NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday, 25 May 2018 9:15 AM — 11:15 AM BST
Venue	Northgate Room, Quince House, West Suffolk Hospital
Description	A meeting of the Board of Directors will take place on Friday, 25 May 2018 at 9.15am in the Northgate Room, 2nd Floor, Quince House at West Suffolk Hospital
Organiser	Karen McHugh

Agenda

AGENDA

Agenda Open Board 25 May 2018.docx

9:15 GENERAL BUSINESS

1. Introductions and apologies for absence
   To NOTE any apologies for the meeting and request that mobile phones are set to silent
   Apologies: Dawn Godbold
   Presented by Sheila Childerhouse

2. Questions from the public relating to matters on the agenda
   To RECEIVE questions from members of the public of information or clarification relating only to matters on the agenda
   Presented by Sheila Childerhouse

3. Review of agenda
   To AGREE any alterations to the timing of the agenda
   Presented by Sheila Childerhouse

4. Declaration of interests for items on the agenda
   To NOTE any declarations of interest for items on the agenda
   Presented by Sheila Childerhouse

5. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 27 April 2018
   Presented by Sheila Childerhouse

   Item 5 - Open Board Minutes 2018 04 27 April Draft.docx

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6. Matters arising action sheet
   To ACCEPT updates on actions not covered elsewhere on the agenda
   Presented by Sheila Childerhouse

   Item 6 - Action sheet report.doc

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7. Chief Executive's report
   To ACCEPT a report on current issues from the Chief Executive
   Presented by Stephen Dunn

   Item 7 - Chief Exec Report May 18.doc

9:35 DELIVER FOR TODAY

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8. Alliance and community services report
   To RECEIVE update
   Presented by Nick Jenkins

   Item 8 - Alliance and community services report cover sheet May 2018.doc

   Item 8 - Community and Alliance update 180525 V2.pdf

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9. Integrated quality and performance report
   To ACCEPT the report
   Presented by Rowan Procter and Helen Beck

   Item 9 - Integrated Quality & Performance Report_APRIL_2018_Draft_v1.docx

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10. RTT recovery plan
    To APPROVE the report
    Presented by Helen Beck

    Item 10 - Trust Board RTT Update report - 25 May 2018.doc

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11. Finance and workforce report
    To ACCEPT the report
    Presented by Craig Black

    Item 11 - Finance and workforce report cover sheet.docx

    Item 11 - Finance Report April 2018 FINAL.docx

10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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12. Nurse staffing report
    To ACCEPT a report on monthly nurse staffing levels
    Presented by Rowan Procter

    Item 12 - Nurse staffing Report - April 2018 data.doc

    Item 12 - Nurse staffing WSFT Dashboard - Apr 2018.xls

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13. Learning from deaths - Q4 report
    To ACCEPT a report
    Presented by Nick Jenkins

    Item 13 - Learning from deaths Q4 Board report.docx

    Item 13 - Learning from deaths Q4 Board report dashboard.pdf

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14. Quality and learning report – Q4
    To ACCEPT a report, including review of hospital acquired pressure ulcers
    Presented by Rowan Procter

    Item 14 - Quality and Learning report - May 2018.docx

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15. NHSBSP Screening incident briefing
    To ACCEPT the report
    Presented by Nick Jenkins

    Item 15 - NHSBSP Screening incident briefing - May 2018.docx

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16. Freedom to speak up guardian
    To ACCEPT a report
    Presented by Nick Finch

    Item 16 - Freedom to speak up guardian report - May 2018.docx

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17. NHS Resolution - maternity improvement standards
To APPROVE a report
Presented by Craig Black

Item 17 - Coversheet CNST Board Report.doc

Item 17 - CNST-Board-report-final v3.doc

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18. Putting you first award
To NOTE a verbal report of this month's winner
Presented by Jan Bloomfield

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19. Consultant appointment report
To RECEIVE the report
Presented by Jan Bloomfield

Item 19 - Consultant Appointments report - May 2018.doc

10:50 BUILD A JOINED-UP FUTURE

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20. e-Care report
To RECEIVE an update report
Presented by Craig Black

Item 20 - eCare WSFT Trust Board May 18.doc

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21. IM&T strategy
To APPROVE a report
Presented by Craig Black

Item 21 - Information Management and Technology Strategy cover sheet.doc

Item 21 - Information Management and Technology Strategy 2018 FINAL.docx

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22. Experience of care strategy
To APPROVE a report
Presented by Rowan Procter

Item 22 - Experience of care strategy cover sheet - May 2018.doc

Item 22 - Experience of care strategy - April 18.pdf

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23. Emergency preparation, resilience and response (EPRR) assurance process and annual work plan
To ACCEPT a report
Presented by Helen Beck

Item 23 - EPRR report - May 2018.doc

11:00 GOVERNANCE

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24. Trust Executive Group report
Due to bank holidays and COO interviews no meeting was held in May
Presented by Stephen Dunn

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25. Remuneration Committee report
To receive the report
Presented by Angus Eaton

Item 25 - Remuneration Committee report.doc

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26. Charitable Funds Committee report
To RECEIVE the report
Presented by Gary Norgate

Item 26 - Charitable Funds Board Report 25th May 2018.doc

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27. Use of Trust seal
To RECEIVE the report
Presented by Richard Jones

Item 27 - Use of Trust Seal Report and Coversheet 25 May 2018.doc

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28. Agenda items for next meeting
To APPROVE the scheduled items for the next meeting
Presented by Richard Jones

Item 28 - Items for next meeting.doc

11:15 ITEMS FOR INFORMATION

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29. Any other business
To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency
Presented by Sheila Childerhouse

30. Date of next meeting
To NOTE that the next meeting will be held on Friday 29 June 2018 at 9:15 am in the Northgate Room.
Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

31. The Trust Board is invited to adopt the following resolution:
"That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act 1960
Presented by Sheila Childerhouse

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To AGREE any alterations to the timing of the agenda

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4. Declaration of interests for items on the agenda

To NOTE any declarations of interest for items on the agenda

Presented by Sheila Childerhouse

5. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 27 April 2018

Presented by Sheila Childerhouse

NHS West Suffolk NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 27 APRIL 2018

COMMITTEE MEMBERS				
			Attendance	**Apologies**
Sheila Childerhouse	**(SC)**	Chair	•	
Helen Beck	**(HB)**	Interim Chief Operating Officer		•
Craig Black	**(CB)**	Executive Director of Resources	•	
Jan Bloomfield	**(JBI)**	Executive Director Workforce & Communications	•	
Richard Davies	**(RB)**	Non Executive Director	•	
Steve Dunn	**(SD)**	Chief Executive	•	
Angus Eaton	**(AE)**	Non Executive Director	•	
Nick Jenkins	**(NJ)**	Executive Medical Director	•	
Gary Norgate	**(GN)**	Non Executive Director	•	
Rowan Procter	**(RP)**	Executive Chief Nurse	•	
Alan Rose	**(AR)**	Non Executive Director	•	
Steven Turpie	**(ST)**	Non Executive Director/Deputy Chairman		•
In attendance				
Alex Baldwin	**(AB)**	Deputy Chief Operating Officer (for Helen Beck)		
Catherine Waller	**(CW)**	Honorary Non-Executive Director		
Ruth Williamson	**(RW)**	PA, Trust Office *(minutes)*		
Richard Jones	**(RJ)**	Trust Secretary		
Tara Rose	**(TR)**	Head of Communications		

Action

GENERAL BUSINESS

18/082 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies received from Steve Turpie and Helen Beck. SC welcomed Alex Baldwin to the meeting, attending on behalf of Helen Beck.

18/083 QUESTIONS FROM THE PUBLIC

- Liz Steele advised that a matter had been raised by one of the public governors. A recent newspaper article stated that 30% of patients go undiagnosed with dementia whilst in hospital. Could the Trust be assured that dementia was a focus in the hospital? RP advised that starting next month a lead nurse for frailty would be working in the Emergency Department to help to identify such patients at the front door. The forthcoming Dementia Awareness Week will help raise the issue throughout the organisation. There is also a link nurse for dementia on every ward. A monthly audit has identified that an average of between 25% and 31% of inpatient adult beds have a patient with a level of confusion, whether diagnosed as dementia or not. The national audit recommences in a couple of months and will aid identifying any issues.

- Jon Illeson (JL) referred to Page 4, finance report, contained in the Cost Improvement Programme (CIP) for the last financial year. He noted savings made and referred to the £3.8million attributed to a staffing review and asked what this related to. CB advised that an extensive report had been undertaken by KPMG and reported on at a previous Board meeting, which went in to greater detail regarding CIPs. Agreed CB to provide JL with copy of report. **CB**

- Joe Pajak referred to the e-Care report and the impressive steps taken as global digital exemplar. He asked whether there were any plans to extend further than Cambridge hospitals with access to patient records, i.e. opticians etc. CB advised that the population health aim was to link with opticians and dentists, but was currently unfunded. SD advised of a wider system bid for interoperability to allow other hospitals to view records.

18/084 REVIEW OF AGENDA

The agenda was reviewed and there were no issues noted.

18/085 DECLARATION OF INTERESTS

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

18/086 MINUTES OF THE MEETING HELD ON 29 MARCH 2018

The minutes of the above meeting were agreed as a true and accurate record.

18/087 MATTERS ARISING ACTION SHEET

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

1475 – **Leadership Programme** – paper to be presented at June Board Meeting. **JBl**

1563 – **STF Bonus Decision** – item 18/092 (1) of today's agenda refers.

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

1547 – **Staffing & Productivity** - work remaining. Outcome to be in May Board finance report, having first been sighted by GN. CB to action. **CB**

1544 – **Pressure Ulcer RAG Rating** – RD stated that January had seen a high total number of pressure ulcers, of which a large proportion were avoidable. However, the green rating percentage did not demonstrate this. Agreed RP to provide a separate report on how the Trust undertakes RCAs for avoidable pressure ulcers and how they are tracked. RD requested that number of falls per bed day also be included. RP and RD to meet to discuss provision of this report. **RP/RD**

18/088 CHIEF EXECUTIVE'S REPORT

Noted Princess Anne had visited the Trust, as patron of the Royal College of Occupational Therapists, providing a great boost to staff.

Jeremy Hunt, Secretary of State for Health & Social Care, had made his first visit to West Suffolk yesterday, (26 April) and offered his congratulations on the Trust's Outstanding CQC rating. RP and NJ gave a presentation demonstrating the can do attitude of staff and achievements made in challenging times.

JBl thanked TR and the Comms Team for the work undertaken on both these visits.

The Every Heart Matters campaign had recently linked up with Park Run in Bury, along with Bury Beer Festival, offering free pulse checks. This is a great example of outreach; a link to health whilst raising charitable awareness.

Noted Quality Improvement Conference taking place at the Trust on 30 April.

CW asked if any feedback has been received following the recent increase in car parking charges. Noted no negative feedback received as yet via PALS, but the charges are yet to go live (1 May). The situation will be monitored. GN stated this would never be a popular decision but he had been encouraged by the way the Trust had reached out to the membership and should be proud of this engagement. The Board offered its thanks to TR and the governors for enabling.

DELIVER FOR TODAY

18/089 INTEGRATED QUALITY & PERFORMANCE REPORT

Noted ED performance is 3rd in the region for the month. Periods of activity in March were as busy as January and at times have reached physical capacity. Improvement plans continue and a Task & Finish Group has been convened to improve resilience performance. RP, NJ and AB will provide support and challenge to the department. AR asked, now that the pressure had eased, what were the major bottlenecks for the department. AB advised of a high level of attendances correlating to shift changes. RP is looking at flow to include GP streaming. AR asked for a prediction of the April position. AB anticipated an improvement over the past couple of weeks and an aggregate improvement; however challenges remain.

RD referred to Page 10 of the report and asked for the reason for the significant reduction in GP referrals. AB advised that work was to be done on referral patterns and work streams in order to manage demand. CB advised that in respect of the 2017 data, at the point of going live on e-Care, there had been some issues with RTT such as duplication of referrals/double counting.

GN referred to the ED 4 hour wait. Previous discussions had highlighted the fact that March would be the busiest month for volume and assurance was given that acuity would be less. However, the department seemed to have struggled. Was this due to a difference in acuity or a failure to plan ahead? RP advised that ECIST had reviewed the situation and, looking at 60 admissions, all were deemed appropriate; the level of acuity has been unprecedented. NJ advised that acuity in an emergency department can decrease as winter ends and springs begins, but acuity in the hospital remains as high as ever. SD advised that the planning and financial framework did not enable the Trust to build resilience to match surges, such as the “Beast from the East”. However plans will be put in place for next year together with additional capacity in order to avoid this year’s scenario.

CW referred to cancer patients and the fact that some would appear not to have been offered an operation date within 28 days. AB advised that there had been an element of patient cancellation and the Trust was working with the CCG to encourage attendance. The Trust had worked hard to keep cancer targets on track over the busy winter period. NJ advised that whilst the Trust was not delivering everything it wanted to, it was doing as much as possible. SC wished to record her thanks to the orthopaedic team for their tremendous work, motivation and drive during the busy period.

RP advised of an improvement in performance regarding pressure ulcers and that efforts were being made to understand apportionment as it was unclear whether any of these were acquired in the community. This has had an impact on lessons learned.

AR asked, in respect of CIPs and staff deployment, whether the Trust was under pressure to reduce nursing staff. RP gave an emphatic no, delivering safe care required appropriate staffing levels. Recruitment was the issue both at the Trust and in the community, not finances. Noted there is a national reduction in district nurse

training posts as well as availability of qualified nurses. JBL offered assurance to the Board of recruitment plans in place for both community and Trust nursing staff. HR directors and chief nurses across the region have met to discuss the challenges faced in the East of England. Noted London has a "capital nurse" working across the city and similar is being considered for the region via a working group. SC asked how this related to the workforce stream in the Trust's STP, as there was more than one STP in the east. JBl advised that this would be facilitated by Health Education England, who support the Local Workforce Action Boards so will have absolute connectivity with all the STPs.

RD referred to Page 42 of the report and complaint response time. The narrative suggests delays in receiving information are a reflection of the capacity within the PALs team. However, it is understood that these vacancies have been filled; did a capacity issue remain? RP advised it was not an issue within the team but the capacity of individuals required to respond to the matters raised during the recent period of high activity.

AE highlighted the falls section and the fact that the falls numbers quoted in the narrative did not correlate to the table. RP confirmed that this was an error and would be rectified. **RP**

GN agreed that fall numbers and staff deficits were of concern and was reassured by the plans in place. However, the Trust was running on the edge of an acceptable risk for both patients and staff. RP advised that workforce planning was under consideration. The CIP was being reviewed, together with bay base nursing, by increasing the number of nursing assistants who remain in the bay but reducing the number of registered nurses. This was trialled last year and continued on F3 (geriatric orthopaedic ward). This had been a success, with no hospital acquired pressure ulcers during that time. This issue was an executive priority and reported on a monthly basis. A further report will be made to the Board in May. NJ advised that the Trust was looking at alternatives to complete certain roles currently performed by doctors. Noted two Physician Associates have been employed, with a further three anticipated before the summer. Lauren Rottman, PA, is working with Jo Churchill, MP, to push for accreditation of the role.

AE asked for further discussion in respect of productivity and system as a whole. Agreed RTT recovery plan to be reported to Scrutiny Committee and Board (92% by Oct). **HB**

JBl wished to acknowledge the resilience of staff during these busy times, as witnessed by the sickness and attendance record.

18/090 WINTER 20187-18 REFLECTIONS

AB advised of the success of one particular initiative; safer support to go home within the ITT teams, resulting in an improvement in flow through the hospital. This, together with other initiatives, led to the Trust going into winter with a one day reduction in length of stay. However, demand is increasing. Key learning was that DTOC fluctuated significantly during winter, due predominantly to a delay in packages of care and social services assessments. At times the Trust was reactive rather than proactive in management of the system. The Trust also suffered from a lack of effective escalation ward planning, assumptions having been that an escalation ward would not be required. As a result G9 was used and staffed successfully, together with F4 a surgical orthopaedic ward; however, as a result of this 350 elective cases were cancelled. Planning for 18/19 and the winter to come, has shown that the Trust needs to focus on a system approach with all system partners coming together. Demand management is a key area of focus and frailty and respiratory are two key

elements within this. Via refurbishment there will be additional capacity on G3 and CCU. Also plans are in place for a new AAU for additional capacity. The Trust needs to ascertain what capacity is likely to be and how much of this is within the hospital or in the community.

SC said that whilst operating within one STP system, part of the Trust's work included Cambridgeshire, governed by another. RP advised that liaison with the CCG is required, as they, as the lead commissioner, will need to coordinate the other commissioners to engender movement. Noted some issues with border patients remaining in Trust beds whilst conversation had with their CCG.

CB advised that reductions in NHS funding resulted in a loss of resilience to cope with peaks in demand. The Trust would plan differently for next year, but could not cope with spikes in demand similar to this. It was a matter of a flexible response and reprioritisation. The IQPR was a reflection of this reprioritisation which happens at the point the Trust comes under pressure.

AR referred to the chart on page 4, 3.2, ED attendances - GP practice trends (WSCCG only) and the fact that West Suffolk was seeing more ED referrals from West Suffolk GP practices than East Suffolk. NJ advised that the CCG have recognised this and are talking to the practices. Analysis is being carried out of patients' distance by postcode to the ED in an effort to identify any particular practices. Also suggested that GP streaming at the Trust may be being utilised as a replacement for primary care.

RD said that with the importance of social care packages to winter planning were there risks locally from organisations providing care and if so, could the Trust mitigate against this? AB advised that the risks were not any higher than previously and the Trust was working proactively with the CCG to try and ensure any risks are minimised and mitigated. This conversation is ongoing with no conclusions reached as yet.

GN queried the Trust's inability to meet surges in capacity. In the early part of the year the Trust's demand was significantly below that of the previous year, but in the same period the monthly deficit was larger than at any point. He wished to understand the dynamic between spikes in demand and cost, as the deficit did not seem as large in the Trust's most troubled and challenging months. Could he assume that ED with its struggles to maintain a service level was not actually a big driver of costs? CB responded that ED represented a very small proportion of costs; approximately 4% of expenditure, the bulk of which related to capacity and the fact it was open 24 hours a day and required staffing at all times for patient arrival.

SD advised that the exec team had discussed capacity issues and that this winter had seen a significant spike. There had been a poor experience with the winter escalation ward and the Trust should not have tried to cope without those plans in place. Visits are being made to care homes together with provision of a link worker. RD asked if any work had been done to look at mid-morning surges in system terms as he believed the way GPs worked had an effect on admissions. AB advised of a scheme in Norfolk that gives the hospital more control in the conveyance of patients to hospital.

The contents of the report were accepted and the Board gave their support of the approach currently being taken. Further updates will be provided.

18/091 ALLIANCE AND COMMUNITY SERVICES REPORT

DG advised that options were being progressed in respect of children in care initial assessments.

Paediatric speech and language waits for children between packages of care have seen a great improvement in the period, a result of pathway redesign and provision of additional resource.

DG reported that the Buurtzorg team have been invited to make a presentation at the national launch of community provider network in London on 10 May. RD referred to difficulties experienced in recruiting to the Buurtzorg team and asked whether, due to the short pilot period, this presented a risk. Noted the trial will continue until the month end. It has been surprising not to have received more interest from district nurses, but it was thought people were watching and waiting, together with some uncertainty as to what role they would return to once the trial was over.

GN asked for clarification in relation to point 7.4.1, maintenance of waiting times and the requirement for an additional 14.5 FTE. He asked if it was part of the plan and if the Trust was actively seeking to recruit and whether it been budgeted for. DG advised that the Trust was not actively seeking to recruit. This was the ideal scenario to keep up with demand. The output of a review of the pathway with the county council and CCG was awaited. In the meantime temporary staff were being utilised.

AE asked about demonstrating the positive impact that the community work was having on the overall system. DG responded that the team was collecting a "story book", with case examples and quotes from staff to be shared with Comms.

The report was accepted and the recommendation contained within 7.7.1 was agreed by the Board.

It was further agreed that for future Open Board meetings the alliance and community services report would appear before the Integrated quality and performance report on the agenda. RJ to action. **RJ**

18/092 FINANCE AND WORKFORCE REPORT

1 **Finance and Workforce report**

CB advised that the organisation broke even last year, a loss of £300k on a turnover of £254million. March appeared unusual; referring to Page 3 of the Finance Report which detailed month by month performance, showing a surplus of £6million in March, after suffering a loss in each of the 11 months previously.

The position was a better performance than planned. Without the sustainability and transformation funding, the Trust had a deficit plan of £11.1million, but actually delivered a deficit of £9.9million. Noted the Trust received £700k from the CCG in March, a contribution to the KPMG report and to some costs in pathology.

Given that the Trust beat its control total where others didn't, it has received £5.3million in bonus money and this is what has driven the overall finance position. Before sustainability and transformation funding (STF), the Trust achieved a deficit of £9.9 million and received £9.6 million in total of STF for the year. This leaves a bottom line of £0.3million deficit. This is real cash and cash was of concern to CB as the Trust entered this financial year. The cash will be received sometime in June/July after finalisation of the year end accounts. There is a genuine benefit to the

organisation as a result of the financial performance delivered. CB wished to thank the finance department for submitting the accounts to the auditors three weeks after year end, a phenomenal achievement.

GN wished to acknowledge the Trust's performance. He asked if there were any potential issues that may be highlighted by the auditors. CB responded that there were significant estimates in the production of the accounts, but he was not taking any risks in the achievement of numbers. These accounts were produced on the same basis as they always were and there had not been any audit issues previously. Discussions have also taken place at the Audit Committee. The most significant estimate is the value of equipment out in the community.

AE referred to cash spend and the fact that a lot of time had been spent talking about CIPs. He wanted to ensure an appropriate balance in keeping an eye on the cash position. CB referred to the draft operational plan that was to be discussed in the Closed Board and the previous finance report. Cash is regularly mentioned and next year the Trust is not planning on receiving sustainability and transformation funding. The deficit is more significant and as such has a requirement for funding in cash. An organisation cannot make deficits without cash support.

AR suggested Page 4 of the report as the Trust's real achievement, i.e. attainment of nearly £14million worth of cost savings, £10millon of which are recurring. He asked if CB believed the momentum could continue. CB advised of an improvement in processes during the course of the financial year just ended. These were now firmly embedded. Savings had been delivered in the first month of year, to be reported next month. The Trust continues to develop new cost improvement ideas which are developed and then taken to RP and NJ for quality impact assessment. Such a meeting has already taken place in April.

2 **Mandatory Training Report**

JBL referred to Page 1 of the report and the two proposals to maintain performance;

1. Any staff member who is out of date with their mandatory training would be unable to apply for study leave until they become compliant.

2. Currently four different compliance targets for mandatory training. It is proposed that these be simplified to a standard of 90% for all subjects, apart from information governance which has a national target of 95%. SD asked if the Trust was setting itself up to fail with a target of 90%. It was agreed that this new target be trialled and then reviewed.

The Board duly accepted these proposals.

AE referred to the enabling of staff to complete mandatory training and the IT process currently available. JBl agreed that IT was a challenge and the OLM system not particularly user friendly; however it was free. Noted the Trust has invested in Articulate to improve the e-learning process. The Trust is looking at inter-authority transfers for staff who have completed their national mandatory training not having to repeat.

NJ suggested that in view of the poor performance of the OLM system it might be worthwhile sourcing an alternative. JBl advised that other organisations were utilising OLM and therefore it would be beneficial to review their performance. The matter will be discussed at the Mandatory Training Group.

AR asked how much of the training was Trust specific; could the STP play a role in

this. JBl advised that the HR directors across the region had attended a streamlining group, resulting in ten core mandatory training items to meet the national standards, in order to effect a seamless transfer of staff across the region.

Agreed JBl to undertake a review of the barriers to staff achieving mandatory training compliance (inc. IT and community) and set out options for improvement. **JBl**

3 **Appraisal Report**

Report noted. GN believed that application of a similar measure to mandatory training would aid in engagement with appraisal, i.e. no further study leave. JBl believed the best way of driving this forward was by discussion at performance meetings. Noted next year will see increased pressure to complete as incremental progression will be linked to appraisal. This remains high on the executive director agenda.

18/093 TRANSFORMATION REPORT

AB drew attention to Pathway 1 – support of patients whose needs can safely be met at home with re-ablement support. This will be very transformational to the way the Trust works, with a large amount of integration for the therapy team and potential for significant impact on flow delivery.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

18/094 NURSE STAFFING REPORT

RP advised that the highest levels of vacancies existed on in-patient wards, F7, G8 and F9. The plan to support these areas is via ongoing recruitment. Escalation beds will be closed together with closure of bays on these wards to accommodate and maintain flow. The Trust could be assured that staffing is reviewed on a daily basis to mitigate any staffing shortfalls. Plans are also in place for vacancies within the community.

18/095 GUARDIAN OF SAFEWORKING REPORT

NJ advised that Sarah Gull, the previous Guardian of Safeworking, has retired, having been replaced by Patricia Mills, who will attend the Board to present the report for Quarter 1, followed by an annual attendance.

RD enquired as to the situation with regards to a rest room for doctors at night. NJ advised that this situation had been resolved by use of MTU with recliner chairs, not required at night.

AE referred to the reluctance on the part of some junior doctors to bother the consultant on-call/ward consultant and asked if this was a cultural indicator. Noted this situation was improving and was one NJ was keeping an eye on.

18/096 VOLUNTARY SERVICES REPORT

Report received. SC advised how very impressed she had been with the volunteer service during a recent visit and encouraged the non-execs to do the same.

18/097 NATIONAL STAFF SURVEY REPORT

Following the recent survey, JBl advised that work was now being conducted on an action plan, to include wider environs than West Suffolk. HR directors across the region have been in discussion about common themes to enable joint working. One commonality was violence against staff, not solely from within the emergency department.

GN asked if there was a breakdown of trends on particular wards. JBl advised that reporting was by divisional staff group. Each division has been supplied with a copy of their report and through performance management meetings, action plans are being produced.

18/098 PUTTING YOU FIRST AWARD

Noted two awards being made:

1. Jo Russell, Community Respiratory Nurse, following a referral from a GP.
2. Alex Baldwin, Deputy Chief Operating Officer, nominated by a senior member of the nursing team.

18/099 CONSULTANT APPOINTMENT REPORT

Report noted.

BUILD A JOINED UP FUTURE

18/100 e-CARE REPORT

Report received.

GOVERNANCE

18/101 TRUST EXECUTIVE GROUP REPORT

CW referred to the General Data Protection Regulation (GDPR) and the risk around information mapping not being available for 25 May. CB confirmed that this has been flagged as a risk and the situation was being monitored.

18/102 USE OF TRUST SEAL

Report duly noted.

18/103 AGENDA ITEMS FOR NEXT MEETING

No items for the next agenda were noted.

ITEMS FOR INFORMATION

18/104 ANY OTHER BUSINESS

No further items of business were noted.

18/105 DATE OF NEXT MEETING

The next meeting would take place on Friday 25 May 2018 at 9.15am in the Northgate Room.

RESOLUTION TO MOVE TO CLOSED SESSION

18/106 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.

6. Matters arising action sheet

To ACCEPT updates on actions not covered elsewhere on the agenda

Presented by Sheila Childerhouse

Board of Directors – 25 May 2018

Agenda item:	Item 6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	18 May 2018			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

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

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

Actions are RAG rating as follows:

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

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

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

Previously considered by:	The Board received a monthly report of new, ongoing and closed actions.
Risk and assurance:	Failure effectively implement action agreed by the Board
Legislation, regulatory, equality, diversity and dignity implications	None

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1475	Open	29/9/17	Item 13	Develop a set of metrics which will provide an indication of the success of the leadership programme	Report in progress to be received at June meeting	JB	29/06/2018 (revised)	Green
1529	Open	26/1/18	Item 7	2018-19 winter planning update to be received by the Board (including learning from 2017-18)	Being developed as part of system based learning exercise. Agreed to consider 'big data' and e-Care population health as part of this work indicating a roadmap and timescales. Scheduled for May to include system learning from 2017-18 **Winter planning Board workshop taking place on 24 May. The outcome of this discussion will be written-up and reported to the Board**	HB	29/6/18 (revised)	Green
1555	Open	29/3/18	Item 2	The issue of an independent STP chair to be raised at the chairs meeting and Programme Board by Sheila and Steve respectively	To be addressed through the STP Board and chairs meetings. **Verbal update**	SC / SD	25/05/2018	Green
1566	Open	29/3/18	Item 18	Schedule a wider Board discussion on the e-Care (GDE) programme and future options/plans	Reviewing schedule for board and subcommittees	RJ	29/06/2018	Green
1574	Open	27/4/18	Item 16	Undertake a review of the barriers to staff achieving mandatory training compliance (inc. IT and community). Set out options for improvement.	Discussion of options to address barriers to take place at next mandatory training steering group. Update to be provided to the Board.	JB	27/07/2018	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1537	Open	26/1/18	Item 18	e-Care - schedule report on the findings of the patient portal pilot	**AGENDA ITEM**	CB	25/05/2018	Complete
1544	Open	2/3/18	Item 8	Agreed to amend the pressure ulcer RAG rating so that five avoidable PUs is the target	At meeting on 27/4 confirmed that further work to be undertaken on performance measure and reporting. Agreed Richard Davies to receive proposals for improved report **AGENDA ITEM (Quality and learning report – Q4)**	RP	25/05/2018 (revised)	Complete
1547	Open	2/3/18	Item 10	Agreed that Gary Norgate and Craig Black consider how to provide greater visibility of staffing and productivity within the finance report	Information sent to Gary Norgate and Gary incorporated into the finance report.	CB	25/05/2018	Complete
1556	Open	29/3/18	Item 7	Agreed to develop a recover 'glide path' for ED performance in the context of the work of the re-established Task & Finish Group.	**Part of IQPR**	RP / HB	25/05/2018	Complete
1557	Open	29/3/18	Item 7	Receive an update on the analysis for TEG regarding ethnicity breakdown for bullying and harassment data.	Information presented to the equality and diversity steering group, including good staff representation. Findings and action plan being progressed e.g. unconscious bias training. PEC schedule includes monitoring of progress.	JB	29/06/2018 (revised)	Complete
1559	Open	29/3/18	Item 7	Schedule a recruitment update for May meeting	Included with winter plans for 2018-19 as part of Board workshop (see action point 1529)	JB	25/05/2018	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1560	Open	29/3/18	Item 7	Develop a sensitivity analysis for activity planning to support elective programme and winter - to include assessment of staffing, capacity and financial impact	*[Links with actions 1529, 1561 and operational plan].* Request at meeting on 27/4 that this also includes community staffing and confirmed that these aspects will be drawn together for the May meeting**. AGENDA ITEM - RTT report and part of Board workshop (see action 1529)**	HB / CB (with JB / RP / NJ)	25/05/2018	Complete
1561	Open	29/3/18	Item 10	Operational plans for RTT recover to be developed which consider resource requirements, including financial impact	Part of Operational Plan **AGENDA ITEM - RTT report**	HB / CB	25/05/2018	Complete
1567	Open	29/3/18	Item 19	Include update on the West Suffolk Alliance strategy and delivery plan on the agenda of the next Board meeting	**AGENDA ITEM**	DG	25/05/2018	Complete
1571	Open	27/4/18	Item 8	RTT recovery plan to be reported to Scrutiny Committee and Board (92% by Oct)	**AGENDA ITEM - RTT report**	HB	25/05/2018	Complete
1572	Open	27/4/18	Item 8	Review data accuracy for narrative/tables re incidents and falls	Updated IQPR	RP	25/05/2018	Complete
1573	Open	27/4/18	Item 10	Move the Alliance and community services report further up the Board agenda schedule	Amended on agenda	RJ	25/05/2018	Complete

7. Chief Executive’s report

To ACCEPT a report on current issues from the Chief Executive

Presented by Stephen Dunn

Board of Directors – 25 May 2018

Agenda item:	7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	18 May 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

It was a pleasure to welcome the **Secretary of State for Health and Social Care** to our Trust at the end of April in order to hear about patient safety from a national perspective. In the NHS we're all passionate about patient safety – it's the bread and butter of what we do and why we're here, and it was a fantastic opportunity to highlight the work we're undertaking to continuously improve.

During his visit to the West Suffolk Hospital, the Rt Hon Jeremy Hunt MP commended staff for their efforts in achieving the Trust's latest 'outstanding' rating from the Care Quality Commission, and highlighted the "fantastic work" undertaken on their learning from deaths programme. After hearing about tools from electronic dashboards to new equipment and apps that WSFT is using to improve patient safety, Mr Hunt spoke candidly to staff about his own experience and journey of patient safety in the NHS. Mr Hunt discussed the role of the Care Quality Commission, performance, patient satisfaction, and the importance of listening to and acting on patient experiences, before taking questions from staff in the room.

Mr Hunt said: "I want to thank staff at West Suffolk Hospital for welcoming me so warmly. I was hugely impressed by their commitment to improving patient safety - in particular the push to ensure technology to benefit patients is used right across the Trust, whether through innovative apps or electronic records. It was fantastic to see the work they're doing on the learning from deaths programme - setting an example for the rest of the NHS to follow.
"Staff should be rightly proud of the outstanding rating from the CQC - and the rest of the NHS should take note of their commitment to improve beyond outstanding to 'world-leading'. Keep up the excellent work."

He also praised leaders and staff alike for securing the top spot in the recent NHS Staff Survey 2017, where WSFT came top in the country against comparable trusts for staff recommending the Trust as a place to work or receive care. He was then shown a demonstration of the Trust's new vital signs monitors by nurse and nursing informatics lead Ian Coe; these machines measure a patient's blood pressure, temperature, oxygen saturation and pulse and all other required parameters to enable immediate calculation of Early Warning Scores (EWS), which help to identify acutely unwell patients early. By scanning a barcode on the patient's wrist, these readings are then placed directly into the patient's electronic care record, reducing the risk of human error and saving time from data having to be inputted manually.

As part of our ongoing integration journey I am delighted that senior matron Sharon Basson has been appointed to a new role, as **head of nursing with integrated services**, a division of the Trust that brings together community and hospital services. Trained at the West Suffolk, Sharon has a wide variety of experience, including as a community nurse with the Victoria and Mount Farm GP surgeries in Bury. She has worked in commissioning as part of the continuing health care team, in discharge planning at the hospital and for the past two years as senior matron. As the integration of services across west Suffolk continues, Sharon has been closely involved with community services, including the setting up of Glastonbury Court; and working with community teams and specialists. She has also been instrumental in setting up the neighbourhood nursing and care team, based on the Buurtzorg model, a community service currently being tested in the area.

Nursing recruitment pressures are being felt at the Trust – recruitment is a national problem – with nearly 90 registered nurse vacancies at West Suffolk Hospital. The Trust is not only carrying out overseas recruitment but is also trying to attract more people to nursing through welcome and retention initiatives, as well as return to nursing and recommend a friend schemes. Our first three Filipino nurses will join us in July with a further 45 expected to join before Christmas (subject to meeting NMC requirements). We have a further visit to the Philippines scheduled for July to support additional recruitment. In addition, we have identified 10 nursing assistants who are registered nurses in their own country and we are supporting them with UK registration.

We have also launched a new nursing apprenticeship scheme starting in September, we have received 84 applications for 13 posts. External candidates who fit the criteria but are unsuccessful will be offered nursing assistant posts with a view to future consideration. We're embarking on a recruitment programme, which is being supported by areas from across the Trust, to do what we can to show the nursing community why the west Suffolk is such a fantastic place for them to come and work. We'll also be supporting our pharmacy team, who have a number of vacancies. The team held a fantastic open day event last weekend to attract interest and really should be commended for their efforts.

April's performance shows we reported two C. difficile cases in the month. We continue to focus on reducing patient falls and pressure ulcers, with 68 falls and 5 pressure ulcers reported. Referral to treatment (RTT) performance for patients on an incomplete pathway increased to 90.38% against the target of 92%. Unfortunately we have reported 19 patients breaching 52 weeks. The year to date performance for all cancer targets is ahead of the national threshold at 96.7%. Emergency department 4 hour wait performance was 85.89 % for April, with demand remaining higher year on year.

The **month 1 financial position** reports a deficit of £1.8m which is £0.1m worse than planned. As the Trust has not agreed a control total no Sustainability and Transformation Funding (STF) is included within the position. The 2018-19 budgets include a cost improvement plan (CIP) of £9.4m and the overall planned deficit is £16.6m. The Trust is currently applying for the cash support from DH to support this revenue deficit and also the planned capital programme of £29.2m.

On 30 April we held our first ever **quality improvement (QI) conference**, to share good practice, innovation and ideas, to hear what quality improvement is (and is not!), and to learn the basics of QI. It was an opportunity to network with like-minded people, both from within our organisation and outside of the Trust, including clinical and non-clinical colleagues, representatives from the clinical commissioning group and other NHS trusts, and visitors from US Airforce Lakenheath. A day of learning, creativity and ideas, it was a brilliant first step in our proper quality improvement journey. It will no doubt be exciting to see what developments and innovations we see in the next year.

We continue on our journey as a **Global Digital Exemplar trust**; and have reached two years of e-Care already! I am so proud of all that has been achieved, and thank the entire e-Care team for their commitment and perseverance in implementing the various changes. Huge thanks must also go to all other staff that use e-Care; we know it's not always smooth, but your patience and testing as we go is so valuable. We are seeing real and positive outcomes for both staff and patients and there is so much more to come in the future.

Chief Executive blog
http://www.wsh.nhs.uk/News-room/news-posts/Very-important-people-visiting-our-very-important-Trust.aspx

Deliver for today

Dying Matters Awareness Week – 14 to 20 May
Over the course of the week, our end of life team has been raising awareness of dying, death and bereavement. From the South Suffolk Show at Ampton to Newmarket Hospital, West Suffolk College, Sudbury Health Centre and Bury St Edmunds town centre, the team was kept busy, chatting to visitors and providing vital support and information.

At West Suffolk Hospital, the week started with a presentation at Core Brief, where those attending learned more about our rotation scheme partnership with St Nicholas Hospice, how consultant cover has made significant improvements in meeting the needs of our patients, and how the end of life team promotes cornea donation sensitively and professionally. There was also an opportunity to highlight our volunteer ward companions and officially launch the new 'blue ribbon' scheme (see below).

Blue ribbon patients
On 14 May the Trust launched a three-month trial of the 'blue ribbon' scheme. The aim of this scheme is to prevent multiple ward moves for patients identified as inappropriate for transfer, to help make them more comfortable at the end of their life. The scheme is explained to the patient and their family so that they understand that they will not be moved to another ward, unless under exceptional circumstances and agreed with the senior manager on call. The blue ribbon will be marked in the capacity management application and patients, who are identified by the palliative care team and reviewed daily, will have a blue ribbon symbol at their bedside.

Invest in quality, staff and clinical leadership

The Trust came together on 11 May in honour of International Nurses Day 2018
The day marks an international celebration held around the world on 12 May each year; on the anniversary of Florence Nightingale's birthday, the traditional founder of modern nursing. We were delighted to host a visit from Jo Churchill, MP, who spent the morning shadowing Maddie O'Brien, endoscopy department sister and RCN representative, who has worked in the NHS since 1983. Maddie said: "Being a nurse is a privilege and an honour. My patients place their trust in me and allow me into their lives so they can talk openly and I can support them." Jo also met Helen Beard, head of nursing surgery and acute medicine, who showed Jo a photo of herself on the Trust memory walk from 1990, then welcomed Jo to the matron's office, where staff were invited to drop-in all day for tea and cake.

International Day of the Midwife - Saturday 5 May
Our midwives were at the Arc shopping centre in Bury St Edmunds last Saturday to let people know what it's really like to be a midwife, and to show what a brilliant service they provide, both at West Suffolk Hospital and in the community. This was all part of the celebrations for International Day of the Midwife on Saturday, 5 May. The stall gave the public an opportunity to speak to our midwives, see the plans for the labour suite refurbishment and receive breast feeding support.

Build a joined-up future

Diabetes prevention week - 16 - 22 April

For diabetes prevention week this year the diabetes team proactively supported our patients to prevent the onset of Type 2 diabetes. However, we all need to look after our own health too!

Type 2 diabetes facts:

- Around 60% of cases of type 2 diabetes can be delayed or prevented by making lifestyle changes

- Type 2 diabetes can lead to stroke, blindness, heart disease, kidney failure, limb amputation and early death
- In our 2017 national diabetes inpatient audit around one in six patients at West Suffolk Hospital had diabetes
- Approximately 90% of these patients had type 2 diabetes.

Spending less time sitting down and more time being active is key to preventing type 2 diabetes. Having a healthy balanced diet can help reduce your risk of type 2 diabetes.

National news

Deliver for today

Partial knee replacements may be better for patients and cheaper for NHS
Partial knee replacements may be better for some patients than total knee replacement and could help the NHS save money, according to new research supported by the NIHR. Partial replacement procedure is less invasive, allows for a faster recovery, carries less post-operative risks and provides better function. It is also a cheaper intervention for the NHS, in both the short and long term. NIHR.

Creative and cultural activities and wellbeing in later life
This report from Age UK outlines the importance of participating in creative and cultural activities to maintain wellbeing as we get older. The research identifies the key factors that enable participation and enjoyment of cultural activities and those that present barriers to participation.

NHS England pledges specialist mental health services for new mums in every part of the country
NHS England has confirmed that new and expectant mums will be able access specialist perinatal mental health community services in every part of the country by April next year.
The health service is now spending £23 million rolling out the second wave of community perinatal services to underserved parts of the country and is on course to achieve full geographical coverage, when as recently as 2014 it was estimated that only 3% of the country had good access to perinatal mental health care.

Invest in quality, staff and clinical leadership

Freedom to Speak Up: guidance for NHS trust and NHS Foundation trust boards
This sets out the expectations of NHS Improvement of boards and board members in relation to Freedom to Speak Up and presents a new self-review tool. “We want all trust boards in England to use the self-review tool to identify areas for development and improve the effectiveness of their leadership and governance arrangements in relation to Freedom to Speak Up.”

The Lord Darzi Review of Health and Care: Interim Report
The independent Lord Darzi Review aims to examine the state of quality in health and care services on the NHS’s 70th birthday and make recommendations for future funding and reform of the system. Launched in December 2017, the Lord Darzi Review is aiming to:

1. Examine the quality – meaning safety, effectiveness, timeliness, efficiency and equitability – of care in the NHS and social care service today.
2. Establish the funding settlement and reforms needed to drive improvements in the quality of care in the coming decade.

This interim report of the Lord Darzi Review of Health presents evidence in preparation for the final report which will be published in the lead up to 70th anniversary of the NHS and will set out a long term funding and reform plan for health and care.

Utilising the skills of the clinical pharmacist within the MDT for improved medicines optimisation

The Carter Report (2016) recommended that NHS trusts deploy more clinical pharmacists, including pharmacist prescribers, and use them to drive value from the £6.7bn that NHS hospitals spends on medicines every year. At Western Sussex NHS Trust pharmacists have been integrated into the MDT at ward level. This ensures the skills of clinical pharmacists are utilised to support decision making at the point of prescribing. Interventions made during the ward round have been recorded, collated and reported to show the added value of including clinical pharmacists (both prescribing and non-prescribing). NICE Shared Learning database

Build a joined-up future

Plans to strengthen NHS cyber security announced

A new deal with Microsoft will ensure that all health and care organisations are using the latest Windows 10 software with up-to-date security settings to help prevent cyber-attacks. Since 2017 the government has invested £60 million to address cyber security weaknesses. A further £150 million will be spent over the next 3 years to improve the NHS's resilience against attacks. This will include setting up a new digital security operations centre to prevent, detect and respond to incidents. GOV.UK

Jeremy Hunt talks about 10-year plan for the NHS

In an exclusive article with the Health Service Journal, Secretary of State for Health and Social Care Jeremy Hunt has revealed his top priorities for the forthcoming 'long term plan' for the NHS. Mr Hunt said the plan, which has been promised by the prime minister for the NHS's 70th birthday, should include "full integration of the health and social care system". He also said that over the 10 year plan period, the NHS will need to become "massively more teched up" and identify "really big efficiency improvements". He said that meeting core performance targets, such as those for waiting in emergency departments and for planned operations, will be an "early milestone" for the NHS in the long-term plan.

Mental health "game-changer" care leads to 75 per cent reduction in hospital admissions

Improved mental health care for patients with physical ailments has reduced demand for GP appointments and cut hospital admissions by 75% in a pilot scheme as part of a programme of new services that NHS England is rolling out across the country. Since 2016, the NHS has begun testing new services which integrate mental and physical treatments, as part of its Improving Access to Talking Therapies programme. People with long-term health issues like diabetes, heart problems or respiratory illness are now routinely given a 'whole-person assessment', focusing on what additional mental health care they may need to manage their condition.

Main estimates: Government spending plans for 2018-19

This briefing discusses Parliament's approval of the Government's spending plans. It includes a summary of each government department's spending plans for 2018/19. Public spending overall (including that within Estimates) in 2018-19 is forecast to be 1.9% higher than in 2017-18, rising from £797.4 billion in 2017-18 to £812.9 billion in 2018-19. Day-to-day spending on health is up by £2.2 billion (+1.8%). Commons Library Briefing Papers.

1st Joint Report of the Education and Health and Social Care Committees

The government's Green Paper on mental health: Failing a generation.
Commons Library Briefing Papers.

Tackling obesity – what the UK can learn from other countries

This latest report from 2020 Health argues that the UK still lacks a strategic response to obesity and observes that a strong and mandated central policy, supporting bold, holistic, local action is still needed to impact what is arguably the greatest health challenge of the 21st century.

Spending on and availability of health care resources: how does the UK compare to other countries?

This briefing, from the King's fund, focusses on a small number of key resources – staff, beds, equipment and medicines – using data from the Organisation for Economic Co-operation and Development (OECD).

9:35 DELIVER FOR TODAY

8. Alliance and community services report

To RECEIVE update

Presented by Nick Jenkins

Trust Open Board Meeting - 25 May 2018

Agenda item:	8			
Presented by:	Nick Jenkins, Executive Medical Director			
Prepared by:	Dawn Godbold, Director of Integration and Community Services			
Date prepared:	15/05/2018			
Subject:	Community Services and West Alliance update			
Purpose:	x	For information		For approval

Executive summary:

Work to progress integration internally between acute and community services, and externally across the system is progressing well. There continues to be a large amount of enthusiasm and good engagement from all parts of the system.

Main Points:

This paper describes the progress being made on:

- Integration between acute and community services
- Development of the West Suffolk Alliance
- Production of the West Suffolk Alliance Strategy document.
- Development of the delivery plan to accompany the strategy

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 and receipt of the West Suffolk Alliance Strategy document	

Community Services and Alliance Update

West Suffolk NHS Foundation Trust Board

25th May 2018

1.0 Introduction

1.1 The work on both integration between acute and community services and development of the Alliance for the west of Suffolk is progressing well. The newly created post of Head of Nursing for Integrated Services has been successfully recruited to. This further re-enforces the commitment to fully embrace community nursing into the Trust.

1.2 This paper describes the progress being made on:

- Integration between acute and community services
- Development of the West Suffolk Alliance
- Development of the Alliance strategy document

2.0 Acute and Community Integration

2.1 Since the transfer on the 1st April 2018 of the therapy services from the clinical support services division to the community structure, operational benefits continue to be realised, for example:

- The budget for pulmonary rehab will now be moved to sit under Integrated Therapies which is where the staff are, therefore reducing recharges between cost centres. This also gives the flexibility of pulling from a wider pool of respiratory staff that can cover for pulmonary rehab which will improve resilience of the smaller community team.
- Future plan when Pulmonary Rehabilitation service is at full establishment for oxygen assessments to be done at the same time as patients doing a pulmonary rehab programme. This will be a much more efficient way of working and mean the respiratory nurses can focus on more urgent work.
- Joint education talks have started being delivered by the lead COPD nurse (community) and the lead respiratory physio (acute).
- "My COPD" app is now launched and our first patient recruited. This is a joint venture between COPD and PR with joint acute and community clinical leads. This will ensure that **ward patients and community patients** can benefit from this initiative, so covering all patients across the system.
- An acute funded community respiratory nurse is now recruited to. This will improve the link between acute and community staff and pathways. The post holder will review respiratory patients in the hospital which will support earlier discharge from the ward.

2.2 The clinical element of the wheelchair service also transferred into the Trust on 1st April 2018 and are realising the benefits of:

- Improved professional advice and guidance for community staff
- Acute staff are receiving training from community wheelchair staff on provision of wheelchair pressure relieving cushions, these acute staff will then train other acute staff in house
- Acute therapy leads for neurology, surgery and medicine all spending time in the community wheelchair clinic

2.3 The joint work with the County Council to enable therapists from both sectors to order core equipment on behalf of the other is progressing well. The pressure care training and walking aid training has now started and social care staff will soon be able to get their walking aid competencies signed off by the health teams

2.4 A workshop has been facilitated by NHS Elect to develop a plan for joining the hospital and community I.V therapy services into one service.

2.5 System-wide Trusted Assessment project:

- Community staff are now accessing Care First 6, the social care record.
- The policy and privacy impact assessment are out for approval.
- Trusted assessor roles are being scoped for possible use within the discharge planning team.

2.6 System-wide falls pathway review:

- A system-wide falls steering group and operation group have been set up
- “Personalise my Zimmer” is being planned for roll-out into care homes

2.7 System-wide integrated therapy strategy development:

- Workshops have taken place with clinical leads to develop priorities

2.8 Case example of integrated working from Mildenhall/Brandon:

Arthur is an 84 year old gentleman with Parkinson Disease and lives with his wife at home. He is one of our most prolific ‘fallers’. The priority for both he and his wife is to remain as independent as possible and at the moment they will not consider 24 hour care.

The community health Occupational Therapist has worked closely with the County Council Community Care Practitioner trialling extensive variations of equipment to aid safety. Both therapists have also worked closely with the domiciliary carer’s.

Many joint visits occur regularly to keep Arthur safe at home. The Community Matron is also now involved.

When asked how integration had changed the way this situation is being managed the team responded with:

"I think proximity is probably the key, it definitely enhances informal conversations – but in particular the ability to discuss more complex issues far more quickly. For example, straight away on return from seeing the patient and therefore not having to call into a call centre or find the relevant person, it is easier to arrange suitable times to meet with the patient together. (We've got both the diaries there!)".

3.0 I.T Progress

3.1 The trusted assessment project has linked into the GDE work to help inform the system wide strategy for I.T.

3.2 There is a priorities paper being drafted to review SystmOne and how this is used alongside other I.T systems to enable locality working in the integrated neighbourhood teams.

3.3 SystmOne management group has been set up formally with an operational and strategic element.

3.4 The West Alliance Community I.T Team are currently configuring and testing access to the West Suffolk Hospital Cerner HIE Interface. Having access to the HIE would enable community staff to view important clinical information from patients previous visits to West Suffolk Hospital. In the future any clinical notes from patients encounters at Addenbrookes Hospital will be added to the HIE view.

4.0 Buurtzorg Test and Learn Update

4.1 The Buurtzorg Test and Learn went live at the beginning of March 2018. The Test and Learn will run for 12 months, during which time work will be undertaken to understand how the model could be replicated at scale.

4.2 Members of the team were asked to present at the national launch of the Community Providers Network in London on 10th May. The presentation was well received and prompted lots of lively debate about funding, model criteria, challenges of scale and benefits of joint working.

5.0 West Suffolk Alliance Development

5.1 The newly established System Executive Group continues to meet monthly. The group brings together system leaders from all Alliance partners, the CCG and the Borough Council. To reflect its system wide remit, the group has now amended its membership to include key partners from the hospice and Health Watch Suffolk

5.2 The group reviewed the latest version of the strategy document. This was also presented to the ICS project board as was well received. The document was submitted to the STP board on 11th May and is enclosed as **Appendix 1**.

5.3 Work has commenced on the delivery plan that will accompany the strategy document. The delivery plan will contain key milestones and timescales for each of the ambitions and actins set out in the strategy. The delivery plan will be submitted to the ICS project board at the end of June.

5.4 Each locality (six) will develop its own local plan and agree its priorities, which will then be brought together into one overarching delivery plan.

5.5 A series of roadshow type meetings are being arranged for the summer between the CEO and our community staff to start this discussion. A series of similar meetings are being arranged for primary care to improve engagement and increase involvement of GP's in Alliance discussions.

West Suffolk Alliance Strategy 2018-2023

All about people and places

May 2018 - Edition 1

Introduction

In September 2016 health and care partners formed the West Suffolk Alliance. We have committed to work together to improve the health and care system in West Suffolk for all people whether they be a child, part of a family or a single adult. Our belief is that by working together in an Alliance we can have an impact on wellbeing, care and physical and mental health outcomes for people.

Our focus within the Alliance is on **people and places.**

The strategy for our Alliance is to move from working as individual organisations towards being a fully integrated single system, with a shared vision, clear local priorities, able to both provide an improved service for people in West Suffolk and also to tackle the sustainability issues faced by the system together.

Delivery of our strategy is a critical element of the wider Suffolk and North East Essex Sustainability and Transformation Partnership Plan.

We have developed four interrelated ambitions. These demonstrate how as Alliance partners we will make progress together. They do not displace our own organisational priorities, but rather show the added value from Alliance working. This strategy is backed up with a Five Year Delivery Plan.

This strategy consolidates the development work across the health and care system that has taken place since the Health and Care Review in 2014. It is based on consultation and engagement sessions where we have spoken to local people about what matters to them and their families. Our commitment to coproduction will mean that as we develop our plans further we will work with people and staff to get their input both on the direction of travel and on specific changes that might be proposed.

West Suffolk Alliance members

Suffolk County Council (in particular Adult and Community Services, and Health, Wellbeing and Children and Young People Services)

West Suffolk Foundation Trust (hospital and community health provision)

The Suffolk GP Federation

Norfolk and Suffolk Foundation Trust (mental health services)

Working closely with the **West Suffolk Clinical Commissioning Group**

The Alliance sees the partnership with the Ipswich and East Alliance, and with wider stakeholders as crucial, including District and Boroughs, the Ambulance Service, independent care providers and the voluntary and community sector, employers, education providers and business.

West Suffolk in numbers

1 hospital - West Suffolk Hospital

24 GP surgeries

30 health beds in community

4 health centres

49 care homes

1 hospice

1 inpatient mental health unit

29 Home care providers registered in west Suffolk

3 District and Borough Councils

Over **2,000** voluntary and community groups

6 Integrated Neighbourhood Teams /Connect sites

West Suffolk population is **227,800**

2016 ONS estimate

89 schools

What are the big challenges for people in West Suffolk?

The health and wellbeing gap

Overall the population of West Suffolk is generally healthy with high life expectancy.[1] However, it is estimated that 1 in 6 adults smoke,[2] 6.7% of people have diabetes, nearly 10% of adults have a Body Mass Index of 30 or over, and there is much higher incidence of osteoporosis than in England as a whole.[3] These factors have a significant impact on wellbeing and health, incidence of disease and healthy life expectancy.

The care and quality gap

The challenge in West Suffolk is from a combination of the forecast rise in population (11.6% between 2017 and 2037)[4] and the anticipated larger proportion of residents who have multiple long term conditions including dementia. For example the number of people living with dementia is likely to almost double in the next 20 years and most of these new cases will be in people aged over 85. The system will need to be responsive to the changing demographics of West Suffolk over the next 20 years.

The funding and efficiency gap

It is imperative that the Alliance works collaboratively to develop new models of health and care. Current arrangements will not address the rising needs for services, and the associated costs of these. Nor will they deal with the anticipated reduction in the ratio of working to non-working people and the impact on both our workforce and the numbers of people that will require health and care provision.

> ***Our staff are critical for getting moving - they care about services for people in West Suffolk, and they know what needs to be fixed. We must harness that knowledge and passion.***
>
> **Dr Stephen Dunn**
> Chief Executive, West Suffolk Foundation Trust

[1] http://webarchive.nationalarchives.gov.uk/20160109203331/http:/www.ons.gov.uk/ons/dcp171776_356961.pdf
[2] https://www.gov.uk/government/publications/smoking-and-tobacco-applying-all-our-health/smoking-and-tobacco-applying-all-our-health
[3] https://fingertips.phe.org.uk/profile/prevalence/data#page/1/gid/1938132820/pat/46/par/E39000031/ati/152/are/E38000204/iid/90443/age/239/sex/4
[4] https://www.healthysuffolk.org.uk/uploads/Population_Projections_FINAL.pdf

What are the assets and opportunities for West Suffolk?

West Suffolk has many assets and opportunities to help overcome these challenges and enable delivery of our vision:

- Our towns and villages have many vibrant community and voluntary sector organisations who provide invaluable activities and services and work actively with us and our local authority partners.
- We have excellent clinical and professional leaders and staff in all of our organisations who are increasingly working together.
- We have a strong track record in working in partnership - across organisations and most importantly with patients to make services better whilst managing costs and cutting waste.
- Communities and politicians are in support of retaining and building services locally.

CQC rate the quality of our health and care services as good, in many areas outstanding, and there is a clear plan for services which need improvement.

- West Suffolk Hospital is rated as 'outstanding.'
- 22 GP practices are rated 'good' and the other 2 are rated 'outstanding.'
- SCC Children's Services are rated good in all aspects.
- Over 80% of our care homes and home care services are rated 'good' or 'outstanding.'
- Mental health services require improvement and are working with partners to deliver agreed improvements and explore future service models.
- Special Education Needs and Disability services for children and young people were rated as 'inadequate' but are now recognised by the Department for Education and Ofsted as making good progress.
- 87% of schools in Suffolk are judged 'good' or 'outstanding' by Ofsted.

"Mrs Proctor was full of praise for the carers she had when she came out of hospital. She said they went over and above to support her recovery. One of them came to her in the snow at 10.00pm at night. She felt she could not fault the care they gave."

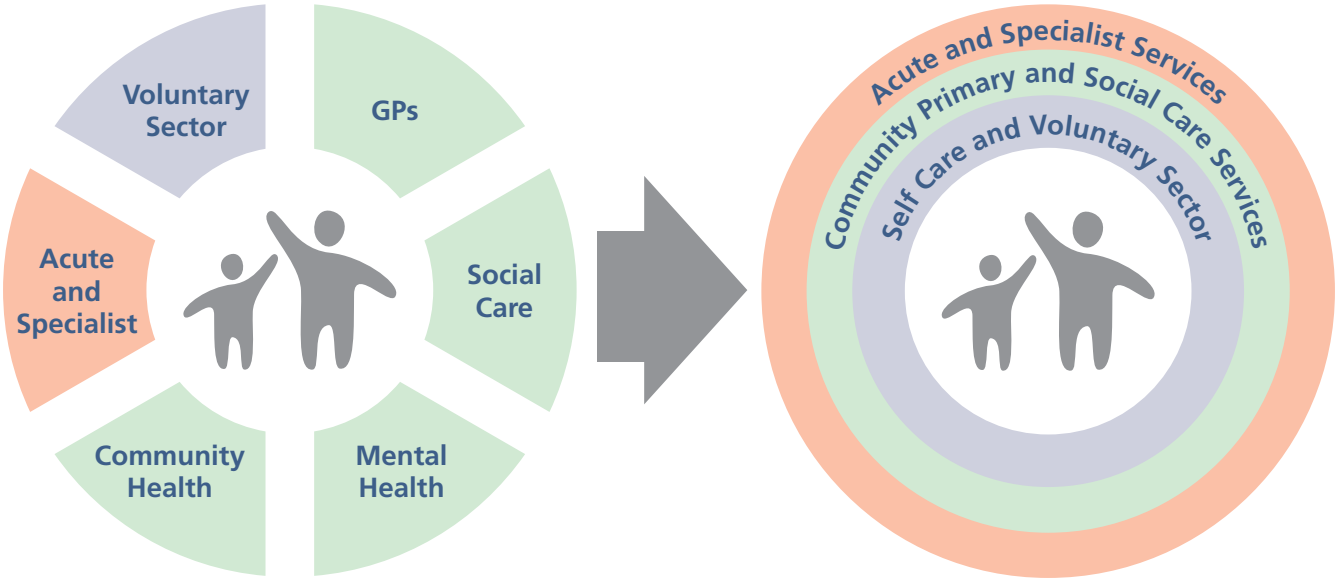
"Walter wrote to thank the Brandon Community Healthcare Team for all the care and attention they had given him. It had been difficult at times, but the family has come through and the team are brilliant."

A key relationship for us is with the Sustainability and Transformation Partnership, as we are delivering large elements of their programme.

Pete Devlin
Operations Director, Suffolk, Norfolk and Suffolk Foundation Trust

Our vision

Co-ordinating services around the individual - so that if feels like one service



From this

'I have to tell my story multiple times to different people.'

'I'm left waiting for services whilst they argue over who pays.'

'I don't get a say in my treatment.'

'When I'm discharged from a service, I'm not sure where to go next.'

To this

'I completed an integrated care plan, setting out who will provide care and support to me and when.'

'I receive more care in or near to my home, and haven't been to hospital for ages.'

'I feel fully supported to manage my own conditions and live independently.'

Joining up services around the needs of people

Case Study: Why taking a co-ordinated approach is important

The Alliance has committed to joining up services around the needs of people. This case example shows how we need to work better with partner agencies to support people to stay well and living in their own communities. The case study highlights that individuals with complex needs require coordinated input and support from system partners. At times this can be difficult to achieve, particularly when people do not want to engage with services. However, it is important that we commit to this coordinated approach as fragmented care impacts individual quality of life and makes additional demand on the services offered by system partners.

Mark is in his early twenties and has a diagnosed mild learning disability. He was admitted to a specialist hospital placement after concerns about his challenging behaviour and contact with the criminal justice system.

His stay in hospital was for over a year and whilst in hospital there were problems with aggression towards staff and damage to property. During the admission Mark was also diagnosed with a personality disorder. Mark was assessed as having capacity to consent to his care and support plan. As risk and challenge increased, the level and intensity of support was increased. Eventually Mark had two people to support him 24 hours a day.

Despite having this intensive support there were multiple serious incidents of self harm, aggression to staff and involvement with criminal justice and multiple safeguarding referrals. After an assault on a staff member that led to Mark's arrest, the support provider withdrew their service due to the level of risk he posed to staff members.

Mark has continually refused help from Mental Health Services, and does not engage with any support or treatment offered. Attempts to refer Mark to specialist residential placements have been unsuccessful either because providers are worried about risk or because he will not engage.

As a result of the assault and the offending committed whilst in receipt of 2 to 1 support Mark received a custodial sentence and is now in prison. Social care staff are working with colleagues across the mental health trust, probation and the clinical commissioning group to consider next steps and plan for prison discharge. There is also a need to look at the skills and capacity of our provider sector require to support people with behaviour that challenges services and who pose a risk to themselves and others.

Connect

The Connect programme is central to the delivery of our strategy - **All about people and places.** People's health and wellbeing are influenced by a large number of factors. The Connect programme aims to harness the statutory, voluntary and community sectors to work together to develop a co-ordinated approach in our localities, to improve the health and wellbeing of individuals and communities. We already have many examples of joint working, for example with the District and Borough Councils, with the police force and with local community organisations but we plan to focus on this much more during the following year.

Integrated Neighbourhood Teams are a core element within each Connect area and work across a defined group of GP practices. They are made up of health and care staff, and will provide co-ordinated joined up care for people and proactive support for those most at risk of deteriorating health. INTs have been established in **Haverhill, Bury Town, Bury Rural, Sudbury** and **Mildenhall,** with a team in **Newmarket** to be developed. There are of course strong links to specialist provision, and to the local and regional hospital network, but the aim is to pull in more and more specialist support through the INT so that people can be supported to manage their health and care needs in their own homes, in their local community.

Case study -
Mildenhall Integrated Neighbourhood Team

Collaborating and working in an Alliance way

"It's brilliant sitting next to community health Occupational Therapists. I can pop over and talk to them instead of making referrals. The person we are working with gets a much better service."

Suffolk County Council Home First OT

The development of the Integrated Neighbourhood Teams (INT) is a key feature of model in West Suffolk. In Mildenhall the health and social care team are now co-located and have been working closely together over the past six months to develop a shared approach to their caseload through implementing trusted assessment and care coordination.

The health and social care therapists, nurses and Home First teams now work more closely holding weekly Multi-Disciplinary Team reviews of their caseloads ensuring the care to the individual is coordinated and without duplication. The INT work in Mildenhall will now move on to focus on bringing shared access to the two main IT systems and how equipment budgets can be aligned.

Staff have embraced the ideas of Freedom to Act and Freedom to Speak Up and we have added Freedom to Integrate in order to support our teams to work more collaboratively.

As Alliance partners we have agreed the following values:

We will:

- Focus on **people and places** in West Suffolk integrating services around people's homes, neighbourhoods and communities. We will give priority to what works for families, individuals and communities and will be bold and ambitious about what can be achieved.
- Create a **financially sustainable system** through managing demand differently and through committing to using the West Suffolk pound in the best way locally, reducing duplication and waste.
- Address **health inequalities** across West Suffolk focusing on prevention, accessibility, integration, effectiveness and sustainability of services to ensure that existing health inequalities in West Suffolk are reduced.
- Strive for the **best quality services** based on the outcomes we have agreed, within the resources available.
- Design things together and **collaborate** working with people, communities and partner organisations in West Suffolk. We will agree collectively how we do things so that we only do them once and support each other through change as our organisations adapt, building trust and having frank and honest discussions when needed.
- Be **innovative** redesigning our services using the experience of people and front line staff, and looking at national and international evidence. We will coproduce our changes designing effective and integrated services which meet people's needs.

This is about evolution, not revolution - learning what we can do together, and making sure the budgets we each hold support doing the right thing clinically and professionally.

Dr Nick Jenkins
Medical Director, West Suffolk Foundation Trust

Our commitment is to deliver the following four interconnecting ambitions. Action on these ambitions is taking us from where we are now to where we want to be in 2023.

1. Strengthening the support for people to stay well and manage their wellbeing and health in their communities

Building local integrated working, across all ages and across both physical and mental health.

2. Focusing with individuals on their needs and goals

Looking at how we co-ordinate services to help people of all ages keep well, get well and stay well.

3. Changing both the way we work together and how services are configured …

… so that health and care services are sustainable into the future and work well for people.

4. Making effective use of resources

We will use the West Suffolk pound in the best way locally, reducing duplication and waste. All our organisations face challenging finances and if we work together we can use our resources better.

We strongly believe that working as an Alliance will lead to better services for people in West Suffolk.

Allan Cadzow
Director for Children and Young People, Suffolk County Council

Ambition 1 - Strengthening the support for people to stay well and manage their wellbeing and health in their communities

Our future vision

We want to reduce health inequalities and keep people healthy at home by treating them earlier. We want to stop people from becoming unwell by giving them the right support close to home, with hospitals only needed for specialist care. Our communities should be safe and healthy and should support wellbeing and prevent ill health, alongside a health and care system that is organised with an increased focus on prevention.

We want to provide more integrated services, driving efficiency and high quality care. This requires local leadership and a willingness to work across all aspects of our systems to do what is right for people of all ages and with both physical and mental health.

Our partners are keen to play a full part in the delivery of this Strategy and we recognise the critical importance and range of the opportunities they bring.

Action we are taking to achieve this

1. We are introducing different ways of working that help people to manage health and care problems earlier. For example, through proactive risk stratification and follow through, good information and advice and care co-ordination. We also want expertise, experience and efficiencies to be shared widely so that everyone in West Suffolk can benefit equally from the same high standards of specialist care.

2. We are developing local integrated teams so that people's whole needs are looked after rather than each element in isolation. We want GPs, social work staff, nurses and other health professionals, the voluntary sector and others to work together to co-ordinate and deliver care locally.

3. We are exploring how we can jointly deliver short term care to people in a crisis that gives them the help they need to stay out of hospital and long term care.

4. Our teams will be given opportunity to innovate and set priorities for change, with local leadership to bring together all elements of our system to work together, and transform services so that they meet local need. We see the engagement of GPs as critical in making this a success.

5. We recognise the wider influences on wellbeing and health - environment, infrastructure, housing, education and employment. The Alliance will work with the private, voluntary and wider public sector to ensure that our communities can thrive.

Ambition 1 - Strengthening the support for people to stay well and manage their wellbeing and health in their communities

Case Study: Partnership working in Haverhill

The LifeLink project in Haverhill addresses social needs by equipping individuals and families with the tools they need to become more resilient and address their current issues. In addition it provides a space for people to build new relationships and support networks through connecting people - linking lives together.

To date the LifeLink Coordinators have worked with 95 individuals/families helping and providing them with a space to talk through their current situation, needs, interests and aspirations. Both coordinators are trained in coaching techniques, allowing the participant to lead the conversation and realise their own solutions. The LifeLink Coordinators simply listen, ask the right questions and then support them in accessing certain groups, support services and provision.

We have seen very quickly the positive impact this is having on the lives of participants and their loved ones, with a clear uplift in emotional wellbeing and connectivity within the town. We have invested in a wider evaluation with a focus on a reduction on reliance on GP services and prescription drugs, this data will take longer to collate, however some participants have indicated that they no longer feel the need to see their GP or take antidepressants.

It became very clear that social prescribing can support an individual's journey back into employment or volunteering. We therefore teamed up with Department of Work and Pensions and Suffolk County Council Skills Department and rolled out Moving Towards Work with the understanding that this would sit alongside LifeLink to support those furthest from the labour market. A lot of learning has come from this collaboration which will be applied to future endeavours. Partnership working has been key to the success of this project to date and will continue to be at the centre of how we continue to develop this project within Haverhill.

The first twelve months

- We will build our Connect programme across all six localities, setting up locality delivery groups, embedding the locality lead role, with shared decision making, plan with local priorities and common data set.
- Develop new volunteer roles in the community through the Helpforce programme
- Continue to roll out the Making Every Contact Count programme
- Understand who is most at risk from poor health and health crisis and target support to keep them well.
- Develop the SEND local offer so that young people have access to up to date local information to support them to live good lives.

People will start to notice that they can access both health and care together through any of our Alliance organisations.

Ambition 2 - Focusing with individuals on their needs and goals

Our future vision

We believe that if our services can be focused on an individuals needs and goals that this will both work better for people in West Suffolk, and be a more efficient use of resources.

This means changing the way we work, giving people more information and choice, and being more flexible in our responses. It means working closely across our professions, including with non health and care organisations, and with families and family carers so that people get co-ordinated, integrated care.

Action we are taking to achieve this

1. We want to test out new ways of delivering health and care services that break down traditional organisational boundaries. The Buurtzorg Test and Learn site in Barrow is exploring how district nurses can support people through providing more holistic care, and encouraging independence. If the test is successful we would roll out this model across other areas of West Suffolk.

2. We are exploring ways to create person centred plans with people, so that they have one outcome focused plan that explains how services and other supports will help them to meet their wellbeing and health needs, whether they have a physical or mental health problem, whatever their age, or if they are a carer for someone. Wherever possible we will support these plans with a personal budget.

3. When people get help it will be co-ordinated. We will check with people if we can share records across relevant professionals, backed up by trusted assessment, so that they do not have to keep repeating their story.

4. We aim to support self care and self management, handing control back by using health coaching, assistive technology, digital offers as default and through making better use of community pharmacies and social prescribing.

5. Feedback from people who use our services will be used to inform our redesign options, and how we spend our West Suffolk pound.

Ambition 2 - Focusing with individuals on their needs and goals

Case Study: Buurtzorg Test and Learn

Buurtzorg is a Dutch model of care that has been successful in supporting people who have nursing and personal care needs and who are living in their own homes. In West Suffolk, the Neighbourhood Nursing and Care Team are testing a model inspired by Buurtzorg to see how it can work alongside our Integrated Neighbourhood Teams and wider health and care system.

Buurtzorg is very different from our current model of care, as individual nurses do both nursing and personal care tasks. They also work with family, friends and local community groups, alongside other formal professionals, to put in a wide range of supports and options for people so that they can become more independent and live a good life. The evidence is that this approach leads to a reduction in care needed over time and to fewer hospital stays.

It is very early days with the "Test and Learn" and there are challenges trialling a radically different model of care within our existing system.

However, the team have already identified benefits to working in this way, for example:

- Helping families to identify where additional benefits such as Attendance Allowance are due.
- Providing personal care as well as nursing and health care.
- Monitoring blood sugars and supporting better self care.
- Developing "What if" plans so that everyone knows what will happen in a crisis with the person with the health problems or with their family carer.
- Linking people in with local community groups and activities.

The first twelve months

- Develop integrated pathways between acute and primary care.
- Take the lessons from the Buurtzorg Test and Learn to develop a model that works for people in West Suffolk.
- Develop the use of technology and exploit our digital expertise.
- Introduce care co-ordination, trusted assessment and start to develop a shared single customer plan.
- We will streamline and co-ordinate services for children and young people with ADHD, autism and behavioural issues so that they don't have to go through different pathways to receive services.

People will have conversations with health and care staff that are much more holistic and which address people's own priorities.

Ambition 3 - We will change both the way we work together and how services are configured

Our future vision

We want people in West Suffolk to start well, live well, age well and die well - and this means prioritising the prevention of ill health, whether physical or mental, as well as recognising the multiple factors that lead to ill health and deterioration of health.

We believe that working as Alliance partners we have the flexibility and freedoms to use our collective resources to make this happen. Our workforce are key to success and will be at the forefront of this work.

Our priorities for change will be driven by local need so that time and energy goes into sorting out the things that matter most to people in their area and which will make the biggest difference to health inequalities.

Action we are taking to achieve this

1. We are developing a Five Year Delivery Plan which shows how we will deliver the outcomes we have agreed as a system. We have agreed to move away from a focus on our own organisations to delivering what works best for people in West Suffolk.

2. Health and care system leaders are meeting together regularly with other partners, such as district and borough councils and the police, to plan how we deliver our vision for people in West Suffolk and to track action against our delivery plan.

3. We will share this draft strategy more widely with people in West Suffolk, with our staff and with partner organisations so that we can listen to what people think about our plans and use these to improve and strengthen our delivery going forward.

4. Our intention is to move towards an Integrated Care System, where we can truly use our resource flexibly to meet local need, acknowledging that this will take time to develop. Steps on the way will include moving contracts held by Alliance partners under the control of the Alliance and ensuring we have fully engaged GPs in West Suffolk.

5. We are expanding our collaboration with partner organisations such as the voluntary and community sector and the district and borough councils so that we can work together, bringing housing, environment, volunteering and other important factors into the mix, recognising their impact on wellbeing and health.

Ambition 3 - We will change both the way we work together and how services are configured

Case Study: Special Education Needs and Disabilities - working together for improvement

The development of Suffolk SEND strategy for 2017-20 was led by the Suffolk Parent Carer Network (SPCN) and involved partners from health, care and education. Together we developed a shared vision, aims and priorities forming the basis of the strategy. These encompassed inspection findings, but also took account of the wider evidence base we had from SPCN, our staff and local stakeholders. Once the priorities were agreed we jointly developed the objectives that set out the scope of the work. Each priority has co-accountable leads from health, education and social care supported by a critical friend from SPCN. These teams developed the action plans that sit beneath each objective and provide the detailed programme of work that will enable us to deliver the strategy. In parallel we consulted on the strategy, including the objectives, and have incorporated the feedback from the respondents into our final version of both strategy and action plans. There was strong support for the new strategy, with over 80% of the 109 respondents agreeing with the vision, aims and objectives, and 88% agreeing that the priorities identified were the right ones.

We have cross referenced the Ofsted/CQC findings from the inspection against the strategy objectives and action plans to ensure that all the matters raised by inspectors have been addressed within the action plans we have developed. Through this approach we have swiftly been able to develop a new SEND Strategy for Suffolk, while at the same time responding to the inspection findings. We have one integral plan of action to deliver the change we need and are now ready to begin our long term programme.

The first twelve months

- We will develop a Five Year Delivery Plan that shows our priorities and specific actions over the next twelve months. There will be a senior lead for each area of our plan.
- We will set up and deliver an engagement plan to share the draft strategy and the delivery plan.
- We will finalise the outcomes framework and measures and will start to monitor our system together, taking action where we are not making sufficient positive progress.

People who work in our system will no longer experience organisational barriers to change.

Ambition 4 - We make effective use of resources

Our future vision

Between Alliance partners we spend more than £340 million on health and adult social care services in West Suffolk. This does not include the cost to the wider economy of poor health and wellbeing. We believe that we can use our resources even more effectively if we work together, including eventually being able to shift resources between organisations.

This will help us to maintain services whilst demand on our system is growing, whether this be for GPs, social care, mental health services or acute and community health services.

Alongside this we see a greater role for people and our communities, taking charge of - and responsibility for - managing their own health and wellbeing, whether they are well or ill. We will invest more in preventing ill health and aim to replace high cost interventions with lower cost case management.

Action we are taking to achieve this

1. Our Delivery Plan will reverse the current trend that is leading to higher hospital spend by increasing the proportion of our health and care budgets that is spent in the community, and this, alongside a local approach to commissioning in West Suffolk, will help us to achieve value for money.

2. We will work to get a whole system understanding of health and care resources in West Suffolk and how we use them as a key step towards becoming an Integrated Care System.

3. We will work together to address the financial pressures within each of our Alliance organisations.

4. We will develop and implement plans for:
   - Information Technology and Digital Solutions
   - Estates
   - Comms and engagement
   - Workforce
   - Organisational development
   - Communications

5. We will to take every opportunity to use our assets together to reduce duplication and drive out inefficiency. For instance, we plan to share public sector buildings aiming for community hubs in each of our localities, as part of a wider strategy to consolidate corporate functions, and we are looking at how we can share data and create single patient records. We are reviewing pathways to reduce the waste caused by hand offs and reassessment.

Ambition 4 - We make effective use of resources

We will have plans for the following areas that support delivery of effective services on the ground

IT and digital
We will develop the use of technology and exploit our digital expertise. We have a head start in West Suffolk as we are running one of the sixteen Acute Global Digital Exemplar programmes in England. We would like to use technology to deliver benefits to people (for example access to records, self help information, digital monitoring and new innovations such as robotics) and to our organisations (for example shared care records, and a single data reporting view). We are piloting GovRoam in Newmarket Hospital early Summer 2018.

Estates
Making shared use of our public sector estates will help us to achieve a number of our ambitions. Our staff tell us that it will help them to develop Integrated Neighbourhood Teams, plus it will be a more efficient use of resources.

Workforce
Our workforce is our most important asset and we want them to feel a strong ownership of the West Suffolk Alliance Strategy and plan. Our delivery plan will be driven by them along with people who use our services and their carers, which will ensure that our organisational cultures develop in response to system and pathway changes.

Organisational Development
We will recognise talent across our organisations and ensure that career pathways are flexible, including with independent care providers. We have obtained external funding to help us with this work, which is being carried out throughout Suffolk. We want to explore joining up our workforce where this makes sense, across clinical and non-clinical teams. We are putting in place initiatives that will ensure that West Suffolk is an attractive place to work.

Communication
People in west Suffolk expect us to work across barriers and boundaries, and we will need to use their experience and stories to develop our plans and to show where this have changed for the better. Our communications strategy will also be key to creating an Alliance culture, where staff feel part of an integrated system and a priority is ensuring the messages and priorities for the Alliance are cascaded throughout our organisations and with partners.

Our organisations retain their own decision making and accountability, but we put our Alliance principles into action and make sure that decisions are taken with these in mind.

Mike Hennessey
Director of Adults and Community Services, Suffolk County Council

Joining up services around the needs of people

Case Study: Sharing information to make a real difference

On the evening of Sunday 1st April, which was a bank holiday weekend, an acutely unwell lady was brought to West Suffolk Hospital Accident and Emergency Department. She had a stage 4 ovarian cancer, and was very vague about her history and not able to give information about her condition or treatment. We were able to determine that she was under the care of a consultant at Addenbrooks Hospital, but as it was Sunday evening of course there was no one around involved in her care to speak to.

However a recent innovation at West Suffolk Hospital is that we are able to access Addenbrooks Hospital care records. Because of this we were able to see an up to date treatment plan and the results of her most recent scan. Access to this information meant that we were able to expedite her treatment with the right medication and care plan without the need for another CT scan or any other diagnostic tests in order to work out what do next. This meant her stay in hospital was only short and we were able to stabilise her condition, relieve her pain, and discharge her the next day. Importantly we were able to update her patient notes so that her own GP and her own consultant were made aware of what had happened and had live information on her condition and the treatment we had provided.

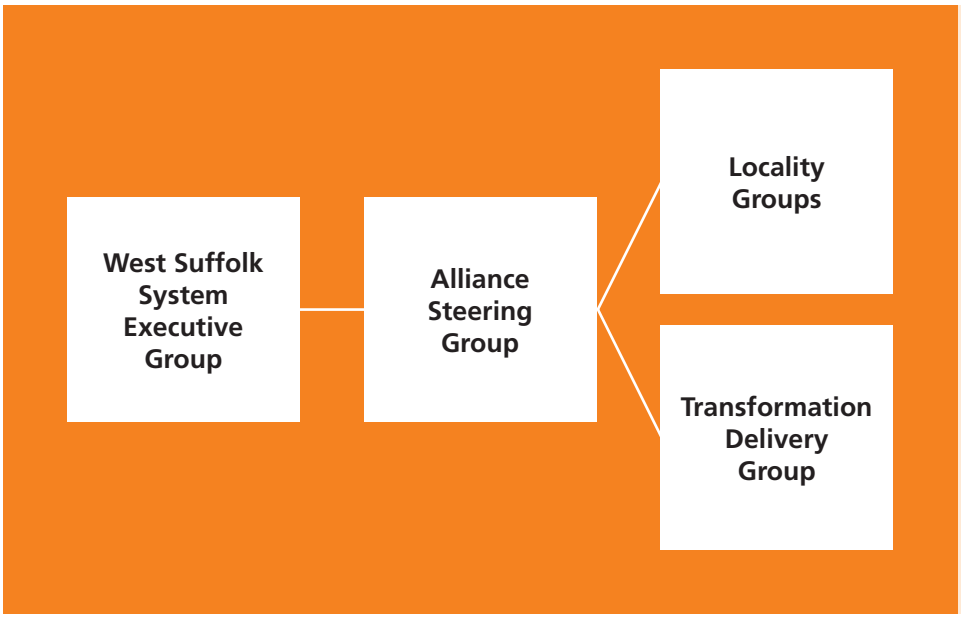
We want to change our health and care system so that it works for people - their lives and ambitions. This is the starting point for the changes we want to make.

Kate Vaughton
Chief Operating Officer,
West Suffolk Clinical Commissioning Group

West Suffolk Alliance forums for discussions and decision

Our Alliance is driven by a System Executive Group comprising director and clinical lead representatives from West Suffolk Hospital, Suffolk County Council - Adult and Children's Services, Norfolk and Suffolk Foundation Trust, Suffolk GP Federation, West Suffolk Clinical Commissioning Group, our district and borough, voluntary sector and patient representative groups. Our nominated lead represents our Alliance at STP level.

Wider system governance



Working with:

Ipswich and East Suffolk Alliance

Childrens Alliance

Mentally Healthy Communities Board

Suffolk Commissioners Group

Suffolk Health and Wellbeing Board

Suffolk and North East Essex Transformation Partnership

West Suffolk Alliance Strategy - in context

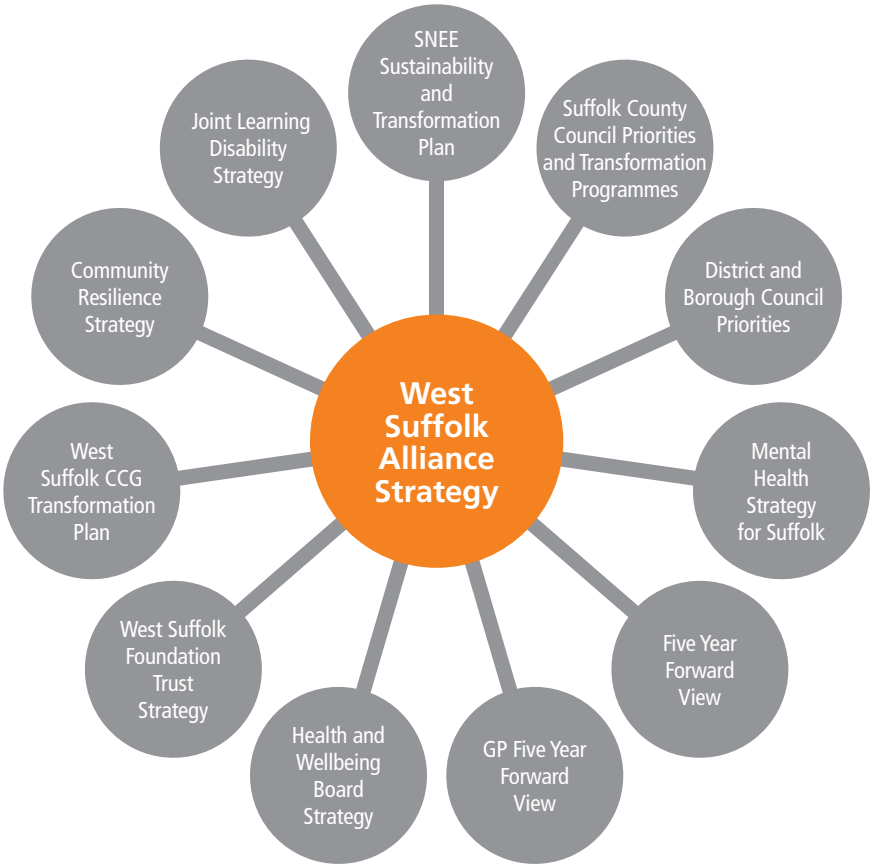
The West Suffolk Alliance Strategy is part of a wider network of plans and strategies and builds on these to show how we will add value through Alliance working.

The Strategy is intended to show how we will deliver key aspects of the Suffolk and North East Essex Sustainability and Transformation Partnership Plan.

It also recognises that to improve the wellbeing, health and independence of people in West Suffolk a wide number of partners must be involved.

The Strategy should be read alongside our Five Year Delivery Plan. This shows the programmes and projects that we are collaborating on together to turn our vision into reality.

Some programmes are led across both Alliance areas on behalf of both East and West Alliance and there are interconnected programmes with North East Essex Alliance partners.



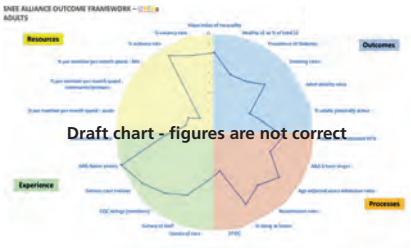
West Suffolk System outcomes

Together we have developed a set of system outcomes around eight domains:

1. **Local people have an excellent experience of care and support**
2. **Health and Care inequalities will be reduced**
3. **Reduction in the incidents of avoidable harm**
4. **Money is used for best effect across the health and care system**
5. **Local people are supported to stay well**
6. **Local people with health and care needs are supported to avoid deteriorating health and manage crisis**
7. **Local people's health and wellbeing is optimised after a period of ill health or injury**
8. **Local people are supported to have a good death**

Progress against these outcomes will show how we are moving forward as a system, and will help us to work together as Alliance partners, not just as individual organisations.

This work is still under development - so the radar chart shown below is an illustrative example of how we would plot our progress. We aim to have measures developed at Alliance level as well as at a locality level.



System outcomes - OPERa framework

OUTCOMES - Health and care outcomes for our population

• Health and care inequalities will be reduced	• The Slope Index of Inequalities narrows
• Alliance activity focuses on effective prevention	• The length of healthy life expectancy, and the proportion of healthy life expectancy within total life expectancy, increases
• Local people are supported to stay well	• Self care, PAM, A&E attendances, 111, Early help metrics (SC)
• Local people with health and care needs, including those with chaotic lifestyles, are supported to avoid deteriorating health and managing crisis	• Unplanned age standardised acute admission rates reduce; chaotic lifestyle metric from RE
• Local people's health and wellbeing is optimised after a period of ill health or injury	• The proportion of eligible people entering reablement and rehabilitation services increases; effective whole system reablement % increases
• There is a reduction in incidents of avoidable harm	• Serious incidents/case reviews within health and care reduce

PROCESSES - We maximise the opportunities available to us through Alliance working to improve health and care processes

• Alliance working leads to a culture change of acting in the interests of the system, not those of constituent organisations	• All Alliance partners can demonstrate effective culture change through business cases, prioritisation decisions and case studies
• Health and care teams and pathways are effectively integrated, increasing efficiency and reducing duplication	• Key Alliance care pathways demonstrate increased efficiency by improving outcomes, reducing cost, increasing throughput etc.
• The Alliance develops a shared vision and values which actively guide decision making	• All Alliance partners can demonstrate use of Alliance vision and values in decision making and case studies
• There is shared control and rapid decision making in all parts of the Alliance system	• All Alliance partners agree that governance arrangements are timely and effective
• The Alliance benefits from shared back office functions through making savings from reduced duplication of functions	• Savings from combined back office Alliance functions are achieved
• The Alliance develops population-level business intelligence across line of business systems to guide targeted, risk-based, interventions	• Effective targeted interventions are introduced based on population insight from combined clinical systems
• The incidence of markers of poor use of Alliance resources reduces (e.g. elective cancellations, readmissions, etc.)	• System DTOCs reduce

System outcomes - OPERa framework

EXPERIENCE - Local people have an excellent experience of care and support

• Local people give positive and consistent feedback about their personal experience of care and support, and their experience of care and support for their loved one	• The proportion of of local respondants who agree with the Alliance's measured 'I statements*' in relation to their own/their loved ones care and support is high, and increases over time; CQC findings; safeguarding volumes
• Local people are supported to have a good death	• Performance against defined key measures in this area (Family and carer feedback; % dying in preferred place of death including home; use of advance care planning) is high and improves over time

RESOURCES - Resources are used for best effect across the Alliance

• Services are delivered within the combined Alliance financial envelope	• System achieves annual budgets/ agreed control totals as per the STP, including efficiency requirements
• Financial flows work to incentivise services which intervene early to improve outcomes and manage need and demand	• PMPM (Per member, per month) spend on unplanned acute care decreases as a proportion of total spend
• The Alliance workforce are motivated, skilled and enabled to work flexibly including within integrated teams	• Staff survey, roster coverage levels, % of workforce with multiple skills, 'trusted assessor' working, caseloads
• The Alliance workforce is sustainable with a larger pool of trained people available to cover hard to fill vacancies and 'strength in depth' making it easier to recruit and manage demands of flexible workforce (particularly GPs)	• The Alliance develops a sustainable workforce and sickness and vacancy rates in key risk staff groups are low and decrease over time

For more information

West Suffolk System Executive Group meeting in April 2018

> ***We have not created new organisations through alliance working. Rather we are developing ways to allow existing organisations to come together to work far more closely and effectively than ever before.***
>
> **Dr Paul Driscoll**
> Chair, Suffolk GP Federation

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9. Integrated quality and performance report

To ACCEPT the report

Presented by Rowan Procter and Helen Beck

Board of Directors – April (25th May) 2018

AGENDA ITEM:	9
PRESENTED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer
PREPARED BY:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer Joanna Rayner, Head of Performance
DATE PREPARED:	May 2018
SUBJECT:	Trust Integrated Quality & Performance Report
PURPOSE:	To update the Board on current quality issues and current performance against targets

EXECUTIVE SUMMARY: This report provides an overview of quality and performance across the Trust. Key elements are: • Aligned to the CQC ratings • 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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NHS Foundation Trust

Integrated quality and performance report



Month One: April 2018

CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

1 EXECUTIVE SUMMARY

March's performance shows we reported two C. difficile cases in the month. We continue to focus on reducing patient falls and pressure ulcers, with 64 falls and 9 pressure ulcers reported. The year to date performance for all cancer targets is ahead of the national threshold; however, the Trust failed to deliver the target for two week wait from referral to date first seen for symptomatic breast patients in March. ED 4 hour wait performance was 85.39% for March, with some exceptionally challenging days. We experienced a 5% increase in attendances at ED in March 2018 compared to March 2017 (285 additional patients) and a 7% increase in ambulance attendances for the same period.

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

ARE WE SAFE?

HCAIs – There were no MRSA bacteraemia cases in April 2018. There were two cases of hospital-attributable Clostridium difficile case for April 2018; The Trust compliance with decolonization Decreased in April 2018 to 85%.

NHS Patient Safety Alerts (PSAs) – A total of 7 PSAs have been received in 2017/8, with 2 in April 2018. All the alerts have been implemented within timescale to date.

Patient Falls (Inpatients) - 68 patient falls occurred in April 2018. (*Recovery Action Plan (RAP) included in main report*).

Pressure Ulcers- The number of ward-acquired pressure ulcers continues to be above the local Trust plan of 5 per month. In April 2018, 5 cases occurred, with YTD total of 174. *(RAP included in main report).*

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons - The rate of cancelled operations for non-clinical reasons was recorded at 0.6% in April 2018. (*RAP included in the main report*).

Discharge Summaries- Performance to date is below the 95% target to issue discharge summaries (inpatients and ED). A&E has achieved a rate of 81.5% in April 2018 whereas Inpatient services have achieved a rate of 72.1%. (*RAP included in the main report*).

ARE WE CARING?

Mixed Sex Accommodation breaches (MSA) – No MSA breach occurred in April 2018, against a national average of over 4 per month.

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

ARE WE RESPONSIVE?

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

Cancer – Cancer performance (provisional figures) of 96.7% is above the national requirement with a significant increase in the number for referrals in 2WW suspected breast cancer there is a risk to this target going forward in May. *(RAP included in the main report).*

Referral to Treatment (RTT) - The percentage of patients on an incomplete pathway within 18 weeks is below national target of 92%, however performance has been maintained despite winter pressures and cancellations with performance in April of 90.3%. Data quality issues and validation of the list continue. The total waiting list remains at 16224 in April. In April, 19 patients breached 52-week standard. *(RAP included in the main report).*

ARE WE WELL LED?

Appraisal - Rates have fallen for the 2nd month in a row, down to 66.96% due to staffing shortages and winter pressures, however, where staffing levels have stabilised, appraisal is being prioritised.

Sickness Absence – This has risen this month to 3.77, and worse than this time last year (3.71).

Actions remain in place to support managers to manage both short term and long term absence. We have had some staff with high sickness levels resign and also one dismissal. Winter pressures are still impacting, with staff off with stress and

low immunity conditions. We will look to offer more advice and guidance about maintaining personal health & wellbeing in the coming months. *(RAP included in the main report).*

ARE WE PRODUCTIVE?

The Trust has not agreed a control total with NHS Improvement for 2018/19 which means there is no access to STF this year. The planned deficit for the year is £16.6m. The planned deficit for month 1 was £1.7m but the actual deficit was £1.8m, and adverse variance of £0.1m. The Trust forecast for this financial year remains at £16.6m deficit.

2. INTEGRATED QUALITY & PERFORMANCE REPORT DASHBOARD

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

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WEST SUFFOLK HOSPITAL INTEGRATED QUALITY & PERFORMANCE REPORT						TRUST TOTAL														
we..	Ref.	KPI	R	A	G	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Av/YTD	Traffic
1. Safe	1.01	NHS E / I Improvement Patient Safety Alerts Total				1	0	0	1	2	1	0	1	0	1	0	0	2	2	
	1.02	NHS E / I Improvement Patient Safety Alerts OS	0	NA	0-0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	1.03	Emergency C-Section Rate	14.2-100%	12-14.1%	0-12%	10%	12%	12%	9%	13%	12%	11%	10%	11%	14%	10%	19%	16%	16%	
	1.04	All relevant inpatients undergoing VTE Risk assessmen	0-90%	90.1-95%	96-100%	87%	89%	89%	86%	90%	88%	95%	97%	95%	97%	98%	97%	98%	98%	
	1.05	Clostridium difficile infections (CDI)	4-20	2-3	0-1.9	3	0	0	1	0	2	6	4	0	1	0	2	1	1	
	1.06	MRSA	1-10		0-0.9	0	0	0	0	0	2	0	0	0	0	1	0	0	0	
	1.07	Patient Safety Incidents Reported				392	508	418	506	466	467	520	588	479	627	553	535	486	486	
	1.08	Never Events	0.1-20	NA	0-0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	
2.	2.04	Canc. Ops - Cancellations for non-clinical reasons	1.5-10%	1-1.5%	0-1%	1%	1%	1%	1%	1%	1%	1%	2%	1%	1%	1%	1%	1%	0%	
3. Caring	3.01	Compliments (Logged by Patient Experience)				41	52	26	56	28	17	33	87	151	64	20	45	21	21	
	3.02	Complaints (Inpatient)	30-100	20-30	0-20	10	10	10	6	16	16	17	13	8	12	19	9	13	13	
	3.03	Mixed Sex Accommodation Breaches	5-10	1-4	0-0.99	0	0	0	0	0	0	0	0	1	0	0	1	0	0	
	3.04	IP - Extremely likely or Likely to recommend	0-80%	80-89%	90-100%	98%	97%	99%	98%	98%	98%	99%	96%	98%	97%	98%	98%	99%	98%	
	3.05	OP - Extremely likely or Likely to recommend	0-80%	80-89%	90-100%	95%	96%	97%	95%	95%	96%	96%	96%	99%	95%	96%	95%	97%	97%	
	3.06	A&E - Extremely likely or Likely to recommend	0-75%	75-84%	85-100%	97%	96%	95%	95%	95%	92%	95%	94%	94%	96%	95%	94%	94%	94%	
	3.07	Maternity - How likely are you to recommend	0-80%	81-89%	90-100%	100%	100%	100%	100%	ND	ND	99%	100%	97%	100%	93%	100%	100%	100%	
4. Responsive	4.01	A&E - Under 4 hr. wait	0-90%	90-95%	95-100%	95%	95%	96%	92%	90%	89%	87%	90%	83%	84%	85%	85%	85%	85%	
	4.02	RTT: % incomplete pathways within 18 weeks	0-88%	88-91%	91-100%	82%	80%	83%	84%	86%	86%	87%	89%	89%	90%	90%	ND	90%	90%	
	4.03	52-week waiters	10-100	5-10	0-5	15	14	15	35	26	29	26	21	15	14	13	ND	31	31	
	4.04	Diagnostics within 6 weeks	0-95%	95-99%	99-100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	ND	#DIV/0!	
	4.05	Cancer: 2w wait for urgent GP Referrals	0-90%	90-93%	93-100%	94%	92%	97%	95%	96%	91%	83%	98%	97%	98%	98%	95%	96%	96%	
	4.06	Cancer 2w wait breast	0-90%	90-93%	93-100%	94%	99%	89%	98%	100%	98%	100%	100%	99%	97%	93%	87%	94%	97%	
	4.07	Cancer 31 d First Treatment	0-92%	92-96%	96-100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	99%	99%	
	4.08	Cancer 31 d Drug Treatment	0-95%	95-98%	98-100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	4.09	Cancer 31 d Surgery	0-91%	91-94%	94-100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	4.10	Cancer 62 d GP referral	0-80%	80-85%	85-100%	89%	83%	86%	85%	86%	87%	94%	90%	87%	87%	80%	88%	91%	91%	
	4.11	Cancer 62 d Screening	0-85%	85-90%	90-100%	100%	100%	90%	100%	100%	91%	100%	83%	100%	93%	86%	95%	80%	80%	

5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)				NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4%	NA	NA		
	5.02	Staff F&F Test % Recommended - care (Qrtly)	0-70%	70-75%	75-100%	NA	NA	95%	NA	NA	95%	NA	NA	ND	NA	NA	NA	NA	#DIV/0!	
	5.03	Staff F&F Test % Rec'mend - place to work (Qrtly)	0-70%	70-74.9%	75-100%	NA	NA	83%	NA	NA	82%	NA	NA	ND	NA	NA	NA	NA	#DIV/0!	
	5.04	Turnover (Rolling 12 mths)	14-100%	11-14%	0-11%	10%	10%	10%	10%	10%	10%	9%	9%	9%	9%	9%	9%	8%	8%	
	5.05	Sickness Absence	4-100%	3.5-4%	0-3.5%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.57%	3.70%	3.72%	4%	4%	
	5.06	Executive Team Turnover (Trust Management)	13-100%	10-12%	0-10%	0%	20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
	5.07	Agency Spend	600-1000	550-600	0-550	307	316	289	336	244	220	187	475	183	ND	237	452	331	331	
	5.08	Monitor Use of Resources Rating	NA	NA	NA	3	3	3	3	3	3	3	3	3	3	3	3	ND	#DIV/0!	
6. Productive	6.01	I&E Margin				ND	-4.90%	-4.30%	-3.90%	0.13%	-3.04%	-2.55%	-2.47%	-2.60%	-2.34%	-2.56%	#######	0.00%	0.00%	
	6.02	Distance from Financial Plan				ND	0.00%	0.40%	0.10%	0.00%	0.00%	0.03%	0.03%	ND	ND	ND	ND	ND	0.00%	
	6.03	Capital service capacity				ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.01	0.00	0.00	- 0.00	ND	ND	0.00	
	6.04	Liquidity (days)				ND	- 12.15	-15.72	-10.94	-11.03	-12.70	-15.14	- 0.10	- 0.13	- 0.11	- 0.07	ND	ND	-0.07	
	6.05	Long-Term Borrowing	47.8-100	NT	0-47.7	44.3	45.7	45.7	45.7	45.7	47.6	47.6	56.7	58.7	64.4	64.1	ND	65.40	0.00	
	6.06	Variance to CIP plan				40	0	-40	10	0	-54	-10	-35	-129	-201	-380	ND	ND	#DIV/0!	
7.Maternity	7.01	Total number of deliveries (births)	>224, <200	>216, <208	208-216	215	192	213	215	233	236	205	194	180	199	211	206	195	195	
	7.02	% of all caesarean sections	22.6-100%		0-22.6%	15%	21%	16%	16%	22%	18%	17%	17%	18%	22%	17%	30%	28%	28%	
	7.03	Midwife to birth ratio	1.32-10		0.00-1.30	1.30	1.27	1.29	1.30	1.33	1.33	1.29	1.28	1.26	1.28	1.29	1.29	1	1	
	7.04	Unit Closures	NT	NT	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	7.05	Completion of WHO checklist	0-79%	80-89%	90-100%	84%	93%	84%	94%	82%	98%	98%	98%	93%	93%	94%	97%	86%	86%	
	7.06	Maternity SIs	NT	NT	NT	1	0	0	0	0	1	1	0	1	2	0	1	2	2	
	7.07	Maternity Never Events	NT	NT	NT	0	0	0	0	0	0	0	0	0	0	0	0	ND	0	
	7.08	Breastfeeding Initiation Rates	0-75%	76-80%	80-100%	80%	81%	88%	77%	85%	79%	81%	80%	80%	82%	76%	79%	76%	76%	
8. Community	8.05	Never Events	1-10	NT	0-0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	8.06	SIs	0.00	0.00	0.00	8	8	9	12	7	6	2	6	5	4	2	4	3	3	
	8.09	Pressure Ulcers Grade 4	2-10	1-1	0-0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	8.16	Community scores from FFT - % Positive	0-80%	80-85%	85-100%	97%	ND	100%	ND	ND	ND	97%	100%	96%	95%	97%	96%	94%	1	
	8.18	Complaints	9-10	5-8	0-5	1	2	3	2	0	3	1	1	0	0	1	1	1	1	
	8.19	18 weeks RTT for Non-Consultant led services	0-90%	90.1-95%	95.1-100%	97%	96%	99%	99%	95%	99%	94%	94%	98%	99%	100%	99%	99%	99%	
	8.21	Community Nursing Red referrals seen within 2hrs	0-97%	97-99%	99-100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	NA	NA	NA	#DIV/0!	
	8.22	Community Nursing Red referrals seen within 4hrs	0-90%	90.1-95%	95.1-100%	100%	100%	100%	100%	NA	100%	NA	NA	100%	100%	100%	100%	96%	96%	
	8.32	Safeguarding Children Mandatory Compliance	0-90%	90-95%	95-100%	96%	96%	97%	97%	97%	97%	95%	96%	96%	96%	96%	97%	98%	98%	
	8.33	Safeguarding Adults Mandatory Training Compliance	0-90%	90-95%	95-100%	96%	96%	97%	97%	96%	96%	94%	95%	94%	94%	93%	96%	96%	96%	

3. IN THIS MONTH – APRIL 2018, MONTH 1

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.

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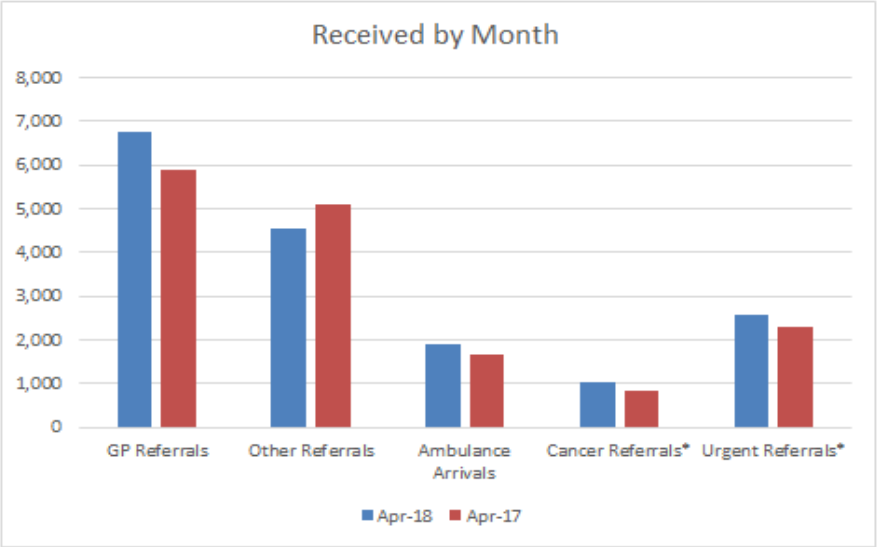
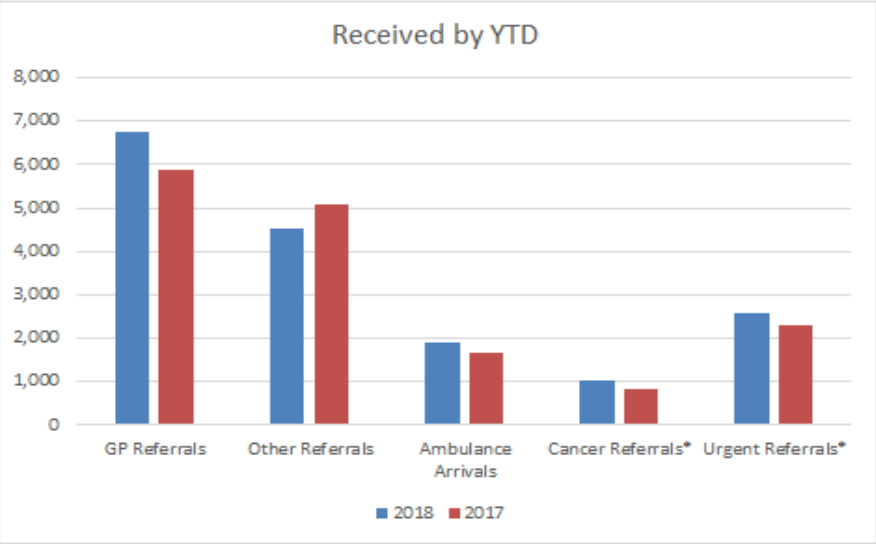
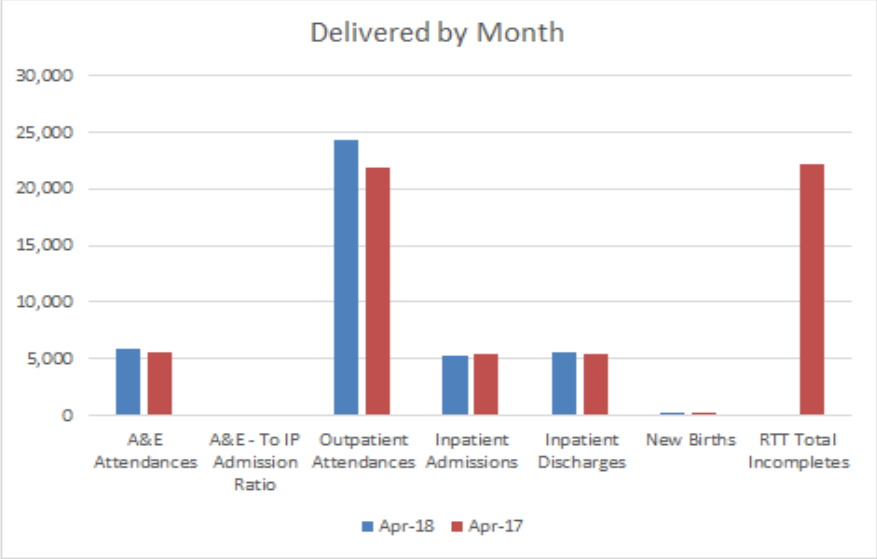
From Month Year	Apr-2018	To Month Year	Apr-2017

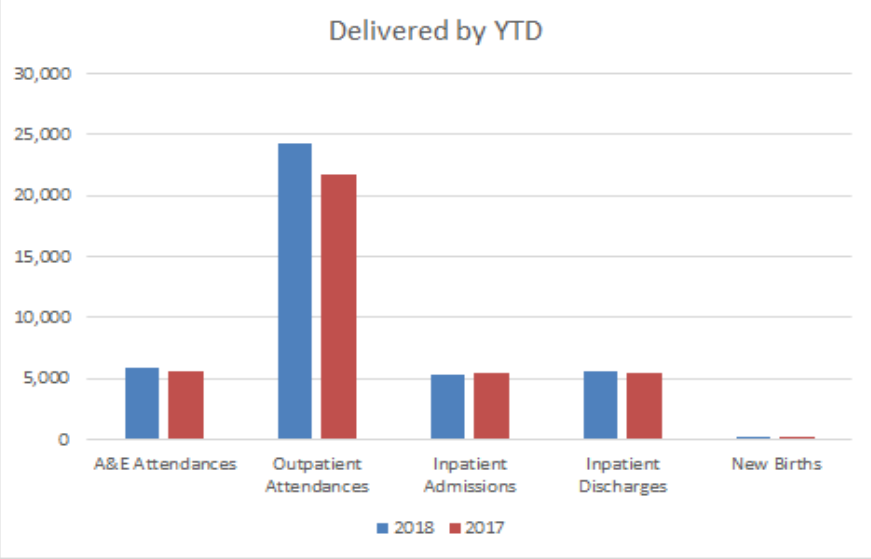
WEST SUFFOLK HOSPITAL INTEGRATED QUALITY & PERFORMANCE REPORT - Summary of New Referrals & Completed treatment											
In this month.... April 2018											
Mth We Received.....	Apr-18	Apr-17	Variance	Var. %	Traffic	YTD We Received.....	2018	2017	Variance	Var. %	Traffic
GP Referrals	6,755	5,893	862	15%	↑	GP Referrals	6,755	5,893	862	15%	↑
Other Referrals	4,535	5,088	-553	-11%	↓	Other Referrals	4,535	5,088	-553	-11%	↓
Ambulance Arrivals	1,887	1,653	234	14%	↑	Ambulance Arrivals	1,887	1,653	234	14%	↑
Cancer Referrals*	1,018	825	193	23%	↑	Cancer Referrals*	1,018	825	193	23%	↑
Urgent Referrals*	2,588	2,296	292	13%	↑	Urgent Referrals*	2,588	2,296	292	13%	↑
Mth We Delivered.....	Apr-18	Apr-17	Variance	Var. %	Traffic	YTD We Delivered.....	2018	2017	Variance	Var. %	Traffic
A&E Attendances	5,967	5,578	389	7%	↑	A&E Attendances	5,967	5,578	389	7%	↑
A&E - To IP Admission Ratio	27.9%	29.1%	-1.2%	-1.2%	↓	Outpatient Attendances	24,321	21,787	2,534	12%	↑
Outpatient Attendances	24,321	21,787	2,534	12%	↑	Inpatient Admissions	5,356	5,409	-53	-1%	↓
Inpatient Admissions	5,356	5,409	-53	-1%	↓	Inpatient Discharges	5,662	5,441	221	4%	↑
Inpatient Discharges	5,662	5,441	221	4%	↑	New Births	195	215	-20	-9%	↓
New Births	195	215	-20	-9%	↓						
RTT Total Incompletes	14,663	22,110	-7,447	-34%	↓						

* - Included in Referrals Above


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

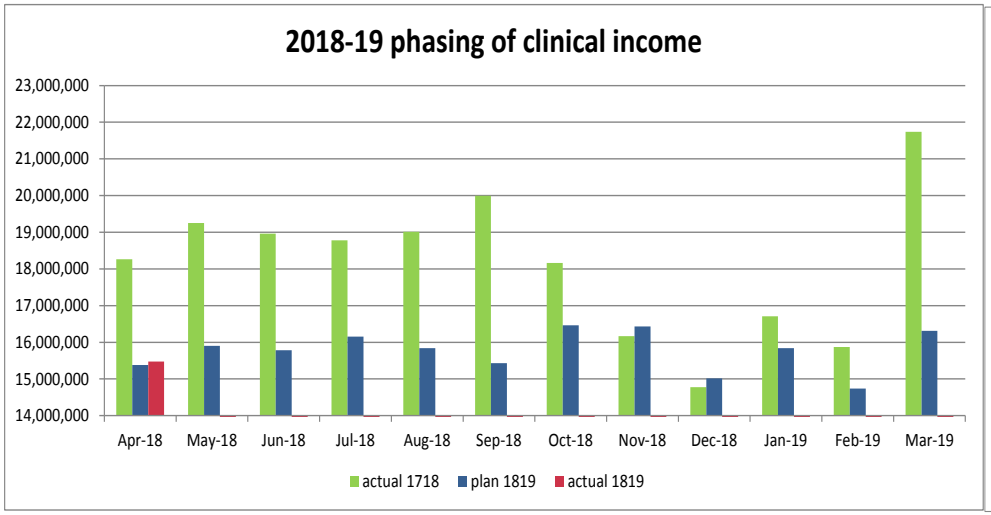

Received by YTD
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
GP Referrals
Other Referrals
Ambulance Arrivals
Cancer Referrals*
Urgent Referrals*
2018
2017

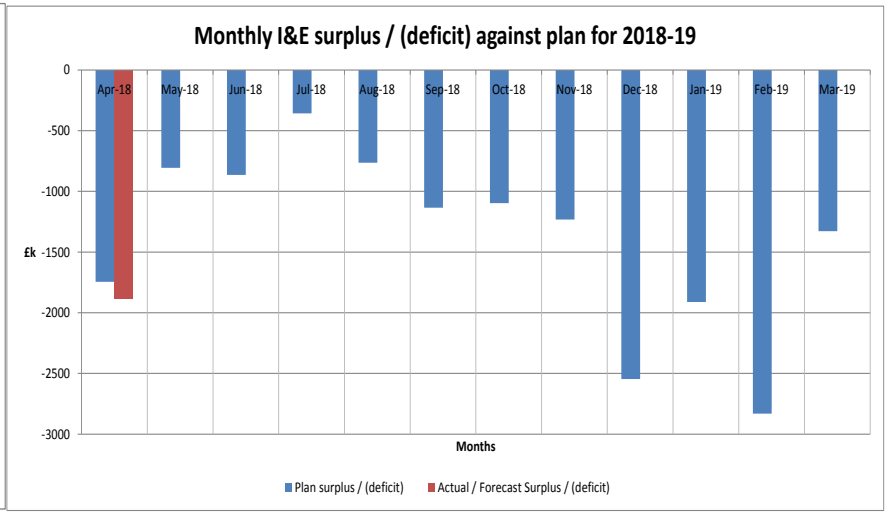

Delivered by Month
30,000
25,000
20,000
15,000
10,000
5,000
0
A&E Attendances
A&E - To IP Admission Ratio
Outpatient Attendances
Inpatient Admissions
Inpatient Discharges
New Births
RTT Total Incompletes
Apr-18
Apr-17


Delivered by YTD
30,000
25,000
20,000
15,000
10,000
5,000
0
A&E Attendances
Outpatient Attendances
Inpatient Admissions
Inpatient Discharges
New Births
2018
2017

4. FINANCE SUMMARY

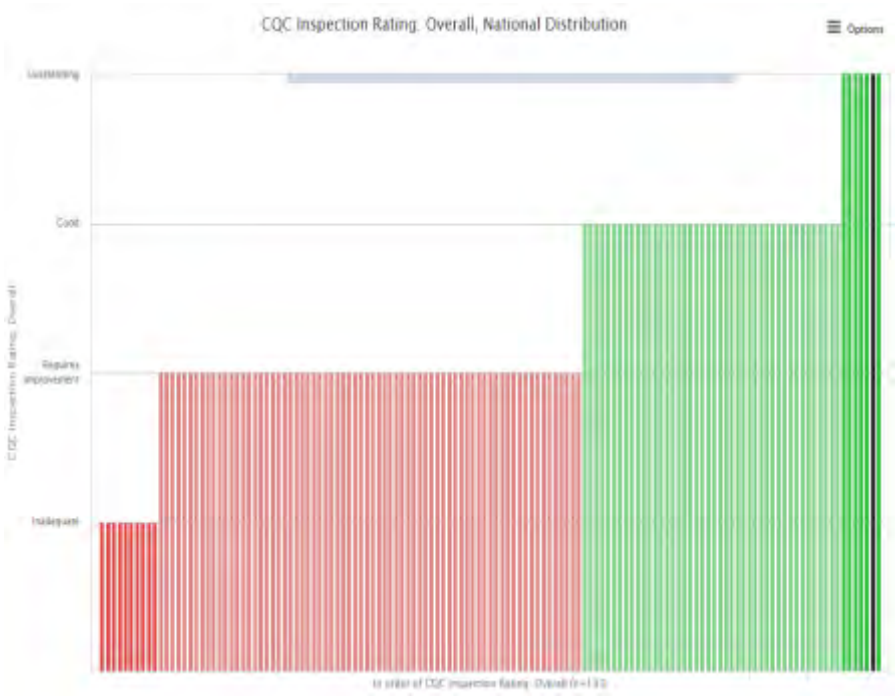
The Trust forecast for this financial year remains at 16.6m deficit. The Trust reported I&E for April 2018 YTD is a deficit of £1,839k, against a planned deficit of £1,745k. This results in an adverse variance of £93k in month. The monthly adverse variance is £93k. This predominantly relates to expenditure on agency staff over and above the budget.



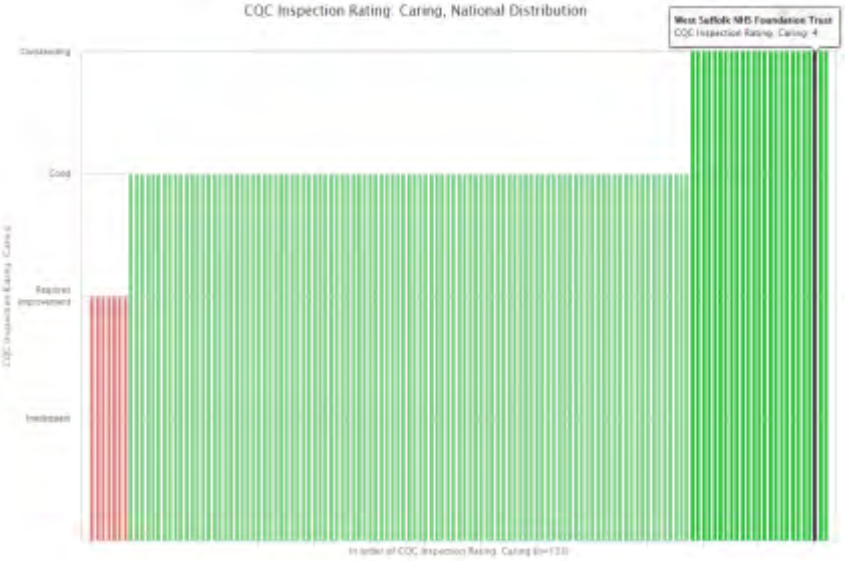


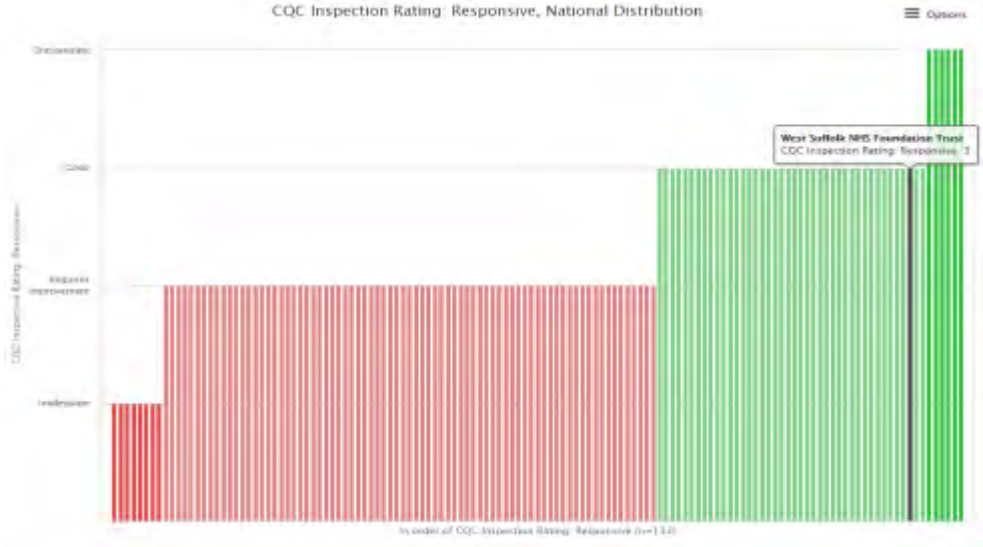
5. CQC OVERVIEW

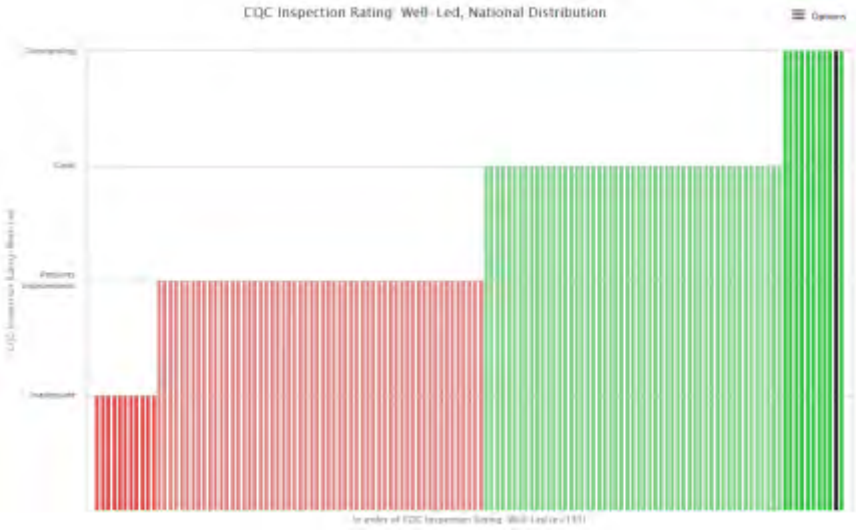
The CQC have launched the Model Hospital website in *alpha* form which highlights comparative indicators in a number of key areas. Quality of Care compartment: CQC ratings as the principal assessment indicators, with additional indicators, including the Friends and Family Test, Ambulance outcomes, & Mental Health Services. The graphs below provide oversight of the Trust's latest comparative performance against these key areas. *(Source – Model Hospital-March 2018)*




CQC Inspection Rating: Effective, National Distribution
West Suffolk NHS Foundation Trust
CQC Inspection Rating: Effective: 4
Outstanding
Good
Requires Improvement
Inadequate

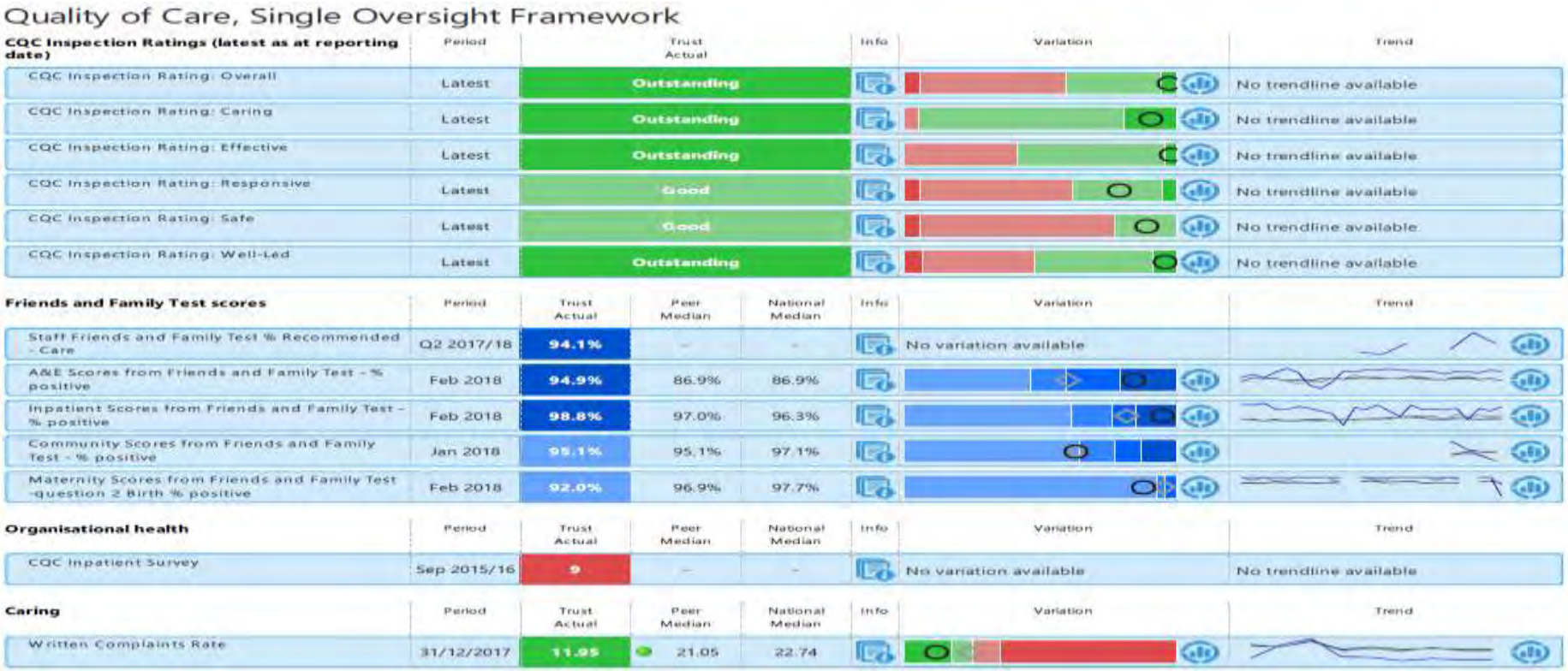

CQC Inspection Rating: Caring, National Distribution
West Suffolk NHS Foundation Trust
CQC Inspection Rating: Caring: 4
Outstanding
Good
Requires Improvement
Inadequate


CQC Inspection Rating: Responsive, National Distribution
Options
West Suffolk NHS Foundation Trust
Outstanding
Good
Requires Improvement
Inadequate


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

CQC - QUALITY OF CARE BENCHMARK DASHBOARD

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



Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Never events	28/02/2018	1	1	2			
Emergency c-section rate	Jan 2018	12.30%	18.16%	15.68%			
VTE Risk Assessment	Q3 2017/18	95.51%	95.75%	95.78%			
Clostridium Difficile - infection rate	To Feb 2018	13.24	9.41	12.91			
MRSA bacteraemias	To Feb 2018	0.74	0.00	0.67			
Potential under-reporting of patient safety incidents	31/12/2017	36.63	42.54	42.36			
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Feb 2018	121	124	127			
Meticillin-sensitive staphylococcus aureus (MSSA) rates to quality indicators	Feb 2018	7	7	8			

Safe	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
Clostridium Difficile - variance from plan	Feb 2018	-1.0	0.0	0.0			

Effective	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
Summary Hospital Mortality Indicator (SHMI)	31/07/2017	0.88	-	0.00			

6. DETAILED SECTIONS - SAFE

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

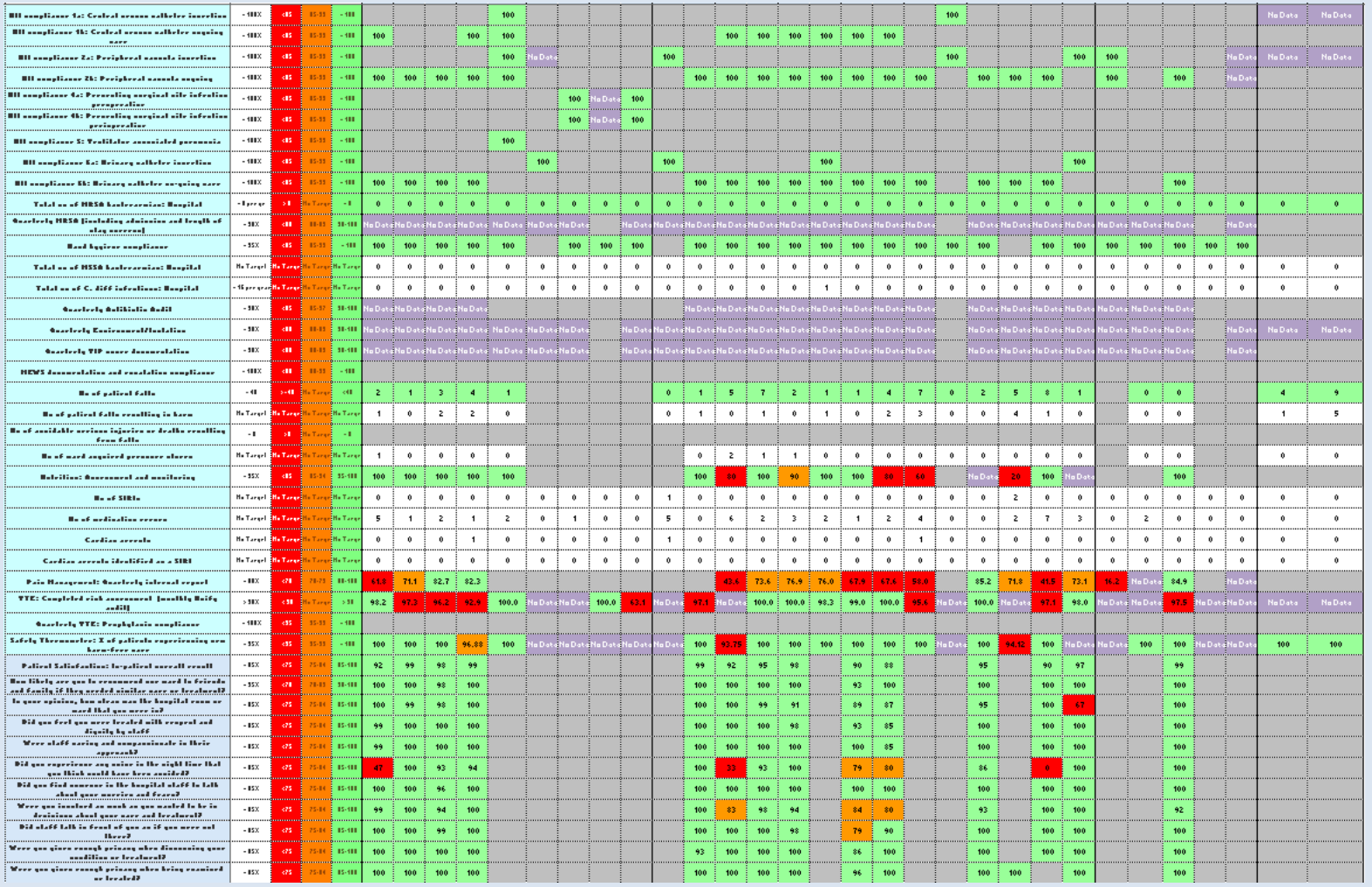
Are we..		Ref.	KPI	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	YTD(Apr18 Mar19)	Traffic
Safe	Dashboard	1.01	NHS E / I Patient Safety Alerts - Total	NT	1	0	0	1	2	1	0	1	0	1	0	0	2	2	
		1.02	NHS E / I Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
		1.03	Emergency C-Section Rate	14%	10.3%	11.6%	11.5%	8.5%	12.9%	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	16%	
		1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	86.5%	88.6%	88.8%	85.8%	89.7%	88.0%	94.8%	96.9%	94.7%	96.9%	97.6%	97%	98.2%	98%	
		1.05	Clostridium difficile infections (CDI)	16	3	0	0	1	0	2	6	4	0	1	0	2	1	1	
		1.06	MRSA (Hospital)	0	0	0	0	0	0	2	0	0	0	0	1	0	1	1	
		1.07	Patient Safety Incidents Reported	NT	392	508	418	506	466	467	520	588	479	627	553	535	486	486	
		1.08	Never Events	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	
	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	96%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	100%	100%	100%	100%	97%	100%	98%	97%	100%	100%	100%	100%	100%	100%	
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	100%	97%	98%	93%	97%	99%	99%	97%	96%	99%	100%	100%	100%	100%	
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
		1.14	HII Compliance 4b: Preventing surgical site infection perioperative	100%	100%	85%	100%	95%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	100%	100%	100%	100%	100%	78%	100%	100%	100%	100%	100%	100%	
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	100%	100%	100%	100%	78%	100%	100%	100%	100%	100%	100%	100%	
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	81%	92%	94%	88%	99%	97%	91%	92%	95%	100%	99%	97%	100%	100%	
		1.18	HII Compliance 7: Clostridium Difficile - prevention of spread	100%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	
	Incidents	1.19	Safety Thermometer - Harm-Free Care (New Harms)	100%	98.82%	98.26%	98.91%	98.64%	98.18%	97.18%	97.63%	98.38%	98.54%	97.90%	97.71%	98.47%	99.2%	99%	
		1.20	No of SIRIs	NT	9	5	7	7	6	5	11	14	10	20	11	6	8	8	
		1.21	RIDDOR Reportable Incidents	NT	3	4	5	0	3	0	2	0	3	0	2	1	2	2	
		1.22	Total No of E. Coli (Trust level only)	NT	2	0	2	2	1	2	1	2	2	2	1	3	ND	0	
		1.23	E. Coli Infection Rate															0	
		1.24	Inpatient Falls (WSH)	<48	53	52	50	66	64	39	47	56	60	68	74	64	68	68	
		1.25	Inpatient Falls resulting in harm (WSH)	<10	9	17	20	14	18	10	19	15	19	27	25	19	24	24	
		1.26	Falls - Per 1000 bed days	5.60	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	0	
		1.27	Number of avoidable serious injuries/deaths resulting from falls (WSH)	NT	0	0	0	0	1	0	0	0	0	0	ND	0	ND	0	
		1.28	Number of medication errors	NT	64	80	69	78	70	69	70	78	63	72	49	76	60	60	
		1.29	Actual patient harm resulting from medication incidents	0.01	1	0	0	0	ND	ND	ND	ND	ND	ND	ND	ND	ND	0	
		1.30	No of ward acquired pressure ulcers	NT	10	9	18	9	13	14	18	17	12	30	15	9	5	5	
		1.31	Pressure Ulcers - Avoidable ward-acquired PUs (YTD)	<+30%	40%	37%	30%	30%	34%	33%	32%	28%	28%	29%	ND	ND	ND	28%	

6 DETAILED SECTIONS - SAFE

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

Reporting	1.33	MRSA Quarterly Std (including admission and LOS screens)	90%	NA	NA	92%	NA	NA	93%	NA	NA	90%	NA	NA	92%	92%	3	
	1.34	MRSA - Decolonisation	95%	92%	93%	95%	95%	90%	91%	98%	85%	91%	94%	86%	95%	92%	2	
	1.35	MRSA - RCA Reports	NA	0	0	0	0	0	0	0	0	0	0	0	0	0		
	1.36	MSSA (Hospital)	NT	ND	1	0	0	1	1	0	1	1	1	0	0	6		
	1.37	SIRI final reports due in month submitted beyond 60 workin	0	0	1	0	0	0	4	5	4	0	0	1	3	18	2	
	1.38	SIRIs reported >2 working days from identification as red	0	0	0	0	0	1	2	3	6	5	7	3	ND	27	1	
	1.39	RAG active/accepted risk assessments not in date	0	ND	ND	ND	9	0	1	5	0	2	1	4	0	22	3	
	1.40	Datix Risk Register Red / Amber actions overdue	0	ND	ND	ND	22	0	0	0	0	0	0	1	3	26		
	1.41	Outstanding actions complete in date for Red/Amber entries on Datix	95%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND	ND	ND	100%	3	
	1.42	Quarterly standard principle compliance	90%	NA	NA	95%	NA	NA	95%	NA	NA	97%	NA	NA		96%	3	
	1.43	Rapid access chest pain clinic access within 2 wks.	100%	100%	98%	100%	95%	97%	97%	96%	100%	100%	100%	100%	99%	99%	2	
	1.44	Verbal Duty of Candour outstanding at month-end	0%	3	0	0	0	2	0	1	2	0	2	2	1	13	2	
	1.45	Hand Hygiene Audits	95%	98%	99%	99%	100%	99%	98%	99%	99%	99%	99%	100%	100%	99%		
	1.46	Quarterly antibiotic audit	98%	NA	NA	91%	NA	NA	94%	NA	NA	93%	NA	NA	89%	92%	3	
	1.47	RCAs beyond deadline for completion	=<4	3	1	3	4	1	7	2	9	14	9	8	4	65	2	
	1.48	% of Green Patient Safety incidents investigated	NT	60%	66%	54%	53%	68%	58%	67%	56%	55%	59%	74%	68%	62%		
	1.49	PEWS documentation and escalation compliance	NT	80%	100%	90%	100%	100%	90%	ND	ND	ND	ND	ND	ND	93%	2	
	1.50	Quarterly Environment/Isolation	90%	NA	NA	91%	NA	NA	92%	NA	NA	92%	NA	NA	91%	92%	3	
	1.51	Quarterly VIP score documentation	90%	NA	NA	84%	NA	NA	80%	NA	NA	87%	NA	NA	80%	83%	2	
	1.52	Isolation data (Trust Level only)	95%	90%	95%	90%	90%	88%	88%	90%	88%	88%	90%	90%	89%	90%	2	
	1.53	Pain Mgt. Quarterly internal report	80%	75%	NA	NA	61%	NA	NA	61%	NA	NA	59%	NA	NA	64%	1	
	1.54	Nutrition Risk Assessment 48hrs	95%	91%	87%	89%	82%	85%	90%	89%	87%	93%	92%	89%	90%	89%	2	
	1.55	Median of NRLS upload (No. of days)	41	81	87	65	65	58	55	48	61	66	75	65	63	66	1	

SAFE – WARD ANALYSIS



6. EXCEPTION REPORTS – SAFE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

Compliance with completing risk assessments and weighing patients has remained unchanged overall this month at 90%. This is mainly due to poor results in two ward areas who have high vacancy rates and experience daily staffing deficits. The majority of wards are achieving 100% compliance.

There has been an improvement in compliance on Ward F3 and G4 where there has been some focused quality improvement work with the NHSi Nutrition Collaborative. F3 has seen three consecutive months achieving 100% compliance with weights and completing risk assessments and G4 has seen a marked improvement in weighing patients.

Going forward, the team involved with the collaborative work plan to review the quality improvement measures and roll the improvement initiatives out to the remainder of the Trust to provide assurance that nutritional care remains a high priority for quality improvement.

Trend — Recovery Trajectory

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

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

Description	Owner	Start	End
Focused work on two wards to improve compliance with nutrition assessments, promote quality of these assessments and monitor that interventions are appropriate. This is part of the NHSi Nutrition Collaborative initiative the Trust has been selected to be part of.	HoN	Nov-17	May-18
To work in collaboration with the Quality improvement lead to refine an improvement measurement tool	HoN	May-18	Jun-18

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

The decrease in numbers of hospital acquired pressure ulcers has continued in April with only four in total. There was one grade 3 and three grade 2. The majority of the reported cases were isolated to only a few areas, with many wards managing to achieve a further month free of any harm despite the ongoing staffing deficits and high acuity. Following a variety of preventative initiatives, the target of less than 30% avoidability has been achieved and sustained for several months in 2017 / 18. This has been against a backdrop of high acuity, staffing challenges and capacity pressures

There continues to be an increased focus on early detection of risk, assessment of preventative measures and reporting of damage on admission. There is also a drive to promote timely completion of investigations to ascertain avoidability and promotion of learning from incidents. A recent deep dive of incidents has highlighted a need to improve documentation with regard to preventative care and ongoing management of wounds. Poor documentation is often a key factor in deeming avoidability, as there is a lack of evidence to support an unavoidable status. There are plans to address this issue by reviewing documentation and developing expected standards of record keeping for nursing staff.

The Tissue Viability team continue to have high visibility and are actively promoting preventative care strategies. They are targeting areas with high numbers of HAPUs to provide teaching and support.

With further improvement in mind, WSFT has applied to join the NHSi pressure ulcer collaborative, with the aim to support some focussed quality improvements in some key priority areas within the acute and community settings.

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	Apr-18
Target	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%
Total Pressure Ulcers	10	9	19	10	13	15	19	17	12	30	15	9	4
% of patients with avoidable ward acquired pressure ulcers YTD	40%	37%	30%	30%	34%	33%	32%	28%	28%	29%	28%	ND	ND

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Tissue Viability team are exploring the concept of Kennedy grading for end of life patients. This is being discussed with NHE Improvement prior to local pilot on wards G1 and G4	TVN team	Mar-18	Jul-18
To develop standards for record keeping for nursing staff	HoN	May-18	Aug-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	Anne How
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

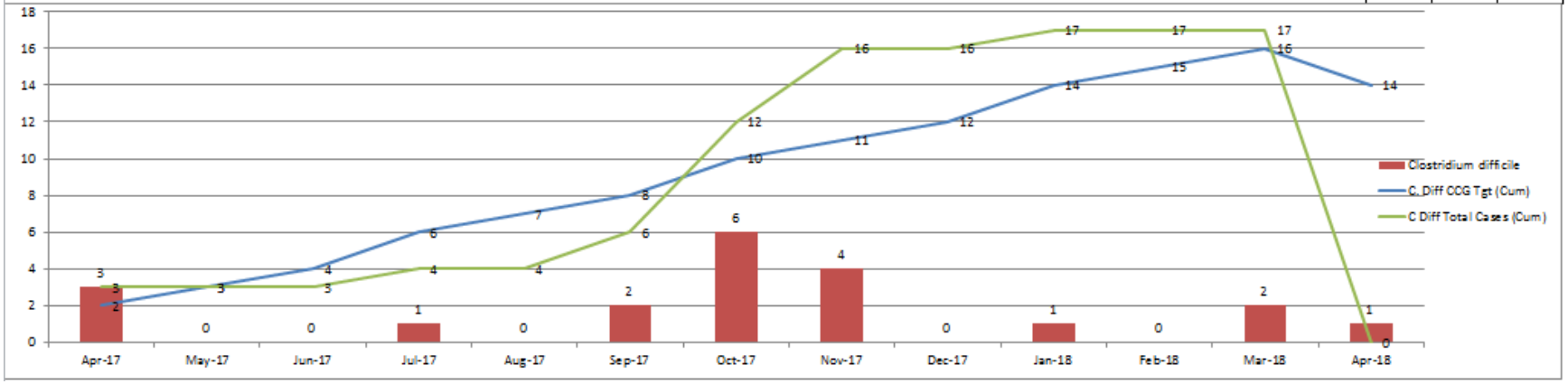
There were 2 cases of Hospital attributable CDT in March 2018. Overall summary as of 31st March 2018, there have been 19 reported cases of C difficile, 10 of which are Non Trajectory, 7 are Trajectory and 2 are awaited. Whilst the Trust was under trajectory in the first two quarters, Q3 was over trajectory with 10 cases at 31/12/17 (5 trajectory 5 non trajectory). Q4 has finished as 1 under trajectory. The Global shortage of Tazocin which has required the use of antibiotics associated with a higher risk of Clostridium difficile infection is recorded on the Trust Risk register.

The Trust recorded an MRSA bacteraemia in February 2018, this has been investigated and agreed with the CCG for submission as Third Party in line with the previous two episodes for this patient.

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	Apr-18
C. Diff CCG Tgt (Cum)	2	3	4	6	7	8	10	11	12	14	15	16	14
Clostridium difficile	3	0	0	1	0	2	6	4	0	1	0	2	1
C Diff Total Cases (Cum)	3	3	3	4	4	6	12	16	16	17	17	17	0
MRSA	0	0	0	0	0	2	0	0	0	0	1	0	0

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

Description	Owner	Start	End
MRSA - NHS England have 28 working days to arbitrate and we await their decision.	RP	Feb-18	Mar-18



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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	Apr-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	Trust is in lowest quartile

Summary of Current performance & Reasons for under performance

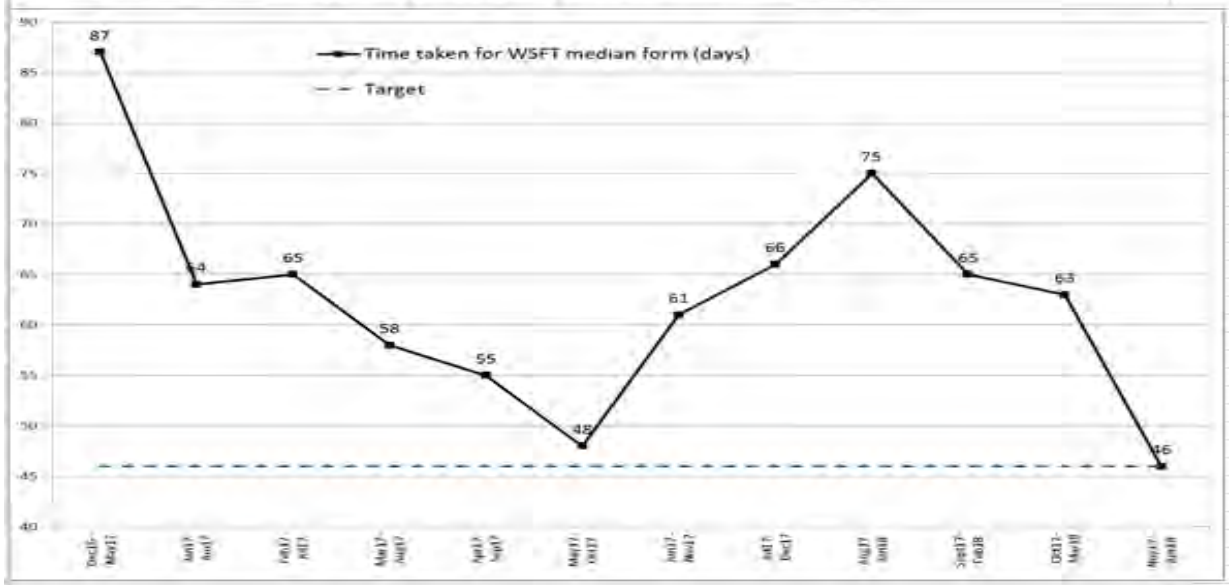
Performance has improved in April mainly as a consequence of the work to achieve the regular scheduled six-monthly NRLS 'close-down' (reporting of all Oct-Mar incidents to NHS England by the end of May). The challenge is to maintain this improving trajectory after the external deadline has passed.
Actions taken in 2017/18 included: providing additional adminstrative resource to the Datix adminstration function, simplifying the green investigation process to allow 'single-sign off', creating a grade 2 pressure ulcer concise template to reduce the need to complete standalone reports and removing fields collating potential risk coding which are already captured in the risk register. Future plans for 2018/19 include a simplification of the falls investigation form.
A more meaningful RAG rating based on performance within the interquartile range for our peer group is planned for 2018/19 with a target set to be better than the median trust in the group. The report providing the peer group data for this indicator is expected to be published in late May.

Trend — Recovery Trajectory

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Median NRLS	87	64	65	58	55	48	61	66	75	65	63	46

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Falls
Standard	No of patient falls / falls resulting in harm / No of avoidable serious injuries or deaths resulting from falls / Falls per 1,000 bed days
Name	Rowan Procter
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Summary of Current performance & Reasons for under performance

There were 68 inpatient falls in April, an improvement from 72 in March of these falls one resulted in major harm (Ward G9 - JR), 21 were classed as negligible / minor harm with no moderate harms recorded. At Newmarket Hospital there were 4 falls recorded in April (seven in March) and at Glastonbury Court there were 9 falls recorded for April (one in March), these falls are included in the Trust total.

In the month of April four patients were assisted to the floor (six in March preventing them from falling). A total of six patients fell more than twice (one of which fell four times) during their inpatient stay in April (six in March).

The Trust has been able to estimate Falls per 1,000 bed days using the locally generated (estimated) data that has been made available as an interim solution whilst Cerner solve the curent ECAre technical solution. The performance using this estimated data shows the Trust meeting the 2016/17 CCG targets (which were derived from the National audit of Falls) see graph below.

The factors of cognitive and perceptual impairment continue to be reflected in the high numbers of patients falling. This has been exacerbated by the inability to meet core staffing levels, and to provide staff to 'special' patients in relation to the number of beds currently occupied in existing, escalation and surge capacity areas.

1 x Red Fall – G9 (Winter Escalation) - Elderly patient admitted with Vitamin D deficiency, had been struggling at home and had refused assistance. The patient whilst mobilising with her frame became caught in the tied back curtain and fell resulting in a #NOF. The patient was transferred to Ward F3 for repair of the #, where she is still currently an in-patient.

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	Apr-18
Total InPatient Falls [WSH]	53	52	50	66	64	39	47	56	60	68	74	64	55
Total InPatient Falls [Community Hospitals]	8	14	6	9	5	5	9	17	9	8	8	8	13
InPatient Falls resulting in harm [WSH]	9	17	20	14	18	10	19	15	19	27	25	19	18
Percentage of falls resulting in harm [WSH]	17%	33%	40%	21%	28%	26%	40%	27%	32%	40%	34%	30%	33%

Actions in place to recover the performance	Expected timeframes for improvements		
The Falls Focus Group meets on a bi-monthly basis, information from this group is then fed back in to the Trust higher level Falls Group led by Dr Suresh.	Falls Group	now complete	
The trust has now provided Falls Pocket Cards (currently being distributed by the Falls Focus Group / Senior Matron Team members).	Falls Group	now complete	
RCP information booklets for patients / relatives on preventing falls are currently being re-produced for the clinical areas to provide to these groups.	Falls Group	now complete	
There are now 3 options in footwear available for in-patients at the WSFT to aid in safe mobility and reduce the number of slips, trips and falls.	Falls Group	2018	Ongoing
L&S BP task now set for all ii-patient areas at the WSH as per NICE guidance, this allows for the identification of individuals at risk of falling and the implementation of the appropriate care plans / order sets. There will be new observation machines rolled out to all WSH in-patient areas which will support this process and ensure the timely and accurate inputting of data.	Falls Group	2018	Ongoing
All 'Amber' classification falls will now be subject to the Level 1 Concise RCA for Falls to ensure appropriate lessons are learnt and information is available to support the duty of candour process.	Falls Group	now complete	
The current falls care plan within eCare is being reviewed and possible amendments will be made to appropriately reflect interventions for consideration and to highlight actions taken.	Falls Group	Apr-18	Jul-18
The Falls Group and the sub Focus Group are currently exploring the option of the 'Catch a Falling Star' falls study day, focusing on the prevention of falls and appropriate treatment post fall. This has successfully been implemented in a London Trust with good results and could be tailored for the specific purposes of the WSFT. The option of a Falls Prevention video for patients to watch (as used in Michigan – Bronson Healthcare Group) is being explored to try and assist in the reduction of falls.	Falls Group	May-18	Jun-18
Falls per 1000 bed day data provided as an estimate for two years in this months report needs to be reported on a monhtly basis going forward. This requires confirmation of provision of OBD data (currently estimated) from th eInformation team to the Head of Nursing for Medicine.	Information Team	Jun-18	TBC

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

Compliance with completing risk assessments and weighing patients has remained unchanged overall this month at 90%. This is mainly due to poor results in two ward areas who have high vacancy rates and experience daily staffing deficits. The majority of wards are achieving 100% compliance.

There has been an improvement in compliance on Ward F3 and G4 where there has been some focused quality improvement work with the NHSi Nutrition Collaborative. F3 has seen three consecutive months achieving 100% compliance with weights and completing risk assessments and G4 has seen a marked improvement in weighing patients.

Going forward, the team involved with the collaborative work plan to review the quality improvement measures and roll the improvement initiatives out to the remainder of the Trust to provide assurance that nutritional care remains a high priority for quality improvement.

Trend | Recovery Trajectory

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

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Focused work on two wards to improve compliance with nutrition assessments, promote quality of these assessments and monitor that interventions are appropriate. This is part of the NHSi Nutrition Collaborative initiative the Trust has been selected to be part of.	HoN	Nov-17	May-18
To work in collaboration with the Quality improvement lead to refine an improvement measurement tool	HoN	May-18	Jun-18

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Timeliness of SI final report submission
Standard	
Name	Rowan Procter
Month	Apr 18
Data Frequency	Monthly
CQC Area	Safe
National Rank	NA

Summary of Current performance & Reasons for under performance

There were three RCA reports which did not meet the 60 working day target in April. One case (a deteriorating patient) was reported one day beyond target and another (a Grade 3 pressure hospital acquired pressure ulcer) was reported six days beyond target due to the timeframe of receipt of final report. One other report (a delayed diagnosis) has not yet been sent. The Medical Director is aware of this case.

Trend

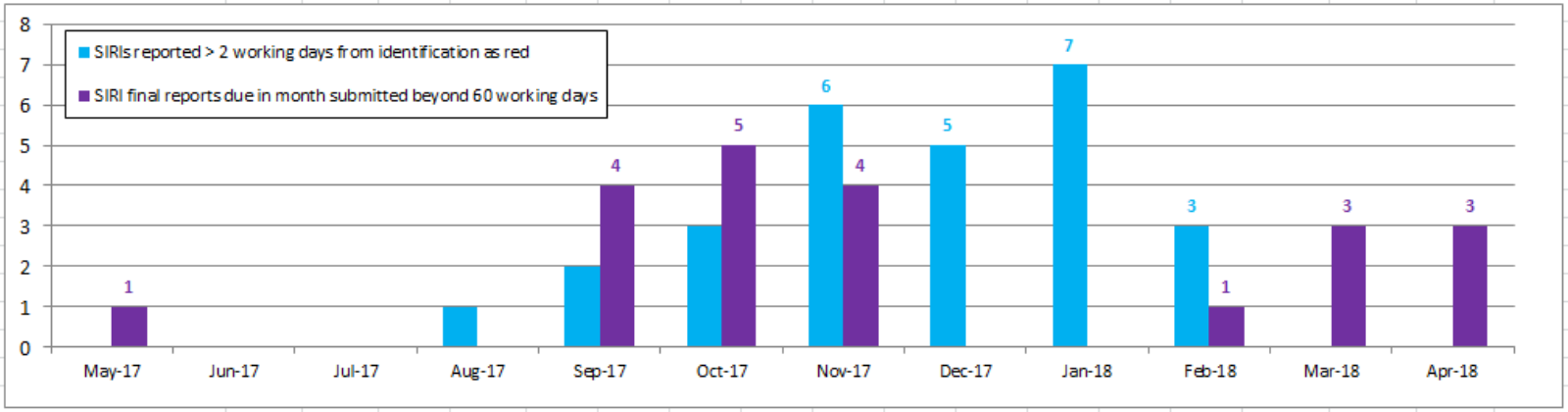
Recovery Trajectory

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

Actions in place to recover the performance

Expected timeframes for improvement

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Isolation Data
Standard	95%
Name	Anne Howe
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Safe

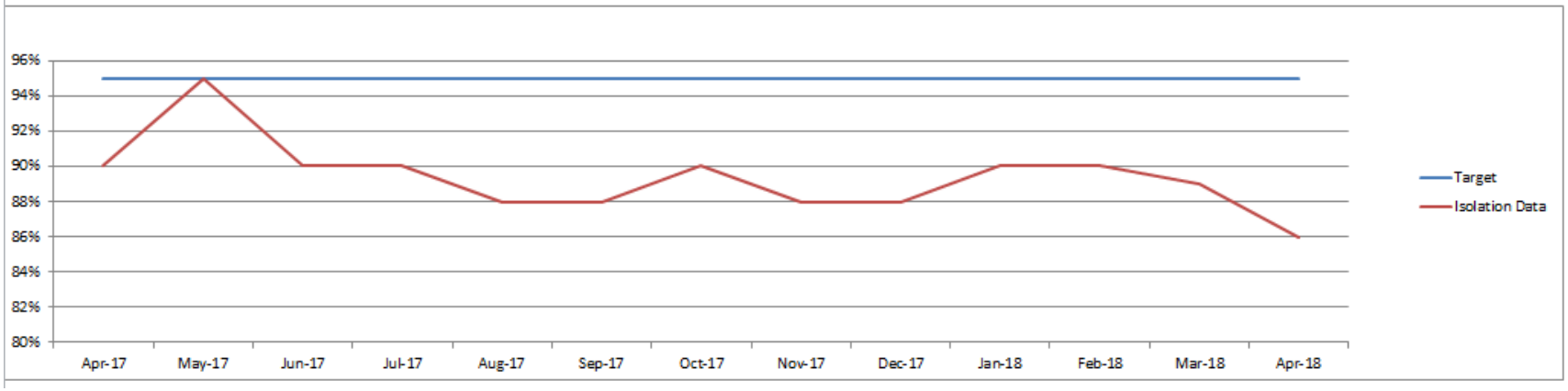
Summary of Current performance & Reasons for under performance

3 patients were with multi resistant organisms in catheterized urine could not be isolated. 1 patient managed a trial without the catheter the other 2 were catheter dependant. The patients who were in the siderooms had conditions which were risk assessed as more infectious.

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	Apr-18
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Isolation Data	90%	95%	90%	90%	88%	88%	90%	88%	88%	90%	90%	89%	86%

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

Description	Owner	Start	End
Wards were advised on the measures required to mitigate onward transmission.	HB	Sep-17	Mar-18



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Background

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

The Trust score for APril 2018 for new harm free care was 99.18%. 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 March 2018 and the Trust results for April 2018. The National average for March is 97.9%

RAG rating is defined by the Trust's score compared to the National average. April's National average has not been published yet but if it remains at 97.9 as it has done for the last five months the Trust's score will be above the National average and therefore green

Trend | Recovery Trajectory

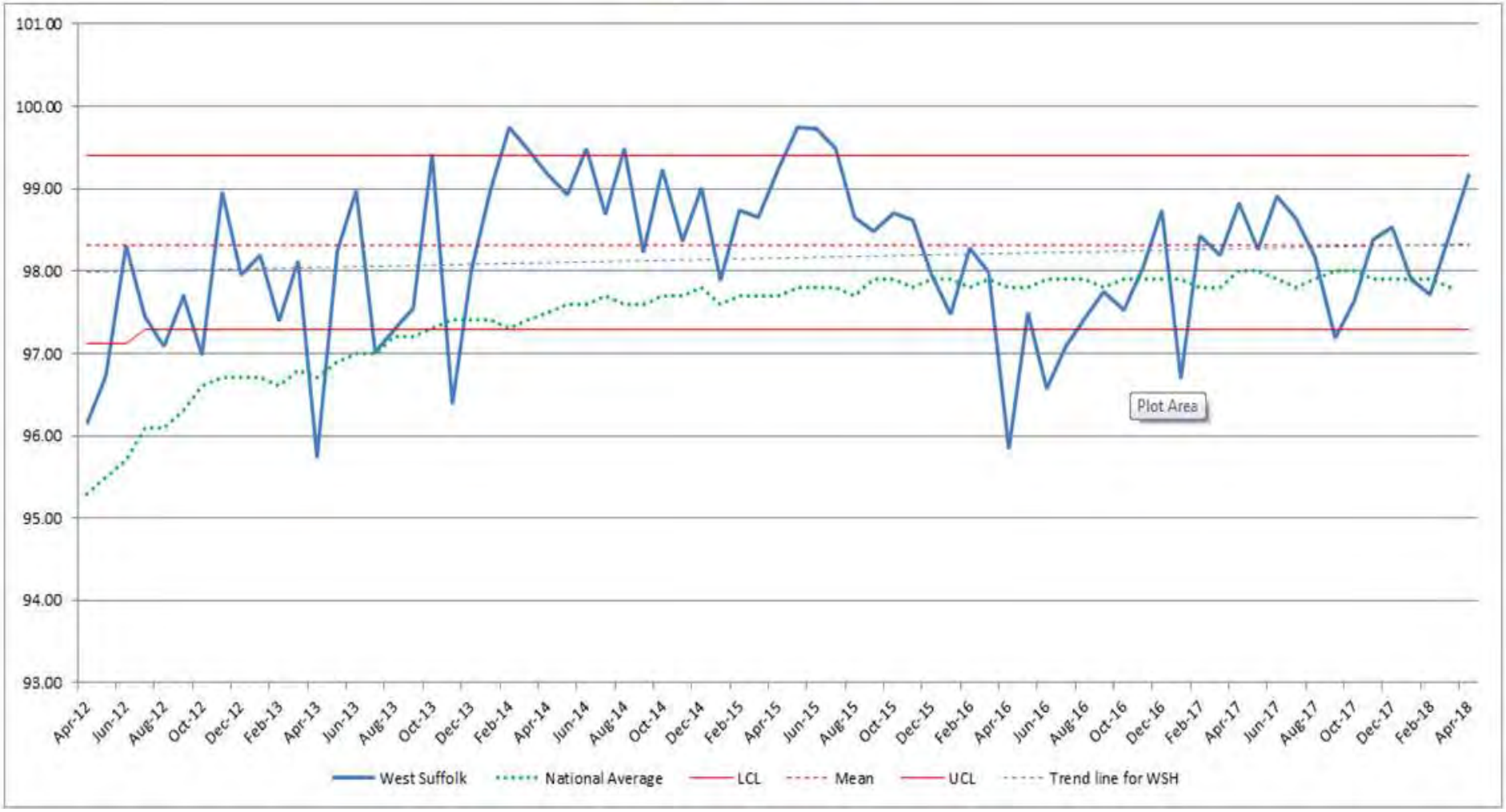
Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Safety Thermometer - Harm-Free Care	98.43%	98.19%	98.53%	98.26%	98.91%	98.64%	98.18%	97.18%	97.63%	98.38%	98.54%	97.90%	97.71%	98.47%	99.18%

Key Recovery Actions

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

West Suffolk Safety Thermometer Data

April 2012- April 2018



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Duty of Candour (DoC)
Standard	Verbal DoC competed within 10 working days
Name	Rowan Procter
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Responsive
National Rank	NA

Summary of Current performance & Reasons for under performance

The Trust's policy PP197 Being Open - The Duty of Candour sets out a process to undertake verbal DoC within 10 working days with an accompanying notification letter to follow. The completion of DoC is captured on the Datix incident system and administered by the Nursing & Governance Directorate. The pathway for capturing DoC undertaken by the Community Health teams is being put into place and is therefore not currently included in the data. It is anticipated that there will be data from April onwards available in next month's report.

There is one case (an Amber incident) requiring verbal DoC before the end of March that is still pending. The Executive Medical Director and Clinical Director for Surgery have been made aware.

Trend

Recovery Trajectory

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Verbal DoC competed within 10 working days	0	0	0	2	0	1	2	0	2	2	1	1

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Ongoing follow up of leads for overdue DoC	Governance	2018	2018
The Community teams have been made aware of how to complete DoD on the Datix record. This will be completed prospectively from June with a retrospective review of April and May cases to allow full year reporting	LAMS / HoN	May-18	Jun-18

7. DETAILED REPORTS - EFFECTIVE

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

Ref.	KPI	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	YTD(Apr18-Mar19)
2.03	Emergency Re-admissions within 30d	8%														
2.04	Canc. Ops - Cancellations for non-clinical reasons	1%	0.6%	0.6%	1.1%	1.0%	1.2%	1.0%	1.4%	1.9%	1.3%	0.8%	1.2%	0.9%	0.6%	0.0%
2.05	OP Clinic Utilisation Rate	TBA														
2.06	Theatre Utilisation Rate	TBA														
2.11	Cardiac arrests	NT	4	6	4	2	3	6	4	ND	ND	7	ND	ND	ND	0
2.12	Cardiac arrests identified as a SIRI	-	0	0	1	0	0	0	0	0	0	ND	ND	ND	ND	#DIV/0!
2.13	CAS (central alerts system) alerts overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.14	NICE guidance baseline and risk assessments not completed within 6 months of publication															
2.15	WHO Checklist (Qrtly)	100%	NA	NA	99%	NA	NA	99%	NA	NA	99%	NA	NA	98%	NA	#DIV/0!
2.16	National clinical audit report baseline & risk assessments not completed within 6 months of publication															0
2.19	Av. Elective LOS (excl. 0 days)		2.75	3.26	2.7	2.54	2.79	2.73	2.93	2.85	2.98	3.06	2.27	3.32	3.29	3.29
2.20	Av NEL LOS (excl 0 days)		7.59	7.85	7.66	7.47	7.93	7.54	8.23	7.66	7.56	8.40	7.63	7.67	8.05	8.05
2.21	% of NEL 0 day LOS		19.4%	18.6%	20.3%	18.6%	17.4%	17.5%	18.8%	16.6%	14.7%	13.2%	13.4%	13.51%	13.8%	14%
2.22	NHS number coding	99%	99.7%	99.7%	99.7%	99.4%	99.5%	99.6%	99.6%	99.7%	99.6%	99.7%	99.7%	99.69%	99.5%	100%
2.23	Fractured Neck of Femur : Surgery in 36 hours	85%	97%	96%	96%	85%	97%	97%	96%	84%	100%	100%	96%	93%	89%	89%
2.25	Discharge Summaries (OP 85% 3d,)	85%	65%	62%	57%	57%	57%	55%	58%	58%	58%	60%	58%	56%	62.0%	62%
2.26	Discharge Summaries (A&E 95% 1d)	95%	87.9%	88.8%	87.5%	86.7%	85.7%	85.9%	83.6%	84.2%	82.6%	84%	83.4%	82.3%	81.5%	81%
2.27	Discharge Summaries (IP 95% 1d)	95%	92.0%	93.3%	93.4%	ND	ND	ND	ND	ND	70.9%	71.1%	70.3%	71.6%	72.1%	72.1%
2.28	Choose and Book - Available Slots	95%	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND	ND	ND	#DIV/0!
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%
2.30	Canc. Ops - Patients offered date within 28 days	100%	93.33%	93.75%	93.18%	88.46%	75.00%	92.00%	84.62%	98.11%	76.67%	94.74%	96.55%	91.67%	85.7%	85.7%
2.31	Canc. Ops. - No. Cancelled for a 2nd time	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Putting you first

7. EXCEPTION REPORTS – EFFECTIVE

Emergency Flow - NHS Improvement has produced a high-level flow benchmark analysis which is set out below (Trust data up to February 2018 for some Indicators- *Source: Model Hospital – May 2018*).

Putting you first

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	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	YTD(Apr18-Mar19)	WTG	Traffic
3. Caring	Dashboard	3.01	Compliments (Logged by Patient Experience)		41	52	26	56	28	17	33	87	151	64	20	45	21	21		
		3.02	Formal Complaints	20	10	10	10	6	16	16	17	13	8	12	19	9	13	13	6	
		3.03	Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	6	
		3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	98%	97%	99%	98%	98%	98%	99%	96%	98%	97%	98%	98%	99%	98%	6	
		3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	95%	96%	97%	95%	95%	96%	96%	96%	99%	95%	96%	95%	97%	97%	6	
		3.06	A&E - Extremely likely or Likely to recommend (FFT)	85%	97%	96%	95%	95%	95%	92%	95%	94%	94%	96%	95%	94%	94%	94%	6	
		3.07	Maternity - Extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	100%	ND	ND	99%	100%	97%	100%	93%	100%	100%	100%	6	
		3.08	Community - Extremely likely or likely to recommend (FFT)																	
	Other Friends and Family Test Scores	3.09	IP overall experience result	85%	93%	92%	94%	94%	93%	93%	96%	96%	95%	94%	95%	96%	97%	97%	3	
		3.10	OP overall experience result	85%	92%	85%	88%	89%	91%	89%	95%	94%	95%	96%	97%	96%	97%	97%	3	
		3.11	A&E overall experience result	85%	94%	96%	94%	94%	95%	94%	93%	94%	94%	94%	94%	94%	94%	94%	3	
		3.12	Short-stay overall experience result	85%	99%	99%	100%	99%	99%	99%	99%	99%	99%	99%	99%	98%	85%	85%	3	
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	90%	98.7%	98.6%	99.7%	99.5%	99%	99%	99%	97%	100%	99.4%	99.7%	99%	100%	100%	3	
		3.14	Maternity - overall experience result	85%	98%	100%	100%	100%	100%	100%	100%	98%	95%	100%	93%	100%	99%	99%	3	
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	ND	ND	100%	100%	ND	ND	ND	ND	ND	100%	100%	3	
		3.16	Maternity birthing unit - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	ND	ND	100%	100%	100%	ND	100%	100%	ND	100%	100%	3	
		3.17	Maternity antenatal community - extremely likely or likely to recommend (FFT)	90%	97%	98%	100%	ND	ND	100%	96%	ND	ND	ND	ND	ND	100%	100%	3	
		3.19	F1 Parent - overall experience result	85%	97%	99%	99%	95%	100%	100%	99%	95%	98%	98%	98%	98%	96%	96%	3	
		3.20	F1 - Extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	92%	100%	100%	100%	94%	97%	100%	100%	100%	92%	92%	3	
		3.21	F1 Children - Overall experience result	85%	ND	100%	94%	ND	ND	ND	ND	ND	ND	ND	ND	ND	85%	85%	3	
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	ND	ND	100%	100%	100%	78%	85%	100%	79%	79%		
		3.23	King suite - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	ND	ND	100%	100%	94%	93%	100%	100%	ND	#DIV/0!		
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	ND	ND	96%	100%	97%	100%	97%	95%	94%	94%		
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	ND	ND	100%	100%	100%	90%	100%	90%	100%	100%		
		3.26	Community specialist nursing teams - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	ND	ND	100%	100%	95%	100%	93%	100%	92%	92%		
		3.27	Stroke Care - Overall Experience Result	85%	94%	ND	98%	99%	ND	99%	100%	85%	ND	98%	95%	100%	95%	95%	3	
		3.28	Stroke Care - extremely likely or likely to recommend (FFT)	90%	93%	ND	95%	100%	100%	95%	100%	100%	ND	100%	100%	100%	100%	100%	3	
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	90%	ND	90%	100%	100%	93%	94%	100%	100%	87%	92%	100%	100%	92%	92%	3	
		3.30	Complaints responded to within agreed timeframe	90%	100%	90%	75%	100%	85%	67%	81%	82%	50%	60%	17%	54%	31%	31%	1	
		3.31	Number of second letters received	1	3	0	2	1	1	1	2	0	1	0	0	1	2	2	3	
		3.32	Ombudsman referrals accepted for investigation	0	0	2	0	1	0	0	0	0	1	1	1	0	0	0	2	
		3.33	No. of complaints to Ombudsman upheld	0	ND	ND	ND	ND	ND	ND	ND	0	0	0	0	0	0	0		
		3.34	No. of PALS contacts	NT	172	188	169	176	137	167	190	167	124	161	178	205	183	183		
		3.36	No. of PALS contacts becoming formal complaints	<=5	0	0	0	1	4	2	3	4	1	3	6	1	4	4	3	

8. EXCEPTION REPORTS – CARING

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Mixed Sex Accommodation Breaches
Standard	0%
Name	Irene Serrant
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Caring

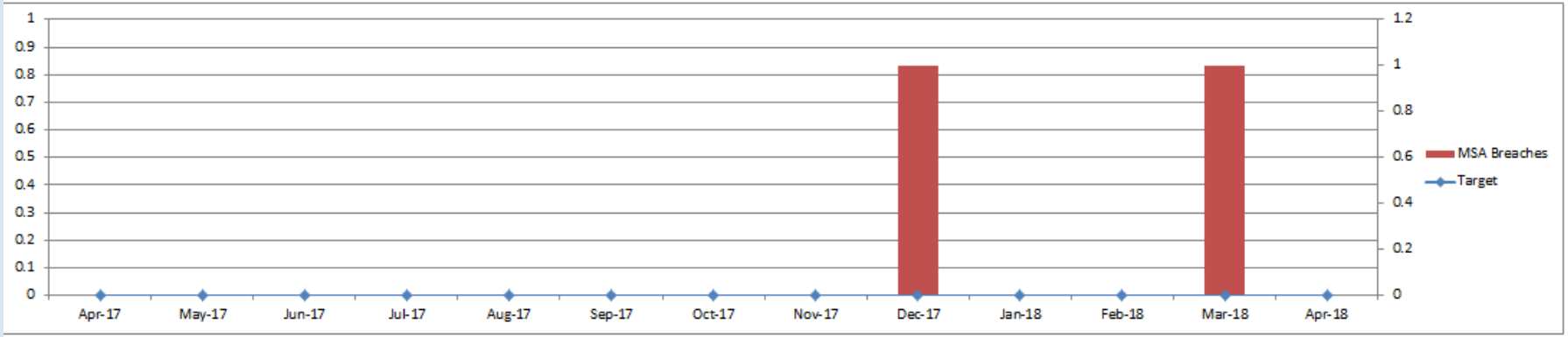
Summary of Current performance & Reasons for under performance

Same sex accommodation breaches are rare and reported in ITU. On this occasion it lasted for a few hours while a ward bed for one of the patients was available.

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	Apr-18
Target	0	0	0	0	0	0	0	0	0	0	0	0	0
MSA Breaches	0	0	0	0	0	0	0	0	1	0	0	1	0

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

Description	Owner	Start	End
Bed managers are informed when a patient is made wardable. The risks of same sex accommodation breaches are considered before moving patients into HDU/ in or out of side rooms. Patients are discharged as soon as a ward bed is available. Expected timeframes for improvements - Dependent upon Trust pressures and bed availability however it was agreed at the recent TEG to make ITU discharges a priority.			



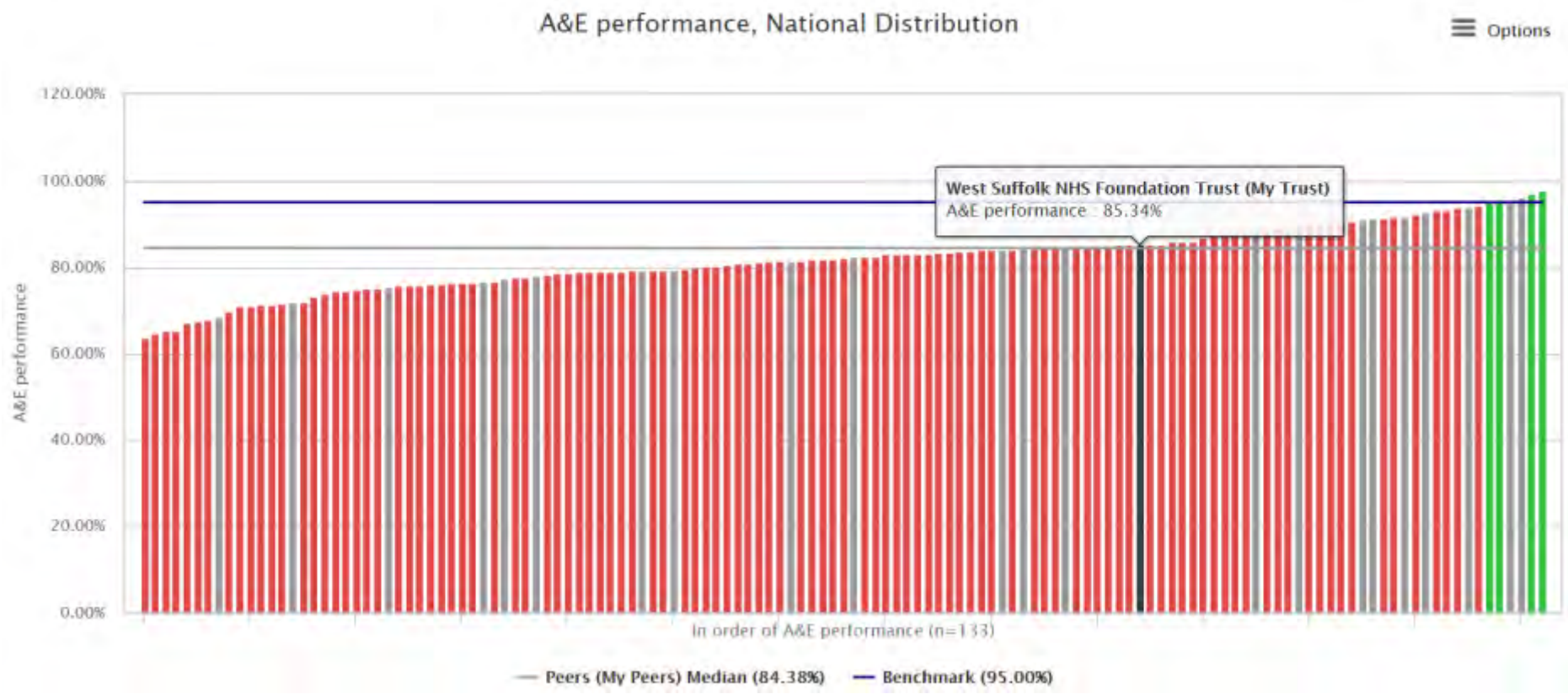
DETAILED REPORTS - RESPONSIVE

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

Are we..		Ref.	KPI	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	YTD Apr 18-Mar 19
4. Responsive	Dashboard	4.01	A&E under 4 hr. wait	95%	95%	95%	96%	92%	90%	88%	87%	90%	83%	84%	85%	85%	85%	85%
		4.02	RTT: % incomplete pathways within 18 weeks	92%	82%	80%	83%	84%	86%	86%	87%	89%	89%	90%	90%	ND	90%	90%
		4.03	52 week waiters	0	15	14	15	25	25	25	25	21	15	14	13	ND	13	13
		4.04	Diagnostics within 6 weeks	99%	99.9%	99.9%	100%	99.5%	100%	100%	100%	100%	100%	100%	99.8%	99.3%	ND	ND
		4.05	Cancer: 2w wait for urgent GP Referrals	93%	93.9%	92.3%	96.6%	94.5%	96.0%	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	96%
		4.06	Cancer 2w wait breast symptoms	93%	94.0%	99.3%	88.8%	88.1%	######	98.3%	######	######	99.1%	97.1%	92.9%	86.7%	96.7%	97%
		4.07	Cancer 31 d First Treatment	96%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	99%	99%
		4.08	Cancer 31 d Drug Treatment	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		4.09	Cancer 31 d Surgery	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		4.10	Cancer 62 d GP referral	85%	89%	83%	86%	85%	86%	87%	94%	90%	87%	87%	80%	88%	91%	91%
		4.11	Cancer 62 d Screening	90%	100%	100%	90%	100%	100%	91%	100%	83%	100%	93%	86%	85%	80%	80%
		4.12	Incomplete 104 day waits		ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	3	3
	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	NT	417	411	511	481	565	337	250	279	314	326	393	321	208	208
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	NT	35	43	52	52	50	62	59	41	62	57	75	64	70	70
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	09:57	13:57	10:10	13:53	11:46	12:01	15:44	22:04	16:48	18:11	17:18	19:50	18:14	18:14
		4.16	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
		4.17	A&E - Admission waiting 4-12 hours from dec. to admit		14	3	6	5	5	14	10	17	50	122	30	46	17	17.0
		4.18	A&E - To inpatient Admission Ratio	27%	29.1%	29.0%	28.3%	27.9%	29.2%	30.5%	30.4%	30.0%	32.8%	31.9%	32.1%	29.6%	27.9%	27.9%
		4.19	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	1
		4.20	A&E/AMU - Amb. Submit button complete	80%	93.0%	91.1%	91.7%	91.0%	89.8%	90.3%	87.7%	88.2%	89.4%	85.7%	89.6%	93.5%	92.7%	93%
		4.21	A&E - Amb. Handover above 30m	30m	21	38	31	39	19	15	0	84	110	72	87	74	ND	ND
		4.22	A&E - Amb. Handover above 60m	60m	3	16	9	7	16	30	0	46	54	38	30	17	ND	ND
		4.23	A&E - Type 1&2 high risk patients reviewed by a EMC	14%	94%	87%	93%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
	RTT	4.24	RTT - 18w Admitted (Completed)	90%	69.2%	67.8%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	ND	73.4%	73%
		4.25	RTT - 18w Non-admitted (Completed)	95%	86.2%	87.0%	87.3%	87.6%	83.8%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	ND	92.8%	93%
		4.26	RTT waiting List		22110	22144	19931	#####	17346	17236	16694	16641	16195	15363	15804	ND	16224	16224
		4.27	RTT waiting list over 18 weeks		3929	4492	3316	2629	2441	2467	2171	1843	1775	1504	1650	ND	1561	1561
	Stroke	4.28	Stroke - % Patients scanned within 1 hr.	77%	87%	80%	72%	82%	79%	78%	76%	74%	76%	86.7%	76.7%	70%	74%	74%
		4.29	Stroke - % patients scanned within 12 hrs.	96%	98%	98%	95%	95%	96%	90%	97%	92%	96%	98.3%	######	97.5%	95%	95%
		4.30	Stroke - % Patients admitted directly to stroke unit w	75%	89%	71%	76%	78%	79%	83%	72%	73%	60%	75.4%	79.3%	72.5%	58%	58%
		4.31	Stroke - % greater than 80% of treatment on stroke ur	90%	98%	88%	88%	94%	98%	93%	89%	93%	91%	93.0%	96.6%	87.5%	82%	82%
		4.32	Stroke - % of patients treated by the SESDC	48%	50%	48%	75%	46%	33%	51%	50%	31%	32%	61.5%	50.0%	51.4%	55%	55%
		4.33	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	93%	86%	95%	92%	88%	85%	83%	82%	89%	93.3%	83.3%	95%	79%	79%
		4.34	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	87%	80%	90%	88%	90%	92%	77%	76%	78%	93.0%	86.2%	86.8%	95%	95%
		4.35	Stroke -% of eligible patients given thrombolysis	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	######	######	######	100%	100%
		4.36	Stroke -% of stroke survivors who have 6mth f/up	50%	ND	58%	ND	ND	ND	58%	ND	ND	ND	61%	ND	ND	ND	ND
		4.37	Stroke -Provider rating to remain within A-C	C	ND	C	ND	ND	ND	ND	ND	ND	ND	C	ND	C	C	C
		4.38	Sepsis - 1 hr neutropaenic sepsis	100%	63.6%	47.1%	63.2%	68.8%	82.6%	62.5%	79.0%	73.9%	53.9%	80%	75%	58.3%	63.6%	63.6%

EXCEPTION REPORTS – RESPONSIVE

A&E performance has fallen from 95.1% in Qtr. 1 to 85% in Qtr.4 at West Suffolk. The first table (latest available data – March 2018) shows the relative performance of West Suffolk compared with peers and the national average. The second chart show performance of West Suffolk against the peers and national median (*Source: Model Hospital – April 2018)*.


A&E performance, National Distribution
Options
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
A&E performance
West Suffolk NHS Foundation Trust (My Trust)
A&E performance : 85.34%
In order of A&E performance (n=133)
Peers (My Peers) Median (84.38%)
Benchmark (95.00%)

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E 4 hour wait
Standard	95%
Name	Darin Geary
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

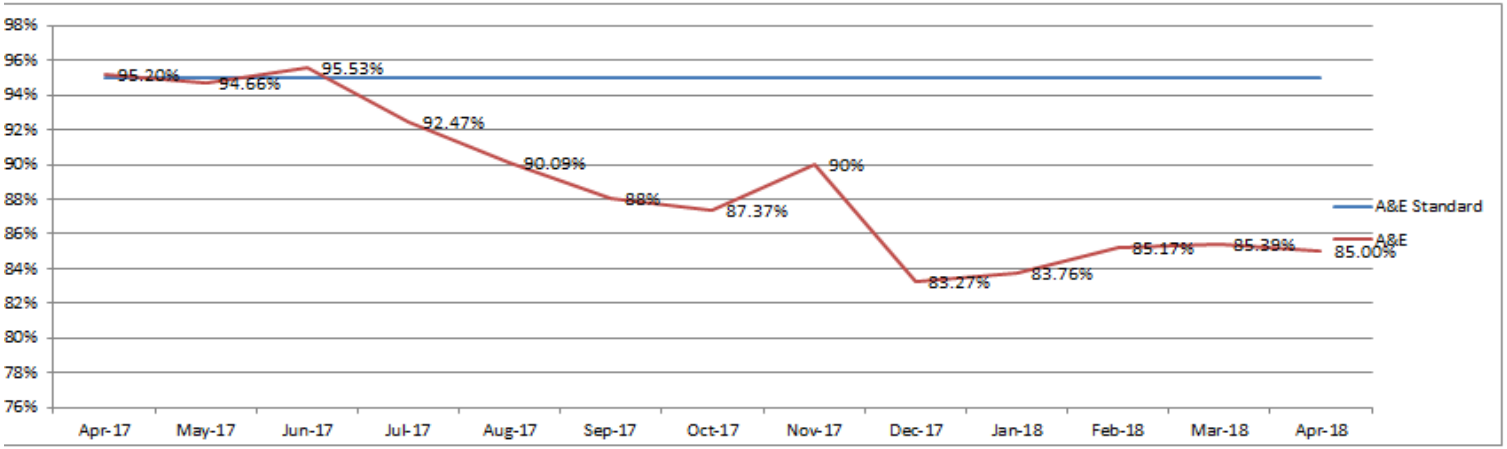
Demand has remained higher than this time last year. Main reasons for non-compliance with the 4 hour target continues to be delay to be seen by a clinical decision maker (CDM), with a majority of the delays being out of hours. This is due to gaps in the medical workforce which continue at middle grade level. There continues to be capacity issues related to flow of patients from ED to the Assessment areas.

The ED Task & Finish group are reviewing the Demand and Capacity data from 2017/18 and looking at options to improve medical staffing. Work continues on planning for the new AAU unit to open in November 2018.

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	Apr-18
A&E Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
A&E	95.20%	94.66%	95.53%	92.47%	90.09%	88%	87.37%	90%	83.27%	83.76%	85.17%	85.39%	85.00%

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

Description	Owner	Start	End
A number of actions are in progress to improve performance as per ED Performance Action plan discussed with Executive Directors on 16th May 2018.	HB	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E 4-12 Hr DTA
Standard	4.16
Name	Darin Geary
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Responsive

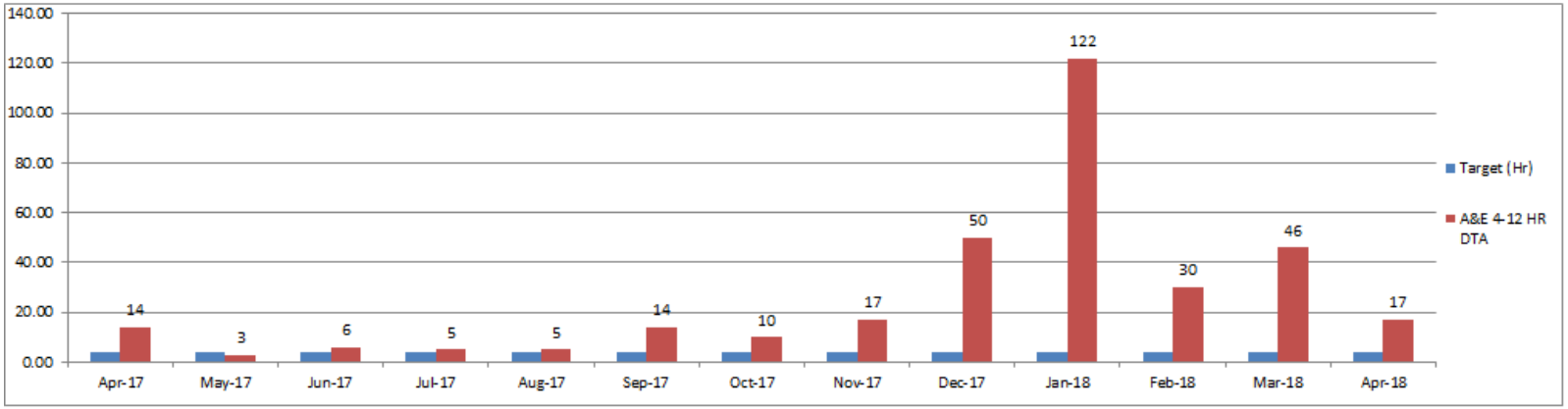
Summary of Current performance & Reasons for under performance

Delays in DTA are related to the following:
a) Reduced level of middle grade doctors in ED especially at night
b) Increased demand
c) Capacity issues caused by flow constraints across the Trust
d) Delays to be seen by speciality team (not meeting Internal Professional Standards)

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	Apr-18
Target (Hr)	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16
A&E 4-12 HR DTA	14	3	6	5	5	14	10	17	50	122	30	46	17

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

Description	Owner	Start	End
A number of actions are in progress to improve performance as per ED Performance Action plan discussed with Executive Directors on 16th May 2018.	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Stroke
Standard	
Name	Jane Allen
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

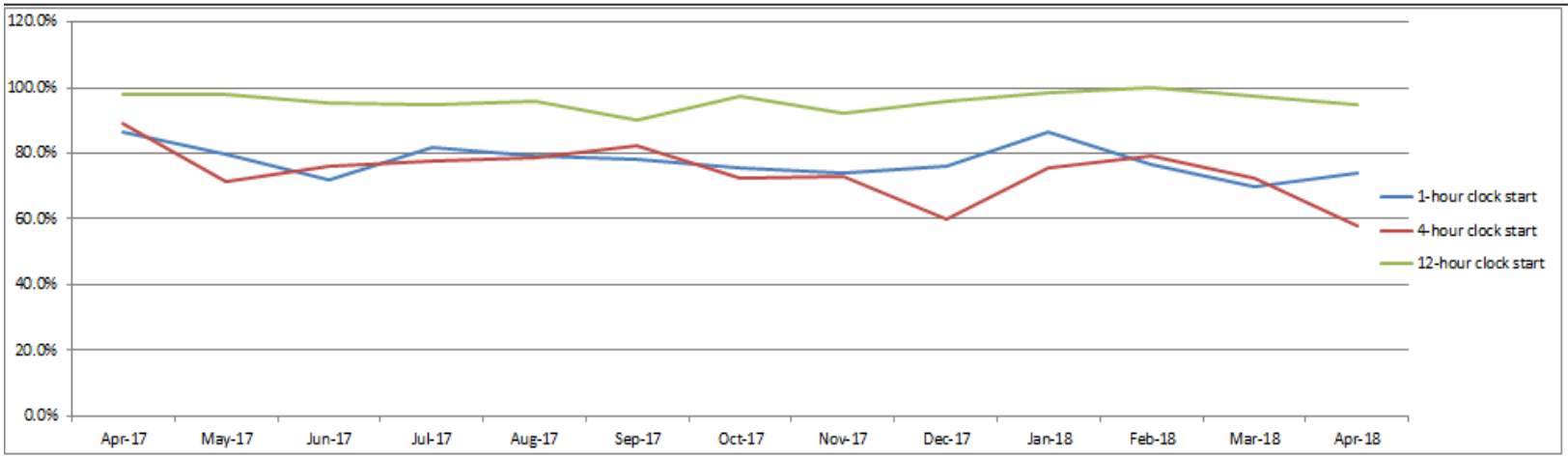
Out of 38 patients discharged from the stroke unit 10 patients failed to meet the **1 hour to scan target.** Of thise, 7 were attributed to delays in either, triage, doctor review or informing ESOT. 1 was a patient with a potential different diagnosis, 1 an inpatient who missed by ten minutes and 1 who was discovereed after passing away who was never referred to ESOT. **12 hour to scan target**, 3 breaches, 1x ED, 1X differential diagnosis and 1x passed away and ESOT not notified. **4 hrs to stroke unit** - 16 breaches, The two main reasons were no bed on the stroke unit and delays in ED. **Action:** This month there were many delays in ED, causing storke breaches. A meeting is being arranged between lead consultants of stroke and ED and service managers from both areas to deivse an action plan of how the situation can be improved.

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	Apr-18
1-hour clock start	86.7%	79.6%	72.1%	81.6%	79.2%	78.1%	75.7%	74%	76%	86.7%	76.7%	70%	74%
4-hour clock start	88.9%	71.4%	76.2%	77.8%	78.7%	82.5%	72.2%	73%	60%	75.4%	79.3%	72.5%	58.0%
12-hour clock start	97.8%	98.0%	95.4%	94.7%	95.8%	90.2%	97.3%	92.3%	96%	98.3%	100%	97.5%	95.0%

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Work going on throughout the Trust to improve patient flow.	HB	Sep-17	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

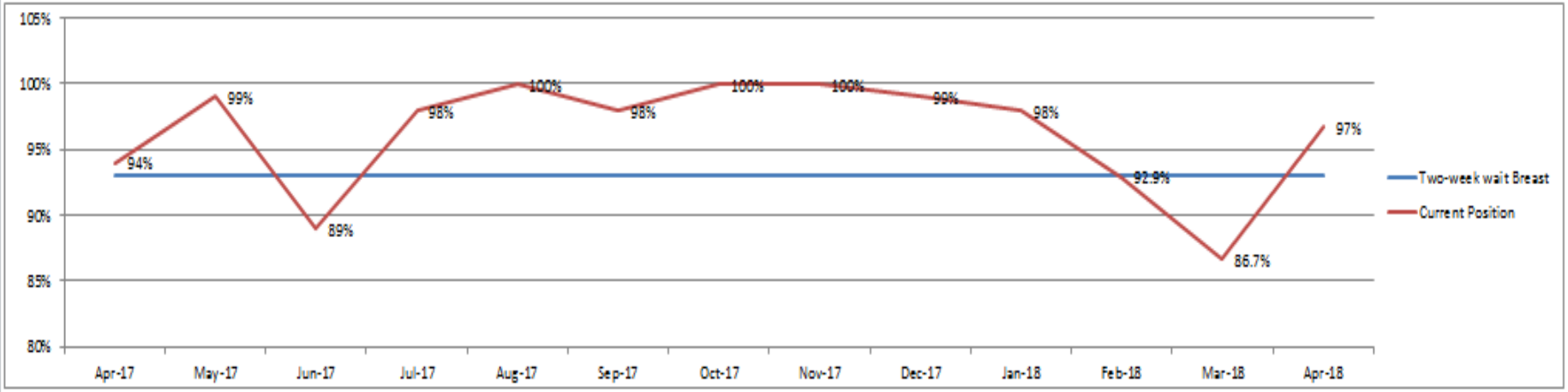
Indicator	Cancer: 2-week wait Breast Referrals
Standard	93%
Name	Sam Dhungana
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current Performance: 96.7% is above the national requirement.
with significant increase in the number for referrals in 2 WW suspected breast cancerthere is an ongoing risk of Knock on effect to this target going forward in May.

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	Apr-18
Two-week wait Breast	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	94%	99%	89%	98%	100%	98%	100%	100%	99%	98%	92.9%	86.7%	97%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Trust has agreed with the CCG for them to provide a patient reminder card highlighting the importance of accepting first offered appointments. CCG are in process to make these cards available across their practices and which is aimed to improve patient attendance.	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer: 62-day Screening
Standard	90%
Name	Sam Dhungana
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

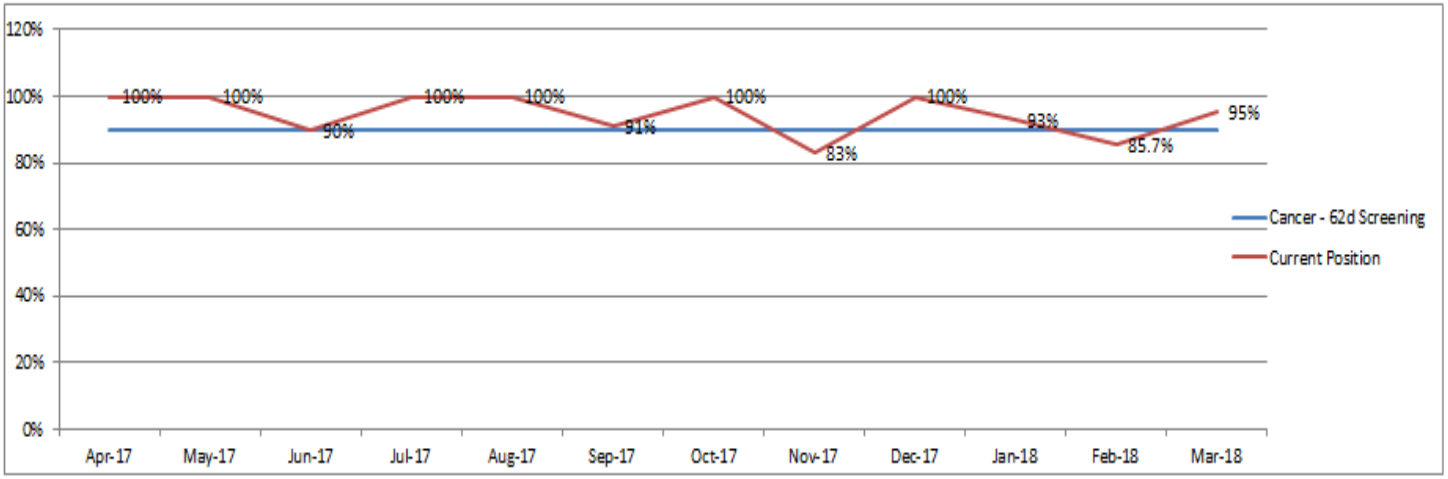
Current Position - 80% against a threshold of 90%. This is owing to two very late referred patients from the Bowel cancer screening programme, one of them was a prisioner. The small numbers of Breast screening patients treatment this month meant that the denominator for this standard was just 3+4x.5 total conut to report. We are predicting a recovery in this performance in May.

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	Apr-18
Cancer - 62d Screening	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	100%	100%	90%	100%	100%	91%	100%	83%	100%	93%	85.7%	95%	80%

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Trust will recover this perforamance in May but it's sustainance relies on timely referral from the Screening HUB and number of patients to report in month.	HB		



Referral to Treatment

Progress is being made to reduce the number of people on the RTT waiting list and to treat 92% of patients from point of referral to treatment in aggregate – patients on an incomplete pathway. However, the Trust remains a national outlier in term of overall performance as demonstrated in the slides below. No exception reports related to RTT available at the time of preparation of IQPR due to issues pertaining to e-Care reports.

Rolling 13 Month Performance against National Standard (*Source – Model Hospital – April 2018*)

	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
Incomplete	89.9%	82.2%	79.7%	83.4%	85.9%	85.9%	85.7%	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%
Admitted	68.9%	60.2%	67.8%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	74.1%
Non Admitted	84.6%	86.1%	87.0%	87.3%	87.6%	85.9%	87.3%	84.9%	85.6%	90.6%	88.7%	93.9%	93.4%

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT -18 wk Admitted & Non-Admitted
Standard	90% & 95%
ED Name	Simon Taylor
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

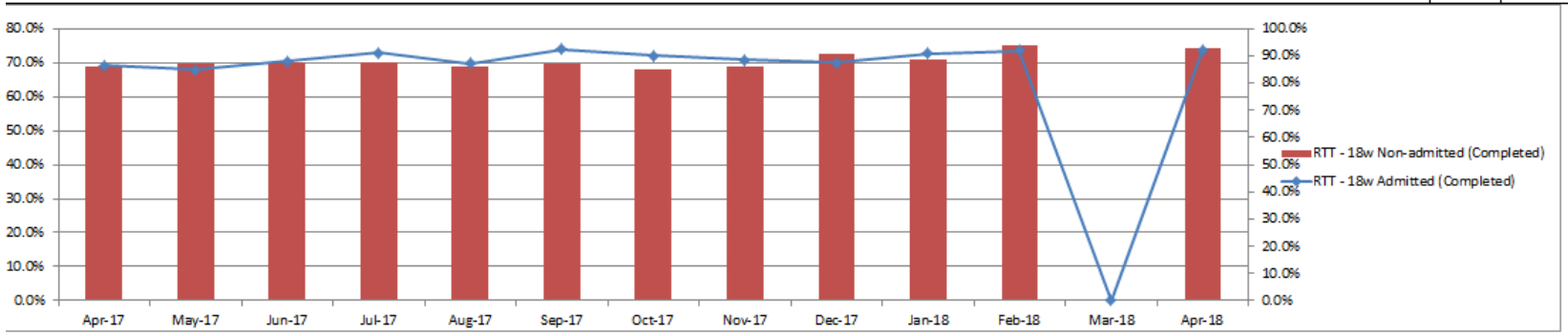
RTT 18 week admitted 73.4% against a target of 90% and RTT 18 week non-admitted 92.8% against a target of 95%. This continues to be predominantly due to longer waits for first appointment in Dermatology and Ophthalmology. Particular challenges remain evident in Urology, ENT, and Vascular Surgery on the elective waiting list.

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	Apr-18
RTT - 18w Admitted (Completed)	69.2%	67.8%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	ND	73.4%
RTT - 18w Non-admitted (Complete	86.2%	87.0%	87.3%	87.6%	85.8%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	ND	92.8%

Actions in place to recover the performance

Expected timeframes for improvements

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT -18 wk Admitted & Non-Admitted
Standard	90% & 95%
ED Name	Simon Taylor
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

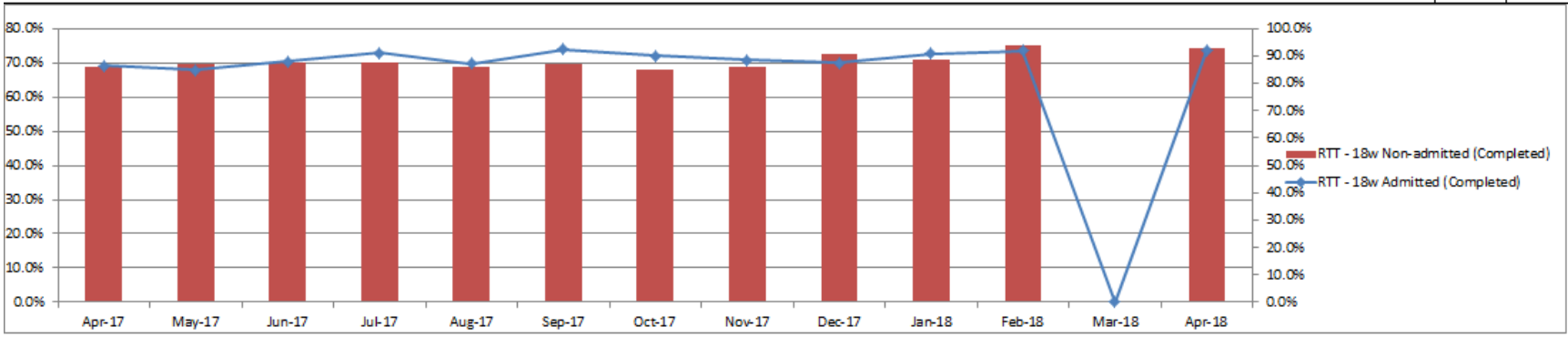
RTT 18 week admitted 73.4% against a target of 90% and RTT 18 week non-admitted 92.8% against a target of 95%. This continues to be predominantly due to longer waits for first appointment in Dermatology and Ophthalmology. Particular challenges remain evident in Urology, ENT, and Vascular Surgery on the elective waiting list.

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	Apr-18
RTT - 18w Admitted (Completed)	69.2%	67.8%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	ND	73.4%
RTT - 18w Non-admitted (Complete	86.2%	87.0%	87.3%	87.6%	85.8%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	ND	92.8%

Actions in place to recover the performance

Expected timeframes for improvements

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT - Incomplete waiting list
Standard	92%
Name	Simon Taylor
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

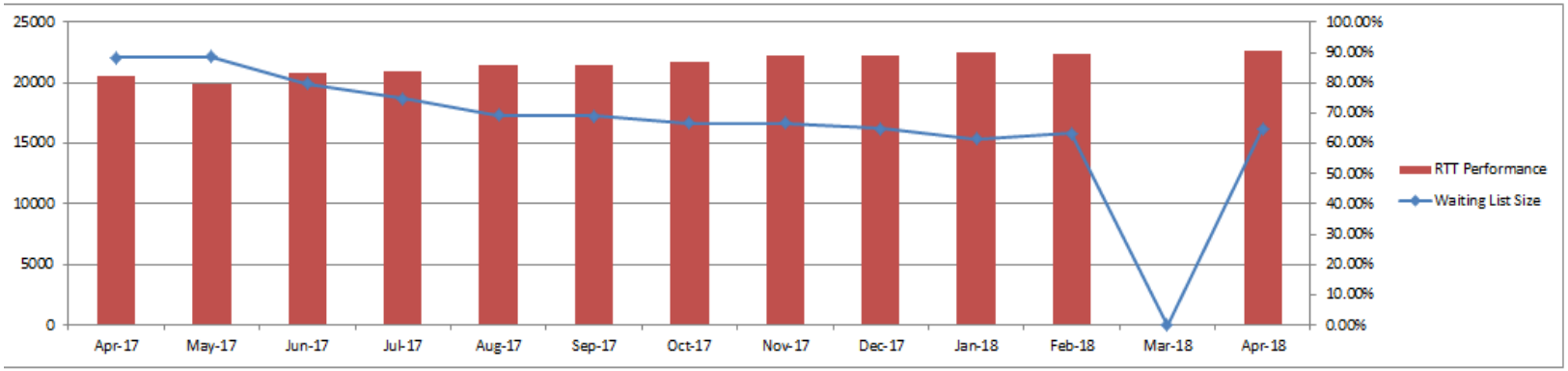
April has seen a a further improvement in the aggregate position to 90.38%. This reflects the ongoing work to recover the RTT position by the trust. Services that remain under pressure include Ophthalmology, Urology and Vascular Surgery.

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	Apr-18
Waiting List Size	22110	22144	19931	18676	17346	17236	16694	16641	16195	15,363	15,804	ND	16224
RTT Performance	82.23%	79.71%	83.36%	83.92%	85.93%	85.69%	87.00%	88.92%	89.04%	90.21%	89.56%	ND	90.38%

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
1. Targeted work is being undertaken to reduce and manage the back log in challenged specialties. 2. There is a specific focus and ongoing work to review the vascular surgery pathway to ensure appropriate referrals to treatment are in place. 3. Targeted work on theatre utilisation and reducing DNA and cancellations on the day is underway.	HB	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT - 52-week waiters
Standard	0%
Name	Simon Taylor
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Responsive

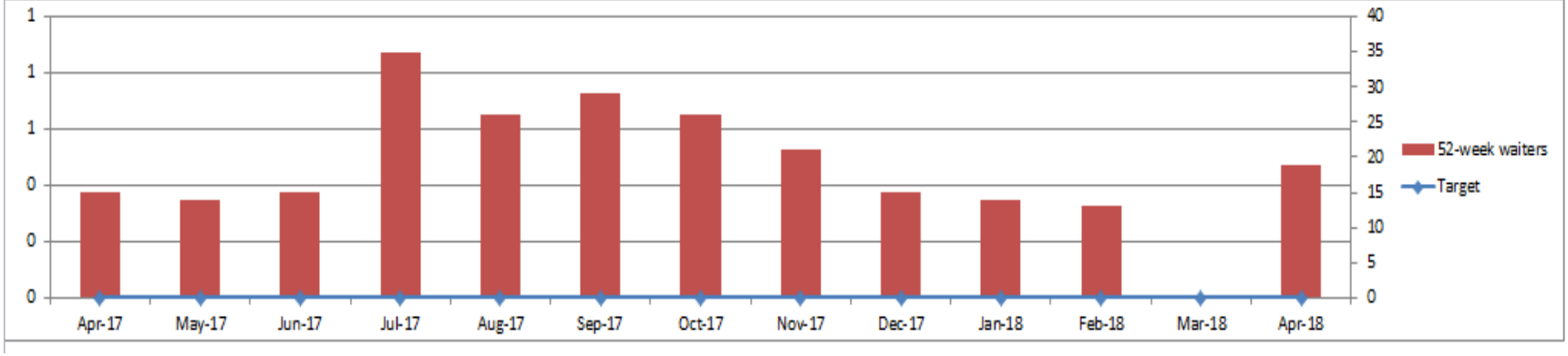
Summary of Current performance & Reasons for under performance

At the end of April, 19 patients had waited over 52 weeks. Fifteen of which have either now been treated or have a date for treatment scheduled. The remaining four are yet have TCI dates allocated with decisions only having been made very recently at OPA regarding treatment plans for three of the patients, the last is a complex ophthalmology patient awaiting a TCI date. The weekly access meetings are focussing on those at risk of breaching 52 weeks and patient level plans are discussed at this meeting. We are working with the IST to review the 52 week waiters and a rolling clinical harm review process is being implemented.

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	Apr-18
Target	0	0	0	0	0	0	0	0	0	0	0	0	0
52-week wait	15	14	15	35	26	29	26	21	15	14	13	ND	19

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

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



DETAILED REPORTS – WELL-LED

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

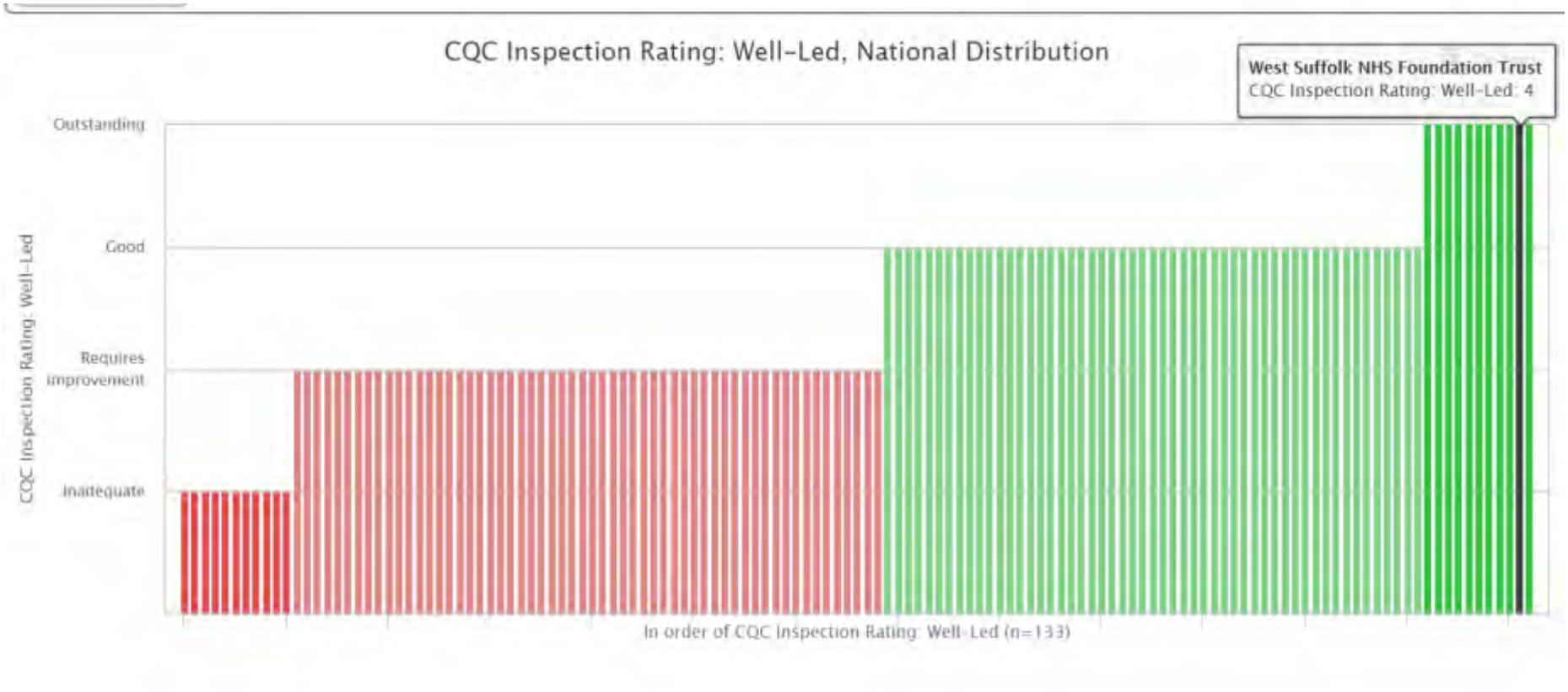
Are we.		Ref.	KPI	Target	Apr-17	####	####	####	####	####	####	####	####	####	####	####	Apr-18	YTD(Apr18-Mar19)
Well Led	Dashboard	5.01	NHS Staff Survey (Staff Engagement score -A	NT	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	####	NA	NA	
		5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	NA	NA	95%	NA	NA	95%	NA	NA	ND	NA	NA	ND	NA	NA
		5.03	Staff F&F Test % Recommended - place to wo	75%	NA	NA	83%	NA	NA	82%	NA	NA	ND	NA	NA	ND	NA	NA
		5.04	Turnover (Rolling 12 mths)	<10%	10.30%	####	####	####	####	####	####	####	####	####	####	####	8.43%	8%
		5.05	Sickness Absence	<3.5%	3.7%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.5%	3.5%	3.6%	3.7%	3.7%	3.8%	3.8%
		5.06	Executive Team Turnover (Trust Management)	<10%	0%	20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		5.07	Agency Spend		307	316	289	336	244	220	187	475	183	ND	237	452	331	331
		5.08	Monitor Use of Resources Rating		3	3	3	3	3	3	3	3	3	3	3	3	ND	ND
	Agency, WTE & vacanci	5.09	Agency Spend Cap		378	378	378	378	378	378	378	378	378	378	378	378	486	486
		5.10	Bank Spend		380	287	282	372	315	422	327	331	398	312	399	343	579	579
		5.11	Bank/agency Spend percentage		4.6%	3.9%	3.7%	4.9%	3.6%	4.7%	3.8%	4%	5%	5.7%	ND	6%	4.2%	4.2%
		5.12	Proportion of Temporary Staff		11%	11%	10%	12%	11%	11%	10%	11%	8%	11%	11%	ND	11%	11%
		5.13	Locum and Medical agency spend		309	368	361	381	347	270	357	381	508	495	487	ND	338	338
		5.14	Total Vacancies		7%	8%	6%	8%	7%	8%	8%	8%	8%	7.1%	7.9%	ND	8%	8%
		5.15	Corporate & Admin Costs as %	<7%	8.48%	####	####	####	####	####	####	####	####	####	####	ND	9.73%	9.73%
		5.16	% Staff on Maternity/Paternity Leave		2.15%	2.15%	####	####	####	####	####	####	####	####	####	1.93%	1.99%	1.99%
	Other	5.18	Grievance reviews		ND	ND	ND	ND	ND	6	6	6	5	5	5	4	5	5
		5.20	Recruitment Timescales - Av no. of weeks to re	7	ND	6	5	5.40	6.40	7	6.90	6.90	6.40	5.40	5.40	5.40	5.40	5
		5.21	DBS checks	95%	92.8%	####	####	####	####	####	####	####	####	####	####	97%	98.0%	98%
		5.22	Staff appraisal Rates	90%	ND	92%	92%	ND	ND	####	####	####	####	####	####	63%	67%	67%
		5.26	Trust Participation in on-going National Audits	90%	NA	NA	94%	NA	NA	96%	NA	NA	96%	NA	NA	96%	NA	NA

Training	5.27	Infection Control Training (classroom)	85%	95%	96%	95%	95%	96%	94%	95%	95%	95%	94%	94%	95%	94%	94%
	5.28	Infection Control Training (eLearning)	185%	88%	88%	90%	90%	88%	83%	85%	88%	88%	90%	90%	90%	90%	90%
	5.29	Manual Handling Training (Patient)	80%	81%	83%	84%	83%	83%	80%	80%	84%	84%	79%	79%	79%	74%	74%
	5.30	Manual Handling Training (Non Patient)	80%	81%	81%	83%	83%	82%	86%	84%	88%	88%	89%	89%	88%	88%	88%
	5.31	Staff Adult Safeguarding Training	80%	88%	89%	90%	90%	89%	89%	90%	92%	92%	92%	92%	92%	91%	91%
	5.32	Safeguarding Children Level 1	90%	86%	86%	87%	88%	87%	86%	88%	89%	90%	91%	91%	90%	90%	90%
	5.33	Safeguarding Children Level 2	90%	87%	88%	90%	90%	87%	88%	89%	90%	92%	92%	92%	91%	91%	91%
	5.34	Safeguarding Children Level 3	90%	85%	83%	81%	81%	76%	73%	79%	83%	86%	86%	88%	83%	95%	95%
	5.35	Health & Safety Training	80%	88%	89%	89%	89%	89%	89%	90%	91%	91%	92%	92%	91%	90%	90%
	5.36	Security Awareness Training	80%	88%	89%	90%	90%	89%	89%	90%	90%	91%	91%	91%	90%	90%	90%
	5.37	Conflict Resolution Training (eLearning)	80%	81%	83%	85%	86%	80%	80%	81%	82%	95%	76%	85%	84%	86%	86%
	5.38	Conflict Resolution Training	180%	75%	75%	77%	77%	76%	75%	76%	76%	75%	88%	76%	76%	69%	69%
	5.39	Fire Training (eLearning)	####	85%	86%	87%	87%	85%	85%	85%	85%	84%	84%	84%	82%	80%	80%
	5.40	Fire Training (classroom)	80%	90%	90%	90%	90%	90%	89%	90%	91%	91%	90%	90%	90%	90%	90%
	5.41	IG Training	80%	80%	81%	85%	84%	85%	84%	87%	86%	87%	84%	84%	82%	86%	86%
	5.42	Equality and Diversity	80%	93%	94%	95%	95%	93%	92%	93%	94%	94%	88%	88%	83%	81%	81%
	5.43	Majax Training	80%	86%	86%	88%	88%	87%	86%	88%	88%	89%	90%	90%	88%	88%	88%
	5.44	Medicines Management Training	80%	87%	87%	88%	88%	87%	87%	86%	87%	88%	89%	89%	88%	87%	87%
	5.45	Slips, trips and falls Training	80%	84%	85%	87%	87%	85%	85%	86%	88%	88%	87%	87%	87%	85%	85%
	5.46	Blood-borne Viruses/Inoculation Incidents	80%	84%	84%	86%	86%	84%	84%	85%	86%	87%	86%	86%	86%	85%	85%
	5.47	Basic life support training (adult)	80%	83%	85%	85%	85%	84%	82%	81%	81%	82%	80%	80%	78%	75%	75%
	5.48	Blood Products & Transfusion Processes (Refr	80%	80%	82%	83%	82%	79%	79%	80%	78%	80%	75%	75%	72%	73%	73%

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

EXCEPTION REPORTS – WELL LED

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Sickness Absence Rate
Standard	<3.5%
Name	Ian Beck
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

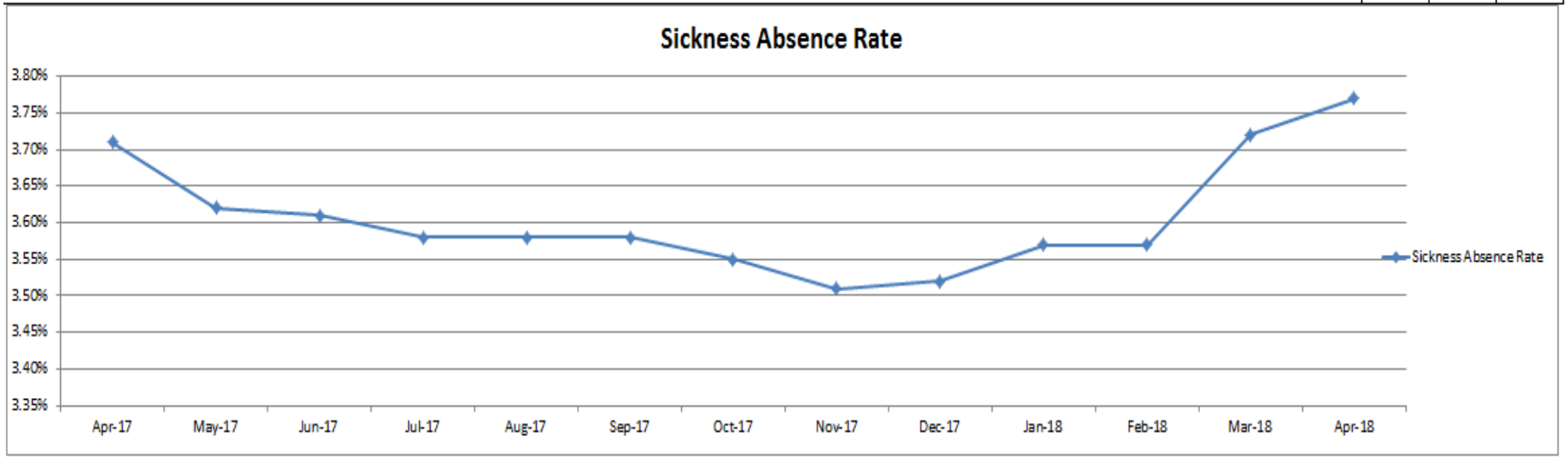
The sickness absence rate has risen this month to 3.77, and worse than this time last year (3.71).
Actions remain in place to support managers to manage both short term and long term absence. We have had some staff with high sickness levels resign and also one dismissal. Winter pressures are still impacting, with staff off with stress and low immunity conditions. We will look to offer more advice and guidance about maintaining personal health & wellbeing in the coming months.

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	Apr-18
Sickness Absence Rate	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.57%	3.57%	3.72%	3.77%

Actions in place to recover the performance

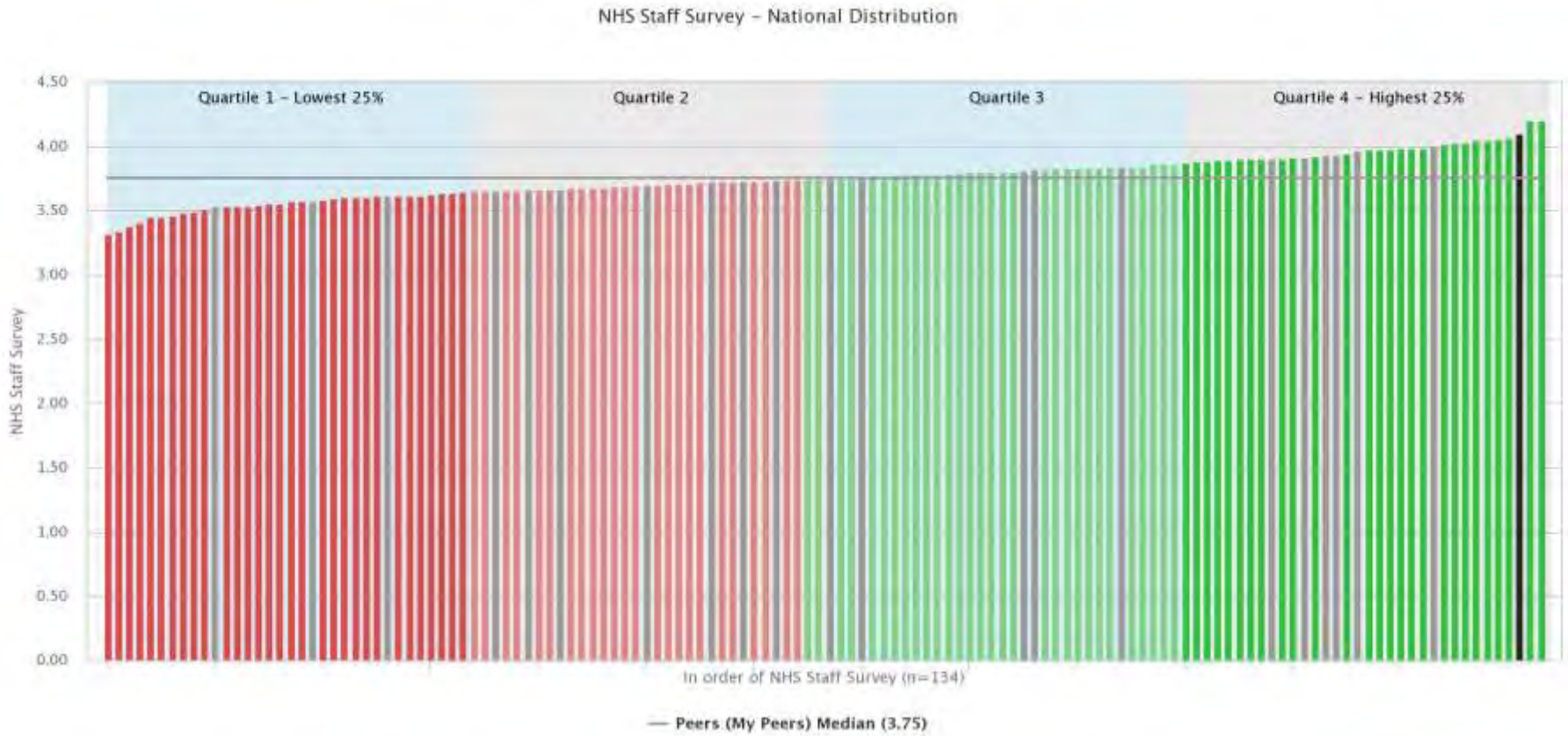
Expected timeframes for improvements

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



Staff F&FT

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



DETAILED REPORTS – PRODUCTIVE

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

Are we..		Ref.	KPI	Targe	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	YTD(Apr 18-Mar-19)
6. Productive	Dashboard	6.01	I&E Margin	Var	ND	-4.9%	-4.3%	-3.9%	0.1%	-3%	-2.6%	-2.5%	-2.6%	-2.3%	-2.6%	-2.5	ND	0
		6.02	Distance from Financial Plan	Var	ND	0.0%	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%	ND	ND	ND	ND	ND	ND
		6.03	Capital service capacity	Var	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.01	0.00	0.00	- 0.00	2.266	ND	ND
		6.04	Liquidity (days)		ND	- 12.15	-15.72	-10.94	- 11.03	- 12.70	-15.14	- 0.10	- 0.13	- 0.11	- 0.07	3.970	ND	ND
		6.05	Long Term Borrowing (£m)	3.5%	44.3	45.7	45.7	45.7	45.7	47.6	47.6	56.7	58.7	64.4	64.1	65.4	ND	65.4
		6.06	CIP Plan Variance (£000s)	1.9	40	0	-40	10	0	-54	-10	-35	-129	-201	-380	-380	ND	ND
	Activity	6.07	A&E Activity		5578	5971	5922	6124	5831	5743	6065	5985	5959	6033	5639	6172	5967	5967
		6.08	NEL Activity		2409	2440	2429	2375	2385	2466	2586	2491	2528	2539	2406	2557	ND	ND
		6.09	OP - New Appointments		5125	6244	6148	5706	5635	5633	6182	7230	5482	6769	5849	6324	6031	6031
		6.10	OP- Follow-Up Appointments		9541	11667	11542	11147	11333	11116	11815	12668	9769	12673	11103	11609	11140	11140
		6.11	Electives (Incl Daycase)		2593	3004	2898	2796	2829	2786	2868	3157	2545	2841	2632	2871	ND	ND
	Finance	6.12	Agency Rating (spend £000)		307	316	289	336	244	220	187	475	183	ND	237	ND	ND	ND
		6.13	Financial Position (YTD)	Var	-937	-2906	-2758	-3290	-3300	-3953	-3956	-4114	-5170	-6600	-6525	287	ND	-93
		6.14	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	2	ND	ND
		6.15	Cash Position (YTD £000s)	Var	####	5093	2689	7460	3300	4846	2654	4458	3518	4924	6870	3601	ND	5,322
	Ratios	6.16	% Consultant to Consultant Referrals		10%	9.6%	9.7%	12.3%	12.9%	10.2%	10.6%	10%	10.9%	12.7%	13.7%	13.0%	14%	13.5%
		6.17	New to FU Ratios	1.9	1.86	1.87	1.88	1.96	2.01	1.97	1.91	1.78	1.79	1.87	1.90	1.84	1.85	1.85
		6.18	Non-Clinical Floor Space	<35%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	ND	ND	ND	ND
		6.19	Unoccupied Floor Space	<2.5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	ND	ND	ND	ND
	CIPs	6.2	Plan (£000s) YTD	Var	840	1000	820	810	1420	1094	1123	1504	1312	1356	4025	14375	ND	ND
		6.21	Actual (£000s) YTD		880	1000	780	820	1420	1040	1113	1469	1183	1155	3645	13836	ND	ND

OPERATIONAL PRODUCTIVITY – TRUST OVERVIEW

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

Operational Productivity, Trust Overview

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 as the finance report contains full details.

MATERNITY

		Ref.	KPI	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	YTD(Apr18-Mar19)
Maternity	Dashboard	###	Total number of deliveries (births)	210	215	192	213	215	233	236	205	194	180	199	211	206	195	195
		###	% of all caesarean sections	<22.7%	15%	21%	16%	16%	22.32%	18.22%	17.10%	17.0%	18.3%	22.1%	17.1%	30.1%	28%	28%
		###	Midwife to birth ratio	1.30	1.30	1.27	1.29	1.30	1.33	1.33	1.29	1.28	1.26	1.28	1.29	1.29	1.27	1.27
		###	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		###	Completion of WHO checklist	100%	84%	93%	84%	94%	82%	98%	98%	98%	93%	93%	94%	97%	86%	86%
		###	Maternity SIs	NT	1	0	0	0	0	1	1	0	1	2	0	1	2	2
		###	Maternity Never Events	NT	0	0	0	0	0	0	0	0	0	0	0	0	ND	0
		###	Breastfeeding Initiation Rates	80%	79.8%	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79%	76.1%	76%
	Safe	###	Elective Caesarean Sections	10%	5%	10%	4.3%	7.0%	9.4%	6.4%	5.9%	7.2%	7.8%	8%	7%	11%	12%	12%
		###	Emergency Caesarean Sections	<13%	10%	12%	12%	9%	13%	12%	11%	10%	11%	14%	10%	13%	16%	16%
		7.11	Grade 1 Caesarean Section (Decision to delivery time m	100%	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%	100%	100%	100%	100%
		###	Grade 2 Caesarean Section (Decision to delivery time n	80%	92%	93%	93%	83%	57%	82%	88%	50%	80%	83%	83%	81%	82%	82%
		###	Homebirths	2%	1.4%	3.7%	2.4%	3.3%	2.6%	2.1%	3.9%	2.6%	3.3%	3.0%	2.4%	0.5%	2.6%	3%
		###	Midwifery led birthing unit (MLBU) births	>13%	18%	17%	17.3%	18.8%	15.5%	15.3%	17.1%	16%	15%	19.1%	18%	14%	16%	16%
		###	Labour Suite births	75%	81%	79%	80.3%	77.9%	82.0%	82.6%	79.0%	81.4%	81.7%	1	79.6%	85.4%	81%	81%
		###	Induction of Labour	NT	43%	41%	40.9%	36.6%	38.2%	34.3%	35.1%	43.8%	43.9%	0	41.2%	37.4%	41%	41.0%
		###	Instrument Assisted Deliveries (Forceps & VentoUse)	NT	4.45%	6.80%	4.9%	4.2%	3.0%	4.7%	4.2%	7.2%	5.9%	0	7.6%	6.8%	13%	13%
		###	Critical Care Obstetric Admissions	0	1	1	0	1	0	1	0	0	0	2	0	1	1	1
		###	Eclampsia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Effective	###	Shoulder Dystocia	2	2	4	3	5	3	7	6	4	5	4	5	8	5	5
		###	Post-partum Hysterectomies	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
		###	Women requiring a blood transfusion of 4 units or more	0	1	0	0	0	0	0	0	0	ND	ND	ND	ND	0	0
		###	3rd and 4th degree tears (all deliveries)	12	8	9	6	10	4	4	6	3	8	9	7	2	9	9
	Caring	###	Maternal death	NT	1	0	0	0	0	0	0	0	0	0	0	0	0	0
		###	Stillbirths	NT	1	0	0	0	0	1	2	1	0	2	0	0	1	1
		###	Complaints		0	0	1	2	1	0	0	0	1	0	0	1	ND	0
		###	No. of babies admitted to Neonatal Unit (>36+6)	NT	15	9	17	18	13	15	15	11	9	8	16	12	18	18
	Responsive	###	No. of babies transferred for therapeutic cooling	0	0	0	0	0	0	0	1	0	1	0	0	0	1	1
		###	One to one care in established labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	94%
		###	Reported Clinical Incidents	60	51	62	46	64	43	52	61	57	49	63	46	48	46	46
		###	Hours of dedicated consultant cover per week	60	93	110	99	99	96	99	99	108	90	102	93	93	94	94
		###	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
		###	OPD cover for Theatre 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	ND	#DIV/0!
		###	No. of women identified as smoking at booking	NA	27	35	37	32	30	37	27	28	17	26	21	30	26	26
		###	No. of women identified as smoking at delivery	NT	20	30	26	32	27	25	25	24	26	21	22	24	23	23
		###	UNICEF Baby friendly audits	NT	10	10	10+	10+	10+	10+	10+	10+	10+	10+	ND	10+	ND	0
		###	Proportion of parents receiving Safer Sleeping Suffolk a	NT	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	62.9	62.9
	Other	###	No. of bookings (First visit)	NA	208	262	244	272	245	265	259	245	193	279	253	274	240	240
		###	Women booked before 12+6 weeks	95%	95%	95%	98%	95%	100%	93%	99%	97%	97%	96%	96%	ND	95%	95%
		###	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	0	0	0	0	1	0	0	0

EXCEPTION REPORTS - MATERNITY

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Emergency Caesarean Sections
Standard	12%
Name	Jane Lovedale
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

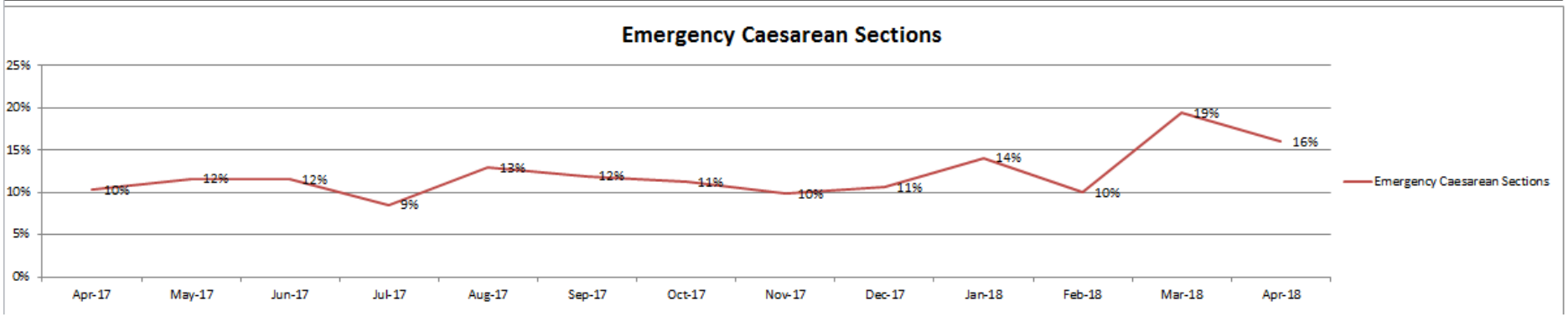
According to the National and Maternity perinatal Audit 2017 the proportion of women in the UK requiring an emergency CS was 14.2%. with an overall CS rate of 25%. The WSH maternity service has remained under this rate for 2017/18 each month except for March 2018 when there was an increase at 19%. Although April has seen a fall in the rate at 16.4% it remains higher than expected . The NMPA states that the CS rate must be considered within the context of both spontaneous and instrumnetal deliveries, in April both overall instrumental and spontaneous delivery rates were down. This may be partly due to the increase in the number of CS, as well as recognising that where expedited birth is considered necessary in the first stage of labour CS is the only option. The service routinely reviews carefully all emergency CS. The dashboard will be reviewed at the Womens Health governance on the 21/05/18 in particularly the increase in CS this month will be discussed and appropriate action taken.

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	Apr-18
Emergency Caesarean Sections	10%	12%	12%	9%	13%	12%	11%	10%	11%	14%	10%	19%	16%

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

Description	Owner	Start	End
Caesarean sections are reviewed weekly at the case management meeting and any learning is shared. Data to be discussed at the WH Governance with the obstetric team on the 21/05/18			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Total Caesarean Sections
Standard	23%
Name	Jane Lovedale
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

CS both emergency and Elective is offered for a range of reasons for the safe delivery of mother and baby. The maternity service was disappointed with last months figure of 30.1% and although there has been a decrease in the percentage this month at 28% the rate for the last two months is still higher than at any time in the previous 12 months . It is difficult to understand the reason why this is. The increase was discussed at the WHG last month and was considered to be a one off occurrance, however this continued rise for a second month putting the service above the commisioned rate requires further scrutiny. These figures will be reviewed by the Women Health Governance meeting on the 21/05/18 to see if there are any trends in indications and clinicians.

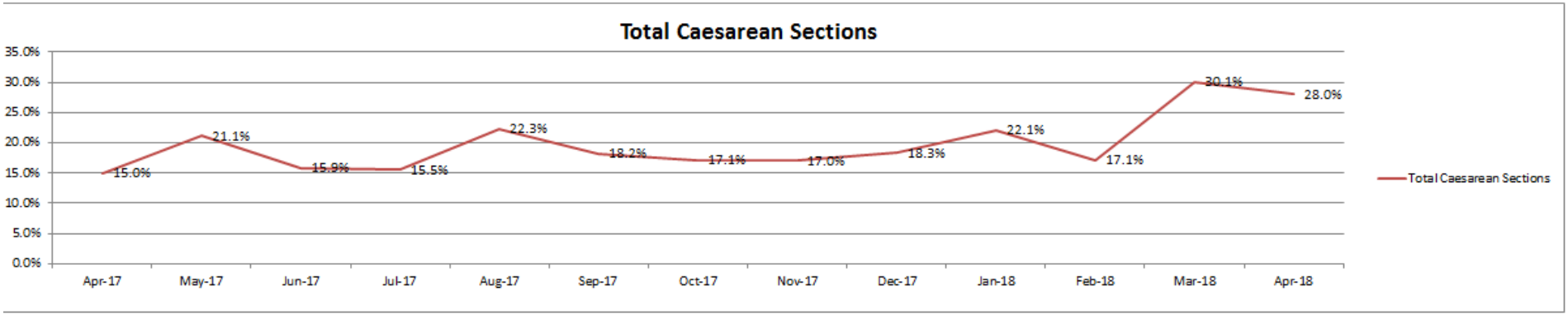
Trend | Recovery Trajectory

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	Apr-18
Total Caesarean Sections	15.0%	21.1%	15.9%	15.5%	22.3%	18.2%	17.1%	17.0%	18.3%	22.1%	17.1%	30.1%	28.0%

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
In depth review at the Womens health governance Meeting 21/05/18			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Total women delivered who breastfed babies within first 48 hours
Name	Jane Lovedale
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

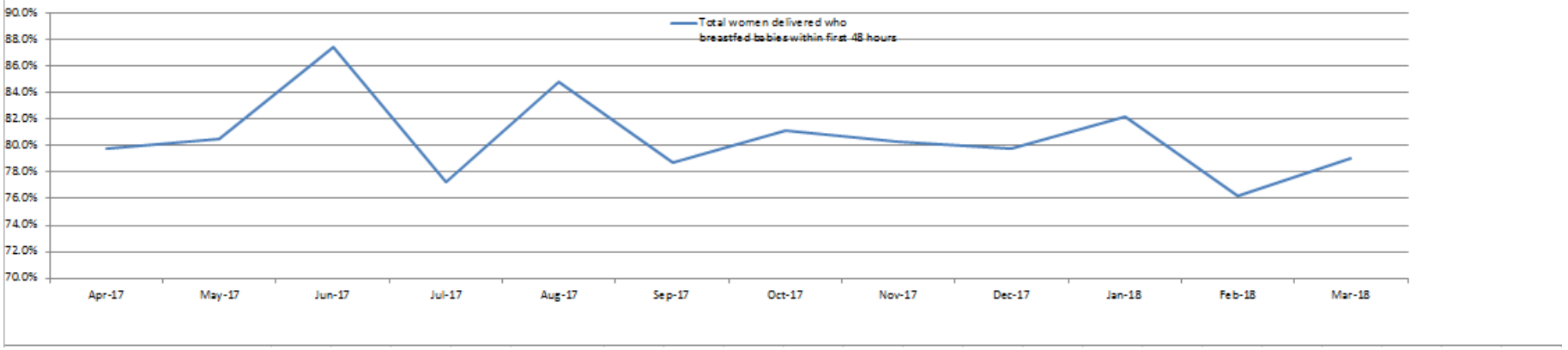
The is a known very large variation between site in recording of breast feeding rate . (National Maternity P erinatal Audit 2017 NMPA) Overall the proportion of babies recieving breast milk at first feed in England is 74.1%. However we contiue to aim to achieve compliance at 80% and above .Compliance with the 80% target of babies receiving breastmilk within 48 hours of life was reached this month at 81% The maternity service is constantly looking at ways to improve the breastfeeding initiation rate and is currently working with the Maternity Voice Partnership on the possible introduction of a peer support service (voluntary). Continue to improve breast

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	Apr-18
Total women delivered who breastfed babies within first 48 hours	79.8%	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79%	81.0%

Actions in place to recover the performance

Expected timeframes for improvements

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity - Shoulders Dystocia
Standard	2
Name	Jane Lovedale
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

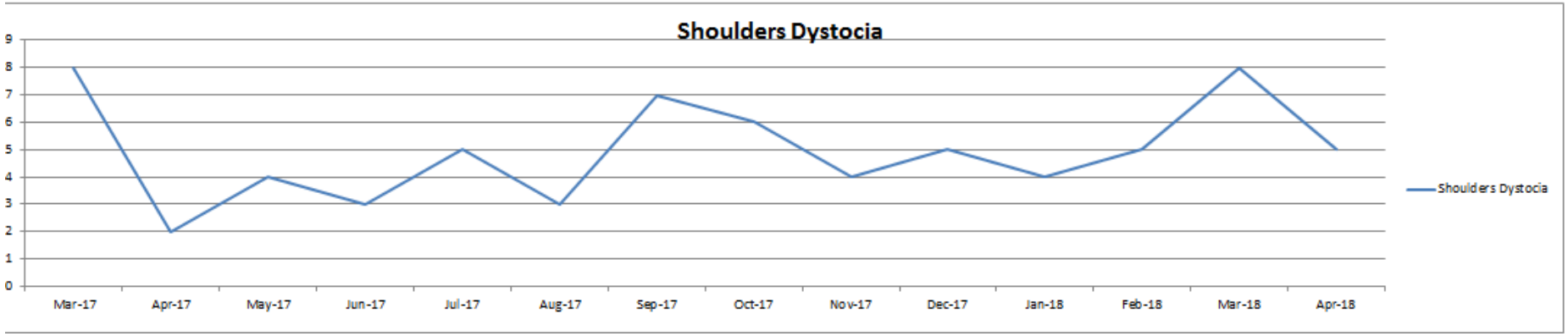
Aprils figure of 2.6% for Shoulder dytocia showed a pleasing reduction from March 2018. The NMPA national data does not include shoulder dystocia probably because of the unpredictability to allow prevention in the large majority of cases. , Induction of labour at term can reduce the incidence of shoulder dystocia in women with gestational diabetes and the maternity service offers this to this group of women. The management of shoulder dystocia is a key factor in improvement in perinatal outcomes. The service maternity service provides live drills to all staff anually in the management of shoulder dystocia, this practical training has been shown to improve knowledge and confidence. The service continues to monitor all incidents of shoulder dystocia with a critical analysis of the manouvres used in the management. Of significance there has been no reported incidents this month of neonatal injury following shoulder dystocia.

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

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Continue to monitor and maintain records for skilld drills in manegment of shoulder dystocia.	RS	Jul-17	Ongoing



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Maternity WHO Checklist
Standard	100%
Name	Jane Lovedale
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Maternity WHO Checklist

Summary of Current performance & Reasons for under performance

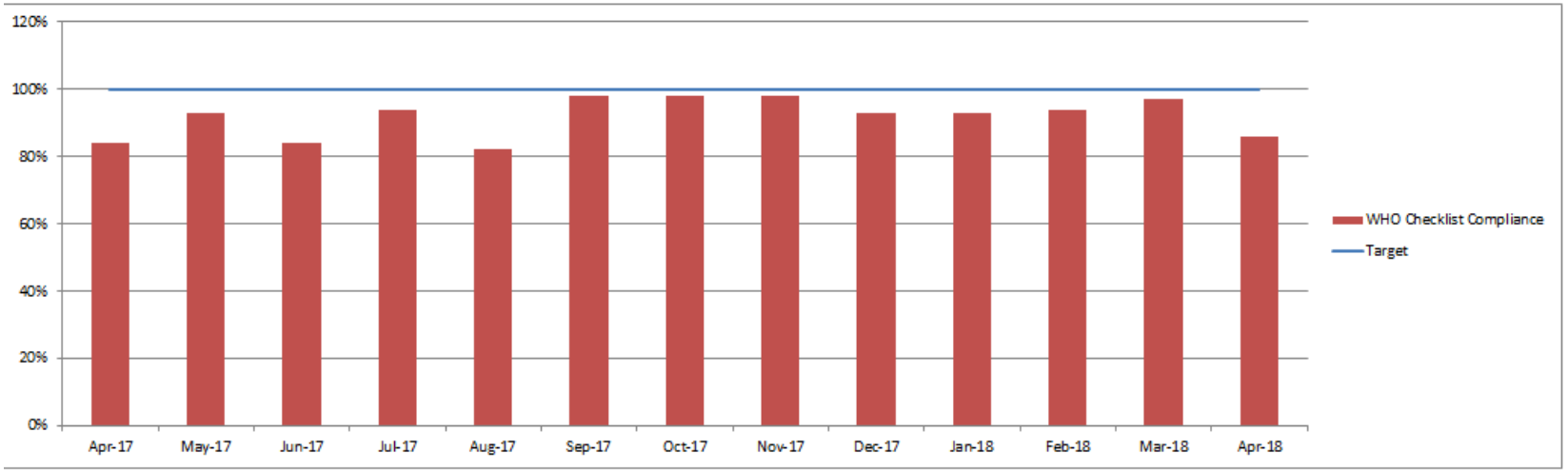
The focus has always been to achieve full completion of all WHO safety checklists with an improvement in March at 97%. however a change of WHo form was introduced in April 2018. Unfortunately this showed a significant fall to 86% a huge disappointment Although this was not completely unexpected for everyone to full understand a slightly different process. The non compliance was mostly around the 'sign in' although these had always been completed they were not always signed by both the theatre staff and the obstetrician. 6 checklists had one signature missing this is much higher number than has been seen since September. In 4 cases the theatre staff had not signed in 2 cases the failures were by the obstetric registrar. This was highlighted to theatre staff and obstetric regisrar during the month and did see some improvement towards the end of the month. The obstetric consultant who revised the checklist is currently in discussion with the Governance lead for the Safer Surgery checklist.

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	Apr-18
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
WHO Checklist Compliance	84%	93%	84%	94%	82%	98%	98%	98%	93%	93%	94%	97%	86%

Actions in place to recover the performance

Expected timeframes for improvement

Description	Owner	Start	End
Discussion at the WHG 21/05/18 and an update from the Obsteric consultant involved in the revised form.	RP	Feb-18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Third and fourth Degree Tears
Standard	7
Name	Jane Lovedale
Month	01-Apr-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

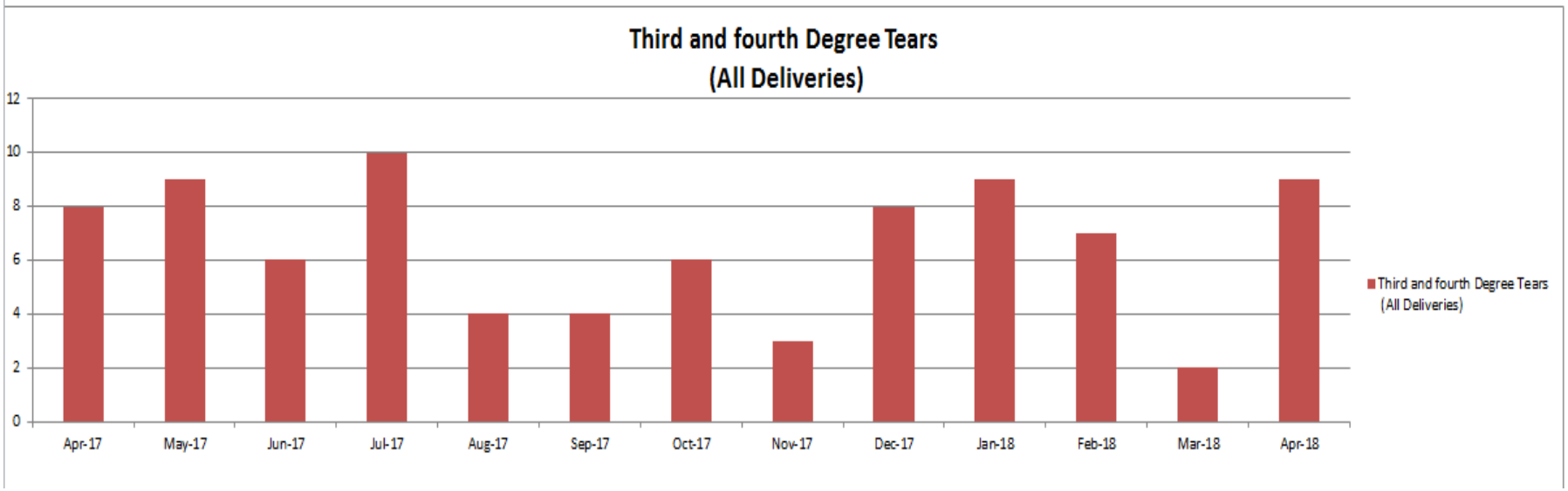
The maternity service has included in this financial years dashboard a rating for Obstetric Anal sphincter injury this has been done in line with the NMPA data 2017. April showed a figure of 4.6% which is just in the range of 3.7% to 4.6% calculated as within the expected range for this size of unit according to the NMPA, however there has been a significant focus by the maternity service in reducing the incidence of third and fourth degree tears and March 2018 showed a significant decrease in the rate at just 2 cases. The service has introduced the use of Episscissors which is part of a national initiative to reduce rates.The maternity service continues to maintain the focus on keeping the rate low so this months figure is disappointing. The figures highlight the majority of

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	Apr-18
Third and fourth Degree Tears (All Deliveries)	8	9	6	10	4	4	6	3	8	9	7	2	9

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Discussed at the Women's Health Governance meeting on 21st May 2018. Look at the individual cases to identify any thesemes and involve the PDM to look at any training issues required.A number of workstreams continue to look at perineal trauma	RP	Mar-18	



COMMUNITY

Are we..		Ref.	KPI	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	YTD(Apr18-Mar19)
Community	Safe	8.01	Patient Safety Thermometer		ND	ND	ND	ND	ND	ND	98%	99%	99%	99%	99%	98%	99.38%	99%
		8.02	Hand Hygiene Audits	100%	99%	99%	99%	99%	98%	99%	97%	97%	98%	98%	99%	100%	97%	97%
		8.03	MRSA	0	0	0	0	0	1	ND	0	0	0	0	0	1	0	0
		8.04	Clostridium difficile (No of cases)		0	0	0	0	1	1	1	0	0	0	0	2	0	0
		8.05	Never Events		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		8.06	SIs	NT	8	8	9	12	7	6	2	6	5	4	2	4	3	3
		8.07	Pressure Ulcers Grade 2	<=13	0	3	3	4	3	4	3	3	0	3	0	10	8	8
		8.08	Pressure Ulcers Grade 3	<=2	1	0	0	0	1	1	1	0	1	1	0	4	5	5
		8.09	Pressure Ulcers Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		8.10	Falls - Total number	NT	30	47	40	56	39	29	10	17	9	9	9	8	13	13
		8.11	Falls per 1000 bed days (Moderate or significant harm)	1.25	2.30	3.20	4.70	6.50	3.20	3.50	3.10	0.85	3.27	0.79	0.83	1.00	1.00	1.00
		8.12	Number of medication incidents resulting in harm	NT	15	12	13	13	9	6	0	0	0	1	0	0	17	17
	Effective	8.13	Hospital av LOS	NT	17.81	20.83	25.05	19.74	20.12	18.07	19.34	16.52	17.57	17.06	19.61	17.53	6.64	6.64
		8.14	DTOCs	NT	26	32	32	24	19	26	22	24	20	12	20	23	21	21
		8.15	% of relevant patients with a Personal Health Plan (PHP)	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Caring	8.16	Community scores from FFT - % Positive	85%	97%	ND	100%	ND	ND	ND	97.25%	100%	95.70%	95.15%	97.39%	96%	94%	94%
		8.17	Compliments		46	44	36	56	47	28	2	ND	7	6	5	3	6	21
		8.18	Complaints		1	2	3	2	0	3	1	1	0	0	1	1	1	1
	Responsive	8.19	18 weeks RTT for Non-Consultant led services	90%	97%	96%	99%	98.8%	94.7%	99.4%	93.7%	94.4%	98.4%	98.7%	100%	99.37%	99.2%	99%
		8.20	Paediatric Audiology Diagnostics - waiting less than 6 v	95%	99%	100%	100%	99%	100%	98%	97%	100%	100%	100%	100%	100%	99%	99%
		8.21	Community Nursing Red referrals seen within 2hrs	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	NA	NA	NA	#DIV/0!
		8.22	Community Nursing Red referrals seen within 4hrs		100%	100%	100%	100%	NA	100%	NA	NA	100%	100%	100%	100%	96%	96%
		8.23	Community Nursing Amber referrals seen within 72hrs		98.1%	99%	99.4%	98.6%	95.6%	98.6%	90.9%	96.9%	100%	100%	96.4%	97.63%	98.8%	99%
		8.24	Community Nursing Green referrals seen within 18 wks		98.4%	98.3%	98.3%	98.6%	98.2%	98.6%	99.3%	97.8%	98.0%	99.3%	98%	99.93%	99.3%	99%
		8.25	PR completed prescribed course within 18 weeks		99.8%	99.7%	99.8%	99.6%	99.2%	98.9%	99.9%	100%	100%	99.8%	99.9%	100%	NA	#DIV/0!
		8.26	Adult SLT Priority 1 seen within 10 Operating Days		95.5%	96.3%	91.9%	100%	85.7%	86.4%	100%	64.2%	83.3%	100%	93.6%	100%	100%	100%
		8.27	Adult SLT Priority 2 seen within 20 Operating Days		100%	100%	100%	100%	75%	100%	80%	100%	66.7%	100%	100%	100%	100%	100%
		8.28	Paediatric S&LT Waiting List Community Clinics		218	219	252	249	202	180	179	184	171	165	150	173	136	136
		8.29	Paediatric S&LT waiting over 6 mths		7	9	22	16	30	25	24	25	30	29	22	22	16	16
		8.30	Paediatric S&LT WL Schools		131	135	140	176	184	114	106	112	85	108	107	107	96	96
		8.31	Paediatric S&LT WL over 6 mths.		15	22	23	21	24	18	18	18	8	10	18	13	9	9
		8.32	Safeguarding Children Mandatory Compliance	98%	96.1%	96.4%	96.9%	96.9%	97.1%	96.8%	95.3%	96.1%	96.0%	95.9%	95.7%	96.98%	98.2%	98%
		8.33	Safeguarding Adults Mandatory Training Compliance	98%	96.0%	96.2%	96.8%	96.6%	96.2%	96.1%	94.3%	95.3%	94%	94.1%	93.2%	95.56%	96.0%	96%
		8.34	Dementia awareness training	95%	94.8%	95.3%	96.1%	96.4%	96.7%	96.1%	94.3%	95.9%	95.2%	93.3%	92%	92.94%	95.1%	95%
		8.35	Infection Control Training	100%	86.5%	91.8%	91.8%	89.1%	87.9%	87.8%	90.1%	90.7%	91%	89.4%	88.9%	88.10%	87.1%	87%

Preface from April 2018 WSFT Community Contract Report

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

- Our FFT score for April was 94% from 135 responses, with our community health teams achieving 100%
- We received 1 formal complaint in April regarding the waiting time for the paediatric speech and language therapy service
- Our response times for community health teams were all met in April
- In April 22 patients had their discharge delayed, with a total of 156 days being lost. This is a slight improvement on the March position. The main reason for delayed discharges in April was the wait for domiciliary care packages.
- The average length of stay in our community beds has reduced slightly compared to the position in March
- The paediatric speech and language therapy has seen a reduction of waiting times in both the mainstream school and the community clinic service. The latter now being at he lowest level for 12 months. There is a CEO level meeting arranged for the 11th June with SCC, and the CCG to discuss the demands and funding for this service
- The community equipment service continued with its improved performance meeting all of the KPI's in April
- The children in care service continues to have process challenges for timely notification and receipt of paperwork, both of which are hindering performance. There is a CEO level meeting to discuss actions for improvement with SCC and the CCG arranged for the 11th June

This report has been approved by Craig Black Director of Resources WSFT.

APPENDIX 1: PEER HOSPITAL LIST USED BY CQC

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

10. RTT recovery plan

To APPROVE the report

Presented by Helen Beck

Trust Board – 25 May 2018

Agenda item:	10			
Presented by:	Helen Beck			
Prepared by:	Alex Baldwin/ Joanna Rayner			
Date prepared:	9th May 2018			
Subject:	Referral to Treatment			
Purpose:	x	For information		For approval

Executive summary:

The paper provides an update on performance as at the end of April 18 and progress to date against sustainable delivery of compliance with the RTT standard at 92%.

The Trust delivered 90.38% in April and has agreed a recovery trajectory which will deliver 92% by October 18.

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

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

Previously considered by:	*RTT Steering Group*
Risk and assurance:	*Detail relevant issues within the report*
Legislation, regulatory, equality, diversity and dignity implications	*Constitutional standard*

Recommendation:
The Board is asked to note progress outlined in the paper and the plan to deliver 92% by October 18.

Progress to date

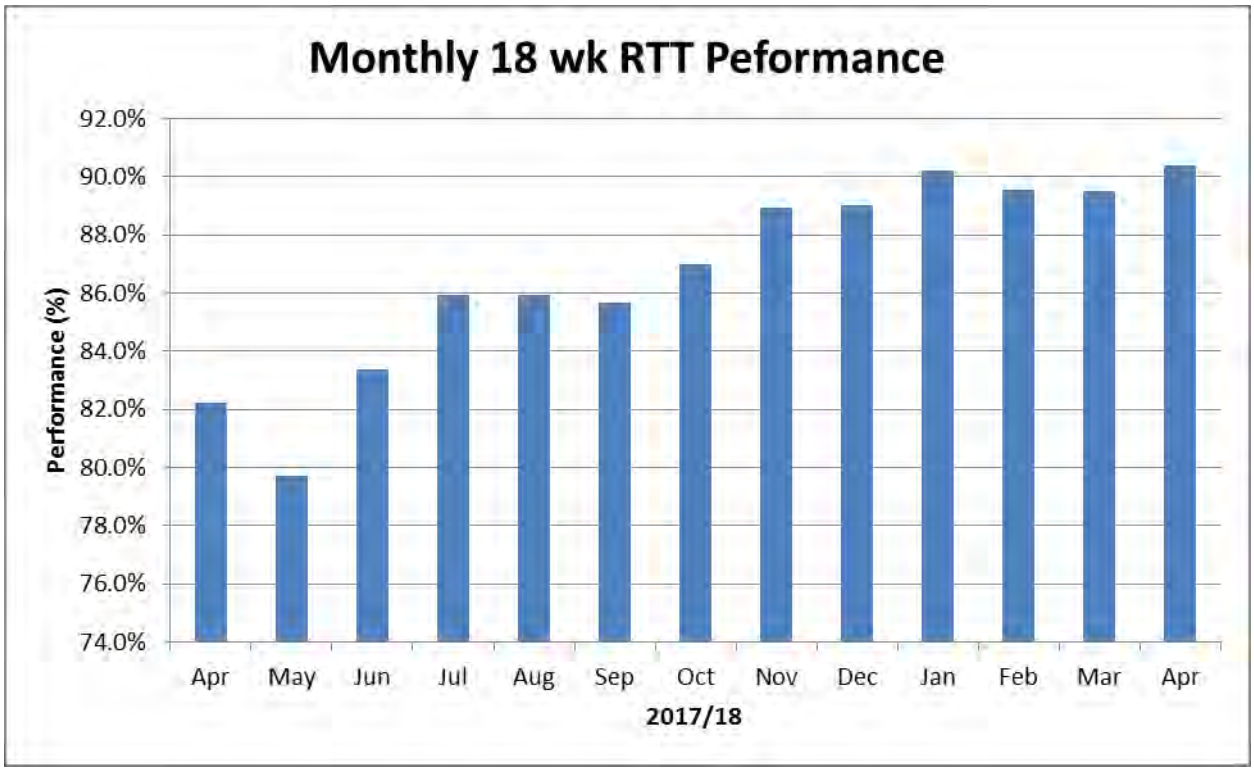
There has been sustained improvement in performance against the 18 week standard of 92% as demonstrated by the chart below with performance for April at 90.38%. Performance has recovered following winter pressures with weekly completed pathways returning to autumn levels.

Sustained improvement has been delivered using the IST Assessment tool with a robust plan to deliver a minimum compliance score of 2 or higher in all domains.

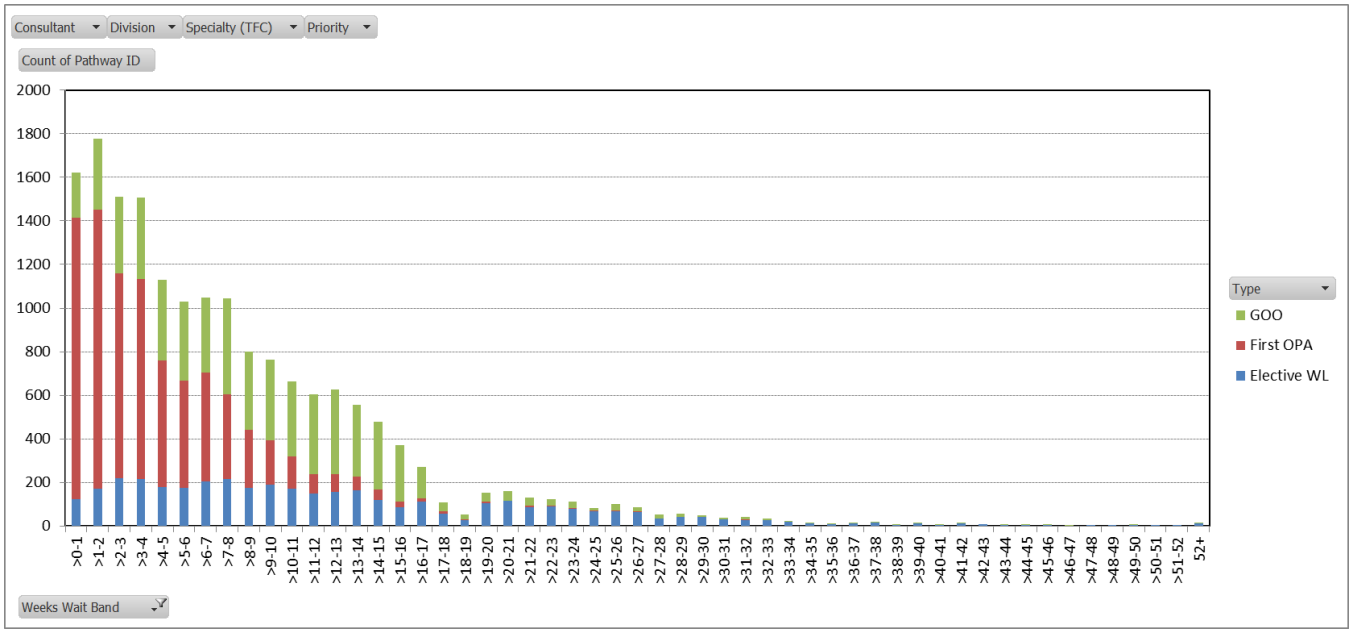
We continue to engage with the IST on capacity and demand modelling and a review of 52 week waits the results of which are expected at the end of May.

The access policy and supporting standard operating procedures (SOP's) are now in place and will provide a framework to ensure the correct patients remain on the waiting list for treatment.

Performance is managed with a joined up approach with CCG via the Transformation Team and a fortnightly joint RTT scrutiny group.



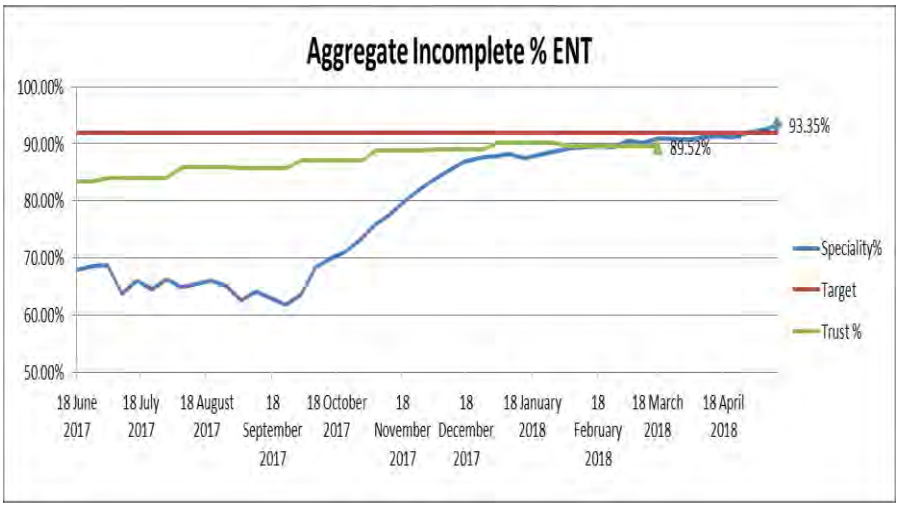
Current Position - April 2018:



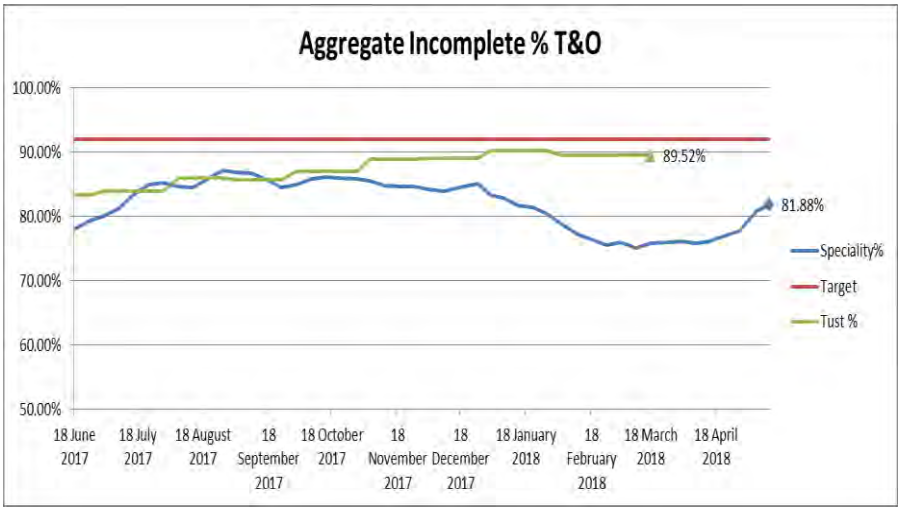
This chart shows the position in April 2018;

- Average first outpatient waits are sustained at 13 weeks or shorter.
- Occasional longer waiters, all patients have reason and plan.
- 15 patients currently waiting 52+ weeks (0 patients without a plan).
- Proactive management of potential +52 week breaches although patient choice at the end of pathways impacting
- Waiting list tail has significantly reduced.

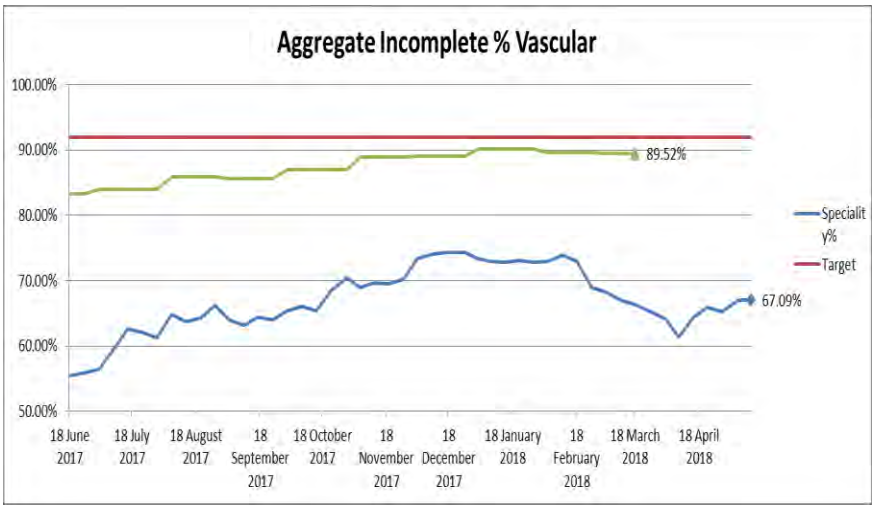
At specialty level, ENT has seen a significant improvement over the last 6 months recovering from just above 60% to 93% in April 2018.



T&O was the worst affected with the winter cancellations and the impact of the intense focus from the team can be seen with a steep increase in performance in this area, which is anticipated to continue.



Vascular remains an underperforming specialty and will be the next area of focus to deliver performance improvement.



52 week waiters

Winter pressures and cancellations of routine elective activity significantly impacted on those patients waiting 52 weeks for treatment. Whilst no cancer or clinically urgent patients were cancelled it did increase patient's waiting times and increase the risk of 52 week breaches.

At the end of April, 19 patients had waited over 52 weeks. These have either now been treated or have a date for treatment scheduled. There are two patients booked over 52 weeks in June. As part of the recovery plan we agreed to work towards no patient waiting longer than 52 weeks beyond June. To support this ambition, the access policy was launched to ensure those who were waiting were correct as well as introducing the need for approval from an Associate Director of Operations (ADO) for any patient wishing to book outside of the 52 week window. Despite these targeted actions we know that we have small numbers of patients electing to wait until beyond June. The weekly access meetings are focussing on those at risk of breaching 52 weeks and patient level plans are discussed at this meeting.

We are working with the IST to review the 52 week waiters and this will assist with the diagnosis of any further root cause and will support our approach to managing this cohort of patients.

A clinical harm review has assessed 74 patients who have waited 52 weeks or more. 70 identified as no harm, 2 mild harm (increased stress) and 2 potential harm (prolonged pre-operative management). A review is scheduled to be completed by 25th May to develop a rolling clinical harm review process.

Cerner update

A Planned PTL is now in place and is currently being validated prior to implementation. The diagnostic PTL is still required.

Delivering 92%

The ambition is to achieve 92% in aggregate by October 2018. In order to achieve this an additional 250 clock stops will be required per month at aggregate level and specific specialty level plans are being developed to achieve this. This will be achieved through a combination of increased utilisation of OPD and DSU capacity, reduced DNA / CNA rate for day case procedures and additional clinical sessions. Joint work with the CCG is ongoing to look at reducing demand which will be expected to have some impact from October 2018 onwards.

Next steps

Significant improvements have been demonstrated through sound governance to support delivery of IST sustainability plan and this will continue. The demand and capacity modelling is being revised and this will then provide definitive sub-speciality actions. The IST recently visited to deliver some high level training and this will inform the development of a comprehensive Trust-wide RTT training plan.

An interim access manager has been appointed who is taking forward this work.

11. Finance and workforce report

To ACCEPT the report

Presented by Craig Black

Board of Directors – 27 April 2018

Agenda item:	11			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Louise Wishart, Assistant Director of Finance			
Date prepared:	21st May 2018			
Subject:	Finance and Workforce Board Report – April 2018			
Purpose:	x	For information		For approval

Executive summary:

The Trust has not agreed a control total with NHS Improvement for 2018/19 which means there is no access to the Provider Sustainability Fund (PSF, previously STF) this year. The planned deficit for the year is £16.6m.

The reported I&E for April 2018 YTD is a deficit of £1,839k, against a planned deficit of £1,745k. This results in an adverse variance of £93k in month.

The monthly adverse variance is £93k. This predominantly relates to expenditure on agency staff over and above the budget.

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*	

FINANCE AND WORKFORCE REPORT

April 2018 (Month 1)

Executive Sponsor : Craig Black, Director of Resources
Author : Louise Wishart, Assistant Director of Finance

Financial Summary

I&E Position YTD	£1.8m	loss
Variance against plan YTD	-£0.1m	adverse
Movement in month against plan	-£0.1m	adverse
EBITDA position YTD	-£1.0m	
EBITDA margin YTD	-10.3%	adverse
Total STF Received	£0.0m	
Cash at bank	£5,322k	

Executive Summary

- The Trust has not agreed a control total with NHS Improvement for 2018/19 which means there is no access to STF this year. The planned deficit for the year is £16.6m.
- The planned deficit for month 1 was £1.7m but the actual deficit was £1.8m, and adverse variance of £0.1m.
- The Trust forecast for this financial year remains at £16.6m deficit.

Key Risks

- Securing cash loan support from DH for the 2018/19 revenue and capital plans.
- Delivering the £9.4m cost improvement programme.
- Containing the increase in demand to that included in the plan (3.2%).

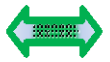
SUMMARY INCOME AND EXPENDITURE ACCOUNT - April 2018	Apr-18 Budget £m	Apr-18 Actual £m	Apr-18 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget	Year end forecast Actual	Year end forecast Variance F/(A)
NHS Contract Income	15.4	15.5	0.1	15.4	15.5	0.1	189.3	189.3	0.0
Other Income	2.7	2.5	(0.2)	2.7	2.5	(0.2)	33.3	33.3	0.0
Total Income	**18.1**	**17.9**	**(0.1)**	**18.1**	**17.9**	**(0.1)**	**222.6**	**222.6**	**0.0**
Pay Costs	12.7	13.0	(0.3)	12.7	13.0	(0.3)	151.0	151.0	0.0
Non-pay Costs	6.3	5.9	0.3	6.3	5.9	0.3	75.0	75.0	0.0
Operating Expenditure	**18.9**	**18.9**	**0.0**	**18.9**	**18.9**	**0.0**	**226.0**	**226.0**	**0.0**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	3.0	3.0	0.0
EBITDA excl STF	**(0.9)**	**(1.0)**	**(0.1)**	**(0.9)**	**(1.0)**	**(0.1)**	**(6.4)**	**(6.4)**	**0.0**
Depreciation	0.6	0.5	0.0	0.6	0.5	0.0	7.2	7.2	0.0
Finance costs	0.3	0.3	(0.0)	0.3	0.3	(0.0)	3.0	3.0	0.0
SURPLUS/(DEFICIT) pre S&TF	**(1.7)**	**(1.8)**	**(0.1)**	**(1.7)**	**(1.8)**	**(0.1)**	**(16.6)**	**(16.6)**	**0.0**
Sustainability and Transformation Funding									
S&T funding - Financial Performance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
S&T funding - A&E Performance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
S&T funding - Incentive		0.0	0.0		0.0	0.0	0.0	0.0	0.0
S&T funding - Bonus		0.0	0.0		0.0	0.0	0.0	0.0	0.0
SURPLUS/(DEFICIT) incl S&TF	**(1.7)**	**(1.8)**	**(0.1)**	**(1.7)**	**(1.8)**	**(0.1)**	**(16.6)**	**(16.6)**	**0.0**

FINANCE AND WORKFORCE REPORT – April 2018

Contents:

Key:

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

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

FINANCE AND WORKFORCE REPORT – April 2018

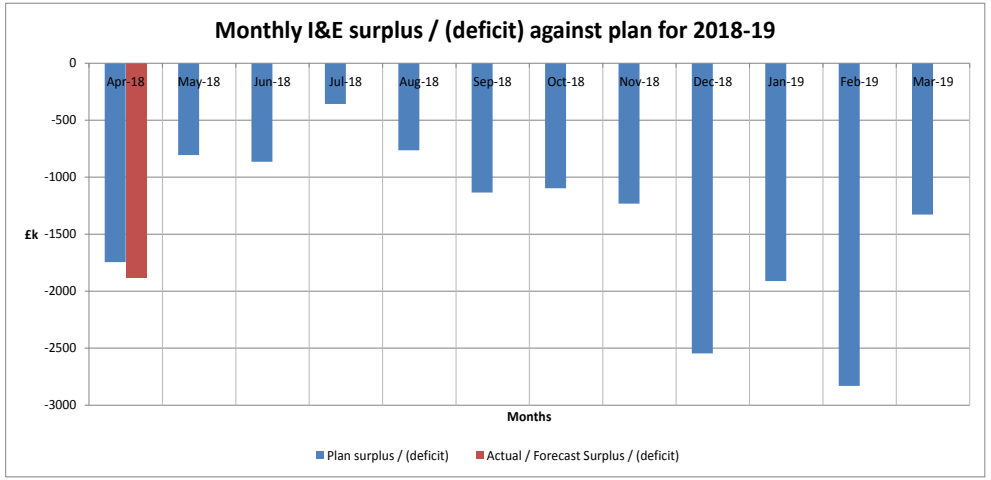
Income and Expenditure Summary as at April 2018

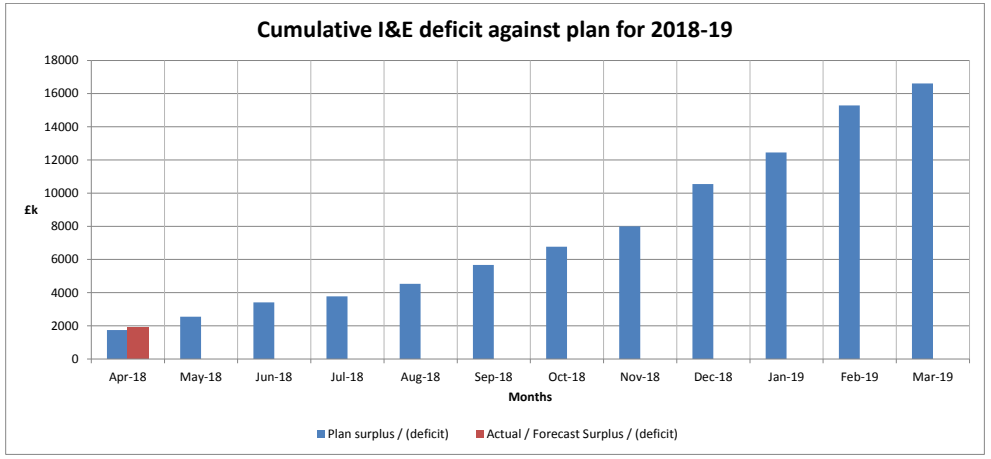
The reported I&E for April 2018 YTD is a deficit of £1,839k, against a planned deficit of £1,745k. This results in an adverse variance of £93k in month.

The monthly adverse variance is £93k. This predominantly relates to expenditure on agency staff over and above the budget.

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)	(1,745)	(1,839)	(93)	↓	Red
YTD surplus / (deficit)	(1,745)	(1,839)	(93)	↓	Red
Forecast surplus / (deficit)	(16,615)	(16,615)	0	↑	Amber
EBITDA (excl STF) YTD	(897)	(989)	(92)	↓	Red
EBITDA (%)	(5.0%)	(5.5%)	(0.6%)	↓	Red
Clinical Income YTD	(15,380)	(15,473)	93	↑	Green
Non-Clinical Income YTD	(2,672)	(2,451)	(221)	↓	Red
Pay YTD	12,684	12,984	(301)	↓	Red
Non-Pay YTD	7,114	6,778	336	↓	Amber
CIP target YTD	655	285	(370)	↑	Red





FINANCE AND WORKFORCE REPORT – April 2018

Cost Improvement Programme (CIP) 2018-19

The April position includes a target of £655k YTD which represents 7% of the 2018-19 plan. There is currently a shortfall of £119k YTD against this plan.

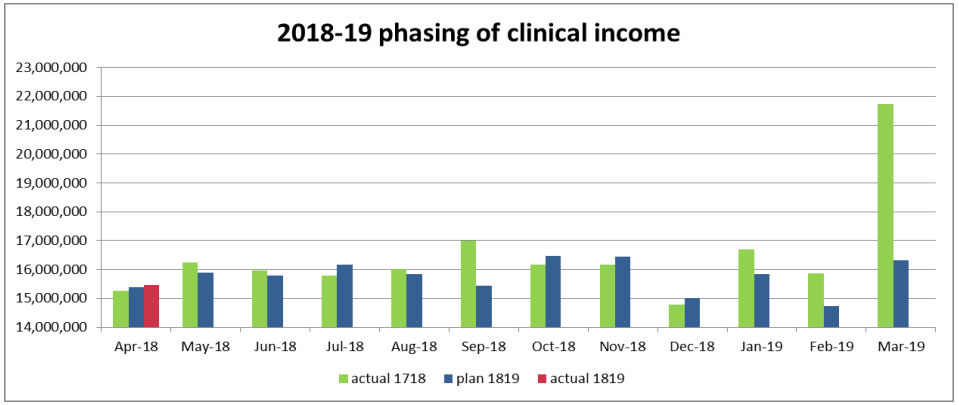
Summary	2018-19 Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Local			
Medicine	1,856	107	43
Surgery	1,942	116	120
Womens & Childrens and Clinical Support	830	69	51
Community Services	1,337	98	57
Estates & Facilities and Corporate	468	39	39
PMO *			
Integrated pain	86		
Joint Pharmacy	105		
Review off-contract claims	48		
Optimising Medicines (model hospital)	14		
Off contract claims (differential costs)	7		
Endoscopy	69		
Cross Cutting *			
Flow (length of stay)	810	68	68
Operating Theatres	186	16	16
Grip and Control (annual leave)	283	24	24
Bay-based Nursing	419	35	35
Clinical Nurse Specialists	338	28	28
Outpatients	246	21	21
Administrative and Clerical	123	10	10
Lease cars change of provider	50	4	4
EoE Procurement Hub	180	15	15
Local Mail postage	7	1	1
Newmarket coffee shop	2		
Grand Total	**9,406**	**649**	**530**

* Profiling of CIP to be adjusted in M2

In order to deliver the Trust's planned deficit of £16.6m deficit in 2018-19 we need to deliver a CIP of £9.4m (3.9%). To date we have identified £7.0m of risk adjusted CIP schemes, (£9.4m non-risk adjusted) for 2018-19.

Income Analysis

The chart below summarises the phasing of the clinical income plan for 2018-19, including Community Services. This phasing is in line with activity phasing which is how the income is recognised.

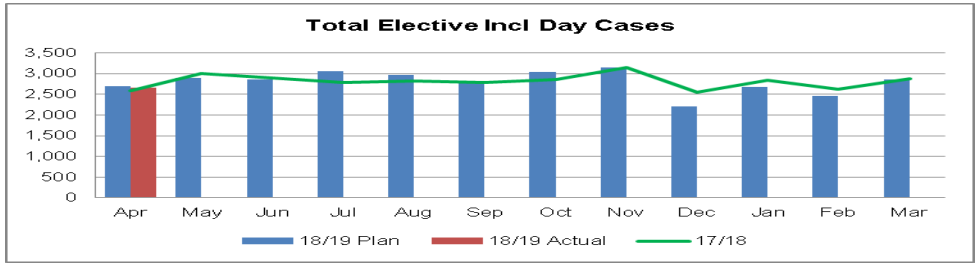


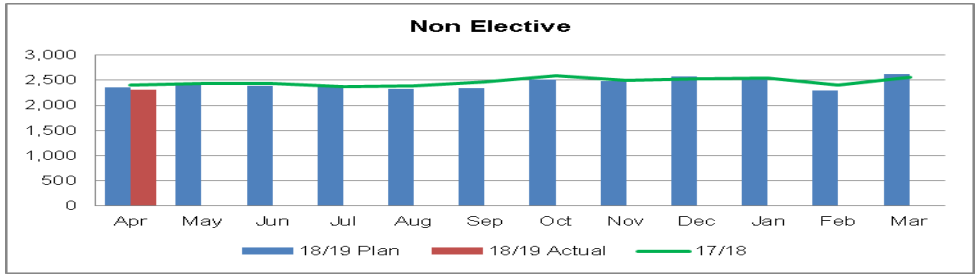
The March 2018 actual income includes bonus and incentive STF.

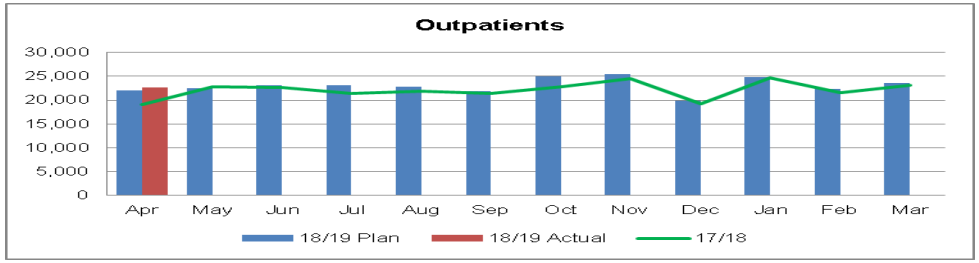
The income position was ahead of plan for April, with over performance being seen within the Non Electives and under performance within the Electives.

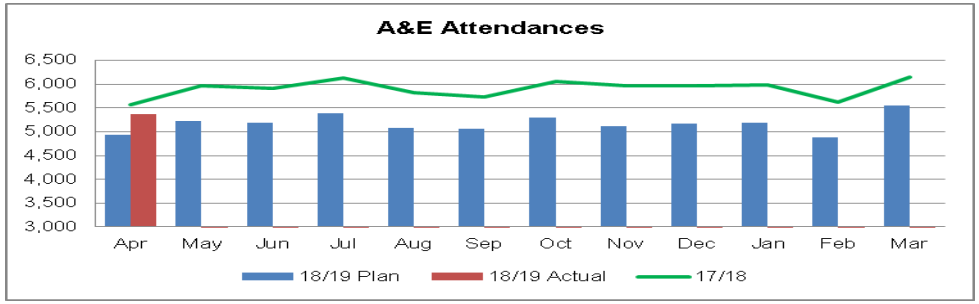
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	676	667	(9)	676	667	(9)
Other Services	2,009	2,025	16	2,009	2,025	16
CQUIN	304	307	4	304	307	4
Elective	2,746	2,629	(118)	2,746	2,629	(118)
Non Elective	5,281	5,462	180	5,281	5,462	180
Emergency Threshold Adjustment	(333)	(369)	(36)	(333)	(369)	(36)
Outpatients	2,658	2,722	64	2,658	2,722	64
Community	1,633	1,633	0	1,633	1,633	0
Total	**14,975**	**15,075**	**101**	**14,975**	**15,075**	**101**

Activity, by point of delivery

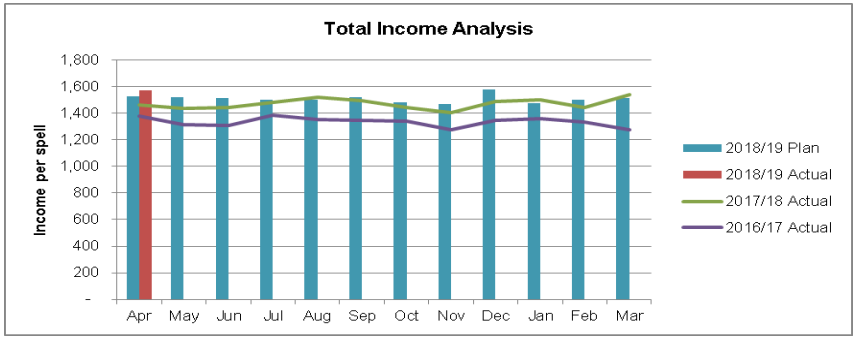


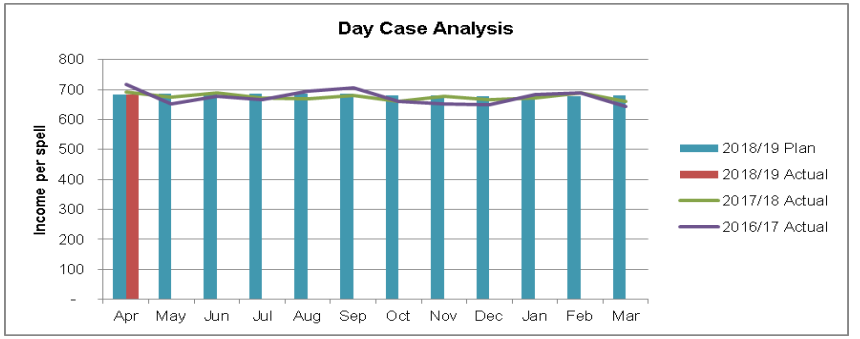


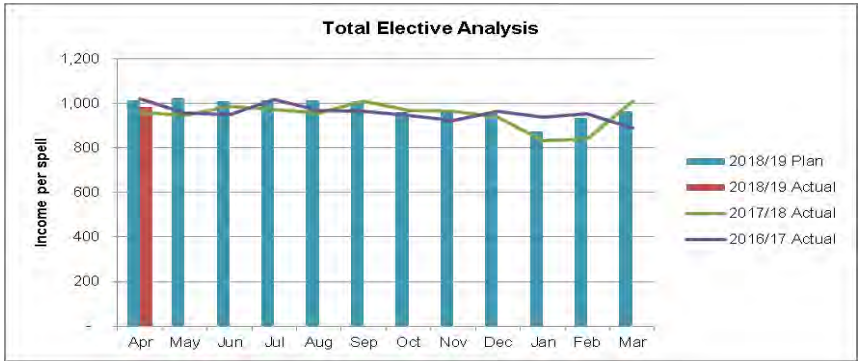


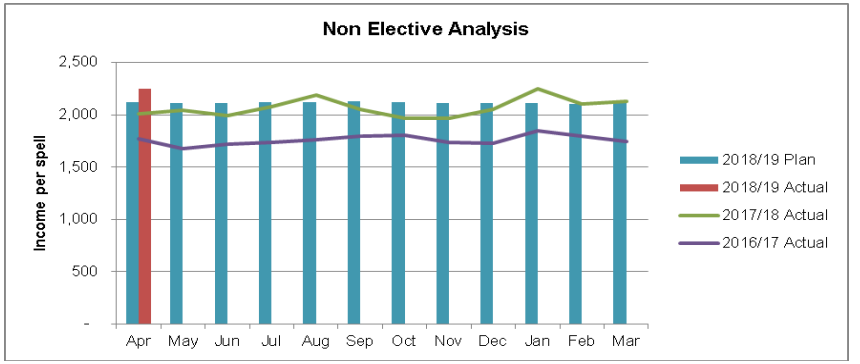


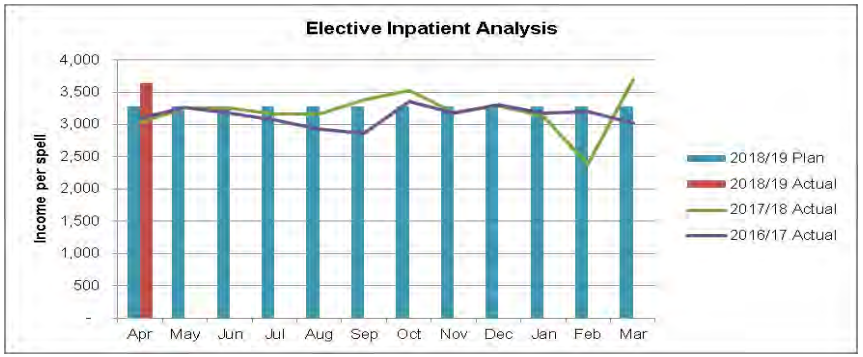
Trends and Analysis

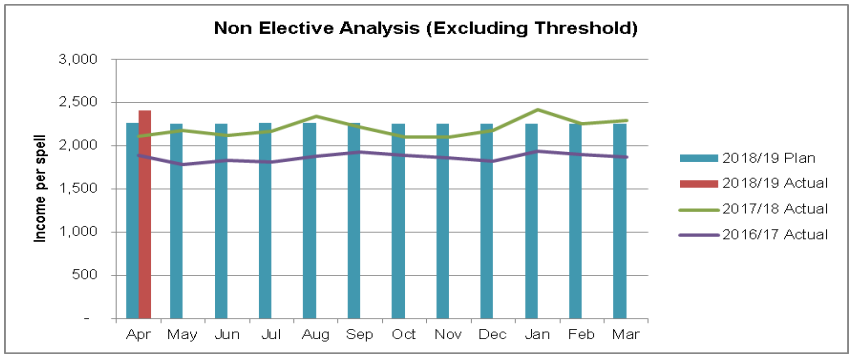












FINANCE AND WORKFORCE REPORT – April 2018

Workforce

Monthly Expenditure Acute services only				
As at April 2018	Apr-18	Mar-18	Apr-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**11,167**	**10,856**	**10,798**	**11,167**
Substantive Staff	9,859	9,677	9,553	9,859
Medical Agency Staff (includes 'contracted in' staff)	132	258	143	132
Medical Locum Staff	256	176	166	256
Additional Medical sessions	298	211	223	298
Nursing Agency Staff	127	89	72	127
Nursing Bank Staff	347	212	228	347
Other Agency Staff	41	52	45	41
Other Bank Staff	145	110	152	145
Overtime	139	117	109	139
On Call	64	49	44	64
Total temporary expenditure	1,549	1,276	1,181	1,549
Total expenditure on pay	**11,408**	**10,953**	**10,734**	**11,408**
Variance (F/(A))	(241)	(97)	64	(241)
Temp Staff costs % of Total Pay	13.6%	11.6%	11.0%	13.6%
Memo : Total agency spend in month	300	399	260	300

Monthly Expenditure Community Service				
As at April 2018	Apr-18	Mar-18	Apr-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,517**	**1,532**	**1,078**	**1,517**
Substantive Staff	1,461	1,428	1,074	1,461
Medical Agency Staff (includes 'contracted in' staff)	6	11	10	6
Medical Locum Staff	3	3	3	3
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	11	15	1	11
Nursing Bank Staff	14	12	8	14
Other Agency Staff	14	27	43	14
Other Bank Staff	7	(12)	9	7
Overtime	9	6	5	9
On Call	3	3	2	3
Total temporary expenditure	67	66	81	67
Total expenditure on pay	**1,528**	**1,494**	**1,155**	**1,528**
Variance (F/(A))	(11)	38	(78)	(11)
Temp Staff costs % of Total Pay	4.4%	4.4%	7.0%	4.4%
Memo : Total agency spend in month	31	53	54	31

Monthly whole time equivalents (WTE) Acute Services only			
As at April 2018	Apr-18	Mar-18	Apr-17
	WTE	WTE	WTE
Budgeted WTE in month	**3,121.7**	**3,086.1**	**3,095.6**
Employed substantive WTE in month	**2771.75**	**2757.47**	**2737.36**
Medical Agency Staff (includes 'contracted in' staff)	12.67	21.73	8.52
Medical Locum	18.46	16.13	12.32
Additional Sessions	20.82	16.6	22.15
Nursing Agency	25.06	23.52	11.47
Nursing Bank	110.45	72.42	73.21
Other Agency	7.76	11.77	12.73
Other Bank	68.3	50.88	75.33
Overtime	41.67	38.28	50.88
On call Worked	8	5.86	8.51
Total equivalent temporary WTE	**313.2**	**257.2**	**275.1**
Total equivalent employed WTE	**3,084.9**	**3,014.7**	**3,012.5**
Variance (F/(A))	36.7	71.4	83.1
Temp Staff WTE % of Total Pay	10.2%	8.5%	9.1%
Memo : Total agency WTE in month	45.5	57.0	32.7

Sickness Rates	3.81%	3.75%	2.31%
Mat Leave	2.23%	2.21%	2.3%

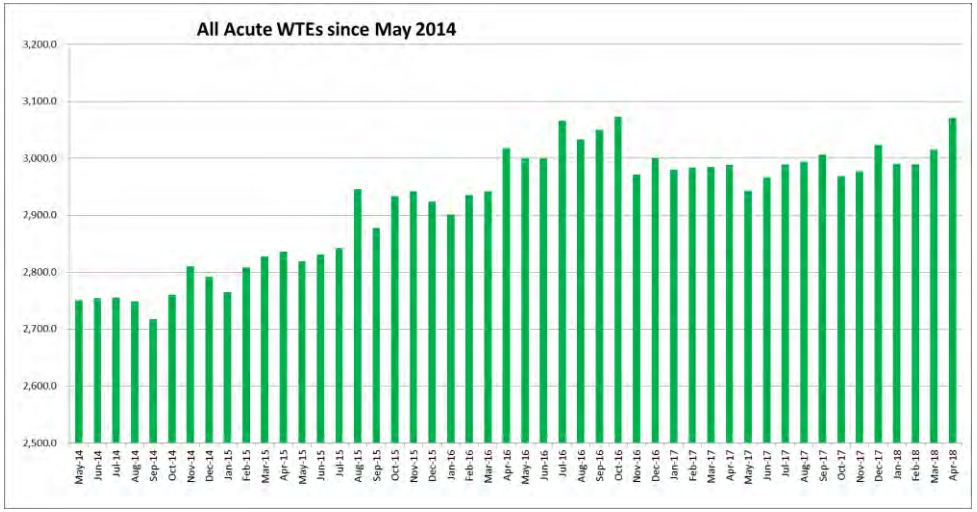
Monthly whole time equivalents (WTE) Community Services			
As at April 2018	Apr-18	Mar-18	Apr-17
	WTE	WTE	WTE
Budgeted WTE in month	**482.69**	**496.6**	**380.57**
Employed substantive WTE in month	**458.75**	**441.63**	**344.5**
Medical Agency Staff (includes 'contracted in' staff)	0.42	0.69	1.5
Medical Locum	0.35	0.35	0.4
Additional Sessions	0.00	0.00	0.0
Nursing Agency	2.05	2.74	0.4
Nursing Bank	4.86	3.96	4.6
Other Agency	3.62	6.69	9.2
Other Bank	2.30	1.25	3.3
Overtime	2.61	1.85	2.3
On call Worked	0.00	0.00	0.0
Total equivalent temporary WTE	**16.21**	**17.53**	**21.70**
Total equivalent employed WTE	**474.96**	**459.16**	**366.2**
Variance (F/(A))	7.73	37.44	14.37
Temp Staff WTE % of Total Pay	3.4%	3.8%	5.9%
Memo : Total agency WTE in month	6.1	10.1	11.1
Sickness Rates (Feb / Jan)	3.61%	3.56%	2.31%
Mat Leave	2.45%	2.41%	1.10%

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

FINANCE AND WORKFORCE REPORT – April 2018

Staffing levels

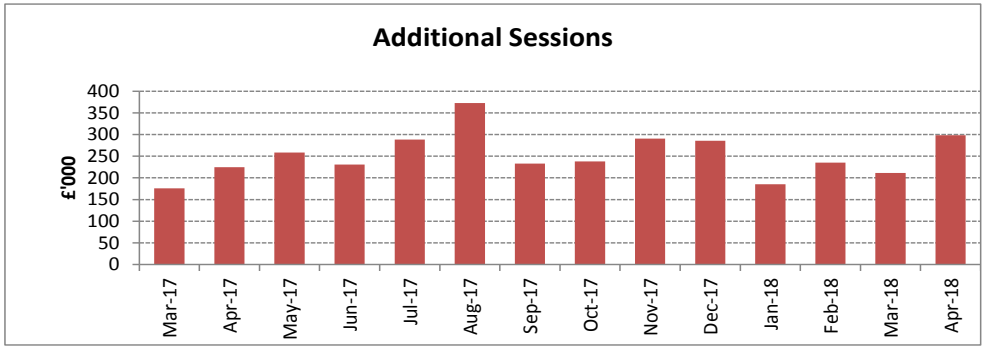
The following graphs exclude Community staff and Glastonbury Court but include Capitalised staff. The impact of opening Glastonbury Court in November 2016 can be seen but if this were included around 28 WTE would be added to the actual WTEs. They have been rebased to reflect hours worked by junior doctors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

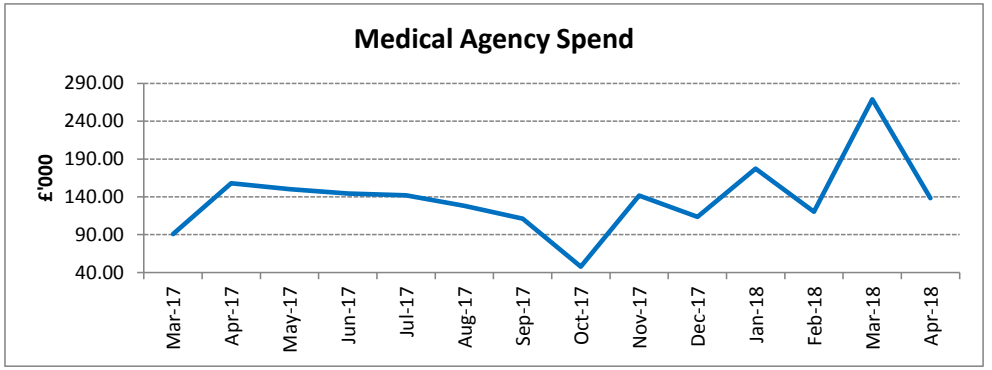


Since May 2014, (excluding Community staff) the Trust has employed 374 more WTEs, an increase of 13.6%.

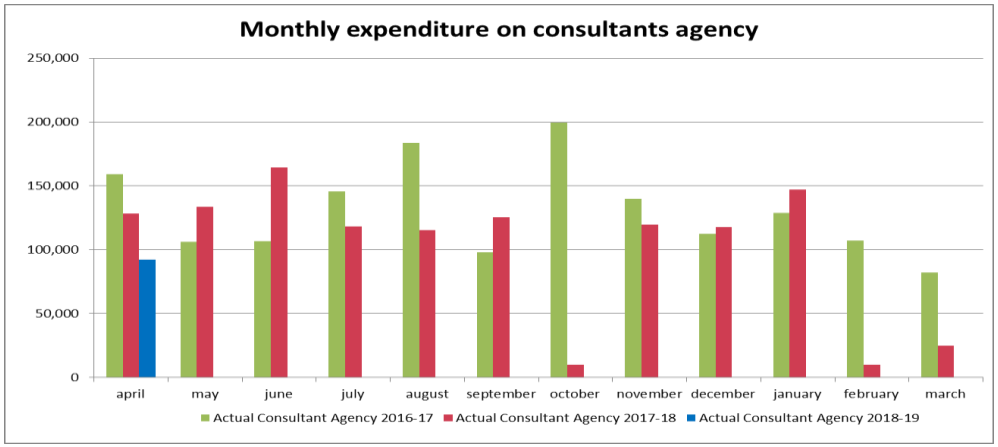
Pay Trends and Analysis

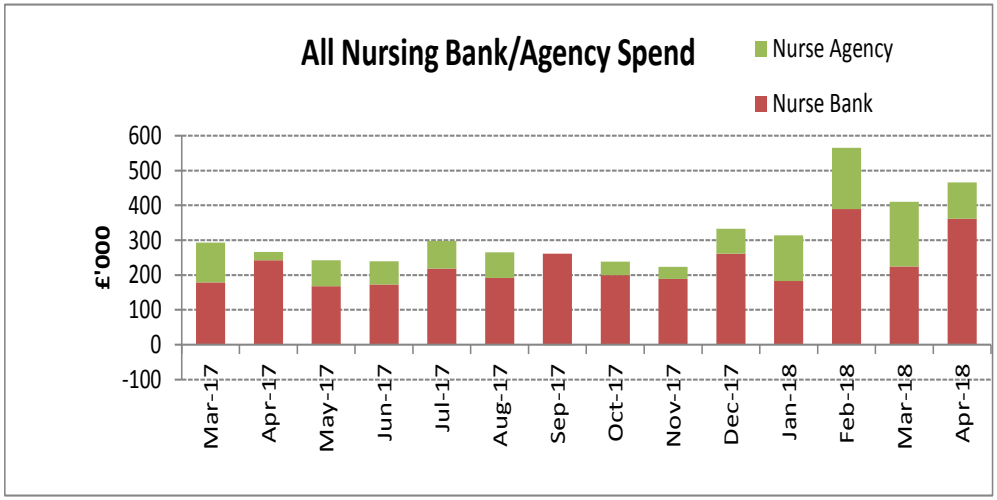
The Trust spent £301k more than budget on pay in April.

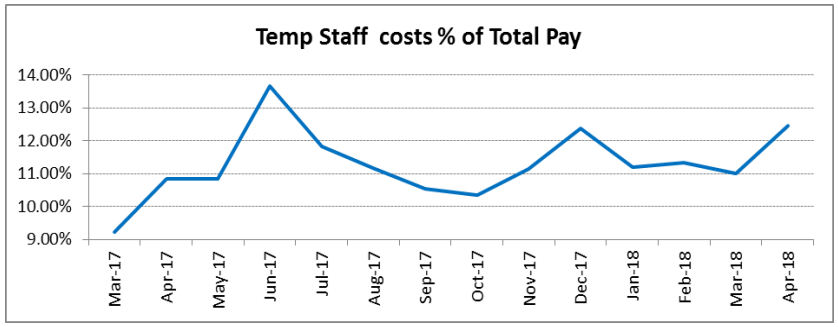


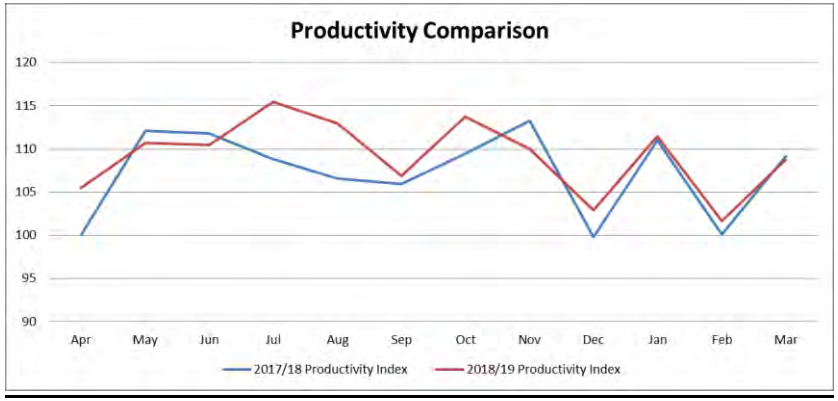


FINANCE AND WORKFORCE REPORT – April 2018









Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Apr-18 Budget £k	Apr-18 Actual £k	Apr-18 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(5,564)	(5,684)	120	(5,564)	(5,684)	120
Pay Costs	3,496	3,629	(134)	3,496	3,629	(134)
Non-pay Costs	1,436	1,358	78	1,436	1,358	78
Operating Expenditure	4,932	4,988	(56)	4,932	4,988	(56)
SURPLUS / (DEFICIT)	632	697	64	632	697	64
SURGERY						
Total Income	(4,838)	(4,943)	105	(4,838)	(4,943)	105
Pay Costs	2,931	3,031	(100)	2,931	3,031	(100)
Non-pay Costs	1,158	1,159	(1)	1,158	1,159	(1)
Operating Expenditure	4,089	4,190	(101)	4,089	4,190	(101)
SURPLUS / (DEFICIT)	749	753	4	749	753	4
WOMENS and CHILDRENS						
Total Income	(1,912)	(1,760)	(152)	(1,912)	(1,760)	(152)
Pay Costs	1,123	1,156	(34)	1,123	1,156	(34)
Non-pay Costs	138	152	(14)	138	152	(14)
Operating Expenditure	1,260	1,309	(48)	1,260	1,309	(48)
SURPLUS / (DEFICIT)	651	451	(200)	651	451	(200)
CLINICAL SUPPORT						
Total Income	(904)	(902)	(2)	(904)	(902)	(2)
Pay Costs	1,301	1,315	(14)	1,301	1,315	(14)
Non-pay Costs	987	1,035	(49)	987	1,035	(49)
Operating Expenditure	2,287	2,350	(63)	2,287	2,350	(63)
SURPLUS / (DEFICIT)	(1,383)	(1,448)	(65)	(1,383)	(1,448)	(65)
COMMUNITY SERVICES						
Total Income	(3,061)	(2,978)	(84)	(3,061)	(2,978)	(84)
Pay Costs	1,994	2,000	(5)	1,994	2,000	(5)
Non-pay Costs	1,149	1,199	(51)	1,149	1,199	(51)
Operating Expenditure	3,143	3,199	(56)	3,143	3,199	(56)
SURPLUS / (DEFICIT)	(82)	(221)	(140)	(82)	(221)	(140)
ESTATES and FACILITIES						
Total Income	(382)	(303)	(79)	(382)	(303)	(79)
Pay Costs	752	740	12	752	740	12
Non-pay Costs	632	491	141	632	491	141
Operating Expenditure	1,384	1,231	153	1,384	1,231	153
SURPLUS / (DEFICIT)	(1,002)	(928)	74	(1,002)	(928)	74
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	(1,722)	(1,355)	(367)	(1,722)	(1,355)	(366)
Pay Costs	1,088	1,113	(25)	1,088	1,113	(25)
Non-pay Costs (net of contingency and reserves)	1,097	533	563	1,097	533	563
Finance & Capital	849	850	(1)	849	850	(1)
Operating Expenditure	3,033	2,496	537	3,033	2,496	537
SURPLUS / (DEFICIT)	(1,312)	(1,142)	170	(1,312)	(1,142)	170
TOTAL (including penalties, contingency and reserves)						
Total Income	(18,383)	(17,924)	(460)	(18,383)	(17,924)	(459)
Contract Penalties	0	0	0	0	0	0
Pay Costs	12,684	12,984	(301)	12,684	12,984	(301)
Non-pay Costs	6,596	5,928	668	6,596	5,928	666
Finance & Capital	849	850	(1)	849	850	(1)
Operating Expenditure (incl penalties)	20,129	19,763	366	20,129	19,763	366
SURPLUS / (DEFICIT)	(1,745)	(1,839)	(93)	(1,745)	(1,839)	(93)

Medicine (Annie Campbell)

The division was £64k ahead of plan for the month. ED contract income was just below plan, despite attendances being above plan, 4 hour performance was static (83.99%), against a backdrop of a national improvement (82.34% from 76.42% in March). The increased attendances resulted in more Emergency Admissions, particularly of those greater than one day. May has been significantly better, as bed pressures relent and flow returns to the hospital.

Elective work exceeded plan (£28k inpatients, £6k outpatients) – whilst April results are awaited, March Referral to Treatment was at 97.32% for the Division, with two specialties at 100%. One issue concerning the Division is the "Advice and Guidance" consultations due to the time this takes, and the quick turnaround required (72 hours). These pressures mean the cost to the Trust is greater than the Telephone attendance tariff the division receives.

Expenditure was overspent by £134k, surge beds were kept open, but without any winter pressures funding. There are currently 57 Band 5 Nurse vacancies throughout the Division and 5 Middle grade vacant posts in ED – all crucial to operations. In response the Division has had to rely upon Agency (£204k) and overtime (£60k) – all at a premium.

The Divisional CIP target (£1.856m) has suffered some pressure, firstly from a delay in the Angio/Pacing suite implementation, but mainly due to problems with biosimilars. Adalimumab, the highest grossing drug in the world has been the subject of significant litigation worldwide, and NHSE expect implementation no earlier than October 2018, a slippage from the April target (£190k impact). The Division continues to investigate ways in which these losses can be mitigated.

Surgery (Simon Taylor)

The Division has over performed by £4K. Income overachieved against plan by £105k, both outpatients (£73k) and admitted care (£37k) over achieved against plan. Admitted care over delivery is related to Non-elective care (£150k). Surgery has seen winter pressure remain through April. Critical care significantly over performed against plan.

Pay is overspent by £100k. This is due to temporary staffing (£235k) to cover rota gaps and additional sessions and vacancies. Anaesthetics had 10 sessions each week that need to be covered with additional sessions owing to staff absence and vacancy. This will improve with planned recruitment and the division will continue to monitor temporary staff spend carefully.

Non-pay is overspent by £1k. Non pay is near budget, this would have over spent if Surgery had been able to fully delivery the Elective plan in month one. Work is being undertaken to look at ways to restrict the expenditure.

Women and Children's (Rose Smith)

In April, the Division reported a deficit of £200k.

Income reported £152k behind plan in-month. In-month, inpatient and outpatient activity was lower than expected. This created variances against the contract income plan of £129k and £23k respectively.

Pay reported a £34k overspend in-month. In-month, gaps in the middle grade rota in Obstetrics & Gynaecology were covered with agency and locum registrars. In addition, a vacancy in the Obstetrics and Gynaecology consultant rota was covered by spending on agency and locum consultants.

Non pay reported a £14k overspend in-month. This position is mainly dictated by Addenbrooke's maternity part pathway charges that were greater than the budget.

Clinical Support (Rose Smith)

In April, the Division reported a deficit of £65k.

Income for Clinical Support reported £2k behind plan in-month.

Pay is £14k overspent in-month. The microbiology and radiology services have had difficulties in filling the gaps in the senior medical rotas and are currently employing unbudgeted locums. A fixed term consultant microbiologist has now been recruited and no further spend on microbiology locums is anticipated.

Non pay was £49k overspent in-month. This is attributable to stock adjustments in pharmacy. This position is currently under review.

Community Services (Dawn Godbold)

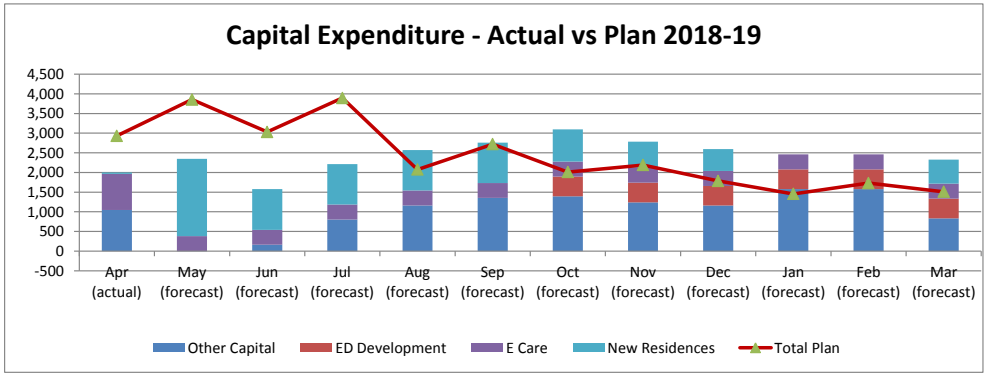
Community Services reported an £140k under performance in-month and YTD. Income reported a £84k under recovery in-month and YTD.

The main variances within Integrated Therapies £34k, decrease in income partly offset by an increase in internal recharges.

Paediatrics £25k under recovery due to an decrease in Paediatrics SALT income this will be adjusted next month and doctors in training £6k, where funding has been received corporately.

Non pay reported a £51k overspend in-month and YTD. Main variances include NHS Property Services £43k, accruals have been increased based on the charges schedules received in April for 2017/18 charges. Further information is required from NHS Property Services for both 2017/18 charges and 2018/19 charges. Central Equipment Services reported a £17k overspend due to CIP being applied evenly across the year, some of the changes have just started to be introduced and it is expected that CIP achievement will improve during the year.

Capital Progress Report



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	2018-19
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
E Care	916	380	380	380	380	380	380	380	380	380	380	384	5,100
ED Development	0	0	0	0	0	0	500	500	500	500	500	500	3,000
New Residences	37	1,965	1,038	1,030	1,027	1,027	819	663	559	0	0	610	8,774
Other Schemes	1,047	-0	161	804	1,162	1,352	1,396	1,239	1,158	1,579	1,579	834	12,312
Total / Forecast	1,999	2,345	1,579	2,214	2,568	2,759	3,095	2,782	2,597	2,459	2,459	2,328	29,186
Total Plan	2,932	3,855	3,031	3,895	2,074	2,721	2,010	2,190	1,784	1,455	1,730	1,509	29,186

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 April 2018 at £29,186k. At this point in the year the phasing of schemes is subject to change. Expenditure on e-Care for the year to date is £916k with a forecast for the year of £5,100k.

The forecast for the year is behind the plan submitted to NHSI. At the time of submission the MModal project was planned to be spent during the first quarter. The bulk of this expenditure (software licences) was incurred in the latter part of the 2017/18 financial year. The plan also assumed the next tranche of capital expenditure as part of the radiology and endoscopy managed service agreements would be spent in April. The business case for this expenditure is still to be submitted for Board approval. As a result of this the forecast has deferred this expenditure to the last quarter of the financial year.

The forecasts for all projects have been reviewed by the relevant project managers. There are no significant financial risks to the budgets reported. Year to date the overall expenditure of £1,999k is below the plan of £2,932k.

Statement of Financial Position at 30th April 2018

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2018 * £000	Plan 31 March 2019 £000	Plan YTD 30 April 2018 £000	Actual at 30 April 2018 £000	Variance YTD 30 April 2018 £000
Intangible assets	21,562	26,841	22,994	23,908	914
Property, plant and equipment	95,300	111,911	96,124	94,954	(1,170)
Trade and other receivables	2,472	2,472	2,472	2,472	0
Other financial assets	0	0	0	0	0
Total non-current assets	**119,334**	**141,224**	**121,590**	**121,334**	**(256)**
Inventories	2,712	2,600	2,600	2,557	(43)
Trade and other receivables	22,866	26,414	21,987	19,812	(2,175)
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	3,601	1,050	4,550	5,322	772
Total current assets	**29,179**	**30,064**	**29,137**	**27,691**	**(1,446)**
Trade and other payables	(24,975)	(27,274)	(25,101)	(25,155)	(54)
Borrowing repayable within 1 year	(3,114)	(2,729)	(2,841)	(3,083)	(242)
Current ProvisionsProvisions	(94)	(61)	(61)	(94)	(33)
Other liabilities	(963)	(1,295)	(1,295)	(2,848)	(1,553)
Total current liabilities	**(29,146)**	**(31,359)**	**(29,298)**	**(31,180)**	**(1,882)**
Total assets less current liabilities	**119,367**	**139,929**	**121,429**	**117,844**	**(3,585)**
Borrowings	(65,391)	(101,984)	(69,813)	(64,069)	5,744
Provisions	(124)	(158)	(158)	(124)	34
Total non-current liabilities	**(65,515)**	**(102,142)**	**(69,971)**	**(64,192)**	**5,779**
Total assets employed	**53,852**	**37,787**	**51,458**	**53,652**	**2,194**
Financed by					
Public dividend capital	65,803	66,353	65,803	65,803	(0)
Revaluation reserve	8,021	8,021	8,021	8,021	0
Income and expenditure reserve	(19,972)	(36,587)	(22,366)	(21,971)	395
Total taxpayers' and others' equity	**53,852**	**37,787**	**51,458**	**51,852**	**394**

* draft figures subject to audit

Non-Current Assets

There is some slippage on the capital programme and also the draft brought forward values from 2017/18 are lower than assumed in the plan although these are still subject to change.

Trade and Other Receivables

These have decreased by £3.0m in April and are £2.2m below plan, mainly because a number of balances have now been cleared due to the need to seek agreement between NHS bodies at year-end.

Cash

Cash is £0.7m higher than plan at the end of April. Loan drawdowns have been delayed until the cash is required.

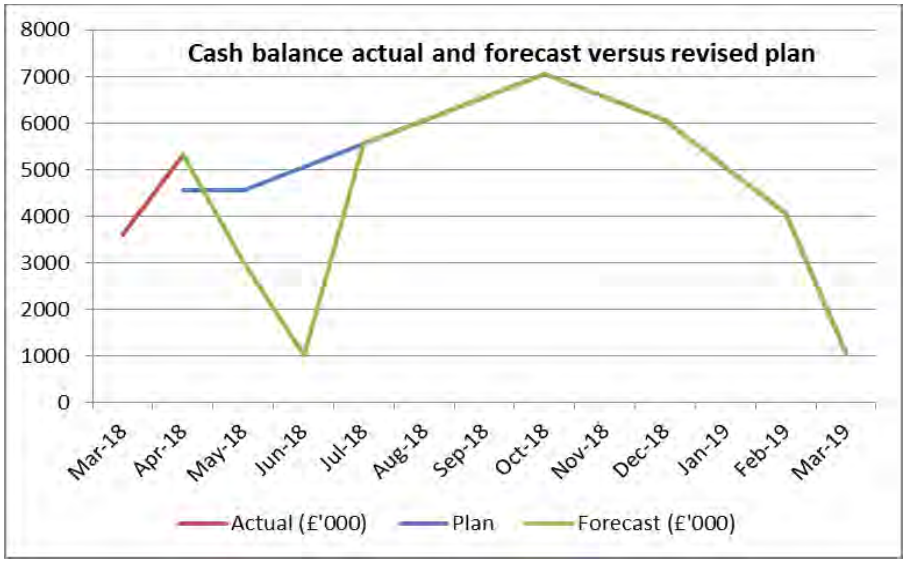
Other liabilities

This balance reflects the difference between the income received, mainly for patient care, and the amount that we are able to recognise following the delivery of service. The amount is higher than plan due to the planned delivery of clinical income in April being less than assumed in the plan for other liabilities.

Borrowing

The Trust is currently in discussion with NHSI to secure the borrowing required for the 2018/19 revenue and capital plan. Until this is in place the Trust is only able to draw down the remaining capital borrowing already agreed. No borrowing was required in April so this was not drawn down but this will be kept under close review.

Cash Balance Forecast for the year



The graph illustrates the cash trajectory since March, plan and revised forecast.

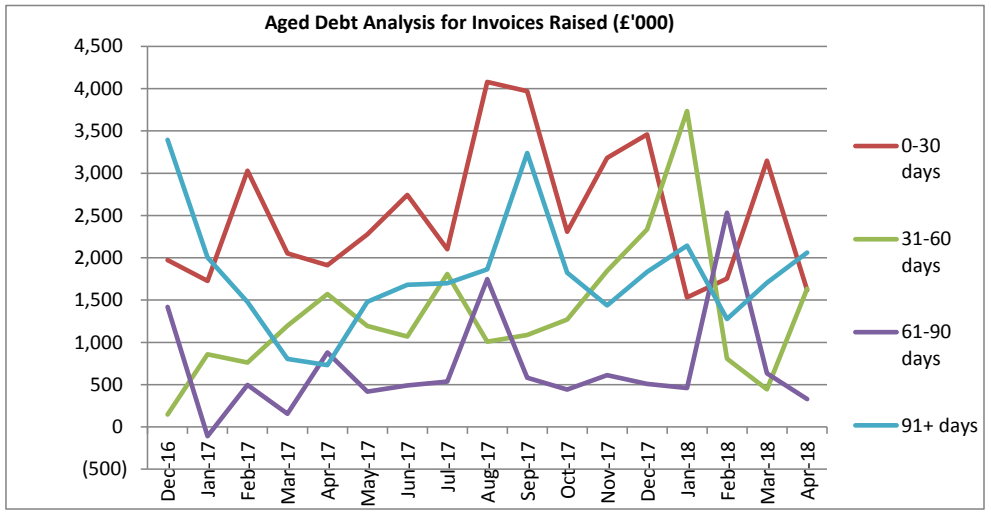
The Trust is required to keep a minimum balance of £1 million.

There is significant uncertainty around the timing of cash receipt for STF and also the timing of securing agreement from DH on the planned borrowing so it is assumed the cash reserves will reduce until both are received.

Debt Management

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

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



The overall level of invoices raised but not paid has decreased by £0.3m in April.

The increase in debts over 91 days is due to the £0.5m invoice outstanding from NHSI towards the cost of the FIP2 project but this has been received since month end.

The increase in debt between 31 and 60 days is due to an invoice to West Suffolk CCG for £727k related to additional income agreed at year end but this was paid at the beginning of May.

10:15 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

12. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

Presented by Rowan Procter

Trust Board – 25th May 2018

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

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	5 medication errors	High agency & bank use. High RN & NA vacancy. High amount of overtime.
F7	7 medication errors	High agency & bank use. High RN & NA vacancy. High amount of overtime. High sickness
F8	-	High agency & bank use. High amount of overtime. High sickness
CCS	-	High amount of overtime.
Theatres	-	High RN vacancy & sickness. High amount of overtime
DSU	-	High sickness & bank use.
CCU	-	High bank use. High sickness.
G1	-	High bank use.
G3	-	High bank use & NA vacancy. High amount of overtime
G4	-	High bank use. High amount of overtime.
G5	6 medication errors	High agency & bank use. High sickness. High RN & NA vacancy. High amount of overtime
G8	4 medication errors & 3 falls with harm	High bank & agency use. High sickness. High RN & NA vacancy.
F1	-	High bank use & RN vacancy.
F3	5 medication errors	High RN vacancy. High amount of overtime. High bank & agency use
F4	-	High agency & bank use. High RN vacancy.
F5	-	High bank use.
F6	-	High agency use. High RN vacancy. High amount of overtime. High sickness
F9	-	High bank use & vacancy in RNs. High sickness. High amount of overtime
F10	-	High bank use. High RN & NA vacancy. High sickness. High amount of overtime
Maternity	-	High bank use & sickness. High midwife vacancy.
F12	-	High bank use & sickness.
Kings Suite	5 falls with harm	High bank use. High amount of overtime. High sickness.
Rosemary Ward	-	High bank use & amount of overtime.

Vacancies – In West Suffolk Hospital, there are significant vacancies in registered staff, and is 93.25 WTE and there is an unregistered vacancy of 40.36WTE. The registered figure is slightly lower than last month but unregistered has increased. HR and operations are working on different method to recruit and retain nursing staff. The escalation ward is now closed and Discharge waiting area is covering two bays in Ward G9
The Admission Prevention Service has considerable vacancies and has resulted in the service hours being reduced.

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 2 areas less than March. Annual leave is the main cause for being over standard.
We are unable to collect this information in the community

Sickness – Out of 27 areas, 16 are over the Trust Standard of 3.5% (one less than last month) (Day surgery unit & ward are counted as one area).
In the community, 5 out of the 9 areas are over the Trust Standard.

Updates in March

Community areas have been included in this report and dashboard; however some information sources are still to be determined. Community Children's establishment is currently being reviewed. Community Matrons section will be removed out of table next month as they are normally included as part of area establishment

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Apr-18			Establishment for the Financial Year 2017/18						Data for Apr 2018													
										Workforce												Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Overtime (Hrs)	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night				Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	81.79	70.47%	29.53%	N/A	1 - 4	1 - 5	117.7%	85.5%	112.8%	106.5%	10.00%	7.67%	524	-5.48	-6.20	3.70%	N/A	21.80%	N/A	5	0
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	66.5%	64.7%	103.7%	98.4%	12.54%	8.07%	209	-10.90	-2.47	7.70%	6.19	23.60%	0	7	1
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	89.6%	112.1%	92.8%	135.5%	17.34%	6.49%	220	-2.20	3.20	1.20%	12.93	25.30%	0	3	0
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	96.9%	87.9%	N/A	N/A	2.10%	0.00%	101	-1.39	0.00	1.20%	27.69	21.70%	0	2	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	103.3%	100.0%	N/A	N/A	3.58%	0.00%	314	-8.39	-0.60	7.50%	N/A	24.00%	0	1	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	138.3%	90.3%	83.1%	N/A	1.98%	0.00%	0	-1.40	-0.10	0.70%	N/A	19.60%	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	56.5%	N/A	91.7%	N/A	0.00%	0.00%	29	-0.70	-1.00	5.60%	N/A	30.20%	0	0	1
	Day Surgery Wards													10.09%	0.00%	16	0.00	0.10	1.00%		28.20%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	96.3%	86.7%	74.4%	N/A	9.68%	0.00%	80	-0.60	-0.70	5.40%	11.14	24.60%	0	0	1
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	91.6%	98.3%	78.7%	N/A	6.25%	0.59%	69	-0.53	-0.40	3.90%	8.78	23.20%	0	2	1
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	89.0%	78.4%	77.8%	100.6%	14.43%	0.00%	112	-0.50	-6.83	2.20%	4.16	17.80%	0	1	0
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	85.5%	78.4%	111.0%	107.2%	16.22%	0.36%	241	-1.43	-2.53	3.50%	5.48	26.70%	0	2	2
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	79.9%	81.3%	97.9%	121.0%	10.91%	2.80%	183	-4.62	-3.33	8.50%	4.52	26.80%	2	6	0
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	70.6%	73.7%	92.5%	99.4%	22.59%	7.34%	35	-8.53	-6.27	8.00%	4.52	27.80%	0	4	3
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	78.1%	107.8%	138.6%	N/A	17.35%	0.00%	99	-3.97	-0.10	3.00%	28.23	21.40%	N/A	0	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	87.7%	97.2%	142.0%	110.2%	6.71%	3.84%	420	-4.20	-1.60	4.00%	4.97	22.20%	1	5	1
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	87.6%	88.3%	114.9%	191.1%	13.94%	15.22%	81	-4.73	-1.90	0.70%	9.72	20.50%	0	1	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	91.1%	98.4%	93.4%	116.6%	6.17%	0.26%	0	-0.50	-1.03	3.80%	5.22	22.00%	0	2	2
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	83.6%	91.5%	113.3%	111.4%	3.28%	5.66%	478	-5.31	-2.60	7.30%	4.66	20.00%	0	1	2
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	69.9%	80.2%	86.9%	103.4%	11.72%	0.25%	288	-8.69	-1.80	4.00%	4.24	18.20%	1	2	1
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	97.1%	70.0%	92.3%	92.5%	14.67%	0.26%	188	-6.50	-3.10	5.40%	5.27	24.20%	1	3	0
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	112.0%	94.7%	91.5%	57.1%	17.85%	0.00%	29	-5.93	0.50	7.00%	N/A	20.50%	0	2	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	74.1%	78.4%	33.2%	109.9%	11.86%	1.29%	82	-2.95	0.00	6.00%	7.33	24.60%	0	0	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	99.0%	98.5%	N/A	N/A	0.00%	0.76%	93	-0.70	-0.40	3.40%	11.2	21.10%	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	91.6%	N/A	40.5%	N/A	0.00%	0.00%	0	-0.20	0.00	0.00%	N/A	19.90%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	117.2%	84.4%	16.7%	53.3%	0.31%	0.00%	12	-1.19	-1.40	3.10%	24.37	20.10%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	116.0%	102.3%	98.3%	73.3%	4.97%	0.00%	169	-0.91	0.00	2.93%	7.30	N/A	0	0	1
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	99.4%	91.8%	79.6%	94.6%	11.44%	0.0%	163	-0.80	0.20	6.40%	4.50	24.70%	0	0	5
										92.07% AVG	88.83% AVG	89.89% AVG	104.56% AVG	9.21% AVG	2.17% AVG	4235 TOTAL	-93.25 TOTAL	-40.36 TOTAL	4.18% AVG		22.99% AVG			

Trust	Team 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)		Patient facing contact (hrs)	Another method workload measurement to be determined	Bank staff use %	Agency staff use %	Overtime (Hrs)	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day (June 2017)	Unplanned requests	Pressure Ulcer Incidences (In our care)	Nursing/Midwifery Administrative Medication Errors	Missed visits
					Registered	Unregistered		Day	Night						Registered	Unregistered						
Community	Bury Town	Community Heath Team	No community equivalent	21.59	25.94%	74.06%	No equivalent tool for community nurses	No specific number		1490.70		We are unable to collect this information this month		To be confirmed if can measure	Not provided in time		0.73%	No equivalent tool for community nurses	42	14	0	2
Community	Bury Rural	Community Heath Team		11.20	10.71%	89.29%				707.68							3.88%		19	0	0	0
Community	Mildenhall & Brandon	Community Heath Team		14.50	20.07%	79.93%				869.00					3.15	0.09	8.27%		42	2	0	0
Community	Newmarket	Community Heath Team		11.25	28.00%	72.00%				548.27					0.84	0.60	0.30%		19	0	1	2
Community	Sudbury	Community Heath Team		25.92	32.25%	67.75%				1147.92					3.80	1.00	2.47%		28	1	1	2
Community	Haverhill	Community Heath Team		13.20	32.05%	67.95%				761.00					0.13	0.00	13.35%		13	2	0	2
Community	Admission Prevention Service	Specialist Services		13.73	25.13%	74.87%				111.80					4.02	1.90	7.93%		0	0	0	0
Community	Community Matrons	Complex needs		3.60	100.00%	0.00%				162.92					0.00	0.00	0.00%		0	0	0	0
Community	Children	Community Paediatrics		32.89	47.07%	52.93%				1043.53					0.00	0.00	7.14%		0	N/A	0	0
										6842.82 TOTAL		#DIV/0! AVG	#DIV/0! AVG		11.94 TOTAL	3.59 TOTAL	4.90% AVG		163.00 TOTAL			

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 - Closed during April

Pressure Ulcer Incidences (In our care) - includes DTI's

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

Target - 3.5%

ETC had no recorded nurse sensitive indicators. G9 had four falls with harm in and two medication errors

13. Learning from deaths - Q4 report

To ACCEPT a report

Presented by Nick Jenkins

Trust Board Meeting – 25 May 2018

Agenda item:	13			
Presented by:	Dr Nick Jenkins, Medical Director			
Prepared by:	Dr Helena Jopling, Consultant in Healthcare Public Health			
Date prepared:	17th May 2018			
Subject:	Learning from Deaths			
Purpose:	X	For information		For approval

Executive summary:

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

Since then the Board has received quarterly reports presenting the key mortality statistics in a locally-developed dashboard and a narrative on the learning which has emerged from cases where there have been problems in care.

The change programme hit an important milestone on 26th February 2018 when the medical reviewers started their new posts. The medical reviewers are a team of senior doctors who will review the case notes of every patient who dies in the trust. They do this on behalf of their consultant colleagues to introduce objectivity into the reviews and to improve their timeliness. The team comprises two surgeons, two physicians and an anaesthetist.

The medical reviewers have successfully started work and their activities have been successfully integrated into the bereavement service that the trust provides to families who have lost a loved one. The reviews the reviewers are completing are generating a phenomenal volume of data on the quality of care at WSFT. The first of this data is presented in the bar chart on the dashboard today, showing the reviewers' judgments of the overall quality of care the trust has provided to people who died in March.

The change programme continues; the next steps are to make sure the findings of the reviews are shared with patients' families and to start sharing the data in its completeness throughout the trust, so it can be used to make improvements. The trust's bespoke database which captures all the learning is being adapted, in order to make sharing the learning as comprehensive as possible.

The Board will remember that the trust is also required to publish a summary of its mortality statistics and learning from deaths in the annual quality account. This information has been submitted.

Outcomes of reviews of deaths, quarter 4, 2017/18

The medical reviewers are using a different method to that used by consultants to review their own deaths before 26th February. In this quarter, therefore, two sets of findings are presented together, one from the old method and one from the new method.

Please see the accompanying dashboard. In summary:

- In quarter 4 there were 315 inpatient deaths

- 191 have been reviewed by the consultants who cared for them (deaths before 26th February)
- 101 have been reviewed by a medical reviewer (deaths since 26th February)

The old method judged preventability using a six-point scale, from definitely not preventable to definitely preventable (shown in the pie chart). In Q4:

- four deaths were judged to have been slightly preventable
- one was judged to have been possibly preventable.

One learning theme was identified from these cases: the need to recognise and escalate patients whose condition is deteriorating more promptly. This is a safety improvement priority already so the insight from these cases will be incorporated into the existing workstreams.

The new method judges the overall quality of care on a five-point scale from excellent to very poor (shown in the bar chart). In quarter 4:

- 80% people who died in the trust were judged to have received good or excellent care
- 6 people received poor care
- 1 person received very poor care

Three cases of poor or very poor care have been investigated under the reviewed under the Serious Incident Framework for harm caused

- 1 has been closed and referred back to the clinical team
- 1 was judged to have caused moderate harm and is being investigated (amber)
- 1 was judged to have caused major or catastrophic harm and is being investigated (red)

Cases of poor and very poor care which do not require investigation will be referred back to the clinical team for a reflective review, to identify any learning points for themselves, but also to recommend learning for other teams or departments. One case has completed this journey so far; the learning point was to improve the recording of conversations which had been had with the patient's family over the course of their illness and deterioration.

All families are offered a phone call with a medical reviewer to give their opinion on the quality of care which was received. Eighty percent of families are taking this up. It gives them an opportunity to raise any concerns they may have, to direct the reviewer's attention to problems in care which may not be obvious from the medical record. In a small number of cases, concerns have been raised and looked into. In a larger number of cases, the relatives have been very complimentary of the ward teams and even individual doctors and nurses who have really gone the extra mile.

The Learning from Deaths group is acutely aware that, while it is imperative that the trust learns from the small number of deaths where care has been poor, we must also recognise and learn from these positive examples. The medical reviewers are sending Thank You cards to teams and individual members of staff who are named by relatives as really having gone the extra mile. Three cards were sent in quarter 4 and one member of staff was nominated for a Putting You First award.

Another item to note in the dashboard is that we have improved the identification of people with a learning disability and/or severe mental illness, so that the deaths in people in these very vulnerable groups can be paid particular attention to for any evidence which suggest the trust is not providing parity of esteem and equitable care. Deaths in people with a learning disability are also all referred to the national Learning Disability Review programme (LeDeR) for a truly independent assessment.

Disseminating our approach more widely

WSFT continues to be recognised as a best practice site for our implementation of the Learning from Deaths guidance. The team continues to advise other trusts in the region. The LfD lead presented our approach to the Department of Health and NHS Improvement national programme board on 12th March 2018, and the Secretary of State complemented our approach at and after his visit to the trust on 26th April.
https://twitter.com/Jeremy_Hunt/status/989554481200336897

We are also facilitating a fledgling regional network of learning from deaths groups' lay members.

<table>
<tr><td rowspan="2">Trust priorities
[Please indicate Trust priorities relevant to the subject of the report]</td><td colspan="2">Deliver for today</td><td>Invest in quality, staff and clinical leadership</td><td colspan="3">Build a joined-up future</td></tr>
<tr><td colspan="2">X</td><td></td><td colspan="3"></td></tr>
<tr><td rowspan="2">Trust ambitions
[Please indicate ambitions relevant to the subject of the report]</td><td>Deliver personal care</td><td>Deliver safe care</td><td>Deliver joined-up care</td><td>Support a healthy start</td><td>Support a healthy life</td><td>Support ageing well</td><td>Support all our staff</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Previously considered by:</td><td colspan="7">Learning from Deaths group</td></tr>
<tr><td>Risk and assurance:</td><td colspan="7">Safety risk if the trust fails to identify problems in care which lead to patient harm and preventable death, and fails to act to reduce them.

Reputational risk if the trust fails to report preventable deaths and fails to demonstrate action to reduce them.</td></tr>
<tr><td>Legislation, regulatory, equality, diversity and dignity implications</td><td colspan="7">The report describes the trust's approach to meeting the National Quality Board's guidance on Learning from Deaths, which must be reported in the annual report from 2017/18 onwards.</td></tr>
<tr><td colspan="8">Recommendation:

To note the information on the Learning from Deaths dashboard and the narrative in this summary.</td></tr>
</table>

Learning from Deaths dashboard – Quarter 4 2017/18

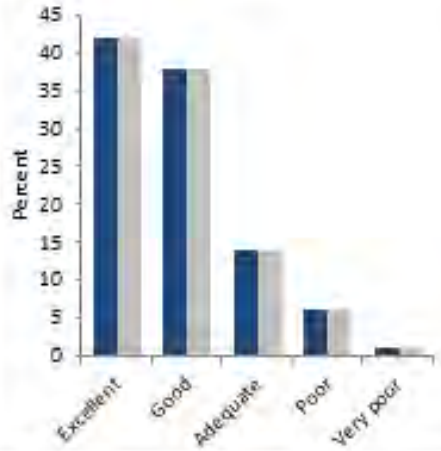
Accurate 17 May 2018

West Suffolk NHS
NHS Foundation Trust

Inpatient deaths	Total	Reviews completed
Quarter 4	315	292
Year to date	1030	939

Overall quality of care

Q4 and YTD (grey), 2017/18

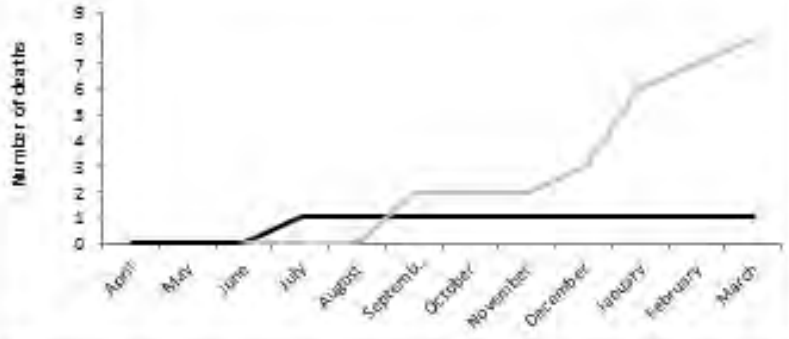


Outcomes of reviews

Quarter 4

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

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



Preventability benchmarks

3.0 – 4.3%
Research

0.50%
Real world

0%
Q4 WSFT

0.10%
YTD WSFT

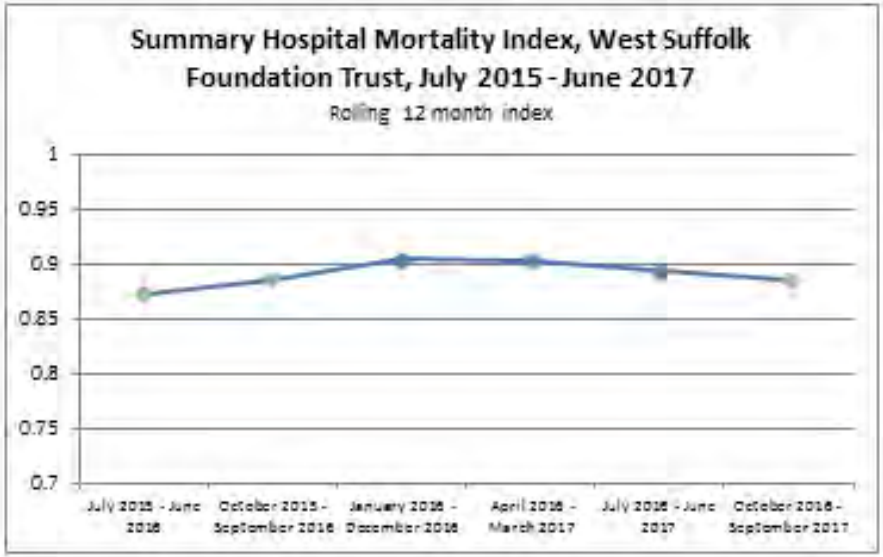
Deaths in people in groups under special focus – Q4 (YTD)

Group	Total	> 50% likely preventable
People with learning disabilities	3 (7)	0 (1)
People with severe mental illness	5 (18)	0 (0)
Maternal deaths	0 (0)	0 (0)
Stillbirths	3 (8)	n/a
Child deaths		1 (0)

Learning themes identified

Contributing to preventable deaths	Recognition of deteriorating patient and poor medical handover
Not contributing to death	Delayed escalation

Summary Hospital Mortality Index (SHMI)



14. Quality and learning report – Q4

To ACCEPT a report, including review of hospital acquired pressure ulcers

Presented by Rowan Procter

Trust Open Board – 25th May 2018

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

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 31/03/18.

Information has been obtained from the following data sources:

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

Key highlights in this report are as follows:

- Learning from Incidents, demonstrates further development on Outliers, Pressure ulcers and human factors.

Please note:

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

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

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X	X				X
Previously considered by:	-						
Risk and assurance:	-						
Legislation, regulatory, equality, diversity and dignity implications	-						
Recommendation: The Board to note this report.							

Activity within the quarter

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

Learning themes from investigations in the quarter

SI RCA reports submitted in Q4

Incident details	Learning
Pressure ulcers	There were 13 'Hospital acquired' and 13 'Community in our care' pressure ulcer reports submitted in Q4. Of these 12 / 26 were deemed 'avoidable'. Learning included the following: ▪ Missed opportunity to visually skin check ▪ Independent patient not encouraged to move more frequently ▪ Inconsistencies noted on repositioning on nurse rounding ▪ Patient's not moved as regularly as required ▪ Very limited documentation due to low risk rounding. No documentation of repositioning, lack of assessment, lack of update of assessment on a weekly basis ▪ Lack of appropriate equipment ▪ Staffing resource ▪ Risk assessments not completed in timely manner and not initiated in ED following long lie ▪ Inappropriate protection on vulnerable areas such as bridge of nose, top of ears
Falls	Reports were submitted for three patients who fell and sustained a neck of femur fracture.
Norovirus	Two reports of ward closure (one on G4 and one linked on F9 / F10) due to outbreak of Norovirus noted the following: The lack of provision of doors on bays is recorded on the Trust Risk Register (Management of outbreaks no.627) Red rating. It has been agreed by the Trust management team that the provision of doors on bays will be included in any new builds or refurbishment of wards
C. difficile increased incidence	The report noted that stroke patients with Clostridium difficile have conflicting clinical needs. The Sentinel Stroke National audit programme (SSNAP) aspirational target of 90% stay on a dedicated Stroke ward is one which the Trust acknowledges and aims to fulfil. The potential however for further onward transmission of Clostridium difficile is increased if the index patient remains on the ward. Transfer of patients to another facility will break the chain of infection preventing onward transmission. Further cases of the same ribotype should not then be identified. The index patient may not have 90% stay on the Stroke ward but by preventing any further cases the ward will remain operational and not close to admissions whilst remedial actions and cleaning are implemented. Actions identified in the report included: ▪ SSNAP target superseded by the need for specialist isolation. ▪ Source of a hypochlorite wipe for intensive rehabilitative therapy surfaces ▪ The guidance for probiotic prescription has been laminated and attached to all the work station on wheels equipment where prescribing takes place. ▪ A micro-guide is available to all prescribers and on the Trust Intranet to support correct prescribing. ▪ Antibiotic audits were completed weekly for a month in order to support prescribers ▪ Space utilization will be examined to establish if there is capacity to increase the number of single rooms within the current G8 footprint
Unexpected	A patient was admitted with probable motor neurone disease which was not confirmed and had delayed investigations. The patient deteriorated throughout the admission due to

death	their poor condition. Whilst the delay in tests did not necessarily contribute to the deterioration, more expedient tests may have indicated what level of treatment and escalation was appropriate. Action agreed was as follows: ▪ Ensure care standardised process for ensuring that results from a spirometry test are carried out in a timely fashion are documented and handed over to the relevant teams caring for the patient. As part of the investigation it was noted that EPARS was completed for this patient at the beginning of his admission, this could have been re-visited during his time on the ward due to obvious deterioration and the benefit of higher level of care and the likelihood of CPR being of any benefit should the need arise due to the patient's condition. It was also highlighted that there were multiple teams involved in this patient's care and the use of 'message centre' for communication between multiple teams involved could be useful for patients with multiple and complex needs.
Clinical Care/Safe Guarding	A patient attended the Trust in 8 admissions over a period of 9 weeks. Her admissions during this time were for medical management of Liver disease symptoms. The complexity of the Liver disease required time to diagnose the Drug Induced Liver Injury which resulted from antibiotics prescribed by the GP. Her inpatient admissions were equally important to ensure the correct treatment was given along with optimum symptom management. Unfortunately as part of the Management Plan the patient had a Liver biopsy with a recognised complication of a bleed and was transferred to CUH where she died. A full review was required to ensure that all clinical care was given. This case is also being investigated by the Coroner. This patient had Learning difficulties and so elements of the consent process were reviewed. There will nil Care or Service Delivery issues identified. The report focused on questions by the family involving improving communication i.e. use of words and trying to relay anxiety.
Data protection breach	An appointment letter was sent to an incorrect address which highlighted the potential of a safeguarding risk. Fortuitously no actual adverse outcome resulted. Recommendations of this report were as follows: ▪ Develop a consistent registration process across the trust. To be agreed with Health Records Committee. ▪ WSFT to be connected to the NHS spine with a risk assessment to be agreed until connection is established. ▪ Develop communication strategy with CCG to ensure patient addresses are up to date at GP practice. The CCG to require address check at GP practice

There were two reports submitted on behalf of other organisations

Incident details	Details
WSH-IR-34547 [Never Event] Overdose of Methotrexate for non-cancer treatment	A Never Event was reported by the Trust however a number of the issues highlighted relate to the GP practice and actions required were for the CCG. The report found that the root cause of this incident was human error when the methotrexate prescription details were entered on the GP electronic health record system. This information was entered as a repeatable oral methotrexate prescription rather than as a "no issue" medicine record of the use of sub-cutaneous methotrexate. The incorrect oral repeatable prescription was then subsequently ordered by the patient after a hospital rheumatology department appointment, where the patient understood that she should start oral methotrexate. The split prescribing responsibility for methotrexate, with different processes for oral and sub-cutaneous methotrexate prescribing, leads to the need for complex recording processes to manage these patients in both primary and secondary care. The appropriate, safe and effective management of patients on methotrexate is reliant on correct patient selection and the safe and effective monitoring of treatment. Patient selection and treatment initiation is best placed in the hospital rheumatology department. Once treatment has been initiated and stabilised it is appropriate for this care to be transferred to general practice under the agreed the shared care agreement not yet

	implemented. In Suffolk this occurs for oral methotrexate. In the majority of CCG's in England this also occurs for subcutaneous methotrexate. The shared care agreement was agreed for Suffolk in 2012. The implementation of shared care for methotrexate subcutaneous injection has been (and continues to be) problematic. Recommendations of the report were as follows: ▪ For methotrexate to be consistently managed in the community setting a single set of Shared Care Agreements and Standard Operating Procedures should be adopted. This would ensure that the risks of duplicate prescribing is minimised through the use of existing and well established safety controls within GP health record systems ▪ GP practices must ensure that all staff are appropriately trained in the use of their electronic health record system and that systems are in place to record the issuing and completion of the practices GP induction packs. ▪ Documented systems must be in place in practices to ensure that medications prescribed to patients from sources external to the practice are consistently recorded in the practice electronic health record system. These processes must be supported by a full set of standard operating procedures ▪ Patients on methotrexate must be counselled to only take methotrexate once a week and must only ever be being treated with either oral methotrexate or sub cutaneous methotrexate, NEVER both simultaneously. ▪ Patients on Methotrexate must be counselled to ensure that they tell any healthcare professional consulted (Doctor, Dentist, Nurse, Pharmacist etc.) that they are taking either oral or subcutaneous methotrexate. ▪ Patients on methotrexate must be issued with the NPSA methotrexate booklet. Patients must be encouraged to show the NPSA methotrexate booklet to their GP, Nurse or community pharmacist whenever a new prescription is required ▪ The West Suffolk Hospital rheumatology department patient checklists have been amended to improve the clarity of statements regarding once a week oral or subcutaneous methotrexate. ▪ All healthcare professionals should always refer to methotrexate subcutaneous injection and methotrexate tablets. Use of any abbreviations or acronyms should be avoided as (e.g.) 'sub cut' methotrexate may also on another occasion be misinterpreted as tablets.
WSH-IR-34254 Hepatitis C	Incorrect assay parameters used on Triturus (T4) analyser at the West Suffolk microbiology laboratory (service delivered by Public Health England). An RCA investigation was commissioned the Executive Director of the PHE National Infection Service, and was undertaken on-site on 13th December 2017 by an external team from Public Health England. This identified the root and contributory causes of the incident and made national recommendations to prevent reoccurrence at any laboratory. Locally, immediate corrective action was taken following identification of the issue and there is no risk of incorrect results from this date forward. The re-testing of a large number of patient samples has not identified any patients with Hepatitis C infection who have been given a negative result in error. This had been considered the main area of concern before the investigation commenced.

Quality Walk About from Q4

Over the past quarter we have been to the following areas, F10, Pharmacy, Therapies, Theatres, Eye Treatment, G3, G8, G9, Education/Sim and G9, a total of 9 different areas have been visited. These have been facilitated by the clinical governance team and have had attendance from the Chief Executive, Chair, Executive Chief Nurse, Medical Director and several governors have supported these walkabouts. These have been able to facilitate a real opportunity to observe, review and interact with both staff and patients.

In total 19 actions have been raised as a result following walk abouts. These have involved items requiring escalation to e-care, associate directors of operations and both senior nursing and operations staff, and others have been able to be managed at the ward level. Examples of these have included Feedback to staff involving implementation of planned e-care to areas new to the programme, equipment and access to charitable funding, additional charging points, heightened focus on improving checking and quality assurance are just some of the action points raised.

Following the Mortuary walkabout, mortuary storage was identified as an issue and was raised as a red risk. At the initial meeting chaired by an executive, funding was agreed for surge capacity rental to be agreed and mid-long term plans initiated.

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

Please see below.

1. **Subject / Theme** Outliers
Source Green: 6, Red: 1, (Soft intelligence)
Risk register entry (RR192) (Accepted risks)
Trust owner[1] Outlier task & finish group
Summary of learning and areas for improvement in this topic

A SIRI regarding the death of a patient with learning disabilities, highlighted that the patient was a medical outlier on a surgical ward. They were medically optimised for discharge however still remained an inpatient due to a safeguarding investigation. Unfortunately the patient died during this stay unexpectedly following an acute event (respiratory arrest) brought on by their chronic medical condition, “Obesity Hypoventilatory Syndrome” which often caused them to desaturate at night.

The SIRI highlighted the following Service Delivery Problem as a contributing cause;

- Patient located in a sub-optimal location (despite their complex discharge planning needs).

The following lessons were learnt:

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

- Patients with complex requirements i.e. chronic medical needs, learning disabilities and safeguarding issues should be placed within an appropriate clinical area so the medical team can have better oversight of the their patient. This did not happen as the patient was admitted in the hospital during a period of no bed capacity locally and regionally.

- If the patient is not in an appropriate location it is more difficult for the medical staff to liaise effectively with both ward nursing and professional staff. The patient had respiratory requirements that were not clearly documented or made aware to the ward staff.

The action of this outcome was followed by initiation of a Task and Finish Group "Management of Outlier Patients". The Task and Finish group has consisted of Medical, Nursing, Patient Flow, Service Delivery Management and Governance input to create Guidelines. The Guidelines are created to assist clinical staff with patient flow within the clinical areas when the hospital is facing external bed pressures. The guidelines consist of a Risk Assessment that will allow staff to assess the most appropriate patient to move in such circumstances and if this is not achievable to document that the risks have been mitigated. This will involve documentation within e-care.

The guidelines are currently in draft status awaiting to be reviewed and approved at TEG June 2018. The Guidelines will then be implemented. The paper based Outlier Risk assessment has been trialled in some wards and has been well received as easy to use by ward nurses.

Despite there being no Datix Reference category for Outliers, a review of the last 12 months have highlighted 5 green incidents that have related to patients being outlied. It should be noted that Outlier Management awareness in the clinical areas and the difficulties they add to ensuring optimal patient care is often discussed anecdotally. NHS Improvement (2016)* explain how the number of outlier patients should be reduced as outliers are disadvantaged by missing out on daily ward rounds and having less access to specialist nurses and allied health professionals. Stylianou et al (2017)* completed a retrospective study of an NHS hospital that showed outliers have longer length of stays.

* Seven-day services in hospitals: clarification of priority clinical standards NHS Improvement (December 2016) Publication code: CG 41/16

* Stylianou N, Fackrell R, Vasilakis C. Are medical outliers associated with worse patient outcomes? A retrospective study within a regional NHS hospital using routine data. BMJ Open 2017;7:e015676. doi:10.1136/ bmjopen-2016-01567

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2. **Subject / Theme** Paediatrics care of the deteriorating child
Source Incidents
Risk register entry Not currently on Risk Register
Trust owner[2] Paediatric Task & finish group (chaired by ADO for W&C/CSS)

Summary of learning and areas for improvement in this topic

A review of incidents including the care of the deteriorating paediatric has identified further development of the human factors and deteriorating child training. The team including Paediatrics, deteriorating patient team and human factors. This will be a 1 day course

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

covering a mixture of group work, A-E assessment, Human factors, PEWs, Trauma and dealing with multiple paediatric casualties. This will be for all health professionals and will be supported by several different areas of the organisation to ensure the greatest level of learning and involve several specialities. We will also be involving our colleagues from USAF in the day.

There will be an update provided in the next quarterly report.

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3. **Subject / Theme** Pressure ulcers
Source Incidents
Risk register entry RR888 Pressure ulcer prevention
Trust owner[3] Pressure ulcer prevention group
Summary of learning and areas for improvement in this topic

See Annex 1.

Updates from themes reported in previous quarters

Oxygen
It was established during the last quarter there was no pre-alert on e-Care for oxygen prescription and no set time frame for completion. Following a table top review of oxygen prescription it was noted there were inconsistencies in recording and administration of oxygen prescription. It was agreed by the deteriorating patient group that the most effective mechanism for change would be to link the oxygen assessment with the VTE assessment within 4 hours of the decision to admit.
There is currently a change request sitting with e-Care team and it is proposed this will be changed within the next month. There is a plan to re-audit the data following a period of settlement.

Mental Health
Following the presentation of the new proposed policy, further work was identified as being required to ensure this policy achieved what was required to ensure mental health patients receive the appropriate level of care and escalation where required. The head of patient safety has meet with representatives from WSH and the mental health trust. The meeting explored development of the current service with extending the psychiatric service until 2100. There is currently recruitment underway. Also the Access and assessment team are now based both the East and the West.
On review of the policy with the mental health trust there are several developments which could further enhance the policy and this is currently being amended.

Mitigated red risks

During Q4 action to mitigate and downgrade two red risks was taken. This related to staff shortages in Microbiology which was downgraded following the recruitment of a locum consultant and the Mortuary capacity which was downgraded as the Trust now has the facility to set up and use a temporary mortuary facility.

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

Learning from RIDDOR incidents

During Q4 the number of incidents reported to the HSE under RIDDOR remained low (4). Learning and mitigation included:

- Targeted staff training in moving and handling techniques
- Environmental awareness briefings to staff
- Conflict resolution and Breakaway training to be completed for key staff

Learning from patient and public feedback:

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

- Patient feedback highlighted that an upgrade in the pharmacy system had removed the ability to print labels in large font. As a result a new system has now been put into place and staff trained on how to print large front labels.
- New coffee machine in the Macmillan Unit for relatives or visitors of patients receiving chemotherapy.
- Guidelines have been amended in relation to oncology patients with a temperature of 37.5° or above, requiring those within this category to be admitted and commenced on antibiotics. This has changed from 38°.
- Education sessions on motor neurone disease to be made available to all nursing and midwifery staff, as well as delivery at the nursing and midwifery council.

Appendix 1 - Review of hospital acquired pressure ulcers over a six month period

<table>
<tr><td colspan="8">Executive summary:

This report reviews the incidence of hospital acquired pressure ulcers (HAPUs) at the West Suffolk NHS Foundation Trust (WSFT) within the period of the past 6 months, from November 2017 and up to, and including April 2018.

During this period, there have been 83 reported HAPUs, 59 grade 2 and 24 grade 3. There have been no incidents of grade 4 HAPUs.</td></tr>
<tr><td rowspan="2">Trust priorities
[Please indicate Trust priorities relevant to the subject of the report]</td><td colspan="2">Deliver for today</td><td colspan="2">Invest in quality, staff and clinical leadership</td><td colspan="2">Build a joined-up future</td></tr>
<tr><td colspan="2">x</td><td colspan="2">x</td><td colspan="2">x</td></tr>
<tr><td rowspan="2">Trust ambitions
[Please indicate ambitions relevant to the subject of the report]</td><td>Deliver personal care</td><td>Deliver safe care</td><td>Deliver joined-up care</td><td>Support a healthy start</td><td>Support a healthy life</td><td>Support ageing well</td><td>Support all our staff</td></tr>
<tr><td>x</td><td>x</td><td>x</td><td></td><td></td><td></td><td>x</td></tr>
<tr><td>Previously considered by:</td><td colspan="7">-</td></tr>
<tr><td>Risk and assurance:</td><td colspan="7">-</td></tr>
<tr><td>Legislation, regulatory, equality, diversity and dignity implications</td><td colspan="7">-</td></tr>
<tr><td colspan="8">Recommendation:
Receive this report for assurance.</td></tr>
</table>

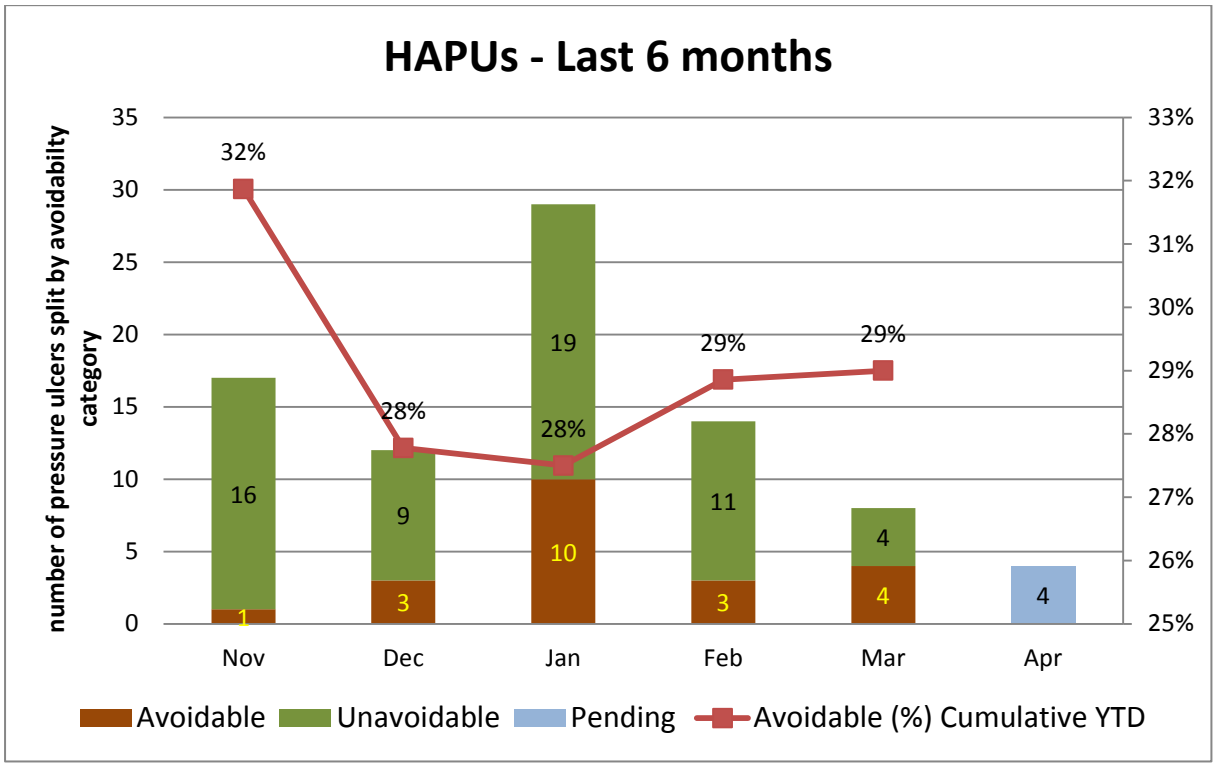
Purpose

The purpose of this report is to review the incidence of hospital acquired pressure ulcers (HAPUs) at the WSFT within the period of the past 6 months, from November 2017 and up to, and including April 2018.

Incidence

During this period, there have been 82 reported HAPUs, 58 grade 2 and 24 grade 3. There have been no incidents of grade 4 HAPUs within this period. The definitions of the HAPU grading can be found in Appendix 1.

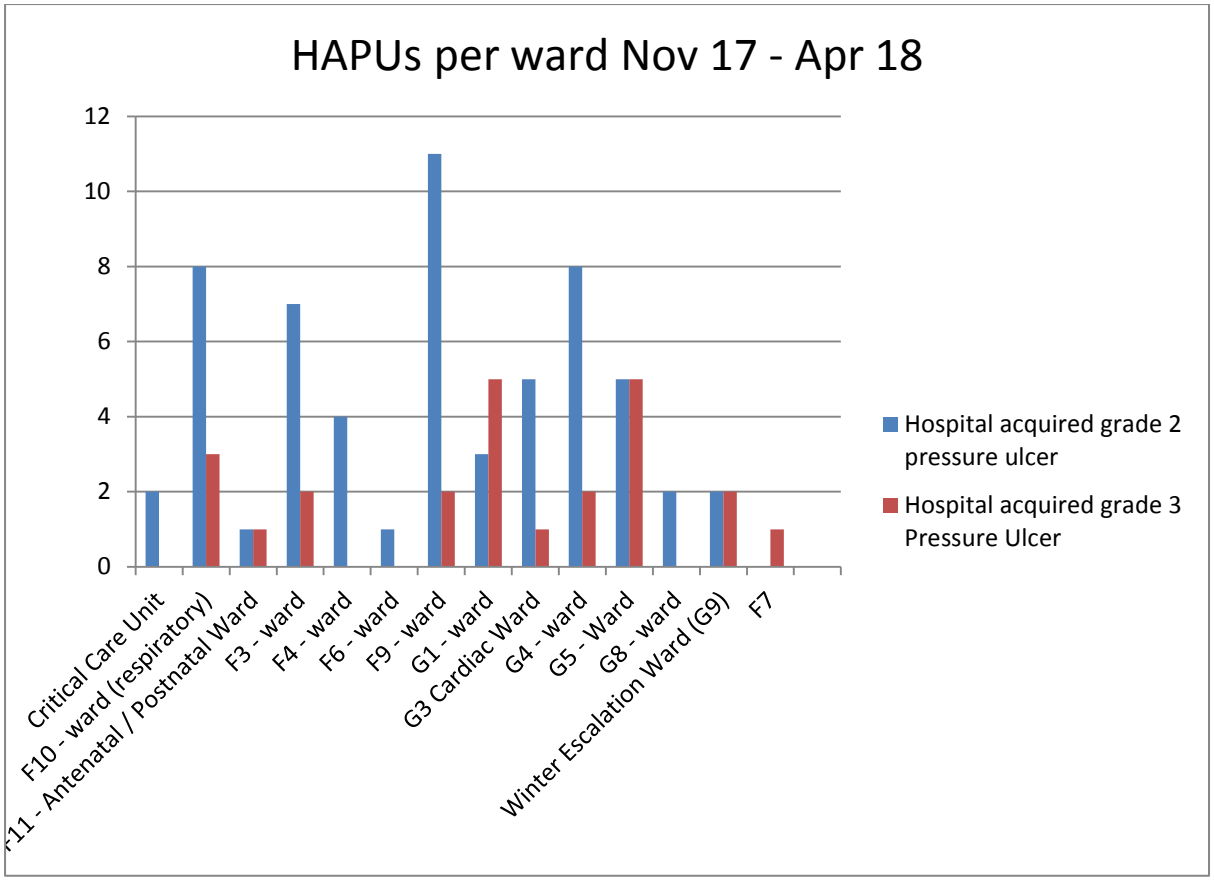
Of these 82 HAPUs, 22 have been deemed avoidable at the time of this report, with 4 incidents still to be determined as to whether the pressure ulcer could have been avoided. This is detailed in the chart below:



As indicated in this chart, there was a sharp rise in the number of HAPUs in January 2018. There is potentially a combination of reasons for this, with the main reason being the exceptionally high number of attendances and acute admissions in this period.

It is likely that the low numbers reported in December, specifically the latter part of December impacted on the figures for January. Nursing staff were overwhelmed during this period with increased capacity, acuity and trying to safely manage multiple escalation beds. Coupled with high numbers of Registered Nurse vacancies, there were nurse staffing deficits throughout the organisation, which led to a delay, in some cases, of assessing risk factors and instigating pressure damage prevention strategies. Following a review of the number of community acquired pressure ulcers (CAPUs) reported in this period, there is evidence that there was a decrease in the number of CAPUs reported in December, which may suggest that some CAPUs were not detected on admission, or within the first 72 hours of admission, leading to the skin damage being attributed to the inpatient stay.

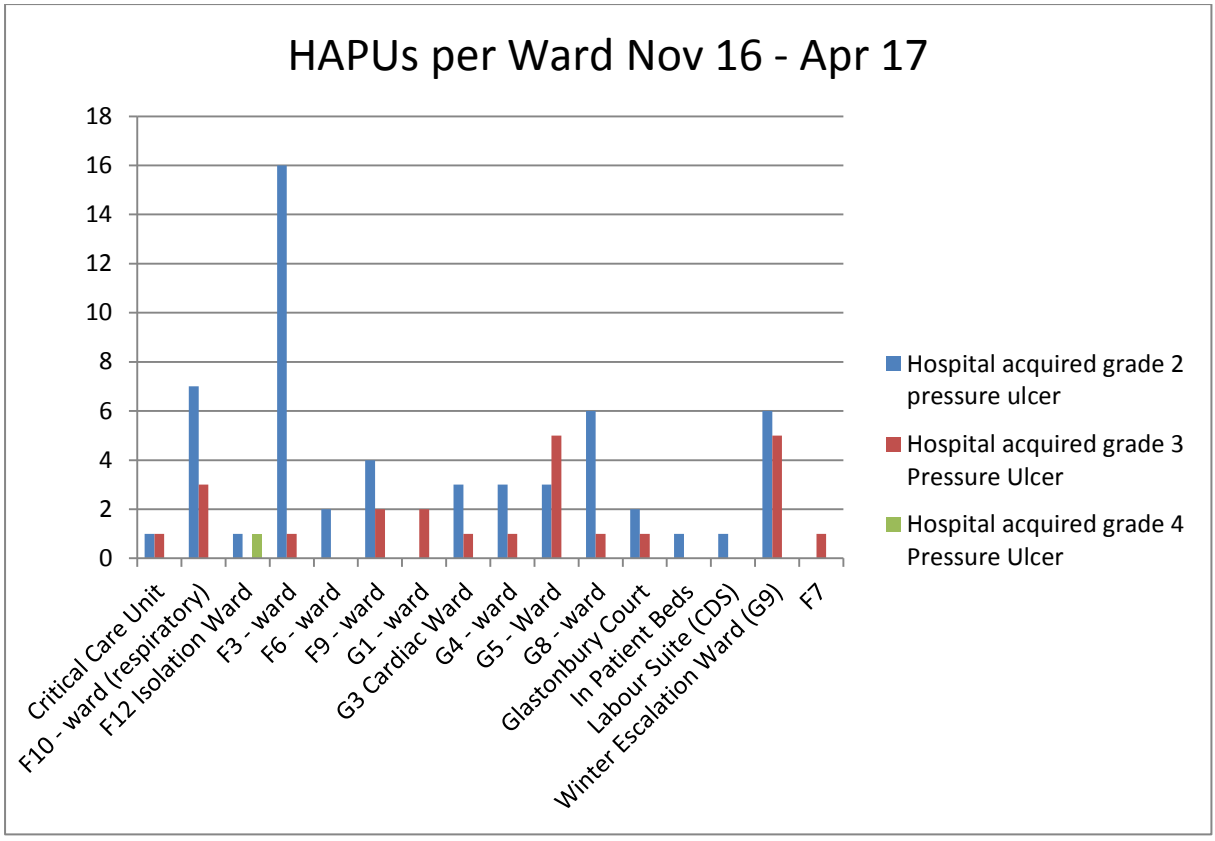
The following chart provides a breakdown of the incidence of pressure damage per ward:



The wards with higher incidence of HAPUs; F3, F9, F10, G4 and G5 have all experienced high acuity, staffing deficits and have substantial numbers of frail, vulnerable, elderly patients, many with complex comorbidities, placing them at greater risk. However, Ward G8 should be acknowledged and commended for the low numbers of reported HAPUs, despite a similar cohort of patients and staffing deficits over the past 6 months.

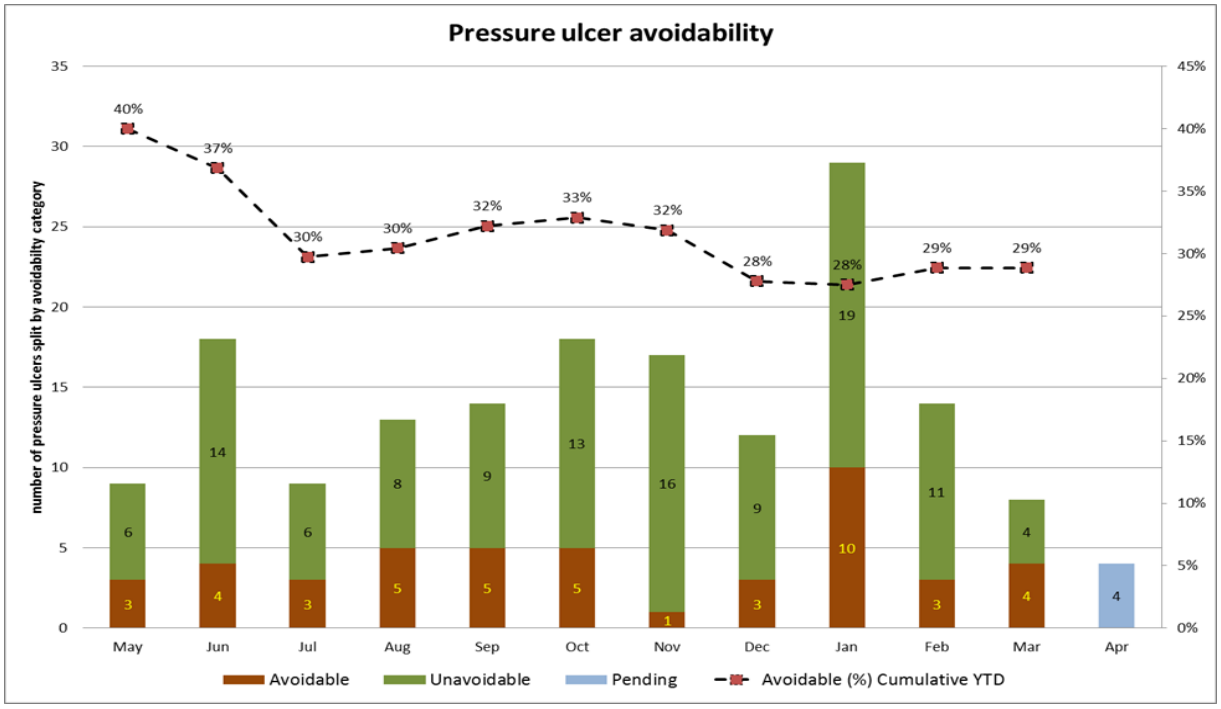
Ward F5 does not feature on the chart as there have been no HAPUs reported in the past 6 months. In total, there has only been one occurrence of pressure damage within the past 2 years on the ward and it is important to acknowledge this and share the learning that this has been achieved by a team who are fully engaged with preventing pressure damage, ensuring the SSKIN principles are promoted and have taken on board learning from the few incidents of HAPUs which have occurred in the past.

In comparison, the following chart indicates data from the same six month period in 2016/17. This indicates the improvements demonstrated by Wards F3 and G8 in pressure ulcer prevention. This has been achieved by focussed education and support from the Tissue Viability team and Senior Matrons. The teams in these areas have engaged with assessing risk factors, promoting preventative measures and endorsing the SSKIN principles. There is a significant decline on Wards F9, G4 and G5 and these are current areas of focus for the Tissue Viability Team with support from the Senior Matrons.



Reducing avoidable HAPUs

Despite the number of HAPUs reported, there has been a decrease in the percentage of avoidable pressure ulcers over the past 12 months, with the Trust achieving the target of less than 30% consistently for several months within the past two quarters. This is demonstrated in the chart below:



Learning from incidents

Of those HAPUs deemed avoidable, there continues to be shared learning and opportunity for quality improvement initiatives, with the purpose to continue to reduce the incidence of pressure damage occurring and maintaining the safety and skin integrity of those patients within our care.

Following a deep dive review of the avoidable HAPUs within the past 6 months, the following themes for shared learning have been identified:

- Missed opportunities to visually check patient's skin
- Independent patients not encouraged to move more frequently
- Inconsistencies noted on repositioning on nurse rounding
- Patient's not moved as regularly as required
- Very limited documentation due to low risk rounding. No documentation of repositioning, lack of assessment, lack of update of assessment on a weekly basis
- Lack of appropriate equipment
- Inadequate staffing levels
- Risk assessments not completed in timely manner and not initiated in the Emergency Department following a long lie on the floor prior to admission
- Inappropriate protection of vulnerable areas such as bridge of nose, top of ears

Poor record keeping features heavily and consistently within these themes. When reviewing the avoidable pressure ulcers, there is frequently lack of evidence that risk assessments have been completed within six hours of admission or at weekly intervals. Other common failings are the daily review of and recording of skin condition and integrity and preventative measures have been put in place.

Infrequent positioning of patients is another common theme. It is unclear whether there is a lack of evidence to support that position changes have been performed, offered or encouraged, or whether it is an aspect of care and prevention which could be improved.

Improvement initiatives

In order to improve some of these themes, a group is being set up to review nursing documentation as a whole, with the objective to produce standards for record keeping within the electronic system. The project will be led by the Head of Nursing for Surgery with input from nursing staff of all grades, the eCare Informatics lead and representation from the Governance team.

The Tissue Viability (TV) team, with support from the Senior Matron team, continue to promote a variety of other preventative initiatives to improve the care and positioning of patients, promote the SSKIN principles and ultimately to reduce the number of HAPUs and percentage of avoidable pressure ulcers:

- **The Heel Hero's** initiative, launched in November 2017, has been ongoing and in February there was further awareness training, promoting pressure relief and use of the kerrapro products as an aid to promote skin integrity. There will be a further 'heel hero's' recruitment drive in the beginning of June.

Since the launch of the initiative, there has been a decline in heel HAPUs from 24 reported between May to October 2017 to 21 reported from November to the end of April 2018.

- **Link Nurse Days**: Preventative practice continues and the Tissue Viability team continues to utilise its team of TV link nurses to feedback good practice to the wards and departments.
- **Developing Student Nurses**: In conjunction with the university of Suffolk and the Practice development team we have secured the Tissue Viability Service as a one week Bespoke placement for the pre-registration student nurses. This is an excellent opportunity to instil good practice and governance of pressure area management at an early stage, which will hopefully set up greater quality of care for this emerging work force.
- **Bite size training:** Tissue Viability's ongoing bitesize training sessions are well established now and continue to broaden its subjects in our fortnightly sessions. There are plans to work with other colleagues to provide an MDT approach to training; this is reflected in sessions planned this summer in conjunction with the pain team.
- **Maternity Services:** Tissue Viability has been working closely with Maternity services to develop a more robust skin care and pressure risk assessment regime, this is now up and running and the maternity services have adopted an adapted Anderson tool for use on all inpatient women on ward and various Maternity departments. This will act as a prompt to assess and consider the potential skin care implications of 'at risk women'. Although Maternity services do not have a high volume of HAPU It has been noted that there have been several issues with moisture damage which can puts women at increased risk of skin breakdown and 2 pressure ulcers have been reported this year so far. As well as this tool the Tissue Viability Service has designed a training package to raise awareness of skin care and pressure area care as well as wound management.
- **Moisture damage awareness:** Following last quarters higher incidence of cases of moisture damage, there has been additional education of skin care both within bitesize training sessions and on ward training through the representatives that supply the various barrier creams used across the Trust. In conjunction to this, by reducing the supply of procedure sheets, which were being inappropriately used to manage incontinence and promoting the appropriate use of continence products to ensure the skin is protected, the Tissue Viability service has seen a significant reduction in referrals to assess moisture damage across the trust. This has a significant impact on pressure ulcer prevention as moisture lesions frequently lead to chronic wounds and skin breakdown.

  As a by-product of this initiative, a saving of £4500 has been achieved within the first quarter by reducing the use of the procedure sheets.
- **Monthly Bulletin:** In order to raise tissue viability and pressure ulcer prevention awareness, the Tissue viability department has constructed a monthly 'Tissue Viability Bulletin' that is available through a link on the green sheet, the bulletin is

providing updates on wound care and pressure area issues and keeping staff informed of up and coming training opportunities.

A further initiative being developed by the TV team is the Inclusion of the Kennedy ulcer on the reporting system. It is evident that many pressure ulcers occur during the final stages of life, as potentially, a direct result of the 'dying process'. Tissue viability is looking to clarify the process of management and reporting of pressure ulcers that present in the last days of life. These are commonly known as 'unavoidable Kennedy Ulcers' (rapidly deteriorating pressure ulcer at the end of life). Currently the process for these patients is to follow the same reporting process of StEIS for these ulcers as in any other reportable pressure ulcer. We are therefore putting forward that due to the circumstances of the development of a 'Kennedy Ulcer' that a separate category should be created to identify these ulcers. Nationally in many localities these ulcers are not raised as a SI and are instead a quarterly report is provided to CCG on this additional category. This initiative is currently being considered by the CCG to gain approval to trial this concept.

It has also been recognised that there is variability in determining whether a pressure ulcer is deemed avoidable or not. The Tissue Viability team are working with the Governance team to set some criteria to ensure consistency and transparency.

Summary

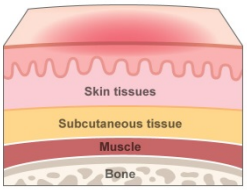
Overall, with the exception of January's figures, there appears to be a trend towards the reduction in number of patients who acquire pressure damage during their inpatient stay at WSFT and a reduction in avoidability, however, there is still a need to improve the experience and safety of those in our care and strive for further improvements in the quality of care delivered. A strategy to continue to drive for improvement is being developed and detailed in the action plan. WSFT has also been accepted to join the NHS Improvement pressure ulcer prevention collaborative which will support and enable some focused quality improvements and initiatives and promote shared learning with other organisations.

PRESSURE ULCER PREVENTION ACTION PLAN 2018 /19				
Issue	**Action**	**Lead**	**RAG rating**	**Deadline**
Incidence of avoidable pressure ulcers	To reduce number of HAPUs overall and number of avoidable HAPUs by 10%	HoN Surgery/ TVNs / Matrons		August 2018
There are inconsistencies with record keeping; specifically risk assessments not completed on admission and every 7 day, plans of care not initiated, documenting visual skin checks and position changes. .	Development of a group to review documentation	HoN Surgery		May 2018
	Development of standards for record keeping for the nursing staff	HoN Surgery		August 2018
	Development of quality improvement measures to monitor compliance	HoN Surgery		September 2018
	Support staff to attend TVN bitesize teaching sessions.	Matrons		May 2018
	TVN to deliver ward based training on completing skin and wound assessments.	TVNs		May 2018
	Assurance of completion of safety assessments via Perfect Ward audits	Matrons		May 2018
	Monthly review of compliance of patient safety reports	Matrons		May 2018
Improve consistency with determining avoidability status	Development of criteria to determine avoidability / unavoidability	TVN / Governance team		July 2018
Incidence of pressure ulcer onset in last days of life	Initiate process of Kennedy ulcer reporting for patients in the last days of life	TVNs		July 2018
Repositioning of patients is inconsistent	Promote regular repositioning via teaching sessions and education	TVNs		June 2018

	Review documentation as part of standards for record keeping	HoN Surgery		August 2018
Lack of assessment of skin integrity within Emergency Department	Review benefits of introducing risk assessment scoring to Emergency Department	ED manager / TVN		May 2018
Review of Governance process	Matrons and Ward Managers to continue to share specific concerns at Governance meetings and via harm free action plans	Matrons		May 2018
	Tissue Viability to continue to oversee the pressure ulcer prevention group (PUPG) plan and report quarterly to CSEC	TVNs		May 2018

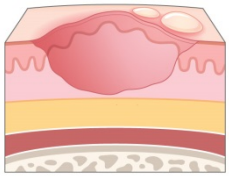
Pressure ulcer staging

Stage 1



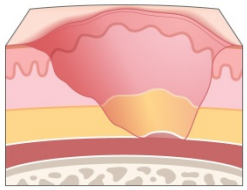
Non-blanching erythema of intact skin.

Stage 2



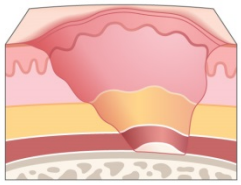
Partial thickness skin loss involving epidermis, dermis or both. Superficial and presents as blister or abrasion.

Stage 3



Full thickness skin loss involving damage / necrosis of subcutaneous tissue may extend to underlying fascia.

Stage 4



Extensive destruction, tissue necrosis, damage to muscle, bone, supporting structures +/- full thickness skin loss.

15. NHSBSP Screening incident briefing

To ACCEPT the report

Presented by Nick Jenkins

Trust Board Meeting – 25th May 2018

Agenda item:	15			
Presented by:	Nick Jenkins, Executive Medical Director			
Prepared by:	Emma Senior, Director of Breast Screening & Consultant Radiologist			
Date prepared:	May 2018			
Subject:	Update on Screening Incident NHSBSP			
Purpose:	X	For information		For approval

Executive summary:

The incident is related to the way patients are routinely called for their last screening mammogram. Essentially this is a problem with the definition of "70" and the age extension trial, which was set up at the same time as the screening age was extended to 70 back in 2009. The error was identified when BSIS, a new system we have to look at data, was introduced. Breast screening units were not informed until after Jeremy Hunt had made his announcement and they had discovered from the media.

There are two subsets of patients who have been identified: patients who only recently missed a mammogram who are under 72 and they will be given an appointment to attend, and a further cohort from 72-79 who will be sent a letter inviting them to self refer. All women who are older than the parameters set for automatic invitation are already eligible to self refer.

We have been sent a list from PHE of 54 patients under 72 who we are expected to send an appointment letter to, and a further 966 who will receive a letter offering them a self referral.
So far we have a list of the 54 patients details and by cross referencing with screening records we think only 10 of them are eligible to be rescreened, not 54. This is because of the way they have been identified by PHE, we believe in error, as they have used the date the office batched them not the individual's "next test due date". This is similar across other units and we are currently in discussion with PHE as we believe these women should not be sent an appointment (no error was made and by IR(ME)R rules it is difficult to justify the test). The medical director will provide a verbal update to Board on this aspect of the situation, in light of a (long-standing, planned) programme board meeting with PHE on Wednesday.

In the meantime evenings and weekends when additional screening will be done have been identified. There are only four film readers and each film has to be double read. It is anticipated this would be done out of hours. For patients recalled to assessment it is hoped to have capacity in pre-existing assessment clinics. However, this will displace symptomatic patients and we are currently experiencing a large increase in these referrals (even before breast screening made the news).

On 16th May we received a joint letter from NHSI and NHSE regarding managing the financial impact of this incident. It was clearly stated that concerns for funding should not delay the important work of booking and carrying out the additional screens required to deliver the catch up programme. They also reassured the Trust that we would receive reimbursement for all additional screening activity carried out in delivering the catch up programme. The rate of reimbursement will take account of unavoidable additional costs that the Trust may reasonably need to incur.

The situation is changing daily and the team, the CEO and medical director are being kept up to date.

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:	-						
Risk and assurance:	-						
Legislation, regulatory, equality, diversity and dignity implications	-						
Recommendation: To note the current update.							

16. Freedom to speak up guardian

To ACCEPT a report

Presented by Nick Finch

Trust Open Board Report – 25 May 2018

Agenda item:	16			
Presented by:	Nick Finch, Freedom to speak up guardian			
Prepared by:	Nick Finch, Freedom to speak up guardian			
Date prepared:	May 2018			
Subject:	Freedom to speak up guardian report			
Purpose:	X	For information		For approval

Executive summary:

This report outlines the work I have carried over the last few months as the Freedom to Speak Up Guardian for the Trust.

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

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

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

Recommendation:

The Board is asked to note this report

Background

In February 2015, Sir Robert Francis published his final report which made a number of key recommendations under five overarching themes with actions for NHS organisations and professional and system regulators to help foster a culture of safety and learning in which all staff feel safe to raise a concern. Two key elements include the appointment of a local Guardian in each Trust and a national Guardian for the NHS. In April 2016 NHS Improvement published a national policy for raising concerns for NHS organisations in England to adopt as a minimum standard. The Francis report emphasises the role of the NHS constitution in helping to create a more open and transparent culture in the NHS which focuses on driving up the quality and safety of patient care.

Role of the Guardian

Independent In the advice they give to staff and trust's senior leaders, and free to prioritise their actions to create the greatest impact on speaking up culture and able to hold trusts to account for: creating a culture of speaking up; putting in place processes to support speaking up; taking action to make improvements where needed; and displaying behaviours that encourage speaking up.

Impartial and able to review fairly how cases where staff have spoken up are handled.

Empowered To take a leading role in supporting staff to speak up safely and to independently report on progress on behalf of a local network of 'champions' or as the single role holder.

Visible To all staff, particularly those on the frontline, and approachable by all, irrespective of discipline or grade.

Influential With direct and regular access to members of trust boards and other senior leaders

Knowledgeable In Freedom to Speak Up matters and local issues, and able to advise staff appropriately about speaking up.

Inclusive and willing and able to support people who may struggle to have their voices heard.

Credible with experience that resonates with frontline staff.

Empathetic to people who wish to speak up, especially those who may be encountering difficulties and able to listen well, facilitate constructive conversations, and mediate to help resolve issues satisfactorily at the earliest stage possible.

Trusted by all to handle issues fairly, take action as necessary, act with integrity and maintain confidentiality as appropriate.

Self-aware and able to handle difficult situations professionally, setting boundaries and seeking support where needed.

Forward thinking and able to make recommendations and take action to improve the handling of cases where staff have spoken up, and freedom to speak up culture more generally.

Supported with sufficient designated time to carry out their role, participate in external Freedom To Speak Up activities, and take part in staff training, induction and other relevant activities with access to advice and training, and appropriate administrative and other support.

Effective monitoring the handling and resolution of concerns and ensuring clear action, learning, follow up and feedback.

Updates

Current work undertaken by the Freedom to Speak Up Guardian for West Suffolk NHS Foundation Trust to date includes:

- FTSUG met with and was interviewed by the CQC as part of their inspection
- On January 11th 2018 we had a very successful visit by Dr Henrietta Hughes the National Freedom to Speak Up Guardian who met members of the Trust board and a selection of Trust staff, this concluded with her giving a talk at the Five O Clock Club to a good cross-section of Trust staff. The feedback received from her was extremely positive; she felt the Trust was well led with a highly very motivated staff.
- FTSUG attended Preceptorship days for newly qualified Nurse and Midwifes.
- FTSUG attended the Marketplace and helpfulness staff event and given a presentation about my role.
- FTSUG attended the Bullying and Harassment at work event for Band 7s and above.
- A working link with the new Senior Independent Non – Executive Director – Gary Norgate
- FTSUG continues to work with the National Guardians Office.
- FTSUG works with the Eastern Region Guardians Office, attending meetings and telephone conferences.
- FTSUG continues to attend Trust Inductions.

Concerns Raised

Concern	Numbers	Status
Behaviour/ attitude	2	Resolved
Trust procedure/practice	2	Resolved
Capacity/workload	0	
Miscellaneous	4	Resolved

This table shows the number of concerns raised over the last three months where the FTSUG has been asked to investigate and currently working with staff.

Behaviour/attitude These are two cases where I am either working with staff and HR or where I have been asked to support staff.

Trust procedure/practice This case was raised by a member of staff who identified safety issues. The case was forwarded to the line manager and director responsible and resulted in a change in practice.

Capacity/workload No cases to date.

Miscellaneous FTSUG was approached by four different members of staff who raised issues but had not communicated with the line manager first**.** They were advised accordingly and matter resolved without the need of the Freedom to Speak Up Guardian.

Future plans

- To continue meeting with all staff groups to advertise of the role and support where necessary.
- To work with the new trusted partners when appointed and the staff governors.
- Continue to raise the profile so that staff are fully aware who I am and how I can be approached.
- To forge a link with our new community staff, this process has now started but further work needs to be done.
- Reporting to the Trust board on a more regular basis outlining the work being carried out by the Freedom to Speak Up Guardian.
- To meet the new intake of overseas Nurses in July.

Conclusion

Over the last year staff have become more aware of FTSUG and what the role of the Freedom to Speak Up Guardian entails. This has been made apparent by the number of staff who have raised concerns or in some cases contacted me to ask advice about how to report an issue.

FTSUG being visible and the role being well advertised gives staff confidence to come forward with issues and know they will be listened to and in some cases given the help they need.

17. NHS Resolution - maternity improvement standards

To APPROVE a report

Presented by Craig Black

Trust OPEN Board Meeting – 25th May 2018

Agenda item:	Item 17			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Lynne Saunders, Acting Head of Midwifery			
Date prepared:	21st May 2018			
Subject:	Maternity CNST Board Report			
Purpose:		For information	x	For approval

Executive summary:

The Maternity Safety Strategy set out the Department of Health's ambition to reward those who have taken action to improve maternity safety by trialling a CNST incentive scheme for 2018/19. In 2016, members of the CNST pricing consultation overwhelmingly supported incentivising safer care through CNST safety initiatives, which was also directly aligned to the NHS Resolution Intervention objective in their Five year strategy: Delivering fair resolution and learning from harm.

This report details current performance against the 10 Maternity Safety Strategy initiatives highlighting our compliance and progress with all actions to demonstrate qualifying for the 10% rebate of our contribution to the incentive fund. We are suggesting that we are compliant with 9 out of the 10 standards with partial compliance in the remaining standard.

The area of partial compliance relates to the need to deliver increased ante-natal ultrasound scanning to high risk women. We offer a risk based approach, targeting those women at most risk and delivering an increased number of scans. This approach does not currently deliver the desired range or frequency of additional scanning – options to increase capacity are contained in the action plan.

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:	**Trust Executive Group**
Risk and assurance:	

Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: To agree to the submission of the compliance position statement.	

Board report on West Suffolk NHS Foundation Trusts progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 25/05/2018

Introduction

The Maternity Safety Strategy set out the Department of Health's ambition to reward those who have taken action to improve maternity safety by trialling a CNST incentive scheme for 2018/19. In 2016, members of the CNST pricing consultation overwhelmingly supported incentivising safer care through CNST safety initiatives, which was also directly aligned to the NHS Resolution Intervention objective in their Five year strategy: Delivering fair resolution and learning from harm.

Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified to CNST in 2016/17, obstetric claims represented 10% of the volume and 50% of the value. This is the background to the 10 Maternity Safety Strategy actions evidenced in this report, highlighting our compliance and progress with all actions to demonstrate qualifying for the 10% rebate of our contribution to the incentive fund.

Evidencing the safety actions

SECTION A: Evidence of Trust's progress against 10 safety actions:

Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard.

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	The maternity service has registered to use the NPMRT, and all retrospective data from January 2018 to April 2018 has been uploaded. The tool will now be used when an eligible case occurs.	**Y**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	The trust is currently compliant and can demonstrate achieving the submission of 10 out of the 10 required criteria in the latest report available from NHS Digital. (Appendix 1)	**Y**
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	The Maternity and Neonatal Services at WSH have recently introduced a transitional care unit. Plans for this introduction were discussed and agreed with the Neonatal Network lead who undertook a site visit in March 2018 (see operational policy, working document, Appendix 2). The admission criteria were agreed by the National Neonatal network lead at this time and a further visit has been requested to review progress. Informal feedback from parents is positive about this new initiative which reduces separation of mothers and	**Y**

	babies, more formal feedback will be sought once the service is more established. The services have been working on this introduction for some time however implementation has been phased due to a forthcoming refurbishment of the Labour Suite. The admission criteria have been limited due to capacity however the service plans to introduce a wider criteria as soon as possible after the refurbishment is completed and will use the intervening time to enhance skills of the midwives (with regards to intravenous antibiotics for neonates). We will also introduce the use of the NEWTS charts, in conjunction with the NNU practise development nurse. This service introduction has enhanced how the two areas work together to improve the service to mothers, families and babies in our care.	
4). Can you demonstrate an effective system of medical workforce planning?	The maternity service achieved the target of having "no more than 20% of middle grade sessions on a labour ward filled by consultants acting down from other sessions", between the 1st March 2018 and 28th March 2018. This was demonstrated using the new 2018 Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool template (Appendix 3). The maternity service has had a long term approach to supporting the obstetric medical workforce and over the last 2-3 years has employed a number of acute consultants. These staff work in the acute setting as a planned activity and therefore reduce the impact of a reduction in specialist registrars rotating into the service and the need for consultants to act down.	**Y**
5). Can you demonstrate an effective system of midwifery workforce planning?	The maternity service can evidence meeting all of the elements of effective midwifery planning.	**Y**

	Element 1: Evidence of a systematic, evidence-based process to calculate midwifery staffing establishment. The maternity service undertook a robust internal review of maternity staffing in April 2016, supported by an external midwifery consultant (Appendix 4). This established that the overall midwifery staffing was adequate to provide a ratio of 1 midwife to every 28 births, although it identified that community caseloads were lower than would be expected. Therefore some realignment was undertaken to ensure that the hospital was able to provide a compliant service. Since this time, establishment, ratios and caseloads have been monitored on a monthly basis. Both midwife to birth ratios and the percentage of one to one care in labour appears monthly on the maternity service's dashboard. Example included in Appendix 5. **Element 2: Trust policy demonstrating that, as standard, midwifery labour ward shifts are rostered in a way that allows the labour ward coordinator to have supernumerary status (defined as having no case load of their own during that shift).** The maternity service outlines its expected staffing standards in all maternity areas in a local guideline which includes details of the local escalation process in place for when the labour suite coordinator is not able to maintain her supernumerary status; (Appendix 6) this was last updated in November 2017. The guideline describes four levels of escalation and the maternity service has not escalated beyond Level 2 in the period January to March 2018.	

	Element 3: Good practice includes neonatal workforce within work force plans. The neonatal unit workforce plans are included within Women's and Children's Divisional plans and additionally the escalation process for the neonatal service is included within the maternity unit escalation guideline (Appendix 6).	
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	The maternity service can evidence fully meeting the requirements of three of the four elements of the Saving Babies' Lives (SBL) care bundle. Partial compliance is achieved with the fourth element (all bar element two, intervention 2). ***Element 1: Reducing Smoking in pregnancy.*** The maternity service is fully compliant with this element of the care bundle. All women who are smoking at booking have CO monitoring undertaken at booking and referral is made to Live Well Suffolk, our partner organisation. Additionally we have introduced an onsite clinic run by Live Well Suffolk to encourage uptake of smoking cessation advice. The maternity service dashboard records data on smoking at booking and smoking at delivery each month. ***Element 2: Risk assessment and surveillance for fetal growth monitoring.*** **Intervention 1:** The maternity services are fully compliant with this intervention. **Intervention 2:** The maternity service is not able to demonstrate full	**Partial**

	compliance with this intervention. Some women identified as high risk receive serial ultrasound scans. The maternity service is addressing the capacity to undertake ultrasound scans for all women in the high risk group at the recommended frequency. This is addressed in Section B and the plan is included as Appendix 7 **Intervention 3:** The maternity services are fully compliant with this intervention. All women assessed as low risk have fetal growth assessment using symphysis fundal height measurement and customised growth charts (GAP protocol). **Intervention 4:** The maternity service uses the Growth Assessment Protocol (GAP) to monitor for small for gestational age babies. All births are recorded on the system and a birth centile provided. The service has evidence on the detection rates it is achieving provided by the Perinatal Institute.(Appendix 8) **Intervention 5:** The maternity service is currently undertaking an audit of SGA cases not detected during the antenatal period. Preliminary findings from a cohort of 14 cases were discussed at the Clinical Governance Steering group on 17th May 2018. The agenda is included in Appendix 9. This intervention is also addressed in Section B. ***Element 3: Raising awareness of reduced fetal movement.*** **Intervention 1:** The maternity service provides all women with the recommended information leaflet on reduced fetal movements, at 16 weeks of pregnancy (Appendix 10). At all antenatal appointments fetal movements are discussed and the leaflet will be reoffered if appropriate.	

	Intervention 2: The maternity service uses a proforma for all women who present with suspected reduced fetal movements. This is based on the RCOG guidance. See Appendix 11. ***Element 4: Effective fetal monitoring during labour.*** **Intervention 1:** The maternity service has in place an on line training package (K2) staff are expected to complete this on an annual basis. This on-line tool includes a competency assessment. **Intervention 2:** The maternity service has a well embedded "Fresh Eyes" system for assessment of CTGs in labour. This is supported by the use of stickers to assess the CTG. Both are described in the local guideline. (Appendix 12).	
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	The Head of Midwifery and others members of the midwifery and neonatal team are regular attendees and contributors to the Maternity Voices Partnership (MVP) forum. This forum is well established and all meetings include some feedback from service users, this may be general feedback or may be focused on a particular topic. Minutes of the meeting demonstrate both the discussion and where appropriate actions have been taken in response to feedback. A random sample of minutes has been provided to support this. (Appendix 13 Minutes of Jan 2018 demonstrating feedback on forthcoming Labour Suite refurbishment. Appendix 14 Minutes of March 2018 demonstrating discussion of general service user feedback).	**Y**
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-	The maternity service has had an established Practical Obstetric Multi-Professional Training (PROMPT) session in place since 2012. This provides staff, including obstetricians, midwives and anaesthetists, with evidence	**Y**

house' multi-professional maternity emergencies training session within the last training year?	based, outcome focused training, supporting the progressive development of clinical skills and team working in line with the latest local and national guidance. Our 'local training record' form (Appendix 15) demonstrates that in aggregate significantly more than 90% of staff have attended this training. The only individual group falling below the standard is a group of two staff where 50% attendance has been achieved within the last year. A number of additional staff groups also attend training including student midwives, paramedics from the local service, operation department assistants, medical students on placement at WSH and theatre nurses.	
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	The Trust identified board level safety champions as part of it's participation in Wave 1 of the Maternity and Neonatal Safety Initiative. As such the Medical Director and Executive Chief nurse supported the team who lead this initiative. The maternity service has identified 2 safely champions (a consultant obstetrician, who participated in the Maternity and Neonatal Safety Initiative and the Head of Midwifery) as part of the team for the Maternity and Neonatal Safety Initiative. There are now bi monthly formal meetings arranged between these individuals to discuss safety within the maternity service. Previously these were not formal meetings. The agenda and notes for the first meeting are included in Appendix 16 and 17 to support compliance with this requirement.	**Y**

10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	The maternity service is reporting all relevant cases to the NHS Resolution Early Notification Scheme using the form provided. This information is captured on the Trust's incident reporting system.	**Y**

SECTION B: Further action required:

Requirement 6 Element 2 Intervention 2:

The maternity service at West Suffolk Hospital is not able to demonstrate full compliance with this intervention. The service has undertaken a review to assess the impact of the guidance for increased antenatal surveillance for women at high risk of fetal growth restriction, as included in Saving Babies Lives (NHS 2016), on its services and this assessment indicates that there would be a 12.5% to 15% increase in the requirement for additional ultrasound scans. Currently a number of women whose pregnancy is considered high risk do receive serial ultrasound scans, for example those with maternal diabetes both pre-existing and gestational. Others receive targeted ultrasound scans in pregnancy.

It has therefore developed a risk based structured approach to achieving full compliance and this is included as Appendix 7. Whilst the maternity service is not able to offer all women at high risk of fetal growth restriction serial ultrasound scans as per the suggested algorithm, it has identified by thematic review of previous stillbirths, the most high risk group who are currently not receiving serial ultrasound scans and is currently targeting these high risk women as a priority.

The approach to increasing the capacity of ultrasound scans has included both increasing the number of sonographers and training midwives in third trimester scanning (two have recently been accepted on a course). Once they have completed training they will have dedicated sessions in the ultrasound department.

Additionally the maternity service is trying to ensure that there are adequate facilities to undertake scanning and the approach detailed indicates how this will be achieved.

Requirement 6 Element 2 Intervention 5:

Although compliant with this intervention the process is not fully embedded. Detection rates are above the rate for other GAP users (Appendix 8) but the process of individual case note audit has only recently commenced albeit with a larger sample size than that recommended in the guidance. The maternity governance department has recently recruited additional staff and therefore it is anticipated that this audit will join the regular audit programme followed by presentation and discussion at the Clinical Governance Steering Group.

SECTION C: Sign-off

……..

For and on behalf of the Board of West Suffolk NHS Foundation Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: **…….**

Date: **…….**

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

SECTION D: Appendices

Requirement No	Appendix No	Item	Doc
2.	Appendix 1	NHS Digital Report	CNST Criteria - October November ar
3.	Appendix 2	Operational policy for Transitional care.	Operational Policy April 2018.docx
4.	Appendix 3	Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool	Cnst-workforce-data -collection-tool-report
5.	Appendix 4	Staffing report April 2016	Review of West Suffolk Hospital Mate
5.	Appendix 5	Maternity Services dashboard April 2017 to March 2018	Copy of 2017 2018 dashboard April 2018
5.	Appendix 6	Copy of maternity services guideline M AT 0163 Escalation policy for the maternity unit. November 2017.	MAT0163-Escalation PolicyfortheMaternity

6.	Appendix 7	Plan to introduce serial ultrasound scans for women at high risk.	Plan of implementation of the
6.	Appendix 8	PI report on antenatal SGA detection rates and centile submissions.	GAP submission rates.docx SGA detection rates.docx
6.	Appendix 9	Agenda for Clinical Governance Steering Group May 2018	Agenda May 2018.doc
6.	Appendix 10	Copy of information leaflet on reduced fetal movements in use at West Suffolk Hospital.	Scan_Saunders Lynne_20180515-132
6.	Appendix 11	Copy of Reduced fetal movements proforma	Scan_Saunders Lynne_20180515-134
6.	Appendix 12	Fetal Monitoring in Labour Guideline	MAT-0046-Fetal-Monitoring,-Oct-2015.pdf
7.	Appendix 13	Minutes of Maternity Voices Partnership meeting January 2018	24 01 2018 MVP Minutes.doc

7.	Appendix 14	Minutes of Maternity Voices Partnership meeting March 2018	 28 03 2018 MVP Minutes.doc
8.	Appendix 15	CNST training records	 cnst re training.msg
9.	Appendix 16	Agenda for Safety Champions meeting	 Maternity Safety Champions Bi Monthly
9.	Appendix 17	Notes of meeting	 Maternity Champions meeting .msg

18. Putting you first award

To NOTE a verbal report of this month’s winner

Presented by Jan Bloomfield

19. Consultant appointment report

To RECEIVE the report

Presented by Jan Bloomfield

BOARD OF DIRECTORS – 25th May 2018

Agenda item:	19			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	17th May 2018			
Subject:	Consultant Appointments			
Purpose:	X	For information		For approval

Executive summary:

Please find attached confirmation of Consultant appointments

Trust priorities	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	

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

Previously considered by:	Consultant appointments made by Appointment Advisory Committees
Risk and assurance:	N/A
Legislation, regulatory, equality, diversity and dignity implications	N/A

Recommendation:

For information only

POST:	Consultant – Histopathology
DATE OF INTERVIEW:	Thursday, 3rd May 2018
REASON FOR VACANCY:	Replacement Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	4 2 2

POST:	Consultant – Histopathology
DATE OF INTERVIEW:	Thursday, 3rd May 2018
REASON FOR VACANCY:	Replacement Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	3rd August 2018
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	4 2 2

10:50 BUILD A JOINED-UP FUTURE

20. e-Care report

To RECEIVE an update report

Presented by Craig Black

Trust Open Board Meeting – 25th May 2018

Agenda item:	20			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Jane Relf, e-Care/Global Digital Exemplar Operational Lead			
Date prepared:	20 May 2018			
Subject:	To receive update on e-Care and Global Digital Exemplar Programme			
Purpose:	X	For information		For approval

Executive summary:
This paper describes progress against delivery of the Global Digital Exemplar (GDE) programme. In particular the Board should note the delay to implementation for new functionality within the emergency department.

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

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

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

Recommendation:
The Board is asked to note the report

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

1. Background

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

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

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

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

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

1.4 Our GDE programme comprises of four pillars:

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

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

2. Pillar one – digital acute trust

2.1 We were due to launch new functionality (called Launchpoint) into the emergency department on 14 May but this has been delayed due to some issues identified during testing that could not be resolved prior to this date. A revised go live date of 27 June 2018 has been agreed. This delay will also enable us to undertake a full dress

rehearsal and further user acceptance testing prior to go live. Milton Keynes University Hospitals NHS Foundation Trust (MKUHFT), our fast follower trust, are implementing Launchpoint over the weekend of 18/19/20 May and we are sending staff over to ensure that we can learn from their implementation.

2.2 Two of our projects are dependent on sufficient storage space. The procurement for a new storage area networks (SAN) has been delayed and this may impact on the timelines for implementing new cardiology and ophthalmology functionality. An impact assessment is currently being completed which will enable us to understand the full impact of the SAN delay on the project.

2.3 We are also implementing the Cerner modules for anaesthetics and surgery. These projects have commenced with initial focus on ensuring full understanding of current workflows and how the new system will impact on this. Likewise, we have held an initial discovery week for the MMODAL voice recognition project which is aiming to enhance the secretarial workflow and improve clinician productivity. We are confident from this initial review that we can make a significant impact with this project.

2.4 All main outpatient areas are now live with VitalsLink integrated devices. This means that the vast majority of clinical areas in the hospital are now using these devices and benefitting from the productivity gains.

2.5 Our focus also continues on optimisation and the team are trialling a new approach whereby they will target a specific ward and spend a week within that area offering intensive 'at the elbow' support and coaching with an aim to improving productivity and efficiency for staff. We are also focussing on improvements for discharge summaries, fluid balance management and the reduction of acute kidney injury.

3. Pillar two – supporting the integrated care organisation

3.1 The new Health Information Exchange (HIE) link between Cambridge University Hospitals NHS Trust and the hospital continues to prove popular with clinicians from both sites. We have several examples where clinicians have confirmed that they did not complete tests on patients because they could see the results of recent tests at the other hospital.

3.2 The number of users registered to use the new patient portal continues to grow. We now have 476 patients registered. This has been achieved in 10 weeks of the pilot and we are delighted with this result. The pilot ends at the beginning of May and we have sent a user survey to all users to identify how they are using the system and their suggestions for improvements. We have also sought volunteers to participate in a patient portal user group.

3.3 We will be extending the reach of the pilot after May and are hoping to work with cardiology, oncology and diabetes. We have also approached two GP surgeries to see if we can target their patients.

4 Pillar three – exemplar digital community

4.1 Our fast follower MKUHFT have gone live with their own version of e-Care over the weekend of 28/19/20 May. Members of our staff are going to the hospital to support their go live. A verbal update on their implementation will be provided at the board meeting.

4.2 Members of the e-Care team visited Radboud University Medical Centre in the Netherlands. Radboud are a HIMSS level 7 site and there was significant learning around how a trust achieves this HIMSS status. The Board are reminded that achievement of HIMSS 7 is a key success criteria for the GDE programme. We are currently at level 5. We have invited the HIMSS organisation to come on site and complete a gap analysis of what the trust will need to do to achieve HIMSS 6 and then 7.

5. Pillar four – hardware and infrastructure

5.1 A key component of the GDE programme is to ensure that our supporting infrastructure is

sound and enabling the new initiatives described above. We continue to focus on security, storage and network functionality. To date we are on target to achieve all GDE milestones as required under pillar four.

7. Reporting

7.1 We continue to work with Cerner to correct the highest priority outstanding RTT reporting issues. There are 4 defects outstanding affecting referral to treatment reporting. Of these defects, 1 is awaiting a fix to be provided by Cerner and 2 have a fix that has failed, so is back with Cerner to investigate. The remaining issue is under investigation with the Trust to identify the root cause and with Cerner to identify if the data can be included in submissions. Historical Bed Occupancy is now with Cerner's Engineering team as there is currently no fix identified to solve the issue historically. A fix was implemented on 13th April that means accurate data is available from that point onwards.

21. IM&T strategy

To APPROVE a report

Presented by Craig Black

Trust Open Board Meeting – 25th May 2018

Agenda item:	21			
Presented by:	Craig Black			
Prepared by:	Michael Bone			
Date prepared:	Jan – Mar 2018			
Subject:	Information Management and Technology Strategy			
Purpose:		For information	X	For approval

Executive summary:

The attached document is the new Information Management and Technology Strategy for the West Suffolk NHS Foundation Trust. It incorporates the draft Information Strategy issued in 2017 and also reflects the needs of the Community Health Team that joined the Trust in October 2017. It covers the period April 2018 – March 2021 but will be subject to regular 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	X				X

Previously considered by:	*The draft IM&T Strategy has been presented to TEG and subject to a few small adjustments was approved in principle.*
Risk and assurance:	*All risks arising from the IM&T Strategy will be managed at all levels (Project, Programme and Portfolio) Governance model. The notable risks will come to the Programme Board, whilst anything exceptional will be presented at either TEG or Trust Board as appropriate*
Legislation, regulatory, equality, diversity and dignity implications	*As far as it applicable the Strategy is compliant with UK legislation, regulatory, equality, diversity and dignity requirements.*

Recommendation:

The Trust Board is asked to review the draft IM&T Strategy and either return it for further update or approve it as the new Trust IMT Strategy for the period April 2018 to Mar 2021.

West Suffolk NHS Foundation Trust

Information Management & Technology Strategy

April 2018- March 2021

Version Control

Release	Author	Date	Action
Draft V1	M. Bone	04/12/2017	For review by IT Leads
Draft V2	M. Bone	22/01/2018	Portal Update
Draft V3	M. Bone	28/01/2018	1st Update
Draft V4	M. Bone	05/02/2018	Business Systems Update
Draft V5	M. Bone	19/03/2018	Finance/Procurement Review
Draft V6	M. Bone	20/04/2018	Update following TEG Review
Draft V7	M. Bone	23/04/2018	Benefits Update

Executive Summary

Background

In 2014 the Trust embarked on a major digital journey designed to use technology to enable the delivery of higher quality and safer healthcare for all patients. At the heart of this objective was the procurement and subsequent implementation of the Cerner Millennium electronic patient record (EPR) system known locally as e-Care. By May 2016 the first five modules of e-Care were operational, and almost all new patient clinical notes had become digital. In late 2016 the Trust digital agenda was accelerated by the appointment of the Trust as an NHS Global Digital Exemplar (GDE) and by its close in March 2019 it will have extended e-Care to 11 modules and upgraded many of the back-office systems.

In April 2017 the NHS suffered a significant cyber-attack which added further impetus to drive to update systems, reduce the software patching cycle and improve security. A whole section of this strategy reflects on security and this will remain a Trust Board level risk over its life time.

In October 2017 the Trust changed following the acquisition of Community Health Services (CHS). The need to use technology to enable the patient journey as part of a wider programme of service integration remains key. Yet the level of digital maturity in CHS is lower and this is reflected in the need to invest in technology and interoperability across the wider health community.

Global Digital Exemplar

The strategy therefore is focussed on the delivery of the GDE programme, across all four of the pillars of work that make up the West Suffolk GDE programme. In terms of Pillar One, the on-going delivery of new modules for the Trust e-Care EPR is its primary focus. Building on the five major modules delivered in phase one, this work will greatly extend the functionality of e-Care most notably in Women's and Children's Services (Maternity and Paediatrics) and in Surgical Services (Anaesthetics, Materials Management and Operating Theatres). As part of the GDE the Trust needs to achieve the HIMSS EHRAM standard at level 6 and then progress such that by December 2018, the Trust is preparing to apply for level 7. The strategy recognises that there is an issue with Closed Loop Medical Administration (CLMA) but continues to work closely with NHS Digital to address this national short fall.

Pillar Two is all about the extension of the Trust Digital Programme into the wider health Community. Initial work to establish a Health Information Exchange (HIE) with local GP Surgeries is already underway, as is an HIE link to Cambridge University Hospital. The HIE programme will continue over the life of this strategy with aim of creating as two near real-time flow of data across primary and secondary care, community health services, mental health, social care and the local ambulance service. Alongside HIE the strategy will also deliver a patient portal, providing the citizens of West Suffolk with access to their own and others (subject to authorisation) medical records. Expectations are high for the portal and so over the lifetime of strategy is should grow and develop as the views of our stakeholders become known to us and as new software is released as a response.

Also part of pillar two is a far wider investment made by the Trust in a population health solution. This application will take data feeds from primary and secondary care, community health services, mental health, social care and the local ambulance service creating a truly longitudinal patient record that can be shared across the entire health community. In addition population health is an excellent tool for health care planning and disease research, fully recognised by the Trust by the appointment of a full time consultant in public health. This key role will be augmented through the development of a clinical informatics team to maximise the benefits for all patients from this GDE funded investment.

Pillar three covers the Trust role as a GDE both Nationally and Internationally, with relationships being formed with other organisations across Europe and the USA. This ability to share experience and draw on expertise from those who have already been down this road is a critical success factor for the Trust.

Pillar Four is all about Infrastructure, as without the underlying technical platforms it will not be possible to delivery much of what is included in the other pillars. This work will see major updates to: the Trust security perimeter (both fixed and mobile), wireless networks, remote access provision and data storage solutions. By the end of 2018 the Trust will have uplifted all back end Microsoft products to the latest releases and be ready to commence the migration of endpoint devices to Windows 10. This work will also see the Trust attain the nationally mandated secure e-mail standard and commence the delivery of GOVROAM allowing any authorised public sector staff to connect over the Trust wireless networks back to their base systems.

Community Health Services

Also key to the success of the strategy is the integration of Community Health Services into all areas of the Trust Information Management and Technology service. Early work includes inter-connection of digital infrastructure through work with North East London CSU who currently manage the CHS IT Service and by the federation of CHS systems to allow data to flow freely. Over the life time of the strategy, on a step by step basis improved connectivity (such as the proposed HSCN network); greater systems integration (most notably with TPP SystmOne) and the consolidation of Trust data will remove remaining digital constraints across the former organisational boundaries. This approach, over time, will fully align the outcomes of service redesign with the IM&T support required to deliver it.

Information

Perhaps the greatest area of change within the strategy is the need to increase access to information, create and optimise clinical informatics and deliver a fully operations Information reporting service. Early work involves the strengthening of the WSH Information Management team, the appointment of clinical staff into informatics roles and the introduction of divisional informatics teams. Alongside this is a focus on resolving both local and national reporting issues, most notable Referral to Treatment (RTT), the Patient Transfer List (PTL) and bed occupancy.

Over the lifetime of the strategy, work will be undertaken to generate a new Enterprise Data Warehouse (EDW) that could see this undertaken through collaborative work with Suffolk County Council. This will build upon the shared access to data across Community Health bringing together all elements of Trust data within a single digital structure. This will be a significant challenge around data entity definitions and data validation; however it is necessary if corporate and regulatory reporting requirements are to be met both now and into the future.

However, in parallel working in partnership with Milton Keynes University Hospital (the Trust GDE Fast Follower) and a selected commercial partner, the Trust will build a data lake using direct data feeds from a wide range of Trust systems. Access will be via an agreed reporting tool so that clinicians and managers can attain real-time access for business intelligence to a wide range of data entities. In many ways this will assist senior staff in providing an immediate view of the data delivered by their teams. This in turn will create feedback loops where data quality is sub-optimal and so generate corrective actions.

Security

In recent years the Trust has achieved some success around Information Security having met the ISO standards requirements for ISO27001 and for the Cyber Essentials accreditation. However as the May 2017 WannaCry cyber-attack demonstrated there is still much to do. As a result the Security team is being strengthened and plans are well advanced to reach the Cyber Essentials plus accreditation.

Investment

In September 2017, the Trust Board signed off on a revised programme of investment in Information Management and Technology. A summary of that investment plan is shown below

	Total 2016-17	Total 2017-18	Total 2018-19	Total GDE	Total 2019-20	Total 2020-21	Total 2021-22	Total 2022-23	Total 2023-24	Total 2024-25	Grand Total
Costs											
Pay Costs (to Dec 18)											
Band 3	44,846	44,846	33,635	123,327							123,327
Band 4	126,034	126,034	94,526	346,594							346,594
Band 5	217,586	217,586	163,190	598,362							598,362
Band 6	330,790	330,790	248,093	909,673							909,673
Band 7	338,529	338,529	253,897	930,955							930,955
Band 8a	180,312	180,312	135,234	495,858							495,858
Band 8b	62,220	62,220	46,665	171,105							171,105
Band 8c	48,420	48,420	36,315	133,155							133,155
Band 8d	45,156	45,156	33,867	124,179							124,179
Medical Staff	129,291	129,291	96,968	355,550							355,550
Agency/ Contractor Staff	880,742	880,742	660,557	2,422,041							2,422,041
Other Staff		157,862	1,008,140	1,166,002							1,166,002
Leave in revenue	0	(600,000)	(600,000)	(1,200,000)							(1,200,000)
Total Pay	**2,403,926**	**1,961,788**	**2,211,087**	**6,576,801**	-	-	-	-	-	-	**6,576,801**
Non Pay Costs											
Cerner (pre 1617 = £1.75m)	2,033,333	3,055,886	2,168,000	7,257,219	1,565,000	1,179,000	989,000	1,013,725	1,039,068	355,015	13,398,027
Cerner GDE upgrades		150,000	150,000	300,000	700,000	800,000	800,000	800,000	800,000	600,000	4,800,000
IT Equipment: including E-Care Implementation on Wards		527,000		527,000							527,000
Leased Network Equipment		438,000		438,000							438,000
Projected Leased Equipment Capitalised (ordered, incl VAT)		914,250		914,250							914,250
SAN upgrade (service provided, eg cloud, VAT recoverable)		100,000	100,000	200,000	100,000	100,000	100,000	100,000	100,000	100,000	800,000
Estimated futures - EDM Upgrade		144,000		144,000							144,000
Other											-
2nd stage email upgrade			450,000	450,000							450,000
Wireless Network upgrade		60,000	250,000	310,000	290,000						600,000
Office 2016 deployment				-		272,623					272,623
SCCM upgrade		384,000		384,000							384,000
E-Care Hardware		100,000	630,000	730,000							730,000
E-Care Software		20,000	70,000	90,000	160,000	160,000	160,000	160,000	160,000	160,000	1,050,000
Ad Hoc : (available for IT Capital)				-	157,540	260,917	723,540	698,815	673,472	1,557,525	4,071,809
Accommodation- assumed no longer required				-							-
Data Migration (Softcat and EPRO only)				-							-
Training Backfill funding				-							-
Capitalised Interest	17,460	77,460	137,460	232,380	227,460	227,460	227,460	227,460	227,460	227,460	1,597,140
Total Non Pay	**2,050,793**	**5,970,596**	**3,955,460**	**11,976,849**	**3,200,000**	**3,000,000**	**3,000,000**	**3,000,000**	**3,000,000**	**3,000,000**	**30,176,849**
Grand Total	**4,454,719**	**7,932,384**	**6,166,547**	**18,553,650**	**3,200,000**	**3,000,000**	**3,000,000**	**3,000,000**	**3,000,000**	**3,000,000**	**36,753,650**
Funding											
Funding GDE - external	3,333,333	3,333,333	3,333,333	10,000,000							10,000,000
Funding GDE - internal	2,000,000	2,000,000	3,000,000	7,000,000	3,000,000						10,000,000
Funding GDE - contingency		720,436	833,214	1,553,650	200,000						1,753,650
Funding - Existing Capital Programme (IT)				-		3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	15,000,000
Funding - Existing Capital Programme (slippage)	(878,614)	1,878,614	(1,000,000)	-							-
Grand Total	**4,454,719**	**7,932,383**	**6,166,547**	**18,553,650**	**3,200,000**	**3,000,000**	**3,000,000**	**3,000,000**	**3,000,000**	**3,000,000**	**36,753,650**

Over the life time of the strategy it is likely that further funding for specific provision (such as Wireless Networking, Cyber Security et al) will be forthcoming and the Trust will actively bid for funds from any sources that helps to sustain the Trust Digital agenda.

People

Finally, underpinning the whole strategy are the people who will make it happen. The investment in people includes the formation of new teams, strengthening of others and for some a change in role or approach. Yet throughout, the need to invest in the development, education and training of staff is an imperative if the strategy is to succeed. This will be a period of significant change, yet the opportunities for both patients and staff make the investment truly worth the effort.

Benefits

In summary, the benefits of the strategy start with the wider connectivity of health care users across the whole of West Suffolk, driven by the delivery of a new Health and Social Care Network. This will enable ever more authorised staff to gain access to real-time patient data, enabling decision around their healthcare to be made from an informed position. Over time such connectivity will be extended through the deployment of increased wireless networking including GOVROAM and in tandem with more e-Care workstations on wheels, tablet computers running Power Chart Touch and Smartphones running the SystmOne Mobile application will see such staff being truly able to work from almost any location.

The improved connectivity can then be combined with new Unified Communications tools, advanced platforms such as the Enterprise Image Archive and innovation such as Medic Bleep to allow all members of

the patient's clinical team to participate in on-going care of the patient, even where the patient journey crosses organisation boundaries. New clinical systems, further modules in e-Care, greater interoperability both within the Trust and across the STP further enhance the quality and safety of our patient journeys.

Alongside what are largely operational changes the strategy also has a significant focus on Information. The ability to measure clinical success and quickly address clinical issues will be driven from the investment proposed. The direct provision of access to clinical patient data by all members of the clinical team will allow authorise staff to check on the performance of their teams and the associated patients. The benefits also extend to improved patient engagement via the new Patient Portal and when used for research.

The introduction of divisional reporting will enable General and Service Managers to generate information dash boards and so become more agile in their decision making. In light of the pressure on bed numbers and service capacity, the drive towards evidence-based decision-making is of benefit to both the Trust and its patients. The formation of a new Clinical Informatics team working alongside the new Population Health solution will see the Trust move towards stratified medicine as well as, in time, producing an STP wide longitudinal health record for every patient in West Suffolk. The benefits of such records in the planning and commissioning of health care are very significant.

In line with existing expectations, the continued investment in security personnel, controls and monitoring solutions is a key feature of the strategy. The benefits come from the reduction is security risks, the management of emerging threats, the on-going education of users in good practice and the maintenance of the high standards already set. Of note West Suffolk NHS Foundation Trust is one of only a small number to be both ISO27001 and Cyber Essentials accredited, with further work underway to reach the Cyber Essentials Plus standard during the life of strategy.

Finally, the continued investment in Information Management and Technology staff is designed to ensure that the Trust remains at the forefront of the digital agenda both now as an NHS Trust and going forward as part of any future migration to an Integrated Clinical System. The strength that the IM&T Team has across all of its disciplines combined with the quality of the management team ensures that whole service remains focussed on supporting and enabling clinical team to treat patient and business team to sustain the organisation.

1. Introduction

This Information Management and Technology strategy sets out the Trust vision for both information and technology to sustain a major period of change from April 2018 to March 2021. Work commenced in 2014 under the previous strategy and at its centre was the procurement of a fully integrated electronic patient record system, known as Millennium from the Cerner Corporation. This procurement was driven into the Trust through a complex information and technology programme known locally as the e-Care. The e-Care Programme is focussed on the provision of acute electronic patient record and to date has completed the first two stages covering key clinical areas across the Trust. A third phase is now work in progress and is now combined with an on-going optimisation programme to maximise the benefits available from the e-Care solution.

However, in October 2017 West Suffolk NHS Foundation Trust (WSFT) became a combined Trust including Community Health Services (CHS) and also a member of a county wide Alliance that includes the GP Federation (GPF) and Suffolk County Council (SCC). The inclusion of CHS enhanced the focus on a greater integration of acute and CHS for every appropriate patient care pathway. In combination with the Alliance membership this also drives a need for greater systems integration and data sharing across the areas served by WSFT and across the county.

The Trust Board fully recognises that Information Management and Technology are key enablers for change and in particular clinical transformation; at a time when the NHS needs to become more efficient and optimise the use of all resources. It is aligned to the NHS Five Year Forward plan and is designed to facilitate the desired objective of being a paperless organisation by 2020. Yet at West Suffolk it has also built on the seven values that underpin the Trust Strategy and assure patients of the quality and safety of the services provided.

This strategy builds upon the successful delivery of first phase of e-care which went live in the summer of 2016 and the second that went live in October 2017.

2. Purpose

This strategy document is designed to outline what the Trust hopes to deliver for the period covering April 2018 to March 2021. It encompasses what is already known and fully understood, such as further expansion of the Trust EPR (Phase3) and the delivery of supporting clinical systems that sit outside the EPR. Also, what is known and only partly understood such as the new STP wide HSCN network, improved operational reporting and clinical data sharing along with direct access to health informatics for clinical leaders. Finally, what is desired and yet to finalised in any meaningful manner such as real-time digital clinical communications, population health and truly mobile access to patient records.

The strength behind the strategy remains the staff of West Suffolk NHS Foundation Trust with its excellent reputation for strong leadership (in all its facets); high levels of stakeholder engagement, flexibility and adaptability around all forms of service delivery and above all its desire to put the patient first. It is recognised that the current Trust structure may change during the life of this strategy and this will likely require updated governance and a potential re-alignment of roles and responsibilities. However, the benefits arising from the continued investment in information and technology services remain a key enabler to such change.

The key to the delivery remains the use of a structured approach, built on sound planning against this strategy (or any agreed variation to it); engaged delivery that links leaders from operational, clinical and IM&T roles with comprehensive testing of the solution and training right across the Trust at every level.

3. Strategic Objectives

The IT Strategy is built around six strategic objectives as follows:

INFRASTRUCTURE

The Trust needs to continue to investment in all facets of infrastructure, each of which underpins one or more strategic components and enables successful delivery of this strategy. At this time core strategic areas of interest include:

Review existing Data Centre configuration
Revisions to data Archive and Backup Services
Continue to invest in advanced Server Technology
Extension of Virtualisation across the Data Centres
New STP wide HSCN Network (to replace N3)
Grow wireless network to cover all sites
Adopt Digital links for external connectivity
Decommission Analogue Switches and Lines
Plan migration of Paging to a Digital platform
Consolidate Infrastructure Management Platforms
Explore use of Smartphone Technology
Introduction of Teleconsultation
Exploitation of Cloud Services
Update and expand Digital Communications
Expansion of Core and Edge Networks
- Provide extra capacity
- Improve network performance

Exploit GOVROAM across the STP
Expand use of Digital Telephony (VoIP)
Migrate analogue services to Digital
Launch Windows 10
Expand Tap and Go
Optimise secure use of Tablets
Upgrade/Exploit AV to improve MDT

Whilst this table of strategic components covers all likely core areas, it is not exclusive as the IM&T Strategy needs to be flexible and responsive to changes within the Trust and across the technology industry.

SYSTEMS

This Strategy recognises that the Trust has already set the primary direction of travel for clinical systems by way of the significant investment made in the Trust e-Care EPR. At the time of this strategy the Trust has formally adopted the following modules;

Emergency Department	Patient Administration System	Clinical Documentation
Electronic Prescribing and Medicines Management	Order Communications	Dynamic Documentation
	Health Information Exchange	Patient Portal
Power Chart Touch	Paediatrics	Patient Flow
Infection Control	Maternity	Patient Vital Links
Anaesthetics including Medical Device Integration	1st Phase of Population Health (HealtheRecord & HealtheEDW)	
	Operating Theatre Management	FHIR Ignite Resources

As the e-Care EPR sits at the heart of the IM&T strategy for clinical systems this will be the primary area of clinical systems development over the life of this strategy. However, there are a notable number of systems that sit outside the e-Care EPR and these play a pivotal in the delivery of high quality patient care. As the overall aim is to create a single electronic record the Trust will continue to use systems outside of e-Care as we strive to achieve this aim.

Alongside e-Care the Trust also has systems outside the hospital setting, most notable of which is the SystmOne Community System. In parallel the strategy needs to be cognisant of the Buurtzorg Community model that commenced as a pilot in 2017 and will likely need one or more bespoke systems if it is to achieve the clinical maturity seen in Holland.

Notably much work has also been undertaken to share clinical information across the Alliance and wider Health Community using solutions such as the Health Information Exchange for both GP's and local hospitals (Cambridge University Hospital). The on-going development of all these clinical systems and the resultant data sharing forms a key component of this strategy.

However, the strategy also recognises the importance of business and back-office systems that support non-clinical functions. Adoption of national solutions such as the Electronic Staff Record (ESR), on-line learning and range of departmental systems must also be addressed by the strategy. As part of this development a significant investment has already been made in upgrading back-office software including Microsoft Active Directory (AD) and the Trust e-mail solution. This too will continue across the life of the strategy.

Finally, will look to develop the excellent work already undertaken by the IM&T Development Team in building interfaces, automating data flows and creating bespoke applications for use in all areas of the Trust.

MOBILITY

Across the Trust one of the largest areas of growth is and will continue to be the demand to be able to work whilst on the move. Today we will in an "always on" society and expect to be able to access information that supports our daily activities at any time regardless of location. Access to such information not only comes in terms of human demand, but also machine (device) demands most ably demonstrated by the growth in the Internet of things (IOT). Healthcare is a major adopter of IOT with data enabled devices is common use right across the Trust. As a result, three key focus areas for the mobility section of the strategy will be on mobile connectivity, mobile platforms and mobile enabled applications.

However, mobility if not limited to the needs of the Trust as a single entity as often physical locations and clinical/service team are multi-organisational and/or multi-disciplinary. As a result mobility solutions must remain cognisant, in particular as the Trust moves towards becoming an integrated clinical system, and ensure that any proposed strategic solution is able to operate across such boundaries.

INFORMATION

The provision of timely and accurate information is the life blood of any organisation. Therefore, the effective use of information is critical as it:

- Supports clinical decision making
- Measures quality and performance
- Informs effective service planning

However traditional information needs have been changing for some years and to the strategy must address these different facets of information provision. The requirement to provide

mandated national and local report remains an on-going challenge yet is highly regimented in comparison to dynamic dashboards used for operational management and data modelling by way of a business intelligence tool.

The strategy is also cognisant of the role of information in the planned deployment of a population health solution. This is a new challenge for Trust as not only does it combine data from multiple health and social care sources but also from other relevant sources.

The strategy will therefore focus on each of the internal strands separately and envisage an approach that is timely, enabling for informaticians and operationally efficient; whilst proposing an approach that is appropriate to cross organisation needs of the population health solution.

SECURITY

Information Security is an embedded component into every Information Management and Technology operation and project. The strategy therefore must not only continue to address the policy needs and operational controls required to protect Trust IM&T assets; but also the cultural and educational needs of all staff so that everyone is aware the risks.

As part of the NHS GDE programme the Trust is an active member of the NHS Cyber Security programme and is already certified to ISO27001 and Cyber Essentials standards. As part of this strategy the IM&T service will look to build on these security standards, adopt best practise and be recognised as a Trust where security is paramount. Yet the approach taken will focus on optimising IM&T security such that is does not impinge on the delivery of business and clinical services.

PEOPLE

There is little doubt that for the IM&T service our people are our greatest asset and therefore continued investment in the skill, experience and knowledge of our staff is mandated as part of any IM&T strategy. There is, of course, a similar parallel for all WSFT staff who utilise any of our systems and so a training strategy document is also being produced, a copy of which can be found in Appendix E

Outside of education and training the strategy will also address the development of IM&T services. At this time the Trust is undergoing very considerable change, driven by the formation of the new Alliance, integration of CHS and by the NHS GDE programme, all of which are accelerating the delivery timetable for technology enabled change.

Whilst these strategic objectives set the tone for the strategy they are only the headlines. Section 4 that follows takes these strategic objectives and breaks them down into greater detail for each area. However, care has been taken to define these sub-sections as a set of strategic directions as opposed to a detailed roadmap. As noted in the Section2 currently there are some strategic elements where delivery is already known and fully understood, others where delivery is known but only partly understood and finally those where delivery is envisaged but is yet to be defined in any meaningful manner.

4. Strategy

This section breakdown the strategic objectives detailed in section 3 above and provides the specific strategic thinking behind the headlines. For some sub-sections much of the strategic thinking, such as for the e-Care/GDE programme, is already well advanced and so this strategy will be easily recognisable. However, for the remainder the strategic thinking has either not yet started or remains in the early stages of development.

INFRASTRUCTURE

Data Centre

There is a recognised International standard for the construction and provision of services that make up a data centre. Overseen by the Telecommunications Industry Association (TIA) the data centre standards document reference is 942-2. It defines four tiers of data centre with tier 1 being entry level and tier 4 being the most advanced. Appendix A contains a summary definition of each tier and the recommended level for NHS data centre is tier 3.

At this time the Trust has two computer rooms, one located in the main IT room at the rear of the hospital and one located adjacent to Ward G8. Neither of these rooms is fully compliant with the TIA 942-2 standard but practically they are closest to tier 2. In the short term improved power provision needs to be addressed with a replacement uninterruptible power supply (UPS) in each room.

Strategically the provision of both rooms on a single site is non-compliant with British Continuity Institute recommendations as current best practice requires a greater physical separation of the two rooms. Additionally, the room in main IT has limited available space and so little room to grow. Therefore, over the life of this strategy the Trust will need to consider change to this configuration to cater for future growth and improved business continuity.

In considering the data centre strategy the Trust should continue to review options to deliver IT systems as a managed and/or hosted service. Yet at this time the e-Care EPR system is provided as a hosted solution by the Cerner Corporation and it is likely that the new Ophthalmology system (OpenEyes) will also be a hosted solution. Alongside this there are an increasing number of health care applications that are being delivered as a managed service, such as Perfect Ward that is already deployed at WSH.

The Trust also needs to be cognisant of the Government “Cloud First” strategy that looks to drive benefit from cloud computer for all public sector organisations. However, the NHS is already an adopter of cloud services with notable growth with industry leaders such as Amazon and Microsoft. Preparation for cloud is already underway with specific reference to the procurement of the new HSCN wide area network, which includes dedicated cloud service network connections. In all cases the adoption of cloud, hosted or managed services must offer the Trust a combination of value for money, risk reduction and an operating efficiency and be defined in a recognised and approved business case.

As part of the data centre strategy the Trust must also review its existing data backup and archive arrangements. In recent years the Trust growth in data has been running at around 10Tb per annum and in late FY17/18 a new storage solution (SAN) was procured. At this time the Trust has

four separate SAN solutions and whilst plans exist to consolidate these, work is also required to develop the current backup and archive arrangements. As part the Trust needs to look at options to store a real-time copy of its data at a network connected offsite location.

Recommendations

i. In FY18/19 the IM&T service will undertake a review of existing data backup and archive services and develop a business case or work plan to optimise the solution including a real-time copy of the data at a suitable offsite location.

ii. In FY18/19 the IT Department in collaboration with the Estates Department will plan the provision of improved resilient power provision (UPS) to each computer room.

iii. In FY19/20 the Trust conduct an options appraisal on suitable offsite data centres and develop a business case to relocate one of the existing computer rooms to a suitable offsite location.

Digital Communications

One of the strategic keys to the successful delivery of the Trust digital agenda is the provision of high speed digital communications. In summary this comprises three layers of technology, these being the wide area network (WAN), wired local network (LAN) and wireless local network (WLAN).

Wide Area Network

Over the past 20 years the NHS has enjoyed the use of a dedicated WAN linking all manners of healthcare facilities together so that information may be shared, and communication links established. The current version of this network is known as NHS N3 but following further integration with Social Care is now to be replaced with a new Health and Social Care network known as HSCN.

At this time procurement of the new HSCN is being undertaken by the Suffolk and North East Essex STP with Suffolk County Council taking the lead. The procurement is full OJEC and will result in a managed WAN service being delivered across the STP by around September 2018.

In terms of WSFT all Trust locations including as many of the CHS locations are as known have been included in the procurement. Each of the locations has been specified in terms of the capacity and performance of the HSCN connection based upon the number of staff and services provided from the location. This approach will ensure that sufficient bandwidth is available to run such Open Convergence services that might be foreseeable at each location.

In the early stages of the strategy this will be largely voice (see the *Infrastructure* sub-section on Telephony); data and video. The latter will prove important as the Trust seeks to further move traditional acute healthcare services closer to the patient's home and establish deliver of such as a Community Service.

Outside of the new HSCN Service the Trust must continue to invest in WAN services where these offer business benefit and either cannot be delivered over the new HSCN or are provided as a secondary link for resilience. An example of this is the existing link between WSH and Newmarket Community Hospital that will be retained after HSCN goes live.

Finally, in terms of WAN links the strategy needs to be cognisant of the STO agreement to deploy GOVROAM (see the *Infrastructure* sub-section on Wireless Networks) into multi-tenancy locations as this provides connectivity for any health and local authority services across the WAN.

Recommendations

i. Over the next two years the Trust should complete the HSCN procurement and then review WAN requirements following deployment of the new service. Upon completion the IM&T Strategy should be updated to reflect any major changes. Small changes should be managed via the IT Capital Programme or through individual business cases.

ii. The Trust should continue to invest in secondary WAN circuits where these either provide resilience or offer clear benefits to the Trust.

Wired Networks

Diagram 1 below shows all five layers of the that make up an enterprise network. Currently at WSFT there is no Distribution layer (this is defined as a collapsed backbone) and the Data Centre layer is not yet physically separate. The Trust network therefore has a Core layer and an Edge layer with Compliance and Open Converged components and so the strategy will primarily address Core and Edge layers.

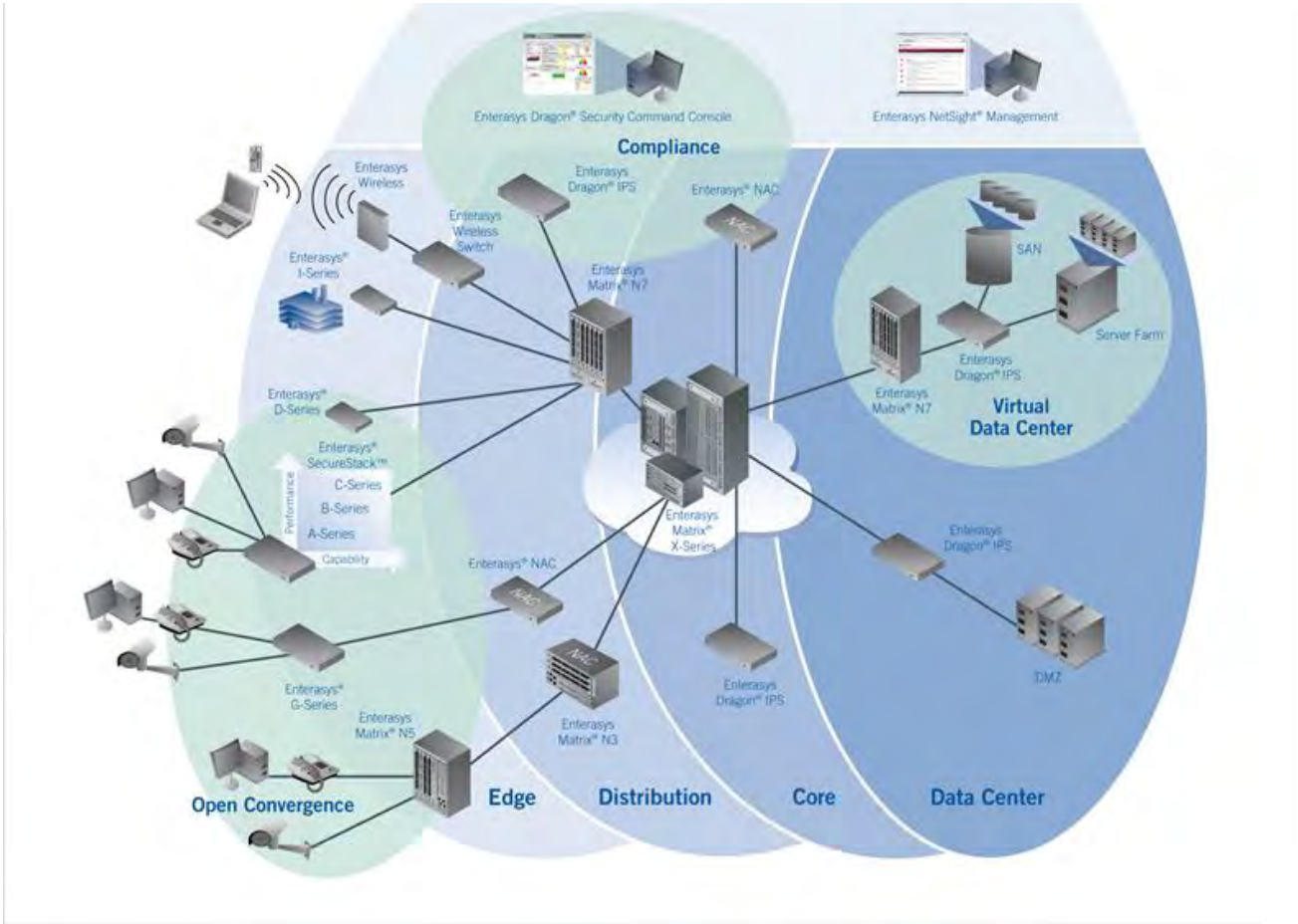


Diagram 1
Picture Courtesy of Enterasys Limited

Switch Fabric

At this time many areas of core IT infrastructure are moving away from being largely hardware based and are becoming software defined. The use of software defined infrastructure provides a significant improvement in switch security, greater flexibility, faster response to requests for change and if driven in part by the emerging trend towards infrastructure itself being provided as a service.

This change of emphasis has seen our primary supplier (Extreme Networks) introduce a new switching technology that uses an approach (known as switch fabric) to facilitate a software defined solution. The major advantage of the fabric is that it consolidates up to eight existing protocols (quality of services, virtualisation, network segregation et al) into a single protocol with all of these functions moved into software. As a result all new switch technology will be based upon switch fabric technology.

West Suffolk Hospital

Core Network

During FY14/15 the Trust invested in two enterprise grade network switches (Extreme S8 models) with one located in each computer room. Each has sufficient capacity to accommodate the strategic developments that are known across the life of the strategy. However by the end of the strategy these switches will be 6 years of age and so are likely to be a first call on the next strategy as items for replacement. It would therefore be prudent to include the replacement programme for the core switches as an integral part of the proposed move to an offsite data centre. This approach would allow the Trust to adopt switch fabric technology as part of the move and so assure future growth in the core for at least a further five years (subject to normal levels of growth). In the meantime, if Core capacity needs to expand due to a change in strategic direction (such as further GDE work) then further investment will be required to accommodate such a requirement.

There is, however a limitation on the core network design that has seen many of the Trust system servers connected directly to the core switches. Whilst this approach provides resilience across the two data centres, it is virtual resilience rather than physical, as if a single core switch was lost, then the direct connections would also be lost. Classic data centre network design resolves this through the installation of aggregation switches. These switches are mounted at the top of the server racks and use fibre optic cabling to connect the aggregation switches back to both core switches. The fibre optic cables are routed over a different physical pathway and so ensure that all Trust servers remain on-line in the event of a single core switch failure.

In addition, the current fibre optic network that links both core nodes together and provides network links to the Edge layer has a finite throughput of 10Gb/s. It is possible to create more bandwidth by bonding multiple 10Gb links together and indeed the Trust already has bonded links across the Core layer. Yet in the life of this strategy new 100Gb/s links will become available and with the current rate of growth the Trust will need to take advantage of this over the next three years.

Fibre optic cabling is also used to link the Edge layer to the core with Edge switches deployed either as single units or in stacks where up to 5 Edge switches may be deployed in areas where device densities are high. At present such high-density areas are fed by 2 x 10Gb links one to the top of the stack and the other to the base. As a result, the fibre optic replacement programme will need to

cover all Core to Edge connections start with those Edge locations that are deemed to be high density.

Edge Network

During FY16/17 the Trust has made significant investment in new Edge network switch technology. All primary Edge switches have been replaced, however a small number of secondary units remain and these will be replaced as they reach obsolescence. It is noted however that the Trust intends to make a significant investment in the wireless network provision and this may require some elements of the Edge network to be further upgraded. If this becomes necessary, any recently replaced Edge switches will be recycled to replace the older secondary units.

Given the recent emergence of switch fabric technology our strategic approach should be to adopt edge switches from the new EXOS range. These units are fully compatible with our existing technology yet include the new switch fabric technology, which can be fully enabled at the point when we migrate to a switch fabric enabled core network.

At this time the copper cabling that links endpoint devices to the Edge layer is predominantly built to the category 5 cabling standard. Most common is the Cat 5E variant that provides a throughput of 1Gb/s and this is widely used across the Trust. More recently category 6 and 7 cabling standards have been released with the Cat 6a variant offering throughput of 10Gb/s. Strategically the Trust will utilise the Cat 6 variant for all new cabling and Cat 6a where the location requires additional bandwidth. There is no immediate need to replace the existing cat 5 cabling, as this can be done on an opportunistic basis as the digital agenda drives technology change across the Trust.

<u>Recommendations</u>

i. The Trust should continue to invest in both the Core and Edge layers of the wired network either via the IT Capital Programme or through individual business cases.

ii. From 1st April 2018, all new network switches will include switch fabric technology to assure future performance, flexibility and security of the Trust digital communications platform.

iii. The IT Department will develop a business case for funding to provide aggregation switches for each computer room, along with a reconfiguration of the core network to assure network resilience. The business case will advise on the need for aggregation switches which are mandated when the Trust relocated an existing computer room to an offsite data centre.

iv. The IT department should development a fibre optic cabling replacement programme designed to deliver 100Gb/s links between the Core switches and into the two computer rooms for server connectivity. Over time programme should also provide 100Gb fibre optic cabling between the Core and Edge layers starting with those Edge layer switches nodes where 100Gb bandwidth would provide clear operational benefit. The Core fibre optic replacement must be complete with the lifetime of this strategy.

v. The IT department should adopt the category 6A copper cabling for new projects that show clear benefit from the additional performance available from CAT6A. In parallel the IT Department will replace existing CAT5E on an opportunistic basis again where the provision of new cabling will provide clear operational benefit.

Community Health Services

At this time all Digital Communications across CHS are provided as a break/fix service by the North East London Community Support Unit (NEL CSU). The contract duration is 5 years and will be 2 years old on 1st April 2018. Following CHS transition, IT staff from East and West Suffolk are busy undertaking a detailed survey of the digital infrastructure deploy across all CHS sites. The provision of a new WAN is covered by the HSCN procurement (although the on-going funding is CHS sites remains to be fully agreed) and whilst all sites have some form of wired network only 3 sites any form of wireless network.

The detailed survey will identify where further investment is required and the strategy needs to be aware of national funding that is being made available to provide wireless networking into all CHS sites. In respect of CHS sites the Trust will need to work closely with other Alliance Partners as some sites are multi-tenancy with GP Fed, SCC and Mental Health staff co-located.

However, there are several short-term changes that will deliver benefit for the nascent combined Trust. At present both networks are separate and there is no route from one to the other. This needs to change such that CHS staff can be given access to Trust systems on the WSH network and vice versa.

Recommendations

i. The Trust should complete the detailed survey of CHS sites and feed the result into an update to the IM&T Strategy. A programme of work to update CHS Digital Communications should following utilising funding from every both national and local sources. If necessary, the Trust should develop a business case for consideration by NHS Digital and/or NHS England to funding the programme as part of the National Digital Programme.

ii. The Trust should engage with NEL CSU to provide network to network access to CHS systems from any WSFT location.

Wireless Networks

West Suffolk Hospital

The current wireless network at WSH provides wireless network services for patients, visitors and staff across all of the WSFT buildings on the WSH site. The wireless network is now legacy but not yet obsolete and there is small number of known ‘holes’ in the network where coverage is poor and/or intermittent.

As part of the NHS GDE Programme the Trust has already procured and installed new WLAN control units and has funding to upgrade the WLAN to the latest standard in two phases of work to follow. In FY18/19 the current network will be uplifted and in FY19/20 it will be extended to cover external spaces to support the increasing demand for mobile working. The new technology includes additional services that improve roaming across the network, security of the network and the detection of other conflicting network services and the provision of a new network protocol that offers faster connectivity and the ability to move greater volumes of data across the wireless network.

As part of the WLAN upgrade the Trust will work with both network and media suppliers create three networks aligned to the new Mobile Phone and Device Policy (2017). The first is a trusted

network for staff using Trust technology and will full access (subject to user authentication) to all Trust services. The second network is more restricted being limited to staff using a non-Trust device or to a guest or visitor using a Trust device. The second network addresses the growing need for secure BYOD access. The final network has no access to Trust resources and is the guest network. As part of the upgrade the IT Department will improve the interface for patients and visitors as whilst the current interface is functional it is not intuitive and this needs to be addressed.

The fully upgraded WLAN at WSH is expected to provide sufficient WLAN capacity for WSH across the life of this strategy.

As noted in the WAN section above the Trust is also working in close co-operation with SCC under the STP umbrella to deploy GOVROAM to Newmarket Community Hospital as part of a wireless roaming pilot. On overview of GOVROAM can be found at:

https://www.youtube.com/watch?v=jPpvagzMFOw&feature=youtu.be

In summary it allows staff from different public sector organisations to securely access a single WLAN in a multi tenancy building and back haul to systems provided by their own organisation. Plans exist to allow GOVROAM to offer authorised access to any system on the WAN and in time the Trust expects to exploit this functionality, however it is currently outside the scope of the STP GOVROAM pilot.

Recommendations

i. In FY18/19 the IT Department in collaboration with Extreme Networks will, as part of a major upgrade, reconfiguration the wireless network and align it to the nascent Mobile Phone and Device Policy as outlined above.

ii. As part of the reconfiguration the IT department will use the new security features to detect other local wireless signals to determine if they are legitimate or require investigation.

iii. As part of the reconfiguration the IT department will reconfigure the guest wireless network to greatly improve enrolment and ease of use.

iv. As part of the reconfiguration the IT department will explore the possibility of enabling video streaming over at least one wireless network including if feasible the guest wireless network.

v. As part of the reconfiguration the IT department will update the wireless network policy to define what is acceptable as a legitimate secondary wireless service and what is not as some may have been present for some time.

vi. Over the lifetime of the strategy the Trust will continue to invest in the wireless network either via the IT Capital Programme or through individual business cases.

vii. Included in the FY18/19 upgrade and any future upgrades of the wireless network will be the provision of GOVROAM to allow authorised service groups access to digital services over the Trust wireless network. Examples of this include staff from Primary Care, Community Health Services, Mental Health, Clinical Commissioning Groups, Local Authority and all blue light services.

Community Health Services

As noted above very few of the current CHS sites have a WLAN and this will need to be addressed. As part of a survey into CHS Digital Communications infrastructure the Trust will shortly be able to determine the technical requirements for WLAN at each site. Once this is known it can be included in a Trust wide investment plan for all CHS sites as detailed above.

The Trust is aware that central funding from NHS England is being made available during FY18/19 for both Community and Secondary care services. It is therefore important that available funding from NHS England be fully utilised to support the adoption of WLAN across CHS. -

The strategic approach will be to deploy wireless using what ever funding can be access across all (or as many as possible) CHS sites built to the GOVROAM standards (outline below). This approach provides assurance that whatever service groups have authorised access to the building, they will be able to access services over the wireless network.

Recommendations

i. The Trust should complete the detailed survey of CHS sites and feed the result into an update to the IM&T Strategy. A programme of work to update CHS Digital Communications should following utilising funding from every both national and local sources. If necessary, the Trust should develop a business case for consideration by NHS Digital and/or NHS England to funding the programme as part of the National Digital Programme.

ii. In FY18/19, the IT Department working in collaboration with CHS submit bids from central funding across both Community and Secondary care to fund the adoption of wireless network across CHS premises. If insufficient funds are received to cover all CHS sites, the management team will agree a priority list of locations.

iii. All CHS wireless deployments will be built to the GOVROAM standards to allow authorised service groups access to digital services over the wireless network.

Remote Access

Whilst the wireless network is one facet of mobile working remote access also has a role to play, in particular for any authorised users who cannot access a suitable network. In FY17/18 the Trust made a significant investment in a new remote access solution. The new solution offers two methods of connection: the first (called VPN) provide an extension of the Trust network to the location the user is connecting from and is ideal for laptop users away from their base. The VPN provides all the same features and access as the use would experience from their own desk.

The second (called remote desktop) will operate in areas where the connecting network only offers modest capacity and/or where patient data needs to be accessed in an open environment, such as a remote CHS or outpatient (OPD) clinic.

Whilst this service is fully operable for WSFT staff whose base is WSH, the remote access solution needs to be extended to facilitate the same remote access options for CHS staff to CHS systems.

Recommendations

i. As part of the wider Mobility programme the Trust should continue to invest to extend the new remote access for wider Trust use via suitable NHS funding streams, the IT Capital Programme or through individual business cases.

Telephony and Paging

West Suffolk Hospital

For many years the Trust all telephone solutions have been analogue and have operated over a separate hard-wired network. As part of the commissioning of Quince House at WSH the Trust has introduced IP Telephony to deliver voice over IP (VoIP) services. The initial investment comprises a Unify Hybrid (IP and Analogue) VoIP switch with a total capacity of 5000 extensions and around 200 IP phones made up of standard and advanced desk handsets, wireless mobile handsets and conference phones. The VoIP package also includes a Unified Communications server and a software phone application that can be deployed on computers, tablets or smart mobile phones.

Recently the Trust has acquired a second smaller Unify VoIP switch with capacity for 1000 users as a fall-back unit to deploy and so provide the necessary resilience to use VoIP for clinical services. As part of this reconfiguration of the Trust will look to reverse role such that the Hybrid VoIP switch takes on the role of primary telephony service allowing the old iSDX analogue switch to become secondary. Once complete it will then be possible to migrate remaining analogue services onto the Hybrid switch and decommission all former analogue services.

Also included in the reconfiguration will be a change to incoming and outgoing telephone line services which at present are analogue and expensive. When the Hybrid VoIP switch takes on the role of primary telephony service it will connect to a new modern digital service (called SIP) and all incoming calls will route in over SIP. A second SIP connection will be made to the fall-back VoIP switch and will (under normal use) provide a route for outbound calls. If either switch fails, the remaining SIP line will be capable of providing both incoming and outgoing calls as part of the disaster recovery (resilience) programme.

In making the change the switchboard operator consoles will also be updated allowing the IT service to decommission the very last Windows XP computers in operation use at WSH. The new consoles integrate via the Unified Communications server with Microsoft Exchange providing the switchboard operators with visibility of staff diaries which will help route calls. This integration also includes access to Microsoft AD and so be default provides an electronic staff telephone directory that can be published on the Trust intranet.

Once deployed the Unified Communications server also provides video and voice conferencing functionality (akin to Cisco WebEx) with up to five concurrent conferencing running at any one time with a maximum of 250 users per conference. This has extended value when deployed across audio visual enabled meeting rooms such as those in Quince House.

Use of the Unify software phone application in combination with the Unified Communications server will allow authorised users to deploy a Trust telephone on a computers, tablets or smart mobile phone of their choice. In the case of the former this will allow staff to take their work extension offsite with them and is particularly useful for staff working away from site. The latter allow staff to carry a single device (smartphone) and yet receive calls as if they were at their desk

and is particularly useful for staff who are on-call. The software phone allows users to direct calls to differing locations based either upon their exchange diary or through choices made by the individual.

Recommendations

i. Complete the build and deployment of the Unified Communications server and test the conference functions across Trust meeting rooms.

ii. Finalise the acquisition, installation and deployment of the second Unify VoIP switch and test its operational functionality.

iii. Order and deploy two disparately route SIP trunks and connect one to each Unify VoIP switch.

iv. Revise the configuration of telephony service so that the Hybrid VoIP switch takes on the role of primary telephony service.

v. Link primary and secondary VoIP switches and associated SIP Trunk connection into a configuration that provides a fall over capability (disaster recovery) in the event of a local incident.

vi. Procure, install and commission new switchboard operator consoles, ensure that they are fully integrated with existing 3rd party services (e.g. Trust paging solution)

vii. Configure the Unified Communications server to provide access for switchboard operators to Microsoft Exchange and enable staff diary visibility.

viii. Configure the Unified Communications server to integrate with Microsoft AD and so enable an electronic staff telephone directory to be created. Made said directory available to switchboard staff on operator consoles and to all staff via the Trust intranet.

viii. Pilot the use of the software telephone application with both operational and clinical staff. Generate a benefits appraisal and based upon the appraisal create policy and standard operating procedures for software phone users.

iv. Migrate all remaining analogue lines away from the existing iSDX switch and on to the Unify Hybrid VoIP switch. Decommission all analogues lines and services that are no longer required or in use.

Community Health Services

The Trust is aware that some CHS locations already have IP Telephony and VoIP deployed; for example, Newmarket Community Hospital. As part of a survey into CHS Digital Communications infrastructure the Trust will shortly be able to determine where such technology exists and from this data agree a strategy to exploit it.

At the heart of this strategy needs to be an approach to use the nascent HSCN network and other appropriate WAN links to interconnect as many CHS locations that have IP Telephony and VoIP deployed. The primary objective will be to enable 'on-net' calls and so reduce the use of the Public Switched Telephone Network (PSTN) and the associated telephone bills.

Where viable the strategy needs to identify where switchboard services can be consolidated, operational costs reduced, and the level of available services enhanced. It is noted that some negotiation may be required with Alliance partners to transfer any service components currently provided by NEL CSU and that capital investment may also be required.

Recommendations

i. Upon receipt of the CHS Digital Communications survey data the IT department will work with the Trust Facilities team to formulate a strategy to integrate existing IP Telephony and VoIP solutions into a seamless Trust wide service.

ii. The Trust will need to engage NEL CSU to provide network to network links to enable the proposed IP Telephony and VoIP integration.

iii. As switchboard staff are managed by the Facilities team any proposed changes to switchboard operations will be fully reviewed with those responsible for the switchboard service.

Paging Services

The strategy needs to consider paging services from two differing perspectives. The first is the continued use of medium range radio pagers predominately at WSH and the second the use of long range pagers right across WSFT. Whilst the former is an aging technology it remains supported and operates at a modest cost; the latter is a commercial service that is dwindling as traditional service provides switch to mobile telephone (GSM/3G/4G) cellular services. Indeed, at the time of this strategy the incumbent supplier of long range paging services for the Trust has given notice that it plans to cease providing services from June 2018. Whilst it would be easy simply to look to migrate long range paging services to cellular provision, the level of cellular signal coverage in Suffolk is highly variable and there are many known dead spots within the Trust boundaries.

The strategy is also cognisant of the 'Medic Bleep' pilot that was held at the Trust in October 2017 and was well received by all the clinical team involved. Although 'Medic Bleep' still requires considerable development it would be a quantum change to clinical communications and if the necessary investment is available it is likely that 'Medic Bleep' would make an excellent replacement for non-critical alerting both for the radio pagers at WSH and for the long-range pagers in use across WSFT.

Recommendations

i. Review the use of clinical communications solutions such as 'Medic Bleep' as a long terms replacement for non-critical alerting both at WSH and across the wider WSFT.

ii. Engage with remaining traditional radio pager service provides for critical alerts and determine if any change is required across the life of this strategy

iii. Review the use of long range pagers, working with clinical service managers and solution providers to determine the levels of risk in migrating to a cellular based service.

Endpoint Technology

Endpoint technology is defined as any user interface device used to deliver Trust services and in general this includes personal computers, (desktop and laptop), tablets and smartphones. Currently the predominant endpoints in use at the Trust are desktop personal computers with around 2460 deployed across the Trust. A little over 220 workstations on wheels (WOW) are also in use today and when Phase 3 of the e-Care programme goes live this number will increase further. The Trust also has some 300 laptop computers in use all running a Microsoft Windows operating system (OS), the majority of which (circa 2100) use Windows 7. The Trust also has close to 500 tablet and smartphones deployed almost all of which use Apple iOS with the majority being iPhones.

The industry standard for Microsoft OS devices is now Windows 10 and currently the Trust has only a tiny handful of Windows 10 machines and does not yet have an agreed enterprise level build for Windows 10. This is due to a few security issues with data protection software (DLP) and the notable change at Microsoft from a buy and utilise licensing model to an annual payment (subscription) model. Issues with the Office suite software deployed on these endpoints is reviewed below and with security in the *Security* section of this Strategy. There are also significant issues with the browsers in use today which need to be addressed before migration to Windows 10 can commence. The official end of life date for Windows 7 was July 2015 with extended support to July 2020. This would suggest that the Trust only has 2 more years to migrate but in reality; Windows 7 is so widely deployed across every industry worldwide that Microsoft are already discussing extending the final support date. However, there will be an end date and so the strategy must address our path to reach Windows 10.

The use of Apple iOS devices is also growing with some 150 iPod Touch units deployed as part of the new Patient Flow module and a further 100 iOS devices expected to go live in 2018 with Power Chart Touch. Internally the Trust also uses iOS devices for Clinical Photography having developed the application software in house, as a mobile platform for Directors and Senior Manager and for Perfect Ward a nurse audit tool that is delivered as a managed service. For endpoints Apple iOS is clearly the platform of choice for tablet and hand-held devices and so this strategy seeks to build out on that position.

In order that we the strategy is able to address the browser issues it is necessary to understand the constraints that have precluded a move to later versions of browser software. In January 2017 a stock take report covering all things IT was prepared. At the time the Trust used Microsoft Active Directory (AD) version 2003 which was three releases behind the latest version (2008, 2012 and 2016 were all in service). The primary reason for continued use of the obsolete version of AD were the continued use of numerous Windows 2003 servers running back-office and clinical applications (including Operating Theatres, Electronic Document Management and ICE Order Communications). These applications are old versions and therefore only certified against older browser software. Therefore, during FY17/18 considerable investment has been made and recently the Trust has upgraded AD to the 2008 version. All back-office Windows 2003 servers have been upgraded or replaced and work is now in progress to upgrade the two of the three clinical applications (EMR and ICE) and migrate the third to e-Care. This work takes time and so the strategy is reflective of the journey the Trust is on. Finally, during FY18/19 all back-office applications are expect to be upgraded to 2016 or 2017 released enabling the MS AD to be uplift to at least the 2012 version.

For tablet and smartphone devices work is also required to upgrade the current Mobile Device Management software (Good for Enterprise [GFE]) and replace it with an Enterprise Mobility Suite (EMS). The security of data on NHS mobile devices is taken seriously with data encryption and device protection specified by NHS Digital. In FY17/18 the Trust procured the Blackberry EMS and work is now underway to configure and test it. Once done this all existing GFE devices must be upgraded and Blackberry EMS installed.

Rolling Replacement

The strategy is cognisant of the major investment in endpoint technology made since 2015; initially as part of the original e-Care programme and more recently as part of the NHS GDE programme. As noted above this has seen the number of endpoint device growth substantially which creates an increasing cost pressure for the Trust. Small endpoint devices typically have a lifecycle of around 3 years, whilst for larger units the lifecycle extends up to 5 years.

In the past the Trust has been able to extend the life of endpoint technology by accepting lower performance and/or more frequent repair intervals over an increased lifecycle as little of the endpoint technology was truly front line. However, by the end of FY18/19 the Trust will have over £1M worth of endpoint technology (such as ward based workstation on wheels) in everyday front-line use.

As a result, this strategy must address the need for a rolling replacement programme, if the benefits of the NHS GDE investment is to be fully realised.

Recommendations

i. Complete the update of the data protection software (DLP) to the latest version.

ii. Migrate the Operating Theatre back end to a Windows 2008 server platform (ahead of migration to e-Care)

iii. Replace the remaining Windows XP computers in the Operating Theatres with Windows 7 technology (using hardware that can run Windows 10)

iv. Upgrade the Kainos Evolve EMR to the latest release and use Windows 2012 servers as the back end platform.

v. Install, configure and test new Blackberry Enterprise Mobility Suite. Recall all mobile devices running GFE and replace with EMS. Integrate EMS into iOS Gold build.

NOTE Recommendations vi. to xxii. also apply in full to Community Health Services

vi. Work with NEEPS Pathology Service to upgrade ICE OCS to latest version

vii. Install Internet Explorer 11 for PC test group and test core business and clinical applications

viii. Build, test and review Windows 10 Enterprise build – agree Gold standard

ix. Deploy Windows 10 to PC test group and test core business and clinical applications

x. Specify Windows 10 as default operating system for all new Microsoft OS computers

xi. Work with specialist Apple supplier to build, test and review secure iOS Gold standard build

xii. Agree a suitable approach to funding endpoint technology replacement to sustain the Trust digital agenda.

Office Suite

As noted in the *INFRASTRUCTURE* section 2017 has seen initiated significant change in many of the back-office systems. Most notable of these has been the upgrade of the Microsoft Exchange E-Mail platform from the 2003 release to the 2016 release and the upgrade of Microsoft SQL server from the 2005 release to the 2017 release. In turn these back-office changes now enable the Trust to move forward not only with Windows 10 as the base operating system (see the *Infrastructure* sub-section on Endpoint technology) but also to consider the future direction of Microsoft Office and other desktop applications.

On January 29th 2013 Microsoft launched a new version of its Office suite called Office 365. Unlike all previous versions of the Office suite, 365 is licensed on an annual subscription basis rather than a perpetual (buy one and use) model. There are now several variants of Office 365 each of which offer a different level of functionality. Office 365 E3 is the variant most closely matched to the functionality of Office 2010 currently use right across WSFT.

However, the unit cost of Office 365 E3 to NHS Trusts is around £180 per user per annum and this represents a 25% discount when compared to the Enterprise list price. Of note the subscription model is licensed on a per user basis rather than a per device basis. As a result, this licensing model has been a notable issue for all NHS Trust and for WSFT equates to an annual cost of around £630,000. In the short to medium term this makes Office 365 E3 unaffordable and so a different approach is required.

As part of the Microsoft Enterprise Agreement that WSFT signed in December 2016, the Trust was required to take 500 Microsoft Office 365 licenses and so has a mix of K1, E1 and E3 variants. The K1 variants will be used for staff using a Kiosk device (such as the Porters and Housekeepers on Patient Flow) as this will provide a suitable client to Microsoft Exchange allowing access to e-mail, calendars et al. The E1 variants will be used for fixed Office staff and are suitable for users across HR, Finance, Estates, Procurement, Catering et al. but require an Internet connection to authenticate. The E3 variants will be used for Directors (both Exec and Clinical), Consultants, GM and Senior Managers on the move as E3 allows each user to have up to five instances installed; one each on a PC, Laptop, Tablet, Smartphone et al. Whilst the minimum subscription is 500 units the balance across the variants can be adjusted.

For all other users the proposed approach will be license an enterprise copy of MS Office 2019 using a perpetual license with an end of life date in 2027. It is understood that Microsoft plans to withdraw perpetual licensing for the Office Suite in 2020 and so the Trust will need to plan for a revenue based model going forward. It is also understood that NHS Digital are deep in conversation with Microsoft around the impact of the revenue licensing model and it is hoped that this will result in a substantial reduction in unit cost.

Outside of the licensing issues with the Office Suite, the only other issue that concerns desktop application software is Voice Recognition that is also reviewed below.

Recommendations

i. Following the successful build of a Windows 10 Enterprise computer install and test Microsoft Office 365 E1 and E3 variants. When complete generate Gold standard build images, one for each variant.

ii. Install and test Microsoft Office 365 K1 variant on a full-size tablet, iPod and Smartphone. When complete generate Gold standard build images for each device type.

iii. Download, install and test Microsoft Office suite 2019 on PC's running both Windows 10 and Windows 7. When complete update existing Gold standard build images for each OS.

iv. Procure perpetual license for an Enterprise copy of Microsoft Office suite 2019. Generate a deployment plan and manage rollout of new Office suite to all users.

v. Work with NEL CSU to agree a deployment plan for all CHS users.

vi. Agree with NEL CSU how access to WSFT back-office services can be provided for all CHS staff.

Printing

A sizeable majority of Trust computer printing continues to be undertaken using small deskside printers. Whilst the purchase of these units is often low, the cost per copy is high and the maximum throughput is frequently less than required. These factors equate to low value for money (in terms of cost per page), with toner cartridges being changed frequently and many wasted IT Helpdesk calls, particularly as units age. In 2016 the Facilities team ran a successful project to replace deskside (local) printing by placing Multi-Function Devices (MFD) in strategic locations. The MFD is a networked combined scanner, photocopier and printing device that included secure access controlled by the users Trust ID badge where users can collect their print jobs from any MFD across the Trust.

The pilot also separated access to black and white (B&W) printing from access to colour printing, by setting the default to B&W so that the more expensive colour printing had to be selected by choice. The pilot demonstrated that up to 20% of all print job send to the MFD were never collected and that the use of colour printing fell by almost 40%. However, the pilot is now complete and yet many unnecessary deskside printers remain.

It is also of note is that under the current MFD contract waste MFD products are disposed of in line with WEEE regulations at no additional cost. All other Trust printer waste products (also compliant with WEEE regulations) are handled under the Trust waste disposal contract but at a cost to the Trust.

Recommendations

i. The IT department in collaboration with Facilities and Finance will review the annual cost of deskside printing and undertake an appraisal of printing costs for a range of use cases. This review to include details of any cost saving arising from changes to the waste disposal process.

ii. Based upon the output of (i) above the Trust should generate a policy that mandates the use of MFD units except for a specific list of exceptions.

iii. The IT department in collaboration with Finance should migrate the funding for toner cartridges (held by IT) into a revenue funding stream for managed MFD devices.

Voice Recognition

The maturity of voice recognition (VR) has now advanced to a position where it can be used seriously to created digital patient notes and correspondence in real-time. This contrasts with the current use of digital dictation, which whilst still a useful technology requires a transcription service to translate the dictated material into the final output. The Trust is aware of the efficiencies that can be generated by a migration from digital dictation to voice recognition, particularly if the latter is combined with suitable hand-held endpoint technology, such as a smartphone or small format tablet.

In parallel with the advances in voice recognition, clinical systems software suppliers are becoming cognisant of the advantages as a means of data entry. This has seen some early adoption of VR integration including some base work undertaken by the Trust EPR vendor Cerner. Strategically the Trust will explore this technology and seek to exploit the benefits offered.

Recommendations

i. Over the life time of the strategy the Trust will explore voice recognition and seek to maximise the benefits that it offers.

Management Platforms

2017 has seen the IT department install and implement a considerable quantity of new hardware and software solutions and this will continue in 2018 as part of the NHS GDE programme. In line with IT industry trends a much of this new technology is 'software defined' and so the ability to create warnings and alert to aid pro-active management has greatly increased. In the short term the focus has been on getting the technology installed and into operational use with the management side being a secondary consideration.

However, the complexities of what has been installed and what is yet to come in 2018 means that time and effort will be required to configure all the new technology to deliver such warnings and alerts. In addition, rules will need to be created to filter the new warnings and alerts into those that are routine and so can be picked up through the daily review process and those that are urgent and should be notified in real-time.

Finally, the current approach is to operate a range of individual management platforms that provide monitoring and management for the specific technologies to which they relate. Whilst this approach is acceptable in the short to medium term it is almost impossible to get a high-level view of the health of IT infrastructure and so for IT managers to be aware of high impact issue in context. Yet there are 3rd party management platforms that can receive real-time performance data and presenting it as a graphical representation. They include colour coded graphics using amber for warning and red for alerting with drill down function to allow IT managers to see exactly where the issues lie. This approach is widely used across the industry and allows the IT department to take a far more pro-active approach to infrastructure service management.

Recommendations

i. Continue to deliver new operational infrastructure during 2018 as part of the NHS GDE programme.

ii. Update IT department standard operating procedures in respect of the daily review of warnings and alerts such that these are recorded, assigned to an individual or team and monitored in terms of progress to resolution.

iii. As new infrastructure transitions into operational use, review the range of warnings and alerts available, creating filters to classify them as routine or urgent. Where a warning or alert is urgent configure the management platform to relay it to the agreed destination in real-time so that IT staff can intervene and resolve the problem.

iv. In FY20/21 review the market for suitable enterprise level management platforms. Generate an options appraisal and business case to procure, installed and commission the platform such that the IT department can take a far more pro-active approach to infrastructure and service management.

SYSTEMS

Clinical Systems (Acute)

In terms of acute Clinical Systems, the Trust strategy is to utilise the Cerner Millennium electronic patient record system known locally as e-Care to address as many clinical services as is practical, affordable and operational expedient. As noted in Section 3 to date the Trust has delivered 11 modules from the e-Care suite and has immediate plans to deliver a further 8 modules in 2018. The strategy is cognisant that two the modules in Phase 3 are focused on Population Health and so more about the engagement of the Trust with the wider Health Community.

The delivery of the original e-Care project was always ambitious and the award of NHS GDE status to the Trust has seen this rate of change increase. As a result, the Trust has agreed to initiate a programme of workflow review and process optimisation as part of the 2018 programme. Yet the challenges of successfully operating a tightly coupled and highly complex clinical EPR, such as e-Care means that strategically the optimisation programme needs to be on-going and aligned to the life of the EPR solution.

Whilst e-Care is primary solution for clinical systems software modules do not exist for every clinical speciality and as noted above there are some where the available e-Care module is not practical, affordable and/or operational expedient. In such circumstances it is necessary to select a solution that best delivers the clinical needs of the Trust. However, this cannot be the only driver as modern day clinical systems must also include software event triggers to allow data to be sent or receive via standard based interfaces or an open API when key activities occur. Additionally, such systems must also be open for data extraction into 3rd party solutions to support data stratification, reporting and research. This approach will ensure that any clinical systems outside e-Care can, for example, exchange data freely with e-Care, Population Health and the Information Management team Enterprise Data Warehouse.

Prior to e-Care the Trust had a 'best of breed' approach to clinical systems which often resulted in the systems administrator being a member of staff within the department or specialty delivering the clinical service. However, e-Care is a single integrated electronic patient record system and as such all the systems administration is therefore centralised. As noted above the growth of e-Care has been rapid and new modules have been deployed the existing application support team has been able to absorb the additional workload. However, going forward, the application support team will need to expand to manage the increased workload and continue to provide subject matter expertise across the range of e-Care modules.

Recommendations

i. Deliver e-Care Phase 3 during 2018 as part of the NHS GDE programme.

ii. Establish a suitable workflow review and process optimisation team whose remit is to work closely with system users, subject matter experts and Cerner to address issues with the existing workflow, identify waste and inconsistency in current processes and constraints within e-Care and so create an improved approach as part of an agreed package of change.

iii. Upon completion of the NHS GDE Programme re-visit the clinical systems roadmap and the availability of Trust funding to determine what can be included for FY19/20 and FY20/21.

iv. Regularly review the capacity and skill mix of the e-Care application support team to ensure that it has sufficient capacity and knowledge to support e-Care going forward.

Clinical Systems (Community)

In terms of CHS Clinical Systems, the Trust strategy in the short to medium term is to utilise the TPP SystmOne (S1) solution to underpin the delivery of CHS. However, the level of expert resource currently available to CHS users is inadequate. There is no System Manager, whose role would be to provide a local level of expertise on S1 akin to the Integration Architect that the Trust has for e-Care. There is limited user training available with the only training resource (2 x 0.5 WTE) being based in the East and currently there is no Super User Programme. There is no data warehouse capability within S1 and at present external reporting is limited to a series of data extracts that are then manipulated manually for complex reporting.

At this time there is no integration between S1 and e-Care, although the Trust is aware that TPP and already engaged with Cerner UK and are working to improve integration. This is strategically important as a cornerstone of the Trust strategy is to fully integrate CHS and acute services and so provide the patient with a seamless clinical journey. On this basis the Trust needs to understand the proposed development roadmap and what level of linkage will be possible to e-Care moving forward. For clarity it is not believed at this time that Cerner (who supply e-Care) have any plans to develop modules for use in the CHS space. However should this change this approach will need to be revisited.

As with acute care there will be some CHS needs that cannot be met by SystmOne or where the SystmOne module is not practical, affordable and/or operational expedient. In such circumstances the same rules as outlined above will apply.

Recommendations

i. Through the Community Information Management and Technology Group continue to engage with CHS stakeholders to determine clinical requirements as part of a CHS clinical roadmap. Periodically update the IMT Strategy to reflect changes emerging as part of this roadmap.

ii. Meet with TPP SystmOne to understand existing functionality and development roadmap. Identify how the SystmOne and e-Care can be better integrated to sustain the delivery of clinical services.

iii. Generate a CHS clinical roadmap and map against the acute clinical roadmap. Identify when and how the two roadmaps can converge and what opportunities for service improvement that will enable.

iv. Agree the appointment of an expert level S1 system manager to exploit the capabilities of S1 and drive integration between acute and CHS services.

v. Agree the appointment of an additional full-time post into the Trust IT Training team. Uplift the training skills of multiple members of the training team to be able to deliver S1 user training

vi. Agree a training programme for selected CHS staff to attain super user status and be able to support existing and new staff in the better use of S1

vii. As part of the Information Agenda (see the *Information* section) include CHS in the development of a Trust/Alliance/System wide Enterprise Data Warehouse.

Image Management

Over the past 12 months there has been considerable debate on how best to manage images, particularly those that need to form part of the e-Care patient record. At the head of this debate has been Cardiology and the potential for the Trust to adopt the e-Care Cardiology module. The quotation received from Cerner in September 2017 put this option in the unaffordable category and so an alternative solution is required.

During 2017 the Radiology department has been renewing its contract with Agfa for the Picture Archive and Communications System (PACS) and being aware of the issues with imaging it was agreed to take a new solution of Agfa. The new contract therefore provides the Agfa Enterprise Image Archive (EIA) which is designed and built as a vendor neutral archive (VNA). This means that it can store a wide range of image types including radiology, cardiology, ophthalmology, digital pathology and patient photography to name but a few. The EIA comes with a suite of tools for image management, supports XDS and XDSi (which are the standard for image exchange) and the solution include a full content management wrapper which allows meta-data to be embedded as part of the image and to be searchable thereafter.

Of note the new EIA also comes with a zero-footprint viewer which will enable direct access to images from a wide range of tablet and mobile devices with minimal network requirements. This is key as it will allow authorised clinicians to access non-diagnostic images from any location with a modest internet signal. It is also possible to access diagnostic images subject to security approved and sufficient network bandwidth.

As part of the recent review for patient photography the Agfa EIA, when it comes on line will store patient photographs and has also been agreed (in principal) as the preferred store for cardiology and ophthalmology images when the new systems go-live in 2018.

Finally, the EIA is the platform upon which Agfa are developing their scanning software that uses artificial intelligence to interpret patient images and propose a diagnosis. As an early adopter of this technology Agfa have already expressed a willingness to work with WSFT to optimise the delivery of clinical images into e-Care.

Recommendations

i. The Agfa Enterprise Image Archive be adopted as the primary clinical image store across the Trust.

ii. The IT development team work closely with both Agfa and Cerner to link the electronic patient record to the associated patient images held in EIA, making access from within e-Care as seamless and context enabled as possible. As a second phase of this recommendation access to images (both ways) from other local HSCN organisations (e.g. CUH) should also be explored.

iii. IT and Radiology collaborate to combine the new remote access solution, voice recognition and the toolset within EIA to allow Radiologists to remotely access images from any suitable location; particularly from home to facilitate remote radiological image reporting.

iv. The Trust and Agfa collaborate on the use of artificial intelligence to interpret patient images and propose a diagnosis to optimise the work flow initially within radiology and if successful across other image modalities within the Trust.

Business Systems

Procurement

At this time the Procurement Team operates a mix of systems covering e-Catalogue, Procurement and Stock Management. The level of integration across the systems is inadequate and where data does transfer the process of often manual. As a result there is a clear need to link procurement to the Trust financial ledger to enable commitment accounting and also to the JAC Pharmacy system provide real-time reporting of drugs and medicine orders.

In 2012 the National Information Board proposed the use of GS1 barcoding to improve the safe delivery of patient medication and improve the management of logistics and procurement. Whilst several of the Trust's key systems support the GS1 standard, to date little progress has been made around the live adoption of this standard. Of particular note is the use of prosthetics with an annual value of £4M, where the use of barcoding will improve the ordering, receipting and management of this high value work stream.

Recommendations

i. In FY18/19 the Procurement team will undertake a trail of the Integra procurement solution (which is integrated into the ledger) as a replacement for the existing Powergate solution.

ii. In FY19/20 the Procurement team in collaboration with the Trust Executive Group will draw up a plan for GS1. This will include an initial proof of concept (likely to be Prosthetics), followed by a rollout programme across the Trust.

iii. In FY19/20 the Procurement team in collaboration with the IM&T department and systems suppliers' will draw up plans for system integration and obtain costs for each of the proposed system interfaces.

iv. In FY20/21, subject to funding, the IM&T department in collaboration with the systems suppliers' and the Procurement team will deliver some or all system interfaces outlined in iii above.

Estates

Estate Management

Estates Management operates the Estates/FM helpdesk and provides all of the estate management services. This is a mix of planned work including routine maintenance and reactive work usually following a request being logged on the helpdesk. The helpdesk system is now a legacy solution that has limited downstream supplier management, no integration capability and limited reporting tools.

The planned work is managed by the IFM solution which is now an obsolete system that needs to be replaced. It lacks the ability to record all of the required data for planned maintenance, cannot operate in real-time and does not support the use of mobile devices.

Estates Management also includes equipment management including clinical equipment that comes under the electro-bio mechanical engineering (EBME) team. Whilst the Trust has an

inventory of all current equipment, there is little information regarding the location of the equipment that is notably acute for equipment that is mobile. The EBME also operate a helpdesk that manages requests for equipment or takes calls about equipment that has is faulty or has failed.

Facilities

The Facilities team manages support services including Housekeeping, Portering, Catering and Switchboard. The Facilities team also operates a helpdesk that picks up requests for housekeeping and portering services. Whilst the functionality is operable the solution is fairly basic. In addition, some of the work traditionally undertaken via the helpdesk now arises from the e-Care EPR solution for both housekeeping and porters. However, the e-Care solution currently only operates at WSH and there is clear benefit to deploy it to Newmarket Hospital. Housekeeping also operates a standalone stock control system that manages cleaning products and materials. Of note the Trust is working with Cerner to develop the e-Care Materials Management module for use in the UK. This module has functionality that may offer an improved solution once it is operational for not only its target location (Theatres) but also for Facilities.

The catering team operates a solution called Menu Mark that manages catering stock and generates orders. Whilst Menu Mark has good catering functionality, reporting is limited and it is not integrated with the Powergate. As a result, data has to be printed out of Menu Mark and manually re-entered into Powergate which is very time consuming.

As noted in the Infrastructure section the Trust strategic position on telephony is to move towards a Voice over IP solution. As part of this section the strategy recognises the recommendations made within the Infrastructure section and endorses them in respect of the switchboard service.

Finally, Facilities also manage the Multi-Function Device (MFD) contract and as with switchboard this section the strategy recognises the recommendations made within the Printing section and endorses them in respect of the MFD contract.

Estate Development

Estates Development manages the on-going Estates development of all Trust sites. Each year they deliver a substantial programme of capital works ranging from simple replacements through to full scale building projects. They work with many detailed scale drawings, complex tender documents and technical specifications as well as managing on site contactors who help to deliver the annual programme. As a result the ability to securely share documentation with authorised suppliers and view drawings and specifications across the site are key components of daily life.

Alongside this the Estates Development team manage the Trust Sterile Services Department (SSD) who sterilise a wide range of medical and surgical instruments, so they are safe for patient use. The Trust benefits from a brand new SSD house on the ground floor of Quince House. The inclusion of Theatres and Anaesthetics as e-care modules in Phase 3 presents an opportunity to improve the identification of instruments and the tracking of theatre instrument trays.

<u>Recommendations</u>

i. In FY18/19 the IT Department in collaboration with Estates Management and Facilities will draw up a specification for an integrated generic helpdesk solution that meets the needs of IT, Facilities Housekeeping, Estates Management FM and the EBME department. Aided by the Trust Procurement team the specification will be market tested to determine whether or not a single helpdesk product could be shared across two or more client groups.

The assumption is that this will save money and allow staff working in one client group to provide cover to any other client group. If the outcome of the review is positive the inclusive client groups will work together to create a business case for Executive review.

ii. In FY18/19 the Estates Management team with support from the IT Department will draw up a specification for a new planned maintenance solution to replace IFM. The specification will address the current shortfall issues detailed above. Aided by the Trust Procurement team the specification will be market tested And the results fed into a business case for Executive review.

iii. In FY19/20 building on the FY18/19 upgrade to the Trust wireless network, the Estates Management team will investigate the use of Radio Frequency Identification (RFID) to track both high value and high volume assets and generate a report for Executive review. If the outcome is favourable the review will feed into a business case for Executive review and funding.

The strategy is cognisant of the Materials Management modules proposed as part of Phase 3 of the GDE e-Care Programme and RFID capabilities of the e-Care Care Aware solution. The functionality of both will be included in the review.

iv. Upon the completion of the GOVROAM wireless service at Newmarket General Hospital (NGH), the facilities team working in collaboration with the e-Care team will review what is required to rollout the Care Aware package for Housekeepers and Porters to Newmarket Hospital over the nascent wireless network.

v. In FY19/20, following the consolidation of Procurement Systems, the Facilities team working in collaboration with the IT Department will review the options for an interface between Menu Mark and the designated procurement solution (e.g. Integra). An options appraisal paper will be generated for Executive review. If the outcome is favourable the review will feed into a business case for Executive review and funding.

vi. In FY18/19 the Estates Development team with support from the IT Department to test the ability to access detailed scale drawings, complex tender documents and technical specifications over the new wireless network using one or more suitable tablets and/or computers. In FY18/19 this will be within WSH and NGH buildings only but as Trust wireless networks extend this will include outside spaces at WSH and multiple sites across CHS.

vii. In FY19/20 building on iii above Estates Development team will review options to trace individual medical and surgical instruments as they move around the Trust. An options appraisal paper will be generated for Executive review. If the outcome is favourable the review will feed into a business case for Executive review and funding.

Finance

The Finance Department has good IT systems that provide the full range of services required to operate financial services. The payroll service is outsourced to a company called SERCO and the service meets the requirements drawn up the Trust. However, there have been issues with the speed of the wide area network connection required to reach the Integra Finance systems. Currently the Trust operates two NHS N3 connections, each of which is now at full capacity and so at peek times access to the ledger can be slow.

In addition a lack of integration between the Trust procurement system (POWERGATE) and the general ledger means that data must either be transferred manually or re-entered. This requirement was also identified in the Procurement section of this strategy above.

Following the addition of Community Health Services (CHS) to the Trust both hospital and CHS procurement goes through POWERGATE but at this time CHS staff do not have access that would allow goods to be receipted from CHS locations.

Recommendations

i. As an immediate action the IT Department will connect with the NHS N3 team and seek to increase the capacity of the primary link, such that access to all NHS hosted solution is not impacted by peek time Internet traffic.

ii. As noted above in FY18/19 the Finance team in collaboration with the Procurement team will undertake a trail of the Integra procurement solution (which is integrated into the ledger) as a replacement for the existing Powergate solution.

ii. In FY18/19 the IT Department will open up access to the Powergate procurement system from all CHS locations.

Human Resources

At this time stakeholder engagement with HR remains work in progress.

Interoperability

Interoperability is a key component the NHS National Information Board strategy and so very relevant to the Trust IM&T strategy also. As already noted in the sub-sections above WSFT needs to improve interoperability between e-Care, EMIS and SystmOne as clinical service become ever more integrated and between e-Care the Agfa EIA for image management. Specific work is required to drive improvements for the management of frailty, stroke and diabetes services all of which are delivered at both WSH and by CHS.

The need for systems integration also applied to the new clinical systems such as Ophthalmology, Endoscopy and Cardiology each of which needs to link seamlessly with e-Care. System interface will also need to be updated as the Agfa EIA replaces the PACS and images are migrated into the new archive. As part of the 2018 GDE programme (e-Care Phase 3) the Trust will develop an interface between e-Care and the Pharmacy back end system (JAC) to automate updates to pharmacy stock and release pharmacist time. Indeed, the use of data integration and system interfaces to automate routine test is also key interoperability theme for this IM&T strategy.

The current standard for many of these system interfaces is to use Health Language version 7 (HL7) often in combination with XML for textual data. Whilst each of the standards remain valid the Trust has been nominated by NHS Digital to lead on the development of an updated electronic discharge feed and new clinic letter to the EMIS GP system using the new Fast Healthcare Interoperability Resources software tools.

The Trust will also explore ways to improve access to clinical data, particularly e-Care data, using data extraction, translate and load (ETL) tools to feed an updated Information Management data

warehouse. Alongside this raw data from e-Care will be processed using the ETL tools and to create a data lake as part of new business intelligence stack. Over the life of the strategy the data lake will be expanded in include all available clinical data.

Working with other Cerner sites nationally the Trust is leading to define data management and coding standards for the Cerner mPages development platform. This approach will ensure that UK Cerner sites create and manage mPages in such a way as to allow mPages created on any UK site operate on any other.

As noted in the *Infrastructure* sub-section on Management Platforms work is in progress to better manage technology generated warnings and alerts. As noted above data integration and systems interfaces are critical to the day to day delivery of patient care. Over the life of this strategy the IT department will generate improved warnings and alert for data integration services and the systems interface. The start point will be a set of benchmarks that set the expected level of performance along with interval test to ensure that services and interfaces are fully operational. If a service falls below the benchmark a warning will be issued, and should a service fail then urgent alerts will be generated and relayed both in and out working hours so that immediate action can be taken to restore the effected service(s).

In all this work the Trust Interface and Development team play a critical role in the successful delivery of each of these strategic development areas.

Recommendations

i. As noted above the Trust will meet with TPP SystmOne to understand existing functionality and development roadmap. The Trust will then engage with Cerner and TPP SystmOne to agree how levels of interoperability can be improved across both system.

ii. As part of recommendation (i) above the Trust will lead discussion with both suppliers on work to drive improvements for the management of frailty, stroke and diabetes services across WSFT.

iii. As part of e-Care Phase 3 the Trust will collaborate with Cerner and JAC to develop and interface between e-Care and the Pharmacy back end system to automate updates to pharmacy stock.

iv. Over the life of this strategy the IT Interface and Development team will seek opportunities to use data management tools, software scripts, ETL software and the integration engine to automate manual processes and release time for more complex tasks that need human input.

v. As part of the deployment of the new Agfa EIA the IT Interface and Development team will support Radiology and collaborate with both Agfa and Cerner to complete the successful migrate of clinical images from the PACS to the EIA; such that they continue to be seamlessly available within the e-Care patient record.

vi. As part of recommendation (v) above the Trust the IT department will support Cardiology and Ophthalmology, collaborate with Cerner and the new clinical system suppliers to migrate the associated clinical images from their current store into the EIA; such that they become seamlessly available within the e-Care patient record.

vii. As part of e-Care Phase 3 the IT Interface and Development team will collaborate with NHS Digital, Cerner and EMIS to develop an updated A&E electronic discharge summary and new clinic letter for the EMIS GP system using the new Fast Healthcare Interoperability Resources software tools.

viii. During 2018 the IT department will improve access to clinical data, particularly e-Care data, using data extraction, translate and load (ETL) tools to feed an updated Information Management data warehouse.

ix. Over the life time of the strategy the IM&T service create process to access raw data from e-Care using ETL tools and so start to build a data lake as part of new business intelligence stack so that authorised clinicians have direct access to clinical data.

x. Over the life time of the strategy the IT department will review data integration services and systems interfaces and generate warnings and alerts such that should a service fall below the benchmark a warning will be issued, and should a service fail then urgent alerts will be generated and relayed both in and out working hours so that immediate action can be taken to restore the effected service(s).

xi. Over the life time of the strategy the IT Interface and Development team will take a leading role nationally in defining data management and coding standards for the Cerner mPages; such that mPages built to these standards will operate on any UK Cerner installation.

Collaboration

The use of technology is enable collaboration is now a well-worn path for many industries yet is, at best, patchy in its uptake across the NHS. Collaboration tools enhance the ability of staff to share documents, presentation, video and social media, reduce the need to travel, can be used for education and training and often without regard to location. Modern collaboration tools operate on a range of platforms including PC's, Tablets, Smart Phones and TV et al.

Video Conferencing

In 2017 the Trust made an initial investment in basic video conferencing technology with the purchase of Skype 4 Business (S4B). This is deployed natively into the Northgate meeting room in Quince House and onto computing devices for all Executive Directors and staff across the e-Care Programme. S4B is also integrated into Microsoft Exchange allowing calendar meeting invites to video based and IT are currently piloting a virtual meeting room.

In 2018 the Trust will deploy a Unified Communications server that includes an application called WebEx. This software enabled both audio and video conferencing and will provide the Trust with 5 virtual meeting room, each of which can host up to 250 attendees. WebEx includes the ability to share media (such as presentations) or to host a broadcast where one user presents, and the audience can ask questions.

Each of these collaboration tools offers many benefits that the Trust needs to exploit, particularly as the new HSCN network enables CHS sites to link up on these platforms.

Teleconsultation

As part of the GDE Programme the Trust is required to undertake a pilot around Teleconsultation. A simple option would be to use the video conferencing technology detailed above, however the way in which the technology is built does not comply with NHS Security requirements. Strategically the better approach comes in two parts: The first where the appointment is initiated by the Trust where a message to the patient would advise that an appointment is available via the patient portal. The formal registration function of the portal would provide assurance that the person in receipt of the message is indeed the patient. Upon login to the portal the patient would find a one-time link to an NHS approved teleconsultation solution.

The second is less formal and would allow the Trust to advise a patient or group of patients that teleconsultations sessions are available at a specific date/time. The patient makes a request to access a teleconsultation slow via the patient portal at a date and time to suit. This second approach works well for disease specific sessions manned by a team of staff. For example: diabetes where the diabetics nurses agree to take participate in teleconsultation sessions every Thursday between 13:00 and 14:00. Upon receipt of a request via the portal the patient is notified of his/her date/time and is provided with a simple URL link to initiate a one-time connection.

Multi-Disciplinary Teams

As part of the clinical agenda, S4B and WebEx can be used to assemble patient information, such that a team of clinical specialist can review a patient health record including images and reports to facilitate agreement on the optimum way forward. These are common place in the Trust at present but rely on a single obsolete MDT video conferencing platform (VCP) and where staff gather in the location of the MDT VCP. Using S4B and WebEx clinical staff should be able to participate from their own office or from any other suitable location, such as home.

Recommendations

i. The Trust should, via a suitable group such as the Programme Group or TEG, look for opportunities to utilise S4B for non-patient facing VC and exploit the reduced need to travel and/or the ability to convene disparate groups of staff quickly.

ii. As part of recommendation (i) above the Trust will include health and social care organisations outside WSFT and/or suppliers to derive the same business benefits.

iii. Upon release of the Unified Communications server for operational use, the IT department should hold awareness and training sessions on its availability and use. Once complete the current charge able 3rd party conferencing services (such as Pow-wow-now) should be blocked as such services are expensive to use.

iv. in 2018, as part of the GDE, the Trust should commence a pilot for teleconsultation using a solution that is technical sound and that can be scaled as demand grows. A discussion with the CCG should also be scheduled to review the tariff payments associated with on-going teleconsultation such that they are commercially attractive to the Trust.

v. As part of the deployment of the patient portal the use of an embedded teleconsultation solution should be included as a formal part of the project. Using the two approaches outlined above a clinical service trial for each methodology should form part of the project scope.

vi. Over the lifetime of this strategy the Trust should review the current approach to MDT and identify how S4B and/or WebEx can be exploited to improve MDT efficiency, save travel time and so improve patient care.

Data Sharing

Truly joined up healthcare can only be achieved if authorised clinical staff have access to all of their patient's health data. The section above on interoperability proposes several strategies to achieve this through data integration and systems interfaces. However, the current organisational structure of the NHS means that boundaries do exist even though patients need to flow over these. Data sharing is therefore critical if the primary objective is to be realised.

As part of e-Care Phase 1 the Trust introduced the Cerner Health Information Exchange (HIE) and to date this provides most local GP practices with read only access to the patient records within e-Care. During 2018 the Trust will seek to engage the remaining GP practices not yet connected and uplift the exchange to two way, so that authorised clinical staff gain visibility of the patient's GP record.

As part of the GDE programme the Trust will extend the use of HIE into CHS through the SystmOne CHS modules, into Social Care in collaboration with SCC and into the ambulance service working with the East of England Ambulance team. Furthermore, it is hoped that the Trust will extend the use of HIE into Mental Health with Norfolk and Suffolk NHS Foundation Trust.

The Health Information Exchange has also been used to share two way data with Cambridge University Hospital and whilst this is not yet fully operational this is expected to conclude in Q4 FY17/18. Based upon the experience gained developing this exchange, the Trust has already open communications with DXC who are the suppliers of the Lorenzo health care platform with the intent of building a similar exchange. This is significant as the Lorenzo platform is used by several local NHS Trusts, most notable Ipswich and Papworth hospitals and for Mental Health by Norfolk and Suffolk NHS Foundation Trust.

The Trust is also engaged around HIE nationally through the Cerner CIO forum and HIE special interest group (SIG). These groups are initially looking at a London wide HIE for all the Cerner sites in London, but with a longer term view of including all health and social care organisations based in the capital. The Trust expects to learn from the progress of this work with the view that a Suffolk or even East Anglia wide HIE may be a possible outcome.

As part of e-Care Phase 2 the Trust completed a technical go-live for the e-Care Patient Portal called HealtheLife. The HealtheLife patient portal provides patients with access to key components of their health record, enabling them to take much greater responsibility for their own health. At this time we are working with clinicians to agree an initial rule set for what we will display.

In February 2018 we will be launching a pilot for HealtheLife focussing on a small number of patients to test the initial build. Initially we are launching with a very conservative offer so that we can then work with users to build and grow the portal functionality over time. It is very important that patients are driving the future direction of HealtheLife.

The pilot will run until end of May 2018 after which the lessons learned from the pilot will be evaluated and if appropriate the Trust will then launch more widely on a specialty by specialty basis.

As part of Phase 3 of the e-Care programme the Trust has included two primary modules from the Population Health suite. Building around these modules the Trust will seek to create a fully integrated information system across the West Suffolk health and care economy. It will synthesise data currently held separately into a single patient record for every member of our population. The potential that the resulting databank offers, to help us transform our approach to improving the population's health, is phenomenal.

It must not be forgotten, though, that clinical data belongs to the people whose health it describes. In all circumstances, the use we make of that data and the information which it provides us with will be governed by the following principles:

The overriding purpose of the clinical information system is to improve the health of the people of West Suffolk.

- Some of this will achieved through action we take, based on the information it gives us, to improve the quality of our care.

- Some of it will be achieved through information-sharing with other organisations and agencies who contribute to the population's health.
- Using system-wide information to improve quality necessitates a whole-system perspective on what quality is. We will use the World Health Organisation definition of quality, which suggests we should seek to make improvements over six dimensions: care must be effective, safe, person-centred, accessible (in time and space), efficient and equitable[1].

- We will design our information system so that it can be adapted to operate at any appropriate organisational or geographical scale.

    - In this way it will be ready to extend beyond our walls as the accountable care organisation develops; it will also support partnership working with all our councils, NHS partners and the sustainability and transformation footprint.

- The creation and use of information will be prioritised in line with the health needs of the population.

    - We will spend most of our time and resources on health topics which have the biggest impact on healthy life expectancy and quality of life, and from which the greatest health gains can be achieved.

    - We will make sure we are agile in our approach, to be flexible and responsive as the needs of the population change over time.

- We will understand how to ask good questions. This is not as straightforward as it might seem.

[1] World Health Organisation (2006). Quality of care: a process for making strategic choices in health systems.

- Patients are the experts of their health experience and the care they receive. We will frame our questions around what matters to them and what they tell us about their health and care.

- Clinicians, managers and information specialists will work together to define the problem, understand what the system can tell us about it, describe what action will be taken as a result and make sure we can measure whether the changes have happened or not.

- This will require the development of knowledge and skills in information science amongst clinicians and managers. We will train staff from all professional groups and at all levels of seniority to be able to obtain the necessary expertise. We will also invest in the workforce of the future by offering student placements in clinical informatics.

- If the data we need doesn't exist, we will work together to design new methods to collect it.

- Turning data into good information is also not straightforward. We will have a dedicated clinical Information department with the right mix of skills and expertise to produce information which is accurate and meaningful.

- Once the questions have been determined and the information has been produced, audiences within the trust (and eventually across the system) will have self-service access to it in formats which are accessible. Information is no use to anyone if it does not speak to them clearly.

  - We will train our audiences to interpret it with confidence.

- Similarly, information has no use if it does not result in action. The information strategy will be complimented by an increase in knowledge and skills in improvement science.

- We will be transparent in how we use clinical information.

- We will also evaluate how we use it, to identify, measure and describe the benefits it is creating for the population.

  - If the ways in which we are using it are not providing benefit, we will change our approach.

- The integrated clinical information system will become the single source of truth. Alongside its core purpose of improving quality and outcomes, it will also meet all our corporate needs.

  - It will support appraisal, external audit, operational management and regulatory and contractual reporting, and be responsive to changes in these stakeholders' requirements.

  - There will be no need for any other clinical databases to be held.

Finally, we have the opportunity not only to improve the health of the people of West Suffolk , but also that of a much wider population, by disseminating our experience and spreading the good practice we establish.

Recommendations

i. In 2018 the Trust will complete the rollout of two way HIE to all local GP practises and bring the HIE interface to CUH into live two way operational use.

ii. As part of Phase 3 the Trust, working in collaboration with Cerner UK will create further HIE instances linked to the SystmOne CHS module, to the SCC Liquid Logic Social Care system.

iii. Over the life of this strategy the Trust, working in collaboration with Cerner UK will seek to create further HIE instances linked to the East of England Ambulance Services and to Norfolk and Suffolk NHS Foundation Trust.

iv. Over the life of this strategy the Trust, working in collaboration with Cerner UK will seek to create further HIE interfaces to the Lorenzo healthcare platforms at Ipswich and Papworth Hospitals.

v. Over the life of this strategy the Trust, working through the Cerner CIO forum and HIE SIG, will participate in the development of HIE solutions for wider use across the health sector.

vi. In early 2018 the Trust will launch a pilot for the Patient Portal focussing on a small number of patients to test the initial build. Initially we are launching with a very conservative offer so that we can then work with users to build and grow the portal functionality over time. It is very important that patients are driving the future direction of the HealtheLife Patient Portal.

vii. As part of e-Care Phase 3 the Trust will commence building a Population Health platform to synthesise data currently held separately into a single patient record for every member of our population. For phase 3 the scope will be limited to e-Care data only.

viii. Over the life time of the strategy the Trust will progress the development the Population Health platform to include data from other sources including but not limited to: CHS, Primary Care, Social Care, Mental Health and Ambulance Service data. If appropriate this work will extend to other suitable data sources (e.g. Housing, Environmental et al) with the scope of the working being determined each year by the e-Care programme board.

MOBILITY

Vision

The previous sections of this strategy have already made consider reference to the need to enable Trust staff to work on the move and from any suitable location. The vision is therefore simple: that any authorised member of staff has access to all the information they need in real-time to deliver their job role from any suitable location.

However, there are constraints that limit what can be done and yet a significant opportunity to use technology to enable the vision. This section of the strategy comes in two parts: the first identifies the constraints and opportunities; whilst the second articulates the actions required to deliver what we already know is possible.

Opportunities

The capability to work on the move today is enabled by wide range of technologies all of which already exist. High speed and pervasive wireless networking (WiFi) is common across organisation from multi-national enterprise companies, national public sector providers such as the NHS, through SME's and right down to our own homes. Public WiFi today can be found in hotels and cafes, on public transport and in many public and private buildings up and down the country.

On the move fixed WiFi is today augmented by a range of cellular networks that provide 3G and 4G data enabled connections via out tablets and smartphones. Indeed, the modern day smartphone can now be used as a WiFi hotspot allowing other devices such as a laptop to utilise the cellular service.

Across the UK more than 85% of homes now have broadband that provides video streaming, full access to the internet and a platform for remote access into the workplace. More than half the population have their day to day lives integrated through the internet using mobile connections for a huge range of services from banking and shopping to home security and parking the car. In short, we now live in an 'always on' society.

Constraints

Although the nirvarna described above is all available today, coverage across the UK varies widely. The rural nature of Suffolk means that cellular services such as 3&4G are at best patchy and away from the A14 corridor broadband services are generally bandwidth and so slow by comparison.

As noted in the *Infrastructure* sub-section on Wireless Networks, coverage across CHS locations is spare with only 3 locations currently covered. The wireless network WSH is better although it is legacy and does have a few holes in the coverage. During 2018 and 2019 investment has been assigned to update the WSH network to provide a modern campus wide solution.

The Trust is also aware that NHS England has a programme to provide wireless networking to CHS and secondary care sites, but to date details on what will be provided and when is scant. Further news is expected in early but until this arrived planning for CHS mobility will need to wait.

Approach

The IT department are holding regular meetings with mobile network suppliers to gain a view of their roadmap of service updates, so we know when coverage will improve. There is an on-going review of technology and healthcare solutions that are appropriate for use over the cellular network and where appropriate local technology is being used to boost cellular signals.

The provision of broadband across the Trust area is monitored but this is largely a domestic service only limited discussion with service suppliers is possible.

Mobility in e-Care

In Q4 FY17/18 a pilot for the first 10 users of Power Chart Touch (PCT) will commence. This will provide the selected clinicians with access to e-Care over the wireless network using a tablet computer. Upon completion of the pilot the Trust will roll out a further 90 users as the initial tranche will longer term plans to provide PCT for all clinicians.

As part of Phase 2 the Trust went live with Patient Flow and equipped Porters and Housekeepers with iPod Touch units that connect over the wireless network. In 2018 there are plans to add the Microsoft Office 365 K1 variant to the device so that these users have access to their e-mail. In addition, when the new software phone application becomes available this too will be added to the device making it possible to call and/or message these staff on the move. Of note delivery of both upgrades are contingent on the planned upgrade to the WSH wireless network.

As noted in the *Systems* sub-section on Image Management the IT department and Radiology will collaborate to combine the new remote access solution, voice recognition and the toolset within EIA to allow Radiologists to remotely access images from home to facilitate remote radiological image reporting. This service will be further extended when appropriate for Digital Pathology as this is brought on stream by NEEPS.

GOVROAM

As noted in the *Infrastructure* sub-section on Wireless Networks the Trust as part of the STP is piloting the use of GOVROAM. This service operates over a local wireless service and allows authorised users to connect using their normal login credentials. Each organisation that subscribes to the service provides a connection back to their home network and a technology called Radius. The Radius technology then authenticates the user and established a connection back to the systems that the user is authorised to access.

The pilot is being undertaken at Newmarket Community Hospital (NCH) as CHS, Mental Health, Acute and Social Care staff are all based at NCH making it an ideal test bed. If the pilot is successful the STP will apply for funds to deploy GOVROAM across all multi tenancy sites within the STP footprint. A more technical explanation of the component part of GVROAM is included in Appendix B.

<u>Recommendations</u>

All of the issued raised in the Mobility section that require action are already included in other sectional recommendations.

INFORMATION

The Trust currently has two Information Management teams, one based at WSH focussed on hospital data and a second at Sandy Lane focussed on community data. Each team provides a wide range of reporting services to National and Contractual bodies, for clinical and operational service management and as a silo for data stored in Trust IT systems. This strategy addresses the wider information requirements for both Acute and Community Health Services.

National Context

The Department of Health's Information Strategy "The Power of Information: Putting all of us in control of the health and care information we need" (2012) sets out a ten-year framework for transforming information for health and care. It highlights the requirement to harness information and new technologies to achieve higher quality care and improve outcomes for patients and service users. The categories covered by the framework are shown in diagram 2 below:

Diagram 2
Picture Courtesy of Department of Health

The Trust has a good record in respect of National reporting and is agile and responsive to change as seen recently working closely with CCG and IT staff recently to deliver the new National Daily NHS Sit Rep and CCG Live Dashboard, using tools from NHS reporting specialist, Beautiful Information. Strategically this success is built upon close collaboration and use of the right technologies to assemble and delivery quickly and accurately within the agreed timescale.

Strategically the national strategy, urges health and social care services to make full use of online technologies to put patients in control of their health and health records. The ambitions outlined below overlap those set out in this strategy:

- A change in culture in which our health and care professionals, organisations and systems recognize that information in our own care records is fundamentally about us;

- Our electronic care records progressively become the source for core information used to improve our care, improve services and to inform research, etc.

- A culture of transparency, where access to high-quality, evidence-based information about services and the quality of care held by the Government and health and care services is open and easily available to us all;

- An information-led culture where all health and care professionals – and local bodies whose policies influence our health, such as local councils – take responsibility for recording, sharing and using information to improve our care.

- The widespread use of modern technology to make health and care services more convenient, accessible and efficient;

- An information system built on innovative and integrated solutions and local decision-making, within a framework of national standards that ensure information can move freely, safely, and securely around the system.

Therefore, as part of this strategy the wider IM&T service will work as a team with local and national bodies to build information solutions that exploit technology for ease of access and fully engage the citizen.

The e-Care Patient Portal is one example that will bring about change in culture in which our health and care professionals, organisations and systems recognize that information in our own care records is fundamentally about the patient (or citizen). It is also symptomatic of our drive towards providing access to high-quality, evidence-based information about services and the quality of care held by the Trust that is open and easily available to our patients.

The e-Care EPR is wholly about having an electronic care records that progressively become the source for core information used to improve patient care, improve services and to inform research.

The Trust participation in the NHS GDE Programme and our commitment to the e-Care EPR, the Health Information Exchange and the new Population Health solution are all evidence of not only WSFT but the Alliance and the STP moving to an information-led culture where all health and care professionals – and local bodies whose policies influence our health, such as local councils – take responsibility for recording, sharing and using information to improve our care.

The e-Care Programme and the acceleration provided by the NHS GDE have directly lead to wide spread use of modern technology to make health and care services across the Trust convenient, accessible and efficient.

Finally work proposed as part of this strategy and included in the Trust Digital Agenda that runs to 2024 are all geared to building an information system that is innovative and integrates solutions and local decision-making, within a framework of national standards that ensure information can move freely, safely, and securely around the system. The adoption of NIB recommendations such as SNOWMED-CT, Secure E-Mail, DM&D and algorithm driven early warning are as part of the Trust drive to become a centre of digital excellence.

Recommendations

i. The Information department will continue to work collaboratively with other Trust departments and external bodies to ensure that all national and local reporting requirements are met with accurate and timely information.

ii. The Information department, through TEG and the e-Care Programme Board will lead on the drive to build an information-led culture where all health and care professionals – and local bodies whose policies influence our health, such as local councils – take responsibility for recording, sharing and using information to improve patient care.

iii. The Information department will work collaboratively with IT to automate routine IM processes using scripts, ETL Tools and AI to strip out manual processes, releasing time for more complex IM activities.

Local Context

The Trust Operational Plan outlines three operational drivers around the local context: First to be a transformation-led digital acute Trust using technology as a key enabler. Second to support aims of the ACO, where information based decision support is a critical success factor and third to promote our exemplar digital community, using our experience to drive up the digital maturity of our local partners by providing mentorship in all aspects of deployment, including leadership, informatics and intellectual property (IP) development.

Strategically we see the effective use of information and technology as a key component of delivering the Trust strategy and being essential to:

- Supporting clinical decision-making
- Measuring quality and performance
- Informing effective service planning

In the immediate term our focus is around addressing reporting issues that have arisen as part of the rapid implementation of the new EPR. These will deliver reliable real-time operational and clinical reporting and so sustain the Trust Quality and Performance framework. The IM&T service will review the progress currently used to extract, process and present data – seeking to apply Lean tools and a Six Sigma approach to automate and streamline routine reporting and so release skilled Informatician time for more complex work.

A key part of this process will be to improve data quality trough enhanced data validation and by creating feedback loops. We have agreed a new operational structure as shown in diagram 3 below:

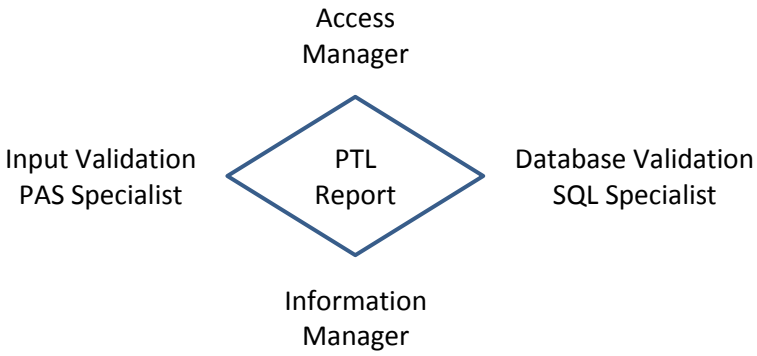


Diagram 3

This revised approach drives operational data quality through the inclusion of the Trust Access Manager and improved input data validation from the inclusion of a PAS SME. The inclusion of an SQL expert will allow the Trust to identify single records in error and use these to pattern match as often where there is one there are usually more. As the system can identify the source of both input errors and those that have made it into the EPR this can be fed back via the Information Manager resulting in process clarification, additional user training and ultimately far higher quality data that is fully validated.

Divisional Informatics

The revised model above is an example of how the Trust can automate and drive up the quality of reporting for what is core reporting. However, the Trust operates a divisional management model covering: Surgical, Medical, Women's and Children's plus Clinical Support Services and Community Health. The latter is covered later in this section but for the three acute division; strategically there is a need to drive close informatics engagement within the division.

There is international evidence, provided by the Advisory Board who support the Trust IM&T service, showing how improvements within divisional reporting can be driven up by the creation of a divisional health informatics team. Nominally comprising the Divisional Manager, a Clinical Medical Information Officer (CMIO), a Clinical Nursing Information Officer (CNIO) and a specialist Informatician. As part of the Information department structure there are 4 Senior Information Analysts assigned one to each Division, plus one assigned to Clinical Reporting.

The proposal is therefore to embed each of the Senior Information Analysts into new divisional health informatics team. They would work closely with the Divisional General Manager, Clinical Director and the clinical specialists to drive up reporting that is focussed on the clinical and operational needs of the division. However, they would also retain their position within the wider Information department to sustain professional standards, assure training and facilitate the transfer of knowledge to other members of the team. The expectation is that these team will drive divisional dashboards, use information to support divisional initiatives generating the 'before' and 'after' numbers to measure success (or failure) and so support the transition to an information-led culture for all health and care professionals.

Recommendations

i. If the Trust is truly to adopt an information led culture then the Information Management team needs to be strengthen. At present only one of the five Senior Information Analysts has a supporting junior and there is no obvious career development path within the time. As a result, in FY18/19 a revised structure should be adopted and funded for the Information Team that ensures that critical functions are known to multiple staff and which provides a career development pathway.

ii. The Information department will focus on operational and clinical reporting to resolve the reporting issues arising from the implementation of PIEDW as part of e-Care.

iii. The Trust will build a new SME team that will seek to drive up data quality through improved validation at input, identify issues with operation reporting and use back end SQL skills to correct and revalidate the source data and create feedback loops so that the sources of poor quality data are identified and the cause rectified.

iv. The Trust will create a Divisional Informatics team in each of the three Acute Service Divisions and so drive up reporting that is focussed on the clinical and operational needs of the division.

v. The IM&T service will engage with Trust will create a Divisional Informatics team in each of the three Acute Service Divisions and so drive up reporting that is focussed on the clinical and operational needs of the division.

Access to Information

Where information is needed for any new initiative or project the current process is to place a request and wait for the information to come back. The service perceived as slow and remote with no local control. However, this is perhaps a naive view as the use of unqualified information will lead to incorrect assumptions being made and often an incorrect outcome. The challenge for the Information department is how to resolve the dilemma between taking the time to fully validate data and yet still being able to respond quickly.

Strategically it is believed that answer is to maintain a fully validated Enterprise Data Warehouse (EDW) and alongside it build a data lake. Whilst the latter will contain data that has not been subject to the full rigour of detailed data definition and the resultant data validation, the person who entered the data believed it to be correct at the time it was recorded. If we combine this position with the approach outlined above to drive up data quality at both the front and back end of every process, we should reach a point where the risk is acceptable. This is, of course, subject to users of the data lake being aware; but as such staff are mainly those in contact with the data on a day to day basics such an approach in reality, introduces a further information data validation layer.

Business Intelligence

The provision of a fully validated Enterprise Data Warehouse (EDW) should provide qualified Informatics staff access to an ever-increasing source of information from which all manner of business intelligence and formal reporting can be driven. Through the use advanced extract, translate and load (ETL) tools and the adoption of a point and click enterprise reporting tool providing data in response to all but the most complex or enquires should be available as a fast and

efficient service. Whilst this remains a service provided by the Information department for many Trust leaders this is fully acceptable as the information received is fully validated.

The provision of a fully validated EDW is then the platform upon which to run analytics. The stage of analytics sees Information departments seeking to frame the problem as they progress from an early stage which includes monitoring, reporting and retrospective analysis. Retrospective analytics is the foundation layer for analytics and looks at what has already happened, helping the Trust to understand why events have taken place. This is the type of analytics most commonly found in healthcare because it draws empirical conclusions.

As access to data improves and data availability switches from an overnight dump to real-time or near real-time updates so the ability of the Information department to work more closely with the clinical and operational teams to create tools and intelligence, include triggers and so re-act to change. This layer of analysis is reactive analytics and is most commonly found in real-time dashboards. As events change the clinician or manager can change the care plan or operational activity within limits and minimise any disruption. However, the success of reactive analytics is highly dependent on having the right resource available at the time to enable the change.

As shown in diagram 4 below the next step in the progression is to move to predictive analytics

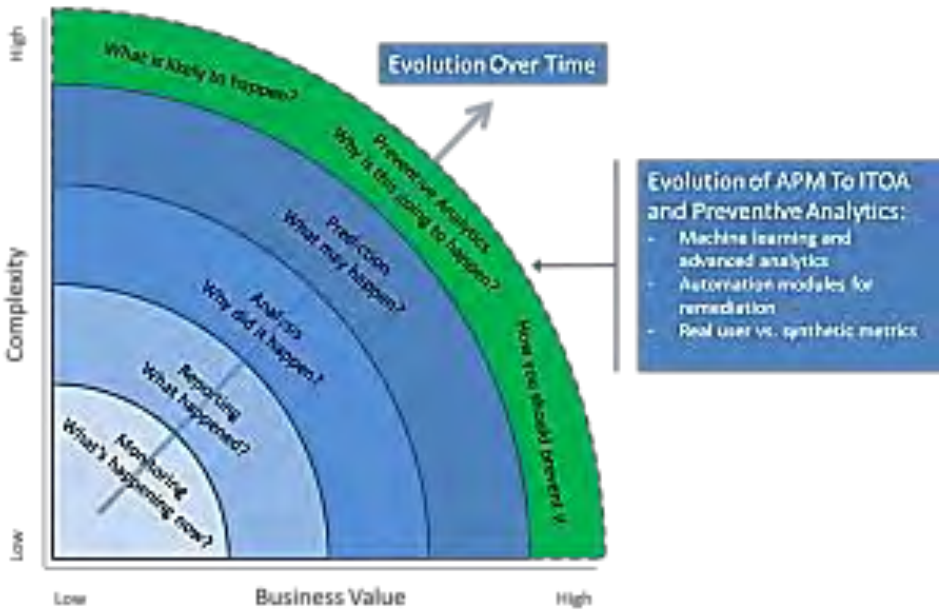


Diagram 4

Predictive analytics takes a higher, forward looking view drawing conclusion from a wealth of existing data that provides the ability to speculate (sometimes to a high degree of accuracy) on what will happen. For example, Predictive analytics can help to identify the cancer patients with a high risk of returning to the hospital by combing Trust data with known clinical research. Once we know who the patients are then additional measures can be put in place to manage their care and so reduce the likelihood of a return. Predictive analytics does not provide a known outcome only the likelihood that an event or condition may occur.

Current analytical theory is looking at Prospective Analytics, where Hospital Information departments (or Clinical Informatics teams) can combine the data from retrospective and predictive analytics and then drill down to show clinician or manager available options for changing the current state and the associate consequences. An example would be an ability to measure the influx of patients attending ED whenever grass track racing is held on a local farm. Retrospective analysis provides a base line by showing how many patients were typically treated on Saturday afternoons and Predictive analytics showed us in which areas the Trust may need to increase services such as Radiology and Orthopaedics when the racing is on. The theory is that Prospective Analytics allows the Trust to consider changes based on high likelihood of a change in demand.

Clinical Query

However as noted above this strategy also sets out plans to build a data lake using data extracted in raw format from e-Care to start and from an increasing number of Trust clinical systems over the life of the strategy. Access to this data will be provided directly to clinical and operational staff on a read-only basis and subject to awareness around the lack of final validation. Strategically this approach will allow those who wish to use it, immediate access for simple queries. For example, it will allow Trust consultants to ask: How many patients have I seen within a given date range, who have a specific diagnosis that I treated with a specific medication and what is their latest related pathology result.

This approach puts the data in the hands of the clinical staff treating the patient at the exact moment when they want it. If there are data issues the clinicians using the data are well placed to spot any errors and can cross check the data with any held in e-Care or elsewhere. Instances of this are likely to be low and with any clinical decision the training and experience of the clinical staff will also play a critical part.

Recommendations

i. The Information department will review the functionality of the new Cerner HealtheEDW (HIEDW) to determine whether it is fit for purpose.

ii. If HIEDW is deemed fit for purpose the Information department will work with Cerner to migrate clinical and operational data into HIEDW and initiate routine reporting from it. If not, the Trust will review EDW options and procure or utilise an alternative EDW.

iii. Using existing ETL tools the IM&T service will commence the creation of a data lake. It will initially be populated with data from the e-Care EPR but over the life of strategy will grow to receive data from any appropriate system.

iv. In 2018 the IM&T service, working in collaboration with the CCIO and CNIO will deploy a simple reporting tool (such as Tableau) linked to the emerging data lake providing direct read-only access to clinical information.

iv. Over the life time of this strategy using the new EDW the IM&T service will generate a roadmap to take the Trust from retrospective analytics to at least predictive analytics and prospective if possible. The roadmap will examine the technical components, analytical skills, data model and external intelligence required to optimise the analytical outputs.

Clinical Informatics

As noted above the strategic direction for the Trust in respect of Information is all about cultural change; access to high-quality, evidence-based information built on innovative and integrated solutions to enable local decision-making. If these goals are to be met, then Clinical Informatics must become a significant component of the solution. Today an ever larger percentage of Trust data is now clinical, and the depth and complexity of the data is expanding rapidly. The adoption e-Care and the goals of the Trust Digital Agenda to only drive this position to even higher level. Yet today the Trust has very few clinical staff directly involved in data or information production or in its subsequent use to improve the health of our patients.

In terms of clinical informatics, the strategic vision needs to expand beyond the current horizons of the Trust as the delivery of healthcare to our patients is, at the very least, a journey across the local health system and for some a great deal more. As a result, there are no finite recommendations for Clinical Informatics other than the establishment of Clinical Informatics team as part of the Trust GDE work, which is already underway. More a need to regularly revisit the need to engage clinical staff within not only the Trust Informatics programme but across the STP, AHSN and ICS as these wider entities grow and take shape.

In the short term the adoption of a Population Health Management system, the proposed work to build a clinical data lake and the option for a cross organisational enterprise data warehouse will all drive this agenda. As the sources of data increase further options around mass data analysis, the potential to include disease specific registries and the adoption of artificial intelligence will further extend the need to have clinical staff at the heart of the informatics services.

On this basis the Trust should revisit the strategic development of the clinical informatics service on a regular basis, not less than annually.

SECURITY

Information Security in a modern healthcare system comprises many layers each of which provides one or more security controls, which when combined present a formidable level of protection. Whilst this layered approach increases the difficulty in breaching the Trust security solution the pace of change in technology already changes very rapidly and is increasing every day. As a result the Trust has to take Information Security very seriously as we progress the digital agenda.

Security Perimeter

As noted in the *Infrastructure* sub-section on Wired Networks, the Trust has made a major investment in new firewall technology. This is a quantum leap forward in comparison to the 7 individual firewall units that new virtual solution replaces. The obsolete technology being replaced centres in a gateway device with an outward facing connection to the NHS N3 network or the Internet and an inward facing connection to the Trust network. All perimeter security was provided by a series of rule that ran on the gateway.

Whilst the new firewall continues to provide the basic gateway function but now augmented by the provision of a sandbox function. This provides a secure space into which any suspicious network packets can be placed for further evaluation. Specialist software called Threat Emulation that

include a learning capability drive Artificial Intelligence then executes the network packets to determine if they present a threat. If they do the packets are quarantined in the sandbox and ultimately destroyed and if they do not they are forwarded to original destination. This new technology forms part of the 2017 NHS GDE programme of work.

In 2018 an additional client software component will be added. This highly advanced software is loaded on to every Endpoint on the network and provides the same level of Sandbox and Threat Emulation and the core solution. The major advantage with the client software is that extends the security perimeter, using virtualisation to every Endpoint and every location in which that Endpoint operates.

Further software is now available that will target the Internet of Things (IOT). This is important as every more network enabled devices, including many medical devices, are now network enabled. For IOT devices the focus is often on the functionality of the device itself and the new ability to connect to the network. Sadly, this occasionally means that the levels of security offered are less than needed and so the device becomes a way into the network for cyber criminals.

For the Vital Links project now underway a Welch Allen unit will be provided to both our network and firewall vendors who will conduct a range of tests to confirm that it is safe to use. Of note we do not expect the Welch Allen device to fail but we will isolate all network enabled medical devices into a separate virtual network.

Recommendations

i. In 2018 the IT department will install and test the firewall client software component and upon completion of successful testing will roll the client software component out to every Endpoint device.

ii. As part of Phase 3 the IT department in collaboration with Extreme Networks and Checkpoint will review and test one of the Welch Allen Vital Links medical devices to ensure that device is safe to use on the Trust network.

iii. As part of (ii) above the IT department will create a separate virtual LAN dedicated to connection of approved IOT medical devices. Working in collaboration with Extreme Networks and Checkpoint the new VLAN will be configured and tested for IOT medical device use.

iv. Over the life of this strategy the Trust, working in collaboration with established Security product suppliers, the IT department will continue to review and test security solutions as part of the wider NHS and Trust Information Security service.

v. Upon completion of the new firewall project the IT department will configure the firewall logging Server to capture security data within an agreed set of parameters. The resulting data will be reported back through the Trust Information Governance Steering Group as part of the standing Information Security reporting.

Network Access Control

In 2017 as part of the GDE Programme, the IT department undertook a pilot on network access control. Specifically, this work focussed on testing the 802.1x network protocol that is used for port control. Port control allows the IT department to limit what any network port can connect to and

which devices are able to make the connection. It an extension of the existing virtual LAN security software that allow the IT department to group ports together to provide segregation across the network.

The management of network ports using 802.1x is not new but until recently was not widely adopted as the level of network administration required to assign VLAN and devices right to thousands of network ports, often where such things are subject to frequency change (think of the number of devices in an office move) was very significant. Yet the IT industry is now moving rapidly into software defined entities and so the new 802.1x software is now very much policy driven allowing significant moves and changes to be completed quickly. As a result, the IT department expects to implement 802.1x across all network ports at WSH during 2018.

Whilst originally 802.1x was designed for wired ports, network access control also now applies to devices connecting via the wireless network. New network access control software is available for wireless connections but considering the major wireless network upgrade deployment in 2018 will be limited to wire ports. A level of protect will exist across the wireless network as every wireless access point connects to the network via a wired port but full compliance will not be reached until FY19/20.

Recommendations

i. In 2018, building on the pilot undertaken in 2017, the IT department will install 802.1x network access control software on every wired LAN switch port across WSH.

ii. As part of 2018 wireless network upgrade installed and test the wireless network access control software. Upon completion rollout the 802.1x software as a function the wireless network upgrade project.

iii. In FY20/21 include network access control testing as part of the external security testing undertaken every year in line with NHS IG Toolkit requirements.

iv. Upon completion of the new network access control project the IT department will configure the NAC Server to capture security data within an agreed set of parameters. The resulting data will be reported back through the Trust Information Governance Steering Group as part of the standing Information Security reporting.

Enterprise Mobility Suite

As noted in the *Infrastructure* sub-section on Endpoint, the existing Mobile Device Management (MDM) software (Good for Enterprise [GFE]) has reached end of life. As MDM software provides only device protection it will be replaced an Enterprise Mobility Suite (EMS). The EMS differs from GFE as the former only provides device management whereas EMS provides MDM, mobile application management (MAM) and mobile content management (MCM).

The Trust has procured two EMS solutions: the first being the Enterprise Edition that full MDM along with secure email, contacts, calendar, corporate intranet access and web browsing applications pre-installed. The Enterprise edition also includes a secure container for Trust applications (for example Clinical Photography) and any associated data. The Trust has 600 licenses for the Enterprise edition assigned to the existing 300 GFE users, plus 150 Patient Flow users and 100 PCT users with 50 in reserve for new devices.

The second is the Collaboration Edition which include all the Enterprise Edition functions along with secure access to shared files, secure instant messaging and full native document editing that is aligned to MS Office 365. The Trust has 10 licenses for the Collaboration edition with only 1 to date assigned to the new Trust chairman. What collaboration potentially adds is the ability to undertake all day to day computing using a secure tablet, subject to the limitations of the tablet itself.

The security of data on NHS mobile devices is taken seriously with data encryption and device protection specified by NHS Digital. In FY17/18 the Trust procured the Blackberry EMS and work is now underway to configure and test it. Once done this all existing GFE devices must be upgraded and Blackberry EMS installed.

Whilst the device management element is covered off in the Endpoint sub-section, mobile security incident management and reporting also needs to be addressed. Therefore, as part of the rollout of EMS the IT department will configure the EMS Server to capture security data within an agreed set of parameters. The resulting data will be reported back through the Trust Information Governance Steering Group as part of the standing Information Security reporting.

Recommendations

i. In 2018, the IT department will complete the upgrade from GFE to EMS Enterprise for all existing GFE users.

ii. In 2018, the IT department in collaboration with the Facilities team, recall all the Patient Flow iPod devices and replace GFE with EMS Enterprise. If appropriate and agreed by the Facilities team add the software telephone application and allow the iPod to make/receive calls over the hospital network.

iii. In 2018, the IT department will deploy EMS Enterprise on all PCT tablets and work with the CCIO to exploit the improved functionality to improve the clinician experience.

iv. In 2018, the IT department will deploy EMS Collaboration on an iPad Pro and explore its use as a replacement for or adjunct to the personal computer.

v. Over the life of this strategy the IT department, working on collaboration with Apple UK and Appurity Ltd. (Specialist EMS Vendor) explore how EMS functionality can be exploited to securely deliver the Mobility vision outlined above.

Patching Cycle

In June 2017 following the National Wannacry Cyber-Attack that debilitated many NHS organisations a Cyber-Attack report was generated that reported and what had happened and what actions needed to follow. Key features with the report were: the level of Microsoft AD (2003); the number of Windows 2003 servers and the time taken to test and apply software patches to both Servers and Endpoint devices. The Microsoft AD was recently uplifted from 2003 to 2008 with plans to uplift it again in to 2012 within the life of this strategy. The number of 2003 servers has been reduced with E-Mail and Remote Access now on 2012 servers and work in progress to migrate Operating Theatres to 2008 by April 2018. The latter is stop gap to ahead of the delivery of e-Care Phase 3 that will see Operating Theatres become part of the EPR. A business case to upgrade the Electronic Document Management system (Evolve) to run on 2012 servers is written, is funded and is expected to be approved in January 2018 for immediate upgrade.

Originally an upgrade to the Trust data warehouse was also included in the Cyber report on the assumption that all data would have been migrated to the Cerner EDW by this time. However as part of Phase 3 the Trust has chosen to take the new Cerner EDW and plans are now being revised. As soon as the data is migrated the old data warehouse will be decommissioned.

However sufficient progress has been made to allow the Trust to proceed with the upgrade to Microsoft System Centre Configuration Manager (SCCM) which manages the automated deployment of software patches. This work will commence in Q1 FY18/19 and in combination with the uplift to AD 2008 will reduce the time taken to deploy patches from current elapse time of up to 2 months, down to around between 3 and 4 weeks.

Of note the addition in 2018 of the firewall client software component will further extent the level of cyber protection and will complete proposed actions outlined in the June Board paper, a copy of which is provided in Appendix C.

Recommendations

i. In 2018, the IT department will complete the migration of all Windows 2003 server based systems (excluding the legacy data warehouse) to Windows 2008 or Windows 2012 servers.

ii. In 2018, the Information department will complete the migration of the data warehouse into a new EDW solution.

iii. In 2018, the IT department will install and test the latest version of Microsoft SCCM and update the client software on test Servers and Endpoints. Once complete the client software on all remaining Servers and Endpoints will be updated and the reduction in the patching cycle measured.

Community Health Services

Whilst much of what is outlined in this security section applies equally to WSH and to Community Health Services, the level of digital maturity for the latter is less than the former. This is well known to the Community Transition Board and Group with work in progress on how to bring the level of digital maturity across CHS up to a higher level.

Operationally the issues covered in this section are currently delivered by NEL CSU under a contract held by the CCG. Regular meetings are held between the CCG and NEL CSU and IT staff from IHT and WSFT are now engaged in a dialog with NEL CSU to review the longer term strategy. However progress is slow as the contract also includes the GP Federation and both CCG. Whilst there is little doubt that all parties take security seriously managing day to day risk remains a top priority.

Awareness

In 2017 the Trust Executive Group received a presentation from the Suffolk Constabulary lead on Cyber Security. This was summary of a far longer presentation attend by IT Management and Security leads some months early. One of the key points raised was that 67% of all Cyber Crime is initiated by people and therefore continued activities to raise awareness are required to help reduce the risk.

In 2017 the IT department Security Team held several awareness days, including a Cyber quiz in time out and attendance at a range of service and divisional meetings to present specific topics.

The IT department is currently recruiting an IT Security Officer to assist the IT Security Manager with part of this role being to sustain the security awareness programme.

Recommendations

i. In 2018, the IT department will complete recruitment of an IT Security Officer.

ii. In the life time of this strategy IT Managers and Security specialists will attend security briefings to ensure that subject knowledge and the latest intelligence are sustained.

iii. Every year IT security team will continue to run awareness events and attend operations meetings to maintain a high level of Information Security awareness.

People

As already noted the Trust's greatest asset are the staff. The staff in IM&T are knowledgeable; highly skilled and many are subject matter experts in their own field. The IM&T service is customer facing and its client are the 4000+ users of any form of technology or information. Our strategic approach must therefore remain one of high quality customer service, strong professional skills and a desire to deliver an outstanding level of service.

Education and Training

There is no doubt that the provision of education and training around all facets of IM&T is an imperative if the Trust it to continue to deliver the outstanding performance that makes the Trust the best across the Midlands and East of England. The adoption of the e-Care EPR, which is a tightly-coupled, highly complex clinical solutions means that the Trust must continue to invest in clinical systems training as an on-going activity. In support of this aim Appendix D contains a copy of the Trust Training Strategy for IM&T systems.

In parallel with the clinical systems training, more specific training on technical and informatics subjects also needs to be developed. As a result every business case developed that includes a technology and/or informatics requirement must now include the cost of training IM&T specialist to support the business case delivery objectives. Appendix E

In light of the time pressures on all staff and clinical staff in particular, the Trust must also exploit innovative ways to deliver training and so balance the absolute need to train with the impact the absence has in the workplace. The use of online training and mobile training applications that are accessible over the Internet are key to improving the level of training and ease with which it can be delivered.

Development

Whilst education and training, as outlined above, delivers specific skills and knowledge the Trust also needs to seek to develop the staff it employs. Through the use of appraisals and 1-2-1 meeting IM&T service managers will seek to develop staff to progress through the organisation. This may include offering a secondment to another section within the service or to an operational or diagnostic service to expand the knowledge base. It may also be development in the more general management skills providing technical staff with the skills to write papers that non-technical staff can understand or to manage staff and/or budget.

Out of Hours

The IM&T service nominally operates between 08:00 and 17:00 Monday to Friday. Outside of these hours the IT department provides an on-call service and this is largely a technical solutions service. The staff that provide on-call are largely drawn from 2nd and 3rd line engineer, augmented by one member of the application support team. Yet with the introduction of e-Care, new clinical systems have been introduced into many areas that before used paper. The e-Care EPR has also adsorbed an increasing number of former standalone clinical applications and folded these into the EPR. As a result there has been a notable increase for out of hours application support.

In 2017 the2nd and 3rd line engineer teams have been adjusted as the Trust has reduced the number of contractors and so it now seems appropriate to revisit the provision of IT on-call services.

Recommendations

i. Clinical Systems training will continue to be developed as the e-Care and GDE programmes deliver further EPR functionality.

ii. Over the life time of the strategy the Trust will seek to exploit innovative ways of delivering IT systems training such that the right level of training is delivered but balanced against the impact on operational services.

iii. All business cases that include IM&T components must be reviewed by the IM&T service to ensure that where specific IM&T training is required that it is included in the business case.

iv. In line with Trust policy review individual training requirements as part of appraisal and staff development process.

v. In 2018 review current IT department on-call arrangements and prepare a business case for a revised on-call service that reflects the increased need for application support as part of the on-call provision.

5. International/National Standards and NHS Guidelines

At this time the Trust has been accredited against several International standards for the services that it provided. Examples of this include ISO9000 for quality, ISO27001 and Cyber Essentials for Information Security, SCCI1596 for Secure e-mail and TAPS for user training. These certifications demonstrate the knowledge, skills and ability of the Trust IM&T functions not only internally but also across the wider health community.

The Trust is also mandated, often under UK Law, to reach compliance against a range of statutes or compliance standards. Examples of this include the current Data Protection Act, Computer Misuse Act and both ISO0160 and ISO0129 around the safe use of computer software and hardware for direct treatment of patients.

Therefore, as the Trust continues to deliver the digital agenda, the strategic position will be to assure continued compliance will all statutes and compliance standards. In addition the IM&T functions will seek to sustain certification against the standards already achieved and review options to achieve further certification, as is appropriate to the services being delivered.

Appendix A

DATA CENTRE TIER STANDARDS

Telecommunications Industry Association standard number 924 entitled "Telecommunications Infrastructure Standard for Data Centres" was issued originally in May 1998, with the latest version B issued in July 2017. This widely recognised standard provides a series of models for data centres in four tiers, which in summary are defined as follows:

Tier One: Basic Site Infrastructure

A tier one data centre has non-redundant capacity components and a single, non-redundant distribution path serving communications and computing equipment. Tier one sites are susceptible to disruption from both planned and unplanned activities including human error that will cause a loss of service. The unplanned outage or failure of any single component will impact communications and/or computing equipment. The whole site infrastructure has to be shutdown to perform safety checks, undertake maintenance or install new components.

Tier Two: Redundant Site Infrastructure

A tier two data centre has redundant capacity components combined with a single, non-redundant distribution path serving communications and computing equipment. Tier two sites are able to have redundant capacity components removed from service without causing a service disruption. However they remain susceptible to disruption from both planned and unplanned activities including human error that will cause a loss of service. An unplanned outage or failure of any single component may impact communications and/or computing equipment and like tier one sites the whole site infrastructure has to be shutdown to perform safety checks, undertake maintenance or install new components.

Tier Three: Concurrently Maintainable Site Infrastructure

A tier three data centre has redundant capacity components and multiple independent distribution paths serving communications and computing equipment. All equipment has dual power feeds and power supply units that can be switched seamlessly without affecting the service provision. Any capacity component and/or element in the distribution path may be removed from service on a planned basis without impacting any communications and computing equipment. Tier three sites are however susceptible to disruption from unplanned activities including human and operational error. As a result unplanned outage or failure of either capacity components or elements of the distribution path will impact the service provision. However, planned site infrastructure safety checks, maintenance or installation of new components can be undertaken safely using the redundant components to support communications and computing equipment.

Tier Four: Faults Tolerance Site Infrastructure

A tier four data centre has multiple, independent, physically isolated systems that provide redundant capacity components and multiple, independent, diverse and active distribution paths serving all communications and computing equipment. In a tier four data centre, a single failure of any capacity component or any element of the distribution path will not impact the communications and computing equipment. In addition the equipment that provides capacity and distribution is configured to automatically respond (deemed as self healing) to any failure by bringing additional capacity, where required, on-line. Finally tier four data centres have sufficient capacity to meet the needs of the site even when redundant components or distribution paths are removed from service.

Appendix B

GOVROAM

GOVROAM, which stands for 'government roaming', is a RADIUS-based infrastructure providing an exclusive wireless/Wi-Fi roaming service for public services and governmental administrations. Being authorised to use GOVROAM allows users visiting another institution connected to GOVROAM to log on to the Wi-Fi and connect back to the same systems as they use at their home institution. Authentication is undertaken in two parts: the first being confirmation that the device is known and registered (using a MAC Address) for use on GOVROAM and the second that the same is true for the user (using a the same username and password issued to the use by their home organisation).

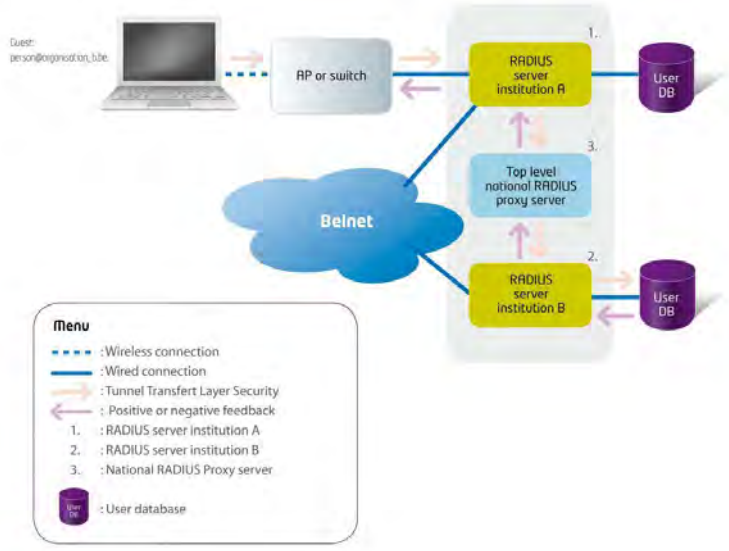
How does GOVROAM Work

The GOVROAM service makes use of the RADIUS protocol that facilitates the sharing of data. Organisation A is host to a user from organisation B and this user logs on to the wireless network of organisation A. At that moment, the RADIUS server of organisation A will forward the user data (user name and password) to the RADIUS server of organisation B for verification.

This is done via the RADIUS server at GOVROAM, which receives a request from the RADIUS server of organisation A. The GOVROAM server then immediately sends a request to the RADIUS server of organisation B. Thanks to the creation of a Transport Layer Security tunnel between the user and his or her organisation, the server of organisation B can securely verify its user.

After verification, the RADIUS server of organisation A receives the message that the user is known within organisation B. And thus the user gains access to the wireless network of organisation A.

The advantage of GOVROAM is that once it is deployed across multiple public sector sites in a location, such as the Suffolk and NE Essex STP, any public sector staff based in the locale may use any GOVROAM enabled building as a base to work from.



In reality this enables truly mobile working for staff who otherwise would have to result to manual data entry that then has to be entered as a later date or time.

As a result, and as part of the WSFT IMT Strategy, all locations owned or managed by WSFT will as part of the Digital Agenda have their existing or new wireless network configured to broadcast the GOVROAM service.

Appendix C

Cyber Attack Report

West Suffolk NHS Foundation Trust

Cyber Attack Report

Introduction

This report relates to the NHS cyber-attack which took place between 12/05/17 and 16/05/17 and the concerns that have subsequently been raised around the software patching processes in use within the IT Department. In summary the Trust was not affected by the cyber-attack but found it necessary to patch over 2,500 servers and endpoint computers over the weekend of 13/05 and 14/05 using a Microsoft patch that had been released on 28/03/17. As a result questions have been raised as to why this patch had not been applied prior to the cyber-attack.

Security Advice

The Trust has contacts with two primary vendors who provide security advice. The first is FourSys Limited who supply the Trust Security Software, including anti-virus from an international vendor called Sophos. The second is Dark Trace who provide information about security risks that are either anticipated or are known to have arrived across the Internet. In the case of the recent NHS cyber-attack early warning was received from FourSys which allowed the IT department to react and so prevent the Trust from being affected.

Level of Threat

The Trust routinely deals with around 400 computer viruses every quarter. In a year we receive over 2 million e-mails of which some 50,000 are blocked as being suspicious. New threats including ransom ware, zero day attacks and virus are routinely e-mailed to Trust staff and we are heavily reliant on staff being aware, not auctioning such e-mail and alerting IT.

As a result new staff induction, all junior doctors handovers and regular training sessions are held to inform staff of the risk and advise on how best to proceed should such an e-mail be received. Indeed the need to constantly remind staff of the risks is paramount in keeping the Trust computers and data safe.

Current Patching Cycle

At this time the Trust stores all of its computer user and device information in a software product called Microsoft Active Directory (MS AD). The release we are using is the 2003 version which is now a legacy product. We need to remain on MS AD 2003 as currently we have some 21 servers that run the Windows 2003 Server operating system. These 21 servers provide the following applications to the Trust:

- Data Warehouse (Old)
- Electronic Document Management (Evolve)
- Electronic Mail (Exchange)
- Operating Theatre (Opera)
- Remote Access

Each of these applications comprises at least two servers, one being the live system and the second a backup server that is also used for testing. All of these servers are running legacy versions of the application software.

It is Microsoft policy to issue patches for the current release of Active Directory (2016) and for the two prior releases (2012 and 2008). As we continue to run MS AD 2003 routine patches are no longer designed for our Windows 2003 servers. Therefore every time a patch is released the IT Department has to install the new patch on the test server and run the application to ensure that the patch does not bring down the system. Whilst this is a standard approach across all industries the level of testing required at WSH is high due to the number of legacy servers and applications that we continue to use and so the current patching cycle is around two months in duration. Indeed of note is that the cyber-attack patch was due to be rolled out two weeks after the attack occurred.

Infrastructure Investment Plan

In January 2017 a full stock take was undertaken in IT which highlighted the need for immediate infrastructure investment to address a range of issues. As a direct result of the IT stock take business cases for investment have already been raised and approved for Electronic Mail (Exchange) and Remote Access and so upgrades to these are now work in progress.

A business case for the upgrade of Electronic Document Management (Evolve) is currently being prepared and IT is working with the Opera supplier as we believe that the current version of our Operating Theatre application will run successfully on a Windows 2008R2 server. The Trust would prefer not to upgrade to the latest version of Opera as the cost is over £100K and as part of the e-Care programme Anaesthetics and Theatres are expect to transfer to our EPR. Finally the old Data Warehouse is coming to the end of its life and so can be decommissioned later this year.

Once IT has migrated all of the Windows 2003 servers to Windows 2008R2, the Active Directory can be updated to MS 2008.

Cyber Protection

Outside the planned upgrade to MS AD and Windows server, the IT department has also initiated a programme of updates specifically aimed at improving our security protection level. At the heart of this is a new very advanced firewall solution which was recently approved at Trust Board. This will work in close company with new Data Loss Protection software and Computer Security Software including anti-virus. At this time IT is also proposing to upgrade the current Computer Security Software to include a new technology called Intercept-X. This new software is specifically aimed at Zero Day and Ransom ware viruses, like the one used in the recent global cyber-attack. Once approved, this will add a further layer of protection to the overall security package.

Future Patching Cycle

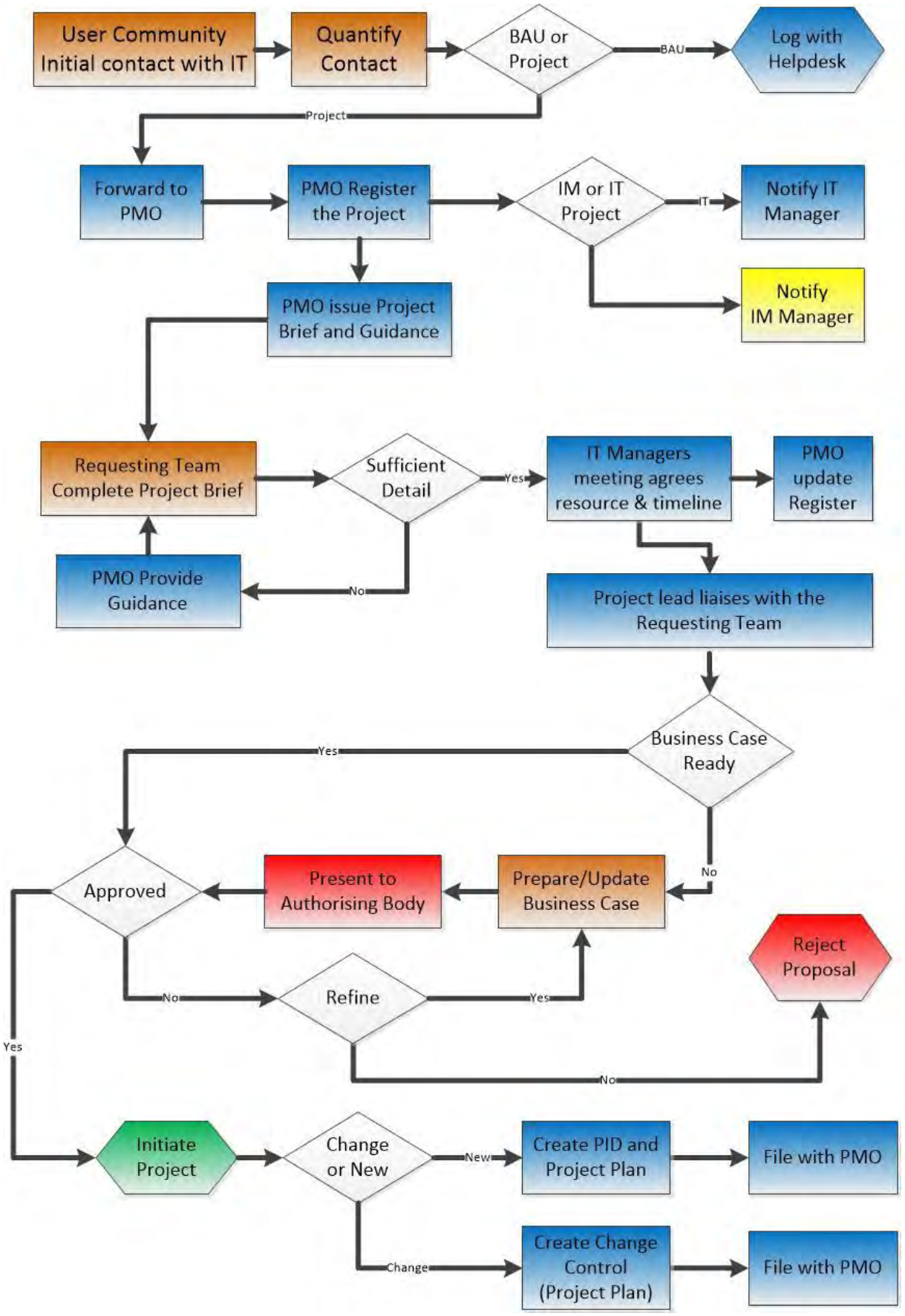
As noted the IT department are aiming to complete the migration to MS AD 2008 by no later than December 2017. This will mean that a higher percentage of patches can be applied more quickly and expect to be able to reduce the patching cycle to a six weeks turnaround. This level of turnaround time would then be considered normal in terms of industry standards.

Yet it is noted that MS AD 2008 is now the oldest base AD that is supported by Microsoft. As a result IT is already engaged with Microsoft and Trust suppliers to develop a roadmap to migrate to MS AD 2012. As

part of this IT is generating a business case to upgrade an existing legacy technical application called System Center Configuration Manager (SCCM) from Microsoft to the 2012 release. If approved the new SCCM 2012 will be fully aligned with MS AD 2012 and the value of SCCM is its ability to automate the application of software patches to servers and endpoint computers and support the latest versions of Windows Server and Windows 10 operating systems, something our current release cannot do. As noted in the introduction when the cyber-attack occurred IT had to manually check over 2500 machines and install over 500 patches and so SCCM will automate much of this currently manual process. On this basis it then should be possible to further reduce the patching cycle. However given that testing has to take place to assure critical applications are not adversely affected the likely optimum patch turnaround will be 3-4 weeks in duration. This level of turnaround would then be considered best practice in term of industry standards.

Appendix D

IM&T service Engagement



IM&T PROJECT BRIEF

The purpose of this document is to provide Information Management and Technology (IM&T) staff with an overview of any project or change work that any manager, department or division wishes to undertake. This information created in dialogue with IM&T staff and recorded in the project brief will allow the appropriate resources to be allocated to the work and a date/time agreed by both parties.

Note: *This document is a simple project brief, typically no more than 3 pages, with sufficient detail to allow the required resources at an optimum time. If you are struggling, please speak to IM&T.*

1. **Background, Title and Team**
   The first section needs to provide some background on the proposed work. Is it a new project, a change to an existing service or work to decommission an IM&T solution? To aid in communications the project brief must have a title which will be used throughout the process. It also must have a named project sponsor who has the authority to make decisions on the project. Please indicated who else is to be involved (project team) and if applicable include a named project manager, who will be prime point of contact. Please note that any project brief without a named Project Sponsor will be rejected.

2. **Mandate and Scope**
   To help assess the project brief, it needs to include information on the mandate and scope. Is it driven by a change in UK Law or NHS regulation; an NHS programme (e.g.: GDE or STP); updates to professional standards or by a Trust strategy or policy. In terms of scope, please identify what is included and what is not.

3. **Strategic/Operational Context**
   Based upon 2 above, describe how the project aligns with National, Local and/or Trust Strategy and/or Trust Business Plans. If not strategic, please provide the operational context.

4. **Objectives and Outcomes**
   Please describe the specific objectives the project is to achieve and the desired outcome(s) of the proposed work.

5. **Timescale and Key Milestones**
   Please provide details of the expected timescale and duration of the project. Please describe any key milestones and the dates at which these need to be reached.

6. **Benefits and Risks**
   Please describe the benefits that are to be gained from the project and any risks to the project that are known at this time. Wherever possible, benefits should be expressed in terms of qualative and/or quantative measures and risk in terms of impact and likelihood.

7. **Business Options and Costs**
   Please provide a summary of any options that have been considered for this project. Please advise if IM&T costs have been considered and if an overall package of funding has been allocated. If funding has been provided, please include full details (if possible in terms of both capital and revenue costs) for each option.

8. Fallback Position

Please describe the impacts on all service(s) and how they will operate if the proposal is either rejected and cannot be delivered to the timescale as outlined in section 5.

If any time you are unsure discuss with your team (please include IM&T representation)

Note: *The IM&T Programme Office (PMO) act as prime contact for all IM&T proposals. If you need help, please call or e-mail the PMO and return the completed project brief to them. Please do not contact individual members of IM&T staff directly as this will only confuse the process and may result in additional communications and possible delays in assessing your project brief.*

Appendix E

West Suffolk NHS Foundation Trust
IM&T Training Strategy

Table of Contents

Introduction

This document sets out the West Suffolk Hospital Foundation Trust IT Training Strategy for 2018 – 2021. The IT Training team works within the larger cohort of IM&T but also has close links with many departments within the Trust that have a requirement for IT Training and support.

Purpose

The purpose of the West Suffolk Hospital Foundation Trust Training Strategy is to outline how the Trust plans to support and deliver End User Training to all staff and the wider health community over the next 4 years.

Vision

West Suffolk Hospital Foundation Trust IT Training Strategy will provide a progressive, flexible, comprehensive and efficient training service in order to develop the skills, knowledge and abilities of our staff both internal and community based.

Strategic Objectives and Principles

IT Training and development for Clinical and Admin staff is vital to ensure the effective and efficient use of the IT systems and software to support improvements to the quality of services to patients. At the heart of this is e-Care which supports the wider use of an Electronic Paper Record (EPR) system. The main priority for the team is to ensure the workforce have the relevant knowledge, skills and competencies required to use existing and future clinical systems effectively.

Strategic Objectives:

1. The IT Training programme is underpinned by a Training Needs Analysis (TNA), which identifies the IT Skills gaps in all new staff to the Trust and these TNAs will be used to assess the level of training delivery required for each person and if additional support is required. This will help to support staff to use the IT systems effectively and efficiently within their roles.

2. *Microsoft Training*: IT Training uses the NHS Skills Pathway to support the training requirements of staff who may need to develop their skills using Excel, Word, Powerpoint, and Outlook. Including Basic Windows and Desktop skills. IT Training will also provide classroom training for Web and Windows for those staff not confident in using elearning.

3. Ensure that IT Training is considered integral to successful implementation and ongoing use of IT systems. Therefore it is essential that the training team are involved at an early stage of all new IT Clinical Systems within the organisation.

4. Continue to ensure that the Training delivered adds value to the Trust and that priorities are driven by the Trust Strategy and the IM&T objectives.

5. To provide an efficient and effective training management service to secure appropriate learning and development opportunities for the right people, working to the right standard.

6. Apply agreed professional and quality standards to the design, provision and evaluation of our IT Training service.

7. Engage actively with Community and additional community services to ensure that the IT Training needs of those staff are met through the provision of our IT Clinical systems.

8. Be able to demonstrate the tangible and intangible benefits derived from the investment in IT Training.

9. Continuously improve our training provision whilst ensuring costs are kept at a minimum.

10. IT Training to continue to promote more modern methods of learning to be able to deliver to a more geographically widened population within the larger health community.

11. Continue to work closely with Medical Staffing and the Post Graduate Medical Centre (PGMC) to ensure that the delivery of all Doctors Inductions are on time and the training is relevant and effective.

Benefits

The delivery of the IT Training Strategy is expected to include a number of beneficial outcomes such as:

- Supporting all new and existing staff to be able to easily access IT Training to ensure that they have the right skills and knowledge to use the IT Systems.
- Supporting operational contraints through flexible IT Training methods and liaising with Senior and Operational Managers.
- Reduction in manual recording of training intervention.
- Ensuring that IT Training can respond and adapt to short term urgent demands whilst remaining aligned with long term strategic objectives.
- Adopting and ensuring best practice covering Information security and governance processes.
- Better learner engagement from blended approach.
- Ensuring better and more accurate reporting methods.
- Supporting mobility learning.
- Ensuring that appropriate outcomes are met through continuous evaluation and feedback.

Trust Progress to Date

Traditionally at WSFT the IT Training has been very much driven by the need for classroom training as a way to also evaluate competency whilist practising in a safe training environment. We have already adopted a blended approach to our IT Training delivery but the platform used, Powerpoint, has many limitations and is no longer appropriate for easy accessibility 24/7 and many of those end users who have submitted feedback has suggested that this form of elearning is far too busy and disengaging. Progress is being made to purchase an elearning software fit for purpose to help develop this strategie's plan for a more modernised blended approach to training delivery.

Further progress has also been made in the use of the IT Clinical Skills Lab as part of the blended approach to IT Training. This Lab supports the teaching, learning and assessment of clinical staff within a simulated environment. This was used as part of the training delivery for Phase 1 in 2015 and again in Phase 2 for

Paediatrics, supporting the knowledge already learnt from the classroom sessions. This is a method that can be continued to be used for a number of other IT modules and is considered pivotal in making the IT Training more practical and relevant to the end user.

Since the introduction of our new EPR system, Doctors induction in particular August intake has seen the increase of Doctor's IT Training from 3 hours to cover a whole day over a two day period which seems to have worked well since it's inception last year. However more could be done here to increase the other Junior Doctors intake sessions throughout the year so that the same level of IT training is delivered to all Doctors regardless of when they start.

The use of agency nurses within the Trust inparticular during very busy periods such as Winter pressure has seen the training team increase their level of BAU nurse sessions for Cerner to several over the past couple of months to meet the demands of the Trust. This displays the flexibility of the team with the current staffing level but will need to be reviewed after March 2019.

Phase 2 training of Cerner also used for the first time Videos to support those staff who were unable to attend training, this proved to be quite a demanding task and with the current hosting method the training team were unable to report how many staff members viewed them and many were developed amongst a number of staff who had the time to create them, including the training team. This strategy addresses this by centralising the development of such material within the training team but will require a central Learning Management System (LMS) to administer these and collate the reports.

As a Trust we have also used elearning and the videos to train our short term Locums. There is a Locum spreadsheet updated by HR which the IT Training Team have access to and notifies us when they are likely to start. IT Training set up their access to the learning and they are notified straightaway if they have passed. If so a generic username and password is created for them only used by the Locum elearning so they are traceable meaning they can work straightaway. They are then advised that will expire and they must obtain their own username and password via the helpdesk. This has been in place for a while now and appears to be working well.

Progress has started towards the inception of a "Play Domain" to allow staff to be able to practise what that they have learnt once they have been trained. This is seen as a beneficial part of training delivery and engagement but more work is being done on how this will be managed by the Training team and it requires a considerable amount of build work as well as testing. This is to be regarded as work in progress. To compensate a number of drop in sessions are scheduled as part of training delivery to allow staff to come along to a dedicated training area and practise using a work book of scenarios and exercises to help inbed what they have learnt.

The Training team as well as many of the Workstream Leads has already created a library of reference material in terms of Quick Reference Guides (QRGs). This has proved to be very useful by staff but cumbersome to navigate to find the correct one quickly. Work is being undertaken by the IT Training team and communications to try and make this more user friendly ready for Phase 3 2018/2019 and for Business as Usual (BAU.)

Further to this improvement of the QRGs is the use of eCoach which is a help facility within Cerner. All staff can access this as well as QRGs it can house elearning content. More discussions need to take place with regards to using this facility as it will require some clinical input. Traditionally the upkeep of this facility is seen as an activity owned by the IT Training team. The benefits of having this is that accessibility is within Cerner as opposed to looking via the intranet.

In FY18/19 the Trust has estabalished an optimisation team, lead by our CNIO that aims to review clinical process and drive process improvement enabled through the better use of technology. The changes to workflow arising from these process improvements will need to be reflected in the various programmes of training offered to staff. Included in the optimisation team is a coaching role that will augment the training programme by re-enforcing the good practice that further reflect the instruction provided by the training team. Taking this approach we create a feedback triangle with optimisation driving improvement, training delivering the updated approach and coaching re-enforcing this in the workplace.

Trainers are also responsible for the input, testing and design of training data and material that forms the source of the Training environment for Cerner. This has proved to be very time consuming but we are working with the IT Development team to try and automate some of the repetitive tasks which will eventually reduce the time spent on having to manually enter specific information.

Organising and Resourcing

It is important to recognise that the IT Training team are already delivering a more blended approach to the training delivery provision in terms of elearning, one to one, classroom and Quick Reference Guides. However with the addition of IT Training requirements from the wider health community and the potential of more IT Clinical Systems such as SystmOne being incorporated into the Trust's IT Training programme there is a requirement to review the challenges around resources available for service delivery.

Further investment is required with regards to obtaining a more accessible and widely used elearning software so that we can continue to promote more creative methods of training for all staff to access. This is already being actively pursued and awaiting review and sign off. This would also compliment the work already being done by the Trust with regards to mobility and the demand to be able to work on the move. Many organisations are also looking at the possibility of more "Microlearning" which allows short bursts of learning on the go offering the opportunity for the learner to repetitively practise knowledge and skills and this can be through quizzes, videos, scenarios. This method would not be one used in isolation but as part of a package.

In addition to reach a wider audience the use of Webinars and Webex would also offer the opportunity to staff to be able to book onto a session that can be interactive and scheduled at certain times. These can then be recorded and accessed as part of the training resources portfolio.

There is also a need to improve the current IT Training booking system and make better leverage of the Internet so that some of the manual processes carried out can be more automated and provide a more seamless experience to the end user.

Currently there is work being carried out on the creation of a Training database bringing together all sources of learning confirmation and completion to provide a single place to quickly access and retrieve a learners IT Training record, again seen as a requirement of service improvement.

Formalisation of Training requests regardless of GDE or other IT Training projects has been implemented via a Training Request Package document. Each trainer works with the Project Lead to ascertain the Training resources required for that project, training approach and identify any Risks and Issues. This is recorded in the document and brought to weekly meetings to highlight any concerns and identify any additional resource requirements.

IT Trainers:

Currently the IT Training team consists of a Training Manager, 1 Training Administrator and 6 IT Trainers (mix of FTC, PT and FT), one of which is the Training Team Lead. These resources are to provide Training (BAU), admin support, as well as to deliver for 2018 -2019 the modules included as part of the Global Digital Exemplar site (GDE). Once GDE is complete there will be a requirement to review and agree substantive training team over the lifetime of the Strategy to help support and drive the continued optimisation programme, support Community and the growth of AVI and mobility.

Statistics now show that with Community there is approximately 4000 staff who have access to IT Clinical systems and in some cases the use of Skype for Business and Webex are on the increase. There is now the New Exchange for 2016 and new Windows 10 plus Office 365 that may well incur additional training and an increase to the current training programme we are delivering.

To avoid service incidents being raised, high quality regular training is key to the implementation of this strategy, including a number of refresher programmes.

Training rooms:

Currently there are 3 dedicated IT Training rooms with the use of a further training room shared with Workforce development. For previous and the current GDE programme there will be a requirement to obtain further rooms for training or alternative locations within departments. Beyond GDE 2.5 Training rooms are seen as suffice for continued BAU and community training. Once community training becomes more established there may be the possibility for the Trainers to also deliver the training onsite so the need for additional mobile kit, the use of a Pool car and the testing of the local infrastructure will be part of the service plan moving forward.

Clinical Skills Lab:

As mentioned previously in this strategy the inclusion of the Clinical Skills Lab with Phase 3 will improve the engagement of the Training provided and underpin what has been taught either in the classroom or through elearning.

Locations:

During FY18/19 and for the lifetime of this strategy other locations may be sought as part of the IT Training service to offer more flexibility within Community, these are to be explored.

Knowledge and Skills Transfer:

Each IT Trainer is a Subject Matter Expert (SME) in the process and training of certain IT Clinical System modules, such as Firstnet in ED, Capacity Management and Clinical Docs. The process within the team is for each member to train the others on those expert areas so that as IT Trainers they are able to deliver BAU if that Trainer is not available. The benefits of this is to be able to increase the Trainers knowledge and to have a team that can cover the requirements of the training schedule as well as transfer skills.

This appears to work well but with the increase of potential modules, Legacy systems and further community training part of the strategy is to establish a continued learning programme for the trainers so

that knowledge continues to be shared and is up to date, this may also include to introduction and expansion of a Trainers' knowledge database.

Process and Governance:

OnLine Management System (OLMs)

Within the NHS all new starters and existing staff are subject to Mandatory Training and as such all Staff have access to their Electronic Staff Record (ESR) which also shows their level of compliance with Mandatory training. The Online Management System (OLM) hosts the local e-Learning content as well as being able to book into a classroom session. The accessibility of elearning with OLM means that elearning content can be accessed remotely allowing the learner the convenience of availability 24 hours a day 365 days a year. However OLM does have it's limitations and has proved cumbersome in retrieving reports and attendance sheets. Any changes have to go via an area committee. Therefore IT training use their own booking system but as previously mentioned this is now being looked at to cater for more dynamic usage and better reporting facilities.

Accreditation of Skills and Learning:

IT Training continue to accredit learning opportunities to a nationally recognised qualification from an awarding body The Training Foundation. All IT Trainers are asked to attend the 3 Day Delivery Skills course known as the Training Activity Programme (TAPS) This course ensures that all Trainers have the same skills competency to deliver all our classroom training and will underpin our Training design and content of all our courses. This accreditation is also recognised in many NHS organisations as the preferred standard for all IT Trainers. The TAPS Delivery Skills accredititation expires after 3 years and the Trainers will then need to attend a 1 Day refresher to renew their accreditation.

It is recognised that within the next four years and with the financial challenges that the Trust is continuing to overcome that continued or further TAPs accreditation may be a challenge therefore there is a recognised need to try and ring fence costs for such training to ensure Trainer compliance.

Learner/IT Training Charter:

In order to establish a more professional approach to IT Training over the coming years and to replace the past IT Training prospectus the introduction of a Learner Charter will help to inform the Trust of the expectations from a qualified professional team and the standards to uphold as well as the expectations of all learners when they attend training.

Information Security:

In line with the Information Security Policy. The IT Department administer all of the Computer access forms. IT Training will deliver all of the appropriate training before access is given to the staff and signpost as well as inform those attending training of the use of patient data.

Assessment, Training Needs and Prioritisation:

Prioritisation:

Prioritisation is currently driven by a mixture of optimisation requirements, BAU and current GDE programme. In terms of training this means attendance at the Change Control Board (CCB), Education Strategy Group and Mandatory training steering group. Any risks or issues identified this is then escalated to the relevant Project and and Programme boards where attendance may be necessary and possible mitigation discussed.

Identifying Training Needs:

The IT Training needs of staff are identified at the following levels:

Level of Need	Responsibility of Identification
Trust Level	Iindividual completing the TNA
Group/Team	Service Manager/Line Manager/Team Lead/Individual
Individual	Individual with their Line Manager through annual appraisal

Identifying Training needs can be complex and depending on the person responsible for identifying the need can sometimes have an impact on the level of the outcome:

The Training need can come from a variety of resources such as:

- New legislation such as CQUINNs, or government policy changes.
- Feedback from community
- Requirements from Projects
- Corporate or performance driven requirements
- Team/Group or individual demands via an appraisal
- New National Programme

Approach to Collaboration/Engagement

As part of the GDE funding West Suffolk Hospital Foundation Trust is also an Exemplar site which means that other NHS Trusts such as Milton Keynes is a fast follower engaging with the Trust to learn more about how they can successfully implement their EPR programme and system.

IT Training continue to engage with the Training Team at Milton Keynes in providing Training Material, advising on Training approach, methods and Strategy and being able to offer Train the Trainer for certain

modules.This also has advantages for WSFT as we can utilise their training material to help us to adopt our approach to modules we are implementing and they already use.

The IT Training team will also continue to engage with other Trusts where site visits are part of the projects to gain some familiarisation and understanding of the training element involved in deploying additional modules within eCare. This will help to obtain added value to a learning programme and compensate for skills that are not evident in the organisation or economy of scale in delivery of a programme.

Evaluation of Learning

All our elearning, lesson plans, training materials are version numbered, date stamped and a record of sign off is given. This ensures that the learning and workflow has been clinically signed off and evaluated to the standard that should be used within the Trust.

Evaluation of Training programme:

IT Training uses online Evaluation as well as Surveys to evaluate training to clarify and substantiate the effectiveness of stated objectives, course learning experiences and course content to provide evidence of the effective transfer of learning into improved performance in the workplace. Occassionally clinical input such as for Doctors Induction also helps the team to evaluate their training delivery and content to maximise effective use of the IT Clinical system.

There is more work to be done around the evaluation process with a possible look at adopting more of the KirkPatrick four-level evaluation model as shown below which will help to clearly define the evaluation plan at the beginning of the training design process. This is used in part within IT Training but is more concentratred at Level 1 and 2.

Assumptions and Constraints

Key constraints

- Increase in BAU, community training and the potential increase in elearning will all help to drive the optimisation of performance but this can only be achieved with an agreement on a substantive training team. Without this it is likely that some of the objectives set out in this Strategy will be placed under significant pressure to deliver. This includes a process to safeguard current knowledge and experience within the team.
- IT Skills assessment not completed by some end users may result in delegates attending courses without having attended the required pre-requisite.
- Reduction in funding for TAPS accredited courses will leave trainers not TAP qualified and will undermine the Learning Charter and standards set by the Team and agreed by the Trust.
- Possible restricted access to the Clinical Skills lab as priority given to other clinical groups.
- Upgrade and upkeep of other legacy Training environments such as Aria, Evolve, and ICE need to be managed more effectively with refresher training available to the Trainers, otherwise this will impact the BAU programme if knowledge is lost.

Abbreviations

Abbreviation	Description
BAU	Business as Usual
CCB	Change Control Board
EPR	Electronic Patient record
NHS	National Health Service
OLM	Online Learning Management
QRGs	Quick Reference Guides
SME	Subject Matter Expert

Document History

Revision History

Date	Version	Description of Change	Author
08/01/2018	1.0	Document creation	Seema Moss
11/02/2018	2.0	Document Review and update	Seema Moss

Reviewers

Date	Version	Approver	Company
08/02/2018	1.0	Mike Bone	West Suffolk Hospital Foundation Trust

Approvals

Date	Version	Approver	Company

Publication/Distribution

Version	Description	Date
1.0	Initial Release	08/01/2018
2.0	Second Release	11/02/2018

22. Experience of care strategy

To APPROVE a report

Presented by Rowan Procter

Board of Directors – 25 May 2018

Agenda item:	22			
Presented by:	Rowan Procter, executive chief nurse			
Prepared by:	Cassia Nice, patient experience lead			
Date prepared:	15 May 2018			
Subject:	Experience of care strategy 2018-2021			
Purpose:		For information	X	For approval

Executive summary

At West Suffolk NHS Foundation Trust, we are proud to call ourselves a caring and compassionate organisation which puts the patient first in everything we do.

To underpin all of the fantastic work our staff do every day for our patients and their loved ones throughout the acute and community care experience, we have developed this strategy with the assistance of our patient VOICE group and patient experience committee to ensure we are focusing on issues that truly matter to our community.

Feedback tells us that many of our patients had a good experience of care, but we know we don't always get it right. We hope that by focusing our attention on our three key experiences of care elements we will continue to strive for the best:

- Feedback: listen and understand
- Engage: working together
- Improve: making changes that matter to you

Engagement in forming the strategy

VOICE were consulted at the outset of the strategy building, forming a key partner in the development of its objectives; which will be set on an annual basis outlining the coming year's priorities.

Following consultation with the patient experience committee, several alterations were made to the strategy including limiting repetition of the elements, removal of the equality impact assessment and adaptation to highlight joined-up working.

The patient experience committee and VOICE will monitor the delivery of the strategy.

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:	Patient Experience Committee						
Risk and assurance:	Failure to appropriately engage with patients and the public or learn to feedback.						
Legislation, regulatory, equality, diversity and dignity implications	NHS complaints regulations Patient and public participation in commissioning health and care guidance						
Recommendation: Approve the experience of care strategy							

NHS
West Suffolk
NHS Foundation Trust

Experience of care strategy

2018 - 2021

Contents

> We are proud to call ourselves a caring and compassionate organisation

Rowan Procter, executive chief nurse

Hello, my name is Rowan Procter. At West Suffolk NHS Foundation Trust, we are proud to call ourselves a caring and compassionate organisation which puts the patient first in everything we do

To underpin all of the fantastic work our staff do every day for our patients and their loved ones throughout the acute and community care experience, we have developed this strategy with the assistance of our patient VOICE group to ensure we are focusing on issues that truly matter to our community.

A better experience forms one of our organisation's ambitions of delivering personal care. Research has shown that a positive experience not only contributes to a more therapeutic relationship with our patients, and consequently improved clinical outcomes, but it also reduces costs. Patients have demonstrated greater self-management skills and quality of life when they report positive interactions with their care providers. There is a strong body of evidence about the links between patient experience, clinical safety and clinical effectiveness.

Encouraging improvements in patient experience has also been shown to result in greater employee satisfaction and subsequently reduces staff turnover by making their work experience a better one.

Feedback tells us that many of our patients had a good experience of care, but we know we don't always get it right. We hope that by focusing our attention on our three key experience of care elements we will continue to strive for the best.

Rowan

Why engagement matters

Engagement is about enabling people to voice their views, needs and wishes, and to contribute to plans, proposals and decisions about services.

Effective engagement enhances services and care, improves health outcomes, strengthens public accountability and supports the Trust's reputation. With assessments of quality, and potential financial incentives, also linked to patient experience, there is a compelling case for investing the time, effort and energy into effective engagement.

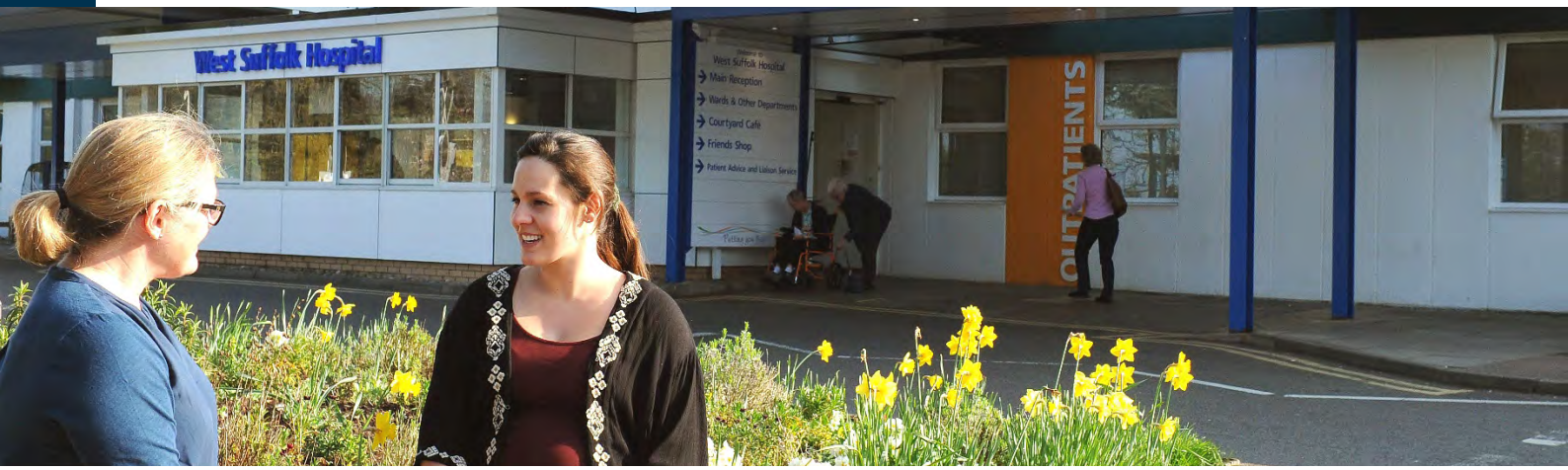
Conversely, as starkly illustrated by the Francis Inquiry into events at Mid Staffordshire Hospitals NHS Trust, when the NHS does not take account of the views of patients, carers and staff, the consequences can be very serious.

Consultation and engagement is built into the NHS Constitution:

> **Principle 4 of the NHS Constitution:** *'The patient will be at the heart of everything the NHS does.'*
>
> *'Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.'*

Section 242 of the NHS Act 2006 also covers public involvement and consultation for foundation trusts:

> *'Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in—*
>
> *(a) 'the planning of the provision of those services,*
>
> *(b) 'the development and consideration of proposals for changes in the way those services are provided, and*
>
> *(c) 'decisions to be made by that body affecting the operation of those services.'*
>
> **Section 242 of the NHS Act 2006**



The Trust has committed in its ambitions to deliver 'personal care' to its community, and its overarching value is 'putting you first'. There are many ways in which the Trust involves staff, patients, carers and members of the public in its work. But there is more it could do to ensure these voices are truly at the centre of its everyday business and decision-making – including the design and delivery of services.

In this Experience of Care Strategy, we will lay out our commitment to regular, high-quality engagement, and our intentions for embedding this into our culture at the Trust.

Our experience of care cycle

To truly engage with people and improve experience of care, we intend to implement an experience of care cycle, made up of three elements:

Element one – Feedback: listen and understand

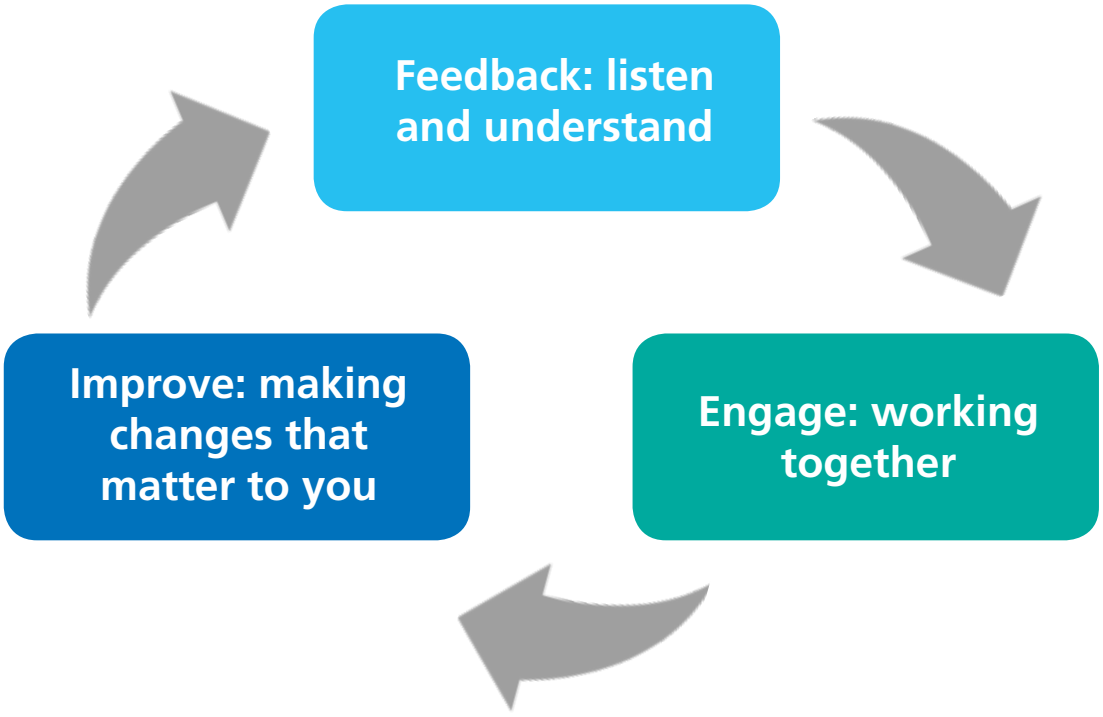
Element two – Engage: working together

Element three – Improve: making changes that matter to you

This cycle ensures that:

- We are effectively collecting the views and feedback of our patients, their loved ones and members of the public
- We are involving people in decisions about the services we provide or matters that affect them
- We use the intelligence we have collected to make changes that are most important to them
- We demonstrate that we have listened and value their input by publicising the changes we have made as a result of their feedback and engagement.

The first element of the cycle (feedback) therefore features as the first step of the cycle, and also the final step of the previous cycle; ensuring we provide feedback at the end of each project to communicate its outcomes and the impact it has had.



The experience of care cycle.

Our values

The Experience of Care Strategy is a vital driver in meeting the first of our seven rust ambitions: deliver personal care.

The three elements and their associated aims laid out in this document will support a full cycle of patient, staff, visitor, family carer and relative involvement throughout every step of the patient pathway; ensuring the patient experience is the best it can be, and that everyone has a voice in shaping our services.

The Trust's vision, priorities and ambitions

1. Feedback: listen and understand

What we want to do

- **Support multiple methods for patients, visitors, family carers and loved ones to provide feedback about their experiences of our services**
- **Support staff, volunteers and local partners to develop feedback initiatives**

Why we want to do it

Allowing people the opportunity to give their views on care and services is the first step to enabling quality improvement. Without intelligence from people receiving care, we are less likely to make decisions that are truly patient-focused.

Similarly, our staff can be true advocates of our service, and are often the people who know first what is going well, and what can be improved. Encouraging staff feedback helps to embed a culture of honesty, openness and enhances both patient safety and innovation.

How we will do it

Many feedback resources are already available to us both locally and nationally. We will continue to develop the wide variety of feedback options available to our patients, staff and community by rolling out feedback stations, mystery shopper and area observation programmes, and further developing the ability for staff to make suggestions about patient experience quality improvements.

The varieties of methods we use include those outlined below:

Feedback collection methods

2. Engage: working together

What we want to do

- **Engage with patients and the public in order to obtain their views, needs and wishes about services**
- **Involve staff, patients and the public in contributing to plans, proposals and decisions about services**

Why we want to do it

Effectively communicating and engaging with patients will help us to assess whether services are meeting patient needs, in terms of access, quality of experience and health outcomes. Involving patients in their care and treatment improves their health outcomes, boosts their satisfaction with services and can, in some cases, help to bring significant cost reductions

Recent research studies also show how good staff engagement can positively impact on the quality of service provision. It is also associated with patient satisfaction, as staff gain valuable insights into ways in which the services can be more responsive. The more engaged staff members are, the better the workplace environment, enabling staff to thrive and better the outcomes for patients and the organisation generally.

How we will do it

Vision, opportunity, insight, challenge, empower (VOICE)

VOICE will become a group of patient, public and family carer representatives, who volunteer their time to help us make improvements to our service.

Passionate about healthcare, VOICE members will make a positive contribution to our community and assist our workforce. They will represent the patient, public and family carer voice in contributing to decisions about service changes and developments, including connecting with minority groups and existing community associations.

VOICE will conduct and assist with quality improvement projects across the organisation, and help us obtaining feedback from our patients and local community in order to understand what matters most to them.

Members will volunteer within specific areas or services across the organisation, building relationships with staff in order to offer valuable on-going support. They will also have the ability to escalate concerns or additional support that clinical areas may need via the VOICE group, which feeds into the Trust's Patient and Carer Experience Group, chaired by heads of nursing.

For information about accessing VOICE, please refer to appendix B.

VOICE
Vision
Opportunity
Insight
Challenge
Empower

Council of Governors

Our Council of Governors work closely with our Foundation Trust members, the local community and staff in order to hold the Board of Directors to account.

The Governors will conduct sessions in the Courtyard Cafe to collect feedback from our patients and visitors about their experience of our services, and will meet with VOICE on an annual basis to coordinate their intelligence.

Experience of care feedback week

A week-long event will be held every year, to promote the organisation and its services but also collect feedback and suggestions from our patients and community. Each week will have a specific theme, which can be influenced by th current needs of the organisations, or following trends identified throughout the yea .

healthwatch Suffolk

Healthwatch Suffolk

Our community development officer will continue to conduct regular feedback sessions across the organisation and will, as a valued member of our quarterly patient and carer experience group, discuss the feedback Healthwatch Suffolk have received about the services we deliver as well as feature as a member of our equality and diversity group.

WSFT is a member of the regional complaints managers' forum and patient experience forum, both chaired by Healthwatch Suffolk.

We aim to build on these established links with Healthwatch Suffolk in order to form a more cohesive partnership in improving the care of people in Suffolk.

Suffolk Family Carers

With family carer support workers working in both our early intervention team (supporting patients and family carers with their health at home following an admission to hospital) and across our inpatient wards, we hugely value the support provided by Suffolk Family Carers.

We were recently awarded a family carer friendly award by this organisation and continue to strive towards improving the family carer experience by involving them every step of the way.

Suffolk Family Carers
Living Fuller Lives

Staff and volunteers

We will continue to regularly promote the various ways in which staff can give their feedback and make improvements, including: Freedom to Improve, Freedom to Speak Up, incident reporting on Datix, staff Friends and Family test and NHS Staff Survey results, Core Brief, health and wellbeing staff group, and staff suggestion boxes. We will acknowledge and act on feedback quickly and efficientl .

Proactive engagement and consultation in service changes

If the Trust is making a material change to its services that will impact on how people access those services, or their experience of them, we will engage and involve patients and staff as far as possible before a decision has been made.

The scale of the change, and the number of people it will affect, will dictate whether formal consultation or more informal engagement is required.

Assessing the benefits of patient and public participation, and the legal duty to involve, the Trust will always consider the benefits of involving the public in its work and seek to take account of feedback.

If formal consultation is required, the Trust will follow the principles outlined in Appendix C. Examples of circumstances in which the legal duty to involve would likely arise:

- The relocation of a service from one location to another, e.g. moving a service from a community outreach location to the hospital
- Reduction in service being provided, e.g. making a clinic available once a month instead of once a week
- The permanent closure of a service or clinic
- The investment in a new service or clinic
- Service reconfiguration

Engagement and consultation methods could include, but are not limited to: focus groups; news releases to print, TV and radio media; information and feedback pages on our website; intranet information; email; social media; newsletters; internal communications channels (Green Sheet, Staff Briefing, Core Brief); drop in surgeries; exhibitions; letters; surveys and questionnaires; public interest groups; events; leaflet drops

The range and extent of methods used will be chosen and targeted dependant on the scale of the engagement, and target audiences.

WSFT is committed to providing inclusive care. To comply with the Equality Act 2010, equality impact assessments should be undertaken for every project or service development proposal. As part of your assessment you should consider whether your proposals have any influence on any of the equality strands in relation to promoting equality, eliminating discrimination and achieving equality.

3. Improve: making changes that matter to you

What we want to do

- **Utilise the feedback provided in order to drive the changes that matter to our patients and the public most**
- **Develop initiatives to improve the patient experience**
- **Report on and publicise outcomes of feedback and involvement**

Why we want to do it

Collection of feedback and involving our patients, the public and the local community is vital in truly improving the patient experience.

The NHS is an organisation which every person uses at some stage in their life, so it is extremely important that we give everybody an opportunity to offer their feedback, suggestions or assistance with changes and developments. We cannot improve the experience of our patients or their relatives without first listening to them and allowing them to opportunity to work with us to shape a better WSFT.

This is where the third element of the Experience of Care strategy is brought into play. Having collected feedback from our patients and involved them our work, we must then ensure we have acted on their involvement and evidence how this has made a difference.

How we will do it

Our robust governance and assurance structure, shown in Appendix B, will ensure that feedback is captured, collated, and shared. Actions arising from engagement work or feedback given will be monitored, and responsibility allocated, to ensure completion.

It is essential that we then communicate the vital part our patients and public have played in the way we have developed or improved services; from large scale proposals to small team-based projects. Not only will this inform our

patients and public of the importance of their roles, it will allow us to make improvements that matter most, resulting in a truly improved patient experience.

In order to do this, we will:

- Publicise the results of feedback we have received, both to staff and to the community
- Publicise what we have changed as a result of the feedback
- Raise awareness of current patient experience improvement projects and their outcomes
- Ensure our patients, the public and the community are involved at every stage, and from the outset
- Restart the Experience of Care cycle, obtaining feedback on whether the project has had the desired outcome: improved experience of care. The first element features as both the first step i a new cycle and also the final step of the previous cycle

For details of our yearly objectives, please refer to appendix A.

Glossary

Area observations	Members of our VOICE group or staff who have expressed an interest in observing an area of the organisation. The manager of the area will be briefed and feedback provided following the observation. They will be provided with a discreet form to assist them with observing the area to ensure it is patient-friendly and staff are professional. These will normally last a maximum of 45 minutes.
Community associations	Groups of people who meet in the community either to build on or improve their community or for another shared purpose. For example, a faith group.
Courtyard Café sessions	The Council of Governors conduct monthly feedback sessions in the Courtyard Café, within West Suffolk Hospital. They will speak with patients and visitors in the café to obtain their feedback about their experience as well as promote Foundation Trust membership.
CQC - Care Quality Commission	The independent regulator of health and adult social care in England. The CQC ensure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.
Environmental walkabouts	The walkabouts begin by visiting Main Reception and meeting with the Voluntary Services Manager to discuss any issues, as this is a 'high traffic area. This is followed by a visit to one or two departments, by prior arrangement with the department manager. To look at general public areas (waiting rooms, corridors, courtyards) to support the department managers in ensuring that the Trust's corporate identity and values are represented accurately, including clear and accurate signage.
Feedback stations	Stations will be positioned around the organisation to allow patients and members of the public to provide feedback about their experience. The stations will also publicise feedback already received.
Foundation Trust	Foundation Trusts are a different type of NHS organisation with a stronger local influence. They have freedom to decide locally how to meet their obligations; are accountable to local people who can become 'Foundation Trust members' or 'Foundation Trust Governors' and are authorised and monitored by an independent regulator for NHS Foundation Trusts called NHS Improvement.
Foundation Trust Governors or Council of Governors	The Council of Governors is the collective body that supports and advises the executive and non-executive directors of the Trust. It works closely with the Trust Board to make sure services are meeting the needs of the local community. The Council of Governors consists of 25 governors who gather the views of the Foundation Trust members and give them a voice at the highest level of the organisation. Governors are elected into their positions.

Friends and Family Test	The Friends and Family Test (FFT) is a national requirement whereby all NHS organisations are to ask patients whether they would recommend our services to friends or family if they required similar care or treatment. The results of this test are published in the public domain on a monthly basis, allowing patients to identify organisations which are most recommended by other patients.
Healthwatch	Healthwatch is a national independent champion for consumers and users of health and social care in England. They listen to what people like about services and what could be improved and have the power to make sure people's voices are heard by the government and those running services.
Local surveys	Local surveys refer to those that are designed and run internally for a set period of time. For example, a survey measuring the success of a project for a two month period.
Minority groups	This refers to a group of people who are fewer in numbers in comparison to the social majority. For example, there are a higher number of patients using our services that are over the age of 75 in comparison to those under 16.
Medicine for members	Talks for members and the public focused on clinical services or planned developments. These are held in different locations across our membership area with a focus on improving understanding and receiving feedback.
Mystery shoppers	Patients or relatives who have expressed an interest in acting as a 'mystery shopper' during their hospital appointment or stay. They will be provided with a discreet pack to assist them with measuring their experience of the hospital.
National CQC survey	The CQC conduct comprehensive surveys measuring patients' experiences of their care and treatment. These are usually run for a one month period on a yearly or two-yearly basis.
NHS Choices reviews	NHS Choices is the national patient and public website for the National Health Service (NHS). It provides a platform for a wide variety of information about the NHS including local services and advice about your health. NHS Choices also has a function in which patients or members of the public can submit an online review of an NHS organisation, which is referred to as NHS Choices reviews within this document.
PALS	The patient advice and liaison service (PALS) is a friendly, confidential service which is available to patients, relatives and the public. PALS can help with queries, support and any concerns they may have about facilities or services provided by WSFT.
Patches	Patches of the organisation refers to a selected collective of wards or departments.

Patient stories	A patient story is usually a story of an experience a patient or family have had of the organisation. This can be a letter, email or video which is then presented at the Trust Board meeting.
PLACE	Patient-led assessments of the care environment (PLACE) are self-assessments undertaken by teams of NHS providers and include at least 50% members of the public, known as patient assessors. These assessments focus on the environment in which the care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration and the extent to which privacy and dignity is supported.
VOICE	VOICE is the organisation's patient and public user group made up of volunteer patients, family carers and members of the public. The group work closely across the organisation to assist with projects and plans. They will obtain feedback from the public on the organisation's behalf to make sure feedback is representative of the community and the patient voice is heard.

Appendix A: year one plan

Objectives	Element 1	Element 2	Element 3
1. Build patient and public engagement into decision-making, co-production of projects and business planning procedures		✓	✓
2. Implement the 'leading with compassion' initiative whereby patients can personally thank staff members for acts of compassion, enhancing both staff and patient experience	✓	✓	
3. Roll-out of feedback stations across the organisation, improving accessibility to provide views on care	✓		
4. Developing initiatives such as mystery shoppers and involving patients in area observations to assess the experience and environment of patient areas	✓	✓	
5. Furthering our digital methods of collecting feedback	✓	✓	
6. Enabling greater patient involvement in care through the development of the e-Care patient portal		✓	
7. Developing filmed patient stories for true impact	✓		✓
8. Introducing standard 'welcome packs' across the hospital for inpatients			✓
9. Trialling video interpreting to improve the experience of non-English speaking patients			✓
10. Continue our dementia-enhancement programme:			
10.1. Improving the inpatient environment for patients with dementia			✓
10.2. Extend the memory walk			✓
10.3. Digital reminiscence therapy system to be purchased for further areas			✓
11. Open a family carers room, providing support to family carers for them to relax and recuperate in a safe and comfortable environment	✓		✓
12. Explore what additional support can be put into place for people dying at home	✓	✓	✓

Years two and three will be agreed following engagement with relevant stakeholders and approval by the Patient Experience Committee.

Both the organisation's patient and carer experience group and patient experience committees will receive a detailed action plan in line with the aforementioned objectives for monitoring and assurance purposes.

Appendix B: How to access a VOICE representative

Our VOICE group can help you to successfully embed your experience improvement initiative; ensuring patients' needs are put first whilst giving hands on assistance to alleviate the workload involved in running a project.

The level of their involvement will be agreed between you and the VOICE representative(s) and a member of the patient experience team at the outset of their involvement, to both ensure you are comfortable with the scope of the project and that the VOICE representative is able to commit the level of time needed.

Hypothetical examples of VOICE involvement are listed below:

- Project A: the senior matron team are monitoring call bell response times on their inpatient wards. They would like the VOICE representatives to assist with conducting an audit of how long patients are waiting for their call bell to be responded to.

  Once this data has been collected, the senior matrons would like assistance with:

  o Collating the data on a computer system

  o Collecting qualitative feedback from patients about the call bell response times

  o Speaking with ward staff about the issues they face that impact on call bell response times

The outcome of the findings above highlights that a new call bell system is required which has a financial implication. The senior matron team demonstrate that they have engaged with the public with quantitative and qualitative evidence from their study to support their business case.

- Project B: the estates and facilities team are planning a new café development and would like to understand our patients, relatives and visitors preferences and needs. The VOICE group can collect this on the estates and facilities team's behalf and collate this feedback as part of their planning.

- Project C: the organisation is required to comply with a new set of government guidelines. A VOICE representative is invited to the internal task and finish group to co produce the guidelines alongside staff. This enables the decisions to be truly patient-centred. It also increases the chances of potential issues being highlighted prior to implementation of the guidelines; ensuring problems are ironed out at the very early stages. Patients will bring a different perspective to the table that staff may not have considered.

How to access VOICE

Email: VOICE@wsh.nhs.uk

Telephone: 01284 713949

Please outline this information when enquiring:

- Details of what your idea or project is
- Timescale of when the project needs to be completed (if known)
- How you would like VOICE to help

We will be in touch as soon as a VOICE representative has been allocated to your project. You will be introduced and given the opportunity to get to know one another, with the primary focus of discussing your idea and how you would like them to be involved. Their involvement may develop over time as the project does.

The VOICE representative(s) will report to their quarterly VOICE meeting to discuss how the project is developing and eventually the outcome of the project including the impact it has had. This will then be publicised in line with Element three of this strategy: 'improve – making changes that matter to you'.

Appendix C: Best practice steps for when consultation is required

A joint process with the clinical commissioning group

Consultation should be undertaken in collaboration with the relevant clinical commissioning group (CCG), and/or NHS England, as the bodies that commission services.

The below details an overview of the step-by-step process the Trust and CCG should follow when undergoing, or considering, consultation and engagement:

A. The Trust to inform NHS West Suffolk Clinical Commissioning Group (WSCCG) if it believes changes need to be made to a service or services.

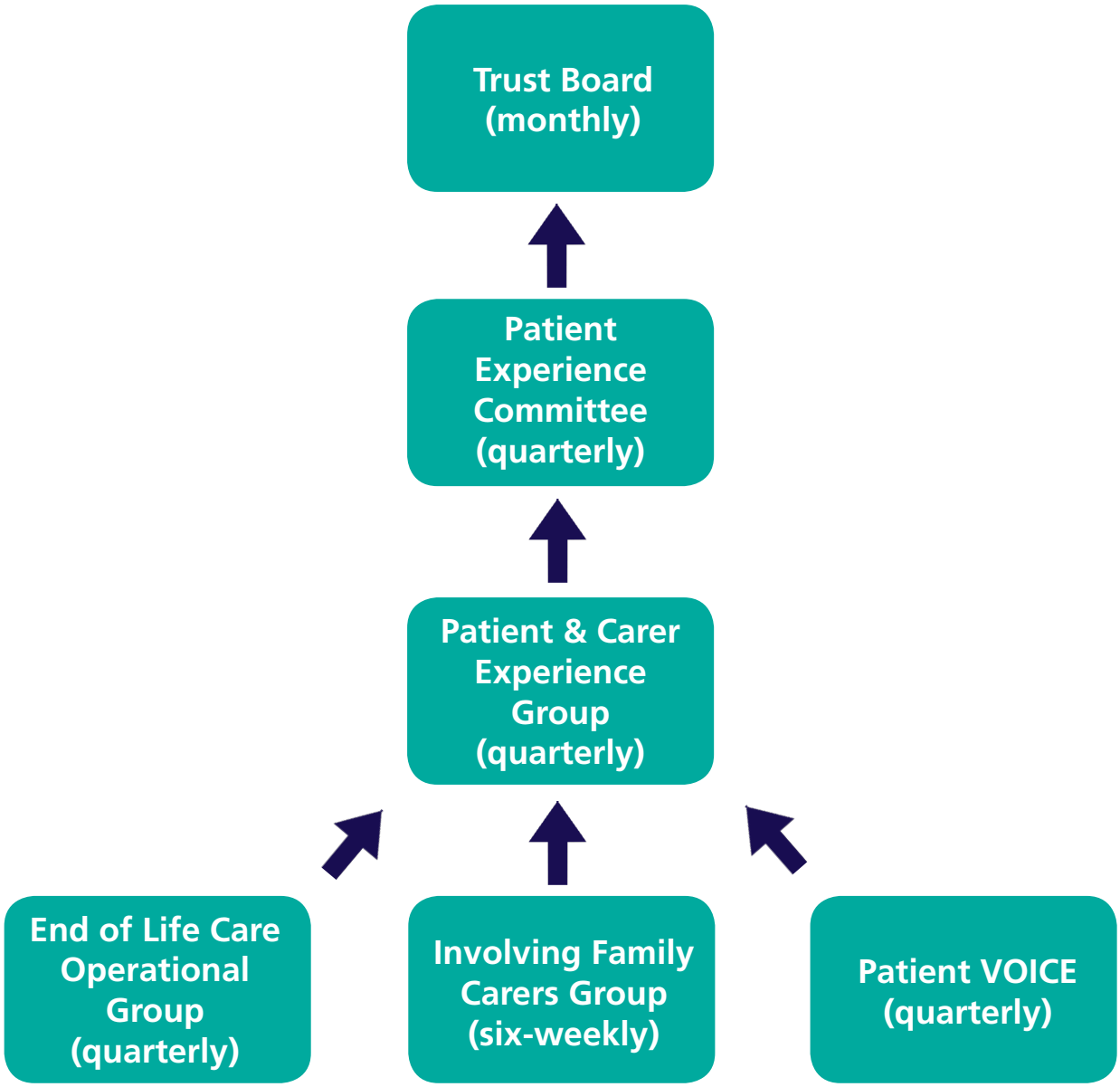
B. The CCG will work with the Trust to establish whether engagement or proportional consultation is required, and give advice and support throughout the process.

C. Proposals should be written down in a clear and concise manner, following the Government's set of consultation principles (January 2016).

D. A plan should then be developed on how comments and feedback will be collected and - vitally - how these will be considered before the decision is made. The plan should include clear timescales and describe how the Trust intends to feedback to the population.

E. A list of interested groups should be compiled. The scale of service change will dictate what groups need to be engaged with. As well as patients affected, communication with councillors, MPs, Healthwatch, Health Scrutiny Committee etc. should be completed. The West Suffolk CCG will support this.

Appendix D: Governance and assurance structure



23. Emergency preparation, resilience and response (EPRR) assurance process and annual work plan

To ACCEPT a report

Presented by Helen Beck

Board of Directors – 25th May 2018

Agenda item:	23			
Presented by:	Helen Beck			
Prepared by:	Barry Moss. Head of Emergency Preparedness, Resilience and Response (EPRR)			
Date prepared:	18th May 2018			
Subject:	Emergency Preparedness, Resilience and Response Annual Report FY17/18			
Purpose:		For information	X	For approval

Executive summary:
The Trust submits an annual return of compliance against NHS resilience core standards. Although the report covers the financial year, it is submitted in September. For FY17/18 the Trust reported 'substantial compliance' against core standards as we were deficient in 9 of the 104 assessment criteria. As a result of a comprehensive capability development programme, we have improved against all standards, meeting full compliance with 5 of the 9 deficient standards. The development of resilience capability in this Trust is now forging ahead, and we are delivering unique and dynamic capabilities as a result.

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:	Trust Executive Group
Risk and assurance:	Residual risk is reported and currently consists of 3 operational matters: Communication of, and during, lockdown; Ability to evacuate, Switchboard business continuity. Assurance is delivered by the Emergency Preparedness Team, Corporate Risk Committee, Trust Executive Group, Accountable Emergency Officer (COO) and the EPRR Non-Executive Director.
Legislation, regulatory, equality, diversity and dignity implications	Ability to be fully compliant with NHS EPRR Core Standards is determined by the analysis behind this report. Inability to meet EPRR Core Standards will result in NHS E investigation for potential non-compliance with Civil Contingency Act 2004 requirements.

Recommendation: Endorsement of this report.

FY 2017/2018 EPRR CORE STANDARDS REPORT TO THE BOARD

1. **Background**: The EPRR element of Trust Resilience is part of a systematic approach to the delivery of preparedness and mitigation for business continuity, critical or major incidents across all Trust sites and outputs, including in the Community. EPRR activity is delivered in the context of the practical bespoke application of defined outcomes addressing identified threats, hazards, consequences and impacts. This paper is presented to give a broad overview of the current EPRR situation in the Trust. NHS EPRR overview information may be found at https://www.england.nhs.uk/ourwork/eprr/.

2. **Requirement**: NHS England requires Accountable Emergency Officers (AEO – Trust Chief Operating Officer) to deliver an annual EPRR report. This is the means by which NHS England obtains assurance that NHS funded organisation are sufficiently able to response to emergencies. The requirements of the process are that organisations carry out a self-assessment against the updated core standards using the template provided, including a more detailed assessment area which for FY17/18 was focussed on Governance. The self-assessment is subjected to executive scrutiny, and then the results submitted for NHS England and Local Health Resilience Partnership review.

3. **EPRR Application at WFST:** The Trust is redeveloping EPRR in conjunction with stronger links to Security, Fire, Health & Safety and Risk, delivered through the cross-Trust Emergency Planning Team chaired by Head EPRR, and overseen by the DCOO and the ECOO (as the Accountable Emergency Officer). As of October 2017, the arrangements for WSH and West Suffolk Community fell under one methodology with a transitional plan (delivered in concert with IHT EPRR) for a cross-Trust validated arrangement.

4. **Development Process:** We have instigated a phased development plan, including a Trust-wide 3-yearly validation exercise conducted in April 2018. The root-and-branch review undertaken in mid-2017 informed a capability development plan which is currently well underway. Deliverables for FY18/19 are:

   a. Threat / Risk analysis to inform bespoke plans and planning.
   b. Construction of a Command, Control and Coordination Plan.
   c. Community resilience integration planning.
   d. Review of all tactical plans to form a new plans framework.
   e. Command, Control and Communications review to address the leadership delivery for resilience outputs, to include the provision of appropriate command infrastructure and command training.
   f. A validation programme to prove competency and identify improvements.

5. **Reporting of Achievement**: The Trust annual report for FY17/18 had to be submitted in September 2017 to account for regional and national NHS reporting amalgamation activity. This report indicated that, at that time, the Trust had achieved a 'substantial compliance' (see table overleaf) with core standards Of the 66 core standards, 32 equipment standards, and 6 points of specific focus for the FY17/18 report, the Trust was in 'full compliance' with all but 9. This grade indicated that we had judged, by very critical self-assessment, that the Trust had a number of core standards where we had work to do to meet the required outcome. By 1st April 2018, we had reached 'full compliance' in a further 5 core standards, with the remaining 4 likely to be resolved in the remainder of the FY.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant*	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

6. **Areas of Focus:** This following areas are subject to additional focus as part of the capability development plan in FY18/19:

a. Counter-CBRN capability improvement through enhanced equipment, processes, training and exercising.
b. At the Operational, Tactical and Strategic levels within the Trust, command, control and coordination (C3) requires infrastructure, process, and delivery improvement..
c. Audit of the Community sites and capabilities under this Trust's purview resulting in additional elements of capability development being added to the Trust's EPRR Strategy for rapid implementation.
d. Fundamental review and upgrade of all EPRR capability, including plans, procedures and policies to ensure that the Trust has appropriately robust and dynamic arrangements in place, and which have been rehearsed and tested to ensure a high level of competency.

7. **Summary**: This Trust takes Resilience seriously and believes that, in this age of extreme clinical pressure, no additional system hardship should be tolerated, especially that which can be dealt with by proactive planning and dynamic delivery. We assert that the progressive work programme in place will appropriately address all the core standards within a short timeframe.

8. **Recommendation:** The Board is invited to note the above report, and to endorse the statements and intent therein.

11:00 GOVERNANCE

24. Trust Executive Group report

Due to bank holidays and COO interviews no meeting was held in May

Presented by Stephen Dunn

25. Remuneration Committee report

To receive the report

Presented by Angus Eaton

Board of Directors – 25 May 2018

Agenda item:	25			
Presented by:	Angus Eaton, NED and Chair of Remuneration Committee			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	17 May 2018			
Subject:	Remuneration Committee report – 27 April 2018			
Purpose:	X	For information		For approval

Executive summary

The Committee undertook the following:

1. Reviewed the performance, remuneration and 2018-19 objectives of the Executive Directors. The committee considered the Trust's performance, individual Executive's performance, benchmarking data and the prevailing market position (including recruitment and retention of individuals) and agreed relevant remuneration changes.

   It was recognised that the benchmark of executive salaries in mid-sized trusts provides a useful base for comparison and discussion, however, it was not considered sufficiently detailed or reliable to be used as a direct determinant of salary increase or as an indication of future salary growth. As a result, it is only one of a number of considerations in considering remuneration changes, as opposed to being the determining one.

2. Reviewed and approved the schedule for future meetings.

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 Committee meets on a six-monthly basis and provides a report to the Board summarising issues discussed and any issues for escalation.
Risk and assurance:	Failure of the Board to maintain oversight of executive director responsibilities, objectives and performance.
Legislation, regulatory, equality, diversity and dignity implications	NHSI's code of governance NHSI's guidance for very senior managers
Recommendation: The Board notes the report and decisions made.	

26. Charitable Funds Committee report

To RECEIVE the report

Presented by Gary Norgate

Trust Open Board Meeting – 25th May 2018

Agenda item:	26			
Presented by:	Gary Norgate, Non-Executive Director			
Prepared by:	David Swales, Technical Accountant			
Date prepared:	21 May 2018			
Subject:	Charitable Funds Board Report			
Purpose:	X	For information		For approval

Executive summary:

The Charitable Funds Committee met on 27th April 2018. The key issues and actions discussed were:-

- The Every Heart Matters appeal stands at a total of £178k.
- There has been a lot of fund raising activity in progress and being planned and the Committee were pleased with the progress being made.
- The Committee were advised of a legacy of potentially £500k, as there was property involved it could be sometime before this was received. The legacy is for general funds.
- Work was planned to increase fund raising activity for Community Services.
- The Committee requested that further work was done to encourage fund holders to spend the money that is in their funds particularly on capital projects.
- The Committee agreed the Ethical Fundraising policy.
- The Committee agreed the Requesting Fundraising from Commercial Organisations policy.
- Following work undertaken by a subgroup of the Committee it was agreed that the Charity would invest its surplus funds of £1,150k into the CCLA Ethical Investment fund. This is a fund that is specifically aimed at the charity sector.
- A minor update to the charitable Funds policy in respect of reimbursement of charitable expenditure to staff was approved.
- The use of charitable funds to support Continuing Professional Development following the withdrawal of these funds was discussed. It was agreed that the Charity would underwrite the shortfall as some funds may be still received. The agreement would be reviewed a quarterly report and would need to be reviewed annually.

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

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	**X**	**X**	**X**	**X**	**X**	**X**
Previously considered by:	Charitable Funds Committee						
Risk and assurance:	None						
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Trust Board is asked to consider the report of the Charitable Funds Committee							

27. Use of Trust seal

To RECEIVE the report

Presented by Richard Jones

Trust Board Meeting – 25th May 2018

Agenda item:	27			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Karen McHugh, PA			
Date prepared:	May 2018			
Subject:	Use of Trust's seal			
Purpose:	X	For information		For approval

Executive summary:

To note use of the Trust Seal, pursuant to Standing Order section 8. The Trust Seal was used on the following occasions:

Seal No. 126
WSH residential accommodation design and build contract 2016 – Sealed by Craig Black and Stephen Dunn, witnessed by Richard Jones (4th May 2018)

Seal No. 127
WSH residential accommodation design and build contract 2016 – Sealed by Craig Black and Stephen Dunn, witnessed by Richard Jones (4th May 2018)

Seal No. 128
NHS Collaborative Procurement Partnership members agreement– Sealed by Craig Black and Stephen Dunn, witnessed by Kathryn McMahon (15th May 2018)

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

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

Previously considered by:	None
Risk and assurance:	None

Legislation, regulatory, equality, diversity and dignity implications	WSFT's Standing orders
Recommendation: To note the use of the Trust's seal	

28. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

Presented by Richard Jones

Board of Directors – 25 May 2018

Agenda item:	28			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	18 May 2018			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

The attached provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points.

The final agenda will be drawn-up and approved by the Chair.

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

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

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 29 June 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
Alliance and community service report	✓		Written	Matrix	DG
Integrated quality & performance report, including staff recommender score (if available)	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
2018-19 winter planning update, including ED, staffing and capacity (following Board workshop)	✓		Written	Action point	HB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nursing staffing strategy , annual review	✓		Written	Matrix	RP
Nurse staffing report	✓		Written	Matrix	RP
Medical revalidation annual report	✓		Written	Matrix	NJ
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
e-Care report	✓		Written	Matrix	CB
Estates strategy (master plan)	✓		Written	Matrix	CB
Annual licence certification report - general condition 6 and Continuity of Services condition 7	✓		Written	Matrix	RJ
Strategic update, including Alliance, System Executive Group and System Transformation Partnership (STP)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Audit Committee report	✓		Written	Matrix	ST
Council of Governors report, including Foundation Trust Membership Strategy	✓		Written	Matrix	SC
Annual governance review	✓		Written	Matrix	RJ
Scrutiny Committee report, including private physiotherapy report		✓	Written	Matrix	GN
Board assurance framework – review of new risks from operational plan		✓	Written	Matrix	RJ

Confidential staffing matters		✓	Written	Matrix – by exception	JB
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

11:15 ITEMS FOR INFORMATION

29. Any other business

To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency

Presented by Sheila Childerhouse

30. Date of next meeting

To NOTE that the next meeting will be held on Friday 29 June 2018 at 9:15 am in the Northgate Room.

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

31. The Trust Board is invited to adopt the following resolution:

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

Presented by Sheila Childerhouse