strategies were in place to ensure and sustain service delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges, and priorities in their service, and beyond. The end of life strategy, supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. There was strong collaboration, team working, and support across all functions with a common focus on improving the quality and sustainability of care and people's experiences within end of life care. The trust celebrated safe innovation and there was a clear, systematic, and proactive approach to seeking out and embedding new and more sustainable models of care.
- In outpatients the service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. There were concerns

following a change to electronic patient recording when the trust had been unable to accurately report referral to treatment time data and had resorted to estimating data. This had been resolved and we were assured that the trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The outpatient management teams identified risks, and had planning processes in place to eliminate or reduce them. However there were ongoing concerns regarding photographic image governance, and this remained an issue on this inspection. The trust was in the final stages of implementing a secure app to capture patient consent and upload image data securely to trust systems but there was no implementation date as yet.

See guidance note 7 then replace this text with your report content. (if required)…

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

The information for Outpatients in the ratings table also applies to Diagnostic Imaging because the services were inspected together in 2015. We now inspect the two services separately.

Outstanding practice

We found examples of outstanding practice in end of life care services.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including

For more information, see the Areas for improvement section of this report.

Action we have taken

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

- The SPCT developed a staff rotation scheme in partnership with a local hospice that enabled staff to shadow each other in their respective care settings to gain knowledge and share expertise in end of life care.
- The trust had employed a Macmillan education nurse on a two-year contract who was influential in offering a broad range of training and external stakeholder engagement to raise end of life issues across the trust and within the local community.

Summary of findings

- Consultant cover had improved since our last inspection in March 2016. The staff team felt that this had made a significant improvement in terms of meeting the needs of end of life patients as well as supporting the SPCT and wider staff team.
- The SPCT team sensitively and professionally promote cornea donation amongst the patients and families of end of life care patients. The team work closely with the tissue donation teams to provide this service.

The trust had made significant improvements to its Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) process since our last inspection.

Areas for improvement

Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services.

In outpatients:

- Should ensure that all equipment in outpatients is appropriately electrically safety checked.
- Should ensure that all staff receive an appraisal.
- Should ensure that patients receive treatment in a timely way.
- Should ensure team meetings are minuted.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as outstanding because:

- The trust had a stable, experienced leadership team with only one executive being an interim appointment. This person had however worked at the trust for some time. There were clear systems in place to ensure that leaders had the skills and experience to complete their role effectively. This was reviewed regularly by ongoing checks. This met the regulation for Fit and Proper Persons (Regulation 5).
- All executive and non-executive directors were clear of their areas of responsibility. There was a structure in place for corporate decision making and a scheme of delegation clearly identified who was responsible for decision making.
- The senior team were a cohesive unit whilst able to challenge appropriately. We observed a public board meeting. There was the effective use of data and information to challenge executives. Non- executive directors gave consistent challenge to executive directors throughout the meeting. In all the challenges there was a clear focus on the impact on patient care with the patient being at the centre of decision making.
- There was an effective governance and performance system which was focussed on the best outcomes for patients. It was regularly reviewed, as we observed at the public board meeting, and adapted to ensure the most useful information was received. There was clinical and non-clinical representation at meetings across the organisation.

Summary of findings

- Following the implementation of eCare, the trust had significant problems in providing accurate referral to treatment time (RTT) figures. This meant that senior executives could not be sure that all patients were being seen in line with national standards. The trust has worked with the software provider of eCare, NHSI and NHSE to recover the situation. At the time of our inspection they were able to provide complete RTT figures. There had also been concerns about the quality of discharge summaries. The trust had worked with stakeholders to address these concerns which had seen an improvement in the quality of the summaries.
- There was a clear board to ward structure which all executives could describe. It ensured performance and risks were correctly escalated and addressed. The corporate risk register had identified risks and showed mitigations taken as well as the individual responsible for managing the risk.
- The trust had fully implemented processes for the learning from deaths reviews. This included asking if family wanted to contribute to reviews and the appointment of clinical reviewers to consider all aspects (not just clinical) of patient care. This was being supported by the further development of the Quality Improvement (QI) agenda at the trust.
- There was a comprehensive talent identification programme in place and a number of leadership programmes, individually tailored to meet the needs of leaders at different levels of the organisation. Leadership programmes were open to leaders at different levels of the organisation and not just those traditionally seen as senior leaders. There were novel leadership initiatives such as the 5 o'clock club which was open to all staff.
- Senior leaders were visible and approachable. All the staff we spoke with told us that the executive team were approachable with an open door policy. Staff felt well supported by the senior team who addressed concerns and enabled them to make positive changes to service delivery locally. Members of the senior team visited areas of the trust regularly.
- Staff we spoke with were overwhelmingly positive about the trust and leadership and committed to the values and direction of the organisation.
- All of the executive and non-executive directors we spoke with articulated a clear vision and strategy.
- The clearly defined strategy included the integration of community services was aligned to the local Sustainability and Transformation Plan (STP). Significant steps had been taken to align services with these plans. All the work streams and strategies across the organisation such as the estates strategy was patient focused and cross referenced each other to demonstrate a consistent approach to achieving the trust vision.
- The trust had very positive NHS staff survey results. The trust had the best staff engagement score in England and had built on a very positive score in the preceding year. Staff motivation and recommending the trust as a place to work or receive treatment were much better than the England average. Executives and trust governors were not complacent about the improved performance and action plans had been put in place to address areas of weaker performance.
- Significant work had been undertaken to address concerns regarding culture in maternity services since our last inspection.
- The trust had a number of mechanisms for stakeholder and public engagement both formal and informal. Healthwatch Suffolk attended one meeting and the trust was planning further engagement with them.
- The workforce race equality standard (WRES) was comprehensive and identified areas where the trust needed to improve. There was an action plan to address this alongside innovative methods to address the issues.
- The trust had made significant investment in its ICT strategy over the preceding two years. The centrepiece to this was the introduction of the electronic patient record. We found in the services we inspected that staff were confident in using the system and they spoke of the benefits of having information in one place as well as the timeliness in retrieving information.

Summary of findings

- There was a strong focus on continuous learning and improvement at all levels of the trust and a culture to support innovation. The executive team encouraged quality improvement (QI) within the trust and had recently appointed a QI practitioner to embed quality improvement across the organisation. Following our last inspection there had been a focus on improving care across the organisation and we saw improvements within end of life care.
- The trust proactively supports a culture of innovation and improvement with a number of initiatives being driven from the staff at the hospital. At this inspection we saw the introduction of a green cup used to highlight soluble medicines on wards. This was a suggestion from a student nurse. Staff told us there were no barriers (other than usual governance requirements) to the implementation of ideas and that they were supported to make change to practice locally.
- The trust had been recognised as a Global Digital Exemplar for its integrated digital technology supporting patient care.
- The trust had appointed a public health consultant, one of only approximately 15 in acute trusts in England. They were able to bring a wider population perspective when designing services and pathways. The consultant was in the process of setting up a strategy group encompassing trust staff and local GP's to work on pathways that fit the demographics and specific clinical needs of the local population. The public health registrar along with the medical director had been instrumental in the developing of learning from deaths and had been proactive in involving relatives in this work and looking beyond clinical aspects of the care of patients.

Ratings tables

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good Nov 2017	Outstanding ↑ Nov 2017	Outstanding ➔➔ Nov 2017	Good ➔➔ Nov 2017	Outstanding ↑ Dec 2017	Outstanding ↑ Dec 2017

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for West Suffolk Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Medical care (including older people's care)	Good Aug 2016	Outstanding Aug 2016	Outstanding Aug 2016	Good Aug 2016	Good Aug 2016	Outstanding Aug 2016
Surgery	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Critical care	Good Aug 2016	Outstanding Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Outstanding Aug 2016	Good Aug 2016
Maternity	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016
Services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good →← Nov 2017	Good ↑ Nov 2017	Outstanding →← Nov 2017	Good →← Nov 2017	Outstanding ↑ Nov 2017	Outstanding ↑ Nov 2017
Outpatients	Good →← Nov 2017	Not rated	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017
Overall*	Good →← Nov 2017	Outstanding ↑ Nov 2017	Outstanding →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Outstanding ↑ Nov 2017

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall*	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

West Suffolk Hospital

Hardwick Lane
Bury St Edmunds
Suffolk
IP33 2QZ
Tel: 01284713538
www.wsh.nhs.uk

Key facts and figures

The West Suffolk NHS Foundation Trust has one acute hospital site in Bury St. Edmunds, Suffolk. The hospital was built as 'Best buy' hospital in the 1970s as a serves a population of around 280, 000 in West Suffolk and surrounding areas. The trust also provides care in the community through Newmarket Hospital and community health services in West Suffolk that transferred to the trust in October 2017.

Acute services are provided at West Suffolk Hospital and encompass urgent and emergency care, planned medical and surgical care, critical care, maternity, neonatal and paediatric care, end of life and outpatient care. The hospital has a total number of 477 beds that includes 443 general and acute beds, 31 maternity beds and 11 critical care and six coronary care beds.

Prior to the acquisition of community services the trust employed 3, 063 staff of which 411 were medical, 975 were Nursing and 1, 787 other clinical and non-clinical staff.

For the last full year there were 62, 673 inpatient admissions, 389, 701 outpatient attendances and 62, 106 accident and emergency attendances.

The trust was last inspected in March 2016 as part of our comprehensive inspection programme. At the 2016 inspection we rated the Trust good overall. Safe, effective, responsive and well led were rated as good with caring being rated outstanding.

We rated urgent and emergency care, surgery, intensive care, services for children and young people, end of life care, maternity and outpatients as good overall with medical care being outstanding.

West Suffolk NHS FT is a part of the Suffolk and North East Essex STP.

Summary of services at West Suffolk Hospital

Outstanding ☆ ↑

Our rating of these services improved. We took into account the current ratings of services not inspected this time. We rated them as outstanding

A summary of our findings about West Suffolk Hospital appears in the overall summary

End of life care

Outstanding ☆ ↑

A summary of our findings about this service appears in the Overall summary.

Key facts and figures

West Suffolk NHS Trust provides end of life care to patients across all clinical areas and treats patients with a variety of conditions, including cancer, stroke, cardiac and respiratory disease and dementia.

The hospital does not have a dedicated ward for end of life care. The specialist palliative care team (SPCT), which consists of specialist consultants and nurses, provide advice, assessment and treatment to patients across all clinical areas within the hospital. The SPCT also supports ward staff to deliver care to patients at the end of life.

Between 1 Jan 2017 and 31 Oct 2017, there were 8,404 patients referred as suspected cancer and first seen in the West Suffolk hospital. Of these 658 patients commenced treatment for a new cancer during that period, giving the cancer conversion rate of 7.8%.

The SPCT was available six days a week, from 9am to 5pm, Monday to Friday and 8am until 4pm on Saturdays. Outside these hours, on call consultants from the local hospice and SPCT provided support by via telephone.

A bereavement team provided support to relatives from Monday to Friday 8am to 4pm and a chaplaincy service was available to patients, relatives and staff, 24 hours a day, seven days a week. The executive chief nurse had responsibility for end of life care within the executive team.

The service was previously inspected in March 2016 and was issued with a requirement notice in relation to Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent and Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

Concerns included the trust's policy was inappropriate and misleading with regard to applying and following the principles of a Mental Capacity Assessment and Deprivation of Liberty Safeguards DoLS. Staff knowledge around the use and implementation of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was inconsistent. Completion of Escalation Plan and Resuscitation Status (EPARS) forms was inconsistent and often did not match other documentation or had sections incomplete. We inspected all five key questions to ensure that the issues in the requirement notice had been met.

We completed an unannounced inspection of the end of life care service on the 9 and 10 November 2017 staff did not know we were coming, to enable us to observe routine activity. We visited eight wards, including the stroke unit, accident and emergency, medical wards, and surgical wards. We also visited the mortuary and the multifaith chapel. We spoke with three patients. We spoke with 25 members of staff including medical and nursing staff, allied health professionals, the SPCT, porters, mortuary and chaplaincy staff. We reviewed ten patient care records, seven Do Not Attempt Cardiopulmonary Resuscitation

Summary of this service

The hospital does not have a dedicated ward for end of life care. The specialist palliative care team (SPCT), which consists of specialist consultants and nurses, provide advice, assessment and treatment to patients across all clinical areas within the hospital. The SPCT also supports ward staff to deliver care to patients at the end of life.

End of life care

Between 1 Jan 2017 and 31 Oct 2017, there were 8,404 patients referred as suspected cancer and first seen in the West Suffolk hospital. Of these 658 patients commenced treatment for a new cancer during that period, giving the cancer conversion rate of 7.8%.

Our rating of this service improved. We rated it as outstanding because:

- The trust had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The nurse staffing for the specialist palliative care team (SPCT) was in line with national guidance. This was an improvement since our last inspection.
- The trust managed patient safety incidents well. Staff recognised incidents and reported them appropriately using the services electronic incident-reporting tool.
- The trust controlled infection risk. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The trust had suitable premises and equipment and looked after them.
- The trust prescribed, gave, recorded and stored medicines. Patients received the right medication at the right dose at the right time.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date, and available to all staff providing care. The service had implemented an electronic patient records system since our last inspection. Staff completed individualised care, which was in line with national guidance, and record keeping had improved since our last inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The trust had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The nurse staffing for the specialist palliative care team (SPCT) was in line with national guidance. This was an improvement since our last inspection.
- The trust provided care and treatment based on national guidance and evidence of its effectiveness. Where the organisation did not meet clinical indicators there were actions from audits in place.
- The trust provided care and treatment based on national guidance and evidence of its effectiveness. We reviewed end of life care clinical guidelines and found that they were version controlled, ratified and in date for review. Staff in the SPCT informally monitored their response times, preferred place of death and preferred place of care, and audited this data.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other preferences.
- The trust monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The trust made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff always had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update patient care records.

End of life care

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Consent to treatment was sought in line with legislation and guidance. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms completed well. We reviewed seven DNACPR forms and found that these included records of discussions with patients and relatives and signed by a senior clinician, this was an improvement since our last inspection.
- Staff truly respected and valued patients as individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional and distinctive service.
- Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. Patients said that staff went that extra mile and their care and support exceeded their expectations.
- The end of life service had a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. We found strong caring, respectful and supportive relationships between people who used the service, those close to them and staff. Staff highly valued these relationships and felt promoted by leaders.
- Staff recognised and respected the totality of people's needs. They always considered people's personal, cultural, social, and religious needs, and found innovative ways to meet them.
- Staff consideration of people's privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these are recorded and communicated.
- Staff saw people's emotional and social needs as being as important as their physical needs.
- Staff at the service treated patients with compassion, dignity, and respect and involved them in their care. All patients we spoke to were positive about the care given by staff and staff went over and above their normal roles to provide addition care and support.
- The service took account of patients' individual needs. Staff took account of the spiritual and religious needs of patients and actively sought to promote these within individual care plans.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.
- The trust planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- The end of life care services received no complaints in the 12 months prior to our inspection. However, staff knew how to treat concerns and complaints seriously, investigate them and learn lessons from the results, to share with all staff.
- The trust had compassionate, inclusive, and effective leadership at all levels. Leaders at all levels demonstrated high levels of experience, capacity, and capability needed to deliver excellent and sustainable care.
- Comprehensive and successful leadership strategies were in place to ensure and sustain service delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges, and priorities in their service, and beyond.

End of life care

- The end of life strategy, supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.
- The SPCT were proud of the organisation as a place to work and spoke highly of the culture. Staff were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process.
- There was strong collaboration, team working, and support across all functions with a common focus on improving the quality and sustainability of care and people's experiences within end of life care. The trust celebrated safe innovation and there was a clear, systematic, and proactive approach to seeking out and embedding new and more sustainable models of care.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- The trust had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The nurse staffing for the specialist palliative care team (SPCT) was in line with national guidance. This was an improvement since our last inspection.
- The trust managed patient safety incidents well. Staff recognised incidents and reported them appropriately using the services electronic incident-reporting tool.
- The trust controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The trust had suitable premises and equipment and looked after them appropriately.
- The trust prescribed, gave, recorded and stored medicines appropriately. Patients received the right medication at the right dose at the right time.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date, and available to all staff providing care. The service had implemented an electronic patient records system since our last inspection. Staff completed individualised care, which was in line with national guidance, and record keeping had improved since our last inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The trust had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The nurse staffing for the specialist palliative care team (SPCT) was in line with national guidance. This was an improvement since our last inspection.
- The trust provided care and treatment based on national guidance and evidence of its effectiveness. Where the organisation did not meet clinical indicators there were actions from audits in place.

Is the service effective?

Good 

End of life care

Our rating of effective improved. We rated it as good because:

- The trust provided care and treatment based on national guidance and evidence of its effectiveness. We reviewed end of life care clinical guidelines and found that they were version controlled, ratified and in date for review. Staff in the SPCT informally monitored their response times, preferred place of death and preferred place of care, and audited this data.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other preferences.
- The trust monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The trust made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff always had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. All staff had access to an electronic patient records system that they could all update.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Consent to treatment was sought in line with legislation and guidance. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms completed well. We reviewed seven DNACPR forms and found that these included records of discussions with patients and relatives and signed by a senior clinician, this was an improvement since our last inspection.
- Staff at the service treated patients with compassion, dignity, and respect and involved them in their care. All patients we spoke to were positive about the care given by staff and staff went over and above their normal roles to provide addition care and support.
- The service took account of patients' individual needs. Staff took account of the spiritual and religious needs of patients and actively sought to promote these within individual care plans.
- Staff involved patients and those close to them in decisions about their care and treatment.

Is the service caring?

Outstanding ☆ ➔➔

Our rating of caring stayed the same. We rated it as outstanding because:

- Staff truly respected and valued patients as individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional and distinctive service.
- Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. Patients said that staff went that extra mile and their care and support exceeded their expectations.

End of life care

- The end of life service had a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. We found strong caring, respectful and supportive relationships between people who used the service, those close to them and staff. Staff highly valued these relationships and felt promoted by leaders.
- Staff recognised and respected the totality of people's needs. They always considered people's personal, cultural, social, and religious needs, and found innovative ways to meet them.
- Staff saw people's emotional and social needs as being as important as their physical needs.
- Staff consideration of people's privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these are recorded and communicated.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people.
- People could access the service when they needed it. Waiting times from treatment were, arrangements to admit, treat, and discharge patients were in line with good practice.
- The service took account of patients' individual needs.
- The end of life care services received no complaints in the 12 months prior to our inspection. However, service knew how to treat concerns and complaints seriously, investigate them and learn lessons from the results, to share with all staff.

Is the service well-led?

Outstanding 

Our rating of well-led improved. We rated it as outstanding because:

- The trust had compassionate, inclusive, and effective leadership at all levels. Leaders at all levels demonstrated high levels of experience, capacity, and capability needed to deliver excellent and sustainable care. The SPCT were respected throughout the organisation for their support of staff and patients.
- Comprehensive and successful leadership strategies were in place to ensure and sustain service delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges, and priorities in their service, and beyond.
- The end of life strategy, supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. The end of life care strategy patient centred and was fundamentally supported by the trust's nursing strategy and aligned to the overall trust strategy.
- All staff we spoke with recognised end of life care as a priority for all across the organisation which had been driven by the specialist palliative care team and trust leadership.
- There was a clear focus on improving care quality, in aligning services and comprehensive auditing of the service.

End of life care

- The SPCT were proud of the organisation as a place to work and spoke highly of the culture. The trust actively encouraged staff to speak up and raise concerns, and all policies and procedures positively supported this process.
- There was strong collaboration, team working, and support across all functions with a common focus on improving the quality and sustainability of care and people's experiences within end of life care. The trust celebrated safe innovation and there was a clear, systematic, and proactive approach to seeking out and embedding new and more sustainable models of care.

Outstanding practice

- The SPCT developed a staff rotation scheme in partnership with a local hospice that enabled staff to shadow each other in their respective care settings to gain knowledge and share expertise in end of life care.
- The trust had employed a Macmillan education nurse on a two-year contract who was influential in offering a broad range of training and external stakeholder engagement to raise end of life issues across the trust and within the local community.
- Consultant cover had improved since our last inspection in March 2016. The staff team felt that this had made a significant improvement in terms of meeting the needs of end of life patients as well as supporting the SPCT and wider staff team.
- The SPCT team sensitively and professionally promote cornea donation amongst the patients and families of end of life care patients. The team work closely with the tissue donation teams to provide this service.
- The trust had made significant improvements to its Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) process since our last inspection.

Outpatients

Good

Key facts and figures

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

West Suffolk NHS Foundation Trust provides its main outpatients services at West Suffolk Hospital. It also provides outpatients clinics at services based at Newmarket Hospital and in local health centres. These satellite services are managed by the same team who oversee main outpatients. We did not inspect any of the other locations during this inspection.

There are consultant, allied health professional and nurse-led outpatient clinics across a range of specialities, which are provided in the outpatients department and in separate dedicated clinics around the hospital. Outpatient clinics are held from Monday to Friday from 8am until 6pm with some late clinics until 7.30pm and regular Saturday appointments are provided dependant on specialty.

The main outpatient department provided approximately 180 clinics per week but this did not include speciality clinics such as the pain clinic, breast clinics, or oncology clinics.

The trust had 360,873 first and follow-up outpatient appointments between July 2016 and June 2017.

The previous inspection in 2016 rated the service as good, the negatives were;

•We could not be confident that outpatient clinics were appropriately staff by skilled and qualified staff, for example paediatric dermatology.

•Some outpatient areas, for example audiology, were very cramped.

•Policy making in the outpatients department lacked timeliness, trust-led scrutiny or endorsement.

The trust was also required to; ensure a robust process for data management with regard to medical photography and comply with all information governance protocols including informed consent, data protection, tracking and tracing and appropriate audit systems implemented to ensure quality improvement.

During this unannounced inspection we visited the main outpatient area where we observed dermatology and colorectal and orthopaedic and fracture clinics, and visited other clinics including cardiology and respiratory physiology, ophthalmology, diabetes, breast, pain and gynaecology. During the inspection we spoke with 46 members of staff including three consultants, seven managers, 23 nurses, four administrative or support staff, one junior doctor and one volunteer. We spoke with16 patients and two relatives of patients. We looked at the environment, we observed staff interacting with patients and their colleagues and we looked at eight patient's records, and information including policies, procedures, and audits.

Summary of this service

West Suffolk NHS Foundation Trust provides its main outpatients services at West Suffolk Hospital. It also provides outpatients clinics at services based at Newmarket Hospital and in local health centres. These satellite services are managed by the same team who oversee main outpatients. We did not inspect any of the other locations during this inspection.

See guidance note AL4 then add your text after the standard text paragraph below (and delete this help text).

Outpatients

Our rating of this service stayed the same. We rated it it as good because:

- Staff ensured equipment and premises were clean and ready to use and used appropriate practises to prevent and protect people from a healthcare associated infection.
- Medicines and prescriptions were stored and monitored safely and records were accessible clear and up to date.
- Staff understood how to protect patients from abuse and had training on how to recognise and report abuse and they knew how to apply it.
- Staff cared for patients with compassion and empathy.
- Staff involved patients and those close to them in decisions about their treatment and provided emotional support. Many of the specialist services had telephone advice lines to where patients were able to access advice and support.
- The service provided care and treatment based on national guidance and monitored evidence of its effectiveness to improve outcomes.
- There were sufficient staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment and there was good support and access to training for staff to develop.
- Staff of different kinds worked together as a team. Staff also worked well with other health care providers to benefit patients.
- The trust planned and provided services in a way that met the needs of local people and of individuals who required additional support. Clinics were easily accessible and the newer specialist clinics were well planned and comfortable.
- The trust has consistently performed better than the England average for people being seen within two weeks of an urgent GP referral, and receiving treatment within 31 days for a suspected cancer.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The service had managers at all levels with the right skills and abilities to run the service providing high-quality sustainable care and had vision for what it wanted to achieve and workable plans to turn it into action.
- Managers across the trust promoted a positive culture that supported and valued staff. There was good team work within the teams and staff were proud of their service and this was evident in the family like atmosphere and good interpersonal relationships.
- The concerns following a change to electronic patient recording when the trust had been unable to accurately report referral to treatment time data had been resolved and we were assured that the trust collected, analysed, managed and used information well.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

However:

- Appraisal rates were not consistent across staff groups and did not meet trust targets. Mandatory training was below trust targets and the trust had not addressed the training of clinicians to Safeguarding level three for children despite them seeing 4,742 children between May and October.

Outpatients

- We were not assured that all equipment was regularly tested for electrical safety.
- There was no obvious information available to patients regarding the availability of chaperones which meant that patients did not know to ask for a chaperone if required.
- The overall referral to treatment times for non-admitted pathways were worse than the England average between September 2016 and August 2017 (89.6% versus 85.9%). However 11 specialties were better than the England average with 7 worse. The trust had a cohort of patients on a 'backlog' or patient tracking list (PTL) awaiting outpatient appointments some of whom had been waiting more than 52 weeks for first treatment .
- There were concerns raised in the inspection in 2016 regarding ward and clinic staff compliance with standards of photographic image governance, and this remained an issue on this inspection. The trust was in the final stages of implementing a secure app to capture patient consent and upload image data securely to trust systems but there was no implementation date as yet.
- Although outpatient services had regular team meetings we were not provided with minutes to ascertain content so were not assured that all information was passed to all staff from 'board to ward'.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- There were reliable systems in place to prevent and protect people from a healthcare associated infection. Staff kept themselves, equipment and the premises clean.
- The service prescribed, gave, recorded and stored medicines well. Prescriptions were stored and monitored safely.
- Resuscitation equipment was regularly checked and there was suitable personal protection equipment available for staff.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and had training on how to recognise and report abuse and they knew how to apply it.
- There were sufficient staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

However:

- We found several pieces of equipment that did not have electrical testing date stickers. The trust supplied data which did not assure us that all equipment was regularly tested for electrical safety.

Is the service effective?

We do not rate outpatients services for effective.

- The service provided care and treatment based on national guidance and evidence of its effectiveness. There were processes to ensure that the most recent guidance was reviewed and applied.

Outpatients

- Staff gave patients enough food and drink to meet their needs. The main outpatients had introduced a volunteer service to provide refreshments following minor procedures.
- The service monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their roles and there was good support and access to training for staff to develop.
- Staff of different kinds worked together as a team. Staff also worked well with other health care providers to benefit patients.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

However:

- Appraisal rates were not consistent across staff groups and did not meet trust targets. Overall rates between August 2016 and July 2017 showed 53.4% of staff within Outpatients had received an appraisal compared to a trust target of 90%.

Is the service caring?

Good 

We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness and we observed staff were friendly and welcoming and offered assistance when it was needed.
- Staff involved patients and those close to them in decisions about their treatment. We observed staff discussing options with patients and relatives and making joint decisions about care.
- Staff provided emotional support to patients to minimise their distress and we heard of staff going out of their way to support patients. Many of the specialist services had telephone advice lines to where patients were able to access advice and support.

However:

- There was no obvious information available to patients regarding the availability of chaperones which meant that patients did not know to ask for a chaperone if required.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. Clinics were easily accessible and the newer specialist clinics were well planned and comfortable.
- The trust has consistently performed better than the England average for people being seen within two weeks of an urgent GP referral, and receiving treatment within 31 days for a suspected cancer.

Outpatients

- The service took account of patients' individual needs. The trust provided good extra support for those who needed it and ensured people were seen in clinics in a timely way when there were transport needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- Staff informed patients if a clinic was running late and there were pagers available if patients wanted to leave the department.

However:

- The overall referral to treatment times for non-admitted pathways were slightly worse than the England average between September 2016 and August 2017 (89.6% versus 85.9%). However 11 specialties were better than the England average with 7 worse.
- The trust had a cohort of patients on a 'backlog' or patient tracking list (PTL) awaiting outpatient appointments some of whom had been waiting more than 52 weeks for first treatment. Patients had been clinically assessed and prioritised to reduce the risk for those waiting longer times.
- There was no hearing loop in existence so patients who were hard of hearing were at a disadvantage.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with were very proud of their service and this was evident in the family like atmosphere and good interpersonal relationships.
- Staff told us there was good team work within the teams and we saw that on a day to day basis, staff worked together to resolve issues, and were flexible to accommodate the service needs.
- The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- There were concerns following a change to electronic patient recording when the trust had been unable to accurately report referral to treatment time data and had resorted to estimating data. This had been resolved and we were assured that the trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The outpatient management teams identified risks, and had planning processes in place to eliminate or reduce them.
- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Outpatients

However:

- There were concerns raised in the inspection in 2016 regarding ward and clinic staff compliance with standards of photographic image governance, and this remained an issue on this inspection. The trust was in the final stages of implementing a secure app to capture patient consent and upload image data securely to trust systems but there was no implementation date as yet.
- Although outpatient services had regular team meetings we were not provided with minutes to ascertain content so were not assured that all information was passed to all staff from 'board to ward'.

Our inspection team

The inspection was led by Mark Heath, Inspection Manager. Fiona Allinson, Head of Hospital Inspection, supported our inspection of well led for the trust overall.

The team included 2 inspectors, 2 doctors, 2 nurses a board level nurse and governance specialist.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

NHS West Suffolk NHS Foundation Trust

Trust Board – 2nd March 2018

Agenda item:	12			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sinead Collins, Clinical Business Manager			
Date prepared:	23 February 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 January's and progress of nurse staffing review made below.

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	7 medication errors	High agency and bank use. High RN & NA vacancy. High amount of overtime. High sickness
F7	4 medication errors & 5 falls with harm	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. High sickness
CCS	-	High RN vacancy
Theatres	-	High RN vacancy. High sickness. High amount of overtime
Recovery	-	High sickness
DSU	-	High sickness and bank use.
CCU	-	High bank use.
G1	5 pressure ulcers & 3 falls with harm	High sickness. High amount of overtime
G3	5 medication errors & 3 pressure ulcers	High bank use. High RN & NA vacancy. High sickness. High amount of overtime
G4	4 medication errors	High bank use. High RN vacancy. High amount of overtime
G5	5 pressure ulcers & 4 falls with harm	High bank use & sickness. High RN vacancy. High amount of overtime
G8	4 falls with harm	High bank and agency use. High sickness. High RN & NA vacancy.
F1	-	High bank use. High RN vacancy. High amount of overtime.
F3	3 pressure ulcers	High RN vacancy. High sickness. High amount of overtime
F4	-	High agency and bank use. High RN vacancy. High sickness
F5	-	High RN vacancy
F6	4 medication errors	High agency use. High RN vacancy. High amount of overtime. High sickness
F9	4 pressure ulcers & 3 falls with harm	High bank use & vacancy in RNs. High sickness. High amount of overtime
F10	3 pressure ulcers	High bank use & vacancy in RNs.
Maternity	-	High bank use & sickness. High midwife vacancy.

F12	-	High bank use & sickness. High RN vacancy
MTU	-	High sickness
Kings Suite	-	High bank use & sickness. High amount of overtime
Rosemary Ward	-	High bank use & sickness. High amount of overtime

Vacancies – There are significant vacancies in registered staff, and is 90.97 WTE. 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 amount varying. Recruitment in Philippines completed and now in the HR process stage

Roster effectiveness – Out of 26 areas, 17 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is 4 areas lower than December.

Sickness – Out of 27 areas, 24 are over the Trust Standard of 3.5% (two higher than last month) (Day surgery unit & ward are counted as one area).

Update on progress of Nurse Staffing Review

Due to improvement in roster effectiveness but increase in sickness, it can be determined that use of annual leave on wards has improved and been regulated more effectively

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Jan-18			Establishment for the Financial Year 2017/18						Data for Jan 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	117.6%	93.2%	112.7%	100.4%	4.56%	6.66%	331	-3.82	-5.40	6.90%	N/A	20.90%	N/A	7	1
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	83.3%	73.6%	95.4%	94.7%	9.11%	10.50%	199	-7.90	-3.24	12.20%	6.21	26.60%	1	4	5
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	71.9%	219.6%	76.2%	449.3%	29.42%	7.59%	161	-2.20	-0.80	8.40%	N/A	25.90%	0	2	0
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	92.3%	86.0%	N/A	N/A	1.77%	0.00%	96	-3.26	0.00	3.90%	21.99	19.80%	2	3	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	102.4%	100.0%	N/A	N/A	2.17%	0.00%	161	-7.76	-1.40	7.00%	N/A	21.50%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	128.0%	100.0%	82.9%	N/A	0.00%	0.00%	93	-1.04	-0.10	5.00%	N/A	20.00%	0	2	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	58.4%	N/A	88.4%	N/A	0.44%	0.00%	18	-0.70	-1.28	13.30%	N/A	35.70%	0	0	0
	Day Surgery Wards													7.96%	0.00%	0	0.00	0.10	7.90%		33.40%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	95.9%	81.3%	61.0%	N/A	5.01%	0.00%	96	-1.60	-0.70	4.90%	11.45	23.20%	0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	87.1%	96.7%	95.6%	N/A	3.00%	0.00%	115	-0.30	-1.00	13.10%	7.77	32.80%	5	3	3
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	93.4%	86.0%	83.5%	94.1%	14.10%	0.00%	132	-3.53	-3.82	7.60%	4.38	20.70%	3	5	2
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	80.7%	79.7%	108.4%	113.3%	12.84%	0.98%	395	-3.79	-2.20	4.80%	6.09	21.20%	0	4	2
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	75.2%	86.3%	98.1%	97.5%	4.98%	2.30%	164	-3.61	-0.65	8.60%	4.53	21.10%	5	1	4
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	79.4%	88.9%	88.2%	97.2%	10.59%	8.10%	29	-6.40	-3.86	11.00%	5.6	26.30%	0	1	4
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	81.5%	120.7%	138.7%	N/A	9.25%	0.00%	103	-3.95	2.50	3.00%	N/A	18.00%	N/A	1	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	87.9%	95.6%	138.4%	97.8%	2.99%	3.06%	351	-3.20	-2.10	8.40%	5.35	18.30%	3	3	1
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	107.8%	111.5%	80.7%	192.9%	17.97%	14.04%	35	-5.74	-2.30	9.90%	I/D	23.40%	2	1	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	90.4%	86.1%	101.9%	134.5%	3.58%	0.67%	0	-3.37	-0.24	3.50%	5.22	15.90%	0	2	1
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	86.0%	94.3%	109.3%	92.9%	2.83%	5.51%	459	-4.39	-1.80	11.20%	6.29	22.90%	0	4	0
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	81.1%	93.3%	92.7%	98.8%	10.87%	0.47%	174	-6.63	-1.70	5.20%	4.76	17.00%	4	0	3
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	102.0%	72.5%	89.4%	96.3%	8.42%	1.56%	91	-5.47	-2.20	4.60%	5.83	19.70%	3	2	0
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	115.3%	95.1%	59.8%	57.5%	10.98%	0.00%	67	-4.14	-0.50	9.80%	N/A	22.10%	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	0	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	76.3%	76.3%	29.3%	105.8%	16.46%	0.63%	50	-3.97	-1.90	6.00%	7.27	19.20%	0	1	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	100.4%	101.6%	N/A	N/A	0.72%	0.00%	75	-0.70	-0.40	1.40%	N/A	18.20%	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	88.6%	N/A	41.3%	N/A	0.00%	0.00%	0	-0.20	-0.80	8.20%	N/A	31.60%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	98.6%	90.1%	16.7%	32.3%	0.65%	0.00%	12	-2.40	-1.40	0.70%	I/D	17.40%	N/A	1	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	99.2%	100.0%	86.2%	100.0%	5.73%	0.15%	133	-0.20	-0.69	7.48%	6.60	N/A	0	0	1
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	99.4%	98.5%	85.4%	96.4%	8.64%	0.0%	183	-0.90	-0.50	7.40%	4.70	24.90%	1	0	0
										91.85% AVG	97.07% AVG	85.84% AVG	119.54% AVG	7.32% AVG	2.22% AVG	3723 TOTAL	-91.17 TOTAL	-38.38 TOTAL	7.19% AVG		22.88% 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 pressure ulcers, four medication errors and one fall with harm

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 2nd 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:	**Nursing Workforce - Current Vacancies and Recruitment Strategy**			
Purpose:	☑	For information		For approval

Executive summary

This paper provides;

- An analysis of current registered and un-registered nurse vacancies, and the potential recruitment numbers required by the trust in the coming months
- An update on the various areas nurses are recruited from, and potential planned numbers, up until 2021.
- An explanation of other initiatives, in place or planned, to encourage recruitment and retention in this area.

A briefing paper explaining the new apprenticeship levy and how it might provide the potential for the trust to "grow our own" nursing staff going forward, is attached at appendix A.

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:	*N/A*
Risk and assurance:	Risk to patient safety due to lack of staff. Action plan and risk assessment to be produced
Legislation, regulatory, equality, diversity and dignity implications	Legislation, regulatory, equality, diversity to be included in plan

Recommendation: For information

Nursing Workforce - Current Vacancies and Recruitment Strategy

Analysis of Vacancies

The following tables summarise the ward based nursing vacancies at WSFT as at December 2017, split between registered and unregistered nurses. They have also estimated the nursing that would be required to staff any increase in capacity.
This suggests the number of staff that needs to be recruited in the yellow highlighted column. This assumes that all current vacancies, turnover and any increased capacity are filled with substantive staff.
However, in broad terms, if all existing vacancies and turnover were recruited with substantive staff (pink shading), existing temporary staff could provide the staff needed for the additional capacity (as demonstrated in the Memo column). Based on the RN recruitment plans to February 2019 the Trust would have a gap of 14.8 which could be covered by bank and agency staff.
Other assumptions that have been made:

- Vacancies are derived from substantive and temporary WTE budgets less actual WTE in post where the actuals are less than the budget
- Nursing staff are able to move between wards depending on activity levels
- Annual turnover of registered nursing staff is 7%, Unregistered nursing staff is 10%
- All temporary staff above temporary staffing budgets are currently used to fill substantive vacancies (bank, agency and overtime)

Table 1.1 Registered Nurses (RN)

	WTES - Trained Nurses					
Ward	Vacancies	Annual turnover (7%)	Existing capacity recruitment required	Additional Capacity	Total required	MEMO: Temporary posts filling vacancies at Dec 17
Accident & Emergency	6.3	3.8	10.2		10.2	3.7
C.C.U.	2.2	1.1	3.3		3.3	0.6
Cardiac Ward	3.9	1.4	5.2		5.2	0.3
Community - Glastonbury Court	1.6	0.8	2.4		2.4	1.1
Emergency Assessment Unit	6.6	2.0	8.7		8.7	6.6
Neonatal Unit	2.9	1.3	4.2		4.2	0.1
Newmarket Hospital - Rosemary Ward	(0.4)	1.0	0.5		0.5	1.3
Ward F1 Paediatrics	2.7	1.2	3.9		3.9	1.6
Ward F10	5.0	1.3	6.3		6.3	0.4
Ward F12	2.9	0.6	3.5		3.5	0.5
Ward F14 (Gynae Ward)	0.1	0.8	0.9		0.9	
Ward F3	2.2	1.3	3.5		3.5	0.9
Ward F4	2.7	0.9	3.6		3.6	3.1
Ward F5	2.3	1.5	3.8		3.8	1.0
Ward F6	4.0	1.5	5.5		5.5	3.9
Ward F8 Ambulatory Care	3.0	0.9	3.9		3.9	1.6
Ward F9	5.8	1.1	7.0		7.0	0.1
Ward G1	1.8	1.6	3.3		3.3	
Ward G4	2.1	1.4	3.5		3.5	0.5
Ward G5	3.2	1.3	4.5		4.5	0.8
Ward G8	5.8	1.7	7.5		7.5	2.6
Ward G9 Escalation Ward	(1.0)	0.3	(0.7)		(0.7)	3.4
Additional Assessment Capacity	0.0	0.0	0.0	12.0	12.0	
Backfill G3	0.0	0.0	0.0	12.0	12.0	
DOSA on CCU	0.0	0.0	0.0	1.3	1.3	
Overnight on F8	0.0	0.0	0.0	3.0	3.0	
Open G9	0.0	0.0	0.0	10.0	10.0	
Grand Total	**65.5**	**29.0**	**94.5**	**38.3**	**132.8**	**34.0**
Recruitment Plan					118.0	152
					Surplus	19.2

Table 1.2 Unregistered nurses (Nursing Assistants)

Ward	WTES - Unregistered Nurses Vacancies	Annual Turnover	Existing Capacity Recruitment Required	Additional Capacity	Total Required	MEMO: Temporary Posts Filing Vacancies at Dec 17
Acident and Emergency	8.3	1.7	10.0		10.0	0.9
C.C.U	1.0	0.3	1.3		1.3	0.3
Cardiac Ward	5.5	1.7	7.2		7.2	3.9
Community - Glastonbury Court	1.3	1.1	2.4		2.4	0.2
Emergency Assesment Unit	5.1	2.6	7.6		7.6	4.3
Neonatal Unit	0.3	0.3	0.5		0.5	0.0
Newmarket Hospital - Rosemary Ward	0.2	1.3	1.4		1.4	0.3
Ward F1 Paediatrics	0.7	0.7	1.4		1.4	0,2
Ward F10	2.5	1.7	4.2		4.2	1.0
Ward F12	0.6	0.5	1.1		1.1	0.7
Ward 14 (Gynae Ward)	0.4	0.0	0.4		0.4	0.0
Ward F3	1.9	1.9	3.7		3.7	0.4
Ward F4	3.3	1.1	4.4		4.4	2.5
Ward F5	-0.1	1.4	1.4		1.4	1.2
Ward F6	-0.1	1.5	1.4		1.4	0.9
Ward F8 Ambulatory Care	1.5	1.2	2.7		2.7	0.4
Ward F9	0.1	2.3	2.4		2.4	2.9
Ward G1	0.0	1.0	1.0		1.0	1.3
Ward G4	1.2	2.7	3.8		3.8	5.0
Ward G5	0.1	2.3	2.4		2.4	2.8
Ward G8	3.4	2.0	5.4		5.4	1.2
Ward G9 Escalation Ward	-1.0	0.6	-0.4		-0.4	5.1
Addional Assessment Capacity	0.0	0.0	0.0	10.0	10.0	0.0
Backfill G3	0.0	0.0	0.0	10.0	10.0	0.0
DOSA on CCU	0.0	0.0	0.0	1.3	1.3	0.0
Overnight on F8	0.0	0.0	0.0	3.0	3.0	0.0
Open G9	0.0	0.0	0.0	10.0	10.0	0.0
Grand Total	35.9	29.8	65.6	34.3	99.9	35.3
Recruitment Plan					110	
					Surplus	45.4

NB: Information supplied by finance

2. Registered Nurse recruitment

Currently we recruit newly registered adult nurses from the following programmes:

- **University of Suffolk (UoS)** – this is a 3 year programme funded by the student with a government loan. Students complete their placements at the WSFT and within the community setting. Upon qualification students often apply for a registered nurse position within the acute Trust or the community. Please note the reductions in numbers since the removal of the NHS bursary (Sept 2017 qualifying Sept 2020)

- **Return to practice (UoS)** – this is a programme for those who wish to regain their NMC Pin following a period out of practice. Length of the programme is dependent on the time spent out of practice although the maximum time is 15 weeks. Interest in this programme is varied and staff often do not always wish to work within an acute setting when they have regained their PIN.

- **Work based learning (UoS)** – this is a 2 year apprenticeship programme for nursing assistants who have completed a Foundation Degree. The nursing assistant is a student for 15 hours per week and works within their current job role for the remaining hours. Wages are paid by the Trust and the course is paid via the apprenticeship levy.

- **4 year RN apprenticeship (UoS)** – this is a 4 year programme for those with A levels or a level 3 qualification. The nursing assistant is a student for 15 hours per week and works within their current job role for the remaining hours. Wages are paid by the Trust and the course is paid via the apprenticeship levy. We are hoping that this programme will start in September 2018 with the first cohort registering as adult nurses in 2022.

- **Overseas recruitment** – to obtain a NMC Pin nurses with a non EU registration need to complete the following:
    - English language test
    - Computer based multiple choice test
    - Objective Structured Clinical Examination practice exam (OSCE)

- The first 2 tests are completed within their own country and upon arrival to the WSFT the student is supported with a OSCE preparation programme to enhance their success with the exam. Currently we have offered positions to 55 nurses from the Philippines who are working towards the first 2 tests and hope to see the first cohort arriving in the UK in May/June. Further recruitment trips are being planned for June 2018. The cost per candidate is 10K a budgetary provision has been made.

- **Staff who are RN but not registered with NMC –** The Trust is aware that we have a number of overseas nursing assistants already working within the Trust who have been a registered nurse within their own country. We are looking to offer support both financially and clinically to enable them to apply for NMC registration and then work as a registered nurse within the organisation.

- **University of East Anglia (UEA)** – we are now offering placements to nursing students at UEA and hope that following their time at the WSFT some of them will apply for registered nurse positions.

  Please see the table below for predicted numbers of newly qualified staff that **could** apply for positions within the WSFT. Please note that '*' indicates predicted numbers as we do not have confirmed numbers for these programmes.

Table 2.1 RN recruitment plan

	Feb 2018	Sept 2018	Feb 2019	Sept 2019	Feb 2020	Sept 2020	Feb 2021
General Recruitment	0	5	5	5	5	5	5
Qualifying from UoS (Ipswich)	10	13	7	31	17	16	8 *
Return to Practice			2 *		2 *		2 *
Work Based Learning		2			4		4 *
4 year apprenticeship		13 **					
Overseas recruitment		25 *	30 *	25 *	30 *		
Qualifying from UEA (Norwich)	2 *	2 *	5 *	5 *	5 *	5 *	5 *
Nursing Assistants currently working at WSFT with overseas registration		5 *	5 *	5 *	5 *	5 *	5 *
PREDICTED TOTAL	**12**	**52**	**54**	**71**	**68**	**31**	**29**

** Nursing apprenticeship to start and will qualify in 2022. This will count towards nursing assistant recruitment and not RN recruitment until 2022.

2.1 Engagement with schools and future/higher education

The Education Team within the Nursing Directorate promotes the WSFT and healthcare careers within local schools and colleges throughout the year. We attend events externally, support work placements for programmes and hold insight events within the Trust for those looking to begin student programmes. We attend job fairs at the local universities to promote the WSFT as the organisation to begin your professional career. In the past 12 months we have engaged and talked with over 1500 students interested in healthcare careers. We also offer elective placements to students studying at other universities and have had some interest in students seeking employment at the Trust following qualification.

2.2. Incentive payments

Introduce a friend – The Trust offers staff a bonus of 1k to introduce a RN to Trust £500 on appointment and another £500 when the new appointee completes a year

Golden hello's – The Trust is looking at introducing an incentive payment to newly appointed RN this will support appointment and retention

2.3 Open days

The Trust is planning Open days throughout 2018 to attract newly qualified Nurses and Nursing Assistants to the Trust

3. Nursing Assistant – recruitment plans

The Trust advertises for Nursing Assistants 1-2 times a month via NHS Jobs. Following shortlisting, candidates are invited to a group interview which is facilitated by the Nursing Workforce Lead with support from two Ward Managers. These tend to be from the wards with the most vacancies.

The group interview take approximately 3 hours and consist of a tour of the hospital, discussing the role of a nursing assistant, what qualities are needed to make a good nursing assistant, scenario based questions (which incorporate the Trusts Patient First Standards), and the group watch a video about empathy and compassion. The interviews are completed with 1:1 discussions with each candidate.

Following the interview each successful candidate is assigned to a ward and if the ward manager has not attended the interview they will contact the candidate and given them the opportunity to come in and meet the ward manager, ward staff and have a tour of the ward.

This yields around 10 Nursing assistants a month. The challenge to the Trust is to retain Nursing Assistants. The Trust Nursing Apprenticeship programme should support retention however the Trust has to balance the financial and operational issues that come with introducing such a programme. Attached at Appendix 1 is a briefing Jan Bloomfield prepared for Jo Churchill MP which sets out the apprenticeship challenge. This has resulted in a Ministerial discussion between the Department of Health and Department of employment.

4 Retention strategies – Registered Nurses and Nursing Assistants

4.1 Preceptorship programme - All newly registered professionals are offered the opportunity to attend the preceptorship programme within the Trust. This is a 12 month programme consisting of 6 study days and a workbook to aid the transition from student to a competent and confident practitioner. This is a multi-professional programme and the feedback has been good.

4.2 Expert Navy – This programme has been developed internally and is offered to all new band 7 ward managers and also band 6 nurses who are looking to move towards a band 7 positions. The programme consists of 4 study days and the opportunity to network and gain support from peers.

4.3 Continuing Professional Development (CPD) – Over the past 3 years HEE funding for CPD has seen a reduction of 55% with £186,000 received for 2015/2016 to £85,000 received in 2017/2018. This has required the Trust to look towards in-house training and apprenticeship frameworks to further develop clinical and non-clinical staff within the organisation. However presently the availability of suitable programmes is limited as each standard and programme takes at least 18 months to develop into an apprenticeship.

4.4 Flexible working – The Trust is receiving feedback that staff are leaving or not attracted to working at the Trust due to the restricted flexible working. The Trust will look to see how they can

offer flexibility against the background of running an efficient and safe ward. The Trust is currently looking at each individual request to see whether it can be supported. Recent analysis on turnover has identified that the Trust is losing a disproportionate number of staff in their first year of employment particularly nursing assistants.

4.5 Improving the on-board processes - The Trust has introduced a new appointment letter and welcome card (with feedback loop) to improve new staff sense of belonging.

4.6 Internal transfer system for nursing assistants/RN to move around the Trust – The trust is investigating a process where it will advertise for staff to join an internal transfer database. This will allow staff to move around the Trust without going through a time consuming recruitment process.

4.7 Devise pre-exit interview – Often staff get "itchy feet" before they decide to apply for other jobs and leave the Trust. It is important the Trust identifies these staff and interviews them to establish whether the Trust can support the member of staff to stay.

5 Recommendations

5.1 This paper sets out the Trust plans and action in relation to hospital nurse recruitment. This paper does not address community nurses

5.2 It is for information only.

Appendix A

Briefing for Jo Churchill, MP

National apprenticeship levy – nurse career pathway

1. Introduction

The purpose of this paper is to provide information on how the introduction of the National Apprenticeship Levy creates an opportunity to develop a pathway for 'growing our own' nurses through a stepped career progression model. The aspiration is to offer a career pathway for our support staff which will support a reduction in overseas nurse recruitment and reduction in temporary staffing by increasing registered nursing staff numbers over a period of time while also improving the retention of support staff through our 'grow your own' initiative.

2. Background

The aim of the Trust's apprenticeship strategy is to realise the potential through its people, creating a skilled and varied workforce that is responsive to the changing climate of the NHS.

With the changes to bursary support for pre-registration nurses and midwives from September 2017, HEIs have seen a reduction of 30% in the number of applications. At the same time major changes are being implemented by Health Education England which will result in a significant reduction of training income.

The introduction of the apprenticeship levy gives the Trust the opportunity to identify the workforce needs and establish a pathway that meets the needs of the future service being developed. The levy provides access to funds that will support the academic component of development opportunities and gives the group the flexibility to develop a workforce pipeline to meet the future needs of the Trust

Across the East of England the apprenticeship levy will amount to around £20,000,000, with the Trust contribution in the region of £700k annually. The nursing apprenticeship model alone will help the Trust meet the National targets for public sector bodies which is currently proposed to be 2.3% of headcount established as part of the Enterprise Act. Based on current headcount a minimum of 85 apprenticeship starts will need to commence per year to meet the statutory requirement.

3. Context – at West Suffolk NHS Foundation Trust

Currently, our total registered nursing workforce vacancies of c.55 WTE which is expected to increase if we do nothing. In particular for the Band 5 nurse workforce where we have the most pressing issues in recruitment.

While continued efforts are made to improve retention, introduce new roles to ease pressure on the registered nursing workforce and recruit from overseas, there is still a significant Band 5 nursing gap going into the future. The Trust has recently recruited 55 nurses from the Phillipines – with the NMC requirements this may only yield 40 Nurses at a cost of £9,300 per candidate (a breakdown can be provided).

Other nursing workforce challenges

Other challenges driving the need to devise strategies to 'grow our own'' nursing workforce include:

- Competition

  Despite the expected increase in the number of newly qualified nurses available to be employed from 2019 onwards as a result of expansion in nurse training places commissioned by HEE between 2013 and 2016, the competition faced by all Trusts means that it is expedient to explore alternative ways to fill our nurse staffing shortages.

- Change in UKBA rules

Increases in newly qualified numbers will present further difficulties in recruiting overseas as the government will significantly reduce certificates of sponsorship for overseas nurses. Brexit implications as well will mean that the pool of overseas nurse applicants will reduce.

From the above there is a clear case to do things differently if nurse workforce requirements are to be met. The introduction of the Apprenticeship Levy therefore provides the opportunity to invest in growing our own talent from the ground up using new models and the latest technology to integrate learning, work and improved performance to achieve desired workforce numbers.

4.0 Nurse degree apprenticeships

The government's objective of the Apprentice Levy is to provide a clear option for workforce development, which has the potential to attract new staff, increase social mobility whilst complimenting employer workforce priorities such as recruitment, staff development, talent management and retention.

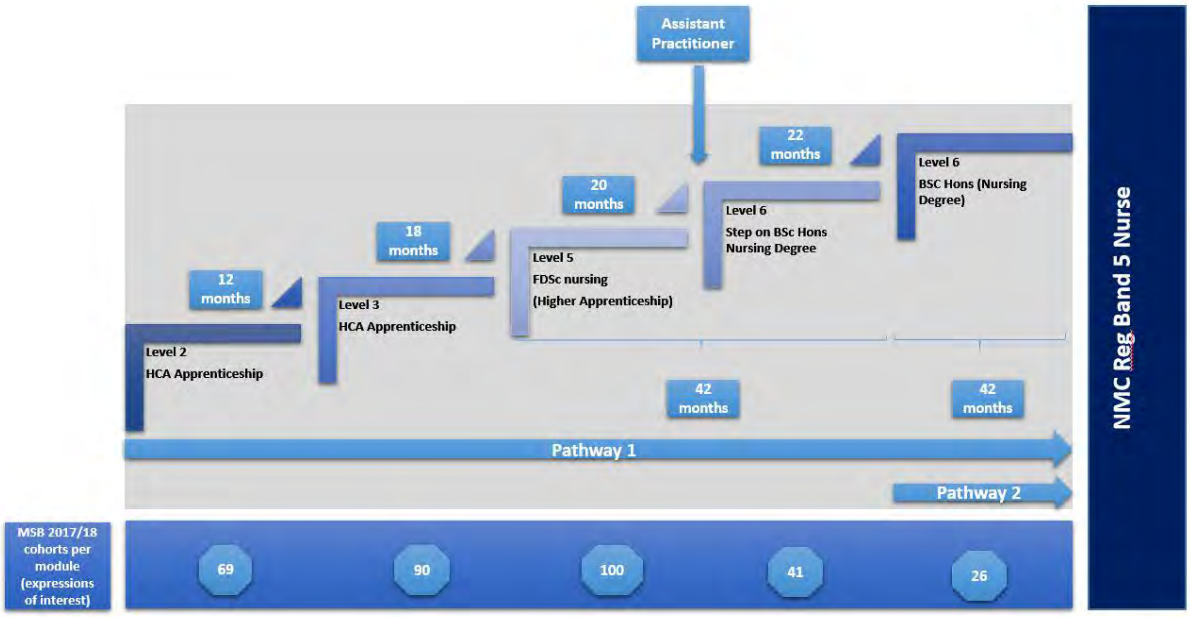
The development of the Nurse Degree Apprenticeship model, will open a progression pathway for nursing support staff to qualify as registered nurses. Higher education is quickly trying to catch up on this development – they must make sure that their courses are fit for purpose and meet the Apprenticeship standards. At this moment in time the first course in Suffolk will start in September nearly 18 months after the introduction of the Levy

The NMC have formally adopted the Nurse Degree Standard, thus paving the way to develop a career pathway which enables the organisation to offer the workforce a stepped career progression using apprenticeship standards from entry level to registered nursing while supporting the pipeline of nurse development The aspiration is to offer a career pathway for our support staff which demonstrates a return on investment through the reduction in overseas nurse recruitment and reduction in temporary staffing through increased retention from the 'grow your own' initiative.

4.1 The nurse career pathway

The career pathway proposed via the apprenticeship model is summarised in Fig 2 below.

Fig2. Nurse Apprenticeship Pathway



The first pathway requires obtaining a level 2 and level 3 apprenticeship is the initial phase. A level 3 qualification (or A levels) and maths and English at level 2 qualifies the employee to progress to next phase of the foundation degree / higher apprenticeship and then to top up to obtain BSc (Hons) Nursing degree apprenticeship. This entire process could take 72 months in total from initial phase to registered nurse. However, this is a step on and off programme which allows flexibility and career progression. At the end of Level 5 staff are qualified to work as Assistant Practitioners.

The alternative pathway is a 42 month Nurse Degree Apprenticeship programme. This requires a level 3 qualification (or A levels) and a maths and English requirement at level 2.
Both pathways mean that staff will be undergoing training while salaried and on the job but will also need to spend 20% of their contracted hours on ''off the job training''. This is not funded through the Levy. Only OFSTED accredited training organisations have the ability to draw the money down from the Levy. West Suffolk at this stage has only drawn down 120K from its Levy of 700k for this financial year

It is important to note currently there is a national pilot for the development of Nursing Associates supported by Health Education England (HEE) and the Nursing and Midwifery Council (NMC) however this paper and the career development pathway proposed does not include this development route. These training posts are supported by a separate funding stream outside of the apprenticeship levy.

4.4.1 Cost of pathway

The costs for the entire pathway over the initial 12 month period can be viewed in Appendix 2 which provides a breakdown cost of the levy, salary costs as well as the time out costs. (All individuals undertaking apprenticeship training programmes must spend a minimum of 20% of their contracted hours engaged in "off the job training" and as a consequence there will be a time out cost for each individual).

There is a huge variation in the time out cost for the staff that undertake the Foundation degree approach and top up BSc (Hons) Nursing degree apprenticeship, as opposed to the full 42 month programme. The foundation degree component requires on average one day a week release for the 20 month programme. It is only during the second phase, step on BSc (Hons) Nursing Degree Apprenticeship where the time out component increases to provide specialist placements to meet NMC requirement with maximum time out costs coming to **£21,905** per person. The full placement BSc (Hons) Nursing degree apprenticeship time out costs are estimated at **£31,990.65** per person. This cannot be drawn down from the Levy.

4.3.2 Tendering process

The procurement for the delivery of the nurse career pathway is another operational issue but correct process to ensure the Trust receives value for money. The Trust cannot just select a provider this has go through a tendering process This again adding further contractual costs to the Trust which has not been funded before. These costs cannot be drawn down from the Levy.

5.0 Challenges and associated mitigations

5.1 Off the job training

New apprenticeship reforms dictate that 20% of apprentice time is protected for study; this includes existing staff that are not paid a trainee apprentice salary. The impact of this will be pressure in operational teams to release team members for study as well as delivery of education within workplaces by the education provider. However, this has been recognised nationally and programme providers are being encouraged to offer considerable flexibility in respect of the delivery of learning thus minimising the impact on service delivery.

5.2 Supervision and mentoring

Supervision and mentoring is a significant challenge to the requirement to establish a robust support framework that enables staff to be supported throughout the pathway. From commencement of the top up Nursing degree apprenticeship and the 42 month programme, individuals will be required to be supervised by a qualified Mentor (NMC requirement). This will add additional pressure to clinical areas where student mentorship capacity is a constant challenge.

6.0 Benefits

The above approach to 'growing our own' across the Trust through the maximisation of the apprenticeship levy is a key part of our organisational development plan. Aside helping to fill our Band 5 nurse vacancies this approach will:

- Ensure we maximise the use of the levy.
- Up-skill and retain the unregistered nurse workforce.
- Provide a new entry level to attract school leavers into career pathways in health.
- Reduce the risks associated with an aging workforce.
- Promote the development and progression of the existing workforce by investing in workforce development.
- Improve engagement and morale within the nursing workforce.
- Improve community engagement via schools and colleges.
- Improve system working across the STP (rotational working/learning through acute, community, mental health & primary care).

7.0 Conclusion

The introduction of the levy provides an opportunity for growing our own registered nurse workforce.

Though the outputs will not be seen immediately, once a steady pipeline is in place the trust will start to achieve results going into the future. It is recognised that this is not an entire solution to the nurse Band 5 shortage situation across the group as the modelling indicates there would still be a vacancy factor especially in the initial years. This however presents opportunities for role redesign and other ways of working to address the vacancy situation.
It is also acknowledged that as a result of building this pipeline there will be a gap within the unregistered nurse workforce which will need to be filled as these staff move into qualified nurse positions.

Jan Bloomfield
Executive Director of Workforce and Communications
West Suffolk NHS Foundation Trust

Trust Open Board – 2nd March 2018

Agenda item:	14a			
Presented by:	Rowan Procter – Executive Chief Nurse			
Prepared by:	Governance Department			
Date prepared:	February 2018			
Subject:	Learning and Improvement			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 31/12/17.

Information has been obtained from the following data sources:

- Investigation of serious incidents and resultant action plans
- Thematic analysis of incidents at all grades for the quarter
- Review of complaints received and responded to within the quarter
- Review of claims received and settled within the quarter
- Themes arising from the PALS service
- Clinical risk assessments created or updated within the quarter
- 'Learning from deaths'
- Other soft intelligence gathered within the quarter

Key highlights in this report are as follows:

- Partial compliance for Mental Health Nation Confidential enquires Patient Outcomes and Death (NCEPOD).
- Learning from Incidents, demonstrates further development on communication, documentation and the Human Factors that influence in the provision of care

Please note:

- Key performance indicators (KPIs) relating to the subjects listed above are reported separately in the Open Board Integrated Quality & Performance report (IQPR).
- Assurance reporting including Executive-led walkabouts and table top exercises and 'Deep dive' audits are provided to the Board sub-committees CSEC, PEC and CRC.
- Escalation (including serious new incidents, Red complaints, claims and dated inquests of concern) are reported separately to the Closed Board.

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
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: The Board to note this report.							

Activity within the quarter

This will include some or all of the following sources: completed SI investigations, aggregated incident investigations, complaints responses, themes from PALS enquiries, settled claims, learning from deaths, Executive walkabouts and table-top exercises and concluded inquests.

Learning themes from investigations in the quarter

SI RCA reports submitted in Q3

Incident details	Learning
Pressure ulcers	3 / 10 were deemed 'avoidable'. Learning included the following: Need for more vigilance and consistency with 2 hour repositioning, daily visual skin checks, and the completion and documentation of Waterlow risk scoring
Intrauterine death	Contributory factors: Late booking, Did not attend routine appointments between 27 weeks and 4 days to 34 weeks and 4 days gestation, Increased risk of pre-eclampsia due to raised BMI and Possible pre-existing pre-eclampsia Root cause - Intrauterine death from placental abruption likely as a result of severe pre-eclampsia. Lessons learned • Staff must ensure they explain to patients the reasons why we undertake urinalysis in pregnancy in particular those who decline testing. • The maternity service must ensure that telephone advice given is documented on the designated telephone triage form and this must be included in the maternal records. • Staff working in the hospital switchboard must be fully aware of maternity emergency calls and respond appropriately.
Baby transferred out for therapeutic cooling	Root causes It was not possible to give a definite root cause for the antepartum vaginal bleeding and baby's condition at delivery requiring the need for transfer out for therapeutic cooling. The placenta showed a velementous insertion of the cord and this was confirmed on placental histology, it was agreed at the RCA that this could be a likely cause in this case. Staff reported that the paediatric SHO appeared unsure at the resuscitation process and use of the panda resuscitaire. Where clinical activity allows, neonatal nurses attend deliveries where advanced resuscitation is anticipated. Lessons learned • A paediatric consultant is not included in the neonatal emergency cascade bleep and therefore staff need to be aware that if a consultant is requested they will need contacting on their own bleep or switchboard, if out of normal hours. • Paediatricians required to attend a C. section where resuscitation is anticipated should ask for support from a senior paediatrician.
Complication during operation	The surgeon was carrying out high risk surgery agreed with the patient; in trying to reduce the risk to the patient he did not take his routine approach for the procedure. The consequence of the smaller incision was that the surgeon was unable to view the whole surgical field. Following discussion of the case across the colorectal and general surgeons there is now a procedure that has been identified to be undertaken at the point of forming the stoma to definitively check if the correct end of the bowel is being used. Implementation of the procedure that has been identified to be undertaken at the point of forming the stoma to definitively check if the correct end of the bowel is being used.
Mortality review case	Root causes: The patient was in the incorrect location for best management of her complex chronic medical, psychological and social needs; the co-ordinating group on the ward was inexperienced (or lacked support) for her medical conditions; and there was no

	mechanism to repatriate her to a medical ward. Lessons learned: • Patients with complex requirements i.e. chronic medical needs, learning disabilities and safeguarding issues should be placed within an appropriate clinical area so the medical team can have better oversight of their patient. This did not happen as the patient was admitted in the hospital during a period of no bed capacity locally and regionally. • If the patient is not in an appropriate location it is more difficult for the medical staff to liaise effectively with the ward nursing and professional staff. The patient had respiratory requirements that were not clearly documented or made aware to the ward staff. • The patient had chronic conditions which would have been optimally managed in a home rather than a hospital environment where 'deconditioning' is almost inevitable. Safe-guarding issues should be quantified and weighed against the risks of hospital stay. There should be co-ordination of key personnel and appropriate escalation to expedite the patient's discharge to a suitable environment. • Careful clinical consideration should be given to patients with known respiratory insufficiency and the use of medications that could potentially cause respiratory depression i.e. zopiclone being given to the patient.
Delay in providing diagnosis	Root causes: Lack of adherence to the pathway of a male presenting with potential Testicular Torsion – pain of the lower abdomen should have examination of the testes and scrotum to exclude Testicular Torsion. Lessons learned: • All males presenting with unspecified abdominal pain should have an examination of the testes. • All males presenting with testicular pain (regardless of whether sexually active) should be considered for testicular torsion. • All patients referred to the general surgeons from ED with testicular pain must be referred immediately to the urology consultant team in the first instance.
Norovirus	Symptomatic patients were reported across the ward, including in side-rooms, as well as staff. The following factors that may have enabled the spread of infection: • Lack of hand hygiene facilities within the ward. There are two sinks within the bay and a sink in each side-room, however no hand-wash basin on the main corridor. • Sluice room door 'propped open'. • Doors to side-rooms were not closed during this time. • Evidence of staff water bottles and hot drinks within the ward. Lessons learnt: Nursing and therapies staff are to be reminded that : • It is essential that the Infection Prevention Team are informed of any symptomatic patients to enable them to assist in the management of any potential outbreak. • Episodes of diarrhoea and/or vomiting must be documented by the health care worker at the time of the episode using the daily data sheet which is to be commenced at midnight in order to ensure that any overnight activity is captured. • Eating and drinking is not permitted within the ward environment. • Hands are to be decontaminated with soap and water upon entering and leaving a patients room.
Patient fall resulting in #NoF	Care and service delivery problems • Significant postural drop recorded with lying and standing blood pressure and no evidence that this was escalated. • Assessment and diagnosis of right hip pain, there was repeat radiology imaging over 5 days causing confusion regarding the mobility status of Patient N. • Delay in post fall review Contributory factors • Fracture to right hip causing difficulty with mobilisation • A period of bed rest post toe surgery possibly caused patient to be unstable on his feet. • Significant postural drop in blood pressure, possibility this was not communicated as a

	falls risk. Root cause • Postural drop not acted upon • Right hip fracture and prolonged radiology imaging over several days leading to reduced mobility.
Safeguarding (adults) incident whilst patient in WSFT care	Root causes Patient's mental health needs were unmet due to the reduced mental health services commissioned in Suffolk. Lessons learnt: • Discharge check list and Transfer of care discharge summary not done immediately • Patient deemed a vulnerable adult – had alert on electronic record highlighting patient was alleged victim of domestic abuse. Patient assumed to have phoned police, staff did not confirm this. Patient was found by member of the public in her hospital gown with no money. Improved consideration of the safeguarding patient pathway is required • Staff to have an awareness of the appropriate clinical area for a patient requiring mental health assessment and where the mental health services will visit i.e. ED, Ambulatory Care (AMU
Diagnostic delay	Root causes: • The investigation found that the delay in the patient's diagnosis of dermatofibrosarcoma protuberans (DFSP) was due to a lack of recognition that the patient's lesion was a malignant, albeit, rare lesion. • The patient followed a benign treatment pathway on each occasion until the case was referred for a second opinion and conclusive diagnosis in 2017. Lessons learned: A safe and good quality service should be provided at all times. This investigation has found that the specialties involving both Surgical and Histopathology staff should; • Improve their awareness of the specific condition of dermatofibrosarcoma protuberans • Refer unusual cases with unfamiliar characteristics for specialist review. • Have more consideration and caution when reviewing a case or interpreting any lesion that recurs. • Discuss complex or unusual General Surgical cases at an MDT meeting. The investigation has agreed there is a need to identify if there are any more cases that could have been misdiagnosed as spindle cell lipomas, there is a plan now in place to review all cases back to 2009 SNOMED coded as spindle cell lipomas to ensure that no other cases have been misdiagnosed. The case has been shared and discussed with all the histopathologists in the Trust. It was agreed that the diagnosis was difficult with the material submitted. This investigation has raised the awareness of the diagnosis of a dermatofibrosarcoma protuberans(DFSP) and highlighted the need for collaboration with colleagues, including referral for second opinion. This patient had suffered a significant delay in her conclusive diagnosis and treatment of dermatofibrosarcoma protuberans (DFSP). The case is a rare type of skin cancer of intermediate- to low-grade malignancy. The investigation found that it was explicable that the condition was not recognised and diagnosed by the general surgeons; combined with the fact that the microscopic features were misinterpreted by the histopathologists due to the biopsy material being fragmented with unusual microscopic features. However, there was a lack of acknowledgment that this was a case showing unusual features that required specialist review. The delay in diagnosis and further treatment was further compounded by the absence of correlation and collaboration between the general surgeons and other speciality colleagues. This caused the delay in the patient receiving specialist diagnosis and treatment, this has resulted in the patient requiring more invasive surgery that may not have been required if the referral to specialists had been made earlier in the patient's pathway

Quality Walk About from Q3

Over the past quarter we have been to the following areas, G1, outpatients, G4, Mortuary, F12, ED, F6, G5, F5, Education/outreach services, a total of ten different areas have been visited. These have been facilitated by the clinical governance team and have had attendance from the Chief Executive, Chair, Executive Chief Nurse, Medical Director and several governors have supported these walkabouts. These have been able to facilitate a real opportunity to observe, review and interact with both staff and patients.

Patient experiences have been good and many complimenting on the quality of the food and the availability and choice of the food. Some of the patients have described at times feeling frustrated by not always being clear on what is doing on with the plan of their care. These concerns and or confusions have been addressed whilst on the walk about and patients been reassured as a result. All of our interactions have praised the hard working and dedication of the staff and many describe the compassion, caring and dedication of the staff that have treated them.

In total 26 actions have been raised as a result following walk about's. These have involved items requiring escalation to Estates and Facilities, House Keeping, Senior Nursing and Medical teams and others have been able to be managed at the ward level.

One Red Risk has been agreed following a visit. The department was then supported and the matter addressed within one week with support of a successful short term solution and the commencement of a medium to long term plan project team.

The quality walkabouts have enabled staff to raise concerns or frustrations directly to senior leaders and also governors directly. This has received much positive feedback and we continue to plan our next quarters walk about plan. The information gained from these help to inform when combined with our Datix system the areas to be explored further in our table top quality reviews in which were started in quarter 3. Please see below.

1. **Subject / Theme** Mental Health
Source Three SI, two complaints, one Amber incident, one inquest
Risk register entry RR2143 *Psychiatric Liaison Service* (Closed risk)
Trust owner[1] Mental Health Task & Finish group led by GM Medicine
Summary of learning and areas for improvement in this topic

A Task and Finish group has been instigated which has reviewed the Missing Persons Policy and led to the creation of a Mental Health Policy on the welfare of patients presenting with signs and symptoms of self-harm. The Mental Health Policy details the patient pathway in presenting to the hospital with symptoms of self-harm and looks at a form of Risk assessment of the patient to plan and complete observation to reduce further harm and appropriate mental health follow-up. The draft policy is being led by The Medical General Manager and is awaiting approval. This has been sent to our partners at Norfolk and Suffolk Mental Health Trust for comment.

Mental Health and self harm was the subject of a query to the Trust from the CQC last year following a complaint letter sent to the Trust and copied to the CQC. The case was investigated as an SI and the work undertaken by the Task and Finish group was in part as a consequence of that investigation as well as an earlier SI which was the subject of an Inquest.

This task and finish group has been working closely with NSFT and the CCG regarding the commissioning of the appropriate provision of mental health services for those patients attending or are inpatients to the West Suffolk Trust. At present there has been an agreed increase in the

[1] Trust owner is the committee and or individual who lead for this subject in the organisation. This may be on a permanent basis or temporary (e.g. through a task & finish group set up specifically to address this issue)

provision of Psychiatric Liaison Service (PLS) to expand the service to the base wards. This has been in response to problems accessing mental health services for those on the base ward areas and has resulted in transferring of patients to facilitate mental health assessment solely due to physical ward location. This however does not address the lack of a service able to respond between 1700 and 2100 between the PLS finishing and the Access and Assessment Team (AAT) starting in the west. This has been raised with the quality team at the CCG who are in turn escalation this within the CCG.

It is also vital that as a trust we also work collaboratively with both the CCG and NSFT to meet with Core 24 standards and recommendations;

- Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults
  https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf

- The five year forward view for mental health
  https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

  https://www.england.nhs.uk/mental-health/resources/

A recent HSIB interim report warns that a shortage of trained staff to assess mental health patients in emergency departments is leading to inconsistent care and could have “severe consequences”. The warning comes from the HSIB’s interim bulletin into the provision of mental healthcare to adults in the emergency department. It will publish a full report with recommendations on how these safety concerns can be addressed in due course. It has so far flagged issues around access to psychiatric liaison services, the difficulties in the sharing of patient information within the emergency department, and the appropriateness of assessment tools to identify patients most at risk. However, HSIB did also acknowledge that “effort” has gone into improving mental health services in A&Es following the publication of the Five Year Forward View for Mental Health.
The HSIB publication also made reference to the NCEPOD report ‘*Treat as One - Mental Health in General Hospitals’* (issued 26th January 2017).

The Trust’s baseline assessment was completed in February 2017 and highlighted the trust is only partially compliant due to the following;-

- Only commissioned to provide 0.5 WTE Liaison Psychiatry Service Consultant who assesses complex patients and will provide a diagnosis. Non-complex patients are assessed by the Nurses who will provide description of symptoms and condition.

- The PLT is not commissioned to support all services provided at West Suffolk Hospital.

- The PLT is not commissioned to provide assistance for patients with dementia or delirium.

- All details are provided to the patient’s GP. Partial information is entered on patient’s e-Care records. The PLT would provide assistance or guidance around capacity, but in keeping with the ACT it is those closest to the decision i.e. the overseeing medical team that would lead the assessment. Any assessment would need to be time and event specific. The PLT would only lead if the question was purely around psychiatry care/follow-up.

- The WSH has no power to detain locally. This is not in keeping with the majority of general hospitals.

- Commissioned to provide 0.5 WTE Liaison Psychiatry Service Consultant which does not cover all services provided at West Suffolk Hospital. Care is provided by Nurse Prescribers.
- Limited by commissioning arrangements which do not provide funding for 24/7 service. We are currently guided by Keogh and CCG KPIs – however this is with the current constraints of the team in addition to locally agreed timeframes.

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2. **Subject / Theme** Radiology Reporting Delays
Source One SI, one Amber, six other incidents, three complaints
Risk register entry RR305 *Pressure on Radiologists to cope with the 18 week processes.* Risk to accuracy and delay of reports, failure to meet targets, missed diagnosis, health of radiologists (Active risk)
Trust owner General Manager Clinical Support

Summary of learning and areas for improvement in this topic
This is an ongoing issue related to an increase in the activity and the recruitment and the retention of Radiologists within the Radiology department which is acknowledged as a national issue.
The long standing Risk assessment for this issue has been reviewed and upgraded to a red risk as a result of the recent incidents which have seen an increased risk of harm to patients as a result of reporting delays. The Radiology Management Group is monitoring the issue monthly.
The Radiologists are currently triaging the images for reporting based on the referrals received. This process does reply on the referring clinicians accurately indicating the level of urgency in the referral it has been identified that there is a need for this to be communicated to all referring clinicians.

A paper to TEG in November was provided in response to a pair of incidents of delayed diagnosis (31380 and 34373), and to a letter sent to all NHS Chief Executives by Professor Ted Baker, Chief Inspector of Hospitals, on 17th November 2017 requesting information regarding radiology reporting timescales.

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3. **Subject / Theme** Oxygen

A planned executive-led table top review was undertaken by the Clinical Service Manager for Resuscitation and Outreach Services together with the Governance Manger to identify if there were discrepancies between oxygen prescription and the prescription of the target saturations as this had been a causal factor identified in recent SIRI investigations. There have been several incidents in which oxygen therapy and administration have been involved. The thematical issues from these include; oxygen cylinders running out in areas which do not have piped oxygen, lack of prescription and setting of target ranges, unclear communication and documentation regarding oxygen therapy. This incidents affected both Medical and surgical areas. This resulted in a table top oxygen audit being conducted.

During this review three wards were audited to assess the timeliness of oxygen prescriptions and the subsequent target saturations. Initial findings were inconsistent timings of prescription and target saturations. An action was identified to update the oxygen policy to ensure it is clear that oxygen prescription is required within four hours of admission to hospital which is part of the order set coupling VTE assessment and management plan. A further review and audit is required to review and audit the wider aspects of oxygen administration and the communication of decisions.

In Q3 there were 28 incident relating to Oxygen

There will be an update of further work and a review of the updated policy during subsequent table-top reviews.

National issues raised regarding oxygen management and patient safety during January 2018;

It was reported in the national press in January that an NHS investigation has been launched following the deaths of six patients when hospital staff accidentally switched off their oxygen cylinders. The Healthcare Safety Investigation Branch have opened an investigation into the errors.

In addition NHS Improvement on the 9th January issued the Safety alert NHS/PSA/W/2018/001 Patient Safety Alert - Failure to open oxygen cylinders.pdf. Locally there have been 28 incidents involving the administration of oxygen or the use of oxygen/cylinder equipment. However there have been no incidents with harm directly relating to oxygen administration in the last three months.gi

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4. **Subject / Theme** Obstetric Anal Sphincter Injuries (OASI)
Source Clinical Audit: One active claim & (amber /red alert Maternity Dashboard 17/18)
Risk register entry
Trust owner Women and Children's Health

Summary of learning and areas for improvement in this topic
Nationally there has been an increase in the incidence of OASI - rates have tripled in England from 1.8% in 2000 - 5.9% in 2012 *(Singleton, term, cephalic, vaginal first births)* There is currently a large-scale project/ campaign in progress nationally to raise awareness of the impact of OASI amongst health professionals, and examine ways to reduce the rising rates. The maternity dashboard showed amber /red alert on four occasions to date in 2017/18.An audit was undertaken with the aim was to raise awareness amongst health professionals about the seriousness of OASI and improve skills to reduce the incidence among women giving birth at the West Suffolk Hospitals NHS Trust.

Summary of learning - the audit showed good practice in the management of repair technique, follow up management of prescribing appropriate medication, referral to a physiotherapist and postnatal follow up referral with a consultant obstetrician.

Areas for improvement in this topic

- Trial Episcissors-60 to improve medio-lateral episiotomy technique.
- There is evidence to suggest that warm compresses should be offered for all women during the second stage of labour to reduce the risk of OASI and pain.
- Consider implementing information leaflet about perineal massage in the third trimester.
- More detailed documentation of repair method and technique to include completion of diagram. Improve documentation of discussion and explanation to women following birth.
- Improve education (midwives and medical staff), episiotomy training and the increased risks associated with the lithotomy position –consider using the PEACHES training tool.
- All 3rd and 4th degree tears should continue to be reported via Datix (only 30% were reported)
- Update trust guideline
- Actions included on the Women Health Governance Action Plan.

Mitigated red risks

During Q3 action to mitigate and downgrade one red risks was taken. This related to the sterile services department (SSD). This risk was closed when SSD moved from the old site on Hospital Road, with significant concerns regarding business continuity, to the new premises Quince House.

Learning from RIDDOR incidents

During Q3 the number of incidents reported to the HSE under RIDDOR remained low (5). Learning and mitigation included:

- Testing flooring using the slip alert device and ensuring slip hazard is minimised through appropriate scrubbing and drying
- Targeted staff training in moving and handling techniques
- Planned preventative maintain programme and warning signs for the new carpark to mitigate the risk of trip hazard on loose gravel
- To prevent accidental injury protective edging has been installed on racking in bed washing area.

Learning from patient and public feedback:

Details below of action taken within the quarter relate to high-level issues and do not reflect all learning that has taken place on individual cases.

- Learning Disability Liaison Nurse is conducting targeted refresher training in the fracture clinic
- From April 2018, all registered nurses and nursing assistants in the ED will attend a full study day around caring for patients with dementia. Posters have been positioned around the department promoting the role of the Care of the Elderly clinical nurse specialist
- Developing the e-Care alerting system to better meet the needs of patients with individualised care plans, safeguarding concerns or emergency requirements. Meeting with relevant stakeholders to agree requirements and implementation
- Explore implementing care home red bag initiative but with a different coloured bag for those with specific needs
- Based on experience engaging a patient's relative with end of life care champion training
- Based on concerns raised we have improved the lighting in car park A.

Learning from Deaths dashboard – Quarter 3 2017/18

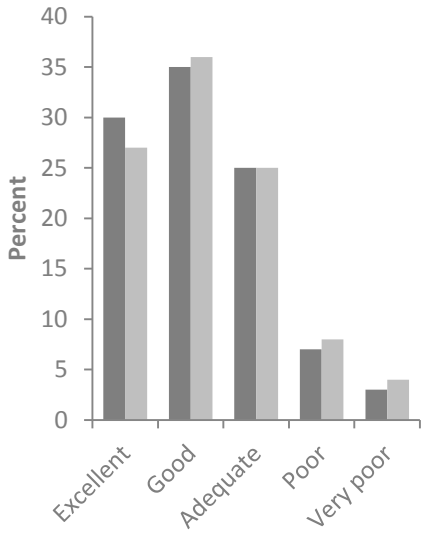
Accurate 15th February 2018

West Suffolk NHS
NHS Foundation Trust

Inpatient deaths	Total	Reviews completed
Quarter 3	292	242
Year to date	744	670

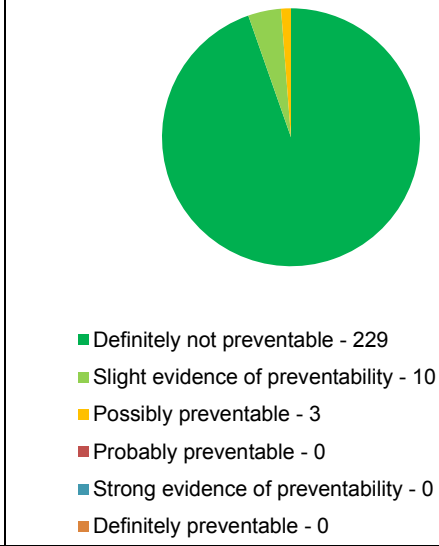
Overall quality of care

QX and YTD (grey), 20XX/XX



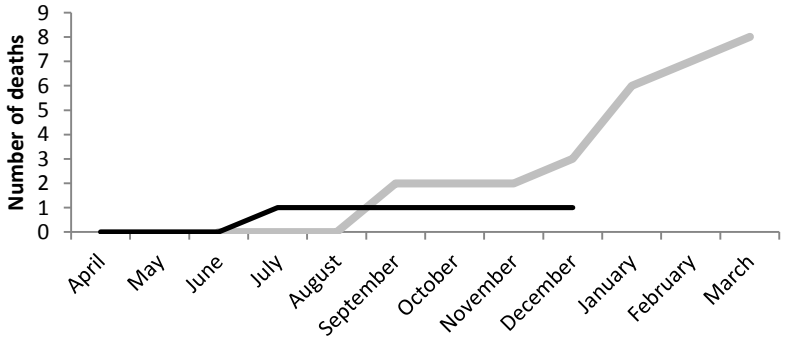
Outcomes of reviews

Quarter 3, 2017/18



Cumulative incidence of deaths judged to have >50% likelihood of preventability

2017/18 (black) compared to 2016/17 (grey)



Preventability benchmarks

3.0 – 4.3%
Research

0.5%
Real world

0.0%
Q3 WSFT

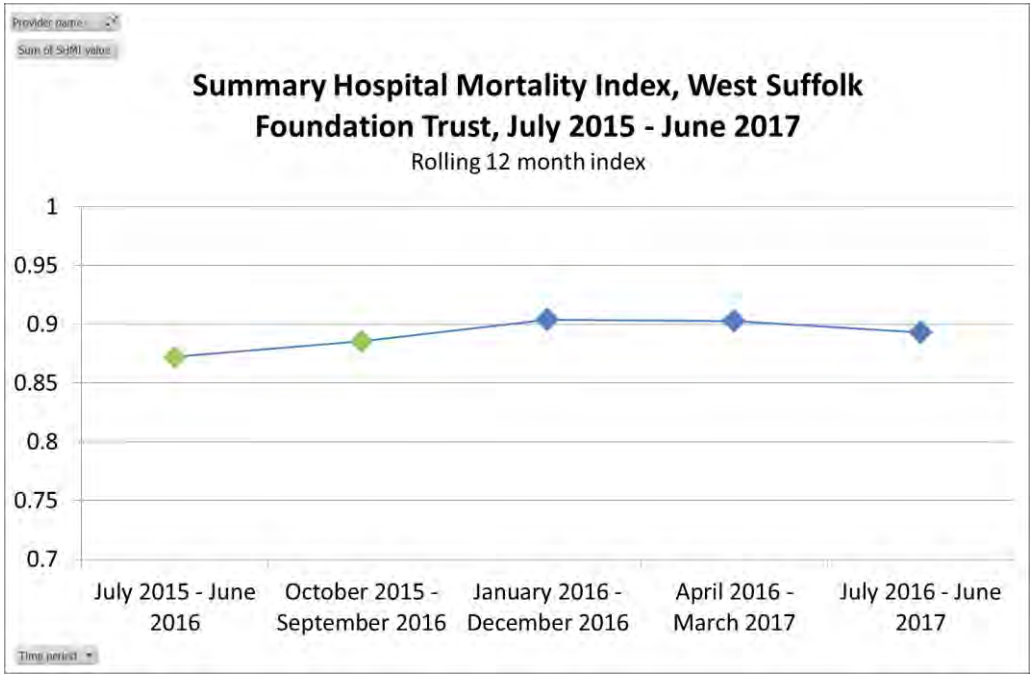
0.14%
YTD WSFT

Deaths in people in groups under special focus – Q3 (YTD)

Group	Total	> 50% likely preventable
People with learning disabilities	1 (2)	0 (0)
People with severe mental illness	0 (1)	0 (0)
Maternal deaths	0 (0)	0 (0)
Stillbirths	0 (5)	n/a
Child deaths	Not governed through Learning from Deaths in this period	

Learning themes identified

Contributing to preventability	None identified yet – results of serious incident investigations awaited
Not contributing to death	Improve knowledge of management of acute aortic dissection



NHS
West Suffolk
NHS Foundation Trust

Trust Board – 02 March 2018

Agenda item:	14b			
Presented by:	Dr Nick Jenkins, Medical Director			
Prepared by:	Dr Helena Jopling, Consultant in Healthcare Public Health			
Date prepared:	22nd February 2018			
Subject:	Learning from Deaths			
Purpose:	X	For information		For approval

Executive summary:

At the meeting on 26th May 2017, the Board received a report on the national Learning from Deaths guidance issued by the National Quality Board and the changes that WSFT needed to make to its mortality review process as a result.

The Board approved a programme of work which included:

- adoption of a trust policy on Learning from Deaths
- recruitment of medical reviewers to perform objective reviews of patient care using an evidence-based method
- measures to increase the involvement of relatives and carers in improvements resulting from learning from deaths
- changes to the way in which information about problems in care associated with deaths in the trust is reported.

This report provides an update on progress with the work programme. It also reports information for quarter 3 2017/18.

Outcomes of reviews of deaths, quarter 3, 2017/18

The Board will remember that the trust is required to publish information on the number of deaths in the trust, the number of case record reviews that are done, learning themes which are identified from the case reviews and the number of deaths judged to have been more than 50% likely to have been able to be prevented, were it not for a problem in care.

Please see the accompanying dashboard for information. In summary:

- In quarter 3 there were 292 inpatient deaths
- 242 have been reviewed
- 229 were judged to be definitely not preventable
- 10 were judged to have slight evidence of preventability
- 3 were judged to be possibly preventable, 50-50 but a close call

It should be noted that these are the judgments made by consultants reviewing their own cases. Cases in which the named consultant considers there to have been any degree of preventability are peer-reviewed by a clinical director. It is common for the cases to be 'down-graded' after peer review – usually because the clinical director considers that despite there being a problem in care, an outcome of death was unfortunately probably inevitable.

Two deaths from quarter 3 are being investigated as serious incidents. The investigations are ongoing and the outcomes will be described in a future board report.

One learning need has been identified from deaths in quarter 3; that junior doctors' knowledge of the management of acute aortic dissection could have been better. The clinical team have responded very well; the case has been presented at the local clinical governance meeting and a junior doctor has prepared a clinical practice review article which will be published in the new digital quality improvement platform which is being developed to help disseminate learning. The doctors will give a presentation to the Learning from Deaths group at their April meeting.

Learning from deaths in previous quarters

In the quarter 2 report, the Board learnt that a preventable death had occurred in a person with a learning disability. The recent inquest into the death of Richard Handley, who died in Suffolk in 2012, demonstrates the poor experience and quality of care that people with learning disabilities can be vulnerable to. Mr Handley's case can be read about in the serious case review report, in which he is referred to under the fictitious name of James.

In our case, the learning which was identified included:

- needing a clear rationale for locating medical patients on surgical wards (referred to as "outlying") and a method for assessing whether patients' care could suffer if they were outliers
- making sure oxygen is prescribed and administered accurately
- finding more effective ways to plan for patients' discharge from hospital when safeguarding concerns have been raised
- not giving medicines which can cause respiratory depression to people who already have respiratory insufficiency.

Two other investigations have also concluded since the Board's last report. Learning comprises:

- that the falls assessment the trust currently uses is not sensitive to the complex needs of some patients. A better 'safety and orientation' assessment will be developed to help keep people with complex needs safer.
- The term 'medically fit for discharge', whilst clinically accurate, is misleading for patients and families because it infers that discharge will happen imminently, which very often is not the case
- Our use of spirometry and the recognition of the importance of abnormal spirometry results needs to be improved
- When a patient starts to deteriorates, it is important to continue to:
    - maintain good clinical documentation
    - review the decisions previously made about resuscitation and escalation of care if they are no longer responding to treatment.

Actions to address each of these learning points are underway.

Actions in response to previous learning

In the quarter 1 report, the Board heard that the death of a person with a severe mental illness had revealed that in the trust, people who are vulnerable because of mental illness are not always assessed in a timely manner for their risk of self-harm or suicide, and the Missing Person's procedure can be difficult to follow if the individual absconds.

In response, a task and finish group was formed to amend the trust policies to support the care of this vulnerable group of people.

The group is chaired by a general manager and comprises a governance manager, the portering services manager, the head of emergency planning and a head of nursing. The group presented an amended Missing Persons policy to the trust executive group on 5th February 2018. The crucial change to the procedure laid out in the policy is that, when making an assessment of risk after a

person has gone missing, whatever the risk score that the assessment tool returns, if a member of staff continues to feel concerned about the missing person's welfare and safety, the level of search can be escalated. The policy was approved on this basis but it was noted that the policy was only really written with West Suffolk Hospital in mind; the task and finish group were therefore asked to make it equally applicable to the community facilities.

The group are also drafting a new policy for the welfare of people presenting with self-harm, in partnership with colleagues from Norfolk and Suffolk NHS Foundation Trust.

Progress with the Learning from Deaths work programme

As already mentioned, the medical reviewers start in post in the week beginning 26th February. The team will work alongside the bereavement office, the patient advice and liaison service, the clinical governance team and the mortuary team to provide seamless care for families and carers after the death of a loved one, in all circumstances.

Families will be invited to tell the reviewers about the quality of care their relative received from us and to raise any concerns they had about the care or the course of the illness.

With the help of the family representative on the Learning from Deaths group, we are looking at how we can involve families whose relatives have suffered from problems in care in making sure we implement the actions we need to take to reduce the risk of the same thing happening again in the future.

To help disseminate the learning, as well as developing the new digital platform, the first of a new programme of bimonthly shared learning events will be held on 6th March 2018. Staff from all clinical professions will be invited to learn together with case presentations and personal reflections from colleagues involved in incidents, service evaluations or quality improvement projects.

Disseminating our approach more widely

WSFT continues to be recognised as a best practice site for our implementation of the Learning from Deaths guidance. A case study on our locally developed dashboard was featured in an NHS Improvement publication and a number of trusts have approached us to adopt or adapt it for their own use. Others have asked advice about the medical reviewer model we are operating. We have also been engaged to conduct a peer review of Southend University Hospital Foundation Trust's mortality processes and recovery plan given their high and rising SHMI.

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	X				

Previously considered by:	Learning from Deaths group
Risk and assurance:	Safety risk if the trust fails to identify problems in care which lead to patient harm and preventable death, and fails to act to reduce them.

	Reputational risk if the trust fails to report preventable deaths and fails to demonstrate action to reduce them.
Legislation, regulatory, equality, diversity and dignity implications	The report describes the trust's approach to meeting the National Quality Board's guidance on Learning from Deaths, which must be reported in the annual report from 2017/18 onwards.
Recommendation: To note the information on the Learning from Deaths dashboard and the narrative in this summary. To note the actions taken in response to previous learning themes identified.	

BOARD OF DIRECTORS –23/02/2018

Agenda item:	15			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	13/02/2018			
Subject:	Consultant Appointments			
Purpose:	**X**	For information		For approval

Executive summary:
Below is the consultant appointment report for this period.

POST:	Consultant in Anaesthetics
DATE OF INTERVIEW:	Thursday 1 February 2018
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	6 4 4

POST:	Consultant in Anaesthetics
DATE OF INTERVIEW:	Thursday 1 February 2018
REASON FOR VACANCY:	Replacement

CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	6 4 4

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:	N/A						
Risk and assurance:	N/A						
Legislation, regulatory, equality, diversity and dignity implications	N/A						
Recommendation: For information only.							

NHS West Suffolk NHS Foundation Trust

Open Trust Board – 2nd March 2018

Agenda item:	17			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Jane Relf, e-Care/Global Digital Exemplar Operational Laed			
Date prepared:	23 February 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. Of particular note are finalisation of the content for phase 3 delivery and that some components of this will be delivered beyond the GDE milestone of December 2018. In addition the paper highlights the launch of the 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

<table>
<tr><td>1.</td><td>Background</td></tr>
<tr><td>1.1</td><td>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</td></tr>
<tr><td>1.2</td><td>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</td></tr>
<tr><td>1.3</td><td>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.</td></tr>
<tr><td>1.4</td><td>Our GDE programme comprises of four pillars:

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

The remainder of this paper provides an update on implementation of the GDE programme.</td></tr>
<tr><td>2.</td><td>Pilar one – digital acute trust</td></tr>
<tr><td>2.1</td><td>The GDE team have worked closely with the Medical Director and Nursing Director to agree the priorities for the next phase of e-Care implementation. As part of this the need for a clear and separate focus on optimisation has been identified. Ian Coe, Chief Nursing Information Officer (CNIO) will be leading this piece of work and is currently working with clinical leaders to agree priority focus. The team are also engaging staff on the ‘shop floor’ to ensure optimisation plans will also reflect feedback received from e-Care users as to their main priorities.</td></tr>
</table>

The e-Care/GDE Programme Board have agreed the following programme of works for Phase 3 implementation of e-Care.

Early 2018

- Integrated vital monitoring equipment which will upload readings directly into e-Care
- A new ED data collection (ECDS) enhancing information collected about patients
- Powerchart touch pilot (a consultant mobile application to allow for faster viewing of the patient record with ability to use voice recognition)
- Emergency department optimisation (including launchpoint, child protection information sharing (CPIS), new emergency dashboards)
- Outpatient single encounter

Large drop end 2018

- Ophthalmology using OpenEyes system
- Powerchart touch full roll out
- Anaesthetics (potentially including bedside medical devices)
- Theatres
- Infection control (subject to interface)
- Population health (platform, registries, data warehouse)
- Maternity
- RPAS (further PAS upgrade)
- Cardiology upgrade
- Bedside medical devices (other)

Through the year

- FHIR pilot
- Voice recognition
- Patient portal live
- Continued Health Information Exchange roll out
- Further EPMA enhancements
- Electronic Mortuary system (ADT integration to e-Care – subject to funding)

WSFT and Cerner are in the process of signing off the domain strategy to support delivery of phase 3 along with a detailed project and resource profile. The original GDE milestone required the relevant milestones to be delivered by 31 December 2018. As a result of Cerner's requirements for lead time and the complexities of the domain strategy all parties have agreed to work towards a large drop during March 2019. We have informed NHS Digital of this and will be raising a formal exception report.

3. Pillar two – supporting the integrated care organisation

3.1 There are four main components to pillar two:

Patient portal	Providing a secure patient portal which would provide people with access to their own health records. There is the potential for people to be able to view test results, send online messages to their doctor and ultimately for us to integrate apps that enable people to manage and track their own conditions.
Health Information Exchange (HIE)	Our aim is to integrate e-Care with other care providers across the county, creating one record for each patient's medical history that is available to all clinicians in real time. This would minimise duplication of work and speed up communications between health professionals.
Population health	Introducing a population health management platform that will provide us with a rich data source that can inform the priorities of our new integrated neighbourhood teams and provide us with intelligence that can underpin how we deliver services across partners. We will look to create a system wide business

		intelligence function working in partnership to delivery population health.
	Teleconsultation pilot	Running a pilot of using video conferencing facilities to deliver patient consultations.

3.2	The most significant progress for pillar two is the launch of the patient portal which went live as a pilot on 12 February. The pilot is initially focussing on three main groups: • Staff (as patients) • Rheumatology patients • Small number of dietetic patients At the time of writing this report we have received 260 requests to register with the portal from staff. We will be launching to rheumatology patients on 05 March. Overall we had set ourselves the target of 300 pilot users across all three areas and we are therefore on target to exceed this significantly.
3.3	For the initial pilot, we will have the following functionality: • Ability to review results from pathology and radiology. We will be putting in a three-week delay to releasing the information, so that we can avoid inadvertently giving 'bad news' to a patient prior to them having seen a clinician. • Ability for clinicians to message patients (and for them to reply to the message). The system allows for direct contact from the patient to the clinician but we have chosen not to turn this functionality on currently. This will be reviewed after the pilot. • Ability to view clinical documentation. For launch this will include letters and inpatient discharge summaries. • Ability to view and cancel appointments.
3.4	The functionality of the portal will grow further over time and it is important that the patients are driving the look and feel of the site. As such we will be looking to work closely with PALs to agree best approach to patient engagement and exploring opportunities for innovative ways to engage patients in the programme.
3.5	As part of our pre-launch preparations we have been engaging clinicians from the trust in how the portal launch may affect their practice. There is naturally some concern from clinicians which is mainly around: • Ability of the patient to understand the information provided. We have been clear in the supporting narrative for the portal that we are providing clinical information to the patient rather than writing specifically for the patient. Evidence from elsewhere shows that this is not a problem for patients. • That there will be increase in contact to doctors or secretaries as a result of people having queries on results. This will be reviewed during the pilot however again evidence from elsewhere suggests that patients are actually less likely to make a call with the portal in place. • That there are rare occasions when they may need to write a letter that is not appropriate to share with the patient. A non-portal letter has been created for this purpose.
3.6	The health information exchange (HIE) enables the sharing of clinical data across organisations. At this stage we have rolled out HIE to 31 of the West Suffolk GP practices including all GPs in central Bury St Edmunds central. This provides GPs with access to the e-Care record. A key ambition is to make HIE bi-directional and we are working closely with the two main GP IT suppliers to test and develop this. We have a group of practices identified to run pilots during the spring. We are also actively pursuing two way interfaces with Lorenzo (EPR system for Papworth Hospital, Ipswich Hospital and Norfolk and Suffolk

	Partnership Trust), EPIC (EPR system for Addenbrookes) and Liquid Logic (Suffolk County Council social care record).
3.7	We continue to make steady progress with population health ambitions and now have dedicated Cerner support to help us move this forward. We are working closely with senior colleagues from the clinical commissioning group (CCG), STP and social care to ensure system alignment to the population health plan. We recently met with and received the full support of the Digital Strategy and Innovation Board to purse population health goals. Kate Walker, Head of Digital Strategy and Transformation for the STP is reviewing current analytical capability and capacity across the system and attending to the need for clinical safety officers in each organisation.
3.8	We will be able to use the new analytics pack (called Tableau) from May which will enable early training of staff and for us to create some compelling outputs for use for future engagement. Initially this will be using our own hospital data only. By the end of July we will have our own acute and community data integrated onto the population health platform and able to start doing some more complex analysis. We will be attending a GP shutdown on March 13th to socialise the population health opportunities and ambition.
3.9	There are early discussions around tele-consultation pilot with the likelihood of initial focus on ear nose and throat patients. Further and fuller details will be provided to a future board.
4	**Pillar three – exemplar digital community**
4.1	Milton Keynes University Hospital Foundation Trust are our fast follower and the relationship is maturing well and proving to be fruitful to both partners. We held a face to face meeting in December, at which time we shared our lessons learned from the phase two implementation. We are also sharing collateral to the trust (such as training plans and go live plans) and will be actively supporting their go live with provision of a small number of floorwalkers. This includes sending some staff to observe the go live in maternity, so that we can gain some learning for ourselves.
4.2	The national blue printing programme is now underway. Initially three trusts will be producing initial blue prints so that a template can be developed and shared with other GDE sites. At this stage the three pilots are: A Care Setting: A&E - Luton A Pathway: Sepsis – Liverpool A Digital Capability: ePrescribing – Cambridge The NHS Digital blue printing lead will be visiting the trust in March with a view to agreeing our final blue print requirements. We have submitted 20 potential areas for consideration.
4.3	We are also delivering a range of webinars as part of the national learning network as shown below.

Subject	Covering	Date
Operational Readiness	Stressing the importance of paying attention to the non-technical parts of preparing to receive an electronic patient record.	Delivered
Patient safety	Our journey with safety dashboards, perfect ward audit tool and vital links	01 Mar 2018
Capacity Management	Sharing our learning from implementing Capacity Management	To be agreed
Patient portal	Sharing our learning from implementing our patient portal	Late 2018

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.

WSFT Board Meeting – 2 March 2018

Agenda item:	18			
Presented by:	Dawn Godbold, Director of Integration and Community Services			
Prepared by:	Dawn Godbold, Director of Integration and Community Services			
Date prepared:	19/02/2018			
Subject:	Community Services and West Alliance update			
Purpose:	x	For information		For approval

Executive summary:

- This paper provides an update on community integration and transformation progress. The paper covers the following areas:
    - Integration between acute and community services
    - Development of the West Suffolk Alliance and West Suffolk System governance
    - Progress on pieces of work that will support integration both internally and externally

Main Points:

- Work is progressing well on respiratory services, and improving patient flow initiatives
- Discussions have commenced to address workforce and IT challenges to ensure a joint approach
- The Community Equipment Service procurement is underway
- The clinical elements of the Community Wheelchair Service will be brought in house from 1 April 2018
- A review of services that were split east/west, and those that continue to be county wide will be undertaken during March
- The work on Children's Services now has a clearer plan and timeline
- The governance framework and forums to enable system collaboration continue to mature and embed.

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 in relation to:

- Acute and community integration
- Development of the West Alliance
- Children's Services transformation

Community Services Update

West Suffolk NHS Foundation Trust Board

2nd March 2018

1.0 Introduction

1.1 This paper provides an update for the board on acute and community services integration and covers:

- Integration between acute and community services
- Development of the West Suffolk Alliance and West Suffolk System governance
- Progress on pieces of work that will support integration both internally and externally

2.0 Acute and Community Integration

2.1 During the last month discussions have taken place between colleagues to explore how working together could improve patient pathways and staff development in the following areas:

- Possible amalgamation of the community admission prevention nurses and the hospital Home IV Therapy team – this would reduce patient handoffs, increase resilience, create capacity, and avoid admission
- Community staff participated in perfect week and have identified actions that will improve patient flow, assist complex discharge planning, avoid admissions and improve information sharing
- Therapy professional leads jointly attended training and innovation event
- Respiratory Service re-design continues and additional staff and training have commenced
- Joint session held to determine IT priorities that will enable future working and integration
- Joint workforce challenges and planning session to be held 5 March 2018
- Exploration of community roles as part of the Helpforce Programme
- Work continues to ensure community services data and information is included in trust reports

2.2 Previous discussions supported an evolutionary approach to any structural management changes required to strengthen integration. Following these discussions the Head of Therapy Post will transfer from the Clinical Support Services Division to the Community Division on the 1 April 2018.

2.3 A further discussion with the current community senior managers is scheduled for 9 March 2018.

2.4 The procurement of the Community Equipment Service is underway with the new contract scheduled to start on 1 October 2019. This re-procurement will also affect the Community Wheelchair and Assistive Technology Services. The clinical element of the wheelchair service (assessment and prescribing) will be brought back in house from the current sub-contractor (Bartrams Ltd) on the 1 April 2018. This will allow for greater oversight and control of access waiting times and provide the clinicians with improved clinical support.

2.5 The service will be placed within the Head of Therapies management structure to provide the necessary supervision and professional advice required.

2.6 During February and March 2018 (6 months into contract provision) discussions are being held to:

- Review the financial assumptions/share
- Review the specialist service disaggregation
- Review the services still provided on a county wide basis
- Finalise the contractual KPI's

3.0 Services for Children and Young People

3.1 Children's Services transformation continues through the county wide multi-agency Children's Strategy Group. The system has recognised that the Transformation work for children's services has not progressed at the same pace as adult services. To assist, the county council and the CCG have agreed to create a new jointly funded post Head of Children and Young Peoples Transformation. This is currently out to recruitment. The strategy group have also re-invigorated the work programme and have agreed the following six priorities:

3.2 **Priority 1: Children's Emotional Health and Wellbeing Plan**
Delivery of the multi-agency plan and all projects contained therein.

Key Milestones	
April 2018	Emotional Wellbeing Hub (NSFT and SCC CYP joint point of access)
April 2018	Crisis Pilot for children and young people (NSFT additional capacity)
September 2018	Review of third sector grants and mainstreaming
November 2018	Refresh of Annual Report

3.3 **Priority 2: Special Educational Needs and Disability (SEND)**
Delivery of multi-agency plan and system response to findings of Department for Education (DfE) and NHSE Inspection.

Key Milestones	
April 2018	Next visit from Department for Education (DfE) and NHSE Inspection Team
March 2018	All statements and LDAs must be transferred to EHCPs
May 2018	SaLT and Communications work stream
Summer 2018	Delivery of multi-agency assessment centres
October 2018	Development of a neuro-developmental and behaviour pathway incorporating autism, ADHD, conduct disorder and behaviour

3.4 **Priority 3: Speech and Language Therapy and Communication**.
Review of current service provision and agreement of new Suffolk model/joint commissioning arrangements.

Key Milestones	
December 2017 to February 2018	Review of current offer completed
February 2018 to May 2018	System-wide pathway to be clarified and opportunities including joint commissioning of SaLT and communications services to be considered

3.5 **Priority4: Neurodevelopmental and Behaviour Pathway**
Agreement of a system wide pathway supporting Autism (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder and Behaviour.

Key Milestones	
December 2017 to February 2018	Waiting times and current offer clarified
February 2018 and on-going	Full outcomes and milestones by organisation to be agreed

3.6 **Priority 5: Children and Young Peoples Community Health Services**

Delivery and implementation of service specification for Integrated Community Paediatric Services.

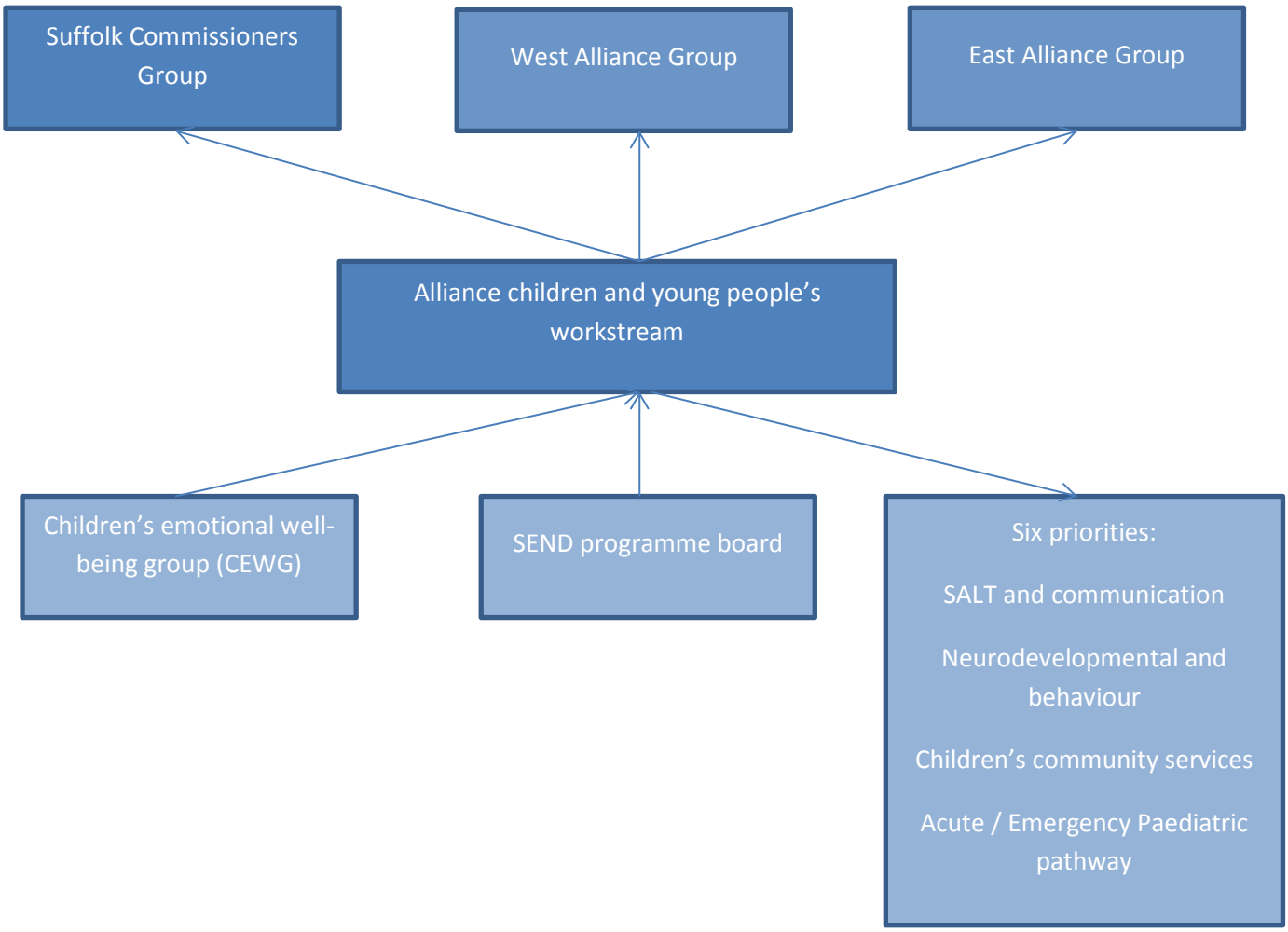
Key Milestones	
February 2018 to May 2018	Links to Emotional Health and Wellbeing Hub (to be clarified)
February 2018 to December 2018	Multi-disciplinary teams – MDT working is in place, but there are opportunities for further development
February 2018 to December 2018	Delivery of a 7-day per week Complex Childrens Nursing Service

February 2018 to December 2018	I.T development to achieve paper-light records and mobile working. We would like to see paper-light working and remote access to SystmOne at the point of care. Resourcing implications to be clarified

3.7 **Priority 6: Agreement of Acute/Emergency Paediatric Pathway**
Clarity on urgent care pathways in, out and via Ipswich Hospital and West Suffolk Hospital.

- The Children and Young People's Alliance work stream will meet monthly to oversee the development and delivery of agreed priorities and report into the two Alliance Groups and Suffolk Commissioners Group.
- The membership will comprise the following organisations: SCC, CCG (Ipswich, East and West), IHT, WSH, NSFT, Integrated Community Paediatric Services and Suffolk Parent Carer Network (SPCN)
- The Children's Trust will meet quarterly extending the work stream group to include other reps (e.g. Waveney).

Alliance Children's workstream governance



4.0 West Suffolk Alliance Development

4.1 The West Suffolk Alliance became responsible for the community services contract on 1 October 2017. The Alliance is working as a partnership of providers under an agreed memorandum of understanding (MOU)

4.2 The Alliance continues to establish a shared governance framework, vision and strategy and agree the processes for decisions to be made/ reached/ratified and implemented. The Alliance has held its second formal meeting and has begun discussions to establish and agree what its priorities are.

4.3 The group has identified its preferences for the spending of the Improved Better Care Fund (IBCF) and elected a member to represent it on the STP ICS programme group.

4.4 Discussions continue to implement the locality based model of service delivery, develop the neighbourhood teams and networks. The group have agreed the process and scope for identifying a locality lead for each locality. The group agreed that the main emphasis to recruit should be on skills needed rather than the current role of interested individuals.

4.5 The role will be circulated for expressions of interest and discussed with each locality group for them to determine who in their locality may be the best person. The group agreed this lead does not have to be from a formal Alliance partner.

4.6 The process for how we redirect current CCG GP resources to the localities to influence and drive the service changes required has begun and will form part of the upcoming CCG GP recruitment/nomination process.

4.7 A small working group of individuals from ACS/CCG/WSFT has been established to drive forward the work that is needed to implement the transformational changes, establish the localities and locality boards. This group is meeting weekly.

4.8 Through this group work has begun on producing an engagement pack to improve messaging and understanding of the Alliance and what it hopes to achieve.

4.9 WSFT are housing a discussion on Accountable Care on 22 February and an Alliance “shutdown” to hold a shared clinical development day is scheduled for 13 March 2018.

5.0 Conclusion

5.1 The work to integrate services continues.

5.2 The Alliance is maturing and embedding its governance and forums and now has a high level timeline of how to move forward to be fully integrated as a system.

5.3 The STP ICS project board will be established during February and will assist Alliance development.

5.4 The Children's services work now had greater emphasis and rigour.

5.5 The Board is asked to note the progress being made.

Board of Directors – 2 March 2018

Agenda item:	Item 19			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	22 February 2018			
Subject:	Trust Executive Group (TEG) report – 5 and 19 February 2018			
Purpose:	X	For information		For approval

Executive summary

Steve Dunn provided an introduction to the meetings with reflection on the sustained **winter pressure** and action to continue to ensure safe care for our patients. He recognised the positive feedback from staff following the announcement of the CQC inspection rating for the Trust as 'Outstanding'. An update was provided on operational planning for 2018-19 and the role of sustainability and transformation partnerships (STPs) financial and service planning.

The **integrated quality and performance report** (IQPR) was reviewed. The sustained pressure on the emergency department (ED) was significantly impacting on the 4 hour wait standard and we continue to use F4 for emergency surgical activity. It was reported that the predictive modelling shows sustained pressure until the end of February. The RTT impact was reviewed and the risk regarding 52 week breaches recognised as a result of the sustained cancellation of orthopaedic surgery.

Planned changes to **ambulance handover** arrangements were discussed and a standard operating procedure is being agreed between all parties. A risk summit was attended by Steve Dunn and it was recognised that to deliver the 30 handover standard a clinical assessment of safety for the patient was required between all parties with clear escalation arrangements if handover is not safely achievable.

The **medical e-rostering** implementation plan was reviewed ahead of the Scrutiny Committee and Board's consideration of the final business case.

The **capital programme** was considered with a proposed application to DH for £37.2m. It was recognised that this plan looks uncertain. The prioritisation between winter bed capacity for 2018-19, theatre capacity and refurbishment of the concourse was also being reviewed. It was recognised that there is a time critical path in these decisions to deliver additional capacity for winter 2018-19.

The options for creating additional winter capacity were considered in more detail including the possibility of phasing the AAU development (in the former Trust Office area) to create half of this capacity for winter 2018-19. The staffing and operational planning to meet the needs of this facility would need careful consideration and planning.

An update was received on the **community services** integration and the model of working for neighbourhood teams.

The report from the **Quality Group** set of the action plan in response to the recent CQC inspection report. The framework for quality improvement and quality priorities within the Trust was also reviewed and will be subject to further development.

The **gender pay gap** report for the Trust was consider and will be subject to further development prior to receipt at the open Board at the end of March.

A proposed change to the structure of conflict resolution training to focus on **managing challenging behaviour** was approved. The content includes managing confused and wandering patients as well as aggressive patients. This uses sound communication and teamwork, ensuring physical intervention is always a last resort.

The draft **IT strategy** was commented on. It was recognised that the document needs to be underpinned by an operational plan with clear deliverables, timescale and resource implications.

Relevant **policy documents** were considered and approved:

a) Missing person policy
b) Welfare of patients presenting with self-harm
c) Access policy
d) GDPR update briefing will be circulated to members

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:	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

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – Friday 2 March, 2018

Agenda item:	20			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Ruth Williamson, PA			
Date prepared:	23 February, 2018			
Subject:	Quality and Risk Subcommittee Reports			
Purpose:		For information	X	For approval

Executive summary:

A presentation from the Buurtzorg team was received which set out progress and plans for the test and learn pilot. Governors and external partners were invited attend this session.

Reports from the subcommittees of the Quality and Risk Committee were received. These reports are submitted for assurance and governance.

(a) **Corporate Risk Committee (16/11/17)**
The matter of Display Screen Equipment assessments was asked to be escalated to the Quality & Risk Committee for information and to note mitigating plans. Noted the Trust's arrangements are fit for purpose and will be monitored via the work place inspection programme.

(b) **Clinical Safety & Effectiveness Committee (15/12/17)**
No issues were identified for escalation. Noted following concern at levels of clinical attendance at this committee, the meeting day had been changed to a Monday.

(c) **Patient Experience Committee (08/12/17)**
No issues were identified for escalation. Noted a new experience of care strategy is being prepared.

A report was received from the Quality Group which had been established to provide operational focus on assurance and improvement. It was noted that this group had incorporated relevant elements of the disbanded Patient Safety & Implementation Group (PSIG). The risk escalation framework was updated to reflect this change (Annex A).

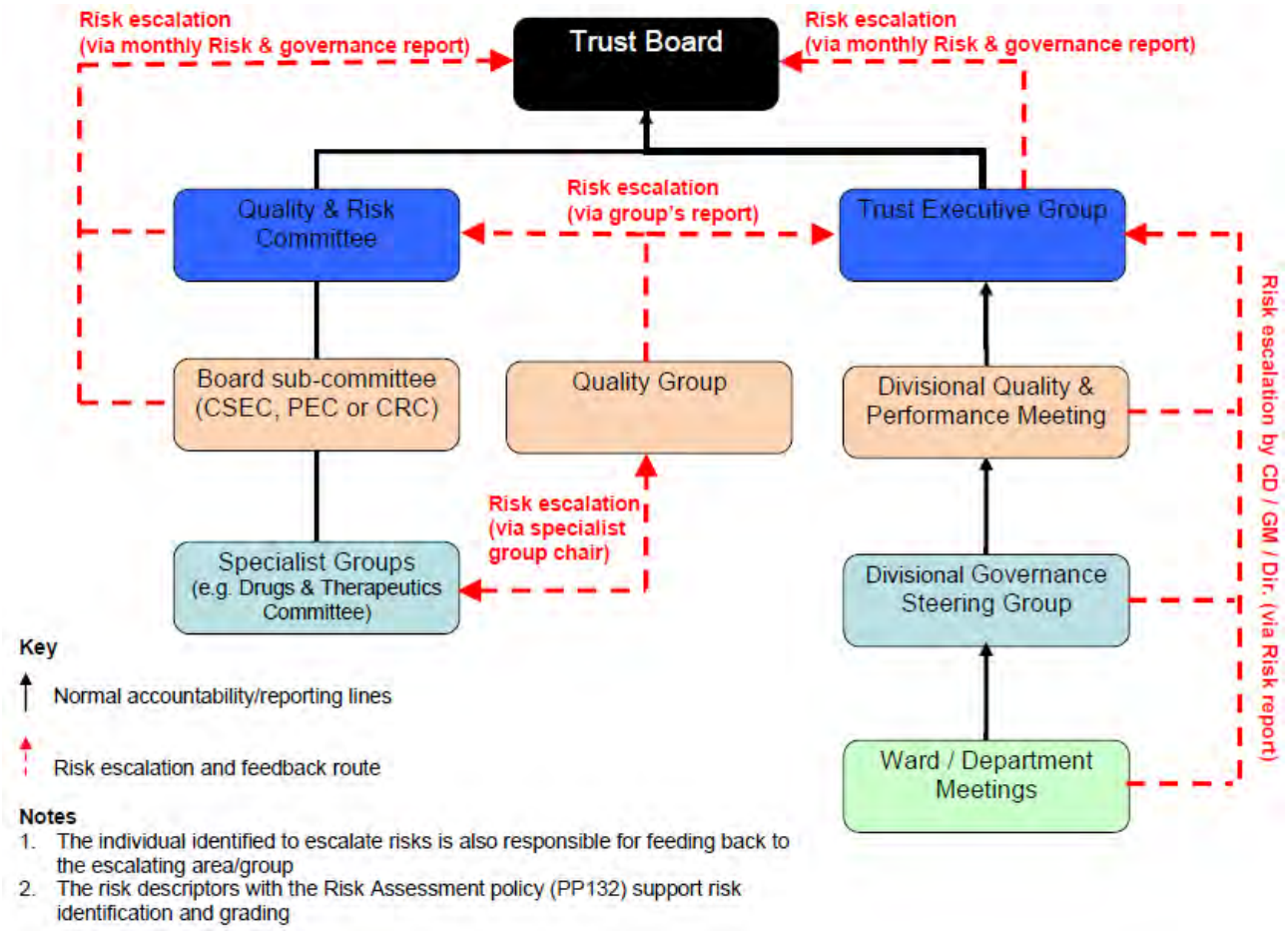
Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X		

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:	**-**						
Risk and assurance:	-						
Legislation, regulatory, equality, diversity and dignity implications	-						

Recommendation:

- To receive the report and minutes for information and assurance
- Approve the change to incorporate the Quality Group into the risk escalation framework (Annex A) as part of the Trust's risk management strategy

Annex A: Updated risk escalation framework (from Risk Management strategy)



QUALITY & RISK COMMITTEE
Minutes of the meeting held on Friday 29 September, 2017,
Commencing at 2.00 p.m. in the Northgate Meeting Room, Quince House, WSFT

COMMITTEE MEMBER			Attendance	Apologies
Sheila Childerhouse	**(SC)**	Chair (Chair)	**X**	
Stephen Dunn	**(SD)**	Chief Executive	**X**	
Craig Black	**(CB)**	Director of Resources	**X**	
Nick Jenkins	**(NJ)**	Medical Director	**X**	
Helen Beck	**(HB)**	Interim Chief Operating Officer		**X**
Jan Bloomfield	**(JBl)**	Director of Workforce & Communications	**X**	
Rowan Procter	**(RP)**	Chief Nurse	**X**	
Gary Norgate	**(GN)**	Non-Executive Director	**X**	
Steve Turpie	**(ST)**	Non-Executive Director	**X**	
Catherine Waller	**(CW)**	Honorary Non-Executive Director	**X**	
Richard Davies	**(RD)**	Non-Executive Director	**X**	
Richard Jones	**(RJ)**	Trust Secretary & Head of Governance	**X**	
Alan Rose	**(AR)**	Non-Executive Director	**X**	
Angus Eaton	**(AE)**	Non-Executive Director		**X**
In attendance				
Catherine Waller	**(CW)**	Placement Non-Executive Director		
Ruth Williamson	**(RW)**	PA to Medical Director (Minutes)		
Buurtzorg Presentation				
Theana Warden		Neighbourhood Nurse		
Samantha Whitehead	**(SW)**	Neighbourhood Nurse		
Jonathan Algar	**(JA)**	Neighbourhood Assistant Practitioner		
Kate Laybourne	**(KL)**	Neighbourhood Assistant Practitioner		
Hannah Gower	**(HG)**	Neighbourhood Assistant Practitioner		
Michelle Glass	**(MG)**	Local Area Manager, West Suffolk Community Services		
Michael Ogden	**(MO)**	Information Services Manager, Healthwatch Suffolk		
Anita Farrant	**(AF)**	Head of Nursing & Early Help, Suffolk County Council		
Diana Kearsley	**(DK)**	District Councillor, Mid-Suffolk District Council		
Sue Deakin	**(SDe)**	Clinical Director, Surgery, WSFT		
Alec Edwards	**(AE)**	IM&T Project Manager, WSFT		
Amanda Keighley	**(AK)**	Governor		
Jane Skinner	**(JS)**	Governor		
Peter Alder	**(PA)**	Governor		
Florence Bevan	**(FB)**	Governor		
June Carpenter	**(JCa)**	Governor		
Justine Corney	**(JCo)**	Governor		
Judy Corey	**(JCy)**	Governor		
Jayne Gilbert	**(JG)**	Governor		
Adrian Osborne	**(AO)**	Governor		
Joe Pajak	**(JP)**	Governor		
Liz Steele	**(LS)**	Governor		

Action

Buurtzorg Team Presentation

It was noted that the Buurtzorg principles, founded in Holland, in 2006, offered truly patient centred and autonomous care. Staff worked as a self-managing, non-hierarchical team.

Noted that recruitment has been an issue, with a disappointing level of applicants. Unsure at this stage if related to a national nursing shortage, lack of knowledge of Buurtzorg itself or the fact that jobs are advertised as a 24 hour service and community nurses do not work nights. To combat this a "meet and greet" session was organised to encourage formal applications. This has resulted in a higher quality, with three recent successful appointments.

Noted IT issues are also proving an obstacle. Buurtzorg in Holland have a specific system but the West Suffolk team have had to utilise that within the NHS. However, this will evolve with time to serve the needs of patients.

A base site has been chosen and a room will be rented within the GP surgery at Barrow. Part of the ethos of Buurtzorg is a strong sense of connection to location.

RD asked if any issues were anticipated when mixing social and nursing care. KL advised that these were not anticipated due to the skill base and knowledge within the team. DB advised that the role of the "heat shield" was to manage system pressures and free up the team. NJ queried how the "heat shield" would cope. Noted they could also manage upwards. The team said they felt protected and still self-managed.

ST asked how the work of the Buurtzorg team linked with the Early Intervention Team (EIT) and the allocation of patients, particularly in light of only a small number of staff. MG advised that the team was starting off small and working closely with EIT. They would not replace current services, but work in collaboration with. The referral criteria was in the process of being established. Initially, the team would be focusing solely on Barrow, working in conjunction with the GP practice and community care staff. It was anticipated that eventually their work would avoid the revolving door of carers that many patients experienced.

Noted the Kings Fund would be involved in service evaluation.

Funding is to be shared between the Trust, Suffolk County Council, Local Government Association, District council and CCG.

JCa asked when the first patient would be seen. This is anticipated for June, once IT issues have been resolved.

CB asked how the team established clinical boundaries and dealt with any conflict in a self-managed team. KL advised that ground rules are set and any decisions are discussed as a team. If not able to resolve, the team refer to the Buurtzorg web or coach for advice. However, Buurtzorg select their team members and so have an understanding of the people they are working with. SW suggested that conflict was a good thing as it provided challenge. TW advised that the staff were working to a code of conduct.

RP stated that the Band 4, Nursing Associate, role had not previously been embraced, but within Buurtzorg there was a strong competency framework. It was felt that this role was a linchpin between nursing and therapy and helped to

keep a patient ticking over.

AR asked whether, as the majority of the caseload was frail, elderly, how the team would stop the list from building up and patients becoming dependent. HG advised that the ethos was about empowering the patient, providing education on their condition and enabling them to self-care. It was anticipated that the building of informal networks would assist with independent living and eventual discharge.

JBl asked if there was an opportunity for volunteers from within Barrow to work with the team. TW advised that she had recently attended a village breakfast where the WI had stated their wish to include the socially isolated. It was agreed that assistance from volunteers within the Trust should also be sought, with the suggestion from PA of a link to a good neighbour type scheme.

The Committee thanked their team for an excellent presentation and wished them well in their endeavours.

GN left 2.45.

The presentation ended at 3.05 pm, guests left and Committee members moved to Room 10 to continue the meeting proper.

Craig Black gave his apologies for the remainder of the meeting. Departing at 3.05 p.m.

1. **Apologies for Absence**

Apologies received as detailed above.

2. **Minutes of Previous Meeting**

The minutes of the meeting held on 29 September, 2017 were accepted as a true and accurate reflection of the meeting.

3. **Matters Arising Action Sheet**

Completion of matters arising references 35 and 36 was duly noted.

4. **Reports from Sub-Committees**

a. ***Clinical Safety & Effectiveness Committee***

Item 5.4a – Medicines Management - RD requested that the minute be amended as follows *"SW highlighted the issue of Trust supply of subcutaneous methotrexate. One thousand patients are currently being treated on a regular basis. The Trust is working with the CCG to move this away from the Trust and in to the community as the Trust has insufficient space and resources to manage this number of patients safely. RD queried ~~whether the reason for the high numbers related to over enthusiastic prescribing of methotrexate~~ the reason for subcutaneous prescribing, when the drug could be given orally. SW advised that it had been found by treating aggressively at the start, this negated the need transfer to biologics*". RW to action **RW**

Item 6.4 - Clinical Audit Programme Report – ST queried the issue with regards to the struggle in obtaining relevant data as this had not been flagged at the previous Audit Committee. RD advised that it related to the national inflammatory bowel disease audit. ST asked if this presented a risk to patients.

NJ advised that the Trust was asked to participate in this audit for the greater national good. He believed it to be a human factors issue rather than a matter of the information not being available. Plans are in place to rectify, part of which relate to Dr. Helena Jopling, Consultant, Public Health, providing assistance to junior doctors to enable them to participate in audits as part of their quality improvement work.

Item 8 – Reflections on the Meeting - SC queried the poor level of attendance at the Trauma Committee and asked if this was something about which the Trust should be concerned. Noted this is being looked in to. RJ reported that attendance at this committee had previously been an issue, but the day for future meetings had been amended to ensure maximum clinical attendance.

b. ***Corporate Risk Committee***

Item 3.3 - Display Screen Equipment (DSE) - NJ has been asked by Corporate Risk to escalate the issue of display screen equipment (DSE). There is some compliance work to be done and Neville Hounsome, ex-non-executive director, had queried whether this was being expedited.

RJ advised that as part of the Trust's Health & Safety Regulations programme, each required regulation is reviewed and DSE was undertaken recently. The Trust's arrangements are fit for purpose, but not being implemented rigorously. It was agreed at the last meeting of the Health & Safety Committee to utilise the team of trained and qualified health and safety link persons within the wards and departments to drive this forward. With the instigation of e-Care and the wider range of devices being utilised within clinical environments, the DSE risk has altered. Realistic plans for delivery are in place, but these will take some time to embed. However, this will be monitored through the work place inspection programme.

Item 8 - Reflection and Issues for Escalation to the Quality & Risk Committee or Trust Board - SC queried the fact that only one of these items had been escalated to this committee. Noted that the others had gone to the Board.

Item 5.3 – Central Alerting System (CAS) - RD referred to the matter of oxygen running out in theatre and asked whether action had been taken to ensure this did not happen again. RP advised that a cylinder had run out, but other oxygen had been available. A review of checklists, forming part of the new audit system will rectify this.

STP - AR asked whether the STP had requested a risk/escalation process to accommodate the larger system. RJ reported that the STP have advised that governance arrangements are still evolving and the suggestion was that going forward, this be managed via the newly established System Executive Group (SEG) attended by the alliance partners.

c. ***Patient Experience Committee (PEC)***

No items for escalation were noted.

RP advised that a strategy was and new structure for PEC was being drafted. This will to be discussed, via a workshop, at the next committee meeting. SC stressed the need for this workshop to take place prior to any governor engagement being sought.

Item 4.2 - End of Life Care Operational Group - SD offered his congratulations on the excellent CQC result for the Trust's end of life care.

5. **Quality Group Report**

RP advised that as part of the 2018/19 priorities each subcommittee was being asked to set three quality priorities. RJ advised that this was progressing well and the intention was for the product of the work from the Quality Group to be fed through to TEG and onwards to the Board. Noted the new Head of Quality & Improvement is due to commence employment at the beginning of March.

RJ asked that it be noted that the Quality Group has incorporated the Patient Safety & Implementation Group (PSIG) and this has been reflected in the risk escalation process. ST asked for assurance that the Quality Group had picked up any outstanding matters from PSIG. RP confirmed that it had.

AR asked how NEDs would have sight of output from the new Quality Group. NJ advised that this was not a Board committee. However, any items for escalation would be raised at the Trust Executive Group (TEG) and if necessary onwards to the Board. However there will be a quarterly report made at this committee. Agreed that the diagram provided supplied did not demonstrate this; RJ to amend. SD believed the new group would provide an appropriate process for agreement of quality priorities and would be evidenced based. The Committee agreed the new group was a step forward. **RJ**

Noted the Quality Group would oversee the improvement action plans from the previous CQC visit. Work would be ongoing to help maintain the current standard.

6. **Any Other Business**

No further business was noted.

7. **Reflection on Meeting and Identify Any Issues for Escalation or Capture/Review on the Risk Register**

AR appreciated the fact that external guests, such as the governors, had been invited to the Buurtzorg presentation.

8. **Date and Time of Next Meeting**

Please note the meeting will start at 14:00 in the Northgate Meeting Room, Quince House, WSFT.

29 March, 2018
29 June, 2018
28 September, 2018

The meeting closed at 3.35 p.m.

NHS West Suffolk NHS Foundation Trust

Trust Open Board Meeting – 2nd March 2018

Agenda item:	21			
Presented by:	Gary Norgate, Non-Executive Director			
Prepared by:	Kathryn McMahon, EA to Executive Director of Resources			
Date prepared:	February 2018			
Subject:	Charitable Funds Board Report			
Purpose:	X	For information		For approval

Executive summary:

The Charitable Funds Committee met on 26th January 2018. The key issues and actions discussed were:-

- The Audit Committee signed off the Charitable Funds 2016/17 Accounts and these were signed and submitted following the meeting that took place prior to Trust Board on 26th January 2018.
- The Holistic Therapies Centre Business case would be coming back to Charitable Funds following Exec Directors Sign off (at a Exec Director Meeting in March).
- A full legacy strategy paper would be supplied to the next meeting in April 2018 this would include all grant applications to date.
- An action was agreed for a formal register to be established recording significant donations/sponsorship to the Trust. This register would in turn form part of the charitable funds annual report and also be published publicly.
- It was discussed and decided that the Ethics Policy would be updated to reflect the checking of ethical sources of all donations.
- A change in policy for 'thank you' letters for donors was discussed, so that they go out from the Fundraising Department directly. In addition David Swales and Sue Smith would discuss the best possible way of keeping track of all donations into the Trust, this being kept in one central database and for all donations to be directed into the Trust via the Fundraising Dept.
- It was decided that Sue Smith would send a communication around to staff/managers to advise of the availability of charitable funds to support expenditure that might otherwise have been funded from ward budgets.

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:	Charitable Funds Committee
Risk and assurance:	None
Legislation, regulatory, equality, diversity and dignity implications	None
Recommendation: The Trust Board is asked to consider the report of the Charitable Funds Committee	

Trust Board Meeting – 2nd March 2018

Agenda item:	22			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Karen McHugh, PA			
Date prepared:	February 2018			
Subject:	Use of Trust's seal			
Purpose:	X	For information		For approval

Executive summary:

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

Seal No. 122
Litigation Funding Deeds, associated with mandatory relief on rates – Sealed by Craig Black and witnessed by Julie Pettit (on 19th January 2018).

Seal No. 123
Lease for Thetford Healthy Living Centre, ground floor - Sealed by Craig Black and witnessed by Jean Le Fleming (on 22nd January 2018).

Seal No. 124
Renewal lease for WHSmith Hospitals Ltd till 2 July 2019 – Sealed by Craig Black and witnessed by Jean Le Fleming(on 22nd January 2018).

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:	None
Risk and assurance:	None

Legislation, regulatory, equality, diversity and dignity implications	WSFT's Standing orders
Recommendation: To note the use of the Trust's seal	

Board of Directors – 2 March 2018

Agenda item:	Item 23			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 January 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 – 29 March 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 appraisals	✓		Written	Matrix	HB/RP
RTT recover plan	✓		Written	Action point - 1513	HB
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Voice recognition software business case		✓	Written	Business case	CB
Education report - including undergraduate training	✓		Written	Matrix	JB
e-Care report	✓		Written	Matrix	CB
Gender pay gap report	✓		Written	Matrix – by exception	JB
Voluntary services report	✓		Written	Action point - 1496	JB
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
e-Care report	✓		Written	Matrix	CB
Alliance and community service report, including SLT patients that are waiting or a package of care	✓		Written	Matrix	DG
Hospital concourse development (depending on capital programme)	✓	✓	Written	Action point - 1489	CB
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
Council of Governors report	✓		Written	Matrix	SC
Audit 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

Non-executive director responsibilities review	✓		Written	Matrix	SC
Well-led review		✓	Written	Action point - schedule	SD
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	RQ