NHS
West Suffolk
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 26 January 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	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 1 December 2017	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.	**Finance and workforce report (attached)** To accept the monthly report	Craig Black
10.	**RTT report (verbal)** To receive a verbal update in the context of winter pressure.	Helen Beck
11.	**Transformation report (attached)** To approve the report	Helen Beck
10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
12.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter
13.	**Pathology services report (attached)** To accept a report	Nick Jenkins

14.	**Health and wellbeing report (attached)** To accept a report	Jan Bloomfield
15.	**Mandatory training report (attached)** To accept a report	Jan Bloomfield
16.	**Safe staffing guardian report – Q3 (attached)** To accept a report	Nick Jenkins
17.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
10:50 BUILD A JOINED-UP FUTURE		
18.	**e-Care report (attached)** To receive an update report	Craig Black
19.	**Alliance and community services report (attached)** To receive update	Nick Jenkins
11:00 GOVERNANCE		
20.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
21.	**Remuneration Committee report (attached)** To receive report	Angus Eaton
22.	**Charitable Funds Committee report (attached)** To receive report	Gary Norgate
23.	**Council of Governors report (attached)** To receive report	Richard Jones
24.	**Register of interests (attached)** To note the update	Richard Jones
25.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:15 ITEMS FOR INFORMATION		
26.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
27.	**Date of next meeting** To note that the next meeting will be held on Friday, 2 March 2018 at 9:15 am in the Committee Room.	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
28.	The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act l960	Sheila Childerhouse

Item 5

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 1 DECEMBER 2017

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

Action

GENERAL BUSINESS

The Chairman welcomed guests and congratulated governors who had been re-elected. He introduced Alex Baldwin, Deputy Chief Operating Officer who was attending the meeting as an observer.

17/233 APOLOGIES FOR ABSENCE

There were no apologies for absence.

17/234 QUESTIONS FROM THE PUBLIC

- Joe Pajak referred to agenda item 13, appraisal process and asked about actions that had been put in place to target this. It was explained that this would be addressed under agenda item 13.

- June Carpenter asked how many staff had now had flu jabs and also if the Trust was sure that there were adequate plans in place for winter. It was explained that flu jabs would be addressed under item 7, Chief Executive's report.

  Rowan Procter reported that the final meeting had taken place with regard to opening of the winter escalation ward and maintaining safety across the organisation. WSFT was also block booking agency staff to cover wards, which would enable substantive staff to cover the winter escalation ward.

- Judy Cory noted from the Chief Executive's report that discussion by the board about the front of hospital refurbishment had been deferred until January. She reported that the first meeting had taken place with certain parties to discuss the ongoing situation with the Friends and what was happening.

  The Chief Executive thanked her for this helpful update.

- June Carpenter referred to the TEG report and the wider leadership programme and thanked the board for allowing governors to attend the 5 o'clock club, which she found very interesting. She asked if this would a have any effect on the leadership programme.

  Jan Bloomfield explained that the 5 o'clock club was where the organisation talked about leadership and quality improvement, and anyone with an interest was welcome to attend. The Trust was trying to cover a wide range of subjects and this was an opportunity for people across the organisation to connect. There were some excellent speakers for next year and the aim was to link the programme with what WSFT was trying to achieve as an organisation. Dr Henrietta Hughes would be speaking on 11 January, Claire Sullivan on 27 February, which would link to AHP day, and 20 March would be 'Hello My Name Is' day with Chris Pointon.

  The Chief Executive explained that this was part of a wider leadership 20:30 programme for training leaders of tomorrow. A succession plan for key leaders across the organisation was also being looked at. The Trust was building on the leadership summit which began in December 2014 and the next one, which was taking place in December, would be specifically targeting band 6s and 7s.

  He thanked the board members and governors for their attendance and support at the 5 o'clock club and also paid tribute to Steve Turpie for his excellent presentation.

  Jayne Gilbert asked if there were any plans to repeat these talks, as not everyone was able to attend them. The Chief Executive explained that they would be looking at videoing /podcasting these.

- June Carpenter, on behalf of the Council of Governors, thanked the Chairman for everything he had done and wished him well in his retirement. She added that governors were looking forward to working with Sheila Childerhouse.

The Chairman introduced Sheila Childerhouse who was attending the meeting as an observer.

He thanked the governors for being so supportive and at times challenging. He had found working them a very interesting experience and they had added to the Trust during his time as Chairman.

17/235 REVIEW OF AGENDA

The agenda was reviewed and the Chairman explained that KPMG would be attending for item 18. It was a very full agenda and he asked for questions to be kept to the point.

17/236 DECLARATION OF INTERESTS

There were no declarations of interest.

17/237 MINUTES OF THE MEETING HELD ON 3 NOVEMBER 2017

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

Page 9, 17/217, final sentence to be amended to; "It was taking a robust line on sickness absence which was approximately 4%; this was lower than the national average".

17/238 MATTERS ARISING ACTION SHEET

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

Item 1467 – provide clear action and deliver improvement in maternity WHO compliance. Angus Eaton asked about progress to date in addressing the actions. Nick Jenkins reported that they had been nearly compliant for two months and performance this month was similar. Therefore this action has been completed and staff were now very focussed on this and there had been a significant change. The maternity team would also be looked at their WHO checklist and why it was different from the WHO checklist used by the rest of the organisation. He confirmed that the target was 100% and that performance in completing WHO checklist forms correctly had improved considerably.

Rowan Procter explained that page 51 of the quality report showed performance in this area.

Item 1497 – set out plan for how we are managing the acute/community integration process with key milestones for delivery/success, to include opportunities which evolve to develop shared working. Gary Norgate asked how progress on integration and synergies that should arise from bringing acute and community services together would be reported. He proposed extending this action or creating a new action to produce a dashboard to measure synergies, ie length of stay, reduction in admissions, avoidance of pressure ulcers.

Steve Turpie reported on the good work that was being undertaken in children's services as a result of integration, ie asthma pathways. He said that the Trust needed to work towards more of this across other services.

The Chief Executive agreed and said that it would be helpful if a dashboard could be produced and indicators identified that could be tracked over a period of time. The Chairman asked the executive team to look into this, ie what outcomes the Trust was looking for and how these would be measured. **D Godbold**

Helen Beck reported that she was working with Dawn Godbold on key indicators for success. Jan Bloomfield said that this also needed to include how this would work culturally, and this would be incorporated in the staff survey.

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

The Chairman noted that items 1488 and 1496 should remain open, as they were not due for completion until 26 January and 2 March respectively.

Item 1495 – Consider routes to promote support for staff in raising concerns of harassment or bullying. Catherine Waller asked about the whistleblowing policy which she had previously noted was due for review in April 2016. Jan Bloomfield confirmed that this had been reviewed and reissued.

Neville Hounsome asked about physiotherapy services and recalled that there should be a paper to review this after a year. Craig Black explained that he had asked for details on this to be included in the December report to the board. The area was also reviewed by the Scrutiny Committee. **H Beck**

17/239 CHIEF EXECUTIVE'S REPORT

The Chairman considered this to be a good report with a lot of content.

The Chief Executive explained that the focus was on ensuring that the organisation was safe for winter and there was integrated working. It was proposed that there should be two new primary care representatives on the Council of Governors and this would further support plans for integration.

He referred to the retirement of Roger Quince as Chairman at the end of this month. He recalled when he first met the Chairman ten years ago, as part of the team which was aiming to get all organisations to FT status by 2010. He said that the Chairman's legacy for the board, hospital and community was ensuring that West Suffolk Hospital achieved FT status. His focus of the board on quality of care provided for the patients of WSFT and its community had been relentless and dogged. The Trust also had the most engaged staff in the country, as shown in the last staff survey.

There would be an official naming of Quince House on 19 December and the planting of a quince tree.

The Chief Executive said that he had enjoyed working with the Chairman and he had been a great Chair and friend and a real asset to the community. Sheila Childerhouse also exhibited many of these qualities and he was sure she would carry on his legacy.

The Chairman said that when he was interviewed for the role of Chair he was asked why he wanted this position. He had said that it sounded interesting, and it had indeed been an interesting journey. This was now a better hospital than ten years ago which would be to the benefit of everyone in the future. The key issue was the quality of care provided by the hospital and the strategy of integration which was so important for the future of health care in England and Wales. He was very pleased that WSFT was progressing so well with this.

Neville Hounsome referred to North East Essex and Suffolk Pathology Services (NEESPS) and asked if the board could be reassured in terms of safety issues. He asked Nick Jenkins if staffing and manning of the laboratory was improving. Nick Jenkins said that this was no worse but was also no better yet. The performance meeting at Colchester hospital had been moved, at WSFT's request, to next week in order to enable him to prepare appropriately for this meeting. As there had not been a meeting since the last board meeting he had not had a chance to talk to the leadership team. However, the local team on site had said that more cogent plans were being put in place for Christmas and these would be presented at the next meeting.

Neville Hounsome said that he felt much more reassured, now that there was medical input in place and suggested that there should be a plan for the board and governors to say by when it would be safe. Nick Jenkins said that he considered that it was safe now but quality assurance was a particular challenge. He stressed that this was not connected to daily checks on quality of equipment etc.

Steve Turpie asked how turnaround times for test results were monitored. Nick Jenkins explained that there were metrics which demonstrated that results were not being reported in the timescales they should be, although these were not a million miles away from where they should be. However, this was not impacting on patient care or safety. He explained that point of care testing machines were available in the emergency department which were accurate enough to provide information.

The Chairman proposed that there should be more evidence on the safety issue and how the problem might be worked around. Rowan Procter said that she was satisfied because of the strong reporting of clinical incidents that no harm had come to any patient due to a delay in results. Nick Jenkins said that he would bring a sample of data that was looked at locally to a board meeting. Gary Norgate proposed that this should be included as an item for the Clinical Safety & Effectiveness Committee (CSEC). **N Jenkins**

The Chairman said that the reassurance required by the board was that there were measures and these were being tracked. Helen Beck confirmed that these were tracked at multiple levels.

Richard Davies referred to the stranded patient multi-disciplinary team (MDT) and said this was an excellent initiative. He asked for clarification that individual primary care teams were represented on this. Helen Beck explained that they were not represented in these meetings. However, as part of working more closely with community teams a more focussed meeting on discharges would take place on a Friday and community matrons would be attending to ensure that appropriate care packages were in place for patients who were discharged at weekends. These meetings would also be attended by junior doctors.

DELIVER FOR TODAY

17/240 INTEGRATED QUALITY & PERFORMANCE REPORT

The Chairman explained that the board would be looking at the new format of this report at this meeting, although the original format had also been included in the board pack for reference and any points raised by Board Members could refer to either.

Rowan Procter referred to the exception report on pressure ulcers, page 17. She reported that following over 500 days with no pressure ulcers, F5 cared for an end of life patient who had recently developed a hospital acquired grade 2 pressure. This was reviewed and considered to be unavoidable. F6 was also performing very well on preventing hospital acquired pressure ulcers. There was now a full task and finish group working on the prevention of pressure ulcers.

There had been the highest number of cases of *c.difficile* reported in month since March 2012. As a result the Trust was looking at whether there had been lapses in care or other issues relating to care. It was agreed that 'target' was not the correct word and that this should be 'ceiling'.

Alan Rose referred to pressure ulcers and noted that despite all the actions that had been put in place the Trust did not seem to be making the headway that it would like to. Rowan Procter explained that there were a number of factors that had an impact on avoiding pressure ulcers, eg nutrition and hydration. To ensure an appropriate care plan was put in place there was an assurance process, and a risk assessment was undertaken for every patient within the first 24 hours of being admitted

Steve Turpie said that the board had received a number of reports on pressure ulcers and asked why performance was not improving, ie if patients were more challenging or if staff were missing something. Rowan Procter explained that the number of avoidable pressure ulcers was very low, compared to the total number of pressure ulcers, and that patients had a right not to be moved.

Nick Jenkins reported that staff on F5 were very upset about the fact that one of their patients had developed a pressure ulcer and had given him full details of how this had occurred. They had also been heard discussing this in Time Out, which showed how

much they cared and he did not consider there was any complacency about pressure ulcers. Steve Turpie asked him if ward managers on all the other wards would be able to provide the same level of detail for each pressure ulcer that occurred. Nick Jenkins said that he did not think that there was a nurse in the hospital who did not take a pride in avoiding pressure ulcers.

Gary Norgate asked for assurance that a situation was not developing where there were some areas that were excellent and some areas that were not so good. Rowan Procter said that she would provide more detail on avoidable and unavoidable pressure ulcers. Craig Black agreed that this would be beneficial and said that assessment as to whether a pressure ulcer was avoidable or unavoidable needed to be speeded up. **R Procter**

Gary Norgate suggested that there was also a need to look at how this was being monitored in the community. Rowan Procter agreed that this also needed to be looked at in the community and said that pressure ulcers were very unpleasant whether avoidable by WSFT or not.

Gary Norgate noted the deterioration in performance in urinary catheter insertion from 100% in September to 78% in October. He asked for assurance that there was not a problem or issue with catheter insertion. Rowan Procter explained that she was not sure what the issue was and therefore targeted work in this area was being undertaken with staff.

Richard Davies referred to this work and noted that there was no ward level data on this in the new report, whereas the old pack had highlighted areas where there was an issue, eg G4. Rowan Procter said that there was not a problem with G4. Richard Davies asked for ward level data to be produced with quality indicators. The Chairman agreed that there should be ward level data within this report. **R Procter / C Black**

Alan Rose noted that there was not a lot of community data in this new report. Dawn Godbold explained that separate data was provided at the back of this report but an integrated report was also being developed. **D Godbold / C Black**

The Chairman referred to RTT and asked for more detail, ie how many patients were affected and whether this was due to patient choice. He also requested more evidence to why the trajectory was not being met. Helen Beck explained that ENT and dermatology were the key drivers. There had been an improvement of approximately 50 patients in dermatology and ENT was also improving. The position at the end of November would be approximately 87% and she was expecting more detailed reporting on this from Cerner by the next board meeting.

Angus Eaton asked for assurance that the plan to address 52 week waits would get this back on track. Helen Beck confirmed that this was being delivered to plan, however there were four patients who had elected not to come in before the end of December which meant that they were showing in January's figures. Apart from this she was expecting zero breaches. Clinical harm reviews had been undertaken on all 52 week breaches apart from ENT which would be undertaken. Of these reviews, two patients had been identified for further consideration and a more detailed review was undertaken but no harm was identified. Harm had been considered in its broader sense and there was no evidence of this.

Neville Hounsome noted that this had only improved by 1% per month for the last five months and asked if anything else could be done to improve on this for the next board meeting. It was proposed that there should be a separate report to include a revised recovery trajectory and details of 52 week breaches. **H Beck**

The Chief Executive stressed that everyone was very focussed on this and ENT had improved from 40 weeks to 6-7 weeks.

The Chairman noted the improvement on completion of the maternity WHO checklist and asked for the Board's thanks to be fed back to the team.

Nick Jenkins referred to the grade 1 Caesarean section that had not met the time frame. 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 an anaesthetic, ie not hitting the target at the expense of patient care.

Catherine Waller asked for assurance about the use of cameras in the hospital. It was confirmed that there was a policy relating to this which was strictly adhered to.

17/241 FINANCE AND WORKFORCE REPORT

Craig Black reported that the Trust remained on target to achieve the control total. Performance was currently £114k behind plan year to date and a significant part of the contingency had still been retained.

The risks around receiving sustainability and transformation funding (STF) were currently being clinically assessed. Each quarter 30% of this funding was contingent on achieving the A&E performance target. Currently, for quarter 3, A&E performance was below the 90% target that the Trust needed to exceed. This meant that £450k was at risk which would have consequences in terms of financial and cash performance. A&E performance would need to be at 92-93% for the remainder of the quarter in order to achieve this.

Expenditure on agency medical and nursing staff remained significantly below the targets set by NHSI.

A recent review of schemes showed that WSFT was set to underspend its capital programme significantly. Therefore leases were being reviewed to see if there was any opportunity to capitalise some of these so that there was not an under spend. More detail on this would come back in the next finance report.

The cash position was currently reasonably good and the Trust had not had to draw down the loan in October. However, cash remained a concern for the short and medium term and would continue to do so; this was monitored on a daily basis.

Alan Rose asked if, following the budget, WSFT was actively bidding to try and get additional money for this year or next year. Craig Black explained that £335m had been announced for this winter and that NHSI had indicated that there would be a bidding process to allocate this funding, which was very disappointing. A fair share of the funding would be £1.25m, however WSFT would be bidding for substantially more of this.

It had also been announced in the budget there would be a significant amount of capital, ie £2.6b for this year and next year. WSFT had already bid for £15m for the emergency department and was hoping to have received an indication in the budget that it had been successful. However, 12 schemes had been awarded funding with first call on this money, ie 10% of the funding and WSFT was not one of these schemes.

An additional £1.6b had been announced for next year, which was substantially less than the current overspend in the acute sector and would therefore not address the financial issues or true scale of the problem.

Craig Black said that this would be approximately 2% of planned turnover, but would not help get into the surplus required.

Gary Norgate asked about the impact of A&E performance on funding and the bid for additional money. He asked if WSFT was still forecasting to hit its target regardless of this funding and the Trust's performance. Craig Black explained that at the last meeting it was agreed to commit the contingency to funding escalation for winter, which meant that WSFT would now be bidding for money to cover winter plans.

WSFT had been instructed to continue to forecast that it would receive NHS funding until it was known that it would not achieve its plan, which meant it would not receive STF funding. This would then have an adverse effect on the forecast, ie if it did not hit the A&E target for the quarter it would not receive £450k, therefore would be £450k behind forecast.

Gary Norgate referred to the CIP of £18.3m (8%) next year which would be a real challenge. He asked what the run rate would need to be for next year and what indicators the board would receive to provide assurance that the Trust was on target. Craig Black explained that CIPs were continually being identified and implemented and the impact of these was continually looked at. Some of these schemes would not take effect until September next year. Gary Norgate proposed a calendarisation of the £18.3m and it was agreed that Craig Black would send a proposal to him, including the run rate required. **C Black**

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/242 NURSE STAFFING REPORT

The Chairman considered that this report would be more meaningful if there was ward data.

Alan Rose asked if the nursing sensitivity indicators in the quality and workforce dashboard were Rowan Procter's key metrics for providing assurance. She confirmed that this was the case and that the purpose of these was to show the impact that sickness, agency use etc could have on a ward, ie medication errors linked to short staffing etc. There had been a concern on F1 about the number of medication errors which, when followed up, was traced to one individual who was stopped from giving medication and had subsequently resigned.

Neville Hounsome commented on the improved metrics at Glastonbury Court.

Catherine Waller referred to the transparency of overtime and asked how this was being used. Rowan Procter explained that as part of the health roster system the use of agency, bank and overtime could be looked at, and currently the use of overtime was being looked at. Catherine Waller asked if there would be more detail on the use of overtime in this report. Rowan Procter said that she would send her the information from health roster. **R Procter**

Gary Norgate noted that 19 areas were over the Trust's standard for sickness. Rowan Procter confirmed that all sickness was looked at as to whether it was related to stress etc. This was locally driven and supported by HR.
Jan Bloomfield explained that there was a process for this, particularly around stress related illness. She confirmed that WSFT's sickness absence rate was well below the national average.

Angus Eaton asked what the trend was for the health and wellbeing of staff. Jan Bloomfield explained that a piece of work was being undertaken on how to evaluate the health and wellbeing programme. There was also a drive to improve the recording of 1-3 day sickness.

Nick Jenkins reported that the Trust was currently surveying all consultant staff about burnout, as nationally there was a concern about burnout of consultant staff. The Chairman asked if these two reports could come back to the board. The timescale for this would be provided at the next board meeting. **J Bloomfield**

Angus Eaton said that, from his experience, the figures would increase as this was looked at in more detail.

17/243 LEARNING FROM DEATHS

The Chairman asked Nick Jenkins to thank Helena Jopling for this report, which he considered to be very good. He asked about recruitment of reviewers.

Nick Jenkins explained that more medical reviewers had been recruited this week but this process still needed to be completed. He highlighted actions on page 1, which answered all the questions from the previous board meeting. This report now included a cumulative graph which aimed to show more detail about >50% preventability over a year.

WSFT had been asked to present its experience as a case study for other trusts to learn from and also to lead a review on mortality and data processes.

Alan Rose asked if there was data available to benchmark at a specific level, eg orthopaedics. The Chairman explained that de facto information went to the Clinical Safety & Effectiveness committee (CSEC), which was too detailed to come to the board.

Nick Jenkins stressed that there was no plan to benchmark against other organisations and the secretary of state had stated that there would be no league table; however he felt that this might appear as a news story.

17/244 SAFE GUARDING CHILDREN LEVEL 3 TRAINING

Jan Bloomfield explained that this report set out the recovery plan for safeguarding training based on the number that it was expected to achieve in December, ie a trajectory of 91%. Action taken on non-compliance would result in individuals being risk assessed and if necessary asked to withdraw from practice until this was completed.

17/245 APPRAISAL REPORT

Jan Bloomfield explained that this report set out exactly what was being done about appraisals. In January she should be able to say whether this was a reporting issue rather than a completion issue, and she considered that this was more likely to be about reporting than completion.

The executive team were assisting in assuring that this was achieved and the Chief Executive confirmed that it had been made clear that mandatory training and appraisals required leadership focus. Jan Bloomfield agreed and said that appraisals were a key part of investing in and evaluating individuals.

Steve Turpie considered this to be a very good report and noted that this had been a cultural problem for years. He suggested that there might be a slightly different approach to non-compliance, ie of managers if they had not undertaken appraisals for their staff. Jan Bloomfield explained that there was a good triggering system but this would need to be looked at carefully as to whether this was a disciplinary issue. She proposed that completion of appraisals for all their staff could be part of a manager's appraisal.

The Chairman reported that the partner governor from Cambridge University Hospital Trust (CUHT) had said that Addenbrooke's were very active in ensuring completion of appraisals for all staff.

Gary Norgate cautioned against becoming too focussed on compliance versus quality of appraisals. Jan Bloomfield agreed and said that she had received positive feedback about the revised paperwork for appraisals.

Angus Eaton asked what the answer would be if all staff were asked if they knew what their manager thought about their performance. Jan Bloomfield agreed that this was a valid point but with staffing pressures it became urgent versus important.

The Chairman proposed asking questions relating to appraisals during quality walkabouts on Tuesday mornings, ie raise the profile. Rowan Procter said that the new audit tool should help with this. She also said that using team appraisals was very helpful and HR was supporting managers in taking this approach.

J Bloomfield

It was requested that updated report be provided on appraisals, including assessment of the quality of the process and how to include questions as part of quality walkabouts.

17/246 HELPFORCE INITIATIVE

Jan Bloomfield explained that there had been a very successful visit from Sir Tom Hughes-Hallet and he would be visiting the Trust again. He was very impressed by the bleep volunteers and wanted to do a case study, as there was nowhere else in the NHS with this role

Alan Rose considered this to be a very good communications opportunity and that this should be highlighted.

Rowan Procter explained there were now fully trained End of Life volunteers to sit with patients who did not have local relatives.

The new Voluntary Services Manager had started on 1 November. The Chairman suggested that the new manager should be asked to come to a board meeting and report on the activities of the volunteers etc, eg quality presentation.

17/247 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that Moya Roberts and the F10 team; Steve Shrimpton, a radiology appointment facilitator and Clare Dion Carr and Gabriella Palliser-Ames of the PALS team had received a Putting You First awards this month.

Moya Roberts and the F10 team had been nominated for going above and beyond to ensure that one of their dying patients received the award he deserved for his service to St. John Ambulance. Their action was recognised by the Divisional President of St John Ambulance but more importantly had put patient experience above all.

Steve Shrimpton was nominated following feedback on a Radiology comment form which read 'After phoning to enquire about a CT scan appointment there was a knock on my door about 6pm. A man called Steve from the CT Scanning department was there. He said that my phone was out of order, so had bought my results. How brilliant was that'.

Clare Dion Carr and Gabriella Palliser-Ames were nominated for their continued hard work in developing the Patient Advice & Liaison Service in order to provide information, advice and support in their time of need to over 150 patients and relatives every month.

The son of a patient who was nearing the end of life and sadly died, said 'I can't begin to tell you how important this [support from PALS] is to us and how important it has been for me to have had a point of contact in the darkness, who takes my calls and responds quickly to emails'.

The board congratulated the above on their dedication and commitment to ensuring that patients and relatives received the best experience possible from WSFT.

BUILD A JOINED UP FUTURE

17/248 e-CARE REPORT

Steve Turpie considered this to be a very good report, particularly section 7 which was a good description of what e-Care meant. He suggested that this should be expanded and developed to help with a general understanding of what it would mean as e-Care developed.

The Chief Executive agreed that this was a very important communication about where the organisation was going with e-Care and what it would mean for patients in the future. He proposed that this should be put out in various forms of communication. **J Bloomfield**

He said that it should be recognised that the recent go-live was an exemplar of how to implement a paediatric go-live from Cerner's point of view.

Richard Davies agreed that this was an excellent report, but expressed caution about 7.2, ('Imagine if ……we could prevent citizens from, becoming unwell and needing hospital care), and not getting carried away with the idea of using technology for the sake of technology. This needed to be evaluated and evidenced. Nick Jenkins agreed and explained that a clinical and operational IT balance was designed to ensure that this did not happen.

17/249 ALLIANCE AND COMMUNITY SERVICES UPDATE

a) <u>Delivery and integration update</u>

The Chairman considered that good progress was being made. Alan Rose said that the examples of projects on page 2 were very helpful and highlighted changes that had occurred to show the benefits and effect that integration was having.

The board agreed that these were great steps forward.

The Chairman referred to page 6, item 7, and said that this needed to be thought about carefully and a thorough evaluation undertaken, whatever the outcomes, ie Buurtzorg model analysis.

b) System governance report

It was explained that the board were asked to approve the principles set out in Annex A. This proposed a change to the structure of the Council of Governors, which had been approved by the governors. It was noted that these would be representatives from primary care, not necessarily GPs.

Alan Rose asked what posts had been dropped in order to accommodate these. The Chairman explained that there had previously been issues with representatives from the voluntary sector as they could only represent the group that they were part of and they had not always attended meetings on a regular basis. It was explained that the voluntary sector would be part of the Alliance. Jan Bloomfield said that the Trust also engaged with the voluntary sector through the Patient & Carers group. The Chief Executive noted that there were two staff governors from the community and two who were medical.

The board approved the proposed constitutional change to establish two primary care representatives on the Council of Governors as partner governors. A revised constitution would be submitted to the NHSI. **R Jones**

Angus Eaton referred to annex A, 3.1 and considered that this did not highlight patient care and patient safety sufficiently. The Chief Executive explained that this would be going to the system executive group for further discussion, but stressed that it did not replace WSFT's own strategy. **R Jones**

17/250 PATHOLOGY SERVICES

This had been discussed earlier in the meeting, under agenda item 7, Chief Executive's Report (minute 17/239). Nick Jenkins explained that the recommendation on the summary sheet gave three options for scrutiny in order to ensure that NEESPS delivered and executed its plan.

Gary Norgate noted that the board had not yet received documented details of the plan and timescales. Nick Jenkins agreed that this was not good enough and he had said fed this back.

Catherine Waller asked about the blood transfusion inspection and how confident WSFT was that this would be compliant. Nick Jenkins explained that MHRA would be visiting the laboratory again in January and the team were more confident about this though a number of issues remained.

17/251 FINANCIAL IMPROVEMENT PROGRAMME

Craig Black explained that the board had received a presentation from KPMG prior to their starting work on phase three of the programme. This was now approaching completion and the purpose of this report was to provide a briefing on the outcome of this work. He introduced Jason Parker and Ben Garside from KPMG.

Gary Norgate noted that this report started to highlight the tough actions that would have to be taken and asked what assurance there was that these actions would achieve a result. Craig Black said that there was now a methodology, the results of which had been seen in theatres and flow. This would be equally applied to admin and clerical, which meant that there was the best chance of success compared to previously, however there was no guarantee.

KPMG said that the Trust had a strong track record of delivering CIPs and WSFT's adjusted cost of treating patients was below the national average. It was strong on productivity and efficiency but there was still a significant financial challenge.

The 2018/19 control total was very challenging and continuous performance improvement would be key. The Trust was in a good position for 2017/18 and had made substantial inroads into identifying CIPs for 2018/19.

Ben Garside reported that compared to other organisations WSFT had been able to identify significantly higher savings for 2017/18, and for 2018/19 it was in a league of its own. He thanked the Chief Executive and the team for their engagement.

Work around operating theatres over the last ten weeks had shown a week on week improvement in the number of patients treated. This meant that the Trust would be treating 2000 more patients per year within its core resources.

Work on patient flow over the last twelve weeks had resulted in an overall reduction in delayed transfers of care (DTOC) due to work undertaken with clinicians on Red2Green, board rounds etc. Again, this had resulted in an improvement to patient experience and quality of care.

With regard to nursing, the level of control across the organisation was very good and work had been undertaken to transform the way care was delivered. Again, this improved patient experience and also provided financial benefits.

KPMG had now handed over this work to the Trust's project management office (PMO).

Steve Turpie referred to 2018/19 and noted that £4m had been identified of the £18m savings required. He said that although WSFT was well ahead of other organisations in this respect it was still not in a good position. It was explained that this figure was risk adjusted. He asked if £18.3m of savings was achievable, considering only 25% had been identified. It was explained that the full value of the schemes identified was £12m; this had been risk assessed down to £4m. Craig Black said that he did not consider £18.3m to be achievable.

Ben Garside explained that there was just under £10m of adjusted schemes that could be delivered, however there was still a large gap.

Angus Eaton asked about transfer of skills and if middle management was well led and capable of identifying schemes. Ben Garside said that the majority were confident of working to ensure that processes and governance were in place so that schemes could be developed and moved forward. Over the past twelve weeks eleven workshops had been held across the organisation. These had been supported by KPMG, but facilitated by middle management working with their teams who had identified 130 ideas to help improve productivity. This has had been an outstanding achievement for the organisation and the PMO would now be able to continue with this work.

A readiness assessment exercise had come out as green/amber. Jan Bloomfield explained that part of this readiness assessment had been built into the leadership programme.

Helen Beck said that it was very important that KPMG was leaving tools behind to assist in moving forward.

Gary Norgate suggested that £18.3m was not achievable and a decision needed to be made as to how to determine a figure which would become the target.

The Chairman asked Jason Parker what he considered this figure should be. Jason Parker said that anything over 5%, ie £11.5m would be challenging.

Nick Jenkins asked if there was a point at which the CIP target went above a certain percentage where it would have an impact on the quality of care. Jason Parker noted that Lord Carter had said that anything above 4% would be very difficult to achieve, but there was not a specific figure as to when it became unsafe. It was stressed that all CIPs were quality impact assessed.

Angus Eaton asked how the board should oversee the CIP programme. Jason Parker said that the monitoring that was currently in place within the organisation, ie monthly performance meetings, could consider additional scrutiny and that NED involvement could be positive. He said that the governance that was now being undertaken was adequate, but if the Trust moved away from this it would need to be looked at in greater detail.

Rowan Procter explained the process that had been set up for monitoring CIPs within nursing.

The Chairman thanked Jason Parker, Ben Garside and Maurizio Privitelli for all their work and asked them to pass on his thanks to the team. He said that this had been the most positive and productive relationship with a team of consultants during his term as Chair.

GOVERNANCE

17/252 TRUST EXECUTIVE GROUP REPORT

Angus Eaton referred to recent reports in the media and asked about the new red risk regarding radiology staffing capacity. Nick Jenkins explained that he had discussed this with the clinical lead for radiology. WSFT had been asked for assurance some time ago and had already submitted the information requested. He assured the board that chest x-rays were not being left unreported and that this was being done in a timely fashion, ie riskiest first. However, this was not always as timely as he would like due to a lack of radiologists.

17/253 AUDIT COMMITTEE REPORT

The board approved the extended internal audit contract with RSM for one year.

It also approved delegated authority for the Audit committee to sign off the charitable funds accounts.

17/254 SENIOR INDEPENDENT DIRECTOR

The Chairman explained that it had originally been considered that a Senior Independent Director was required who was used to and worked well with governors. However, following the appointment of Sheila Childerhouse it was now felt that someone with recent commercial experience would be more appropriate.
Therefore it was proposed that Gary Norgate would be the ideal person for this role and to work with the new Chair. This had been discussed with the Council of Governors who had approved this proposal.

The Chairman thanked Alan Rose for his time and work as Senior Independent Director, particularly in working with governors.

Jan Bloomfield noted this role also included working with the Freedom to Speak Up Guardian.

The board approved the proposal that Gary Norgate should take on the role of Senior Independent Director.

17/255 USE OF TRUST SEAL

The board noted the use of the Trust seal.

17/256 CANCER OPERATIONAL POLICY

Helen Beck explained that it was a requirement that the board signed this off.

The Chairman said that the feedback he got from cancer patients was not necessarily about the treatment, but about the uncertainty. He requested that this should be an objective.

Nick Jenkins explained that there would be a patient story about this at the next meeting, when this would be discussed further. **N Jenkins / R Jones**

17/257 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were approved.

ITEMS FOR INFORMATION

17/231 ANY OTHER BUSINESS

The Chairman thanked Neville Hounsome for all his work as a Non-Executive Director, including with the Council of Governors and other work he had undertaken. He wished him all the best in his future ventures.

Neville Hounsome thanked the Chairman and said that it had been a privilege to be a Non-Executive Director for WSFT. He wished everyone success in the future and considered that WSFT was very well run and governed.

17/259 DATE OF NEXT MEETING

The next meeting would take place on Friday 26 January 2018 at 9.15am in the Northgate Room.

RESOLUTION TO MOVE TO CLOSED SESSION

17/260 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 – 26 January 2018

Agenda item:	Item 6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 January 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
1466	Open	29/9/17	Item 6	Provide clarity on future provision of stroke service as part of STP service model	Part STP acute service discussions	NJ	26/01/2018	Green
1475	Open	29/9/17	Item 13	Develop a set of metrics which will provide an indication of the success of the leadership programme	Denise Pora, Deputy Director of Workforce (Organisation Development) has had discussions about possible metrics to measure the outcome of investment in leadership development with Lani Jaques-Hoare at AVIVA and looking to learn from experience at BT. Current thinking is to base our metrics where possible on existing KPIs and we are exploring how meaningful links can be made between these and leadership development activity.	JB	26/01/2018	Green
1488	Open	3/11/17	Item 7	Schedule a Buurtzorg presentation for Board	Team scheduled to present at the Q&RC on 26 January.	RP	26/01/2017	Green
1496	Open	3/11/17	Item 16	Provide a report from the new voluntary service manager. To provide Board visibility and oversight of the service offered and future plans	New voluntary services manager (Ian McKee) commenced on the 1 November. He is scheduled to provide a report to the Board on 2 March 2018.	JB	02/03/2017	Green
1508	Open	1/12/17	Item 6	Schedule report on private physiotherapy to the January Board meeting	**Details included in finance report and service review report scheduled for Scrutiny Committee in February.**	HB	02/03/2018	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1512	Open	1/12/17	Item 8	Develop the IQPR to include community data	Reviewing with Joanna Rayner, new Head of Performance	DG/CB	02/03/2018	Green
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.	**Verbal update on the position and report scheduled for next meeting to allow for impact of winter cancellations to be factored into the trajectory.**	HB	2/3/18 (revised)	Amber
1515	Open	1/12/17	Item 9	Provide more detail information for Gary Norgate on the exit run rate required and 'calenderisation' for 2018-19 delivery.		CB	26/01/2018	Green
1521	Open	1/12/17	Item 18	Trigger discussion with NHSI on the level of control total for WSFT based on KPMG findings and Carter recommendations	Discussions have taken place with the regional finance lead for NHSI. Feedback will be provided from the Performance Management Review meeting with NHSI scheduled for 23 Jan	CB	26/01/2018	Green
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

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1491	Open	3/11/17	Item 8	Provide a clear analysis of the RTT 'pot size' with updated improvement trajectory	Work is ongoing with Cerner to understand and address patients tracking list (PTL) reporting. **Incorporated into action point 1513.**	HB	26/01/2018	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
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 Phillipines 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 pipeline). In addition we are introducing where possible more flexible working in order to retain and attract nurses back to the Trust.	JB	26/01/2018	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1497	Open	3/11/17	Item 21	Set out a plan for how we are managing the acute/community integration process with key milestones for delivery/success. The plan will need to include opportunities which evolve to develop shared working.	Also consider financial and service opportunities associated with community services vertical integration and incorporate these in to the rolling programme for CIPs. 1/12/17 update - cover synergy opportunity through acute/community integration setting out outcomes and how will measure success examples of service changes within DG's community paper (page 2) **AGENDA ITEM**	DG	26/01/2018	Complete
1509	Open	1/12/17	Item 7	Provide further evidence of the safety procedures in place within pathology - sample of KPIs such as turnaround test results	**AGENDA ITEM**	NJ	26/01/2018	Complete
1510	Open	1/12/17	Item 8	Review the presentation of the PU data, including the timing of avoidability data	Provide further evidence of the safety procedures in place within pathology - sample of KPIs such as turnaround test results	RP/CB	26/01/2018	Complete
1511	Open	1/12/17	Item 8	Include ward level data in the new IQPR (as previously reported)	Updated IQPR - includes ward level data	CB	26/01/2018	Complete
1514	Open	1/12/17	Item 9	Provide detail report on proposal to use capital programme to capitalise leases	**PART OF FINANCE REPORT**	CB	26/01/2018	Complete
1516	Open	1/12/17	Item 10	Incorporate overtime data into the ward staffing report	Updated report on agenda	RP	26/01/2018	Complete
1517	Open	1/12/17	Item 10	Provide an indication of the proposal and timescale for improved health and wellbeing reporting including sickness absence and consultant burn-out survey.	AGENDA ITEM	JB	26/01/2018	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1518	Open	1/12/17	Item 13	Provide update on appraisal performance and proposed management response to drive improvement. Include how assessing the quality of appraisal process. Structure also to be provided to include appraisal into the quality walkabout process.	AGENDA ITEM	JB	26/01/2018	Complete
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.	JB/HB	02/03/2018	Complete
1520	Open	1/12/17	Item 16	Implement agreed constitutional changes with primary care partners and submit revised constitution to NHSI. Also ensure that proposed system governance arrangements place quality at centre of strategy.	Constitution updated and submitted to NHSI.	RJ	26/01/2018	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1523	Open	1/12/17	Item 23	Nick Jenkins to provide a patient story to next Board in the context of the cancer policies - reflects the patient priority regarding communication and uncertainty at difficult time	AGENDA ITEM	RJ	26/01/2018	Complete

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 26 January 2018

Agenda item:	Item 7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	17 January 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 am delighted to welcome **Sheila Childerhouse** as our new chair. Sheila, has vast experience of both the public and voluntary sector having served on various local and regional health bodies since 1984 in non-executive and chair roles, most recently at the East of England Ambulance Service NHS Trust (EEAST) and Anglian Community Enterprise, Sheila brings a wealth of expertise to the position. I am confident that the Trust will benefit hugely from her extensive experience and expertise.

Since Christmas the Trust has seen **sustained winter pressure**, with high numbers of attendances and admissions of very sick patients. In response we opened our planned escalation beds but due to the significantly higher than expected numbers of admissions we have also had to open additional surge beds. 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.

Throughout this period our staff have once again gone above and beyond. I have to say that times are tough, and the pressure feels relentless at times, but I have been in every day since Christmas day and see our hospital and community staff pull together time and time again, and I thank them all for their professionalism and commitment.

In December we experienced over 6% more admissions to the hospital than the same period in 2016 - with emergency attendances hitting 230 on one day, compared to 178 for the same period the previous year. Over the last six months we have worked to reduce the number of 'stranded patients' (inpatients that have been in hospital for seven days or more). Through initiative such as 'red to green' we have exceed our target of 160 and regularly achieved numbers as low as 140. At this level the hospital is able to run, achieving good patient flow. In the last few weeks the number of stranded patients has risen as high as 208 and remains high. This reflects the high acuity of patients admitted to the hospital and some social care delays following the Christmas and New Year bank holiday period. Our partners in social care have worked hard to address this issue and have provided additional social worker capacity as well as purchasing additional care. As a result stranded patient numbers have dropped but remain above our target of 160.

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:

- Cancelling routine elective activity – we have continued to provide urgent elective surgery, including cancer treatment
- Using the area that we established as our discharge waiting area (DWA) to create 13 additional inpatient beds
- 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
- For a short period (48 hours) we admitted female surgical patients to our maternity beds, again we selected these patients carefully to minimise the risk to mothers and babies on the ward and we provided nursing support to work alongside our midwives
- Working sensitively with patients and families to support suitable placement in the community pending their destination of choice becoming available.

It is hugely disappointing that since the New Year we have had to cancel more than 88 patient admissions for planned operations. 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. Patients whose operations are cancelled will be rebooked as soon as possible but with limited capacity to provide the surgery this will impact on our activity and performance for some time.

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.

October's performance shows we reported no C. difficile cases in December. We continue to focus on reducing patient falls and pressure ulcers, with 69 falls and 13 pressure ulcers reported in December. Referral to treatment (RTT) performance for patients on an incomplete pathway is 89% against the target of 92%. Unfortunately we have reported 15 patients breaching 52 weeks. RTT remains the most significant performance challenge facing the Trust and we are working with KPMG and the Intensive Support Team to support performance improvement. Cancer performance improved during December, with all targets being achieved. The Trust achieved the 62-day wait for first treatment from NHS Cancer Screening Service referral target in December with performance of 100% against a target of 90%. The year to date performance for all cancer targets is ahead of the national threshold. ED performance deteriorated to 83% for December, with some exceptionally challenging days.

The **month 9 financial position** reports a deficit of £734k for December which is worse than plan by £889k.The reported cumulative position is therefore £1,079k worse than plan. There has been an increase in our costs relating to escalation capacity during December and since our use of escalation capacity has been significant in January this expenditure pattern is likely to continue 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 £9.7m has been achieved by the end of December (67%).

Further to the positive **Care Quality Commission's (CQC)** inspected end of life and outpatient services on 9 and 10 November, the CQC undertook a 'well led' inspective of the Trust from 30 November to 1 December 2017. This was part of their normal scheduled programme of inspections. It is expected that the inspection report will be published within the next week.

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. The formal report from the inspection is pending and while improvements were identified it is expected that the report will identify that further work is required to address staffing and validation of equipment.

Initial plans for the **main entrance refurbishment** have considered and we continue to obtain feedback from patients and visitors as well as those who deliver services within the area. The feedback will be used to inform the development which expected to be considered by the Board when it meets in March 2018. The proposal is to fully refurbish the main hospital entrance concourse with an extended café, new pharmacy outlet and a new toilet block built. The proposal sets out to provide a clean, crisp, modern entry point to the hospital.

Chief Executive blog
As the year came to a close, like many other I stopped and reflected on the last 12 months; and what a 12 months it's been for us here at West Suffolk NHS Foundation Trust (WSFT).

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

Deliver for today

As part of our winter planning, the Trust ran a '**perfect week'** exercise across West Suffolk Hospital from 2 – 9 January. This is because every year, after Christmas and New Year, the NHS experiences higher levels of patient demand. The week saw staff from both clinical and non-clinical areas pull together to focus on supporting patient flow throughout the hospital, in order to maintain high quality standards of care and positive patient experience.

Many administrative staff volunteered to be ward liaison officers, which saw them switch their usual role and instead work with staff directly on the wards. By the liaison officers taking on simple tasks such as serving meals to patients, assisting with bed making, collecting prescriptions from the pharmacy, and answering telephones, clinical staff were able to focus on patient care and the safe and timely discharge of patients as they moved through stages of care. Perfect week was just another example of the 'West Suffolk way', and I am proud and grateful for all our staff do for the Trust and our patients. Times are tough, and the pressure feels relentless at times, but I them pull together time and time again, and have expressed my unwavering thanks for their continued professionalism and commitment.

'Support to go home' team success - a care-bridging service we are hosting in partnership with Suffolk County Council is seeing patients get home more quickly and helping to save bed days in the hospital. Since its launch in September, the 'support to go home' service has so far helped 151 patients to get home more quickly, and saved 763 bed days in the hospital. The team aims to make sure patients can still be discharged home if there's a delayed start date for their out-of-hospital package of care. Care is provided seven days a week, in a patient's home by a WSFT team, which support patients with washing, dressing, medication prompts and meal preparation. We're really seeing a positive impact as a result of this service, and our team of reablement support workers are doing a fantastic job enhancing the recovery of patients in their own home. The service is one of many initiatives supporting our patient flow focus for winter and beyond.

The **National Emergency Pressures Panel** (NEPP) met at the start of the month, chaired by Professor Sir Bruce Keogh, to discuss the pressure NHS trusts have been facing. The panel noted that the NHS has been under sustained pressure over the Christmas period with high levels of respiratory illness, bed occupancy levels giving limited capacity to deal with demand surges, early indications of increasing flu prevalence and some reports suggesting a rise in the severity of illness among patients arriving at A&Es. Amongst other recommendations, the panel took the step to urge health trusts to delay non-urgent operations until at least the end of the month. Officials said up to 55,000 operations could be deferred.

Invest in quality, staff and clinical leadership

We're delighted to be 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. HelpForce is starting with a focus on critical moments in hospitals where staff and patients would benefit from additional support, for example at meal times or discharge from hospital. It is also prioritising volunteer help for patients who do not have their own family or wider support network.
We are so proud to have more than 400 volunteers who dedicate their tireless energy to helping both our patients and our staff have the best experience they can, and hope our collaboration with HelpForce will allow us to implement new innovations and integrate our volunteers even further.

We're very proud to have received the prestigious, internationally recognised **Baby Friendly Award** – an accreditation set up by Unicef and the World Health Organisation. The Baby Friendly Initiative is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. In the United Kingdom the initiative works with public services to protect, promote, and support breastfeeding, and to strengthen mother-baby

and family relationships. Achieving full accreditation involved a series of three stage assessment visits to ensure that recognised best practice standards were in place. The assessment report said: 'Mothers reported that the whole atmosphere at West Suffolk was calm and friendly. The team were very welcoming and all mothers reported that staff were kind and considerate, and that they were very happy with their care. The team achieved exceptional scores in this area.'
We're delighted that our maternity teams have been recognised in this way.

Specialist nurses in the integrated community paediatric service (ICPS) are working with colleagues to ensure that the **voice of the child** is heard and recorded. Jo Hutchings, named nurse for safeguarding children in community services, and Teresa Mann, specialist nurse for children in care, are training all their ICPS colleagues on ways to capture the voice of the child in records. Since the training started the team has seen real results in the reports prepared by staff, who are thinking outside the box to hear and capture the thoughts of the children they see. More than 140 staff have already done the training, with Jo and Teresa being asked for more dates.

European Union citizens who have made their lives in the UK have made a huge contribution to our country, and to our NHS, and we want them to stay. The UK government has now reached an agreement with the EU to safeguard citizens' rights. The agreement will provide EU citizens and their family members living in the UK certainty about their rights after we leave the EU and most importantly, allow them to stay here.

No EU citizen currently living here lawfully will have to leave the UK when we leave the EU. There will be plenty of time for people to apply for, and receive, their new residence status after the UK leaves the EU. EU citizens who arrive by 29 March, 2019, and have lived in the UK for five years will be able to apply to stay indefinitely by getting 'settled status'. People who won't have been here for five years when we leave, but arrive here by 29 March, 2019, will be able to apply for permission to stay on until they reach the five-year threshold. They can then also apply for settled status.

Following consultation, a revised version of the **never events policy and framework** and updated never events list have been published. This list now includes two additional types of never event. These aim to provide clarity for staff providing services who may be involved in identifying, investigating or managing never events and ensuring there is a focus on learning and improvement.

Health Education England (HEE) has published a draft **health and care workforce strategy for England to 2027** - facing the facts, shaping the future. The draft workforce strategy sets out the national strategy for recruiting, training and supporting the largest workforce in the country. It is currently out for consultation, with the publication date of July 2018. The document is deliberately broad in its inclusiveness, covering all staff groups, including the adult social care workforce. It tells the story of the last 5 years, lays out where we are now and looks forward, using both the Five Year Forward View frame and a more aspirational 10 year timescale. The Trust will be discussing and responding to the draft strategy initially through the Clinical Workforce Strategy Group, all comments received will be collated and feedback to HEE by the 23rd March 2018.

Build a joined-up future

New cardiac build underway

The first piece of ground has been broken in preparation for the build of our new £5.2 million state-of-the-art cardiac catheterisation and pacing suite. We're hugely excited about this clinical build, which is set to transform and improve the scope and quality of care that our cardiology patients will receive. The new cardiac suite will mean quicker access to investigations and treatments and will enable angiography and pacemakers to be fitted on site, significantly reducing length of stay for patients, and improving patient experience.

Our My WiSH Charity is also doing its bit to support the suite and help create a fully-integrated cardiac centre; the latest appeal, Every Heart Matters, is looking to raise an extra £500,000 to move cardiac diagnostic functions from the first floor of the hospital onto the ground floor with the new suite. It has currently raised more than £125,000 towards the project.

New sterile services department opens
Our new purpose-built premises to bring the cleaning and sterilising of medical equipment on site at West Suffolk Hospital has been officially opened. The new sterile services department is now fully operational after moving from the Hospital Road site, where it has been based since 1971, to the new purpose-built premises. Sterile services plays a vital role in cleaning and sterilising medical and surgical equipment. It processes an average of 96,000 sets of equipment each year, serving West Suffolk Hospital's wards, clinics and operating theatres, Newmarket Community Hospital and local GPs. With staff no longer influenced by delivery times and couriers, the service is much more efficient and can react to the demands of the busy hospital and external services.

National news

Deliver for today

Out in the cold – Lung disease, the hidden driver of NHS winter pressure
Analysis by the British Lung Foundation of the role that lung disease plays in exacerbating winter pressures due to seasonal flare ups of lung disease, and a discussion of how this could be alleviated next winter.

NHS to consider routine use of 'drunk tanks' to ease pressure on A&Es
An estimated 12–15% of attendances at emergency departments in the UK are due to acute alcohol intoxication. This peaks on Friday and Saturday evenings, particularly over the festive period, when as many as 70% of attendances can be alcohol related. NHS England Chief Executive Simon Stevens has announced that the NHS will decide this year whether "drunk tanks" should routinely be used take pressure off hard-pressed A&E departments and 999 ambulance services during the seasonal holiday period. Supervised areas where revellers who have over-indulged can be checked and even sleep it off if necessary, rather than being taken to casualty, are already used in some areas such as Newcastle, Bristol, Manchester and Cardiff.

Invest in quality, staff and clinical leadership

NHS England approves use of National Early Warning Score (NEWS)2 to improve detection of acutely ill patients
The Royal College of Physicians has updated its National Early Warning Score (NEWS), first produced in 2012. NEWS2 has now received formal endorsement from NHS England (NHSE) and NHS Improvement (NHSI) to become the early warning system for identifying acutely ill patients, including those with sepsis, in hospitals in England.

NHS becomes first healthcare system in the world to publish numbers of avoidable deaths
The publication of this data seeks to protect patients by showing how many deaths might have been caused by problems in care. It is an opportunity for trusts to share lessons and learn from failings.

Why Middle Managers Are the Key to Quality Improvement Success
Middle managers need more than clinical or service expertise to meet their organizations' key strategic and quality improvement objectives. (Institute for Healthcare Improvement)

Retaining your clinical staff: a practical improvement resource
This resource was developed in response to trusts' requests for examples of best practice around improving retention through interviews with trust HR directors, directors of nursing and medical directors.

Good work, wellbeing and changes in performance outcomes
This report found trusts that made the most extensive use of good people management practices were over three times more likely to have the lowest levels of staff sickness absence and at least four times more likely to have the most satisfied patients. They were also more than twice as likely to have staff with the highest levels of job satisfaction compared to NHS Trusts that made least use of these practices, and over three times more likely to have staff with the highest levels of engagement.

Build a joined-up future

Admissions of inequality: emergency hospital use for children and young people
This briefing looks at the relationship between deprivation and the use of emergency hospital care by children and young people in England. It aims to describe and highlight areas of inequality and to explore how they have changed over time. As well as looking at the overall patterns of emergency hospital use, the briefing focuses on three common conditions – asthma, diabetes and epilepsy – where more timely and effective primary, community or outpatient care could prevent admissions.

Framework for maximising the use of care homes and use of therapy-led units for patients medically fit for discharge
This best practice framework aims to address two models and the implementation approach that needs to be taken by sustainability and transformation partnerships (STPs) and their provider organisations with ensuing threats to patient safety, during the winter months.

Flow of patients between the NHS and social care - local performance metrics
A new dashboard which allows local areas to assess the flow of patients across the boundary between the NHS and social care. It provides a set of six measures indicating how health and social care partners in every Local Authority area in England are performing at the interface between health and social care. Included in the dashboard is a breakdown of delayed days attributable to social care per 100,000 of the population and the equivalent for NHS-attributable delays.

Making obesity everybody's business: a whole systems approach to obesity
This briefing, written in partnership with Public Health England and the Association of Directors of Public Health, focuses on the Whole-Systems Obesity programme which will provide local authorities with a different approach to tackling obesity that involves whole local systems. The programme is exploring current evidence and local practice to develop guidance and tools to help councils set up a whole-systems approach to obesity.

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Board of Directors – January (26th January) 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 David Matthews, Interim Head of Performance
DATE PREPARED:	January 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 nine: December 2017

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CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

1 EXECUTIVE SUMMARY

ARE WE SAFE?

HCAIs - The Trust has no MRSA cases for December 2017. There were no Clostridium difficile cases for December 2017 as well.

NHS Patient Safety Alerts (PSAs) – A total of 6 PSAs have been received in 2017/8, but none were reported in December. All the alerts have been implemented within timescale to date.

Patient Falls - 69 patient falls occurred in December, bringing the YTD total to 530; of these falls, 23(155 YTD), resulted in harm. (Recovery Action Plan (RAP) included in main report).

Pressure Ulcers- The number of acquired pressure ulcers continues to be above the local Trust plan of 5 per month. In December 13 cases occurred, with YTD total of 121. *(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 is above the 1% threshold, but unfortunately the data was not available in December as of yet. The YTD performance is below target at 1.09%.

Discharge Summaries- Performance to date is below the 95% target to issue discharge summaries within 48 hours. A&E has achieved a rate of 82% in December whereas Inpatient services have achieved a rate of 70.87%. *(RAP included in the main report).*

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

ARE WE CARING?

Complaints - The number of complaints has fallen compared to last year, with a total of 106 for the YTD to December. 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) – Only MSA breach has occurred in December, but against a national average of over 4 per month. *(RAP included in the main report).*

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

ARE WE RESPONSIVE?

A&E 4 hour wait - The Trust achieved the A&E target at Qtr. 1 with performance at 95% and achieved 91% for Qtr. 2. The December performance has fallen to 83% 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 performance at 100% for each month since April and performs ahead of the peer group average.

Cancer – Cancer performance (provisional figures) improved during December, with achieving all the targets. The Trust achieved the 62-day wait for first treatment from NHS Cancer Screening Service referral target in December with performance of 100% against a target of 90%. The YTD performance for all cancer targets is ahead of the national threshold. *(RAP included in the main report).*

Referral to Treatment (RTT) - The percentage of patients on an incomplete pathway within 18 weeks is well below the national target of 92%, with performance in December of 89%. Data quality issues and validation of the list continue. The total waiting list has reduced to 16,195 in December. In December, 15 patients breached the 52-week standard, with YTD total of 196. RTT remains the most significant performance challenge facing the trust and KPMG and the Intensive Support Team are working with the Trust support performance improvement. *(RAP included in the main report).*

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

ARE WE WELL LED?

Staff FFT – The survey for the period to December 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 December, below the Trusts aim to maintain turnover rates below 10%.

Sickness Absence – Sickness absence rates are equivalent to the local 3.5% ceiling at 3.52% for December. The Trust average is lower than the peer group average of 3.74% and the national average of 3.86%. *(RAP included in the main report).*

Agency Spend – Agency spend is below the local plan and agency ceiling, although this is £183k in the month of December, with average spend £284k for the YTD.

ARE WE PRODUCTIVE?

Financial Position – The reported I&E for December 2017 YTD is a deficit of £4,849k, against a planned deficit of £3,293k. This results in an adverse variance of £1,556 YTD. The December position also includes revised income and expenditure to reflect the new contractual arrangements for providing Community Services in Suffolk, effective from 1st October 2017.

This does not impact on our overall forecast deficit, but does reduce both income and expenditure in the remainder of 17-18. Community based staffing numbers are also affected.

Cost Improvement Programme (CIP) - The December position includes a target of £9,928k YTD which represents 69% of the 2017-18 plan. There is currently a shortfall of £218k YTD against this plan.

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

2. INTEGRATED QUALITY & PERFORMANCE REPORT DASHBOARD

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

WEST SUFFOLK HOSPITAL INTEGRATED QUALITY & PERFORMANCE REPORT									TRUST TOTAL												
Are we..	Ref.	KPI	ED	Target	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	AvYTD	WTC	Traffic	Sparkline
1. Safe	1.01	NHS E / I Improvement Patient Safety Alerts Total	RP	3	0	0	1	0	1	0	0	1	2	1	0	1	0	6			
	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%	12%	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	10%	11%	11%	6		
	1.04	All relevant inpatients undergoing VTE Risk assess	RP	95%	87%	87%	87%	86%	87%	89%	89%	86%	90%	88%	95%	97%	95%	90%	4		
	1.05	Clostridium difficile infections (CDI)	RP	16	2	0	0	1	3.00	0.00	0	1	0	2	6	4	0	16	6		
	1.06	MRSA	RP	0	0	0	0	0	0.00	0.00	0	0	0	2	0	0	0	2	6		
	1.07	Patient Safety Incidents Reported	RP	NT	449	460	459	463	392	508	418	506	466	467	521	592	471	4341			
	1.08	Never Events	NJ	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2		
2. Ef	2.01	Overall HSMR - DFI	NJ	<90	84%	ND	ND	ND	88%	88%	88%	88%	85%	87%	ND	ND	ND	87%	6		
	2.04	Canc. Ops - Cancellations for non-clinical reasons	NJ	<1%	1%	1%	0%	1%	1%	1%	1%	1%	1%	1%	1%	2%	ND	1%	4		
3. Caring	3.01	Compliments (Logged by Patient Experience)	JB		59	33	41	28	41	52	26	56	28	17	33	87	151	491			
	3.02	Complaints (Inpatient)	JB	19.50	17	18	12	11	10	10	10	6	16	16	17	13	8	106	6		
	3.03	Mixed Sex Accommodation Breaches	R	0.00	0	0	2	0	0	0	0	0	0	0	0	0	1	1	6		
	3.04	IP - Extremely likely or Likely to recommend	R	90%	95%	99%	98%	99%	98%	97%	99%	98%	98%	98%	99%	96%	98%	98%	6		
	3.05	OP - Extremely likely or Likely to recommend	R	90%	97%	97%	97%	96%	95%	96%	97%	95%	95%	96%	96%	96%	99%	96%	6		
	3.06	A&E - Extremely likely or Likely to recommend	R	90%	95%	95%	96%	96%	97%	96%	95%	95%	95%	92%	95%	94%	94%	95%	6		
	3.07	Maternity - How likely are you to recommend	R	85%	90%	91%	100%	100%	100%	100%	100%	100%	ND	ND	99%	100%	97%	99%	6		
4. Responsive	4.01	A&E - Under 4 hr. wait	HB	95%	86%	87%	84%	93%	95%	95%	96%	92%	90%	89%	87%	90%	83%	91%	4		
	4.02	RTT: % incomplete pathways within 18 weeks	HB	92%	92%	90%	90%	90%	82%	80%	83%	84%	86%	86%	87%	89%	89%	85%	2		
	4.03	52-week waiters	HB	0%	0	7	7	8	15	14	15	35	26	29	26	21	15	196	2		
	4.04	Diagnostics within 6 weeks	HB	99%	95%	96%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
	4.05	Cancer: 2w wait for urgent GP Referrals	HB	93%	98%	90%	98%	98%	94%	92%	97%	95%	96%	91%	83%	98%	97%	94%	4		
	4.06	Cancer 2w wait breast	HB	93%	93%	88%	96%	94%	94%	99%	89%	98%	100%	98%	100%	100%	99%	98%	6		
	4.07	Cancer 31 d First Treatment	HB	96%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	99%	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%	86%	85%	88%	83%	89%	83%	86%	85%	86%	87%	94%	89%	85%	87%	6		
	4.11	Cancer 62 d Screening	HB	90%	96%	100%	89%	97%	100%	100%	90%	100%	100%	91%	100%	83%	100%	96%	6		
5. Well Led	5.02	Staff F&F Test % Recommended - care (Qrtly)	JB	75%	94%	NA	NA	93%	NA	NA	95%	NA	NA	95%	NA	NA	ND	95%	6		
	5.03	Staff F&F Test % Rec'mend - place to work (Qrtly)	JB	75%	ND	NA	NA	79%	NA	NA	83%	NA	NA	82%	NA	NA	ND	83%	6		
	5.04	Turnover (Rolling 12 mths)	JB	<10%	10%	10%	11%	10%	10%	10%	10%	10%	10%	10%	9%	9%	9%	10%	6		
	5.05	Sickness Absence	JB	<3.5%	4.48%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.58%	4		
	5.06	Executive Team Turnover (Trust Management)	JB	<10%	0%	0%	0%	0%	0%	20%	0%	0%	0%	0%	0%	0%	0%	2%	6		
	5.07	Agency Spend	CB	19248	422	459	354	258	307	316	289	336	244	220	187	475	183	284	6		
	5.08	Monitor Assurance Governance Rating	JB	2	4	4	4	3	3	3	3	3	3	3	3	3	3	3			
6. Productive	6.01	I&E Margin	CB	Var	-4.93%	-5.13%	-5.10%	-1.50%	ND	-4.90%	-4.30%	-3.90%	0.13%	-3.04%	-2.55%	-2.47%	-2.60%	-2.95%			
	6.03	Capital service capacity	CB	Var	- 2.59	- 6.74	- 2.81	1.41	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.01	0.00	0.01			
	6.04	Liquidity (days)	CB		- 16.45	- 19.70	- 21.76	- 7.28	ND	- 12.15	- 15.72	- 10.94	- 11.03	- 12.70	- 15.14	- 0.10	ND	- 0.10			
	6.05	Long-Term Borrowing	CB		32.06	33.06	36.06	44.30	44.27	45.70	45.70	45.70	45.70	47.62	47.62	56.67	ND	56.67	6		
	6.06	Variance to CIP plan	CB		-2550	-3268	-3247	0	40	0	-40	10	0	-54	-10	-35	ND	-11.13			
7.Maternity	7.01	Total number of deliveries (births)	0	210	234	198	197	238	215	192	213	215	233	236	205	194	180	1883	6		
	7.02	% of all caesarean sections	0	<22.7%	19%	16%	13%	19%	15%	21%	16%	16%	22%	18%	17%	17%	18%	18%	6		
	7.03	Midwife to birth ratio	0	1.3	ND	1.28	1.28	1.33	1.30	1.27	1.29	1.30	1.33	1.33	1.29	1.28	1.26	1.29	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	1	96%	93%	87%	89%	84%	93%	84%	94%	82%	98%	98%	98%	93%	92%	4		
	7.06	Maternity SIs	0	NT	3	0	1	1	1	0	0	0	0	1	1	0	1	4			
	7.07	Maternity Never Events	0	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
	7.08	Breastfeeding Initiation Rates	0	0.8	80%	74%	80%	76%	80%	81%	88%	77%	85%	79%	81%	80%	80%	81%	6		
		Weightage			182	170	180	190	184	184	196	184	174	180	176	172	172	YTD	204	of	336

3. IN THIS MONTH – DECEMBER 2017, MONTH 9

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

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

In this month…. December 2017

Mth 9 We Received……	2017/18 December	2016/17 December	Variance	Var. %	Traffic
GP Referrals	5,480	5,600	-120	-2%	↓
Other Referrals	4,231	4,301	-70	-2%	↓
Ambulance Arrivals	1,997	1,768	229	13%	↑
(Included in referrals above:)					
Cancer Referrals	692	710	-18	-3%	↓
Urgent Referrals	2,121	2,210	-89	-4%	↓

YTD We Received……	2017/18 To December	2016/17 To December	Variance	Var. %	Traffic
GP Referrals	56,493	58,845	-2,352	-4%	↓
Other Referrals	45,715	47,196	-1,481	-3%	↓
Ambulance Arrivals	16,158	15,349	809	5%	↑
(Included in referrals above:)					
Cancer Referrals	8,369	8,889	-520	-6%	↓
Urgent Referrals	22,356	24,090	-1,734	-7%	↓

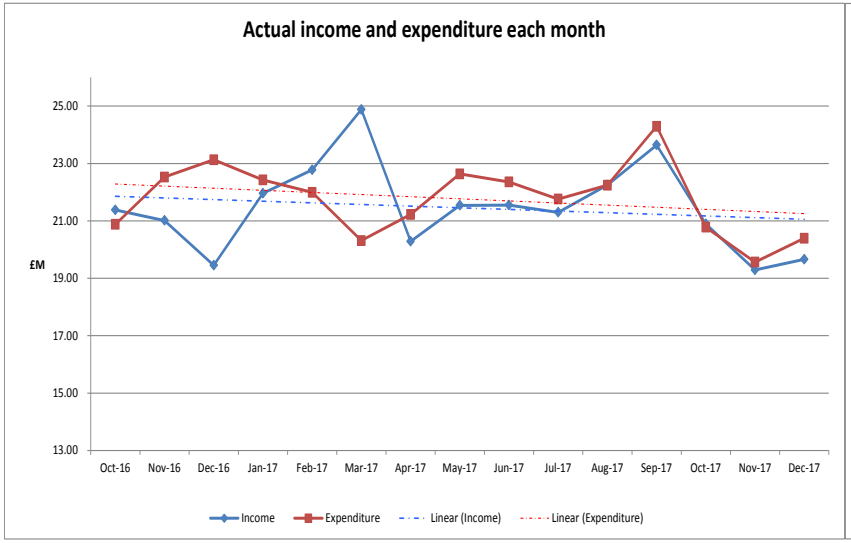
Mth 9 We Delivered……	2017/18 December	2016/17 December	Variance	Var. %	Traffic
A&E Attendances	5,455	5,510	-55	-1%	↓
Outpatient Attendances	21,160	22,742	-1,582	-7%	↓
Elective (incl Daycase)	2,542	2,553	-11	0%	↓
Nonelective Admissions	2,527	2,623	-96	-4%	↓
Inpatient Discharges	5,556	5,454	102	2%	↑
New Births	180	234	-54	-23%	↓
RTT Total Incompletes	16,195	17,663	-1,468	-8%	↓

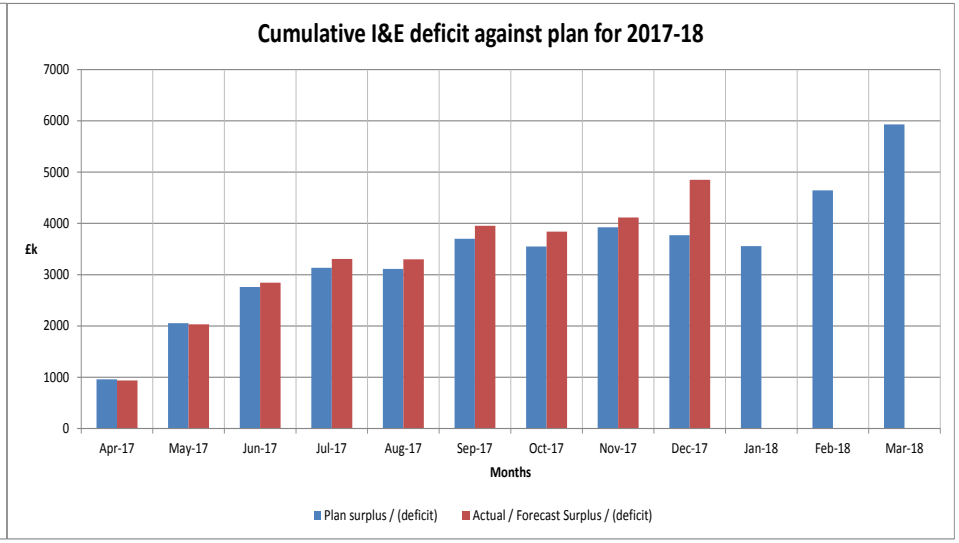
YTD We Delivered……	2017/18 To December	2016/17 To December	Variance	Var. %	Traffic
A&E Attendances	52,408	50,895	1,513	3%	↑
Outpatient Attendances	220,293	223,867	-3,574	-2%	↓
Elective (incl Daycase)	25,473	24,416	1,057	4%	↑
Nonelective Admissions	22,115	22,307	-192	-1%	↓
Inpatient Discharges	51,645	50,182	1,463	3%	↑
New Births	1,883	1,946	-63	-3%	↓

4. FINANCE SUMMARY

The reported I&E for December 2017 YTD is a deficit of £4,849k, against a planned deficit of £3,293k. This results in an adverse variance of £1,556 YTD. The monthly adverse variance is £889k which is after receiving winter pressure funding of £537k. This is due to unfunded cost pressures relating to:

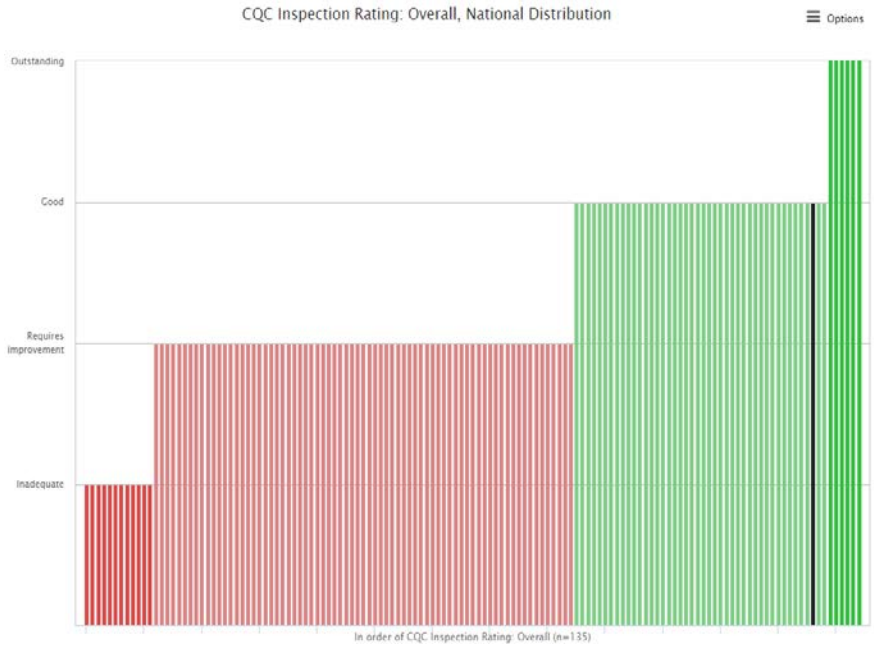
- Recognition of failure to meet A&E target and therefore drop in STF funding (£468k)
- Remaining KPMG invoices (£388k) which may be mitigated by further CIP schemes delivering savings during Q4
- Overspend on medical and surgical expenditure in December (£300k)
- Overspend on pay relating to escalation capacity (£250k)

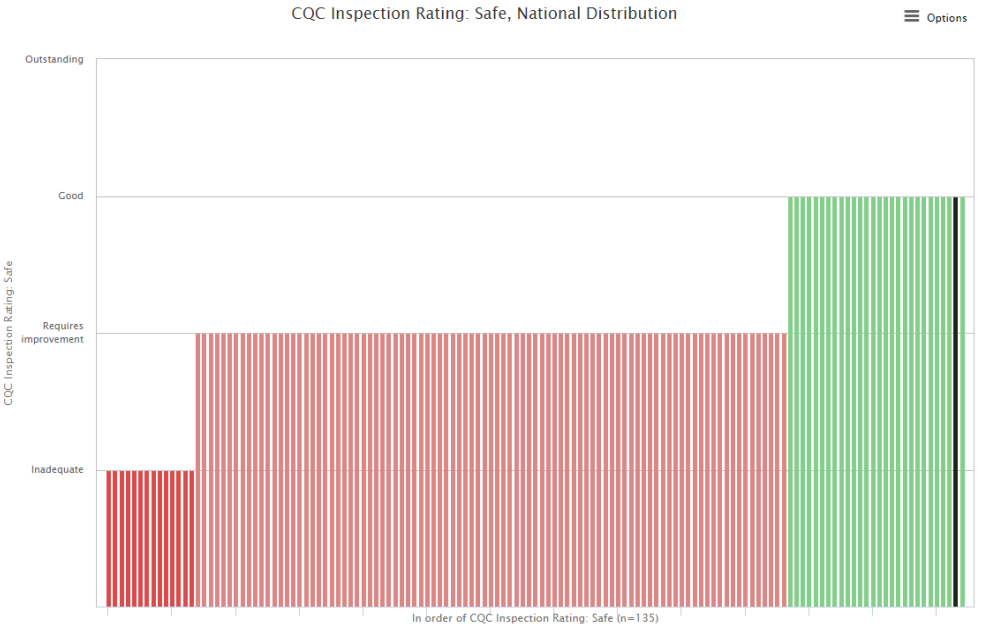


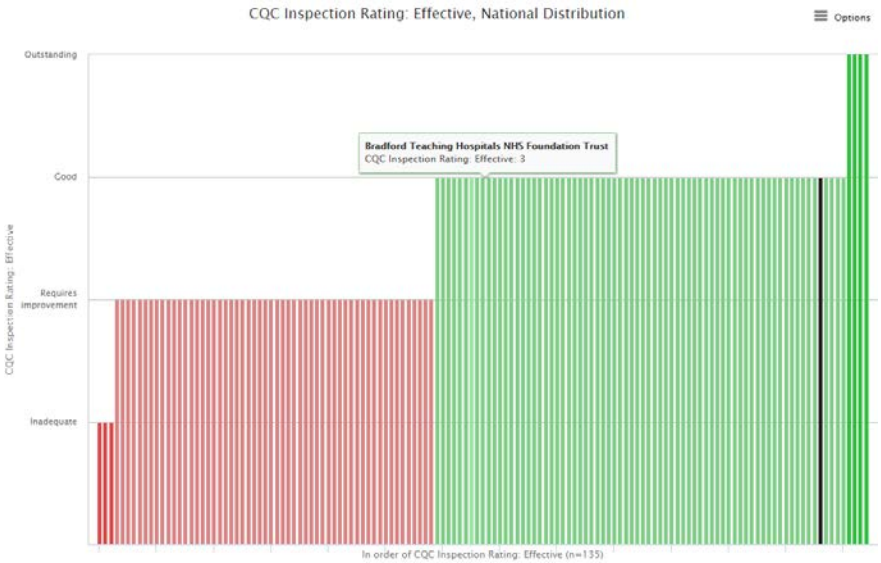


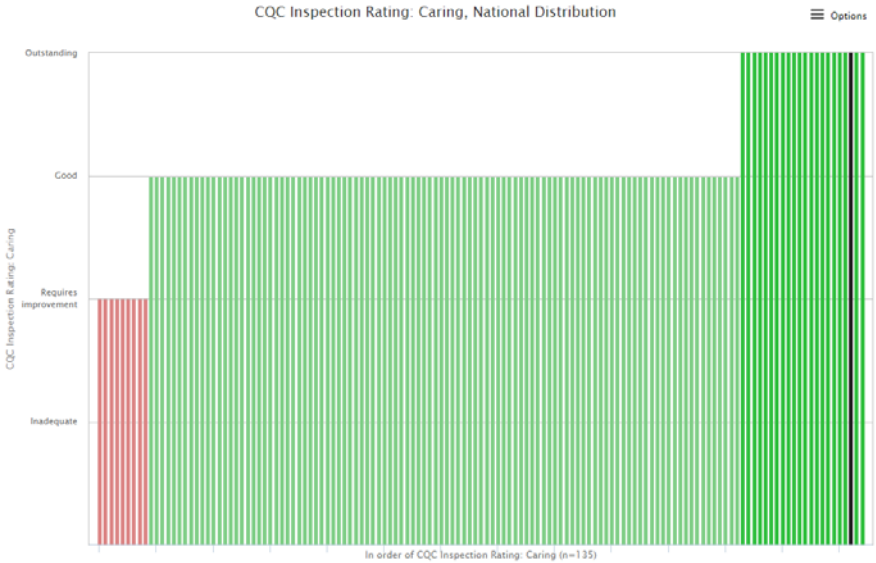
5. CQC OVERVIEW

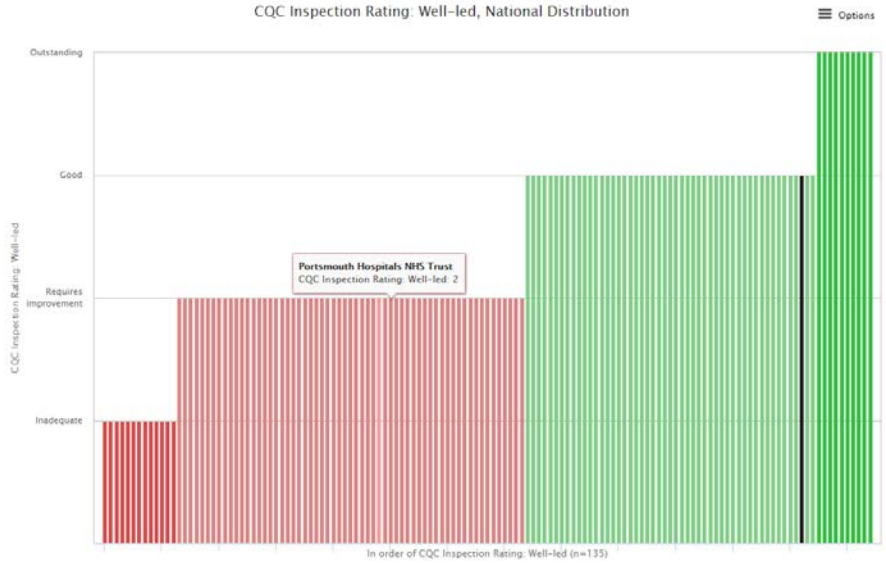
The CQC have launched the Model Hospital website in *alpha* form which highlights comparative indicators in a number of key areas. The Quality of Care compartment: includes the CQC ratings as the principal assessment indicators, with additional indicators, including the Friends and Family Test, Ambulance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

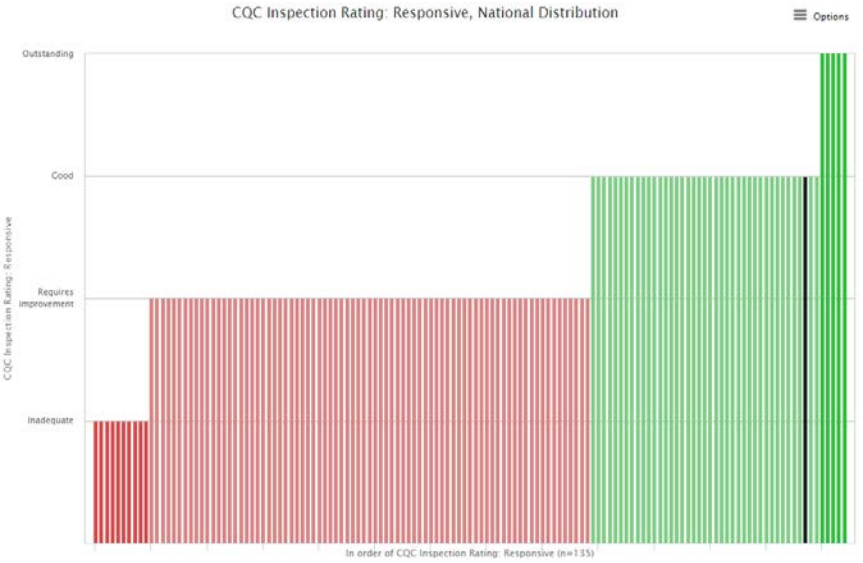





CQC Inspection Rating: Effective, National Distribution
Options
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Effective
Bradford Teaching Hospitals NHS Foundation Trust
CQC Inspection Rating: Effective: 3
In order of CQC Inspection Rating: Effective (n=135)


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


CQC Inspection Rating: Well-led, National Distribution
Options
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Well-led
Portsmouth Hospitals NHS Trust
CQC Inspection Rating: Well-led: 2
In order of CQC Inspection Rating: Well-led (n=135)


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

CQC - QUALITY OF CARE BENCHMARK DASHBOARD

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

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	Good			No trendline available
CQC Inspection Rating: Caring	Latest	Outstanding			No trendline available
CQC Inspection Rating: Effective	Latest	Good			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	Good			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	Q4 2016/17	93.5%	-	-		No variation available	
A&E Scores from Friends and Family Test - % positive	May 2017	96.0%	89.2%	88.9%			
Inpatient Scores from Friends and Family Test - % positive	May 2017	96.8%	96.7%	96.6%			
Maternity Scores from Friends and Family Test -question 2 Birth % positive	May 2017	100.0%	100.0%	98.2%			

Organisational health	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Aggressive Cost Reduction Plans	Jun 2017	5.1%	4.5%	4.7%			

Caring	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Mixed Sex Accommodation Breaches	Jun 2017	0	0	0			

Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
VTE Risk Assessment	Q4 2015/16	99.96%	96.13%	95.88%			

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

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	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	YTD(Apr17 Mar18)	WTE	raffi	Trend
Safe	Dashboard	1.01	NHS E / I Patient Safety Alerts - Total	NT	0	0	1	0	1	0	0	1	2	1	0	1	0	6			
		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%	12%	8%	9%	12%	10.3%	11.6%	11.5%	8.5%	12.9%	11.9%	11.2%	9.8%	10.6%	11%	6		
		1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	87%	87%	87%	86%	87%	89%	89%	86%	90%	88%	94.84%	96.87%	94.69%	90%	4		
		1.05	Clostridium difficile infections (CDI)	16	2	0	0	1	3	0	0	1	0	2	6	4	0	16	6		
		1.06	MRSA (Hospital)	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2	6		
		1.07	Patient Safety Incidents Reported	NT	449	460	459	463	392	508	418	506	466	467	521	591		3869			
		1.08	Never Events	0	0	0	0	0	0	0	0	0	0	0	1	0		1	2		
	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	99%	2		
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	100%	100%	95%	100%	96%	100%	100%	100%	96%	100%	100%	100%	100%	99%	2		
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	100%	98%	98%	98%	100%	100%	100%	100%	97%	100%	98%	97%	100%	99%	2		
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	99%	93%	98%	95%	100%	97%	98%	93%	97%	99%	99%	97%	96%	97%	2		
		1.13	HII Compliance 4a: Preventing surgical site infection preop	100%	95%	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%	100%	88%	100%	95%	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%	100%	78%	100%	98%	2		
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	78%	100%	100%	98%	2		
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	93%	95%	95%	82%	81%	92%	94%	88%	99%	97%	91%	92%	95%	92%	2		
		1.18	HII Compliance 7: Clostridium Difficile - prevention of spre	100%	NA	NA	NA	NA	ND	ND	ND	ND	ND	ND	ND	ND	ND				
	Incidents	1.19	Safety Thermometer - Harm-Free Care (New Harms)	95%	99%	97%	98%	98%	98.5%	98.3%	98.9%	98.6%	98.2%	97.2%	97.6%	98.4%	98.5%	98%	3		
		1.20	No of SIRIs	NT	11	14	6	8	9	5	7	7	6	5	11	14	10	74			
		1.21	RIDDOR Reportable Incidents	NT	0	0	0	0	0	0	1	0	1	0	2	0	3	7			
		1.22	Catheters and New UTIs	NT	0.00	0.25	0.26	0.78	0.29	0.29	0.27	0.00	0.00	0.00	0.15	0.16	0.44	0.18			
		1.23	Total No of E. Coli (Trust level only)	NT	ND	19	9	9	2	0	2	2	1	2	1	2	2	14			
		1.25	Patient Falls	<48	65	61	54	71	54	52	50	69	68	39	56	73	69	530	1		
		1.26	Patient Falls resulting in harm	<10	19	11	14	16	9	17	20	17	18	10	23	18	23	155	1		
		1.27	Falls - Per 1000 bed days	5.60	ND	5	5	5	5	5	ND	ND	ND	ND	ND	ND	ND	10	3		
		1.28	Number of avoidable serious injuries/deaths resulting from	NT	ND	0	0	ND	0	0	ND	ND	0	0	0	ND	0	0	3		
		1.29	Number of medication errors	NT	16	23	18	25	64	80	69	78	70	69	70	78	63	641			
		1.30	Actual patient harm resulting from medication incidents	0.01	15	23	16	20	1	0	0	0	ND	ND	ND	ND	ND	1			
		1.31	Pressure Ulcers - Inpatients	<5	14	22	10	4	9	8	13	7	13	15	13	18	13	121	1		
		1.32	Pressure Ulcers - Avoidable ward-acquired PUs	NT	ND	ND	ND	ND	4	3	4	ND	ND	ND	ND	ND	ND	11			
	Reporting	1.33	MRSA Quarterly Std (including admission and LOS screer	90%	89%	NA	NA	91%	NA	NA	92%	NA	NA	93%	NA	NA	90%	92%	3		
		1.34	MRSA - Decolonisation (Trust level treatment and post scre	90%	96%	93%	90%	90%	92%	93%	95%	95%	90%	91%	98%	85%	91%	92%	3		
		1.36	MSSA (Hospital)	NT	0	1	2	1	ND	1	0	0	1	1	0	1	1	5			
		1.37	SIRI final reports due in month submitted beyond 60 workir	0	0	0	0	0	0	1	0	0	0	4	5	4	0	14	2		
		1.38	SIRIs reported >2 working days from identification as red	0	0	0	0	2	0	0	0	0	1	2	3	6	5	17	2		
		1.39	RAG active/accepted risk assessments not in date	0	1				ND	ND	ND	9	0	1	5	0	2	17	3		
		1.40	Datix Risk Register Red / Amber actions overdue	0					ND	ND	ND	22	0	0	0	0	0	22			
		1.41	Outstanding actions complete in date for Red/Amber entrie	95%	100%	100%	100%	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND	100%	3		
		1.42	Quarterly standard principle compliance	90%	93%	NA	NA	95%	NA	NA	95%	NA	NA	95%	NA	NA	97%	96%	3		
		1.43	Rapid access chest pain clinic access within 2 wks.	100%	90%	52%	100%	100%	100%	98%	100%	95%	97%	97%	96%	100%	100%	98%	2		
		1.44	Verbal Duty of Candour outstanding at month-end	0%	1	ND	ND	ND	3	0	0	0	2	0	1	2	1	9	2		
		1.45	Hand Hygiene Audits	95%	100%	99%	99%	98%	98%	99%	99%	100%	99%	98%	99%	99%	99%	99%	2		
		1.46	Quarterly antibiotic audit	98%	92%	NA	NA	93%	NA	NA	91%	NA	NA	94%	NA	NA	93%	92%	3		
		1.47	RCAs beyond deadline for completion	=<4	15	9	9	8	3	1	3	4	1	7	2	9	14	44	2		
		1.48	% of Green Patient Safety incidents investigated	NT	60%	69%	64%	60%	60%	66%	54%	53%	68%	58%	67%	56%	55%	60%			
		1.49	PEWS documentation and escalation compliance	NT	100%	100%	100%	100%	80%	100%	90%	100%	100%	90%	ND	ND	ND	93%	2		
		1.50	Quarterly Environment/Isolation	90%	93%	NA	NA	91%	NA	NA	91%	NA	NA	92%	NA	NA	92%	92%	3		
		1.51	Quarterly VIP score documentation	90%	83%	NA	NA	79%	NA	NA	84%	NA	NA	80%	NA	NA	87%	84%	2		
		1.52	Isolation data (Trust Level only)	95%	93%	90%	95%	89%	90%	95%	90%	90%	88%	88%	90%	88%	88%	90%	2		
		1.53	Pain Mgt. Quarterly internal report	80%	NA	68%	NA	NA	75%	NA	NA	61%	NA	NA	61%	NA	NA	66%	1		
		1.54	Nutrition Risk Assessment 48hrs	95%	83%	84%	83%	90%	91%	87%	89%	82%	89%	93%	89%	87%	93%	89%	2		
		1.55	Median of NRLS upload (No. of days)	41	ND	50	50	51	81	87	65	65	58	55	48	61	65	65	1		

SAFE – WARD ANALYSIS

Group	Indicator	Target	Red	Amber	Green	Surgery										Medicine														Women & Child		
						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	F51	F14
Patient Safety	HII compliance 1a: Central venous catheter insertion	= 100%	<95	95-99	= 100					100										No Data				No Data	No Data	100							
	HII compliance 1b: Central venous catheter ongoing care	= 100%	<95	95-99	= 100	No Data	No Data	No Data	100	100						No Data	No Data	100	100	No Data	No Data	No Data	100				No Data	No Data	No Data				No Data
	HII compliance 2a: Peripheral cannula insertion	= 100%	<95	95-99	= 100					100	No Data				No Data									No Data	No Data	100				100	100		
	HII compliance 2b: Peripheral cannula ongoing	= 100%	<95	95-99	= 100	100	100	100	100	100						100	100	100	40	No Data	100	100	80				100	No Data	100		100		100
	HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<95	95-99	= 100							100	No Data	100																		
	HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<95	95-99	= 100							100	No Data	100																		
	HII compliance 5: Ventilator associated pneumonia	= 100%	<95	95-99	= 100					No Data																						
	HII compliance 6a: Urinary catheter insertion	= 100%	<95	95-99	= 100						100				No Data					No Data									100			
	HII compliance 6b: Urinary catheter on-going care	= 100%	<95	95-99	= 100	100	100	100	100							100	100	100	25	No Data	100	100	100				100	No Data	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
	Quarterly MRSA (including admission and length of stay screens)	= 95%	<80	80-89	90-100	100	93	100	100	100	No Data	No Data		No Data	No Data	100	61	71	69	88	83	94	88				91	No Data	83	91	No Data	100	100
	Hand hygiene compliance	= 95%	<85	85-94	= 100	100	100		100	100		100	100	100		100		100	100	93	100		83			100	100		100	100	10	100	100
	Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Quarterly Standard principle compliance	90%	<80	80-90%	90-100	87	98	98	93	97	No Data	No Data		No Data	No Data	100	97	98	100	100	91	95	94	No Data	No Data		100	No Data	93	100	100	97	100
	Total no of C. diff Infections: Hospital	= 18 per year	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Quarterly Antibiotic Audit	= 95%	<85	85-94	95-100	100	94	90	92							91	99	91	85	100	94	94	93				98	No Data	94	100	100	No Data	100
	Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	88	92	95	90	95	95	95		95	79	94	93	82	91	90	95	92	91	No Data	No Data		97	No Data	88	91	94	90	95
	Quarterly VIP score documentation	= 90%	<80	80-89	90-100	50	92	83	93	100	No Data	No Data		No Data	No Data	100	84	76	100	88	100	100	100				100	No Data	91	100	80	100	80
	MEWS documentation and escalation compliance	= 100%	<80	80-99	= 100																											
	No of patient falls	= 68	>=68	No Target	<68	8	3	1	2	0					0	1	8	8	8	2	2	5	8	3	8	0	0	5	5	0		0	0
	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	1	0	1	2	0					0	1	2	4	1	1	1	1	2	0	4	0	0	1	1	0		0	0
	No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0																											
	No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	2	1	1	0	0						0	3	2	1	2	0	0	1	0	0	0	0	0	0	0		0	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	90	100	100	100	100						100	90	89	100	No Data	100	71	90				86	No Data	80	No Data			100
	No of SIRIs	No Target	No Target	No Target	No Target	1	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	No of medication errors	No Target	No Target	No Target	No Target	3	1	1	2	2	0	1	1	0	6	1	1	5	1	3	1	4	1	1	0	0	0	1	10	3	0	1	0
	Cardiac arrests	No Target	No Target	No Target	No Target	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	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
	Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	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
	VTE: Completed risk assessment (monthly Unify audit)	> 95%	<=88	No Target	> 88	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100																											
	Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<85	85-94	= 100	93.94	100	95.24	96.55	100	No Data	No Data	No Data	No Data	No Data	85.71	100	96.43	100	100	96.55	100	96.88	93.75	100	No Data	100		100	No Data	No Data	100	100
Patient Experience: In-patient	Patient Satisfaction: In-patient overall result	= 90%	<75	75-84	85-100	87	99	95	97							97	100	95	99	98	92	100					83		98				98
	How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	= 90%	<70	70-89	90-100	92.86	100	97.37	100							100	100	91.67	100	100	97.14	100					100		100				100
	In your opinion, how clean was the hospital room or ward that you were in?	= 90%	<75	75-84	85-100	99	100	98	100							100	100	97	95	98	98	100					100		97				99
	Did you feel you were treated with respect and dignity by staff?	= 90%	<75	75-84	85-100	98	100	97	100							100	100	100	100	100	99	100					100		100				100
	Were staff caring and compassionate in their approach?	= 90%	<75	75-84	85-100	98	100	99	100							100	100	100	100	100	99	100					100		100				100
	Did you experience any noise in the night time that you think could have been avoided?	= 90%	<75	75-84	85-100	95	100	84	88							83	100	100	100	100	77	100					50		100				98
	Did you find someone in the hospital staff to talk about your worries and fears?	= 90%	<75	75-84	85-100	94	100	100	98							100	100	100	100	100	91	100					100		100				100
	Were you involved as much as you wanted to be in decisions about your care and treatment?	= 90%	<75	75-84	85-100	90	100	89	100							100	100	94	100	100	84	100					50		100				93
	Did staff talk in front of you as if you were not there?	= 90%	<75	75-84	85-100	99	100	97	100							100	100	100	100	100	90	100					75		100				100
	Were you given enough privacy when discussing your condition or treatment?	= 90%	<75	75-84	85-100	98	100	100	100							100	100	100	100	100	94	100					100		100				100

6. EXCEPTION REPORTS – SAFE

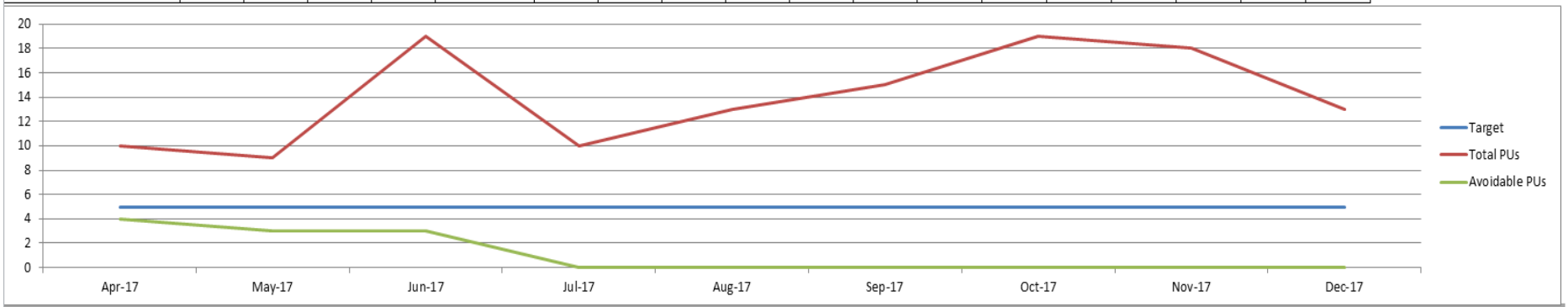
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Background

December has seen a further decrease in the number of hospital acquired pressure ulcers (HAPUs) from the previous month. There were 13 in total, a decrease from 18 in November.
Ward F6 continues to have no reported hospital acquired pressure damage, managing 11 months, a highly commendable achievement.

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	Feb-18	Mar-18
Target	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Total PUs	14	22	10	4	10	9	19	10	13	15	19	18	13					
Avoidable PUs	ND	ND	ND	ND	4	3	3	ND	ND	ND	ND	ND	ND					



Key Recovery Actions

Description	Owner	Start	End
The Tissue Viability team continue to maintain excellent visibility and support for ward teams, promoting pressure ulcer prevention via bite size teaching sessions, one to one education and promoting awareness and improvement of staff knowledge and practice in promoting skin health and integrity. The Head of Nursing for Surgery and the Tissue Viability team are supporting the wards to achieve more timely completion of investigations. Datix has been updated to reduce the burden of investigation for grade 2 ulcers whilst still capturing the key points of information to allow learning.	RP	Apr-17	Mch 18

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-Dec-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

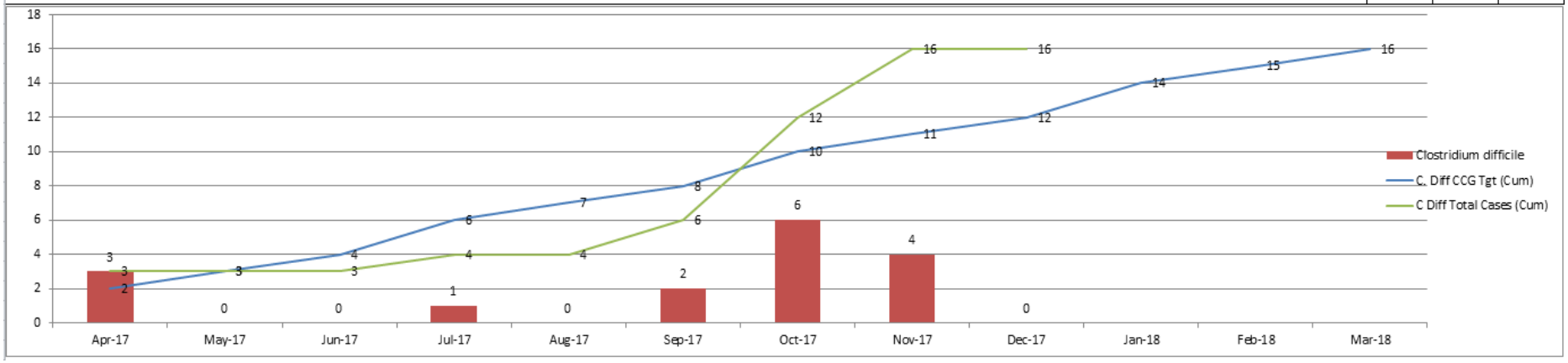
There were no cases of Hospital attributable CDT in December (or from the community, the first month in which there have been zero cases).
Overall summary as of 31st December 2017, 16 reported cases 7 of which are Non Trajectory, 5 are Trajectory and 4 are awaited.

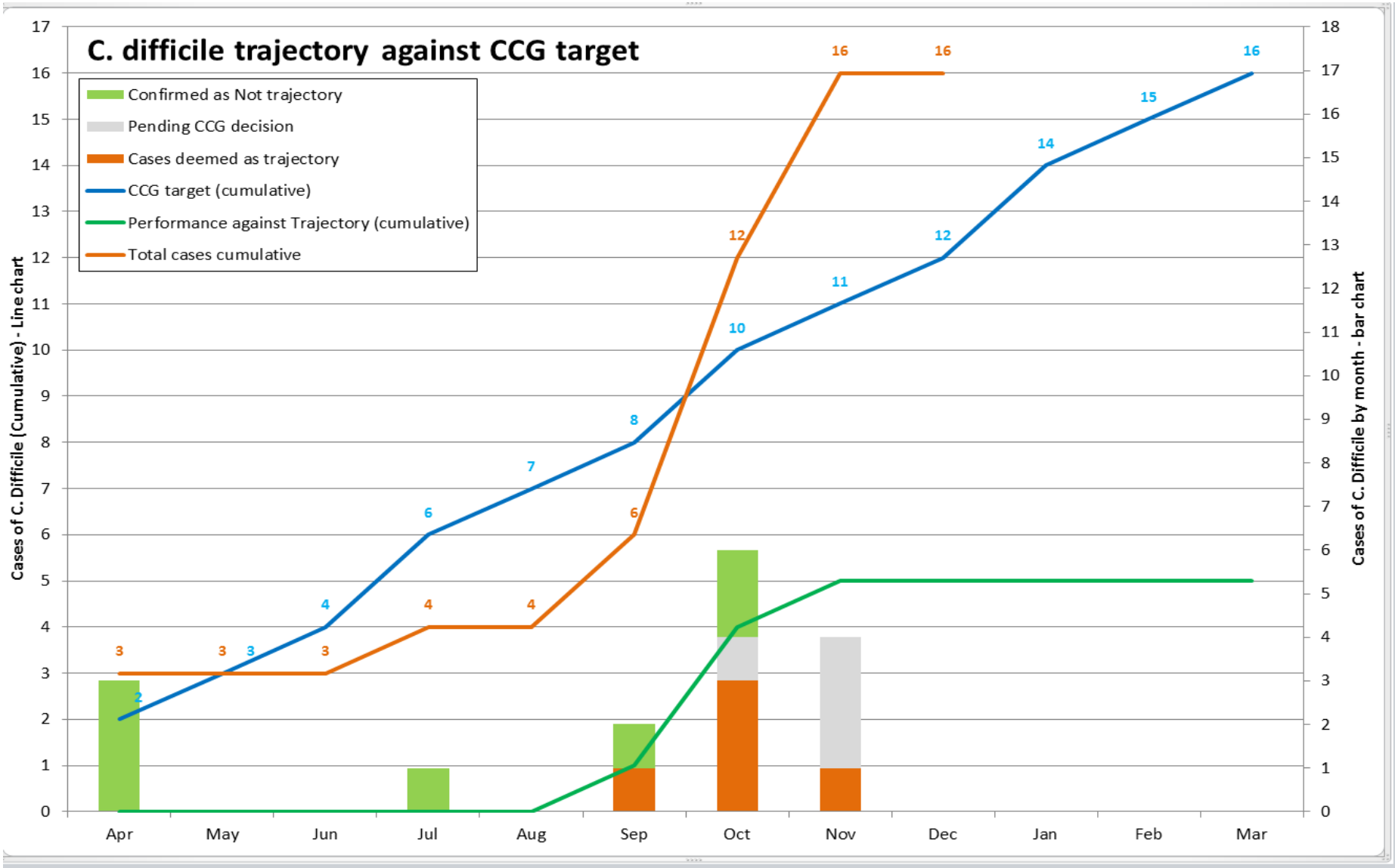
Trend | Recovery Trajectory

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			
C Diff Total Cases (Cum)	3	3	3	4	4	6	12	16	16			
MRSA	0	0	0	0	0	2	0	0	0			

Key Recovery Actions

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-Dec-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Background

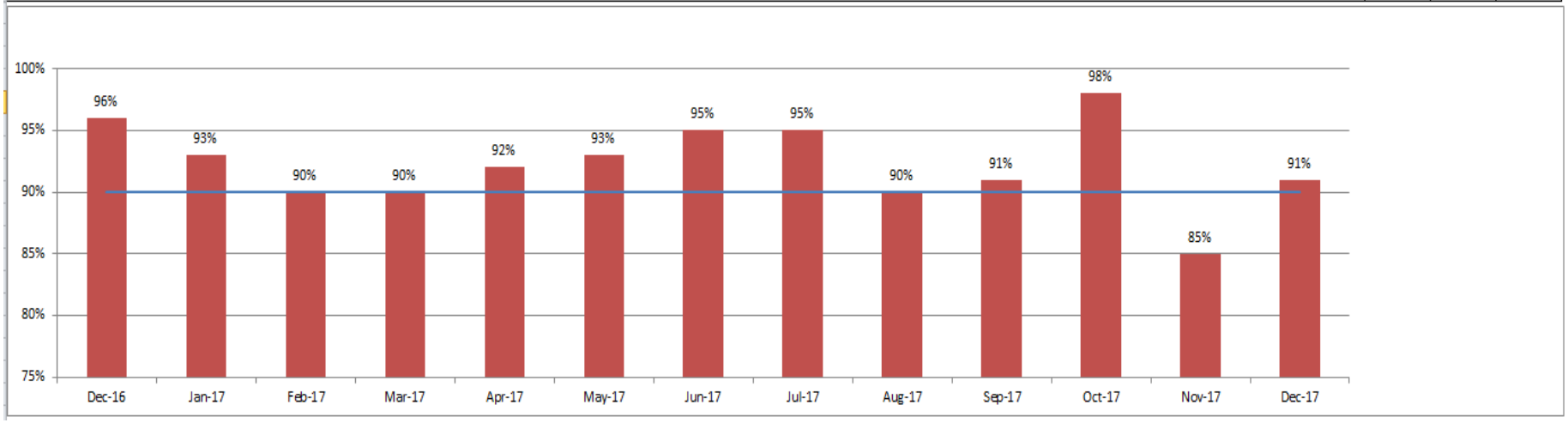
The Trust compliance with decolonization improved in December 2017 back to 91%.

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	Feb-18	Mar-18
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%					
MRSA Decolonisation	96%	93%	90%	90%	92%	93%	95%	95%	90%	91%	98%	85%	91%					

Key Recovery Actions

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	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	VTE
Standard	95%
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Background

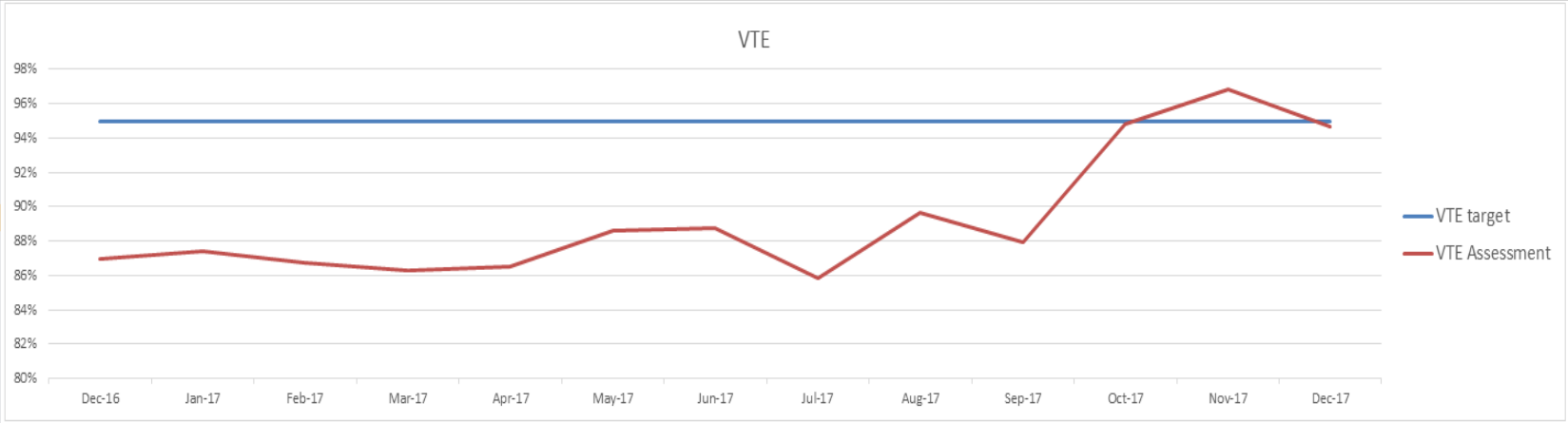
Venous thromboembolism (VTE) is a significant international patient safety issue. The first step in preventing dealth and disability from VTE is to identify those at risk so that preventative treatments (prophylaxis) can be given. The Trust has been unable to fully collate VTE data in 2016/17, but quality audits suggested that the Trust was delivering close to the 95% target. Since April 2017 data has been sent to UNIFY2 and performance has been below 90% for the YTD. In December the Trust achieved an position of 94.69% against a threshold of 95%.

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	Feb-18	Mar-18
VTE target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
VTE Assessment	87%	87%	87%	86%	87%	89%	89%	86%	90%	88%	95%	96.87%	94.69%					

Key Recovery Actions

Description	Owner	Start	End
There is a progressive increase and we are now finalising consultant level data for specific action and learning.	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-Dec-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	Trust is in lowest quartile

Background

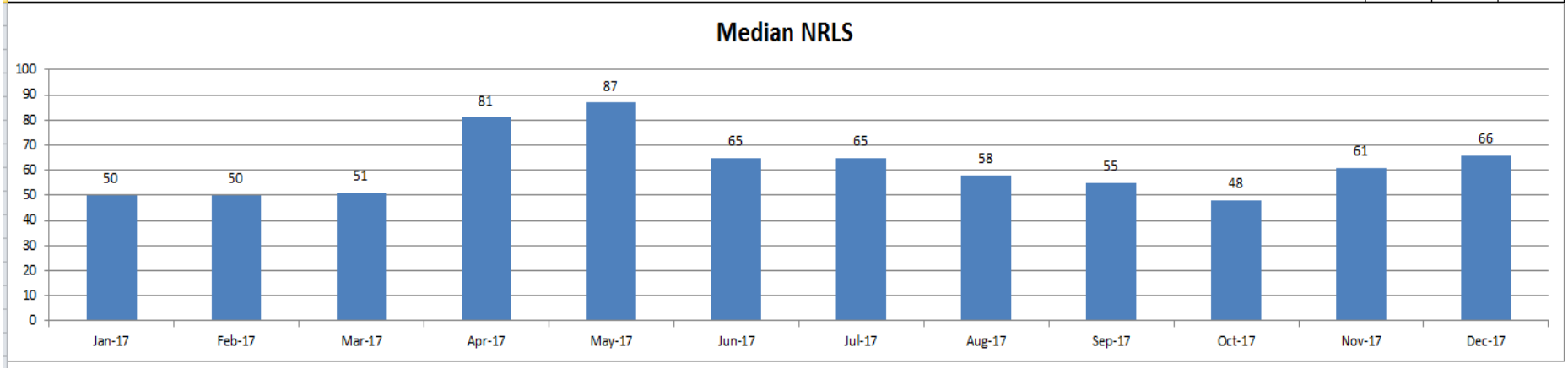
Performance has dropped following a continued period of improvement since May 2017. This is likely to be as a consequence of training new administrative staff (which should produce a positive impact in subsequent months), implementing Datix in the new community teams and activity and acuity levels of the clinical inpatient areas.
NB: This data is a locally derived proxy for the national benchmarking data as that is issued in retrospect (most recently issued for March 2017).

Lack of timely completion of green incident investigations in areas throughout the organisation.

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	Feb-18	Mar-18
Median NRLS	50	50	51	81	87	65	65	58	55	48	61	66					

Key Recovery Actions

Description	Owner	Start	End
Clinical Directors meeting have agreed to take greater oversight of medical completion rates to encourage more timely completion. Divisions ongoing monitoring and oversight throughout year not just at NRLS close-down timeframes	RP	Aug-17	Mar-18



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

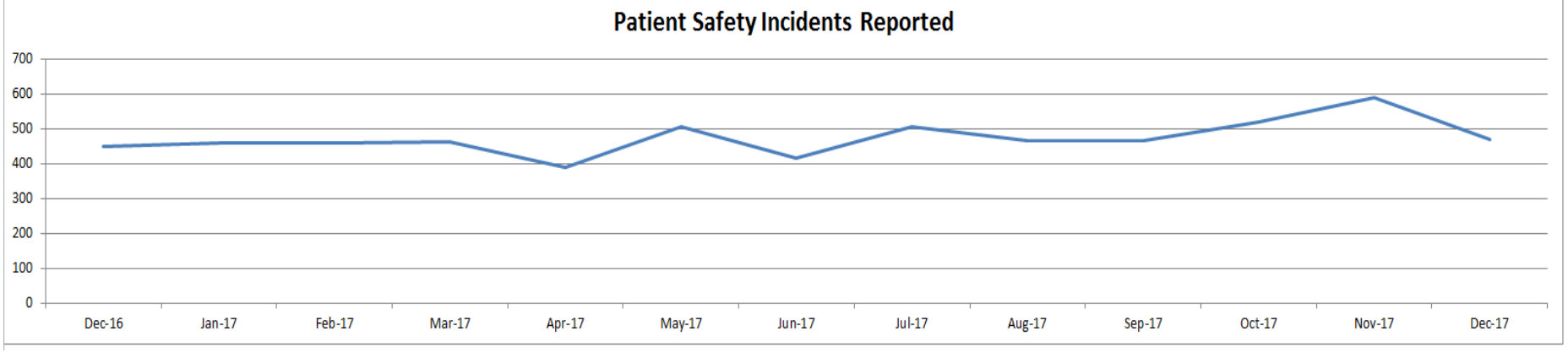
There were 645 incidents reported in October including 591 patient safety incidents (PSIs). This was higher than October and reflects the increased reporting now that the Community services have joined the trust. This is above the NRLS median threshold. The number of 'harm' incidents remains low although it has risen as a consequence of Community reporting, mainly relating to pressure ulcers.

Trend | Recovery Trajectory

Indicator	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Patient Safety Incidents Reported	449	460	459	463	392	508	418	506	466	467	521	591	471					

Key Recovery Actions

Description	Owner	Start	End
	RP	Aug-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Background

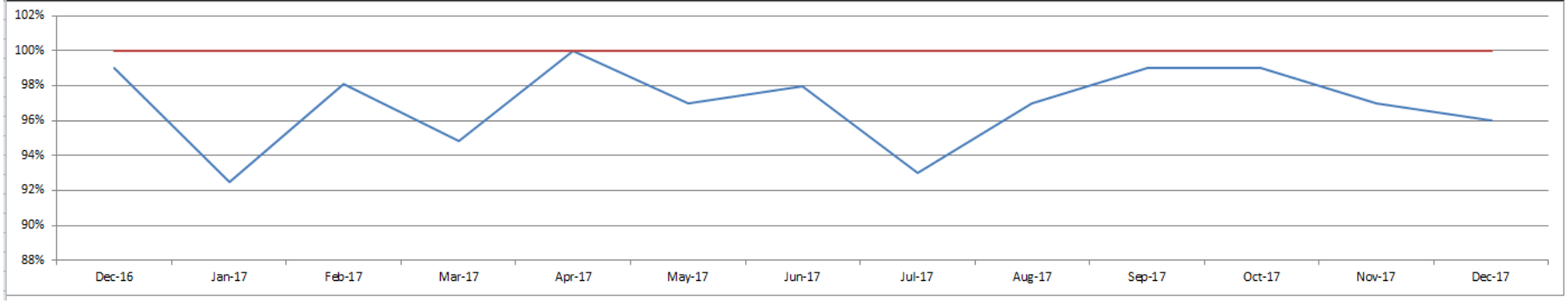
Compliance with documentation, following changes to eCare still poses a challenge. The Senior Matron team continue to discuss performance at the Monthly Quality Meeting and share examples of good practice and strategies adopted to improve compliance.
Senior Matrons to continue to undertake regular discussions with Senior Ward Nursing Teams at 1:1's and Ward Team Meetings to highlight current performance and discuss options in improving practice. Specific action plans to be supported and monitored by Senior Matrons and Head of Nursing for areas with persistent poor performance.

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

Key Recovery Actions

Description	Owner	Start	End
Continuing episodes of staffing deficits coupled with the need for the provision of escalation capacity have impacted upon the accurate and timely completion of assessments and documentation. The Senior Matron and Operational Teams attempt to mitigate the impact of these pressures on compliance through staff re-deployment in line with activity and acuity being experienced.	Ward managers & Matrons	Aug-17	Mar-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Background

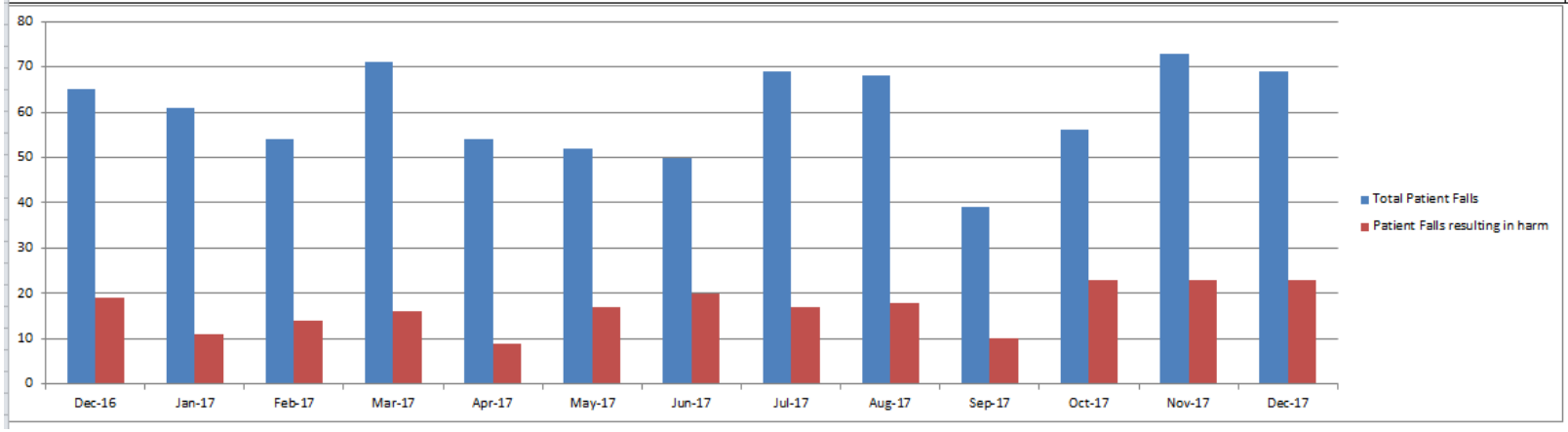
There were 60 falls in December (down from 73 in November), there were no incidents of major harm, though there was one moderate harm incident where a patient had fallen resulting in a fractured shoulder requiring conservative management. This has resulted in a RAG rating of Red due to more than 48 falls occurring.
Newmarket Hospital had three falls in December (a decrease from seven falls in November). Glastonbury Court had six falls (a decrease from 10 falls in October). The falls for Newmarket Hospital and Glastonbury Court are reported separately. There were a total of five patients who fell in non-inpatient areas (2 x ED / 1 x Physiotherapy / 1 x Clinical Photography / 1 x Fracture Clinic). A total of four patients were assisted to floor in December (three in November) preventing them from falling. There were eight patients in total who fell more than twice (two patients falling three times and six patients falling twice) in December (an increase from three in November).

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	Feb-18	Mar-18
Total Patient Falls	65	61	54	71	54	52	50	69	68	39	56	73	69					
Patient Falls resulting in harm	19	11	14	16	9	17	20	17	18	10	23	23	23					
Percentage of falls resulting in harm	29%	18%	26%	23%	17%	33%	40%	25%	26%	26%	41%	32%	33%					

Key Recovery Actions

Description	Owner	Start	End
The Falls Focus Group continues to meet on a bi-monthly basis, information form this group is then fed back in to the Trust higher level Falls Group led by Dr Suresh. Work is ongoing with regards to the updating of the current Datix and eCare systems so as to ensure that they are reflective of current recognised best and local practice to ensure that they are responsive in tackling the issue of patients falling. It is planned that a lying and standing blood pressure task will be set for all patients admitted to the Trust who are over 65 years of age as per NICE guidance. Performance against RAG ratings - The RAG rating for number of falls is historic and does not reflect the current activity. A better indicator of performance is the Falls per 1000 bed days as this is the benchmark provided in the National Falls audit and is the indicator in the 2017/18 CCG Quality report (currently no data provided). It is proposed that 2018/19 IQPR reports falls numbers (including harm data) with no RAG rating and, upon availability of 1000 bed days data, uses that as the RAG rated KPI.	Dr Suresh	Aug-17	Mar-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Nutrition: Assessment and monitoring
Standard	95%
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

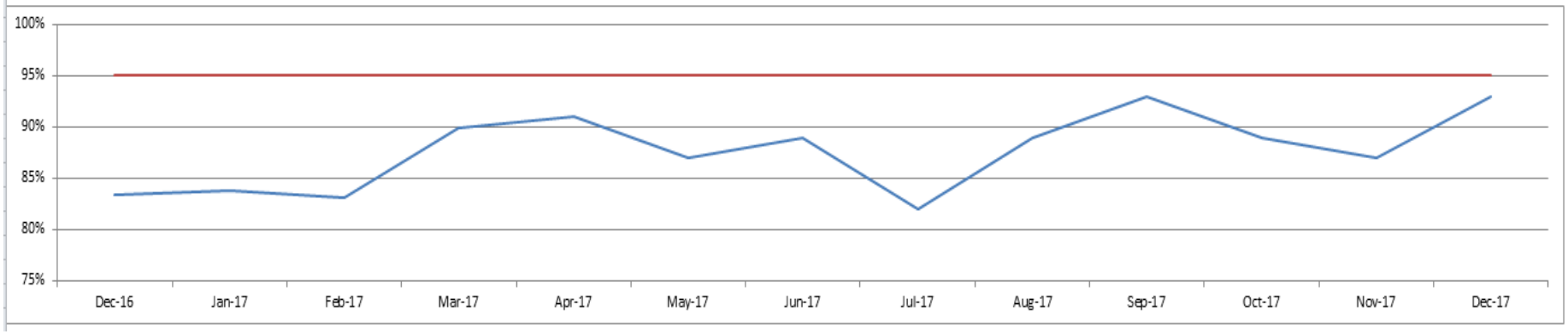
Despite a busy month with high demand, December has seen an increase in compliance in weighing patients and completing the nutrition risk assessment and MUST score from 87% in November to 93% in December. There remain some small pockets of poor compliance amongst teams, specifically with weighing patients 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	Feb-18	Mar-18
Nutrition Risk Assessment 48hrs	83%	84%	83%	90%	91%	87%	89%	82%	89%	93%	89%	87%	93%					
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%					

Key Recovery Actions

Description	Owner	Start	End
These areas are being supported by their Senior Matron to encourage and improve compliance.	RP	Aug-17	Feb-18



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-Dec-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

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 and pressures of work in the wards have led to some delays around reporting and investigation primarily of pressure ulcers over the Christmas break.

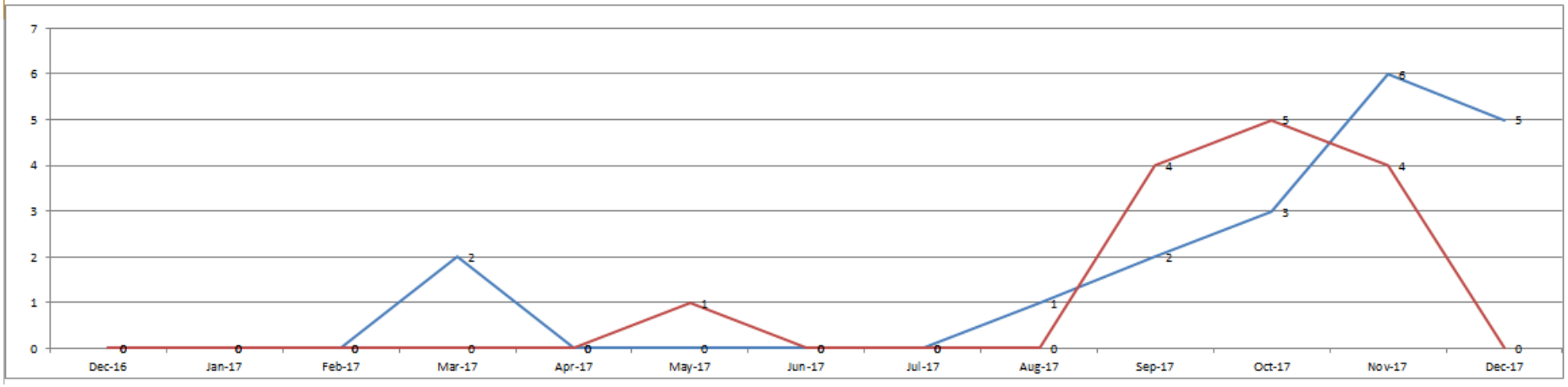
5/11 missed the deadline for SIRIs reported > 2 working days from identification as red; four of these were over the Christmas break where staffing levels were reduced. One other was reported one day later than the 2 working day deadline

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	Feb-18	Mar-18
SIRIs reported >2 working days	0	0	0	2	0	0	0	0	1	2	3	6	5					
SIRI beyond 60 working days	0	0	0	0	0	1	0	0	0	4	5	4	0					

Key Recovery Actions

Description	Owner	Start	End
Continue to aim for 100% compliance	RP	Aug-17	Jan-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Isolation Data
Standard	95%
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Background

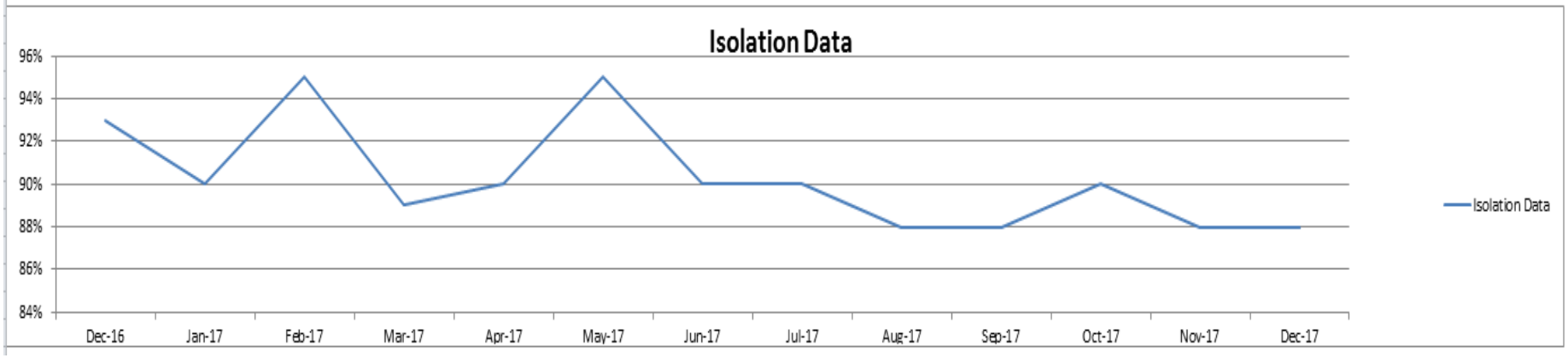
Compliance with Isolation is at 88%. F12 Adult Isolation ward was also at capacity throughout December.

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	Feb-18	Mar-18
Isolation Data	93%	90%	95%	89%	90%	95%	90%	90%	88%	88%	90%	88%	88%					

Key Recovery Actions

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RCA Actions beyond deadline for completion
Standard	NA
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Background

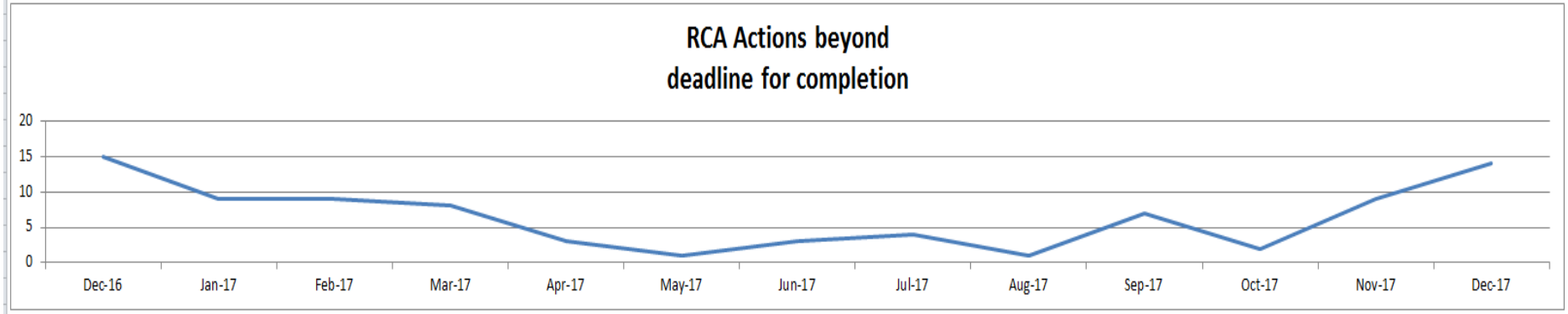
On completion of an SIRI investigation an action plan is developed to address the care or service delivery problems and root cause(s) and any additional lessons learned. Actions are designed to be SMART and are recorded on Datix with a named lead and completion target date. When an action reaches its 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	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
RCA Actions beyond deadline for completion	15	9	9	8	3	1	3	4	1	7	2	9	14					

Key Recovery Actions

Description	Owner	Start	End
Clinical Directors meeting have agreed to take greater oversight of RCA action completion. Discussion with Senior matrons and Ward Managers at Nursing & Midwifery and Clinical Council (NMCC).	RP	Aug-17	Mar-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Safety Thermometer - Harm-Free Care (New Harms)
Standard	95%
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Background

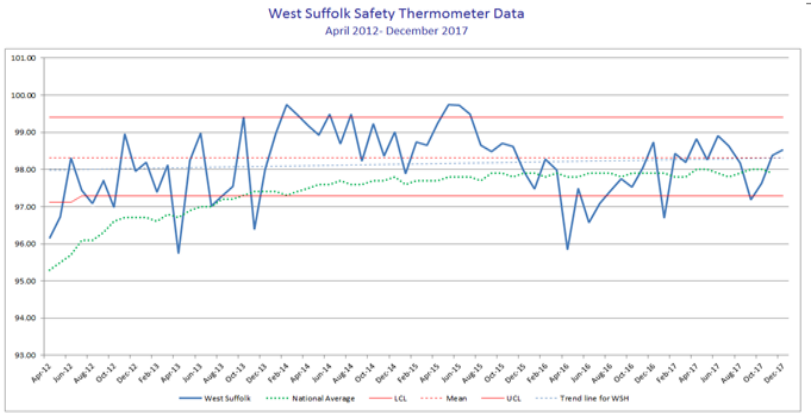
The National 'harm free' care composite measure is defined as the proportion of patients without a pressure ulcer (ANY origin, category II-IV), harm from a fall in the last 72 hours, a urinary tract infection (in patients with a urethral urinary catheter) or new VTE treatment.

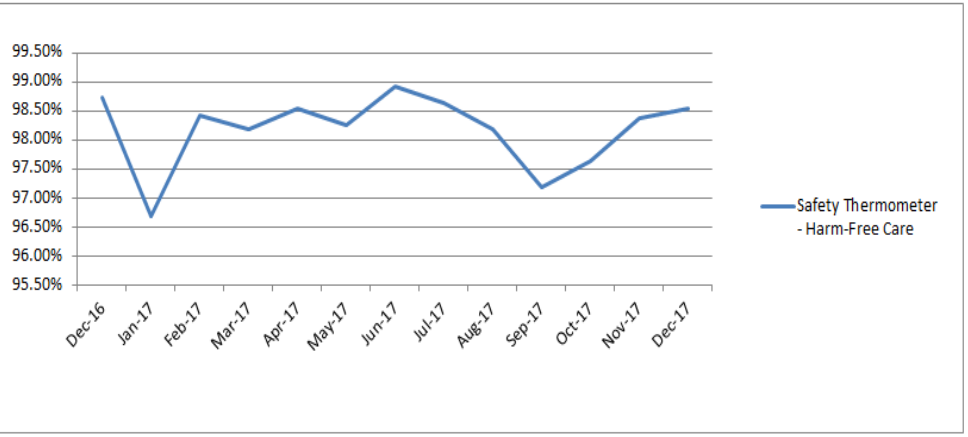
The Trust score for December 2017 was 1.46% therefore, our new harm free care was 98.54%. The National new harm for December has not been published yet however, if it remains the same as November at 97.9% then we will be above the National Average.
It should be noted that the Safety Thermometer is a 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	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Safety Thermometer - Harm-Free Care	98.73%	96.69%	98.43%	98.19%	98.53%	98.26%	98.91%	98.64%	98.18%	97.18%	97.63%	98.38%	98.54%					

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	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	YTD(Apr17-Mar18)	WTG	Traffic	Trend
2. Effective	Dash	2.01	Overall HSMR - DFI	<90	84%	ND	ND	ND	88%	88%	88%	88%	85%	87%	ND	ND	ND	87%	6		
		2.04	Canc. Ops - Cancellations for non-clinical reasons	1%	1.28%	1.35%	0.49%	0.93%	0.62%	0.56%	1.05%	1.00%	1.21%	0.97%	1.44%	1.85%	ND	1.09%	4		
	Mortality	2.09	No of Deaths	NT	102	103	99	95	72	69	71	62	76	70	ND	ND	ND	420			
		2.10	Percentage of deaths	NT	1.89%	1.85%	1.82%	1.47%	1.34%	1.20%	1.25%	1.12%	1.36%	1.23%	ND	ND	ND	1.3%			
		2.11	Cardiac arrests	NT	7	3	8	13	4	6	4	2	3	6	4	ND	ND	29			
		2.12	Cardiac arrests identified as a SIRI	-	1	1	1	0	0	0	1	0	0	0	0	0	ND	0.13			
	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%	97%	NA	NA	ND	NA	NA	99%	NA	NA	99%	NA	NA	99%	99%	3		
		2.16	TA (Technology appraisal) business case beyond deadline	0%	ND	ND	ND	ND	0	0	0	0	0	0	0	0	0	0			
		2.19	Av. Elective LOS (excl. 0 days)		3.03	3.11	2.49	2.92	2.75	3.26	2.7	2.54	2.79	2.73	2.93	2.85	2.98	2.84			
		2.20	Av NEL LOS (excl 0 days)		8.65	8.88	8.83	7.73	7.59	7.85	7.66	7.47	7.93	7.54	8.10	7.26	7.18	7.62			
		2.21	% of NEL 0 day LOS		20%	18%	18%	20%	19.4%	18.6%	20.3%	18.6%	17.4%	17.5%	18.8%	16.6%	14.9%	18%			
		2.22	NHS number coding	99%	100%	100%	100%	100%	99.74%	99.66%	99.69%	99.44%	99.50%	99.59%	99.61%	99.66%	99.65%	100%			
		2.23	Fractured Neck of Femur : Surgery in 36 hours	85%	97%	97%	97%	88%	97%	96%	96%	85%	97%	97%	96%	84%	100%	94%			
		2.26	Discharge Summaries (A&E 95% 1d)	95%	99%	98%	98%	97%	98%	98%	88%	87%	86%	86%	84%	84%	82%	88%	1		
		2.27	Discharge Summaries (IP 95% 1d)	95%	92%	94%	93%	92%	92%	93%	93%	ND	ND	ND	ND	ND	70.87%	87%	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%	100%	100%	3		
		2.30	Canc. Ops - Patients offered date within 28 days	100%	90%	100%	92%	97%	93%	94%	93%	88%	75%	92%	85%	98%	ND	90%	1		
		2.31	Canc. Ops. - No. Cancelled for a 2nd time	NT	0	ND	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-Dec-17
Data Frequency	Monthly
CQC Area	Effective
National Rank	NA

Background

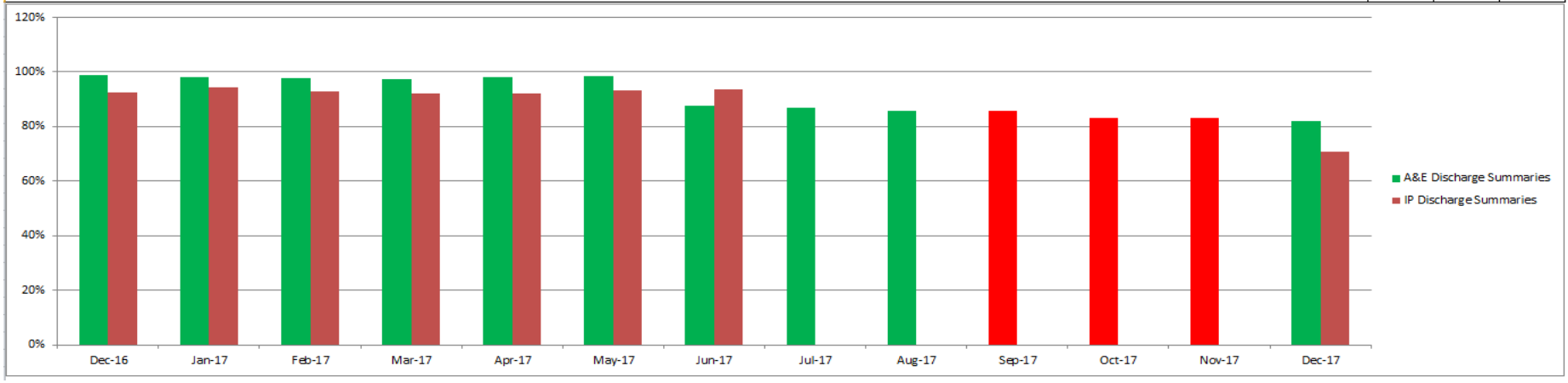
Clear and complete documentation in a patient's health record is directly linked to the quality of care they receive. Detailed and accurate documentation helps reduce negative outcomes, by ensuring that all clinical staff caring for patients have access to the information they need to deliver a good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

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	Feb-18	Mar-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
A&E Discharge Summaries	99%	98%	98%	97%	98%	98%	88%	87%	86%	86%	83%	83%	82%					
IP Discharge Summaries	92%	94%	93%	92%	92%	93%	93%	ND	ND	ND	ND	ND	71%					

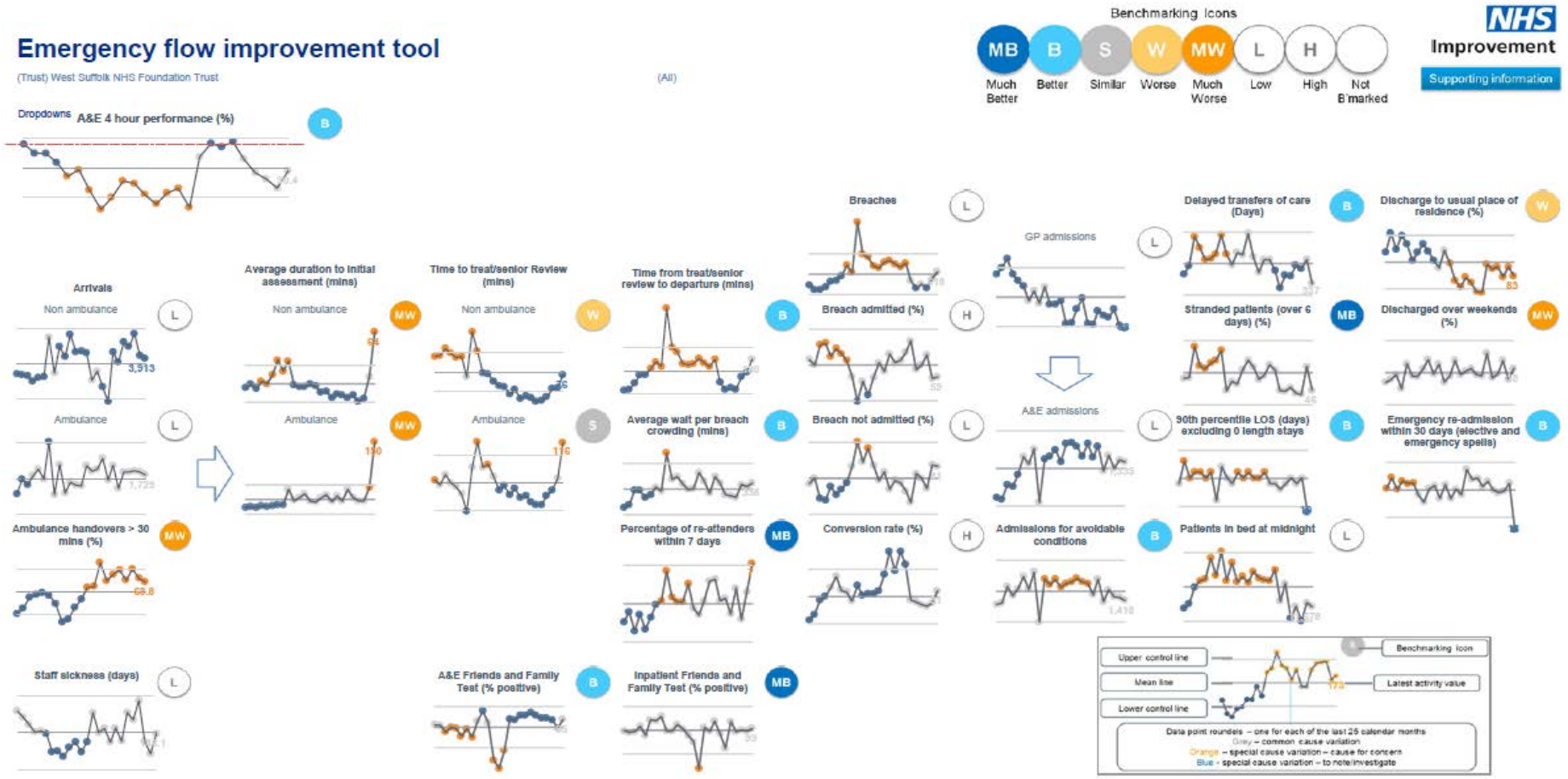
Key Recovery Actions

Description	Owner	Start	End
Around 40% of 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). There are also plans to improving automatic completion of discharge summaries as part of the ED optimisation project over the next few months.	Nick Jenkins	Jun-17	Feb-18



Emergency Flow

The new indicators in the Effective dashboard will be populated using the new Cerner System. NHS Improvement has produced a high-level flow benchmark analysis which is set out below (Trust data up to November 2017 for some Indicators).



DETAILED REPORTS - CARING

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

Are we..		Ref.	KPI	Target	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	YTD(Apr17 Mar18)	WTG	Traffic	Trend
3. Caring	Dashboard	3.01	Compliments (Logged by Patient Experience)		59	33	41	28	41	52	26	56	28	17	33	87	151	491			
		3.02	Complaints (Inpatient)	20	17	18	12	11	10	10	10	6	16	16	17	13	8	106	6		
		3.03	Mixed Sex Accommodation Breaches	0	0	0	2	0	0	0	0	0	0	0	0	0	1	1	6		
		3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	95%	99%	98%	99%	98%	97%	99%	98%	98%	98%	99%	96%	98%	98%	6		
		3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	97%	97%	97%	96%	95%	96%	97%	95%	95%	96%	96%	96%	99%	96%	6		
		3.06	A&E - Extremely likely or Likely to recommend (FFT)	85%	95%	95%	96%	96%	97%	96%	95%	95%	95%	92%	95%	94%	94%	95%	6		
		3.07	Maternity - How likely are you to recommend our ward to friends and family?	85%	90%	91%	100%	100%	100%	100%	100%	100%	ND	ND	99%	100%	97%	99%	6		
	Other Friends and Family Test Scores	3.09	IP overall experience result	85%	92%	94%	93%	94%	93%	92%	94%	94%	93%	93%	96%	96%	95%	94%	3		
		3.10	OP overall experience result	85%	91%	92%	92%	91%	92%	85%	88%	89%	91%	89%	95%	94%	95%	91%	3		
		3.11	A&E overall experience result	85%	95%	96%	93%	94%	94%	96%	94%	94%	95%	94%	93%	94%	94%	94%	3		
		3.12	A&E children overall experience result	85%	ND	ND	98%	100%	ND	100%	94%	ND	ND	ND	ND	ND	ND	97%	3		
		3.14	Short-stay overall result	85%	99%	99%	99%	98%	99%	99%	100%	99%	99%	99%	99%	99%	99%	99%	3		
		3.15	Short-stay Extremely likely or Likely to recommend	90%	100%	100%	100%	100%	99%	99%	100%	100%	99%	99%	99%	97%	100%	99%	3		
		3.16	Maternity - overall	85%	97%	94%	96%	100%	98%	100%	100%	100%	100%	100%	100%	98%	95%	99%	3		
		3.17	Maternity - postnatal ward recommendation to F&F	90%	90%	91%	100%	100%	100%	100%	100%	ND	ND	100%	100%	ND	ND	100%	3		
		3.18	Maternity - birthing unit recommendation to F&F	90%	100%	ND	ND	ND	100%	100%	100%	ND	ND	100%	100%	100%	ND	100%	3		
		3.19	Maternity -antenatal community care rec. to F&F	90%	100%	99%	100%	95%	97%	98%	100%	ND	ND	100%	96%	ND	ND	98%	3		
		3.20	Maternity -post-natal community care rec. to F&F	90%	98%	100%	100%	100%	100%	98%	ND	ND	ND	100%	98%	ND	ND	99%	3		
		3.21	Children's services overall result	85%	93%	99%	95%	ND	100%	ND	ND	ND	98%	98%	99%	95%	98%	98%	3		
		3.22	F1 Parent overall result	85%	98%	97%	99%	97%	97%	99%	99%	95%	100%	100%	99%	95%	98%	98%	3		
		3.23	F1 Parent - Extremely likely or Likely to recommend (FFT)	90%	96%	96%	100%	100%	100%	100%	100%	92%	100%	100%	100%	94%	97%	98%	3		
		3.24	Stroke Care - Overall FFT	85%	93%	94%	95%	95%	94%	ND	98%	99%	100%	99%	100%	85%	ND	96%	3		
		3.25	Stroke Care - How likely is it that you would recommend the service to friends and family?	90%	100%	100%	100%	100%	93%	ND	95%	100%	100%	95%	100%	100%	ND	98%	3		
	Complaints Handling	3.27	Complaints acknowledged within 3 working days	90%	ND	ND	ND	ND	ND	90%	100%	100%	93%	94%	100%	100%	87%	96%	3		
		3.28	Complaints responded to within 25 working days	90%	100%	86%	86%	100%	100%	90%	75%	100%	85%	67%	81%	82%	50%	81%	2		
		3.29	Number of second letters received	1	2	2	2	1	3	0	2	1	1	1	2	0	1	11	2		
		3.30	Health Service Referrals accepted by Ombudsman		0	0	0	0	0	2	0	1	0	0	0	0	1	4	2		
		3.31	No. of complaints to Ombudsman upheld	0	ND	ND	ND	ND	0	2	0	1	0	0	0	0	0	3			
		3.33	No. of PALS contacts	NA	122	171	189	230	172	188	169	176	137	167	190	167	124	1490			
		3.34	No. of PALS contacts becoming formal complaints	<=5	2	0	0	1	0	0	0	1	4	2	3	4	1	15	3		
	Other	3.37	Environment & cleanliness - Patient Satisfaction Overall	75%	96%	89%	91%	89%	93%	92%	92%	92%	94%	93%	94%	95%	94%	93%	3		
		3.38	Catering - Patient Satisfaction with food - overall	75%	84%	80%	83%	82%	83%	81%	85%	78%	85%	81%	87%	77%	85%	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-Dec-17
Data Frequency	Monthly
CQC Area	Caring
National Rank	

Background

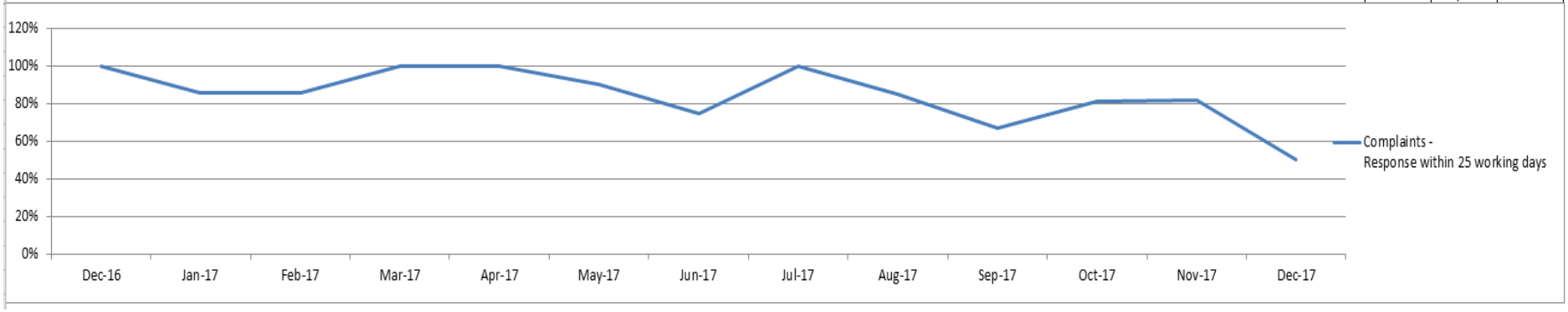
7 out of 14 complaint responses due in December were overdue. This is a reflection in part of the pressures across the organisation and subsequent delays in providing statements and also the capacity of the Patient Experience Team.

Trend | Recovery Trajectory

Indicator	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Feb-18	Mar-18
Complaints - Response within 25 working days	100%	86%	86%	100%	100%	90%	75%	100%	85%	67%	81%	82%	50%					

Key Recovery Actions

Description	Owner	Start	End
To continue to monitor	HB	Sep-17	Jan-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Mixed Sex Accommodation Breaches
Standard	NA
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Caring
National Rank	

Background

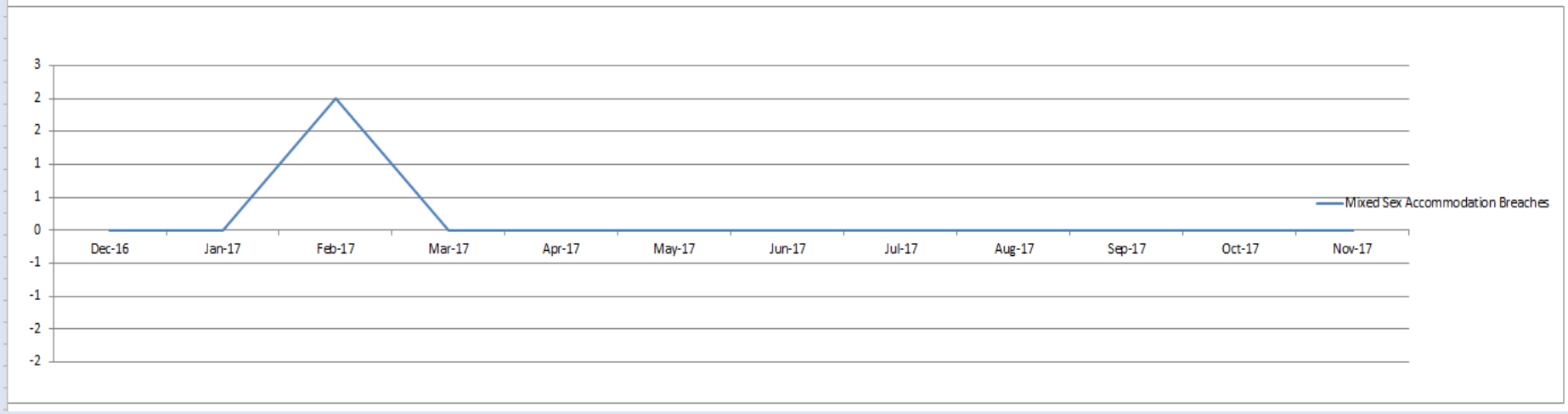
Unavoidable due to Trust pressures.
Critical care unit overcapacity the previous day so wardable male patient moved to recovery in accordance with escalation plan for patient safety across the area. Female level 2 patient was moved to recovery to facilitate admission of a post-operative patient. She was subsequently made wardable which resulted in a same sex accommodation breach as we could not move either patient to a ward bed within 4 hours. Curtains and a large portable screen were used to separate the patients completely as best practice in this situation. The patients were not directly opposite each other as there is a supporting pillar obstructing view. At least one member of nursing staff is in the department continuously. Explanation given to both patients and present family and assurance we were working towards resolving issue.

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	Feb-18	Mar-18
Mixed Sex Accommodation Breaches	0	0	2	0	0	0	0	0	0	0	0	0	1					

Key Recovery Actions

Description	Owner	Start	End
Continue to anticipate breaches of the same sex accommodation standard and prevent where possible Continue to flag up to patient flow team when patients are wardable and potentially same sex accommodation breaches	RP	Oct-17	Mar-18



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?

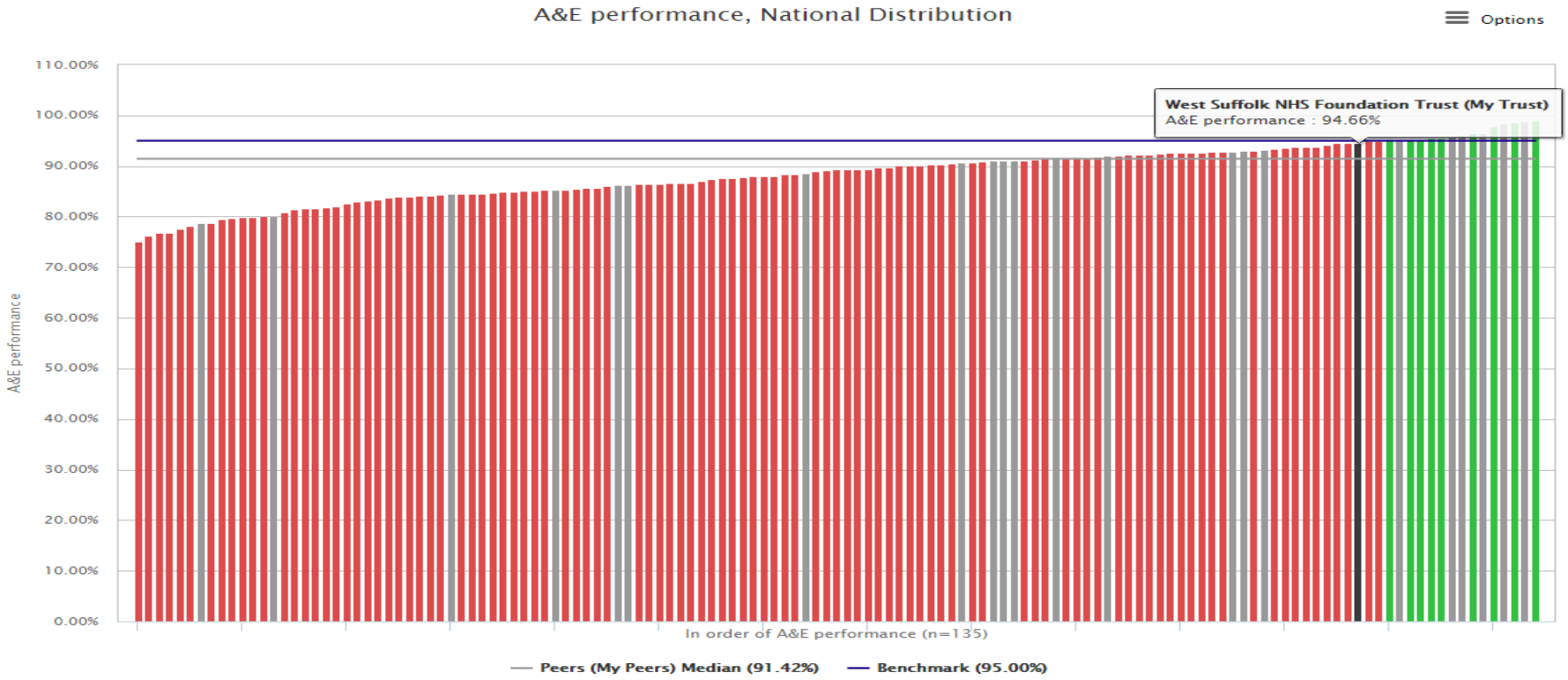
Are we..		Ref.	KPI	Target	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	YTD(Apr17-Mar18)	WTG	Traffic	Trend
4. Responsive	Dashboard	4.01	A&E under 4 hr. wait	95%	86%	87%	84%	93%	95%	95%	96%	92%	90%	89%	87%	90%	83%	91%	4		
		4.02	RTT: % incomplete pathways within 18 weeks	92%	92%	90%	90%	90%	82%	80%	83%	84%	86%	86%	87%	89%	89%	85%	2		
		4.03	52 week waiters	0	0	7	7	8	15	14	15	35	25	23	25	21	15	195	2		
		4.04	Diagnostics within 6 weeks	99%	95%	96%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	6		
		4.05	Cancer: 2w wait for urgent GP Referrals	93%	98%	90%	98%	98%	94%	92%	97%	95%	96%	91%	88%	98%	97%	94%	4		
		4.06	Cancer 2w wait breast	93%	93%	88%	96%	94%	94%	99%	83%	98%	100%	98%	100%	100%	99%	98%	6		
		4.07	Cancer 31 d First Treatment	96%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	99%	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%	86%	85%	88%	83%	89%	83%	86%	85%	86%	87%	94%	89%	85%	87%	6		
		4.11	Cancer 62 d Screening	90%	96%	100%	89%	97%	100%	100%	90%	100%	100%	91%	100%	83%	100%	96%	6		
		4.12	Incomplete 104 day waits	0																	
	Emergency Care &Emergency Flow	4.20	Number of Delayed Transfer of Care - (DTOCs)	NT	565	566	464	294	417	411	511	481	565	337	250	279	314	396			
		4.21	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	NT	56	50	48	53	35	43	52	52	50	62	59	41	62	456	3		
		4.22	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	17:28	13:19	12:25	22:32	09:57	13:57	10:10	13:53	11:46	12:01	15:44	22:04	16:48	14:02			
		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	3	12	5	14	3	6	5	5	14	10	17	50	124	1		
		4.25	A&E - To inpatient Admission Ratio	27%	34%	35%	34%	32%	32%	31%	31%	31%	32%	34.19%	33.92%	34.91%	40.31%	33%	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	9	3		
		4.27	A&E/AMU - Amb. Submit button complete	80%	90%	90%	84%	88%	93%	91%	92%	91%	90%	90%	88%	88%	89%	90%	3		
		4.28	A&E - Amb. Handover above 30m	30m	46	39	53	48	21	38	31	39	19	15	ND	ND	ND	163	3		
		4.29	A&E - Amb. Handover above 60m	60m	13	21	34	18	3	16	9	7	16	30	ND	ND	ND	81	3		
		4.30	A&E - Type 1&2 high risk patients reviewed by a EMC	14%	94%	80%	89%	100%	94%	87%	93%	ND	ND	ND	ND	ND	ND	91%	3		
	RTT	4.31	RTT - 18w Admitted (Completed)	90%	71%	68%	69%	69%	69%	68%	70%	73%	70%	74%	72%	71%	70%	71%	1		
		4.32	RTT - 18w Non-admitted (Completed)	95%	89%	88%	85%	85%	86%	87%	87%	88%	86%	87%	85%	86%	91%	87%	1		
		4.33	RTT waiting List		17663	17816	18126	18127	22110	22144	19931	18676	17346	17236	16694	16641	16195	18553			
		4.34	RTT waiting list over 18 weeks		1407	1729	1833	1834	3929	4492	3316	2629	2441	2467	2171	1843	1775	2785			
	Stroke	4.35	Stroke - % Patients scanned within 1 hr.	77%	81%	76%	69%	88%	87%	80%	72%	82%	79%	78%	76%	74%	76%	78%	3		
		4.36	Stroke - % patients scanned within 12 hrs.	96%	97%	100%	91%	100%	98%	98%	95%	95%	96%	90%	97%	92%	96%	95%	2		
		4.37	Stroke - % Patients admitted directly to stroke unit within 4h	75%	77%	84%	63%	75%	89%	71%	76%	78%	79%	83%	72%	73%	60%	76%	3		
		4.38	Stroke - % greater than 80% of treatment on a stroke unit	90%	89%	92%	91%	88%	98%	88%	88%	94%	98%	93%	89%	93%	91%	92%	3		
		4.39	Stroke - % of patients treated by the SESDC	48%	68%	47%	42%	34%	50%	48%	75%	46%	33%	51%	50%	31%	32%	46%	2		
		4.40	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	86%	82%	84%	94%	93%	86%	95%	92%	88%	85%	83%	82%	89%	88%	3		
		4.41	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72 hrs. and have negotiated goals within 5d.	75%	89%	77%	80%	72%	87%	80%	90%	88%	90%	92%	77%	76%	78%	84%	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%	ND	50%	ND	ND	ND	58%	ND	ND	ND	58%	ND	ND	ND	58%	3		
		4.44	Stroke -Provider rating to remain within A-C	C	ND	B	ND	ND	ND	C	ND	ND	ND	ND	ND	ND	ND	C			
	Othe	4.45	RCA Actions beyond deadline for completion	4	15	9	9	8	3	1	3	4	1	7	2	9	14	44	2		
		4.46	Sepsis - 1 hr neutropaenic sepsis	50%	90%	72%	94%	80%	64%	47%	63%	69%	83%	62.50%	78.95%	73.91%	53.85%	66%	3		

110 out of 132

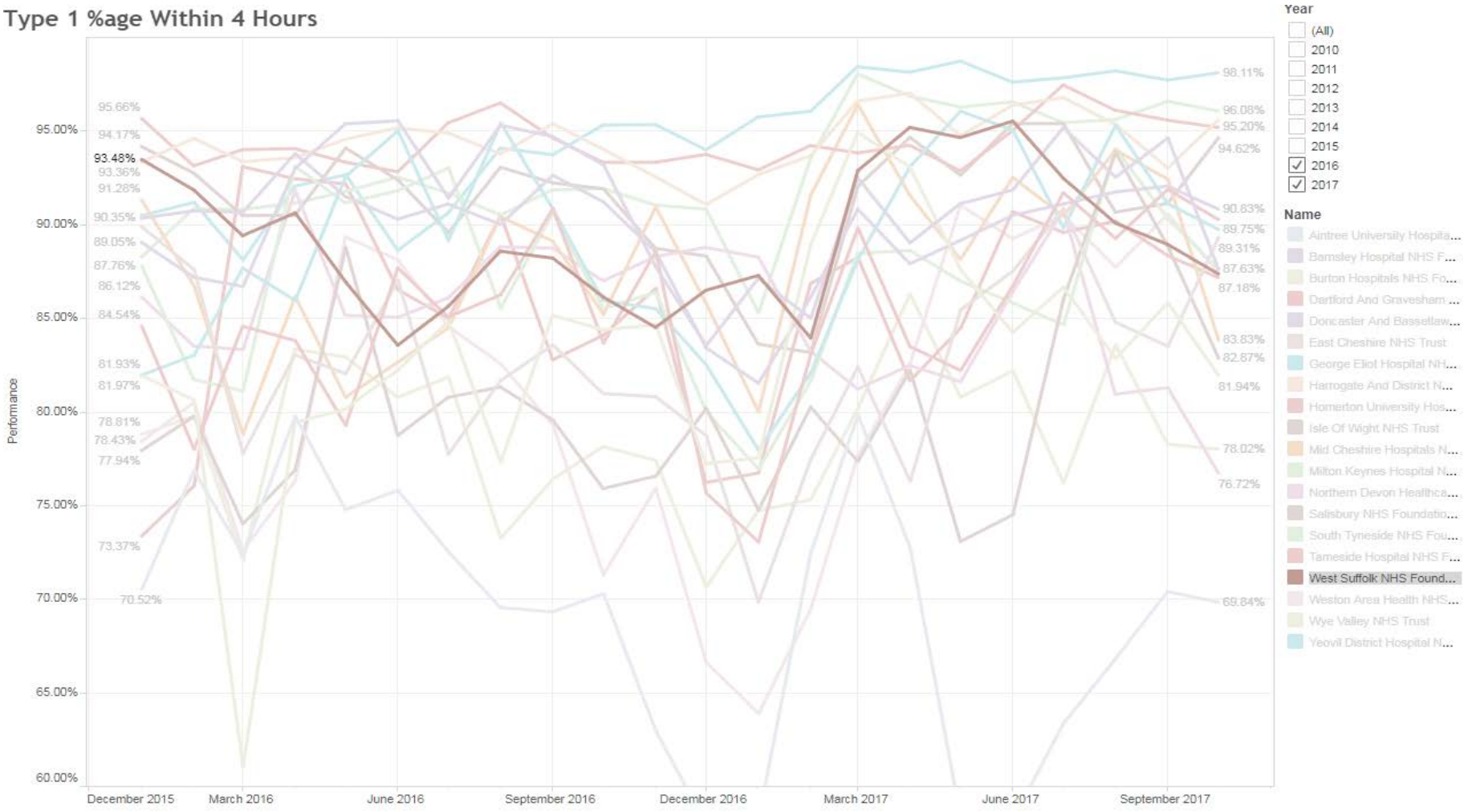
Putting you first

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 – May 2017) shows the relative performance of West Suffolk compared with peers and the national average. The second chart show national attendances and A&E 4 hour performance over time and the final table reviews the recent performance of West Suffolk and associated recovery actions.



A&E Type 1 Percentage within 4 hours depicted in a report compared with Small Trust List. (Source Data – NHS I)



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Background

83.3% against a threshold of 95% - December has seen a deterioration in the 95% 4 hour target from 90.3% in November to 83.3% in December.

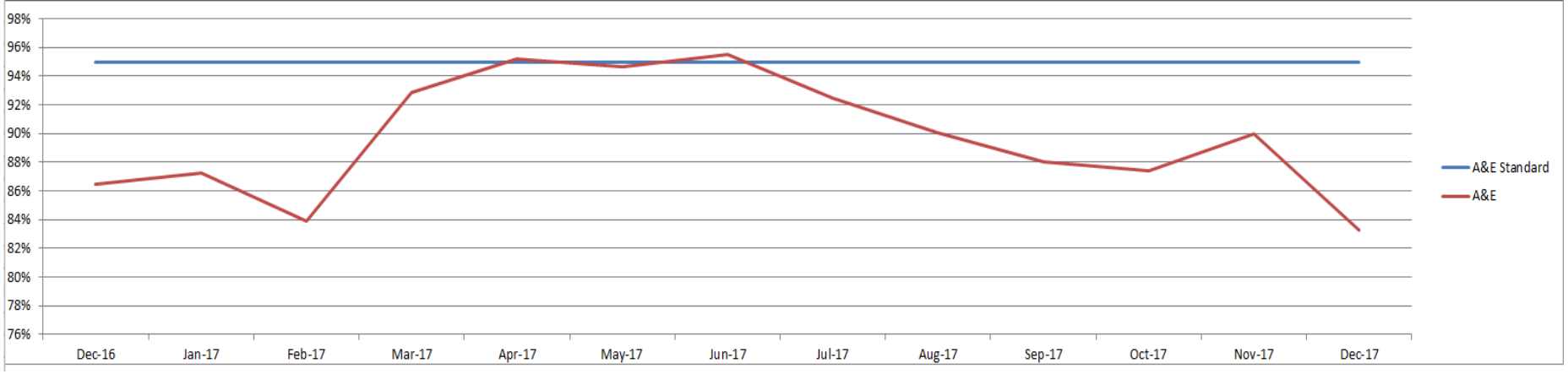
A&E - Single longest Wait (Admitted & Non-Admitted) - 16:48

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	Feb-18	Mar-18
A&E Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%					
A&E	86%	87%	84%	93%	95%	95%	96%	92%	90%	88%	87%	90%	83%					

Key Recovery Actions

Description	Owner	Start	End
Delays in being seen by a clinical decision maker (CDM) continues to be the main reason 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, there continue to be gaps on a frequent basis. There has been agreement for additional consultant support during weekend days which commence in Q4 and additional locum consultant cover which will provide additional support overall. Secondary continues to be bed availability in the Trust. Additional initiatives have commenced which have had a positive impact. However, the number of speciality expected patients being seen in ED has adversely affected our capacity and ability to manage ED patients in a timely manner.	HB	Jul-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Stroke
Standard	
Name	Helen Beck
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	NA

Background

Stroke: % of patients scanned within 1 hour of clock start: A variety of reasons including 5 patients admitted under medics with a differential diagnosis and later to be found as stroke, 1 radiology delay as only one CT scanner working, 3 delays in ESOT being informed, 1 ED delay – department exceptionally busy, 1 patient clinically needed an MRI

Stroke: % of patients admitted directly to Stroke Unit within 4 hours of clock start: Unfortunately 18 patients breached this target. Five were the patients with a differential diagnosis. The remaining 13 breaches were all attributed to no ned being available. This was at a time when ED was experiencing a huge demand on its services and the Trust was on an internal critical bed incident. Even when there were medical patients who were on the stroke unti who could move out, there was nowhere for them to transfer to.

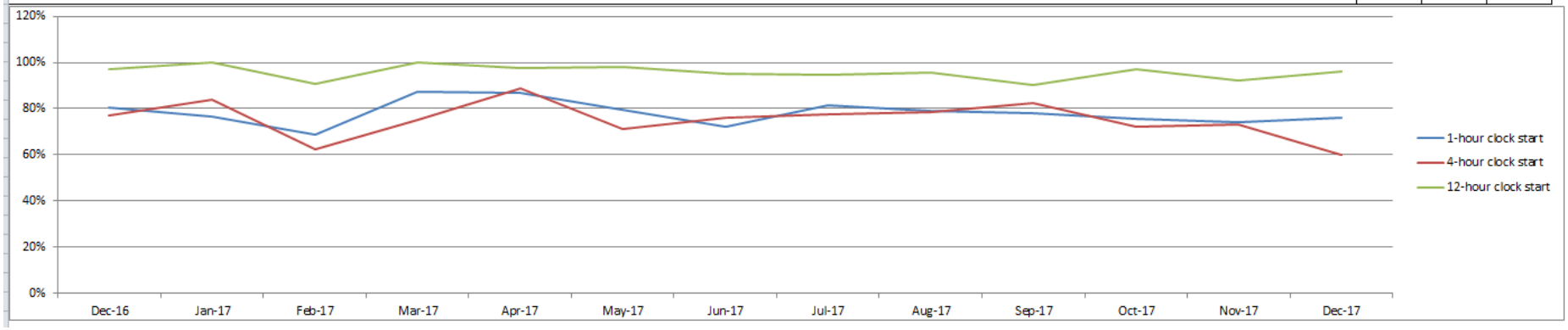
Stroke: % of patients admitted directly to Stroke Unit within 12 hours of clock start: 2 patients breached this from the list above, both admitted under medics with a differential diagnosis and later found to be a stroke.

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	Feb-18	Mar-18
1-hour clock start	81%	76%	69%	88%	87%	80%	72%	82%	79%	78%	76%	74%	76%					
4-hour clock start	77%	84%	63%	75%	89%	71%	76%	78%	79%	83%	72%	73%	60%					
12-hour clock start	97%	100%	91%	100%	98%	98%	95%	95%	96%	90%	97%	92%	96%					

Key Recovery Actions

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	Jan-18



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-Dec-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Background

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

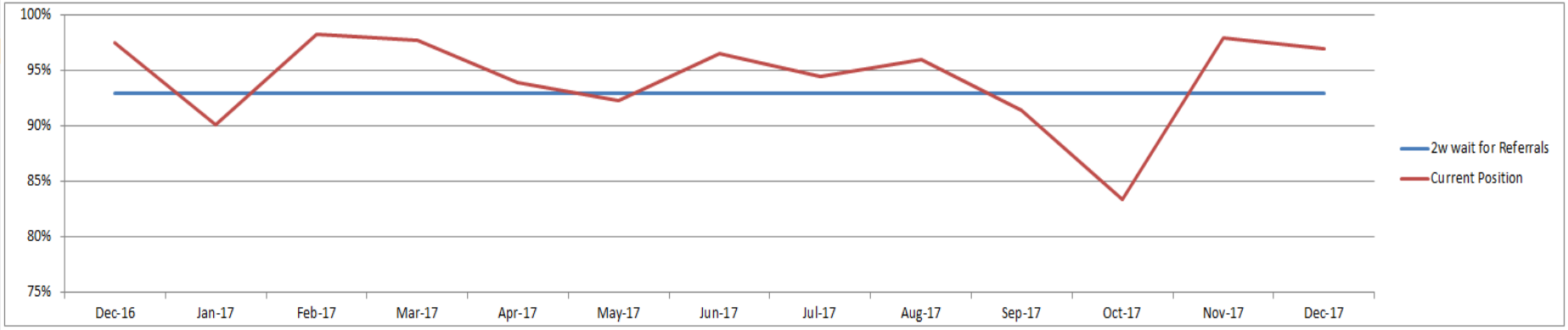
Current Position - 97% against a threshold of 85%

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	Feb-18	Mar-18
2w wait for Referrals	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%					
Current Position	98%	90%	98%	98%	94%	92%	97%	95%	96%	91%	83.4%	98%	97%					

Key Recovery Actions

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, with December figure of 97%.	HB	Jul-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer: 62-day Screening
Standard	90%
Name	Helen Beck
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Background

Cancer: 62-day Screening

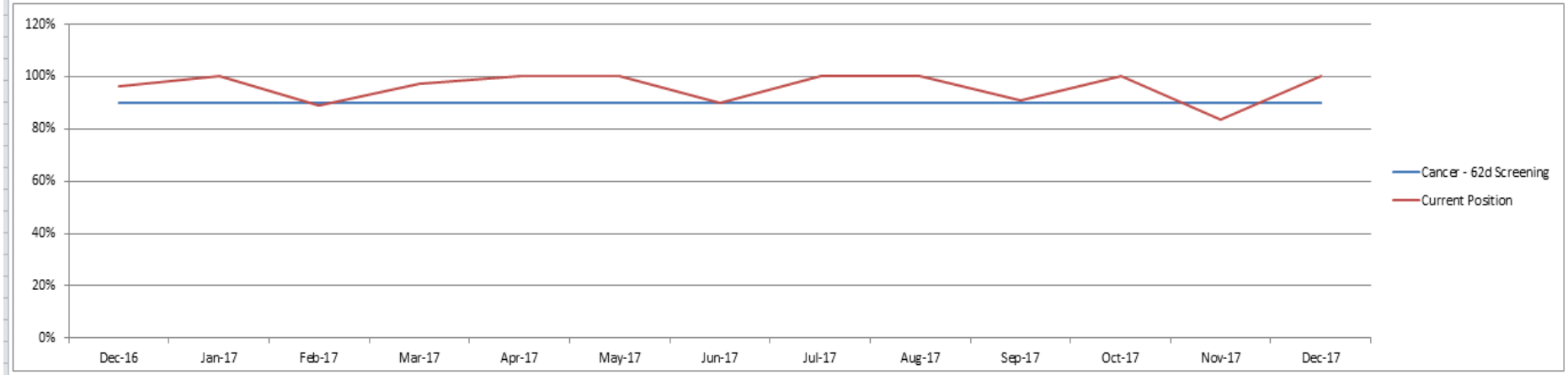
Current Position - 100% against a threshold of 90%

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	Feb-18	Mar-18
Cancer - 62d Screening	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%					
Current Position	96%	100%	89%	97%	100%	100%	90%	100%	100%	91%	100%	83%	100%					

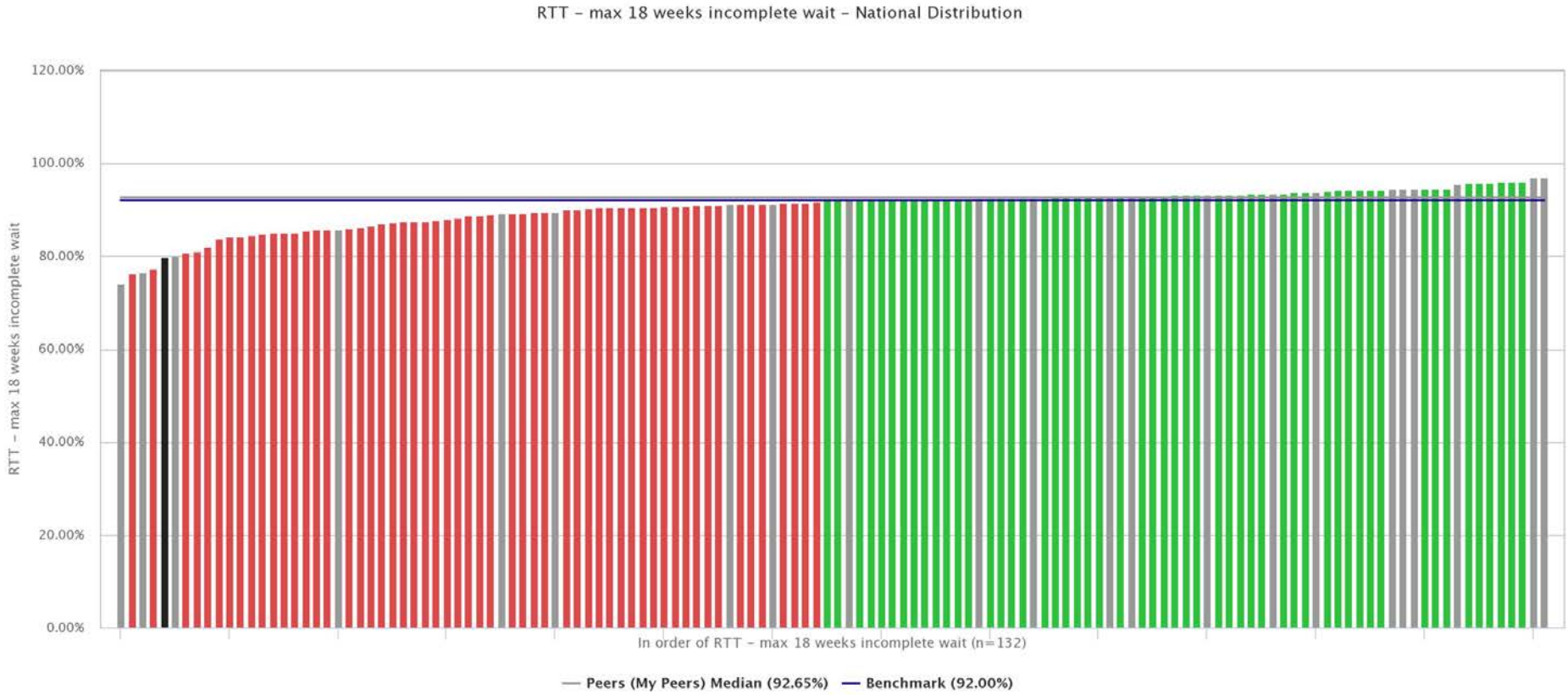
Key Recovery Actions

Description	Owner	Start	End
Improved the position from 83.3 in November to 100% in December 2017	HB	Jul-17	Dec-17

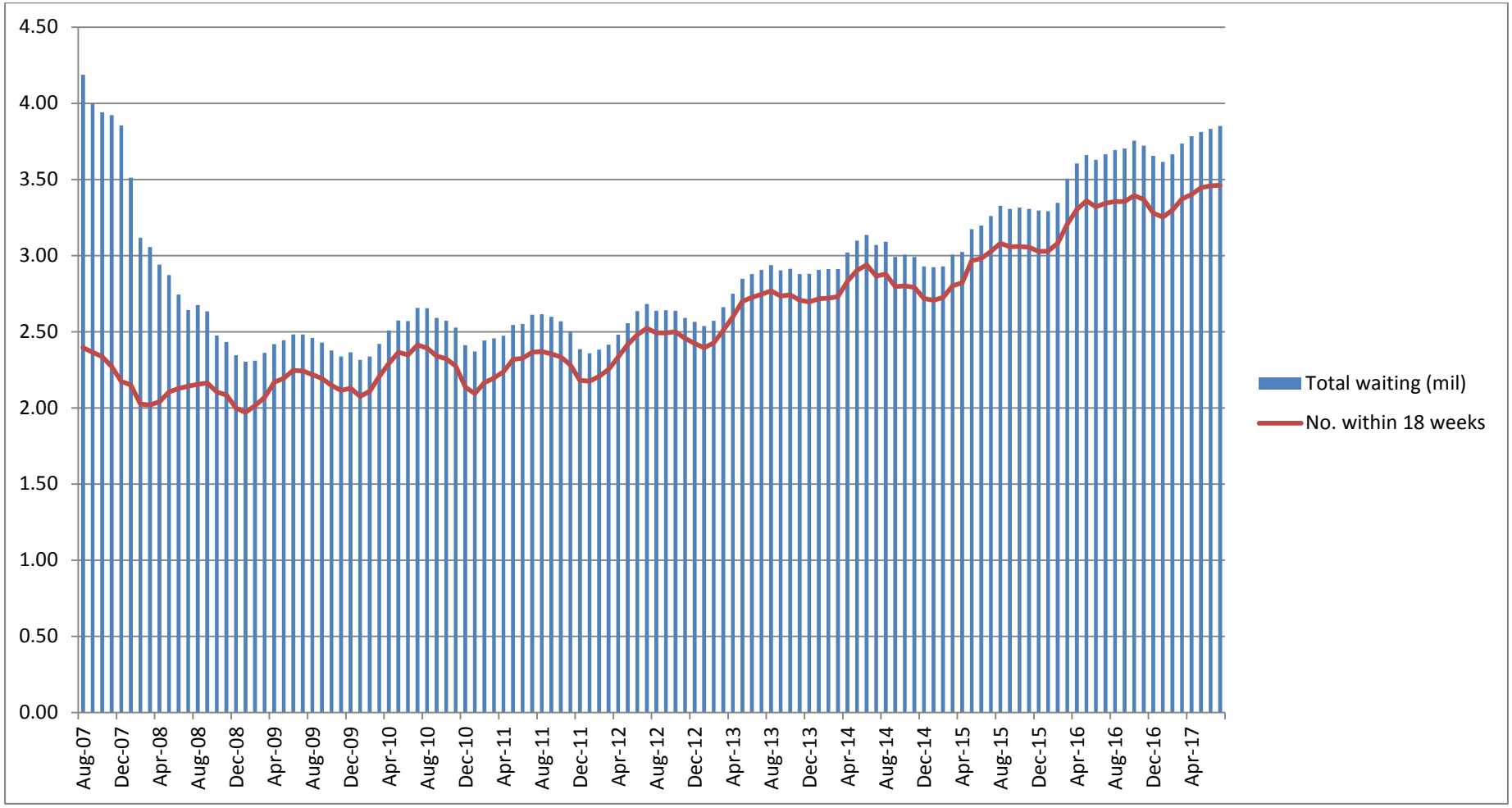


Referral to Treatment

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



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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Background

Current Position: 89% against a threshold of 92%. The waiting list at the end of December has a total of 16,195 patients (16,641 at the end of November) with 1775 patients breaching 18 weeks (1843 in November). There remain persistent data quality issues within this number leading to a reported position which we believe is slightly worse than our actual position.

1. Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks - 95.94%. There are on-going significant capacity issues within the ENT, Vascular, Urology, and Dermatology services. Patients are experiencing extended waits for surgery within Urology, Vascular Surgery, and Ophthalmology. There remains significant pressure on rapid access referrals in Dermatology. The plastic surgery service has taken on a number of referrals from dermatology to support the service. However, this is giving the appearance of a drop in performance for the plastic surgery service itself.

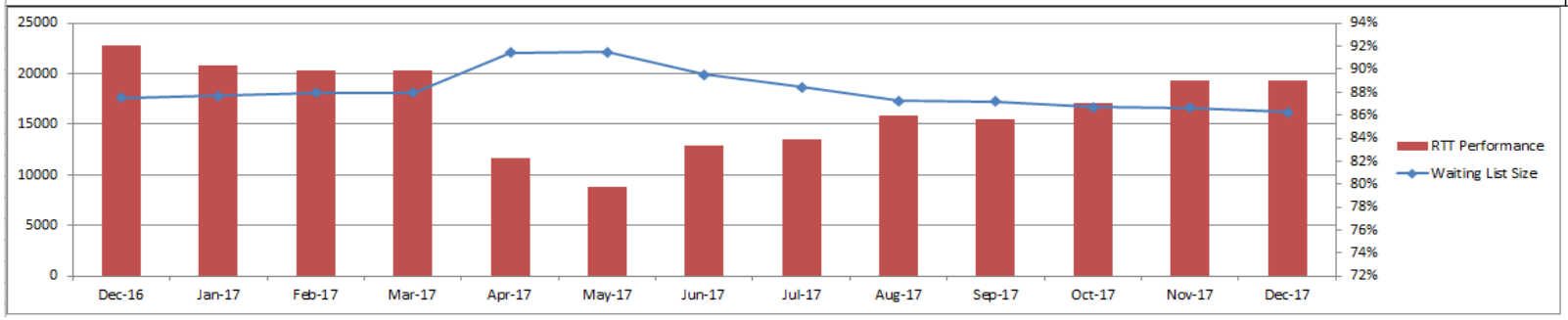
2. Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted - 69.91%.
3. Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted - 90.62

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	Feb-18	Mar-18
Waiting List Size	17663	17816	18126	18127	22110	22144	19931	18676	17346	17236	16694	16641	16195					
RTT Performance	92%	90%	90%	90%	82%	80%	83%	84%	86%	86%	87%	89%	89%					

Key Recovery Actions

Description	Owner	Start	End
1. Targeted work is being undertaken to reduce the back log in challenged specialties including ophthalmology but capacity issues remain in others such as ENT and dermatology having a consequential effect on aggregate performance. There is a specific focus to review the vascular surgery pathway to ensure appropriate referrals to treatment are in place. Recruitment and sickness absence challenges in the theatre teams are impacting on the ability to run some additional theatre lists that have been planned to aid in reducing backlogs. However, this is showing some signs of improvement but the impact of winter pressures on the elective schedule will add further pressure to the waiting list and the ability of clinical teams to assist in addressing additions to the back log. 2. Patients continue to be treated in longest waiting order, close monitoring and proactive management continues to support RTT position in all specialities. 3. This represents an improving position but continues to be predominantly due to excessive waits for first appointment in Dermatology with much improved waiting times in ENT. On-going work with the CCG and frequent monitoring of the action plans for these specialities.	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-Dec-17
Data Frequency	Monthly
CQC Area	Responsive
National Rank	

Background

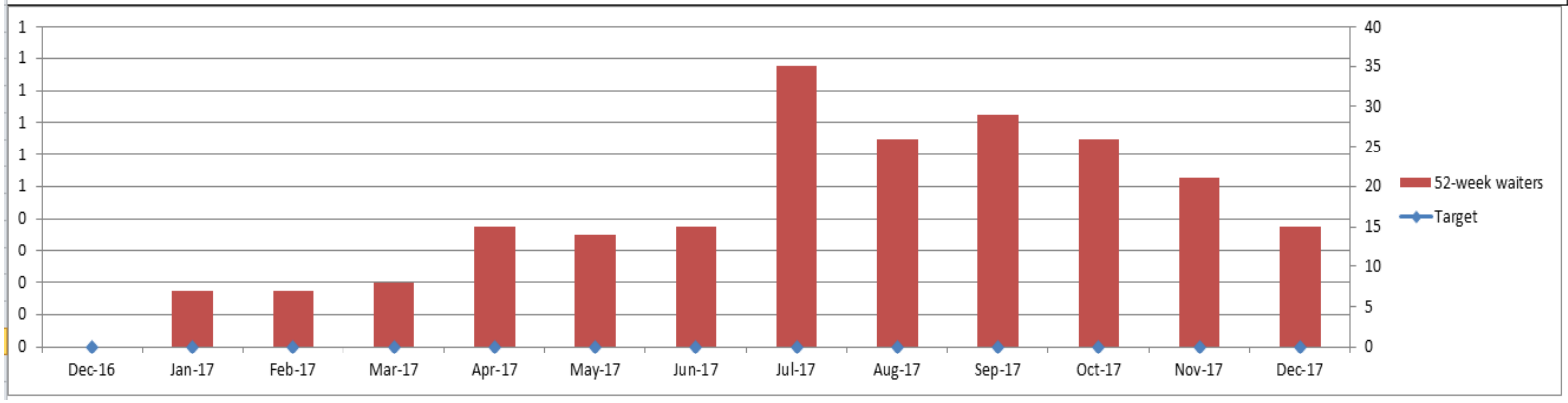
In December 15 patients breached 52 weeks. There were 2 Audiology patients 1 Colorectal, 5 ENT, 3 Urology, and 4 Vascular surgery patients. Of these 15 patients, at the time of reporting on the 19th of January, 5 have completed treatment, 1 will be seen in clinic in January, 3 are awaiting OPA to be booked, and 5 are booked for surgery in February.

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	Feb-18	Mar-18
Target	0	0	0	0	0	0	0	0	0	0	0	0	0					
52-week waiters	0	7	7	8	15	14	15	35	26	29	26	21	15					

Key Recovery Actions

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



DETAILED REPORTS – WELL-LED

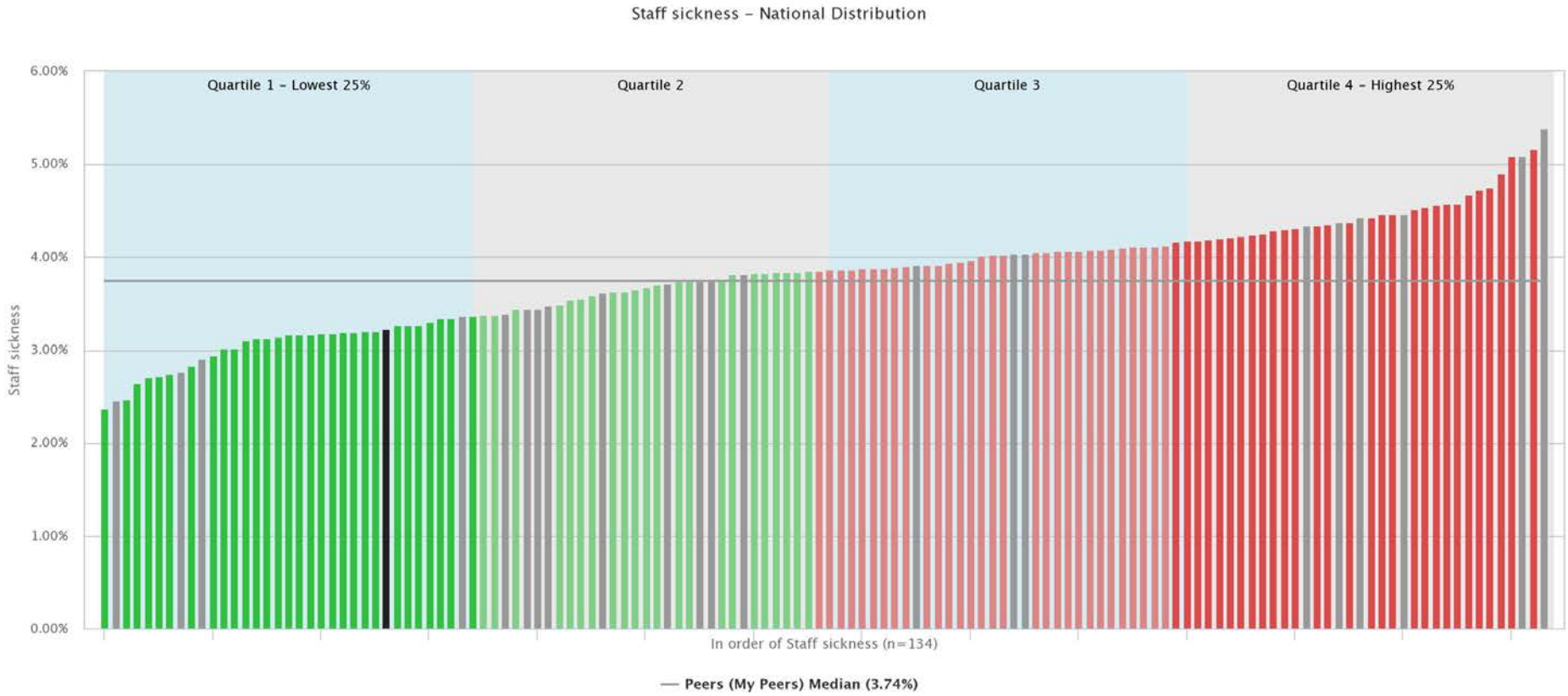
Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we		Ref.	KPI	Target	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	YTD(Apr17 Mar18)	WTG	Traffic	Trend
5. Well Led	Dashboard	5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	94%	NA	NA	93%	NA	NA	95%	NA	NA	95%	NA	NA	ND	95%	6		
		5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	ND	NA	NA	79%	NA	NA	83%	NA	NA	82%	NA	NA	ND	83%	6		
		5.04	Turnover (Rolling 12 mths)	<10%	10%	10%	11%	10%	10%	10%	10%	10%	10%	10%	9%	9%	9%	10%	6		
		5.05	Sickness Absence	<3.5%	4.48%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.58%	4		
		5.06	Executive Team Turnover (Trust Management)	<10%	0%	0%	0%	0%	0%	20%	0%	0%	0%	0.0%	0%	0%	0%	2%	6		
		5.07	Agency Spend		422	459	354	258	307	316	289	336	244	220	187	475	183.00	284	6		
		5.08	Monitor Use of Resources Rating		4	4	4	3	3	3	3	3	3	3	3	3	3	3			
	Agency, WTE & vacancies	5.09	Agency Spend Cap		422	459	354	258	307	316	289	336	244	220	187	475	183	284			
		5.10	Bank Spend		302	319	307	334	380	287	282	372	315	422	327	331	398	346			
		5.11	Bank/agency Spend percentage		4.99%	5.78%	4.45%	4.15%	4.6%	3.9%	3.7%	4.9%	3.6%	4.7%	3.8%	4%	5%	4.2%	2		
		5.12	Proportion of Temporary Staff		11.40%	11.20%	10.90%	9.30%	11%	11%	10%	12%	11%	10.6%	10%	11%	8%	11%	3		
		5.13	Locum and Medical agency spend		323	297	325	234	309	368	361	381	347	270	357	381	508	365			
		5.14	Total Vacancies		5.90%	5.89%	5.82%	5.55%	7%	8%	6%	8%	7%	8%	8%	8%	8%	8%	3		
		5.15	Corporate & Admin Costs as %	<7%	9.33%	9.36%	9.39%	9.56%	8.48%	8.57%	9.46%	9.47%	9.49%	9.50%	8.60%	8.60%	11.11%	9.25%			
		5.16	% Staff on Maternity/Paternity Leave		2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2.01%			
		5.17	% Fill rate of Reg. Nurse shifts	90%	68.89%	69.15%	71.93%	80.47%	83.20%	81.32%	83.60%	80.89%	79.60%	80.84%	ND	ND	ND	81.58%			
	Corporate	5.23	% use of Core First (Qtrly)		ND	ND	ND	ND	2%	ND	ND	5%	ND	ND	ND	ND	ND	4%			
		5.25	Grievance reviews		3	3	4	4						6	6	6	5	23			
		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	6	3		
		5.28	DBS checks	95%	93%	93%	93%	93%	93%	93%	93%	98%	98%	99%	98%	98%	99%	96%	3		
		5.29	Staff appraisal Rates	90%	92%	92%	92%	92%	ND	92%	92%	ND	ND	53%	51%	56%	62%	68%	1		
		5.38	Trust Participation in on-going National Audits (Qtrly)	90%	100%	NA	NA	ND	NA	NA	94%	NA	NA	96%	NA	NA	96%	95%	3		
	Training	5.39	Infection Control Training (classroom)	85%	94%	94%	94%	95%	95%	96%	95%	95%	96%	94%	95%	95%	95%	95%	3		
		5.40	Infection Control Training (eLearning)	185%	87%	87%	88%	88%	88%	88%	90%	90%	88%	83%	85%	88%	88%	88%	3		
		5.41	Manual Handling Training (Patient)	80%	80%	82%	80%	79%	81%	83%	84%	83%	83%	80%	80%	84%	84%	82%	3		
		5.42	Manual Handling Training (Non Patient)	80%	86%	87%	84%	83%	81%	81%	83%	83%	82%	86%	84%	88%	88%	84%	3		
		5.43	Staff Adult Safeguarding Training	80%	87%	86%	87%	88%	88%	89%	90%	90%	89%	89%	90%	92%	92%	90%	3		
		5.44	Safeguarding Children Level 1	90%	87%	86%	87%	86%	86%	86%	87%	88%	87%	86%	88%	89%	90%	87%	2		
		5.45	Safeguarding Children Level 2	90%	86%	86%	87%	87%	87%	88%	90%	90%	87%	88%	89%	90%	92%	89%	2		
		5.46	Safeguarding Children Level 3	90%	81%	81%	79%	78%	85%	83%	81%	81%	76%	73%	79%	83%	86%	81%	2		
		5.47	Health & Safety Training	80%	87%	86%	87%	88%	88%	89%	89%	89%	89%	89%	90%	91%	91%	89%	3		
		5.48	Security Awareness Training	80%	87%	87%	87%	88%	88%	89%	90%	90%	89%	89%	90%	90%	91%	89%	3		
		5.49	Conflict Resolution Training (eLearning)	80%	76%	77%	81%	83%	81%	83%	85%	86%	80%	90%	81%	82%	95%	84%	3		
		5.50	Conflict Resolution Training	180%	74%	74%	74%	75%	75%	75%	77%	77%	76%	75%	76%	76%	75%	76%	2		
		5.51	Fire Training (eLearning)	280%	87%	86%	86%	85%	85%	86%	87%	87%	85%	85%	85%	85%	84%	86%	3		
		5.52	Fire Training (classroom)	80%	89%	89%	89%	89%	90%	90%	90%	90%	90%	89%	90%	91%	91%	90%	3		
		5.53	IG Training	80%	82%	82%	82%	82%	80%	81%	85%	84%	85%	84%	87%	86%	87%	84%	3		
		5.54	Equality and Diversity	80%	91%	91%	92%	93%	93%	94%	95%	95%	93%	92%	93%	94%	94%	94%	3		
		5.55	Majax Training	80%	85%	85%	86%	86%	86%	86%	88%	88%	87%	86%	88%	88%	89%	87%	3		
		5.56	Medicines Management Training	80%	85%	85%	86%	87%	87%	87%	88%	88%	87%	87%	86%	87%	88%	87%	3		
		5.57	Slips, trips and falls Training	80%	83%	82%	84%	85%	84%	85%	87%	87%	85%	85%	86%	88%	88%	86%	3		
		5.58	Blood-borne Viruses/Inoculation Incidents	80%	82%	81%	84%	85%	84%	84%	86%	86%	84%	84%	85%	86%	87%	85%	3		
		5.59	Basic life support training (adult)	80%	81%	81%	80%	81%	83%	85%	85%	85%	84%	82%	81%	81%	82%	83%	3		
		5.60	Blood Products & Transfusion Processes (Refresher)	80%	77%	76%	78%	80%	80%	82%	83%	82%	79%	79%	80%	78%	80%	80%	3		

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.



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

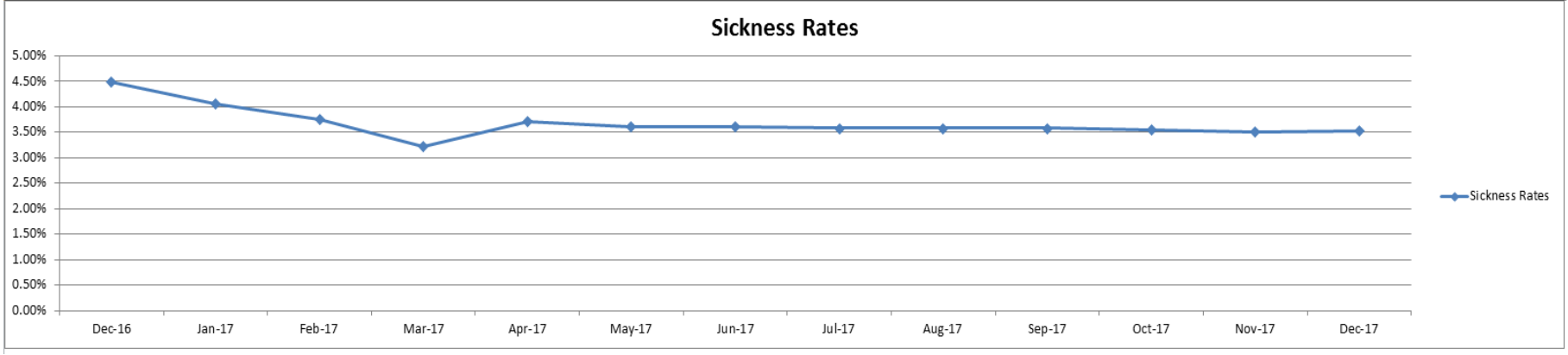
Background

The Trust is .02% off the target.

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	Feb-18	Mar-18
Sickness Rates	4.48%	4.06%	3.76%	3.22%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%					

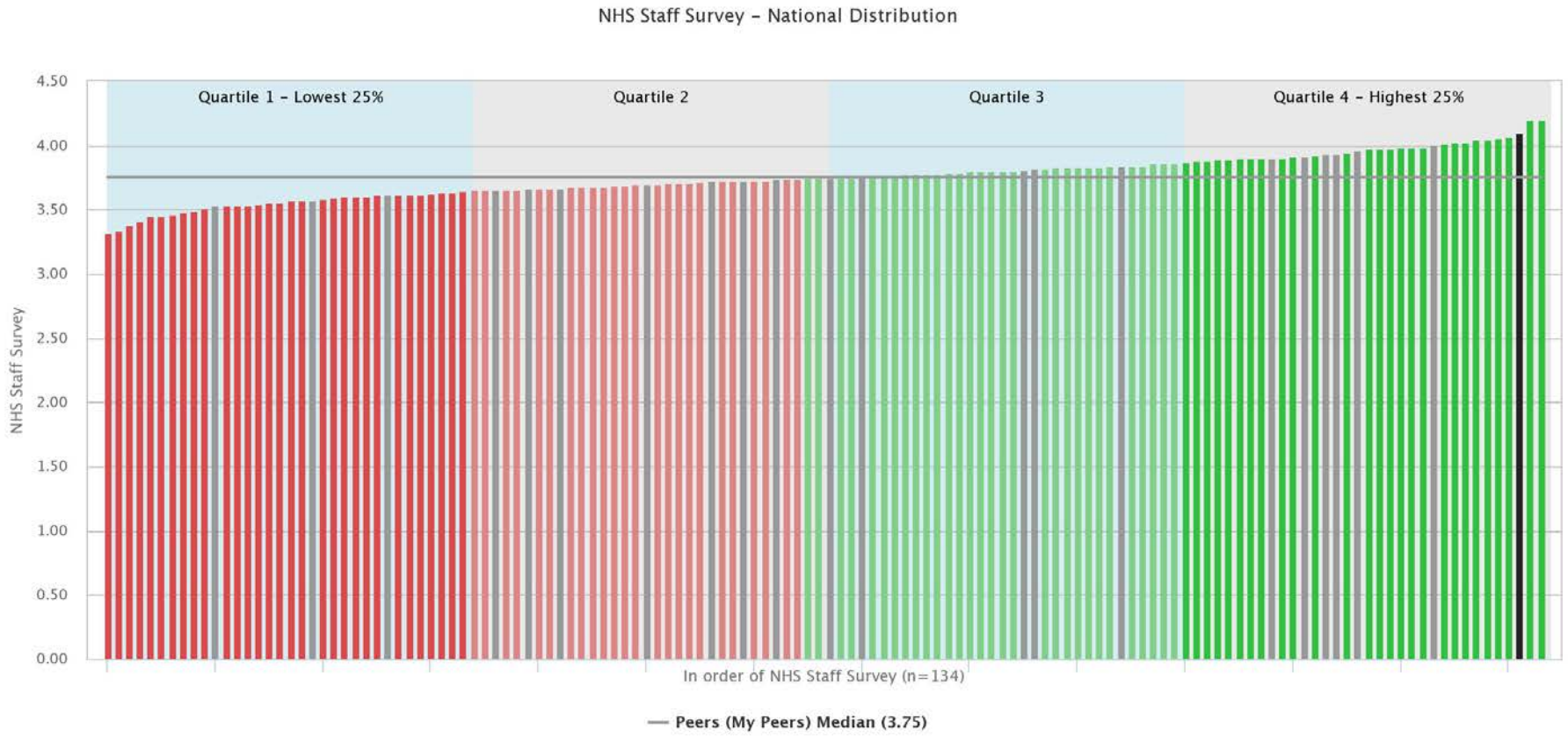
Key Recovery Actions

Description	Owner	Start	End
Sickness Rates - This is a positive figure when compared with other years, and the current staffing and sickness challenges. December 2016 was 3.93%.	JB	Apr-17	Mar-18
All Staff to have an appraisal - The appraisal compliance percentage (62.64% in December) has risen significantly since moving to the new process of recording. The Trust has seen an 11.81% in that time.			



Staff F&FT

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



DETAILED REPORTS – PRODUCTIVE

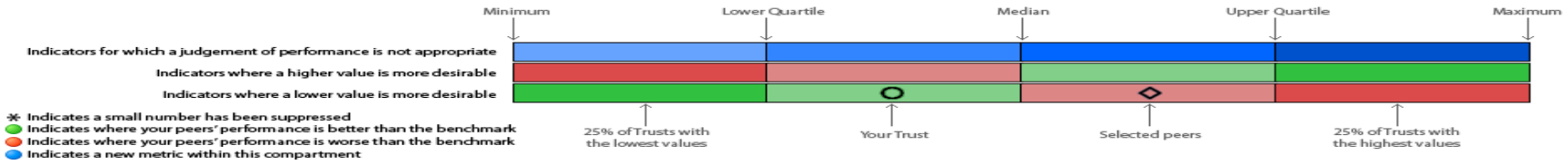
Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	Target	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	YTD(Apr17-Mar18)	WTG	Traffic	Trend
6. Productive	Dashboard	6.01	I&E Margin	Var	-4.93%	-5.13%	-5.10%	-1.50%	ND	-5%	-4.3%	-3.9%	0.1%	-3.04%	-2.55%	-2.47%	-2.60%	-3%			
		6.02	Distance from Financial Plan	Var	ND	ND	ND	ND	ND	0.0%	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%	ND	0.0%			
		6.03	Capital service capacity	Var	- 2.59	- 6.74	- 2.81	1.41	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.52%	0.16%	0.52%			
		6.04	Liquidity (days)		- 16.45	- 19.70	- 21.76	- 7.28	ND	- 12.15	- 15.72	- 10.94	- 11.03	- 12.70	- 15.14	-9.64%	ND	-9.64%			
		6.05	Long Term Borrowing (£m)	3.5%	32.06	33.06	36.06	44.30	44.27	45.70	45.70	45.70	45.70	47.62	47.62	56.67	ND	56.67	6		
		6.06	CIP Plan Variance (£000s)	1.9	-2,550	-3,268	-3,247	0	40	0	-40	10	0	-54	-10	-35	ND	-11			
	Activity	6.07	A&E Activity		5308	5064	4740	5570	5574	5970	5922	6124	5828	5741	6058	5736	5455	52408			
		6.08	NEL Activity		2623	2480	2350	2750	2409	2440	2429	2375	2385	2465	2576	2509	2527	22115			
		6.09	OP - New Appointments		5556	6119	5697	6849	5125	6244	6148	5706	5635	5633	6182	7410	5452	53535			
		6.10	OP- Follow-Up Appointments		10218	11999	11483	12790	9541	11667	11542	11147	11333	11116	11815	12673	9766	100600			
		6.11	Electives (Incl Daycase)		2553	2877	2819	3303	2593	3004	2898	2796	2829	2786	2868	3157	2542	25473			
	Finance	6.13	Agency Rating (spend £000)		422	459	354	258	307	316	289	336	244	220	187	475	183	2557			
		6.14	Financial Position (YTD)	Var	9228	10649	11736	3327	-937	-2906	-2758	-3290	-3300	-3953	-3956	-4114	ND	-4114			
		6.15	Financial Stability Risk Rating	Var	4	4	4	3	3	3	3	3	3	3	3	3	3	3			
		6.16	Cash Position (YTD £000s)	Var	4302	3598	1538	1352	7,955	5093	2689	7460	3300	4846	2654	2654	ND	2654			
	Ratios	6.17	% Consultant to Consultant Referrals		ND	ND	ND	ND	10%	10%	10%	12%	13%	10%	10.57%	10.03%	10.92%	10.7%			
		6.18	New to FU Ratios	1.9	2.15	2.11	2.12	2.07	1.86	1.87	1.88	1.96	2.01	1.97	1.91	1.78	1.79	1.89			
		6.20	Non-Clinical Floor Space	<35%				29%	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	8,019	9,554	10,912	12,500	840	1000	820	810	1420	1094	1123	1504	ND	8611			
		6.23	Actual (£000s) YTD		5,469	6,286	7,665	12,500	880	1000	780	820	1420	1040	1113	1469	ND	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)

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	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	YTD(Apr17-Mar18)	WTG	Traffic	Trend
Maternity	Dashboard	7.01	Total number of deliveries (births)	210	234	198	197	238	215	192	213	215	233	236	205	194	180	1883	6		
		7.02	% of all caesarean sections	<22.7%	19%	16%	13%	19%	15%	21%	16%	16%	22.32%	18.22%	17.10%	17.0%	18.3%	18%	6		
		7.03	Midwife to birth ratio	1.30	ND	1.28	1.28	1.33	1.30	1.27	1.29	1.30	1.33	1.33	1.29	1.28	1.26	1.29	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%	96%	93%	87%	89%	84%	93%	84%	94%	82%	98%	98%	98%	93%	92%	4		
		7.06	Maternity SIs	NT	3	0	1	1	1	0	0	0	0	1	1	0	1	4			
		7.07	Maternity Never Events	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	-			
		7.08	Breastfeeding Initiation Rates	80%	80%	74%	80%	76%	79.8%	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	81%	6		
	Safe	7.09	Elective Caesarean Sections	10%	7%	8%	5%	7%	5%	10%	4.3%	7.0%	9.4%	6.4%	5.9%	7.2%	7.8%	7%	3		
		7.10	Emergency Caesarean Sections	<13%	12%	8%	9%	12%	10%	12%	12%	9%	13%	12%	11%	10%	11%	11%	3		
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	100%	100%	89%	1		
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	81%	71%	70%	89%	92%	93%	93%	83%	57%	82%	88%	50%	80%	80%	2		
		7.14	Homebirths	2%	ND	2%	3%	2%	1%	4%	2.4%	3.3%	2.6%	2.1%	3.9%	2.6%	3.3%	3%	3		
		7.15	Midwifery led birthing unit (MLBU) births	>13%	21%	24%	19%	16%	18%	17%	17.3%	18.8%	15.5%	15.3%	17.1%	16.0%	15.0%	17%	3		
		7.16	Labour Suite births	75%	76%	74%	78%	82%	81%	79%	80.3%	77.9%	82.0%	82.6%	79.0%	81.4%	81.7%	81%	3		
		7.17	Induction of Labour	NT	34%	34%	36%	37%	43%	41%	40.9%	36.6%	38.2%	34.3%	35.1%	43.8%	43.9%	39.6%			
		7.18	Instrument Assisted Deliveries (Forceps & VentoUse)	NT	4.35%	4.60%	4.85%	6.20%	4.45%	6.80%	4.85%	4.20%	3%	4.65%	4.15%	7.20%	5.85%	5%			
		7.19	Critical Care Obstetric Admissions	0	0	0	0	1	1	1	0	1	0	1	0	0	0	4	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	7	3	2	8	2	4	3	5	3	7	6	4	5	39			
		7.22	Post-partum Hysterectomies	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	2		
		7.23	Women requiring a blood transfusion of 4 units or more	0	ND	ND	0	ND	1	0	0	0	0	0	0	0	ND	1	2		
		7.24	3rd and 4th degree tears (all deliveries)	12	4	5	4	7	8	9	6	10	4	4	6	3	8	58	3		
	Caring	7.25	Maternal death	NT	0	0	0	1	1	0	0	0	0	0	0	0	0	1			
		7.26	Stillbirths	NT	3	0	1	0	1	0	0	0	0	1	2	1	0	5			
		7.27	Complaints		1	0	0	0	0	0	1	2	1	0	0	0	1	5			
		7.28	No. of babies admitted to Neonatal Unit (>36+6)	NT	20	8	8	0	15	9	17	18	13	15	15	11	9	122			
	Responsive	7.29	No. of babies transferred for therapeutic cooling	0	0	1	1	1	0	0	0	0	0	0	1	0	1	2	3		
		7.30	% of babies admitted to NNU with normal temperature	80%	100%	100%	100%	100%	87%	66%	88%	100%	100%	86%	81%	92%		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	48	54	49	64	51	62	46	64	43	52	61	57	49	485	2		
		7.33	Hours of dedicated consultant cover per week	60	75	63	81	60	93	110	99	99	96	99	99	108	90	893	3		
		7.34	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	90	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	ND	27	35	37	32	30	37	27	28	17	270			
		7.37	No. of women identified as smoking at delivery	NT	ND	ND	ND	ND	20	30	26	32	27	25	25	24	26	235			
		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	ND	156	157	165	143	170	174	205	155	192	151	156	186	1532			
	Other	7.40	No. of bookings (First visit)	NA	226	262	247	275	208	262	244	272	245	265	259	245	193	2193			
		7.41	Access - Assessment of need by 12 weeks (women booked)	95%	95%	93%	95%	96%	95%	95%	98%	95%	100%	93%	99%	97%	97%	96%	3		
		7.42	Return of women with perineal problems		ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	0			
		7.43	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	0	0	0	0	0	0	ND	0			
																					90

EXCEPTION REPORTS - MATERNITY

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity - Total number of deliveries (births)
Standard	
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

Background

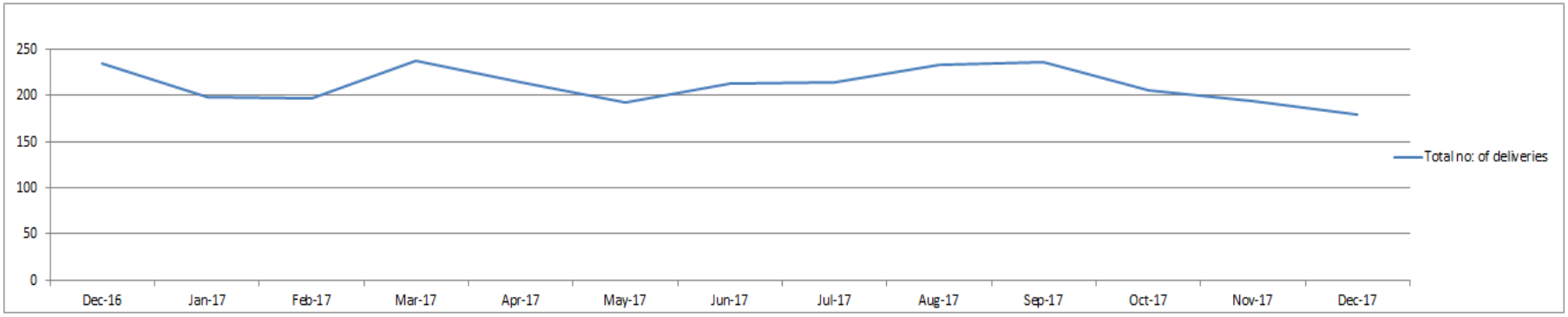
In December 2017 the maternity service delivered less babies than expected. The year to date total is at present 1872 deliveries, slightly behind the position in previous years.

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	Feb-18	Mar-18
Total no: of deliveries	234	198	197	238	215	192	213	215	233	236	205	194	180					

Key Recovery Actions

Description	Owner	Start	End
The trajectory suggests that we will achieve a total of approx. 2,500, in line with previous years, during the financial year.	RP	Oct-17	Mar-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity - Shoulders Dystocia
Standard	100%
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

Background

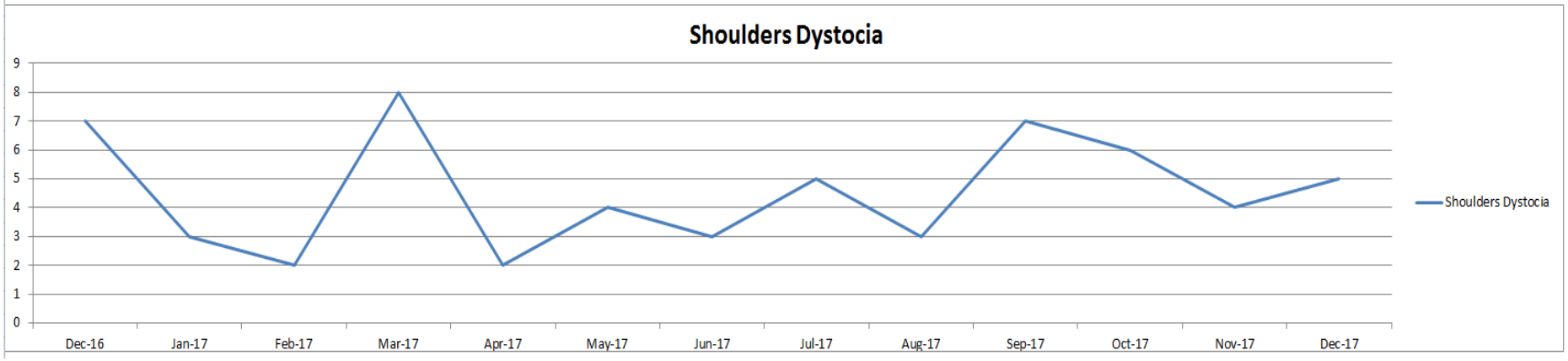
An increase level of incidents of shoulder dystocia were identified in December 2017, similar to previous months.

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	Feb-18	Mar-18
Shoulders Dystocia	7	3	2	8	2	4	3	5	3	7	6	4	5					

Key Recovery Actions

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	Feb-18



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-Dec-17
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

Background

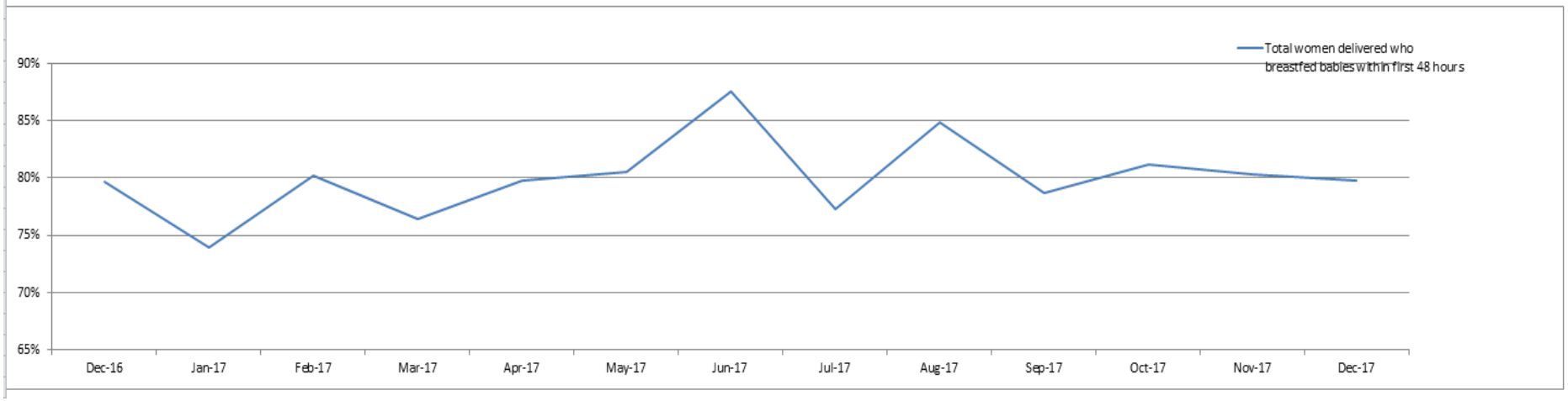
Compliance with the 80% target of babies receiving breastmilk within 48 hours of life was marginally missed in December 2017.

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	Feb-18	Mar-18
Total women delivered who breastfed babies within first 48 hours	80%	74%	80%	76%	79.8%	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%					

Key Recovery Actions

Description	Owner	Start	End
There are a number of ongoing initiatives in place to support initiation of breastfeeding and these will continue.	RP	Oct-17	Dec-17



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Background

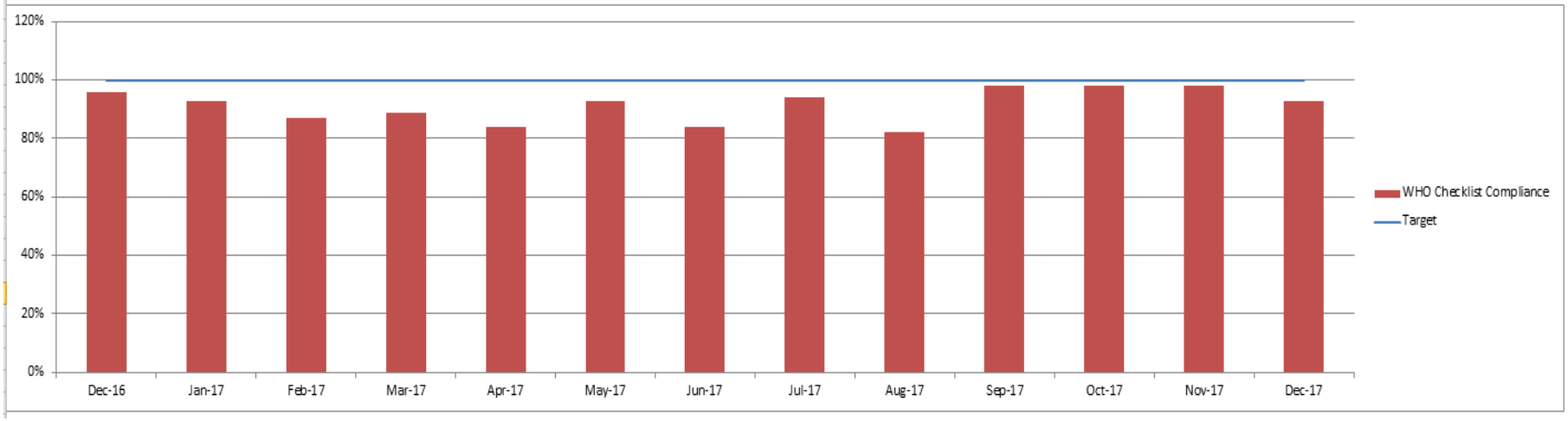
Despite the focus on completion of the Maternity WHO checklist completion rates reduced in December 2017.

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	Feb-18	Mar-18
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
WHO Checklist Compliance	96%	93%	87%	89%	84%	93%	84%	94%	82%	98%	98%	98%	93%					

Key Recovery Actions

Description	Owner	Start	End
There were three forms which failed the audit and this has been followed up with individual members of staff.		Jul-17	Jan-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity - Babies transferred for therapeutic cooling
Standard	0%
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

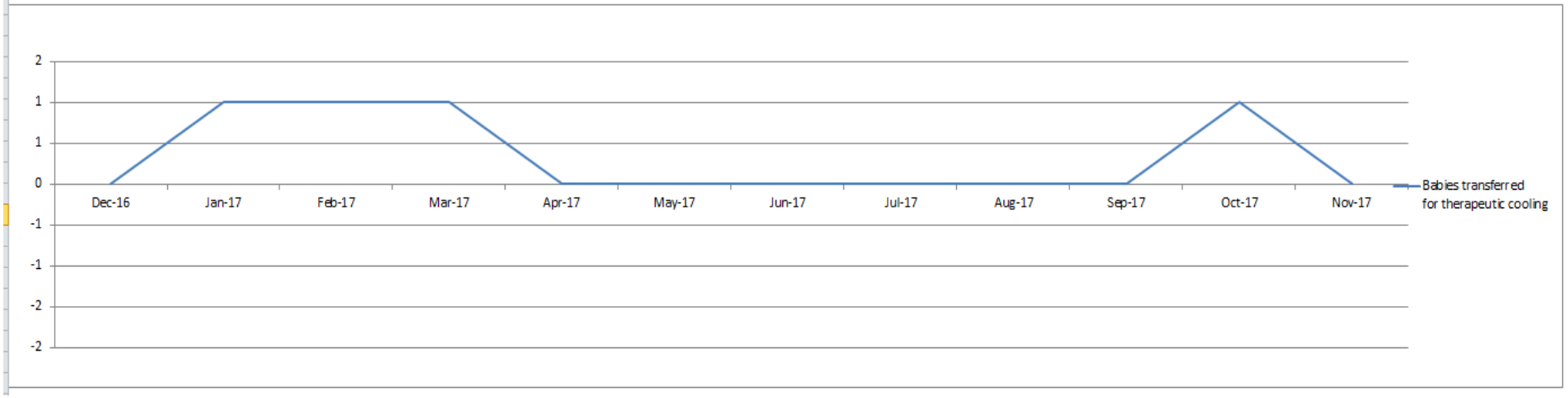
Background

One baby was transferred to a tertiary unit for therapeutic cooling in December 2017.

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	Feb-18	Mar-18
Babies transferred for therapeutic cooling	0	1	1	1	0	0	0	0	0	0	1	0	1					

Key Recovery Actions

Description	Owner	Start	End
In line with the recommendations of Each Baby Counts these are now reported as serious incidents and an investigation is ongoing.	RP	Oct-17	Mar-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Third and fourth Degree Tears
Standard	100%
Name	Rowan Procter
Month	01-Dec-17
Data Frequency	Monthly
CQC Area	Maternity
National Rank	

Background

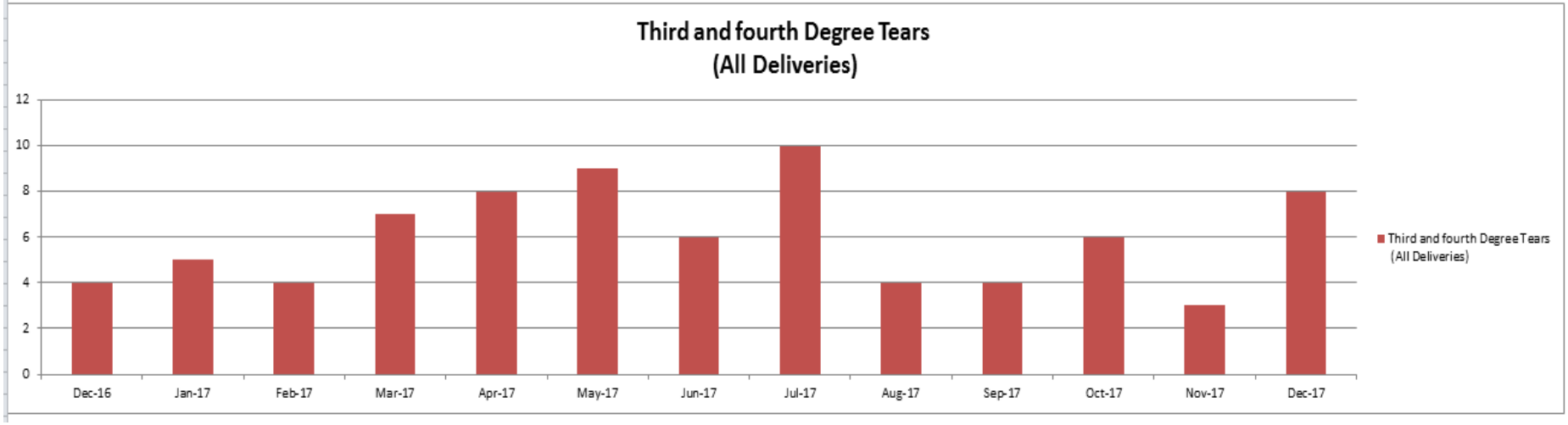
Rated as amber in December 2017

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	Feb-18	Mar-18
Third and fourth Degree Tears (All Deliveries)	4	5	4	7	8	9	6	10	4	4	6	3	8					

Key Recovery Actions

Description	Owner	Start	End
Discussed at the Women's Health Governance meeting on 15th January 2018, to be monitored.		Jul-17	Jan-18



COMMUNTY INFORMATION

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

APPENDIX 1: INDICATOR CHANGES

Comparison of KPI changes from the existing Performance Report

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

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

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

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

KPIs REMOVED

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

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

Appendix 2: PEER HOSPITAL LIST USED BY CQC

Airedale NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Bedford Hospital NHS Trust
Burton Hospitals NHS Foundation Trust
Dartford and Gravesham NHS Trust
Dorset County Hospital NHS Foundation Trust
East Cheshire NHS Trust
George Eliot Hospital NHS Trust
Harrogate and District NHS Foundation Trust
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

NHS
West Suffolk
NHS Foundation Trust

Board of Directors - December 2017

Agenda item:	9			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	19th January 2018			
Subject:	Finance and Workforce Board Report – December 2017			
Purpose:	x	For information		For approval

Executive summary:
The reported I&E for December 2017 YTD is a deficit of £4,849k, against a planned deficit of £3,769k. This results in an adverse variance of £1,079k YTD.

Given the use of escalation capacity has been significant in January the expenditure pattern in December is likely to continue but without any further funding. We are therefore concerned that our 17-18 control total may not be met, which would impact on our Q4 STF relating to financial performance .Early indications suggest we are unlikely to receive A&E performance STF in Q4.

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

December 2017 (Month 9)

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

Financial Summary

I&E Position YTD	£4.8m	loss
Variance against plan YTD	-£1.1m	
Movement in month against plan	-£0.9m	
EBITDA position YTD	£0.8m	deficit
EBITDA margin YTD	1.2%	deficit
Cash at bank	£3,518k	

Executive Summary

- The Month 9 YTD position is £1,079k behind plan.

Key Risks

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

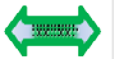
SUMMARY INCOME AND EXPENDITURE ACCOUNT - December 2017	Dec-17 Budget £m	Dec-17 Actual £m	Dec-17 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance £m
NHS Contract Income	14.0	14.7	0.7	160.2	160.4	0.2	206.8	206.7	(0.1)
Other Income	5.2	4.9	(0.3)	25.7	27.1	1.4	33.4	35.2	1.8
Total Income	**19.2**	**19.6**	**0.5**	**185.9**	**187.5**	**1.6**	**240.2**	**241.9**	**1.8**
Pay Costs	12.5	12.7	(0.3)	109.5	109.8	(0.3)	147.0	147.3	(0.3)
Non-pay Costs	4.0	4.6	(0.6)	76.7	78.3	(1.6)	95.3	96.7	(1.4)
Operating Expenditure	**16.4**	**17.3**	**(0.9)**	**186.2**	**188.1**	**(1.9)**	**242.3**	**244.0**	**(1.7)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**2.7**	**2.3**	**(0.4)**	**(0.2)**	**(0.6)**	**(0.4)**	**(2.2)**	**(2.1)**	**0.1**
EBITDA margin	17.0%	11.9%	(5.1%)	1.7%	1.2%	(0.5%)	1.3%	1.1%	(0.2%)
Depreciation	2.2	2.2	0.0	5.0	5.1	(0.1)	6.7	6.7	0.0
Finance costs	0.9	0.9	0.0	1.9	2.1	(0.2)	2.2	1.8	0.4
SURPLUS/(DEFICIT) pre S&TF	**(0.4)**	**(0.8)**	**(0.4)**	**(7.1)**	**(7.8)**	**(0.6)**	**(11.1)**	**(10.6)**	**0.5**
S&T funding - Financial Performance	0.4	0.4	0.0	2.4	2.4	0.0	3.6	3.6	0.0
S&T funding - A&E Performance	0.2	(0.3)	(0.5)	1.0	0.5	(0.5)	1.6	1.1	(0.5)
SURPLUS/(DEFICIT) incl S&TF	**0.2**	**(0.7)**	**(0.9)**	**(3.8)**	**(4.8)**	**(1.1)**	**(5.9)**	**(5.9)**	**0.0**

FINANCE AND WORKFORCE REPORT – December 2017

Contents:

Key:

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

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

FINANCE AND WORKFORCE REPORT – December 2017

Income and Expenditure summary as at December 2017

The reported I&E for December 2017 YTD is a deficit of £4,849k, against a planned deficit of £3,293k. This results in an adverse variance of £1,556 YTD.

The monthly adverse variance is £889k which is after receiving winter pressure funding of £537k. This is due to unfunded cost pressures relating to:

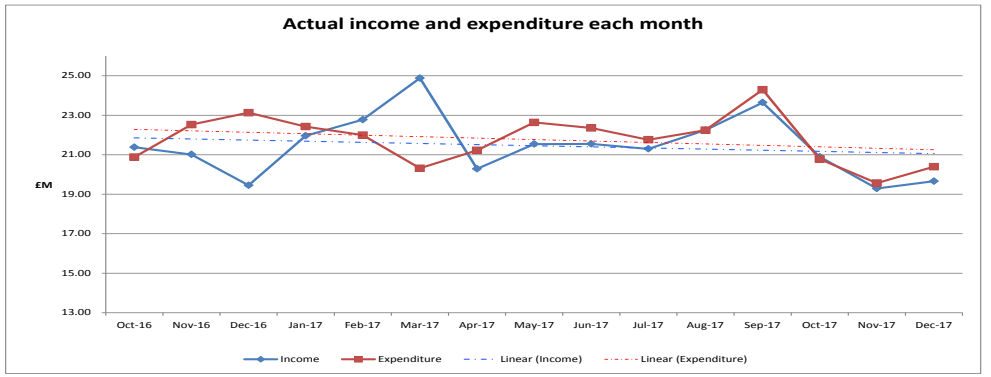
- recognition of failure to meet A&E target and therefore drop in STF funding (£468k)
- remaining KPMG invoices (£388k) which may be mitigated by further CIP schemes delivering savings during Q4
- overspend on medical and surgical expenditure in December (£300k)
- overspend on pay relating to escalation capacity (£250k)

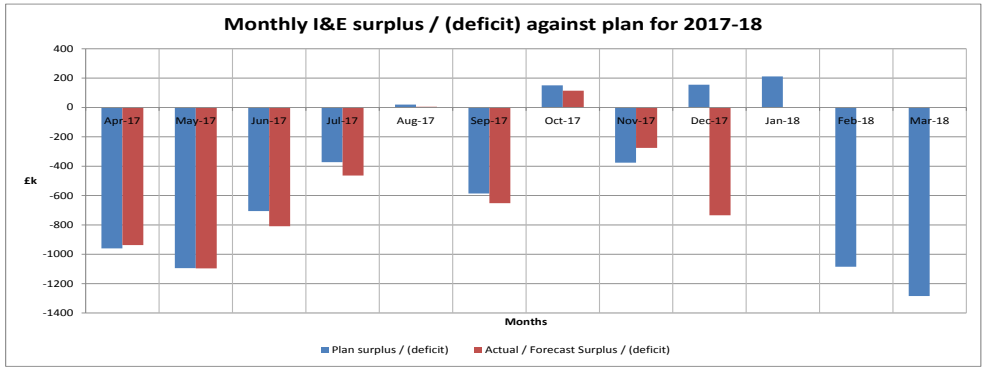
Given the use of escalation capacity has been significant in January the expenditure pattern in December is likely to continue but without any further funding. We are therefore concerned that our 17-18 control total may not be met, which would impact on our Q4 STF relating to financial performance .Early indications suggest we are unlikely to receive A&E performance STF in Q4.

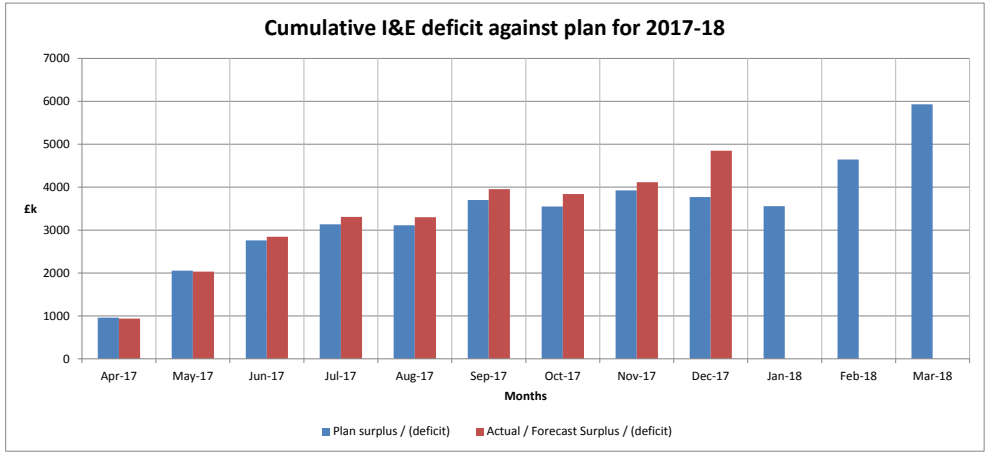
This year's contingency has been largely deployed against costs relating to RTT, Pathology Services, NHSPS settlement and the SCH community contract

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)	155	(734)	(889)	↑	Red
YTD surplus / (deficit)	(3,770)	(4,849)	(1,079)	↑	Red
Forecast surplus / (deficit)	(5,928)	(5,928)	0	↔	Amber
EBITDA YTD	3,141	2,321	(819)	↑	Amber
EBITDA (%)	1.7%	1.2%	(0.4%)	↑	Amber
Use of Resources (UoR) Rating fav / (adv)	3	3	0	↔	Amber
Clinical Income YTD	(160,219)	(160,410)	191	↑	Green
Non-Clinical Income YTD	(29,099)	(29,991)	892	↓	Green
Pay YTD	109,475	109,756	(281)	↑	Green
Non-Pay YTD	83,613	85,494	(1,881)	↑	Amber
CIP target YTD	(9,923)	(9,705)	(218)	↑	Amber





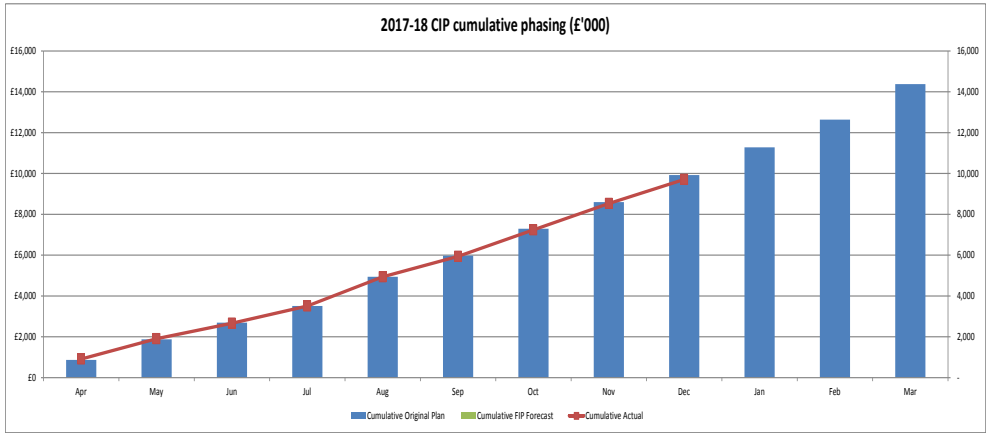


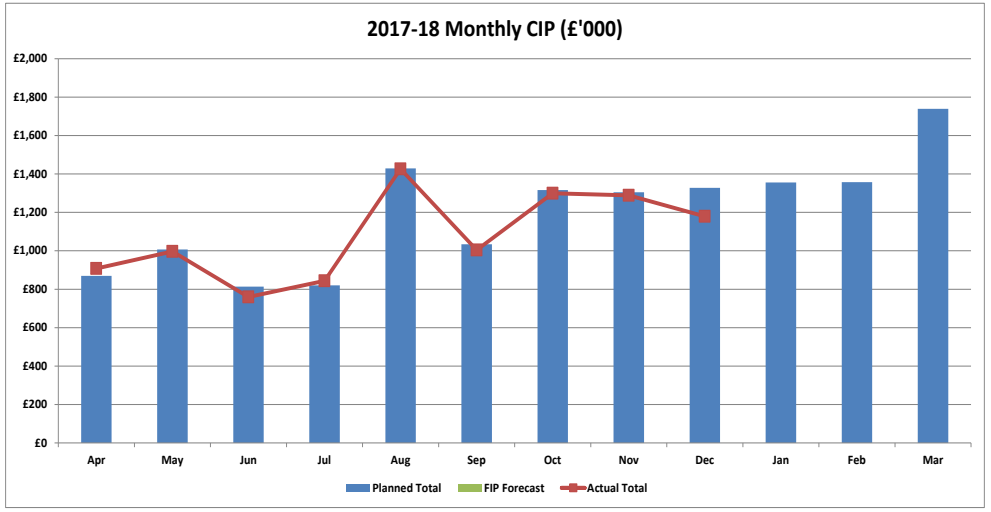
FINANCE AND WORKFORCE REPORT – December 2017

Cost Improvement Programme (CIP) 2017-18

The December position includes a target of £9,928k YTD which represents 69% of the 2017-18 plan. There is currently a shortfall of £218k YTD against this plan.

Recurring/Non Recurring	Summary	2017-18 Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Activity growth	297	216	106
	Car Park Income	400	300	187
	Other Income	167	122	123
	Consultant Staffing	326	223	217
	Additional sessions	192	144	74
	Staffing Review	2,722	1,567	2,260
	Agency	482	362	164
	Procurement	1,801	1,250	963
	Community Equipment Service	465	305	80
	Contract review	8	6	9
	Drugs	326	199	174
	Capitalisation	466	346	236
	Other	2,048	1,673	1,618
	Theatre Efficiency	275	138	138
	Patient Flow	300	150	150
	Pay controls	337	169	169
	Outpatients	190	95	95
Recurring Total		**10,801**	**7,265**	**6,761**
Non-Recurring	Activity growth	300	300	300
	Other Income	19	14	19
	Additional sessions	10	8	34
	Staffing Review	20	15	-
	Contract review	41	31	38
	Estates and Facilities	389	292	292
	Non-Recurring	396	396	396
	Capitalisation	350	275	375
	Other	398	296	459
	GDE revenue	1,650	1,031	1,031
Non-Recurring Total		**3,573**	**2,658**	**2,944**
Grand Total		**14,375**	**9,923**	**9,705**





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%).

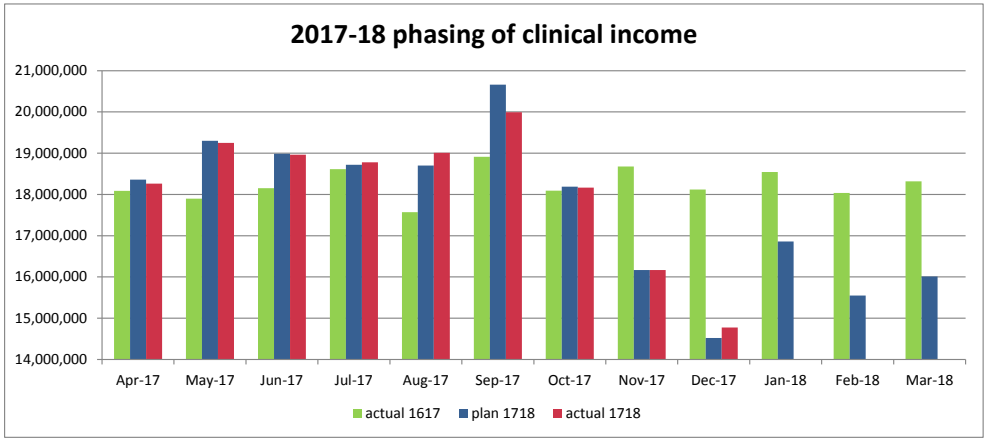
To date we have identified £5.1m of risk adjusted CIP schemes, (£9.4m non-risk adjusted) for 2018-19. We therefore have a gap of £8.9m against the 2018-19 target which we are discussing with NHSI

FINANCE AND WORKFORCE REPORT – December 2017

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.

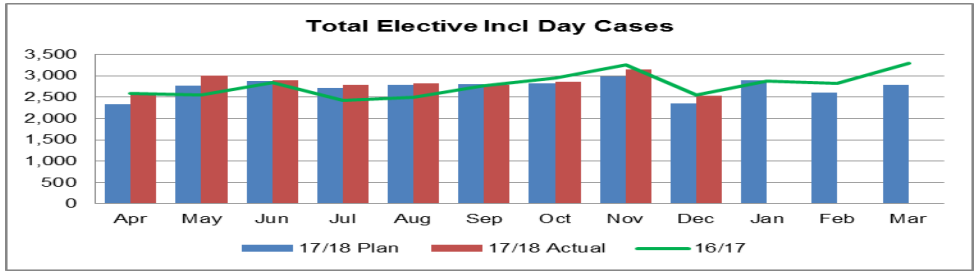
Income earned from within Suffolk is on plan since we have block contracts with Suffolk CCGs for their activity. However, variances can be seen within Divisions with any balances reflected within the Corporate Division.

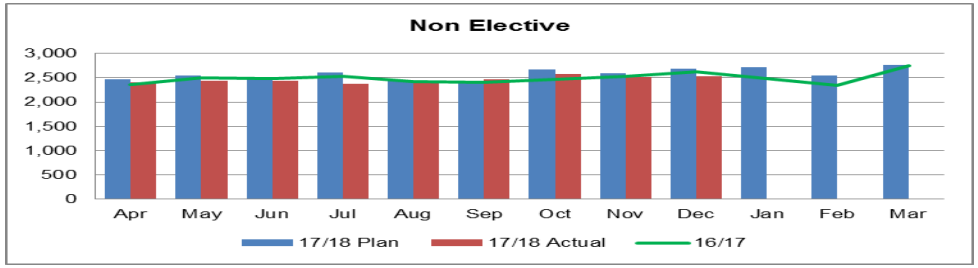


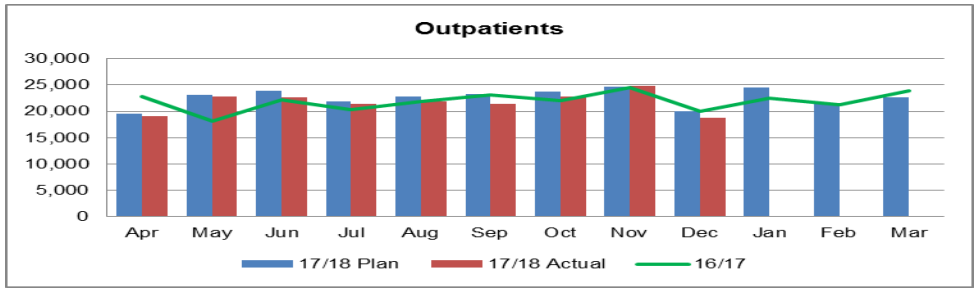
The income position was ahead of plan for December, with over performance being seen within the Elective and Community services.

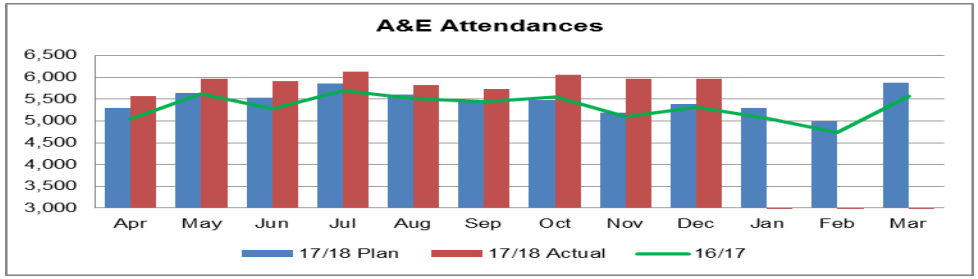
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	668	695	27	6,131	6,471	341
Other Services	1,653	1,625	(27)	21,607	19,239	(2,368)
CQUIN	289	289	(0)	2,696	2,728	32
Elective	2,293	2,405	112	23,479	24,796	1,317
Non Elective	5,351	5,431	80	45,645	47,190	1,545
Emergency Threshold Adjustment	(293)	(382)	(89)	(2,602)	(3,400)	(798)
Outpatients	2,406	2,355	(51)	24,352	23,726	(626)
Community	1,633	2,307	674	38,911	39,660	749
Total	**14,000**	**14,725**	**725**	**160,219**	**160,410**	**191**

Activity, by point of delivery



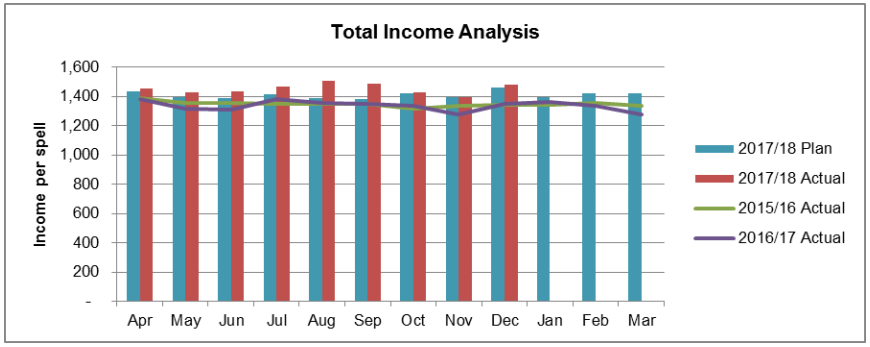


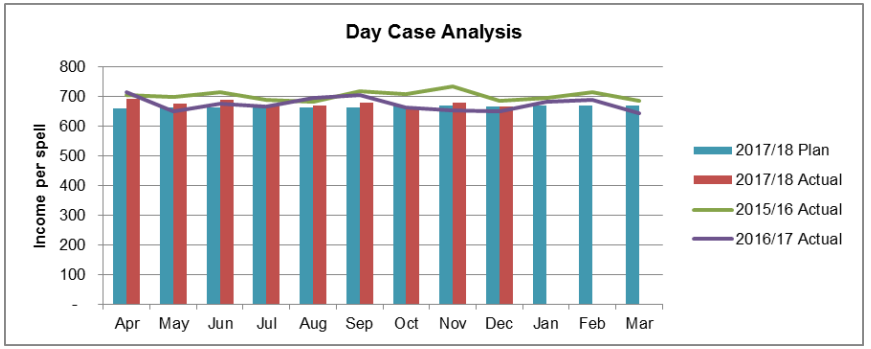


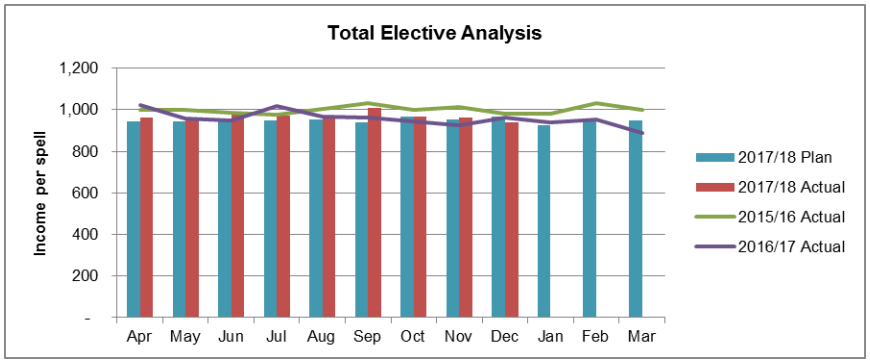


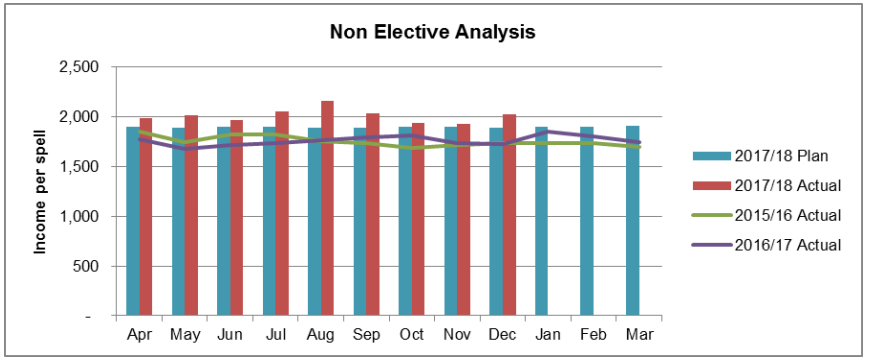
FINANCE AND WORKFORCE REPORT – December 2017

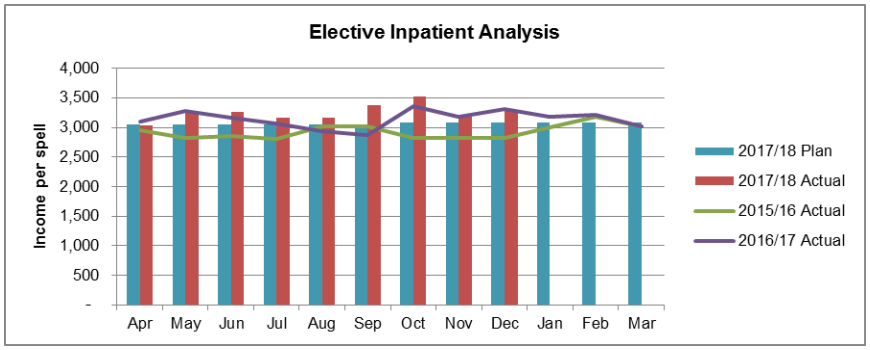
Trends and Analysis

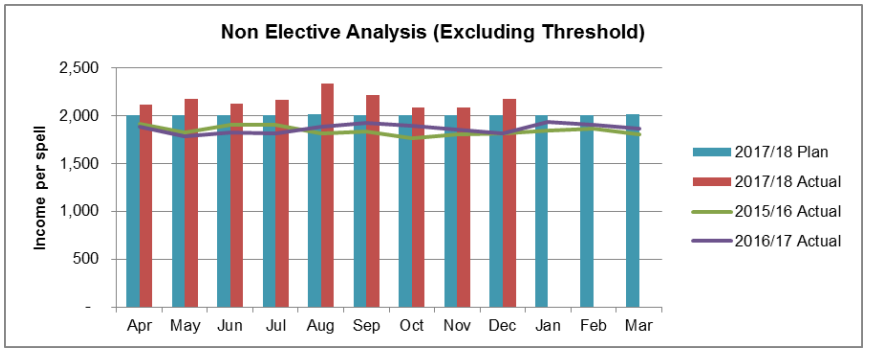












FINANCE AND WORKFORCE REPORT – December 2017

Workforce

Monthly Expenditure Acute services only				
As at December 2017	Dec-17	Nov-17	Dec-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,920**	**10,968**	**10,710**	**98,438**
Substantive Staff	9,753	9,765	9,522	87,419
Medical Agency Staff (includes 'contracted in' staff)	102	129	160	1,023
Medical Locum Staff	391	236	163	2,213
Additional Medical sessions	286	290	238	2,433
Nursing Agency Staff	123	72	143	569
Nursing Bank Staff	245	176	175	1,779
Other Agency Staff	47	91	92	619
Other Bank Staff	135	141	127	1,281
Overtime	128	120	78	918
On Call	51	55	47	473
Total temporary expenditure	1,509	1,309	1,222	11,307
Total expenditure on pay	**11,262**	**11,074**	**10,743**	**98,726**
Variance (F/(A))	(343)	(107)	(33)	(288)
Temp Staff costs % of Total Pay	13.4%	11.8%	11.4%	11.5%
Memo : Total agency spend in month	273	291	394	2,211

Monthly whole time equivalents (WTE) Acute Services only			
As at December 2017	Dec-17	Nov-17	Dec-16
	WTE	WTE	WTE
Budgeted WTE in month	**2,931.4**	**2,981.4**	**3,016.6**
Employed substantive WTE in month	**2745.58**	**2747.66**	**2,730.6**
Medical Agency Staff (includes 'contracted in' staff)	8.44	13.15	12.1
Medical Locum	21.64	13.72	15.8
Additional Sessions	22.21	22.52	22.1
Nursing Agency	24.31	14.23	22.1
Nursing Bank	76.63	57.52	58.0
Other Agency	12.17	22.27	27.0
Other Bank	67.16	59.28	63.7
Overtime	35.42	35.82	36.1
On call Worked	6.64	7.28	8.5
Total equivalent temporary WTE	**274.6**	**245.8**	**265.4**
Total equivalent employed WTE	**3,020.2**	**2,993.5**	**2,996.0**
Variance (F/(A))	(88.8)	(12.0)	20.6
Temp Staff WTE % of Total Pay	9.1%	8.2%	8.9%
Memo : Total agency WTE in month	44.9	49.7	61.3
Sickness Rates (Dec/Nov)	3.51%	3.53%	3.93%
Mat Leave	1.3%	2.4%	2.1%

Monthly Expenditure Community Service				
As at November 2017	Dec-17	Nov-17	Dec-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,528**	**1,530**	**1,080**	**11,037**
Substantive Staff	1,397	1,387	1,011	10,445
Medical Agency Staff (includes 'contracted in' staff)	12	13	(15)	109
Medical Locum Staff	3	3	3	30
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	8	0	5	1
Nursing Bank Staff	16	12	8	128
Other Agency Staff	5	12	38	187
Other Bank Staff	2	2	11	74
Overtime	4	4	4	42
On Call	2	5	3	15
Total temporary expenditure	53	51	57	585
Total expenditure on pay	**1,449**	**1,438**	**1,068**	**11,030**
Variance (F/(A))	79	92	11	7
Temp Staff costs % of Total Pay	3.6%	3.5%	5.4%	5.3%
Memo : Total agency spend in month	25	25	28	297

Monthly whole time equivalents (WTE) Community Services			
As at November 2017	Dec-17	Nov-17	Dec-16
	WTE	WTE	WTE
Budgeted WTE in month	**497.6**	**494.6**	**359.1**
Employed substantive WTE in month	**447.8**	**442.0**	**337.8**
Medical Agency Staff (includes 'contracted in' staff)	0.7	0.8	0.0
Medical Locum	0.4	0.4	0.4
Additional Sessions	0.0	0.0	0.0
Nursing Agency	1.3	0.0	0.7
Nursing Bank	4.6	3.8	2.7
Other Agency	1.4	4.6	9.4
Other Bank	0.7	0.4	3.2
Overtime	1.4	1.4	2.2
On call Worked	0.0	0.0	0.9
Total equivalent temporary WTE	**10.5**	**11.3**	**19.5**
Total equivalent employed WTE	**458.3**	**453.3**	**357.3**
Variance (F/(A))	39.3	41.3	1.8
Temp Staff WTE % of Total Pay	2.3%	2.5%	5.5%
Memo : Total agency WTE in month	3.4	5.5	10.1
Sickness Rates (Nov /Oct)	3.55%	3.42%	3.96%
Mat Leave	2.1%	2.1%	1.7%

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

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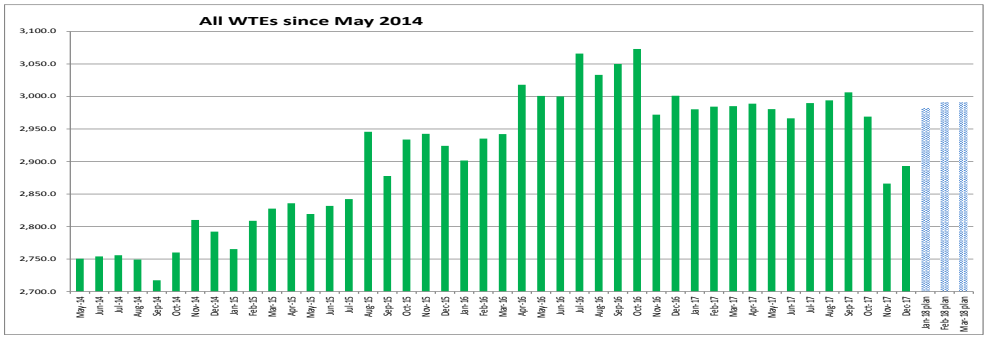
Staffing levels

The community staffing tables above include increases in community staffing from October 2017 in line with the new community contract.

However, 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 December onwards is the level of staffing required to achieve the original CIP, although this needs to be updated to reflect the proposals in FIP. As at December 2017 we employed a total of 49.5 WTE more than planned and 24 WTE more Acute staff than in December 2016.

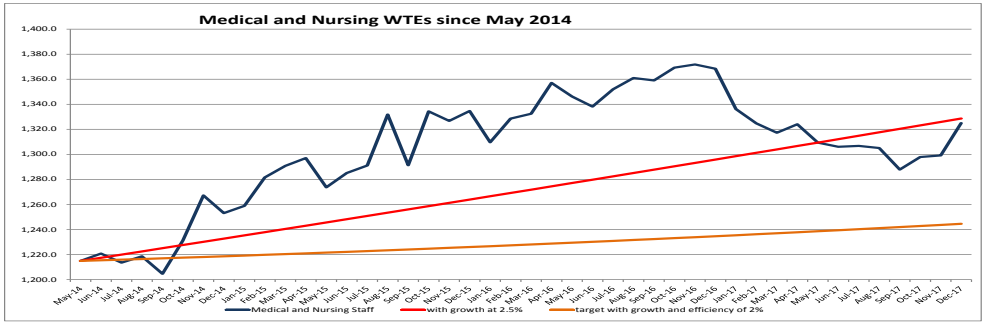


Since May 2014, (excluding Community staff) the Trust has employed 257.5 more WTEs, an increase of 9%. During this period activity has grown by around 8.7%

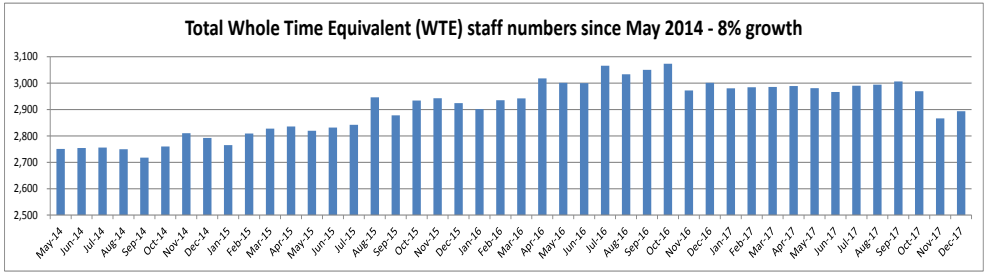
The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 110 WTEs (blue line). This includes around 29 WTE Consultants which are analysed further below.

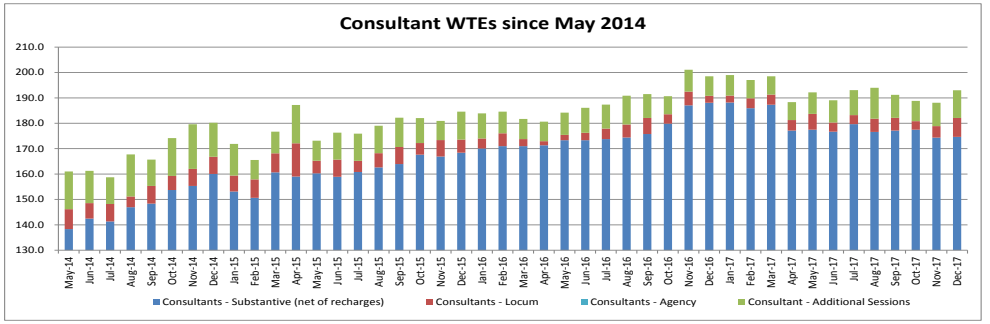
There has been an increase of 25.8 WTE during December. Medical staff have increased by 31.7 WTE since April 2017, due to increases in junior doctors.

If medical and nursing staffing levels had increased in line with our growth in activity of broadly 2.5% we would currently be employing 3.7 more WTEs (red line). In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 84 WTE fewer than at December 2017



The graphs below highlight the increase in Consultant WTEs of 25% since April 2014. Substantive staff has increased by 36.8 WTEs whilst temporary staff have decreased by 0.4 WTEs.





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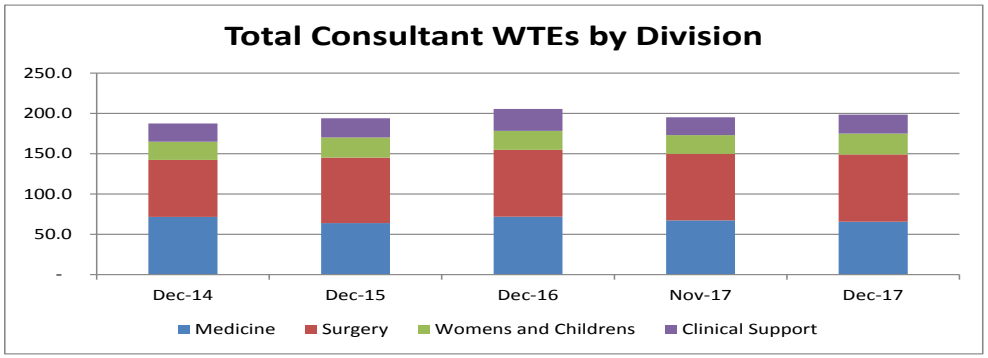
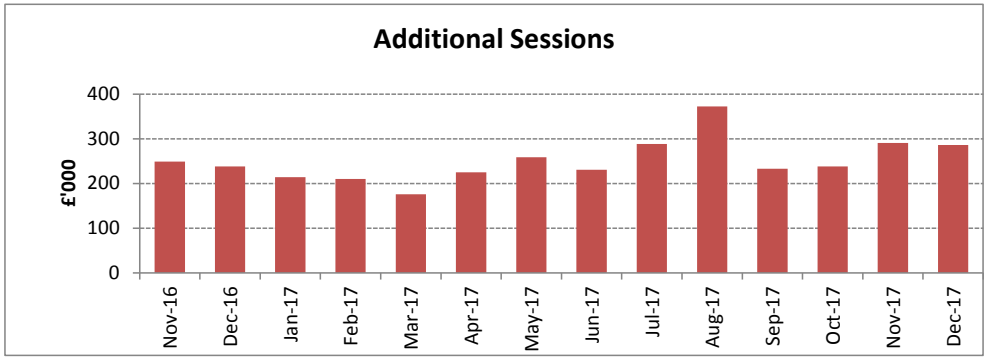
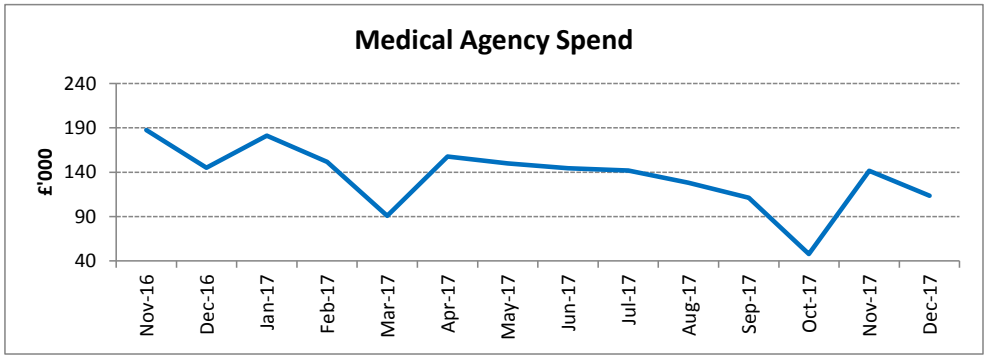


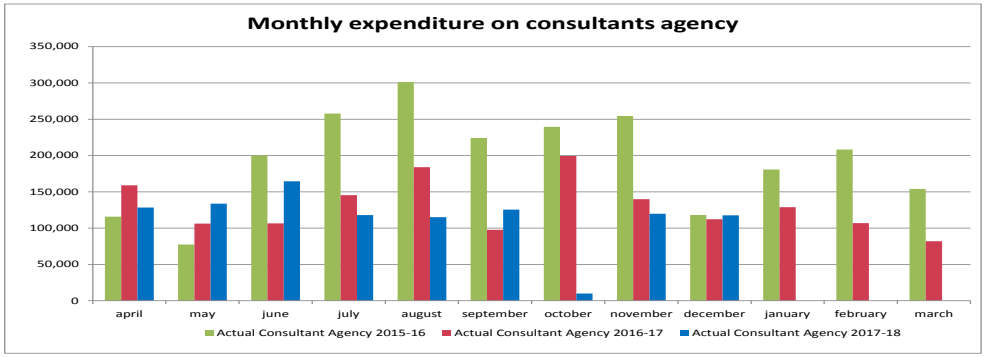
Division	Specialty	Sum of Dec-15	Sum of Dec-16	Sum of Jul-17	Sum of Aug-17	Sum of Sep-17	Sum of Oct-17	Sum of Nov-17	Sum of Dec 17
Medicine	A&E Medical Staff	5.8	7.4	8.1	8.2	8.2	7.5	7.9	7.0
	Cardiology	3.6	5.4	5.9	6.0	6.2	4.8	4.8	4.8
	Chest Medicine	4.3	4.3	4.0	4.0	4.2	3.8	4.2	3.8
	Chronic Pain Service	1.1	0.7	0.7	0.7	0.7	0.8	0.9	0.7
	Clinical Haematology	4.1	4.4	4.4	4.4	4.4	4.4	4.4	4.4
	Dermatology	4.1	4.4	5.0	3.5	4.3	3.5	5.6	4.0
	Diabetes	4.3	4.3	4.4	4.3	4.3	4.3	4.3	4.3
	Eau Medical Staff	8.7	6.7	7.2	9.6	7.2	7.6	7.4	8.0
	Gastroenterology	6.7	6.7	7.5	7.2	7.5	7.1	7.2	6.8
	General Medicine	6.6	6.6	5.8	4.6	5.3	5.4	4.8	5.2
	Nephrology	0.9	0.1	1.5	1.6	1.6	1.5	1.5	1.5
	Neurology	2.9	2.5	2.6	2.7	2.7	2.7	2.7	2.7
	Oncology	4.3	3.3	3.4	3.4	3.4	3.4	3.4	3.4
	Palliative Care	-	0.3	0.3	0.3	0.3	0.3	0.3	0.3
	Rheumatology	3.3	3.9	4.0	3.9	3.9	4.0	4.0	4.0
	Stroke	3.1	3.7	3.5	4.0	3.7	4.1	3.9	4.5
Medicine Total		**64.3**	**65.2**	**66.5**	**68.4**	**67.9**	**65.1**	**67.1**	**65.5**
Surgery	Anaesthetics	31.9	34.7	33.6	34.4	33.5	33.6	33.3	32.2
	E.N.T.	3.3	3.3	3.3	3.3	3.3	3.3	4.6	5.1
	General Surgery	13.1	10.5	9.8	9.8	9.8	9.8	10.6	10.7
	Ophthalmology	7.3	8.6	8.3	7.9	7.8	7.7	8.4	8.1
	Oral & Maxofacial Surg	1.3	1.6	0.0	0.0	0.1	-	-	0.0
	Plastic Surgery	3.2	3.6	3.0	2.3	2.4	3.4	3.4	3.7
	Trauma & Orthopaedic	13.9	13.1	14.2	14.7	14.0	14.5	13.7	15.2
	Urology	7.1	6.3	6.2	6.5	7.5	5.0	7.2	7.2
	Vascular Surgery	-	1.2	1.1	1.1	1.1	1.3	1.4	1.3
Surgery Total		**81.2**	**82.9**	**79.5**	**80.1**	**79.7**	**78.7**	**82.5**	**83.5**
Women and Childrens	Obstetrics	11.3	11.9	13.3	13.4	13.2	13.0	13.4	13.2
	Paediatrics	13.7	11.8	11.3	11.3	11.3	10.4	10.1	12.7
Women and Childrens Total		**25.1**	**23.6**	**24.6**	**24.7**	**24.4**	**23.4**	**23.5**	**25.9**
Clinical Support	Chemistry	0.7	1.0	-	0.6	0.3	-	-	-
	Histopathology	7.6	7.3	8.5	9.3	8.3	9.0	7.6	8.0
	Microbiology	3.3	3.3	3.2	3.2	3.2	3.5	3.5	4.3
	MRI	1.0	0.9	0.9	0.9	0.9	0.9	-	-
	Xray - Wsh	12.1	14.6	12.1	12.3	12.4	12.5	12.8	13.2
Clinical Support Total		**24.6**	**27.1**	**24.6**	**26.2**	**25.0**	**25.9**	**24.0**	**25.5**
Grand Total		**195.2**	**198.8**	**195.2**	**199.4**	**197.0**	**193.2**	**197.1**	**200.4**

Pay Trends and Analysis

The Trust overspent pay budgets by £264k in December (£281k overspent YTD).







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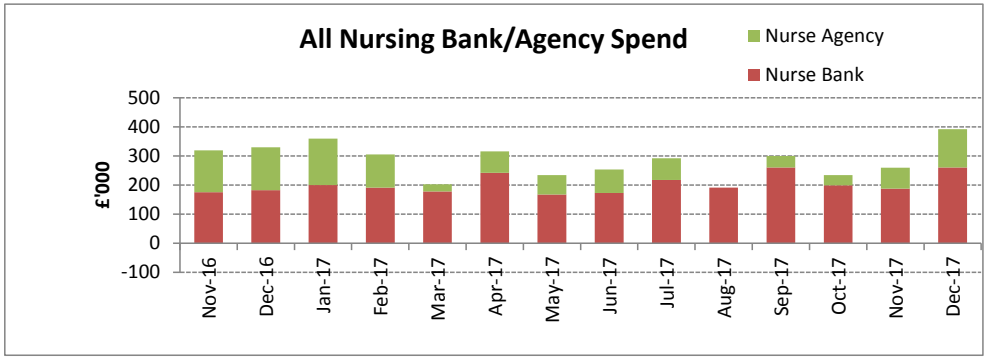
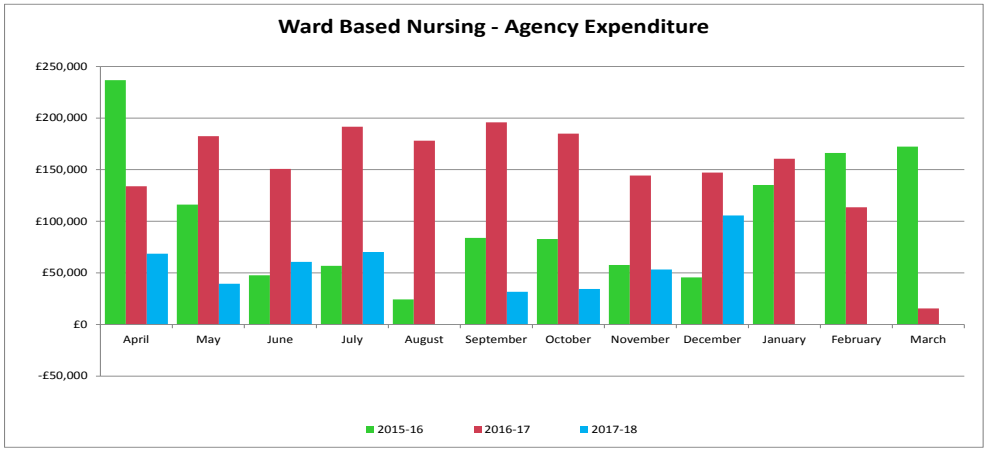
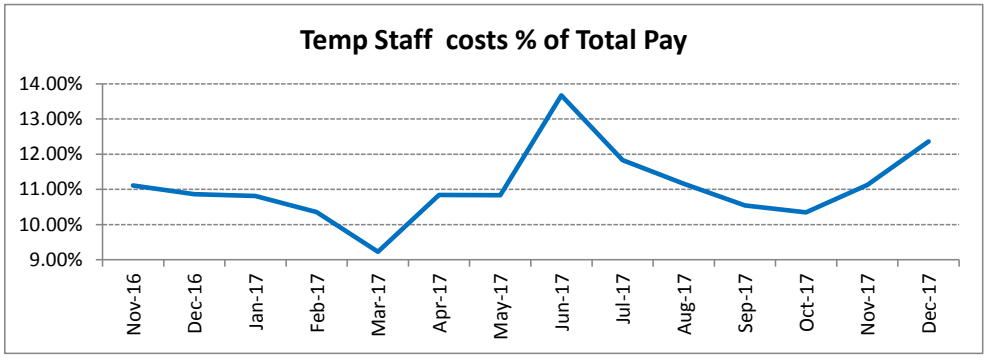
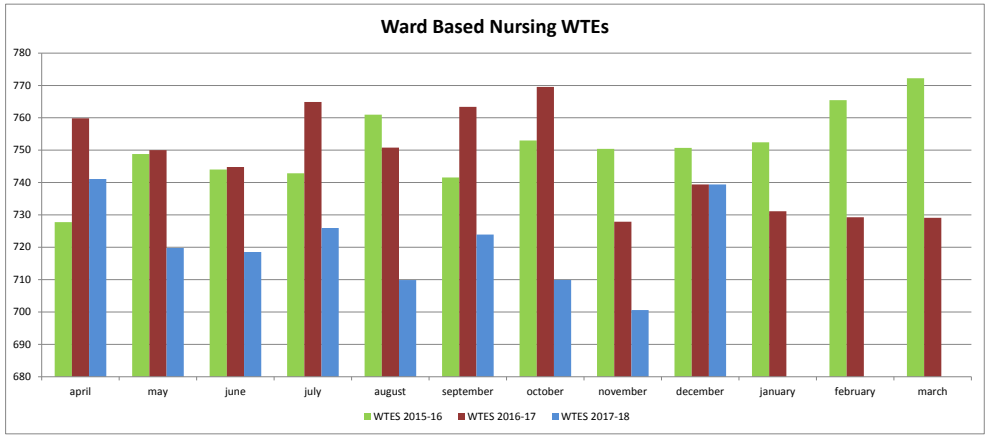
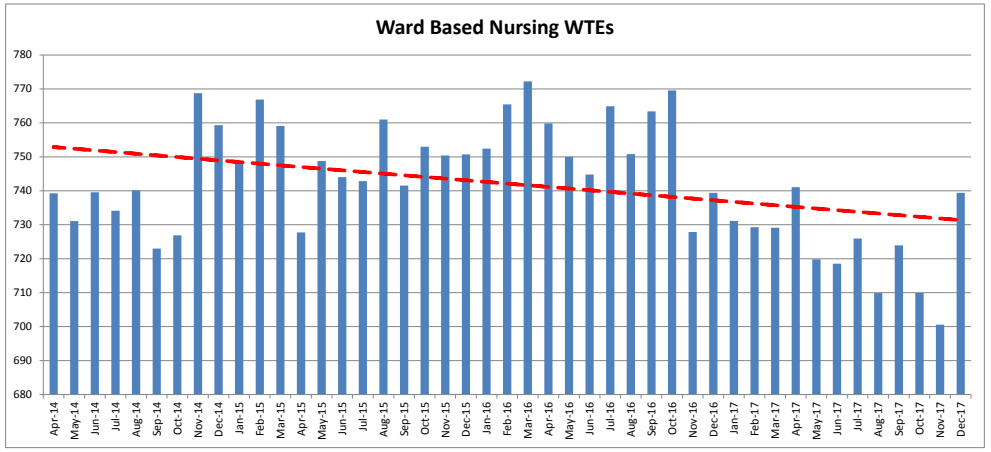






Ward Based Nursing





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Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Dec-17 Budget £k	Dec-17 Actual £k	Dec-17 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(5,348)	(5,373)	25	(49,297)	(49,950)	653
Pay Costs	3,421	3,470	(49)	30,608	30,654	(46)
Non-pay Costs	1,286	1,331	(45)	11,837	12,091	(253)
Operating Expenditure	**4,707**	**4,801**	**(94)**	**42,446**	**42,745**	**(299)**
SURPLUS / (DEFICIT)	**641**	**571**	**(69)**	**6,851**	**7,205**	**354**
SURGERY						
Total Income	(4,394)	(4,648)	254	(42,752)	(43,858)	1,106
Pay Costs	2,901	3,072	(172)	26,384	26,894	(509)
Non-pay Costs	1,063	1,298	(235)	9,480	10,352	(872)
Operating Expenditure	**3,964**	**4,370**	**(406)**	**35,864**	**37,245**	**(1,381)**
SURPLUS / (DEFICIT)	**430**	**278**	**(152)**	**6,888**	**6,613**	**(275)**
WOMENS and CHILDRENS						
Total Income	(1,914)	(1,725)	(189)	(18,358)	(18,210)	(149)
Pay Costs	1,105	1,138	(34)	9,942	10,064	(122)
Non-pay Costs	133	134	(1)	1,238	1,345	(107)
Operating Expenditure	**1,238**	**1,272**	**(34)**	**11,180**	**11,409**	**(229)**
SURPLUS / (DEFICIT)	**677**	**453**	**(223)**	**7,178**	**6,801**	**(377)**
CLINICAL SUPPORT						
Total Income	(925)	(890)	(35)	(8,731)	(8,363)	(369)
Pay Costs	1,707	1,854	(146)	15,308	15,369	(61)
Non-pay Costs	197	285	(88)	8,710	9,180	(470)
Operating Expenditure	**1,905**	**2,138**	**(234)**	**24,018**	**24,549**	**(531)**
SURPLUS / (DEFICIT)	**(980)**	**(1,249)**	**(269)**	**(15,287)**	**(16,186)**	**(900)**
COMMUNITY SERVICES						
Total Income	(3,593)	(3,581)	(13)	(42,414)	(44,433)	2,018
Pay Costs	1,428	1,449	(21)	10,937	11,030	(93)
Non-pay Costs	1,289	1,281	8	29,173	31,075	(1,902)
Operating Expenditure	**2,717**	**2,730**	**(13)**	**40,110**	**42,105**	**(1,995)**
SURPLUS / (DEFICIT)	**877**	**851**	**(26)**	**2,304**	**2,327**	**23**
ESTATES and FACILITIES						
Total Income	(371)	(329)	(43)	(3,376)	(3,268)	(108)
Pay Costs	745	723	22	6,725	6,586	138
Non-pay Costs	614	679	(65)	5,367	5,602	(236)
Operating Expenditure	**1,360**	**1,402**	**(42)**	**12,091**	**12,188**	**(97)**
SURPLUS / (DEFICIT)	**(989)**	**(1,074)**	**(85)**	**(8,715)**	**(8,921)**	**(205)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	(3,063)	(3,114)	51	(24,461)	(22,320)	(2,140)
Pay Costs	1,040	1,005	36	9,472	9,159	313
Non-pay Costs (net of contingency and reserves)	(581)	(401)	(180)	11,069	8,680	2,389
Finance & Capital	3,105	3,076	29	6,910	7,170	(259)
Operating Expenditure	**3,564**	**3,680**	**(115)**	**27,451**	**25,009**	**2,443**
SURPLUS / (DEFICIT)	**(501)**	**(565)**	**(64)**	**(2,990)**	**(2,688)**	**302**
TOTAL (including penalties, contingency and reserves)						
Total Income	(19,609)	(19,660)	51	(189,390)	(190,402)	1,013
Contract Penalties	0	0	0	0	0	0
Pay Costs	12,348	12,712	(364)	109,375	109,756	(381)
Non-pay Costs	4,001	4,606	(605)	76,874	78,325	(1,450)
Finance & Capital	3,105	3,076	29	6,910	7,170	(259)
Operating Expenditure (incl penalties)	**19,454**	**20,394**	**(940)**	**193,160**	**195,250**	**(2,090)**
SURPLUS / (DEFICIT)	**155**	**(734)**	**(889)**	**(3,770)**	**(4,849)**	**(1,079)**

Medicine (Annie Campbell)

The Division under performed by £69k in December (over performed by £354k YTD)

December was the first month in the year where the Division did not meet its plan in the month, although for the year to date it is still well ahead.

Contracted income over performed by £28k. ED saw 577 attendances more than planned (£27k), and the attendance to admission ratio increased significantly, resulting in admitted patients being £62k ahead of plan. The high attendance to admission ratio suggests GPs were sending appropriate patients and that the acuity of patients was higher than normal. The GP Streaming initiative saw 467 patients – an average of 15 patients per day demonstrating that capacity is considerably higher.

Outpatients depressed contract income performance (£48k blow plan), with Dermatology and Nephrology being the main problems – the former due to vacancies, the latter awaiting work to be repatriated from Addenbrookes.

Expenditure was the driver for the poor performance (£98k), with the start of winter pressures. Patient flow issues meant that both ward G9 and F8 facilities were open for large parts of the month. The extra capacity opened contributed to £89k being spent on nurse agency (£39k above budget). Medical staff cover at weekends was also increased which resulted in a £5k overspend (£74k spent in month).

Non-pay issues – drugs (£28k), patient transport (£15k) and security (£10k) all resulted from the need to address capacity and to discharge patients as quickly and appropriately as possible. The drugs position will improve as there are some further claims to be made on excluded and HIV drugs.

The outlook is for contract income to continue to perform well, but with the possibility that expenditure will exceed budget over the "winter pressures" period whilst flow dictates that capacity is increased over that budgeted.

Surgery (Simon Taylor)

The Division under performed by £152k in December (£275k YTD)

Income overachieved against the plan by £254k, which is split evenly between elective and non-elective activity.. Trauma & Orthopaedics non-elective is

significantly above plan, but this has had a negative impact on elective activity. Ophthalmology overachieved in the month, but both General Surgery and Breast Surgery underperformed.

Pay is overspent by £172k. The main overspend is on consultant additional sessions (83k). The balance relates to temporary staffing due to difficulties in recruiting.

Non-pay is overspent by £235k. The overspend is predominantly in Theatres and Eye Treatment Centre as a result of the increases in activity.

Surgery CIPs have overachieved by £8k YTD.

Women and Children's (Rose Smith)

Women and Children's reported an under performance of £223k in-month (£377k YTD).

Clinical income reported £189k behind plan in-month and is £149k behind plan YTD. Overall inpatient, outpatient and antenatal activity levels were below plan for the month which has also pushed the YTD clinical income position behind plan.

Pay reported £34k overspent in-month and £122k overspent YTD. In-month the Paediatric consultant budget has returned to full establishment whilst the department continues to use the services of locum consultants. Year to date there have been problems covering the specialist registrar rotas in both Paediatrics and Obstetrics & Gynaecology which has resulted in unbudgeted spend on locum registrars.

Non pay reported £1k overspent in-month and £107k overspent 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 £269k in-month (£900k YTD).

Clinical income for Clinical Support reported a £35k under performance in-month and is £369k behind plan YTD. This can be attributed to lower than planned activity for radiology direct access and breast screening.

Pay is £146k underspent in-month and is £61k underspent YTD. The pathology and radiology services have had difficulties in filling the gaps in the senior medical rotas and are currently employing unbudgeted locums. It is hoped that by offering posts on a locum basis sufficient rapport can be built to fill the permanent posts that are being advertised without any applicants.

Non pay reported a £88k overspend in-month and is £470k overspent YTD.

Community Services (Dawn Godbold)

Community Services reported a £26k under performance in-month (£23k ahead of plan YTD).

Contract Income reported a £13k under recovery in-month and £2,018k over performance YTD. The under recovery in-month, is mainly due to a reduction in income for both Community Equipment Service and Buurtzorg directly offset against expenditure. There has also been a reduction in income from South Norfolk CCG due to lower than planned activity. Offset against increase in income from IHT due to increase in recharges directly linked to an increase in non-pay expenditure.

Pay reports a £21k overspend in-month and £93k overspend YTD. In part this is due to nursing overspends on both Rosemary Ward and Glastonbury Court.

Non pay reports an £8k underspend in-month and a £1,902k overspend YTD. There were underspends within Community Equipment Service offset against a provision for the dilapidations for Bury Depot and IHT expenditure.

The large YTD variances on income and non-pay reflect costs and income associated with the NHSPS settlement and changes within the structure of the SCH contract.

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	0.160	4
Liquidity rating	-12.858	3
I&E Margin rating	-2.60%	4
I&E Margin Variance rating	-0.03%	2
Agency	-42.06%	1
Use of Resources Rating after Overrides		**3**

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

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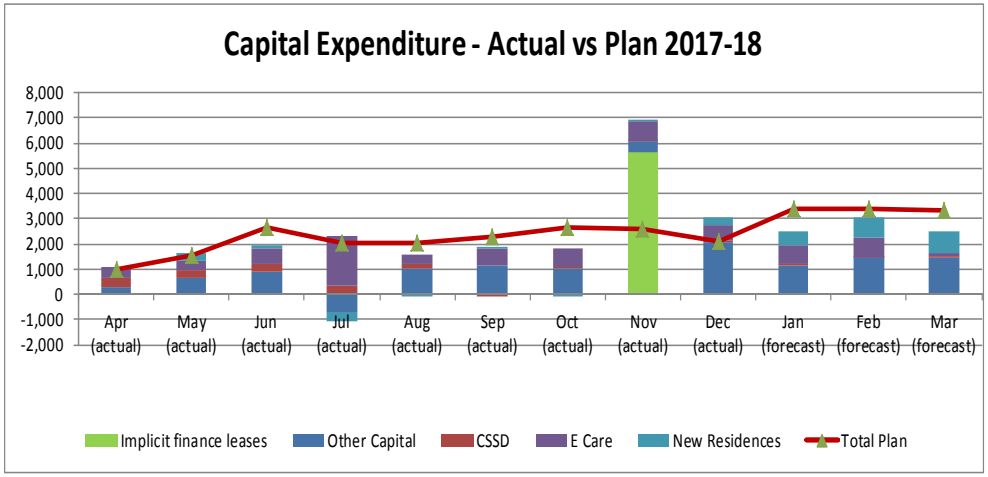
Capital Progress Report



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	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	752	760	152	8,202
CSSD	384	283	319	352	197	-10	8	12	26	60	50	25	1,707
New Residences	0	284	140	-373	-33	68	-9	26	300	566	800	830	2,599
Implicit finance leases	0	0	0	0	0	0	0	5,667	0	0	0	0	5,667
Other Schemes	296	665	922	-684	1,009	1,150	1,057	397	2,077	1,133	1,427	1,471	10,919
Total forecast / Forecast	1,095	1,613	1,947	1,285	1,542	1,862	1,826	6,866	3,032	2,511	3,037	2,478	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 with 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. Once the CSSD is in operation this will revert to a revenue cost. The final expenditure on this project relate 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 £6,539k 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 funding has not been received and there are no indications of when this will be received.

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 £21,069 is above the plan of £18,988k. This is as a result of the implicit finance lease review (noted below) and slippage on a number of key projects:

- Fire compartmentation £647k
- Residences £3,885k
- Main entrance concourse £650k
- Ambulatory Assessment Unit £625k
- Labour suite refurbishment £594k

These have been rephased into future years.

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 the current month. The managed services reviewed include MRI, Radiology and Endoscopy. Early discussions with our auditors indicate acceptance of the principles involved and that our proposed treatment of this as a prior period adjustment is a sensible approach to take.

Statement of Financial Position at 31st December 2017

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2017 * £000	Plan 31 March 2018 £000	Plan YTD 31 Dec 2017 £000	As at 31 Dec 2017 £000	Variance YTD 31 Dec 2017 £000
Intangible assets	15,611	19,711	18,945	19,905	960
Property, plant and equipment	74,053	94,189	86,301	85,750	(551)
Trade and other receivables	0	0	0	0	0
Other financial assets	0	0	0	0	0
Total non-current assets	**89,664**	**113,900**	**105,246**	**105,655**	**408**
Inventories	2,693	2,600	2,700	3,145	445
Trade and other receivables	18,345	11,700	15,796	20,938	5,142
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	3,000	3,518	518
Total current assets	**22,390**	**15,300**	**21,496**	**27,601**	**6,105**
Trade and other payables	(23,434)	(28,195)	(25,419)	(25,364)	55
Borrowing repayable within 1 year	(534)	(1,796)	(2,049)	(2,440)	(391)
Current ProvisionsProvisions	(61)	(61)	(84)	(89)	(5)
Other liabilities	(1,325)	(295)	(2,500)	(4,890)	(2,390)
Total current liabilities	**(25,354)**	**(30,347)**	**(30,052)**	**(32,783)**	**(2,731)**
Total assets less current liabilities	**86,700**	**98,853**	**96,690**	**100,474**	**3,783**
Borrowings	(44,375)	(55,951)	(52,189)	(58,653)	(6,464)
Provisions	(181)	(158)	(163)	(192)	(29)
Total non-current liabilities	**(44,556)**	**(56,109)**	**(52,352)**	**(58,846)**	**(6,494)**
Total assets employed	**42,144**	**42,744**	**44,338**	**41,628**	**(2,711)**
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)	(25,015)	(25,558)	(543)
Total taxpayers' and others' equity	**42,144**	**42,744**	**44,338**	**41,628**	**(2,710)**

*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 £0.4m ahead of plan but the year-end position is expected to remain within plan.

Trade and Other Receivables

These have increased by a further £1.6m in December, the balance includes:

- The £518k 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.
- An invoice to Suffolk County Council for £0.7m as a contribution towards Glastonbury Court which was still outstanding and is being chased at Executive Director level.
- £0.8m SLA income from Ipswich Hospital that should have been paid by 15/12/17 had not been paid by the end of the month. In addition a further £0.7m due by 15/1/18 has not been received. This matter is also being dealt with at Executive Director level.

Trade and Other Payables

The balance on trade and other payables has increased since November by £2.9m but is in line with plan. No payment was made to suppliers in the last week of the month due to lower staffing levels between Christmas and the New Year which is the usual practice for the Trust. Our weekly payment run to suppliers is usually of this order.

Other liabilities

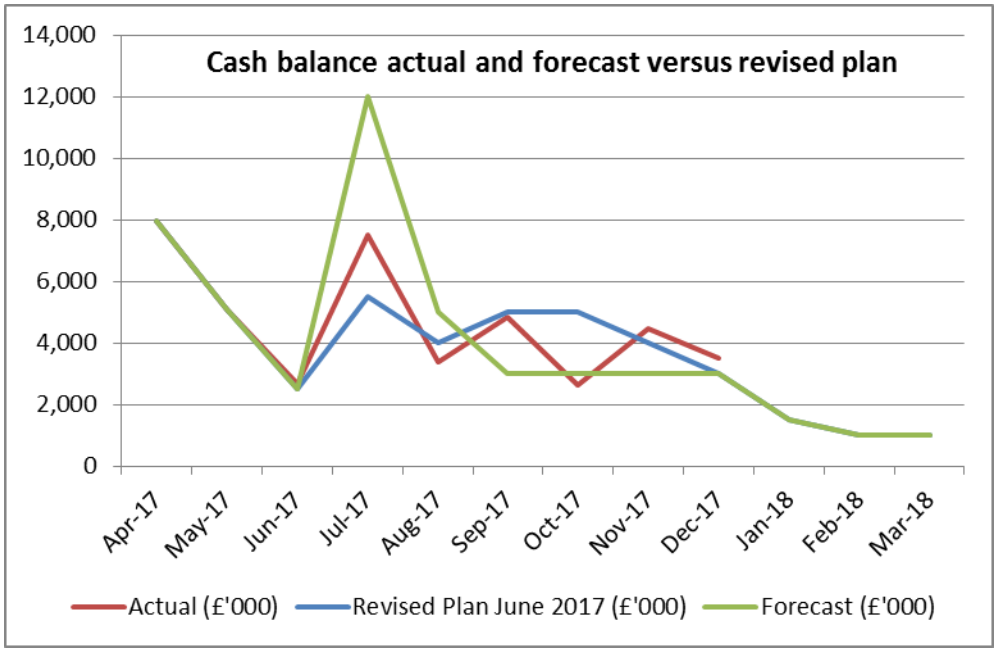
This balance continues to reduce reflecting that the payments for the block contract are weighted towards the earlier months in the financial year for cash purposes but the income cannot be recognised until it has been earned in terms of patient care being delivered. The block contract cash payments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

Borrowing

Borrowing has increased by £2.3m in December. This is £1.3m capital borrowing in line with our previously agreed plans plus £1m for Q2 STF income advanced and then received just before Christmas without advanced notice.

Cash Balance Forecast for the year

FINANCE AND WORKFORCE REPORT – December 2017



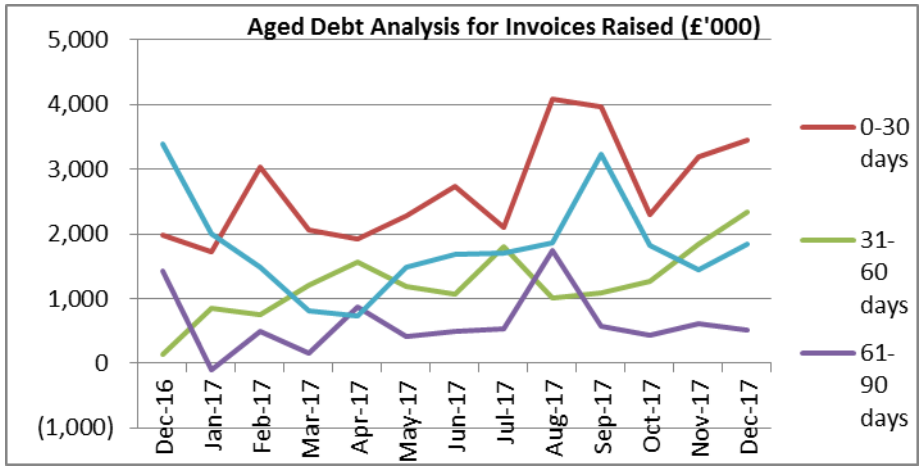
The graph illustrates the cash trajectory year to date, plan and revised forecast.

The Trust is required to keep a minimum balance of £1 million which will be a significant challenge in March 2018.

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 has increased by £1.0m in December.

The invoices to Suffolk County Council for £0.7m and West Suffolk CCG for £0.3m regarding Glastonbury Court remained unpaid at the end of December and are still outstanding currently although both organisations have made a commitment to pay imminently.

The invoice for the revenue element of GDE funding £1.6m was raised in December but remains unpaid pending approval at national level. £0.6m invoices have been raised to Cambridge University Hospital NHS Foundation Trust for their use of Newmarket and £0.2m transformational funding for Community services is outstanding from Ipswich and East CCG.

Trust Board - 26 January 2018

Agenda item:	11			
Presented by:	Helen Beck - Interim Chief Operating Officer			
Prepared by:	Lesley Standring - Senior Transformation Lead Urgent Care Tracy Morgan - Senior Transformation Lead, Planned Care Sheila Broadfoot - CQUIN Lead			
Date prepared:	17 January 2018			
Subject:	Transformation board Report			
Purpose:	√	For information		For approval

Executive summary:

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

The report provides an update on recruitment to the WSFT and WSCCG joint transformation team and to the PMO, recruitment to the latter which has been successful and will see identified recruits starting in post over the next three months.

Initial feedback on "A SAFER Start" is included. In the first week of January admissions were 6% higher than the same period last year which contributed to a mismatch between capacity and demand. The entire organisation assisted to ensure safe clinical services were maintained during this period.

The report provides and update on planned care programme highlights including the 100 day challenge which launces on 2nd February.

Lastly the report summarised items for further development which include the relaunch of the patient choice policy, implementation of the trusted assessor model and further work to ensure robust review of stranded patients.

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:	-
Risk and assurance:	-
Legislation, regulatory, equality, diversity and dignity implications	-
Recommendation:	

1.0 Update of the WSFT and WSCCG Joint Transformation Team Staffing

Since the last Trust Board update, there has been recruitment to two of the vacant posts one within each of the areas.
The Planned Care Transformation Team is now fully recruited to and is working across both organisations. Most posts within the team are joint appointments. The vacancy on secondment returns full-time to the planned care team on 22 January.

2.0 PMO Recruitment

The Trust has managed to appoint to all five posts in the substantive PMO structure, including two interim PMO contractors as Head of PMO and PMO Manager. The two interim's have been working in the PMO over the last year and have been pivotal in the development of the programme governance, process and CIP Tracker. Whilst there will be a bedding in period for the new recruits, the Trust is confident that it has taken all the necessary steps to ensure that the PMO can maintain programme delivery, including use of the CIP Tracker, under business as usual conditions, following supplier exit in January 2018, on the back of a successful recruitment campaign.

The interim Head of PMO has also been involved in establishing the weekly integrated Cross Cutting Governance Meeting with the Finance Managers and the Deputy Director of Finance and also in the development of the relevant documentation to ensure effective management of cross cutting CIP's. The cross cutting governance is crucial to the success of the CIP programme and is now operating effectively on a business as usual basis.

The intern Head of PMO and a PMO Manager take up their substantive roles in February 2018. The other new recruits are subject to provision of notice periods at their current place of work and will arrive at the Trust in late February, mid-March and the end of April respectively.

In the meantime, short term part-time interim support has been brought in to the PMO (four days per week) to support the development of the Community and Estates and Facilities CIP Programmes, as agreed at the last TSG in December 2017.

3.0 Integrated Care Programme Project highlights

3.1 Red to Green/SAFER

Transformation team are planning an evaluation of Red 2 Green and SAFER a year post implementation and liaising with NHSi who are reviewing the implementation across the country. NHSi informatics lead linked in with Jon Reynolds re SAFER information.

3.2 EndPJParalysis

From 14 September to 22 December, WSFT participated in the East of England 100 day challenge to raise the importance of getting our patients up, dressed and moving to reduce the risk of deconditioning. Now planning a national campaign.

3.3 GP/Primary Care Streaming

	1-31st Dec	1-15th Jan	% variance
Sessions filled	79%	90%	
Total streamed	1670	1059	26.83%
No. streamed to ED	1055	715	35.55%
No. streamed to GP	510	295	15.69%
No. returned from GP to ED	51	19	-25.49%

NB: Variance calculated by doubling figures from 1-15th January

This table compares the full month of December 2017 with the period 1-15th of January 2018. As 13 half-day sessions were not filled during December 2017 but only 3 half day sessions have so far been unfilled for this period in January, the fill rate has improved from 79% to 90% so far.

As the service embeds we are seeing the fill rate increasing, the service more fully utilised and the number of patients returned to ED reducing. The governance structure has been created and includes a review of patients by an ED Consultant and a Lead GP to ensure continuous learning and review. The SOP has been reviewed and updated by the group and is due to come to the Executive Team week commencing 22 January.

3.4 Discharge to Optimise and Assess (D2OA)

Workstream leads identified. Funding for a project manager agreed with ACS advert out next week. Public Health are supporting the evaluation of D2OA across all pathways.

3.5 Red Bag

The Red bag pilot was launched successfully for the 7 care homes. Evaluation framework is currently being developed.

4.0 Perfect week

4.1 Initial Feedback from 'A SAFER Start'

Demand outstripped capacity due to a 6% increase in admissions compared to the same period last year

Positive Outcomes	Requires more work
• Ward Liaison Officers Recruiting staff from none clinical roles was positively received by the ward staff.	• Friday Focus To identify patients suitable for review and discharge at the weekend
• Implementation of a new command and control structure for supporting patient flow Reduce numbers of staff in bed meetings Clear actions and escalation process	• Discharge waiting area Restrictions of our estate meant we had to use admission and discharge areas to bed patients which caused us to become completely gridlocked. Action is to identify alternative locations next year.
• Increased support at the weekend Discharge doctors, nurses, social care, therapy, pharmacy and transport	• Consistent declaration of empty beds by ward staff Use of ecare CapMan to support
• Operational staff supporting wards and identifying and unblocking RED reasons	• Portering Consider specific porters for radiology to prevent back log

4.1 Recommendations

- Embed the new structure for managing flow
- Appoint Head of Patient Flow to reduce variance
- Embed use of CapMan in ward areas
- Review weekend arrangements
- Develop the Focus on Friday
- Consider options for Easter weekend

5.0 Planned Care Programme Project Highlights

5.1 100 Day challenge

This national programme is designed for primary and secondary care to jointly test ways of improving patient experience and speeding up access to elective care and will focus in three areas: Rethinking referrals/Shared decision making and Transforming Outpatients.

West Suffolk is in wave three of the programme; the specialties are Cardiology, Urology and ENT. We have appointed three coaches and three project leads from the current team to support the process. Day 0 for the teams is the 5th February. All the initial team meetings are booked and the "leadership launch" is planned for the 2nd February.
We will be reporting progress at checkpoint events at 25, 50 and 75 days with a final close down event at 100 days. These dates are being arranged with NHSE and will follow in due course.

5.2 Right Care Programme – Cardio Vascular Disease (CVD), Respiratory and Neurology

'RightCare' is about the whole health system taking an evidence based approach to focus on key areas that will improve health outcomes for the population, reduce unwarranted variation in care and save money. The benchmark data packs have been received and reviewed by the three specialties Respiratory, Neurology and Cardiovascular Diseases (CVD) to identify opportunity for improvement which are-

- A review of CVD pathways across the STP with a focus on Atrial Fibrillation linked to the Elective Care Challenge and Hypertension.
- Varicose veins procedures - A review at West Suffolk Hospital starting on 22 January 2018 with the aim to support 18 weeks referral to treatment work by ensuring compliance with the low priority procedure.
- Reviewing variation in community heart failure services & linking CVD to the diabetes transformation programme
- The health population programme is aiming to have a longitudinal patient record, the proposed pilot specialties are diabetes and CVD.
- Review of Neurology and Pain pathways across the STP.
- My COPD pathway - The STP is working to roll out a digital innovation called my COPD. This web-based self-management platform, (or app), will support patients to manage their long-term condition through education, rehabilitation and symptom reporting.
- Medicines Management within these specialties.
- Reducing avoidable emergency attendances within these specialties.

5.3 Diabetes Prevention Programme

The NHS Diabetes Prevention Programme is a joint initiative led by NHS England, Public Health England and Diabetes UK and aims to deliver services which identify people with non-diabetic hyperglycemia who are at risk of developing Type 2 Diabetes.

The STP and Suffolk and Essex PH are working jointly on a plan to support GP practices in undertaking audits of practice registers to identify the at risk population with existing non-diabetic hyperglycemia and referring them to behaviour change management programmes.

Procurement of the change management service provider is currently underway. An evaluation panel has been selected and briefed on their involvement and responsibilities during the mini procurement process, through to award in March '18.

Wave 3 of the national programme will launch in June 2018.

5.3.1 Treatment and Care Funding – Diabetes Management

This NHS England led programme, aims to help improve the outcomes of patients with diabetes in two key areas –

- Increased attendance on structured education courses to improve understanding and self-management of individuals with diabetes.
- Improve achievement levels for the three core diabetes treatment targets, namely blood glucose control (HbA1c), blood pressure and cholesterol levels.

To coincide with World Diabetes Day the STP launched a marketing campaign to raise awareness of diabetes and the importance of attending structured education courses, the teams achieved

- Press coverage and interviews with clinicians and people living with diabetes on BBC Radio Suffolk and Essex.
- Promotional stands in the centres of Ipswich and Bury St Edmunds with digital adverts displayed at Supermarket Entrances and at pay points in garage forecourts to support the promotion.
- All linked with Public Health's diabetes prevention campaign in the New Year.
- A refreshed STP advertising campaign is planned for late January.

The additional posts based at WSFT in nursing and admin within the Diabetes Service to underpin the work in primary, secondary and community care are now beginning their roles.

The target of 300 DESMOND (Type 2) places funded by this programme doubles existing DESMOND provision by WSHFT; existing referrals are down at 50% for 2017 compared to previous two years. The GP Incentive scheme, as well as a strategy worked on by the Trust and CCG should boost referrals of newly diagnosed and prevalent T2 patients to structured education.

The Trust plans to over perform on the targeted 40 places for DAFNE (Type 1) structured education provision.

5.4 Integrated Pain Management Service (IPMS)

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

YTD reduction of 26.4% (61) First OPD appointments compared to 2016/17.
YTD reduction of 10.4% (62) Follow Up appointments compared to 2016/17.
Shared care arrangements between the Community Pain Management Service and WSFT are now in place, which should increase activity delivered in the community.

5.5 Ophthalmology

The need to change the delivery system of eye care services to enable a sustainable and affordable clinical model for the growing elderly population of Suffolk is in progress. It aims to integrate eye

services for the patient through a strategic partnership model of care where the consultants can direct where work should appropriately be undertaken and the clinical skill level required in the community. This requires the CCG to:

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

WSFT ophthalmology consultants are required to develop the clinical governance strategy.

Procurement started on 2nd January 2018 for lot 1 with I&ESCCG, Ipswich Hospital and West Suffolk Hospital and the expected date for the service to mobilize is 1 September 2018.

5.6 Stroke

The STP baseline review has been undertaken and the wider review is starting. A meeting is arranged for 22nd January with clinical leads from the acute hospitals across the STP to agree the scope of the review. The aim is to enhance what we already have and future proofing stroke services rather than major reconfiguration. The Stroke Early Supported Discharge Service contract and the Stroke Association contract are to be extended to be in line with the review.

5.7 Demand Management

This work programme is aiming to pull together and support the delivery of a range of schemes to support demand management e.g. improving Advice and Guidance between clinicians in different care settings and changing the way outpatient consultations are delivered.

Referral to treatment times (RTT) remains a large part of the programme and supporting this has been the main focus. A model has been built to demonstrate the impact of winter, cancellations and the timescales for each specialty to improve. Teams from the CCG and WSH have worked together to build the model; currently in testing. Meetings to demonstrate and agree the model is being arranged and once agreed aims to support RTT improvements.

6.0 Next Steps

6.1 Patient Choice

Relaunch the revamped patient choice policy.
Communication and training to ward staff re the importance of adhering to the policy
Support from Matrons for the implementation.

6.2 Trusted Assessor

Discharge planning team working closely with care homes to implement the trusted assessor model which will negate the need for care homes to come in and assess. 3 care homes signed up to the initial pilot
Investigate a similar role where a community member of staff identifies patients known to the community teams and liaises with them and the patients to reduce length of stay.

6.3 Stranded patients

Currently a review of patients in hospital over 7 days takes place. Plans in place to move this to reviewing the patients on each ward with the nurse in charge

7.0 CQUIN Projects 2017-8-9

Staff CQUINs title:	Progress	RAG
1a) Staff Health & Wellbeing: Improved results by 5% on the national Staff Questionnaire re: H&W provision plus MSK & Stress not being 'due to work'.	Staff H&W initiatives in place including for MSK. Latter 2: Rely on staff own perception re: main cause. National Staff Survey results due Feb/March 2018 for Q4 report.	
1b) Food & Drinks sold at WSFT: Continue changes made 2016-7 re: items high in fat, sugar or salt. Introduce 3 new changes 2017-8.	All progress in place including liaison with W H Smith: Reduced % of sugary drinks, high calorie sweets and sandwiches on track for amended shelf displays by March (Q4). 1b) Board Report in preparation for March Agenda as required.	
1c) Flu vaccination of staff: 70% uptake by end of February. (2018-9 target increases to 75%)	Current staff vaccinated: 67.41%. 2.59% = 100 staff needed within 5 weeks. Managers to highlight: Flu outbreak now in the region, there is still time to protect yourself and others & help stop the spread.	
Patient CQUINs title:	**Progress**	**RAG**
2a) Sepsis screening of all ED and inpatients. Target 90%	Q3: on target 100%. eCare adds symptoms together & prompts 'Suspected Sepsis' when relevant.	
2b) Severe/ High Risk Sepsis treatment ED & Inpatients: IV anti-biotic within 1 hour of diagnosis. Target 90%	Timely treatment improvements required. November was 76%. December TBC. Q3: part met as predicted. Sepsis Group to review results & communicate to relevant staff. eCare alerts are now in place.	
2c) Severe/ High Risk Sepsis patients ED & Inpatients: antibiotic prescription review within 72 hours. Target 90%	Q3: on target.	
2d) 2% reduction in all & 2 specific Antibiotics vs 2013-4	Report due end of Q4. Low baseline year unrealistic to improve from – predict not met. Other factors: antibiotic need, resistance.	
4) Mental Health need in ED – Selected cohort reduced ED attendance/ care plans in place/ improved use of diagnosis in ED re: MH. Year 2: reduce overall MH attendance.	Q3: will be met with the required Data Quality Improvement Plan. Q4: Reduce the cohort of 13 patients' ED re-attendance by 20% (from 2016-7) – on track. Outstanding: 13 patients care plans to be created – liaison between NSFT and ED required. New cohort of frequent attenders to be identified for care plans and to measure 2018-9.	
6) Advice & Guidance to GP pre referral via eRS. Specialties offering A&G covered at least 35% of referrals received 2016-7 (aim A&G will reduce referrals). 2 working day response.	Q3: met for 'live' specialties offering A&G via eRS. Daily checks on eRS queries in place & reminders sent. Varied compliance of 2 day turnaround so far (7 specialties). Clinician ideally responds direct on eRS: work arounds in place with PAs as required. If GPs do not receive timely response: they may resort to refer.	
7) e-Referrals for GPs: all services & consultant led 1st outpatient appointments published on eRS. Reduce ASI.	Q3: Met: Over 90% published on eRS. ASI down from 16% Q2 to 10% Q3 due to review of services and polling ranges. Q4: ASI target 4%.	
8a) Proactive & Safe Discharge (age 65 & over): increase by 2.5% in Q3&4 'patients being discharged within 3-7 days to their usual place of residence'	Report due Q4. Q3 % results so far on track due to all the Trust initiatives & collaborative plans in place as reported in Q2: e.g. Discharge to Optimise & Assess, Red to Green, SAFER.	
8b) Emergency Care Data Set: system updates for improved reporting	Q3: data was due from October but due to circumstances beyond WSFT control, supplier (Cerner) delay go-live to March. IT plan is in place including education.	
10) STP (Suffolk Transformation Programme) Support	Local CQUIN. Q3: met re: evidence of meeting minutes.	
2018-9: 9a-e) Inpatient Smoking & Alcohol screen, advice, refer	eCare build in preparation for pre Q1 start 1 April. Education & communication being planned e.g. PGME 17/1/18.	

Trust Board – 26th January 2018

Agenda item:	12			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sinead Collins, Clinical Business Manager			
Date prepared:	17 January 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 December's and progress of nurse staffing review made below.

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	6 medication errors	High agency and bank use. High RN & NA vacancy. High amount of overtime. High sickness
F7	10 medication errors	High agency and bank use. High RN vacancy. High amount of overtime. High sickness
F8	-	High bank use and sickness. High amount of overtime
Theatres	-	High RN vacancy. High sickness. High amount of overtime
DSU	-	High sickness and bank use. High RN vacancy
CCU	-	High bank use
G1	-	High sickness
G3	-	High bank use. High NA vacancy. High sickness. High amount of overtime
G4	4 medication errors	High bank use & sickness. High amount of overtime
G5	3 pressure ulcers	High bank use & sickness. High RN vacancy.
G8	-	High bank and agency use. High sickness. High RN & NA vacancy.
F1	-	High bank use and sickness
F3	-	High sickness. High amount of overtime
F4	-	High bank and agency use.
F6	-	High agency use. High sickness. High amount of overtime
F9	4 medication errors & 4 falls with harm	High bank use & vacancy in RNs. High sickness. High amount of overtime
F10	-	High bank use & vacancy in RNs. High sickness. High amount of overtime
Maternity	-	High bank use & sickness
F12	-	High bank use & sickness
F14	-	High sickness
Kings Suite	4 falls with harm	High bank use
Rosemary Ward	-	High bank use & sickness

Vacancies – There is significant vacancies in registered staff, and is 74.06 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 a 30 bed escalation ward has opened on G9 as of 13th December. Recruitment in Philippines completed and now in the HR process stage

Roster effectiveness – Out of 26 areas, 21 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is 6 areas higher than October.

Sickness – Out of 27 areas, 21 are over the Trust Standard of 3.5% (three higher than last month) (Day surgery unit & ward are counted as one area).

Update on progress of Nurse Staffing Review

Nurse Specialist review is complete and it has been agreed that no CNS will be moved to wards, so as not to disrupt RTT, cancer targets etc

Due to different sizes of wards and external requirements, e.g. CCU has shared roles. Service Managers and HR are in the process of agreeing the appropriate % of annual leave per ward and there will then be a performance process in place.

Item 12

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Dec-17			Establishment for the Financial Year 2017/18						Data for Dec 2017														
										Workforce													Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	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	109.1%	93.0%	116.4%	96.5%	5.65%	6.88%	501	-4.05	-8.40	6.40%	N/A	23.00%	N/A	6	0
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	79.0%	79.9%	83.4%	96.8%	10.03%	10.42%	207	-7.20	-3.13	11.60%	6.34	25.50%	0	10	1
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	56.8%	N/A	68.2%	N/A	10.92%	5.53%	198	-4.20	0.20	4.00%	N/A	22.00%	0	3	0
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	91.4%	87.0%	N/A	N/A	0.93%	0.00%	56	-2.26	0.00	2.10%	18.56	18.00%	0	2	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	91.4%	101.3%	N/A	N/A	1.81%	0.00%	353	-6.49	-2.70	10.50%	N/A	24.90%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	127.6%	83.2%	73.7%	N/A	1.20%	0.00%	0	-1.22	-0.10	1.40%	N/A	17.40%	0	1	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	51.8%	N/A	75.1%	N/A	0.00%	0.00%	26	0.70	-1.48	10.90%	N/A	22.90%	0	0	0
	Day Surgery Wards													15.16%	0.00%	0	0.00	0.10	3.90%		24.90%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	98.3%	88.1%	63.8%	N/A	5.02%	0.00%	29	-0.60	-0.70	3.80%	11.41	21.60%	0	1	1
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	88.8%	96.9%	91.3%	N/A	4.17%	0.00%	77	-0.80	1.00	7.00%	8.14	21.10%	2	3	1
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	92.8%	78.9%	79.6%	97.7%	12.40%	0.97%	239	-3.29	-5.12	5.30%	4.51	19.50%	0	1	1
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	89.9%	71.0%	110.3%	114.7%	11.93%	0.60%	353	-2.75	-0.10	5.70%	5.85	22.10%	0	4	1
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	79.8%	83.1%	96.8%	109.7%	11.33%	0.94%	140	-3.92	-0.60	7.00%	4.65	23.60%	3	1	2
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	79.5%	80.8%	89.4%	95.4%	10.20%	6.28%	109	-4.80	-4.27	9.00%	5.58	24.10%	1	1	2
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	77.9%	146.4%	106.5%	N/A	7.95%	0.00%	94	-1.80	2.50	6.90%	N/A	20.80%	N/A	0	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	86.6%	98.0%	141.9%	92.2%	3.04%	2.57%	330	-2.20	-2.30	6.90%	5.22	20.80%	2	3	1
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	85.7%	89.8%	97.3%	170.4%	15.14%	5.73%	104	-3.65	-1.30	3.40%	11.01	16.90%	1	1	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	88.3%	93.6%	99.7%	126.6%	3.74%	1.00%	60	-2.30	-0.35	2.20%	5.75	18.20%	1	1	1
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	82.1%	93.8%	104.2%	92.1%	2.80%	5.64%	240	-2.95	-1.70	7.40%	7.75	23.20%	0	2	2
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	87.7%	92.4%	81.1%	109.1%	9.11%	0.81%	333	-5.00	-0.10	9.60%	5.01	24.00%	2	5	4
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	99.8%	71.7%	83.3%	93.2%	7.53%	1.03%	189	-5.19	-2.80	9.50%	5.89	24.60%	1	1	1
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	108.6%	95.6%	72.1%	60.0%	12.24%	0.00%	72	-3.19	-0.07	8.30%	N/A	25.00%	0	1	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	89.4%	85.4%	26.5%	87.4%	16.64%	0.59%	44	-2.88	-0.50	10.10%	7.7	22.50%	0	0	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	98.8%	101.1%	N/A	N/A	0.00%	0.00%	114	-0.70	-0.40	2.10%	N/A	20.70%	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	85.5%	N/A	61.1%	N/A	0.66%	0.00%	0	-0.20	0.00	5.10%	N/A	18.00%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	100.0%	90.2%	11.3%	32.3%	0.48%	0.00%	51	-2.22	-1.40	3.30%	26.08	21.50%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	99.2%	98.4%	83.8%	100.0%	7.72%	0.00%	No data	0.00	-0.69	5.37%	6.20	N/A	1	1	0
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	96.4%	99.2%	86.5%	102.3%	8.30%	0.0%	85	-0.90	-0.50	3.70%	4.80	20.90%	0	0	4
																	-74.06	-34.91	Target - 3.5%		Trust standard is 20%			

Explanations	
	WSFT have some significant environmental layout challenges and additional activity that are not reflected in the SNCT(F14/G1/G8/F12/CCU/NCH)
	Some units do not use electronic rostering therefore there is no data for those units
	In vacancy column: - means vacancy and + means overestablished. This month refer to report however
	Roster effectiveness is a sum of Sickness, Annual leave and Study Leave
	DSU has been split into ward and unit only by HR, that is why only a section has been split in this dashboard
	G9 - will hopefully be added next month. G9 template includes shifts which are not in use, F8 and it includes the Discharge Waiting Area Team so the percentages are not an accurate reflection of need vs usage. They one fall with harm and one medication error in Dec

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

NEESPS Quality, Compliance and Regulatory Affairs Report

NHS
North East Essex and Suffolk Pathology Services
A Partnership of Hospitals

1. Introduction

This Quality, Compliance and Regulatory Affairs report has been designed to provide visable and transparent information for all shareholders of NEESPS. The aim is to provide assurance in relation to the activities and efforts of the NEESPS Team in getting the business back into a compliant state with the regulatory authorities. We now have an enriched governance and oversite group to review our activities and issues, which is chaired by NHSI and involes NHSE, the Medical Directors of each partner Trust, the executive sponsor of NEESPS and the NEESPS Senior ManagementTeam.
This report will be used to detail progress and to also address deficiences and highlight area's of concern. Clinical input will also be provided by our clinical leads across sites in order to provide further assurance in our quality outputs and delivery of safety to patients.
It is important to note that at the point of NEESPS formation the Quality Management System was derelict. We are operating under a very tight financial envelope with an expectation that we live within our means and therefore have limited additional resource available to us. As a consequence we are having to prioritise our resource and efforts. The prioritisation is continued focus on MHRA Complaince at WSH and rectification of the non-conformances across IHT, with a view to attaining UKAS compliance in March 2018. We will then be able to redirect some of our resources to WSH and CHUFT with a view to being able to apply for UKAS Accrediatation again in June/July 2018.

2. Regulatory Assessments completed and pending

Site	Accreditation Visit	Current Status	Non Conformance Deadline	Progress (NC closure)	RAG
Ipswich	UKAS Haematology & Transfusion	Given CPA and transition to 15189 with satisfactory completion of Non-Conformances	25/01/2018	Completed 16 out of 80, 33 in progress, 31 pending	On track
Ipswich	UKAS Histology	Non-Conformances cleared and evidence submitted to UKAS. Awaiting feedback from UKAS in relation to their review of the evidence submitted.	12/11/2017	Completed 66 out of 66	Completed
WSH	UKAS Histology	ISO 15189 Accreditation achieved.	06/09/2017	Completed 73 out of 73	Completed
Ipswich	UKAS Chemistry	Given CPA accreditation without transition to 15189 with satisfactory completion of Non-Conformances	05/01/2018	Completed 18 out of 68, 30 in progress,15 pending , 5 duplicate's	On track
WSH	MHRA Transfusion	Cease and Desist warning issued	18/01/2018	Completed 204 out of 240, we are not expecting to have all	On track

				Non-Conformities completed by 18th Jan 2018. The Non-conformities relating to Computer Systems Validation will not be completed until April/May 2018, as previously discussed and agreed with MHRA in June 2017.	

Suspended Accreditation

Site	Accreditation	Current status
WSH	UKAS Haematology & Transfusion	Voluntary suspension of haematology, loss of transfusion accreditation due to MHRA findings
	UKAS Chemistry	Voluntary suspension
Colchester	UKAS Haematology & Transfusion	Voluntary suspension
	UKAS Histology	Voluntary suspension
	UKAS Chemistry	Voluntary suspended

3 New Quality Management System Build Status

<table>
<tr><th></th><th>IPS</th><th>WSH</th><th>CHUFT</th><th>Summary</th></tr>
<tr><td>Quality Policy</td><td>Y</td><td>Y</td><td>Y</td><td>This has been completed and has been approved by UKAS during their inspection at IHT.</td></tr>
<tr><td>Quality Manual</td><td>N</td><td>N</td><td>N</td><td>Document in draft format at the moment. Introduction of new document to be in-line with new QPULSE rollout. Historical Quality Manuals are in place at Ipswich but will be replaced by new Quality Manual in line with the overall NEESPS Quality Management rollout. On track.</td></tr>
<tr><td>Risk Assessments</td><td>Y</td><td>Y</td><td>Y</td><td>The NEESPS risk register is active and follows the CHUFT policy. We are revising the scoring of our risks and the register will be provided in the next return of this report.</td></tr>
<tr><td>SOP’s & controlled document creation or revision</td><td>Y</td><td>Y*</td><td>Y**</td><td>Documents created or revised on QUPLSE since the formation of NEESPS in May 2017.

<table><tr><th>Site</th><th>Discipline</th><th>Number of documents</th></tr><tr><td>WSH</td><td>Transfusion</td><td>70</td></tr><tr><td>WSH</td><td>Histology</td><td>472</td></tr><tr><td>IHT</td><td>Haematology & Transfusion</td><td>256</td></tr><tr><td>IHT</td><td>Biochemistry</td><td>696</td></tr><tr><td>CHUFT</td><td>Biochemistry</td><td>60 (210 in draft)</td></tr><tr><td>CHUFT</td><td>Transfusion</td><td>112</td></tr><tr><td>CHUFT</td><td>Haematology</td><td>75</td></tr><tr><td>CHUFT</td><td>Histology</td><td>4</td></tr></table>
*SOP’S exist but they are in need of a full review overall and require further input into QPULSE. Transfusion has been the priority.
** Progress is being made but it is slow due to minimal Quality resource available at CHUFT at the moment.
A great deal of shared learning and document sharing will be undertaken across sites where appropriate.</td></tr>
<tr><td>Audit Schedule</td><td>Y</td><td>Y*</td><td>Y**</td><td>*The audits are focused on Blood Transfusion and more work is required to create a detailed audit programme for Blood Sciences.
** Limited audits have taken place overall due to resourcing and more work is required to create a detailed audit schedule.</td></tr>
</table>

Business continuity plan	N	Y*	N	WSH completed a document, which is in review and will be cascaded across the other sites as appropriate.
Training	N*	N*	N*	*The Training function has not been standardised overall but is being delivered within transfusion. We are in the process of recruiting a person who can take ownership of the training functionality overall.
Competencies	N*	N*	N*	*As Above
Verifications and Validations	N*	N*	N*	*Templates have been issued to evaluate Validation data across our repertoire. Although a lot of progress has been made there is a huge amount of further resource implications to fully discharge this function. This is noted in the risk register.
Build and roll-out of new Q-Pulse Enterprise	N*	N*	N*	*Validation of this system is required and is planned for Jan –March 2018. However, there will be a challenge in relation to delivering this within the timeframe due to lack of resources.

3. Number of Current Pathology DATIX Incidents

Please Note there is ambiguity across the trend analysis as we need to align the sub-category identification within the three datix systems.
This is therefore best observed as a snapshot

Category of DATIX incident	Number	Trend
Submitted by Biochemistry IHT CHUFT WSH Total	 6 11 8 25	Failure to follow process. SOP reviews required across all sites and is being done in line with the QMS Build.
Submitted by Cellular Pathology IHT CHUFT WSH Total	 0 6 0 6	Under reporting suspected investigate, WSH and IHT reporting via qpulse
Submitted by Haematology IHT CHUFT WSH Total	 7 9 2 18	Failure to follow process. SOP reviews required across all sites and is being done in line with the QMS Build.

Submitted by Transfusion IHT CHUFT WSH Total	 6 4 15 25	Samples arriving with inadequate patient identification.
Submitted as General Specimen reception/Phlebotomy	16	Failure to follow process. SOP reviews required across all sites and is being done in line with the QMS Build. Further training and competency assessments required.

4. Incidents by Category

Incident Category	Total for Nov	Trend identified/Further work required
Analytical	2	
Complaints	2	
Process	27	
Sample Handling	11	
Sample Acquisition	6	
Equipment	4	
Laboratory error	4	
Clinical	4	
H&S	8	
IT	27	
Staffing Levels	2	

5. Never Event Total

The value recorded is zero

6. Significant Planned Change

Priority	Program	Timeframe	Status	Comments	Revised Date	Completed date
1	NEESPS Quality Team build	Aiming to fill all posts by March 2018 at the latest	On track	There has been a great deal of difficulty in recruiting to the Quality Management Team. It may still be possible that we cannot recruit to all posts by the timeline set.		
2	Qpulse Enterprise implementation	March 2018	On track	The build of the new system begins in Jan 2018.		
3	Lims retrospective validation WSH/ CHUFT	June 2018	On track	This may become delayed due to lack of resource.		
4	New Grifols Transfusion analyser implementation WSH/CHUFT	June 2018	Intervention Required	Delayed due to unresolved interfacing issues. Issues will be discussed with both Capita and Clinisys over the next several weeks during the contract renegotiation phase.		
5	New Haemonetics Blood Control system Implementation WSH/CHUFT	June 2018	Intervention Required	Delayed due to MHRA visit and approval of validation process.		
6	New Biochemistry analyser implementation WSH/ CHUFT	TBC – awaiting lead-in times from supplier				
7	New Haematology Coagulation analyser implementation WHS/CHUFT	TBC – Awaiting lead-in times from supplier				
9	LIMS Enterprise Implementation Ipswich	TBC – The programme timelines are to be recalibrated in Jan 2018.				

7. Audits Status

Detailed view of Blood Transfusion

Scheduled Start Date	Number	Title	Ipswich	West Suffolk	Colchester
01/04/17 00:00	AUD711	Audit of time for samples to reach blood transfusion from blood science	Complete	Complete	Complete
01/04/17 00:00	AUD669	Reagent and test kit batch acceptance	Complete	Complete	To do
01/05/17 00:00	AUD705	Cold chain and blood transport	Complete	Complete	Complete
01/06/17 00:00	AUD672	Telephone request procedure	Complete	Complete	Complete
01/07/17 00:00	AUD671	Incident Reporting-Local/SHOT/SABRE	Complete	Complete	To do
31/08/17 00:00	AUD641	Recall procedures internal/external	Complete	Complete	Complete
01/09/17 00:00	AUD674	Vertical Audit (cross site) of Blood Grouping and Antibody Screening	Complete	Complete	Complete
01/09/17 00:00	AUD712	Training and competency assessment (cross site)	Complete	Complete	To do
31/10/17 00:00	AUD643	Automated Blood Group and Screen	Complete	Complete	Complete
01/11/17 00:00	AUD676	Crossmatch and Electronic Issue	Complete	In progress	To do
01/12/17 00:00	AUD677	Change Control	Complete	To do	To do
01/01/18 00:00	AUD678	Horizontal audit against BSQR/MHRA standards 2018	To do	To do	To do
01/02/18 00:00	AUD679	Horizontal Audit of Transfusion Equipment Records	To do	To do	To do
01/03/18 00:00	AUD681	Traceability process	To do	To do	To do

Summary view of Biochemistry, Haematology and Histology

Department/Site	Trajectory/Status
Biochemistry IHT	On track
Biochemistry WSH	More work needed to create a detailed audit schedule but focus has been on IHT in order to attain accreditation.
Biochemistry CHUFT	More work needed to create a detailed audit schedule but focus has been on IHT in order to attain accreditation
Haematology IHT	On track
Haematology WSH	More work needed to create a detailed audit schedule but focus has been on IHT in order to attain accreditation
Haematology CHUFT	More work needed to create a detailed audit schedule but focus has been on IHT in order to attain accreditation
Histology IHT	On track
Histology WSH	On track
Histology CHUFT	More work needed to create a detailed audit schedule but focus has recently been on IHT in order to attain accreditation.

8. External Quality Assurance Performance

All EQA reports are reviewed and signed off by the technical and consultant leads

Biochemistry	
IHT	
Overall performance	Good
Improvement necessary	N/A for this return.
Unacceptable returns	Gentamicin and Vancomycin – transcription error.
Summary: Performance is steady with exception to the transcription errors of EQA results for the recent Gentamycin and Vancomycin assays. The corrections have been sent to the EQA Scheme for update to the scoring. There appears to be a slight positive bias for albumin on the 2nd Roche line and this will be monitored closely.ACE has been poor but this will be monitored very closely and there will be increased calibration of this assay.	
WSH	
Overall performance	Good
Improvement necessary	N/A for this return.
Unacceptable returns	N/A
Summary: Total Cholesterol is running a positive bias on the 1st Roche line but is within the method mean.Cortisol is showing a negative trend so requires monitoring.	
CHUFT	
Overall performance	Good
Improvement necessary	B12 requires close monitoring.
Unacceptable returns	N/A
Summary: B12 has a positive bias in relation to the method mean.	
Haematology	
IHT	
Overall performance	Good
Improvement necessary	N/A in this return
Unacceptable returns	N/A
Summary: All Within concensus	

WSH	
Overall performance	Good
Improvement necessary	N/A in this return
Unacceptable returns	N/A
Summary: Within Concensus	
CHUFT	
Overall performance	Good
Improvement necessary	N/A for this report
Unacceptable returns	N/A
Summary: Within Concensus	
Transfusion	
IHT	
Overall performance	Good
Improvement necessary	N/A in this return
Unacceptable returns	N/A
Summary: Within Concensus	
WSH	
Overall performance	Good
Improvement necessary	N/A in this return
Unacceptable returns	N/A
Summary: Within Concensus	
CHUFT	
Overall performance	Good
Improvement necessary	N/A for this report.

Unacceptable returns	N/A.
Summary: Within Concensus	
Cellular Pathology	
IHT	
Overall performance	Good
Improvement necessary	Improvement required for making the Elastin Van Geison stain. Continue to monitor.
Unacceptable returns	N/A
Summary: A score of 5 for Special Method A - Elastin / Van Geison, where the staining appropriately demonstrates the expected staining results but the staining is suboptimal and improvements are required. This is a nationally recognised problem with the EVG, as there has been a problem with the commercial stains and those made in house. We make ours in house and one of our BMS has been tasked with improving the technique.	
WSH	
Overall performance	Good
Improvement necessary	Improvement required for making the Elastin Van Geison stain. Continue to monitor.
Unacceptable returns	N/A
Summary: For the last EQA performance round we were fine for Immunocytochemistry and for Cellular Pathology Techniques except for a score of 5 for Special Method A - Elastin / Van Geison, where the staining appropriately demonstrates the expected staining results but the staining is suboptimal and improvements are required. This is a nationally recognised problem with the EVG, as there has been a problem with the commercial stains and those made in house.	
CHUFT	
Overall performance	Good
Improvement necessary	Improvement required for making the Elastin Van Geison stain. Continue to monitor.
Unacceptable returns	N/A
Summary: For the last EQA performance round we were fine for Immunocytochemistry and for Cellular Pathology Techniques except for a score of 5 for Special Method A -	

Elastin / Van Geison, where the staining appropriately demonstrates the expected staining results but the staining is suboptimal and improvements are required. This is a nationally recognised problem with the EVG, as there has been a problem with the commercial stains and those made in house.

9. Risk Assessments and Register

Updated risk register will be submitted within the next return of this report as we are reviewing our approach to scoring of risks.

Commentary : Data

New TATs (with an 'a' suffix) added based on time specimen taken to result all others s based on receipt date. WSH & Col (except Micro) reported from WinPath. IPS were unable to supply sample to result TATs this month

PT01 – Restricted to specific tests in blood sciences plus microbiology at WSH

PT02 - IPS have only supplied for Q1

PT22 – Only available for IPS and then only for Glucose & D Dimer. Times over-written in PathManager

PT23 – Reported from WinPath so COL Micro not avail

PT24 – Is the percentage of requests where the LIMS do not have an NHS no. recorded for the patient.

Discussions on-going with PHE in respect to their ability to change extracts for the metrics supplied for Microbiology data

Commentary : Trends

Actions

Level : DIVISION

Organisation : Pathology

Domain : Pathology

ID	Indicators	Weight	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
PT01	the % of tests that are rejected because the sample is too old to analyse	5	1.0%	0.2%	0.3%	0.2%	0.2%	0.4%	0.3%	0.2%	0.2%				
PT02	ANC haemoglobinopathy Performance	2		98.1%	98.1%	98.2%	99.7%	98.4%	98.6%	99.1%	99.0%				
PT03	A&E Basket of Tests - Sodium	3	95.0%	94.3%	85.9%	92.2%	93.6%	94.2%	84.9%	93.5%	93.3%				
PT03a	A&E Basket of Tests - Sodium (Sample To Test)	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	59.9%	64.2%				
PT04	A&E Basket of Tests - Troponin	3	95.0%	93.0%	86.6%	92.0%	92.2%	93.0%	91.9%	90.1%	91.3%				
PT04a	A&E Basket of Tests - Troponin (Sample To Test)	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	46.1%	47.5%				
PT05	A&E Basket of Tests - D Dimer	3	95.0%	93.0%	95.5%	97.6%	92.1%	92.7%	92.3%	93.7%	93.8%				
PT05a	A&E Basket of Tests - D Dimer (Sample To Test)	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	55.1%	53.3%				
PT06	A&E Basket of Tests - Full Blood Count	3	95.0%	95.7%	94.9%	96.4%	96.6%	95.7%	96.2%	96.1%	94.8%				
PT06a	A&E Basket of Tests - Full Blood Count (Sample To Test)	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	84.0%	84.7%				
PT07	Acute Basket of Tests - Sodium	2	95.0%	88.8%	82.4%	83.6%	87.5%	86.8%	86.7%	85.9%	87.0%				
PT07a	Acute Basket of Tests - Sodium (Sample To Test)	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	72.5%	75.7%				
PT08	Acute Basket of Tests - Full Blood Count	2	95.0%	98.0%	97.0%	97.7%	97.9%	97.5%	97.7%	97.2%	97.1%				
PT08a	Acute Basket of Tests - Full Blood Count (Sample To Test)	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	92.3%	90.7%				
PT09	Acute Basket of Tests - ANCA MPO	2	95.0%	97.1%	98.3%	98.3%	99.1%	98.9%	98.4%	99.5%	98.4%				
PT10	Acute Basket of Tests - Blood Group and Screen	2	95.0%	97.7%	92.7%	98.0%	98.1%	98.2%	97.6%	98.2%	97.8%				
PT010a	Acute Basket of Tests - Blood Group and Screen (Sample To Test)	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	97.4%	96.9%				
PT11	Acute Basket of Tests - Feto-maternal haemorrhage	2	95.0%	87.5%	87.8%	91.1%	89.6%	91.2%	85.3%	86.1%	88.2%				
PT011a	Acute Basket of Tests - Feto-maternal Hemerrhage (Sample To Test)	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	80.9%	81.3%				
PT12	Acute Basket of Tests - Antenatal Blood Group and Screen	2	95.0%	99.4%	98.9%	99.3%	99.3%	99.6%	99.1%	99.0%	99.0%				
PT012a	Acute Basket of Tests - Antenatal Blood Group and Screen (Sample To Test)	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	98.2%	98.5%				
PT14	Histology TAT - Lab 3 day	2	80.0%	83.8%	78.9%	82.1%	89.1%	83.2%	78.7%	72.5%	79.8%				
PT15	Histology TAT - Lab 7 day	2	80.0%	44.2%	48.9%	49.2%	52.3%	42.8%	42.8%	42.8%	47.4%				
PT16	Histology TAT - Lab 10 day	2	90.0%	59.7%	63.5%	62.3%	69.1%	55.3%	54.0%	61.3%	67.8%				
PT17	Histology TAT - Lab 21 day	3	95.0%	87.8%	90.5%	91.2%	92.6%	80.5%	79.4%	94.9%	97.3%				
PT18	Microbiology - MRSA Screen Routine (Rate)	3	95.0%	85.6%	85.0%	89.6%	85.5%	88.1%	88.4%	87.2%	89.4%				
PT20	Microbiology - Faecal Clostridium Difficile (Rate) (i)	3	95.0%	86.0%	93.8%	95.4%	97.8%	95.0%	92.0%	94.9%	96.7%				
PT21	Total Activity	0		1171554	1175712	1290945	1266109	1302590	1258973	1325403	1332489				
PT22	Critical results communication (acute)	4	97.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A				
PT23	Percent of Electronic Orders	0	95.0%	64.9%	64.2%	65.8%	66.4%	66.1%	66.9%	67.1%	67.2%				
PT24	Percent of Orders with NHS Number	4		96.3%	96.3%	96.4%	96.4%	96.3%	96.4%	96.7%	96.6%				
PT25	Community Basket of Tests - Sodium	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	58.2%	67.4%				
PT26	Community Basket of Tests - Full Blood Count	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	98.5%	98.2%				
PT27	Community Basket of Tests - Transglutaminase Antibody	0	95.0%	N/A	N/A	N/A	N/A	N/A	N/A	99.3%	99.3%				
	Total Maximum Weighted Score			44	44	44	44	44	44	44	44				
	Total Failed Indicators Score			26	30	20	23	23	28	28	25				
	Monthly Failed Percentage Performance			59.1%	68.2%	45.5%	52.3%	52.3%	63.6%	63.6%	56.8%				
	Domain Score			3	2	3	3	3	2	2	3				

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Trust Open Board Report – 26th January 2018

Agenda item:	13			
Presented by:	Nick Jenkins, Executive Medical Director			
Prepared by:	Nick Jenkins, Executive Medical Director			
Date prepared:	22nd January 2018			
Subject:	Pathology Service Report			
Purpose:	X	For information		For approval

Executive summary:

Attached is a copy of the new format NEESPS performance report. This was considered at the Scrutiny Committee of the Board earlier this month and it was expected that an update would be available for the Board. However the reporting cycle for NEESPS makes this difficult and therefore it is proposed that in future this report is received by Scrutiny Committee with agreed enhancements and that the Board receive a summary report with any exceptions and new issues.

Also appended to this report is example key performance indicators, as requested at the last 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**

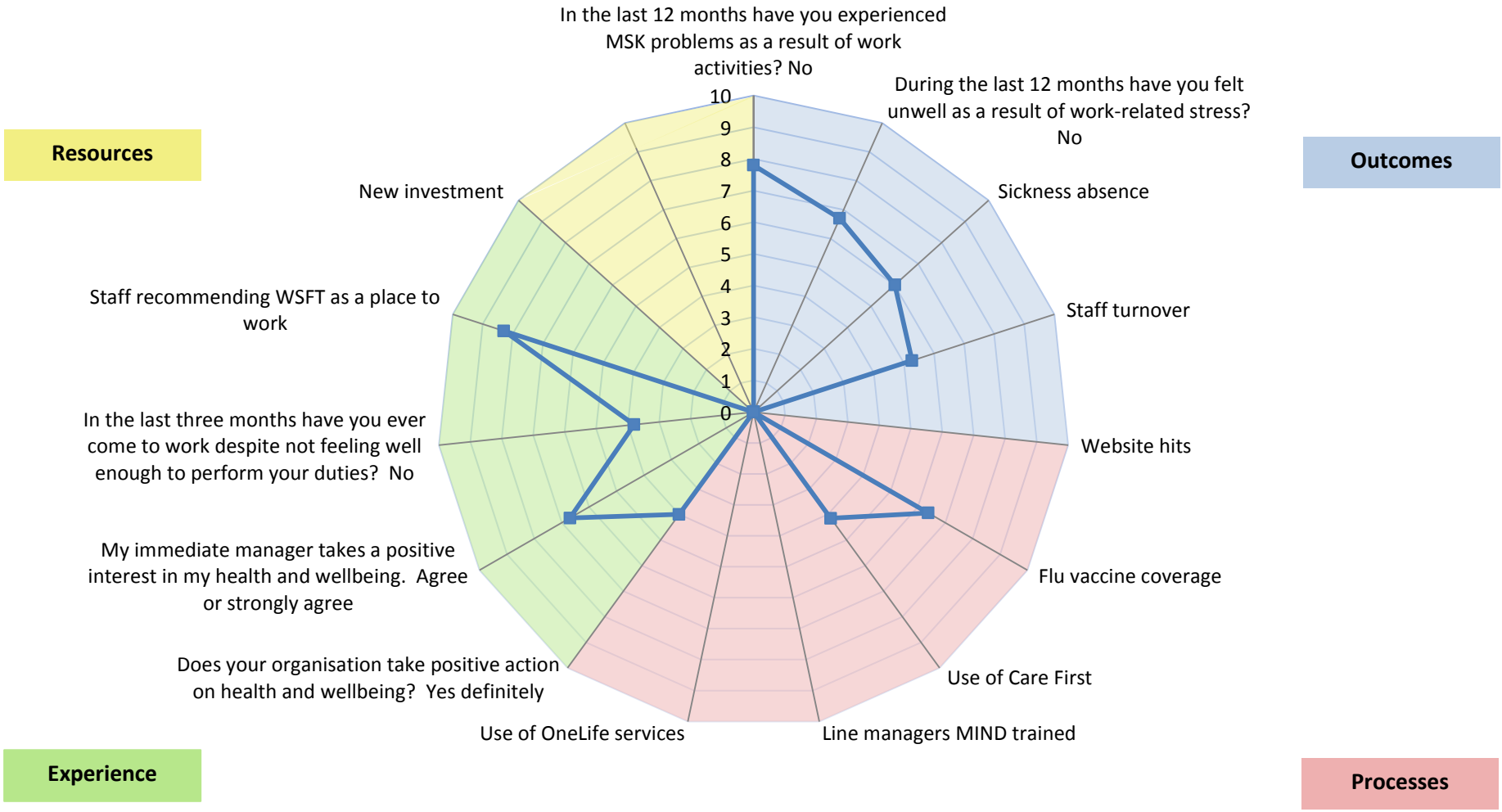
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X				

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

Recommendation:
For trust board delegate responsibility for routine NEESPS monitoring to scrutiny committee

Item 14

WSFT Staff health and wellbeing outcome framework 2016



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Staff health and wellbeing evaluation framework and dashboard

Structures	Processes	Outputs	Outcomes
Physical wellbeing			
	NHS health checks delivered	Staff set quit dates with on-site stop smoking service Achievement of healthy food CQUIN Flu vaccine coverage	NHS Staff survey - % experiencing work-related MSK problems
Mental wellbeing			
Tea & Empathy rota established Rota coordinator identified		Uptake of Care First Line managers attended full MIND training	NHS staff survey - % experiencing work-related stress
Overall			
Quarterly staff focus groups established Greensheet monthly focus published Ongoing coordination of programme secured Staff led initiatives enabled	Staff webpages hits	NHS staff survey - % reporting organisation definitely takes interest in H&W Achievement of Workplace Wellbeing Charter standards Staff webpage click throughs	Sickness absence rate • Total • 0-3 days • % declared stress, anxiety, depression Staff turnover rate NHS staff survey - % coming to work despite not feeling well enough • Of those - % felt pressure from manager • % felt pressure from colleagues • % felt pressure from themselves NHS staff survey - % agree or strongly agree immediate manager takes interest in health and wellbeing Staff F&F test - % recommend as place to work

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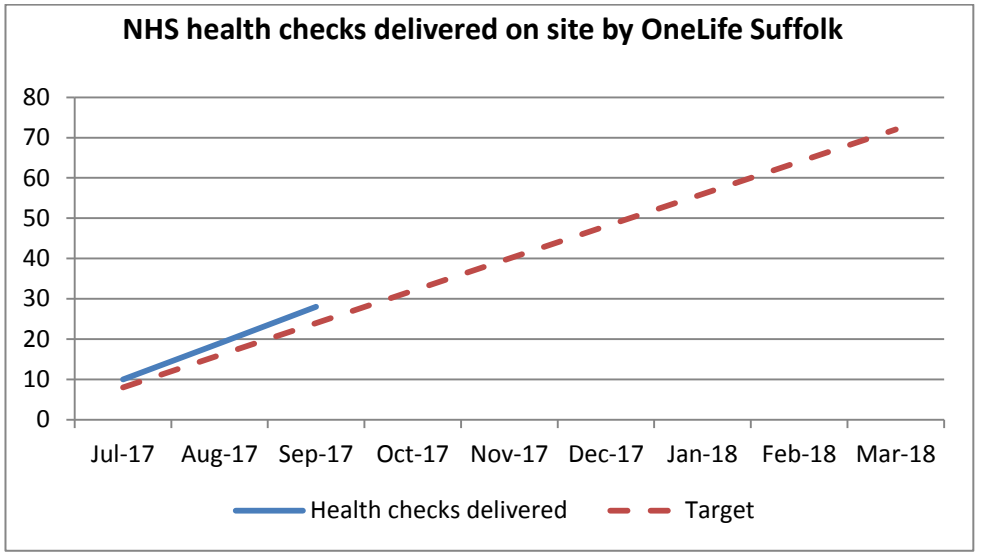
Quantitative indicators

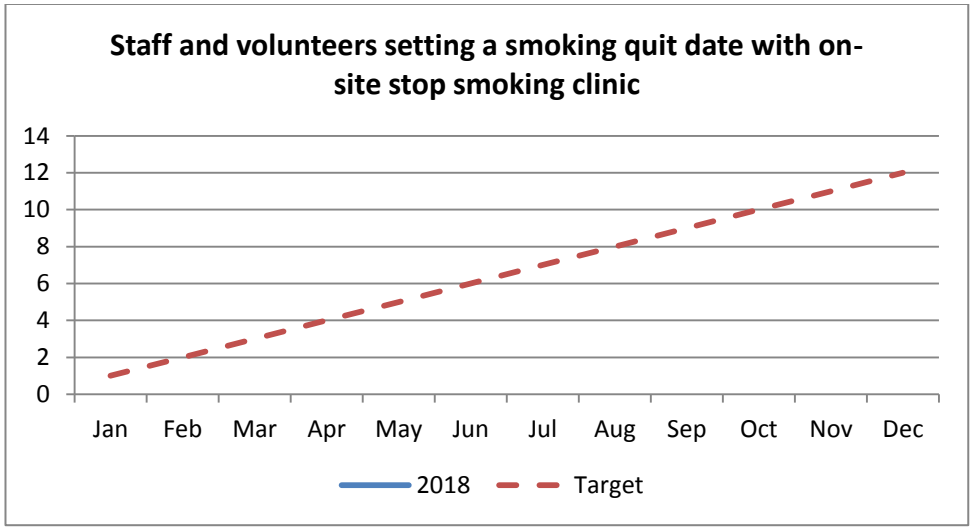
NHS health checks delivered on-site to staff and volunteers

Source	Frequency	Target/notes
OneLife Suffolk	Quarterly	Target = 10 clinics per annum, 8 out of 10 slots per clinic filled = 80 per annum Clinics are promoted to staff and volunteers of WSFT From January 2018 also promoted to NSFT Wedgwood House staff and volunteers



Staff and volunteers setting smoking quit dates with on-site clinic

Source	Frequency	Target/notes
OneLife Suffolk	Quarterly	Baseline being established Clinic to move to antenatal clinic and extend hours to Mondays 8am-1pm Accessible by staff, volunteers, patients and relatives/carers Data being collected from Jan 2018



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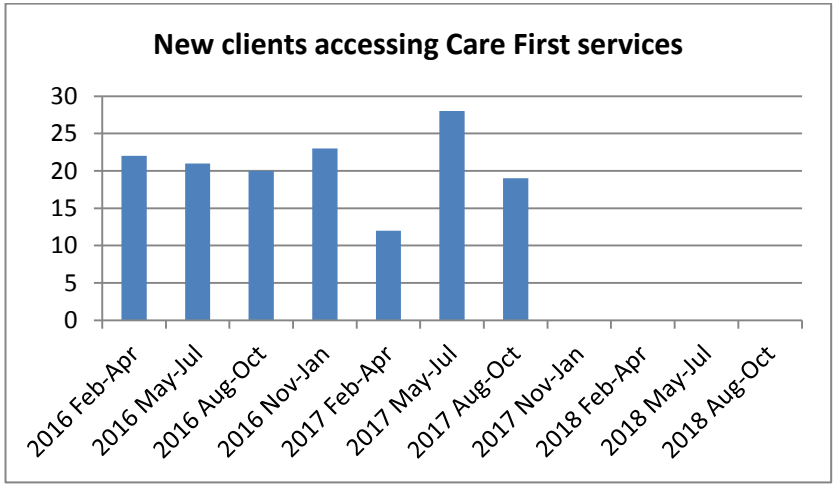
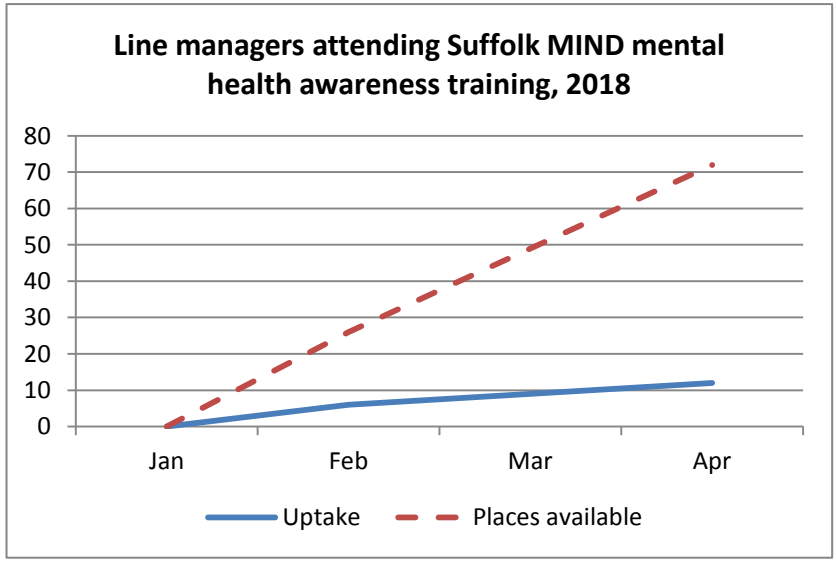
Uptake of Care First

Source	Frequency	Target/notes
Care First	Quarterly	Experience is still early with Care First and a benchmark for a good level of uptake hasn't been ascertained yet. Care First describes our usage figures as demonstrating a "fantastic level of awareness within the organisation".



Line managers attending MIND training

Source	Frequency	Target/notes
Suffolk MIND	Monthly	Courses are 2 x 1 day, 2 weeks apart Starting in February 2018 and running monthly, piloting 3 months at first Capacity is 20 per course Uptake = bookings so far



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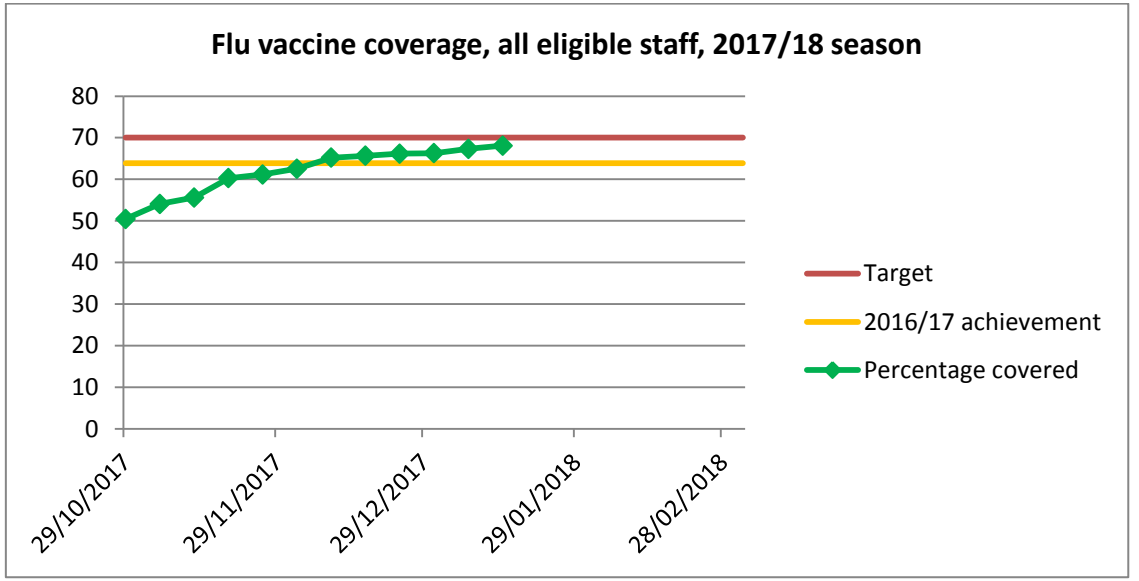
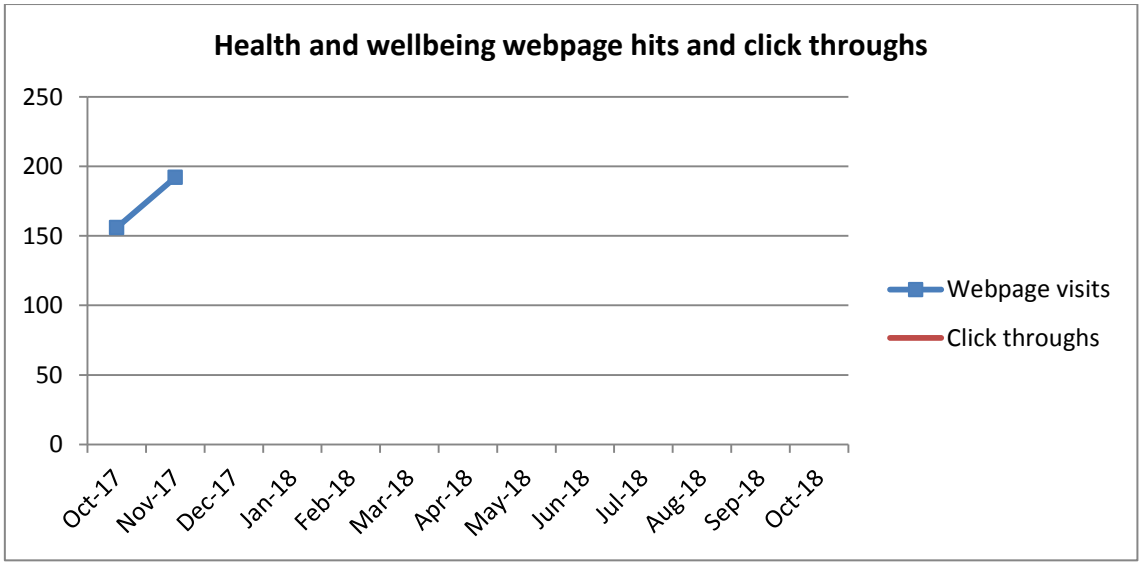
Flu vaccine coverage

Source	Frequency	Target/notes
Cambridge Health @ Work	Weekly during flu season	Target is 70% of eligible staff Season runs October to February



Health and wellbeing webpages hits and click throughs

Source	Frequency	Target/notes
Communications	Monthly	Comparative figures from when pages were sited on intranet are awaited Links for click through include to external sites and internal information pages External facing webpages live since 11th October 2017 Click throughs counting turned on in December 2017



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Qualitative indicators

	Source	Notes	On track?
Achievement of healthy food CQUIN	Transformation	Milestones reported quarterly to CCG	Yes
Tea & Empathy rota established	Public health	Rota began in May 2017	Complete
T&E rota coordinator identified	Public health	Administrator to Guardian of Safe Working	Complete
Quarterly focus groups	Communications	Requirement = 4 per year	Complete in 2017/18
Greensheet monthly focus published	Communications	Requirement = 12 per year, began Jul 2017	Yes – 7 by Jan 18
Ongoing coordination of programme secured	Public health	Cambridge Health @ Work contract extended from 01 April 2017	Complete
Achievement of Workplace Wellbeing Charter standards	CH@W	Goals set out in H&W strategy: • 'Commitment' met by end 2016 • 'Achievement' met by end 2018 • 'Excellence' met by end 2019/20	Behind – 'Commitment' not yet met at Jan 2018

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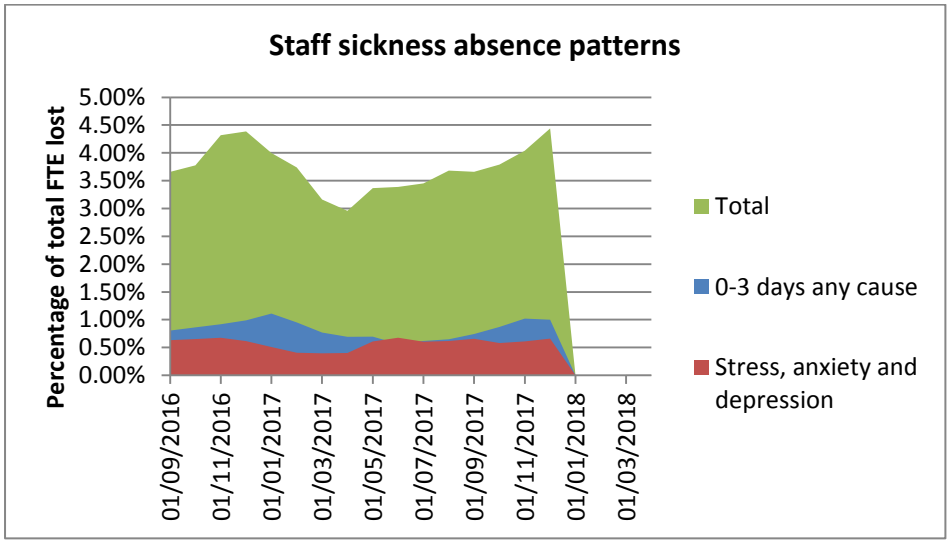
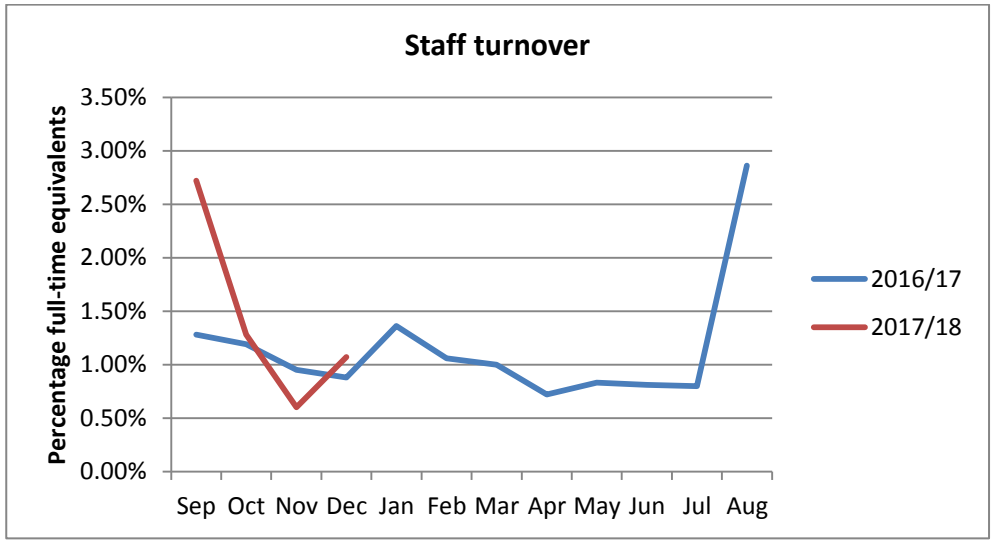
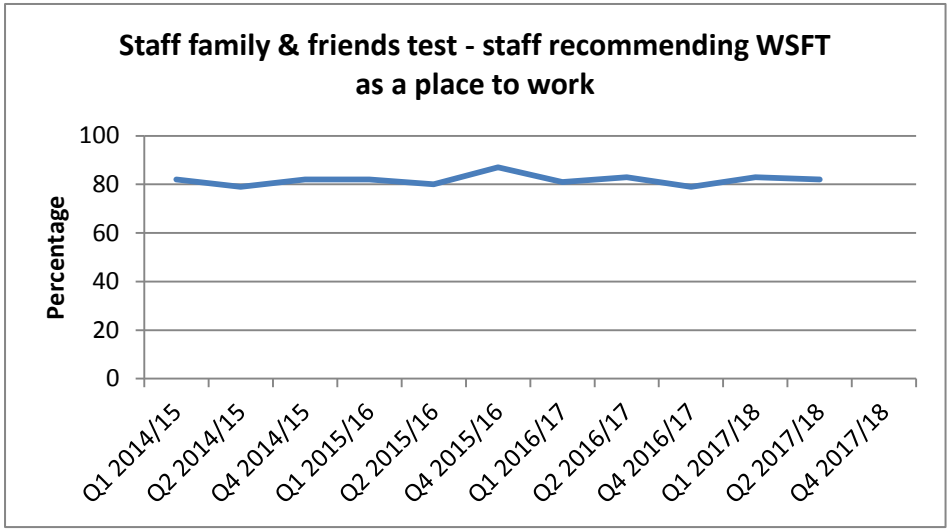
Outcomes indicators







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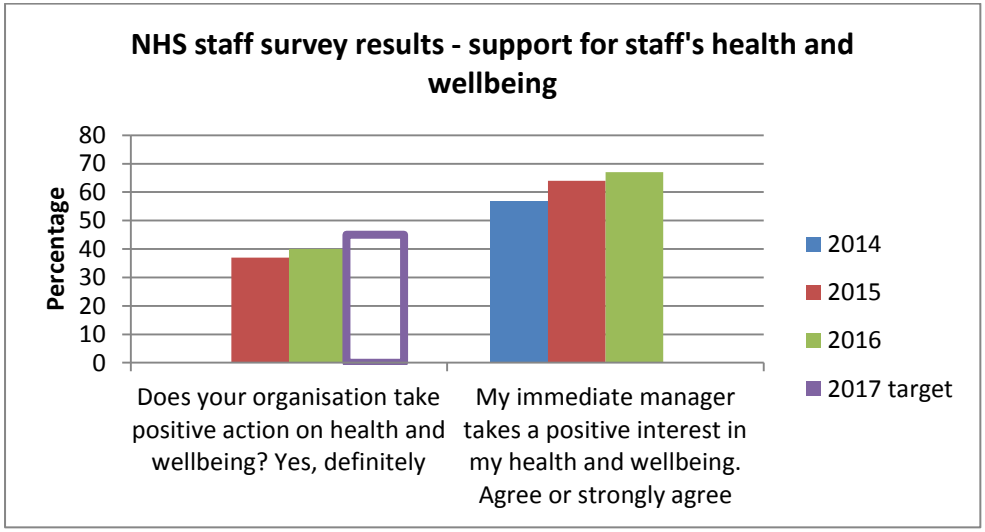

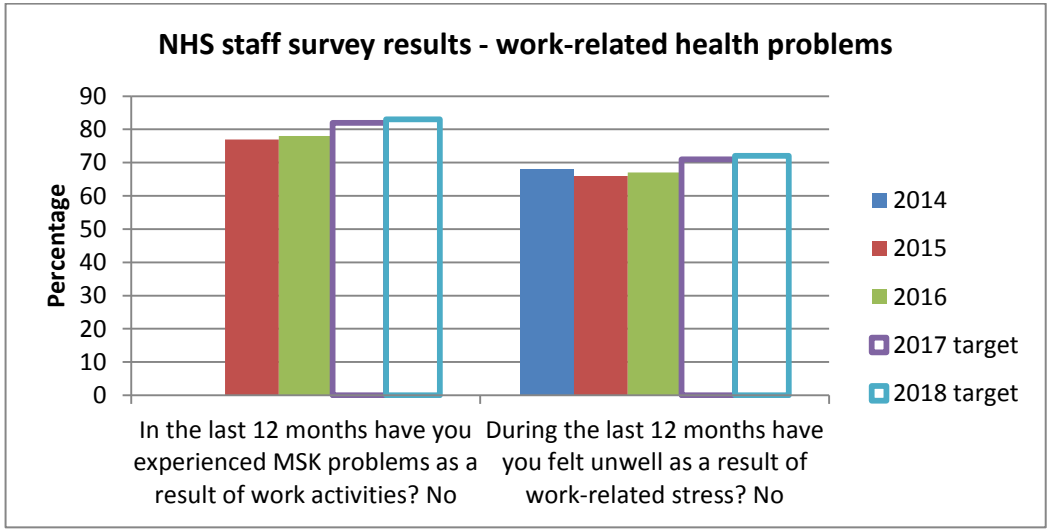

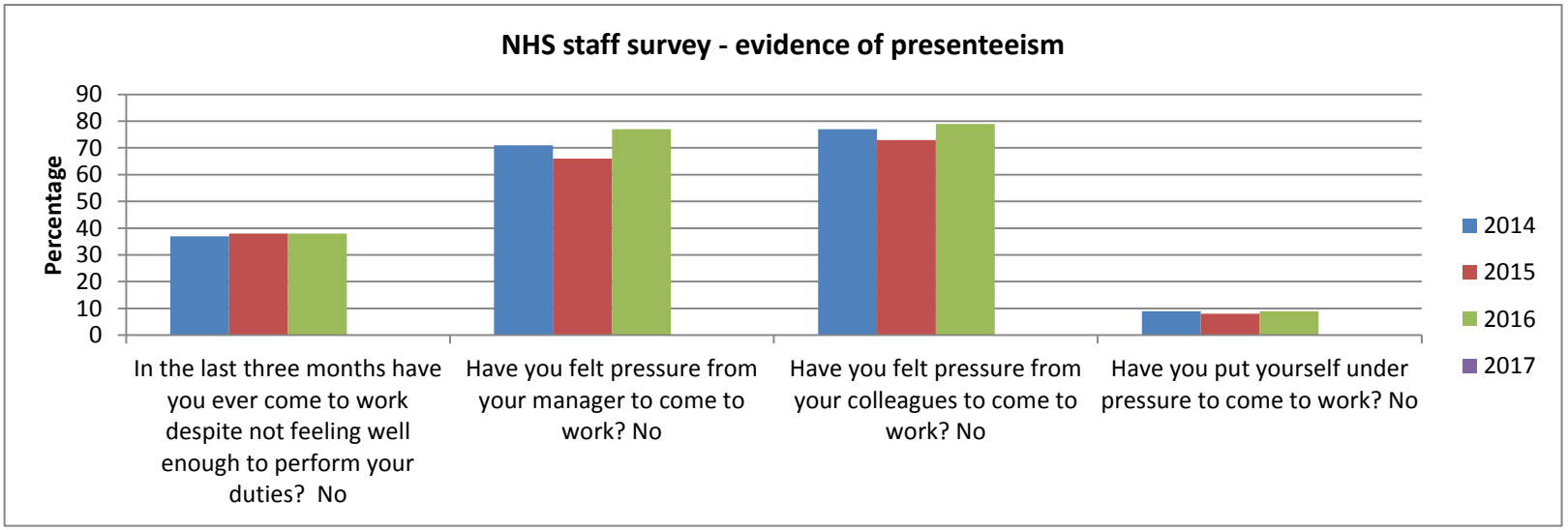

Note: 2017 staff survey results are due for publication in March 2018

West Suffolk NHS
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Trust Board – 26th January 2018

Agenda item:	14			
Presented by:	Jan Bloomfield, Director of Workforce and Organisational Development			
Prepared by:	Dr Helena Jopling, Consultant in Healthcare Public Health			
Date prepared:	17 January 2018			
Subject:	Staff health and wellbeing programme			
Purpose:	X	For information		For approval

Executive summary:
Happy, healthy staff are essential to West Suffolk NHS Foundation Trust in order to maintain its quality and performance**.** The trust has a staff health and wellbeing policy and strategy and a range of initiatives and services have been in place for several years. During 2017 a programme of increased promotion and expansion of the health and wellbeing offer has been undertaken, applying the evidence base where it exists and innovating where it does not.

The programme has been recognised as good practice by external agencies. An evaluation framework has been developed to measure the programme's impact and baseline data is presented to the Board for the first time. The report also describes the forward plan for continued development of the programme in 2018/19.

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

Previously considered by:	None
Risk and assurance:	Financial risk if investment in staff health and wellbeing do not produce a financial return in reduced sickness absence or reduced staff turnover. This risk is mitigated by mobilising existing resources as far as possible; the amount of new investment required so far is low.

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Legislation, regulatory, equality, diversity and dignity implications	The trust is required to take action to reduce staff sickness.
Recommendation: To receive the report, to celebrate the trust's role in promoting and improving staff health and wellbeing and to recognise the benefits of staff being healthy and happy for patient care.	

Introduction

Happy, healthy staff are essential to WSFT in order to maintain its quality and performance, and WSFT has a role to play as an exemplary employer for the local economy. The trust has a health and wellbeing policy[1] and a three-year strategy for its implementation (lifetime 2016-19). In November 2016 the trust executive group received an analysis of the strengths, weaknesses, opportunities and threats to the trust's action on staff health and wellbeing. The report made eight recommendations for further improvement. This paper describes the progress made against those recommendations, evidence of success of the programme in general and plans for continued development in 2018/19.

Evidence base

The evidence base for the benefits of employers taking action to protect and promote staff health and wellbeing is strong. Guidance has been published by several national organisations including the National Institute for Health and Clinical Excellence[2], the Sainsbury Centre for Mental Health[3] and the Work Foundation[4]. Specific to healthcare settings, the 2009 Boorman Review[5] demonstrated the link between staff health and wellbeing and patient safety and experience; not just in general terms but also in very specific high-impact ways, such as the relationship between better staff health and wellbeing and lower rates of methicillin-resistant *Staphylococcus aureus* (MRSA). Staff health and wellbeing was named as a priority in the Five Year Forward View and NHS England began incentivising structured programmes in the 2016/17 CQUIN.

Population health benefit

Beyond the direct benefits to patient care and the trust's financial and operational performance, looking after our staff also makes an important contribution to the health of our community. West Suffolk NHS FT employs over 3,500 staff, the majority of whom live within the trust's own catchment area. As a responsible employer, the trust can therefore play a role in protecting and improving the health of more than 1% of the West Suffolk population, and the preventative effect is amplified because there are also direct and indirect benefits to the health of staff's children and families.

Development of the staff health and wellbeing programme in 2017

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[1] www.wsh.nhs.uk/CMS-Documents?Trust-policies/251-300/PP(15)288Healthandwellbeingatwork.pdf
[2] https://www.nice.org.uk/guidance/ng13
[3] Sainsbury Centre for Mental Health (2007). Mental health at work: developing the business case. Policy paper 8. London: Sainsbury Centre for Mental Health
[4] www.theworkfoundation.com
[5] http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108910.pdf

In November 2016, the trust already had a wide range of services available to staff, including effective actions in place to meet the 2016/17 CQUIN requirements on healthy food and musculoskeletal injuries. Based on the results of the SWOT analysis, the trust executive group accepted eight recommendations to increase uptake of those services and develop the offer further. The recommendations are presented in table 1 overleaf with progress status and an explanation of the actions taken. The programme is led by the health and wellbeing steering group which meets quarterly and is chaired by the Director of Workforce and Organisational Development.

It is important to highlight that the vast majority of the improvements made have been at no financial cost to the trust. By working with community organisations and mobilising existing resources, the programme has been expanded in a highly cost-effective manner. The total cash investment in 2017/18 will be approximately £10,000.

Table 1: Progress against recommendations to develop the staff health and wellbeing programme, 2017

#	Recommendation	Status	Actions taken
1	Celebrate and continue the great work already underway to improve staff health and wellbeing	Complete	A trust publication, *Protecting and improving your health and wellbeing, together*[6] was published in May 2016 with a section describing examples of initiatives available to staff
2	Emphasise the organisational culture of valuing and promoting staff health and wellbeing by identifying a clinical leader for the agenda.	Complete	Better than a single person, several clinical leaders are providing visible senior leadership for the agenda, including the Chief Nurse, Director of Medical Education, Deputy Medical Director and Foundation Training Programme Director.
3	Audit management practices using a suitable tool and consider the results at a future meeting.	Complete	The trust is using the Workplace Wellbeing Charter[7] as an audit standard, in partnership with the member organisations of the Suffolk Health and Wellbeing Board. Baseline assessment has been completed and the health and wellbeing steering group has actions in hand to achieve the first level of accreditation
4	The design and delivery of the health and wellbeing programme should be co-produced with staff. Enable it by widening the membership of the health and wellbeing steering group.	Complete	Learning from good practice elsewhere, instead of expanding membership of the steering group we have started hosting staff health and wellbeing focus groups instead. The focus groups meet for healthy lunches once a quarter. Four groups have been held so far, well attended by a representative range of staff. The feedback and ideas gathered in focus groups directly inform the development of new initiatives.

[6] www.wsh.nhs.uk/CMS-Documents/Trust-Publications/Health-and-wellbeing/Health-and-wellbeing-brochure.pdf
[7] www.wellbeingcharter.org.uk

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5	Strengthen the relationship with OneLife Suffolk, Wellbeing Suffolk and other community-based health improvement services, with two aims: • to raise awareness among staff of the services available, be it for their own use, for referral by line managers, for sign-posting or referral of patients or as knowledge to take into their lives outside of work • to increase the provision of lifestyle services on-site, ideally with an on-going programme of weight management classes, health checks and smoking cessation clinics.	Ongoing	A partnership workplan between the trust and OneLife Suffolk was agreed by the trust executive group on 20 February 2017. A weekly smoking cessation clinic and monthly NHS health check clinics are held on site for staff to access. OneLife Suffolk delivers training to staff in Making Every Contact Count, raising awareness of OneLife's services. MECC training and OneLife's on site services are available to volunteers as well as paid staff. We are also facilitating access for staff of Norfolk and Suffolk NHS FT who work in the Wedgwood Unit. Wellbeing Suffolk has been engaged to start providing wellbeing seminars on site in quarter 4 2017/18.
6	Review the channels and messaging used for health promotion campaigns to maximise impact, and formalise them in the trust's communications strategy	Complete	The 2017-20 Communications strategy agreed by the Board on 27 January 2017 included an objective to "Ensure staff know that their health and wellbeing is important to the trust and how to get the help and advice they might need in this area." Information on the staff health and wellbeing programme has been moved from the intranet to the public website[8]. This allows staff to access the information at any time and also enables prospective applicants to explore the offer available to our employees.

[8] http://www.wsh.nhs.uk/Staff/Health-and-wellbeing.aspx

			A monthly health and wellbeing focus is published in the Green Sheet newsletter. WSFT has signed up to support pan-Suffolk health promotion campaigns run by Suffolk County Council and OneLife, including staff-facing promotion. Face-to-face promotion at staff events has also been found to be highly effective. Events attended include surgical nurse training days, the December leadership summit, foundation doctor teaching sessions and corporate managers' Core Brief.
7	Devise a comprehensive, evidence-based package of mental wellbeing interventions, tailored to staff needs, which should be costed and considered at a future meeting	Complete	A novel model has been devised using a tiered approach to providing support to staff members with different levels of need – please see appendix 2. Low-cost evidence-based interventions or innovations populate each tier. The model was adopted by the health and wellbeing steering group on 7 February 2017. Interventions successfully implemented include: • the Tea & Empathy on-call emotional support service • awareness raising of the Care First employee assistance programme • promotion of general internal and external resources through the diverse communication channels described above • Books for Health and other resources stocked by the library

			The mental health charity Suffolk Mind has been engaged to provide training for line managers in creating a mentally healthy workplace and managing deteriorating mental health in staff. A pilot of three courses will run from February to April 2018.
8	Explore the options for increasing staff resource for coordinating, measuring and reporting on initiatives to improve staff health and wellbeing	Complete	The contract with Cambridge Health @ Work, which provides the trust's occupational health service, has been extended to include coordination and continued development of the staff health and wellbeing programme. A new member of staff has been appointed and will start working with the trust in January 2018.

Evidence of impact

An evaluation framework has been devised with a mix of structural, process and outcome indicators. Performance will be reported to the health and wellbeing steering group in February for the first time. Information correct as at 17th January 2018 is presented in appendix 1.

Headlines:

- uptake of NHS health checks on-site is good
- flu vaccine coverage has not yet met the 70% target but has already exceeded uptake in 2016/17
- the trust has missed its own deadline to meet the Commitment standard of the Workplace Wellbeing Charter (by the end of 2016) but the actions required are small and the health and wellbeing steering group has them in hand
- patterns of sickness absence and staff turnover remain consistent
- the percentage of staff who would recommend West Suffolk NHS FT as a place to work is steady at 80-82%

The outcome indicators measured by the 2017 NHS staff survey are eagerly awaited and will be published in early March.

For the Board's interest, the 2016 baseline data is also presented in appendix 3 in the radar format which is being developed to support measurement and evaluation of the system alliances, described in another paper received by the Board today. This has been done simply to give the Board the opportunity to see the radar format and OPERa framework applied to a real dataset. As the health and wellbeing programme progresses, subsequent years' data will be plotted on the same chart; success will then be defined by an increase in the area within the polygon. This method for visualising high-level indicators works well and is easily generalised. Adopting it within the trust as well as across the alliance could help promote integration and shared understanding.

Returning to evidence of impact, we have also received external recognition that the trust's approach to staff health and wellbeing demonstrates good practice:

- The programme was shortlisted for the 2017 Health Service Journal staff engagement award
- Suffolk County Council and Essex County Council are using West Suffolk NHS FT's approach as a template for support into Ipswich and Colchester Hospitals
- The programme won a regional Better Mental Health for All prize in October 2017
- Professor Viv Bennett, Chief Nurse at Public Health England, described West Suffolk NHS FT as "a great example of a trust taking a positive and proactive course of action to help their communities and staff remain well as opposed to simply treating illness"
- The partnership workplan with OneLife Suffolk more broadly has been selected as a case study for an upcoming King's Fund publication on integrated service models to tackle unhealthy lifestyle behaviours[9]

[9] The report is a follow up publication to Buck D and Frosini F (2012) Clustering of unhealthy behaviours over time. Implications for policy and practice. London: King's Fund.

Forward plan

As well as continuing to deliver the existing programme, further expansion in 2018/19 is planned as follows:

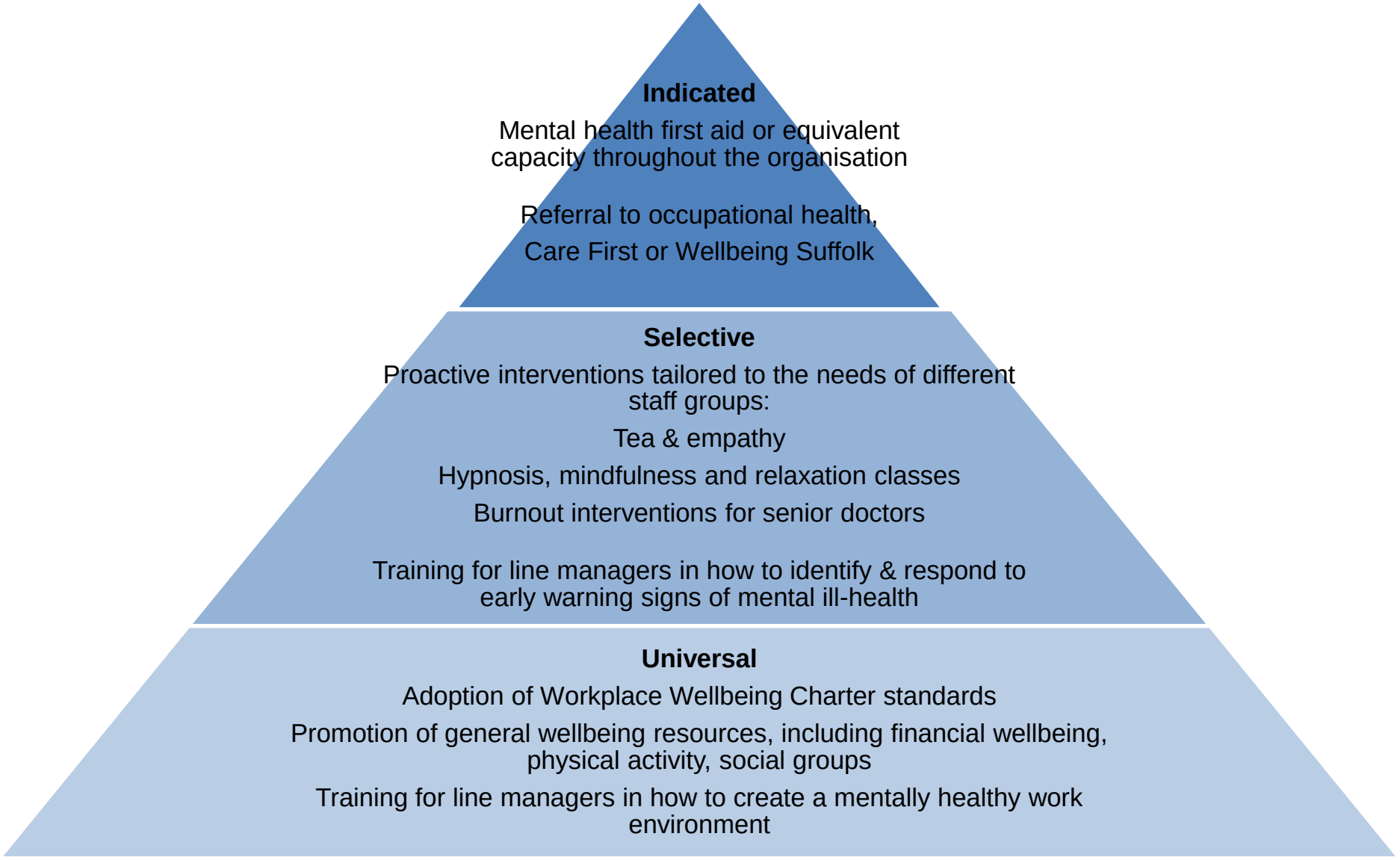
- More use will be made of the Education Centre as a venue for staff-led exercise and relaxation classes
- We will work in partnership with West Suffolk College for students on health and beauty courses to provide spa services on-site
- An online calendar will be created to publicise and promote health and wellbeing activities
- Our existing partnership with Abbeycroft Leisure will be developed to increase the number of staff using of Abbeycroft's facilities
- Self-care sessions on the effect of menopause symptoms at work will be provided
- We will relaunch the trust's partnership with Neyber financial wellbeing service
- Senior doctors will be surveyed for symptoms of burnout and a range of evidence-based interventions made available to help address it
- The steering group will make sure that the full health and wellbeing offer is available to staff based in community settings

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/clustering-of-unhealthy-behaviours-over-time-aug-2012.pdf

Item 14

A model for mental health promotion in the workplace

NHS West Suffolk NHS Foundation Trust



Based on Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016) London: Faculty of Public Health and Mental Health Foundation.

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 26th January 2018

Agenda item:	15			
Presented by:	Jan Bloomfield, Executive Director Workforce & Communications			
Prepared by:	Rebecca Rutterford, Training & OLM Manager			
Date prepared:	15th January 2018			
Subject:	Mandatory Training			
Purpose:		For information	☑	For approval

Executive summary:

Appendix A is the January 2018 Mandatory Training Report, this represents data taken from the system on 10th January 2018.

Appendix B outlines the actions currently in place to improve take up of mandatory training across the Trust in those areas below 80% compliance, 90% for Safeguarding Children and 95% for Information Governance.

Appendix C provides a risk assessment for those areas below the relevant target, compiled by the subject matter experts for each area.

Appendix D The National CQUIN 2015-6 target for Dementia staff training states that the Trust should include quarterly reports to Provider Boards of:
- Numbers of staff who have completed the training;
- Overall percentage of staff training within each provider'.

Appendix E shows mandatory training figures for SCH Community staff. SCH Community currently records training in a system called Staff Pathways.

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 untrained staff. Mandatory Training action plan (attached) and risk assessment						

Legislation, regulatory, equality, diversity and dignity implications	Legislation, regulatory, equality, diversity all included.
Recommendation: Acceptance of the action plan to further improve compliance	

Appendix A

NHS West Suffolk NHS Foundation Trust

Subject Matter - High Level Mandatory Training Analysis January 2018

Competence Name	Trust Target	Does not meet	Meets Requirement	Total	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
179|LOCAL|Infection Control - Classroom|	80%	80	1364	1444	94%	95%	95%	96%	95%	95%	96%	94%	95%	95%	95%	94%
179|LOCAL|Equality and Diversity|	80%	201	3009	3210	92%	93%	93%	94%	95%	95%	93%	92%	93%	94%	94%	94%
179|LOCAL|Safeguarding Children Level 2|	90%	123	1380	1503	87%	87%	87%	88%	90%	90%	87%	88%	89%	90%	92%	92%
179|LOCAL|Safeguarding Adults|	80%	265	2945	3210	87%	88%	88%	89%	90%	90%	89%	89%	90%	91%	92%	92%
179|LOCAL|Health & Safety / Risk Management|	80%	270	2940	3210	87%	88%	88%	89%	89%	89%	89%	89%	90%	91%	91%	92%
179|LOCAL|Fire Safety Training - Classroom|	80%	279	2931	3210	89%	89%	90%	90%	90%	90%	90%	89%	90%	91%	91%	91%
179|LOCAL|Security Awareness|	80%	282	2928	3210	87%	88%	88%	89%	90%	90%	89%	89%	90%	90%	91%	91%
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	90%	319	2891	3210	87%	86%	86%	86%	87%	88%	87%	86%	88%	89%	90%	90%
179|LOCAL|Infection Control - eLearning|	80%	183	1579	1762	88%	88%	88%	88%	90%	90%	88%	83%	85%	87%	88%	90%
179|LOCAL|MAJAX|	80%	338	2872	3210	86%	86%	86%	86%	88%	88%	87%	86%	88%	88%	89%	89%
179|LOCAL|Medicine Management (Refresher)|	80%	163	1280	1443	86%	87%	87%	87%	88%	88%	87%	87%	86%	87%	88%	89%
179|LOCAL|Slips Trips Falls|	80%	249	1792	2041	84%	85%	84%	85%	87%	87%	85%	85%	86%	88%	88%	88%
179|LOCAL|Moving and Handling Non Clinical Load Handler|	80%	49	345	394	84%	83%	81%	81%	83%	83%	82%	86%	84%	84%	88%	88%
179|LOCAL|Blood Bourn Viruses/Inoculation Incidents|	80%	224	1547	1771	84%	85%	84%	84%	86%	86%	84%	84%	85%	86%	87%	87%
179|LOCAL|Conflict Resolution - elearning|	80%	97	643	740	81%	83%	81%	83%	85%	86%	80%	80%	81%	82%	85%	87%
NHS|MAND|Safeguarding Children Level 3 - 1 Year|	90%	42	259	301	79%	78%	85%	83%	81%	81%	76%	73%	79%	83%	86%	86%
179|LOCAL|Information Governance|	95%	472	2738	3210	82%	82%	80%	81%	85%	84%	85%	84%	87%	86%	87%	85%
179|LOCAL|Fire Safety Training - eLearning|	80%	493	2717	3210	86%	85%	85%	86%	87%	87%	85%	85%	85%	85%	84%	85%
179|LOCAL|Basic Life Support - Adult|	80%	359	1592	1951	80%	81%	83%	85%	85%	85%	84%	82%	81%	81%	82%	82%
179|LOCAL|Moving and Handling - Clinical|	80%	300	1328	1628	80%	79%	81%	83%	84%	83%	83%	80%	80%	80%	84%	82%
179|LOCAL|Moving & Handling - elearning|	80%	209	713	922	79%	79%	81%	81%	81%	81%	75%	75%	75%	76%	75%	77%
179|LOCAL|Blood Products & Transfusion Processes (Refresher)|	80%	324	1084	1408	78%	80%	80%	82%	83%	82%	79%	79%	80%	78%	80%	77%
179|LOCAL|Conflict Resolution|	80%	285	928	1213	74%	75%	75%	75%	77%	77%	76%	75%	76%	76%	75%	77%

Jan-18	Attended	Not Attended	Grand Total	% Compliance
179|LOCAL|Trust Induction|	38	2	40	95.00%

Mandatory Training Action Plan Jan 2018

Appendix B

	Jan 2018 %	Method	Actions	Completion date	Responsibility	Progress
Safeguarding Children level 1	90%	E-learning	A bespoke report providing more detailed analysis of Safeguarding Children figures to be provided to the Named Nurse for Safeguarding Children.	Jan 2018	Lisa Sarson	Targeted emails, following up individuals and detailed reports have resulted in a 2% increase. Target now met.
Safeguarding Children level 2	92%	E-learning	A bespoke report providing more detailed analysis of Safeguarding Children figures to be provided to the Named Nurse for Safeguarding Children.	Jan 2018	Lisa Sarson	Targeted emails, following up individuals and detailed reports have resulted in a 3% increase. Target now met
Safeguarding Children level 3	86%	Face to face	A bespoke report providing more detailed analysis of Safeguarding Children figures to be provided to the Named Nurse for Safeguarding Children, also to all high risk areas.	April 2018	Lisa Sarson	Targeted emails, following up individuals, risk assessments and detailed reports have resulted in a 7% increase from the previous Board report. Work to continue until target is met.
Moving & Handling–e-learning	77%	E-learning	Manual Handling Advisor to email mangers encouraging staff to be compliant and complete the eLearning package.	April 2018	Neil Herbert	Manual Handling Advisor has targeted all non-compliant staff, a 2% increase in target since the last Board report.
Information Governance	85%	E-learning	IG team to target non-compliant staff directly with the training slides and compliance test.	April 2018	Sara Ames	The IG team continue to offer one off training sessions to departments that require it. Compliance increase is likely to be slower than others as it's a yearly requirement for all staff. Also the target for Information Governance is the highest of all subjects at 95%
Conflict Resolution	77%	Face to Face	To review our current Conflict Resolution training package and who requires the training.	April 2018	Darren Cooksey	Following national guidance, we are now able to review our conflict resolution training content, along with who requires the training. This gives us the opportunity to ensure we are

	Jan 2018 %	Method	Actions	Completion date	Responsibility	Progress
						providing our staff with the most effective training outcomes and target the key staff groups and areas. A proposal will be taken to the Corporate Risk committee.
Prevent Awareness	TBC	e-learning	Awareness of Prevent is a national requirement for all staff. The awareness is currently embedded within our Safeguarding Adults package which all staff are required to complete every three years. Compliance reporting to be provided to Board in April 2018.	April 2018	Prevent Lead	Training has been captured for the last 2 years; the necessary work to provide compliance figures is underway and will be available from April 2018.
Prevent WRAP (Workshop to raise awareness of Prevent)	TBC	Face to Face	A national target of 85% to be reached by March 2018 has been set for all staff who are involved in assessing patients. Restrictions with trainer requirements and a vacancy for the subject lead post has resulted in a delay in rolling out a training package. Training, communication and system maintenance required.	March 2018	Prevent Lead	Train the trainer programmes are now underway, training courses have been organised and published monthly throughout 2018. WRAP has been added to Registered and Non-Registered inductions. The necessary work to provide compliance figures is ongoing and will be available from April 2018. Whilst it is not expected that we will meet the 85% target for March, we are able to show progress towards this target.

Risk Assessments

Appendix C

Subject	Issues	Risks	Description of Action	Lead	Status *
179|LOCAL| Moving and Handling –e-learning	• Poor uptake	• Potential staff injury • Financial implication such as sick pay, staff cover, court costs, compensation.	• Reminders to be sent to those who are non-compliant	Moving and Handling Advisor	Low
179|LOCAL| Conflict Resolution|	• Staffing levels and the Ward/ Departments ability to backfill will affect the numbers attending • Release of staff on clinical areas.	• Failure to recognise body language indications of possible aggression. • Failure to recognise warning signs when an aggressor is agitated or distressed. • Failure to recognise danger signs which may indicate imminent attack. • Failure to employ applicable communication skills • Litigation consequences • Potential staff injuries resulting in RIDDOR absenteeism. • Poor staff morale	• Training compacted to four hours to enable staff attendance. • LSMS and Portering can be called to via 2222 to assist staff in managing difficult situations • Police assistance can be summoned. • Restrictive Physical Intervention team may be employed when managing clinically confused patients. • Refresher sessions for staff who have expired, lasting 2 hours. • Discussion taking place to incorporate conflict resolution, dementia awareness and break away training into one package.	Portering and Security manager	Low
179|LOCAL|Information Governance|	• Annual training replaced 3 yearly training in 2014 • 95% compliance target explicit in 2015/16 IG toolkit	• Increased risk of IG breaches and vulnerability to ICO fine if staff awareness of IG is poor. • IG toolkit compliance will be unsatisfactory (level 1 only) if we cannot demonstrate achievement of 95% target.	• Outstanding staff are contacted on a monthly basis to update training. • Training materials and test attached to email to facilitate a quick and convenient way to carry out training.	IG Manager	Medium

Subject	Issues	Risks	Description of Action	Lead	Status *
NHS|MAND| Safeguarding Children Level 3 - 1 Year|	• Poor uptake • Specialised face to face learning • Annual dates for departmental sessions scheduled past staff expiry dates	• Failure to recognise signs & symptoms of abuse in a child • Failure to recognise parental factors that predispose a child to significant harm • Failure to understand how to report concerns for child • Failure to recognise and act upon more specialised areas of child protection	• Paediatric, neonatal and midwifery level 3 training offered over a number of dates throughout the year. • Extra training sessions advertised • Three sessions per year open to all Trust employees and partner agencies presenting a range of topics • Unit managers for areas with high contact with children and young people also receive lists of non-compliant staff. • Emails of those non-compliant sent to managers and risk assessments requested.	Named Nurse Safeguarding children	Medium
179|LOCAL| Blood Products & Transfusion Processes (Refresher)|	• Failure of staff to use on line training package provided • Not clear of process within Trust to ensure mandatory training is complied with and consequences	• Staff unaware of updated national/local guidelines to minimise the risks of transfusion. • Potential "never event" of ABO incompatible transfusion resulting in patient harm • Potential Litigation • Non-compliance with DoH circular 'Better Blood Transfusion'.	• Line managers receive monthly compliance reports to enable them to identify non-compliant staff • Blood Assessors receive copies of the monthly reports to enable them to assist the line managers proactively plan training & assessments • Individuals need to be called to account for their non-compliance through individual PDP process. • Medical staff are being targeted at their Induction and also via email	Blood Transfusion Committee	Medium

Appendix D – Dementia Training Figures

2017/18

Month	Number require training	Total number trained	% Compliance
April	917	870	94.87%
May	919	874	95.10%
June	918	878	95.64%
Q1.	**2754**	**2622**	**95.21%**
July	905	866	95.69%
Aug	822	793	96.47%
Sep	811	783	96.55%
Q2.	**2538**	**2442**	**96.22%**
Oct	797	766	96.11%
Nov	792	763	96.34%
Dec	781	750	96.03%
Q3.	**2370**	**2279**	**96.16%**

Appendix E – SCH Community
Mandatory Training – as at December 2017

West Suffolk	December-2017						
	All			Enabling**	Operations*	Facilities	Paediatrics
Topic	Compliant	NonCompliant	% Compliancy				
Conflict Resolution	462	36	92.77%	100.00%	92.09%	69.57%	95.81%
Dementia Compliance	474	24	95.18%	100.00%	93.68%	73.91%	99.07%
Equality and Diversity	450	48	90.36%	100.00%	87.75%	65.22%	95.81%
Fire	443	55	88.96%	100.00%	82.61%	86.96%	96.28%
Health & Safety	470	28	94.38%	100.00%	91.30%	86.96%	98.60%
Infection Control	453	45	90.96%	100.00%	86.96%	82.61%	96.28%
Information Governance	458	40	91.97%	100.00%	90.12%	78.26%	95.35%
Learning Disabilities	470	28	94.38%	100.00%	94.07%	60.87%	98.14%
Life Support	357	53	87.07%	100.00%	84.81%	N/A	90.00%
Mental Capacity	127	42	75.15%	100.00%	74.85%	N/A	N/A
Moving and Handling	442	56	88.76%	100.00%	86.96%	78.26%	91.63%
Safeguarding Adults	468	30	93.98%	100.00%	96.05%	60.87%	94.88%
Safeguarding Children	478	20	95.98%	100.00%	95.65%	69.57%	99.07%
Overall % for all topics	**5552**	**505**	**91.66%**	**100.00%**	**89.39%**	**73.91%**	**96.02%**

*** Enabling = Informatics, Business support, Quality,*
** Operations = Newmarket Hospital, Specialist nurses & CHT Teams*

West Suffolk NHS
NHS Foundation Trust

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

1st October 2017 – 31st December 2017

Executive summary

Introduction

This is the fourth report produced since the introduction of the 2016 Terms and Conditions of Service (TCS) for Doctor and Dentists in Training by NHS Employers. Full details of this contract are to be found here: http://www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-2016-contract

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaces monitoring of working hours. This is done using Allocate software, a system already in place at West Suffolk, but extended for this purpose. This report covers the three month period (1st October – 31st December inclusive) to fall into line with the calendar year.

The report is also informed by the monthly Junior Doctors' Forum. This meeting is held in two parts: The first is an open (unminuted) forum for all junior doctors; the second is chaired by the GOSW and includes Junior Doctor representatives, including the mess president, chief resident and BMA representatives, and also the Director of Education, The Director of the Foundation Programme, members of HR, rota co-ordinators, and BMA advisors. This meeting is minuted.

All trainees taking up appointments are on the New Contract. It should be noted that a further 49 doctors working in Trust grade positions are on contracts that mirror the new Contract. There are currently just 3 trainees left on the old contract whom are on maternity leave.

From Dec 2016- July 2017 there were just 30 doctors involved. There was a large increase on August 2nd to 132 doctors when a change in rotation to this Trust occurred

Summary data

Number of doctors / dentists in training (total):	136
Number of doctors / dentists in training on 2016 TCS (total):	133 (includes p/t trainees)
Amount of time available in job plan for guardian to do the role:	1 PAs / 4 hours per week
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee[1]
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

a) Exception reports (with regard to working hours)

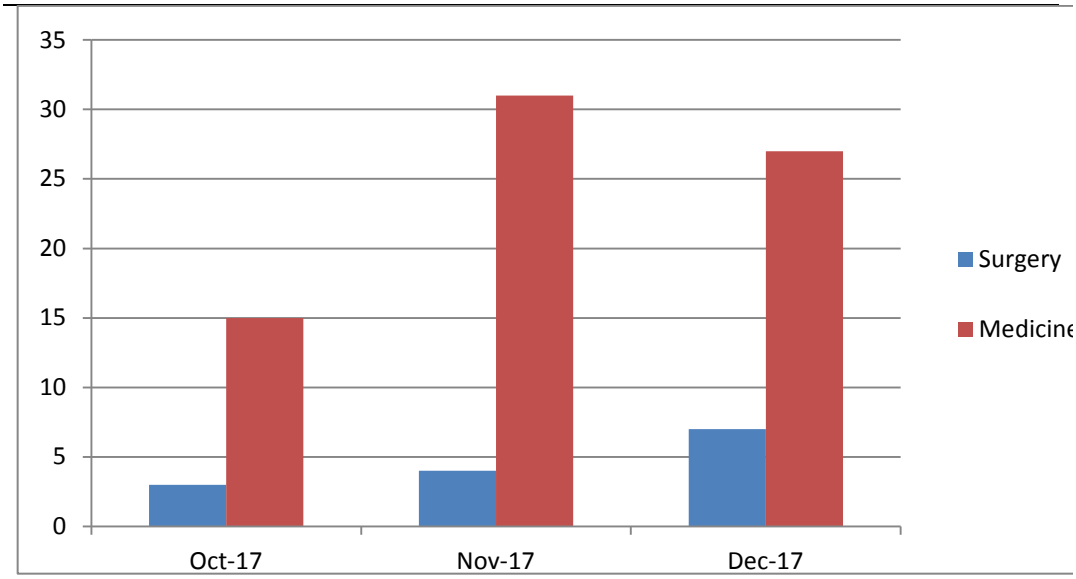
The purpose of exception reporting is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained. If there are consistent problems a work schedule review should be carried out. A process is in place on Allocate for the Junior Doctors to fill in the report, which at present requires permission from a consultant and a narrative of the situation which led to exceeding the contractual obligation. Details are sent to the Guardian and Clinical /Educational Supervisor.

Patterns are now developing which may prompt reflection on working practice within some departments and highlight difficulties which are discussed below.

Exception Reports by DEPARTMENT				
Specialty	No. exceptions carried over from before 30th Sept 17	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	9	15	15	0
Medicine	0	81	71	10
Woman & Child	3	0	0	0
Clinical Support	0	0	0	0
Total	12	96	86	10

Exception reports by ROTA & GRADE					
Specialty		Exceptions carried over from before 30th Sept 17	Exceptions raised	Exceptions closed	Exceptions outstanding
General Surgery	F1	3	5	5	0
	F2/CT/ST3	6	10	10	0
General Medicine	F1	0	28	21	7
	F2	1	11	10	1
	CMT/ACCS	0	42	40	2
Woman & Child	F1	0	0	0	0
	F2	2	0	0	0
	ST3	1	0	0	0
Total		13	96	86	10

Exception reports – RESPONSE TIME				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
Surgery	7	7	1	15
Medicine	22	34	25	81
Woman & Child	0	0	0	0
Total	29	41	26	96



b) Work schedule reviews check last review

Work schedule reviews for individuals may be requested by either the doctor, or the education/clinical supervisor, service manager or guardian in writing. None have been carried out in this period.

Any future reviews will be presented thus:

Work schedule reviews by department	
Surgical	0
Medical	0
Woman & Child	0
Clinical Support	0

Work schedule reviews by grade	
F1	0
F2	0
T3+	0

Locum Bookings : 1st October – 31st December 2017

TABLE 1 : Shifts requested between 1st October – 31st December 2017 by 'reason requested'

Department	Extra/Rota Compliance/ Induction Cover	Leave (Annual/Study/ Interview)	Maternity/ Paternity Leave	Sickness/ Reduced Duties	Vacancy	Grand Total
A&E	47	104		50	213	414
Anaesthetics				5		5
Dermatology					26	26
ENT	7			2		9
General Surgery	8			6	61	75
ITU	3	2	7	1	5	18
Medicine	139	6		37	55	237
O&G	1			3	34	38
Ophthalmology					20	20
Paediatrics		1	7	2		10
T&O	4	2		24	31	61
Urology		1		2		3
Grand Total	**209**	**116**	**14**	**132**	**445**	**916**

TABLE 2 : Shifts requested between 1st October – 31st December 2017 by 'Agency / In house fill'

Department	Doctors on call	IDM	Interact	Locum People	NC Health Care	NHS	Unfilled Shift	Grand Total
A&E		3	3	6	32	279	91	414
Anaesthetics						5		5
Dermatology						26		26
ENT						9		9
General Surgery						66	9	75
ITU						18		18
Medicine						179	58	237
O&G						38		38
Ophthalmology						20		20
Paediatrics	3					6	1	10
T&O						45	16	61
Urology						1	2	3
Grand Total	**3**	**3**	**3**	**6**	**32**	**692**	**177**	**916**

TABLE 3 : Shifts requested between 1st October – 31st December 2017 filled 'In house only by grade'

Department	F1	F2/ST	SAS Dr	ST3/4+	Grand Total
A&E		105		174	279
Anaesthetics		1		4	5
Dermatology			26		26
ENT		3		6	9
General Surgery	3	13		50	66
ITU		9		9	18
Medicine	4	170		5	179
O&G				38	38
Ophthalmology				20	20
Paediatrics		1		5	6
T&O		45			45
Urology				1	1
Grand Total	**7**	**347**	**26**	**312**	**692**

Vacancies

HR have provided details of current vacancies:

Department	Grade	Oct 2017	Nov 2017	Dec 2017
A&E	CF (ST3+)	1	1	1
	GP	2	2	2
	ACCS	1	1	1
Anaesthetics	ST3+	0	1	1
Surgery*	TD (F2)	2	2	2
Medicine	CT	1	1	1
	ST3+**	1	1	1
	CF (ST1)	1	0	1
	CF (ST3+)	1	1	1
Obs & Gynae	ST3+	0	2	2
Ophthalmology	ST3+	1	1	1
Total		**11**	**13**	**14**

*2 new posts were created in General Surgery for Trust Doctor (F2 Level) to help support the rota.
**Rota adjusted ahead of vacancy to reflect training numbers

c) **Fines**

There is a system of financial penalty now in place where exception reporting demonstrates the following:
-a breach of the 48-hour average working week across the reference period agreed for that placement in the work schedule
-a breach in the maximum 72-hour limit in any seven days
- the minimum 11 hours rest requirement between shifts has been reduced to fewer than 8 hours.

In the previous quarter's report, a fine was reported in Trauma and Orthopaedics. No further fines have been identified at this time.

Guardian Fund (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£73.80	0	0	£73.80

Matters arising

-**Exception Reporting.** Whilst there has been an increase in the amount of Exception Reporting, this has not been in proportion to the greatly increased number of doctors now involved in the contract. Reasons for this are likely to be complex, and have been discussed at length in the JD Forum. There is a general view that the figures under-represent the true picture. Possible causes of this include:

- a perception that the process of ER is cumbersome to complete

-reluctance on the part of the JD to bother the consultant on-call/ward consultant for permission

- discouragement from some consultants

The Guardian has tried to address these issues by writing to all the consultants to encourage reporting where it is actually necessary, but more importantly to ensure safe working practice within departments to ensure that JDs are not required to work beyond contracted hours. She has also written to all Junior staff to encourage them to overcome their hesitancy, for whilst we would wish to have a low level of Exception Reporting this should be for the right reasons, i.e because it is not necessary. She has spoken to individual consultants within Surgery and Acute Medicine to encourage support.

Concern remains from Junior Doctor reps that the need to gain permission from a consultant is acting as a deterrent. However, this should provide an opportunity for the consultant involved to resolve the issue.

-**Patterns of Reporting.** During this three month period the majority of ERs have come from Medicine. It is clear that the JDs involved have a heavy workload and are doing their best to manage the patients safely. Narrative reports, which accompany the ER highlight a number of issues, which may involve other staff groups, including the nursing staff being understaffed, or consultants being away. There are references to ward rounds extending late in the afternoons, which then generates more ward work, and a need for family discussions, particularly around care of the dying.

Almost exclusively, ERs have been the F1/F2 doctors, rather than specialty trainees.

It may be significant that there are fewer ERs from surgical specialties since the introduction of ward-based working for F1 doctors. However, concern has been expressed this leads to a loss of training opportunities beyond the ward (in theatres or clinics), which should be addressed in Work Schedules.

Trust Doctors, who are also working similar working patterns, are not part of this contract and therefore are not included in any figures related to Exception Reporting. It is proposed that details about any reported breaches are included where possible and that this data should be collected.

-Fines For the first time a small fine has been levied within Surgery (Trauma and Orthopaedics)

-Other ways of working Use of non-medical staff, such as Clinical Skill Practitioners and Physician Assistants is generally welcomed. Two surgical CSP posts have been agreed. There may also be ways of streamlining work processes, which could reduce the workload on Junior Doctors safely: a member of the e-care team has been attending the early part of the JD Forum.

-Locums. The two biggest areas where locum support has been required are A&E, and Medicine. In both specialties this is due to a combination of vacancies, rota gaps, and leave arrangements. 717/765 shifts

were filled with NHS staff “in-house”. Could this be addressed through other ways of working? I wonder, for example, if there might be ways of reducing duplication of effort for admissions via A&E to Acute Medicine. The Guardian will explore this further with the consultants involved.

Appendices

1. HEEoE require that 0.25 PA is paid per trainee in a numbered post for Educational Supervision and also to Named Clinical Supervisors. This is a requirement on all trusts in the region with trainees and was set as a requirement in the Trust’s Action Plan following our Quality and Performance Review visit last June.

Sarah Gull

Guardian of Safe Working Hours (January 2018)

NHS
West Suffolk
NHS Foundation Trust

Trust Open Board Report – 26th January 2018

Agenda item:	16			
Presented by:	Nick Jenkins, Executive Medical Director			
Prepared by:	Sarah Gull, Guardian of Safe Working Hours			
Date prepared:	January 2018			
Subject:	Safe staffing guardian report			
Purpose:	X	For information		For approval

Executive summary:

This is the fourth report produced since the introduction of the 2016 Terms and Conditions of Service (TCS) for Doctor and Dentists in Training by NHS Employers. Full details of this contract are to be found here: http://www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-2016-contract

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaces monitoring of working hours. This is done using Allocate software, a system already in place at West Suffolk, but extended for this purpose. This report covers the three month period (1st October – 31st December inclusive) to fall into line with the calendar year.

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		X

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

Recommendation:
To accept report

Trust Board – 26 January 2018

Agenda item:	18			
Presented by:	Craig Black, director of resources			
Prepared by:	Sarah Jane Relf, e-Care/global digital exemplar operational lead			
Date prepared:	21 January 2018			
Subject:	To receive update on e-Care/global digital exemplar (GDE) programme			
Purpose:	X	For information		For approval

Executive summary:

This paper provides the trust board with an update on e-Care implementation and the global digital exemplar (GDE) programme overall.

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

Previously considered by:	*e-Care Programme Board, e-Care Programme Group, e-Care/GDE updates also regularly go to scrutiny committee.*
Risk and assurance:	*none*
Legislation, regulatory, equality, diversity and dignity implications	*none*

Recommendation:
The Board is asked to note progress with e-Care and Global Digital Excellence programmes.

To receive an update on e-Care/global digital exemplar (GDE) programme

1.	**Purpose**
1.1	This paper provides the trust board with an update on e-Care implementation and the global digital exemplar (GDE) programme overall.
2.	**Background**
2.1	West Suffolk Hospitals NHS Foundation Trust (WSFT) journey to digital maturity began in April 2013 when the trust board approved an outline business case to procure a new electronic patient record (EPR) system. In July 2014, Cerner Millennium was selected as preferred supplier for the EPR and the board approved the full business case to proceed with implementation. We branded this deployment and our digital transformation activities as e-Care.
2.2	After an initial 'big bang' launch in May 2016 we have continued to build new and enhanced functionality into e-Care as shown below:

Phase 1 – May 2016	• Replacement of the Patient Administration System (PAS). • Introduction of FirstNet within the emergency department • Introduction of electronic medicines management (EPMA) • Basic clinical documentation • Limited OrderComms functionality – requesting radiology and cardiology.
Phase 2 – May to Nov 2017	• Full pathology OrderComms functionality • Sepsis/acute kidney infection (AKI) alerting June 2017 • VTE assessment and management • Antimicrobial review alerting and management • Paediatrics • Capacity management (managing the flow of patients through the hospital) • Enhanced clinical documentation (including new care plans and care pathways) • Medication enhancements – such as duplicate paracetamol alerts, new more intuitive workflow for discharge summaries and new diabetic care plan

2.3	In recognising our achievements, the trust was one of 16 hospitals in the country chosen to become a flagship GDE site. GDE status was awarded to hospitals considered to be the most advanced technologically. We received £10million portion of national GDE funding as a result. Our GDE programme covers four main pillars:	

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

	The remainder of this paper provides an update on progress against each of these pillars and a picture of what we are ultimately striving for with this programme.
3.	**Pillar one – digital acute trust**
3.1	We are currently in the final phases of launching phase three for e-Care. This is a combination of GDE requirements and additional new functionality. Over the next 15 months we will be introducing the following over two drops (exact dates of drops to be agreed within the next few weeks). **Drop one** • A new live emergency department (ED) dashboard showing status of department • A new ED data collection form to improve the information collected about patients • A new ED bed view providing more intuitive and user friendly screens • Simplified consultant workflows • Integrated vital monitoring equipment which will upload readings directly into e-Care • Improved reporting functionality across the trust • A consultant mobile application to allow for faster viewing of the patient record wherever the clinician is and the ability to utilise voice recognition **Drop two** • Continued roll out of self-service kiosks for checking-in at outpatients • An integrated theatres system • An integrated anaesthetics system • An integrated materials management system to allow for tracking and costings from surgery • An integrated maternity system • An integrated cardiology system • An integrated ophthalmology • A new outpatient administration system • An infection control module to monitor and track infection across the Trust • Additional electronic prescribing functionality • Additional electronic documentation • Continued improvements to the patient portal
3.2	In addition, the e-Care programme board is shortly to sign off a new optimisation strategy that will outline how the trust will work with clinicians and staff to improve the current workflows. This will be a combination of training/coaching for staff and identifying amendments to build that could enhance current workflows. The phase three programme plan allows for up to four drops across the next year, so that any optimisation changes can be implemented without delay.
4.	**Pillar two – supporting the integrated care organisation**
4.1	There are three main elements that underpin pillar two.

Patient portal	Providing a secure patient portal which would provide people with access to their own e-Care health record. 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 rich data source which can inform the priorities of our new integrated neighbourhood teams and provide us with intelligence that can underpin how we deliver services across partners.

4.2	Our main focus over the last few weeks has been on preparing to launch the pilot of the patient portal during February. The final stages of build have been complete and the site is ready to launch. We have been taking time to introduce our own clinicians to the concept of the portal, as this will be a significant culture change for all.
4.3	The initial pilot will run until end of May and will include three key components: • Members of staff (as patients) will be encouraged to sign-up as users of the portal • Patients from one clinical service (likely to be rheumatology) • A selection of dietetic patients We are aiming to recruit 300 users for the pilot from across these three groups who we hope will work with us to test and refine the initial system. As part of the pilot we will also establish user groups that we will ask to guide us in future developments of the system.
4.4	The HIE is already working in 23 GP practices providing GPs with a view only access to the e-Care electronic patient record. A key aspiration is to make HIE two-way, so that we can see information in the primary care patient record as well. In the future, we will be extending the reach of HIE interface to include: • EPIC (in use at Cambridge University Hospitals NHS Foundation Trust) • Lorenzo (in use at Papworth Hospital NHS Foundation Trust, The Ipswich Hospital NHS Trust and Norfolk and Suffolk NHS Foundation Trust), • Suffolk County Council systems
4.5	We have been working closely with senior colleagues from across the clinical commissioning group (CCG), sustainability and transformation programme (STP) and social care to start early discussions around how population health can support the system ambitions. Helena Jopling, Consultant in Public Health is currently talking to key stakeholder groups to introduce the concept of population health and to agree how best to take this forward in a co-ordinated way.
5.	**Pillar three**
5.1	We continue to work closely with Milton Keynes as our fast follower trust and support them with their forthcoming go live. This includes sharing lessons learned, providing resources such as training plans, go live plans and provision of floorwalker support. Milton Keynes are currently due to go live in April 2018. We will also be sending some maternity staff to observe their go live so that we can ensure learning is passed back to us regarding our own forthcoming go live.
5.2	We are continuing to work with NHS Digital on blue printing. Three trusts have been selected to produce initial blue prints as a pilot for the approach. NHS Digital will then agree which topics other trusts will focus on. We have expressed interest in completing blue prints on the following topics: • Medicines transcription • Patient safety dashboard • Red to green whiteboard • Venue summary (summaries all nursing information in one place) • Operational readiness • Approaches to training – our experience of what works and what doesn't (including learning contracts) • Patient portal development • Discharge summaries (learning from our incident) • Alerting • Optimisation • VitalLinks implementation

	• Diabetic care plan • Nursing care plans • AHP documentation • Deployment methodologies (MethodM versus Agile) – working with Milton Keynes on this. • Dynamic documentation – working with Milton Keynes on this • PowerChart touch • Paediatrics dose range checking • Insulin unit rule • Paracetamol duplication alert
6.	**Pillar four**
6.1	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.

Transformation Roadmap

Item 19

	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	2019 On-wards	Work stream End Date
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				Agree decision making, governance and sign off process													
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	Two alliance partners added to WSFT Board																
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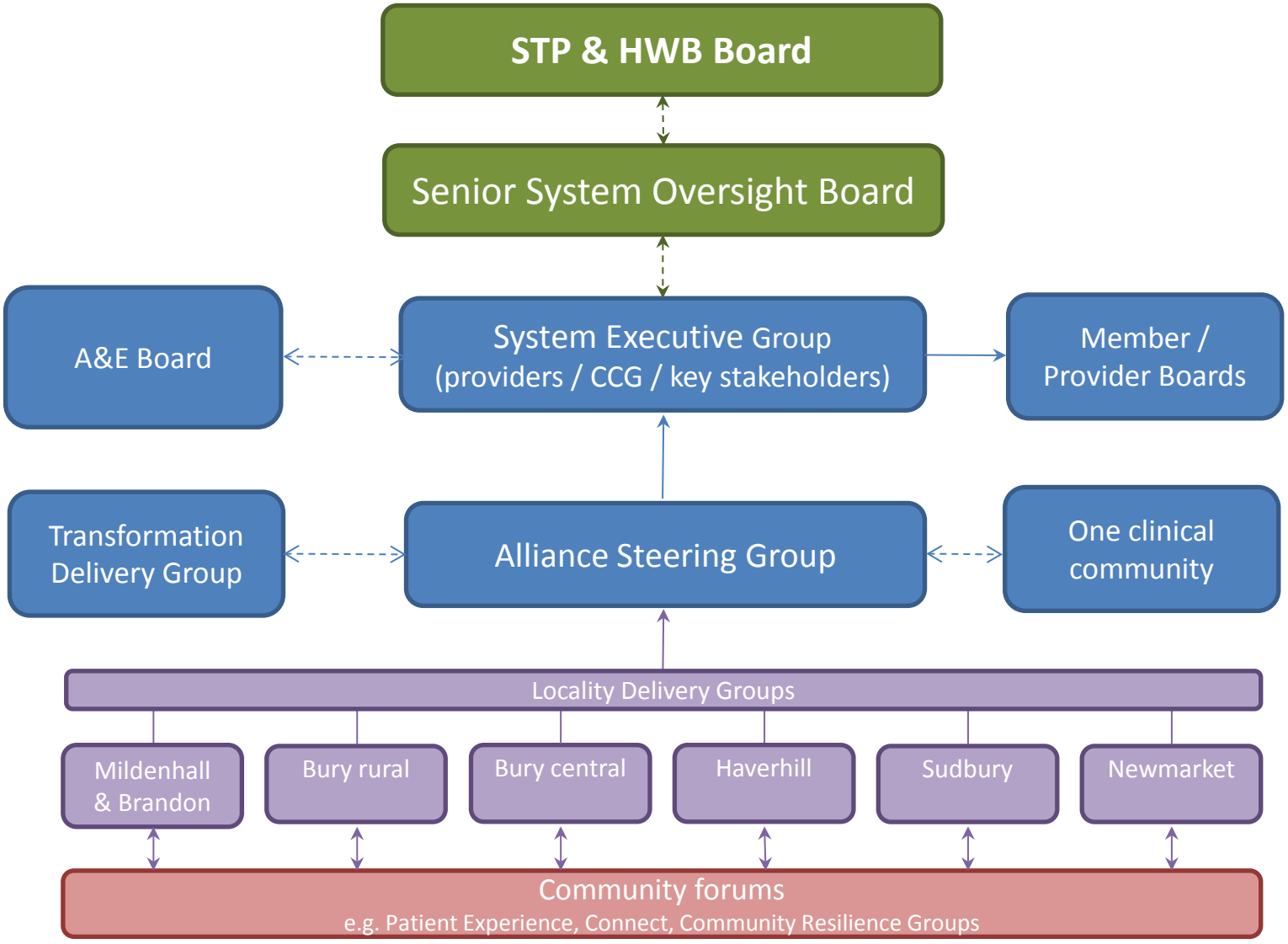
	Supporting the Acute Trusts review and development of the Children's emergency pathways																
	Children's Emotional Health and Wellbeing strategy – delivery of the Suffolk 2020 strategy																
	Completion of ICPS Objectives (see objectives for details)																TBC

Transformation work started/completed from consortium/acute working pre-Alliance:

* Vertically integrated therapy TKR and THR pathway between acute and community
* Vertically integrated therapy hand therapy pathway between acute and community
* Vertically integrated dietetics service
* STGH service set up to support hospital discharges
* Pilot of the Frailty Case Coordinator role

Item 19

West Suffolk System



West Suffolk NHS
NHS Foundation Trust

Community Services Update

West Suffolk NHS Foundation Trust Board

26th January 2018

1.0 Introduction

1.1 The community services contract transferred to the trust on 1 October 2017. The trust is working as part of an Alliance of providers to deliver community services. The trust is committed to building, shaping and being at the centre of, a collaborative integrated health and care system that operates without organisational boundaries.

1.2 This paper sets out:

- Progress on integration between acute and community services
- Progress on the development of the Alliance
- Early thinking on the transition of the Alliance to an Accountable Care model of operation
- Early thinking on the stages for the STP to become a single strategic commissioning body
- Information on measures, metrics and quality indicators that will be used to determine our success/failure

2.0 Acute and Community Integration

2.1 Since the 1 October, acute and community colleagues have been familiarising themselves with each other and their respective services. A number of forums have been held to facilitate this, with community representation on all of the relevant trust committees and meetings.

2.2 Two members of community staff have been elected as staff governors.

2.3 It was agreed pre-October 2017 that we would put in place a temporary operational management structure for the community services to ensure both a safe transfer and to provide some stability and continuity for community staff. A previous paper presented to both the Board and Trust Executive Group setting out our ambition to build an integrated structure set out the following time line:

- Stage 1 October 2017 – December 2017: explore options
- Stage 2 January2018 – March 2018: scope recommended model and impact (consult if necessary)
- Stage 3 April 2018 onwards: implement

2.4 Following discussion at the Trust Executive Group it was agreed the best approach to Stage 1 would be to form a small task and finish group of volunteers from the acute and community. The group was established with good representation from both and jointly led by the Chief Operating Officer and the Director of Integration and Community Services and has met fortnightly to explore options and share views.

2.5 Information has been shared amongst the task/finish group on different models elsewhere in the UK of trusts who have combined acute and community services, plus good staff FFT scores.

2.6 There has been a telephone call, plus a follow up face to face meeting held with the Advisory Board, who has also shared useful material from elsewhere for our consideration.

2.7 Through these discussions it has become apparent that there is already a great deal of integration and collaboration happening, with clear tangible examples of transformation and service re-design emerging. Some examples of these have been previously shared with the Board. The transformation is being approached jointly with the CCG and is built on the neighbourhood model and Connect programme.

2.8 The Advisory Board therefore recommended that we consider an evolutionary approach rather than a radical re-structure, which can be disruptive and time consuming, particularly given the amount of change that community staff have undergone in recent years.

2.9 This has been discussed with task/finish group members who are supportive of this approach. This does not mean that we will not be changing acute and community structures, but that these changes will occur in a planned way, as and when service re-design indicates that they should. This will enable form to follow function, as natural groupings for services emerge from the transformation work, and prevent us from becoming too immersed in structures.

2.10 This approach was successfully taken with the joint acute and GP Federation Lymphoedema service and is being considered for the pain service.

2.11 It is proposed that we continue with the task/finish group who will be the ‘reference point’ and critical friend for any discussions relating to structure changes and will make recommendations on any changes to the relevant trust groups and Board.

2.12 The first change that is proposed is to move the Head of Therapies post and portfolio from the Clinical Support Services directorate into Community Services under the Director of Integration and Community Services. This group of services already contains many that are delivered outside of the hospital, compliments the ‘one therapy resource vision’ and embeds the clinical and professional supervision framework we have put in place between acute and community therapists.

2.13 The re-allocating of responsibilities at a senior level will still need to happen to eventually have all operational services sitting with the Chief Operating Officer rather than the Director of Integration and Executive medical Director. We will still approach these changes in a phased way once services have settled into new ways of working.

3.0 West Suffolk Alliance Development

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

3.2 The Alliance now needs to establish a shared governance framework, vision and strategy and agree the processes for decisions to be made/ reached/ratified and implemented. This needs to include escalation processes and dispute resolution processes, as well as risk and gain share agreements.

3.3 It needs to define the steps and processes required to implement the locality based model of service delivery, develop the neighbourhood teams and networks as well as design and implement the locality delivery boards and locality lead role. Appendix 1 shows a high level plan with milestones.

3.4 Work has commenced on scoping these functions; draft job descriptions have been shared and discussions have commenced on how we redirect current CCG GP resources to the localities to influence and drive the service changes required.

3.5 Early discussions have commenced on how we could align acute medical clinicians and the Clinical Directors with localities to maximise shared learning and ensure any redesign is clinically led and owned.

3.6 The Alliance has had its first contract meeting with the CCG and has also held its first System Executive Group meeting (SEG). We have established a West Alliance Steering Group to oversee the development of the locality structures and to monitor and support the progress of the Alliance.

3.7 The Alliance Steering Group will report into the System Executive Group. These are important steps that strongly signal changes to the way we are now operating as a system rather than as a single organisation. This is shown in Appendix 2.

3.8 We have begun to build some capacity and resilience to support the development of the Alliance by re-defining existing roles where we can to direct them towards Alliance working. We have identified a resource to concentrate on communication and engagement for the Alliance. This is a critical function to ensure that there is a shared and clearly understood vision of what we are trying to achieve and a shared plan of how we will deliver these changes.

3.9 An Alliance ‘shutdown’ to hold a shared clinical development day is scheduled for 14th March and the trust is also extending invites to Alliance partners for relevant internal events.

4.0 From an Alliance to an Accountable Care way of working

4.1 As part of our future planning, it is envisaged that the West Suffolk Alliance will, over time, operate in a way that is similar to an Accountable Care Organisation (ACO) Model. As the trust already has foundation status it would be possible to use this as the basis for development of a shared way of working in a strong single partnership. Partner organisations would evolve their governance into this framework so that a single framework for decision making and accountability exists. This does not mean that we would fully adopt the American ACO framework, but that we would build a strong partnership of organisations that collaborate for the benefit of its patient population.

4.2 One of the main tasks for the Alliance is to move to a way of working as one single partnership that would, in time, hold some commissioning functions, devolved from the STP/ACS. The main differences between operating as an Alliance under a MOU and operating in an Accountable Care way of working are described below:

Alliance Approach:

- Alliances are partnerships, not a single accountable organisation with clear governance and authority including a unitary board and CEO
- Deliver a culture of accountability and commitment to shared resolution of challenges and decision making.
- Deliver an improved integrated service model, moving beyond organisational boundaries across primary, community and hospital services.

Accountable Care Approach:

- Has clear governance and authority that may include a unitary board and CEO.
- Takes collective responsibility for delivery of all care for a given population within a shared financial control total.
- Big enough to take on responsibility and accountability for whole populations; small enough to reflect differences in place/geography.
- Responsible for the delivery of local care in a way which meets local needs.
- Embedded in local communities, working with local stakeholders.

4.3 A Delivery Board for the 3 Alliances within our STP to assist with maturing the Alliances has been established by the STP programme board. The WSFT Director of Integration and Community Services is the West Alliance representative on this.

5.0 From STP to a single strategic commissioning way of working (ACS)

5.1 Our STP has begun the process to move towards working as a single strategic commissioning body. Some elements of which, replicate the American Accountable Care System (ACS) model. A stock take of our readiness as a system has been completed and submitted. There are some clear requirements that we will need to have in place to progress. We made our submission to be part of the second wave of Vanguards on 15th December. There will be a visit from the national team in March. The known key milestones are shown in Appendix 1, it must be noted that this is still under development and will be subject to change.

5.2 A single strategic commissioning body will need to have in place, collective decision making, work alongside regulators, and have agreed system outcomes and KPI's

5.3 A Support Unit will be established to assist this development. The West Suffolk Chief Operating Officer has been seconded part time to the STP which will provide access to central support and increase resources for Alliance development.

5.4 It is envisaged that the STP will begin to operate in shadow ACS form during 2018-19, and evolve to a fully functioning ACS during 2019-2020.

5.5 An Accountable Care System can be described as:

- The totality of the operating model for a system that describes how the commissioners (NHS and Local Authorities) and providers work together.
- Accountable care systems are place-based systems which have taken on the collective responsibility for managing performance, resources and the totality of population health. In return, they receive greater freedoms and flexibilities from NHS England and NHS Improvement.
- Work is currently underway to define this operating model for Suffolk and NE Essex

5.6 Strategic Commissioner

- A single organisation responsible for population needs assessment and strategic planning.
- Accountable upwards – should seek to take some functions from regulators (NHS England, NHS Improvement) and holds ability to intervene.
- Improves focused and prioritised clinical outcomes and addresses health inequalities.
- Supports the development of Accountable Care in localities.

6.0 Measures and Benefits

6.1 As part of the MCP process for the community services contract the Alliance was required to develop some suggested measures that would reflect and demonstrate whole system working and move from capturing and counting activity, to an outcome based method of assessing services.

6.2 As a result of 2 system wide workshops, led by public health colleagues a set of system measures was agreed. These consist of 8 domains, each with sub-outcome measures and are based on 'I' statements. These 'I' statements will be further broken down into sub-sets of metrics that can be determined by local need. The domains, 'I' statements and examples of how the information could be presented is shown in Appendix 3.

6.3 There is recognition that to capture the impact and benefits of changing the way we work a variety of measures will be required. There will need to be a mix of both soft and hard data, particularly focussing on patient experience and health outcomes.

6.4 An extensive trawl of population health and care outcome indicators has been completed by public health, and a set of measures suggested that relate to both

physical and mental health for adults, children and young people. These measures can be applied at either local or STP level.

6.5 The measures selected build on the 'I' statements and ideally would be incorporated into staff and patient surveys, or existing methods of data collection. The data is presented in a RADAR chart format, and using OPERa components (outcomes, process, experience, resources). An example of this is shown in Appendix 3 **note: this is example data only**

6.6 These measures and components could be further broken down into sub-groups for specific population cohorts e.g. over 75's, those with a long term condition and even further broken down to neighbourhood level.

6.7 Presentation of the data in this way allows us to track progress over time, is simple but effective and can be built up/down depending on the level of data required, e.g. the same set of data can be presented by neighbourhood, by West Alliance or by STP footprint.

6.8 For some areas of transformation individual case studies/patient stories will be used to demonstrate effectiveness. Staff experience, skills enhancement/learning, resource efficiencies, reduction in duplication and job satisfaction will all be captured to ensure progress is being made.

6.9 Consideration will be given to how/what can be measured as an 'Alliance collective'. For example, do we set collective targets and thresholds for never events to encourage shared accountability, decision making and learning? Consideration will also be given to how we engage with and involve local groups/people and users of our services to devise meaningful ways of demonstrating improvements.

6.10 Radar charts can be developed by 'service grouping' e.g., separate charts for mental health, primary care, for the Alliance as a collective, or by subject of specific disease or service.

6.11 The proposed approach is to develop shared information, data and dashboards across the health and care system to support the integration of informatics resources that will produce system wide integrated performance reports.

7.0 Conclusion

7.1 The transformation programme in relation to community services has moved into the implementation phase. There are many areas of work that are now well underway. The services are beginning to integrate in a planned and phased way.

7.2 The Alliance is maturing and embedding its governance and forums and now has a high level timeline of how to move forward to become an Accountable Care Organisation.

7.3 The wider STP system thinking is also maturing and evolving which will support the Alliance in its development.

7.4 Work has begun on agreeing how we will measure and map progress.

7.5 The Board is asked to note the progress made.

Appendix 1

Transformation Roadmap

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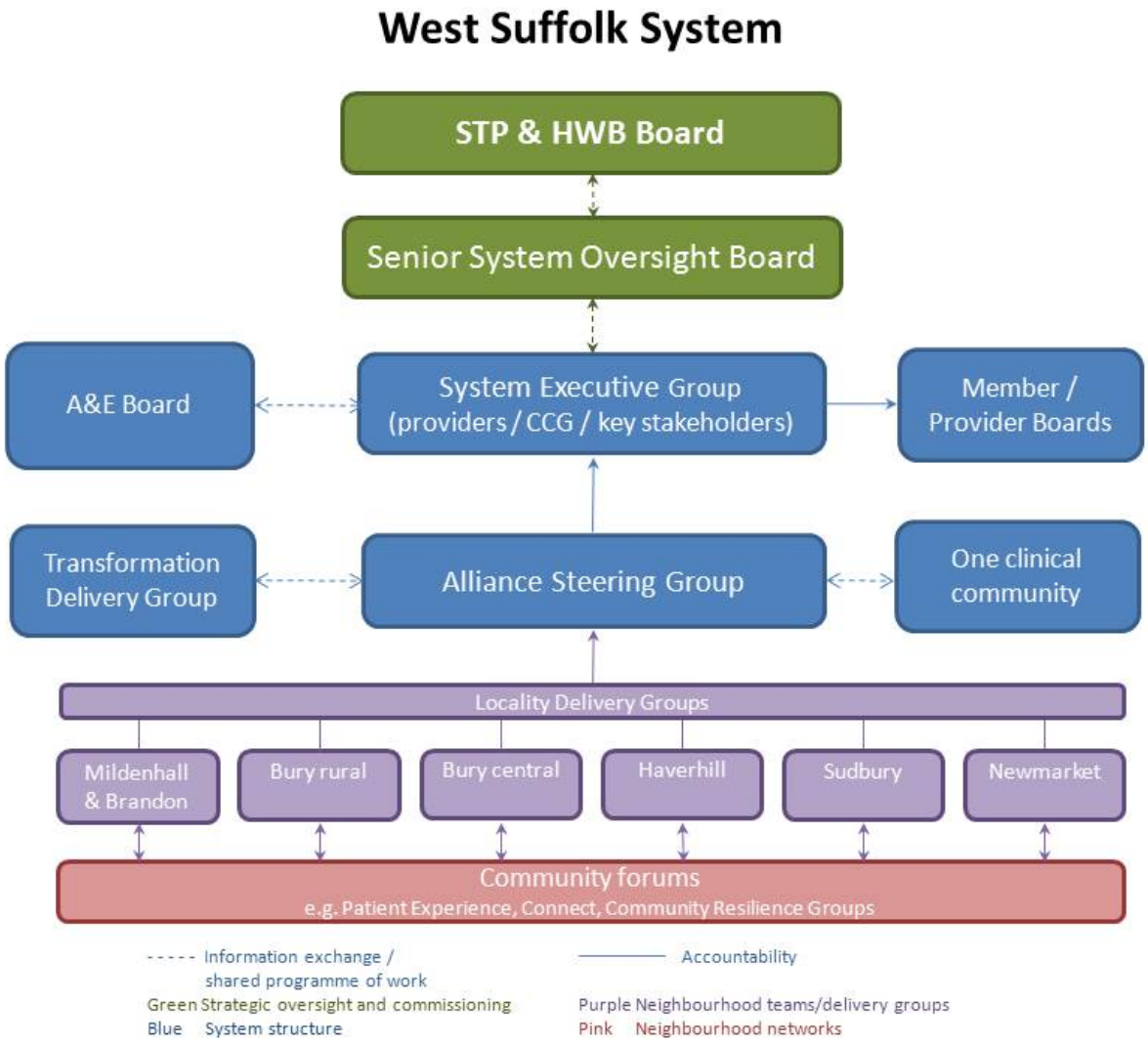
* Vertically integrated dietetics service

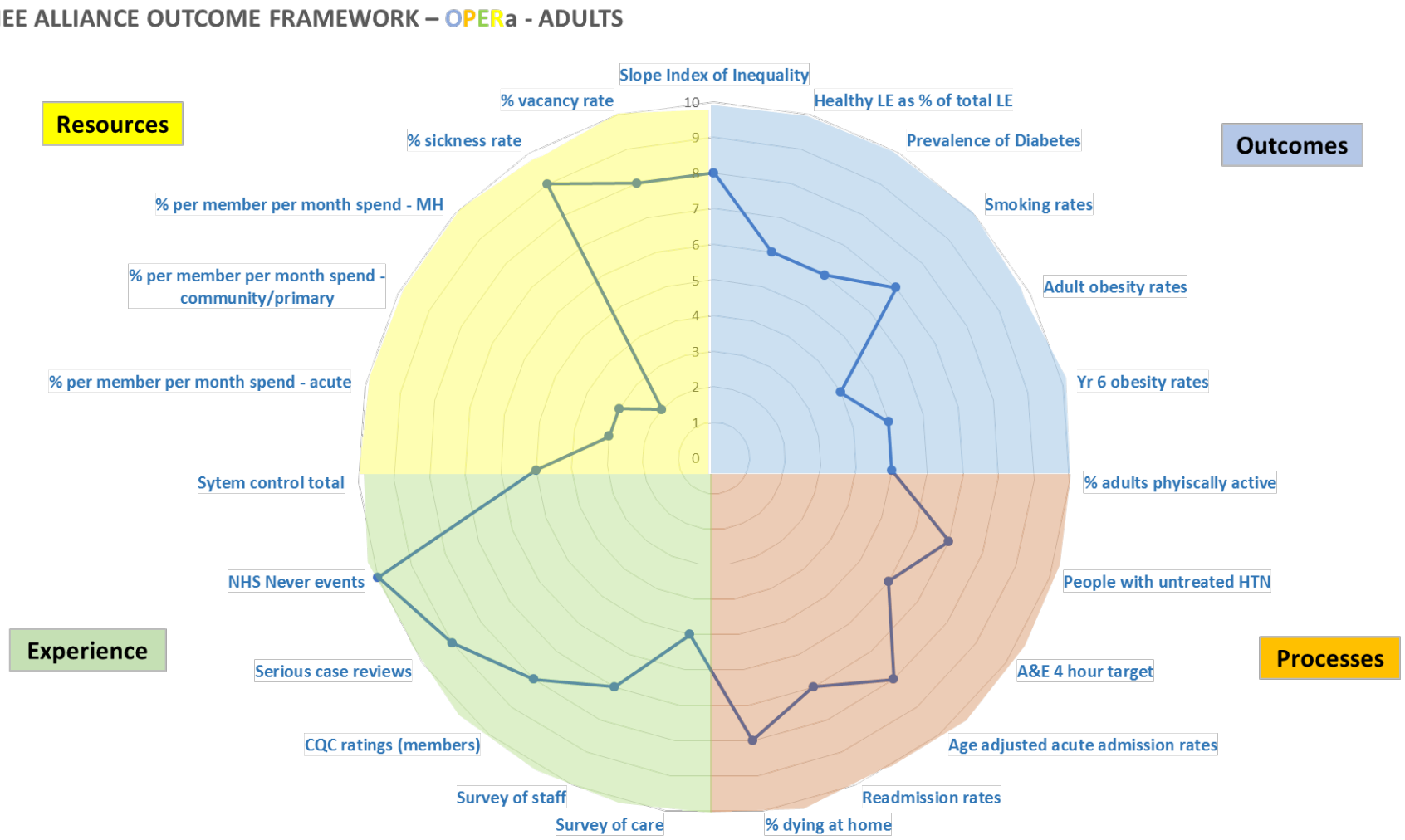
Appendix 2


West Suffolk System
STP & HWB Board
Senior System Oversight Board
A&E Board
System Executive Group
(providers / CCG / key stakeholders)
Member /
Provider Boards
Transformation
Delivery Group
Alliance Steering Group
One clinical
community
Locality Delivery Groups
Mildenhall
& Brandon
Bury rural
Bury central
Haverhill
Sudbury
Newmarket
Community forums
e.g. Patient Experience, Connect, Community Resilience Groups
Information exchange /
shared programme of work
Accountability
Green Strategic oversight and commissioning
Purple Neighbourhood teams/delivery groups
Blue System structure
Pink Neighbourhood networks

Appendix 3

Local people have an excellent experience of care and support	1.1	I feel involved in the planning and delivery of my care
	1.2	I receive care and support that is timely coordinated and meets my needs
	1.3	We are confident as a system that the care and support is of the best quality
	1.4	I am listened to if I have a concern
	1.5	I understand the choices available to me and the implications of consequences
	1.6	If I care for someone I will be supported
Health and Care inequalities will be reduced	2.1	My individual circumstances are taken into account
	2.2	My local community gets the support and information it needs to be a safe and healthy place to be
	2.3	Support and services are available to me
Reduction in the incidents of avoidable harm	3.1	When I am at risk I will be protected
	3.2	We will deliver care that keeps you safe from harm
	3.3	I will receive care from services who share what works and learns from mistakes
Money is used for best effect across the health and care system	4.1	The services we provide are affordable within our combined financial envelope
	4.2	I experience the minimum number of handovers across the health and care system
	4.3	We move resources across the health and care system to best meet the needs of the population
	4.4	Our workforce is appropriate to meet our outcomes
Local people are supported to stay well	5.1	Our population have additional years of healthy life expectancy (KPI)
	5.2	I am able to live a healthy life for long as possible
	5.3	I feel connected to friends, families and their local community
	5.4	I feel positive about my life
Local people with health and care needs are supported to avoid deteriorating health and managing crisis	6.1	I am supported to manage my long term condition
	6.2	I am supported to avoid a crisis
	6.3	In a crisis I will receive care in the place that is right for me
	6.4	I am able to live as independently as possible
Local people's health and wellbeing is optimised after a period ill health or injury	7.1	I will get back to my normal way of life or be supported if my normal has changed
	7.2	I will be supported and challenged to change the circumstances that contributed to my ill health if needed
Local people are supported to have a good death	8.1	I will be supported to die with dignity and according to my wishes
	8.2	I will be helped to make informed choices and develop an advanced plan about the end of my life
	8.3	My plan will still hold in a crisis

Appendix 3 continued



WSFT Board Meeting – 26 January 2018

Agenda item:	19			
Presented by:	Nick Jenkins, Executive Medical Director			
Prepared by:	Dawn Godbold, Director of Integration and Community Services			
Date prepared:	3rd January 2018			
Subject:	Community Services 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 Alliance
- Transition of the Alliance to an accountable care model of working
- Stages for the STP to become a single strategic commissioning body
- Information on measures, metrics and quality indicators that will be used to determine our success/failure

Main Points:

Since the 1st October, acute and community colleagues have been familiarising themselves with each other and their respective services.
It was agreed pre-October 2017 that we would put in place a temporary operational management structure for the community services to ensure both a safe transfer and to provide some stability and continuity for community staff. A previous paper presented to both the board and Trust Executive Group setting out our ambition to build an integrated structure set out the following time line:

- Stage 1 October 2017 – December 2017 : explore options
- Stage 2 January2018 – March 2018 : scope recommended model and impact (consult if necessary)
- Stage 3 April 2018 onwards implement

A task and finish group has been established and support and advice taken from the Advisory Board. Through these discussions it is proposed that the best approach to integration would be to evolve new structures as a direct result of the re-design of services and care pathways where integration is already happening at an operational level.

The West Alliance is establishing its operating mechanism for the community services contract and now needs to plan for the stages of change to work within an accountable care model.

The STP is progressing and strengthening its plans to become a single strategic commissioning body and WSFT is represented on the relevant work programmes and forums.

As an Alliance we have begun to develop tools for how we will demonstrate our effectiveness, measure our successes, learn from our mistakes and collectively change the way we work to improve the services we provide.

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*
- *Development of the STP*
- *The high level plan and milestones*
- *The early work on measures development*

Board of Directors – 26 January 2018

Agenda item:	Item 20			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	18 January 2018			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

15 January 2018

As part of winter preparations meetings in the first week of January had been cancelled so this was the first meeting of TEG in 2018.

Steve Dunn provided an introduction to the meeting and reflection on the **winter pressure** and action taken to ensure safe care for our patients. This included the action taken to respond to the increased demand and the need to create surge capacity. The impact on performance within ED and RTT was recognised but the use of elective surgical capacity had been carefully managed with the support of the clinical director. Discussion included the focus on next steps and ensuring that we are maximising the available elective capacity, including the day surgery unit.

A report was received on **radiology staffing**, building on a risk assessment previously reported to TEG. This was in the context of a national focus on radiology reporting timescales. TEG supported the proposed mitigations which included increased reporting capacity, use of locum staffing and cost effective use of CT scanning.

Following discussion of the clinical and efficiency advantages TEG supported the business case for replacement of the **gamma camera**. This will be subject to negotiation with the CCG as part of the final business case.

The **red risk report** was reviewed with discussion and challenge for individual areas. A new red risk relating to 'Staff shortages in Microbiology' was noted and it was accepted that following immediate action to mitigate, the risk was downgraded to amber.

The business case for **medical e-rostering** was reviewed and the options discussed. This will inform the final business case in terms of preferred option and timing of implementation.

It was noted that the draft **CQC inspection report** had been received with final publication expected by as soon as possible.

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

a) CBRN plan
b) e-Care business continuity plan
c) West Suffolk Hospital search plan
d) Travel plan

Reports were received and noted from the following groups:

a) Health & Wellbeing group
b) Equality & Diversity technical group
c) Sustainability development steering group

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 – 1 December 2017

Agenda item:	Item 21			
Presented by:	Angus Eaton, Non-executive director			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	23 November 2017			
Subject:	Remuneration Committee report			
Purpose:	X	For information		For approval

The Committee undertook:

1. A mid-year performance review for each of the executive directors. Discussion took place on the structure and focus of executive director objectives for 2018-19
2. Reviewed off-payroll rules (often known as IR35, or the intermediaries' legislation) to ensure that individuals who work through their own company pay broadly equivalent taxes as employees, where they would employed if they were taken on directly
3. Received the minutes of the Employers Based Awards Committee held on 10 November 2017
4. Reviewed and approved the Trust's remuneration policy. This has subsequently been updated to reflect the increased threshold for very senior managers pay issued by the Treasury in January 2018 (Annex A)
5. The committee thanked Neville Hounsome for his stewardship as chair of the committee. Angus Eaton was appointed as chair of committee as part of a review of the non-executive director responsibilities.

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:	A summary of each meeting of the committee is provided to the Board
Risk and assurance:	Failure to comply with NHSI guidance on remuneration for very senior managers.
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

To receive the report for information

Remuneration policy

WSFT is aware of public attention given to the levels of remuneration of senior managers within the NHS. WSFT has always strived to operate with openness and transparency when reviewing and setting the pay levels for senior management and we will continue to do this going forward.

To determine Board of Director level salaries the Remuneration Committee **may use** one or more of the following:

- An assessment of an individual's performance
- An assessment of an Trust's performance
- NHS cost of living pay rise, based on the national NHS pay award
- Benchmarking data surveyed confidentially amongst WSFT's peer group
- NHS Providers annual salary survey of NHS Chief Executives and Executive Directors
- NHS and other relevant advertised jobs databases
- NHSI guidance and established ranges
- The prevailing market position, including the ability to recruit and retain individuals.

Other than for the Medical Director, amendments to annual salary are decided by the Remuneration Committee on the basis of the size and complexity of the job portfolio. Annual salary is inclusive of other payments such as bonus, overtime, long hours, on-call, standby, etc. The Medical Director's salary is in accordance with the terms and conditions of service of the consultant contract 2003 plus a responsibility allowance determined by the Committee payable for the duration of office.

Through these arrangements the committee must be satisfied that the remuneration for senior managers is reasonable. WSFT complies with the requirements to seek the opinion via NHS Improvement, from the Chief Secretary to the Treasury for the remuneration packages of very senior managers above £150,000*.

The Trust does not have a performance related pay scheme. The committee, however, has the delegated authority to pay one off discretionary payments in exceptional circumstances. Chief Executive and Executive Director performance is measured against objectives set at the beginning of the financial year and agreed by the Committee.

There are no special contractual compensation provisions for the early termination of Executive Directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the 'Agenda for Change: NHS terms and conditions of service' handbook (section 16); or, for those above the minimum retirement age, early termination by reason of redundancy or 'in the interests of the efficiency of the service' is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

Pay awards agreed nationally for other staff groups working at WSFT, including staff on agenda for change contracts and medical and dental staff, are determined by the Department of Health/NHS Pay Review Body, which looks at salaries and pay conditions across the NHS.

Approved by: **Remuneration Committee**
1 December 2017

* Updated from £142,500 in January 2018 to reflect national guidance

Trust Open Board Meeting – 26th January 2018

Agenda item:	22			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	David Swales, Assistant Director of Finance			
Date prepared:	18 January, 2018			
Subject:	Charitable Funds Committee Report			
Purpose:		For information	X	For approval

Executive summary:

The Charitable Funds Committee met on 24 November, 2017. The key issues and actions discussed were:-

- The Committee recommended that the annual report and accounts for the year ended 31 March 2017 be approved by the Audit Committee on behalf of the Corporate Trustee
- The Committee discussed the approach to sponsorship / donations from suppliers.
- The Committee approved an offer for a property in relation to a legacy.
- The Committee approved a bid for new VDU equipment for the MDT room
- The Committee approved the opening of a new investment account with Charities Aid Foundation (CAF) to replace the existing CAF account
- The Fundraising Report noted that great progress had been made on a number of fundraising initiatives.

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:	None
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	

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Board of Directors – 26 January 2018

Agenda item:	23			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	19 January 2018			
Subject:	Report from Council of Governors, 16 November 2017			
Purpose:	X	For information		For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 16 November 2017. The report is presented to the Board of Directors for information to provide insight into these activities. Key points from the meeting were:

- It was noted that Charles Nevitt had resigned as a public governor and confirmed that he would not be replaced prior to the elections.
- The Chairman referred to the governor elections and thanked the governors for all their work during their current term of office.
- The Chairman reported on the CQC's briefing prior to the well led review and also on the feedback from their unannounced visit.
- The Chief Executive's report provided an update on the challenges facing the Trust and recent achievements. It was proposed that the Courtyard Café sessions could be used to ask patients and visitors about the facilities in the front of hospital concourse.
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge.
- Nick Jenkins gave an update on pathology and the transition from the Pathology Partnership (tPP) to North East Essex and Suffolk Pathology Services (NEESPS) and work being undertaken to improve governance processes.
- An update was given on e-Care, including phase 2 go-live and the four different pillars of phase 3.
- The proposed constitutional change to establish two primary care representatives on the Council of Governors as partner governors was approved. This recommendation would go to the Board for approval.
- A report was received from the nominations committee.
- Reports from the lead governor and staff governors were received.
- Dates for meetings for 2018 were noted.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.						
Risk and assurance:	Failure of directors and governors to work together effectively. Attendance by non executive directors at Council of Governor meetings and vice versa. Joint workshop and development sessions.						
Legislation, regulatory, equality, diversity and dignity implications	Health & Social Care Act 2012. Monitor's Code of Governance.						
Recommendation: To note the summary report from the Council of Governors.							

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Board of Directors – 26 January 2018

Agenda item:	24			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	19 January 2018			
Subject:	Register of Interests			
Purpose:	X	For information		For approval

The register of directors' interests is formally reviewed and updated on an annual basis. At each Board meeting declarations are also received for items to be considered.

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

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

Previously considered by:	The Board receive an annual review of the register of interests.
Risk and assurance:	Failure to adequately identify conflicts and manage accordingly
Legislation, regulatory, equality, diversity and dignity implications	WSFT constitution. NHSI (Monitor) Code of Governance

Recommendation:

To note the summary of the register of directors' interests.

REGISTER OF DIRECTORS' INTERESTS

The Codes of Conduct and Accountability for NHS Trusts requires all Trusts to draw up and maintain a register of director's interests. This register consequently lists all interests, defined by the Codes as relevant and material for all its Board and non-Board directors.

The definition of interests is as follows:

- Directorships held in private companies or plcs.
- Ownership or part ownership of private companies, businesses or consultancies, likely or possibly seeking to do business with the NHS.
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or a voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for NHS services.

Name	Declared interest	Date reviewed / amended
Non Executive Directors		
Sheila Childerhouse	Trustee of the East Anglia's Children's Hospices	26 January 2018
Richard Davies	Salaried GP at Waterbeach Surgery, Cambridgeshire Sub Dean at University of Cambridge School of Clinical Medicine. The Clinical School has a contract with the WSFT to provide clinical student teaching.	26 January 2018
Angus Eaton	Director, AvivaSA Emeklilik ve Hayat A.S. (Turkey) - appointed 16.10.14 Director, Aviva Credit Services UK Ltd – appointed 5.3.15 (note: in the process of resigning as a Director Jan 18)	26 January 2018
Gary Norgate	I hold an executive position in BT Plc which is a service provider to the NHS. My role / division does not directly conduct business with the NHS.	26 January 2018
Alan Rose	Chairman, Howard House Patient Participation Group, Felixstowe (January 2018) Governor, Anglia Ruskin University	26 January 2018

Name	Declared interest	Date reviewed / amended
Steven Turpie	Owner and Director of ASD1 Limited, Management Consultancy - Does not and has not ever provided services to the NHS. Some clients of ASD1 Limited have provided services to the NHS. Chair of Trustees for Brightstars, a registered charity that supports 5-19 year old children and young people with additional needs.	26 January 2018
Executive Directors		
Helen Beck	Nil	26 January 2018
Craig Black	Wife – Marie McCleary, is Director of Finance for Havebury Housing Association	26 January 2018
Jan Bloomfield	Patron, Suffolk West NHS Retirement Fellowship Co-opted Governor, West Suffolk College Board Governor, Radio West Suffolk RWSfm-103 Governor – Sybil Andrews Academy	26 January 2018
Stephen Dunn	Visiting Professor of Health Policy London School of Economics Trustee, Brightstars a registered charity that supports 5-19 year old children and young people with additional needs. Director Helpforce Community Honorary Commander, RAF Lakenheath	26 January 2018
Nick Jenkins	One programmed activity per month for Hillingdon Hospitals, overseeing National Physician Associate Expansion Programme	26 January 2018
Rowan Procter	Nil	26 January 2018
Other regular attendees		
Dawn Godbold	Nil	26 January 2018

Name	Declared interest	Date reviewed / amended
Richard Jones	Director of Friars 699 Limited (which changed its name to "The Pathology Partnership Limited") Councillor of Brockley Parish Council	26 January 2018
Catherine Waller	Non-Executive Director, ITSO Ltd. (Integrated smart ticketing across UK public transport) Owner, Blink Marketing (consultancy providing Data, Customer and Marketing services) - no current expectation of business with the NHS	26 January 2018

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Board of Directors – 26 January 2018

Agenda item:	Item 25			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	18 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 – 2 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
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
Pathology services report	✓	✓	Written	Matrix	NJ
Alliance and community services report, including SLT patients that are waiting or a package of care	✓		Written	Matrix	DG
Quality learning and improvement report – Q3	✓		Written	Matrix	RP
Learning from deaths report – Q3	✓		Written	Matrix	NJ
Voluntary services report	✓		Written	Action point - 1496	JB
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Foundation Trust Membership Strategy	✓		Written	Matrix	RJ
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	✓		Written	Matrix	DG
Hospital concourse development, as part of capital programme	✓	✓	Written	Action point - 1489	CB
Scrutiny Committee report		✓	Written	Matrix	GN
Operational plan 2018/19, including control total		✓	Written	Matrix	CB/RJ
Strategic update, including Alliance, System Executive Group and STP		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Council of Governors report	✓		Written	Matrix	SC
Quality & Risk Committee report	✓		Written	Matrix	AE
Charitable Funds Committee report	✓		Written	Matrix	GN
Board assurance framework		✓	Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JB

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